South-East Asia Regional Certification Commission for Polio Eradication (SEARCCPE)

Report of the second meeting
25-27 January 2012, Chiang Mai, Thailand
South-East Asia Regional Certification Commission for Polio Eradication (SEARCCPCE)

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Abbreviations

AFP  acute flaccid paralysis
aVDPV  ambiguous vaccine-derived poliovirus
BAN  Bangladesh
BHU  Bhutan
BMGF  Bill and Melinda Gates Foundation
bOPV  bivalent oral polio vaccine
CDC  Centers for Disease Control and Prevention
cVDPV  circulating vaccine-derived poliovirus
EPI  Expanded Programme on Immunization
ERC  Expert Review Committee
FHR  family health and research
GPEI  Global Polio Eradication Initiative
GPS  global positioning system
IMB  Independent Monitoring Board
INO  Indonesia
IVD  immunization vaccine and development
iVDPV  immunodeficient vaccine-derived poliovirus
DPRK  DPR Korea
LQAS  lot quality assurance sampling
MAL  Maldives
MMR  Myanmar
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNTE</td>
<td>maternal neonatal tetanus elimination</td>
</tr>
<tr>
<td>mOPV</td>
<td>monovalent oral polio vaccine</td>
</tr>
<tr>
<td>NCCPE</td>
<td>National Certification Commission for Polio Eradication</td>
</tr>
<tr>
<td>NEP</td>
<td>Nepal</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NID</td>
<td>National Immunization Day</td>
</tr>
<tr>
<td>NPSP</td>
<td>National Polio Surveillance Project</td>
</tr>
<tr>
<td>POL3</td>
<td>third dose of polio immunization</td>
</tr>
<tr>
<td>RCCPPE</td>
<td>Regional Certification Commission for Polio Eradication</td>
</tr>
<tr>
<td>SEARO</td>
<td>Regional Office for South-East Asia</td>
</tr>
<tr>
<td>SIAD</td>
<td>short interval additional dose</td>
</tr>
<tr>
<td>SRL</td>
<td>Sri Lanka</td>
</tr>
<tr>
<td>THA</td>
<td>Thailand</td>
</tr>
<tr>
<td>TLS</td>
<td>Timor-Leste</td>
</tr>
<tr>
<td>tOPV</td>
<td>trivalent oral polio vaccine</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UP</td>
<td>Uttar Pradesh</td>
</tr>
<tr>
<td>VAPP</td>
<td>vaccine associate paralytic polio</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WPRO</td>
<td>Regional Office for the Western Pacific</td>
</tr>
<tr>
<td>WPV</td>
<td>wild poliovirus</td>
</tr>
</tbody>
</table>
1. Introduction

The second meeting of the South-East Asia Regional Commission for Certification of Polio Eradication (SEARCCPE) was held from 25-27 January 2012 in Chiang Mai, Thailand. Professor Nazrul Islam chaired the meeting. In addition to SEARCCPE members, the Chairperson of the National Certification Committees on Polio Eradication (NCCPE) or their representative attended the meeting. The NCC representatives from DPR Korea and Maldives could not attend. The agenda of the meeting and the list of participants are attached in Annex 1 and Annex 2 respectively.

The meeting was inaugurated by Dr Monir Islam, Director, Family Health and Research (FHR) and Acting Coordinator, Immunization and Vaccine Development (IVD), WHO South-East Asia Region, who read the message of Dr Samlee Plianbangchang, Regional Director, in his absence. The Regional Director in his message mentioned that great progress had been made over the last 24 months towards polio eradication in the South-East Asia Region. The last case of wild poliovirus in the Region was reported from India on 13 January 2011 and that it was time to re-energize and re-invigorate certification efforts.

He emphasized that sustained polio eradication is only possible with a strong routine immunization programme that reaches all children. This is an important point for countries to remember in order to achieve high population immunity and maintain their polio-free status. Dr Samlee reiterated that WHO would extend every possible support to help achieve the target of global polio eradication.

The participants were provided with global and regional overviews of polio eradication as well as a review of the most recent report of the Independent Monitoring Board (IMB). A special presentation on the polio situation in China was made by the WPRO polio focal point and presentations on India were made by the NCC chairperson, India, a representative of the India Laboratory Task Force and the WHO-National Polio Surveillance Project (NPSP) manager.
2. **Global overview**

The global polio eradication programme marks progress towards polio eradication by looking at the endemic, re-established and outbreak countries at 6 and 12-month intervals. As of December 2011, the overall status of the Global Polio Eradication Initiative (GPEI) is shown in Table 1.

*Table 1: Overall status of the GPEI, December 2011*

<table>
<thead>
<tr>
<th>Categories of countries</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endemic</td>
<td>• on track: India</td>
</tr>
<tr>
<td></td>
<td>• at risk: Nigeria</td>
</tr>
<tr>
<td></td>
<td>• off track: Pakistan/Afghanistan</td>
</tr>
<tr>
<td>Re-established</td>
<td>• on track: South Sudan</td>
</tr>
<tr>
<td></td>
<td>• late: Angola</td>
</tr>
<tr>
<td></td>
<td>• off track: Chad and the Democratic Republic (DR) of the Congo</td>
</tr>
<tr>
<td>Outbreaks</td>
<td>• on track: 18 countries (&lt;6months)</td>
</tr>
<tr>
<td></td>
<td>• off track: Kenya/Uganda</td>
</tr>
</tbody>
</table>

Based on the situation over the past six months, the programme has identified major setbacks and risks. The major setbacks and risks to the global programme are outlined in Table 2.

*Table 2: Major setbacks/risks to the GPEI*

<table>
<thead>
<tr>
<th>Countries</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>• epidemic WPV type 1</td>
</tr>
<tr>
<td>DR Congo/Chad</td>
<td>• persistent outbreaks</td>
</tr>
<tr>
<td>Nigeria</td>
<td>• Kano re-infected</td>
</tr>
<tr>
<td></td>
<td>• five times as many cases in 2011 as compared to 2011</td>
</tr>
<tr>
<td></td>
<td>• persistent cVDPV2 outbreak</td>
</tr>
<tr>
<td>Pakistan</td>
<td>• epidemic WPV type 1</td>
</tr>
<tr>
<td></td>
<td>• persistent WPV type 3</td>
</tr>
<tr>
<td>Outbreaks</td>
<td>• too many new surprises</td>
</tr>
</tbody>
</table>
The key actions taken to address these setbacks and risks include the following: (1) the heads of agencies will meet quarterly and review the Independent Monitoring Board (IMB) report to address issues; (2) partner agencies will expand teams in Angola, DR Congo, Chad, Nigeria and Pakistan; (3) direct engagement of heads of state in Angola, Chad, DR Congo and Nigeria will be improved; and (4) innovative approaches including SIADs, GPS mapping and communication and LQAS will be expanded. The immediate operational priorities for the endemic and re-established countries are shown in Tables 3 and 4.

Table 3: Immediate operational priorities: endemic countries

<table>
<thead>
<tr>
<th>Countries</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Afghanistan | • improve routine polio immunization strategy  
• advocate with governors and provincial leaders (particularly in the south)  
• review district/province management capacity |
| Nigeria | • implement accountability frameworks (GoN’s “Special Task Force”)  
• focus on chronically missed children  
• recruit 1000+ community mobilization  
• recruit an additional 80 district technical staff  
• accelerate routine EPI |
| Pakistan | • “rethink” current implementation strategies  
• recruit 727 subdistrict staff  
• provide direct vaccinator payments  
• outsource immunization activities to NGOs  
• create management accountability structure |
**Table 4: Immediate operational priorities: re-established countries**

<table>
<thead>
<tr>
<th>Countries</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Chad      | • engage President on a monthly basis  
            • recruit 100 new WHO/UNICEF staff  
            • establish five new operation hubs  
            • mapping/engagement of NGO  
            • accelerate routine EPI |
| DR Congo  | • focus on Katanga and Bas Congo  
            • combine mop-up and NID activities  
            • intensify social mobilization activities in resistance areas |

The GPEI identified seven cross-cutting initiatives to help implement operational priorities:

1. **enhanced surge capacity**: manage and coordinate WHO, UNICEF, CDC, Bill and Melinda Gates Foundation surge (nationals/internationals).
2. **more aggressive outbreak response**: “emergency protocols” and rapid assessments at the three-month mark (including surveillance).
3. **further scale up communication/social mobilization**: fully integrate data collection strategy.
4. **tighter monitoring of plans**: use of standard frameworks to track/address “why” for failing programmes.
5. **expand/intensify innovations**: immediately expand technical innovations to include management/culture.
6. **internal accountability**: establish tight accountability mechanisms (build on India/NPSP model, monitor data).
7. **campaign monitoring**: review “independent” monitoring processes and quality controls (including scale-up of LQAS linked to accountability processes).

To summarize, the global programme needs to ensure that the gains made in India are maintained and that the outbreaks in Angola and DR Congo are finished. The primary risks to the global programme are
increasing case count and circulation of wild poliovirus in Pakistan, Nigeria and Chad. The secondary risks to the programme are surveillance gaps in Kenya/Uganda and the outbreak in China.

3. **Overview of the Western Pacific Region**

The Western Pacific Region was certified polio-free in 2000. The five key challenges to the polio programme over the last decade include:

1. Certification in 2000, while a historic achievement, became an event of history.
2. Goals for global eradication set over 20 years ago and repeatedly delayed have resulted in the loss of institutional memory in the current public health leadership.
3. Shifting priorities towards new/emerging diseases (SARS, H5N1, H1N1) and away from polio eradication.
4. Reduction in financial support for polio activities in the Region (US$ 73 million in 2000 to less than US$ 1 million in 2011)
5. No increase in WHO EPI staff at country offices despite expanded responsibilities for measles elimination, hepatitis B control, MNTE and new vaccine introduction, etc.

Despite all efforts to maintain its polio-free status and overcome the above challenges, there was a wild poliovirus importation from Pakistan to China. Four WPV type 1 cases were reported from Hotan prefecture in southern Xinjiang on 26 August 2011. The outbreak spread to three neighbouring prefectures resulting in 21 cases with dates of onset of paralysis from July to October 2011. More than half the cases were in adults (>15 years of age).

The response by the Chinese government was rigorous with a high level of political accountability and multisectoral collaboration. The Government of China conducted three immunization rounds for children in September, October and November as well as two rounds for adults in September and November. In order to meet the demand for oral polio vaccines and conduct the campaigns in a timely manner, domestic vaccine production was increased resulting in an adequate supply of mOPV1 and tOPV for all activities.
Additionally, the Government of China has planned several activities in 2012 to re-establish its polio-free status: (1) there will be an assessment of outbreak response activities and surveillance performance in February, (2) two additional subnational immunization campaigns are planned for March with mOPV1 and April with tOPV, and (3) an international AFP surveillance review is planned for May.

The Western Pacific Region will need to submit documentation to their Regional Certification Committee to evaluate the response in China and decide what additional actions need to be taken in order to declare China and the Region polio-free.

4. Independent Monitoring Board (IMB) recommendations

The Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative was established in 2010 to monitor the progress of the plan of work for 2010-2012. The most recent report was produced in October 2011. The overall assessment of the IMB was that milestones are being missed and the programme is not on track to meet its current 2012 goal unless there are significant changes to address fundamental problems.

The following are the main findings in the IMB report:

(1) Case numbers are rising in five of the seven key countries;
(2) Outbreaks – unwelcome surprises continue;
(3) As many milestones are being missed are being met;
(4) The programme is not on track for its end-2012 goal, or for anytime soon after, unless fundamental problems are tackled;
(5) If problems are tackled, imminent success is entirely feasible, even for the end of 2012;
(6) India is alone among the four endemic countries in being on track to stop transmission in 2011; and
(7) The polio problem in Pakistan and Nigeria is a major concern, particularly in Pakistan.
The IMB identified country-specific and polio programme issues that need to be addressed to get the programme back on track for its end-2012 goal. Tables 5 and 6 outline the main issues identified for each category.

**Table 5: Country-specific issues**

<table>
<thead>
<tr>
<th>Countries</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>• cannot reach one third children in high-risk districts</td>
</tr>
<tr>
<td>Chad</td>
<td>• must deploy technical capacity to good effect</td>
</tr>
<tr>
<td>DR Congo</td>
<td>• right direction but risks election disruption</td>
</tr>
<tr>
<td>Nigeria</td>
<td>• needs political/traditional leaders’ commitment</td>
</tr>
<tr>
<td>Pakistan</td>
<td>• needs fundamental strategy review</td>
</tr>
</tbody>
</table>

**Table 6: Polio programme issues**

<table>
<thead>
<tr>
<th>Area</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>People</td>
<td>• lack of systems for “accountability”</td>
</tr>
<tr>
<td>Plans</td>
<td>• implementation not tracked and remains vague</td>
</tr>
<tr>
<td>Attitude</td>
<td>• slow to appreciate that strategy is not working</td>
</tr>
<tr>
<td>Innovation</td>
<td>• need “strand of systematic innovation”</td>
</tr>
</tbody>
</table>

The IMB identified the main cross-programme findings and divided them between **people and planning** and **need to foster innovation**. These findings are summarized in Table 7.
The IMB noted that improvement would be catalysed by polio receiving higher priority. Polio is a global health emergency and failure would be a disaster. While this report has identified significant issues, addressing them would make success entirely feasible, even by the end of 2012.

5. India programme update

Since 2000, India remained the only country in the Region endemic for wild poliovirus. The circulation of types 1 and 3 wild poliovirus was largely concentrated in the two northern states of Uttar Pradesh (UP) and Bihar. Through tremendous efforts over the last 12-24 months, India has achieved historically low transmission with the last wild poliovirus case reported on 13 January 2011 in Howrah, West Bengal. Genetic and environmental surveillance has confirmed this progress and seroprevalence studies have indicated that polio immunity has remained high.
The strategies contributing to this significant progress have been multi-pronged but the underlying tenet of the programme has been ensuring that the overall quality of AFP surveillance and supplemental immunization activities (SIAs) remained high. One area of focus has been high-risk programming and the intensification of activities for children and special populations: communities with high vaccine refusal, 107 high-risk blocks in Uttar Pradesh/Bihar, and the Kosi riverine. In addition to this high-risk programming, aggressive mop-up operations in response to polio cases have been implemented with the use of vaccines based on the prevailing epidemiology. Bivalent oral polio vaccine (bOPV) was introduced in 2010 and has been an important tool for combating type 1 and 3 wild polioviruses simultaneously.

An important part of the multipronged strategy has been the mapping and outreach to migrant populations. In 2011, the number of sites identified with migrants (slums, nomads, brick kilns and construction sites) throughout India was approximately 162,000. These sites accounted for more than 4.2 million children under the age of 5 years that would have otherwise been missed. Ensuring vaccination coverage for migrants is an extension of immunizing children in transit. During the national immunization days, vaccination teams are deployed to cover children at bus stands, on highways and in markets. During each round, teams immunized approximately eight million children in transit with more than 100,000 of these children immunized on moving trains.

While targeting migrant populations within India has been an important part of the overall strategy, a similar approach to cover the porous Indo-Nepal border has complemented India’s national strategy and provided protection for both countries. As an example, there were 81 continuous vaccination points on the border that immunized over 1.4 million children from April to December 2011.

Expansion of environmental surveillance has provided an important marker of progress and helped to monitor high-risk areas in the absence of wild poliovirus cases. There is cautious optimism about the progress made in India. Several risks remain and will require continued vigilance over the next couple of years. These risks and programme mitigation activities are outlined in Table 8.
Table 8: Risk and mitigation activities in India

<table>
<thead>
<tr>
<th>Area</th>
<th>Issues</th>
</tr>
</thead>
</table>
| Risk                     | • Re-introduction of virus into traditional endemic areas of UP and Bihar through the survival of poliovirus in migrant and mobile communities leading to further spread.  
• International importation from any of the other endemic or re-infected countries.  
• Gaps in AFP surveillance and/or delays in detection of wild poliovirus leading to a late/inadequate response. |
| Mitigation activities    | • Intense surveillance for poliovirus with continued intense SIAs with high coverage especially among migrant and mobile populations.  
• Continued focus on the 107 high-risk blocks of UP and Bihar.  
• Updated emergency preparedness plans and response training to minimize risk of importation and spread of any wild poliovirus (all states have emergency response groups and 163 rapid response teams have been identified and trained). |

6. Risk assessment of importation and circulation for polio-free countries

The Independent Monitoring Board stated in its April 2011 report that CDC has started some valuable work to summarize the risk assessment of polio-free countries across WHO regions. We would welcome CDC maintaining a leadership role in supporting WHO regions to strengthen and standardize these risk assessments. Consequently, early in June 2011 representatives from all WHO regions and CDC met in Atlanta, Georgia to share risk assessment methodologies, discuss harmonizing models, and consider how to use the results to mitigate risk. During the meeting, core and optional variables were proposed and grouped into three categories: susceptibility indicators, surveillance indicators, and population/programme assessment indicators. See Table 9 for the full list of indicators by categories.
### Table 9: Risk assessment categories and variables

<table>
<thead>
<tr>
<th>Categories</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susceptibility</td>
<td>• Routine polio immunization coverage estimates (POL3).</td>
</tr>
<tr>
<td></td>
<td>• Trends in POL3 over for 3-5 years.</td>
</tr>
<tr>
<td></td>
<td>• Subnational immunity gaps as measured by DPT3 coverage.</td>
</tr>
<tr>
<td></td>
<td>• Polio immunity gap as measured by the immunity status of the NP-AFP cases.</td>
</tr>
<tr>
<td></td>
<td>• Supplementary immunization activities conducted.</td>
</tr>
<tr>
<td></td>
<td>• Emergence of cVDPV (or aVDPV).</td>
</tr>
<tr>
<td>Surveillance</td>
<td>• Non-polio AFP rate.</td>
</tr>
<tr>
<td></td>
<td>• Percentage of adequate stools within 14 days.</td>
</tr>
<tr>
<td></td>
<td>• Achievement of both the primary surveillance indicators at the subnational level.</td>
</tr>
<tr>
<td></td>
<td>• Timeliness of laboratory results.</td>
</tr>
<tr>
<td>Population/programme delivery</td>
<td>• Presence of high-risk populations.</td>
</tr>
<tr>
<td></td>
<td>• Status of health system.</td>
</tr>
<tr>
<td></td>
<td>• Clean water/sanitation.</td>
</tr>
<tr>
<td></td>
<td>• Probability of importation: border with polio-affected areas.</td>
</tr>
<tr>
<td></td>
<td>• Probability of importation: travel links with polio-affected areas.</td>
</tr>
</tbody>
</table>

After the meeting in June, Regional Offices re-worked their risk assessment with the new indicators. The group agreed that all core variables should be used but not necessarily weighted the same allowing for flexible standardization. The IMB recommended in their April 2011 report that at each subsequent IMB meeting, they would ask to receive an up-dated risk assessment from each WHO Region with a synopsis of risk mitigation activities for countries that were highlighted as “high-risk”. Since June 2011, CDC has been organizing conference calls to further refine and harmonize the model.
7. Certification and laboratory containment

Nine countries in the Region (Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand) have submitted full country documentations on polio eradication that were accepted by the Regional Certification Commission. These countries are required to submit annual updates to the SEARCCPE and should include information on the status of their laboratory containment of polioviruses.

Countries that have had wild poliovirus importation after submission of their full national documentation and laboratory containment report (Bangladesh, Indonesia, Myanmar and Nepal) will need to re-survey their laboratories, update the national laboratory inventory and submit a report to the SEARCCPE.

8. General recommendations on 2010 annual updates

- All countries should ensure that overall population immunity is maintained through high routine immunization coverage and if necessary conduct high-quality SIAs to prevent circulation after importation of poliovirus and the emergence of VDPV.
- All countries should maintain uniform and highly sensitive AFP surveillance to ensure timely detection and response to an importation:
  - All countries should improve the documentation of discarded AFP cases by providing detailed line-listing of cases with final diagnosis.
  - The expected annual GBS rate of 0.6-0.8 per 100,000 population under the age of 15 years could be used as a gauge to assess completeness and accuracy of AFP report.
- All countries should develop or update national plans for responding to poliovirus importation:
  - Preparedness plans should be submitted with annual updates and include comments on licensure of tOPV/bOPV/mOPV and national/regional policies on emergency access to oral polio vaccine.
All countries with recent circulation of imported wild poliovirus or VDPVs should update the inventories of laboratories that store poliovirus or potentially infectious materials. These countries are Bangladesh, Indonesia, Myanmar and Nepal.

All NCCPEs should review the following to improve the quality of their annual reports:

- Include narratives/descriptions of data that support polio-free status.
- Ensure that a detailed executive summary is included in the annual update. It should be signed by the NCC chairperson.
- Include responses to RCCPE comments on the 2010 annual updates as a part of the 2011 annual update.
- Include a copy of the original National Documentation on Certification of Poliomyelitis Eradication and highlight any changes since submission (e.g. importation of wild poliovirus or VDPVs).
- Include information about laboratory(ies) that process stool specimens for AFP surveillance.

Country recommendations

All countries that previously submitted full documentation that was accepted by the RCCPE submitted a 2010 annual update to the secretariat except DPR Korea. The RCCPE members reviewed the NCC reports according to Table 10.

Table 10: Country annual update (2010) review by SEARCCPE members

<table>
<thead>
<tr>
<th>Country</th>
<th>Primary reviewer</th>
<th>Secondary reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Dr Ali Jafer Suleiman</td>
<td>Dr David Salisbury</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Dr Suniti Acharya</td>
<td>Dr Kyan Nunt Sein</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>Dr Ismoedijanto Moedjito</td>
<td>Dr Suniti Acharya</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Dr Kinzang P. Tshering</td>
<td>Dr Anthony Adams</td>
</tr>
</tbody>
</table>
The SEARCCPE reviewed each country report and made specific recommendations to improve the national certification process and documentation. The secretariat was instructed to provide written feedback to countries through a letter from the RCCPE chairperson to the respective NCCPE chairpersons. Country-specific recommendations are listed in Table 11.
<table>
<thead>
<tr>
<th>Country</th>
<th>Comments/recommendations</th>
</tr>
</thead>
</table>
| Bangladesh | • Provide a copy of the National Documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
• Ensure that the executive summary includes the signature of the NCC chairperson.  
• Clarify the population denominator that is being used to calculate the polio surveillance indicators. (e.g. are they from a recent census or are they projections based on growth estimates?).  
• Explain the approach to detection and reporting of VAPP and VDPV.  
• Provide the active surveillance definition being used by the programme.  
• Explain the lack of timeliness of reporting for routine surveillance data.  
• Provide an explanation of AFP case diagnosis (e.g. the number of acute stroke syndrome and viral myositis cases appear to be excessive).  
• Describe policy and procedures for conducting 60-day follow-ups.  
• Explain the absence of compatible cases in AFP cases line-lists.  
• Describe policy and procedures for cases to be reviewed by the Expert Review Committee (ERC).  
• Include an explanation of the procedure for processing AFP specimens and the laboratory accreditation status.  
• Include re-inventory results from laboratories in the 2011 annual update.  
• Include an updated copy of the polio importation preparedness plan as an attachment to the 2011 annual update.  
• Include a line-list of AFP cases as an attachment to the 2011 annual update.  
• Include the latest EPI/VPD surveillance review report as an attachment to the 2011 annual update. |
<table>
<thead>
<tr>
<th>Country</th>
<th>Comments/recommendations</th>
</tr>
</thead>
</table>
| Bhutan   | - Provide a copy of the national documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
- Ensure that the executive summary includes the signature of the NCC chairperson.  
- Ensure that the report focuses on the active surveillance (IVD to provide support as necessary).  
- Provide description of areas with <80% routine OPV coverage and the actions taken.  
- Ensure that all the tables in the report are filled out completely (e.g., Table 4.2.2 in the 2010 annual update).  
- Include an explanation of the procedure for processing AFP specimens and the laboratory accreditation status.  
- Include the AFP case specimen results as an attachment to the 2011 annual update.  
- Include information about nomadic/migrant populations in the 2011 annual update.  
- Include a line list of AFP cases as an attachment to the 2011 annual update.  
- Include the latest surveillance review report as an attachment to the 2011 annual update. |
| DPR Korea| - DPR Korea is urged to submit updates for the period of 2010 along with the next annual update for 2011. |
| Indonesia| - Provide a copy of the national documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
- Describe policy and procedures for conducting 60-day follow-ups.  
- Ensure that cases reviewed by the Expert Review Committee (ERC) are re-labeled with the final diagnosis.  
- Review routine OPV3 coverage rates at the provincial and district levels (there appears to be an inconsistency in the data provided in different sections of the 2010 annual report).  
- Provide comments on the integration of immunization activities with other inventions and consequences (e.g., linking bed nets for malaria prevention only when a child is fully immunized).  
- Explain the lack of timeliness of reporting for routine surveillance data. |
<table>
<thead>
<tr>
<th>Country</th>
<th>Comments/recommendations</th>
</tr>
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</table>
| Maldives | • Provide a copy of the National Documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
• Explain national policy on stopping the zero dose of OPV.  
• Include a description of any vaccine refusals and actions/strategies taken to engage these groups.  
• Ensure that the report focuses on active surveillance (IVD to provide support as necessary).  
• Consider including experts on the ERC from other countries to improve final diagnosis (via skype, teleconference).  
• Include an explanation of the procedure for processing AFP specimens with the RRL in Sri Lanka and the laboratory accreditation status. |
| Myanmar | • Provide a copy of the national documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
• Include a sub-national risk assessment for state/division level and describe any cross border activities with Bangladesh, China, India, Laos or Thailand.  
• Review tables in annual updates for consistency and correctness (e.g., final diagnosis line list).  
• Provide details of the supply chain for routine oral polio vaccine and any potential stock outs.  
• Makes efforts to obtain and include information from inaccessible areas on oral polio vaccine coverage (POL3) and AFP surveillance indicators.  
• Include an explanation of the procedure for processing AFP specimens and the laboratory accreditation status. |
| Nepal | • Provide a copy of the National Documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
• Ensure that the executive summary includes detailed information on polio free status (similar to narrative during the Chiang Mai meeting).  
• Clarify the population (denominator) that is being used to calculate the polio surveillance indicators.  
• Describe actions taken to improve coverage in districts not achieving >80% coverage for the third dose of polio vaccine (POL3).  
• Describe known risk for importation at the border with India and risk mitigation activities.  
• Describe timelines in the importation response preparedness plan.  
• Review tables in annual updates for consistency and correctness (e.g., final diagnosis line list).  
• Include an explanation of the procedure for processing AFP specimens and the laboratory accreditation status. |
Report of the second meeting

<table>
<thead>
<tr>
<th>Country</th>
<th>Comments/recommendations</th>
</tr>
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</table>
| Sri Lanka | • Provide a copy of the National Documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
    • Ensure that the executive summary includes detailed information on polio free status.  
    • Clarify the population denominator that is being used to calculate the polio surveillance indicators and check population breakdown: <1 years old, <5 years old and total.  
    • Provide description of iVDPV research project.  
    • Include an explanation of the procedure for processing AFP specimens and provide comments on Maldives’ specimens.  
    • Include details of the laboratory accreditation status. |
| Thailand | • Provide a copy of the National Documentation on Certification of Poliomyelitis Eradication report that was accepted by the RCCPE with the 2011 annual update.  
    • Ensure that the executive summary includes detailed information on polio free status.  
    • Clarify the population denominator that is being used to calculate the polio surveillance indicators (the same number is being used for 2009 and 2010).  
    • Describe actions taken to address declining AFP surveillance indicators.  
    • Describe representativeness of the AFP cases (Thai versus migrant/non-Thai populations).  
    • Explain the fluctuation of the AFP reporting sites.  
    • Ensure that the report focuses on active surveillance (IVD to provide support as necessary).  
    • Include an explanation of the procedure for processing AFP specimens and provide comments on specimens from Bhutan and Nepal.  
    • Review tables in annual updates for consistency and correctness. |
| India | Based on the presentations from India NCCPE and WHO-NPSP, it appears that India has interrupted the endemic wild poliovirus transmission. The SEARCCPE appreciated the efforts made by the Government of India with support from the India NCCPE and WHO-NPSP. The SEARCCPE recommends that the India NCCPE should be prepared to submit complete National Documentation on Certification of Poliomyelitis by January 2014. |
In preparation for January 2014, India should submit a preliminary report for review at the third meeting of the SEARCCPE. The SEARCCPE noted that the complete documentation (for submission in January 2014) should include three years of programme and surveillance data before the last detected cases (e.g. 2008, 2009 and 2010) to complement the three years of programme and surveillance data after the last detected case (e.g. 2011, 2012 and 2013). The preliminary report should include preparedness plan(s), cross-border activities, and laboratory containment plans. The SEARCCPE recommended that the secretariat provide any additional assistance needed to ensure that the India NCC completes the preliminary report by June 2012 as well as all the documentation for full submission in January 2014.

**Timor-Leste**

Timor-Leste has not submitted national documentation on polio eradication. However, the RCC appreciated that the newly-constituted NCC provided an update on the situation in Timor-Leste at the meeting in Chiang Mai, Thailand.

The SEARCCPE recognized the low probability of poliovirus circulating following an importation. Timor-Leste is sparsely populated and has not reported a wild poliovirus for more than a decade. The RCC also appreciated the efforts currently undertaken by the Government of Timor-Leste to improve routine immunization coverage and AFP surveillance in the country.

The SEARCCPE urged the authorities in Timor-Leste to complete the membership of the NCCPE, Laboratory Task Force and Expert Review Committee (ERC). Members from other countries could be used to supplement current members if there is difficulty in recruiting members from within the country.

The SEARCCPE requested that the Timor-Leste NCCPE submit national documentation on Certification of Poliomyelitis Eradication for review during the third meeting of the SEARCCPE. The SEARCCPE recommended that the secretariat provide any assistance needed to ensure that Timor-Leste NCCPE completes all documentation necessary for submission by June 2012.
9. NCCPE and WHO Secretariat recommendations

- The next meeting of the SEARCCPE is proposed to be held in August 2012.

- The NCC chairpersons should send the annual updates for 2011 to the WHO Secretariat in SEARO by 1 June 2012. All RCCPE members should receive copies of the country reports (complete version with annexure) by 1 July 2012. Only versions sent by NCCPEs to the commission in advance will be reviewed and discussed by the SEARCCPE at its meeting in August 2012.

- The SEARCCPE will continue with the process of designating primary and secondary reviewers for country reports. The primary reviewer will present a summary of the report submitted by countries. The secondary reviewer will present any remaining issues not mentioned by the primary reviewer. The NCCPE chairpersons will respond only after both reviewers have completed their remarks.

- In order to facilitate communication between the SEARCCPE and NCCPE chairpersons, WHO-SEARO/IVD should provide basic secretariat support for the SEARCCPE chairperson.

- The SEARCCPE chairperson will provide written feedback to the NCCPE chairpersons with specific recommendations on the 2010 annual reports. The 2011 annual reports should include responses to comments on the 2010 annual reports.

- After considering the current epidemiological situation, the SEARCCPE reviewed and adopted the following timeline for certification activities in the South-East Asia Region.
### Table 12: Timeline for polio certification in the South-East Asia Region

<table>
<thead>
<tr>
<th>Month</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2012</td>
<td>• Second meeting of the SEARCCPE</td>
</tr>
<tr>
<td>August 2012</td>
<td>• Third meeting of the SEARCCPE:</td>
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<tr>
<td></td>
<td>• Review 2011 annual updates from Bangladesh, Bhutan, DPR Korea,</td>
</tr>
<tr>
<td></td>
<td>Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand.</td>
</tr>
<tr>
<td></td>
<td>• Review full documentation from Timor-Leste.</td>
</tr>
<tr>
<td></td>
<td>• Review preliminary documentation from India.</td>
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<tr>
<td>February 2013</td>
<td>• Fourth meeting of the SEARCCPE:</td>
</tr>
<tr>
<td></td>
<td>• Review 2012 annual updates from Bangladesh, Bhutan, DPR Korea,</td>
</tr>
<tr>
<td></td>
<td>Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand.</td>
</tr>
<tr>
<td></td>
<td>• Review preliminary documentation from India</td>
</tr>
<tr>
<td>August 2013</td>
<td>• Supplementary meeting of the SEARCCPE: Review the status of the</td>
</tr>
<tr>
<td></td>
<td>Region in preparation for the January 2014 meeting.</td>
</tr>
<tr>
<td>January 2014</td>
<td>• Fifth meeting of the SEACCPE: Review documentation for all Member</td>
</tr>
<tr>
<td></td>
<td>States for submission to the GCC.</td>
</tr>
</tbody>
</table>
Annex 1

Agenda

Wednesday, 25 January 2012
Registration of participants

Welcome address

Status of polio eradication
Global overview/update
WPRO overview/update
Recommendations of the Independent Monitoring Board (IMB)

Polio eradication - India
Programme overview/update
Certification update and plans for 2012-2013
Laboratory containment updates and plans for 2012-2013

Risk Assessment
Risk assessment for polio importation and spread
Risk assessment for SEARO
Risk assessment for WPRO

Close-door session of the SEARCCPE

Thursday, 26 January 2012
Country Review: Bangladesh
Country Review: Bhutan
Country Review: Indonesia
Country Review: Myanmar
Country Review: Nepal
Country Review: Sri Lanka
Country Review: Thailand
Country Review: Timor-Leste

Friday, 27 January 2012

Close-door session of the SEARCCPE
Review main conclusions and recommendations from the SEARCCPE
Potential areas for cross-border and cross-regional collaboration
Partnership for polio eradication: CDC
Final discussion/wrap-up
Annex 2

List of participants

Country Programme Managers

RCCPE Members
Prof. Nazrul Islam (Chairperson)
Vice Chancellor
Bangabandhu Sheikh Mujib Medical University
Dhaka, Bangladesh
Dr David Salisbury
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Head of Department,
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Dr Abraham Joseph
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Vellore, India
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Deputy Director General (Disease Control),
Ministry of Health
Nay Pyi Taw, Myanmar

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Kalubowila, Sri Lanka
Dr Sujarti Jatansen
Department of CDC, MoPH
Bangkok, Thailand

NCCPE Chairpersons
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Chairperson
Dhaka, Bangladesh
Mr Phub Rinchhen
Chairperson
Thimphu, Bhutan
Prof. Narendra K Arora
Chairperson
New Delhi, India
Prof. Sumarmo Poorwo Soedarmo
Chairperson
Jakarta, Indonesia
Dr Abdul Azeez Yoosuf (regrets)
Chairperson
Male, Maldives
Dr Htun Naing Oo
Chairperson
Yangon, Myanmar
Dr Hemang Dixit
Chairperson
Kathmandu, Nepal
Prof. Priyani Soysa (regrets)
Chairperson
Colombo, Sri Lanka
Dr Virna Maria Gusmao dos Reis Martins
Chairperson
Dili, Timor-Leste
Report of the second meeting

Representatives of the National Laboratory Containment Task Force

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Temporary Adviser

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Ms Porpit Warinsathien
EPI Technical Officer
Department of Disease Control
Ministry of Public Health
Bangkok, Thailand

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WHO – WPRO

Dr Sigrun Roesel
Medical Officer, EPI
WHO-WPRO,
Manila, Philippines

WHO – Country Office

Dr Hamid Jafari
Project Manager
National Polio Surveillance Project (NPSP)
New Delhi, India

WHO – SEARO Secretariat

Dr Monir Islam
Director
Family Health and Research

Dr Patrick M O’Connor
Regional Adviser-Polio and VPD Surveillance
Immunization and Vaccine Development

Dr Jagdish Deshpande
Virologist
Immunization and Vaccine Development

Ms Soumya Mathew
Secretary
Immunization and Vaccine Development
The second meeting of the South-East Asia Regional Commission for Certification of Polio Eradication (SEARCCPE) was held on 25-27 January 2012 in Chiang Mai, Thailand. The primary objective of this commission is to guide Member States through the certification process on polio eradication through impartial and transparent verification.

The purpose of the meeting was to review the annual reports from Member States and make recommendations to improve documentation for certification. The Region has made tremendous progress towards polio eradication in the last 12-14 months and is currently on a track for Regional Certification in January 2014.