WHO-EM/POL/377/E

Report on the

# Twentieth meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication

Cairo, Egypt
12–14 May 2009

World Health Organization
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## 1. INTRODUCTION

The Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) held its twentieth meeting on 12–14 May 2009 at the WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt. The meeting was attended by all members of the Regional Commission, chairpersons of the National Certification Committees (NCCs) or their representatives and national programme managers of Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. The meeting was also attended by representatives of Rotary International and the Centers for Disease Control and Prevention (CDC), Atlanta, and staff from WHO headquarters, regional offices for Africa, South-East Asia and the Eastern Mediterranean and the WHO Somalia office.

The meeting was inaugurated by Dr Ali Jaffer Mohammed, Chairman, RCC, who expressed his appreciation for the significant support extended to the RCC activities and their efforts in collection and review of the documentation submitted to the RCC.

A message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean was delivered by Dr Mohamed A. Jama, Deputy Regional Director. In his message the Regional Director referred briefly to the epidemiological situation in the region, particularly to the resurgence of polio in Pakistan and Afghanistan in 2008, and the reasons behind it. He referred also to the continued challenge of importation to some countries of the Region and to its dangerous consequences, especially in those countries with weak routine immunization systems such as Sudan, particularly in the southern states. Dr Gezairy concluded with optimism, noting the high levels of political commitment of national authorities, the dedication of the polio staff and the commitment of polio partners.

The programme of the meeting and the list of the participants are given in 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*

Intensification of polio eradication efforts in the Region continued in 2008, and 2009 and polio-free status was maintained in 19 countries. However, the total number of cases reported from the Region increased three-fold in 2008 as compared to 2007 (175 as compared to 58 respectively). The majority of cases in 2008 were from Pakistan (118 cases). Afghanistan reported 31 cases and Sudan reported 26 cases. As

of 11 May in 2009, 12 cases were reported from Pakistan, 7 from Afghanistan and 33 from Sudan.

The main reason for continued virus circulation in the southern region of Afghanistan is the deteriorating security situation and active fighting hindering safe access to children. The programme continues to use various strategies to access children in these areas including negotiating agreement with all parties to cease hostilities during supplementary immunization activities, short interval doses of mOPV vaccine and making use of every possible window of opportunity to allow access of vaccinators to children. These efforts have allowed limited improvement in access to children in some parts of the southern region. However, so far these efforts could not be sustained long enough to have a real impact on the immunity profile and hence bring an end to transmission.

In Pakistan, the sudden increase in cases starting in second half of 2008 represented an outbreak of WPV 3 in Peshawar (25 cases) and the spread of WPV1 to different parts of the country that was most evident in Punjab where an outbreak due to WPV1 claimed 31 cases after 2 years of freedom from WPV1. Wild viruses also spread to other parts of Pakistan. By the end of 2008 49 districts and towns were infected.

The reasons behind this increase in Pakistan included the decrease in routine immunization from mid 2007, the increased inaccessibility to children in security compromised areas which are endemic foci and the significant population movement out of these areas to other parts of Pakistan. Significant efforts were made on all fronts including advocacy efforts and supplementary immunization activities. As well, updated provincial plans for 2009 were prepared and efforts made to ensure their implementation. While in 2008 the programme implemented 4 NIDs and 7 SNIDs, the plan for 2009 was to increase the number of nationwide activities to 6 NIDs using tOPV in addition to SNIDs and mop-ups using the appropriate mOPV according to epidemiological developments. New tactics including environmental sampling and seroprevalence surveys will be added to better understand the reasons for poliovirus persistence in some areas and to guide future strategies.

In addition to the supplementary immunization activities, several advocacy efforts were made. The Regional Director visited Pakistan and met with H.E. the Prime Minister and other senior officials both at federal and provincial levels. The Prime Minister reaffirmed government commitment to the goal and established an inter-provincial committee for polio eradication. He also launched an action plan for polio eradication in Pakistan focusing mainly on securing active involvement of other sectors in the polio eradication initiatives to ensure a truly national campaign. Coordination also continued with Afghanistan in order to optimize simultaneous comprehensive coverage of the border areas and of children on the move between the two countries.

Sudan is a country at high risk of wild poliovirus importation. There is continuous population movement between Sudan and most of its 9 neighbours including families living on both sides of the borders, nomadic populations, pilgrims on their way to Saudi Arabia, and refugees moving due to insecurity.

Two P3 importations from Chad were recorded in West Darfur in July and December 2008. These detected importations were not followed by secondary cases, which is a reflection of the high immunity level of children and the large-scale high quality immunization response to these importations.

In contrast, following the reporting of 3 P1 cases in Gambella region of Ethiopia early in 2008, the virus started to appear in south Sudan, resulting in spread to 9 different states with 24 cases in 2008 and 28 more cases up to May 2009. This was also followed by detection of 5 related cases, one in Khartoum and four in Red Sea, and spread of virus out of south Sudan to neighbouring countries (Kenya and Uganda). The spread in south Sudan could be explained by the low level of population immunity as a result of weak routine immunization and severe logistical constraints facing immunization campaigns in the country. Supplementary immunization activities using mainly mOPV1 continue to be conducted since May 2008, synchronized with similar activities in Ethiopia. A number of efforts and support, including technical and logistical support, are being provided to address the issues in the quality of supplementary immunization activities.

Coordination with neighbouring countries of other WHO regions is continuing. Coordination meetings for the Horn of Africa (HOA) countries took place in 2008 and 2009 and the HOA bulletin is being issued regularly with input from all countries. As well, the HOA Technical Advisory Group held its third and fourth meetings in July 2008 and February 2009. Synchronization of activities and exchange of information between countries has improved considerably. However, there is still room for improving direct coordination at local levels.

The AFP surveillance system in the Region continues to perform at the accepted international standard and even exceed the required indicators in many priority countries. All endemic, infected or recently polio-free countries have maintained a non-polio AFP rate of at least 2 cases per 100 000 children under the age of 15 and the same was achieved in many other countries, particularly the ones at high risk of importation. None of the countries of the Region reported less than the minimum required level of 1 case per 100 000 population under 15.

The second quality indicator for surveillance (percentage of AFP cases with adequate stool collection) was maintained above the target of 80% at the regional level (90.80%) and in all countries of the Region except in several small countries, where it was slightly lower than the target. These two surveillance indicators are also largely maintained at certification standard at provincial and district levels within countries.

The quality of AFP surveillance is assessed through in depth-review missions. With the exception of the security-compromised Palestine, the system in all countries of the Region has been reviewed by international staff at least once since 2004. These reviews showed that the surveillance systems are adequate to detect any circulating poliovirus or importation. The Regional Office is following up closely the implementation of the recommendations of these reviews.

The regional priorities for polio eradication during 2009 are to:

- interrupt transmission in Pakistan and Afghanistan through intensification of supplementary immunization activities, addressing managerial issues, ensuring high quality performance, and ensuring access to children in the security compromised areas;
- interrupt transmission in south Sudan with focus on improving the quality of supplementary immunization activities and programme management and providing needed logistical support;
- avoid large immunity gaps in polio-free countries; through improvement of routine immunization and implementation of supplementary immunization activities, especially in foci of low population immunity;
- maintain certification-standard surveillance in all countries, both at national and sub-national levels and particularly among high risk areas/populations;
- maintain and further strengthen coordination activities between neighbouring countries, especially between Afghanistan and Pakistan and in the Horn of Africa;
- continue with containment and certification activities; and
- secure the financial resources required to implement the regional plan for eradication.

*2.1.2 Laboratory network / virologic surveillance and containment*
*Dr Humayun Asghar, WHO/EMRO*

The laboratory network continues its high quality of performance and is efficiently supporting AFP surveillance activities. All network laboratories passed the WHO proficiency panel tests for both poliovirus isolation and intratypic differentiation testing (except Kuwait, with ELISA pending) and so all laboratories are fully accredited, except Kuwait, which is provisionally accredited.

The workload of the network laboratories is considerably high. During 2008, the polio network laboratories processed 7613 samples. With the introduction of the new testing algorithm, 95% of samples had culture results within 14 days and 98% had ITD results within 7 days. Overall, in 98% of AFP cases, the final laboratory testing results were provided within 45 days of paralysis onset. The real-time PCR method for rapid characterization of polioviruses is being established in polio intratypic laboratories of the Region.

In early 2008, there was evidence suggesting geographic restriction and decreasing genetic diversity among isolates from Afghanistan and Pakistan. However, there was an increase in the number of cases in Pakistan with numerous chains of transmission introduced into previously polio-free districts, especially in Punjab and Islamabad. Additionally in Sudan viruses are circulating from a single cluster (I-1C5B).

Two WPV1 were isolated from sewage samples; one in September from Al-Haram, Giza and the other in December from El-Haggana, Nasr City. Genomic sequencing showed that the virus isolated from Al-Haram was an importation from Ethiopia, and the virus isolated from El-Haggana was related to a New Delhi, India virus. Environmental surveillance in Karachi and Lahore, Pakistan, will be established soon, pending procurement of equipment and reagents.

All countries of the Region except Afghanistan, Pakistan and Somalia have reported completion of Phase 1 of laboratory survey and inventory activities. National plans of action have been developed by Afghanistan and submitted for the approval of the Ministry of Public Health. 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.

All countries that have completed Phase 1 containment activities were required to submit the quality assurance report. Documentation of the quality of Phase 1 activities was submitted by all of them except Palestine. The original or revised report has not been submitted by 4 countries (Djibouti, Egypt, Lebanon, and Syrian Arab Republic).

*2.1.3 Discussion on the regional overview*

The RCC commended the very informative presentation on the situation of poliomyelitis in the Region. It had noted with concern the increase in the number of cases in 2008 in Pakistan, Afghanistan and Sudan and the reasons behind that. It appreciated actions taken to contain the situation. The RCC regretted that the main reason behind the increase in cases in 2008 in Pakistan, namely movement of the population from security compromised areas, has occurred again in 2009 on a massive scale out of the Swat Valley, an area which has viral circulation and has not been accessible for over a year. The RCC expressed concern about potential consequences of this movement with respect to the epidemiologic situation in Pakistan. It was noted that the polio eradication programme of Pakistan established vaccination posts along the routes of population movement out of Swat and in the camps hosting the displaced populations. However it was noted that the numbers reached are very modest as the majority of displaced persons went into the communities rather than stayed in camps. The RCC recommended that planning for the forthcoming NIDs should take these facts into consideration.

The RCC was also concerned about the potential impact of the devastation that happened as a result of the war on Gaza on the immunity status of children. The commission noted the results of molecular analysis of two isolated vaccine viruses from the environment from West Bank. It also noted that the excellent community participation in ensuring vaccination of their children is resulting in maintaining a good level of routine immunization.

The commission noted with satisfaction the continued progress in maintaining a well functioning regional laboratory network. It was informed of the preparedness of the Regional Laboratory Network to support national efforts for the diagnosis of H1N1 influenza. The commission recommended taking advantage of the importance given to the emerging flu to secure national resources for the establishment of new viral diagnostic and research facilities or the strengthening of existing laboratories in the countries of the Region. This would have the dual effect of supporting the laboratory network for polio and making countries self-sufficient in the diagnosis of priority communicable diseases including influenza.

The RCC noted the strength of the AFP surveillance and was pleased to note the positive impacts of the training workshop for national officers involved in AFP surveillance in countries of the Gulf Cooperation Council. It recommended that similar workshops be held for other groups of countries.

The RCC appreciated efforts being made to strengthen integrated surveillance activities and noted with satisfaction the inputs of the polio surveillance staff in surveillance of other diseases, especially vaccine-preventable diseases. It noted that the chairpersons of the National Technical Advisory groups on immunization will be meeting soon and recommended that the opportunity be taken by polio to brief them on new strategies on polio eradication.

The commission warned against waning in national polio eradication efforts because of the H1N1 pandemic potential and called on national authorities to guard against neglecting polio eradication efforts at this very sensitive juncture in the programme.

### 2.2 South-East Asia Region

*Dr Nalini Withana, Member, SEA Regional Certification Commission*

Of the 11 countries in WHO South East Asia Region, only India has reported WPV transmission (P1-14; P3-26) during the first 4 months in 2009. Of the 4 countries that had polio outbreaks during the past 4 years, either due to an importation only or due to an importation and cVDPV, Indonesia, Bangladesh and Myanmar have been free of polio for more than 2 years. Nepal, which had multiple importations due to its long porous border with the polio endemic states of northern India, has also been free of polio for 6 months.

In 2009, India has a unique opportunity to eradicate WPV1. Efforts are currently focused on breaking transmission in some remote areas in Bihar around the Kosi River. Multiple campaigns with mOPV1 are expected to stop WPV1 transmission and, once WPV1 is eradicated, dealing with WPV3 using more rounds of mOPV3 is expected to be easier.

The endemic and re-infected countries are consistently meeting the targets for surveillance indicators, but some gaps are still seen when the indicators are analysed at the sub-national level. Smaller countries like Bhutan, Maldives and Timor Leste have a problem in reaching the targets that is probably related to the small population size. Thailand and Sri Lanka, which had been maintaining targets regularly, did not meet these targets in 2008 and this is a major concern.

The eradication programme in the region is supported by an excellent polio laboratory network comprising 1 global specialized laboratory (GSL), 3 regional reference laboratories (RRLs) and 12 national poliovirus laboratories (NPLs). Stool samples from Bhutan and Nepal are being tested at RRL Bangkok and those from Maldives, at RRL-Colombo. Seven laboratories in the region are performing intratypic differentiation tests using both antigenic and molecular tests; GSL in Mumbai is doing the genomic sequencing. The network laboratories are reviewed annually and are fully accredited. In 2008, the laboratories have tested 101863 stool samples and ITD tests have been performed on 4439 polioviruses. GSL in Mumbai is also regularly testing environmental samples.

Laboratory containment activities in the region commenced in 2000. Nine countries have completed phase 1 activities and have submitted their final reports; they also continue to provide annual updates. In 2009, India is scheduled to conduct Phase 1 activities in the polio-free areas, the 4 re-infected countries will revise their Phase 1 activities and Timor Leste will initiate containment activities. GSL Mumbai acts as a wild poliovirus repository for the region.

The South-East Asia Regional Commission for Certification of Polio Eradication has 11 members and meetings are held regularly. Full national certification reports have been accepted by the commission for all countries except India and Timor Leste. Countries are regularly submitting updates, including updates on laboratory containment, which is an integral part of certification, updated plans on WPV importation and cVDPV outbreaks, and information related to IHR implementation.

### 2.3 European Region

*Professor David Salisbury, Chairman, EUR Regional Certification Commission*

The polio eradication programme in the WHO European Region concentrated its efforts towards sustaining the polio-free status in the region. It is recognized that the risk of importation of wild poliovirus into the region remain high, particularly as

the travel between Europe and endemic countries is extensive. This risk varies between countries. It was judged to be high in 5 countries, intermediate in 7 countries and low in the rest.

The European Regional Certification Commission (ERCC) emphasized the need to maintain strong political commitment to polio eradication and activation of national plans to address importation.

Most of the countries of the European Region have achieved more than 95% coverage with 3 routine doses. Some countries are using IPV, others OPV and some combined IPV/OPV schedule. However timely provision of immunization is a problem in several countries and national data often show under-performing districts.

Different types of surveillance measures are being implemented in countries of the European Region. Some are implementing AFP surveillance and others are relying on enterovirus and/or environmental surveillance. It is noted that there is a declining trend in the non polio AFP rate during the past 5 years, and it was just over 1 case per 100 000 population under 15 years in 2008. However the quality indicators have been maintained.

The ERCC in its last meeting identified several key areas to address the challenges facing maintenance of the polio-free status, particularly to sustain/strengthen high quality surveillance, maintain/strengthen high level of immunity against polio, assume appropriate response to possible importation, prepare for OPV cessation and assure required financial and human resources at regional and national levels.

### 2.4 African Region

*Professor Oyewale Tomori, Member, AFR Regional Certification Commission*

In 2008, a total of 920 WPV cases were reported from 13 countries, with 806 (88%) from Nigeria alone. As of 29 April 2009, 307 WPV cases have been reported from 13 countries, with Nigeria reporting the highest number of 236 (76.8%) of all cases. There were many episodes of WPV importations and spread in the African Region. In 2008, there were importations from Nigeria into Chad, Democratic Republic of Congo into Central African Republic, Angola into Democratic Republic of Congo. In 2009, importations continue from south Sudan into Uganda and Kenya. Prior to these importations, the last case of WPV in Uganda and Kenya was in 1996 and 2006 respectively.

The continuing spread of WPV in Africa is attributable to several factors including: the high numbers of un-immunized children, despite numerous supplementary immunization activities and reported high coverage by monitoring data; persistent sub-national gaps in AFP surveillance, as evidenced by the detection of orphan viruses in Angola, Chad, Ethiopia, Niger and Nigeria. Other issues are sub-

optimal surveillance data quality (cleaning process, analysis, completeness, timeliness).

The priorities for the African Region in 2009 are:

- Interruption of WPV circulation in Nigeria and importations into other countries;
- Implementation of high quality supplementary immunization activities in west African, central African and Horn of Africa countries;
- Improving sub-national AFP surveillance indicators (to achieve at least NP-AFP rate of 2 per 100 000);
- Enhancing political commitment for polio eradication in the African Region;
- Mobilizing additional resources for the polio eradication programme; and
- Increasing population immunity through high quality routine immunization services.

**2.5 Global overview**

*Dr Roland Sutter, WHO headquarters*

The progress towards polio eradication in 2008 and 2009 (the first 4 months) has been mixed. The number of polio-endemic countries (Afghanistan, India, Nigeria and Pakistan) remains constant since 2005 (when Egypt achieved elimination). The number of countries reporting poliovirus in 2008 was 18 (compared with 12 in 2007). Likewise the number of confirmed polio cases in 2008 (1652 cases) was higher than in 2007 (1315 cases). In 2009 as of 5 May, the reported number of polio cases (n=396) is very similar to the number reported during the same time frame in 2008 (n=383).

The situation has been particularly grim in Africa, where Nigeria continues to conduct suboptimal supplemental immunization campaigns, and again exports poliovirus types 1 and 3 directly and indirectly to neighbouring countries in western, central and eastern Africa. The situation within Nigeria is of concern, as there is now widespread circulation of poliovirus type 1 in southern Nigeria, while in northern Nigeria poliovirus type 1 predominates. There is a glimmer of hope, and the proportion of unvaccinated non-polio AFP cases has decreased in some states. However, these achievements in Nigeria have in the past, in general, been quite fragile.

The rest of Africa is in an outbreak control mode once more. Poliovirus appears to spread westward along the coastal route and in the north through Burkina Faso, with poliovirus as far west as Ivory Coast, as far east as Chad, Uganda and Kenya (the latter infected through south Sudan). Also in Angola and the Democratic Republic of the Congo, outbreak control efforts have been ongoing for several years to combat the outbreaks caused by multiple importations of poliovirus types 1 and 3 from India. In response, an ambitious action plan is being put into effect to boost population

immunity in many countries in the African Region, which should prevent or limit the size of outbreaks after poliovirus importation.

In Sudan, the situation is also of great concern. Over the past few years, the quality of immunization activities has deteriorated in south Sudan, allowing poliovirus to circulate widely, and to be exported to northern Sudan, Uganda, Kenya, and as far north as Egypt (poliovirus detected in environmental samples). The detection of poliovirus in Red Sea Governorate is particularly worrisome, since there are massive population movements moving through this governorate, using the sea ports to reach the Arabian Peninsula for pilgrimage, and for economic reasons.

In Asia, a low level of transmission continues in India, Pakistan and Afghanistan, despite expansion of the number of supplementary immunization activities. The problem in India appears to be variable programme implementation (in general the programme performance is excellent), aggravated by low vaccine efficacy, allowing poliovirus to be imported and circulate locally. In Pakistan and Afghanistan, security and access continue to be a major problem: the recent fighting in and around the Swat Valley, with large populations fleeing the fighting, is an opportunity to reach these populations and administer polio vaccination, and thus improve the population immunity in these vulnerable populations. At the same time it can create problems with respect to viral spread in the areas involved.

In parallel, a number of research projects that may have substantial programmatic implications will come to fruition in the third quarter of 2009. The first is the development of bivalent 1 and 3 OPV (bOPV). bOPV, if more immunogenic than tOPV for types 1 and 3, would be used widely, making decisions easier for programme managers in areas where both serotypes are circulating, and could lead to substantial changes in strategic approaches to enhancing population immunity. In addition, a trial in Moradabad (Western Uttar Pradesh, India, the epicentre of polio in India) is assessing both higher-potency mOPV1 and fractional dose IPV (1/5 of a full dose given intradermally) for their potential role to close the remaining immunity gaps. Again both of these approaches could lead to substantial programme changes. The strategic plan of action for polio eradication in 2010–2014 will likely reflect these changes.

Although there is substantial concern about the slow progress towards eradication, the renewed expansion of poliovirus in Africa, the low-level endemicity of poliovirus Asia, and the effects of the recent fighting in Pakistan, the programme today is much stronger (by virtually all indicators and measures), the population immunity levels substantially higher (confirmed by modelling studies), and the resolve of the world community (reflected in funding and political support) much stronger than it was just a few years ago. With the continuing innovations, including the introduction of new vaccines and strategies, and appropriate programme resources, efforts should finally result in a decrease in the number of polio-endemic countries and substantial decreases in polio incidence worldwide.

### 2.6 Discussion on other regional and global presentations

The discussion referred to competing priorities and the economic recession and its potential impact on polio eradication. It was emphasized that the present situation concerning H1N1 should be utilized for the long term benefits of the programme especially with respect to surveillance and laboratory support.

The RCC expressed concern about the apparent waning in the eradication efforts in many of the countries, especially those that have not seen cases for some years. It was noted that in the Eastern Mediterranean Region regular reporting to countries of the region in the polio fax and at times of the Regional Committee and other meetings such as the regional TAG meeting and the EPI Managers meeting have served to maintain political commitment of all countries of the Region.

### 2.7 Implications of the recommendations of the fifth meeting of the WHO Advisory Committee on Polio Eradication (ACPE)

*Dr Yagoub Al Mazrou, Member of ACPE and EM RCC*

The fifth meeting of the ACPE took place in WHO headquaters on 18 and 19 November 2008. While reaffirming the technical feasibility of polio eradication, the ACPE noted that the milestones established in early 2007 were not fully achieved due to factors of different weight in various countries. Concerning the Eastern Mediterranean Region, the main reason identified in Afghanistan is insecurity, while in Pakistan it is the suboptimal campaign quality and insecurity. The ACPE made specific recommendations for each of the 4 endemic countries to address the main factors behind continued circulation of the virus.

The ACPE welcomed the DG's decision to commission an independent review of the programmes in the 4 remaining endemic countries and looked forward to the outcome of this review.

For the non-endemic countries, the ACPE highlighted the significant risk of importation and recommended that countries at particular risk of WPV importation should consider steps to ensure the immunization of travellers and maintain the highest possible routine immunization coverage of their children.

The full report of the ACPE meeting was published in the WHO Weekly Epidemiological Record (issue No. 3, 2009, 84, pages 17–28). It can be accessed through the website http://www.who.int/wer.

## 3. REVIEW OF NATIONAL REPORTS

### 3.1 Abridged annual updates for the year 2008

The RCC considered the abridged annual update reports for 2008 submitted by Bahrain, Islamic republic of Iran, Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya,

Oman, Morocco, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia and United Arab Emirates and found that they were on the whole satisfactory and needed only minor amendments. Therefore it was decided to provisionally accept these reports. Comments on individual reports will be relayed to the chairperson of the National Certification Committee who will be requested to amend the report and send the amended version to EMRO.

### 3.2 Annual updates for the year 2008

The RCC considered the annual updates for 2008 submitted by the NCCs of Egypt and Yemen and found them to be satisfactory and providing convincing evidence that the two countries remain free of polio. The RCC expressed concern about the low coverage rates with OPV in some districts in Yemen and cautioned against the possibility of build up of immunity gap and recommended that a second round of NIDs be organized within the next few months.

The commission regretted that it has not been possible for the Palestinian team to present their annual update for 2008 and hoped that it would be submitted in the next meeting later in 2009.

### 3.3 National document of Somalia

The RCC noted that it has been possible to constitute a National Certification Committee (NCC) in Somalia in spite of the prevailing circumstances. It noted that the NCC is composed of a large number of nationals and recommended that efforts be made to ensure that the NCC becomes functional and a Chairman is identified.

The RCC greatly appreciated the remarkable efforts of all national and international polio staff in maintaining the polio free status of Somalia under very difficult and dangerous circumstances.

The RCC appreciated the complete and well documented report and 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 temporarily to the WHO focal person from the Chairman of the RCC.

## 4. OTHER MATTERS

The RCC requested to further refine the wording of certain items such as the data about laboratory accreditation for programmes that have no national laboratory.

The RCC reiterated its previous recommendation that national authorities in all countries of the Region take necessary steps to register mOPVs for use in their

countries. This would facilitate their use should it become necessary to address importation.

It was recommended to hold the next (21st) meeting of the RCC on 14–15 October 2009 in Alexandria, Egypt.

**Annex 1**

**PROGRAMME**

**Tuesday, 12 May 2009**

| | |
|---|---|
| 08:30-09:00 | Registration |
| 09:00-09:30 | Opening session |
| | Introductory remarks Dr A. Jaffer Mohamed, Chairman of RCC |
| | Message from RD/EMRO Dr M. A. Jama, DRD/EMRO |
| | Adoption of agenda |
| 09:30-10:30 | Overview of the present situation of polio eradication in the EMR |
| | Dr F. Kamel, WHO/EMRO, Dr H. Asghar, WHO/EMRO |
| 10:30-11:30 | Discussion on the EM regional overview |
| 11:30-12:30 | Overviews of other regions |
| | SEAR Dr N. Withana, Member SEARCCPE |
| | EUR Prof. D. Salisbury, Chairman EUR RCC |
| | AFR Prof. O. Tomori, Member ARRC |
| | Global overview Dr R. Sutter, WHO/HQ |
| 12:30-13:30 | Discussion |
| 13:30-14:00 | Implications of the recommendations of the ACPE meeting, 18–19 November 2008 for certification in the Regions Dr Y. Al Mazrou, Member, ACPE |
| 14:00-16:00 | Private meeting of the EM/RCC |

**Wednesday, 13 May 2009**

| | |
|---|---|
| 08:30-11:00 | Review of Abridged Annual Update Reports of Libya, Tunisia, Bahrain, Iran and Iraq |
| 11:00-13:30 | Review of Abridged Annual Update Reports of Jordan, Lebanon, Morocco and Oman |
| 13:30-15:30 | Review of Abridged Annual Update Reports of Qatar, Saudi Arabia, Syria and United Arab Emirates |
| 15:30-17:00 | Review of Annual Updates of Egypt, Palestine and Yemen |
| 17:00-18:00 | Private Meeting of the EM/RCC |

**Thursday, 14 May 2009**

| | |
|---|---|
| 08:30-09:30 | Private meeting of the EM/RCC |
| 09:30-11:00 | Review of the national documentation for certification for Somalia |
| 11:00-13:30 | Private meeting of the EM/RCC |
| 13:30-14:30 | Closing session and concluding remarks |

## Annex 2

## LIST OF PARTICIPANTS

### Members of the Eastern Mediterranean Regional Certification Commission

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