

12th Meeting of the South-East Asia Regional Certification Commission for Polio Eradication (SEA-RCCPE)

Dhaka, Bangladesh, 18-19 September 2019

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Abbreviations

AFP	acute flaccid paralysis
bOPV	bivalent oral poliovirus vaccine
CCS	containment certification scheme
CP	certificate of participation
cVDPV	circulating vaccine-derived poliovirus
cVDPV1	circulating vaccine-derived poliovirus type 1
cVDPV2	circulating vaccine-derived poliovirus type 2
Endgame Plan	Polio Eradication & Endgame Strategic Plan 2013-2018
GAPIII	WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use
GCC	Global Certification Commission
GPEI	Global Polio Eradication Initiative
IHR	International Health Regulations
IPV	inactivated poliovirus vaccine
mOPV2	monovalent OPV type 2
NAC	national authority for containment
NCCPE	National Certification Committee for Polio Eradication
NCTF	National Containment Taskforce
nOPV2	novel monovalent mOPV2
OPV	oral poliovirus vaccine
PEF	poliovirus essential facility
PIM	potentially infectious materials
RCCPE	Regional Certification Commission for Polio Eradication
SEA	South-East Asia
SEARO	World Health Organization Regional Office for South-East Asia
SIA	supplementary immunization activity
tOPV	trivalent oral poliovirus vaccine
VDPV	vaccine-derived poliovirus
VDPV2	vaccine-derived poliovirus type 2
WHO	World Health Organization
WPV	wild poliovirus
WPV1	wild poliovirus type 1
WPV2	wild poliovirus type 2
WPV3	wild poliovirus type 3

1. Introduction

The sixty-eighth session of the World Health Assembly of the World Health Organization (WHO) in 2015 urged Member States to fully implement all the strategic approaches outlined in the 'Polio Eradication and Endgame Strategic Plan 2013-2018' (Endgame Plan). The Endgame Plan has certification and poliovirus facility containment as one of its four objectives which requires continued active oversight by the Regional Certification Commission for Poliomyelitis Eradication (RCCPE) and National Certification Committees for Poliomyelitis Eradication (NCCPEs).

The Global Polio Eradication Initiative Endgame Strategy 2019–2023 will now guide the programme until global certification is achieved. The key components of the strategy are eradication, integration, certification and containment. The seventy-first World Health Assembly adopted resolution WHA71.16 in 2018 in which it urged Member States to intensify efforts to accelerate the poliovirus containment progress.

Based on the reports received by NCCPEs and presentations made at the 11th RCCPE meeting in November 2018, the RCCPE had concluded that the WHO South East Asia (SEA) Region had remained polio-free during the period of review. While commending the efforts undertaken by countries the RCCPE had cautioned about the risk of complacency and possible movement of resources to other health programmes. The RCCPE was concerned about continued wild poliovirus type 1 (WPV1) transmission and the ongoing and new outbreaks of circulating vaccine derived poliovirus (cVDPV), especially type 2 (cVDPV2). The RCCPE was particularly concerned about the cVDPV type 1 outbreak in Papua New Guinea and its risks and possible implications for the Region, especially Papua Province of Indonesia. The RCCPE considered emergence of cVDPV or transmission of imported vaccine derived poliovirus (VDPV) in areas of low coverage — of which many exist in countries in the Region — to be an equally important risk to the polio-free status of SEAR as imported wild poliovirus (WPV). The RCCPE emphasized that virus spread would be further facilitated by gaps in surveillance and inadequate outbreak preparedness. The RCCPE had noted the outlook of the Global Certification Commission (GCC) on global certification options and recommended that countries report data on their last WPV1 and WPV type 3 (WPV3) to NCCPEs.

In this context the 12th RCCPE meeting was held from 18-19 September 2019 in Dhaka, Bangladesh; with the following objectives:

- (1) to conclude and recommend on (based on review of country progress reports):
 - national and regional risk assessments to highlight gaps in the levels of immunity and the quality of surveillance at national and sub-national levels,
 - national polio outbreak preparedness, and
 - poliovirus containment requirements as per the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);
- (2) to review the implementation status of the recommendations made at the 11th meeting of the SEA-RCCPE; and
- (3) to update the GCC on the polio-free certification status and Endgame Plan implementation of the SEA Region.

The meeting was preceded by a closed session with RCCPE members on 17 September 2018.

The agenda of the meeting is included in annex 1 and the list of participants in annex 2. The meeting was attended by nine RCCPE members, chairpersons and representatives of 10 NCCPEs, officials of the Ministry of Health of Bangladesh and a WHO Secretariat.

2. Opening

The 12th meeting of the SEA-RCCPE was opened by the WHO Representative to Bangladesh, Dr Bardan Jung Rana, on behalf of Dr Poonam Khetrupal Singh, WHO Regional Director for SEA.

The Regional Director sincerely thanked the Government of Bangladesh for hosting this important meeting and appreciated that Professor Mahmudur Rahman has taken over as RCCPE chairperson. The RD welcomed the new members of the Commission: Dr Yagob Yousef Al-Mazrou, chairperson of the Eastern Mediterranean Regional Certification Commission; Professor Kusnandi Rusmil from Indonesia; Dr Shrijana Shrestha from Nepal; Dr Pasakorn Akarasewi from Thailand; and Dr Virna Martins-sam from Timor-Leste.

The Regional Director highlighted that four WHO Regions, including the SEA Region, have been certified as free of the three wild poliovirus serotypes; while two WHO Regions are yet to achieve this milestone. The African Region is close to certification with the last isolation of wild poliovirus occurring in September 2016. Two countries in the Eastern Mediterranean Region remain endemic for WPV1.

Dr Khetrupal Singh noted that while work to interrupt poliovirus transmission in the world's known reservoirs continues, efforts are ongoing to stop cVDPV2 outbreaks in sub-Saharan and the Horn of Africa. The Regional Director expressed concern that the Global Polio Eradication Initiative (GPEI) is currently faced with unexpected outbreak control activities, with the use of monovalent oral poliovirus vaccine type 2 (mOPV2) leading to the emergence of cVDPV2, mainly due to poor campaign quality and the spread of cVDPV2 into adjacent geographies and across borders. For control efforts to be successful, a high proportion of the targeted children must receive the vaccine, requiring improvements in field activities. At the same time, new technologies need to be developed. On that note, the GPEI research agenda has resulted in the first in human use of a genetically more stable "novel" type 2 OPV (nOPV2). Subsequent clinical trials are under way, and if the vaccine performs as expected, large-scale use of nOPV2 will begin in 12–18 months.

Coming from the global perspective to the regional situation, Dr Khetrupal Singh noted that cVDPV type 1 (cVDPV1) outbreaks in 2019 in Papua Province in Indonesia and in Kayin State in Myanmar were both followed by comprehensive investigations, risk assessments and outbreak response immunization campaigns. While the Regional Director commended both countries for their efforts, she urged all concerned to bring these outbreaks to an end as soon as possible and encouraged the RCCPE to have a detailed look at the adequacy and timeliness of response.

Dr Khetrupal Singh observed that all Member States of the Region must further strengthen actions required to maintain the Region's polio-free status. To minimize the risks and consequences of potential VDPVs, national immunization programmes must ensure high routine immunization coverage, conduct surveillance for timely detection of the emergence of cVDPV, and maintain strong outbreak response capacity. Complete

facility containment of polioviruses as per GAPIII must be ensured to mitigate the risk of exposure of communities to any release of type 2 poliovirus.

Likewise, transition plans in Member States that have established significant polio-funded assets need to be implemented. To help do that, they must mobilize domestic resources for long term sustainability. In addition, the engagement of new partners in polio eradication, such as Gavi, the Vaccine Alliance, should be explored to provide time-limited 'bridge' funding to priority countries to maintain essential polio functions and contribute to strengthening immunization systems to help achieve coverage and equity goals.

The Regional Director greatly valued the commitment and continued work of the RCCPE and NCCPEs and considered these bodies are vital to promoting vigilance and to supporting national immunization programmes in their efforts to keep countries polio-free.

The Regional Director acknowledged the contributions of RCCPE members whose tenures were completed at the end of 2018 – that is, Dr Kinzang Tshering from Bhutan, Professor Ismoedijanto Moedjito from Indonesia, Dr Suniti Acharya from Nepal, Professor Tariq Bhutta from Pakistan and former chairperson Dr Supamit Chunsuttiwat.

3. Global progress in polio eradication and Polio Endgame Strategy 2019-2023

WPV transmission: The last wild poliovirus type 2 (WPV2) case was reported in 1999, and WPV2 was officially certified as eradicated in September 2015. Wild poliovirus type 3 has not been detected globally since November 2012, when the last polio case due to this strain was reported in Yobe State, Nigeria. Since that time, all cases of paralytic polio due to WPV have been caused by type 1. In 2018-2019 WPV1 was detected in two countries: Afghanistan and Pakistan. In Nigeria, no new polio case due to WPV1 1 has been confirmed since the detection of cases in the State of Borno in August 2016 and the detection of the virus in a healthy child in September 2016.

Afghanistan and Pakistan continue to be treated as a single epidemiological block. As of 13 Aug 2019; 53 cases of paralytic polio due to WPV1 have been reported in Pakistan (latest onset: 21 Jul 2019), while in Afghanistan, 12 cases (latest onset: 26 May 2019) have been reported. The total number of cases globally in 2018 were 33 of which 12 were in Pakistan and 21 in Afghanistan.

cVDPV transmission: In 2019, outbreaks due to cVDPV2 newly emerged or continued in 13 countries. Of these 13 countries three had presumed local emergence from trivalent oral poliovirus vaccine (tOPV) only (Somalia, China and Philippines), based on estimation of years circulating, three had local emergences from tOPV and / or mOPV2 use (Nigeria, Democratic Republic of Congo, Mozambique), five had importation from an infected country (Niger, Cameroon, Ghana, Benin and Ethiopia) and two countries, Angola and Central African Republic, have multiple local emergences from mOPV2 use in a neighboring country, most likely Democratic Republic of Congo.

In February 2019, a cVDPV1 outbreak was confirmed in Papua province of Indonesia and in July 2019, a cVDPV1 outbreak was confirmed in Kayin state of Myanmar.

The declaration in 2014 of the international spread of wild poliovirus as a **public health emergency of international concern** and the temporary recommendations promulgated under the International Health Regulations (IHR; 2005) remain in effect. All countries currently affected by circulation of either wild or vaccine-derived polioviruses

have declared such events to be national public health emergencies and are implementing national emergency action plans.

Certification of WPV3 eradication: The last case of WPV3 in Asia was in FATA, Pakistan with onset April 2012 and that in Africa was in Yobe, Nigeria with date of onset November 2012. The GCC concluded that certification of WPV3 eradication can proceed if all Regional Certification Commissions submit data to the GCC. The process is expected to be completed in early October.

New GPEI Strategy 2019-2023: The GPEI has developed a new strategy to cover the period 2019-2023. The strategy has three goals of eradication, integration and certification and containment.

4. **Update from the WHO Regional Office of the Eastern Mediterranean:**

WPV1 transmission continues due to few stubborn reservoirs in the joint epidemiological block of Afghanistan and Pakistan. Technical advisory group meetings were held in Pakistan and Afghanistan in August 2019 and expressed concern over the increase in number of cases, particularly in Pakistan.

Key challenges: Reaching all children with immunization remains the key challenge in Afghanistan and Pakistan. The identified barriers are community reluctance, inaccessibility, insecurity, high population mobility and gaps in management of frontline workers. The other challenges include: retaining focus on wild poliovirus eradication considering competing priorities with the global emergence of cVDPV outbreaks; maintaining political and community engagement and will, at all levels and sustaining adequate resources.

Way forward for Afghanistan and Pakistan: Stopping endemic WPV transmission is the overriding priority with renewed national and global commitment. Reviews and assessments leading to sharpened analysis of communities harboring endemic transmission and adjusting tactics, operations communications along with high focus on core endemic reservoir is required. A GPEI Hub has been created in Amman to intensify, consolidate and coordinate GPEI partners' support to country programmes. The hub will support four areas of work; technical assistance including surge, data analytics, additional services and political advocacy.

WPV1 importation into Iran: WPV1 was isolated from environmental surveillance samples in Iran. There was evidence of recent introduction from Karachi, Pakistan. The Ministry of Health, Iran launched a good response by strengthening surveillance and conduction two additional rounds in these areas. The polio event in Iran highlights risk of spread of polio from Pakistan and Afghanistan and the need for highly vigilant surveillance including supplementary surveillance and high population immunity.

5. **Update from WHO Regional Office for the Western Pacific:**

cVDPV1 outbreak in Papua New Guinea: A total of 26 cVDPV1 cases were reported from Papua New Guinea in 2018 with most recent date of onset 18 October 2018. The outbreak response consisted of five high quality national immunization days (NIDs) and three sub-national immunization days (SNIDs) from July 2018 to June 2019. Surveillance

was strengthened with non-polio acute flaccid paralysis (AFP) rate >8 per 100 000 population under 15 years of age in 2018 and 2019. Environmental surveillance was also established in Port Moresby and Lae city. Two outbreak response assessments (OBRA) were conducted in December 2018 and May 2019. The OBRA of May 2019 indicated that the transmission of cVDPV1 was likely interrupted and recommended to further strengthen surveillance and routine immunization for the next six months for the outbreak to be declared closed.

cVDPV2 outbreak in China: In April 2019 cVDPV2 was reported from an AFP case in Sichuan province of China and had genetic linkage with vaccine derived poliovirus type 2 (VDPV20 isolated from environmental sample collected in April 2018 from Xinjiang province. Outbreak response included measures to strengthen surveillance and increase inactivated poliovirus vaccine (IPV) coverage. Two rounds of non-selective vaccination with IPV for children under 5 were conducted in July and August. Mop-up/selective IPV vaccination was implemented in prefectures and cities neighbouring Liangshan prefecture, as well as in Zhaotong area in Yunnan province. mOPV2 was not recommended for the immediate response but the scope of a future mOPV2 response will depend on the epidemiology.

VDPV1 and VDPV2 events in the Philippines: From 1 July 2019 to 27 August 2019, eight VDPV1 isolates and nine VDPV2 isolates have been detected from environmental surveillance sites in Davao City and Tondo, Manila. Field investigation were initiated including community search for AFP cases and close contact sampling. Surveillance has been strengthened with focus on active AFP surveillance and expansion of environmental surveillance. Immediate vaccination response was carried out in August 2019 in Manila City with bOPV for children less than five years of age and another round in planned in October 2019 in the National Capital Region.

6. Regional update on maintaining polio-free status

The WHO SEA Region was certified polio-free on 27 March 2014 and has maintained its polio-free status in 2018-19. However, risk of importation of polioviruses from areas with current circulation and risk of emergence of cVDPVs remain. There is also a risk of re-introduction of poliovirus type 2 into community following a breach in facility / laboratory containment.

The factors that could potentially accentuate the risks are sub-optimal population immunity against polioviruses, population movements (migrants, refugees), surveillance gaps leading to delayed detection of polioviruses, weaknesses in containment of polioviruses, inadequate preparedness to respond to a poliovirus leading to delayed or inadequate response and transition following ramp-down of global polio funding in five large countries may result in programme deficiencies.

Population immunity:

As per WHO and United Nations Children's Fund estimates of national immunization coverage (July 2019) six countries in the Region (Bangladesh, Bhutan, the Democratic People's Republic of Korea / Democratic People's Republic of Korea, Maldives, Sri Lanka, and Thailand) had a routine OPV third dose (OPV3) coverage of >95%, two countries (Myanmar and Nepal) had coverage of 90-95% while India, Indonesia, and Timor-Leste had coverage between 80% and 90%. India conducted supplementary immunization activities (SIAs) in 2018, Indonesia conducted SIA in Papua and West Papua provinces in response to cVDPV1 outbreak of neighbouring Papua New Guinea.

The IPV first dose coverage has improved from previous year. However, the coverage was <80% in five countries of the Region. IPV supply has been restored and all countries of the Region are providing IPV in their routine immunization programme. India, Sri Lanka, Bangladesh and Nepal are administering intradermal IPV as a dose sparing method following Strategic Advisory Group of Experts on Immunization recommendations.

Surveillance performance:

All countries in the Region, except Timor-Leste, maintained certification standard non-polio AFP rates of at least 1 per 100 000 children under 15 years of age, in 2018 (as of 2 September 2019). Six countries, namely Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Myanmar and Nepal had adequate stool specimen collection of >80%. However, for both performance indicators there is considerable subnational variance in several countries.

AFP surveillance is being complemented by environmental surveillance in six countries of the Region. In 2018, a total of 86 sites in 29 provinces of six countries, namely Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, were conducting environmental surveillance. Bangladesh operates four temporary sites in Cox's Bazaar.

There are 16 polio laboratories in seven countries that perform intra-typic differentiation. Three of these laboratories also perform sequencing. There is one global specialized laboratory and two regional reference laboratories in the Region. All laboratories, except the national polio laboratory of Democratic People's Republic of Korea, are accredited.

Poliovirus laboratory containment

Activities to contain type 2 polioviruses in facilities under GAPIII requirements are progressing in the Region. Two poliovirus essential facilities (PEF) have been identified to store/handle type 2 polioviruses in two countries of the Region, namely India (research facility) and Indonesia (vaccine manufacturer). National authorities for containment (NAC) have been established in both countries and processes to undertake certification of these facilities as per the global containment certification scheme (CCS) have commenced. The PEF in Indonesia had its certificate of participation (CP) under the CCS granted by the GCC in May 2019.

Special trainings on GAPIII requirements for national containment taskforces (NCTF), PEFs, NAC and vaccine manufacturers were successively conducted in 2016 – 2019 (with participation from other WHO Regions). A CCS auditors' training was held in January 2017 for India and Indonesia (jointly with Australia and Republic of Korea) and a mock audit exercise conducted in March 2019.

The Regional Polio Laboratory Network has conducted several bio-risk management capacity building activities and network laboratories are conducting self-assessments against GAPIII requirements.

Countries are being supported with direct technical assistance to implement their activity plans for containment of Sabin2/OPV2 infectious and potentially infectious materials. One of the challenges in GAPIII implementation are involvement of facilities that collect, handle and store clinical and environmental samples for purposes other than polio research. These specimens also present a poliovirus transmission risk if samples were collected in a place and time where wild poliovirus or VDPV were circulating or OPV was being used. These facilities are at a disadvantage in that the potential presence of an infectious poliovirus in such samples is both undesirable and uncertain. To support such

laboratories, WHO has developed 'Guidance for non-poliovirus facilities to minimize risk of sample collections potentially infectious for polioviruses (PIM)' which were pilot tested in Bangladesh in December 2017 in a workshop with high risk laboratories. All materials identified in Bangladesh can be stored outside a PEF as per the PIM guidance.

cVDPV1 outbreaks in the SEA Region and outbreak response:

In 2018-2019 outbreaks due to cVDPV1 were detected in two countries of the Region, namely, Indonesia and Myanmar. Both outbreaks were graded by WHO as Emergency grade 1 and immediate response measures were undertaken in the form of large scale immunization campaigns and AFP surveillance strengthening. Indonesia expanded environmental surveillance in Papua and West Papua. Myanmar conducted synchronized immunization activities at cross border with Thailand along with enhancing AFP surveillance.

Risk assessment and outbreak response preparedness:

The WHO Regional Office for SEA (SEARO) presented the revised regional risk assessment tool for national analysis. The tool has been modified after inputs from RCCPE, NCCPEs and other stakeholders to guide countries to perform subnational risk analysis. Similarly, the tool is also being modified for countries with small population size.

All countries have national outbreak preparedness and response plans in place. A systematic review of outbreak preparedness and response plans was conducted, and feedback provided to countries. Most national outbreak plans require some revisions based on risk assessment and current global guidelines.

Transition planning:

The Strategic Action Plan on Polio Transition was presented to the 71st WHO World Health Assembly. The plan has three objectives: sustaining a polio-free world after eradication of poliovirus; strengthening immunization systems, including surveillance for vaccine-preventable diseases to achieve the goals of WHO's Global Vaccine Action Plan; strengthening emergency preparedness, detection and response capacity in countries to fully implement IHR 2005.

Five countries in the Region - Bangladesh, India, Indonesia, Myanmar and Nepal - have significant workforce, systems and processes dependent on the polio funded assets. The polio infrastructure in these countries supports essential polio functions that must be maintained beyond certification. It also supports non-polio programmes like measles elimination, routine immunization, vaccine preventable diseases surveillance, new vaccines introduction, neglected tropical diseases, emergencies and disasters. Significant progress has been made in SEA Region with finalization, endorsement and implementation of national transition plans. The pace of implementation is guided by country readiness - technical, financial and managerial capacity. The transition plan of Bangladesh has been endorsed by the Government and implementation on track. Government of India has also endorsed the polio transition plan and flow of domestic resources to WHO started. In Indonesia, formal endorsement of the plan is awaited however actions have already been initiated for partial self-funding. National transition plan of Myanmar is under consideration for endorsement by the government and endorsement of the national transition plan of Nepal is delayed due to ongoing federalization.

7. Conclusions, observations and general recommendations

Overall

- The RCCPE appreciated the quality of reports submitted and presentations made by the NCCPEs that are analytical, issues have been identified and recommendations made to address those issues.
- Based on the reports received by NCCPEs and presentations made at the 12th RCCPE meeting, the RCCPE concluded that the WHO SEA Region has remained free of indigenous wild poliovirus during the period of review. As such more than eight years have passed since the last WPV case was detected (January 2011).
- While acknowledging the continued efforts in global polio eradication, the RCCPE was severely concerned about continued WPV1 transmission and the ongoing and new outbreaks of cVDPV, especially type 2.
- The RCCPE was also very concerned about the recent cVDPV1 outbreaks in Papua province of Indonesia and Kayin state of Myanmar. These outbreaks confirm the RCCPE's warnings regarding emergence of cVDPV in pockets of low coverage and weak surveillance to be an equally important risk to the polio-free status of SEA Region as imported WPV. While appreciating the immediate actions taken by both countries in responding to the cVDPV1 outbreak, the RCCPE cautioned that gaps in surveillance and population immunity especially in inaccessible and conflict areas along with inadequate outbreak preparedness will further facilitate the spread of virus. The RCCPE urged that lessons learned from these outbreaks in the Region should be documented and shared with other countries.
- The RCCPE furthermore requested NCCPEs to convene a meeting with the national programme as soon as possible but no later than December 2019, to conduct a country specific risk assessment at subnational level to prioritize high risk areas for importation or emergence of cVDPV2. Based on the analysis, the NCCPE should recommend to the national programme to urgently prepare a risk mitigation plan that includes accelerated surveillance in these high-risk priority areas and steps to improve population immunity including bivalent oral polio vaccine (bOPV) SIAs during various opportunities like MR campaigns.
- Considering that after the tOPV to bOPV switch IPV is the only source of protection against cVDPV type 2, the RCCPE urged the national programmes to perform an assessment of their subnational IPV coverage since 2016 and plan to provide IPV to children who were born after April 2016 and missed their IPV dose. The RCCPE recognized the supply constraints of IPV and recommended that technical consultation is required for feasibility of using dose-sparing techniques including fractional use of intradermal IPV.
- The RCCPE urged countries to update their respective national outbreak preparedness plans and align them to the latest GPEI guidelines of January 2019. The RCCPE requested WHO-SEARO to conduct a workshop to discuss the national outbreak response plans and ensure that they are standardized and appropriate for a poliovirus event/outbreak. The national

outbreak preparedness plans should subsequently be tested by conducting table-top simulation exercises.

- The RCCPE recognized that risk assessment needs to be country-specific to correctly capture local situation. The RCCPE requested WHO-SEARO to work with the countries so that national programmes understand the key principles for conducting risk assessment and manage to apply the principles in the local context. The NCCPE should monitor the process of risk assessment and report to the RCCPE on the rationale and outcome.
- The RCCPE noted ongoing work in laboratory containment; with PEFs and respective NACs nominated in India and Indonesia and the GAPIII certification process commenced. As containment needs to identify also laboratories which may store potentially infectious materials and adequately manage them, the RCCPE requested NCCPEs to coordinate with NCTFs for complete inventory reports and documented application of the WHO PIM guidance.
- The RCCPE urged that countries should have cross border collaboration with countries within and outside the Region; with facilitation by WHO.
- The RCCPE continued to encourage NCCPEs to conduct analytical performance review meetings with the national programme; one meeting should be held immediately after this RCCPE meeting to brief the entire NCCPE membership and to develop an activity plan for the next 12 months. At least one more NCCPE meeting is required for in-depth performance review prior to preparing the country report. The RCCPE urged that NCCPE reports should be sent in a timely manner to ensure enough time for members of the RCCPE to review them.

8. Country specific conclusions and recommendations

Bangladesh

- The RCCPE commended the continued strong polio immunization and surveillance performance supported by the WHO surveillance and immunization medical officers network.
- Immunization strengthening activities should continue their focus on addressing coverage gaps in urban areas/city corporations.
- The RCCPE commended the Government of Bangladesh for providing immunization services to the refugees in Cox's Bazar and for conducting special SIAs. They should continue to apply these measures to future refugees also.

Bhutan

- The RCCPE commended measures taken by the country for maintaining population immunity against polio. The RCCPE, however, noted that Thimpu as main population center had a lower OPV3 coverage of 86%.
- While commending the overall surveillance quality of Bhutan, the RCCPE urged to make efforts to maintain surveillance indicator quality and further address timeliness of reporting sites and stool sample shipment especially from remote locations.

India

- The RCCPE commended the national programme for special strategies to strengthen routine immunization, maintain sensitive surveillance and noted the continued high level of commitment to maintaining the polio-free status.
- The RCCPE noted that following global shortage of IPV supply, India decided to transition to fractional dose of IPV. While IPV coverage is increasing it is still not high enough; leaving many children susceptible to poliovirus type 2.
- While overall surveillance remains adequate, the RCCPE noted that there are districts where surveillance needs to be strengthened. In general, as part of polio transition activities, capacity building and ownership of government immunization/surveillance officers should be increased. The WHO surveillance medical officer network should be maintained for technical assistance and capacity building.
- The RCCPE urged the country to reassess their reporting sites and number of active case searches being conducted.
- In containment the CP application process for nominated PEFs should be accelerated.

Indonesia

- The RCCPE commended the country on the actions being taken in response to the cVDPV1 outbreak in Papua province considering the accessibility challenges in the province that are geographical and security related. The RCCPE noted that the case count of cVDPV1 remains one even after improved surveillance in the province.
- The RCCPE however noted that certain inaccessible districts in Papua province have very low coverage and urged the country to reduce immunity gaps in these inaccessible areas.
- The RCCPE concluded that risk of emergence of cVDPVs is further aggravated in other provinces with continued limited active surveillance and gaps in subnational AFP surveillance performance. The RCCPE urged to identify high risk populations and areas to form strategies that can reduce immunity gaps and improve surveillance. Learnings from the outbreak response in Papua should be translated into guidelines and action plan for other provinces.
- The RCCPE considered strengthening of immunization service delivery for both, bOPV and IPV and especially in areas of sub optimal coverages as critical; based on risk assessment and prioritization of high population areas.
- The RCCPE was concerned about the timeliness and completeness of weekly reporting and equally urged to improve AFP surveillance by conducting more frequent active surveillance visits in priority areas combined with other monitoring activities.
- The RCCPE congratulated the country on being one of the few and first countries to receive GCC endorsement on the CP of its PEF while noting that Indonesia has not yet started survey activities for poliovirus type 2 potentially infectious materials.

Maldives

- The RCCPE appreciated the continue high performance of polio immunization.
- As some persistent issues with AFP surveillance continue (for example limited human resource for active surveillance, low stool specimen collection rates and delayed shipment to the Regional Reference Laboratory) the RCCPE encouraged the programme to increase the capacity of existing and new staff for AFP surveillance and make efforts to streamline stool specimen shipment.

Myanmar

- The RCCPE commended the country on the outbreak response following cVDPV1 outbreak in Kayin state of Myanmar including the speed of response, involvement of highest level of government, collaboration with Thailand and engagement of ethnic health organizations in areas which are inaccessible to government staff.
- The RCCPE expressed concern on existence of other similar conflict areas in Myanmar with inaccessibility to government staff leading to extremely low coverages. These areas are at highest risk for emergence of cVDPVs. The RCCPE urged to the programme to start engaging various ethnic groups or local non-governmental organizations to improve routine immunization coverage before an outbreak situation is reached.

Nepal

- The RCCPE commended efforts being taken to maintain an overall high OPV third dose coverage but urged to improve coverage in lower performing high-risk districts having high population density.
- The RCCPE commended that overall surveillance quality has been maintained but suggested that surveillance should be further strengthened by more frequent active surveillance visits, cross border collaboration with China and India, expansion of environmental surveillance in high risk areas and continued technical support of WHO surveillance medical officers.
- As Nepal is in governance transition and reorganizing health and other services, it is critical to monitor the involvement of appropriate entities in immunization and surveillance. The new federal structure should also be addressed in the national outbreak response plan.

Sri Lanka

- The RCCPE commended the continued high performance of immunization with OPV and IPV, as evident by the recent serosurvey.
- The RCCPE appreciated the ongoing efforts to monitor surveillance quality and encouraged the programme to continue maintaining AFP surveillance performance at least at certification quality levels; while aiming to achieve the operational target.
- The RCCPE suggested that the country should conduct a national surveillance review involving in-country experts and consider a research

study on factors associated with a continued low non-polio AFP rate in the country.

Thailand

- The RCCPE commended the actions taken by Thailand in response to the cVDPV1 outbreak in neighbouring Myanmar including epidemiological investigation, risk assessment and two bOPV campaigns in bordering districts.
- The RCCPE noted the continued strong immunization but also subnational gaps in AFP surveillance performance. The RCCPE encouraged the country to continue surveillance strengthening activities and recommends a review of the surveillance system, including data quality review, to address any gaps that are identified on a priority basis.

Timor Leste

- The RCCPE acknowledged that in spite of limited numbers of technical experts, various initiatives are being taken to increase access to immunization.
- The RCCPE was concerned that no AFP case was reported in 2018 and only one has been reported in 2019. The RCCPE urged the programme to review the surveillance system to identify gaps and take specific actions.
- The RCCPE recommended that the country should expand the reporting network to include all community health centers.
- The RCCPE urged the NCCPE to closely monitor surveillance activities and report to the RCCPE during its next meeting.

Democratic People's Republic of Korea

- As part of certification requirements the continued oversight by the NCCPE is required. The RCCPE urged the NCCPE to send its annual report.
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Annex 1

Agenda

- (1) Opening Session
- (2) Global Updates on polio eradication and implementation of the Endgame Strategic Plan 2019-2023
- (3) Stopping poliovirus transition in Afghanistan and Pakistan
- (4) Vaccine derived poliovirus emergence in WHO Western Pacific Region 2018-2019
- (5) Global poliovirus laboratory containment
- (6) Update on global certification aspects
- (7) Updates by National Certification Committees for Polio Eradication on maintaining polio-free status
- (8) Regional summary on maintaining polio-free status in the WHO South-East Asia Region
- (9) Regional summary on GAPIII containment
- (10) Conclusions and recommendations
- (11) Closing

Annex 2

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