WHO-EM/POL/373/E

Report on the

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

Cairo, Egypt
8–9 October 2008

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Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The Nineteenth Meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was held on 8–9 October 2008 in the WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt. The meeting was attended by members of the Regional Commission and Chairs of the National Certification Committees (NCC) of Afghanistan and Pakistan. The meeting was also attended by representatives of Rotary International and the Centers for Disease Control and Prevention (Atlanta) and staff from WHO headquarters, Regional Offices for Africa, the Eastern Mediterranean, Europe and South-East Asia, and country offices for Afghanistan and Pakistan.

The meeting was opened by Dr Ali Jaffer Mohammed, Chairman, RCC, who welcomed all the participants. He referred to the continued progress towards polio eradication in the Eastern Mediterranean 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 welcome address, Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, referred to the tragic death of two polio workers in Afghanistan who were assassinated while preparing for the campaign that was held on UN Peace Day, 21 September. He acknowledged the courage and devotion of thousands of volunteers and polio workers who have been working under extremely difficult circumstances in security-compromised areas of Afghanistan, Pakistan, Somalia and Sudan. He referred to the resurgence of cases of poliomyelitis in Afghanistan and Pakistan and indicated that the situation in Pakistan was discussed at an urgent consultation held in June this year and would be discussed again at a technical consultation being held immediately after the meeting of the RCC.

Dr Gezairy emphasized that there was no other option but eradication; control of poliomyelitis was not an option. He expressed his gratitude to the members of the Regional Certification Commission and National Certification Committees and to the staff of the national programmes in the Region for their dedication and steadfast commitment to the goal of polio eradication in the Eastern Mediterranean Region. He concluded by looking forward to the Commission's appraisal of the current situation and views about actions taken and being planned in this connection.

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

A total of 95 cases of poliomyelitis had been reported in the Region up to end September 2008, including 70 cases from Pakistan, 20 cases from Afghanistan and 5 cases from Sudan, as compared to 38 cases for the same period in 2007. Figures 1 and 2 show the transmission of wild poliovirus in Afghanistan and Pakistan, which are considered as one epidemiological block.

The main challenges facing the programme in Afghanistan include accessing children in security-compromised areas, population movement between Afghanistan and Pakistan and maintenance of immunity in polio-free areas. These challenges are being met by monthly supplementary immunization activities in high-risk areas and implementing special strategies for insecure areas such as short interval additional dose, staggered campaigns, focused district strategy and efforts to ensure accessibility between the fighting factions in Afghanistan, as well as close exchange of information with the programme in Pakistan.

An AFP surveillance review was conducted in four regions of Afghanistan (central, western, north and north-eastern) from 28 August to 6 September 2008. The review found that the AFP surveillance system was well established and staffed by dedicated personnel.

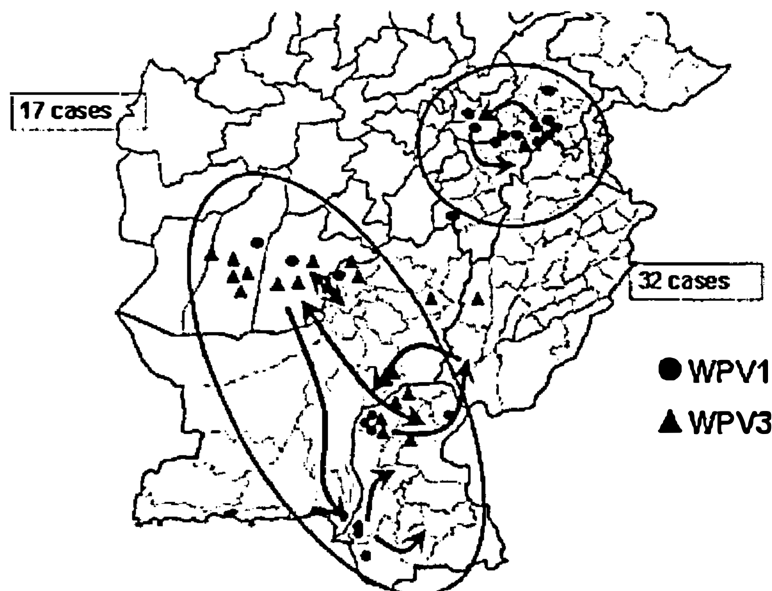

Figure 1. Wild poliovirus (WPV) transmission, Afghanistan/Pakistan, 2007

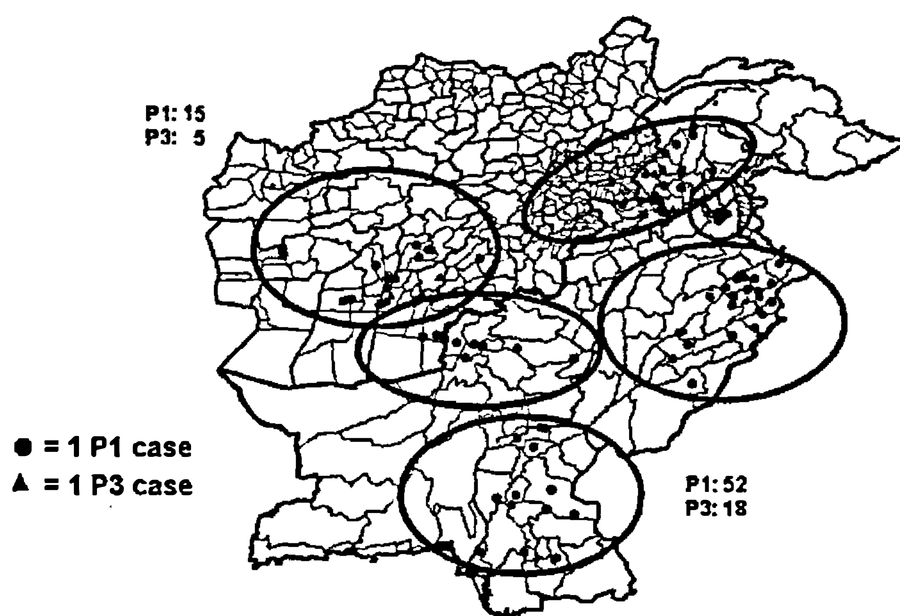

Figure 2. Wild virus cases by type and district, Pakistan and Afghanistan, 01/01/08–05/10/08

The review team was confident that there was no missed circulation of wild poliovirus in the regions that were reviewed. However, the observed exclusion of many initial AFP reports without proper documentation increased the risk that some true AFP cases were being missed.

In Pakistan, by end September 2008, 70 cases of poliomyelitis had been reported, 17 of them in the first 6 months of the year, followed by a sudden increase to 18 cases in each of the months of July and August and 17 cases in September. The number of cases reported in July, August and September far exceeds the number of cases reported in any of these months during the past five years in Pakistan. The province-wise distribution of cases in Pakistan in 2007 and in 2008 is shown below in Table 1 together with the number of districts infected during these two years.

Table 1. Province-wise distribution of cases of poliomyelitis reported from Pakistan in 2007 and 2008 (up to end September) and the number of infected districts

Province	No. of cases of poliomyelitis (no. of infected districts) in 2007	No. of cases of poliomyelitis (no. of infected districts) in 2008 (end Sept)
Punjab	1 (1)	16 (11)
Sindh	12 (7)	16 (13)
NWFP/FATA	11 (5)	28 (11)
Balochistan	8 (5)	6 (6)
Islamabad	4 (0)	4 (1)
Total	32 (18)	70 (42)

The resurgence of cases in Pakistan could largely be attributed to the following factors that led to the creation of a pool of susceptible children, i.e. the development of a substantial immunity gap.

- Difficulty in accessing children in areas of conflict in NWFP/FATA and a significant movement of population from these areas to other parts of NWFP and other parts of the country.
- Persistence of transmission in key reservoir areas due to sub-optimal delivery of vaccine during supplementary immunization activities.
- Low immunity in polio-free areas due to low routine immunization coverage and an inadequate number of supplementary immunization activities.
- Changes in the health leadership at the central, provincial and district level.
- Pockets of refusals.

In Sudan five cases were reported in 2008 (one from El Geneana, West Darfur and 4 from south Sudan) as a result of importation. Somalia continued to be free of polio since the last case reported in March 2007.

On a regional basis, the non-polio AFP rate remains well above the certification standard. The annualized rate for 2008 was 4.51 per 100 000 population, as compared to 4.19 for 2007. The percentage of AFP cases with adequate stool specimen for 2008 was 91.9% as compared to 90.9% for 2007. These achievements have been affirmed through AFP surveillance reviews carried out in nearly all countries of the Region since 2004. As the risk of importation, especially from Nigeria and Chad, has remained high, since 2006 the surveillance reviews have included a critical examination of the plans for preparedness for importation. Currently, reviews are being planned for Somalia, Sudan and south Sudan.

During 2008, supplementary immunization activities, including several rounds of national and subnational immunization days (NIDs/SNIDs), were implemented in Afghanistan, Pakistan, Somalia, Sudan and south Sudan. In addition, supplementary immunization activities were also implemented in several polio-free countries. NIDs were implemented in Djibouti, Egypt, Iraq, Libyan Arab Jamahiriya and Yemen, while mop-ups were implemented in Islamic Republic of Iran, Jordan, Saudi Arabia and Syrian Arab Republic.

Cross-border coordination activities between Afghanistan and Pakistan and between countries in the Hom of Africa continues to be actively pursued through regular exchange of information, meetings of the Technical Advisory Groups, joint missions and synchronization of supplementary immunization activities in border areas and cross participation in activities.

The regional priorities for the coming year include: interruption of poliovirus transmission in Afghanistan and Pakistan; prompt response to the recent detection of virus in previously polio-free areas; consolidation of achievements in Somalia;

sustaining the polio-free status of other countries through avoidance of creation of immunity gaps and maintenance of certification standard surveillance; adequate preparedness to detect and respond to importation; and optimization of collaboration between the programmes for polio eradication and EPI at the national and regional levels.

2.1.2 Update on the polio laboratory network and on laboratory containment activities
Dr Humayun Asghar, WHO/EMRO

All the network laboratories (both the intratypic differentiation and virus isolation laboratories) were fully accredited during 2007–2008 except the Kuwait sub-regional laboratory, which was provisionally accredited. Since 2004, the workload of the network laboratories has increased substantially due to an increase in the number of reported AFP cases and in the samples taken from contacts. During 2007 the network processed 23 364 samples. With the introduction of the new laboratory algorithm, 92% of samples had culture results within 14 days and 93% had ITD results within 7 days. Overall, in 98% of cases of AFP, the results were provided within 45 days of the onset of symptoms.

The molecular sequencing data of wild polioviruses isolated from cases in 2007 from Afghanistan and Pakistan showed decrease in genetic diversity. However, the number of chains of circulating polioviruses increased in 2008. It was also found that multiple chains of poliovirus from reservoir areas have infected districts that were previously polio-free, such as Punjab.

Environmental sampling from 34 sites has continued in Egypt. Two samples from one site showed P2 VDPV that were unrelated. Full investigation is ongoing. A plan for establishing environmental surveillance in Karachi and Lahore in Pakistan has been drawn up and is awaiting allocation of resources.

Regarding progress in laboratory containment, quality assurance reports were received from 15 countries. Still awaited are reports from Egypt, Kuwait and Palestine and a revised report from Djibouti. As regards Pakistan, despite several efforts, it has not been possible to initiate preparations for Phase 1 laboratory survey and inventory of laboratories for containment of wild poliovirus and potentially infectious material.

2.1.3 Discussion

The RCC welcomed the concise and clear regional overview and expressed hope that the ongoing financial crises would not imperil activities related to the polio eradication initiative in either endemic or polio-free countries.

The RCC noted with concern the recent increase in poliovirus spread throughout Pakistan and indicated that all polio-free areas should now be considered at risk of re-

infection. It was pleased to learn of the urgent consultation on polio in Pakistan being convened by WHO EMRO immediately after the meeting of the RCC.

The RCC noted with concern the cases being reported from the border area between Ethiopia and south Sudan, especially as the coverage with routine immunization is low on both sides of the border and the quality of AFP surveillance is poor. It recommended increased efforts to coordinate supplementary immunization activities in the area with the authorities in Ethiopia.

In view of the low coverage with routine immunization in some of the polio-free countries in the Region, the RCC emphasized the need for careful monitoring of the immunity profile to identify immunity gaps early and address them so that importation does not lead to outbreaks.

As the last case in Somalia following the earlier outbreak was reported in March 2007, the RCC decided to request the concerned WHO/UNICEF staff to submit the national documentation for review by the RCC at its next meeting.

The RCC welcomed the information that the EPI team in EMRO has been kept fully briefed about the potential utilization of laboratory and surveillance infrastructure developed in the countries for polio eradication for the programme of elimination of measles.

In view of the persistent difficulties with the sub-regional polio laboratory in Kuwait, the RCC recommended that the sub-regional designation of this laboratory should be withdrawn and it should serve as a national laboratory with its work monitored in the same way as other national polio laboratories participating in the regional network.

The RCC expressed its disappointment with the lack of progress in initiating a laboratory survey as part of Phase 1 of the Global Action Plan (2nd edition) for laboratory containment of wild poliovirus and potentially infectious material in Pakistan. In view of the large size of the country and the absence of a process for a formal registration of clinical laboratories, the national programme could consider a focused approach where efforts are concentrated on laboratories where the possibility of storing infectious material would appear to be high. The national programme could also consider utilizing the services of district surveillance staff in carrying out the required survey of laboratories in their respective geographical areas of responsibility.

2.2 Overview of polio eradication activities in the WHO African Region

Dr Mbaye Salla, WHO/AFRO

During 2007, partly as a result of the increase in routine immunization coverage in the region from 73% to 82%, the total number of cases of poliomyelitis reported (366) decreased considerably as compared to the number of cases reported in 2006

(1192). However, during 2008 there has been a resurgence of cases, notably in northern Nigeria. By end August 2008, Nigeria had reported 675 cases of poliomyelitis in 28 states, as compared to 207 in 21 states for the same period in 2007. So far, in 2008, Nigeria accounts for 85% of the global wild poliovirus type 1 cases and 10% of type 3 cases. During a six month period (from 5 December 2007 to 4 June 2008), Nigeria also reported 28 cases of cVDPV.

The ongoing outbreak in Nigeria is largely due to a failure to vaccinate children. Only 42% of children aged 6–35 months had 3 or more doses in the high burden states, as compared to 86% in the polio-free states of the country. In the four highest risk states (Jigawa, Kano, Katsina and Zamfara), which account for 60% of all cases of wild poliovirus in 2008, the two major reasons for children not being vaccinated in the January, April and May 2008 immunization plus days (IPD) were absence of the child(ren) and non-compliance. Further analysis showed a mix of reasons for non-compliance. Some of these reasons were: concerned with safety of OPV (22%), too many rounds (13%), no felt need (33%), and religious beliefs (12%).

In 2008, eight countries in the African region were experiencing ongoing active outbreaks or had importations. Outbreaks were ongoing in Democratic Republic of Congo (since February 2006 with 3 cases in 2008), Angola (since 2005 with 25 cases in 2008) and Chad (since 2003 with 14 cases in 2008). There were importations from Nigeria into Niger (repeated), Central African Republic, Ethiopia, Benin and Burkina Faso. During 2007, infected countries had implemented at least 4 rounds of Supplementary Immunization Activities during which over 70 million children under the age of 5 years were reached out of an overall target of 75 million. Overall, ensuring the quality of Supplementary Immunization Activities remained a challenge in the region.

High-quality AFP surveillance continues to be maintained in most member states. By end September 2007, 43 (93%) of the countries in the region had achieved certification standard AFP surveillance performance indicators. With the introduction of the new algorithm in the regional network of 16 polio laboratories, 96% of the specimens have results within 14 days in 2008 as compared to 7% in 2006. The regional certification commission has reviewed 23 country documents and has accepted 21. Another eight countries will be presenting their national documents at the tenth meeting of the regional commission in late October 2008.

The main challenges for the polio eradication initiative in the region remain interrupting transmission in Nigeria and other infected countries, ensuring rapid and adequate response to importations, achieving and maintaining AFP surveillance of certification standard at subnational levels and sustaining political commitment for polio eradication.

2.3 Overview of polio eradication activities in the WHO South-East Asia Region
Dr Zobaidul Haque Khan, WHO/SEARO

For polio eradication in WHO's South-East Asia region, India remains a key strategic priority. Up to end September 2008, the region had reported 469 cases of poliomyelitis including 464 from India (48 due to WPV1 and 416 due to WPV3) and 5 cases from Nepal. The number of cases of P1 was the lowest recorded and was due to use of mOPV1 in the endemic states of Bihar (2 P1 and 221 P3) and Uttar Pradesh (41 P1 and 184 P3). In Western Uttar Pradesh (an area of high endemicity), all districts have been free of wild poliovirus 1 since August 2007. Forty cases of P1 reported in and adjacent to Badaun district so far in 2008 were due to an importation from Bihar. In Bihar, there appears to be continued low level WPV1 transmission in high risk blocks and intensified Supplementary Immunization Activities are being implemented with a view to stop this transmission by the end of the year.

Following importations from Uttar Pradesh and Bihar into the adjoining parts of Nepal, cases have continued to be reported: 5 cases in 4 districts in 2006, another five cases each in 2007 and 2008 in respectively 2 and 5 districts.

Since 2004, the non-polio AFP rate is being maintained above the certification standard of 2 AFP cases per 100 000 children younger than 15 years in Bangladesh, India, Indonesia and Nepal. Democratic Republic of Korea, Maldives and Timor Leste have not reached this target since 2004, and the remaining countries in the region (Bhutan, Myanmar, Sri Lanka and Thailand) have attained this target in some of the years.

The South-East Asia Regional Certification Commission has been reconstituted on the basis of its recommendation in April 2008. The Commission has accepted the national documentation from all countries in the region except India and Timor Leste.

The key challenges facing the programme are: stopping polio transmission in India and the transmission of WPV 3 in Nepal due to an importation; maintaining the sensitivity of AFP surveillance in polio-free countries in the region; and sustaining a high level of immunity in all countries until polio is eradicated.

2.4 Efforts to sustain polio-free status in the WHO European Region
Professor Donato Greco, Member, EUR Regional Certification Commission

The 21st meeting of the EU Regional Certification Commission (ERCC) took place on 13–15 June 2007. It was recognized that the risk of importation of wild polioviruses into the region remained high, especially in view of the extensive travel between Europe and the endemic counties. The ERCC judged the risk of transmission following an importation as being high in Bosnia-Herzogavinia, eastern Turkey and adjoining parts of Azerbaijan and Georgia and in Tajikistan. In view of the above,

there is a need for a continuous strong political commitment from the governments in the region and financial support to ensure AFP surveillance of certification standard.

Different types of surveillance measures are being implemented in countries of the region, i.e. AFP, supplementary surveillance through enterovirus and/or environmental surveillance. The majority of countries are using a variable combination of the second two methods. Of the 53 countries in the region, only 43 are reporting surveillance data. The annualized regional non-polio AFP rate for 2008 was 0.77 as compared to 1.11 in 2007 and 1.13 in 2006. In 2008, two adequate specimens of stools were collected from 83.0% of cases of AFP. The corresponding figure for 2007 and 2006 was 82% for both years. The declining quality of AFP surveillance remains a problem.

The WHO Regional Director for Europe has written to all Member States recommending that the NCCs be reconstituted and that they should be independent of the national programmes and charged with reviewing the quality of AFP surveillance and of the national plans for response to importation of wild polioviruses.

Most countries in the region have achieved more than 95% coverage with routine immunization, but timely provision of immunization remains a problem in several countries and the national data show many under-performing districts.

2.5 Global overview

Dr Bruce Aylward, WHO headquarters

Global progress can be assessed against the goals and working targets established in 2007. The former include the interruption of transmission of type 1 poliovirus by end 2008 and of type 3 by end 2009. In view of the outbreaks of P1 in northern Nigeria and western Uttar Pradesh, it appears unlikely that the goal of interruption of transmission of type 1 by end 2008 will be achieved. There has been, however, a drop in type 3 cases in 2008 (535 by end September) as compared to 994 for the same period in 2007.

Renewed international resolve to finish eradication was evident when the 61st World Health Assembly, held on 19–24 May 2008, passed a resolution (WHA 61.1) that specifically urged Nigeria to reduce the risk of international spread of poliovirus by stopping the outbreak in northern Nigeria through intensified eradication activities and also urged India and Pakistan to implement large scale mop-ups now needed to interrupt their final chains of poliovirus transmission.

The recently developed technical and tactical innovations such as the mOPV1 have managed to interrupt indigenous transmission of type 1 poliovirus in one of the most entrenched reservoirs in western Uttar Pradesh in India. However, progress remains fragile as evidenced by the recent outbreak of cases due to an importation from Bihar.

Most of the remaining challenges facing the eradication initiative lie outside the administrative and technical responsibility of the national health authorities. These include active conflict and insecurity, as in Afghanistan and Pakistan; generating increased political commitment and involvement of civil society, as in Nigeria; and the huge financial and logistical challenges being faced in India, with millions of cohorts being born between each campaign.

The immediate priorities at the global level are to work closely with the endemic countries. In India: optimize the response to type 1 importation in western Uttar Pradesh, work with Government of India to rebuild immunity in Bihar following the recent floods and to sustain aggressive mop-up plans in polio-free areas of the country. In Nigeria: engage governors of infected provinces, make full use of national institutions and improve vaccinator selection, training and supervision. In Pakistan: adapt the supplementary immunization strategy to new population movements and security concerns; mop up with mOPV in re-infected areas; and support the government's initiative on full accountability of district leaders for campaign quality. In Afghanistan: increase technical support in key reservoir areas and make optimal use of 'peace days'.

Innovations being explored by the programme include the use of bivalent OPV (type 1 and 3) to complement mOPV in areas where the two wild viruses 1 and 3 are circulating, to complement AFP surveillance through environmental sampling in order to better target key virus reservoirs and sero-surveys to better understand the efficacy of both vaccine and programme delivery to guide the strategy for supplementary immunization activities.

2.6 Discussion

The discussion focused largely on the situation in Nigeria and about how it can be changed so as to access the large number of children that are currently not being immunized and to explore the potential for further advocacy at the highest levels of the government to secure sustained political commitment. It was emphasized that different strata of the government and the civil society need to be assigned clear responsibilities to firmly establish the national ownership for polio eradication.

Comments were made about the possible role of OPV immunization requirements, especially for children less than 5 or 15 years of age, prior to travel to and from endemic countries and the implications this would have for introducing changes in the International Health Regulations. Discussion also took place on how to optimize the use of mOPV in conjunction with tOPV in endemic countries. The RCC noted this issue would be discussed further during the forthcoming consultation on polio in Pakistan. It was clarified that there was no evidence to date about sub-optimal efficacy of tOPV in Pakistan, but this needs to be confirmed by sero-surveys. The RCC was informed that the global financial crisis may affect the unearmarked

donations that support staff costs, which are considerable in places like India and Nigeria.

The European Region was commended for its painstaking and laborious efforts in completing Phase 1 of the Global Action Plan (2nd edition) for laboratory containment of wild poliovirus and potentially infectious material and establishing an inventory of wild polioviruses held in storage.

3. REVIEW OF NATIONAL REPORTS

3.1 Final National Document for Regional Certification of Djibouti

The RCC regretted that due to unavoidable circumstances, neither the Chair of NCC, Djibouti, nor the national programme manager could attend the meeting. However, as the Djibouti Final National Document for Regional Certification had been received earlier and circulated to the members of RCC members, it was decided to go ahead and review it in their absence.

The RCC considered Djibouti a high-risk country for importation because of its geographic location and its fragile polio eradication programme, in view of low coverage with routine immunization, poor quality AFP surveillance and less than optimal NIDs.

On the whole, the report was considered unsatisfactory as it lacked the required information in many section and parts of it were difficult to follow. The RCC made several comments on the report that will be communicated to the Chair, NCC, Djibouti, in a letter from the Chairman, RCC. It was decided that the NCC should re-submit the report with the RCC's comments taken into consideration and with data up to the end of 2008, for review at its next meeting.

3.2 Provisional National Document of Afghanistan

The RCC noted the substantial improvement in the contents of the present report (the third submitted by the NCC), as a whole as compared to the earlier reports. The RCC requested the Chairman of NCC, Afghanistan, to convey its appreciation to the members of the NCC and the national programme staff for their highly commendable efforts towards eradicating poliomyelitis under considerably difficult circumstances and in compiling the report. The RCC made some minor comments that will be conveyed to the Chairman, NCC, Afghanistan, in a letter from the Chairman, RCC.

3.3 Provisional National Document of Pakistan

In considering the fifth provisional National Document submitted by the NCC, Pakistan, the RCC expressed its appreciation for the very comprehensive and well-documented report that depicted very well the current and past situation of

poliomyelitis in Pakistan. The Chairman, NCC, Pakistan was requested to convey these sentiments to the members of the NCC and to the staff of the national programme.

During the discussion on the report, it was mentioned that in line with rules of business of the Government of Pakistan, the procedure adopted to procure vaccines paid from national resources has resulted in a higher price (as compared to that paid when the vaccine was being procured through UNICEF) and to delays in procurement leading to shortages. The RCC advised the secretariat to continue its efforts with national authorities to ensure that vaccines paid from national resources are procured through UNICEF. Until this becomes possible, the Government should be advised at least to ensure that the private suppliers provide the vaccine from WHO pre-qualified manufacturers at competitive prices and also to ensure timely supply of poliovaccine (mOPV and tOPV) in the required amounts.

As already mentioned under 2.1.3, the RCC expressed its disappointment with the lack of progress in initiating a laboratory survey as part of Phase 1 of the Global Action Plan (2nd edition) for laboratory containment of wild poliovirus and potentially infectious material. It recommended that this concern should be conveyed to the national authorities through the Chairman, NCC, in a letter from the Chairman, RCC, that would also include some other comments made by the RCC on the report.

4. OTHER MATTERS

4.1 Review of the second draft of the Regional Overview for Regional Certification

The RCC reviewed the second draft of the Regional Overview for Regional Certification and expressed appreciation for the efforts of the secretariat in preparing the document. It made some comments on the draft. It was recommended that it should include a section emphasizing the diversity of the Region and the special challenges (cultural, economic, civil strife/war etc) faced by the national and regional programmes in eradicating poliomyelitis and how these challenges were overcome. It was agreed, that the report should be treated as work in progress and a third updated and revised draft should be prepared for the RCC's review in two years.

4.2 Draft guidelines for Chairs of NCCs for presentation of country reports at meetings of the RCC

The RCC agreed with the guidelines and suggested some minor editorial changes that will be incorporated in the text before sending it to the Chairs of NCCs for their use at the next meeting of the RCC.

4.3 Modified manual of operations for annual updates and abridged annual updates

The RCC approved the amendments made to the manual of operations for the two types of annual updates. It also agreed on a few amendments to the Manual of Operation for the National Document concerning the number of years for which background information is collected (5 years).

4.4 Dates and venue for the 20th Meeting of the RCC

It was agreed to hold the next (20th) meeting of the RCC on 12–14 May 2009 in Cairo, Egypt.

5. CLOSING

The Chairman, RCC, thanked all the participants, especially the representatives of the partners in the polio eradication initiative, for their valuable contribution and wished the participants a safe journey back to their respective homes.

Annex 1

PROGRAMME

Wednesday, 8 October 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
09:30–11:00	Overview of the present situation of polio eradication EM regional overview / Dr F. Kamel, WHO/EMRO, Dr H. Asghar, WHO/EMRO Discussion on the EM Regional Overview
11:00–13:00	Regional Overviews AFR / Dr M. Salla, WHO/AFRO SEAR / Dr Z. Khan, WHO/SEARO EUR / Prof. D. Greco, WHO/EURO
13:00–14:00	Presentation and discussion of (Provisional) National Document of Afghanistan
14:00–15:00	Presentation and discussion of (Provisional) National Document of Pakistan
15:00–17:00	Private meeting of the EM RCC

Thursday, 9 October 2008

09:00–11:00	Private Meeting of the RCC Members
11:00–12:00	Global Overview, Dr B. Aylward, WHO/HQ
12:00–12:30	Closing

Annex 2

LIST OF PARTICIPANTS

Members of the Eastern Mediterranean Regional Certification Commission

Dr Ali Jaffer Mohammed *Chairman*
Advisor Health Affairs
Supervisor Directorate General Health Affairs
Ministry of Health
Muscat

Dr Malek Afzali *
Professor of Biostatistics
Director of Public Health Research Institute
Teheran

Dr Yagoub Y. Al Mazrou
Assistant Deputy Minister for Curative Medicine
Ministry of Health
Riyadh

Dr Narayan Keshary Shah *
Chairman
South East Asia Regional Certification Commission
Nepal

Dr Magda Rakha
Chief Executive
VACSERA
Cairo

Professor David Salisbury
Director of Immunization
Department of Health
London

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* Unable to attend

Professor Mushtaq Khan
Professor of Paediatrics
Medical Center
Islamabad

Professor Gaafar Ibnauf Suliman
Chairman
Paediatrics and Child Health Council
Khartoum

Professor Oyewale Tomori
Member
African Regional Certification Commission
Lagos

Country Representatives

AFGHANISTAN
Dr Gholam Aram
Chairman, National Certification Committee
Herat

DJIBOUTI
Dr Emma Acina *
Chairperson, National Certification Committee
Djibouti

Mr Abdallah Ahmed Hade *
EPI Manager
Ministry of Health
Djibouti

PAKISTAN
Professor Tariq Iqbal Bhutta
Chairman, National Certification Committee
Lahore

---

* Unable to attend

Representatives of the European Regional Certification Committee

ITALY
Professor Donato Greco
Member, EUR Regional Certification Commission
Rome

Other Organizations

Rotary International
Dr Keith Barnard-Jones
Past Rotary International Director
International PolioPlus Committee Member
Dorset

Centers for Disease Control and Prevention (CDC)
Dr James P. Alexander, Jr.
Senior Epidemiologist
Atlanta

WHO Offices

WHO headquarters
Dr Bruce Aylward
Director
Polio Eradication Initiative
Geneva

Dr Rudolf Tangermann
Medical Officer
Strategy Implementation Oversight and Monitoring
Geneva

WHO AFRO
Dr Mbaye Salla
IVD Monitoring Officer
Brazzaville

WHO SEARO
Dr Zobaidul Haque Khan
Medical Officer
Polio Certification
Immunization and Vaccine Development
New Delhi

WHO Secretariat

Dr Hussein A. Gezairy, Regional Director
Dr M.H. Wahdan, Special Advisor to the Regional Director for Poliomyelitis Eradication
Dr Faten Kamel, Medical Officer, Poliomyelitis Eradication
Dr Humayun Asghar, Virologist, Poliomyelitis Eradication
Dr Javid Hashmi, Short Term Consultant, Poliomyelitis Eradication
Dr Abdalla Elkasabany, Short Term Professional, Poliomyelitis Eradication
Mr Jalaa Abdelwahab, Technical Officer, Poliomyelitis Eradication
Dr Tahir Mir, Team Leader, Poliomyelitis Eradication, WHO Office Afghanistan
Dr N'ima Abid Team Leader, Poliomyelitis Eradication, WHO Office Pakistan
Mrs Fatma Moussa, Administrative Assistant, Poliomyelitis Eradication
Mrs Rasha Naguib, Senior Secretary, Poliomyelitis Eradication
Mr Mohamed Abdel Mohsen, Helpdesk Assistant, Information System Management
Mr Ihab Ismail, Audio-video Technician, Administrative Service Unit