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International Certification Commission for Polio Eradication in the South-East Asia Region

Report of the Sixth Meeting
WHO/SEARO, New Delhi, 23-25 March 2004

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1. BACKGROUND

The International Certification Commission for Polio Eradication in the South-East Asia Region (ICCPE) met for the fifth time at the WHO South-East Asia Regional Office (SEARO) in New Delhi on 5 March 2002 and was briefed on the latest developments in the global poliomyelitis eradication initiative and status in the Region. The ICCPE members reviewed the documentation and updates from all countries and updated the ICCPE Plan of Action (POA). The large poliomyelitis outbreak in India later that year resulted in the postponement of the sixth ICCPE meeting to 23-25 March 2004.

The certification process has progressed with all countries except Timor-Leste having established a National Committee for Certification of Polio Eradication (NCC) and a National Expert Review Committee (NERC) for classification of acute flaccid paralysis (AFP) cases. Laboratory containment for wild poliovirus infectious/potentially infectious materials has commenced and 10 countries have established a national containment task force, as well as, a plan of action (POA). Establishment of the task force in Timor-Leste is still pending.

While poliovirus transmission continues in India, all other countries have maintained their poliomyelitis-free status for more than three years. However, the risk of importation of wild poliovirus continues and Bangladesh and Nepal are at the highest risk because of their geographical proximity to India.

In 2003, all countries, except Maldives and Timor-Leste, achieved the targets for key AFP surveillance indicators.

Some changes have taken place in the ICCPE itself. Prof. Nath Bhamarapravati, the Chairperson of the ICCPE, passed away. His wisdom will be missed. The Regional Director has nominated Dr N.K. Shah as the new Chairperson. Dr Nick Ward also resigned from the ICCPE for personal reasons.

2. CONCLUSIONS AND RECOMMENDATIONS

2.1 General Conclusions

This sixth meeting of the ICCPE provided another opportunity to review the progress reports from all countries, except the Democratic People's Republic of Korea.

The ICCPE thanked the National Certification Committees (NCC) and all country teams for the timely assembly and submission of the update reports, as well as for the informative and comprehensive presentations made at the sixth ICCPE meeting.

The ICCPE was impressed with progress made in India to interrupt wild poliovirus transmission and by the ability of all countries to sustain quality surveillance even though poliomyelitis has not been reported in some countries for several years.

The ICCPE noted that countries have not only maintained but in some instances improved the quality of surveillance since its last meeting. Much effort has also been made to improve surveillance in silent and low-performing areas. The ICCPE congratulated countries, which have made special efforts to establish AFP surveillance in areas that are remote or difficult to access.

The Commission commended the high-risk countries in continuing to conduct supplementary immunization activities. It regards it as a sign of continued commitment to polio eradication that supplementary immunization is considered and implemented to protect vulnerable populations. The Commission also wishes to emphasize that achievement and maintenance of high-quality routine immunization coverage of all birth cohorts is of utmost importance to protect against the spread of an imported wild poliovirus or the emergence and circulation of vaccine-derived poliovirus (VDPV). This will increase in importance once the interruption of transmission of indigenous wild poliovirus has apparently been achieved.

The ICCPE noted the further progress made globally, resulting in only six countries remaining endemic for wild poliovirus. The three major global reservoir countries of India, Pakistan and Nigeria account for >95% of all wild polioviruses detected over the past two years while only small numbers of cases are reported from Afghanistan, Egypt and Niger.

The Commission noted the significance of the WHO Global Strategic Plan for Poliomyelitis Eradication 2004-2008, which takes into account the now apparent additional delays in interrupting wild poliovirus transmission globally. The Global Strategic Plan focuses on closing the immunity gap in endemic countries through increasing the frequency and quality of targeted OPV campaigns, and through rapidly detecting and appropriately responding to wild poliovirus importations into poliomyelitis-free countries.

2.2 General Recommendations on National Documentation

The ICCPE reiterated that the purpose of national documentation is to:

- Provide convincing evidence that indigenous transmission of wild poliovirus was interrupted;
- Provide evidence that imported wild poliovirus and circulating vaccine-derived poliovirus (VDPV) would be quickly and reliably detected and rapidly responded to;
- Describe the laboratory containment process of completing a nationwide survey of laboratories and establishment of an inventory of all facilities holding wild polioviruses or potentially infectious materials, and
- Provide supplemental information where surveillance and immunization performance levels are not up to the accepted standards.

The Commission reiterated that the documentation to be provided for certification should be of the highest possible quality. It pointed out that the Manual of Operations should be considered as a guide for documentation of certification. Additional materials should be included as appropriate and it remains the prerogative of the ICCPE to either request for further information or to accept information that is less than that specified in the Manual of Operations.

The Commission expects the NCCPE to discuss areas of concern with the national programme, what activities have been carried out to address those concerns, what results were achieved, and if any further future action is planned or required.

As the risk of importation of wild polioviruses into poliomyelitis-free areas remains a relevant threat, all national documentation should include plans and demonstrate that measures are in place for detection of and response to imported wild poliovirus. These should also include the programme response to the detection of VDPV.

The overall principle of national documentation is to provide convincing evidence to the ICCPE that indigenous wild poliovirus transmission has been interrupted with the need to prove the negative. A one page executive summary, signed by all NCC members, which details why the NCC has come to this conclusion and recommends to the ICCPE to certify the country as polio-free must be included.

Once a country report has been accepted as satisfactory, the ICCPE will only require annual update reports in the future. This should include the following main components: surveillance indicators, immunization activities to maintain high coverage and prevent emergence of susceptible cases, status of laboratory containment of wild poliovirus infectious and potentially infectious materials, and any other relevant activities.

At the future ICCPE meetings, NCC chairpersons (and eventually national programme managers) will be invited when the country's documentation is being reviewed.

The Commission urged all countries to keep good quality records on surveillance and supplementary immunization activities. These records are essential requirements for certification and should be available to the NCC, the ICCPE and Global Certification Commission as permanent records of the certification process. However, if all data are computerized, paper forms (e.g. laboratory request forms) may be discarded after a specified period of time (e.g. six months) and after a decision on the final classification of acute flaccid paralysis (AFP) cases has been made of the National Expert Review Committee (NERC).

The ICCPE will remain in close contact with the NCC concerning data requirements for certification. The Commission may visit countries, as required, to discuss certification requirements and data quality.

2.3 Recommendations on Documentation Quality

The data elements currently collected for review by the NCC appear sufficient though the ICCPE expresses concern over some missing data in reports. The ICCPE considers it essential that the NCC scrutinize the data carefully and clarify details if necessary prior to submission to the ICCPE. Some tables in the Manual of Operations may need to be amended to increase clarity. The ICCPE Chairman will provide individualized letters to the NCC to suggest points of clarification.

Report verification may also include field visits of the NCC but the ICCPE wishes to reiterate that the role of the NCC is not operational, and that it should not intervene as policy-makers for the programme.

The NCC should provide further details and summary explanations of risk assessments, the impact of national issues on poliomyelitis eradication (e.g. migrant workers from endemic countries, decentralization of public health functions, quality achievements despite conflict or inaccessible geographical areas), and steps that will be taken to address potential future outbreaks.

The ICCPE expressed concern about the low rates of completeness and timeliness of routine and active surveillance reports. Particularly in areas of sub-optimal AFP rates, regular and timely submission of evidence that routine and active surveillance is carried out is essential.

The documentation should describe the management and use of surveillance data (at national and sub-national level). Specifically, descriptions of routine data analysis and how information is used for action (e.g. cluster analysis of AFP cases, results of investigation and active searches, investigation of high-risk cases or 'hot cases') should be provided.

Areas with low AFP and specimen collection rates form one of the most concerning parts of the documentation and should detail activities and the outcomes which have been conducted in low performance areas (e.g. retrospective record reviews, stool surveys among healthy children, supplemental enterovirus surveillance).

There should be sufficient explanation for silent AFP reporting areas, particularly in countries and areas with populations too small to generate AFP cases regularly. Monitoring AFP cases over time in small populations is critical and evidence should be provided that routine active surveillance is being conducted in those areas.

Low non-polio enterovirus (NPEV) isolation rates should be further discussed not only in terms of laboratory quality but also management of the reverse cold chain. Details on any poliovirus isolates, including those from non-AFP sources should be included.

The Commission recognized the continuous high-quality performance of the polio laboratory network as a critical element for programme guidance in terms of timely and reliable virologic results. It requests that the name of virologists responsible for national poliovirus reference laboratories be included in the report under responsibilities.

Sections on the work of the NERC should include composition, terms of reference, protocols for case classification and documentation. Membership of NERC and NCC should be mutually exclusive and should not be linked to programme implementation. In addition, members of the national EPI programme should not be members of the NCC.

The Commission noted a general lack of explanation of compatible cases. More details are needed on investigations and responses to compatible cases. There is a concern about the continuing number of compatible cases. The NCC needs to verify the investigations completed on each compatible case as well as the integrity of surveillance activities in the area.

The documentation of polio compatible cases should include: clinical findings; reasons for classification; final classification; the mapping of compatible cases for each year; comparisons with AFP cases in the area; and the immunization coverage. Information is required on re-investigations conducted of compatible cases, and on their results and effect on the final classification change.

Attempts should be made to describe the distribution of all AFP cases and their diagnosis as a measure of surveillance sensitivity (e.g. in terms of over-diagnosis or non-polio AFP rates inflated by potential non-AFP cases).

Attention should be given to reporting of vaccine associated paralytic poliomyelitis (VAPP) and any potential case should be properly scrutinized to verify surveillance quality.

Low immunization coverage should be further explained and NCC should provide a detailed assessment on why they are still convinced that there is an absence of wild poliovirus transmission (e.g. details on surveillance quality).

The ICCPE welcomed the quality assessment exercise conducted for national inventories of wild poliovirus infectious/potentially infectious materials. NCC should include conclusions on containment aspects in the national reports (e.g. internal audit of non-responders and proper storage of infectious materials).

Annex 1

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Annex 2

PROGRAMME

Tuesday – 23 March 2004

0830 – 0900 hrs	Registration
0900 – 0930 hrs	Opening • Welcome Address-Dr B. T. Burkholder • Tribute to Prof. Nath Bhamarapravati • 2 Minutes silence • Introductions • Appoint ICCPE Chairperson & Rapporteur • Chairperson's Address
1030 – 1230 hrs	Meeting of ICCPE, NCC Chairpersons and WHO Secretariat • Global update on polio eradication • Regional update on polio eradication • Regional laboratory network update • Regional update on Laboratory Containment • WPR experience • Update on certification process and follow-up on the recommendations of 5th ICCPE meeting
1400 – 1430 hrs	Country presentation – India • India status of polio eradication – Dr. Sobhan Sarkar • NCC observations – NCC India
1430 – 1530 hrs	Discussion on national documentation submitted by NCC – India
1545 – 1630 hrs	Country presentation – DPRK (WHO Secretariat)
1630 – 1730 hrs	Closed session of the ICCPE

Wednesday – 24 March 2004

0800 – 1000 hrs	Country presentations – NCC Indonesia and NCC Thailand Discussion on national documentation submitted by NCC Indonesia and NCC Thailand

1030 – 1200 hrs	Country presentations – NCC Sri Lanka and NCC Nepal
	Discussion on national documentation submitted by NCC Sri Lanka and NCC Nepal
1330 – 1500 hrs	Country presentations – NCC Bhutan and NCC Myanmar
	Discussion on national documentation submitted by NCC Bhutan and NCC Myanmar
1530 – 1700 hrs	Country presentations – NCC Maldives and NCC Bangladesh
	Discussion on national documentation submitted by NCC Maldives and NCC Bangladesh
1700 – 1800 hrs	Closed session of the ICCPE

Thursday – 25 March 2004

0830 – 1000 hrs	Closed Session of the ICCPE
1030 – 1100 hrs	Update on Polio eradication – Timor Leste
1100 – 1200 hrs	Conclusions and recommendations on country documentation
1330 – 1430 hrs	Close session of ICCPE to review ICCPE plan of action
1500 – 1600 hrs	Closing session