35th meeting of the European Regional Certification Commission for Poliomyelitis Eradication

6–7 September 2021
Virtual meeting, hosted in Copenhagen, Denmark
The 35th meeting of the European Regional Certification Commission for Poliomyelitis Eradication (RCC), held virtually on 6–7 September 2021, reviewed annual updates submitted by the Member States of the WHO European Region on the status of the national polio eradication programmes in 2020. The RCC concluded, based on available evidence, that there was no wild poliovirus (WPV) transmission in the WHO European Region in 2020. Importation of the circulating vaccine-derived poliovirus in Tajikistan was detected and response to the outbreak mounted. The RCC also concluded that Poland, Romania and Ukraine are at high risk of a sustained polio outbreak in the event of importation of WPV or emergence of cVDPV due to suboptimal programme performance, particularly low population immunity. The RCC was not able to assess the risk status for Bosnia and Herzegovina, Croatia, Iceland, Israel, Luxembourg, Monaco and Montenegro in absence of submitted annual reports.
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Abbreviations

AFP    acute flaccid paralysis
CP     certificate of participation in the containment certification scheme
cVDPV  circulating vaccine-derived poliovirus
cVDPV1 circulating vaccine-derived poliovirus type 1
cVDPV2 circulating vaccine-derived poliovirus type 2
cVDPV3 circulating vaccine-derived poliovirus type 3
DRC    Democratic Republic of Congo
e-APR  electronic annual progress report
ES     environmental poliovirus surveillance
ETAGE  European Technical Advisory Group on immunization
GCC    Global Certification Commission
GAPIII Global Action Plan on Poliovirus Containment
GPEI   Global Polio Eradication Initiative
IMB    Independent Monitoring Board
IPV    inactivated polio vaccine
ITD    intratypic differentiation of polioviruses
LDMS   Laboratory Data Management System
MECACAR Mediterranean, Caucasus and Central Asian republics subregion
mOPV2  monovalent oral polio vaccine type 2
NAC    National Authority for Containment
NCC    National Certification Committee
NITAG  National Immunization Technical Advisory Group
nOPV2  novel oral polio vaccine type 2
NPCC   National Poliovirus Containment Coordinator
OPV    oral polio vaccine
PCR    polymerase chain reaction
POSE   polio outbreak simulation exercise
PEF    poliovirus essential facility
PIM    poliovirus potentially infectious materials
PV2    poliovirus type 2
RCC    European Regional Certification Commission for Poliomyelitis Eradication
SIA    supplementary immunization activities
VDPV   vaccine-derived poliovirus
VPI    Vaccine-preventable Diseases and Immunization Programme of the WHO Regional Office for Europe
WPV    wild poliovirus
WPV1   wild poliovirus type 1
WPV2   wild poliovirus type 2
WPV3   wild poliovirus type 3
WPV1   wild poliovirus type 1
WPV2   wild poliovirus type 2
WPV3   wild poliovirus type 3
Introduction

The 35th meeting of the European Regional Certification Commission for Poliomyelitis Eradication (RCC) was held on 6–7 September 2021 in Copenhagen, Denmark, through virtual participation. The meeting was opened by RCC Chair, Professor David Salisbury, who welcomed the Commission members and meeting participants. The list of participants is provided as Annex 2. The Chair emphasized efficiency of the Secretariat work in preparation and conduct of the RCC meetings.

Scope and purpose of the meeting

The scope and purpose of the meeting were:

- to brief the RCC on the status of global poliomyelitis (polio) eradication and on efforts to sustain polio-free status in the European Region;
- to review annual updated certification documentation on polio in all Member States of the WHO European Region for 2020;
- to review response and risk mitigation activities in the Member States;
- to review the current status of regional poliovirus containment;
- to recommend strategies and/or actions to strengthen efforts to sustain polio-free status of the Region focusing on high-risk countries;
- to discuss the circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreak in Tajikistan and response measures as well as preparedness measures in neighbouring Kyrgyzstan and Uzbekistan;
- to review working procedures of the RCC and to discuss a plan of activities for 2022.

Session 1: Update on global polio eradication and sustaining polio-free status in European Region

Update from WHO headquarters /Global Polio Eradication Initiative (GPEI)

As of early September 2021, it has been six months since any wild poliovirus (WPV) has been detected in Afghanistan. The last environmental isolate was in February 2021 and the last acute flaccid paralysis (AFP) case was in January 2021, and it is believed that these isolates were importations from Pakistan. The virus continues to be isolated from environmental surveillance (ES) samples in Pakistan. One AFP case was detected in January 2021 in Pakistan and no cases have been detected since. Cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) have been prevailing in Afghanistan and Pakistan, although the number of cases has been waning after trivalent oral polio vaccine (tOPV) campaigns took place in both countries. There are still some low performance areas at the provincial level. Most of the cVDPV cases have been found in inaccessible areas.

Afghanistan ES surveillance results are available up to June 2021 and all sites have been negative for WPV since the first quarter of 2021. A notable achievement is that no positive ES samples were reported from the beginning of 2021 until one positive sample was found in Kandahar during February of this year. In Pakistan, there has been a decline in the number and geographic spread of positive WPV samples at ES sites during the past three quarters. All sites in Peshawar and Quetta have been negative for the past 3-4 months. There was a single detection of WPV in Karachi since May 2021. There is room for improvement in the performance of supplementary immunization activities (SIAs) being conducted in Pakistan, particularly in Karachi.

There has been intense transmission of cVDPV in the past 12 months with some decline in isolation in the past 6 months. There are currently 32 countries that have detected cVDPDZ in the past 12 months. A
new hot spot emerged in Nigeria with new emergences in Northern and Southern Nigeria. There is still a lot of transmission in sub-Saharan Africa. The top four emergences since the switch (from trivalent to bivalent oral polio vaccine (OPV)) were in the Democratic Republic of Congo (DRC), Nigeria, Angola and Syria. There have been delays in the timeliness of detection of AFP cases in multiple countries, but most outbreak countries are meeting surveillance targets at the national level.

With regard to novel OPV type 2 (nOPV2) use, there have been notable delays between confirmation of the outbreak and nOPV2 release. Countries with a pending response waiting for nOPV2 verification/dose release as of 26 August 2021 included: Burkina Faso, Egypt, Gambia Mauritania and Senegal, and 40 out of 47 (85%) of countries at high risk of a cVDPV2 are preparing for nOPV2 use.

In terms of nOPV2 readiness, 40 countries have submitted documents towards confirming readiness for nOPV2 use: in Africa (30/31 countries); Europe (2/3 countries); Middle East (8/9 countries); and Asia Pacific (0/4 countries). Of these, 13 countries are verified to use nOPV2: Afghanistan, Benin, Chad, DRC, Egypt, Ethiopia, Liberia, Niger, Nigeria, Sierra Leone, South Sudan, Tajikistan and Uganda. As of this meeting, approximately 70 million doses of nOPV2 have been administered.

**Discussion**

The RCC expressed concerns about the validity of the surveillance data from Pakistan and Afghanistan. There is a need for an external review of surveillance activities in both countries, which is planned for Pakistan in September–October 2021. However, it may be difficult to conduct such a review in Afghanistan right now. The number of AFP cases that were investigated is lower this year compared to last year. In general, WPV and cVDPV2 are different in nature and should be approached separately. There is a strong relationship between cVDPV2 outbreaks and low poliovirus type 2 (PV2) coverage in SIAs.

While nOPV2 is certainly a promising efficient tool, the RCC expressed concerns about the supply of nOPV2. Supplies are considered adequate but there was a negative balance at the time of the meeting with 130 million doses expected by the end of 2021. There were concerns that there will not be adequate supply of nOPV2 to meet demand.

There was discussion about the polio vaccination campaigns in Pakistan and Afghanistan. In Pakistan, Karachi and Baluchistan are not accepting polio-only vaccination campaigns and there is a need to integrate into service delivery to gain access and trust in these communities. Right now, borders are closed, and this will affect the ability to reach all parts of the country. In Afghanistan, the polio programme has been asked by the government to wait on any house-to-house campaigns.

The RCC expressed concern about the quality of reported data from the endemic countries.

**Polio programme update from the Regional Office**

The most important issue in the Region recently was a cVDPV2 outbreak in Tajikistan. The index case was isolated from southern Tajikistan. Onset of paralysis was on 22 November 2020; however, the Regional Office was not notified of the case until 13 January 2021. The Regional Office immediately asked the country to take all necessary actions to strengthen surveillance and provide supplementary immunization. A case importation into the Region was not surprising due to the delay of inactivated polio vaccine (IPV) introduction in three Central Asia countries with an accumulation of two full cohorts of approximately 1.3 million children in Uzbekistan, 550 000 children in Tajikistan and 400 000 children in Kyrgyzstan who had no immunity to type 2 polio. From 13 January 2021, Tajikistan significantly increased surveillance activities, collected contact samples, conducted community sampling and identified additional cases. As of this meeting, there are 31 confirmed AFP cases - one in 2020 and 30 in 2021 as well as confirmed virus in 23 healthy children.

There were delays in the response to this outbreak as the country was preparing for nOPV2 readiness and during this time, transmission of the virus continued. There were bureaucratic delays to the start of
the nOPV2 campaign and the country had to wait 48 days after verification and the WHO Director General’s approval to receive the vaccine and begin their response, which began on 31 May 2021. The RCC noted that it would be helpful if the Global Polio Eradication Initiative (GPEI) could allocate doses in advance so that once a country is verified, doses would be available. Tajikistan conducted two rounds of SIAs in June and July and administrative coverage exceeded 99% after mop-up vaccination followed the SIAs. Lot Quality Assurance Sampling (LQAS) confirmed that coverage was around 92% with lower coverage only in Dushanbe city. No virus has been identified after the second round of SIAs as of yet and the last cVPDV2 case was detected on 26 June. There were 3 AFPs identified with poliovirus type 2 isolated but genetic sequencing is still pending. The country had about 1 million doses of nOPV2 remaining that were to expire, and this was used for targeted mop-up in high-risk areas throughout the country in September. The country did well in establishing ES as part of nOPV2 verification and will probably maintain this surveillance in the future. The next steps will be based on results from ES samples to decide on the strategy moving forward. Obtaining additional doses of nOPV2 for Tajikistan does not seem feasible in the near future. In February, the country conducted a catch-up IPV campaign to cover children who had not received IPV from 2016 through 2018, which may explain why there are fewer AFP cases being detected.

COVID-19 has had an impact on routine immunization activities in the Region. Immunization programmes have been overwhelmed with the COVID-19 response in both 2020 and 2021 which has resulted in decreased surveillance quality and decreased polio vaccination coverage. Surveillance was affected by travel restrictions and vaccine coverage was affected by increased hesitancy in the population as well as limited human resources. The massive COVID-19 vaccination activities in 2021 have put increasing pressure on immunization programmes and have forced the Secretariat to focus on the COVID-19 response, making polio activities less of a priority. This has influenced timeliness and completeness of polio reporting by countries.

Electronic annual progress report (eAPR) submission status:
- Countries were invited to submit by 1 May 2021.
- Reminders were sent in mid-July and mid-August.
- As of 6 September, 46 reports were received, 3 initiated but not submitted (Croatia, Luxembourg and Montenegro).
- 4 reports were not initiated at all (Bosnia and Herzegovina, Iceland, Israel and Monaco)
- Monaco provided the requested statement.
- Switzerland, as recommended, provided two reports: 2019 and 2020,

**Discussion**

The RCC praised Tajikistan for rapid readiness verification but expressed concerns about the delays in getting nOPV2 to countries and would like to see these delays minimized in order to prevent additional AFP cases. There were concerns expressed that transmission may still be ongoing in Tajikistan, but this is not yet known because results on ES samples are not yet available. It was also acknowledged that there are groups in the population that were not included in the vaccination campaigns. Tajikistan may need to increase active surveillance. The country has applied for support to introduce a second dose of IPV in their schedule at 9 months of age, according to recommendations of the Strategic Advisory Group of Experts on Immunization, and the application has been improved. The second dose of IPV will be introduced into the national immunization schedule in 2022.

**WHO European Polio Laboratory Network update and status of poliovirus containment in the European Region**

There are 47 polio laboratories in the WHO European Polio Laboratory Network, which provide service to all 53 Member States. Laboratory data come from three main sources: reports from network
laboratories through the Laboratory Data Management System (LDMS), annual accreditation reports and the e-APR from Member States.

There has been good testing coverage in the Region in 2020 based on the routine reporting albeit with a volume of testing slightly lower in comparison with the years prior. The laboratories in the European Network were performing in accordance with the Network’s criteria despite the challenges of the COVID-19 pandemic. Most of the laboratories have been accredited during the year with just three pending accreditations: one laboratory in Ireland that has ceased all polio activities due to the COVID-19 pandemic workload, and laboratories in Russia Federation and Ukraine, which are finalizing their proficiency panels. There was improvement in the timeliness of investigation of samples - 89% compared to 83% in 2019. However, timeliness of intratypic differentiation (ITD) results dropped to 73% compared to 100% in 2019 as there has been a marked increase in demand for generic molecular biology reagents and supplies due to manifold increase in COVID-19 testing. There have been several episodes of interruptions of access to ITD kits by polio laboratories in 2020 but these have been successfully addressed.

Poliovirus containment has been a major focus of the Region’s polio risk mitigation activities in recent years. As the global poliovirus containment agenda progresses, the European Region will remain the Region with the largest number of facilities retaining wild polioviruses because it has the largest representation of vaccine manufacturers and research facilities performing critical functions, such as new vaccine development and vaccine storage. A containment breach remains the most likely scenario for the reintroduction of a wild poliovirus into the European Region. During 2014–2020 several poliovirus (wild and vaccine) spills from vaccine manufacturing facilities have been documented in publications or through the WHO European Poliovirus Laboratory Data Management System in several countries – Belgium (2014), France (2018), the Netherlands (2015, 2017, 2018, 2020) – demonstrating the importance of the containment agenda. Efforts over the past years have focused on identifying facilities retaining poliovirus materials, destruction of unneeded poliovirus materials, designation of poliovirus-essential facilities (PEFs) and establishment of national authorities for containment (NACs) as per the Global Action Plan on Poliovirus Containment (GAPIII). In 2020 considerable progress was made by most of the PEF-countries in entering the national poliovirus containment certification process in accordance with GAPIII Containment Certification Scheme.

While the decision to retain polioviruses is based on national priorities, the WHO Regional Office for Europe has been working with Member States to rationalize the number of PEFs. For those Member States that have decided not to retain polioviruses, the Regional Office has been supporting the destruction and disposal of polioviruses. It is important to note that there was still no progress on poliovirus containment in Romania and, although the country has declared their intention to establish a PEF, little has been done in the country to ensure that their facility enters the Containment Certification Scheme.

Discussion

The RCC expressed some concern regarding the number of samples tested and reported by the network laboratories of Greece, Portugal, Spain, and Sweden in 2020, which seemed low compared to other European countries.

The RCC acknowledged all the hard work that has been done by the laboratories under difficult circumstances during the COVID-19 pandemic, particularly in countries that have had a diversion of their routine laboratory activities and were not able to maintain polio laboratory services.
Plenary session 2: Sustainability of polio-free status in Europe: Review of national updated documents and risk assessment for 2020 by epidemiological zones

Overview
2020 brought many lessons on how the certification process should be adjusted. While only 41 reports were received by the first session of the 34th meeting of the RCC, all but two countries (Montenegro and Switzerland) submitted reports by the second session and both countries communicated reasons why they were unable to submit reports. By the 35th meeting of RCC in 2021, only 46 reports have been received, 3 more were initiated and 4 were not initiated. The Secretariat plans to revisit the approach for risk assessment next year and develop recommendations for the RCC’s approval. The results of the risk analysis for all countries of the Region are shown in Annex 1.

Nordic-Baltic zone
Based on the information available, the RCC concluded that the probability is high that neither WPV nor VDPV had been circulating in the zone in 2020 and that WPV importation or circulation of VDPV, if any, would have been detected promptly by existing health/surveillance systems. The risk of transmission following importation of WPV or circulation of VDPV in countries of this zone ranges from low to intermediate. Latvia and Lithuania have a higher proportion of the population with low vaccination coverage. It also remains of concern that Denmark has no plan of action for outbreak response. The RCC noted suboptimal poliovirus surveillance in Norway. National Certification Commission (NCC) members in Estonia, Lithuania and Sweden present a potential conflict of interest that needs to be addressed. Late reports were received from Denmark, Estonia and Norway and a report is still missing for Iceland. The RCC appreciated the difficulty the countries experienced in collecting data on routine immunization, surveillance at a time of COVID-19 and recognized this might have impacted all performance. Nevertheless, because of that diversion the risks throughout the Region for all countries are higher. Moreover, in light of the recent events in Afghanistan, all countries need to be aware of the possibility of asylum seekers, migrants, refugees coming from a country that until very recently was reporting poliovirus type 1, and therefore active steps need to be in place to offer vaccination to new arrivals.

Feedback to the countries
- Denmark – is considered to be at intermediate risk due to not having a national plan of action for outbreak response while being a PEF country.
- Estonia – is considered to be at low risk. The RCC noted an AFP case that was reported but did not show up in the lab databases. The RCC noted the lack of a national plan of action for outbreak response.
- Finland – is considered to be at intermediate risk.
- Iceland – is not assessed due to a missing report.
- Latvia – is considered to be at low risk. The RCC, however, noted suboptimal vaccination coverage at sub-national level and the lack of a polio-specific national plan of action for outbreak response. There are NCC members with a conflict of interest.
- Lithuania – is considered to be at intermediate risk due to a high percentage of districts with low vaccination coverage. There are also NCC members with conflicts of interest.
- Norway – is considered to be at intermediate risk due to the suboptimal quality of AFP surveillance.
- Sweden – is considered to be at intermediate risk due to decreased surveillance performance in presence of PEF in the country.
Western zone
Based on the information available, the RCC concluded that the probability is high that neither WPV nor VDPV had been circulating in the zone in 2020 and that WPV importation or circulation of VDPV, if any, would have been detected promptly by existing health systems. The risk of transmission following importation of WPV or circulation of VDPV in countries of this zone ranges from low to intermediate. The countries in this subregion are leading in terms of COVID-19 vaccination, and their polio vaccination rates held reasonably well. Reported coverage is traditionally high, but there were no coverage estimates for Austria, France and Germany for 2019 and 2020 and sub-optimal coverage in children under 12 months of age in a number of countries. France is also missing an action plan. RCC appreciated Switzerland submitting the missing report from the previous year. Late reports were received from France, Ireland and Switzerland and a report is missing from Luxemburg and Monaco. There were conflicts of interest among many of the countries. Germany, the Netherlands and the United Kingdom have reported vulnerable populations in their countries. There is essentially no AFP surveillance in this sub-region and with environmental surveillance the number of samples tested is quite low with the exception of the Netherlands. This sub-region has four PEF countries: Belgium, the Netherlands, France and the United Kingdom. Confirmation of the destruction of wild poliovirus types 3 (WPV3) in Germany and Switzerland is awaited; communication with France and the Netherlands is in process to complete the round of certifying their facilities. France still lacks an appropriate plan of action for outbreak response.

Feedback to the countries
- Austria – is considered to be at intermediate risk. The RCC continues to have concerns over low population immunity in the country.
- Belgium – is considered to be at intermediate risk due primarily to the lack of adequate poliovirus surveillance. There are NCC members with a conflict of interest.
- France – is considered to be at intermediate risk. RCC notes that the county lacks an action plan and there has been a suboptimal pace of PEF certification in its laboratories. There are NCC members with a conflict of interest.
- Germany - is considered to be at low risk. There are NCC members with a conflict of interest.
- Ireland – is considered to be at low risk. The RCC noted that there is sub-optimal vaccination coverage in children under 12 months of age. There are NCC members with a conflict of interest.
- Luxembourg – is not assessed due to a missing report.
- Monaco – is not assessed due to a missing report.
- Netherlands – is considered to be at low risk.
- Switzerland – is considered to be at intermediate risk due to the suboptimal quality of poliovirus surveillance and low vaccination coverage. The RCC also noted a lack of adequate surveillance in the country. There are NCC members with a conflict of interest.
- United Kingdom – is considered to be at low risk.

Central zone
Based on the information available, the RCC concluded that the probability is high that neither WPV nor VDPV had been circulating in the zone in 2020 and that WPV importation or circulation of VDPV, if any, would have been detected promptly by existing health/surveillance systems. Late reports were received from Bulgaria and Hungary. The risk of transmission following importation of WPV or circulation of VDPV in countries of this zone ranges from low to high. Suboptimal immunization coverage and surveillance performance in Poland are a concern. The lack of a plan of action for outbreak response and low surveillance quality in Hungary are also concerns. The RCC expressed concerns about the quality of poliovirus surveillance in Slovakia.
Feedback to the countries

- Belarus – is considered to be at low risk.
- Bulgaria – is considered to be at intermediate risk due to suboptimal population immunity, particularly among subnational population groups.
- Czech Republic – is considered to be at low risk.
- Hungary – is considered to be at intermediate risk due to suboptimal poliovirus surveillance and the absence of a national plan of action for outbreak response while being a PEF country.
- Poland – is considered to be at high risk due to low population immunity and suboptimal surveillance.
- Slovakia – is considered to be at low risk. However, the RCC has concerns about the quality of poliovirus surveillance.
- Slovenia – is considered to be at low risk.

Southern zone

Based on the information available, the RCC concluded that the probability is high that neither WPV nor VDPV had been circulating in the zone in 2020 and that WPV importation or circulation of VDPV would have been detected promptly by existing health/surveillance systems. The risk of transmission following importation of WPV or circulation of VDPV in countries of this subregion ranges from low to intermediate. Of concern is the suboptimal quality of AFP surveillance throughout the subregion. Israel and Malta still have no plans of action to respond to WPV/cVDPV detection. Andorra and San Marino currently do not have a National Poliovirus Containment Coordinator (NPCC) to ensure proper communication on poliovirus containment activities and updates in the country. Reports are missing from Croatia and Israel and reports were submitted late by Malta, San Marino and Spain.

Feedback to the countries

- Andorra – is considered to be at low risk, but the RCC is concerned about the absence of an NPCC.
- Croatia – is not assessed due to a missing report.
- Cyprus – is considered to be at low risk.
- Greece – is considered to be at intermediate risk due to concerns about surveillance performance and the population immunity estimates being several years old and possibly not accurate.
- Israel – is not assessed due to a missing report. The RCC remains concerned over the lack of a formal plan of action to respond to WPV/cVDPV detection.
- Italy – is considered to be at low risk.
- Malta – is considered to be at low risk but the RCC is concerned about the lack of a formal plan of action to respond to WPV/cVDPV detection.
- Portugal – is considered to be at low risk.
- San Marino – is considered to be at low risk. The RCC is concerned about the absence of an NPCC.
- Spain – is considered to be at low risk.

MECACAR zone

Based on the information available, the RCC concluded that the probability is high that WPV had not been circulating in the zone in 2020. Importation of cVDPV was detected by the existing surveillance system, although it was reported with a one-month delay. The risk of transmission following importation of WPV or circulation of VDPV in countries of this zone ranges from low to intermediate. There are
concerns about delayed specimen testing in Armenia, Kyrgyzstan and Turkmenistan due to COVID-19 restrictions and decreasing performance of AFP surveillance in Azerbaijan, Georgia and Uzbekistan. RCC is concerned about decreasing polio immunization coverage in Armenia, Azerbaijan, Georgia, Kazakhstan and Kyrgyzstan. The accumulation of PV2-susceptible children in Kyrgyzstan and Uzbekistan is concerning in light of the cVDPV2 outbreak in Tajikistan.

Feedback to the countries

- Armenia – is considered to be at intermediate risk. The RCC is concerned that the national plan of action for outbreak response has not been updated, vaccination coverage has decreased and there have been delays with shipping samples from the country due to COVID-19.
- Azerbaijan – is considered to be at intermediate risk. The RCC noted that the overall performance of AFP surveillance is decreasing in the country and vaccination coverage is very low in some districts.
- Georgia – is considered to be at intermediate risk. The RCC noted that the overall performance of AFP surveillance is decreasing in the country and there is suboptimal vaccination coverage.
- Kazakhstan – is considered to be at intermediate risk due to suboptimal vaccination coverage.
- Kyrgyzstan – is considered to be at intermediate risk due to delays with shipping samples from the country due to COVID-19, suboptimal vaccination coverage and an accumulation of PV2-susceptible individuals.
- Russian Federation – is considered to be at low risk.
- Tajikistan – is considered to be at intermediate risk and there is an accumulation of PV2-susceptible individuals, which led to the outbreak.
- Turkey – is considered to be at low risk. The RCC remains concerned that Turkey has no national plan of action for outbreak response.
- Turkmenistan – is considered to be at low risk, however the RCC has concerns about delays in shipping samples from the country due to COVID-19.
- Uzbekistan – is considered to be at intermediate risk due to decreases in AFP surveillance, the decreasing performance of AFP surveillance and an accumulation of PV2-susceptible individuals.

Central-Eastern zone

Based on the information available, the RCC concluded that the probability is high that neither WPV nor VDPV had been circulating in the zone in 2020 and that WPV importation or circulation of VDPV would have been detected promptly by existing health/surveillance systems. The risk of transmission following importation of WPV or circulation of VDPV in countries of this zone ranges from low to high. Due to suboptimal vaccination coverage the risk of spread following importation of WPV or cVDPV remains high in Bosnia and Herzegovina, Romania and Ukraine. Suboptimal and declining immunization coverage in most of the countries in this zone remains a major concern. Montenegro did not submit a report this year and hence was not assessed, but data available with the Secretariate indicate poor surveillance and very low immunization coverage. Bosnia and Herzegovina also did not submit an annual report. The RCC is also concerned about containment risks in both Serbia and Romania. Bosnia and Herzegovina did not submit a national plan of action for outbreak response and Romania’s plan has expired.

Feedback to the countries

- Albania – is considered to be at low risk.
- Bosnia and Herzegovina – was not assessed due to a missing annual report but is likely to remain at high risk due to suboptimal vaccination coverage.
- North Macedonia – is considered to be at intermediate risk due to suboptimal immunization immunity and suboptimal surveillance quality.
• Republic of Moldova – is considered to be at intermediate risk due to suboptimal population immunity and sub-optimal surveillance performance.
• Montenegro – was not assessed due to a missing annual report but is likely to be at high risk due to suboptimal population immunity and poor surveillance coverage.
• Romania – is considered to be at high risk due to suboptimal population immunity, with more than 53% of the population living in districts with vaccination coverage with a third dose of polio vaccine <90%. In addition, the county’s national plan of action for outbreak response has expired. There is also a containment risk in Romania.
• Serbia – is considered to be at intermediate risk due to suboptimal poliovirus surveillance and containment risk.
• Ukraine – is considered to be at high risk due to low vaccination coverage and the failure to mount an adequate response to outbreaks of other vaccine-preventable diseases in recent years. The RCC congratulated the country on the improvements in vaccination coverage and efforts in conducting supplementary and targeted immunization activities in early 2020.

cVDPV2 outbreak in Tajikistan and response measures
An outbreak of cVDPV2 was confirmed in Tajikistan on 20 January 2021, with the index case having onset of paralysis on 22 November 2020. At the time of the meeting, 31 cases of paralytic cVDPV2 were registered and all cases are associated with the PAK-GB-1 poliovirus strain. The main reason for this outbreak is the presence of a large population of children born in 2016 and 2017 without immunity against PV2 due to a delayed introduction of IPV. This was an importation of the virus from an endemic country with a common border with Tajikistan. There has been increasing cross-border movement between Afghanistan, Kyrgyzstan, Tajikistan and Uzbekistan due to relaxed COVID-19 restrictions. The national programme decided to use nOPV2 for the rapid response to this outbreak. Emergency measures were put in place to stop cVDPV2 transmission. Control and oversight were taken on by the government in close cooperation with WHO and UNICEF. An emergency task force was established under the Ministry of Health. AFP surveillance was strengthened across the county and there was rapid verification of nOPV2 readiness by 12 April 2021. An environmental surveillance site was established in Dushanbe as well as frequent and efficient shipments of AFP and ES samples for testing. A high-quality nation-wide IPV catch-up SIA was held in February 2021 with coverage of 96–97%. There were also two nationwide rounds of nOPV2 SIAs among children 0–63 months of age. Immunization coverage for these SIAs was 99.2% and 99.1%, respectively. There was one subnational round conducted using nOPV2 among children 0–56 months of age and the preliminary administrative coverage was 95.8%. Catch-up immunization campaigns are being conducted now. An independent post-SIA assessment of two rounds found immunization coverage was 91.67%. The COVID-19 pandemic has had an impact on the response measures (i.e., mask use and social distancing have impacted the SIAs). Environmental specimens from Dushanbe are collected on a weekly basis. This surveillance is a very important tool to prevent the transmission of PV. Since the end of the first round of vaccination until the time of the meeting, the environmental specimens were collected every two weeks and reports provided once a month. The decision to conduct a third, sub-national, round with novel OPV2 (nOPV2) was based on recommendation of the outbreak response assessment mission. For the third round, Soghd and Gorno-Badakshan regions were excluded because they have a low risk of cVDPV2 transmission. For the third round, targeted visits to the homes of refusals and no-shows were conducted and where possible children were vaccinated at home. During the house-to-house monitoring, any children found without finger marks were provided with vaccine. The house-to-house approach was used to find hard-to-reach populations, unregistered families living in Dushanbe, and populations that do not have access to a health facility.
The programme is currently focusing on maintaining strengthened and accelerated AFP and environmental surveillance. Specimens are being sent to the regional reference laboratories in the Russian Federation and the Netherlands and technical assistance from WHO is provided continuously. The RCC also inquired about feasibility of establishing a second environmental surveillance site in the outbreak area. As there are logistical and sustainability challenges, this would need to be assessed carefully.

Discussion
The RCC thanked the Tajikistan representative for sharing their experience during the recent outbreak and thanked them for all of their efforts in increasing surveillance and implementing the vaccine campaign. There are important lessons to be shared with other countries dealing with cVDPV2 outbreaks to try to minimize the gap between making the decision to use nOPV2 in the response and getting access to the vaccine.

The RCC requested clarification on some aspects of the outbreak and response. The country clarified that the children infected during this outbreak were from the cohorts of children who had not received IPV vaccination (i.e., children born in 2017 and 2018) as well as children born in 2020 who resided in high-risk zones, and children from high-risk groups (i.e., children of migrant families, families who refused vaccination- especially injectable vaccination). Tajikistan is implementing active surveillance and has specific sites for AFP identification, which are paediatric neurological units, emergency rooms and paediatric units. Staff provide updates on active surveillance on a weekly basis and visit the active surveillance sites weekly. They also conduct surveillance for adverse event following immunization after nOPV2 vaccination. During the third round of the SIA, they were able to include children that had been missed during the first two rounds. They are still working to cover as many children as possible in districts with lower coverage by doing house-to-house vaccination.

Preparedness measures in Uzbekistan
The population of Uzbekistan has increased substantially in recent years. The current polio coverage of children under 1 year of age is about 100% and coverage in children under 2 years of age is about 99%. Uzbekistan’s Ministry of Health was informed by WHO of the polio cases in Tajikistan and the country began the preparatory process for the introduction of nOPV2. The country has implemented active AFP surveillance in two regions. District-level data are collected from the sites and based on available information they have not identified any cases of cVDPV2 or WPV. AFP surveillance is ongoing, and no AFP cases have been identified. The county has a long border with Tajikistan and there is a high risk of importation of polio into Uzbekistan.

In response to the outbreak in Tajikistan, Uzbekistan decided to provide supplemental immunization to children under 5 years of age. The Ministry of Health prepared an executive order and set up a working group to strengthen surveillance activities in all regions bordering Tajikistan to detect any importation of the virus. The Ministry conducted IPV immunization in Surkhandarya province and vaccinated 52,000 children and is planning to conduct a catch-up SIA by the end of September-early October 2021. The programme plans to conduct IPV catch-up campaigns among birth cohorts 2016–2018 and is preparing for the nOPV2 readiness verification. The country has submitted an application for the introduction of a second dose of IPV into the national immunization schedule. Coverage in the past four years was above 95% in all provinces of the country. Additional cold chain equipment has been provided at all medical institutions for the vaccine introduction.
Discussion
The RCC thanked Uzbekistan for all of the work to prevent a polio outbreak. The RCC asked for information about AFP surveillance in the month prior to the Tajikistan outbreak. The AFP rate in Uzbekistan was rather low in 2020 with a small peak in October just prior to detection of cVDPV2 in Tajikistan. All of these samples were tested and found to be negative. The RCC asked about the border between Uzbekistan and Afghanistan and how frequently people cross this border. A camp has been set up in the Surkhandarya province near the border for migrants and refugees coming to Uzbekistan from Afghanistan and these people have all been tested and isolated from the general population. The RCC inquired about challenges with vaccinating against poliovirus and COVID-19 at the same time and whether they have the cold chain capacity and staffing resources needed. The Uzbekistan representative responded that they are renovating their central warehouse with additional cold rooms and freezers and they should have sufficient cold chain capacity for both vaccines. COVID-19 vaccination was initiated on 1 April 2021 and is proceeding according to the prioritization developed by WHO. Due to additional COVID-19 funding, additional training for the immunization programme staff was conducted. There have been some staff shortages but nevertheless, more than 350 000 people were vaccinated daily against COVID-19.

Preparedness measures in Kyrgyzstan
The outbreak of cVDPV2 in Tajikistan led Kyrgyzstan to take urgent measures to prevent possible spread of poliovirus into the territory.

Similar to the other countries, Kyrgyzstan implemented response measures. The Order of MOH No. 367 was approved on 6 April 2021 and the country announced a level 2 emergency and implemented emergency preventive measures, including: strengthening of active surveillance, weekly AFP reporting, collection of samples from contacts and implementing an IPV catch-up immunization campaign among children born in 2016–2017.

IPV was introduced in 2018. In 2022, the country is planning to introduce HPV vaccine. It currently administers bOPV to children at 2 months, 3.5 and 5 months of age and use IPV at 3.5 months. Immunization coverage at the subnational level in 2021 decreased compared to the first 6 months of 2020 due to the COVID-19 pandemic. In 2020, the country did not reach the necessary targets for immunization coverage and based on the results of the first 6 months of 2020, immunization coverage with IPV was 89%. Some regions reached only 39% coverage for the first 6 months. In 2021, due to the measures taken and the use of mobile immunization teams supported by WHO and Gavi, the programme managed to organize several rounds of mobile immunization campaigns to implement catch-up vaccination and achieved good coverage results in the regions bordering Tajikistan (about 48% coverage).

Since 1993, Kyrgyzstan has maintained polio-free status. There have been no polio cases registered in the country. In April 2021, it initiated an IPV catch-up immunization campaign with a target group of 269 512 children, and 165 072 children were immunized as part of this campaign (61% coverage). The programme also had to implement the COVID-19 vaccination campaign but thanks to the well-established system and mobile teams they were also able to implement the IPV catch-up campaign. By the end of October, the plan was to complete this campaign and fully vaccinate any missed children. Vaccines were supplied by Gavi and additional funds received for emergency measures were used for logistics and communication activities. The southern regions of Batken, Jalal-Abad and Osh share a border with Tajikistan; more than 50% of the children in these areas was covered with IPV and, by the end of October, better results were expected. There is an unstable political situation in Batken region,
but colleagues in that region continued to implement immunization activities. From May through August 2021, over 300 health workers in all regions received polio surveillance training.

Discussion
The RCC thanked the Kyrgyzstan country staff for their hard work under difficult circumstances to respond to this health emergency. There were some questions about surveillance and polio vaccination. Kyrgyzstan has a well-established AFP surveillance system. There were fewer samples collected in 2020 and 30 were sent to a Moscow laboratory for testing, whereas the previous year, 6 specimens were sent for testing. There are no logistical problems and all specialists are well trained. Immunization coverage figures shared are comparisons between the first half of 2020 and the first half of 2021. Kyrgyzstan plans to introduce a second dose of IPV into the national immunization schedule.

RCC discussion on Tajikistan outbreak
The RCC acknowledged the positive achievements of Tajikistan in responding to the outbreak and noted the unacceptable delay between verification of readiness for use of nOPV2 and the availability of nOPV2 in the country. The next few weeks will be of critical importance to see the impact of the efforts made and the RCC endorses the country’s short- and medium-term plans. The RCC felt it may be good to have an additional ES site in the outbreak area temporarily to monitor progress towards ending transmission. There was discussion by the RCC about the AFP cases and whether they were concentrated in a certain part of the country. There was not clustering among the 2020 cases and most of them have been classified. The clustering of cases started only after March 2021 and the first two or three cases were from the unvaccinated cohort. There were concerns expressed by the RCC about the accuracy of the country’s population immunity data. The RCC discussed whether there are potential gaps in routine immunization coverage in many countries and a potential emerging immunity gap for PV due to the COVID-19 pandemic, which has caused challenges related to human resources, inability to access sites, slowdowns in surveillance and limited financial resources. The RCC discussed whether there should be an expansion of ES in the Region. One issue with this is that it may be not of much value to expand ES because the quality of the laboratory testing may not be sufficient and the ES may not yield enough cases to justify the resources. There may be a few places such as Uzbekistan and Kazakhstan where ES is needed programmatically to detect silent transmission and in Tajikistan, and they could see how long they can sustain the current ES in Dushanbe.

Conclusions and recommendations to Member States and WHO

Conclusions
Based on the evidence provided, the RCC concluded that the probability is high that WPV had not been circulating in the Region in 2020. Importation of cVDPV was detected by the existing surveillance system in Tajikistan and an adequate response was mounted. As in previous years, Romania and Ukraine remain at high risk of a polio outbreak in the event of importation of WPV or emergence of cVDPV, due primarily to suboptimal population immunity. Poland has been assessed as high risk due to the deteriorated surveillance performance and significant proportion of the population residing in territories with suboptimal immunization coverage. The RCC was not able to assess the risk status for Bosnia and Herzegovina, Croatia, Iceland, Israel, Luxembourg, Monaco and Montenegro in absence of submitted annual reports. Thus, in total, 3 Member States were considered to be at high risk, 22 were considered to be at intermediate risk, 21 were considered to be at low risk, and 7 remained without assessment.
The RCC is concerned over the increase in detected cVDPV2 cases globally and the continued isolation of WPV1 from environmental samples collected from many sites in Afghanistan and Pakistan. Continued poliovirus transmission in both countries poses a significant risk of importation to all Member States of the European Region with cultural, social and trade links with Afghanistan and Pakistan. The RCC strongly encourages all Member States to take appropriate actions to protect populations against transmission of any imported viruses. The RCC also encourages the WHO Regional Director to take every opportunity to persuade Member States to maintain high population immunity to protect against re-establishment of PV transmission.

The RCC is concerned about financial risks in the Region and shortfalls with nOPV2 supplies for 2022. There would be financial risks in the Region if there were simultaneous PV outbreak and there needs to be capacity to respond quickly. The capacity to respond has been impacted by the COVID-19 pandemic. The RCC also expressed concerns about vaccine hesitance in countries with regard to new COVID-19 vaccines and new nOPV2 vaccines. Vaccine hesitancy is a challenge in many countries.

The RCC is concerned that the quality of PV surveillance may have notably deteriorated, due to various factors. In absence of high-quality AFP surveillance, efficiency of enterovirus and environmental surveillance types should be enhanced.

The RCC is concerned that polio vaccination coverage has been in decline in a large number of countries in the Region, and that some Member States have acquired PV2 immunity gaps through the temporary delays in the introduction of IPV following cessation of tOPV use. The RCC urges all Member States to target immunization resources on identified vulnerable groups to increase overall population immunity. The RCC noted that while the majority of Member States have established a national plan of action to respond to detection of WPV/cVDPV, several Member States have failed to update existing plans and a small number of Member States have failed to provide a plan. RCC strongly urges all Member States to provide a current plan aligned with the GPEI Standard Operating Procedures for a new polio event or outbreak in a polio-free country. Failure to do so will be considered to represent a major risk factor for spread of PV after importation.

Recommendations to Member States and WHO

Population immunity
- Given the continued transmission of WPV1 in Afghanistan and Pakistan, the continued emergence and spread of cVDPV2, and importation of cVDPV2 into the European Region, the RCC is concerned about the continuing decline in vaccination coverage in some Member States and the generation of immunity gaps associated with reduced vaccination coverage in the recent past. All Member States are urged to improve overall population immunity by closing immunity gaps and targeting immunization resources on identified vulnerable groups.

Surveillance
- While COVID-19 has impacted PV surveillance performance in many countries, all efforts must be made to boost AFP and, where it exists, supplementary PV surveillance to timely detect the virus.
- Laboratory-based PV surveillance remains critically important in the Region at this time and the countries need to work with the Regional Office to develop long-term sustainability plans.

Containment
- All Member States considering the establishment of PEFs are again urged to become fully aware of the international requirements for certification of PEFs and to carefully consider whether a PEF is needed, whether they are likely to meet the stringent requirements for certifying a PEF, and whether they are prepared to meet the long-term financial obligations of maintaining a PEF.
**Preparedness**

- While the majority of Member States has developed a national plan of action to detect and respond to a WPV/VDPV event or outbreak, some countries have failed to provide or update their plans. All Member States are expected to provide an adequate plan to the RCC Secretariat for consideration by the RCC.

- For Member States considering the establishment of PEFs, the national plan of action must include detailed plans on the outbreak control response to a containment breach from a certified facility.
Annex 1. RCC conclusions on risk of sustained transmission in the event of WPV importation or emergence of cVDPV, per Member State in the WHO European Region, based on available evidence for 2020

<table>
<thead>
<tr>
<th>Country</th>
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<th>Population immunity</th>
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<th>Composite risk score</th>
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* Croatia, Israel, Luxembourg and Montenegro did not provide annual progress report and thus were not assessed.
** Bosnia and Herzegovina and Iceland submitted the annual report after the RCC meeting and thus were not assessed.
*** Monaco submitted the statement requested by RCC last year but did not provide the annual report and thus was not assessed.
Annex 2: List of participants

RCC members
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Prof Donato Greco, Italy
Dr Tapani Hovi, Finland
Dr Ellyn Ogden, the United States
Dr Rudolf Tangermann, Germany

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WHO European Region
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Dr Sergei Deshevoi, Technical Officer
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US CDC
Dr Patrick O’Connor, Medical Officer

Country representatives
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Dr Dilorom Tursunova, National Immunization Programme Manager, Uzbekistan

Rapporteur
Lisa Jacques-Carroll, WHO consultant
The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

**Member States**

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czechia  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands  
North Macedonia  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan