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Report on the

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

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CONTENTS

1. INTRODUCTION 1

2. OVERVIEW OF THE CURRENT SITUATION OF POLIO ERADICATION 2
   2.1 Eastern Mediterranean Region 2
   2.2 Overview of polio eradication activities in the WHO African Region 8
   2.3 Overview of polio eradication activities in the WHO South-East Asia Region 9
   2.4 Overview of polio eradication activities in the WHO European Region 10
   2.5 Global overview 11
   2.6 Implications of the recommendations of the Fourth Meeting of the WHO Advisory Committee on Polio Eradication (ACPE) 12
   2.7 Discussion on regional and global overviews 12

3. REVIEW OF ABRIDGED ANNUAL REPORTS FOR 2007 13

4. REVIEW OF ANNUAL REPORTS FOR 2007 14

5. REVIEW OF NATIONAL DOCUMENTS 15

6. REVIEW OF FINAL NATIONAL DOCUMENTATION FOR REGIONAL CERTIFICATION 15

7. OTHER MATTERS 16

Annexes

1. PROGRAMME 17
2. LIST OF PARTICIPANTS 19

1. INTRODUCTION

The eighteenth meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC), was held on 14–17 April 2008 in Cairo, Egypt. The meeting was attended by: members of the Commission; Chairs of the National Certification Committees (NCC) or their representatives and national programme managers of Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. The meeting was also attended by representatives of the Rotary International and Centers for Disease Control and Prevention, United States of America, and staff from WHO headquarters and the regional offices for Africa, the Eastern Mediterranean and Europe.

The meeting was opened by Dr Ali Jaffar Mohamed Sulaiman, Chairman, RCC, who welcomed all the participants. He referred to the continued progress towards polio eradication in the Region and commended the efforts of the national programmes and the role played by the NCCs in critically reviewing all elements of the programme in their respective countries.

In his address to the RCC, Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, expressed his gratitude to the members of the Commission and to the national certification committees and the staff of the national programmes in the Region for their dedication and steadfast commitment to the goal of polio eradication. He briefly highlighted some of the main achievements since the last meeting of the RCC: the decrease in the number of cases of polio both in Afghanistan and Pakistan in 2007 as compared to 2006 and the absence of any new case in Somalia since March 2007. Dr Gezairy also referred to the three targets for polio eradication set by the stakeholders in February 2007 and pointed out that the target of interrupting transmission of imported polioviruses had been achieved. However, the target of 50% reduction in the number of polio infected districts in 2007 as compared to 2006 was not fully achieved. The third target, which was to achieve at least the same level of immunity against polio among children in infected districts as that in polio free districts, was achieved in Pakistan but not in Afghanistan because of the prevailing security situation. He emphasized that a sensitive AFP surveillance system remained the cornerstone for early detection of an outbreak and/or an importation. In this respect, it was gratifying that the importation in South Darfur, Sudan, which was reported in September 2007, was detected, investigated and responded to in a timely fashion, and hence had no further spread. Finally, he urged the Chairs of the NCCs to continue their engagement with their respective national programmes with increased vigour as the Region approached certification.

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

2. OVERVIEW OF THE CURRENT SITUATION OF POLIO ERADICATION

2.1 Eastern Mediterranean Region

2.1.1 Overview
Dr Faten Kamel, WHO/EMRO

Following the intensification of polio eradication efforts, the total number of poliomyelitis cases reported during 2007 (58) was the lowest ever recorded in the Region and represented a 46% reduction as compared to cases reported in 2006 (107) and constituted less than 5% of the global cases for the year 2007.

The majority (49 cases) in 2007 were from the two endemic countries (Afghanistan and Pakistan) where there has been a restriction of intensity and extent of transmission. There were 8 cases from Somalia representing the tail end of the outbreak that followed importation of poliovirus and there was a single importation reported from Sudan with no secondary cases. In 2008, up to 14 April, 8 cases had been reported, 5 from Afghanistan and 3 from Pakistan. The recent isolation of a type 1 wild poliovirus from a 22 month old child in Akobo county, Jonglei province, southern Sudan, was being investigated at the time of the meeting of the RCC.

Afghanistan and Pakistan represent a single epidemiological block as evidenced by the epidemiological and genetic patterns of the viruses isolated from each country. The number of confirmed cases of polio in Pakistan decreased from 40 cases (20 P1 and 20 P3 virus) in 2006 reported from 22 districts to 32 cases (19 P1 and 13 P3) from 18 districts in 2007. Similarly in Afghanistan the total number of confirmed cases decreased from 31 (29 P1 and 2 P3) from 17 districts in 2006 to 17 cases (6 P1 and 11 P3) from 13 districts in 2007.

The vast majority of the population in both countries live in polio-free areas. Transmission occurs mainly in two zones as shown in Figure 1.

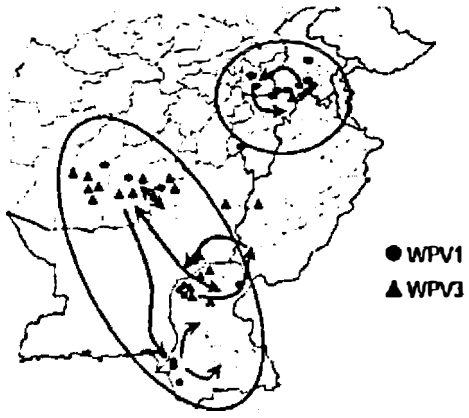

Figure 1. Wild poliovirus transmission, Afghanistan and Pakistan, 2007

The northern zone comprises most of NWFP including the tribal agencies along the border with Afghanistan and sometimes extends into the eastern region of Afghanistan where transmission is mostly due to WPV1. The southern transmission zone, which represented the principal endemic zone in 2007, includes the corridor from the southern region of Afghanistan and continues through Balochistan and southern Punjab into northern and southern Sindh including Karachi. In this zone both types 1 and 3 are present.

Both Afghanistan and Pakistan conducted large-scale house-to-house supplementary immunization activities in 2007. Pakistan implemented four national immunization days (NIDs) and 7 subnational immunization days (SNIDs) covering reservoir and high risk areas. Afghanistan also conducted 4 NIDs and 7 SNIDs in the southern region and adjacent regions along the border with Pakistan. These immunization campaigns were largely synchronized between the two countries and made increasing use of mOPV1 and mOPV3 in addition to trivalent OPV (tOPV). The reported coverage rates of these supplementary immunization activities were in general very high. However, analysis of post campaign monitoring data at the sub-district level has revealed some poorly covered Union Councils in high-risk areas. The coverage also remains suboptimal in security-compromised and hard-to-access areas in southern Afghanistan and along the border in both countries.

The continuation of virus circulation in both countries, despite the implementation of large number of supplementary immunization activities, appeared to be largely due to the difficulty in accessing children living in insecure areas with active conflict in southern Afghanistan and in tribal areas in Pakistan. In addition, the quality of immunization activities remains poor in some endemic areas in Pakistan, especially in Sindh and Balochistan. In Sindh, Karachi has a large mobile population drawn from all over Pakistan and southern Afghanistan that has the potential to spread polio more widely in both countries.

In Afghanistan, several strategies were employed to improve access and immunize children. These included coordination with the International Committee of Red Cross (ICRC) who negotiated an agreement with anti-government elements to issue a statement of support for supplementary immunization activities in their areas of influence. Other strategies employed for insecure areas were short interval additional dose, staggered campaigns and using windows of opportunities for immunizing children. Special efforts were made to access and immunize mobile populations that constantly move across the border between Afghanistan and Pakistan.

The main challenges faced by the programme in Pakistan are problems of access due to insecurity and the reluctance of conservative communities to have their children immunized. There were also managerial issues and the need for political and administrative authorities at the local level to assume ownership of the programme.

Actions being taken to meet these challenges including intensified plans for supplementary immunization activities, SNIDs in high-risk areas, rapid mop-up in response to virus isolation, special strategies for inaccessible areas, intensified social mobilization and communication activities, plans to address managerial issues and to develop and implement a special plan for Karachi in Sindh province.

In Somalia, in the absence of a central functioning government authority, the programme continues to be implemented by WHO and UNICEF. The country has remained polio free since 25 March 2007. The AFP surveillance system is well established based on a large number of national staff and reporting sites and a strong community component. All major surveillance indicators were achieved at national level during 2007. In view of the continuing risk of importation, poor routine coverage and in order to prevent building of a pool of susceptible children, supplementary immunization activities were continuing, and two rounds of NIDs were conducted in the first half of 2008 using tOPV.

Sudan continues to be at high risk of wild poliovirus importation. Two of its 9 neighbouring countries, namely Chad and Democratic Republic of Congo, are still reporting cases due to wild polioviruses and there was continuous population movement across the borders. A polio case due to an imported wild P1 was reported in September 2007 from South Darfur. Genetically this virus was linked to a case reported from Chad. In October 2007, another imported poliovirus (P1) was also isolated from a healthy child in West Darfur. Factors that prevented the spread of virus included the high immunity level of children and the large-scale high quality immunization response using mOPV1.

Overall, the AFP surveillance system in the Region continues to perform at the accepted international standard. A non-polio AFP rate of 4.19 cases per 100 000 children under 15 years was achieved in 2007 and the annualized rate for 2008 (up to 14 April) is 4.11. All endemic, re-infected or recently polio-free countries have maintained a non-polio AFP rate of at least 2 per 100 000 children under the age of 15. The minimum required level of 1 per 100 000 was reached by all individual countries in 2007 except Palestine (0.93), which has a very difficult security situation. The second key quality indicator for surveillance is percentage of AFP cases with adequate stool collection. In 2007, this indicator was maintained above the target of 80% at the regional level (90.9%) and in all countries of the Region except in Bahrain (60.0%) and Lebanon (65.2%), which had a small number of cases.

The quality of AFP surveillance in countries of the Region is periodically assessed through in depth-review missions with actual field evaluation. An account of the reviews conducted during 2007 and in 2008 is given below in section 2.1.3.

In order to maintain a high level of population immunity, supplementary immunization campaigns were implemented in a large number of countries during 2007 and are planned for 2008, including prophylactic supplementary immunization

activities in polio-free countries at risk of importation and in those with low routine coverage.

The main challenges facing the programme are the continuation of endemic wild poliovirus transmission in the shared transmission zones of Pakistan and Afghanistan and the persistent risk of importation of wild poliovirus into the region from remaining endemic countries, resulting in re-infection of polio-free countries, especially for countries in the extended Horn of Africa.

The main regional priorities for the coming year are to:

a) interrupt transmission in Afghanistan and Pakistan as soon as possible through the intensification of high quality supplementary immunization activities using monovalent vaccines;
b) address managerial issues and ensure access to children in security-compromised areas;
c) avoid large immunity gaps from developing in polio-free countries through improvement of routine immunization and implementation of supplementary immunization activities, especially in foci of low population immunity;
d) maintain certification-standard surveillance both at national and subnational levels and among high risk areas/populations; and
e) maintain and further strengthen coordination activities between neighbouring countries, especially between Afghanistan and Pakistan and in the Horn of Africa through synchronization of supplementary immunization activities, exchange of information and local level planning and coordination.

2.1.2 Polio laboratory network
Dr Humayun Asghar, WHO/EMRO

There has been a change in the nomenclature used for designating the laboratories participating in the regional poliovirus network. The national polio laboratories will henceforth be labelled as 'virus isolation laboratories (VILs)' and the regional reference laboratories will be known as 'intratypic differentiation laboratories (ITDs)'.

During 2007, all of 8 VILs and three out of the four ITD laboratories were fully accredited. The ITD laboratory in Kuwait was provisionally accredited. Since 2004, due to the epidemics in Sudan, Yemen and Somalia and with the introduction of contact sampling, the number of specimen processed by the network laboratories has increased considerably.

The new algorithm was successfully introduced in all the VIL and ITD laboratories and this has further shortened the time for reporting positive cases. The average number of days taken for processing specimen since 2005, has reduced by 50%.

The ITD laboratory in Cairo, Egypt, has also continued to process sewage samples from 34 sites all over Egypt. No wild poliovirus has been isolated since 2005.

The genetic diversity of wild polioviruses isolated from cases of poliomyelitis in Afghanistan and Pakistan has continued to shrink. In 2007, there were only two sub-clusters of type 1 and one sub-cluster of type 3 circulating in Afghanistan. A similar situation prevailed in Pakistan where three sub-clusters of type 1 and one sub-cluster of type 3 were circulating in 2007.

During 2007, two iVDPVs (a mix of P1 and P2) were detected from a case in the Islamic Republic of Iran and one P3 iVDPV was detected in Egypt.

2.1.3 AFP surveillance quality in countries of the Region
Mr Jalaa Abdelwahab, WHO/EMRO

During 2007/2008, AFP surveillance reviews were carried out in Bahrain, Djibouti, Kuwait, Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Saudi Arabia, Tunisia and United Arab Emirates.

The objectives of these reviews were to assess whether the AFP surveillance functions adequately enough to allow timely detection of any importation, to make specific recommendations on how to assure and maintain certification standard AFP surveillance and to assess preparedness for possible importation.

In several countries, members of the NCC participated as members of the field teams or were present during the debriefing session with the Ministry of Health. In addition, a member of the RCC participated in the review of AFP surveillance in some countries.

The reviews showed that in all countries reviewed there are well established surveillance systems that are staffed, especially at the central level, with qualified and committed persons. The existing systems were found to be capable of detecting cases of AFP. However, there continued to be some overlap and confusion between zero reporting and active surveillance. The collection and transport of specimens was adequate though the time taken for transport could be improved.

These reviews underlined the need for: developing capacity for AFP surveillance at more peripheral levels of health care; updating of guidelines; introducing a wider base for zero reporting; involving all hospitals that see children 15 years or younger in active surveillance and sensitization and awareness sessions at priority sites and for the private sector. The plans of action for preparedness and response to an importation need to be further refined and made more operationally oriented.

2.1.4 Progress report on laboratory containment activities in the countries of the Region
Dr Humayun Asghar, WHO/EMRO

Laboratory surveys, as part of Phase 1 of the global plan for the containment of wild poliovirus and potentially infectious material, have been completed in 18 of the 19 countries (the exception being Yemen) that are polio-free and whose national documentation has been accepted by the RCC. Fourteen of the 18 countries have also submitted a quality assurance report on the survey.

Future containment activities include follow-up with the relevant national authorities in Afghanistan and Pakistan to revise their plans for laboratory containment and in Yemen to ensure that the laboratory survey is completed. Follow-up will also be made to obtain the outstanding quality assurance reports from Djibouti, Iraq, Kuwait and Lebanon and a revised report from the Syrian Arab Republic.

2.1.5 RCC views and recommendations related to the regional overview

The RCC commended the clear and informative presentations dealing with the status of the polio eradication activities in the Region. It noted that in the epidemiological block of Afghanistan and Pakistan (the two remaining endemic countries in the Region), wild poliovirus circulation is now restricted to two zones. It also noted the coordinated eradication efforts between the two countries.

In view of the importance of maintaining a high quality of AFP surveillance that is of certification standard, especially in polio-free countries, the RCC appreciated the timely and intensive efforts of EMRO and national programmes in conducting the AFP surveillance reviews and welcomed their findings. The reviews also serve to remind the countries that have been polio-free for several years that as long as polio transmission is not interrupted in countries still endemic, all countries remain at risk of importation.

The RCC was pleased to note that WHO EMRO will be soon organizing a training workshop for national and subnational officers involved in AFP surveillance in countries of the Gulf Cooperative Council and it welcomed plans for AFP surveillance reviews to be carried out in Afghanistan, Pakistan (at provincial levels) Somalia, Sudan (north and south separately) and Yemen.

The RCC recommended that reports of these reviews should be shared with the Chairs of NCCs in the concerned countries for their information and for following up the implementation of the recommendation with the respective national programmes. The follow up actions should be included in the NCCs future annual update reports to the RCC.

The NCCs (especially in countries at high risk of importation) were advised, when submitting future annual update reports, to carefully scrutinize the latest version of the plans of action for preparedness and response to an importation for their compliance with the regional guidelines.

In line with the recommendations of the last (sixth) meeting of the Regional Technical Advisory Group (Regional TAG) for polio eradication, the above mentioned plans of action should also include steps to register monovalent vaccines produced by pre-qualified firms in order to procure them in case the need for their use arises such as for example to address an importation.

In view of the above mentioned recommendations, the RCC felt that it may be necessary to modify the reporting format for the abridged annual update and the annual update so that information on above mentioned items could be included. The secretariat was advised to amend the forms for the annual report accordingly.

The RCC once again underscored the threat posed by the ongoing transmission of wild poliovirus in Nigeria and Chad to the polio-free countries in the Region and requested the Regional Office to continue to extend its collaboration with the WHO Regional Office for Africa (WHO AFRO) to deal with this threat.

2.2 Overview of polio eradication activities in the WHO African Region

Dr Samuel Okiror, WHO/AFRO

In 2007, several new strategies were introduced. These included the use of monovalent vaccines in Nigeria and in countries with imported cases, response to outbreaks due to importation within 4 weeks, intensified activities in Nigeria through immunization plus days and focusing on high risk districts and implementation of a new laboratory algorithm. As a result of the implementation of these strategies, there was a marked reduction (nearly 70%) in the total number of cases of wild poliovirus reported in 2007 (367 from 5 countries) as compared to 2006 (1192 from 9 countries). The number of infected districts in the region decreased from 266 in 2006 to 173 in 2007. As of 9 April 2008, 115 cases had been reported from five countries: Nigeria (106), Niger (5), Chad (2), Democratic Republic of Congo (1) and Angola (1).

In Nigeria, though the number of cases decreased from 1122 in 2006 to 286 in 2007, there was a resurgence of type 1 transmission over the past 6 months, not only in the high risk states but also in the middle belt states. Thus, the risk of exporting viruses remains high. A continuing low level cVDPV transmission was also detected in under-performing LGAs in the endemic states of the country.

Countries of the African Region experienced several importations. During 2007, Niger and Chad had importations from Nigeria while Angola had 3 importations from India. The Democratic Republic of Congo had an importation from Angola. Outbreaks

in Ethiopia, Kenya and Namibia resulting from importations have been controlled (no case detected for more than one year).

Some of the main factors that have contributed to the continued circulation of wild polioviruses in the region are: suboptimal routine immunization; poor quality of AFP surveillance especially at the subnational level; inadequate quality of supplementary immunization activities; instability in some of the priority counties and the existence of hard to reach areas.

During 2007, all the infected countries in the region implemented at least four rounds of NIDs/SNIDs where nearly 70 million children under the age of 5 years were reached from an overall target of 75 million. Despite significant efforts, a proportion (between 5% and 23%) of children was still missed. In 2008, up to the time of reporting, several of these countries (Nigeria, Niger, Democratic Republic of Congo, Chad, Benin, Central African Republic and Angola) have already implemented supplementary immunization activities and more activities are planned for later in the year in the same and other countries (Cameroon and Ethiopia).

Regarding surveillance for AFP, in 2007 the majority of countries in the region achieved the targets of non-polio AFP rate of more than 2 per 100 000 and stool adequacy of 80%. Only three countries (Algeria, Malawi and Zimbabwe) were not able to achieve either of these two targets. By June 2007, the new algorithm was introduced in all 16 laboratories of the regional network. In 2008 at the time of reporting, 96% of the specimens had isolation results in 14 days as compared to 70% in 2007 and only 7% in 2006. Similarly, in 2008, 82% of the ITD results became available in 7 days as compared to 57% in 2007.

The main challenges for 2008–2009 were to interrupt transmission in Nigeria and other infected countries, to continue to respond adequately to importations in countries with low population immunity, to achieve and maintain certification standard AFP surveillance, to consolidate the new accelerated laboratory algorithm and to sustain political commitment for polio eradication.

2.3 Overview of polio eradication activities in the WHO South-East Asia Region

Dr N.K. Shah, ICCPE/SEARO

India remains the only endemic country in the region, where the number of cases of wild poliovirus reported in 2007 was 863 as compared to 674 in 2006. However, the number of P1 cases dropped from a high of 646 in 2006 to 80 in 2007. Up to the end of March 2008, 165 cases (including 2 cases of P1) have been reported from 42 districts in India. The rise in P3 cases is related to the preferential use of mOPV1 in the past years. Substantial progress has been achieved in the province of Uttar Pradesh (UP) where no case has been reported since November 2007 and no case in Western UP – previously an area of intense transmission.

In the re-infected countries, no case of wild poliovirus had been reported from Bangladesh and Indonesia, respectively, since 22 November 2006 and 20 February 2006. In the other two re-infected countries: Nepal was re-infected with a P1 importation in 2006 and with P3 in 2007 and 2008, with the last case reported on 16 February 2008. Myanmar was re-infected in 2007 following an importation from UP, India, via Bangladesh. It led to an outbreak confined to two border districts of Rakhine state and accounted for 11 cases. As the last case was reported on 28 May 2007, the outbreak seems to have been controlled.

India and most of the recently infected countries are consistently meeting the targets for surveillance indicators at the national level but have gaps when indicators are calculated at subnational levels. Some of the smaller countries like Bhutan, Maldives and Timor-Leste have problems in reaching the target due to their small population size. Sri Lanka and Thailand were unable to reach the targets in 2007, which was a cause of concern.

Nine of the 11 countries in the region have completed phase 1 of laboratory containment activities. The four re-infected countries will have to conduct their laboratory survey again. National certification documents have been accepted by the WHO South East Asia Region's International Commission for Polio Eradication (ICCPE) for all countries except India and Timor Leste, and except for these two countries the rest are now submitting annual update reports.

2.4 Overview of polio eradication activities in the WHO European Region

Dr Eugene Gavrilin, WHO/EURO

In 2007, the European Regional Certification Commission (EURO RCC) confirmed the polio free status of the region for five years running. In 2006, 27 of the 48 countries (68.8%) in the region reported routine polio immunization in excess of 95%, 15 countries reported between 90% and 95% coverage and five reported between 80% and 89%. Eight countries in the Region had implemented supplementary immunization campaigns in 2007 and 7 countries reported plans to do so in 2008.

Within the region, surveillance for polio is being carried out through surveillance for AFP, through supplementary surveillance (enterovirus and/or environmental surveillance) and in majority of countries through a combination of both methods. In August 2007, a wild poliovirus 1 isolate was found in a sewage sample from the water treatment plant in Geneva, Switzerland. It was genetically related to viruses isolated from Chad. Appropriate actions were taken by WHO and Swiss public health authorities. The isolation constitutes low risk of an outbreak due to good sanitation and high vaccination coverage.

Among the WHO regions, the European Region was the first to successfully complete Phase 1 of laboratory containment. One hundred and two laboratories were found to be storing either wild poliovirus or potentially infectious material.

The EURO RCC at its last meeting held on 13 June 2007 reviewed national updates from Member States and considered the following territories to be at highest risk of poliovirus spread following an importation: Abkhazia, Armenia, Azerbaijan, Bosnia and Herzegovina, Netherlands, southeastern Turkey and Tajikistan. The RCC stressed the need to deal with waning political commitment in view of the presence of competing public health priorities and the need to maintain a high level of immunity particularly in high risk groups and to strengthen national routine immunization. The high quality laboratory based surveillance should be maintained and supported in order to respond to importations or to emergence of cVDPV.

2.5 Global overview

Dr Roland Sutter, WHO/HQ

During the year 2007, there was a marked scale up in the use of new tools (monovalent OPV 1 and 3 and faster laboratory procedures) and strategies (e.g. area specific social mobilization techniques) in all the polio infected areas with the anticipation of interrupting type 1 poliovirus transmission globally by the end of 2008 to be followed by interruption of type 3 poliovirus transmission by the end of 2009.

Studies in India, Pakistan and Nigeria have confirmed that the field efficacy of the monovalent type 1 poliovirus vaccine (mOPV1) was 2 to 4 times more efficacious against that serotype than trivalent OPV (tOPV). Data from the poliovirus laboratory network have shown that the new testing algorithm employed in 2007 has resulted in a striking reduction in the average time to confirm polio infection in endemic regions, from over 42 days in early 2006 to less than 21 days in 2008.

The intensification of the polio eradication efforts using the new tools and strategies has been associated with more than 60% decline in the number of polio cases in 2007 as compared with 2006, and 82% decline in polio cases due to type 1 virus. No type 1 wild poliovirus has been reported for more than 12 months in western Uttar Pradesh, India, and large polio-free zones are emerging in northern Nigeria. Twenty four out of the 27 countries re-infected during 2003 to 2007 have stopped outbreaks, including countries in the Horn of Africa, Bangladesh and Indonesia.

However, there are certain programmatic risks that currently exist and threaten the programme. These are: ongoing WPV1 transmission and continued WPV3 outbreak in Bihar, India; continued geographic expansion of the outbreak in Chad (which poses a real threat to the eradiation efforts in the Eastern Mediterranean Region); detection of new type 1 cases in Afghanistan and Pakistan and the increase in type 1 cases and large number of missed children in states in northern Nigeria.

The current emphasis of the programme is to build on the progress achieved and to respond to the programmatic risks through rapidly enhancing the nature and scale of mop-up operations in the highest risk districts in India (e.g. Bihar) and in Nigeria (e.g. Kano). The programme will conduct special studies to guide strategic planning such as sero-surveys in western Uttar Pradesh, India. The quality of monitoring of polio campaigns, especially in Pakistan, will be enhanced to realistically reflect actual performance during supplementary immunization activities and to guide activities. Innovative strategies will be designed and implemented in security affected, polio-infected areas, especially in Chad and in Afghanistan.

To rapidly address these challenges it is essential to sustain donor confidence and close the funding gap of US$ 525 million for supporting intensified eradication activities during 2008–2009.

2.6 Implications of the recommendations of the Fourth Meeting of the WHO Advisory Committee on Polio Eradication (ACPE)

Dr Yagoub Al Mazrou, Member of ACPE and EM RCC

The fourth meeting of the Advisory Committee on Polio Eradication (ACPE) took place in WHO headquarters, Geneva, on 27–28 November 2007. The ACPE at this meeting noted the substantial progress that had taken place since its last meeting held in October 2006. It discussed the strategic approaches for 2008–2009 in areas with indigenous transmission of wild poliovirus, the spread of wild poliovirus through importations and the epidemiology and risks of cVDPVs and the impact of response activities. Under each of these items the ACPE made several recommendations.

The ACPE also received a comprehensive review of the global programme's work on research and product development. This consisted of two main areas. The first focused on development of new vaccines and diagnostics, epidemiological and serological studies, modeling and communication research. The other area dealt with characterization of post-eradication risks, strategies for making IPV use more affordable and strategies for the control of cVDPVs following the cessation of OPV use.

The full report of the ACPE meeting has been published in the WHO Weekly epidemiological record in the issue of 18 January 2008 (No.3, 2008, 83, 25-36) and can be accessed through the web site www.who.int/wer.

2.7 Discussion on regional and global overviews

In view of the potential threat posed by importations from Algeria into neighbouring countries in the Eastern Mediterranean Region, concern was expressed about the inadequate information on polio eradication activities from this country. Due to this lack of information, it has not been possible to coordinate/harmonize

supplementary immunization activities in the areas of Libyan Arab Jamahiriya, Morocco and Tunisia bordering Algeria.

It was pointed out that maximum use should be made of the experience gained in interrupting transmission of wild poliovirus in highly populous and large countries (such as Bangladesh and Indonesia), in designing strategies to interrupt transmission in the still endemic countries in the African and Eastern Mediterranean Region and to reduce their vulnerabilities to importations.

In response to a query about why a large number of laboratories (102) in the European Region were still retaining wild poliovirus and potentially infectious material, it was clarified that only a small fraction of these are holding wild polio viral isolates.

Regarding the consistency between the advice rendered by the ACPE and the regional or country TAG on the schedule for supplementary immunization activities, it was clarified that the ACPE was concerned with the general strategic direction of the polio eradication initiative and strategies and it was the function of the regional and country TAGs to advise on the schedule for supplementary immunization activities.

3. REVIEW OF ABRIDGED ANNUAL REPORTS FOR 2007

The RCC reviewed abridged annual reports submitted by NCCs of Bahrain, Islamic Republic of Iran, Jordan, Oman, Lebanon, Libyan Arab Jamahiriya, Morocco, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia and United Arab Emirates. All these countries have already submitted final national documentation for regional certification that was previously approved by the RCC.

The RCC found that all the reports submitted by the NCCs in the above-mentioned countries provided adequate technical information as evidence to indicate that these countries remained polio-free and decided to accept all of them on a provisional basis. The RCC, however made comments on all of them that will be communicated to the Chairs of NCCs in an official communication from the Chairman, RCC. The formal acceptance of reports will follow the timely submission of a revised report that had taken in to account all of the RCC's comments.

While considering the above reports, the RCC noted that over the years the quality of the presentations by the Chairmen of NCC of their reports had much improved. However, in some instances the presentations included superfluous information which was not relevant for the purpose of review. The presentation should include key indicators and significant developments since the last report and could be structured for example under the headings of the work of the NCC during the period under review, quality of AFP surveillance, coverage with routine immunization and supplementary immunization activities if any, functioning of the national polio laboratory, progress in laboratory containment and preparedness to respond to an

importation including the status of the licensing of monovalent vaccines from more than one producer. The report should also clearly indicate areas and population groups at particularly high risk.

Similarly, the executive summary at the beginning of the report should:

a) clearly reflect the NCCs critical views on items such as: the status of AFP surveillance in the country; coverage of routine immunization; risk of importation, efforts being made by the national program to ensure that there are no immunity gaps in population groups at high risk and the updated version of the national plan for preparedness and response to an importation;
b) refer to the findings of the review of any acute flaccid paralysis surveillance carried out in the country during the year under review and mention steps being initiated and/or already taken to implement its recommendations;
c) conclude by citing the evidence, on basis of which the NCC is convinced that the country remains free of polio; and
d) be signed by the Chairman and members of the NCC.

The RCC agreed that it would be useful to develop a short guideline for the NCC Chairpersons presentations to the RCC and the secretariat was requested to prepare a draft for the RCC's review at its next meeting.

4. REVIEW OF ANNUAL REPORTS FOR 2007

The RCC discussed the annual updates for 2007 submitted by the NCCs of Egypt, Palestine and Sudan. It was agreed that the reports provided by the NCCs of Egypt and Palestine were on the whole satisfactory and had provided convincing evidence that the two countries remained polio-free and decided to accept these reports on a provisional basis. A formal acceptance of the reports would follow the timely submission of revised versions taking into account the comments of the RCC that will be communicated to the respective Chairmen of NCCs in a letter from the Chairman, RCC.

Regarding the report submitted by the NCC of Sudan, in view of the recent detection of a case of wild poliovirus in Akobo county, Jongeli, south Sudan, it was decided to defer decision about the report until RCC decides on the steps needed to declare Sudan again free from polio.

The RCC recommended that RD/EMRO would write to RD/AFRO emphasizing the need to carry out a joint review of the situation of the polio eradication programme in the border area between Jonglei province of Sudan and the adjoining area of Ethiopia.

5. REVIEW OF NATIONAL DOCUMENTS

The RCC reviewed the national document of Yemen, re-submitted by the NCC, Yemen and the provisional national document of Somalia prepared by WHO and UNICEF staff in Somalia.

Regarding the national document re-submitted by the NCC, Yemen, the RCC noted that while coverage with routine OPV and during NIDs had increased immediately following the outbreak in 2005, it was seriously concerned with the slippage in the coverage rates since then and with the possibility of a build-up of susceptible children. It recommended that the immunity profile of non-polio AFP children should be carefully followed up and the coverage during future supplementary immunization activities be very closely monitored.

The RCC made several comments on the report. However, it was decided to accept the report on a provisional basis. The formal acceptance of the report would follow the timely submission of a revised version that should take into account the comments of the RCC, which will be communicated in a letter addressed to the Chairman of NCC, Yemen, in a letter from the Chairman, RCC.

The RCC noted that it continued to be impossible to constitute a National Certification Committee (NCC) in Somalia due to the prevailing circumstances and the lack of an effective central administrative authority in the country. Therefore, the provisional report submitted to the RCC had been prepared by the WHO and UNICEF polio staff posted in Somalia. The RCC greatly appreciated the remarkable efforts of the WHO and UNICEF polio staff in eradicating polio from the country under very difficult and dangerous circumstances and the efforts of the WHO staff in presenting a comprehensive and well documented report. It was decided to consider it as an information document at this stage. However, the RCC did make some comments on the report that will be communicated in a letter from the Chairman, RCC, addressed to the WHO staff to take into account when preparing the next report.

6. REVIEW OF FINAL NATIONAL DOCUMENTATION FOR REGIONAL CERTIFICATION

The RCC reviewed the final national documentation for regional certification submitted by the NCCs of Iraq and Kuwait. Both these countries have been polio free for five years or more and have completed Phase 1 of laboratory containment of wild poliovirus and potentially infectious material. The RCC made some comments on both of these reports that will be communicated to the respective Chairs in a letter from the Chair of the RCC. Meanwhile, both the reports were provisionally accepted. Formal approval would follow after the amendments proposed by RCC on each of the reports had been incorporated in a revised version.

7. OTHER MATTERS

It was noted that the interaction between the NCC and the national program staff varied considerably in different countries. In several of them, the only contact was at the time of the preparation of the annual report for submission to the RCC. The RCC considered that a closer interaction and continuous dialogue between these two bodies was highly desirable. The RCC recommended that the need for this closer interaction should be further emphasized by the secretariat during the polio presentations at the next intercountry meeting of the national EPI managers.

The RCC decided to recommend to the RD/EMRO that Professor Gafaar Ibnauf Suliman represents the EMR RCC in the African RCC.

It was decided to hold the next meeting 19th of the RCC on 8–9 October 2008 in Islamabad, Pakistan.

Annex 1

PROGRAMME

Monday, 14 April 2008

08:30–09:00	Registration
09:00–09:30	Opening session Introductory remarks, Dr A. Jaffer Mohamed, Chairman of RCC Address by Dr Hussein A. Gezairy, Regional Director, WHO/EMRO Adoption of agenda
09:30–11:30	Overview of the present situation of polio eradication EM regional overview / Dr F. Kamel, WHO/EMRO, Dr H. Asghar, WHO/EMRO Issues dealing with quality of AFP surveillance in countries of the Region / Mr J. Abdelwahab, WHO/EMRO
11:30–12:00	Discussion on the EM Regional Overview Regional overviews
12:00–12:15	AFR / Dr S. Okiror, WHO/AFRO
12:15–12:30	SEAR / Dr N.K. Shah, ICCPE/SEARO
12:30–12:45	EUR / Dr E. Gavrilin, WHO/EURO
12:45–13:00	Global overview / Dr R. Sutter, WHO/HQ
13:00–13:15	Implications of the recommendations of the ACPE meeting for certification in the regions / Dr Y. Al Mazrou, Member, ACPE/EM RCC
13:15–14:30	Discussion
14:30–16:30	Private meeting of the EM RCC

Tuesday, 15 April 2008

09:00–11:00	Abridged annual update reports of Bahrain, Islamic Republic of Iran, Jordan and Oman
11:00–13:30	Abridged annual update reports of Lebanon, Libyan Arab Jamahiriya, Morocco and Qatar
13:30–15:30	Abridged annual update reports of Saudi Arabia, Syrian Arab Republic, Tunisia and United Arab Emirates
15:30–17:00	Private Meeting of the EM RCC

Wednesday, 16 April 2008

09:00–11:00	Review of annual updates of Egypt, Palestine and Sudan
11:00–12:30	review of resubmitted national documentation of Yemen and provisional national document of Somalia
12:30–14:00	Progress report on laboratory containment / Dr H. Asghar, WHO/EMRO
14:00–16:00	Private meeting of the EM RCC

Thursday, 17 April 2008

9:00–11:00	Review of final national documentation for regional certification of Iraq and Kuwait
11:00–13:00	Private meeting of the EM / RCC
13:00–14:00	Closing session and concluding remarks

Annex 2

LIST OF PARTICIPANTS

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