

Report on the

**Twenty-fourth meeting of the Eastern
Mediterranean Regional Commission for
Certification of Poliomyelitis Eradication**

Dubai, United Arab Emirates
12–14 April 2011

© World Health Organization 2011

All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Distribution and Sales, World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 2670 2535, fax: +202 2670 2492; email: PAM@emro.who.int). Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: GAP@emro.who.int.

CONTENTS

1.	INTRODUCTION	1
2.	IMPLEMENTATION OF THE COMMENTS AND RECOMMENDATIONS OF THE TWENTY-THIRD MEETING OF THE RCC.....	2
3.	OVERVIEW OF THE SITUATION OF POLIOMYELITIS ERADICATION	3
3.1	Overview of the Eastern Mediterranean Region.....	3
3.2	Overview of polio eradication activities in the WHO African Region	5
3.3	Overview of polio eradication activities in the WHO European Region.....	6
3.4	Overview of polio eradication activities in the WHO South-East Asia Region	7
4.	DISCUSSION OF REPORTS	10
5.	OTHER MATTERS.....	11
Annexes		
1.	PROGRAMME	13
2.	LIST OF PARTICIPANTS	14

1. INTRODUCTION

The twenty-fourth meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was hosted by the Government of the United Arab Emirates and held in Dubai from 12–14 April 2011. The meeting was attended by members of the RCC and chairpersons of the National Certification Committees (NCC) or their representatives and programme managers from 15 countries (Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Oman, Morocco, Palestine, Qatar, Sudan (north and south), Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen) and WHO Somalia. Unfortunately representatives of the National Certification Committee of the Libyan Arab Jamahiriya could not attend because of the prevailing security situation. The meeting was also attended by WHO staff from headquarters and the Regional Offices for Africa, the Eastern Mediterranean, Europe and South-East Asia and by representatives of Rotary International and the U.S. Centers for Disease Control and Prevention (CDC).

The meeting was opened by Dr Ali Jaffer Mohamed, Chairman of the Regional Certification Commission, who thanked the Government of the United Arab Emirates and the Minister of Health for hosting the meeting and acknowledged the continued and deep involvement of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean in regional and global polio eradication efforts. He welcomed the chairpersons of the National Certification Committees and the programme managers and thanked them for their continued efforts in keeping their countries free of polio and for the timely submission of their reports to the RCC. The chairman welcomed the representatives of Rotary International and CDC and WHO staff from headquarters and regional and country offices.

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, thanked H.E. the Minister of Health of the United Arab Emirates for honouring the meeting with his presence in the opening session, and acknowledged the generous support of the Government of the United Arab Emirates to polio eradication efforts in the Region. He referred with concern to the situation in Pakistan, where wild polioviruses were still circulating and where the number of cases in 2010 was more than at any time in the last 10 years. He hoped that the significant move by national authorities, particularly the development and implementation of a national emergency action plan, would effectively address the polio situation. He also expressed concern about the developments in south and central Somalia with respect to lack of access to children for vaccination, resulting in the creation of a large susceptible pool of hundreds of thousands of children under five. He ended on a note of optimism that with continued efforts of all concerned nationals and the support of partners, the Region would bring an end to the circulation of wild polioviruses in the near future.

H.E. Dr Hanif Hassan Ali, Minister of Health of the United Arab Emirates, acknowledged the efforts of the Regional Director and members of the RCC and national authorities in the eradication of poliomyelitis. He referred to the success achieved in the United Arab Emirates, with the last case of polio reported almost 20

years ago, and reaffirmed the commitment of the Government of the United Arab Emirates to continue its support to the eradication initiative.

The Chairman of the RCC ended the opening session by a note of thanks and sincere appreciation to the Crown Prince of Abu Dhabi for his very generous donation in support of polio eradication efforts in Afghanistan and Pakistan. This support, together with that of other partners, is essential to ensure that the eradication efforts in the two countries will not face financial constraints which could be detrimental at this very critical stage of the programme.

The programme of the meeting and the list of the participants are attached as Annexes 1 and 2, respectively.

2. IMPLEMENTATION OF THE COMMENTS AND RECOMMENDATIONS OF THE TWENTY-THIRD MEETING OF THE RCC

In presenting this subject, Dr M.H. Wahdan indicated that the situation in Pakistan has been the focus of the RCC comments and discussions. He summarized developments related to these comments.

The visit of the Regional Director and Director-General to Pakistan in November 2010 resulted in the President of Pakistan calling for the preparation of a national emergency action plan which was prepared immediately and launched in January 2011. Its objective is to interrupt transmission of polioviruses in 2011. The plan brought several long-awaited elements, particularly engagement of all government arms, sustained oversight at all levels, concentrated efforts in high-risk areas and effective monitoring of programme performance. There is evidence that the national emergency action plan is being implemented and that close follow-up of its implementation is being pursued.

The successful experiences and lessons learned from India and Nigeria are being implemented with the support of WHO. These include introduction of validation tools for independent monitoring such as lot quality assurance (LQA) and use of GPS in monitoring performance.

The RCC's concerns about Djibouti surveillance and immunity are being addressed. A national immunization day campaign (NID) was conducted in December 2010 and efforts to strengthen surveillance are ongoing.

Concerning Sudan, efforts to strengthen surveillance are ongoing and a rapid assessment of surveillance will take place in Sudan immediately following the RCC meeting. A surveillance review in south Sudan was just completed and its recommendations will be implemented. Analysis of the immunity profile shows continued improvement in population immunity.

The RCC noted with satisfaction that the comments and recommendations made during its last meeting on 19–20 October 2010 were and are being implemented.

3. OVERVIEW OF THE SITUATION OF POLIOMYELITIS ERADICATION

3.1 Overview of the Eastern Mediterranean Region

Dr T. Mir, WHO/EMRO

Nineteen countries of Region maintained their polio-free status for five or more years. The epidemic that spread in Sudan starting in June 2008 came to an end after one year, with the last case reported from south Sudan in June 2009. However, the recent isolation of wild poliovirus type 1 (WPV1) from a sewage sample from Aswan, Egypt, linked with poliovirus circulation in Sudan 2008–2009, indicates surveillance gaps. The response to the Aswan isolate included boosting the immunity in this area as well as fixing gaps in surveillance for acute flaccid paralysis (AFP). The recently conducted review of AFP surveillance by an international team of experts in south Sudan and an independent rapid assessment of the surveillance situation in northern Sudan are expected to discover any gaps in surveillance. Concerning efforts to boost immunity, it is planned to conduct a special supplementary immunization activity covering the three Sudan states bordering Egypt, in addition to Khartoum. In Egypt, surveillance in Aswan was reviewed and it is planned to conduct supplementary immunization activities covering this province.

Pakistan and Afghanistan are the only endemic countries in the Region. In Afghanistan, circulation is localized in the southern part of the country and remaining areas are without any established circulation. In the context of milestones of the global strategic plan for polio eradication 2010–2012, the assessment indicates that Pakistan is ‘at risk’. For Afghanistan the assessment is that polio eradication is “progressing but with issues of concern” in the South. Surveillance in both countries is “on track”.

The majority of the polio cases in Pakistan are from Khyber Pakhtunkhwa/Federally Administered Tribal Areas (KP/FATA) and Sindh, where campaign quality is compromised due to security and management reasons. The Government of Pakistan has launched the national emergency action plan with the target of eradicating polio by the end of 2011. Key steps being taken to improve campaign quality include: establishment of the national task force; charging district coordination officers (DCO) with responsibility for supervising activities in their district; updating specific district and Union Council plans with focus on pre-campaign activities to ensure quality implementation; improving mobile population strategy; tightening supervision and monitoring; and not tolerating poor performance. In this regard, weak performing executive district officers and agency surgeons are being changed.

AFP surveillance indicators (non polio AFP rate and percentage of adequate stools) are satisfactory at national and regional levels, but subnational data analysis is showing some gaps. In 2010, AFP surveillance reviews were conducted in 8 countries: Afghanistan, Egypt, Lebanon, Morocco, Somalia (desk), south Sudan (desk), Tunisia and Yemen. The recommendations of these reviews are being addressed by relevant authorities with actions aimed at improvement of the system. The laboratory network is providing excellent support and bio-safety measures are followed up. The isolation of circulating vaccine-derived polioviruses (cVDPVs) from Afghanistan and Somalia reflects poor routine EPI coverage in these areas.

The regional risk assessment model is being used regularly to assess the risk for WPV outbreak following importation. Countries are timely alerted and helped to take necessary action. Recent review has highlighted Somalia and Yemen as high-risk countries. In Somalia, efforts to negotiate access to 770 000 children living in central and southern Somalia under Al Shebab control have not yet succeeded. In Yemen, a vaccination round is being planned with priority being given to the high risk areas.

Discussion

The RCC, having reviewed the epidemiological situation of poliomyelitis in Pakistan, noted with concern the continued deterioration of the situation which is compromising the achievements of the global programme as indicated in the global strategic plan (2010-2012) and noted the fact that Pakistan is the only endemic country where the poliomyelitis situation is deteriorating. As well, Pakistan represents a potentially serious threat of possible spread to polio-free countries of the Region and elsewhere.

The RCC, while acknowledging the potential value of the national emergency plan, believes that only through full and effective implementation of the plan, particularly at the delivery level, will improvements result. The RCC emphasized the need for the development of clear indicators for measuring performance at all administrative levels, particularly at the Union Council level.

The RCC emphasized that the situation in Yemen is of special concern particularly in the light of the risk analysis showing a potentially high risk of spread following WPV importation. As well, the recent political unrest increases this risk. The RCC strongly recommended that a plan be prepared urgently for supplementary immunization activities to be implemented as soon as possible in any one or more provinces.

The RCC noted with concern the isolation of WPV1 through the ongoing environmental monitoring in Egypt from Aswan province. The genomic link between the isolated virus and the latest isolates from north and south Sudan that were circulating during the 2008–2009 epidemic denotes a gap in surveillance during the period since the last isolate from Sudan in June 2009, to the end of 2010. The RCC

took note of actions taken by WHO, Sudan and Egypt authorities both in assessing surveillance to discover weak points and in boosting population immunity in Sudan and Aswan province in Egypt.

3.2 Overview of polio eradication activities in the WHO African Region

Dr S.O. Okiror, WHO/AFRO

As at the end of 2010, a total of 599 cases of confirmed polio affecting 12 countries had been reported in the African Region, compared to 691 affecting 19 countries in 2009. In 2011 as at 8 April, a total of 60 cases (53 WPV1 and 7 WPV3) have been confirmed in the region. The high number of confirmed polio cases in 2010 is attributable to the outbreak of wild poliovirus type 1 transmission affecting mainly adults in the Republic of Congo, which resulted in 383 cases in 2010. Importations in 2009 and 2010 resulted in outbreaks in 15 countries that have been monitored under milestone 1 of the global strategic plan 2010–2012

Three countries in the African Region are categorized as re-established transmission countries namely, Angola, Chad and Democratic Republic of Congo. They continued to report WPVs in 2009 and 2010 respectively.

cVDVPs of all 3 types were reported in the African Region in both 2009 and 2010 in four countries. A total of 164 cVDVPs were reported in 2009, compared to only 50 in 2010. Nigeria accounted for 155 cases in 2009 but this number dropped significantly to only 25 in 2010.

In line with the global strategic plan 2010–2012, the Regional Director for Africa sent letters to all Heads of State in West and Central Africa as well as the Chairperson of the Economic Community of West African States requesting their personal oversight for the implementation of polio eradication activities. Accordingly, 29 countries implemented supplementary immunization activities in response to the epidemiologic situation.

Over 114 million children were reached with over 440 million doses of OPV. During these supplementary immunization activities, independent monitoring was carried out and corrective actions were taken including revaccination of the areas with more than 5% missed children.

At regional and national levels, the two main indicators (non-polio AFP rate and rate of adequate stool) have been achieved, while significant gaps have been identified at subnational level as evidenced by the detection of orphan viruses in a number of countries in the past two years.

All the 16 African polio network laboratories have been fully accredited. At least 96% of the primary isolation results are provided within 14 days of specimen

reaching the laboratory. Additionally at least 90% of ITD results are provided within 7 days.

Certification activities in the region continued to be implemented with countries mostly preparing their annual reports for review by the African RCC. No meeting was held over the past two years as the programme was focused on reducing transmission of wild poliovirus. The number of countries with reports fully reviewed and accepted by the African RCC remains at 25 out of the 46 countries.

3.3 Overview of polio eradication activities in the WHO European Region

Dr R. Martin, WHO/EURO

The European Region of WHO was declared as have eradicated polio in 2002 after the last indigenous case in Turkey in 1998. Most countries of the Region have strong systems for detecting polio cases. Immunization services are well established with high and stable coverage with 3 doses of polio vaccine in a vast majority of Member States. Countries conduct outreach strategies for vulnerable populations – particularly socially isolated, internally displaced and refugee populations mainly in association with the annual European Immunization Week.

Surveillance for polioviruses remains strong in the Region with 43 countries employing AFP surveillance, 38 relying on enterovirus surveillance and 21 conducting environmental surveillance. AFP rates remain high at national level for most countries using AFP surveillance.

The main concerns for the Region include: the timely provision of immunization and under-performing districts in several countries, the slowly declining quality of AFP surveillance (particularly in the western part of the Region), and the declining quality of work of the National Certification Committees.

In 2010, the Region experienced a serious epidemic due to importation. Genetic sequencing revealed that the wild virus was related to polioviruses circulating in Uttar Pradesh, India. In 2010, 477 laboratory-confirmed polio cases were reported (458 from Tajikistan, 15 from Russian Federation, 3 from Turkmenistan, and 1 from Kazakhstan). The last confirmed case in the Region was reported from the Russian Federation with date of onset in September 2010. In response to the outbreak, Tajikistan and other countries in the Region implemented optimum supplementary immunization activities resulting in high coverage. More than 45 million doses of mOPV1 and tOPV were delivered during outbreak response immunization activities in the Region.

The most urgent priorities for the European Region are to:

- stop circulation of WPV in the region, and reduce the risk of subsequent outbreaks;
- strengthen surveillance in all high risk countries to ensure certification-level standard surveillance; and
- strengthen demand for routine immunization – particularly in underserved populations.

In September 2010, the Regional Committee for Europe adopted a resolution calling for ensuring continuous political commitment and support, maintaining high level immunity against poliomyelitis, sustaining high quality AFP surveillance, preserving and expanding (if necessary) supplementary virological surveillance for polioviruses, assuring appropriate response to possible importation of wild poliovirus or detected cVDPV circulation and meeting the requirements for laboratory containment of wild polioviruses, preparing for cessation of OPV, and assuring appropriate financial and human resources to support the work of the initiative.

At its 24th meeting, the European RCC concluded that the evidence presented indicated that WPV transmission had stopped, but that more information was needed about the northern Caucasus owing to the high risk of transmission in the recent past and the presence of molecular evidence of local transmission. Further reports from the infected countries, due in July 2011, will allow the RCC to make a recommendation on the certification status of the WHO European Region.

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

Dr P. O'Connor, WHO/SEARO

India is the only country in the region with endemic transmission of wild poliovirus. Within India, polio transmission has remained endemic in focal areas of only two states, Uttar Pradesh and Bihar. As a result of concerted efforts from 2009–2010, the number of polio cases in India has shown a significant decline. Only 42 polio cases (18 WPV1 and 24 WPV3) were detected in India during 2010 compared to 741 polio cases (79 WPV1, 661 WPV3 and 1 WPV1+3) detected in 2009. The endemic state of Uttar Pradesh has not reported any WPV1 case since November 2009 – the longest period ever since surveillance was initiated in 1997 in India. In 2011, there has been only one case of WPV1 detected in India, in Howrah district of West Bengal.

Nepal is the only other country in the region that had active circulation of WPV in 2010. Six WPV1 cases were detected in 2010 in two districts of Nepal that share a border with Bihar, India. These cases were from two separate importations of wild poliovirus from India. The last case was reported on 30 August 2010.

A single VDPV-P2 case was reported from Myanmar with date of onset 6 December 2010 in a seven-month child with zero doses of OPV. The immediate

response included an active case search (no additional cases were found) and rapid immunization of 13 000 children under 5 years of age in the villages around the case with tOPV. A rapid AFP surveillance review was conducted in February 2011 and made recommendations for enhanced AFP surveillance, supplementary immunization activities and advocacy with the government and partners. This case highlights the importance of routine immunization for maintaining polio-free status in non-endemic countries.

The remaining eight countries in the region are polio-free. However, it is important to remember that all countries in the region remain susceptible to importation of the wild poliovirus from India and other endemic and re-infected countries outside the region.

In all countries of the region, polio eradication strategies include essentially: immunization and AFP surveillance. Countries are requested to maintain high levels of immunity against polio through high routine immunization coverage (OPV3) and limited supplementary immunization activities focusing on border areas with India, migrant/refugee populations, slum/underserved populations, highly dense urban areas, areas with previous imported cases, and conflict and inaccessible areas.

As regards surveillance, countries are requested to sustain uniform high quality AFP surveillance in all districts through regular subnational analysis based on the standard AFP surveillance indicators especially in the high-risk areas. The risk for polio importation and circulation is reviewed and updated biannually on a ten-point criteria system established in 2005. The availability of plans for timely and adequate response to importations remains important in order to prevent local circulation.

All polio-free countries are submitting annual certification updates. However, the last meeting of the South-East Asia RCC was in December 2008. With the substantial progress made in 2010 towards polio eradication in the region, the certification process needs to be revitalized. The next certification meeting is planned for December 2011.

3.5 Achievements with respect to the strategic plan 2010-2012

Dr R. Tangermann, WHO/HQ

The global polio eradication initiative launched a new strategic plan for 2010–2012 in June 2010. In January 2011, the WHO Executive Board noted the impact of the new strategic plan, in particular the strong progress achieved in India and Nigeria, and expressed concern at the ongoing re-established transmission (in Chad, Angola, and Democratic Republic of the Congo), the continued international spread of wild poliovirus, and, in particular, the gap in financing which threatened to undermine recent progress.

In addition, the Executive Board welcomed the establishment of the new Independent Monitoring Board, which held its inaugural meeting on 21–22 December 2010 and a second meeting on 30 March – 1 April 2011. The Board will meet quarterly to monitor the implementation and impact of the new strategic plan 2010–2012 against major milestones and process indicators established for that purpose, and to advise countries and partner agencies on corrective actions as appropriate.

Progress towards the first¹ and third² milestones of the strategic plan is broadly on track; however, other serious obstacles remain. In particular, attainment of the second, end-2010 milestone of stopping all “re-established poliovirus transmission” was missed in Angola and Chad and is at high risk of being missed in the Democratic Republic of the Congo. The only “re-established transmission” country which has probably achieved this milestone is Sudan. However, a wild poliovirus 1 genetically related to 2008 transmission in Sudan was recently detected in a sewage sample collected in Aswan, Egypt.

Both India and Nigeria, and possibly Afghanistan, are ‘on track’ to achieve the third, end 2011 milestone of stopping poliovirus transmission in countries where the virus is endemic.

Recognizing these risks, and in keeping with the provisions of the strategic plan 2010-2012, Angola, the Democratic Republic of the Congo and Pakistan established or updated their emergency plans to intensify eradication activities, under the authority of their respective heads of state. These plans were presented to the Independent Monitoring Board on 21-22 December 2010, with implementation beginning in January 2011; Chad presented its emergency plan to the Board at its second meeting at the end of March 2011.

International spread of wild polioviruses continues to pose a substantial risk to achieving a polio-free world. All except one (Liberia) of the 11 new outbreaks in 2010 have been stopped within six months, or are on track to be stopped in such a time frame. However, the explosive nature of the 2010 outbreaks in the Republic of Congo (Brazzaville) and Tajikistan, both of which are associated with further international spread of wild poliovirus, clearly demonstrates this ongoing risk.

With the declining incidence of wild poliovirus globally, Member States are taking additional measures to reduce the risk of new outbreaks caused by the international spread of wild polioviruses or the emergence of circulating vaccine-derived polioviruses. These measures include supplementary and routine

¹ Interruption, by mid-2010, all outbreaks in previously polio-free countries which started in 2009, and interruption of all outbreaks starting in 2010 within 6 months of the first case

² Interruption of all WPV transmission in at least two of the four remaining ‘endemic’ countries by end-2011

immunization activities to close gaps in population immunity and vaccination of travellers to and from poliomyelitis-affected areas. Similarly, ensuring timely vaccination responses to circulating vaccine-derived polioviruses has become increasingly important as progress is made towards the eradication of wild polioviruses. In 2010, outbreaks due to cVDPVs have occurred in Afghanistan, Democratic Republic of the Congo, Ethiopia, India and Nigeria.

4. DISCUSSION OF REPORTS

The RCC reviewed 17 reports from NCCs about the situation in 2010. Fourteen of these reports were abridged annual reports and three were annual updates.

The RCC reviewed the abridged annual update of Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia and United Arab Emirates.

The RCC provisionally accepted the reports but made comments on each of them which will be conveyed to the chairpersons of the NCC with a request to review and update the report taking these comments into consideration.

The RCC reviewed the annual updates of Somalia, Sudan, south Sudan (for the first time separated) and Yemen.

The RCC provisionally accepted the reports. However it made some comments which will be conveyed to the chairperson to take them into consideration in updating.

In order to support the NCC chairpersons with respect to ensuring implementation of the RCC recommendations, it has been agreed with the Regional Director that in addition to the usual letter from the RCC chairman to NCC chairpersons, an additional letter will be sent from the Regional Director to the Ministers of Health conveying the RCC's general recommendations together with the specific comments on the report made by the RCC.

5. OTHER MATTERS

Risk analysis

The RCC welcomed the development of the risk analysis approach of potential transmission of WPVs following importation. The RCC hoped that such analysis would enable national polio eradication programmes in identifying areas and activities for.

Definition of AFP cases

The RCC noted that the reported AFP cases included diagnoses which do not under normal circumstances present with acute flaccid paralysis. As much as the RCC wishes to emphasize on ensuring sensitivity of the AFP system, it warns against the situations in which such diagnoses be included as AFP in order to achieve the recommended AFP rate. The RCC calls on the NCCs to be more critical about this issue when reviewing data provided by the national programmes.

Involvement of national expert groups in the final classification of AFP cases

Further to the standard criteria put for cases to be referred to the National Expert Group for classification, the RCC recommend that for countries reporting less than 20 cases, all the cases be referred to the national expert group. For countries reporting 20 or more AFP cases a substantial number of the cases (10% or more) should be referred to the national expert group.

Environmental surveillance

Some of the NCC chairpersons raised the issue of introducing environmental surveillance as additional supplemental surveillance. The RCC requested the secretariat to refer this subject to the regional TAG for its views about the value of environmental surveillance in various epidemiologic situations.

Diagnosis of vaccine-associated paralytic polio

The RCC wishes to refer the NCCs to the guidelines for diagnosis of VAPP cases which is detailed in the basic national document.

Registration of monovalent OPV

The RCC reiterates its previous recommendation with respect to the national preparedness plan of action to address importation particularly with respect to taking necessary regulatory steps concerning the registration or fast tracking procedures for monovalent vaccines produced by pre-qualified firms in order to be able to procure

them for use in response to importations. The RCC requests the WHO secretariat to prepare letters from the Regional Director to countries of the Region in this regard.

Modifications in the formats for abridged annual update

The RCC requested the secretariat to modify the text of Part (2), items 13a and 26 to ensure uniform response by all NCCs and agreed to the following changes:

Part (2): replace the third paragraph with the following text

Please present your response to this observation in the form of a table with 3 columns:

Item number	RCC Comments	Response of the National Programme
-------------	--------------	------------------------------------

Item (13a)

- Has the National plan of action for preparedness for wild poliovirus importation been updated during the year under review? Yes () No ()

If updated please attach a copy

- Has there been any steps taken to register / fast track procedures for monovalent vaccines produced by prequalified producers? Please specify

Item (26): Immunity profile for the last five years

Please attach the profile obtained from the number of OPV doses received by the non polio AFP cases 6-59 months in the form of a bar chart in which the number of doses are categories to 4 categories: 0 doses, 1-3 doses, 4-6 doses and 7 doses and over.

Should the number of AFP cases 6-59 months be ten or more, please make two profiles one for cases aged 6-23 months and the other for cases aged 6-59 months.

Date and venue of next meeting

The RCC recommends that its next meeting be held on 2–3 November 2011 where the reports of Djibouti, Lebanon and the Libyan Arab Jamahiriya and the provisional reports of Afghanistan and Pakistan will be discussed. The RCC recommends that the venue of this meeting be Pakistan as the first choice, Lebanon as the second choice or the Regional Office as the third choice.

Annex 1

PROGRAMME

Tuesday, 12 April 2011

- | | |
|-------------|--|
| 08:30–09:00 | Registration |
| 09:00–09:30 | Opening session |
| | Introductory remarks |
| | Welcoming remarks by H.E. Minister of Health, United Arab Emirates |
| | Address by RD/EMRO |
| | Adoption of agenda |
| 09:30–09:45 | Implementation of the recommendations of the 23rd RCC meeting |
| 09:45–10:30 | Regional overview |
| 10:30–11:15 | Discussion on regional situation |
| 11:15–12:15 | Regional overviews |
| 12:15–12:45 | Achievements with respect to the strategic plan 2010–2012 |
| 12:45–14:15 | Discussion |
| 14:15–15:15 | Presentation and discussion of abridged annual update reports of the United Arab Emirates, Bahrain and Egypt |
| 15:15–17:00 | Private meeting of the RCC |

Wednesday, 13 April 2011

- | | |
|-------------|---|
| 09:00–11:30 | Presentation and discussion of abridged annual update reports of the Islamic Republic of Iran, Iraq, Kuwait and Morocco |
| 11:30–14:00 | Presentation and discussion of abridged annual update reports of Oman, Palestine and Qatar |
| 14:00–16:00 | Presentation and discussion of abridged annual update reports of Saudi Arabia, Syrian Arab Republic and Tunisia |
| 16:00–17:00 | Private meeting of the RCC |

Thursday, 14 April 2011

- | | |
|-------------|--|
| 08:30–09:30 | Private meeting of the RCC |
| 09:30–12:00 | Presentation and discussion of annual update reports of Somalia, Sudan (north and south) and Yemen |
| 12:00–12:30 | Presentation and discussion of the abridged annual update report of Jordan |
| 12:30–13:00 | Private meeting of the RCC |
| 13:00–13:30 | Closing session and concluding remarks |

Annex 2

LIST OF PARTICIPANTS

MEMBERS OF THE REGIONAL CERTIFICATION COMMISSION

Dr Ali Jaffer Mohamed *Chairman*
Adviser Health Affairs
Supervisor, Directorate General of Health Affairs
Ministry of Health
Muscat

Dr Magda Rakha
Former Executive Member of the Board
VACSERA
Holding Company for Biological Products & Vaccines
Cairo

Dr Yagoub Y. Al Mazrou
Secretary General
Council of Health Services
Riyadh

Professor David Salisbury
Director of Immunization
Department of Health
London

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

Professor Gaafar Ibnauf Suliman
Chairman
Paediatrics and Child Health Council
Sudan General Medical Council
Khartoum

COUNTRY REPRESENTATIVES

BAHRAIN

Dr Khairiya Mossa
Chairperson, National Certification Committee
Manama

Dr Jalila Sayed Jawad
EPI focal point
Ministry of Health
Manama

EGYPT

Dr Salah Madkour
Chairman, National Certification Committee
Cairo

Dr Ibrahim Moussa
EPI Manager
Ministry of Health
Cairo

ISLAMIC REPUBLIC OF IRAN

Dr Seyed Taha Mousavi
Polio Eradication focal point
Ministry of Health and Medical Education
Teheran

IRAQ

Professor Najim El-din Al-Ruznamji
Chairman, National Certification Committee
Baghdad

Dr Yosra Khalef
National AFP Surveillance Officer
Ministry of Health
Baghdad

JORDAN

Professor Najwa Khuri-Bulos
Chairperson, National Certification Committee
Amman

Dr Mohamed Rateb Surour
EPI Manager
Ministry of Health
Amman

KUWAIT

Dr Fayka Al-Raqum
Chairperson, National Certification Committee
Kuwait

Dr Mussab Al-Saleh
Head of EPI Programme
Ministry of Health
Kuwait

MOROCCO

Dr El Hachmia Ait Ben Haddou
Neurologist
University of Medicine
Rabat

Dr Ahmed Rguig
Surveillance Officer
Ministry of Health
Rabat

OMAN

Dr Seif Salem Al-Abri
Chairman, National Certification Committee
Muscat

Dr Salah Al-Awaidy
Director
Department of Communicable Disease Surveillance and Control
Ministry of Health
Muscat

PALESTINE

Dr Mowafak Amer
Chairman, National Certification Committee
West Bank

Dr Iyad Arafeh
National EPI Manager
Ministry of Health
West Bank

Mr Jehad Ahmed
National EPI Manager
Ministry of Health
Gaza

QATAR

Dr Mohammed Ahmed M Janahi
Chairman, National Certification Committee
Doha

Dr Asma Ali Al-Nuaimi
EPI Manager
National Health Authority
Doha

SAUDI ARABIA

Professor Ghazi Jamjoom
Chairman, National Certification Committee
Jeddah

Dr Amin Mishkas
National Poliomyelitis Programme Manager
Ministry of Health
Riyadh

SUDAN

Professor Abdal Rahman Kabbashi
Chairman, National Certification Committee
Khartoum

SYRIAN ARAB REPUBLIC

Professor Ahmed Deeb Dashash
Chairman, National Certification Committee
Damascus

Dr Khaled Baradai
EPI Manager
Ministry of Health
Damascus

TUNISIA

Professor Ahmed Ziribi
Chairman, National Certification Committee
Tunis

Dr Essia Ben Farahat Hmida
Member, Central Team of EPI
Ministry of Health
Tunis

UNITED ARAB EMIRATES

Dr Mahmoud Fikri
Executive Director
Health Affairs Policies
Ministry of Health
Abu Dhabi

Dr Claes G. Henning
Member, National Certification Committee
Abu Dhabi

Dr Safia Salah
National Coordinator for Polio Programme
Abu Dhabi

YEMEN

Professor Ahmed Al-Haddad
Chairman, National Certification Committee
Sana'a

OBSERVERS

United Arab Emirates
Dr Suhad Aranky
Disease Surveillance Officer
Ministry of Health
Abu Dhabi

OTHER ORGANIZATIONS

ROTARY International

Dr Shakil Hasan Ansari
Chairman Eastern Mediterranean Regional Polio Plus Committee
Islamabad
PAKISTAN

Centers for Disease Control and Prevention (CDC)

Dr Robert Linkins
Chief
Vaccine Preventable Disease Eradication & Elimination Branch
Atlanta
UNITED STATES OF AMERICA

UNICEF

Dr Daniel B. Ngemera
Immunization Specialist
UNICEF South Sudan
Juba
SUDAN

WHO OFFICES

WHO headquarters

Dr Rudolf Tangermann
Medical Officer
Strategy Implementation Oversight and Monitoring
Geneva

WHO/AFRO

Dr Samuel Oumo Okiror
Polio Medical Officer
Brazzaville

WHO/EURO

Dr Rebecca Martin
Programme Manager
Vaccine-preventable Diseases & Immunization
Copenhagen

WHO/SEARO

Dr Patrick O'Connor
Regional Advisor - Polio
New Delhi

FACILITATORS

Dr Khodr Awad
Adviser for Foreign Relations and International Health
Ministry of Health
Abu Dhabi
UNITED ARAB EMIRATES

Mr Amar Danora
Senior Officer for Public Relations Department
Ministry of Health
Abu Dhabi
UNITED ARAB EMIRATES

WHO SECRETARIAT

Dr Hussein A. Gezairy, Regional Director
Dr M. H. Wahdan, Senior Consultant, Poliomyelitis Eradication Programme
Dr Ezzedine Mohsni, Coordinator, Poliomyelitis Eradication Programme
Dr Tahir Mir, Regional Advisor, Poliomyelitis Eradication Programme
Dr Raoul Kamadjeu, Medical Officer / Surveillance Coordinator PEI/EPI, WHO
Office Somalia
Dr Amani Abdel Monaim, SSA/Sudan, WHO Office Sudan
Dr Yehia Mostafa, Team Leader / Polio, WHO Office South Sudan
Dr Ali Mohammed Bin Break, SSA/Yemen, WHO Office Yemen
Mrs Fatma Moussa, Administrative Assistant, Poliomyelitis Eradication Programme
Mrs Rasha Naguib, Programme Assistant, Poliomyelitis Eradication Programme
Mrs Ghada Taher, Secretary, Poliomyelitis Eradication Programme