Report on the

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

Cairo, Egypt
24–26 April 2007

World Health Organization
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1. INTRODUCTION

The Seventeenth Meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was held on 24–26 April 2007 in Cairo, Egypt. The meeting was attended by: members of the Commission, Chairs of the National Certification Committees (NCC) and national programme managers of Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen; representatives of the European Regional Certification Commission and Rotary International and WHO staff from headquarters and from the Regional Office for the Eastern Mediterranean.

Dr Ali Jaffar Mohamed, Chairman, RCC opened the meeting and welcomed all the participants. He pointed out that since the RCC had begun to meet, this was the first time that reports from as many as 19 out of 22 countries in the Region had been submitted to the RCC for review. He thanked Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, for his intensive and sustained advocacy for polio eradication that was a source of inspiration for all those working for this goal.

In welcoming the participants to the meeting, Dr Hussein A. Gezairy extended a special welcome to Dr Gaafar Ibnauf Suliman and to Professor Oyewale Tomori, also a member of the African Regional Commission, who were attending as members of the RCC for the first time. Dr Gezairy pointed out that the polio eradication initiative had reached a critical stage in the Region. At a recent high-level consultation convened by the Director General of WHO, the two remaining endemic countries in the Region had once again committed themselves to assigning the highest public health priority to eradicating poliomyelitis and ensuring political support from grass roots to the highest level. In addition, the polio-free status of several countries remained either fragile or seriously threatened by the risk of importation.

Dr Gezairy stressed that at this juncture, it was critical that certification level surveillance was maintained in all countries of the Region, particularly in areas and population groups at high risk. He advised the NCCs to be critical of the quality of data presented to them and called on the Commission to further evaluate these data. He concluded by expressing his continued appreciation for the commitment of all the participants to polio eradication and wished them a productive meeting and a pleasant stay in Cairo.

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

2. CURRENT SITUATION OF POLIOMYELITIS ERADICATION

2.1 Eastern Mediterranean Region

2.1.1 Overview
Dr Faten Kamel, WHO/EMRO

In 2006, there were 107 confirmed wild polio cases in the Eastern Mediterranean Region including 71 from the two endemic countries of the Region (Pakistan 40; Afghanistan 31) and 36 from re-infected countries which had suffered outbreaks due to importations (Somalia 35; Yemen 1, with date of onset February 2006). Sudan had regained its polio-free status. By the end of 2006, circulation of the wild virus in the Region was restricted to limited areas in Pakistan and in Afghanistan. In re-infected Somalia, circulation was apparently restricted to one area. In 2007, as at 23 April, 15 cases have been reported including 7 from Pakistan and 8 from Somalia.

In Afghanistan, of the 31 cases of wild poliovirus reported in 2006, 29 were reported from the southern region and one case each from the eastern region and from the central region. The southern region (where the security situation continues to be of concern) was the only known endemic area in the country with an ongoing risk in the eastern and south-eastern region. Since November 2006 and up to 23 April 2007, no cases of wild poliovirus have been reported.

During 2006, eleven rounds of supplementary immunization activities were implemented; five rounds of NIDs and six rounds of SNIDs. Five of the subnational rounds were conducted in the south and one was essentially for border areas between Pakistan and the southern region. The reported aggregate coverage rates of supplementary immunization activities were in general very high. This was reaffirmed by independent monitors. The vaccination status of AFP cases showed that among children aged 6–23 months, 70% had received seven or more OPV doses. This rate was nearly 95% when calculated for children aged 24–59 months.

The challenging situation in Afghanistan is being addressed through a range of efforts including: advocacy to ensure political support from the highest level and active involvement of provincial and district officials; seeking days of tranquillity between fighting factions; introduction of the focused district strategy; making use of windows of opportunity and conducting one-day operations using village-based vaccination teams leading to better community involvement; use of monovalent OPV type 1 in the southern, southeastern and eastern regions; adding OPV to measles and MNT campaigns in the southern and southeastern regions and improved management at the provincial and peripheral levels through the appointment of suitable persons in suitable places.

As border areas between Afghanistan and Pakistan are considered to be one epidemiological block, several steps were taken by both countries to improve the

coordination of polio eradication activities in these areas. Steps included: joint review of micro-plans to ensure that no border areas are missed during supplementary immunization activities; synchronized vaccination campaigns ensuring that border areas are covered on the same day in both countries; establishment of permanent cross-border vaccination posts; immediate notification of AFP cases to the country of origin; and regular coordination meetings between district teams on both borders.

The situation in Pakistan was characterized in 2006 by the resurgence of type 3 virus particularly in areas where routine immunization was weak, such as in Sind and Baluchistan. The total number of cases reported from Pakistan in 2006 was 40 cases, divided equally between type 1 and type 3. In 2007, as on 23 April, seven cases had been reported of which five were due to type 3 poliovirus and two were due to type 1.

During 2006 and 2007, transmission was largely restricted to the known transmission zones. No wild poliovirus type 1 was reported from the reservoir areas in northern Sind since 2005 and from southern Punjab since July 2006. The immunity profile of the children with non-polio AFP has improved considerably, with a very small proportion of children with zero doses.

The main epidemiological characteristics of polio cases in Pakistan in 2006 and 2007 show that:

- 93% are below 36 month of age.
- Children from highly mobile or minority populations are at high risk.
- Four of every 5 cases are from families belonging to the lowest socio-economic strata.
- 60% of cases are Pashto speaking, which is an indication of a link with border areas with Afghanistan.
- 9% of cases are from families refusing vaccination of their children.
- 70% of cases had received >3 doses and 38% >7 doses (the median number of doses received by non-polio AFP cases under five years was 14).

Surveillance activities remained well above the certification standard, and the polio laboratory continued to perform at exceptionally high standard, including molecular testing of isolated viruses which is helping to identify epidemiological links between isolates and routes of transmission.

During 2006, six rounds of NIDs and six SNIDs were conducted in Pakistan. Though the quality has improved, in some zones of transmission the quality of campaigns has not yet reached the level necessary to interrupt transmission. This was mainly due to limitations on access to most of these areas and inadequate engagement of authorities at some provincial and district levels. So far, in 2007, two rounds each of NIDs and SNIDs have been implemented.

The Joint Meeting of the Technical Advisory Groups on Polio Eradication in Afghanistan and Pakistan (17–18 April 2007) considered that the second half of 2007 presented an exceptional and unprecedented opportunity for interrupting wild poliovirus in the transmission zones in both countries. The main challenges and risks were perceived as accessing children in difficult security areas and among mobile populations, improving the quality of supplementary immunization activities in poor performing areas, maintaining enthusiasm and engagement of all concerned parties and ensuring adequate resources to complete the job. The meeting recommended concentrating efforts in high-risk areas/populations, while maintaining high overall population immunity, and rapidly detecting and responding to importations into polio-free areas. It also emphasized the continuation of cross-border coordination of activities and of efforts to develop effective and sustainable routine immunization.

The importation into Somalia in July 2005 led to an explosive outbreak with the epicentre in Banadir and surrounding regions. Circulation continued in 2006 and 35 polio cases were detected, with 19% from Banadir. Most cases reported since July 2006 belonged to one area (Burao) in Togdher region of northwest Somalia (Somaliland). This area of active wild virus circulation was close to border areas with Ethiopia, representing a shared focus of transmission between the two countries.

Prior to the outbreak in July 2005, three rounds of supplementary immunization activities had been conducted in Somalia including one round using mOPVl. Since the beginning of the epidemic in July 2005, up to the present, NIDs were conducted every 6–8 weeks, mostly with mOPVl. Special mop-ups were conducted in selected areas facing security problems when there were windows of opportunity. The reported overall coverage of the supplementary immunization activities indicated high coverage rates. However, limited data from post-campaign evaluation showed significant gaps in the quality of some supplementary immunization activities, mainly because of difficulty in reaching nomadic populations and a high number of refusals in big towns. Refusals were mainly attributed to religious misconceptions, unfounded rumours and fatigue and sub-optimal performance of vaccination teams and supervisors.

All major surveillance indicators were achieved at national level during 2006. The non-polio AFP rate was 4 in 2006. The national stool adequacy rate was 83.2%. All specimens were tested at KEMRI and VACSERA network laboratories, where laboratory indicators continued to meet the recommended standards.

The situation in Somalia is complicated by the prevailing insecurity that sharply limits accessibility, the very sparse health infrastructure, poor routine immunization, the large nomadic populations and the porous borders with high population movement. These challenges are being met through intensive social mobilization, implementing special plans for nomads, focusing on areas of virus transmission, synchronization of supplementary immunization activities with neighbouring countries and conducting special mop-ups in insecure areas.

The devastating epidemic in Yemen, following the introduction of wild poliovirus from Sudan in 2005, has come to a stop. The last case was reported on 2 February 2006 after a gap of almost 3 months with no cases. In response to this case, two campaigns planned to be of mop-up quality targeting 2.8 million children were conducted in April and May 2006. Independent monitoring of supplementary immunization rounds confirmed overall coverage more than 95%. However it was less than 90% in 31 out of 123 districts covered in the mop-up rounds.

In 2006, the national non-polio AFP rate is 2.51 per 100 000 children under 15 years with stool adequacy rate of 85.4%. However, at sub-national level some governorates had either an AFP detection rate lower than 2 per 100 000 population or stool adequacy less than 80%.

The TAG of Yemen met in June 2006 and emphasized the high priority of strengthening routine immunization and AFP surveillance. The main risks to the programme were identified as inadequate surveillance and low routine coverage in some high-risk areas and the risk of importation due to arrival of immigrants from Somalia, where there is still ongoing poliovirus transmission.

Coordination between countries of the region and these in other regions continued such as in the Horn of Africa and in Operation MECACAR. Coordination in the Horn of Africa is ongoing through contact between the staff, issuance of Horn of Africa Bulletins and holding meetings of the Horn of Africa Technical Advisory Group.

Polio-free countries of the Region have in general maintained certification standard surveillance. Regular AFP surveillance reviews are being carried out in polio-free countries to ensure that the quality of surveillance is maintained. So far in 2007, such reviews were carried out in Djibouti, Iraq, Jordan, Morocco and Tunisia.

The regional priorities for 2007 include: 1) interruption of transmission in the remaining endemic countries and in Somalia as soon as possible through conduct of high quality supplementary immunization activities focusing on endemic areas; 2) maintenance of surveillance of certification standard; 3) avoidance of immunity gaps in polio free countries; 4) coordination of activities between neighbouring countries specially in Horn of Africa; 5) completion of phase 1 of laboratory containment in polio-free countries; 6) optimization of collaboration between the poliomyelitis eradication and EPI programmes; and 7) securing funding.

2.1.2 Polio laboratory network

Dr Humayun Asghar, WHO/EMRO

The twelve network laboratories, including four regional reference laboratories (RRL), were fully accredited during 2006 with the exception of the RRL, Kuwait, which remained provisionally accredited. The network laboratories processed 23 784

specimens during 2006. The technical capacities of the laboratories have continued to develop and the indicators of performance of all the network laboratories continue to be up to standard. During 2006, a timely report was provided within 28 days in 99% of cases and the results of ITD were available within 14 days in 97% of cases. So far in 2007, the two reports have been provided within the stipulated period in 100% of cases.

The new algorithm successfully implemented in the RRL in Pakistan is being gradually introduced in other network laboratories. This has further shortened the reporting time for wild poliovirus.

Environmental monitoring continued in Egypt. None of the 492 samples collected from the 33 sites in 2006 and 129 samples in 2007 were positive for wild viruses. One additional site in the Red Sea was selected for collection of samples in 2007. Other achievements of the network include the designing of new LABIFA software and its pilot testing in 8 network laboratories. The staff of the polio and the measles laboratories in most of the countries of the Region have begun to work together.

2.2 African Region

Professor Oyewale Tomori, Member African Regional Certification Commission

During 2006, a total 1190 cases of wild poliovirus were reported from nine countries in the African Region (Angola, Cameroon, Chad, Democratic Republic of Congo, Ethiopia, Kenya, Namibia, Nigeria and Niger) with by far the largest number of cases (1124) being reported from Nigeria. Three epidemiological areas of wild poliovirus circulation were noted in 2006. One involved Nigeria, Niger, Cameroon and Chad, with multiple importations from Nigeria. The other consisted of Ethiopia, Kenya and Somalia, with original importation from Somalia into Ethiopia and Kenya. The third area comprised Angola, Democratic Republic of Congo and Namibia, with original importation from India into Angola in 2005 and subsequent multiple importations from Angola into the Democratic Republic of Congo and Namibia. During 2007, as of 18 April, 69 cases had been confirmed in 3 countries: Nigeria (55), Democratic Republic of Congo (11) and Niger (3). For the same period in 2006, 463 cases occurred in Nigeria.

Following the introduction of mOPV1 and immunization plus days (IPDs) in Nigeria in 2006, only 14 of the 33 clusters of wild poliovirus type 1 detected during 2004–2005 were still circulating in 2006. By late 2006, 7 out of the 14 clusters had not been detected. Regarding type 3, at the end of November 2006, 13 out of the 16 clusters detected earlier were still circulating.

As coverage with routine immunization continues to be lower than 80% in nearly all the Member States of the African Region, the eradication strategy has continued to rely heavily on supplementary immunization activities. The non-polio AFP rate was at least 2 in the majority of countries, with only a few reporting rates

less than 1 per 100 000 children below 15 years of age. So far, the RCC for Africa has accepted national documents for certification from 15 countries. Reports from 6 others will be submitted for review during 2007.

Persistent low population immunity in several states in northern Nigeria and the weak national health systems are among the major constraints in the fight against polio. Due to strict IATA regulations, difficulties are also encountered in shipping of specimens across countries.

The main priorities for 2007 are interrupting transmission in Nigeria and ensuring high quality supplementary immunization activities in high-risk countries and in those with importations, achieving and/or sustaining certification level AFP surveillance at subnational level and implementation of the accelerated diagnostic algorithm in all of the 16 national polio laboratories.

Cooperation between the African and Eastern Mediterranean regions has been excellent, particularly the provision of technical experts to assist in the preparation for and monitor campaigns in Nigeria. The Regional Office for the Eastern Mediterranean also provided support with regard to the issuance and translation of religious statements to counter the unfounded rumours in Nigeria and organized a visit of Nigerian religious leaders to the Regional Office in Cairo.

2.3 European Region

Professor Adolf Windorfer, Member European Regional Certification Commission

Following regional certification in June 2002, the European Region has remained polio free. According to the latest data (WHO/UNICEF joint reporting form, 2005) coverage with full doses of polio vaccine (OPV or IPV or combinations) has been maintained at 80% or above in nearly all the Member States. During 2006, two rounds of SNIDs were implemented each in the Russian Federation and in Uzbekistan and additional rounds are planned for 2007 for these two countries as well as for Tajikistan and Turkministan.

There was considerable variation in the non-polio AFP rates between and within the 53 Member States of the European Region. The polio laboratory network, comprising 48 laboratories in 37 countries and supervised by 7 global specialized and regional reference laboratories, has continued to function optimally with all the laboratories being accredited during 2006. About 4000 samples from cases of AFP and contacts were processed by the network during 2006.

A regional report on phase 1 containment activities was submitted to the European RCC at its last (19th) meeting held in early June 2006 and was officially accepted as documenting completion of phase 1 of laboratory containment. During 2007, the accuracy and completeness of national records will be verified and destruction of low value wild poliovirus material initiated. Steps will be taken to

ensure mechanisms for maintenance and update of national inventories and to prepare Member States to adopt long-term OPV cessation policies and regulations.

The strength of the polio eradication programme is waning, as shown by a reduction in the financial resources allocated for sustaining a polio-free Europe (US$ 1.45 million in 2006–2007 as compared to US$ 1.73 million in 2004–2005) and a diminution in the political commitment of Member States. Programme data suggest that the quality of AFP surveillance has been slowly declining since 2002 in the presence of significant high-risk subpopulations and underserved areas. The European RCC at its last meeting in June 2006 was greatly concerned that in spite of the progress achieved globally, the risk of importation of wild poliovirus remained high in all Member States and the risk for transmission after importation may be increasing in some countries such as Bosnia and Herzegovina, Greece, southeastern Turkey and Tajikistan.

2.4 South-East Asia Region

Dr N.K. Shah, Chairman of International Commission for Certification for Poliomyelitis Eradication (ICCPE) for South East Asia

India remains the only endemic country in the South-East Asia Region. The total number of wild poliovirus cases reported in 2006 in India was 674 (646 type 1 and 28 type 3) from 114 districts. In 2007, up to 16 April, 31 cases (21 P1 and 10 P3) have been reported from 24 districts.

During 2006, importations of wild poliovirus type 1 took place in Bangladesh, Indonesia and Nepal. In Indonesia, the outbreak resulting from the imported P1 virus occurred concomitantly with the cVDPV outbreak. In Bangladesh, 18 cases (all P1) were reported in 2006 involving 12 districts. No case has been reported since 22 November 2006, the date of onset of the last case. In Nepal, five cases (all P1) were recorded involving 4 districts, with the last case with date of onset of 22 December 2006. A case of cVDPV was recorded in Mandalay province of Myanmar and seven contacts had tested positive. More recently, a case of wild poliovirus type 1 was reported from Maungdaw district, Rakhine province, Myanmar, with date of onset 9 March 2007. The results of genetic sequencing are pending. However, it is likely that this was an importation from Bangladesh, just across the border in Chittagong district where there were cases of P1 in 2006.

On a regional basis, the quality of surveillance for AFP cases continues to remain above the certification standard. Since 2005, the target for non-polio AFP rate in the region is 2 cases per 100 000 children under the age of 15 years. However, there are some gaps at the subnational level, especially in the polio-free countries. Laboratory surveys for containment of wild poliovirus and potentially infectious materials have been completed in 9 out of 11 countries in the region and reports submitted to the Regional Office for Europe. The survey is ongoing in one country and has not started in another. Out of 10 534 laboratories surveyed so far, 17 were storing potentially infectious material and 6 had stores of wild poliovirus.

National documentation for certification of all countries in the region except India and Timor-Leste has been accepted by the ICCPE, and countries are regularly submitting annual updates.

An assessment was carried out of the risk of polio circulation being established following an introduction of wild poliovirus. The following criteria were used for assessing risk:

- coverage with routine immunization; whether or not supplementary immunization activities were conducted recently;
- immunity gap in the population under 5 years: OPV coverage status;
- quality of AFP surveillance;
- population distribution and density and population movement within the country; travel to and geographical proximity of polio infected countries and
- effects of civil unrest or recent natural disasters. Countries were judged as having a high probability of widespread circulation, or a medium possibility of circulation in a limited area or a low possibility of any circulation following an introduction of wild poliovirus.

The regional priorities for the coming year are to interrupt transmission in India, ensure that transmission has stopped in Bangladesh, consolidate cessation of the outbreak in Indonesia and prevent further cross-border transmission and spread in Bangladesh and Nepal. Efforts will continue to strengthen and maintain certification-standard AFP surveillance and routine immunization in all countries.

2.5 Global overview

Dr Rudi Tangermann, WHO/HQ

A Global Polio Stakeholder Consultation was convened by Dr Margaret Chan, WHO Director-General, at the end of February 2007. The consultation was held to examine the collective capacity of the four remaining endemic countries, partners and WHO to overcome the operational challenges to reach sufficient children in the last endemic areas and to mobilize the necessary financial resources for global eradication activities in 2007–2008. The consultation concluded that eradication was both technically and operationally feasible given some of the new ‘tactics’ for stopping transmission in each of the endemic countries such as implementing immunization plus days from both fixed sites and by mobile teams in Nigeria and closing the immunity gaps in young children in India with mOPV1 campaigns every 4 weeks. The consultation also noted that a new economic analysis had concluded that every control option cost more in cases and dollars than finishing eradication (Thompson KM, Tebbens RJ. Eradication versus control for poliomyelitis: an economic analysis. *The Lancet*, 2007, 369:1363–71.

Newly developed ‘tools’ are being introduced to expedite cessation of transmission. The new diagnostic algorithm being introduced in polio laboratory networks in the African and Eastern Mediterranean regions will be able to provide

results in nearly half the time it used to take previously. New international standards were adopted by World Health Assembly in 2006 for polio outbreak response. This has already reduced the number of cases of wild poliovirus in re-infected countries from a little over 1000 in 2005 to nearly 150 in 2006. Similarly, new standards to reduce polio exportations were adopted by the WHO's Executive Board that require full OPV immunization of travellers from infected areas. Recent scientific studies have demonstrated the protective efficacy of mOPV1 in stopping transmission in areas of persistent polio transmission such as western Uttar Pradesh in India.

The immediate priorities for polio eradication are reaching the missed children in the last remaining endemic areas in the four endemic countries, faster and better management of outbreaks, maintaining the sustained interest of the governments from the highest to the lowest political level and closing the financial gap.

It is expected that by end April 2007, a draft document outlining the case for polio eradication will be circulated to all stakeholders for their comments in preparation for a final version released at the World Health Assembly in May 2007.

2.6 Discussion

The RCC appreciated the comprehensive and informative presentations on the status of polio eradication initiative in the Eastern Mediterranean, African, European and South-East Asian regions as well as the global update. The waning strength of the polio eradication programme in the European Region and the diminishing interest of the governments in the programme, in view of competing priorities, was noted with concern. The NCCs and the national programme managers in the Eastern Mediterranean Region must remain vigilant against any slacking of eradication-related activities, especially of any gaps in surveillance for cases of AFP. Ensuring and sustaining a high level of routine immunization is of utmost importance for achieving and maintaining polio eradication in the Region. To this end, special efforts are needed to convince national governments and their partners in health development to allocate adequate resources for the promotion of routine immunization with OPV and strengthening of health systems.

All countries in the Eastern Mediterranean Region, some more than the others, continue to be at risk for importation from endemic countries. In this connection, the RCC was pleased to note the enhancement in cross-border coordination of activities and of exchange of information between AFRO and EMRO. Lack of information on programme activities in Algeria is a concern, especially in view of population movements across the border with the Libyan Arab Jamahiriya.

Clarification was provided, in response to several questions about the diagnostic criteria for VAPP and for VDPV and implications of the findings of such cases. The number of cases of VAPP reported in the Region continues to be lower than

anticipated in some countries and higher in others. It was agreed to seek the views of the Regional Technical Advisory Group for Polio (RTAG)on issues related to VAPP.

The applicability of the revised target of 2 cases of AFP per 100 000 children under the age of 15 years to all countries or only to those at high risk was also discussed. It was decided to refer this issue to the RTAG that will meet early in May 2007.

Representative from some of the polio-free countries expressed an interest in obtaining WHO's current position regarding the introduction of IPV (on its own or in combination with OPV) in their immunization. It was decided to refer this issue also to the RTAG for polio.

3. REVIEW OF NATIONAL DOCUMENTS

3.1 Review of national documentation for certification of Egypt

The RCC welcomed the national documentation for certification presented by the NCC Egypt, after the last case of wild poliovirus was detected nearly three years ago. The RCC found the submitted national documentation quite well prepared and comprehensive. A few minor points were raised by members of the RCC that will be communicated to the Chairman of the NCC and it was decided to provisionally accept the report pending submission of a revised report incorporating the amendments required by the RCC.

3.2 Re-submitted national documentation for certification of Yemen

It was recalled that following the epidemic of 2005, the last case of wild poliovirus was reported over a year ago (2 February 2006) and therefore, it was timely for the NCC Yemen to re-submit the national documentation for certification. The Commission appreciated the efforts of the national programme in stopping transmission following the outbreak in 2005 and preparing the national documentation report.

On reviewing the report, the RCC expressed its concerns about the quality of AFP surveillance in the country. It was felt that surveillance was not sufficiently sensitive and there was a disparity between the findings of the zero reporting and of active surveillance. It was also noted that the coverage with routine immunization continues to be low, and the RCC strongly recommended that the Government of Yemen give priority to ensuring high levels. In the meantime, routine immunization should be supplemented with additional immunization activities in the coming 1–2 years.

It was recommended that the NCC resubmit the document after one year with data up to the end of 2007. In the meantime, the Secretariat should arrange for an in depth AFP surveillance review.

3.3 Provisional national documentation of Somalia

The RCC noted that attempts to constitute a NCC have been severely constrained by the prevailing circumstances in the country. Therefore, as per the recommendations on the Global Certification Commission, the provisional report submitted to the RCC was prepared by WHO Somalia in consultation with UNICEF. The RCC greatly appreciated the efforts of the WHO and UNICEF in eradicating polio from the country under very difficult and dangerous circumstances and thanked the staff for presenting a comprehensive and factual situation report.

The RCC emphasized that efforts to interrupt virus circulation should include optimal coordination with neighbouring countries, especially Ethiopia. It noted that this subject would be discussed in the Horn of Africa Technical Advisory Group that will meet immediately following the RCC.

As with other endemic countries, the preparation of provisional national documentation was a good exercise for the staff. However, it should be considered as an information document at this stage.

3.4 Annual updates of Djibouti, Iraq Palestine and Sudan

Djibouti

It was noted that the quality of surveillance continued to be weak and the coverage with routine OPV low. Also, as the risk of importation from neighbouring countries is high, it was recommended that the national authorities take necessary steps to strengthen routine immunization and surveillance. In the meantime, it will be necessary to continue supplementary immunization activities in the near future. The Secretariat was requested to raise this issue at the forthcoming Technical Advisory Group for Horn of Africa and assist national authorities in seeking the resources required in this regard.

The RCC made some technical comments on the report which will be communicated to the Chair, NCC. Meanwhile it was decided to accept the report provisionally pending submission of a revised report incorporating amendments requested by the RCC.

Iraq

The RCC acknowledged with great appreciation the dedication of the staff of national programme and of the members of the NCC in their efforts to keep Iraq free of polio in the face of extremely adverse circumstances.

The RCC noted that the NCC carries out its work by dividing its membership into three groups as it was operationally difficult for the whole NCC to meet. However, it appears from the report submitted to the RCC that the work of the three groups is not closely coordinated and unified as was evident by the disparities in the executive summary and other sections of the report. The RCC also noted obstacles for the work of the polio laboratory and transport of specimens because of lack of security.

The above and other comments made by the RCC members on the report will be communicated to the Chair, NCC. Meanwhile it was decided to accept the report provisionally pending submission of a revised report incorporating amendments requested by the RCC.

Palestine

The RCC thanked the NCC and the national programme for submitting the annual update report for 2006 in face of the unsettled conditions in the country. It was noted that the surveillance is borderline. However, the coverage with routine immunization including the administration of 2 doses of IPV is high. Environmental surveillance was continuing and the weakness in the AFP surveillance was to be addressed by more efforts to raise awareness of physicians, especially at local level. Comments made by the RCC will be communicated to the Chairman, NCC. Meanwhile, it was decided to accept the report provisionally pending submission of a revised report incorporating amendments requested by the RCC.

Sudan

The RCC noted considerable improvement in the polio eradication-related indicators in the northern state of the country, but the quality of surveillance in the southern states still shows gaps. As well, routine immunization coverage is low in the south. There now seems to be a good prospect for obtaining support from GAVI for EPI-related activities in the south of Sudan. In the meantime, it is necessary to continue supplementary immunization activities. As was noted for Somalia, the ongoing coordination of activities and exchange of information with neighbouring countries should be intensified.

The RCC made some technical comments on the report which will be communicated to the Chair, NCC. Meanwhile it was decided to accept the report provisionally pending submission of a revised report incorporating amendments.

3.5 Abridged annual updates

The following abridged annual updates were submitted by those countries (Bahrain, Islamic Republic of Iran, Jordan, Oman, Qatar, Saudi Arabia and United Arab Emirates) whose final national documentation for regional certification was approved by the RCC at its 15th meeting in April 2006. During the 15th meeting, the RCC made some technical comments on some of these reports that were subsequently communicated in a letter to the respective Chairmen of NCCs with a request to take them into account in the revised versions.

Bahrain

The report was found to be clear and complete and hence it was accepted by the RCC.

Iran

The report was found to be well written. The RCC recommended that steps should be taken to improve the quality of surveillance in the provinces where the indicators have slipped as compared with the previous year.

Jordan

The report was found clear and complete and was accepted by the RCC. The RCC recommended that in view of the large number of Iraqi immigrants in the country, special attention should be paid to the immunization coverage among children of these families.

Oman

The report was found to be well prepared and complete. The RCC made a few observations including the persistent low rate of reported GBS, for which an explanation should be offered by the NCC. Under the progress reported on laboratory containment, reference to preparation for phase 2 of the global action plan should be deleted, as it is premature.

Qatar

The report was found to be complete and clear. The RCC expressed concern about the frequent changes in the in the leadership and membership of the NCC, which may affect the continuity of efforts at this critical stage of the programme.

Saudi Arabia

The report was found to be complete and clear. The RCC noted with concern that the level of routine coverage among illegal immigrants around cities like Mecca and Jeddah was not known for sure, and recommended that steps should be taken to rectify the situation in order to avoid creation of immunity gaps among such high-risk populations.

United Arab Emirates

The report was found to be complete and clear. The RCC once again noted with great concern the persistently low non-polio AFP rate over the last 3 years. This is especially worrying in view of the large number of people from the polio endemic countries who are either working in or transiting through one of the Emirates. The RCC noted the efforts of the programme in some Emirates to orient hospital staff, particularly those in the private sector, about polio eradication in general and about the need to report all cases of AFP in children under 15 years of age. The RCC recommended that these efforts be intensified in all the Emirates. This issue should be further explored during the proposed AFP surveillance reviews in five GCC countries.

3.6 Final national documentation for regional certification

Final national documentation for regional certification was submitted by Lebanon, Libyan Arab Jamahiriya, Morocco, Syrian Arab Republic and Tunisia. The RCC reviewed these reports and found them to be well prepared. It was therefore decided to accept them provisionally. However, the RCC made some comments that will be communicated to the respective National Certification Committee Chairs for their review to be fully accepted. The main comments are detailed below.

Lebanon

AFP surveillance continues to show weaknesses, and the extent of the routine coverage with OPV remains uncertain.

Libyan Arab Jamahiriya

The socioeconomic and health indicators need to be suitably amended and expressed in appropriate terms. In view of the adequate surveillance activities, the possibility of missing any importation from neighbouring countries in the south seems to be remote.

Morocco and Tunisia

In both these countries there is a need to start implementing the recommendations of the recent follow-up surveillance missions.

Syrian Arab Republic

The executive summary of the report needs to be re-written. In view of the large number of Iraqi immigrants in the country, special attention should be paid to the immunization coverage among children of these families. Cases reported as VAPP need to be reviewed with the Regional Office in line with the regional guidelines to avoid over-reporting.

4. PROGRESS OF PHASE 1 LABORATORY CONTAINMENT ACTIVITIES

Dr Humayun Asghar, WHO/EMRO

To date, 16 countries (Bahrain, Djibouti, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Libyan Arab Jamahiriya, Lebanon, Morocco, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia and United Arab Emirates) have completed national surveys of laboratories. A total of 21 858 laboratories have been surveyed so far. The survey is in progress in Palestine and is nearly complete in Egypt. Administrative preparations for undertaking the surveys are ongoing in Afghanistan, Pakistan, Somalia and Yemen.

Countries that have completed laboratory surveys were requested to submit quality assurance reports on the quality of survey and inventory. These reports were reviewed both within the Regional Office and by an external reviewer. Comments on the reports were sent to the relevant national containment coordinators for revision and submitting the reports in a final form. Final quality assurance reports have been received from 12 of the 16 countries that had completed their laboratory survey.

During the coming months, it is proposed to follow up with the countries that have not yet submitted their final quality assurance reports and with those that have not yet completed their laboratory surveys. After verification of national inventories, a regional inventory will be established that will be regularly updated. Steps will be taken to ensure that all national inventories are accurate with complete records of wild poliovirus isolates and/or potentially infectious material and to initiate preparations for phase 2 of laboratory containment, including destruction of material and upgrading of laboratories desirous of retaining infectious material, etc.

The RCC welcomed the concise and informative report and stressed that because satisfactory completion of phase 1 is a requirement in the final national document for certification, countries that have completed their surveys but have not yet submitted their final quality assurance reports should do so as soon as possible.

5. OTHER MATTERS

5.1 Integration of surveillance and laboratory services for other communicable diseases with the poliomyelitis eradication infrastructure

The RCC while reviewing the implementation of recommendations made at its 16th meeting noted that the integration of surveillance and laboratory services for other communicable diseases with poliomyelitis was not being vigorously implemented and some communicable disease control programmes were continuing to develop parallel structures for surveillance and laboratory support. The RCC once again stressed that the infrastructure developed for the poliomyelitis eradication initiative should be used for other communicable diseases without any reservations. The RCC was informed of the ongoing discussions between the polio eradication programme and programmes for control of other communicable diseases and expressed the hope that integration would be pursued with vigour both at country and regional levels.

5.2 AFP surveillance reviews

While reviewing the certification reports of Djibouti, Jordan, Iraq, Morocco and Tunisia, the RCC took into account the findings of the recent surveillance reviews that had taken place in these countries. In order to ensure that there was no slacking in the quality of AFP surveillance, particularly in the polio-free countries, the secretariat was asked to arrange for AFP surveillance reviews to be carried out during this year in GCC countries (with the exception of Saudi Arabia which had a recent review). The RCC recommended participation of some of its members in these reviews and Prof. Gaafar Ibnauf has agreed to participate.

5.3 Technical issues for discussion by the Regional Technical Advisory Group for Polio at its next meeting

The RCC noted that the following technical issues had come up repeatedly during discussion following the regional and global overviews and individual reports and recommended that the secretariat bring these issues to the attention of the regional TAG for polio at its forthcoming (fifth) meeting, to be held on 8–9 May 2007.

- *Revised target for non-polio rate*. Concerning the recommended revised target for non-polio AFP set by the ACPE at two cases per 100 000 children under the age of 15 years for endemic countries and those at high risk, clarification is needed about which countries are considered “high risk”. If this term is applicable only to a selected group of countries in the Region, the criteria for selecting these countries must be defined.

- *Vaccine-associated paralytic polio (VAPP)*. In view of the small number of cases of VAPP that have been reported so far from countries of the Region, should efforts be made to sensitize the polio staff about looking more actively

for cases of VAPP without creating a scare among the communities and compromising the achievements of the programme.

- *Introduction of IPV in the immunization schedule.* Some of the countries have already introduced IPV in their immunization schedule and others are thinking of doing so. There is a fairly urgent need to guide the countries in this connection.

- *Need for supplementary immunization activities in polio-free countries.* In view of the low coverage with routine immunization in some of the recently polio-free countries such as Djibouti, Sudan and Yemen, the RCC felt that there was a need for national authorities to consider implementing supplementary immunization activities. Certain countries that have been polio-free for longer periods but are at risk for importation such as Lebanon, Syrian Arab Republic and Saudi Arabia would also benefit from supplementary immunization activities. The frequency and the scope of the supplementary immunization activities (NIDs or SNIDs) in these countries need to be determined.

5.4 Dates and venue of the 18th meeting of the RCC

The 18th meeting of the RCC will be held in Damascus, Syrian Arab Republic on 21–22 November 2007.

Annex 1

PROGRAMME

Tuesday, 24 April 2007

08:30–09:00	Registration
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 Adoption of agenda
09:30–13:00	Present situation of polio eradication initiative Eastern Mediterranean regional overview, Dr F. Kamel, WHO/EMRO, Dr H. Asghar, WHO/EMRO African regional overview, Prof. O. Tomori, ARCC South East Asia regional overview, Dr N.K. Shah, ICCPE European regional overview, Prof. A. Winderfor, EUR RCC Global Overview, Dr R. Tangermann, WHO/HQ Discussion
13:00–15:30	Presentation and discussion of the national document of Egypt Presentation and discussion of the re-submitted national document of Yemen Presentation and discussion of the provisional national document of Somalia
15:30–17:00	Private meeting of the RCC members

Wednesday, 25 April 2007

08:30–10:30	Review of Annual Updates for 2006 of Djibouti, Sudan, Iraq and Palestine
10:30–15:00	Review of final national documentation of Lebanon, Libyan Arab Jamahiriya, Morocco, Syrian Arab Republic and Tunisia
15:00–16:00	Laboratory containment: review of quality assurance reports from countries that have completed phase 1
16:00–17:30	Private meeting of the RCC members

Thursday, 26 April 2007

08:30–12:00	Review of the abridged annual updates for 2006 of Bahrain, Islamic Republic of Iran, Jordan, Oman, Qatar, Saudi Arabia and United Arab Emirates
12:00–13:30	Private meeting of the RCC members
13:30–14:30	Closing session and concluding remarks

Annex 2

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