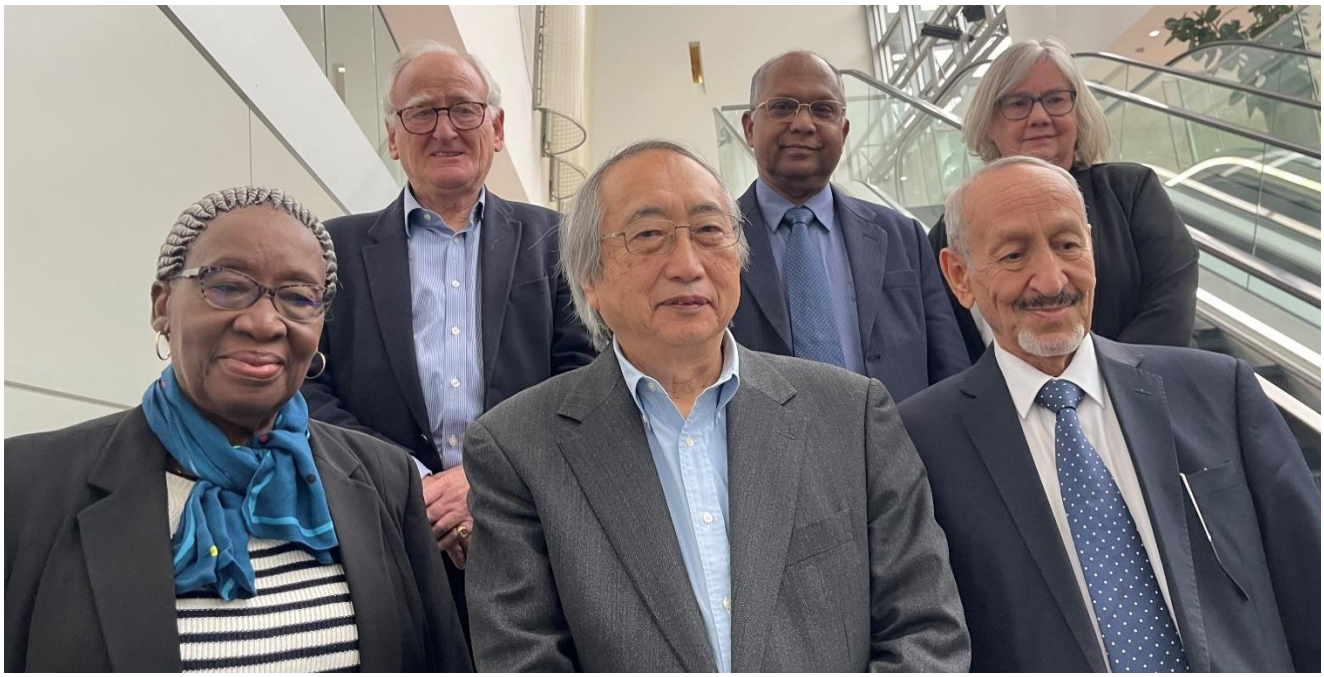
Summary Report from the Twenty-sixth Meeting of the Global Commission for Certification of Poliomyelitis Eradication

Geneva, Switzerland, 21-22 November 2024

World Health Organization

Members of the Global Commission for Certification of Poliomyelitis Eradication, from the meeting on 21-22 November 2024 (Geneva, Switzerland)



From Left to right

Back row: Professor David Salisbury, Professor Mahmudur Rahman, Dr Arlene King

Front row: Professor Rose Leke, Dr Nobuhiko Okabe, Professor Yagoub Al Mazrou

Abbreviations

Containment

CAG	Containment Advisory Group
CC	Certificate of Containment
CCS	Containment Certification Scheme to support GAPIV
CP	Certification of Participation
CWG	Containment Working Group of the GCC
ICC	Interim Certificate of Containment
GAPIV	Global Action Plan for Poliovirus Containment Version IV
NAC	National Authority for Containment
PEF	Poliovirus-Essential Facility
IM	Inventory Management
PMI	Potentially Infectious Materials
NPCC	National Poliovirus Containment Coordinator

Certification

GCC	Global Commission for Certification of Poliomyelitis Eradication
NCC	National Certification Committee
RCC	Regional Commission for Certification of Poliomyelitis Eradication
AMRCC	RCC of the Americas
AFRCC	African RCC
EMRCC	Eastern Mediterranean RCC
EURCC	European RCC
SEA-RCC	South-East Asia Regional Certification Commission
WPRCC	Western Pacific RCC
PCS	Post Certification Strategy

Viruses and vaccines

IPV	Inactivated poliomyelitis vaccine
OPV	Oral poliomyelitis vaccine
bOPV	Bivalent oral poliomyelitis vaccine containing Sabin type 1 and 3
mOPV2	Monovalent oral poliomyelitis vaccine Sabin type 2
nOPV2	Novel oral poliomyelitis vaccine type 2
PV	Poliovirus (PV1 is PV type 1 etc.)
VDPV	Vaccine-derived poliovirus
aVDPV	Ambiguous vaccine-derived poliovirus
cVDPV	Circulating vaccine-derived poliovirus
iVDPV	Immunodeficiency-associated vaccine-derived poliovirus
WPV	Wild poliovirus
WPV1	Wild poliovirus type 1
WPV2	Wild poliovirus type 2
WPV3	Wild poliovirus type 3

Others

AFP	Acute Flaccid Paralysis
BMGF	Bill and Melinda Gates Foundation
CDC	Centers for Disease Control (United States of America)
ES	Environmental surveillance
GPEI	Global Polio Eradication Initiative

IDP	Internally Displaced Persons
IMB	Independent Monitoring Board
KPI	Key Performance Indicator
LQAS	Lot Quality Assurance Sampling
PID	Primary Immunodeficiency Disorders
SAGE	Strategic Advisory Group of Experts on immunization
TAG	Technical Advisory Group
ToR	Terms of Reference
WHO	World Health Organization

Contents

Introduction

The 26th meeting of the Global Commission for Certification of Poliomyelitis Eradication (GCC) took place in Geneva on 21-22 November 2024, chaired by Professor David Salisbury. Commission Members are chairs of their respective Regional Commissions for Certification of Poliomyelitis Eradication (RCC):

- Professor David Salisbury – Chair Global Certification Commission and Chair European Regional Certification Commission
- Dr Arlene King - Chair Regional Certification Commission for Region of the Americas and Chair GCC Containment Working Group
- Dr Nobuhiko Okabe - Chair Western Pacific Regional Certification Commission
- Prof Mahmudur Rahman - Chair Southeast Asian Regional Certification Commission
- Dr Yagob Al Mazrou - Chair Eastern Mediterranean Regional Certification Commission
- Prof Rose Leke - Chair African Regional Certification Commission

Objectives

- Update the GCC on the GPEI strategy timelines revision and the programme planning to timely meet the targets
- Report to GCC on surveillance in the polio endemic countries and seek inputs/guidance
- Present to GCC, reports from the Regional Certification Commissions
- Update GCC about progress on the bOPV Cessation Planning and GCC's role in that process, as well as on Post Certification Strategy
- Update GCC on the implementation of the poliovirus containment plans, as well as highlight any issues for GCC's inputs and guidance

The agenda is included in the Annex.

Session 1: Update on GPEI Strategy (Goals 1 & 2)

Global update, Revised GPEI Strategy timelines, POB meeting outcomes

The Global Polio Eradication Initiative (GPEI) update provided a detailed overview of the current progress, challenges, and gaps in global polio eradication efforts. Polio eradication efforts continue to face significant challenges, particularly in the endemic countries Pakistan and Afghanistan. The eradication effort faces additional hurdles, including 14.5 million "zero-dose" children globally, many of whom reside in conflict-affected areas. Supply constraints until the first half of 2024 for novel oral polio vaccines (nOPV2), though now improving, have limited the impact of this critical tool in reducing new cVDPV2 cases. Global cases of cVDPV2 have declined, with 205 reported in 2024, compared to 395 in 2023 and 688 in 2022. Of note, over 80% of the cVDPV2 cases are concentrated in North-West Nigeria, Eastern DRC, North Yemen, and South-Central Somalia. Recent detections in Spain and Poland, linked to transmission in the African, highlight the ongoing risk of international spread. Although the number of cVDPV1 cases have decreased significantly, from 134 cases in 2023 to 10 in 2024, challenges persist due to low routine immunization coverage, insecurity, and political instability in key geographic areas. Humanitarian crises in areas such as Gaza, Yemen, and Somalia exacerbate these issues, making populations hard to reach and further delaying progress.

Goal 1: Interrupting Wild Poliovirus (WPV1) Transmission

There have been concerning increases in numbers of cases and virus detections in Pakistan and Afghanistan, where cases surged to 73 in 2024 (as of 21 November 2024), compared to 12 in all of 2023. Historic reservoirs of the Quetta-Kandahar block, Karachi, and the Peshawar-Nangarhar block show re-established transmission, driven by operational gaps, community resistance, and increasing insecurity. The most intense transmission is observed in the southern cross-border epidemiological corridor (Quetta-Kandahar block). The southern region of Afghanistan has been unable to implement house-to-house campaigns for about five years, while campaigns in the Quetta Block have been of inconsistent quality for the last two years. Consistent strengthened political commitment, high-quality Supplementary Immunization Activities (SIAs), and enhanced cross-border collaboration are essential to addressing missed children and zero-dose communities. The revised timelines of the GPEI Strategy target WPV1 interruption by the end of 2025, with certification by the end of 2027.

Goal 2: Stopping Circulating Vaccine-Derived Poliovirus (cVDPV) Outbreaks

The burden of cVDPV2 has decreased from 688 cases in 2022 to 205 in 2024, but problems persist in North-West Nigeria, Eastern DRC, Somalia, and Yemen. The cVDPV2 detections in the European Region (Spain and Poland), linked to outbreaks in the African Region, underscore the continuing global risk. A shift to nOPV2, with significantly better genetic stability compared to Sabin-based OPV2, has led to substantial reductions in the number of new cVDPV2 emergences. However, high-quality campaigns remain critical to stopping the ongoing and new cVDPV2 outbreaks. The cVDPV2 interruption target is now set for 2026, with certification of elimination by 2029.

Strategy Extension and Broader Challenges

Based on the current polio epidemiology and programmatic situation, in October 2024 the GPEI Polio Oversight Board extended the strategy timelines, aiming to interrupt WPV1 transmission by the end of 2025 (previously 2024) and achieve certification of eradication by the end of 2027 (previously 2026). Similarly, cVDPV2 interruption is targeted for 2026, with certification of elimination aimed for 2029. Eradicating polio remains a global health priority, requiring adaptive strategies, increased funding, and commitment to close remaining gaps.

The GCC expressed its concern that in the face of the present epidemiology in Pakistan and Afghanistan, the timelines for interruption of WPV1 transmission were unlikely to be achieved.

Low routine immunization coverage, humanitarian crises, operational gaps in outbreak response, and vaccine hesitancy constitute major challenges in the remaining polio strongholds, including northern Nigeria, northern Yemen, south-central Somalia, and eastern DRC as well as the core-reservoirs in the two WPV1 endemic countries.

The extended GPEI strategy emphasizes district-level micro-planning and high-quality campaign-implementation, integration of routine immunization with outbreak responses, and sustained political commitment and effective community engagement. The strategy focuses on using locally appropriate operational and social mobilization strategies to consistently reach the children with polio vaccine. A USD 6.9 billion budget for the period 2025–2029 supports these efforts, aligning with revised timelines to achieve the eradication goals.

The GCC expressed its concern that the extended GPEI Strategy had been developed without consultation with the GCC with regard to the Certification timelines. The GCC requested that before Certification timelines are further adjusted, the views of the GCC should be sought.

Eastern Mediterranean Regional update

In 2024, WPV1 cases rose to 73, up from 12 in all of 2023, with Afghanistan and Pakistan remaining endemic. Transmission has re-emerged in key reservoirs, including Quetta-Kandahar block, Karachi, and Peshawar-Nangarhar block, highlighting the need for intensified interventions. The WPV1 transmission in eastern Afghanistan had recently been observed to be declining, following improvement in the quality of SIAs during the first half of 2024. Meanwhile, cVDPV2 outbreaks persist in multiple regions. In Somalia, transmission has been ongoing since 2017, with spillover into Kenya, Ethiopia, and Djibouti. Improved access has facilitated five Supplemental Immunization Activities (SIAs) using novel OPV2 (nOPV2) in 2024. Yemen has reported 271 cases since 2021, mostly in the northern region, where insecurity has hampered vaccination responses, though two nOPV2 rounds are planned during the first half of 2025. The 2020 cVDPV2 outbreak in Sudan (58 cases across 15 states) was declared closed in September 2022 after two mOPV2 nation-wide vaccination rounds. In 2024, cVDPV2 was detected in White Nile (January and August), Gedarif (May), and SL2 in Kassala (May). In Gaza, cVDPV2 was detected in sewage samples, and one case was confirmed, prompting two nOPV2 rounds that achieved 95% coverage. Egypt experienced outbreaks linked to Sudan and Yemen, with no evidence of current local transmission, with four nOPV2 rounds conducted in affected areas to stop the outbreaks. Countries with IPV coverage below 80% include Afghanistan, Djibouti, Somalia, Sudan, Syrian Arab Republic, and Yemen. These

countries face challenges in reaching the regional immunization target.

Several challenges complicate eradication efforts in the Eastern Mediterranean Region. Conflict and insecurity in regions like Somalia, Yemen, Sudan, and Gaza severely disrupt vaccination campaigns and surveillance activities. In Afghanistan and Pakistan, attacks on health workers and operational difficulties further exacerbate gaps in immunization coverage. Operational barriers, such as restricted vaccine shipments and resource shortages in Yemen and Sudan, impede timely interventions. Additionally, misinformation and mistrust in some areas of Afghanistan and Pakistan reduce the acceptance of house-to-house vaccination campaigns, leaving vulnerable populations unprotected.

Sudan and oPt (Occupied Palestinian territory) are classified as high risk for missed poliovirus transmission due to the ongoing conflict situation. The programme plans to continue regular follow-ups and field missions to oPt, and use of alternative strategies in Sudan. Morocco, Libya, and Tunisia are at medium risk of missed poliovirus transmission, facing operational and system issues. A support mission visited Morocco in 2024, and surveillance reviews are being planned for Tunisia and Libya.

Pakistan and Iran are the only two countries with certified PEF facilities. Pakistan's Poliovirus Serology Laboratory at the National Institute of Health received a Certificate of Participation (CP) valid until June 30, 2025, pending validation of use of the S19 strain to replace live poliovirus. Iran's Razi Serum and Vaccine Institute received an Interim Certificate of Containment, with an audit plan approved by the GCC-CWG.

The RCC during its last meeting, reviewed and provisionally accepted country reports, with revisions pending based on feedback. Emphasis was placed on including granular surveillance and immunization details in high-risk areas for certification of WPV1 and cVDPV eradication. Independent surveillance reviews are planned in Jordan, Libya, Syria, and Tunisia before the end of 2025. iVDPV surveillance in countries like Tunisia, Egypt, and Iran is to be implemented systematically, with plans to expand to GCC countries. Certification now requires containment activities, with NPCCs responsible for related reporting in coordination with the RCC Secretariat.

Updates from Endemic Countries

Polio eradication in Pakistan

As of February 2024, the number of polio cases in Pakistan passed 50. This resurgence follows missed opportunities during a nearly 13-month period of no detections in some of the core-reservoirs and nearly two years of low-grade circulation in some districts of the South KP. Current environmental sample positivity reflects a similar outbreak pattern to that observed in 2019-2020, underscoring the persistent challenges in controlling the WPV1 transmission. There is progressive reduction in the transmission of genetic cluster YB3C, while the genetic cluster YB3A has been sub-divided i.e. YB3A4A and YB3A4B. Genetic analysis indicates breakthrough transmission in 18 districts, including key historical reservoirs such as Peshawar, districts of the Quetta Block, and Karachi, where WPV1 transmission has persisted for over a year.

Pakistan’s surveillance network has expanded significantly, with 127 environmental sites in 87

districts supported by 234 district surveillance coordinators and 250 WHO officers. AFP laboratory testing increased by 30% between 2021 and 2024, with most districts meeting global standards for surveillance indicators. However, challenges remain in 28 districts across Pakistan, which have below 80% stool adequacy. The provincial breakdown shows that Balochistan has the highest number of affected districts (9), followed by Khyber Pakhtunkhwa (8), Sindh (6), Punjab (3), and Gilgit-Baltistan (2). Key districts with low stool adequacy levels include Jhal Magsi (59%) and Killa Abdullah (58%) in Balochistan, Kolai Palas (62%) in Khyber Pakhtunkhwa, and Kashmore (64%) in Sindh.

The quality of vaccination campaigns in the endemic South KP, as well as Karachi, and the Quetta Block remains a concern. The campaign LQAS pass rates of ≥90% have been rarely achieved, hindered by security issues, vaccine refusals, community boycotts, and logistical challenges. In October 2024, mapping identified 1.8 million children among migrant and mobile populations, including nomads and displaced groups; however, vaccination efforts for these groups face significant operational barriers.

To address these challenges, the recently launched National Emergency Action Plan (NEAP) 2024-25 aims to interrupt polio transmission in Pakistan by June 2025. Approved after a three-year gap, it is implemented in three phases: revitalizing emergency operations, addressing HR and operational gaps, and mapping high-risk populations (Phase I); conducting synchronized high-quality immunization campaigns and ensuring accountability (Phase II); and minimizing undetected poliovirus circulation through risk-based SIAs and aggressive outbreak responses (Phase III). The plan's goal is to vaccinate all vulnerable children, reverse current transmission trends and sustain zero vulnerability.

Polio eradication in Afghanistan

In 2024 (as of 21 November), the country reported 23 WPV1 cases and 91 ES positive samples. In 2024 so far, the WPV1 transmission has been the most intense in the South Region, while the East Region has recently showed a declining trend. In 2024, the programme implemented seven campaigns so far, including two nation-wide campaigns, focusing on micro-planning, enhanced training and monitoring, and real-time data analysis to inform corrective interventions. The programme continues with its special attention to high-risk mobile populations and the populations living along the borders, with continued efforts to vaccinate returnees and incorporate nomadic groups into immunization strategies. Progress has been marked by an increase in female frontline worker participation over the last 12 months and expanded vaccination age groups, with children aged 5-10 years vaccinated three times between October and December 2023 in the endemic East Region. Surveillance quality is being maintained, with continued internal and external reviews to identify any gaps. The programme is monitoring surveillance quality for nomadic groups, with consistent non-polio AFP rate of more than three since 2020. An independent audit in East Afghanistan in early 2024 concluded that overall, there is a functioning and well-performing programme, generally achieving high coverage across most districts; however, additional efforts are needed to increase coverage by reaching high-risk mobile populations, addressing refusals and fine-tuning SIA operations to interrupt the endemic WPV1 transmission. On Surveillance, the audit team concluded that the health facility and community-based, as well as environmental surveillance, are functioning well; and there is a need to enhance

surveillance in mobile populations and border areas.

Between 2021 and mid-2024, the programme made considerable progress towards shifting to house-to-house campaign modality, with more than 90% of the target population reached through this modality in July 2024 nation-wide campaign. However, in October 2024, the house-to-house campaign approach fell back to the site-to-site and mosque-to-mosque campaigns, impacting the quality. The East Region though, had the minimal impact of this regression due to efforts of the regional EOC and partners. The programme is taking all measures to maximize the reach through site-to-site campaign modality; however, it is very challenging to achieve the same quality as through house-to-house campaigns.

African Regional Update, progress on Goal-2 (stopping cVDPV2)

The African region has demonstrated mixed performance in AFP (Acute Flaccid Paralysis) and environmental surveillance (ES) indicators over the past year. AFP surveillance generally meets the targets for non-polio AFP rate and stool adequacy in most countries at the national level; however, provincial and district-level gaps remain in certain regions, impacting early detection. Environmental surveillance quality varies by country, with some sites consistently isolating enteroviruses and others showing lower performance. Key challenges include limited access to some conflict-affected areas and logistical delays in sample shipment. These gaps emphasize the need for targeted interventions to enhance surveillance quality and coverage, especially in high-risk and underserved regions.

cVDPV1 situation

The African region has achieved noteworthy progress in reducing cVDPV1 transmission, with cases dropping from 19 across the DRC, Madagascar, Malawi, and Mozambique to just eight cases reported in the last six months, confined to the DRC and Mozambique. Notably, no cases were recorded in Madagascar in 2024 where it has been more than 13 months without any cVDPV1 detection following an explosive and protracted outbreak. Regarding type 1 immunity, Central, West, and certain parts of East Africa show low immunity levels among children aged 6–36 and 6–59 months. In Southern Africa, immunity is particularly low among older individuals, highlighting the need for targeted vaccination campaigns to address these gaps. The persistently low routine immunization and IPV1 coverage in several countries pose a risk to the progress made in controlling cVDPV1 outbreaks in the African region.

cVDPV2 situation

Although cVDPV2 cases have declined from 378 to 233 during the last rolling 12-month period, the number of affected countries has increased from 22 to 27. Environmental surveillance (ES) positive samples increased from 225 to 268 during the same period. In 2024, a total of 16 cVDPV2 emergences have been detected in the African Region, seven of which have newly emerged in 2024. In Central Africa, cVDPV2 cases dropped dramatically from 180 to 24, with Angola and the DRC showing marked improvements. In contrast, the Lake Chad Basin region saw a slight increase in cases, from 138 to 140; across Cameroon, Niger, Nigeria, and Chad, positive ES samples declined from 85 to 78.

In West Africa, cases decreased from 48 to 41 during the 12-month rolling periods, and from 35 to 6 during the 6-month rolling periods across 12 countries. In the Horn of Africa and neighboring regions, however, both cases and affected countries increased from 10 to 27 and from 2 to 4, respectively, involving Ethiopia, Kenya, South Sudan, and Tanzania. In Southern Africa, reported cases declined to just one in the last year. Regarding type 2 immunity, Southern and Eastern Africa continue to show low immunity among children under five, leaving them at high risk of polio transmission.

Containment

African countries are updating their WPV1/3 PIM/IM inventories using the ODK tool and reporting to AFRO as well as incinerating unusable nOPV2 vaccine vials after outbreak response campaigns. Both tasks are ongoing with the support of the AFRO. Angola and the DRC have fully implemented the destruction of poliovirus materials, supported by on-site technical assistance and missions from the WHO Regional Office.

In summary, the African Region has made reasonable progress in combating type 1 poliovirus outbreaks, with the wild poliovirus type 1 (WPV1) outbreak officially closed and efforts on track to end all active poliovirus variant type 1 outbreaks.

Session 1 - Conclusions

Global update, Revised GPEI Strategy timelines:

1. The GCC expressed grave concern over the current WPV1 epidemiological situation in Pakistan and Afghanistan, underscoring significant challenges to achieving the extended GPEI timelines for Goal one.
2. The GCC acknowledged that the revised GPEI Strategy provides an additional 12 months to interrupt WPV1 transmission in the endemic countries. However, the current epidemiological and programmatic conditions in the WPV1 core reservoirs remain deeply concerning and will demand substantial efforts to address the ongoing high-intensity transmission.
3. The GCC noted that polio programmes in Pakistan and Afghanistan are not likely to succeed in stopping WPV1 transmission when continuing with essentially the same strategic and operational approaches. Moreover, repeated extensions to the timeline for WPV1 eradication present a reputational risk to the GPEI.
4. The GCC noted the lack of formal engagement with the GCC during the revision of the GPEI Strategy timelines during the first half of 2024 and emphasized the importance of formal communication with the GCC for any future strategic shifts.

Eastern Mediterranean Regional update

1. The GCC highlighted the persistent risk of WPV1 exportation from endemic countries to other countries within the EMR and globally.
2. The GCC reiterated the critical importance of maintaining sensitive surveillance across the EMR to ensure the timely detection of and response to any WPV1 importations.

3. The GCC highly appreciated the well-coordinated outbreak response efforts in Gaza, recognizing the significant commitment and collaboration demonstrated. However, the GCC noted that no negative environmental surveillance samples have yet been reported from the cVDPV2-affected areas.

Endemic Countries

1. The GCC appreciated the detailed briefings from the Afghanistan and Pakistan polio programs, facilitated by the Eastern Mediterranean RCC and WHO EMRO.
2. The GCC acknowledged the extensive and intensive surveillance mechanisms in place in both endemic countries but notes sub-optimal surveillance quality at the sub-national level in certain key districts and areas.
3. The GCC noted the launch of the National Emergency Action Plan 2024-2025, spearheaded by the highest political leadership in Pakistan, and recognizes the continued programme oversight provided at the ministerial level in Afghanistan.
4. The GCC noted Pakistan's 2-4-6 plan, which reiterates commitments made in several previous plans that have not yet succeeded in interrupting transmission. It was further noted that details regarding key performance indicators (KPIs) to monitor progress, or potential options for course correction, were not clearly articulated.
5. The GCC remains concerned about the persistently sub-optimal campaign quality in critical areas and core reservoirs of Pakistan; namely South KP, Peshawar block, Karachi, and the Quetta block—despite the considerable efforts that have been undertaken. Pakistan missed the opportunity to interrupt WPV1 transmission during 2022 and 2023, when the virus was confined to a few districts in South KP.
6. The GCC is concerned about Afghanistan's shift from house-to-house campaigns to site-to-site and mosque-based modalities, which are insufficient for achieving the coverage needed for eradication.
7. The GCC had previously highlighted the high susceptibility in Afghanistan's South Region, which is now experiencing the most intense transmission, shared with the adjoining Quetta Block of Pakistan.

African Regional Update

1. GCC is encouraged by the WPV1 outbreak closure and congratulates all stakeholders for implementing a coordinated sub-regional response to WPV1 importation in Southeast Africa. The closure of this outbreak reiterates that polio eradication is a feasible goal if recommended strategies are properly implemented.
2. GCC noted the declining type 1 outbreaks but raised concerns about whether zero really means zero due to surveillance gaps at the sub-national level.
3. GCC noted the ongoing high intensity cVDPV2 transmission in Lake Chad Basin and Nigeria due to operational factors, lack of meaningful community engagement, and access-related challenges.

Session 1 - Recommendations

1. While waiting for Zero-Polio in Pakistan, GCC recommends the country programme implements the necessary strategic and operational shifts from the current approaches, which have not been able to achieve the required vaccination coverage levels, leaving sizeable numbers of zero-dose and under-immunized children.
2. GCC recommends, Afghanistan maintains the house-to-house SIA strategy and is concerned about the recent regression to site-to-site and mosque-to-mosque strategies that are not able to achieve the coverage levels required for eradication**.**
3. GCC recommends continuing to explore the possibility of offering additional antigens/vaccines, utilizing the polio outbreak response opportunity in Gaza.
4. GCC recommends that countries having significant population movement with endemic countries should maintain high-quality surveillance, aiming for timely detection in the event of WPV1 importation.
5. GCC recommends in-depth outbreak response and surveillance assessments to inform cVDPV1 outbreak closure in in Madagascar.
6. GCC suggests that in addition to reservoirs, there be a focus on countries with expanding cVDPV2 outbreaks as the risk for exportations will increase.

Session 2: Regional/RCC updates

European Region Update

The Region has achieved notable progress in several areas. Surveillance systems have expanded and now include active Acute Flaccid Paralysis (AFP) surveillance in 44 countries, environmental surveillance in 26 countries, and enterovirus surveillance in 32 countries. These surveillance methods are being integrated in 22 countries, creating a more comprehensive approach to detecting and monitoring poliovirus circulation. On the immunization front, most member states have transitioned to IPV-only schedules, aligning with global recommendations to phase out bOPV and minimize the risks associated with vaccine-derived polioviruses. Additionally, significant progress has been made in certifying Poliovirus-Essential Facilities (PEFs), with 10 out of 11 countries advancing their containment certification processes. Only Romania has expressed a wish to retain WPV materials without entering into the CCS through appointment of a NAC.

Countries such as Ukraine, Romania, and Kyrgyzstan report low vaccination rates, leaving some populations vulnerable to poliovirus resurgence. Ukraine faces critical challenges related to low immunization coverage and surveillance gaps. There are continued concerning gaps regarding poliovirus containment in Romania. The cVDPV2 outbreak in Israel has been closed. Bosnia and Herzegovina were advised by the RCC to enhance their outbreak preparedness to reduce risk levels.

The WHO Regional Office is currently focusing on a series of strategic actions. Surveillance systems will be strengthened through refresher trainings, field reviews, and collaborative workshops in high-risk countries, including Kyrgyzstan, Tajikistan, and Ukraine. Efforts to transition all member states to IPV-only schedules will continue. The certification of PEFs remains a priority, with a coordinated approach involving National Authorities for Containment and WHO to advance containment processes. Additionally, the launch of an e-inventory tool in 2025 aims to improve compliance and tracking of poliovirus containment.

By enhancing surveillance, boosting immunity, and strengthening containment measures—and with the support of global partners—the region is striving to sustain its progress and mitigate the risks of poliovirus resurgence.

Western Pacific Region Update

The Western Pacific Region remains free of polio and circulating vaccine-derived polioviruses in 2024. Regional assessment highlights a risk of delayed detection due to suboptimal performance in countries such as Cambodia, Lao PDR, Papua New Guinea (PNG), and the Philippines. Efforts are underway to improve surveillance systems in these countries. Environmental surveillance was reinstated in PNG after being halted in 2019, with similar plans for Vietnam. Surveillance training sessions and updated guidelines are being implemented in priority countries to strengthen national preparedness.

Low immunization coverage remains a concern, particularly in PNG, Vietnam, and the Philippines, where gaps in population immunity have been identified. Remaining bOPV-using countries will plan transition to IPV-only schedules in accordance with the recent recommendations of SAGE, with concurrent efforts to introduce the second dose of IPV in Cambodia and Mongolia to enhance immunity levels.

On containment, four countries in the region, including Australia, China, Japan, and South Korea, house a total of 12 Poliovirus-Essential Facilities (PEFs). Australia and Japan have made significant progress, achieving certifications for their facilities, while China has pending applications for six PEF certifications. South Korea has one PEF that has received the interim certificate of containment and is pursuing full Certificate of Containment (CC) certification.

The Western Pacific Region has developed significant plans to address current surveillance-related challenges by enhancing systems through ongoing surveillance reviews, targeted training, and sustaining environmental surveillance in key countries. The region also plans to focus on improving routine immunization coverage in high-risk countries and introducing IPV2 in bOPV-using countries to close immunity gaps. For containment, the Region aims to improve inventory completeness and accelerate PEF certifications, ensuring compliance with global standards. Strengthened national outbreak preparedness and the potential use of novel vaccines, such as nOPV2, are key components of future strategies.

Region of Americas Update

The Americas celebrated 30 years without wild poliovirus. Regional IPV1 coverage improved from 89% in 2022 to 90% in 2023, and Polio-3 coverage increased from 83% to 87%. The regional AFP rates also improved from 1.35 to 1.41 between 2022 and 2023. However, surveillance gaps at national and sub-national levels pose an ongoing risk of late detection of polioviruses. The regional risk assessment identified eight very high-risk, nine high-risk, 10 medium-risk, and 17 low-risk countries.

The cVDPV2 outbreak detected through wastewater surveillance in Canada in 2022 was declared closed in 2024. The detection of cVDPV3 transmission in French Guiana, a French territory bordering Brazil and Suriname, is concerning. Brazil and Suriname have been categorized by the RCC as being at high risk and very high risk, respectively, of circulation in the event of importation or emergence of poliovirus. There is a need to strengthen surveillance for polioviruses and poliovirus outbreak preparedness and response plans in both Brazil and Suriname, and the regional office plans to continue providing technical support.

Delayed detection and underperformance have been noted in some countries at the national and subnational levels. Haiti and the Dominican Republic are classified as "very high risk," with significant inter-country migration. Argentina has some underperforming regions requiring attention, while Panama remains delayed in implementing customized vaccination policies for migrants. The RCC plans to maintain advocacy efforts with these high-risk and underperforming countries.

All countries, except Brazil and Mexico, reported the identification or absence of poliovirus materials (inventory) and presented proof of attestation of final disposal (destroy, transfer, store). In the United States of America, a PIM survey for all poliovirus types is ongoing.

South-East Asian Region Update

The cVDPV2 outbreak in Indonesia has persisted since 2022; the country completed two nOPV2 rounds in 2024 through a phased approach. Across the region in 2024, India reported a case of aVDPV1, and Nepal reported an aVDPV3-positive environmental sample. Nepal implemented a bOPV campaign, vaccinating more than 300,000 children. Following the launch of nation-wide PID surveillance in India, two iVDPV3 cases were reported in 2024.

The regional risk assessment identifies Myanmar and Indonesia as high-risk countries. While the national-level polio vaccine coverage is high in the majority of countries, subnational variations do exist. Seven countries in the region have two IPV doses in their routine immunization schedules (India: 3), while DPR Korea, Maldives, Myanmar, and Timor-Leste have a single IPV dose. National Immunization TAGs in all these four countries have recommended the introduction of a second IPV dose. Some countries are also considering the option of introducing a hexavalent vaccine into their routine immunization.

The regional surveillance system continues to function well, with some national and subnational variations. Bhutan, DPR Korea, Maldives, and Timor-Leste have a non-polio AFP rate of less than one. There are 97 environmental surveillance sites across six countries (Bangladesh, India, Indonesia, Myanmar, Nepal, Thailand), complementing the AFP surveillance.

High-risk countries are prioritizing specific targeted actions. Indonesia is enhancing surveillance and addressing low vaccination coverage. An outbreak response assessment is planned in Indonesia during December 2024. India is updating containment strategies and sustaining its immunization efforts. Myanmar is developing outbreak preparedness plans and advancing immunization through strategic collaborations. A surveillance review is planned in the first quarter of 2025 in Thailand. DPR Korea is implementing IPV catch-up campaigns and planning to introduce a second dose of IPV, while Timor-Leste is focusing on AFP surveillance and planning training for VPD surveillance.

Four Poliovirus-Essential Facilities (PEFs) have been identified in the region, three in India and one in Indonesia. National authorities for containment have been established in both countries. These efforts align with the Global Polio Eradication Initiative's standards and aim to maintain readiness for certification.

Session 2 - Conclusions

GCC is encouraged that there is progressive shift in the industrialized countries to strengthen poliovirus surveillance, using existing surveillance mechanisms and expansion of wastewater surveillance.

European Region:

1. GCC noted the cVDPV2 importation events in two countries of the European Region; Spain and Poland, detected through wastewater surveillance.

Western Pacific Region:

1. GCC expressed concern about the declining immunization coverages in Vietnam, PNG, and Philippines, highlighting risk of future poliovirus outbreaks.

2. GCC noted with concern the sub-national surveillance gaps in Cambodia, Lao PDR, PNG, and Philippines, leading to risk of delayed detection.

Region of Americas:

1. GCC noted that cVDPV2 outbreaks in Canada and USA were closed, following outbreak response assessments.
2. GCC considers the cVDPV3 outbreak in French Guiana as a high-risk epidemiological development, with risk of spread in this geographical region, particularly the neighboring Brazil and Suriname of the American Region.

Southeast Asian Region:

1. GCC appreciated the continued efforts on stopping the cVDPV2 outbreaks in Indonesia. However, the commission noted that the outbreaks have persisted, indicating persistent pockets of under-immunized population pockets.
2. GCC expressed concerns about surveillance quality in Thailand, limited access due to conflict, population displacement and vaccine hesitancy in Myanmar and low routine immunization and vaccine hesitancy in some areas of Indonesia with ongoing cVDPV2 outbreak.
3. GCC expressed concern about low IPV1 coverage in Indonesia and Nepal.

Session 2 - Recommendations

1. GCC recommends further strengthening surveillance in the European and American Region, especially the countries assessed as 'high-risk' and continue reporting to the RCCs on progress.
2. GCC recommends that the American and European Regional Offices and Certification Commissions continue to work and advocate with countries for surveillance enhancement. Recent cVDPV2 importations into the European Region countries and reporting of cVDPV3 in French Guiana further highlight the need for surveillance enhancement.

Session 3: Update on Global Polio Surveillance Action Plan (GPSAP)

GPSAP 2022-2024 Implementation Update and Revision of GPSAP for 2025-2026

The GPSAP 2022–2024 completes this year. Among the 28 high-priority countries based on the risk assessment of the GPEI Surveillance Group (SG), 16 had NP AFP rates of more than two (per 100,000 population aged <15 years), with Zambia and Indonesia improving from 2023 to 2024. Twenty-three countries met the target of 80% stool adequacy. Thirteen high-priority countries met the threshold of a 50% non-polio enterovirus isolation rate for environmental surveillance, with Angola, Malawi, Cameroon, Niger, and Nigeria showing improvement, while Ethiopia and Sudan declined from 2023 to 2024.

In most countries, the key performance indicator of the GPEI strategy to have final results reported within 35 days (for countries with sequencing capacity) or 49 days (for countries without sequencing capacity) of polio cases onset or positive ES collection was not met. Orphan viruses continue to be detected, indicating some gaps in surveillance; Nigeria, Chad, and Yemen reported the highest number of orphan viruses during the last 18 months. It is important to focus on the sub-national variations in the countries reporting high surveillance performance nationally.

The GPSAP for 2025–2026 is in the final phase of development; the plan focuses on six key areas, including enhancing and sustaining AFP surveillance quality, optimizing the environmental surveillance, scaling up immunodeficiency-associated vaccine-derived poliovirus surveillance, maintaining and strengthening the Global Polio Laboratory Network capacity, increasing efficiency in data for action, and enhancing surveillance management and accountability. The plan is being developed through an in-depth consultative process with the regional offices, GPEI, and other relevant international health partners, as well as immunization and health emergency teams. The plan defines parameters for polio-infected and polio high-risk countries, as well as for polio-free countries in preparation for certification. The GPSAP 2025–2026 also aligns with the ongoing work on the post-certification strategy.

Session 3 - Conclusions

1. GCC found the global surveillance overview helpful, as an overall snapshot, complementing the detailed regional reports.
2. GCC noted the approach of environmental surveillance planning as per the risk of transmission, to complement the AFP surveillance.

3. GCC acknowledges the inclusion of the concept of risk driven surveillance sensitivity (highly sensitive, very sensitive and sensitive surveillance) in all the regions and countries, which will be required for prospective certification of WPV1 eradication, in addition to quality-surveillance in the WPV1 endemic countries.

Session 3 - Recommendations

1. The GCC noted and agreed with the overall approach of the Global Polio Surveillance Action Plan 2025 – 2026 and recommended the provision of sufficient support to high-priority countries to operationalize the plan.
2. The GCC emphasizes the importance of timely detection and recommends that the Global Polio Surveillance Action Plan prioritize improvements in this area.
3. GCC recommends maintaining robust communication from surveillance systems to inform public health response, importantly at the country level.
4. Given the medium to long-term importance of maintaining surveillance for certification needs, GCC recommends maintaining financial support to high-risk countries, as needed.

Session 4: cVDPV2 Modelling, iVDPV Surveillance, Planning for bOPV Cessation, Post Certification Strategy

Modelling the elimination of cVDPV2

A statistical framework for quantifying the evidence gained from both AFP and environmental surveillance (ES) about the elimination of circulating WPV1 infection has been previously presented to the GCC (May 2024). This presentation described application of this framework to four example cVDPV2 outbreaks, highlighting differences in surveillance sensitivity arising from the lower symptomatic rate of type 2 versus type 1 virus, and the more limited use of ES in many cVDPV2 outbreak settings.

Extensive environmental surveillance in Nigeria counters lower sensitivity of AFP surveillance for cVDPV2, meaning that high confidence (>95%) in elimination may still be achieved within three years (comparable to the criteria for WPV1). In contrast, lower population coverage of ES in both DR Congo and South Sudan result in much longer timelines; projecting from the last three months of observed data, it is estimated that it will take more than twice as long to achieve the same level of confidence in the resolution of the outbreaks in DR Congo, as compared to Nigeria. For the outbreak in South Sudan (where less than 3% of districts have any active ES, capturing less than 1% of the population nationally), this may extend even longer. High risk of re-introduction from surrounding outbreaks of the same emergence group further increases the time to elimination, raising an important question of where to draw the geographic boundary within which elimination is being evaluated.

It is clear that environmental surveillance is even more important for certifying cVDPV2 elimination than it is for WPV1. Information obtained about infection from AFP surveillance is limited by the small proportion of infections that are symptomatic. The lower the assumed case-to-infection ratio, the more important environmental surveillance will be; we must therefore either accept longer timelines for certifying cVDPV2 given existing surveillance coverage or expand ES to increase the strength of evidence obtained about absence of circulation. With respect to expansion, it appears that broader coverage across the region of interest is more informative than increased sampling at few sites, although further investigation is needed to identify whether suitable sites exist from which to capture some high-risk populations.

Update on iVDPV Surveillance, bOPV Cessation planning/role of the GCC, Post Certification Strategy

iVDPV surveillance

Two components of the iVDPV portfolio include: detecting iVDPV excretors through iVDPV surveillance and stopping poliovirus excretion. As of now, there is a single antiviral drug (Pocapavir) available for ‘compassionate use’ while combination antivirals and monoclonals are in clinical

development, albeit with slow progress. The GPEI iVDPV working group considers that field implementation of iVDPV surveillance is feasible; however, countries have very different systems of immunodeficient patient care, some centralized and others fragmented, necessitating a strategy that considers these differences. Experience has shown that there remains a risk of undetected iVDPV excretors, and it takes time to set up iVDPV surveillance. The highest risk of iVDPV emergence and spread is in countries that use bOPV in routine immunization, have large populations, have low routine immunization coverage, and a high proportion of consanguineous marriages. Countries with PID diagnostic and treatment capacity allow PID patients to survive longer. The level of risk posed by iVDPVs to global poliovirus eradication is unclear.

Currently, efforts are ongoing to implement iVDPV surveillance in ten countries, including India, Pakistan, Nigeria, Senegal, Egypt, Tunisia, Iran, China, Cuba, and Colombia. The global programme plans to continue supporting these countries in implementing iVDPV surveillance.

As of November 2024, there is one iVDPV1 excreter in Algeria and three iVDPV3 excreters in Iran, China, and India. Currently, there is no known iVDPV2 excreter globally.

Planning for the cessation of bOPV

The bOPV cessation policy framework prepared by the bOPV cessation task team (BoCET) has recently been endorsed by the SAGE. The framework defines guiding principles, triggers, and enablers for success. The five triggers are:

I. Certification of eradication of WPV1 by the GCC

II. Certification of elimination of cVDPV2 by the GCC, as proof that OPV cessation is possible

III. No persistent (circulation > 6 months) cVDPV1 and cVDPV3 outbreaks in the previous 24-month period at the time of the decision to proceed with bOPV cessation

IV. Available stockpiles of type-specific OPV (novel or Sabin) in sufficient quantity

V. All countries have established at least a 2-dose IPV schedule in RI (per WHO recommendations) for a minimum 2-year duration. In places where IPV coverage is considered suboptimal (IPV2 <80%), a risk-tiered approach for pre-cessation supplementary immunization activities with bOPV and/or IPV will be used to further boost immunity.

The GCC has an important role to support the first three triggers for bOPV cessation. The BoCET is currently developing possible 'fail scenarios' in the event of missing triggers, and mitigation strategies.

The Post-Certification Strategy (PCS)

PCS defines the global technical standards or core set of activities needed to sustain a 'polio-free world' and will start upon completion of goals 1 and 2 under the current Polio Eradication Strategy

planned for 2029 and will run for 10 years. The strategy has three goals, namely: protecting populations, detecting and responding to any polio events, and to containing polioviruses, and may be governed by GPEI or post-GPEI partnership if GPEI dissolution occurs. The GPEI PCS working group will continue working on the strategy, keeping the GCC informed, and aiming to present the draft strategy to the World Health Assembly in 2026.

Session 4 - Conclusions

1. The GCC appreciated the modeling presented as a good contribution to its ongoing deliberations on the criteria for certification of cVDPV elimination and recommends maintaining this practice in support of Global and Regional Certification Commissions.
2. The GCC recognizes the important role of environmental surveillance in certifying cVDPVs elimination and reiterates the SAGE recommendation to strengthen and expand environmental surveillance where required and feasible.
3. GCC acknowledges the focus on iVDPV surveillance in the Global Polio Surveillance Action Plan 2025 – 2026, which is in alignment with the GCC's planning for Certification of Eradication of VDPVs and recommends having regular updates on iVDPV surveillance during its regular meetings.
4. GCC supports GPEI in its efforts to prepare for safe bOPV cessation.
5. GCC will validate the achievement of three out of five triggers recommended by SAGE as conditions required to be met prior to cessation, namely: certification of WPV1 eradication, certification of cVDPV2 elimination, and verification of no persistent cVDPV1 and cVDPV3 transmission/outbreaks during 24 months prior to the decision to proceed with bOPV cessation.
6. GCC noted the ongoing work on Post Certification Strategy (PCS) and its timelines. The GCC looks forward to receiving the final PCS document when available.

Session 4 - Recommendations

1. GCC recommends continuing the modeling work in support of global certification commission and regional certification commissions, as they continue deliberating on the criteria for certification of cVDPVs elimination.
2. GCC recommends incorporating in future modeling work the seeding risk from bOPV use and symptomatic polio rate relevant to the poliovirus type and location/country characteristics (e.g. IPV- only countries and countries with varying immunity levels) and that this be discussed in each WHO region.
3. GCC urges the prioritized ten countries for iVDPV surveillance, to share information systematically and regularly with the Regional and Global Programmes. GCC recommends the Regional Offices facilitate information sharing and that RCCs review the available information during their meetings**.**

The GCC, during its review of the progress on Goals One and Two of the GPEI Strategy, as well as the regional reports, highlighted the importance of routine immunization strengthening, especially in high-risk countries.

- The GCC noted that 35 countries globally have not yet introduced IPV2 in their routine immunization schedules (18 in the African Region, 10 in WPR, 4 in SEAR, and 1 each in EUR, Americas, and EMR) and that IPV1 coverage remains low in a number of polio-infected and high-risk countries.
- To increase population immunity against all poliovirus types, particularly type 2, the GCC recommends that all countries rapidly introduce IPV2 into their routine immunization schedules, conduct catch-up campaigns in cohorts where population immunity is low, and assess and report coverage.
- The GCC recommends that all countries take systematic, concrete measures to improve IPV1 coverage to enhance population immunity, which is critical to stopping the ongoing cVDPV2 outbreaks as well as mitigating the risk of future outbreaks.
- The GCC recommends that a 'routine immunization' update is included in the program of its next meeting, with a particular focus on the African and Eastern Mediterranean Regions.

Session 5: Poliovirus Containment

Update on Poliovirus Containment

The session presented a global update on progress toward the certification of poliovirus containment, including the most recent data on country progression through the Containment Certification Scheme (CCS). As of November 2024, 78 facilities from 22 countries retain polioviruses. Of those 78 facilities, 89% (70 facilities) are performing work with poliovirus and have a CP in place, and 77% (60 facilities) will pursue or have pursued an Interim Certificate of Containment (ICC). 16 facilities currently hold an ICC, and nine additional ICC applications are currently under review by the GCC Containment Working Group (CWG). In Romania, no attempts to engage the country in containment efforts have been successful.

Containment Requirements for WPV Eradication

The GCC discussed and provided clarity to the containment requirements for the certification of WPV eradication[1], established in 2018, which are to be met by end-2026[2]: "Safe and secure containment of WPV retained in facilities, such as laboratories and vaccine production facilities – all facilities retaining WPVs should have a Containment Certificate (CC), or a time-limited Interim Containment Certificate (ICC), with a clear endpoint for obtaining a CC agreed with the GCC". GCC provided clarity that this requirement extends to facilities retaining WPV (all serotypes), VPDV (all serotypes) or OPV2/Sabin2 polioviruses.

Indicators for Poliovirus Survey and Inventory Activities for Harmonized Global Reporting

Following recommendations previously made by the GCC on the implementation of poliovirus surveys and inventories, this session presented revised indicators for monitoring poliovirus surveys and inventories. Data collection on these indicators aims to ensure standardized and harmonized global reporting. The proposed indicators for surveys were, at a country level, the number of facilities responding to the survey / number of facilities receiving the survey and, at a regional level, the number of countries that have reached the threshold for facility survey responses. Qualitative indicators for surveys discussed were completeness and timeliness of information provided by the facilities. The session also included a discussion on whether surveys should be conducted on all facilities within a country or on a prioritized list, and whether surveying should begin anew every year or be built on the previous year's list of facilities surveyed. The proposed description for inventory was the number of facilities retaining poliovirus infectious material, differentiated by poliovirus type (WPV, VDPV, Sabin, OPV) and serotypes.

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[1] Report of the 17th meeting of the Global Commission for the Certification of the Eradication of Poliomyelitis, 26-27 Feb 2018. Available at: https://polioeradication.org/wp-content/uploads/2024/05/polio-eradication-certification-17th-meeting-global-commission-for-certification-of-poliomyelitis-eradication-20180412.pdf

[2] Report of the 24th Meeting of the Global Commission for Certification of Poliomyelitis Eradication Geneva, Switzerland, 22-23 November 2023. Available at: https://polioeradication.org/wp-content/uploads/2024/09/Report-from-the-Twenty-Fourth-Meeting-of-the-Global-Commission-for-Certification-of-Poliomyelitis-Eradication-20240926.pdf

White Paper on Oversight for Facility Implementation of the Biorisk Management of Potentially Infectious Material, Poliovirus

With respect to the requirements for the retention of Potentially Infectious Materials (PIM), November 2023, the GCC recommended that a 'White Paper' on the containment of PIM be developed with the aim of presenting evidence on the risk of poliovirus detection in PIM and assessing the risk of a release of poliovirus from facilities retaining PIM. This session informed the GCC of the findings on these two subjects. Globally, there are 122 poliovirus laboratories, and an estimated 1,210 laboratories belonging to various other WHO disease-specific networks handling PIM. There have been reports of cross-contamination of respiratory and enteric virus reference stocks with polioviruses and examples of isolation of polioviruses from PIM samples or collections from non-poliovirus laboratories. Reports of poliovirus detection in PIM stool samples range from 0% to 19%, while risk for virus detection in respiratory samples are much lower. PIM was not considered for certification of smallpox or rinderpest eradication but was assessed for Rinderpest following eradication, when questions related to PIM were included in yearly facility surveys. No data related to the risk of release of poliovirus from facilities retaining PIM were identified. The session included a discussion of the level of oversight the GCC wishes to have for facilities handling PIM.

Roles of RCCs in reviewing immunization coverage and environmental safeguards

This final session presented immunization coverage and environmental safeguards and the RCCs' role in reviewing these safeguards for countries hosting PEFs. The definitions of these safeguards were presented, along with an explanation of the oversight structure for them. The GCC-CWG and NACs are responsible for oversight of PEFs (global and national containment certification), while the RCCs and NCCs are responsible for oversight of national immunization coverage levels, and together with the NPCCs, containment surveys and inventories. The discussion that followed covered options to facilitate reporting of these safeguards, both to the RCCs and to the CWG. Timelines for the certified containment of WPV1 in Afghanistan and Pakistan were also discussed. To conclude the session, the Containment team requested that containment be a standing item at every GCC meeting.

Session 5 - Considerations

Containment Requirements for WPV Eradication

1. The containment requirements for the certification of WPV eradication, established in 2018, which are to be met by end-2026, apply to all facilities retaining WPV (all serotypes), VPDV (all serotypes) or OPV2/Sabin2 polioviruses.

Indicators for Poliovirus Survey and Inventory Activities for Harmonized Global Reporting

2. Annual surveys should be conducted of facilities on a prioritized list (rather than resurveying every facility annually) developed by the NPCC.
3. Novel poliovirus strains of serotypes 1 and 3 such as nOPV1, nOPV3, S19-poliovirus serotypes 1 and 3 should be added to survey Form 1 (Annex C Facility Reporting Form) for compilation into Form 2 – Progress reporting form on preparations for poliovirus containment.
4. Data on proposed indicators should be collected and compiled into an initial dashboard by country for consideration by the GCC.

White Paper on Oversight for Facility Implementation of the Biorisk Management Potentially Infectious Material, Poliovirus.

1. The GCC will maintain a minimal level of oversight for PIM-retaining facilities.
2. The NPCCs should disseminate the PIM Guidance and communicate to facilities retaining PIM that this guidance should be followed.
3. Confirmation that the PIM Guidance is implemented and followed (in relevant facilities) should be added to the survey form 1.

Roles of RCCs in reviewing immunization coverage and environmental safeguards

1. The RCCs should ensure that countries hosting PEFs provide data on the immunization coverage and environmental safeguards as described in GAPIV and that the data be reviewed.

Session 5 - Recommendations

1. GCC recommended that the text for the containment requirements for the certification of WPV eradication be modified and communicated to all NACs and relevant stakeholders: 'Safe and secure containment of poliovirus retained in facilities, such as laboratories and vaccine manufacturing facilities - all facilities retaining WPV (all serotypes), VDPV (all serotypes) or OPV2/Sabin2 are expected to achieve a CC, or a time-limited ICC, with a clear end-point for obtaining a CC agreed with the GCC'.
2. GCC recommended that all novel poliovirus strains of all serotypes be included on country survey forms e.g., nOPV1 to 3, S19 etc.
3. The GCC recommended that data be collected on the indicators to complete an initial version of the country dashboard for containment indicators and this dashboard should be presented to the GCC for consideration in use to aid in the determination of the certification of containment at a future GCC meeting.
4. GCC recommended that annual surveys should be conducted for facilities based on a prioritized list, rather than resurveying every facility annually, developed by the NPCC.
5. The GCC recommended that data be collected on the indicators to complete an initial version of a country dashboard and that this should be presented to the GCC to guide the determination of the certification of containment at a future GCC meeting.

Annex: Meeting Agenda

Day-1; 21 November 2024		
Session 1: Update on GPEI Strategy (Goals 1 & 2)		
08.30	Welcome Coffee	
09.00	Welcome / Opening Remarks	GCC Chair, David Salisbury
09:05	Opening remarks by WHE Executive Director	WHE EX.Dir - Michael J. Ryan
09.15	Global update, Revised GPEI Strategy timelines, POB meeting outcomes	WHO HQ / GPEI SC Chair
10.00	Eastern Mediterranean Regional update (except the Endemic Countries)	WHO EMRO
10.30 - Coffee Break		
Updates from Endemic Countries		
10.45	Polio Eradication in Afghanistan (Epidemiology and surveillance – progress, challenges and way forward)	AFG POL Team (virtual)
11.45	Polio Eradication in Pakistan (Epidemiology and surveillance – progress, challenges and way forward)	PAK POL Team (virtual)
12.45	Comments of the Technical Advisory Group (TAG) on Polio Eradication on Pakistan/Afghanistan	Chair TAG AFG/PAK (virtual)
13.00 - Lunch		
14.00	African Regional Update, progress on Goal-2 (stopping cVDPV2)	WHO AFRO
Session 2: Regional / RCC Updates		
14.30	European Region Update	WHO EURO
15:00	Western Pacific Region Update	WHO WPRO
15.30 - Coffee Break		
15.45	Region of Americas Update	WHO / PAHO (virtual)
16.15	South East Asian Region Update	WHO SEARO
Session 3: Update on Global Polio Surveillance Action Plan (GPSAP)		
16.45	GPSAP 2022 - 2024 Implementation Update and development of GPSAP 2025 - 2026	GPEI Surveillance Group
17.30	Wrap up	GCC Chair / Secretariat
End of Day 1		
Day-2; 22 November 2024		
09.00	Review draft recommendations	All
Session 4: iVDPV Surveillace, Planning for bOPV Cessation, Post Certification Strategy (PCS)		
09.30	Modelling the elimination of cVDPV2	LSHTM (virtual)
10.00	Update on iVDPV Surveillance, bOPV Cessation planning/role of the GCC, Post Certification Strategy	WHO HQ, PRD / PCS Team
11.00 - Coffee Break		
Session 5: Poliovirus Containment		
11.15	Update on poliovirus containment	WHO CNT
11.45	Discussion on indicators to track containment	All
12.15	Discussion on CAG requested white paper on PIM	All
12.45 - Lunch		
13.45	Discussion on roles of RCCs in reviewing immunization and enviornmental safeguards	All
14.15	Planning for the next meeting, wrap up	GCC Chair / Secretariat
End of Day 2		