

Report on the

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

Cairo, Egypt  
4–6 May 2010

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**World Health  
Organization**

Regional Office for the Eastern Mediterranean

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## 1. INTRODUCTION

The twenty-second meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was held from 4 to 6 May 2010 at the WHO Regional Office for the Eastern Mediterranean (EMRO) in Cairo Egypt. The meeting was attended by members of the RCC and chairpersons of the National Certification Committees or their representatives and programme managers from 16 countries (Bahrain, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Oman, Morocco, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen). It was also attended by WHO Somalia staff and was connected to the National Certification Committee chairman and national responsible officer in Iraq by video. The meeting was also attended by WHO staff from headquarters and the Regional Offices for Africa and the Eastern Mediterranean. The meeting was preceded by a one-day meeting of the chairpersons of the National Certification Committee, in which some members of the RCC participated.

The meeting was opened by Dr Ali Jaffer, Chairman of the Regional Certification Commission. He welcomed the participants and thanked the national committees and programmes for their efforts in keeping their countries free of polio and for the timely submission of their reports to the Regional Certification Commission. He acknowledged the deep involvement of the WHO Regional Director for the Eastern Mediterranean in polio eradication and his endless support to routine immunization and polio eradication as well as his efforts to achieve self sufficiency in vaccine production.

Dr Abdalla Assa'edi, Deputy Regional Director, inaugurated the meeting on behalf of Dr Hussein A. Gezairy, Regional Director, and delivered a message from him. In his message the Regional Director acknowledged the commitment and efforts of participants to maintain the vast majority of the Region polio-free and to restrict viral circulation to only the limited number of districts in the remaining endemic countries (Afghanistan and Pakistan), where accessibility of children was severely affected mainly due to security constraints. Dr Gezairy concluded by expressing the hope that the target would soon be achieved based on the strong national commitment, the devotion of the national and international staff and the continued support of polio eradication partners.

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

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

Detailed actions taken in response to the recommendations of the previous meeting were presented to the RCC. The recommendations were mainly related to Pakistan, Afghanistan and Sudan.

The RCC acknowledged the multiplicity of actions and approaches made specifically in relation to ensuring accurate and timely data about achievements in coverage. These included independent monitoring as well as developments on the political side, particularly the role of the interprovincial ministerial committee and the decision to implement performance-based payment. The RCC recommended continuation of these efforts.

With regards to south Sudan, the RCC noted that the programme is regaining its strength with respect to both personnel and logistics support. The Committee noted that it has been almost one year since the last reported case and expressed the hope that it would be presented with an updated national document during its October 2010 meeting.

## **3. OVERVIEW OF THE CURRENT SITUATION OF POLIO ERADICATION**

### **3.1 Eastern Mediterranean Region**

#### *3.1.1 Overview*

Progress towards achieving polio eradication is continuing in the Region. The major concerns are the endemic wild poliovirus transmission in Afghanistan and Pakistan and the risk of importation, particularly in the Horn of Africa, where importations have been followed by outbreaks.

In 2009, the number of confirmed wild poliovirus cases in the Eastern Mediterranean Region was 172. The majority of cases in 2009 (89 cases) were from Pakistan, with 38 from Afghanistan and 45 from Sudan. To date in 2010, 23 cases were reported: 15 from Pakistan and 8 from Afghanistan. No cases have been reported from Sudan since June 2009.

In Pakistan, virus circulation is persistent only in 3 transmission zones: NWFP/FATA; Quetta block (Quetta, Pishin, and Killa Abdullah) in Baluchistan; and Karachi in Sindh. More than half (56%) of the polio cases in 2009 and so far in 2010 were from insecure areas, in Khyber Pakhtunkhwa (KPK). Efforts to achieve polio eradication in Pakistan have been hampered in some areas of NWFP/FATA and Baluchistan by insecurity and active conflict, affecting access to children and resulting in substantial population movement, and in other areas by poor management

and inadequate implementation of the polio eradication strategies, as is the case in some districts in Baluchistan and towns in Karachi.

The programme in Pakistan took major steps forward to address the constraints facing effective implementation of polio eradication strategies. These included the personal engagement of His Excellency Asif Ali Zardari, President of Pakistan, the launch of the Prime Minister's Action Plan to Eradicate Polio, with more sectors actively supporting the programme, and the establishment and regular meetings of the Interprovincial Ministerial Committee for Polio. However, commitment at district levels is not consistent with the high commitment at the provincial and national levels. More focus is being placed on holding district authorities accountable to their performance. Of particular importance is the development of district-specific plans to interrupt wild virus transmission in the 15 districts at highest risk, and more important, steps towards more accountability of district management and linking payments to performance.

In Afghanistan, where security problems are the main reason for inaccessibility of children, a wide range of approaches is being implemented by the national programme, to ensure accessibility in these conflict-affected areas. These included communication with the Afghani forces and the International Security Assistance Forces to seek cessation of military activities during campaigns. Contact with anti-government elements for the same purpose, has continued through the International Committee of the Red Cross. In the meantime, local efforts have included the recruitment of "local access negotiators" to work with all parties in the conflict-affected areas and the contracting of local nongovernmental agencies which have been responsible for delivering the basic package of health services in these areas, to assume responsibility for implementation of supplementary immunization activities. Specific plans were developed for the 13 persistent transmission districts with the aim of scaling up promising tactics. At the same time, efforts are continuing to sustain good coverage in all accessible areas.

The outbreak that started in south Sudan in 2008 and continued until the end of June 2009 affected 9 of the 10 states of south Sudan. It claimed 64 cases with spread to northern Sudan (5 cases from Khartoum and Red Sea) and neighbouring parts of Kenya and Uganda. Actions were taken to curb the outbreak including strengthening technical support, updating supplementary immunization activities plans, provision of logistic support, enhancing surveillance and enlisting local government commitment and ensuring coordination of actions by all partners. Supplementary immunization activities using mainly mOPV1 have been conducted since May 2008, synchronized with similar activities in neighbouring countries. Efforts are concentrated now to further strengthen surveillance and verify interruption of virus transmission.

Coordination between neighbouring countries within the Region and with other WHO regions is continuing. Coordination between Afghanistan and Pakistan, particularly at the border, continues. Coordination meetings for the Horn of Africa

countries and Horn of Africa Technical Advisory Group are held regularly and the Horn of Africa bulletin is being issued regularly with input from all countries. Synchronization of activities and exchange of information between countries has improved greatly. However, there is still room for improving direct coordination at local levels.

Sustaining the polio-free status of other countries is done by avoiding large immunity gaps in polio-free countries; through improvement of routine immunization and implementation of supplementary immunization activities, especially in foci of low immunization coverage. Polio-free countries of the Region have in general maintained certification standards surveillance. Regular AFP surveillance reviews were being carried out in the polio free countries to ensure that the quality of surveillance is maintained.

The regional priorities for polio eradication during 2010 are to: 1) interrupt transmission in Pakistan and Afghanistan through intensification of supplementary immunization activities, ensuring access to children in the security compromised areas, addressing managerial issues, ensuring high quality performance and making use of the new tools e.g. bOPV; 2) maintain achievements in south Sudan; 3) avoid large immunity gaps in polio-free countries through improvement of routine immunization and implementation of supplementary immunization activities especially in foci of low population immunity; 4) maintain certification-standard surveillance in all countries, both at national and sub-national levels and particularly among high-risk areas / population; 5) maintain and further strengthen coordination activities between neighbouring countries, especially between Afghanistan and Pakistan and in the Horn of Africa; 6) maintain the polio laboratory network and promote its use for other relevant programmes; 7) continue with containment and certification activities; 8) optimize PEI/EPI collaboration; and 9) secure the financial resources required to implement the regional plan for eradication.

### *3.1.2 Overview of the regional polio laboratory network*

The laboratory network continues efficiently to support AFP surveillance activities with high quality results. All network laboratories are fully accredited except Kuwait, which is provisionally accredited. The workload of the network laboratories is high; during 2009 and as of April 2010, the polio network laboratories processed 25 496 and 6270 samples, respectively. The certification standard laboratory performance indicators are maintained: 97 % of samples had culture results within 14 days and 99% had intratypic differentiation (ITD) results within 7 days. Overall, in 98% of AFP cases, the final laboratory testing results were provided within 45 days of paralysis onset.

In 2009, indigenous WPV1 and WPV3 transmission continued in Pakistan and Afghanistan. In 2010, 3 clusters of WPV1 and 02 of WPV3 have been detected to date. Detection of viruses in low transmission season from NWFP (Peshawar, Bajour,



Swat), Sindh (Karachi environmental samples), Baluchistan (Quetta) and Afghanistan (Helmand, Farah) is warning sign that active circulation of viruses may continue in immunity gap areas. The WPVs were detected in sewage water samples collected from Karachi and Lahore sites. An outbreak due to circulating vaccine-derived poliovirus (cVDPV) was detected through retrospective testing of Sabin-like viruses. In 2009, a total of 6 cVDPVs were detected. All, except one of 2009, Somalia VDPVs are not closely related to any of the 2008 viruses, suggesting independent emergence of VDPVs.

Nineteen countries (Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Sudan, Tunisia, United Arab Emirates and Yemen), have reported completion of Phase 1 laboratory survey and inventory activities of laboratory containment of polioviruses and potential infectious material. Three countries (Afghanistan, Pakistan and Somalia) have not started the containment activities. All countries that have completed Phase 1 of containment activities were required to submit the quality assurance report. Documentation of the quality of Phase 1 containment activities was submitted by 19 countries (Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab of Emirates and Yemen).

The real-time PCR method was introduced in 5 of 6 ITD laboratories of the regional poliovirus laboratory network, further adding to the efficiency and timeliness of ITD results reporting, and early flagging of VDPVs. New sewage collection sites have been added to existing Lahore and Karachi sites and plans are under way to introduce environmental surveillance in Peshawar, Quetta, Rawalpindi and Multan.

### **3.2 Discussions on the regional situation**

Several questions were raised, mainly regarding the situation in Pakistan and the rather weak impact seen despite the considerable efforts made. It was re-emphasized that the evident commitment of the President and the Prime Minister has not been translated into action at the peripheral level. The RCC appreciated the recent efforts being made to develop specific district plans for high-risk areas.

The RCC noted that there is no apparent improvement towards interruption of WPV circulation particularly in the reservoir districts in Pakistan, at the district and UC levels due mainly to continuing inadequate response of the national authorities. It proposed that the opportunity of the forthcoming World Health Assembly be used to exert additional pressure on Pakistan by the global community through indicating that the Government of Pakistan would be responsible for hindering the achievement of polio eradication. In the meantime the RCC emphasized the need to accelerate efforts taking into account that the time left to achieve the set goals is becoming short.

The RCC noted the improvement in routine immunization in priority countries receiving GAVI ISS funds and expressed concern that if this support is discontinued it may impact negatively on routine immunization, which is one of the basic strategies for polio eradication.

Concerning the recent reports of cVDPVs cases in Somalia which were discovered as a result of retrospective testing of Sabin viruses isolated during 2008 onward, the RCC expressed concern about this situation and emphasized the need to take necessary action immediately to raise the immunity levels particularly in affected areas.

With respect to surveillance and surveillance reviews, the RCC recommended to prioritize countries with less than optimal surveillance standards for surveillance reviews.

### **3.3 Overview of polio eradication activities in the WHO African Region**

The situation of poliomyelitis eradication in countries of the African Region was presented to the RCC with special emphasis on progress achieved in Nigeria.

The RCC was pleased to note the progress made in Nigeria, with only 2 polio cases as of 28 April 2010 compared to 236 cases over the same period in 2009. The RCC expressed the hope that the factors behind the success in Nigeria could be useful lessons for Pakistan.

The RCC expressed concern over the reported polio cases in Senegal, Mauritania and especially Chad. While noting the efforts being made to contain the situation, the RCC called for more coordination of eradication efforts between these countries and neighbouring countries of the Eastern Mediterranean Region.

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

The situation of poliomyelitis eradication in of the South-East Asia Region was presented to the RCC, with details about progress in India.

The RCC was pleased to note that India is experiencing its longest stretch without WPV1 in Uttar Pradesh and Bihar simultaneously. As well, the outbreak of WPV3 seems to have reached the stage of control. It was noted however that the porous borders of the endemic Indian states have been behind frequent importation to Nepal. Indian WPVs were also detected in Africa and Europe.

While surveillance has reached certification standards in some South-East Asia countries, its level is of concern in others.

### **3.5 Overview of polio eradication activities in the WHO European Region**

The outbreak in Tajikistan has brought to light a number of important lessons.

- One possible factor was that the threat of H1N1 in Europe had diverted attention away from polio surveillance.
- The MECACAR operation was a great success and consideration should be given to its revival.
- The risk analysis which is usually presented to the Euro Certification Commission has highlighted that some countries in Europe are at high risk of viral spread should importation occur. This included Tajikistan. It is noted however, that actions need to follow the risk analysis to strengthen surveillance immunization and importation preparedness.
- The system of risk analysis adopted by EURO should be reviewed for possible use in EMRO.

### **3.6 Global highlights and the strategic plan (2010-2012)**

In Asia, WPV transmission now persists in a relatively small number of districts (<60) in just three countries: India, Pakistan and Afghanistan. From these districts, the indigenous WPV1 and to a lesser extent WPV3 has recurrently re-infected other, polio-free parts of the same country. As well, since 2005 wild poliovirus from India has been exported to the bordering countries of Nepal, Bangladesh and Myanmar, as well as Angola in Africa. In the case of Pakistan and Afghanistan, each country has recurrently re-infected the other, although it appears the latter is now receiving a higher share of the importations.

These persistent transmission districts constitute two distinct groups requiring different strategic approaches. The first group of districts is characterized by very large populations, high birth rates and high population density, often with suboptimal sanitation, and requiring very high population immunity (>95%) to interrupt transmission. This group includes the persistent transmission districts of western Uttar Pradesh and central Bihar in India and the city of Karachi in Pakistan.

The second group of districts is characterized by a lower population density and, in all likelihood, a lower immunity threshold to stop transmission, but with compromised access for supplementary immunization activities due primarily to law and order problems, insecurity or outright conflict. This group includes in Pakistan the adjoining districts of Quetta, Pishin and Killah Abdullah in the province of Balochistan, three Federally Administered Tribal Agencies, and Peshawar in Khyber Pakhtunkhwa (KPK), previously named North-West Frontier Province (NWFP). In Afghanistan, this group includes 13 districts of Helmand, Kandahar and Uruzgan provinces in the southern region.

By comparison with Asia, the transmission of both indigenous and imported WPVs in Africa has been sustained over larger geographic areas, such as provinces/states or groups of provinces/states, as opposed to districts. Furthermore, polio outbreaks due to imported WPVs in Africa have generally resulted in more polio cases over longer periods of time than in Asia. Both of these phenomena are primarily due to the weaker health systems in the remaining polio-infected countries of sub-Saharan Africa, resulting in low routine immunization coverage levels and suboptimal outbreak response. However, these challenges are in part offset by the consistently high per-dose efficacy of OPVs in sub-Saharan Africa, and by the substantially lower population immunity threshold needed to stop WPV transmission as compared to Asia.

By end 2009, indigenous WPV poliovirus circulation in Africa was restricted to a group of eight to 12 states of northern Nigeria, though a further four countries were known (Angola, Chad) or suspected (Democratic Republic of Congo, south Sudan) of having re-established transmission on a national or sub-national scale. In early 2010, an additional six west African countries in the ‘WPV importation belt’ still had ongoing outbreaks due to recent importations. Encouragingly, WPV1 cases fell by 90% in Nigeria in 2009 due to a combination of a) higher vaccine-induced immunity following the major improvements in supplementary immunization activity performance in 2009, and b) a certain degree of natural immunity as a result of the large outbreaks in 2007–2008. Consequently, by early 2010 the risk of new exportations from Nigeria had been substantially reduced. In addition, Democratic Republic of Congo and south Sudan had not reported a case of polio due to their re-established virus for over six months (i.e. since August 2008 and June 2009, respectively).

In 2008, recognizing delays in achieving eradication, the World Health Assembly requested the development of a new Strategic Plan. Since then, a major independent evaluation of barriers to polio eradication, trials on new vaccines, and new approaches for reaching previously missed children helped inform the development of the new Global Poliomyelitis Eradication Initiative Strategic Plan 2010–2012, which was produced in broad consultation with stakeholders and governments of the remaining polio-affected countries. The new plan incorporates lessons learnt since the Global Poliomyelitis Eradication Initiative began, and includes new approaches for achieving its major objectives:

- interrupting wild poliovirus transmission in Asia and in Africa;
- enhancing global surveillance and outbreak response; and
- strengthening immunization systems.

By mid-2010	By end-2010	By end-2011	By end-2012	By end-2013
Cessation of all polio outbreaks with onset in 2009*	Cessation of all ‘re-established’ poliovirus transmission**	Cessation of all polio transmission in at least two of the four endemic countries***	Cessation of all wild poliovirus transmission†	Initial validation of 2012 milestones††

The four major milestones of the new strategic plan 2010–2012 (see above) will be internationally analysed every quarter and graded as ‘on-track’, ‘progressing but with issues of concern’ or ‘at risk for completion’ to alert countries and stakeholders as to emerging risks and guide mid-course corrections. For milestones which are ‘progressing but with issues of concern’ or ‘at risk for completion’, the appropriate national or international Technical Advisory Group will be asked to work with the relevant national authorities to establish a corrective plan within two weeks. A new poliomyelitis eradication advisory body will evaluate the milestones and major process indicators, monitor corrective action plans and provide overall guidance on policy, strategy and priorities.

By the first quarter of 2010, the application of the operating principles of the new strategic plan 2010–2012 was already showing results. In northern Nigeria, all but four states had reduced the proportion of ‘0-dose’ children (i.e. children who had previously never been immunized) to less than 10% by end 2009, with a subsequent 90% decline in polio cases due to WPV1, as a result of new engagement of state politicians and traditional leaders.

In western Uttar Pradesh, India, serological surveys demonstrated that >95% of very young children were now protected against type 1 polio; and the government’s rapid scale-up of health infrastructure in the Kosi river areas of Bihar, combined with the identification and systematic vaccination of more than five million children from migrant groups, had by end 2009 eliminated all but one genetic lineage of WPV1.

In Pakistan and Afghanistan, the systematic application of objective monitoring criteria for supplementary immunization activities, combined with environmental sampling in Karachi and Lahore (Pakistan), facilitated accurate identification and heightened political oversight of the remaining ‘reservoir’ districts, while the piloting of a range of new strategies in conflict-affected areas of Afghanistan demonstrated the feasibility of reaching sufficient children to interrupt the residual WPV transmission in these areas.

Furthermore, by the first quarter of 2010, 10 of the 15 countries which had suffered new outbreaks due to WPV importations in late 2008 and 2009 had again stopped transmission, while two of the four ‘re-established transmission’ countries (Democratic Republic of the Congo and south Sudan) had not had a new case due to their re-established virus for more than six months.

#### **4. REVIEW OF NATIONAL REPORTS**

##### **4.1 Final national documentation reports**

*Egypt:* The RCC appreciated the sustained quality of the polio eradication programme, in particular high routine immunization and sensitive surveillance system

supplemented by sewage waste environmental monitoring. The Commission recommended that this valuable document include a few additional items that need to be recorded, such as the outbreak of VDPVs discovered several years ago.

The RCC decided to accept the final national documentation on a provisional basis. Formal acceptance of the document would follow the timely submission of a revised version taking into account the comments of the RCC, which will be communicated in a letter addressed to the NCC Chairman from the Chairman of the RCC.

*Palestine:* The RCC acknowledged the efforts of the NCC working under challenging and difficult circumstances. It recommended a few amendments and additions in the document itself and in the preparedness plan to respond to importation.

The RCC decided to accept the final national documentation on a provisional basis. Formal acceptance will follow the timely submission of a revised version taking into account the comments of the RCC, which will be communicated in a letter addressed to the NCC Chairman from the Chairman of the RCC.

#### **4.2 Abridged annual update reports**

The RCC considered the abridged annual update reports for 2009 submitted by the NCCs and made the following decisions.

1. The reports submitted by the Islamic Republic of Iran, Iraq, Jordan, Libyan Arab Jamahiriya, Oman, Morocco, Qatar, Saudi Arabia, Tunisia and United Arab Emirates were found to be satisfactory. The RCC highlighted some specific points for each country to be addressed in future reports. The RCC agreed to accept these reports and that the specific comments made by the RCC on each report be sent to the relevant Chairperson of the NCC in the letter of the Chairman of the RCC denoting acceptance of the report.
2. The reports of Bahrain and Kuwait would be provisionally accepted. Final acceptance would be conditioned by ensuring that the reports are amended as per the comments of the RCC which will be sent to the Chairpersons of the NCC of Bahrain and Kuwait from the Chairman of the RCC.
3. Acceptance of the report of Syrian Arab Republic would be deferred until a revised version of the report was received reflecting the significant amendments that need to be made. The RCC calls on EMRO Secretariat to extend any support necessary to the NCC in undertaking the required revision.
4. The report of Lebanon as also indicated by the NCC did not provide the necessary convincing evidence that the surveillance is at certification standard

and it was therefore decided to defer acceptance of the report until the NCC could provide evidence that surveillance has improved to the required level for certification. The RCC recommended to EMRO to give priority to Lebanon in conducting a national surveillance review to be followed by the necessary supportive activities.

### **4.3 Annual updates**

*Yemen:* The RCC noted with satisfaction that the Government of Yemen continues to give attention to organizing supplementary immunization activities and that it is covering most of the costs involved. It called on them to maintain these efforts, particularly as Yemen is vulnerable to importation.

The RCC noted that there are significant discrepancies between the reported routine coverage rates and estimates of routine coverage published by UNICEF and WHO and calls on the NCC to help ensure that national routine immunization continue to receive the required attention by the national authorities.

It was noted that there are areas with low routine immunization, inadequate coverage during supplementary immunization activities and at the same time poor surveillance. The NCC should make every effort to ensure that combined weakness in these strategies is avoided and areas with weakness in one strategy are given special attention to have good levels in the others.

The RCC made some comments that needed amendments in the annual update for 2009 and decided to provisionally accept the update. Final acceptance would be conditioned by ensuring that the report is amended as per the comments of the RCC which will be relayed to the Chairman of the NCC from the Chairman of the RCC.

*Somalia:* The RCC commended the efforts made by WHO and UNICEF to ensure that Somali children are receiving doses of OPV through various means (routine and supplementary immunization and CHDs) and that the performance of the surveillance system is satisfactory. It emphasized that every effort should be made to prevent a significant gap both in surveillance and in population immunity in any community.

The retroactive diagnosis of cases of cVDPV in some foci in Somalia is of concern. Actions taken so far and future plans were discussed. It is hoped that the immunity profile will be monitored closely and no gaps will be allowed.

The RCC decided to accept the annual update on a provisional basis. Final acceptance is conditional upon amendment of the report as per the comments of the RCC, which will be relayed to WHO and UNICEF from the Chairman of the RCC.

## **5. OTHER MATTERS**

### **5.1 General recommendations**

Being aware of the continued danger of importation to polio-free countries of the Region, the RCC recommended to all Member States to:

1. Review national plans of preparedness to address importation and ensure functionality. It recommended that the experience of Oman in conducting a simulation exercise be implemented by all other countries to assess on practical terms that their national plans are implementable and determine any requirements in this regard.
2. Ensure national authorities take necessary steps to register monovalent OPV vaccines 1 and 3 in case they are required to immediately address importation.

### **5.2 Date and venue of the twenty-third meeting of the RCC**

The RCC agreed that 19–20 October 2010 would be the most suitable dates to hold its next meeting. It recommended that the venue be the United Arab Emirates, since some of the delegates were unable to attend because of visa restrictions.

As the meeting will discuss a few reports, 2 days are felt to be sufficient. It is hoped to review the following.

- Djibouti abridged annual update for 2009
- Sudan revised basic national documentation
- Provisional national documentation for certification of polio eradication from Pakistan and Afghanistan
- Other reports as appropriate



**Annex 1**

**PROGRAMME**

**Tuesday, 4 May 2010**

- 08:30–09:00 Registration
- 09:00–09:30 Opening session  
Introductory remarks by Dr Ali J. Mohammed, Chairman of RCC  
Message from Regional Director, WHO/EMRO  
Adoption of agenda
- 09:30–09:45 Implementation of the recommendations of the 21st RCC Meeting
- 09:45–10:30 Regional overview / Dr F. Kamel & Dr H. Asghar, WHO/EMRO
- 10:30–11:15 Discussion
- 11:15–12:15 Regional overviews  
AFR / Dr M. Salla, WHO/AFRO  
SEAR / Prof. N. Islam, SEA/RCC
- 12:15–12:45 Global highlights and strategic plan 2010-2012 / Dr R. Tangermann, WHO/HQ
- 12:45–14:15 Discussion
- 14:15–15:45 Presentation and discussion of the final national documentation for Regional  
15:45–17:00 Certification of Egypt and Palestine  
Private meeting of EM/RCC

**Wednesday, 5 May 2010**

- 09:00–16:00 Presentation and discussion of the abridged annual updates of Bahrain, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia and United Arab Emirates
- 16:00–17:00 Private meeting of EM/RCC

**Thursday, 6 May 2010**

- 09:30–11:00 Presentation and discussion of the annual updates of Yemen and Somalia
- 11:00–12:00 Private meeting of EM/RCC
- 12:00–13:00 Closing session and concluding remarks

**Annex 2**

**LIST OF PARTICIPANTS**

**Members of the Regional Certification Commission**

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