Fourth Meeting of the core Global Certification Commission (GCC)

(13th meeting of the GCC)

Kathmandu, 28 November, 2013

Summary of findings, decisions and recommendations

Introduction

The fourth meeting of the 'core Global Certification Commission' (GCC), consisting of Chairpersons of WHO Regional Certification Commissions (RCCs), was conducted in Kathmandu, Nepal, on 28 November, 2013, following the Sixth Meeting of the South-East Asia Regional Commission for the Certification of Polio Eradication (SEA-RCCPE).

The meeting was attended by Dr Anthony Adams, Chair of the GCC and also Chair, RCC/WPR, Dr Supamit Chunsuttiwat, Chair, SEA-RCCPE, Dr David Salisbury, Chair, RCC/EUR, and Dr Yagoub Al-Mazrou, Chair, RCC/EMR. Dr Rose Leke, Chair, RCC/AFR, and Dr Arlene King, the newly appointed Chairperson of the Regional Commission for the verification of polio-free status in the Americas, were unable to attend.

Participants from WHO were Dr Rudi Tangermann, WHO/HQ, Ms Liliane Boualam, WHO/WPRO, Dr Mbaye Salla, WHO/AFRO, Dr Zainul Khan, WHO/SEARO and Dr Nicoletta Previsani, WHO/HQ.

The Commission observed one minute of silence in remembrance of the late Dr Ali Jaffer, previously Chair, RRC EMR, who had passed away earlier this year.

Briefings and discussions at the GCC meeting focused on the implications of the new polio 'endgame' for the GCC and RCCs, in particular the planned withdrawal of type 2 oral polio vaccine (OPV2), (i.e. the tOPV to bOPV 'switch' for routine immunization in OPV-using countries), and how certification groups can contribute to prepare for this 'switch'.

Other topics discussed were the current work towards laboratory containment of polioviruses, the implications of the prolonged transmission of wild poliovirus type 1 detected by environmental surveillance in Israel, and progress towards establishing fully functional Certification Commissions in all WHO Regions.

1 GCC role in preparations for global OPV2 withdrawal

- The GCC notes the progress made in planning for the coordinated global withdrawal of OPV2 from routine immunization programmes (the 'tOPV-bOPV' switch), including the SAGE recommendation that all countries using only OPV for routine immunization should introduce at least one dose of IPV into their routine immunization schedule beforehand.
- The GCC and RCCs have been charged to oversee and contribute towards establishing two of the five main criteria which will be used to assess global 'readiness' to safely and successfully implement the withdrawal of OPV2 globally:
  - a formal affirmation and declaration by the GCC of wild poliovirus type 2 (WPV2) eradication globally, and
  - completion of Phase 1 containment activities (lab survey and inventory) for all wild polioviruses and wild poliovirus infectious materials, followed by either destruction or appropriate safe handling of WPV2 residual materials in laboratories and IPV production sites.
- The GCC decided that, contingent on the achievement of the necessary containment and surveillance activities, the formal declaration of WPV2 eradication could potentially be made at a GCC meeting to be scheduled during the fourth quarter of 2014.

2 Formal GCC declaration on WPV2 eradication

- A GCC declaration that there has been no evidence of WPV2 transmission for at least the last 10 years globally will be based on evidence from the WHO polio laboratory network to that effect, supplemented and confirmed by each WHO Member State.

- The GCC suggests that, in preparation for its declaration on WPV2 as early as late 2014, the Regional Directors (RDs) of each WHO Region send a formal communication to the Minister of Health in all member states of the Region, copied to the chairs of the RCC and National Certification Committee (NCC).

  The communication from the WHO RDs should present the evidence available to WHO, through the Global Polio Laboratory Network, on the last detection of WPV2 in the country and request the Minister of Health to provide a communication to confirm or supplement this information; this communication should also confirm, if appropriate, that no virological data on the isolation of WPV2 exists.

  The GCC noted that responses to this communication from the WHO RDs might not be received from all countries and decided that RCCs should consider 'no response' as implying the agreement of the respective MoH with the information available to WHO.

- The communication to Ministers of Health should be used as an opportunity to raise awareness of the polio 'endgame' among health leaders in the country, by explaining the background for the request and describing key elements and steps of the polio 'endgame', particularly in countries using exclusively OPV which will need plan for and participate in the tOPV-bOPV switch.

- For countries without fully functioning national health authorities, such as countries in complex emergencies, the evidence to prepare for the GCC declaration on the absence of WPV2 should be compiled and submitted by UN agencies (WHO, UNICEF) involved in implementing polio eradication strategies in the area.

  Similarly, evidence from entities and areas which are not member states of WHO should be sought and assembled from independent experts and mediators which are acceptable to the GCC and in regular contact with such entities, such as through personal contacts of RCC members or through international NGOs or health agencies working internationally.

- The GCC notes that the GCC declaration on the eradication of WPV2 will need to be carefully worded, particularly as it will be publicized and shared with the media. The public may not easily understand the difference between WPV2 and cVDPV2 and may be confused, especially if cVDPV2 cases should continue to be reported throughout 2014. The publication of the declaration will need to be accompanied by well worked-out information and 'Questions and Answers' materials.

3 Milestones towards WPV2 containment to be reached before the GCC declaration on WPV2

- The globally synchronized withdrawal of OPV2, expected to occur earliest by the first quarter of 2016, will be followed by a rapid increase in susceptibility of new birth cohorts to poliovirus type 2 infection; a key measure to mitigate the associated risk will be to provide the option to all OPV-using countries to introduce at least one dose of IPV (inactivated polio vaccine) into their routine immunization schedule.

- However, the removal of OPV2 several years before the eventual cessation of all live oral poliovaccines (type 1 and 3) will also increase the risk associated with the continued storage and use of WPV2 and Sabin 2 virus in laboratories and vaccine production sites using WPV and Sabin virus to manufacture IPV.

- To implement the withdrawal of OPV2 while minimizing the risks associated with continued storage of WPV2 in facilities, key elements of the bio-containment strategy for WPV2 will need to be initiated and accomplished earlier than was planned so far.

- It is urgent to consider and address the implications of OPV2 withdrawal for WPV2 containment and to align the draft "Global Action Plan III for poliovirus containment in facilities (GAP III)".
- The GCC, together with RCCs and supported by NCCs, national poliovirus containment task forces and Ministries of Health, will oversee progress towards the following two poliovirus containment milestones which should be reached before formal declaration on the absence of WPV2 is made:
  - the completion, in all countries globally, of Phase 1 containment activities, i.e. the identification and creation of an inventory of all laboratories and facilities storing WPV2/WPV infectious and potentially infectious material; and
  - either the destruction of unneeded WPV2 materials (or of all WPV materials in case WPV2 cannot be clearly identified), or, if material is to be retained, the 'safe handling' of WPV2/WPV material by transfer into storage at an appropriate biosafety level.

4 Completing containment Phase 1 and containment of WPV2 material

- The GCC notes that considerable efforts remain to complete the containment-related milestones. Phase 1 containment activities in India, the last remaining country in SEAR to accomplish this milestone, are likely to be completed by the end of 2013, in time for the anticipated polio-free certification of the Region at the end of March 2014. However, a major effort to complete Phase 1 containment activities will still be needed in the African Region where 33 of 46 member states (72%) still need to initiate this activity.
- Also, activities to either destroy WPV2 material or transfer it into storage at a higher bio-safety level can only be initiated as inventories are completed and all facilities holding WPV / WPV2 material have been identified.
- WHO will need to prepare for this by working with member states, as soon as possible, to review and possibly adjust or develop relevant national policy for retaining WPV infectious materials, and to establish roles and responsibilities for overseeing risk management in facilities retaining WPV/WPV2 materials.
- Discussions with national authorities and facilities holding WPV/WPV2 infectious materials should follow to determine the fate of these materials, requesting the destruction of all materials for which retention cannot be officially approved.
- In view of the implications for laboratories deciding to retain WPV2 materials, the heads of any such facilities should be requested to provide official statements, through their national authorities to WHO to guarantee that their institution accepts and agrees to manage these risks, considering all implications and consequences of WPV2 use / handling or retention.
  - Because of the substantial financial implications of increasing BSL levels in vaccine production sites, and addressing the consequences of any accidental or intentional release, written statements of intention to retain and work with these materials should be provided from the top management (CEOs) of the parent company of vaccine producers which manufacture IPV from WPV.
- Technical capacity to implement and verify appropriate containment measures, must be urgently addressed by WHO.

5 Timeline to prepare for GCC declaration on the absence of WPV2

- The GCC suggests that, in order to complete all necessary preparations in time before a declaration on WPV2 at the end of 2014, WHO should draw up a timeline of work specifying

when key activities should be accomplished and who should be involved in implementing these.

- The most urgent activities, all to begin in early 2014, with an initial estimate of when they should be implemented / completed, are:
  - drafting and sending of a communication, on the last identified WPV2, from WHO RDs to Ministers of Health of each member state, targeting a response rate of at least 80% by mid-2014;
  - training and technical support for containment in > 30 African countries, to finalize Phase 1 (survey and inventory) activities in all remaining countries by the 3rd quarter of 2014;
  - initiating dialogue with and between national regulatory authorities and heads of laboratories and other facilities, including vaccine manufacturing plants, which currently hold WPV/WPV2 materials, on the planned fate of such materials.

6 Implications of 'silent' WPV1 transmission in Israel

- The GCC notes the report from Israel, where wide-spread and prolonged WPV1 transmission has been detected through environmental surveillance, without the reporting of paralytic polio cases. The GCC discussed the significance and possible implications of this episode for the certification status of the country and of the WHO European Region.
- The event in Israel highlights the potential risks of silent WPV1 circulation in a fully IPV-immunized community, and the importance of OPV in conferring intestinal immunity to maintain sufficient levels of population immunity to stop and prevent WPV transmission. It also serves as a reminder that countries planning to introduce IPV into their routine immunization schedule should carefully consider the benefit of maintaining OPV in a sequential or combination schedule.
- The GCC advises that the situation in Israel should be considered a polio oubreak. The detection and circulation of wild or circulating vaccine-derived poliovirus in a polio-free country or area, whether from human or non-human sources such as a sewage sample, is an outbreak which compromises eradication and which should trigger the same rigorous response activities, regardless of the source from which virus is isolated.
- Of note, many of the existing relevant WHO guidelines and guidance on responding to polio outbreaks, including WHA resolution 59.1, define outbreak scenarios based on WPV-associated paralytic cases identified through AFP surveillance and do not mention findings from environmental surveillance. The GCC suggests that WHO revise existing outbreak response guidelines accordingly, and should seek opportunities to explain and highlight the issue at a higher level, possibly using the WHA discussion on polio in 2014.
- In terms of the persistent WPV1 detection in Israel since February 2013 (notified in May 2013), and its potential implications for the polio-free certification status of the European Region, the GCC refers to its decision of 2005 on importations (9th GCC meeting). Under that decision, countries with importations that persist for less than 12 months should – once the imported virus has been interrupted – submit appropriate documentation to maintain their certification status; countries with re-established poliovirus transmission (i.e. for >12 months) may have their certification status revoked and will at a minimum be required to resubmit full national certification documentation to regain or maintain their certification status.

  The GCC suggests that in early 2014 the European Regional Certification Commission review the status of poliovirus transmission in Israel and the impact of response activities to date, inform national authorities and EURO on the potential implications for the Region's certification status (i.e. whether that status will be maintained, suspended or revoked), and of

the planned process and documentation that would be required should the country's certification status need to be suspended or revoked.

- The GCC agrees, exceptionally, with the proposition of the Chair of the European RCC that as Israel is not situated within continental Europe and does not have a contiguous border with any EUR country, the re-establishment of transmission in that country would affect the certification status of only the country itself rather than the entire European Region.
- The question of when, and based on which type of environmental surveillance results (distribution of env. surveillance sites, frequency of sampling etc.), WPV1 circulation can reliably be considered as interrupted should be reviewed and assessed carefully by experts**.**

7 Role of environmental surveillance for poliovirus and interpretation of results

- The GCC notes the increasingly important role played by environmental surveillance within the GPEI. This is illustrated by the very useful information generated by the expanding environmental surveillance networks in the remaining polio-endemic countries, and highlighted also by the recent detection of wide-spread 'silent' WPV1 circulation in Israel.
- The GCC notes that, as outlined in the 2013-2018 GPEI Strategic Plan, environmental surveillance will continue to play a crucial in reaching the Plan's objectives:
  - to increase the sensitivity of surveillance in monitoring progress towards interruption of transmission in the remaining endemic countries (objective 1),
  - to monitor the successful achievement of objective 2, in particular to assure that persistent cVDVP transmission has stopped before the 'tOPV to bOPV' switch is implemented, and
  - to monitor the effectiveness of containment (objective 3) of PVs in those laboratories and facilities which will be allowed to continue to store poliovirus infectious materials.
- Environmental sampling is an excellent supplement to AFP surveillance, which can, with technically adequate implementation and proper interpretation of results, considerably increase the sensitivity of surveillance to detect circulating polioviruses.
- The GCC emphasizes that the detection of wild or circulating vaccine-derived poliovirus in a polio-free country or area anywhere, whether from human or non-human sources such as from a sewage sample, compromises eradication and should trigger the same rigorous response activities. On the other hand, negative environmental surveillance results must be interpreted with caution, and may not allow to reliably rule out PV transmission.
- Environmental surveillance for poliovirus continues to be very resource- and labor-intensive and its use should remain reserved for the most critical settings requiring increased surveillance sensitivity. It should not be considered as a replacement for low-performing AFP surveillance, which has to remain the 'gold standard' surveillance methodology.

8 Regional Commission for the verification of polio-free status in the Americas

- The GCC is pleased to note the recent appointment, by the Regional Director of the WHO Region of the Americas (PAHO), of Dr Arlene King as the Chairperson of the re-established Regional Commission for the Verification of Polio-free Status in the Region of the Americas.
- It is hoped that this appointment will soon be followed by the identification and designation of Commission members, as well as the designation of a certification focal point in the PAHO office.
- The re-establishment of a Regional Commission in the Americas at this point in time will greatly facilitate input from global and regional polio certification groups towards progress of

the polio endgame, including preparations for a globally representative GCC declaration on the absence of wild poliovirus type 2.

9 Polio vaccination requirements for travellers to and from polio-endemic and polio-infected areas

- The GCC notes with concern that major outbreaks have occurred in 2013 in previously polio-free countries and areas. Large multi-country outbreak response activities again require considerable attention, as well as vaccine, financial and human resources, which ideally should be directed at interrupting transmission in the endemic countries.
- Through their certification work with RCCs and NCCs, members of the core GCC are aware of requests from many polio-free countries for WHO to work on establishing, through the IHR, requirements for travellers from polio-endemic and polio-infected countries and areas to be fully vaccinated before leaving, in order to decrease the risk of WPV importation into polio-free countries and areas.
- The GCC notes WHO's advice, in its 'International Travel and Health' publication, on polio immunization for travellers to and from infected areas, both to protect travellers to endemic areas and to reduce the probability of virus importation into polio-free areas. Health authorities and health professionals in polio-free countries should assure that travellers to infected areas are fully vaccinated before leaving. This advice is in the best interests of the traveller and more likely to be followed than the advice for pre-travel vaccination of persons leaving endemic countries and areas.
- The GCC recommends that WHO consider to establish standard vaccination requirements, through the IHR, for persons traveling from polio-endemic and infected areas, as soon as possible.

10 GCC membership issues and secretarial support for certification in WHO Regional Offices and HQ

- The GCC appreciates the efforts made by WHO, following the GCC recommendation at its 2012 meeting, to designate 'certification focal' points with enough time to provide efficient secretariat services to Regional and Global certification groups.
- Of note, new certification focal points have been appointed, or re-designated over the last 12 months in EMRO, SEARO, WPRO and EURO, with a new focal point to be designated soon in AFRO. The GCC trusts that a focal point will soon be appointed in AFRO and also in the Regional of the Americas, to support the Commissions in both Regions.
- It is also hoped that certification focal points will be able to devote as much time as needed (i.e. 50% of their time or more) in support of their respective Commissions and of certification activities in their Region.

11 Report from the African Regional Certification Commission (A-RCC)

The report from the RCC-AFR was provided by Dr Mbaye Salla, certification focal point in the polio team of AFRO.

Current polio epidemiology in the African Region

Dr Salla outlined the current epidemiology of polio in the Region, highlighting that WPV type 3 had last been detected more than one year ago in Nigeria (last WPV3 case with onset on 12 Nov., 2012), and that WPV1 transmission in Nigeria had been intense in all of Northern Nigeria in 2012 while cases this year are found largely in North-Eastern and North-Central Nigeria, without no cases reported from the North-West this year.

Two countries of the Region - Kenya and Ethiopia, had reported cases as part of the Horn of Africa outbreak and had participated in synchronized outbreak response immunization.

While the genetic diversity of WPV1 in Nigeria appeared to be declining this year compared to last year, a new outbreak of WPV1 had recently been reported from Cameroon (4 WPV1 cases reported as of the time of this meeting). The outbreak was due to an 'orphan virus' originally from Chad, with evidence of at least 2 1/2 years of silent transmission somewhere in the sub-Region.

The three countries which had previously been considered as having 're-established transmission' - Angola, DR Congo and Chad - have now been polio-free for at least 17 months (Chad) or longer.

Environmental surveillance had been established in Nigeria since 2011, and had been extended to currently 5 states and the federal capital territory (FACT); the method has just been introduced in Kenya (first samples taken in Nairobi), and will also be implemented in Angola.

Main remaining risks faced by the GPEI in Africa were

- the failure to access and vaccinate children in infected insecure areas (such as North-East Nigeria and Central African Republic), as well as continued problems to reach sufficient SIA quality in infected areas, and
- the risk of outbreaks following importation in areas with sub-optimal population immunity; in many areas this risk was compounded by gaps in surveillance quality which may lead to late detection of transmission.

Dr Salla noted that currently available records at AFRO indicate that the most recent WPV2-associated polio case in the Region had been reported in 1998; however, the case had not been properly documented.

Update on activities of the African Regional Certification Commission

The African Regional Certification Commission (ARCC) has resumed its work with a regular annual meeting in Addis Ababa in October 2013, following an earlier meeting in Brazzaville to brief new Commission members; the Commission currently has 17 members.

Current status of review of country documentation in AFR is that the Commission has 'accepted' final national documentation from 25 member states; 12 of the 25 countries experienced outbreaks after their documentation was accepted.

Eighteen AFR member states remain which have so far not presented final documentation to the ARCC.

The A-RCC, at its meeting in October, established a work plan for 2014, including to select countries for which the final documentation of polio-free status will be reviewed.

There will be meetings of the A-RCC in May and October 2014. The May meeting will be used to review 'expanded' update reports from countries which had experienced importations following the earlier acceptance of their national documentation, and selected other country documentations will be reviewed in October.

A detailed time plan was also made for 'reviving' or establishing National Task Forces (NTFs) for poliovirus containment, in order to complete Phase 1 (survey and inventory) by the end of 2014.

Of 46 AFR member states, 13 countries completed Phase 1 containment (from 2003 to 2012). In addition to re-establishing NTFs and completion of Phase 1, countries where Phase 1 has already been conducted will need to update their lab inventories, and internal validation exercises are planned to assess the quality of Phase 1 work; external validation will be done for priority countries, such as those affected by recent transmission or those with a large number of labs / facilities.

12 Report from the Eastern Mediterranean RCC

Dr. Yagoub Al-Mazrou presented an update on the current polio situation and on activities of the Eastern Mediterranean Regional Certification Commission (EM-RCC).

Current polio epidemiology in the Eastern Mediterranean Region

Dr Al-Mazrou characterized the current polio situation in the Region as an 'escalating polio emergency'; as of end-October, 75% of polio cases globally in 2013 had been reported from the EMR, largely due to the large Horn-of-Africa outbreak (centred on Somalia), with a new outbreak recently reported from Syria.

Of the remaining two 'endemic' countries in the Region, progress is reported from Afghanistan where the main previously endemic south-eastern Region (Kandahar / Helmand) has not reported wild poliovirus for more than one year. The 8 cases reported from AFG this year have all occurred across the border from the hyper-endemic areas of north-western Pakistan and were genetically characterized as repeat importations.

While the extent of WPV1 transmission in Pakistan has decreased in 2013 compared to previously, the number of cases reported largely from a few hyper-endemic districts and 'tribal areas' in the north-west is now higher than at the same time last year.

While the outbreaks caused a 3-fold increase in the number of cases reported from the Region from 2012 to as of now in 2013, 19 countries of the Region remain polio-free. Also, the outbreak in Somalia and the Horn of Africa is likely to soon be controlled.

However, a multi-country response to the new outbreak reported from an opposition-controlled area in Syria has just begun. Given the large-scale population movements in countries of the sub-Region, large-scale response SIAs will be conducted in 6 neighbouring countries (Jordan, Iraq, Lebanon, Palestine, Egypt, Turkey) in addition to Syria. Special attention has been given to establish central coordination and systematic operations management to assure high-quality, synchronized activities in response to the 'middle east outbreak'.

Strategic priorities towards interrupting transmission in the Region will be to enhance access to children in conflict-affected areas of Pakistan and Somalia, to stop on-going outbreaks in Syria and Somalia, and to reduce vulnerability in the middle East and countries of the Horn of Africa.

Update on activities of the Eastern Mediterranean Regional Certification Commission

The EM-RCC, at their recent meeting in Tunis, discussed the role of the RCC during the polio endgame, particularly vis-à-vis other regional and country-level polio advisory groups.

The group also discussed whether or not there continued to be a need for a Regional Technical Advisory Group on Polio Eradication - a group which had existed but was dissolved a few years ago, as well as what the distribution of roles and responsibilities should be between regional and country level TAGs and certification bodies, as well as between the RCC and R-TAGs on the one hand, and the NCCs, and national immunization TAGs (NI-TAGs) on the other hand.

It would be important to coordinate activities of advisory groups well in order to assure a clear distribution of roles to effectively support progress towards all 4 polio endgame objectives.

13 Report from the European RCC

The EU-RCC currently has 6 members, with one new member to be appointed. The Commission conducted its 27th annual meeting from 30 to 31 May, 2013; extraordinary meeting are conducted when necessary, and there is regular interaction between the secretariat and the RCC throughout the year between meetings.

Main outcomes of the 27th RCC meeting were to note that the quality and sensitivity of surveillance for poliovirus in the Region and the functionality of NCCs has further declined, with an increasing number of countries not submitting annual updates at all, or sending incomplete or late reports. NCCs are no longer in existence in some member states.

The EU-RCC reviews regularly conducted risk assessments by country, based on the estimated population immunity and quality of surveillance for poliovirus to estimate the risk of transmission should WPV be imported. For 2013, the risk of transmission following importation was estimated as high for Ukraine, Romania, Bosnia + Herzegovina, and Georgia. The WHO EURO team, in coordination with the RCC, has further developed the risk assessment methodology, which has recently been published in the journal Nature (29 Oct, 2013).

With increasing time after regional certification, it has been difficult to maintain fully functional NCCs in some countries - thus, NCCs no longer exist in Croatia, Hungary and Italy and are not sufficiently supportive and active in other countries.

The EU-RCC reported on several key activities conducted in member states to mitigate and reduce risk, particularly in countries deemed at high risk of transmission following importation. These activities included sub-national SIAs or NIDs, full EPI programme reviews (Ukraine, 2012), field and 'desk' reviews of surveillance quality, training of AFP surveillance and other capacity building activities, as well as two large 'polio outbreak simulation exercises' (POSE), with participation of multiple countries.

14 Report from the South-East Asian RCC

The 6th meeting of the SEA-RCC, conducted just before the GCC meeting, was attended by all SEA-RCC members, by NCC chairs, members and NPSP staff from India, and NCC chairs and members from DPR Korea and Timor-Leste. Also participating were WHO staff from SEARO and WHO polio certification focal points from AFRO, WPRO and HQ.

The two previous meetings of the SEA-RCC this year had focused on reviewing national documentation from Block 1 and Block 2 states in India - low and medium risk states. Main focus of this third SEA-RCC meeting in 2013 was the final presentation by the India NCC of detailed national documentation covering 'Block 3' - the previous highest risk areas of India Bihar, Delhi, Uttar Pradesh and West Bengal.

The team from India also provided a detailed update presentation on progress towards finalizing Phase 1 of wild PV containment - which is used to assemble a complete inventory of all laboratories and other facilities (i.e. vaccine production sites) storing wild PV infectious or potentially infectious materials.

The series of presentations from India were critically important as the final piece of evidence for the SEA-RCC in anticipation of the possible polio-free certification of the Region in March 2014; India is the only remaining country in the Region for which the SEA-RCC has not yet accepted national polio-free documentation.

The detailed presentations on 'Block 3' states were very well received by the SEA-RCC who noted that the national programme has been very successful in maintaining polio-free status of the entire country through excellent AFP surveillance and laboratory networks, and high coverage from SIAs. The SEA-RCC has concluded that the India AFP surveillance network in Block 3 states is capable of reliably detecting polio viruses (WPVs and VDPVs) and that there is no circulating WPV in Block 3 states. The SEA-RCC congratulated the entire India team for this success.

The coordinator of the National Containment Task Force, Dr Jagdish Deshpande, reported that significant progress has been made to prepare the “National Inventory of laboratories storing WPV/ potentially infectious materials”. The National Task Force estimates that the report on

Phase I containment activities and the final inventory should be completed before regional polio-free certification, envisioned for end-March 2014.

(THIS INFORMATION WAS UPDATED IN EARLY FEBRUARY 2014) A total of 71,469 laboratories were surveyed. This included a wide variety of laboratories, including laboratories of the Indian C... of Medical Research, of the Department of Biotechnology, the Council for Scientific and Industrial Research, the Ministry of Defence, as well as all polio vaccine manufacturers. The survey also included laboratories of other organized sectors (Railways, Employee State Insurance laboratories) and of large autonomous organizations (AIIMS, Post-Graduate Institutes, as well as of the Health Ministry, and also all poliovirus testing laboratories. The list also included all medical college hospitals, large nursing homes, diagnostic laboratories, Primary Health Centres, and pharmaceutical companies.

Based on the survey, nearly 120 laboratories were identified to be 'at risk' of holding infectious or potentially infectious wild poliovirus material. Field visits were made to all at-risk laboratories for on-site validation of information.

Field validation visits further narrowed the group of 'at risk' laboratories to 48. Of these, only one laboratory - the Enterovirus Research Center (ERC) of the Indian Council for Medical Research (ICMR) stores wild poliovirus, while 47 laboratories have potential poliovirus infectious material (faecal samples, enterovirus isolates and throat swabs).

Thus, as of early February 2014, only one laboratory - the ERC ICMR Mumbai - has been identified as possessing Wild Poliovirus isolates and clinical samples, while 47 other laboratories were identified as storing potentially infectious material.

Annual updates from other eight countries including the most recent progress of the programme in 2013 were also reviewed by the RCC. Main overall findings of the SEA-RCC at the 6th meeting were that five SEAR countries - Bangladesh, India, Indonesia, Myanmar and Nepal - have been maintaining the required level of performance of both AFP surveillance and immunization coverage at the national level; however, all countries have sub-national areas where programme performance is sub-optimal.

Six other countries with small population size have challenges to meet the standards. Indonesia, Myanmar and Timor-Leste are considered as high risk for polio importation based on the programme performance at sub-national level.

In terms of progress towards eventual containment of polioviruses, 10 of 11 countries in the Region have conducted their phase-1 laboratory containment activities and have submitted documentation. Phase 1 is in process in India, and re-surveys are currently underway in Bangladesh and Myanmar.

As of now, no laboratory in the Region - except for the ERC ICMR Mumbai, India - has reported storing WPV or WPV infectious materials. One lab reported storing polio-bulk for vaccine manufacturing (Indonesia), and nine labs reported storing environmental specimens for research projects, with detailed reports still expected on these labs.

Main risk assessment and risk mitigation activities in the Region during 2012 to 2013 have included the conduct of risk assessment and identification of high risk areas for intervention in each country. All countries have also implemented intensified routine immunization activities, targeting low coverage areas. Polio SIAs were conducted in Bangladesh, India, Myanmar, Nepal and in Thailand, with reported coverage > 90%.

Field reviews of the EPI and EPI target disease surveillance were conducted in Bangladesh, Bhutan, India, Indonesia, and the Maldives. An Inter-Regional meeting between SEAR and WPR was held in July 2013, to strengthen cross border collaboration and coordinated risk mitigation.

The Regional Commission considers the following to be the main achievements in its work during 2013:

- the conduct of the 5th & 6th meeting of SEA-RCCPE held in March & November 2013,
- missions of RCC members were conducted to nine countries in the Region to advocate for improved polio immunization and surveillance activities;
- submission of annual updates on maintenance of polio-free status of the National documentations and are reviewed by the RCC;
- and significant progress achieved towards completion of laboratory containment Phase 1 in India.

The calendar of certification-related activities for 2014 will include:

- by end-January, 2014, all countries should have completed and submitted their national documentation;
- from 26-27 March 2014, the 7th meeting of the SEA-RCCPE will be conducted at WHO SEARO in New Delhi; all NCCPE chairs will present their 2013 annual updates on the first day, followed by the SEA-RCC decision on the SEAR polio-free declaration and a ceremony of regional certification on the second day.

15 Report from the Western Pacific RCC

The Region was certified polio-free in 2000, following the last indigenous WPV1 case in 1997, in Cambodia. The last known WPV2 case in the Region was reported in China in 1989. Since the certification of the Region, there have been 3 episodes of WPV1 importations from endemic countries into polio-free countries of the Region, including 2 from Pakistan (into Australia and China), and one from Nigeria (into Singapore).

Highlight of the 18th WP-RCC meeting in November of 2012 in China was the RCC's declaration that, following the successful response to the WPV1 outbreak in Xingjian, China, the Region had been free of circulating WPV for the past 12 months and was retaining it's polio-free certification status. The Commission also applauded the NCCs for maintaining their commitment, even 13 years after regional certification.

At the 19th WP-RCC meeting, the Commission commended all countries and areas on their regular and comprehensive annual update reports, which included a section with the identification of current risks, with risk assessments conducted at the first sub-national administrative level.

The Commission noted that sub-national gaps in assessed immunity levels and in the quality of surveillance had persisted from the previous assessment period, without significant improvement, and requested that the secretariat conduct sub-regional risk assessment twice a year for priority countries, and once a year for other countries. Countries should place emphasis on planning and implementing specific mitigation activities in response to the identified gaps and weaknesses.

Phase 1 of poliovirus containment (i.e. survey and inventory) was completed between 1999 and 2008. Of > 77.000 facilities and labs checked, 45 facilities in four countries (Australia, China, Japan and the Republic of Korea) had retained WPV materials.

The RCC noted several key threats to maintaining polio-free status in the Region:

- the ease with which long-distance importations of WPV continue to occur elsewhere(2013: Pakistan origin virus into the Middle East, and Nigeria origin virus into the Horn of Africa),
- the increasing contact with persons from polio-affected countries, including through foreign and overseas workers, religious pilgrims, medical tourists and UN peace-keeping forces,
- the continued lack of political interest in the polio programme in member states, and insufficient allocation of resources.

Priorities for the WP-RCC will be to maintain sufficient preparedness for possible importations through updating outbreak preparedness and response plans in all member states, to request updated lab inventories to initiate containment Phase II, and work with NCCs to play an active role in the endgame, through advocacy efforts at the national level.

ANNEX I: Agenda of 4th core GCC meeting, Kathmandu

4th MEETING OF CHAIRPERSONS OF REGIONAL COMMISSIONS FOR THE CERTIFICATION OF POLIO ERADICATION ('CORE GCC')

Kathmandu, Nepal, 28 November, 2013

AGENDA

Thursday, 28 November, 2013

8:30 - 8:45	Welcome and introduction *chair*	*GCC*
8:45 - 9:15	The 2013-18 Global Strategic Plan and status of preparations for OPV2 withdrawal and IPV introduction	*WHO*
9:15 – 10:30	*GCC declaration on the absence of wild poliovirus type 2 globally* - Role of NCCs and RCCs in preparing and validating the declaration - Evidence and statements to be provided by each country	
10:30 - 11:00	COFFEE BREAK	
11:00 - 11:15	Current status of poliovirus containment and implications of the endgame and OPV2 withdrawal	*WHO*
11:15 - 12:00	GCC discussion: GCC declaration on global absence of wild PV type 2	
12:00 - 13:00	LUNCH	
13:00 - 15:00	Presentations from RCCs (10-15 minutes each plus 5 min for discussion). EUR / WPR / SEAR / AFR / EMR *chairs*	*RCC*
15:00 - 15:30	COFFEE BREAK	
15:30 - 16:00	Implications of WPV1 transmission in Israel for GPEI / certification	*WHO*
16:00 – 17:00	Final discussion and main decisions of core GCC, next meeting dates, and closing *Chair*	*GCC*