

Report on the

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

Cairo, Egypt  
2–3 November 2011



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Organization**

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## **1. INTRODUCTION**

The Regional Commission for Certification of Poliomyelitis Eradication (RCC) held its twenty-fifth meeting in the WHO Regional Office for the Eastern Mediterranean in Cairo, Egypt, on 2–3 November 2011. The meeting was attended by members of the RCC and chairpersons of the National Certification Committees (NCC) of Afghanistan, Lebanon and Pakistan. The meeting was also attended by a representative of Rotary International and WHO staff from headquarters, regional and country offices. The NCC Chairman of Libya was unable to attend.

The meeting was opened by Dr Ali Jaffer Mohamed, Chairman of the Regional Certification Commission, who welcomed all the participants. He acknowledged the continued support and deep involvement of Dr Hussein A. Gezairy in the regional and global efforts of polio eradication since the initiation of the global programme. The Chairman also congratulated Dr Alaa Alwan on his nomination as Regional Director and expressed his confidence that he would continue to give attention to communicable diseases control and particularly poliomyelitis eradication and measles elimination. The Chairman then referred to the recent report of the Independent Monitoring Board (IMB) and praised its critical analysis of the epidemiological situation in endemic and recently infected countries and its recommendations. He proposed that the report be read by members of the RCC.

A message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean was read by Dr M.H. Wahdan. In his message the Regional Director welcomed all the participants and expressed gratitude to members of the Commission, Chairpersons of the National Certification Committees, national polio officers and Rotary International for their continued commitment and support. The Regional Director referred with concern to the deteriorating epidemiological situation in the two endemic countries, Afghanistan and Pakistan partly due to escalation of insecurity and partly due to management problems particularly at the delivery levels. He also expressed concern about the negative impacts of recent developments in a number of polio-free countries on the polio eradication status of these countries. The Regional Director ended his message by expressing the hope that through the sustained commitment of all countries of the region and the dedication of polio workers and the continued and generous support of polio partners, the Region would achieve eradication of poliomyelitis in the near future.

The programme of the meeting was endorsed (Annex 1). The list of the participants is attached as (Annex 2).

## **2. IMPLEMENTATION OF THE COMMENTS AND RECOMMENDATIONS OF THE TWENTY FOURTH MEETING OF THE RCC**

*Dr M.H. Wahdan, Senior Consultant, Poliomyelitis Eradication Programme*

- RCC comments on the National Emergency Action Plan (NEAP) for polio eradication in Pakistan were echoed by the Independent Monitoring Board in its meeting in September 2011. WHO and UNICEF are taking several measures to ensure effective implementation of the NEAP at the peripheral (UC) level.

- The RCC emphasis on the urgent need to implement supplementary immunization activities in Yemen was actively followed up and it is now agreed to conduct two NIDs before end 2011. The first round will be implemented starting 17 November 2011.
- In response to the concern of the RCC about a possible gap in surveillance in Sudan a quick surveillance review was conducted in May 2011 to be followed by a full-scale surveillance review now planned for January 2012.
- The risk assessment tool developed the Regional Office was discussed in a meeting at CDC with similar tools developed by other regions and there is now a global tool.
- Concerning the recommendations addressed to the National Certification Committees, it is hoped that their follow-up will be seen in the 2011 annual reports.

The RCC noted with satisfaction that the comments and recommendations made during its last meeting were and are being implemented.

### **3. SITUATION OF POLIOMYELITIS ERADICATION IN THE REGION**

#### **3.1 Overview**

*Dr Tahir Mir, Regional Adviser, Poliomyelitis Eradication Programme*

In Afghanistan, children in southern region are still inaccessible due to the conflict and due to issues of management in accessible areas. Overall the vaccination status among AFP cases indicates that they are not reached regularly by routine immunization or supplementary immunization activities. A new challenge facing the programme is the extensive spread and polio cases during the high transmission season outside the transmission zone of the southern region. The IMB report says that “this is a strong programme but it is not yet one capable of stopping polio transmission and referred to gaps in both surveillance and vaccination”. The country programme has revised the milestones for 2011–2012 to include stopping polio virus circulation in Farah province (western region) by March 2012, interrupt transmission in one of the two southern provinces (Kandahar and Helmand) by June 2012 and complete interruption of poliovirus in the country by the end of 2012. Other milestones include preventing establishment of poliovirus circulation in rest of the country and maintaining highly sensitive AFP surveillance system.

In Pakistan, after very low transmission during the period 2005 to 2007, polio cases started increasing year after year and reached levels in 2011 not reached since 10 years. In late 2010, the government launched the National Emergency Action Plan (NEAP) aiming to interrupt circulation by 2011. Failure to implement the plan fully and in emergency way resulted in the target being next to impossible to be achieved. The spread of disease in Pakistan clearly indicates that the current level of efforts is insufficient to stop transmission. Wild poliovirus from Pakistan has been recently exported to China. IMB remarks on Pakistan programme are that “Pakistan’s response to polio is the weakest in the world. A fundamental strategic re-think is urgently needed.”

Efforts are under way to accelerate the effective implementation of the NEAP for polio eradication particularly through ensuring accountability for preparation and implementation of high quality campaigns and ensuring appropriate management.

WHO and UNICEF are extending technical support at all levels down to the Union Council (UC) level particularly to cover all the high risk districts. In this regard, recruitment of 300 UC polio workers (WHO) and about 400 UC communications officers (UNICEF) is in progress.

Inaccessibility to vaccinate almost one million children in central and southern Somalia is a situation like sitting on a time bomb. National Immunization Days (NIDs) and Child Health Days (CHDs) are conducted only in accessible areas. Efforts to access these children are continuous but not yet successful.

Importation from Chad is a significant danger to the neighbouring polio-free countries of the Eastern Mediterranean Region (Libya and Sudan) and adequate measures are being taken including supplementary immunization activities conducted in the Darfurs and vaccination of the returnees to Libya.

There are 20 Member States of the Region where there is no polio cases reported since 2009. In Somalia, South Sudan, Sudan and Yemen though there are no cases reported but the immunity level among the target children is fragile. In Libya, Syrian Arab Republic and Tunisia there is no significant impact of the current situation on their polio free status and the programme is vigilant and watchful. Mitigating measures were taken to maintain their polio free status. Supplementary immunization activities were conducted in Djibouti, Somalia (and CHDs), South Sudan and Sudan (additional rounds in Darfur). Supplementary immunization activities are planned in last quarter of 2011 in Iraq, Somalia, South Sudan, Sudan and Yemen.

Circulation of cVDPVs in Afghanistan, Somalia, South Sudan and Yemen is another new challenge.

Surveillance indicators are reaching certification indicators at national level but at subnational level the indicators are showing some gaps. Full-scale and rapid AFP surveillance reviews were conducted and are being planned in a number of Member States.

As far as the risk assessment tool, the regional next step include developing a subnational risk assessment model and tools which will certainly help the Member States for early identification of gaps and taking appropriate measures.

### **3.2 Laboratory aspects and containment**

*Dr Humayun Asghar, Virologist, Poliomyelitis Eradication Programme*

All EMR poliovirus network laboratories are fully accredited and passed the proficiency testing (PT) panels of virus isolation and intratypic differentiation (ITD). Although the workload of the network laboratories is considerably high (over 26000 samples annually), laboratory performance is maintained at certification standard. The real-time PCR (rRT-PCR) method for rapid characterization of polioviruses is now implemented in 7 out of 12 regional laboratories after its introduction in the Morocco National Poliovirus Laboratory. The

nucleotide sequencing of poliovirus is performed in Pakistan and Tunisia Regional Reference Laboratories (RRLs).

Circulating wild viruses in Pakistan and Afghanistan are wild poliovirus type 1. Only two wild poliovirus type 3 cases have been detected in Pakistan. In 2011, in Pakistan there are mainly two wild poliovirus type 1 clusters (A3-D2 and A3-A1A1) and one cluster of wild poliovirus type 3 (B1-C5), while in Afghanistan two wild poliovirus type 1 clusters (A3-D2 and A3-A1A1) are circulating. Many small chain of transmission have disappeared.

Between January and October 2011, circulating vaccine-derived polioviruses (cVDPVs) were isolated from AFP case and contacts in Afghanistan, Somalia and Yemen and one type 2 VDPV was isolated from an AFP case in South Sudan. Two iVDPV type 2 were isolated in Egypt and one iVDPV type 2 was isolated from an immunodeficient child.

Environmental surveillance continued in Egypt and was expanded in major cities of four provinces of Pakistan. Large numbers of sewage samples from all collection sites in Pakistan are positive for wild poliovirus type 1; while the last wild poliovirus type 3 was isolated in October 2010. The nucleotide sequencing of sewage samples isolates is showing relationship with the virus circulation in both reservoir and indicator communities.

The regional laboratory network participated in a number of studies including pilot testing of FTA cards for isolate referral to laboratories, evaluation of selective growth on L20B and high temperature selection for detection of non-Sabin like polio viruses and in iVDPV surveillance. The biosafety training modules were introduced into the laboratory network and the biosafety campaign is fully implemented in network laboratories.

In the discussion that followed the regional overview the following comments were made by the RCC.

- The RCC noted with great concern the continued deterioration of the epidemiological situation of poliomyelitis in Pakistan which is compromising the achievements of the global programme. The RCC agrees with the assessment made by the IMB and with its recommendations.
- Concerning the National Emergency Action Plan adopted by Pakistan to address the situation, the RCC reiterates its emphasis that without full and effective implementation of the plan, particularly at the lowest delivery level, eradication efforts will be compromised.
- The RCC feels that the intense transmission in Pakistan represents a serious threat of possible spread to polio-free countries similar to what has happened in China. The RCC calls on WHO, using the IHR to impose all necessary measures to travellers from Pakistan to limit the possibility of international spread.
- The RCC is concerned by the recent considerable increase in the number of cases of poliomyelitis in Afghanistan and particularly the appearance of cases outside the endemic southern zone, especially as some of these cases are genetically linked to the ongoing circulation in the southern zone.



- The situation in Yemen is also of serious concern because of the very high risk of spread following any wild poliovirus importation. The RCC appraised the actions taken by WHO and UNICEF to implement supplemental immunization activities and acknowledged the efforts of the Regional Director to ensure rapid implementation of the planned supplementary immunization activities.
- For nearly two years there has been continued inaccessibility of nearly 800 000 Somali children under the age of 5 years in the central and southern areas of Somalia to vaccination. This is of serious concern to the RCC. This situation has resulted in a large population immunity gap in these areas with a very high risk of spread of wild poliovirus should it be introduced. The RCC noted the extensive efforts made by the Regional Office to address this serious concern, but noted that unfortunately there has not been success so far.
- With the increasing reports of detection of VDPVs particularly the cVPDVs in the Region, the RCC calls on the Regional Office to send an analysis of this important information to national EPI managers, national immunization TAG and NCC members regularly using the polio fax.
- The RCC, while noting that the polio-free status is so far maintained in 21 of the 23 countries of the Region, remains concerned that the recent developments in a number of polio-free countries have affected the regular delivery of health care services including routine and supplemental immunization as well as surveillance activities. These developments represent a serious threat to eradication efforts in the Region and need very close monitoring.

#### **4. GLOBAL UPDATE**

*Dr Naveed Sadozai, WHO/HQ*

The update focused on highlighting the current epidemiological situation in the endemic, re-established and outbreak countries relevant to the 2010–2012 strategic plan and referred to the polio end game strategies.

- Pakistan is experiencing its worst type 1 epidemic since 1997, when the AFP surveillance was established. It also remains the only country with a persistent type 3 circulation in Asia.
- Afghanistan is also going through an epidemic of type 1. Moreover, it has 6 provinces infected outside the endemic southern zone.
- Nigeria, which had demonstrated significant reduction in the number of wild poliovirus cases in 2010, also saw an increase in the total number of wild polio cases. More significantly the traditionally largest wild poliovirus reservoir of Kano was re-infected. The country has 5 times the number of cases as compared to 2010. It also has circulation of types 1 and 3 and still has ongoing circulation of cVDPV2.
- Democratic Republic of Congo and Chad still continue with persistent outbreaks.

In response, the global programme is supporting national programmes in various ways including improving OPV campaign quality through a significant staffing surge especially in Pakistan and Chad, primarily at the district and sub-district levels, initiating LQAS after

every campaign in all gap areas and strengthening AFP surveillance to close surveillance gaps.

Referring to polio end game strategies, Dr Sadozai indicated that the concept and the re-think was prompted by several reasons including the availability of new diagnostics and the fact that currently type 2 cVDPV is the main post-eradication problem. The new bivalent vaccine (bOPV) is proven to outperform tOPV for types 1 and 3 and is a viable option to replace tOPV. New and very cheap IPV options could allow all countries to continue type 2 immunizations if they want or need to.

The new strategy is therefore based on a parallel instead of a sequential risk management of the polio end game strategy. The guiding principles will include the phased removal of Sabin viruses, beginning with the highest-risk type 2, through switching from tOPV to bOPV for both routine EPI and campaigns and an early introduction of IPV at least in high risk areas for VDPVs to provide type 2 protection. This will help accelerate eradication of type 1 and 3 wild poliovirus and also address more than 90% of the VDPV risk. At the same time global surveillance/response capacity remains at its highest. This can thus substantially shorten the post-eradication phase and possibly boost the eradication effort with new energy.

## **5. DISCUSSION OF REPORTS**

### **5.1 Provisional national documentation of Afghanistan**

The RCC acknowledged the efforts of the NCC of Afghanistan in assembling a very comprehensive report which provides a good model for the national document. The RCC acknowledged the create efforts being made to ensure effective surveillance and achieve access to children in security compromised areas. The RCC made comments on the report which will be relayed to the chairpersons of the NCCs for consideration in future reports.

### **5.2 Provisional national documentation of Pakistan**

The RCC acknowledged the efforts of the NCC Pakistan and its critical review of the data, particularly highlighted in the Executive Summary. The RCC noted the discrepancies in the immunization coverage rates, both routine and supplemental, between administratively reported figures and coverage rates obtained through other methods such as independent monitoring and surveys.

The RCC expressed concern that the report fails to identify the clear disconnect between the epidemiological reality and the information provided. The RCC believes that if the coverage rates were as high as reported, both for routine and supplemental services, there should not be endemic poliomyelitis. It recommended that the NCC makes every effort to include only data it believes reflect the actual situation in order to ensure credibility of the report. Further comments will be relayed to the chairman of the NCC.

### **5.3 Abridged annual update 2010 of Lebanon**

The RCC reviewed the report and noted clear development since 2009. This improvement came as a result of the response of the authorities to the recommendations of the surveillance review conducted by WHO in September 2010. The RCC expressed concern about the low rate of adequate stools and the low rates of timeliness particularly in 4 governorates (Beirut, South, North and Mount Lebanon), where it is less than 50%.

The RCC provisionally accepted the report but made some comments which will be conveyed to the chairman of the NCC with a request to review and update the report taking into consideration the comments of the RCC.

### **5.4 Abridged annual update 2010 of Libya**

The RCC reviewed the report which was originally prepared on 01/03/2011 but it was not submitted due to the prevailing situation in Libya at the time. This report was re-submitted on 03/10/2011 and the RCC decided to discuss it although the NCC chairman was not able to participate. The RCC provisionally accepted the report but made a few comments which will be conveyed to the chairman of the NCC with a request to review and update the report taking into consideration the comments of the RCC.

The RCC expressed concern about the status of the national eradication efforts based on the fact that wild poliovirus is circulating in neighbouring countries in the south where free population movement across the border is occurring and the risk of importation is high. This concern is exacerbated by the fact that routine immunization in 2011 may have suffered significantly and no supplemental immunization activities were conducted in 2010 or 2011 as well as the fact that the AFP rate is showing evidence of significant decrease in 2011.

The RCC noted the efforts being made by EMRO and AFRO with respect to ensuring vaccination of returnees from Chad and Niger to Libya.

## **6. OTHER MATTERS**

The RCC recommended that from 2012 one meeting a year for 3 full days would be implemented. It recommended that its next meeting would be held on 24–26 April 2012 in Dubai, United Arab Emirates.

**Annex 1**

**PROGRAMME**

**Wednesday, 2 November 2011**

- 08:30-09:00 Registration
- 09:00-09:30 Opening Session  
Introductory remarks by Dr Ali J. Mohammed, Chairman of RCC  
Message from Dr Hussein A. Gezairy, Regional Director, WHO/EMRO  
Adoption of agenda  
Implementation of the recommendations of the 24th meeting, Dr M. Wahdan, WHO/EMRO  
Situation of polio eradication in the Region  
Regional overview, Dr T. Mir, WHO/EMRO  
Update on laboratory aspects and containment, Dr H. Asghar, WHO/EMRO  
Discussion
- 11:00-11:30 Global update, Dr N. Sadozai, WHO/HQ
- 11:30-13:30 Presentation and discussion of (Provisional) National Documentation for Certification of Afghanistan, Dr G. Aram, Chairman NCC
- 13:30-14:30 Presentation and discussion of (Provisional) National Documentation for Certification of Pakistan, Prof. T. Bhutta, Chairman NCC
- 14:30-16:00 Private meeting of the RCC members  
Situation of delayed reports  
Final country summaries for regional certification

**Thursday, 3 November 2011**

- 09:00-10:00 Presentation and discussion of the Abridged Annual Update 2010 of Lebanon, Dr J. Rashkidi, Member NCC
- 10:00-11:00 Presentation and discussion of the Abridged Annual Update 2010 of Libya
- 11:00-12:00 Private meeting of the RCC members
- 12:00-12:30 Closing session

**Annex 2**

**LIST OF PARTICIPANTS**

**Members of the Regional Certification Commission**

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

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

Professor David Salisbury  
Director of Immunization  
Department of Health  
London

Professor Oyewale Tomori  
Member  
African Regional Certification Commission  
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Dr Magda Rakha  
Former Executive Member of the Board  
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Professor Mushtaq Khan  
Professor of Paediatrics  
Medical Center  
Islamabad

Professor Gaafar Ibnauf Suliman  
Chairman  
Paediatrics and Child Health Council  
Khartoum

Professor Nazrul Islam  
Chairman  
South East Asia Regional Certification Commission  
Dhaka

### **Country Representatives**

#### **AFGHANISTAN**

Dr Gholam Aram  
Chairman, National Certification Committee  
**Hirat**

#### **LEBANON**

Dr Joseph Rashkidi  
Member, National Certification Committee  
**Beirut**

#### **PAKISTAN**

Professor Tariq Iqbal Bhutta  
Chairman, National Certification Committee  
**Lahore**

### **Other Organizations**

#### **ROTARY International**

Dr Ahmes Ghabrial  
Egypt – Rotary National PolioPlus Committee Chair  
**Cairo**

### **WHO Secretariat**

Dr Ezzedine Mohsni, Coordinator, Poliomyelitis Eradication Programme  
Dr Mohamed H. Wahdan, Senior Consultant, Poliomyelitis Eradication Programme  
Dr Tahir Mir, Regional Adviser, Poliomyelitis Eradication Programme  
Dr Nadia Teleb, Regional Adviser, Vaccine Preventable Diseases and Immunization  
Dr Faten Kamel, Medical Officer, Poliomyelitis Eradication Programme  
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Dr Ann Buff, Medical Officer, Poliomyelitis Eradication Programme  
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Dr Mufti Zubair, Federal Surveillance Officer, WHO Pakistan  
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WHO/EMRO  
Mrs Fatma Abdelmegeed, Service Desk Administrator, Information System Management,  
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Mr Essam Ghoniem, Audiovisual Technician, Administrative Service Unit, WHO/EMRO