WHO-EM/POL/303/E

Report on the

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

Cairo, Egypt
7–8 December 2005

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1. INTRODUCTION

The Fourteenth Meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was held in Cairo, Egypt, on 7–8 December 2005. The meeting was attended by members of the RCC, Chairmen of the National Certification Committees (NCCs) and national programme managers from Egypt, Lebanon, Pakistan and Palestine. Other participants included representatives of Rotary International and the African and European Regional Commissions for Certification and staff from WHO headquarters and Regional Offices for Africa and the Eastern Mediterranean.

Dr Ali Jaffer Mohammad Sulaiman, Chairman, RCC, opened the meeting by welcoming all the participants. He thanked Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean for his continued support and guidance of polio eradication activities. Dr Abdulla Assa'edi, Assistant Regional Director, WHO/EMRO, welcomed the participants and delivered a message on behalf of Dr Gezairy. In his message, Dr Gezairy welcomed all the participants and expressed his thanks to the members of the Regional Certification Commission for their continued dedication to the goal of eradicating polio from the Region. He pointed out that following the reintroduction of polio in Sudan in May 2004, the initiative had faced consecutive problems in the Region: an epidemic in Sudan, another epidemic in Yemen early in 2005 and, more recently, an epidemic in Somalia, where cases were being reported after a gap of nearly three years and just at the time when the national documentation for certification of Somalia was being prepared for review. While these epidemics were most unfortunate, he noted, they did reflect the fragility of the epidemiological situation in several countries in the Region and highlighted the need to be extra vigilant and to ensure maximum coverage of routine immunization and supplementary immunization activities. In view of the experience gained from handling the recent importations and outbreaks, it was essential to revise the national plans for dealing with importation, and these were being submitted to the RCC for its review.

Dr Gezairy referred to the continued improvement of the situation in the endemic countries. Up to the end of November, 6 cases of wild poliovirus had been reported from Afghanistan, 22 from Pakistan as compared with 53 during 2004. No case had been reported from Egypt since May 2004 and results of environmental sampling have been negative since January 2005. During the year, efforts had also been made to strengthen coordination with the WHO Regional Office for Africa including synchronization of eradication activities in Djibouti, Somalia and Sudan with neighbouring countries of Africa.

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

2. CURRENT SITUATION OF POLIOMYELITIS ERADICATION

2.1 Eastern Mediterranean Region

2.1.1 Overview

Dr Faten Kamel, Medical Officer, Polio Eradication, WHO/EMRO

As a result of the epidemics in Somalia, Sudan and Yemen, the number of cases of wild poliovirus during 2005, up to 27 November 2005, had reached a total of 603 as compared with 187 cases in 2004 and 113 cases in 2003. Of the 603 cases reported so far in 2005, 6 were from Afghanistan, 22 from Pakistan, 73 from Somalia, 26 from Sudan and 476 from Yemen (representing almost one-third of the global burden of disease). Seventeen countries have been polio-free for more than three years.

Progress continues to be achieved in the currently endemic countries in the Region. In Pakistan a decrease in the intensity of virus transmission and in diversity of viruses has been noted. There has been substantial improvement in the quality of supplementary immunization activities (SIAs) with intensification in high risk areas. Seven rounds of SIAs have been conducted to date this year. Efforts to access children in insecure and tribal areas need to be sustained. All the 22 cases reported so far are type (1).

In Afghanistan, all the 6 cases (four type 3 and two type 1) reported so far are from the Southern Region which is an area with considerable security problems. Genomic sequencing results show diminished genetic diversity of viruses isolated from Afghanistan and Pakistan, indicating progress towards eradication in these countries.

In Egypt, the last case was reported in May 2004 and the last positive environmental sample was detected in January 2005. Six rounds of NIDs have been implemented with monovalent OPV 1 vaccine used in the May, July and September rounds. It appears that viral circulation in Egypt has most probably been interrupted.

Dr Kamel described the current situation in the three re-infected countries i.e. Somalia, Sudan and Yemen. The outbreak in Sudan, which followed the importation of wild poliovirus from Nigeria through Chad into Darfur in May 2004 and led to a total of 153 cases being reported from all over the country, appears to have wound down with no new confirmed cases reported since mid June 2005. The response to the outbreak, which started in May 2004, has included 3 mop-up rounds followed by successive NIDs for a total of 9 rounds The non-polio AFP rate has been in excess of 2 per 100 000 population under 15 years for all but two states (West Darfur 1.1 and Khartoum 1.9). The surveillance review in the northern part of the country earlier this year has shown an over all well established sensitive surveillance. In the south despite security problems, lack of infrastructure and difficult working environment, there is a well developed community-

based AFP surveillance programme. However, the recent surveillance review in the south indicated that due to in-accessibility and infrastructural constraints it was not possible to exclude the possibility of missed cases in some regions, i.e. Upper Nile, Lakes, Bahr El Ghazal and Eastern Equatoria.

The rapid explosion of the current epidemic in Yemen, which started early in 2005 following a wild poliovirus importation from Sudan (of a virus originating in northern Nigeria), can be attributed to a great extent to the low routine immunization and limited SNIDs in 2002 and 2003, which led to a significant immunity gap. The late recognition of early cases for almost two months also contributed to the widespread virus circulation. By the time the first case was confirmed on 20 April, a total of 145 cases had already occurred in 9 governorates. Following the detection and confirmation of the epidemic the national health authorities quickly mounted a response and 6 national wide polio immunization rounds have been implemented since April 2005 using monovalent oral polio vaccines in 3 rounds and trivalent OPV in others. Independent monitoring has shown improvement and most gaps seen in the May and July rounds have been addressed in subsequent rounds. The cases sharply declined and since early September have been restricted to only a few districts. At the recently held first meeting of the TAG, data were presented that showed an increase in the routine immunization coverage after 3–4 years of decline. The TAG has recommended that nationwide polio campaigns should continue until two full campaigns have been conducted after the last wild poliovirus has been detected.

In Somalia the date of onset of the first case was 12 July 2005 that was rapidly followed by appearance of 72 cases from north and south Mogadishu. There is an increase in the number of reported AFP cases from lower Shabelle which is close to Mogadishu. Approximately half of the wild poliovirus cases were among children under 2 years of age and 57% of them did not receive any doses of OPV. Since the reported importation of the wild virus to Saudi Arabia in late 2004, five rounds of NIDs were implemented in Somalia in 2005. The prevailing security situation represented an obstacle to accessing several areas with resulting low coverage rates. Since the beginning of the outbreak, four rounds have been implemented, the last three with mOPV. Independent observers and monitors have been used to report on each round. Surveillance activities have been intensified and technical support to PEI activities has been increased.

In view of the recent experience of dealing with importations and in line with recent recommendations of the Advisory Committee on Polio Eradication (ACPE), the guidelines for preparing national plans for preparedness have been updated and will be reviewed by the RCC during its present meeting. Subsequent to RCC adoption of the updated guidelines all NCCs submitting reports during 2006 will be requested to revise and update their national plans and submit them with their reports. The Regional TAG has recommended that each country should aim to limit the spread of any importation by

identification of any immunity gap and its elimination through specific targeted immunization activities.

AFP surveillance is well established in all countries and is being used for surveillance of other EPI target diseases. Certification standard surveillance has been maintained since 2001. For the year 2005 as on 27 November 2005, the annualized regional non-polio AFP rate was 3.64 with adequate specimens being collected from 87.7% of cases. In fact, the non-polio AFP rate was well above 2/100 000 both in the currently endemic countries (Afghanistan, Egypt, Pakistan) and those that have been re-infected (Somalia, Sudan and Yemen). In order to validate the quality of surveillance and to identify any weaknesses, the programme has continued to carry out surveillance reviews in polio free countries. Since early this year surveillance reviews have taken place in Yemen (29 January–2 February 2005) and in Saudi Arabia (26 February–3 March 2005) and, in Morocco (from 9–14 May), in North Sudan (from 9–18 June), in the province of Punjab, Pakistan (12–19 July), in the province of Sind, Pakistan (22–30 August), in south Sudan (6–16 September), in Djibouti (16–20 November) and in Islamic Republic of Iran (19–24 November). These surveillance reviews have in general confirmed the sensitivity and reliability of the system.

The political commitment to polio eradication has been sustained at the highest level in all the member states with visits by the Regional Director to priority countries. The regional priorities were to: interrupt the transmission in the remaining endemic countries as soon as possible; continuing SIAs with the same intensity; stopping transmission in the re-infected countries; avoiding immunity gaps in the polio free countries; maintain certification standard surveillance; continue with containment and certification activities and generate the needed resources to implement the regional plan for eradication.

2.1.2 Polio laboratory network
Dr Humayun Asghar, Laboratory Coordinator, Polio Unit, WHO/EMRO

During 2004 all the network laboratories except Iraq NPL were accredited. During the current year, up to 27 November, stool samples from 8102 AFP cases were processed as compared with 6180 AFP cases for the same period in 2004. Regarding timeliness of reporting, 99% of results were being provided within 28 days and ITD within 14 days. The mean time from onset to ITD results is now 33 days, as compared with 37 days in 2004.

Dr Humayun also provided details of the results of environmental sampling in Egypt including molecular sequencing of isolates. The molecular sequencing data showed marked decrease in genetic diversity of poliovirus isolation over the years, and the isolates detected in early 2006 belonged to two different clusters (H and E).

2.2 African Region

Dr Salla Mbaye, Medical Officer, Polio, WHO/AFRO

During 2004, a total of 934 cases of wild poliovirus were reported from 12 countries in the African Region, with the largest number (782) of cases reported by Nigeria. During 2005, 629 cases have been reported from 8 countries as up to 24 November, including 590 (94%) from Nigeria where the number of infected states has decreased from 30 in 2004 to 21 in 2005. Six of the infected countries in 2004 have not reported any cases in 2005. However, there are two new re-infected countries (Angola and Eritrea) in 2005. More than 70% of polio cases are below three years of age and 80% of them have received less than three doses of OPV.

A polio risk management meeting held in June 2005 noted the persistent sub-optimal population immunity in the infected and high risk countries and the gaps in AFP surveillance resulting in delayed detection of wild poliovirus transmission. It has recommended reviewing and updating SIA micro-planning and monitoring guidelines and reviewing of all programmatic data to identify high risk areas that should than be prioritized for additional technical support. Certification standard AFP surveillance has been achieved in 38 countries of the Region. The performance of the polio laboratory network in the Region has continued to improve in 2005 with 98% of the results being provided within 28 days and 93% of ITD within 14 days.

Fourteen countries have presented their national documentation to the African RCC. Hence, 10 have been accepted and 4 have been deferred due to importation of wild poliovirus in two (Cameroon and Guinea) and declining surveillance in the other two (Burundi and United Republic of Tanzania). All 10 countries whose reports have been accepted have developed plans for responding to importations. Thirty-three countries have established national task forces for containment and 9 have completed laboratory survey and inventory. The main challenge to the programme is to expedite progress in Nigeria, where high intensity transmission persists in the north, and to enhance the capacity for effective polio outbreak response and to achieve and sustain high population immunity and high quality AFP surveillance.

2.3 European Region

Professor Sergey Drozdov, Member, European Regional Certification Commission

In the European Region, surveillance for polio is being carried through screening for enteroviruses, by surveillance for acute flaccid paralysis (AFP) in children less than 15 years of age and by a combination of the two methods. The non-polio AFP rate varies considerably in countries where it is being measured, with several states reporting rates of less than 1 per 100 000 population under 15 years. The polio laboratory network by the 46 week of 2005 has processed nearly 3000 samples with 95% of reports being submitted

with 28 days of receipt of samples. With respect to laboratory containment all countries in the region have reported completion of the national survey and inventory. There are 27 countries with no infectious material. In the remaining 25 countries, there are 116 laboratories with stored wild poliovirus infectious material and another 269 with wild poliovirus and potentially infectious materials. Results of quality assessment of Phase 1 containment activities have been satisfactory in all countries except for two. The EUR/RCC at its 18 meeting held on 24–26 May 2005 felt that in view of the ongoing transmission in India and the outbreaks in the Eastern Mediterranean and African Regions, the risk of importation has increased. The Commission expressed concern about diminishing political commitment for sustaining polio eradication, changing public health priorities and reduced funding that is compromising surveillance and laboratory activities in some countries. National plans of action to sustain 'polio-free' status for the period 2006–2008 are being revised, emphasizing the need to sustain immunization coverage, maintain high quality laboratory-based surveillance for wild poliovirus, initiate actions for Phase 2 of laboratory containment and to be prepared to respond to any importation of wild poliovirus or to the detection of VDPV.

2.4 South-East Asia Region

Dr N. K. Shah, Chairman, South-East Asia Regional Certification Commission

The number of wild poliovirus cases has continued to decrease in India with 52 cases (49 P1 and 3 P3) reported as of 28 November 2005, as compared with 127 in 2004, and the number of infected districts has dropped to 29 from 43 in 2004. The results of sewage samples collected in Mumbai up to November 2005 showed that 8 out of 135 (5.9%) samples were positive as compared with 85 positive samples out of 159 (53.4%) in 2004. 2005 also saw an outbreak in Indonesia following an imported case. A total of 326 cases have been reported up to 28 November 2005, with the onset of last case on 19 October 2005. An analysis of the immune status of the polio and non-polio AFP cases showed an immunity gap in children under the age of 5 years with 40% of the polio cases and 9% of the AFP cases having received no dose of OPV. The regional indicators for AFP surveillance were above the certification standard.

Recommendations of the South-East Asia Regional Technical Consultative Group at it last meeting, held in June 2005, included the need for implementation of NIDs in India, Indonesia and Timor-Leste and large-scale SIAs on a case-by-case basis in Bangladesh, Myanmar, Sri Lanka and Thailand. For the remaining countries in the region (Bhutan, Democratic People's Republic of Korea, Maldives and Nepal), large-scale SIAs were not recommended except in response to specific risks, as in the case of recent import in Nepal which was immediately tackled with an aggressive response. All countries in the region were advised to intensify surveillance to meet the operational target of 2 cases of AFP per 100 000 children under the age of 15 years and to enhance routine immunization.

2.5 Global overview

An overview of the global situation was presented by Dr Roland Sutter, Medical Officer, Polio, WHO headquarters. Enormous challenges are posed by the spread of polio due to importation from Nigeria to 21 countries during 2003–2005. Nigeria continues to be the greatest risk to the overall global eradication effort. The country accounts for nearly 37% of global cases. Virus transmission is primarily limited to the north of the country. Five synchronized campaigns from October 2004 to May 2005 have helped the 10 re-infected countries surrounding Nigeria to become polio-free again. A further series of synchronized polio immunization campaigns have started in mid-November. Such campaigns will need to continue until polio transmission is interrupted in Nigeria. A detailed analysis of 20 polio outbreaks between January 2003 and June 2005 has shown that the key factors in polio outbreak response are: speed of initial immunization campaign; geographic extent of response; quality of immunization campaigns; use of monovalent OPV and continuation of rounds until the outbreak stopped. Circulating poliovirus (wild or cVDPV) in a polio-free area is now a potential international health threat and must be treated accordingly.

Dr Yagoub Al-Mazrou, Member of the Advisory Committee on Poliomyelitis Eradication (ACPE) made a summary presentation on the main conclusions and recommendation of the second meeting of the ACPE held on 11–12 October 2005. The ACPE emphasized that the 2005–2006 strategic priorities for accelerating and securing the interruption of wild poliovirus globally should be to: expand the use of mOPV for polio campaigns in infected areas; achieve and sustain AFP rate of 2 or more per 100 000 population under 15 years in all infected and high risk areas; reduce outbreak response time to less than 4 weeks from confirmation of index case; reduce the time for laboratory confirmation of cases; and enhance and maintain routine immunization against polio globally. In view of the risk posed by the ongoing transmission in Nigeria, the ACPE made several recommendations and would be closely monitoring progress in that country.

The ACPE recommended that the Director-General of WHO consider declaring as "public health emergency of international concern" the detection of a circulating poliovirus in any previously polio-free geographical area which does not have a survey-confirmed routine polio immunization coverage of >90% and has not conducted SIAs within the previous 6–12 months and any outbreak which continues to expand geographically more than 60 days after confirmation of the index case. Polio-free countries detecting circulating poliovirus should immediately implement the September 2005 ACPE standing recommendations for responding to circulating polioviruses in polio-free areas, including an expert risk assessment within 72 hours to plan for a large-scale response within 4 weeks. The ACPE also recommended that countries should continue large-scale mOPV polio campaigns until at least 2 full rounds have been conducted after the last virus was detected.

The ACPE discussed and made recommendations about refining the programme of work for cessation of the use of OPV. It reaffirmed that the guidance outlined in the current WHO Position Paper on IPV for OPV-using countries remained appropriate and endorsed the general direction of the proposed supplement to this position paper. Appreciating that knowledge regarding VDPVs is continuing to evolve, priority should be given to better characterizing the incidence and behaviour of these viruses, particularly in the areas of low population immunity. The ACPE endorsed WHO plans to convene an Ad Hoc Advisory Group to provide oversight to the development of policies for the containment of all polioviruses.

2.6 Discussion on the current situation

Most of the interventions that followed the presentations dealt with seeking additional clarification about the situation of polio and of polio eradication activities in various parts of the African, Eastern Mediterranean and South-East Asia Regions.

The RCC further elaborated on the discussions concerning the epidemiological situation in endemic, recently infected and polio-free countries of the Region and on progress achieved in laboratory containment activities. It was felt important to convey some of these concerns to respective Chairmen of NCC, when letters are sent to them inviting them to submit their next set of reports early next year for RCC 15. It was further recommended that in view of the persistent delays in submission of reports by the due date, the NCCs should be advised in unambiguous terms to ensure timely submission of their reports..

The fact that in the reinfected countries the majority of polio cases were found to be among children under 2 years prompted discussions on routine immunization. The RCC appreciated that the PEI activities have indirectly benefited routine immunization programmes through introduction of effective planning principles, workforce development, provision of equipment and, most importantly, through advocacy with national authorities about the importance of strengthening routine immunization. It must, however, be realized that PEI cannot assume responsibility for routine immunization. The RCC noted that contrary to what is sometimes claimed, routine immunization did not improve when NIDs were curtailed.

The RCC agreed with the priorities presented during the regional overview and decided to add to them the need to further strengthen and continue collaboration with WHO/AFRO and with the AFR/RCC. Every effort should be made to ensure the participation of an EM/RCC member plus a staff member of the EMRO Polio Unit in the meetings of the AFR/RCC subject to the invitation being received in time. It was agreed that Dr Malek Afzali would represent EM/RCC at the AFR/RCC meeting, and that in case of his unavailability, Professor Mushtaq Khan or Dr Magda Rakha would attend.

The RCC was informed about ongoing collaborative efforts at the level of the regional offices and involving WHO/HQ and feels that a mechanism will need to be established to maintain regular communication/exchange of information on programme activities not only at regional office level, but also between countries that share borders in the two regions.

3. UPDATE ON THE REGIONAL LABORATORY CONTAINMENT ACTIVITIES

Dr Humayun Asghar, Laboratory Coordinator for Polio Eradication, WHO/EMRO

Laboratory surveys have been completed in 13 countries (Bahrain, Djibouti, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Libyan Arab Jamahiriya, Lebanon, Morocco, Oman, Qatar, Saudi Arabia and Syrian Arab Republic) and are in progress in Egypt and Tunisia. Progress has been slow in completing surveys in the United Arab Emirates. Surveys have not yet started as yet in Afghanistan, Pakistan, Palestine, Somalia or Yemen.

As Sudan was re-infected a fresh survey will have to be carried out as the last case was reported more than 6 months ago. In Yemen, a plan has already been developed and a survey will begin 6 month after the last case has been reported. In Pakistan, nomination of a containment coordinator is expected shortly. To date surveys carried out of more than 19 000 laboratories identified only 6 laboratories as having wild polioviruses. It is satisfying to note that Oman, Saudi Arabia and Sudan are regularly destroying viruses after receiving results of sequencing data. It is planned to collect quality assurance reports from all the countries that have completed their surveys to be reviewed by external experts as well as internally by WHO EMRO and headquarters. Following this review, reports will be sent back to countries to be revised accordingly and submit them to the RCC through their respective NCCs.

4. REVIEW OF REVISED NATIONAL DOCUMENTATION OF PALESTINE

Dr Mowafak Aamer, Chairman, National Certification Committee

The revised National Documentation of Palestine was presented. The RCC appreciated the remarkable efforts done by the NCC of Palestine and of the national immunization programme in compiling the National Documentation. The RCC made several comments on the contents of the report that will be communicated in a letter to the Chairman, NCC, from the Chairman, RCC. It was agreed that the NCC be requested to re-submit the Documentation in light of the RCC's observations and including data up to the end of 2005 for review by RCC at it fifteenth meeting in April 2006. It was also agreed that WHO would provide technical support to the NCC in preparing their revised report.

5. REVIEW OF ANNUAL UPDATE FOR 2004 OF LEBANON

Dr Ghassan Issa, Secretary, National Certification Committee

The Annual Update for Lebanon for 2004 was presented by of Lebanon, on behalf of the Chairman, NCC. The RCC was much concerned about the quality of data presented in the report and the decline in the AFP surveillance indictors in several districts of the country. While the RCC appreciated the frank comments of the NCC as mentioned in the 'executive summary' it felt that it was essential for the NCC to also convey its concerns directly to the national programme. The RCC made several other comments on the report which will be communicated in a letter addressed to the Chairman, NCC, from the Chairman RCC. It was agreed that the Annual Update for 2004 should be revised and submitted to fifteenth meeting of RCC for its review together with a separate Annual Update for 2005.

6. REVIEW OF PROVISIONAL NATIONAL DOCUMENTATION OF EGYPT AND PAKISTAN

6.1 Egypt

Dr Salah Madkour, Chairman, National Certification Committee

The Second Provisional National Documentation report of Egypt was presented. The RCC greatly appreciated the progress achieved in Egypt as it appears that viral circulation in Egypt has most probably been interrupted and commended the national programme on their efforts at eradicating polio from the country. The RCC made a few observations on the report which will be communicated to the Chairman, NCC in a letter from the Chairman. RCC. The RCC anticipated that hopefully the next report to be submitted by the NCC, Egypt will be the definitive National Documentation.

6.2 Pakistan

Professor Tariq Bhutta, Chairman, National Certification Committee

The Second Provisional National Documentation report of Pakistan was presented. The RCC noted with satisfaction the progress that has been achieved so far and the efforts being made to cover every child in the inaccessible and insecure areas of the country in successive rounds to reduce the immunity gap. The RCC made a few observations on the report which will be communicated to the Chairman, NCC, in a letter from Chairman, RCC.

7. OTHER MATTERS

7.1 Plan of work for RCC for the period 2006–2007

The RCC agreed with the proposed outline of the plan and confirmed that as recommended by the GCC, national documents will be invited from endemic countries three years after the last case and one year after the last case in case of re-infected countries.

In view of the close epidemiological link between Pakistan and Afghanistan, it was suggested that the epidemiological situation in both countries would be considered in the discussion of the national documentation of each of them.

The RCC found the schedule of reports to be presented by the NCC during the coming two years quite helpful.

Regarding initiating preparations for compiling RCC's submission to the GCC, the secretariat was advised to review the documentation of EUR/RCC and WPR/RCC and develop a draft outline of the EM/RCC's report for further discussion at RCC 15.

7.2 Review of the abridged format of the Annual Update

The RCC approved the abridged version with a few minor modifications.

7.3 Review of updated guidelines for preparedness and response for wild poliovirus importation and format of national plans

The RCC discussed the revised and updated guidelines and approved them with a few modifications and recommended that all NCCs submitting reports for RCC 15 should be requested to submit revised national plans.

7.4 Dates and venue for the 15th meeting of the RCC

It was agreed that the next meeting (15th) of the RCC would be held from Tuesday 4 April to Thursday 6 April 2006. In view of the impact of such meetings on promotion of national eradication activities, it was suggested to hold the 16th RCC meeting late in 2006 in Yemen.

Annex 1

PROGRAMME

Wednesday, 7 December 2005

08:30–09:00	Registration
09:00–09:30	Opening Session Introductory remarks by Dr Ali J. Sulaiman, Chairman of RCC Message from Dr Hussein A. Gezairy, Regional Director, WHO/EMRO Adoption of Agenda
09:30–11:00	Present situation of polio eradication initiative EM Regional Overview, Dr F. Kamel, WHO/EMRO, Dr H. Asghar, WHO/EMRO AFR, Dr S. Mbaye, WHO/AFRO EUR, Professor S. G. Drozdov, EUR Regional Certification Commission SEAR, Dr N.K. Shah, Chairman, SEAR Regional Certification Commission
11:00–11:45	Present situation of polio eradication initiative (Cont.) Global Overview, Dr R. Sutter, WHO/HQ Outcome of the second ACPE Meeting, Dr Y. Al Mazrou, RCC and ACPE Member Discussion
11:45–12:15	Update on the regional laboratory containment activities, Dr H. Asghar, WHO/EMRO
12:15–13:00	Presentation and discussion of the revised national document of Palestine
13:00–15:30	Private meeting of the RCC members

Thursday, 8 December 2005

08:30–09:00	Review of annual update 2004 of Lebanon
09:00–11:00	Presentation and discussion of (provisional) national documents of Egypt and Pakistan
11:00-12:00	Private meeting of the RCC members

Annex 2

LIST OF PARTICIPANTS

Dr Ali Jaffer Mohamed Sulaiman (Chairman)
Director General of Health Affairs
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Ministry of Health and Population
Cairo

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African Regional Certification Commission
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Undersecretary for Research Affairs
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Other Organizations

Rotary International
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Medical Officer / POLIO

WHO Secretariat

Dr Abdullah Assa'edi, Assistant Regional Director
Dr Mohamed H. Wahdan, Special Advisor to the Regional Director for Poliomyelitis Eradication
Dr Faten Kamel, Medical Officer, Poliomyelitis Eradication
Dr Humayun Asghar, Virologist, Poliomyelitis Eradication
Dr Javid Hashmi, Short Term Consultant, Poliomyelitis Eradication
Dr Hala Safwat, Technical Officer, Poliomyelitis Eradication
Mr Jalaa Abdelwahab, Technical Officer, Poliomyelitis Eradication
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Mrs Fatma Moussa, Senior Secretary, Poliomyelitis Eradication
Mrs Rasha Naguib, Secretary, Poliomyelitis Eradication