

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

Nay Pyi Taw, Myanmar

23-24 November 2017



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Abbreviations

AERF	annual Expanded Programme on Immunization reporting form
AFP	acute flaccid paralysis
bOPV	bivalent oral poliovirus vaccine
CAG	containment advisory group
CCS	containment certification scheme
cVDPV	circulating vaccine-derived poliovirus
cVDPV2	circulating vaccine-derived poliovirus type 2
DPRK	Democratic People’s Republic of Korea
EC	emergency committee
Endgame Plan	Polio Eradication & Endgame Strategic Plan 2013-2018
EPI	Expanded Programme on Immunization
ES	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
IHR	International Health Regulations
IPV	inactivated poliovirus vaccine
fIPV	fractional inactivated poliovirus vaccine
ITD	intratypic differentiation
IVD	Immunization and Vaccine Development
JRF	World Health Organization/United Nations Children’s Fund joint reporting form on immunization
NAC	national authority for containment
NCCPE	National Certification Committee for Polio Eradication
NCTF	National Containment Taskforce
OBRA	outbreak response assessment
OPV	oral poliovirus vaccine
OPV3	the third dose of oral polio vaccine
PEF	poliovirus essential facility
RCCPE	Regional Certification Commission for Polio Eradication

RI	routine immunization
RPNL	Regional polio laboratory network
SAGE	Strategic Advisory Group of Experts on Immunization
SEA	South-East Asia
SEARO	World Health Organization Regional Office for South-East Asia
SIA	supplementary immunization activity
tOPV	trivalent oral poliovirus vaccine
UNICEF	United Nations Children's Fund
VDPV	vaccine-derived poliovirus
VDPV2	vaccine-derived poliovirus type 2
WHO	World Health Organization
WPV	wild poliovirus
WPV1	wild poliovirus type 1
WPV2	wild poliovirus type 2

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Introduction

The World-Health-Assembly-endorsed global 'Polio Eradication & Endgame Strategic Plan 2013-2018' (Endgame Plan) contains 'certification and containment' as one of its four key objectives. In view of this strategic approach, the continued risk of wild poliovirus (WPV) importation from an infected area or country and the close monitoring of the potential vaccine-derived poliovirus type 2 (VDPV2) emergence after the global switch from trivalent oral poliovirus vaccine (tOPV) to bivalent oral poliovirus vaccine (bOPV) in April 2016, it is considered critical that the South-East Asia (SEA) Regional Certification Commission for Polio Eradication (RCCPE) meets on a regular basis to review annual progress reports from all countries.

In this context the 10th meeting of the SEA-RCCPE was held in Nay Pyi Taw, Myanmar from 23 to 24 November 2017 with the following objectives:

1. to review reports from each Member State reporting on maintaining polio-free status, as per requirements of the Endgame Plan;
2. to review the implementation status of the recommendations made at the 9th meeting of the SEA-RCCPE;
3. to review national and regional risk assessments in order to highlight gaps in levels of immunity and quality of surveillance at national and sub-national levels;
4. to review reports from all countries on compliance with poliovirus type 2 laboratory containment requirements in line with the switch from tOPV to bOPV in April 2016;
5. to update the Global Certification Commission (GCC) on the polio-free certification status of the South-East Asia Region.

Opening

The 10th meeting of the SEA-RCCPE was opened by the World Health Organization (WHO) Representative to Myanmar, Dr Stephan Jost, on behalf of Dr Poonam Khetrapal Singh, WHO Regional Director for SEA.

In her message, the Regional Director welcomed the new members of the RCCPE: Dr Nobuhiko Okabe, chairperson of the RCCPE in the Western Pacific, and Dr Mark Steven Oberste, Chief of the Polio and Picornavirus Laboratory Branch at the Centers for Disease Control and Prevention in Atlanta, USA. Dr Khetrapal Singh stated her expectation that, in addition to these experts drawing upon their vast technical expertise and public health experience, Dr Okabe would particularly support the continuation of close inter-regional collaboration and Dr Oberste would bring additional technical capacity to poliovirus laboratory containment.

The Regional Director was pleased to note the encouraging progress in polio eradication globally, highlighting that, of the three WPV types, type 2 was certified as eradicated in September 2015, type 3 last detected in November 2012 and type 1 reported globally this year from only two countries: Afghanistan and Pakistan.

The Regional Director expressed concern, however, about the ongoing transmission of polio outbreaks due to VDPV2 in the Democratic Republic of the Congo and the Syrian Arab Republic

following the global synchronized withdrawal of the type 2 component in oral poliovirus vaccine (OPV) in April 2016 and the continuing shortage of inactivated poliovirus vaccine (IPV). As such, the Regional Director reminded the RCCPE members that pockets of low immunization coverage facilitating vaccine-derived poliovirus (VDPV) emergence remain in the SEA, despite the Region being certified polio-free in March 2014. Therefore, regular risk assessments conducted down to the relevant sub-national level remain critical in each country to identify and address gaps in immunization and surveillance.

Dr Khetrupal Singh concurred with the conclusion of the 9th RCCPE meeting that the emergence of circulating vaccine-derived poliovirus (cVDPV) in areas of low coverage is as great a risk to polio-free status as an outbreak due to WPV importation. The Regional Director concluded that Myanmar and India responded with great commitment to VDPV detection in the past few years. She expressed her gratitude at having the 10th meeting of the RCCPE held in Myanmar, thus supporting advocacy with stakeholders to continue their utmost efforts to keep the country -- and subsequently the Region -- polio-free.

The Regional Director commended all countries of the WHO SEA Region for demonstrating continued leadership and commitment to a polio-free world, especially with national programmes maintaining high quality surveillance for acute flaccid paralysis (AFP) - the gold standard in polio surveillance – in the post-eradication phase when countries tend to turn towards other priorities and are likely to become complacent in implementing activities to maintain polio-free status.

The Regional Director highlighted how efforts by countries in the Region to address the global IPV shortage are guiding global policies. India and Sri Lanka using fractional doses of IPV (fIPV) in their Expanded Programmes on Immunization (EPI) supported the Strategic Advisory Group of Experts on Immunization (SAGE) in recommending use of the fractional dose globally. Dr Khetrupal Singh also commended Bangladesh and Nepal for shifting to a fIPV dose schedule by early 2018.

The Regional Director noted that WPV type 2 (WPV2), eradicated from human populations, now exists only in laboratories, including those of vaccine manufacturers and that poliovirus laboratory containment is, therefore, becoming a priority in the pursuit of a polio-free world. Dr Khetrupal Singh summarized the fact that activities to contain type 2 polioviruses in facilities are progressing in the Region, that all countries are implementing new surveys of biomedical laboratories to meet the requirements outlined 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 that special trainings on GAPIII requirements have been conducted for key stakeholders, followed by training for containment certification auditors in January 2017 and a Regional review and planning meeting in April 2017.

As funding from the Global Polio Eradication Initiative (GPEI) for polio assets (human resources, systems and processes) is expected to decline from this year and eventually stop after 2019, the Regional Director was pleased that the transition planning process is ongoing in five countries of the Region – Bangladesh, India, Indonesia, Myanmar and Nepal - that have substantial polio assets.

Dr Khetrapal Singh emphasized that, despite success, multiple risks persist and the independent oversight and analysis of National Certification Committees for Polio Eradication (NCCPEs) remain critical to the national programmes as well as to the RCCPE and the Global Certification Commission (GCC). As such, she was happy to note that the GCC chairperson, Professor David Salisbury, was attending this meeting.

The Regional Director urged meeting participants to very carefully and comprehensively address during the meeting the four key questions posed regarding polio immunization coverage, immunity and surveillance, containment of polioviruses in laboratories, risk assessments, and the levels of preparedness necessary to respond to any case of poliovirus. She urged meeting participants to reach conclusions and make recommendations based on evidence.

The Regional Director sincerely thanked the Government of Myanmar and the Ministry of Health and Sports for hosting this 10th RCCPE meeting in Nay Pyi Taw.

Dr Thar Tun Kyaw, Director General of the Department of Public Health and the Department of Medical Services at the Ministry of Public Health, Myanmar, welcomed meeting participants in Nay Pyi Taw and reminded of the commitment to global polio eradication since the 41st World Health Assembly in 1988 adopted the respective resolution which marked the launch of the GPEI, spearheaded by national governments, WHO, Rotary International, the US Centers for Disease Control and Prevention, United Nations Children's Fund (UNICEF), and supported by key partners including the Bill & Melinda Gates Foundation. Dr Thar Tun Kyaw highlighted how more than 16 million people are able to walk today, who would otherwise have been paralyzed the number of polio cases has fallen by over 99% and humanity is on the verge of one of the greatest public health achievements in history – eradicating polio. In this context, he thanked WHO and partners in the eradication initiative for such steadfast commitment, including in Myanmar.

Dr Thar Tun Kyaw summarized Myanmar's strong commitment to polio eradication activities and how the Ministry of Health and Sports immediately took the necessary action to respond to the cVDPV type 2 in 2015 as per global GPEI and national guidelines for responding to polio outbreaks. The response was rapid and effective as concluded by outbreak response assessment (OBRA) teams. The government has continued strategic actions to improve immunization coverage in low performing areas through micro planning with development of annual EPI work plans by each township, initiation of integrated hospital based immunization, incentives to midwives, providing increased budget for supervision and monitoring, communication and advocacy meetings with local administrators and crash immunization programmes in hard to reach area. Equally intensive efforts are being made for high quality polio surveillance, poliovirus laboratory containment and developing a polio transition plan. The NCCPE had been reformed in May 2017 and its composition and terms of reference were updated to meet oversight requirements to polio eradication activities.

Global progress in polio eradication and implementation of the endgame plan

WPV transmission in the remaining three endemic countries

In Nigeria no new polio cases due to WPV type 1 (WPV1) were confirmed in 2017, following the detection of cases in August 2016 from Borno State (the isolated viruses were most closely related to a strain of WPV1 previously detected in Borno State in 2011). However, due to continuing surveillance gaps in high-risk and inaccessible areas, undetected and continued circulation of this strain cannot be ruled out. Nigeria has continued to implement an aggressive outbreak response, conducted in close coordination with neighbouring countries across the Lake Chad subregion, within the context of the broader humanitarian emergency affecting the subregion. Lack of access and inability to conduct high-quality vaccination and surveillance in many areas of Borno State remain the primary challenges. A key objective continues to be the prevention of spread of the outbreak to other areas of the subregion. Additional measures are being implemented to increase surveillance sensitivity and boost immunity levels, including scaling up of environmental surveillance (ES), testing of healthy individuals (including adults) as they exit inaccessible areas, establishing permanent vaccination posts at key crossing points between accessible and inaccessible areas in order to vaccinate children and people in older age groups, and rapidly conducting mop-up immunization campaigns as and when windows of opportunity arise or geographic areas become accessible.

Afghanistan and Pakistan have continued to be treated as a single epidemiological block. In 2017, as of 27 September, five polio cases due to WPV1 were reported in Pakistan, compared with 20 in 2016; in Afghanistan, six cases were reported, compared with 13 in 2016. The two countries continued to demonstrate strong progress, with independent technical advisory groups underscoring the feasibility of rapidly interrupting transmission of the remaining poliovirus strains. Both countries have coordinated their activities closely, with efforts focusing on clearly identifying missed children and the reasons why these children have been missed, and putting in place operational plans to overcome the challenges resulting in missed children. In particular, emphasis has continued to be placed on reaching high-risk mobile populations travelling both within the countries and across the border. Virus transmission has been primarily restricted to two cross-border corridors: the first links eastern Afghanistan with Khyber Pakhtunkhwa and Federally Administered Tribal Areas in Pakistan, and the second links southern Afghanistan (Kandahar and Hilmand) with Quetta block, Balochistan province in Pakistan. In 2017, coordination of the polio eradication programme has continued to improve at national, provincial and regional levels, as well as among the bordering districts in the common corridors of transmission, with efforts focused on vaccination of people in high-risk mobile populations and those in populations living along the border. ES in both countries has confirmed the risk of ongoing transmission of virus to polio-free areas due to virus importation from remaining reservoir areas. Of particular concern is Karachi (Pakistan), given the ongoing detection of positive environmental samples and confirmation of a WPV polio case in August 2017, the first in greater Karachi since January 2016. Both Afghanistan and Pakistan have adjusted and fine-tuned their national emergency action plans for polio eradication, building on lessons learned and concentrating on improving programme operations during the low-transmission season (October to May).

cVDPV transmission

In 2017, two countries were newly affected by cVDPV type 2 (cVDPV2) transmission: the Syrian Arab Republic and the Democratic Republic of the Congo, with 40 cases and nine cases reported respectively from these countries. The monitoring of and response to cVDPV2 transmission continues to be a global strategic priority, following the globally-coordinated withdrawal of the type 2 component of OPV in April 2016. Outbreak response is now under way in both countries. These outbreaks underscore the continued risk posed by immunity gaps anywhere in the world. In areas with adequate immunity levels, surveillance for VDPV2 from any source is revealing a steady and rapid decrease in the persistence of such strains.

Public health emergency of international concern

The declaration in 2014 of the international spread of WPV as a public health emergency of international concern and the temporary recommendations promulgated under the 2005 International Health Regulations (IHR) have remained in effect. All countries affected in 2017 by circulation of either WPV or VDPV have declared such events to be national public health emergencies and are implementing national emergency action plans. In November 2017, Myanmar was removed from the list of states no longer infected by WPV type 1 or cVDPV, but which remain vulnerable to re-infection by WPV or cVDPV.

Phased OPV removal

To prepare for the 2016 switch to bOPV, all countries had committed themselves to introduce at least one dose of IPV into their routine immunization (RI) programmes. Global supply constraints that emerged due to technical difficulties encountered by manufacturers in scaling up production resulted in some countries experiencing delays in IPV supply. On the basis of manufacturers' current projections, all countries that have experienced delays should receive the vaccine by the first quarter of 2018. During this period of shortage, the available supply has been prioritized for RI in areas at highest risk of outbreaks of VDPV2 (in Tier 1 and Tier 2 countries). The GPEI has continued to explore with countries the feasibility of instituting dose-sparing strategies, such as intradermal administration of fIPV, as recommended by the SAGE and notably adopted by Bangladesh, India, Nepal, Sri Lanka and countries across the Region of the Americas.

Laboratory containment of polioviruses

Efforts to contain poliovirus type 2 were implemented progressively in 2016 and 2017, guided by GAPIII. Guidance for non-poliovirus facilities to minimize risk of sample collections potentially infectious for polioviruses is being finalized. This guidance will support the last steps in the identification, destruction, transfer of remaining type 2 polioviruses to, or their retention in, certified poliovirus-essential facilities (PEF). The GCC has accepted responsibility for global containment oversight, following the Containment Certification Scheme (CCS) to support GAPIII. A Containment Advisory Group (CAG) has been established to address technical issues related to GAPIII and some amendments to GAPIII have been recommended. WHO is supporting the strengthening of the technical capacity of national authorities for containment (NAC) by training auditors in GAPIII and the CCS.

As of 18 September 2017, 174 countries and territories have reported that they no longer hold WPV or VDPV2, 29 have reported that they intend to retain type 2 polioviruses in 96 PEFs, and two are completing their reports. Inventories of materials containing type 2 polioviruses will have

to be repeated after interruption of transmission in all countries that were affected by cVDPV outbreaks. Of the 29 countries planning to retain type 2 polioviruses, 18 have made significant progress with the establishment of NACs and are preparing to certify their designated PEFs as meeting the containment requirements described in GAPIII.

Regional update on maintaining polio-free status

Surveillance

The overall non-polio AFP rate in the Region in 2016 was 8.38 per 100 000 population under 15 years of age, which exceeds the globally recommended operational target of 2 per 100 000. The non-polio rate was above 2 in 2016 in nine countries, namely Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Thailand and Timor Leste, while it was between 1 and 2 in the remaining two countries – thus meeting the certification standard of at least 1 per 100 000. In 2017, as of week 46, the annualized regional non-polio AFP rate was 6.1 with four countries (Bangladesh, India, Myanmar and Nepal) achieving a rate above 2. While a large number of cases were still pending final classification, AFP rates in all but one country exceeded 1 per 100 000.

In 2016, adequate stool samples were collected from 87% of the reported AFP cases in the Region, as against the globally recommended target of at least 80%. Seven countries, namely Bangladesh, Democratic People's Republic of Korea (DPRK), India, Indonesia, Myanmar, Nepal and Sri Lanka, had collected adequate stool samples from more than 80% of reported AFP cases in 2016. In 2017, as of week 46, the rate for the Region was 86%, with seven countries (Bangladesh, DPRK, India, Indonesia, Myanmar, Nepal and Sri Lanka) achieving more than 80%.

In 2016 and 2017, ES activities in the Region were expanded to include additional sites in Indonesia and India and to initiate surveillance in Thailand, Bangladesh, Myanmar and Nepal. A total of 56 sites are now conducting ES and the data have provided important evidence for the disappearance of Sabin-like poliovirus type 2 following the switch from tOPV to bOPV during 2016. ES data have also helped to guide investigations and responses to VDPVs detected in sewage samples.

During 2016, the Regional polio laboratory network (RPLN) tested almost 100 000 stool specimens. Timeliness of reporting primary culture results within two weeks of receipt of samples was 97% as against the global requirement of 80% or greater. In 2017, as of week 46, almost 70 000 stool samples and over 2500 sewage samples have been tested and 93% of primary culture results are available, as per the required timeliness standard. Over 2400 poliovirus isolates underwent intratypic differentiation (ITD) in 2016 and results were reported for over 95% of these isolates within seven days of receipt of the specimen in the laboratory. In 2017, as of week 46, almost 2000 poliovirus isolates had undergone ITD and timeliness reached a level similar to what it was in 2016. These findings, when measured against global quality standards, indicate a very high level of competence in the RPLN. Accreditation visits reaffirm that the laboratories in the network have updated standard operating procedures for safe handling of AFP specimens and viral isolates and are meeting the global benchmarks for poliovirus diagnostics with 14 laboratories in the Region fully accredited for virus culture and ITD, one laboratory provisionally accredited for ITD and accreditation on hold for one laboratory.

Surveillance efforts detected one VDPV (type 2) in 2017 in sewage sampled in India; detailed risk analysis graded this VDPV as low risk and with no evidence of circulation. The virus detected was adequately responded to in terms of surveillance and RI strengthening. Responses to VDPV isolation in 2016 have already been covered in the report of the 9th RCCPE meeting.

Population immunity through RI and supplementary immunization activities (SIAs)

Six countries — namely Bangladesh, Bhutan, DPRK, Maldives, Sri Lanka and Thailand — have reported coverage with the third dose of OPV (OPV3) as greater than 90% while India, Indonesia, Myanmar, Nepal and Timor Leste reported coverage with OPV3 as being between 80-90% in 2016 (data source: WHO and UNICEF estimates of national immunization coverage, July 2017 revision). Mass polio-vaccination activities with OPV were conducted in Bangladesh, India, Indonesia, Myanmar and Nepal in 2016 to close immunity gaps against polio and in 2017 in India, Myanmar and Nepal while Bangladesh carried out two bOPV campaigns in migrant refugees.

IPV introduction, challenges and actions to mitigate the risks

All countries in the Region introduced IPV between 2014 and 2016. As part of risk mitigation strategies associated with the global IPV shortage, the available IPV supplies are being prioritized towards countries of the Region that are at a higher risk of poliovirus resurgence, namely India, Indonesia, Myanmar and Timor-Leste. Two countries in the Region, India and Sri Lanka, have replaced the full dose IPV schedule with two fractional (one-fifth) doses in their RI schedule in order to stretch the available IPV supplies. Another two countries, Bangladesh and Nepal, will shift to an fIPV dose schedule (instead of a full dose schedule) before end-2017.

Poliovirus laboratory containment

Activities to contain type 2 polioviruses in facilities are progressing in the Region. PEFs have been identified to store/handle type 2 polioviruses in two countries of the Region, namely India and Indonesia. NACs have been established in both countries and processes to undertake certification of these facilities as per the global CCS have commenced. All countries have been implementing new surveys of biomedical laboratories to meet requirements outlined in GAPIII. Special trainings on GAPIII requirements for national containment taskforces (NCTF), PEFs, NACs and vaccine manufacturers were conducted sequentially by WHO in January, February and October 2016, followed by training for CCS auditors in January 2017 and a Regional review and planning meeting in April 2017. The RPLN has conducted several bio-risk management capacity building activities. Countries are being supported with direct technical assistance to implement their activity plans for containment of Sabin2/OPV type 2 materials.

Transition planning

The transition planning process is ongoing in five countries of the Region that have substantial polio assets, namely Bangladesh, India, Indonesia, Myanmar and Nepal. A country-by-country approach is being adopted due to a difference in the scope and type of support being provided by polio networks in different countries, as well as variability in the capacities of different countries to absorb and support functions that are currently supported by polio networks. The transition planning process has progressed well in India and an incremental increase in funding support for the polio network from the domestic budget of the government is being worked out.

Transition plans are also being put in place in Bangladesh, Indonesia, Myanmar and Nepal, with alternative funding options being explored in these countries.

Key challenges

The meeting participants identified the following key challenges faced by the Region with regard to maintaining the Region's polio-free status:

1. Maintaining high-quality AFP surveillance and sustaining high population immunity against polioviruses will become increasingly difficult during the post-eradication phase as countries turn towards other priorities and become complacent in implementing activities targeted to maintain polio-free status.
2. Countries in the SEA Region have been facing difficult decisions as to how to manage the global shortfall of IPV supply.
3. Funding from the GPEI for polio assets (human resources, systems and processes) is expected to decline from 2017 to 2019 and eventually stop, making it increasingly difficult to sustain activities required to maintain the polio networks that are not only supporting activities to maintain polio-free status but are also supporting other public health initiatives in the Region. It remains a challenge to ensure the involvement of national governments and the identification of alternative sources of funding to mitigate the programmatic risks associated with the ramp-down of polio funding. Although containment activities have been agreed upon and are in process, decreased funding and the need to address other priorities may distract countries from completing poliovirus containment activities in accordance with GAPIII. These activities would minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of routine OPV.

Review of country progress reports

During its 9th meeting the RCCPE had welcomed the new format of progress reports and presentations and requested that this more analytical and interactive approach to discussing country situations with regard to maintaining polio-free status be developed further. The RCCPE had requested that the WHO Regional Office for SEA (SEARO) further refine the new approach in progress reports and develop relevant competencies in NCCPEs and their secretariats. Systematic data analysis and consolidation, conducted jointly with WHO, should be carried out prior to the next RCCPE meeting as a critical basis for the performance analysis and presentation in NCCPE reports. The RCCPE also requested an analysis of the implementation status of RCCPE recommendations.

Subsequently, the WHO SEARO Immunization and Vaccine Development (IVD) team prepared data packages for the RCCPE as well as NCCPEs with information routinely submitted by national programmes. These packages included

1. the NCCPE database with details on country's membership, meeting frequency and objectives and other relevant activities including coordination with key stake holders,
2. the analysis of the status of implementation of recommendations from the 8th and 9th RCCPE meetings,
3. the polio laboratory accreditation database,

4. country-specific data packages containing
 - Information on OPV3 and IPV coverage at national and subnational levels, as reported on the 2016 WHO/UNICEF Joint Reporting Form (JRF) / Annual EPI Reporting Form (AERF),
 - the details of polio SIAs and information regarding coverage achieved in these SIAs, drawn from the JRF and AERF (JRF/AERF)
 - Surveillance performance and laboratory testing (database of weekly SEARO IVD bulletin)
 - Polio laboratory performance

5. a summary of the quality assurance process for phase 1 GAPIII surveys

The RCCPE chairperson requested that NCCPE members carefully review the performance data and programme updates and secure additional information from the relevant national teams to come to conclusions about four questions, which are as follows:

1. Are polio immunization coverage and immunity levels high enough to prevent imported WPV circulating and to prevent the emergence of VDPV?
2. Is polio surveillance sensitive enough to rapidly and reliably detect imported WPV and VDPV, should VDPV emerge?
3. Are polioviruses in laboratories adequately handled and contained under GAPIII requirements to prevent reintroduction into population and environment?
4. Are levels of preparedness for timely and reliable detection of and response to poliovirus occurrence adequate and up to date?

NCCPE conclusions – positive or negative – were to be supported with evidence, discussions on remediating actions, the impact of these actions and continuing gaps and recommendations to support the polio-free status of the country in question.

Each NCCPE report was reviewed by two RCCPE members as per the following assignment:

2017 SEA-RCCPE review of polio progress reports		
Country	Reviewer 1	Reviewer 2
Bangladesh	Dr Supamit	<i>Dr Oberste</i>
Bhutan	Dr Oberste	<i>Dr Acharya</i>
DPRK	Dr Abraham	<i>Dr Okabe</i>
India	Prof Rahman	<i>Dr Withana</i>
Indonesia	Dr Sein	<i>Dr Supamit</i>
Maldives	Dr Acharya	<i>Dr Sein</i>
Myanmar	Prof Bhutta	<i>Prof Moedjito</i>
Nepal	Prof Moedjito	<i>Prof Bhutta</i>
Sri Lanka	Dr Tshering	<i>Dr Abraham</i>
Thailand	Dr Okabe	<i>Prof Rahman</i>
Timor Leste	Dr Withana	<i>Dr Tshering</i>

Conclusions and observations

The conclusions and observations made by the RCCPE based on the content of the meeting were as follows:

1. Based on the reports received by NCCPEs and presentations made at the 10th RCCPE meeting, the RCCPE concluded that the SEA Region has remained polio-free during the period of review.
2. The RCCPE appreciated efforts made by NCCPEs to use a more analytical approach in preparing the annual progress reports and providing independent conclusions on the programme performance and risk status of each country. The RCCPE specifically commended the India and Thailand NCCPEs for the analytical approach adopted by these entities in order to understand the risks to maintaining polio-free status in their countries.
3. The RCCPE continued to highly value the work of NCCPEs and also commended national programmes in the SEA Region for their efforts to maintain polio-free status for more than six years. VDPV detections in 2016 and 2017 (in India) have been promptly and adequately responded to. The Emergency Committee (EC) of the IHR, during its 15th meeting in November 2017, concluded that, following the efficient response to the 2016 cVDPV2 polio outbreak, Myanmar will no longer be subject to implementing the temporary recommendations of the EC to limit the international spread of polioviruses.
4. The RCCPE noted with satisfaction that AFP surveillance continues to be conducted in all countries of the SEA Region and that AFP surveillance is supplemented with ES in six countries (Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand).
5. The RCCPE acknowledged that the polio laboratory network in the Region is very strong and was satisfied with its performance. The RCCPE noted the efforts taken in the Region during the last 12 months with onsite accreditation visits and on-the-job training.
6. The RCCPE commended India on the extensive searches for tOPV storage/use that this country conducted following the isolation of type 2 Sabin in sewage samples in 2016, and on the removal from the system of residual tOPV stocks that were found during these searches. The RCCPE noted that, following introduction of fIPV in the EPIs of India and Sri Lanka, two more countries (Bangladesh and Nepal) are preparing to also introduce fIPV. The RCCPE also noted that IPV supplies were likely to be restored in early 2018 to countries of the Region that had faced a stock-out in 2016-2017 due to the global shortfall of IPV. The RCCPE noted that plans are being discussed to provide IPV to cohorts that had missed IPV due to stock-outs in countries concerned in order to reduce susceptibility to type 2 poliovirus resulting from IPV stock-outs.
7. While fully recognizing the complexities and long timelines for poliovirus laboratory containment, the RCCPE commended the Region for steady progress towards meeting the requirements and the substantial capacity building undertaken.
8. The RCCPE noted the efforts being made to address and the risks associated with the polio transition process in five countries of the Region (Bangladesh, India, Indonesia,

Myanmar and Nepal), following a decision to ramp-down GPEI funding over the next three years.

Based on the global update on polio eradication, the RCCPE noted that WPV1 and VDPV2 importation and a subsequent spread of poliovirus remain a risk for the Region as long as there is circulation of WPV1 or VDPV2 in some parts of the world. The RCCPE considers emergence of cVDPV in areas of low coverage — of which many exist in countries in the Region — to be an equally important risk to the polio-free status of SEA. Virus spread would be further facilitated by gaps in surveillance and inadequate outbreak preparedness.

9. The RCCPE again reminded countries of the risk of complacency due to the fact that the Region has been polio-free for many years and urged countries to remain vigilant and continue to give priority to polio eradication activities.
10. The RCCPE noted that chronic issues of inadequate human resources, low priority being given to activities for maintaining polio-free status and complacency and lack of awareness with regard to AFP reporting and investigation continue. While the RCCPE can offer general recommendations on these issues (as was done in the past), these challenges need to mainly be addressed at national level and NCCPEs should play a key role in advocating for these challenges to be addressed.
11. In terms of country-specific observations, the RCCPE noted that many observations have remained similar to those from last year and referred to its 2016 meeting report.
12. The RCCPE commended Bangladesh for taking appropriate programmatic responses to maintain its polio-free status despite natural disasters and other challenges, such as the recent influx of refugees.
13. The RCCPE commended India on the country's continued high level political commitment, multiple initiatives to strengthen RI resulting in measurable improvements in coverage and programme impact, and high quality, targeted SIAs conducted based on risk assessments. It also commended India on its generally strong polio surveillance performance, although noting that some gaps may exist. Outbreak preparedness was also noted to have proven efficient in responses to various VDPV detections.
14. The RCCPE commended the Thailand programme for conducting systematic analysis to identify high risk populations, implementing multiple interventions to achieve high coverage among them and monitoring the impact of these interventions.
15. Although some country-specific challenges exist in their polio eradication programmes, progress reports from Bhutan, DPRK, Maldives, Nepal, Sri Lanka and Timor Leste demonstrated that these countries are at relatively low risk for polio re-emergence. Nonetheless, efforts must be made to address these challenges.
16. The RCCPE concluded that, due to continuous coverage problems (and subsequent growing immunity gaps) and surveillance challenges, Indonesia and Myanmar remain at high risk.

- a. The RCCPE acknowledged the advocacy and oversight roles played by the NCCPEs in these countries. It also acknowledged the programme plans to improve deficits in coverage achieved through the RI programme and supplementary vaccination activities among the underserved populations in Indonesia and Myanmar to mitigate the risk of cVDPV emergence. The RCCPE urged both countries to rapidly and consistently implement the planned activities so that performance improvements can be noted at the next RCCPE meeting.
- b. New polio outbreaks, were they to occur in either of these countries, would, in addition to their national humanitarian, financial and political implications, also put the Regional polio-free status and global progress towards eradication and subsequent certification in jeopardy.

Recommendations

1. The RCCPE encouraged the NCCPEs to continue to undertake a systematic analysis of polio programme performance in the country context on a regular basis (bi-annual at a minimum), using the revised tools that have been developed in the Region to better understand the risks to maintaining polio-free status. Such performance reviews should include results of thorough sub-national risk analyses to identify gaps in surveillance and immunization as well as to specifically look at the actions taken in the country to mitigate these risks. Action taken in response to recommendations made during the RCCPE meetings in 2016 and 2017 should also be noted.
2. Recognizing that surveillance for poliovirus detection at the national and sub-national levels in all countries of the Region is assuming even greater importance now as part of the polio endgame strategy implementation and will be one of the key strategies of the polio post-certification strategy, the RCCPE recommended that NCCPEs and national programmes continue to enhance advocacy for surveillance with national leadership. The RCCPE also recommended that national programmes should intensify efforts to sensitize all individuals that are involved with reporting and investigation of AFP cases.
3. The RCCPE encouraged the Region to continue to look for opportunities to further expand ES, as appropriate and feasible, especially in countries that are at higher risk of VDPV emergence, including those that have initiated ES at only a few sites.
4. To maintain the good performance of the Regional polio laboratory network, the RCCPE recommended that the performance of the laboratories should continue to be monitored closely and appropriate actions taken in a timely fashion based on the findings of accreditation visits.
5. The RCCPE recommended that the process of risk assessment at Regional and national levels be strengthened through updating the objectives of risk assessment and the risk parameters used, and through standardization and documentation of the assessment process.

6. The RCCPE recommended that simulation exercises/table top exercises should be conducted in all countries of the Region with technical guidance by WHO. These exercises should include the participation of NCCPEs, and the NCCPEs should review and present the outcomes of the simulation exercises during the next RCCPE meeting.
7. The RCCPE requested that all countries continue implementing poliovirus type 2 laboratory containment activities as per GAPIII and encouraged the use of standardized data collection and verification mechanisms. Once finalized, the WHO guidance for non-poliovirus facilities to minimize risk of sample collections potentially infectious for polioviruses should be applied in countries concerned. NCCPE reports need to clearly indicate where activities in phase 1 have been completed, so that, on the basis of this information, the GCC can declare global completion of phase 1, expected in 2018.
8. Fully mindful of the risks associated with the ramp-down of polio funding, the RCCPE highlighted the need to ensure greater ownership and involvement of national governments in the development of transition plans, so that alternative sources of funding, (domestic funding or alternative donors), can be identified urgently in order to maintain adequate human resources to support polio activities at optimal levels.
9. The RCCPE requested that WHO continue advocacy and coordination efforts with governments to facilitate NCCPE efforts to support national polio programme implementation at required performance levels.

Annex 1

Agenda

Day 1/time	Thursday, 23 November 2017	Speaker/Facilitator
08:30–09:00	Registration	
09:00-09:30	<p>Opening Session</p> <p>Welcome remarks Ministry of Health & Sports, Myanmar (5 min)</p> <p>Opening remarks SEARO Regional Director by WR (5min)</p> <p>Remarks RCCPE Chairperson (5 min)</p> <p>Introduction of participants (10 min)</p> <p>Meeting objectives & administrative announcements (5min)</p>	<p>Dr Thar Tun Kyaw, Director General, DoPH</p> <p>Dr Stephan Jost</p> <p>Dr Supamit Chunsuttiwat</p> <p>Dr Sigrun Roesel</p>
09:30-10:00	<i>Group Photo & Tea Break</i>	
10:00-12:10	<p>Status update of the Global Polio Eradication Initiative and 4 objectives of Polio Endgame implementation (20 min)</p> <p>Stopping wild poliovirus in Afghanistan and Pakistan (15 min)</p> <p><i>Discussion (15 min)</i></p> <p>Global progress of type 2 poliovirus laboratory containment (15 min)</p> <p>Update on global certification aspects including for poliovirus laboratory containment (15 min)</p> <p><i>Discussion (10 min)</i></p> <p>-----</p> <p>National Certification Committee for Polio Eradication (NCCPE) presentations on country situation Myanmar (30 min)</p> <p><i>Discussion on Myanmar report (10 min)</i></p>	<p>Dr Graham Tallis</p> <p>Prof Tariq Bhutta</p> <p>Dr Graham Tallis</p> <p>Prof David Salisbury</p> <p>Dr Supamit Chunsuttiwat</p>
12:10-13:10	<i>Lunch Break</i>	
13:10-14:30	<p>National Certification Committee for Polio Eradication (NCCPE) presentations on country situation India (30min)</p> <p><i>Discussion on India report (10 min)</i></p> <p>Indonesia (30 min)</p> <p><i>Discussion on Indonesia report (10 min)</i></p>	
14:30-15:00	<i>Tea Break</i>	
15:00-16:50	<p>NCCPE presentations on country situation Bangladesh (20min)</p> <p><i>Discussion on Bangladesh report (10 min)</i></p> <p>Bhutan (20 min)</p> <p><i>Discussion on Bhutan report (10 min)</i></p> <p>Democratic Peoples' Republic of Korea (20 min)</p> <p><i>Discussion on Democratic Peoples' Republic of Korea report (10 min)</i></p> <p>NCCPE analytical oversight - programme performance review and risk</p>	<p>Prof NK Arora</p>

	assessment Experience India (10 min) <i>Discussion (10 min)</i>	
17:00-18:00	RCCPE Closed Session	
18:30	Reception	
Day 2	Friday, 24 November 2017	
09:00-10:30	NCCPE presentations on country situation Maldives (20min) <i>Discussion on Maldives report (10 min)</i> Nepal (20 min) <i>Discussion on Nepal report (10 min)</i> Sri Lanka (20 min) <i>Discussion on Sri Lanka report (10 min)</i>	
10:30-11:00	<i>Tea Break</i>	
11:00-12:00	NCCPE presentations on country situation Thailand (20 min) <i>Discussion on Thailand report (10min)</i> Timor Leste (20 min) <i>Discussion on Timor Leste report (10 min)</i>	
12:00-13:00	<i>Lunch Break</i>	
13:00-14:30	RCCPE Closed Session	
14:30-15:30	Updates from RCC Europe (10min) Updates from RCC Western Pacific Region (10 min) Regional summary on maintaining polio-free status in the WHO South-East Asia Region (20 min) Regional summary on GAPIII containment (10min) <i>Discussion (10 min)</i>	Prof David Salisbury Dr Nobuhiko Okabe Dr Sunil Bahl Dr Sigrun Roesel Dr Supamit Chunsuttiwat
15:30-16:00	<i>Tea Break</i>	
16:00-16:45	Presentation of conclusions and recommendations	RCCPE
16:45-17:00	Closing by WR Myanmar	

Annex 2

List of participants

SEA-RCCPE – Chairperson and Members

1. Dr Supamit Chunsuttiwat
Chairperson SEA-RCCPE
Advisor to Department Disease Control
Ministry of Public Health
Bangkok, Thailand
2. Dr Suniti Acharya*
Executive Director
Center for Health Policy Research and Dialogue
Kathmandu, Nepal
3. Dr Mark Steven Oberste*
Branch Chief
Polio and Picornavirus Laboratory Branch
Division of Viral Diseases, Centers for Disease Control and Prevention
Atlanta, USA
4. Dr Nobuhiko Okabe
Director General
Kawasaki City Institute for Public Health
Kawasaki, Japan
5. Professor (Dr) Tariq Iqbal Bhutta
Professor of Pediatrics and
Former Principal of Nishtar Medical College
Lahore, Pakistan
6. Dr Abraham Joseph¹
Former Professor, Community Health
The Christian Institute of Health Sciences & Research (CIHSR)
Vellore, Tamil Nadu, India

7. Professor (Dr) Ismoedijanto Moedjito
Professor, Pediatrics
Department of Child Health
Medical School Airlangga University
Surabaya, Indonesia
8. Dr Kyaw Nyunt Sein
Senior National Advisor
The Three Millennium Development Goals Fund
Fund Management Office, UNOPS
Yangon, Myanmar
9. Dr Kinzang Tshering
Interim President (Paediatrician)
Jigme Dorji National Referral Hospital
University of Medical Sciences of Bhutan
Thimphu, Bhutan
10. Dr Nalini Withana
Former Virologist WHO/SEARO
Kalubowila, Sri Lanka

NCCPE Chairpersons and Members

11. Professor (Dr) Choudhury Ali Kawser
NCCPE Representative
Professor at Paediatric Department
Bongobondhu Sheikh Mujib Medical University
Dhaka, Bangladesh
12. Dr Tandi Dorji
Chairperson NCCPE
Thimphu, Bhutan
13. Dr Song Chol Nam
NCCPE Representative
Officer, Bureau of State Hygiene Inspection
Ministry of Public Health
Pyongyang, Democratic People's Republic of Korea

¹ Unable to attend

14. Dr Ro Nam Chol
Section Chief
Central Hygiene and Anti-
Epidemic Institute
Ministry of Public Health
Pyongyang, Democratic People's
Republic of Korea
15. Professor N K Arora
Chairperson NCCPE
INCLIN Executive Office
New Delhi, India
16. Dr Hariadi Wibisono
Chairperson NCCPE
Jakarta, Indonesia
17. Dr Abdul Azees Yoosuf
Chairperson NCCPE
Ministry of Health
Male', Republic of Maldives
18. Professor (Dr) Soe Lwin Nyein
Chairperson NCCPE
Director General, Department of
Public Health (Retd)
Ministry of Health and Sports
Nay Pyi Taw, Myanmar
19. Dr Badri Raj Pande
Chairperson NCCPE
Kathmandu, Nepal
20. Professor Lalitha Mendis
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21. Dr Supachai Rerks-Ngarm
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22. Dr Vina Maria Gusmao dos Reis Martins
Chairperson NCCPE
Dili, Timor Leste

Ministry of Health – Myanmar

23. Dr Htay Htay Tin
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24. Dr Htar Htar Lin
Deputy Director (Programme Manager)
Expanded Programme on Immunization
Department of Public Health
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Public Health Department
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Public Health Department
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Ministry of Health and Sports
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Public Health Department
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28. Dr Than Lwin Aung
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Public Health Department
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Ministry of Health and Sports
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29. Dr Hnin Ei Phyu
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Public Health Department
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30. Dr Soe Win Paing
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Rakhine State
Ministry of Health and Sports
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31. Dr Z Lwam Khaung
Team Leader
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Ministry of Health and Sports
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32. Dr Myat Phyu Pyar Aye
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Observers

33. Professor (Dr) David Salisbury
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Global Certification Commission for
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WHO Country Office for Myanmar

35. Dr Stephan Paul Jost
WHO Representative
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36. Dr Tin Tin Aye
National Professional Officer
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37. Ms Myitzu Aye
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38. Ms Lei Lei Mon
Data Assistant
Yangon, Myanmar

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39. Dr Graham Tallis
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Surveillance, Monitoring & Information
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