

SEA-Immun-107  
Distribution: General

# South-East Asia Regional Certification Commission for Polio Eradication (SEA-RCCPE)

*Report of the Eighth Meeting  
Bali, Indonesia, 22–24 September 2015*

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Printed in India



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## Acronyms

AFP	acute flaccid paralysis
CCS	containment certification scheme
EPI	expanded programme on immunization
EV	environmental surveillance
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
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IPV	inactivated poliovirus vaccine
s-IPV	Sabin IPV
ITAG	Immunization Technical Advisory Group
MR	measles rubella vaccine
NAC	national authority for containment
NCCPE	National Certification Committees for Polio Eradication
NID	national immunization day
OPV	oral poliovirus vaccine
OPV3	3rd dose OPV
bOPV	bivalent oral poliovirus vaccine
tOPV	trivalent oral poliovirus vaccine
PEF	poliovirus essential facility

PV2	poliovirus type 2
RCC	Regional Certification Commission
SAGE	Strategic Advisory Group of Experts on Immunization
SEAR	South-East Asia Region
SEA-RCCPE	South-East Asia Regional Certification Commission for Polio Eradication
SIA	supplementary immunization activities
SNIDs	subnational immunization days
SOP	standard operating procedures
TOR	terms of reference
UNICEF	United Nations Children's Fund
VDPV	vaccine-derived poliovirus
cVDPV1	circulating vaccine-derived polioviruses type 1
cVDPV2	circulating vaccine-derived polioviruses type 2
VPD	vaccine preventable diseases
WHA	World Health Assembly
WHO	World Health Organization
WPV2	wild poliovirus type



## 1. Introduction

All 11 countries of the World Health Organization (WHO) South-East Asia Region (SEAR) were certified as polio free by the South-East Asia Regional Certification Commission for Polio Eradication (SEA-RCCPE) on 27 March 2014. In view of the continued risk of wild poliovirus importation from an infected area or country, it was recommended that the SEA-RCCPE and National Certification Committees for Polio Eradication (NCCPEs) should remain active until global certification, in order to assist countries in the Region to remain polio free and maintain preparedness for importations. In addition, the SEA-RCCPE oversight functions also remain critical in the framework of the global 'Polio Eradication and Endgame Strategic Plan 2013–2018' (Endgame Plan) in which 'certification and containment' is one of the four key objectives.

In this context, the eighth SEA-RCCPE meeting was held in Bali, Indonesia, from 22 to 24 September 2015, with the following specific objectives.

- (1) To review updated reports from each Member State on maintaining polio-free status, including poliovirus laboratory containment, since the regional certification in March 2014 and as per requirements of the 'Polio Eradication and Endgame Strategic Plan 2013–2018'.
- (2) To review implementation status of the recommendations made at the seventh meeting of the SEA-RCCPE.
- (3) To review national and regional risk assessments in order to highlight gaps in the levels of immunity and the quality of surveillance at national and subnational levels.
- (4) To review evidence from all Member States that wild poliovirus type 2 has been interrupted in all countries for

more than 10 years and report findings and recommendations to the Global Certification Commission (GCC).

- (5) To update the GCC on the South-East Asia regional polio-free certification status.

## **2. Global progress in polio eradication and implementation of the Endgame Plan**

### **2.1 Wild poliovirus transmission**

As of 15 September 2015, 41 cases of paralytic polio due to wild poliovirus had been reported globally in the year, compared with 178 for the same period in 2014. All the cases were reported from Afghanistan and Pakistan and were caused by wild poliovirus type 1. Wild poliovirus type 3 has not been detected globally since November 2012.

On 20 September 2015, the GCC declared global eradication of wild poliovirus type 2 (WPV2). Of 194 WHO Member States, responses were received from 189 countries (97%) on their last WPV2. Information from the regional and global polio laboratory networks that included data for the nonresponding Member States (Bolivia, Guatemala, Italy, Libya and San Marino) provided additional evidence. The evidence reviewed confirmed that no endemic WPV2 has been reported worldwide since the last case was detected in northern India in October 1999; this is despite substantial improvements in acute flaccid paralysis (AFP) surveillance and expansion of environmental surveillance globally since that time.

In Pakistan, 32 cases were reported up until 15 September 2015, compared with 145 cases for the same period in 2014. In Afghanistan, eight cases were reported in 2015 compared with nine cases for the same period in 2014. In Afghanistan and Pakistan, the interruption of wild poliovirus transmission depends on filling chronic gaps in strategy

implementation and being able to vaccinate children in infected areas that have been difficult to access owing to insecurity.

In Nigeria, no case due to wild poliovirus type 1 has occurred since 24 July 2014; as a result, Nigeria was officially removed from the list of endemic countries on 25 September 2015.

## **2.2 Circulating vaccine-derived polioviruses type 1 (cVDPV1)**

In 2015, in Madagascar, nine new cases of a cVDPV1 were reported, genetically linked to isolates of the same strain first detected in 2014. In Ukraine, two cases were reported, with onset of paralysis on 30 June 2015 and 7 July 2015. In Madagascar, national efforts continue to be intensified to stop the prolonged circulation. In Ukraine, an outbreak response is still awaited.

## **2.3 Circulating vaccine-derived polioviruses type 2 (cVDPV2)**

It is crucial that all cVDPV2 outbreaks are stopped ahead of the planned removal of the type 2 component in oral polio vaccine in April 2016. In Nigeria, one case of disease due to cVDPV2 was reported, with onset of paralysis on 16 May 2015, related to a strain first isolated from environmental samples in August 2014. In Guinea, one case due to cVDPV2 was detected with onset of paralysis on 20 July 2015, related to a strain last detected in the country in August 2014. In Nigeria, the outbreak response is part of the national emergency action plan, overseen by the office of the President. In Guinea and border areas of Mali, outbreak response was initiated within 2 weeks of confirmation of the outbreak. A strain isolated from a case with onset of paralysis in April 2015, detected in South Sudan, is being considered as a circulating strain (cVDPV2), which poses a risk of further spread in the conflict-affected areas. Response activities are ongoing and the strain has not been detected since April 2015.

## **2.4 Polio outbreak preparedness and response**

As endemic wild poliovirus transmission is at an all-time low, it is increasingly important that new poliovirus outbreaks, whether related to poliovirus importations or the emergence of vaccine-derived poliovirus, be responded to as rapidly as possible with large-scale response immunization activities of high quality. In this context, new outbreak response Standard Operating Procedures (SOPs) have recently been elaborated, which include new performance standards and provide more detailed advice than previously existing guidelines on how governments and partners in the Global Polio Eradication Initiative (GPEI) should collaborate to assure effective outbreak response. In addition, a protocol for notification and response to type 2 poliovirus outbreaks in the era following cessation of type 2 OPV has been endorsed by the WHO Strategic Advisory Group of Experts on Immunization (SAGE).

The new SOPs outline a number of main strategies and critical functions to be employed jointly by national governments and GPEI partners to rapidly interrupt new outbreaks; the new SOPs were endorsed in the Sixty-eighth World Health Assembly resolution on polio eradication in 2015. The level of preparedness to respond to new outbreaks in polio-free countries is one of the important parameters overseen by Regional Certification Commissions (RCCs) in their work to maintain the polio-free status in the Region. The systematic approach and key elements of the new outbreak SOPs and the protocol for detection and response to type 2 poliovirus in the post OPV type 2 cessation era should be incorporated into the national outbreak preparedness plans.

## **2.5 Switch from trivalent oral poliovirus vaccine (tOPV) to bivalent OPV (bOPV)**

The SAGE Polio Working Group met recently to review preparations for the planned tOPV-bOPV switch, in particular the progress towards interrupting transmission of persistent cVDPV2 in Nigeria and Pakistan.

Substantial progress is being made towards the introduction of one dose of inactivated poliovirus vaccine (IPV) into the routine immunization programme of all countries not already using IPV, and towards the switch in April 2016, when tOPV will be replaced with bOPV for routine immunization in 156 OPV-using countries.

The Working Group decided to recommend to SAGE that the 'switch' should proceed in April 2016, while Pakistan should increase the pre-switch use of tOPV during supplementary immunization activities (SIAs), and the recently detected cVDPV2 outbreaks in Guinea (Mali) and South Sudan should be stopped as an urgent priority.

## 2.6 Poliovirus laboratory containment

Poliovirus containment is one of the five readiness criteria for the tOPV to bOPV switch. Poliovirus containment activities, described in 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)* and endorsed by the World Health Assembly in May 2015, address the risk of release and transmission of poliovirus from facilities. Of current relevance are the following.

- Phase I: reduction in the number of facilities handling or storing poliovirus type 2 (PV2), involving identification of facilities and destruction of unneeded PV2 materials and designation of poliovirus-essential facilities (PEF) planning to retain PV2 for critical international functions.
- Phase II: appropriate containment of PV2 in PEFs and certification of containment.

Although the number of designated PEFs that will retain type 2 poliovirus materials is anticipated to be less than 50 in a limited number of countries, and the deadlines to meet GAPIII requirements are set for early 2016, it is anticipated that the full implementation of containment

requirements described in Phase II of GAPIII will take a significant additional amount of time.

The implementation of containment in PEFs will take considerable time because a number of facilities are not yet ready and need time and resources to meet the containment requirements described in GAPIII; there also is a need to develop national regulatory frameworks for containment in the host countries that do not yet have such regulations in place. In addition, there is a need for designation or identification of national authorities for containment (NACs) in each host country, as well as for the establishment of international expertise to help oversee and guide the certification of containment in PEFs. Interim risk management measures with interim certification of containment are proposed for Phase II, until full containment is implemented.

The roles and responsibilities of the GCC as the body responsible for confirmation of global containment are evolving. To perform these new tasks, GCC approved the plan to be guided by a working group of containment experts that would be nominated based on experience, knowledge and understanding of containment issues.

### **3. Regional update on maintaining polio-free status**

All 11 countries reported back on the 'last WPV2'; among them, seven never detected WPV2, while three countries reported their last WPV2 in 1993 (Sri Lanka, Thailand) and 1999 (India, this is the last reported WPV2 case globally).

Following regional certification in 2014, the NCCPEs were instructed to remain operational and begin to focus on activities towards keeping countries and the Region free of polio; the NCCPE terms of reference (TORs) are supposed to be updated accordingly. The RCCPE has updated its TORs to address the needs of the Endgame Plan, through 2018, and is currently concentrating on the readiness for OPV2 withdrawal.

The quality of AFP surveillance overall in 2014 was at the required level nationally in seven out of 11 countries, with non-polio AFP rates below 2/100 000 under 15 years only in Maldives, Myanmar, Sri Lanka and Timor-Leste. From January to September 2015, four countries (Bangladesh, India, Maldives and Nepal) had achieved an annualized non-polio AFP rate above the operational target at the time of the RCCPE meeting. Adequate stool sample rates are a challenge in countries with small populations (Bhutan, Maldives and Timor-Leste) as well as in Sri Lanka and Thailand. Combined expanded programme on immunization (EPI) and vaccine preventable disease (VPD) surveillance reviews were conducted in Thailand in November 2014 and Timor-Leste in March 2015. Upcoming reviews will be in Sri Lanka in November 2015 and Myanmar in 2016. Environmental surveillance (EV) for polioviruses is ongoing in Bangladesh, India and Indonesia and there is a plan to expand EV to Myanmar, Nepal, Thailand and Timor-Leste in 2016.

In June 2015, VDPV2 was detected in a child in Myanmar (AFP case, not immune-compromised), with no current evidence of circulation. Two tOPV subnational immunization days (SNIDs) in low routine immunization coverage areas, based on risk assessment at township level, are being considered. VDPV2 was detected in AFP cases and through environmental surveillance in India in 2014 and 2015; four of the VDPV2 isolates detected in 2015 were found in one sampling site in Punjab. Of those four VDPV2 isolates from one sampling site, three isolates were genetically linked, with epidemiological and virological evidence indicating that the source may have been a possibly immune-deficient individual. Follow-up samples from the same site have so far been negative. Response activities included a tOPV catch-up campaign in July 2015 for marginalized and migrant populations in the district concerned and all migrant populations and large townships in Punjab included for coverage with tOPV during the SNID in September 2015. Active case search for immunocompromised individuals in medical colleges/tertiary care centres in Punjab is implemented, with collection of two stool samples of all identified immunocompromised individuals from August 2015 onwards. Active AFP case search in communities was conducted by vaccination teams during the September SNID; active surveillance visits and sensitization of reporting sites are being

increased in Punjab; and a surveillance-cum-immunization review was carried out in September 2015. The frequency of sewage collection at the site has been increased from fortnightly to weekly.

Routine immunization is a concern in four countries: India, Indonesia, Myanmar and Timor-Leste. India continues to do multiple SIAs and routine immunization catch-up campaigns every year, and Timor-Leste targeted all children up to 15 years of age in the 2015 national immunization days (NIDs). Myanmar is planning two rounds of SNIDs in late 2015 or early 2016, and Indonesia will carry out an NID in March 2016.

IPV introduction in the context of OPV2 withdrawal is proceeding; six countries have introduced IPV (Bangladesh, Bhutan,, Democratic People's Republic of Korea, Maldives, Nepal and Sri Lanka), and four other countries (India, Myanmar, Thailand and Timor Leste) have plans to introduce IPV by December 2015. Indonesia was to introduce IPV in July 2016. Activities in preparation for the withdrawal of type 2 OPV are progressing well, and national switch plans are under finalization.

Polio outbreak preparedness and response plans were developed by all countries in 2013–2014, and adjustments in plans are to be made to align them to the new outbreak response SOPs. Simulation exercises were conducted in a few states of India in 2014–2015.

National poliovirus laboratory containment task forces are active in every country, with WHO currently visiting key countries to support completion of Phase I and preparations for Phase II. A regional workshop on containment for 11 National Containment Coordinators will be held in November 2015, and work is ongoing with polio laboratories of the WHO Global networks on the implementation of GAPIII requirements.

Regional WPV2 infectious/potentially infectious material has so far been consolidated in one facility in India. India and Indonesia will have designated PEFs, including laboratory and Sabin-IPV (s-IPV) production facilities. In India, potentially infectious material in 49 facilities was either



destroyed or transferred to only one PEF by end-2015. No other country reported WPV2 infectious materials but further survey work is ongoing for potentially infectious materials in countries with large research capacities.

## **4. Conclusions and recommendations**

At its eighth meeting, the SEA-RCCPE reviewed the progress reports from 10 countries and accepted nine of them. The report of the NCCPE of the Democratic People's Republic of Korea was submitted in November 2015 and an updated report was received from the Thailand NCCPE in 2016. Both reports were considered satisfactory and allowed the conclusion that the Region had remained free of wild poliovirus during the period reviewed.

### **4.1 General recommendations**

#### ***Maintaining polio-free status***

- The RCCPE received with pleasure the GCC declaration on indigenous WPV2 global eradication and thanked countries in the South-East Asia Region for their contribution and timely submission of respective evidence.
- The RCCPE commended the progress in Africa and the remaining endemic countries but noted continued wild poliovirus transmission in Afghanistan and Pakistan and new 2015 cVDPV outbreaks globally. This reaffirms the need for high-quality polio surveillance and immunization activities and importation/response preparedness in all countries in the Region.
- The RCCPE commended NCCPEs for their continued work and submission of progress reports. Considering continuation of NCCPE functions critical at least until global certification, the RCCPE encouraged to ensure adequate capacities and

expertise in NCCPEs to conduct “active” oversight, also beyond regular meetings.

- As highlighted before by the RCCPE, NCCPEs should be independent oversight bodies, and composition should be reviewed to avoid conflict of interest of NCCPE members being directly involved in polio programme implementation. All NCCPEs should ensure that their TORs are updated to the post-certification requirements; still with a focus on monitoring surveillance and immunization activities and polio outbreak preparedness and response.
- The RCCPE noted that the overall AFP surveillance quality in the Region has remained at acceptable levels. However, there seems an increasing risk of complacency and misconceptions after regional certification that activities are no longer required and a subsequent decrease in resources and shift of priorities. Decreasing and continued low AFP surveillance performances in some countries and/or subnational levels are of grave concern, especially in view of the high sensitivity required prior to and after the switch from tOPV to bOPV. As particularly complete and timely zero reporting and sharing of information on active surveillance outcomes is critical, electronic and web-based communication means should be used as applicable. Further specific recommendations are included in the country-specific sections.
- The RCCPE noted the regional environmental surveillance expansion plan to supplement AFP surveillance and its priorities as recommended by the SEAR Immunization Technical Advisory Group (ITAG) in June 2015, as such respective criteria should be carefully reviewed to determine which country requires EV surveillance. Otherwise capacities and resource should focus on strengthening AFP surveillance.
- The RCCPE noted the continued overall good performance of the regional polio laboratory network and appreciates its critical role to ensure that all countries have access to timely

testing at a WHO accredited laboratory – this includes addressing issues with reliable and timely shipment. The RCCPE noted that well-performing polio laboratories in the Region have, in 2015, been accredited based on information provided by laboratories in the accreditation checklists as per policies of the Global Polio Laboratory Network. It is also noted that accreditation visits are planned to selected laboratories based on review of accreditation checklists and past performance.

- The RCCPE noted the identification of VDPV2 in AFP cases in India and Myanmar as well as in sewage samples in India during the period 2014–2015; none of them were circulating VDPVs. The RCCPE concluded that investigations and responses were carried out appropriately, as per current guidelines.
- The RCCPE noted the new WHO global VDPV classification and response guidelines, which should in future be applied in the situation of virus detection.
- The RCCPE commented on continued population immunity issues in several countries (namely India, Indonesia, Myanmar and Timor-Leste) but noted 1) SIAs and routine immunization strengthening efforts and 2) considered switch preparations as an opportunity for further supplementary vaccination campaigns – very high quality is critical requiring comprehensive micro-planning, particularly in conflict areas and for underserved and marginalized populations for which innovative approaches are required.
- The RCCPE observed that current country immunization schedules differ in terms of OPV birth dose and requested the WHO Secretariat for a technical consultation with the SEARO ITAG at its next meeting.
- The RCCPE noted various specific polio vaccination approaches for travellers and requested the WHO Secretariat

for a review and technical consultation with the ITAG at its next meeting.

- The RCCPE appreciated national and subnational risk assessments conducted and considered them as particularly important for the time prior to and after the switch. Particular attention should be given to the risks in border areas and cross-border coordination mechanisms (e.g. data exchange, synchronization of immunization activities, vaccination irrespective of place of residence, regular coordination meetings) should be explored, with support of WHO.
- With the updating of national polio preparedness and response plans conducted in or before 2013, the RCCPE requests all countries to update the plans and align to new requirements related to the switch, and encourages countries to conduct simulation exercises.
- The RCCPE noted and concurs with the recommendations of the 2015 SEARO ITAG.
- The RCCPE appreciated submission of progress reports from all countries except the Democratic People's Republic of Korea and based on the information received concluded that the Region has stayed polio free, with a final decision made after receipt of the Democratic People's Republic of Korea report and respective review (see above).
- The RCCPE reminded Member States and key partners in polio eradication that continued political commitments and adequate resources are needed to protect the huge investments made into achieving polio-free status and prevent the dire consequences of a polio resurgence.

### ***Switch preparations***

- The RCCPE noted the Region's progress towards achieving the objectives of 'Polio Eradication and Endgame Strategic Plan 2013–2018', including IPV introduction and

preparedness for the globally synchronized withdrawal of OPV type 2 by switching from tOPV to bOPV. The RCCPE noted that six out of 11 countries (Bangladesh, Bhutan, Democratic People's Republic of Korea, Maldives, Nepal, Sri Lanka) have introduced IPV, and plans exist in four countries (India, Myanmar, Thailand and Timor Leste) to introduce by December 2015. The RCCPE also noted that Indonesia has decided to introduce IPV in July 2016 (after the switch) and that the country has decided to conduct a national immunization day (NID) with tOPV in March 2016 to build immunity against type 2.

- The RCCPE appreciated the efforts being made by the Region to overcome the challenges associated with the tOPV to bOPV switch.
- The RCCPE reiterated the importance in preparation of the switch; all countries should appropriately manage their tOPV stocks to ensure that there are no stock-outs of tOPV before the switch and that minimum tOPV stocks remain after the switch to minimize the risks associated with use of tOPV. Countries with large tOPV stocks should ensure their use in planned SIAs prior to the switch.
- Countries that self-procure OPV – namely Bhutan, India, Indonesia, Nepal, Sri Lanka and Thailand – should ensure that bOPV is procured in a timely manner to ensure availability of the vaccine after the switch.

### ***Laboratory containment***

- The RCCPE noted the GCC recommendations on the implementation of containment activities under GAPIII, particularly the need to urgently achieve Phase I, with safe handling of all wild poliovirus type 2 infectious and potentially infectious materials (which includes type 2 VDPV materials) in time before the withdrawal of OPV2.

- The RCCPE noted the challenges associated with the containment of polioviruses as per GAPIII in the Region, especially in view of being one of the key requisites for the switch from tOPV to bOPV.
- The RCCPE reminded Member States to pursue or initiate the planning process for containment of all polioviruses as per the containment certification scheme (CCS) under GAPIII as a priority. It will be important to prepare for specific advocacy and information activities to engage countries that are considering having a polio laboratory designated as 'poliovirus-essential facility'.
- The RCCPE considered the GCC advice as equally important that specific guidance and information material be prepared for non-poliovirus laboratories that may store potentially poliovirus-contaminated clinical samples.
- The RCCPE noted the GCC decision related to Phase 2/GAPIII. The GCC, rather than RCCPEs, will be responsible for the approval of issuing final certificates that candidate poliovirus-essential facilities have complied with all GAP III requirements.
- The RCCPE noted that the GCC recommended that in countries hosting candidate PV-essential facilities, RCCPEs and NCCPEs will play a facilitating role to oversee the actual designation and country-level assessment of the candidate facility, according to the CCS.
- The RCCPE awaited support from WHO to the Region and Member States to allow planned intensified communication and advocacy efforts to engage and raise awareness of all relevant parties and groups for them to clearly understand key elements of GAP III, particularly for the urgent need to complete Phase 1 in time, and especially in countries where Phase I is at risk of being delayed.

## 4.2 Country-specific recommendations

### ***Bangladesh***

The RCCPE congratulated Bangladesh for maintaining surveillance performance above certification standards as well as sustaining high routine OPV3 coverage. The RCCPE commended Bangladesh for having initiated EV in 2015 as a supplement to AFP surveillance.

The RCCPE recommended that the programme, while maintaining its overall surveillance and immunization performance, pays attention to the challenges for surveillance in Dhaka City. It also recommended that plans be developed to ensure appropriate handling of the potentially infectious material stored and collected in the International Centre for Diarrhoeal Disease Research (ICDDR,B) as part of diarrhoea research work.

### ***Bhutan***

The RCCPE commended the comprehensive and clear report and the active performance of the NCCPE. The RCCPE concurred with the NCCPE conclusion that the AFP surveillance is generally sensitive enough to detect imported wild poliovirus or VDPV but notes room for improvement in complete and timely zero reporting and active surveillance visits. Focus should also be placed on the small number of AFP cases expected to have a full investigation, including adequate stool specimen collection; for this, all relevant health staff need to be sensitized. The RCCPE noted that polio immunization coverage remains satisfactory and that switch preparation, including poliovirus laboratory containment, is on track.

### ***Democratic People's Republic of Korea***

The RCCPE appreciated submission of the NCCPE progress report in November 2015. While it contained the minimum required information for 2014, the RCCPE concluded that the country had stayed polio free

mainly based on continued reported high immunization coverage and AFP surveillance meeting the key quality indicators in terms of case reporting and stool sample collection. The RCCPE looks forward to an expanded NCCPE report at its next meeting, with particular discussions on national polio laboratory performance, poliovirus laboratory containment and meeting other polio endgame requirements.

### ***India***

The RCCPE commended India for its continued efforts to maintain surveillance performance above certification standards as well as for recent initiatives to improve population immunity in areas with low routine OPV3 coverage. The RCCPE took note of surveillance and immunization activities in the country in response to the VDPVs detected in the sewage samples. The RCCPE noted the progress made in activities in preparation of the tOPV to bOPV switch, including plans of a phased introduction of IPV from November 2015 onwards, the poliovirus containment activities as per GAPIII, environmental surveillance expansion plans and procurement of bOPV for the switch. The RCCPE also noted the successful dry-run of the switch conducted by India and the application of the lessons learnt from the dry-run in the development of the national switch plan.

The RCCPE encouraged India to continue to conduct subnational risk analysis to identify areas with surveillance and immunity gaps as well as focused actions to plug these gaps. Considering that India is a tier 1 country, the RCCPE encouraged India to ensure that IPV is introduced as per the current timeline proposed by the country and complete the containment process as well.

### ***Indonesia***

The RCCPE appreciated the efforts made by the programme resulting in national AFP surveillance and coverage figures at an acceptable level. However, it was of great concern that in this very populous country, surveillance and immunization performance at subnational levels does



not meet certification standards and levels of achievement seem to be declining in 2015, especially in view of the upcoming switch and subsequent risks resulting from large immunity gaps and IPV introduction planned in July 2016. Mitigating these risks must be done comprehensively, and measures need to start as soon as possible. The RCCPE recommended the following:

- Enhancing subnational AFP surveillance by conducting active case searches and targeted performance reviews in high-risk provinces.
- Expanding EV to more sites in population centres, as appropriate.
- Following up on implementation of recommendations made in the comprehensive 2013 EPI and VPD Surveillance Review.
- Ensuring high quality (coverage >95% at relevant subnational levels) of the polio NID planned in March 2016 through timely and comprehensive preparation, use of micro-planning, monitoring and coverage assessment.
- Considering conduct of subnational sero-surveys in provinces of low coverage and considered high risk.
- Ensuring fast IPV roll-out after introduction in July 2016, which requires adequate vaccine availability.
- Independent monitoring of the switch validation process.
- Finalizing the plan to meet laboratory containment requirements under GAP III.

### ***Maldives***

The RCCPE commended a clear report, which highlights again the continued problems with staff capacities, especially for AFP surveillance. With the small number of cases expected per year, a strong focus should be placed on complete and timely zero reporting and active surveillance visits. Special efforts should be made for AFP cases to have

a full investigation, including adequate stool specimen collection and timely shipment to the reference laboratory; for this, all relevant health staff need to be sensitized. The RCCPE noted that polio immunization coverage remains acceptable and that switch preparation, including poliovirus laboratory containment, is on track.

### **Myanmar**

The RCCPE commended on a clear report indicating the challenges that the programme is facing. The RCCPE was concerned about the declining surveillance quality in Myanmar as evidenced by the slipping non-polio AFP rate and the fact that 63% of townships did not report a single AFP case during 2014. The RCCPE was also concerned at the gap in the population immunity against polio as demonstrated by a suboptimal routine OPV3 coverage (76% during 2014 as per WHO/United Nations Children's Fund - UNICEF coverage estimates) and more than 15% of AFP cases having received two or less OPV doses. The emergence of the recent VDPV2 case in Myanmar has confirmed the presence of pockets with low population immunity.

The RCCPE noted the plans presented by Myanmar for IPV introduction in December 2015. The RCCPE also acknowledged that a subnational risk analysis has been conducted by the programme to identify townships with low OPV3 coverage with plans to conduct two SNIDs with tOPV in January and February 2016 in order to improve population immunity against polio in these areas.

The RCCPE recommended Myanmar to identify and implement actions to improve surveillance performance urgently. The RCCPE strongly recommended that the proposed SNIDs should be of high quality to maximize their impact. The RCCPE recommended that, following the two SNIDs, targeted actions in all townships with low OPV3 coverage should be taken to improve routine immunization coverage. The RCCPE also recommended that Myanmar should ensure that IPV is introduced as the per proposed timeline.

## ***Nepal***

The RCCPE appreciated the efforts made by the Ministry of Health and partners in Nepal to ensure OPV administration in the 14 earthquake-affected districts along with measles rubella (MR) vaccine immediately after the earthquake. The RCCPE commended Nepal for the efforts made to improve routine immunization coverage through a 'community-owned initiative'. The RCCPE noted that a subnational risk analysis conducted in Nepal was used to identify high-risk districts that were subsequently covered under a SNID.

The RCCPE encouraged Nepal to continue to identify subnational gaps in surveillance and immunization performance and plug these gaps through targeted actions.

## ***Sri Lanka***

The RCCPE commended a clear report demonstrating very high coverage levels in all provinces and districts. While AFP surveillance continues not to achieve the operational reporting target of the Region, there is no indication that the performance levels have decreased in a well-coordinated system with high levels of zero reporting and case searches in silent areas. Emphasis should though be placed on adequate stool specimen collection, and the RCCPE welcomes the EPI and VPD surveillance review in October 2015 as an opportunity to sensitize health-care workers and also strengthen the involvement of the private and informal health sector.

The RCCPE noted that switch preparation, including poliovirus laboratory containment, is on track.

## ***Thailand***

The RCCPE appreciated the efforts made in the updated report on maintaining polio-free status which compared to the initial submission included the latest NCCPE membership and terms of reference, coverage figure and other details for routine and supplementary

immunization activities and clarifications on key AFP surveillance aspects as requested in a detailed list provided by the WHO Secretariat. Future reports should be of the same good quality. The RCCPE noted important surveillance gaps in reporting rates and timeliness along with localities with significantly low coverage rates and encouraged the programme to accelerate where needed its efforts to close immunity gaps and improve AFP surveillance.

### ***Timor-Leste***

The RCCPE commended a comprehensive and high-quality report and the active performance of the NCCPE. The RCCPE noted the efforts made to improve the quality of the AFP surveillance system but performance levels remain low. While routine polio immunization coverage is still not adequate, the high coverage with OPV during the 2015 national MR vaccination campaign should have contributed to closing some immunity gaps. As such, the recommendations of the 2015 EPI and VPD surveillance review should be fully implemented as a matter of government priority. Particular focus should be placed on capacity-building among health workers and providing the logistics for EPI service delivery. The RCCPE noted that switch preparation, including poliovirus laboratory containment, is on track.

## **Annex 1**

### **Agenda**

- Objectives of the meeting
- Summary on outcomes of Global Certification Commission (GCC) meeting
- Status update of the Global Polio Eradication Initiative:
  - Stopping wild poliovirus in Afghanistan and Pakistan
  - Polio situation in the WHO African Region
  - Polio situation in the WHO European Region
- Polio Endgame and tOPV to bOPV switch
- Poliovirus laboratory containment
- Update on Regional certification process
- Update on maintaining polio-free status and meeting polio endgame requirements in the WHO South-East Asia Region
- Regional update on poliovirus laboratory containment
- Maintaining polio-free status and active certification process in the WHO Western Pacific
- National Certification Committee for Polio Eradication (NCCPE) presentations on country situation:
  - Bangladesh
  - Bhutan
  - India
  - Indonesia
  - Maldives
  - Myanmar

- Nepal
- Sri Lanka
- Thailand
- Timor-Leste
- Discussion on ITAG 2015 – relevant outcomes
- Regional measles elimination and verification process
- Presentation of conclusions and recommendations
- Priorities for 2016, issues and challenges

## Annex 2

### **SEA-RCCPE revised terms of reference (May 2015)**

- (1) Review annual documentation of each Member State on maintaining polio-free status, including poliovirus laboratory containment, as per requirements of '*Polio Eradication and Endgame Strategic Plan 2013–2018*' and report the findings and required actions to the Regional Director (WHO Secretariat) and appropriate National Certification Committees for Polio Eradication (NCCPE).
- (2) Support the NCCPEs and participate in their activities, including the participation by individual commission members in selected NCCPE meetings, and provide guidance, where applicable.
- (3) Conduct site visits as necessary to review and/or verify the data and the status of polio eradication and endgame activities in selected Member States.
- (4) Inform the Global Certification Commission (GCC), through its chairperson, or via the Secretariat, on the status of polio eradication and endgame activities, calling attention to unresolved issues.
- (5) Inform the Regional Director of any action required on the part of the WHO Secretariat and relevant national authorities to ensure that polio-free certification of the WHO South-East Asia Region will be sustained.
- (6) Advise Member States on the risks to polio-free status and actions for mitigation of these risks.
- (7) Review the process and outcome of the inventory of poliovirus stocks and potentially infectious materials and their containment in secure facilities in the Region as per Global Action Plan III.

- (8) Endorse certification of wild poliovirus elimination in the South-East Asia Region to the GCC for Global certification and provide any evidence requested by the GCC in the interim.



## Annex 3

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