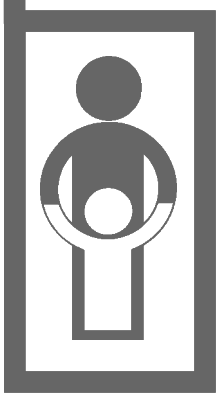
WHO/V&B/01.15
ENGLISH ONLY
DISTR.: GENERAL

Certification of the Global Eradication of Poliomyelitis

Report of the sixth meeting of the Global Commission for the Certification of the Eradication of Poliomyelitis

Washinton D.C., 28-29 March 2001



DEPARTMENT OF VACCINES AND BIOLOGICALS

World Health Organization
Geneva
2001

The Department of Vaccines and Biologicals
thanks the donors whose unspecified financial support
has made the production of this document possible.

This document was produced by the
Expanded Programme on Immunization
of the Department of Vaccines and Biologicals

Edited by: Health & Development Networks (http://www.hdnet.org)

Ordering code: WHO/V&B/01.15
Printed: October 2001

This document is available on the Internet at:
www.who.int/vaccines-documents/

Copies may be requested from:
World Health Organization
Department of Vaccines and Biologicals
CH-1211 Geneva 27, Switzerland
• *Fax:* + 41 22 791 4227 • *E-mail:* vaccines@who.int •

Contents

Abbreviations

AFP	acute flaccid paralysis
ARCC	African Regional Certification Commission
DRC	Democratic Republic of the Congo
EPI	Expanded Programme on Immunization
ERCC	European Regional Certification Commission
GCC	Global Commission for the Certification of the Eradication of Poliomyelitis
ICCPE	International Commission for the Certification of Poliomyelitis Eradication from the Americas
NCCs	national certification committees
NID	national immunization day
OPV	oral polio vaccine
PAHO	Pan American Health Organization
RCCs	regional certification committees
SEARCC	South-East Asia Regional Certification Commission
SIAs	supplementary immunization activities
SNID	subnational immunization day
TCG	Technical Consultative Group
VAPP	vaccine-associated paralytic poliomyelitis
VDPV	vaccine-derived poliovirus
WHO	World Health Organization
WPRCC	Western Pacific Regional Certification Commission

1. Introduction

Sir Joseph Smith and Dr Carlyle de Macedo, the co-deputy chairs of the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC), convened the sixth meeting of the Commission on 28–29 March 2001, in Washington, D.C., USA.

Welcoming members of the GCC on behalf of the Regional Director, World Health Organization Regional Office for the Americas (WHO/AMRO), Dr David Brandling-Bennett, Assistant Regional Director, AMRO, expressed his hope that the GCC would again provide help and guidance to facilitate the successful continuation of the global and regional process towards eventual certification of poliomyelitis eradication.

GCC members attending were:

1. African Region: Dr Rose Leke, Chair, African Regional Certification Commission (ARCC), Professor F. Nkrumah;
2. Region of the Americas: Dr F. Robbins, Chair, International Commission for the Certification of Poliomyelitis Eradication from the Americas (ICCPE), Dr C. de Macedo, Member, Western Pacific Regional Certification Commission (WPRCC);
3. Eastern Mediterranean Region: Dr A. Deria, Member, Eastern Mediterranean Regional Certification Commission (EMRCC);
4. European Region: Sir J. Smith, Chair, European Regional Certification Commission (ERCC);
5. South-East Asia Region: Professor Natth, Chair, South-East Asia Regional Certification Commission (SEARCC);
6. Western Pacific Region: Dr A. Adams, Chair, Western Pacific Regional Certification Commission (WPRCC), Dr Wang Ke An, Member, WPRCC.

The main objectives of the sixth meeting of the GCC were to:

1. update the GCC on the status of the Global Polio Eradication Initiative, and to
2. establish the requirements and processes for evaluating and documenting polio-free status in WHO regions between the time of regional and global certification.

2. Global status of polio eradication

A detailed report on the global status of the eradication initiative was provided to the Commission. Particular emphasis was given to the nature, extent and impact of accelerating activities during the period 1999–2000.

To rapidly interrupt wild poliovirus transmission, polio-endemic countries have increased the number of rounds of supplementary immunization activities (SIAs) since 1999, and have improved the quality of SIAs to reach previously unreached children by delivering oral polio vaccine (OPV) house-to-house. The number of national immunization days (NIDs) rounds in most endemic countries, especially in the 10 global priority countries, doubled between 1999 and 2000.

Extraordinary progress towards polio eradication continued during 2000. With 30 countries considered endemic at the end of 1999, wild poliovirus was identified in only 24 countries throughout all of 2000 (13 in the African Region, 7 in the Eastern Mediterranean Region and 4 in the South-East Asia Region). Transmission was detected in only 20 countries during the second half of 2000. Following the polio-free certification of the Americas in 1994, the Western Pacific Region became the second WHO Region to be certified as free of transmission of indigenous wild poliovirus in October 2000. No wild poliovirus has been isolated, under conditions of high-quality acute flaccid paralysis (AFP) surveillance, in any Member State of the European Region since September 1998.

The number of polio cases reported globally declined by 60%, from 7141 cases in 1999 to 2836 cases in 2000, the lowest level ever recorded (data as of 8 March 2001), despite substantial improvements in surveillance quality between 1999 and 2000. The global non-polio AFP rate increased from 1.3 in 1999 to 1.6 per 100 000 in 2000, and the proportion of AFP cases with adequate stool specimens increased from 67% to 75% in 1999 and 2000, respectively. Type 2 wild poliovirus has not been detected since October 1999, when it was last isolated in Aligarh, Western Uttar Pradesh State, India.

Challenges during 2000 included continued poliovirus importations from endemic into polio-free areas, demonstrating the fragility of any area's "polio-free" status and highlighting the paramount importance of maintaining high polio immunization coverage as well as certification-standard surveillance. The outbreak on the Cape Verde Islands, associated with poliovirus importation from Angola, was a tragic reminder of the potential severity of poliovirus infection (17 deaths), and emphasized that even areas that have been polio-free for many years (or even decades) may be at risk of poliovirus transmission, if an appropriate level of immunity against polioviruses is not maintained.

The outbreak of vaccine-derived poliovirus (VDPV) on Hispaniola Island (Haiti and Dominican Republic, see below) would not have occurred in the presence of sufficiently high population immunity. The outbreak reaffirms the need to maintain high immunization coverage and sensitive surveillance for AFP to allow early detection of and response to such outbreaks.

Once transmission of wild poliovirus in human populations around the world has been stopped, IPV vaccine manufacturers and laboratories worldwide will represent the only remaining source of wild poliovirus. Laboratories may be storing specimens from known cases of poliomyelitis or other materials unknowingly infected with wild poliovirus (i.e. stool samples collected at a time and place when wild poliovirus was circulating and stored under conditions known to preserve polioviruses). Global certification of polio eradication will require documentation that laboratory containment of wild poliovirus has been implemented in each country worldwide. Under the current plan, IPV manufacture must be contained in BSL-3/Polio and Sabin strains in BSL-2/Polio.

During 2000, countries of the three polio-free WHO regions and selected polio-endemic countries have begun creating national inventories of laboratories containing wild poliovirus. Larger countries in these regions have made significant progress towards contacting thousands of laboratories and collecting the necessary information.

Experience during 2000 indicate that reaching the eradication goal in the remaining polio-endemic countries will increasingly depend on meeting three key challenges: (a) gaining access to and immunizing as many children as possible, particularly in conflict-affected countries, (b) maintaining and improving government commitment and multisectoral involvement in view of a disappearing disease, and (c) assuring that the necessary external funding needed to finish the task will be made available.

GCC decisions:

At the next full meeting of the GCC (see other business below), the WHO Secretariat is to provide:

1. a report on the process, procedures and experience to date in implementing the global plan of action for containment of wild polioviruses;[1]
2. a report on current knowledge on prolonged excretion of polioviruses from immunocompromised hosts, the research agenda in this area (including prevalence of chronic excretors, treatment options, etc.) and implications for eventually stopping polio immunization;
3. updated information on ongoing research on the frequency, extent, control and implications of circulating neurovirulent VDPVs.

[1] *WHO global action plan for laboratory containment of wild polioviruses* (WHO/V&B/99.32)

3. Reports from WHO regions certified as polio-free (WPR, AMR)

Following a period of three years during which endemic wild poliovirus could not be found in any Member country of the Western Pacific Region, despite high-quality surveillance, the Regional Commission for the Certification of Poliomyelitis Eradication, Western Pacific Region (WPRCC), concluded on 29 October 2000, that the transmission of indigenous wild poliovirus has been interrupted in all countries and areas of the Region. The WPRCC therefore certified the Region as free of the transmission of indigenous wild poliovirus. Copies of the full WPRCC report, as well as the report's executive summary, were made available to all GCC members at the sixth GCC meeting.

The chairman of the WPRCC, Dr Anthony Adams, outlined in detail the basis of data and information supplied by all WPR Member countries, to the WPRCC, upon which the Regional Commission had based its conclusions. Dr Adams particularly emphasized the Region's plans for monitoring the polio-free status of Member States on a continuous basis until global polio-free certification is achieved, to continue convening annual meetings of the Regional Commission, and the urgency to further enhance work towards completing the Regional plan for laboratory containment of wild poliovirus.

The American Regional Certification Commission (ICCPE – International Commission for the Certification of Poliomyelitis Eradication) has not been formally reconvened or conducted a meeting since the GCC's fifth meeting. The GCC received a detailed report from the Secretariat of the WHO Regional Office for the Americas on the status of polio surveillance and immunization activities in Member States since regional polio-free certification.

The report contained most of the data requested by the GCC at its fifth meeting, and showed that the trend towards lowering of surveillance quality, as well as lowering of routine immunization coverage, continued in some Member countries. The Pan American Health Organization (PAHO) Secretariat pointed out that while AFP surveillance was of sufficient quality to detect the outbreak of VDPV on the island of Hispaniola (see below), the outbreak had occurred largely because of insufficient routine coverage in Haiti and the Dominican Republic, two countries which had stopped conducting supplementary OPV immunization campaigns several years ago.

Compared to other WHO regions, there have only been relatively few activities towards laboratory containment of polioviruses in the Region of the Americas. As yet, neither a Regional plan of action for laboratory containment of polioviruses in the Americas, nor guidelines for its implementation, have been finalized.

GCC decisions:

1. The GCC receives and endorses the report of the Regional Commission for the Certification of Polio Eradication from the Western Pacific. In the light of this report, the GCC congratulates the Western Pacific Region on its achievement and concurs with the Regional Commission's finding that the transmission of indigenous wild polioviruses has been interrupted.

2. The GCC endorses the WPR Commission's plan for monitoring the polio-free status of Member States following regional certification until global certification. In particular, the GCC endorses the continuation of annual meetings of the Regional Commission and enhanced work on the full implementation of regional plans for laboratory containment of wild poliovirus.

3. The GCC recognizes the need for consistent certification requirements across regions, notes the experience gained in the Western Pacific in implementing the Phase 1 containment guidelines, and notes that full cooperation in implementing containment guidelines is dependent on further progress toward global eradication.

4. Given the above, the GCC advises regional commissions that while it may not be possible for Member States to fully implement Phase 1 containment guidelines prior to regional certification, countries must have achieved substantial progress, at a minimum to include a national plan, establishment of a national coordinating mechanism and initiation of the inventory process, before regional polio-free certification can be considered.

5. The GCC reaffirms its concurrence with the 1994 report of the International Commission for the Certification of Poliomyelitis Eradication (ICCPE) in the Americas, certifying that the transmission of indigenous wild poliovirus had been interrupted in the entire Western Hemisphere. The GCC acknowledges the detailed update report presented during the sixth meeting by the secretariat of the WHO Regional Office for the Americas on the status of polio surveillance and immunization activities in Member States since Regional Certification.

6. The GCC requests that the Region of the Americas prepare a Regional plan of action for laboratory containment of wild poliovirus, based on the global containment plan. The PAHO Secretariat should also develop and implement regional guidelines to implement the Regional plan of action for laboratory containment as soon as possible.

4. Report from the WHO European Region

The European Region has been polio-free, under conditions of excellent surveillance, for more than two years, and is close to certification. In nine meetings to date, the European Regional Certification Commission (ERCC) has already reviewed documentation from all Member States except for Turkey, Tajikistan, Turkmenistan and Uzbekistan, which will be reviewed during the ERCCs meeting in September 2001.

The GCC reviewed the ERCCs plan and format for the submission of final documentation from Member States prior to considering certification of the whole Region as polio-free, in which Member States also are requested to comment on how activities will be sustained in the post-certification era, and to present their plans for dealing with any wild poliovirus importations. The ERCC also requires countries to report on vaccine-associated paralytic poliomyelitis (VAPP) cases.

In view of the successful coordination of NIDs in 18 countries of the European and Eastern Mediterranean Regions during "Operation MECACAR", both the European and the Eastern Mediterranean Regional Certification Commissions are now collaborating to assure that high-risk areas on the border between both regions (i.e. minority areas in south-east Turkey, northern Syria, north-west Iran and northern Iraq, as well as central Asian republics and Afghanistan) can be successfully certified as polio-free.

GCC decisions

1. The GCC endorses the plan of the European Region for reviewing the final documentation from Member States prior to considering certification of the Region as polio-free. The GCC agrees that this documentation include a statement on how activities will be sustained in the post-certification era.
2. The GCC concurs with the decision of the European Certification Commission to request Member States to provide data on all reported cases of vaccine-associated paralytic poliomyelitis (VAPP) as an indicator of the sensitivity of surveillance to detect and investigate acutely paralysed children. Noting the recent circulation of vaccine-derived poliovirus in Haiti and the Dominican Republic, the GCC further states that any VAPP case should be properly scrutinized to determine whether it represents a unique event or a circulating VDPV.
3. The GCC notes the collaboration between the European and the Eastern Mediterranean Regional Certification Commissions and encourages the European Regional Commission to continue that dialogue through cross-membership and, when and if appropriate, joint meetings of the commissions.

5. Reports from polio-endemic WHO regions (AFR, EMR, SEAR)

The GCC notes the usefulness of reports on current status of polio eradication and certification activities in those regions that remain polio-endemic and expresses its gratitude to the regional commissions of AFR, EMR and SEAR for the reports (all data reported as of mid–March 2001).

African Region (AFR). The quality of AFP surveillance in the Region has improved in 2000, with a regional non-polio AFP rate of 1.3 per 100 000 compared to 0.8 per 100 000 in 1999. The proportion of AFP cases from which adequate stool samples have been collected increased from 31% in 1999 to 52% in 2000. However, surveillance needs to be further developed in several countries, including those experiencing conflict.

However, an increasingly large number of AFP cases is now classified as "polio-compatible" in those African countries which have switched to use the virological case classification scheme. Expert groups for case classification do not yet exist, and very few cases are followed up at 60 days after onset of paralysis, making it impossible to reliably rule out polio especially in AFP cases from which adequate specimens could not be collected.

Wild poliovirus transmission is largely confined to Central Africa and the Horn of Africa. Progress in the African Region was most visible in the Western block (except Nigeria), where surveillance improved significantly and where synchronized house-to-house NIDs were conducted during the second half of 2000.

Nigeria, the Democratic Republic of the Congo (DRC) and Angola represent the most significant poliovirus reservoirs in the Region. Nigeria reported 637 cases, of which only 11 cases were laboratory-confirmed. However, the location of these 11 cases throughout Nigeria indicated widespread transmission in 2000. Following the large polio outbreak in 1999, Angola continued to detect virus transmission in 2000. Poliovirus type 1 from Angola was found to be the origin of an outbreak detected on the Cape Verde islands in June 2000. A polio outbreak was also reported from Congo–Brazzaville (31 laboratory-confirmed cases) during 2000.

DRC reported 513 cases, with 24 virus-confirmed cases found throughout the country. Circulation in DRC is widespread, including border areas, impacting poliovirus transmission in the entire Central African block. In Ethiopia, only 3 of 144 reported AFP cases were virus-confirmed in 2000; however, transmission is likely to be underestimated due to low quality of surveillance.

Following its second meeting in Victoria Falls in September 2000, the African Regional Certification Commission (ARCC) met again in March 2001, during which agreement was reached on an adapted documentation tool to be used by countries to submit national documentation for certification, as well as on a timeline of certification activities for the Region. The documentation manual and accompanying guidelines have been sent to all AFR Member States.

The ARCC has initiated the selection and designation of national certification committees (NCCs) in almost all countries of the Region, and 20 countries of the Region were chosen to pilot the documentation process. Chairpersons of NCCs in the 20 pilot countries will be briefed on certification requirements during a meeting in May 2001. ARCC members are attending all AFR subregional Expanded Programme on Immunization (EPI) meetings to help to convey relevant information about the certification process to countries. The ARCC also initiated the formation and briefing of national expert committees for case classification in those AFR countries using virological case classification criteria. The AFR Regional Commission will meet again in September 2001, when a first report from all 20 pilot countries is expected.

Eastern Mediterranean Region (EMR). EMR reported 259 wild virus-confirmed cases in 2000 (175 from Pakistan). Wild poliovirus transmission remains widespread in Pakistan and Afghanistan. Following an outbreak during 1999, Iraq has not detected wild poliovirus after January 2000, despite increasingly sensitive surveillance. Wild poliovirus is still endemic in Sudan where four virus-confirmed cases were found during 2000, but where surveillance is not yet sufficient to accurately assess the intensity of virus transmission. Improved surveillance in Somalia identified an outbreak of type 1 poliovirus (41 cases) in the Mogadishu area.

Wild virus transmission continues in upper Egypt, with three virus-confirmed cases reported in the first half of 2000 from the known reservoirs of the Governorates of Minya, Asyut and Fayoum. Wild poliovirus type 1 was also detected at the end of 2000 in samples of sewage from Minya, followed by wild virus-confirmed cases in late 2000 and early 2001.

The EMRCC has met twice over the last year, and has now reviewed documentation from 16 of 23 Member States.

South-East Asia Region (SEAR). Only 271 virus-confirmed cases were reported from SEAR in 2000, compared to 1161 cases in 1999. This rapid decrease was mainly attributable to a great reduction in the number of virus-confirmed cases reported from India, the largest country in the Region (264 virus-confirmed cases in 2000, compared to 1126 in 1999). India maintained remarkably high surveillance quality throughout 2000 with a non-polio AFP rate of 1.95 and collection of adequate specimens from 83% of AFP cases.

Virus transmission in India during 2000 was mostly confined to two northern States, Uttar Pradesh and Bihar, with only few remaining foci of transmission elsewhere in India. In addition to NID and subnational immunization day (SNID) rounds, all locations with wild virus isolation outside northern India were targeted by large-scale mopping-up campaigns, each immunizing at least 1 million children aged < 5 years, conducted throughout 2000.

Transmission in Bangladesh was greatly reduced, with only one wild poliovirus-associated case reported near Dhaka city in September 2000, despite greatly improved surveillance quality. However, virus sequence information suggested that ongoing transmission may have not been detected earlier in 2000. Myanmar reported two wild-virus cases, found in the border area with Bangladesh, in February 2000. Nepal reported three cases in January, November and December 2000 from its border areas with India (Uttar Pradesh and Bihar States).

The International Certification Commission for Poliomyelitis Eradication (ICCPE) in SEAR met in mid–March 2001 to review preliminary documentation from five polio-free countries, presented by the chairpersons of the national certification committees in each country. The ICCPE also updated both the manual of operations for preparing national certification documentation, and the Regional plan of action for certification.

GCC decisions:

1. The first priority for the polio partnership in the remaining polio-endemic regions must be high quality implementation of the strategies needed to interrupt transmission, as well as bringing AFP surveillance to the standards required for polio-free certification. Priorities for regional commissions in these regions should include the evaluation of surveillance performance, particularly in those subregional areas that have not detected wild poliovirus for at least 12 months (i.e. eastern and southern Africa, countries of the Persian Gulf and in northern Africa).
2. The GCC notes with concern that some countries in the remaining endemic regions do not have national expert groups for the final classification of AFP cases and requests WHO to oversee establishment of such groups in all countries as a matter of urgency. At a minimum all countries currently using a virological case classification scheme must have an expert group for AFP case classification in place by mid–2001 and all countries by end–2001.
3. Recognizing the importance to the certification process of close scrutiny and response to all polio-compatible cases, the GCC notes with concern the disproportionately large number of polio-compatible cases being reported from some countries and strongly urges to further increase the collection of adequate specimens, as well as assure 60–day follow-up particularly for cases without adequate specimens, allowing to reduce the number of polio-compatible cases.

6. Regional certification process and documentation prior to global certification

Following regional polio-free certification, countries must continue to conduct a number of important polio eradication activities in order to maintain and document their polio-free status until global certification occurs.

The GCC was impressed by the detailed preparations made in the Western Pacific Region to assure that high-quality AFP surveillance, as well as appropriate levels of immunity against polioviruses in the population are maintained in all Member States.

The Region of the Americas demonstrated that even more than six years after Regional polio-free certification, AFP surveillance and routine immunization in most countries remain at high levels. However, the situation in the Americas also shows that, as more time passes after Regional certification, it becomes more and more difficult to maintain high-level AFP surveillance and appropriate levels of immunity in the population.

GCC decisions:

1. Prior to global certification, all regions will need to ensure that updated country level data is scrutinized and verified by an independent regional mechanism to the satisfaction of the Global Certification Commission. In most instances the Regional Certification Commission should undertake this task.
2. The GCC values the input of NCCs to verify updated national data prior to global certification. However, following regional certification, the Regional Certification Commission (or other independent regional review body) should decide to either continue or reconstitute NCCs for this purpose. The GCC recognizes that regional commissions may wish to have updated national data verified by a national certification committee particularly in those countries at highest risk of undetected circulation of an imported wild poliovirus or of VDPV.
3. The GCC restates its previous decision that prior to global certification all regions will need to provide data demonstrating full implementation of Phase II activities of the Global plan of action for the containment of wild polioviruses.
4. The GCC endorses the concepts outlined in the WHO draft guidelines for documenting continued polio-free status in certified regions with the following amendments: (a) increased emphasis be given to identifying high-risk subnational areas and to the activities undertaken in those areas, (b) that, if possible, all VDPVs be subjected to genomic sequencing, with priority to those associated with clusters of AFP cases and (c) modification of the requirements on regional certification committees (RCCs) and NCCs in accordance with points 1 and 2

above. The GCC requests that the Secretariat further develop the draft guidelines into explicit guidelines for use at regional level and review at the next GCC meeting.

7. Sustained circulation of neurovirulent VDPVs

In the Region of the Americas, beginning 12 July 2000, and continuing into 2001 (last known virus-associated case with onset on July 2001), an outbreak caused by VDPV occurred on the island of Hispaniola – in Haiti (7 laboratory-confirmed cases) and the Dominican Republic (14 laboratory-confirmed cases). All cases were either unvaccinated (n=5) or inadequately vaccinated (n=16).

Genetic sequencing of the virus showed that the outbreak was caused by a vaccine-derived type 1 Sabin (OPV) poliovirus, which appeared to have acquired neurovirulence and transmission characteristics of wild poliovirus. In response, the Dominican Republic and Haiti are implementing three nationwide OPV immunization rounds.

GCC decisions:

1. The objective of the Global Certification Commission is to certify eradication of wild poliovirus, including completion of the containment process. Recognizing that the full benefits of polio eradication will only be realized in the absence of VDPV circulation, WHO must develop a process for verifying the absence of VDPV circulation after certification of wild poliovirus eradication. The implications of circulation of VDPVs for the definition of polio eradication must remain under review.
2. National certification documents must include details of the investigation of any AFP cases associated with VDPVs as well as evidence of an appropriate immunization response to any circulating VDPV.
3. WHO is requested to keep the GCC informed of the potential process for verifying the absence of VDPV circulation, so that the GCC may consider the implications for its work.
4. The investigation and response to a circulating VDPV must be similar to that of an imported wild poliovirus. Contained transmission of a VDPV (i.e. cases for <1 year and limited geographic spread) has no impact on regional certification. Evidence of prolonged (>1 year) or extensive VDPV circulation may postpone regional certification (regions not yet certified) or require re-evaluation of regional certification status (certified regions). The GCC will re-evaluate after the Global Technical Consultative Group (TCG) has considered this issue.

8. Role of certification commissions to facilitate polio eradication and certification under special circumstances

The GCC noted that both eradication and certification activities continue to be difficult in one or more countries or territories in each WHO region, either because of conflict or other political circumstances, or because the area's international status is uncertain, limiting the United Nations system's ability to communicate and access the areas.

In some such situations, regional commission or national committee members, because of their independent status, have been asked to visit the area and promote eradication and certification efforts.

GCC decisions:

1. The GCC reaffirms that the main role of certification commissions and committees is to certify polio eradication. Individuals serving in this capacity should remain independent of the implementation and evaluation of eradication activities, particularly in countries with ongoing transmission of wild poliovirus. However, on the request of the secretariat, and as appropriate, commission members may visit countries to educate national authorities on the certification process, to clarify data or processes, and to promote certification efforts.
2. In countries and areas with which United Nations agencies have limited dialogue or to which they have limited access, the global or regional commission may, if requested by the Secretariat, play a direct role in discussions with local authorities.
3. In countries that have not complied with the requirements for certification, the global or appropriate regional commission may, in consultation with the Secretariat, need to bring this directly to the attention of high-level national authorities.

9. Other business

The GCC expressed its gratitude to the WHO Secretariat, particularly the PAHO, for hosting the sixth GCC meeting and for ensuring the high quality of technical and administrative arrangements.

The GCC noted with sadness the sudden death of Dr Abednego, a member of the GCC and of the SEARCC. The GCC noted the substantial contributions Dr Abednego had made to international immunization, as well as polio eradication and certification efforts and expressed its condolences to his family.

The GCC also extends best wishes for a speedy recovery to its Chairman Professor I. Kostrewski, who could not participate in the sixth meeting due to continuing illness.

GCC decisions:

1. The GCC will use the opportunity of the Global TCG to have an informal meeting, the main purpose of which would be to finalize the date, venue and agenda items for the next full meeting of the GCC.
2. The GCC strongly endorses the suggestion of the secretariat to hold the next full GCC meeting within 12 months. The next meeting should be of at least two days duration, to be convened possibly at either the WHO African or Eastern Mediterranean regional offices in Harare or Cairo. Among the agenda items would be detailed reports and discussion on containment, chronic shedders and VDPV circulation.
3. The GCC strongly stated the need for an official meeting with WHO's Director-General (DG), if possible during the upcoming meeting of the Global TCG in May 2001, to:
    a) familiarize the DG with the work of the GCC and its heavy dependence on continued political support;
    b) report to the DG on the work of the GCC to date; and
    c) indicate to the DG that the remit of the GCC may be affected by the emerging information on the implications of VDPV circulation.

Annex 1: Agenda

Tuesday, 27 March, 2001

08:30–09:00	Registration	
09:00–09:30	Opening Administrative remarks	
09:30–10:00	Global status of polio eradication	WHO/HQ
10:00–10:30	Progress report on GCC decisions from May 2000 meeting	WHO/HQ
10:30–11:00	*Coffee break*	
11:00–11:30	Update and review of final certification proceedings – WPR	RCC Chairman
11:30–12:00	Discussions on AFP surveillance and final certification of the Americas – report from the PAHO TCG meeting	PAHO
12:00–12:30	Discussion	
12:30–14:00	*Lunch break*	
14:00–14:20	Updates on regional certification activities – AFR, SEAR	RCC Chairmen
14:20–14:40	Updates on regional certification activities – EMR, EUR	RCC Chairmen
14:40–15:00	Discussion on regional updates	
15:00–15:30	Outbreak of SABIN-derived poliovirus in the Dominican Republic and Haiti	PAHO
15:30–16:00	*Coffee break*	
16:00–16:15	Implications of the outbreak of Sabin-derived poliovirus in the Dominican Republic and Haiti	WHO/HQ
16:15–17:00	Discussion	

Wednesday, 28 March 2001

09:00–09:30	Review of draft WHO guidelines for regions on submitting update documentation to the GCC between regional and global certification	WHO/HQ
09:30–10:30	Which information should the GCC require prior to global certification from regions already certified as free of indigenous wild poliovirus? – Statements and discussion	Chairmen of: GCC RCCs and (PAHO, WPR)
10:30–11:00	*Coffee break*	
11:00–11:45	Potential role of the GCC and RCCs to promote surveillance and immunization in the years following regional certification	GCC/RCC Chairmen
11:45–12:30	How can the GCC and RCCs contribute in countries where progress has been particularly difficult?	GCC/RCC Chairmen
12:30–14:00	*Lunch break*	
14:00–15:00	Other business	
15:00–15:30	Discussion of draft GCC decisions	GCC Chairman
15:30–16:00	*Coffee break*	
16:00–16:30	Closing of meeting	

Annex 2: List of participants

Professor A. Adams, National Centre for Epidemiology and Population Health, Australian National University, Canberra ACT 0200, Australia

[*] Dr M. S. Ali Jaffer, Director General of Health Affairs, Ministry of Health, P.O. Box 803, 112 Ruwi, Muscat, Sultanate of Oman

Professor N. Bhamarapravati, Center for Vaccine Development, Institute of Sciences & Technology for Development, Mahidol University at Salaya, Nakhonchaisri, Nakhonpathom 73170, Thailand

Dr D. A. Henderson, Director, Center for Civil Biodefense Studies, The Johns Hopkins School of Hygiene, 111 Market Place, Suite 850, Baltimore, MD 21205–6709, USA

Dr C. de Macedo, SMDB Conjunto 0 1 Casa 05, Lago Sul, Brasilia, DF 71680–010, Brazil

Dr A. Deria, 28 Claudia Place, Augustus Road, GB-London SW19 6ES, United Kingdom

[*]Dr S. Drozdov, Director, Institute of Poliomyelitis and Viral Encephalitides, Academy of Medical Sciences of the Russian Federation, Kievskoe Shosse 27, Oblast 142782, Moscow, Russian Federation

Dr W. Ke-An, Chinese Academy of Preventive Medicine (CAPM), 27 Nanwei Road, Beijing 100050, People's Republic of China

Professor J. Kostrzewski, National Institute of Hygiene, Department of Epidemiology, 24 Chocimska Street, PL-00 791 Warsaw, Poland

Dr R. Leke, Department of Immunology and Microbiology, Faculty of Medicine, University of Yaoundé, Yaoundé, Cameroon

Professor F.K. Nkrumah, Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana, P.O. Box 25, Legon, Ghana

Dr F.C. Robbins, Department of Epidemiology and Biostatistics, School of Medicine, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106–4945, USA

Sir J. Smith, 95 Lofting Road, Islington, GB-London N1 1JF, United Kingdom

Consultant: Dr W. Dowdle, Decatur, USA

[*] Unable to attend

Centers for Disease Control and Prevention

Dr R. Sutter, Atlanta, USA
Dr S. Cochi, Atlanta, USA

Technical Consultative Group

Dr P. Figueroa, Kingston, Jamaica
* Dr W. Orenstein, Atlanta, USA

WHO Secretariat

Regional offices

Regional Office for Africa (AFRO)

*Dr S. Okiror, Harare, Zimbabwe

Regional Office for the Americas (AMRO)

Dr C. de Quadros, PAHO, Washington, D.C., USA

Regional Office for Europe (EURO)

Dr G. Oblapenko, Copenhagen, Denmark

Regional Office for the Western Pacific (WPRO)

Dr S. Roesel, Manila, Philippines

WHO headquarters
Geneva, Switzerland

Dr B. Aylward, Polio, Department of Vaccines and Biologicals (V&B)
*Dr B. Melgaard, Director, V&B
*Dr R. Sanders, V&B
Dr R. Tangermann, Expanded Programme on Immunization (EPI), V&B

* Unable to attend