

SEA-Polio-30
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International Commission for the Certification of Poliomyelitis Eradication in the South-East Asia

*Report of the Fifth Meeting
New Delhi, India, 5-8 March 2001*

WHO Project: ICP VAB 200



World Health Organization

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1. INTRODUCTION

The International Certification Commission for Polio Eradication in the South–East Asia Region (ICCPE) held its fifth meeting in WHO–SEARO, New Delhi, on 5 March 2002. The ICCPE members in attendance were: Dr Nath Bhamarapravati, Dr N K Shah, Dr N Ward, Dr David Salisbury, Dr R N Basu, Mr J C Pant and Dr Md Nazrul Islam, Dr N W Vidyasagara, and Dr Broto Wasisto. Also attending the meeting were Chairpersons of the National Certification Committee (NCC) from Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand.

Professor Nath Bhamarapravati (Thailand) was nominated as Chairperson; Dr N K Shah as Co–Chairperson and Dr N. Ward as Rapporteur. (See list of participants at Annex 1).

1.1 Opening Ceremony

The Regional Director, WHO/SEARO, inaugurated the meeting. Noting that this meeting is being held at a most critical period since the launch of the polio eradication initiative in 1988, he said that in the next few months, the results of WHO's efforts in northern India will determine the course of the initiative, not only in the Region but the entire world.

1.2 Objectives

The objectives of the meeting were as follows:

- (1) To brief the members of ICCPE on the latest developments in polio eradication globally and in the South–East Asia Region;
- (2) To review country documentation on polio eradication from Bangladesh, Bhutan, Democratic People’s Republic of Korea (DPRK), India, Indonesia, Maldives, Myanmar and Nepal and to review updates submitted by Sri Lanka and Thailand, and
- (3) To review and update the ICCPE Plan of Action.

2. PROCEEDINGS

The business session started with a global update on polio eradication including updates on vaccine–derived poliovirus and genetic sequencing data demonstrating the decreasing number of circulating strains of poliovirus world–wide. Updates on the regional status of polio eradication, the Polio Laboratory Network in SEAR and the Regional Plan of Action on Laboratory Containment of Wild Poliovirus were made. The ICCPE and attendant NCC Chairpersons jointly reviewed country documentation from Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar and Nepal. Sri Lanka and Thailand provided an updated overview of their progress in documentation for certification. Following this, ICCPE reviewed and updated its plan of action to certification. In the final session, the conclusions and recommendations were reviewed and agreed. (See programme at Annex 2).

Regional Overview of the Status of Polio Eradication in SEAR

Over the years, the Region has made tremendous progress. Reported polio cases in India alone declined more than 90% from

about 35,000 in 1988 to 268 virus-positive cases in 2001. In 2001, the Region accounted for 57% of the global polio burden, down from 75% in 1988. Within the SEA Region, all these cases occurred in India. Although the case count in 2001 was slightly more than in 2000, indigenous poliovirus transmission has now been restricted to three endemic foci in the northern states of Uttar Pradesh and Bihar.

Of the ten Member Countries, in our Region, Bhutan, DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand have been polio-free for more than four years in the context of good quality AFP surveillance. Bangladesh, Nepal and Myanmar have been polio-free for more than one year. Most encouraging of all is the fact that the wild poliovirus type 2 was last isolated in October 1999 in Uttar Pradesh, India. Since then, through good AFP surveillance, it is believed that this virus has probably been eradicated from the Region.

All Member Countries are continuing to implement the recommended strategies for polio eradication. India is moving into a very aggressive strategy of conducting high-risk response immunization in the three endemic foci between 4 March and end-April 2002. This activity will be supplemented by mop-ups, supplementary immunization days and national immunization days, in addition to strengthening routine immunization.

AFP surveillance in the Region continues to improve. Sixteen of the 17 laboratories in the SEAR polio laboratory network are accredited by WHO. The polio laboratory network in the Region is second to none, and can provide results to the programme within

45 days of onset of paralysis, thus permitting timely immunization response.

3. CONCLUSIONS

3.1 Recommendations of the 4th Meeting of ICCPE

The Commission in its fifth meeting appreciates the work of the WHO Secretariat in facilitating the recommendations of its fourth meeting and also that of the responsible officials and national certification committees in Member Countries who have largely translated them into action.

3.2 Areas of Progress

The Commission noted the progress made by the Member Countries of the South-East Asia Region towards polio eradication. With the exception of India, all countries have progressed over one year without confirmation of any cases of polio caused by a wild poliovirus.

The Commission is pleased to note the development of the Polio Laboratory Network in the South-East Asia Region. It is now constituted by competent laboratories, staffed by technically able staff, and well supported by WHO as the technical agency. Its function and performance is consistently monitored and the system of accreditation ensures the quality of virological support within and between countries of the Region. The Commission is looking forward to accreditation of the National Polio Laboratory in Pyongyang, DPR Korea during 2002.

National Certification Committees in all countries have now collected basic data on polio activities largely based on the draft format proposed by WHO. While there is still much work to be done developing and ensuring the completeness of the required data, these documents are becoming a sound basis for essential national documentation. The Commission now believes that through developing this base over the next few years, it will eventually be possible to confidently certify polio eradication from the Region.

3.3 Areas of Concern

Endemic wild poliovirus transmission in the South-East Asia Region appears to be currently confined to two states in northern India.

The occurrence of cases at remote sites in six neighbouring states of India and in two countries of Europe, all caused by the same viruses, demonstrates the actual and potential danger to the rest of India, the Region and the world until the persistent foci of polio, are eradicated.

The priority that must be afforded to achieving this objective in the shortest possible time far outweighs all other activities related to polio eradication and its certification in this Region.

With the slow pace of progress in 2001 towards eliminating the final persistent foci in India, it is clearly unlikely that the regional certification of polio eradication can take place before the second half of 2005. It is critical that the countries of the Region, understanding this fact, ensure that all activities essential for eventual certification, most notably, high quality AFP Surveillance and high levels of immunization coverage, are maintained at the highest possible level. During the next few years, NCCs' have a major responsibility to

ensure that, should there be any decline in the quality of polio related activities, it is detected immediately, reviewed with the appropriate national authorities and corrective action taken.

The slow progress towards final polio eradication being achieved in India is a cause for concern. The persistence of transmission in 30% of foci submitted to house to house mop-up raises serious questions concerning the quality of work being achieved. Recognizing the tremendous effort and resources that have already been committed to this initiative in India, the Commission urges the Government of India, state governments and district authorities to sustain and refine their efforts to reach polio eradication and not to become either discouraged or complacent with the present situation. The longer the delay before polio is eradicated, the greater will be the eventual cost and the difficulties in all countries to sustain activities through to successful certification.

Position of East Timor: The ICCPE needs to be reassured that plans for further political development of the UN Protectorate of East Timor will guarantee its compliance with the need for certification of polio eradication. If, eventually, within the organization of WHO, it becomes a member of a Region already certified to be polio free, it must be submitted to commission scrutiny.

The ICCPE recognizes the progress made in the documentation of polio eradication activities in DPR Korea and reiterates the importance of the NCC chairperson's participation in future ICCPE meetings.

Every country in the region is now using the virological classification scheme for classifying AFP cases. The ICCPE is concerned that polio eradication efforts in Bangladesh and Indonesia are being hampered without regular and timely meetings of the National Expert Review Committee.

4. RECOMMENDATIONS

Country-specific recommendations on the documentation are provided in Annex 3.

4.1 National Certification Commission (NCC)

During the past 12 months, there has been a marked advance towards national documentation required for certification of polio eradication. All countries have nominated NCCs' and, in general, these are working well and with evident enthusiasm. The Commission recommends that ICCPE members have the opportunity to attend NCC meetings where appropriate.

WHO should make every effort to ensure that limited funds are available to provide reasonable support for in-country site visits by NCC members as per the NCC work plans.

4.2 Documentation

(1) ICCPE emphasizes the expert role of the NCCs and their members. While it is reasonable that operational staff conducting polio eradication should provide all basic data, the

NCC has been appointed, based on the distinction and independence of its members'. They are expected

- to critically analyze all programmatic data, seeking both deficiencies and factors to justify its verification;
 - to identify areas both operationally and geographically where data are inadequate and unconvincing, insisting on additional information before endorsing the reports content to the ICCPE;
 - to advise the ICCPE on whether , in their expert opinion, there is sufficient evidence that wild poliovirus transmission has ceased;
 - to be able by their intimate knowledge of the programme and its data, to be able to present it effectively to the ICCPE, and
 - to confidently state their opinion in the executive summary of the document.
- (2) ICCPE requests the NCC to develop its documentation of polio eradication in the country in a specific form, including their expert analysis of data. It should avoid merely completing the WHO format - which was basically intended only as a checklist - in a mechanical manner. Where data requires explanation or justification, this must be provided to clarify key issues. All pertinent evaluation reports should be included in the annex.
- (3) WHO should review its format for national documentation to remove any ambiguity in the content/heading of certain tables, which when completed are producing inconsistent or incomprehensible data. Should such ambiguity persist, additional written explanations are required to clarify any possible confusion.

- (4) NCC should provide an interim progress report by 31 March 2003 in the format to be provided by the WHO Secretariat.

4.3 National Expert Committee (NEC)

ICCPE appreciates the creation of National Expert Committees (NECs) and the appropriate qualification of their members. In order to minimize the workload of NECs' and to guarantee both sufficient time to analyze problem cases and to allow sustained enthusiasm, it is recommended that NECs' examine only the cases of those patients with genuinely problematic or difficult diagnoses as well as those with inadequate stool specimens and those who have died or are lost to follow up before specimens are collected. There should be no need to review cases with either positive or negative poliovirus isolation from adequate stool specimens.

It is hoped that re-emphasizing this need will produce three results:

- A reduced NEC workload;
- Less time before AFP cases reach a final diagnosis, and
- A greater awareness and mapping of compatible cases in all countries with significant populations.

4.4 High Risk Border Areas

ICCPE considers border areas between countries and, to a lesser extent between sub-national administrative divisions, to be areas at special risk. Such areas include the enclosures (Chit Mahal) occupied by "islands" of people not directly physically connected with their own country. The special risks posed by these areas

should be minimized by improved, direct and indirect communications, cross-border notifications of AFP and wild virus associated polio cases, the conduct of synchronous supplementary immunizations and through special attention directed to active AFP surveillance.

4.5 Surveillance / AFP Diagnosis/AFP Rates

ICCPE considers that presently reported AFP rates, while generally meeting international targets for countries, require more detailed analysis, at the second and third administrative level as appropriate, than they presently receive. These analyses primarily relate to three situations:

- where detected AFP rates are unexpectedly high;
- where, in a sufficiently large population, rates remain markedly and/or persistently below 1/100.000, and
- where there is a risk – as appears widely to be the case in South-East Asia, that in spite of high total rates, the expected rates of recognizable causes of AFP, e.g. Gullain Barre' and Vaccine associated paralytic poliomyelitis (VAPP) are not being identified at a level appropriate for the target population.

ICCPE recommends that:

- Markedly high and significantly low rates of detected AFP automatically trigger a review of both the surveillance system in that area and an epidemiological investigation of the local population. The report would form part of the national documentation.

- That when AFP cases are detected, a provisional diagnosis of the cause of the AFP is made, later confirmed or replaced as specialized knowledge is applied or results of testing obtained. ICCPE believes it will introduce a quality indicator that will stop inappropriate inclusion of misdiagnosed cases in AFP rates.
- That greater care be taken ensuring that only actual AFP cases are included and that cases eventually proved not to be AFP, nor likely to mimic polio are discarded.
- That regular analysis of AFP cases is carried out to detect VAPP cases and results presented to the ICCPE.

4.6 Reporting

ICCPE emphasizes that two factors, both of which have not occurred in the past 12 months, are essential to proceed smoothly to certify polio eradication:

- Documentation/evidence of continuous reliable reporting of AFP cases, zero reporting and active case searches, without any interruption, for at least three years after the last indigenous case.
- Certification standard AFP surveillance must be maintained without evident false/over-reporting or failure to detect and identify specific diseases causing AFP that might reasonably be expected to have occurred.

Annex 1

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Annex 2

PROGRAMME

Tuesday, 5 March 2002

0800–0830 hrs Registration

0830–0930 hrs Inauguration

Address by Regional Director
Introductions
Nomination of Chair and Rapporteur

1000–1230 hrs **Meeting of ICCPE, invited NCC and WHO Secretariat**

- Chairman's Address
- Global update, including VDPV and certification issues
- Regional update on polio eradication
- Update on Laboratory Network and containment

Headquarters
Dr Arun Thapa
Dr Nalini
Withana

1400–1530 hrs Presentation NCC Chair Bhutan

- Country review: Bhutan

1545–1700 hrs Presentation NCC Chair Maldives

- Country Review: Maldives

Wednesday, 6 March 2002

0830–1000 hrs Presentation NCC Chair Bangladesh

- Country Review: Bangladesh

1030–1200 hrs Continue Country Review: Bangladesh

1330–1500 hrs Presentation NCC Chair Nepal

- Country Review: Nepal

1530–1700 hrs Presentation NCC Chair Myanmar

- Country Review: Myanmar

Thursday, 7 March 2002

0830–1200 hrs India update:

- Progress and status
- Road-map to interruption of transmission (NPSP/Dr Paul Francis)

Presentation NCC Chair India

- Country Review: India

1330–1430 hrs Presentation NCC Chair Indonesia

- Country Review: Indonesia

1500–1630 hrs Presentation NCC Chair DPR Korea

- Country Review: DPR Korea

Friday, 8 March 2002

0830–1000 hrs Conclusions and recommendations on country documentation

1030–1200 hrs Review of ICCPE Plan of Action

1330–1430 hrs Continued: Review of ICCPE Plan of Action

1500–1630 hrs Finalize ICCPE Plan of Action

Closing

Annex 3

REVIEW OF COUNTRY DOCUMENTATION AND COUNTRY-SPECIFIC RECOMMENDATIONS

Bhutan

- (1) Please add an Executive Summary with a critical assessment of the current situation in Bhutan and a note from the NCC chairperson expressing the NCC's opinions regarding polio eradication status.
- (2) Page 1 paragraph 2: Total Population; please adjust placement of comma.
- (3) Page 2 paragraph 3: Bhutan is not the least populated country in SEAR.
- (4) Section 3.2.5: The Commission recommends that active surveillance be carried out more frequently than twice per year.
- (5) Page 12 Table IX: Total TT Cases column is repeated twice.
- (6) Page 9 Table VI: Age of OPV dose 1 given at birth should be dose number 1. There is an error in reference to the first dose of OPV being given with measles.
- (7) Page 22 Table XV for year 2000: second dose is greater than first dose. Please verify these figures. Please explain the decrease in number of children receiving OPV3 from 1999 onwards.

- (8) Section 1.3.4: Routine AFP reporting occurs monthly. Please clarify the system established for rapid reporting of cases of AFP investigated.
- (9) The Commission notes that in high Himalayan states fewer cases of polio are reported than in the low lying states. Can the NCC state with confidence that this is due to lack of sustained transmission rather than lack of reporting?
- (10) Please include a line listing all AFP cases from 1997 onwards.

Maldives

Please elaborate on activities that are undertaken to ensure that polio eradication in Maldives will be achieved. Though there is little history or data pertinent to wild polio transmission in Maldives other information should be provided to establish confidence that there is no risk of indigenous or imported spread of wild poliovirus.

- (1) Please add an Executive Summary with a critical assessment of the current situation in Maldives and a note from the NCC chairperson expressing the NCC's opinions regarding polio eradication status.
- (2) Section 3.2.5: Please complete columns 3 through 6. If no data is available or no action has been taken, please provide appropriate explanation. Please include the number of supervisory visits made to far off atolls.
- (3) Section 6.2.4: Please provide all pertinent information regarding the directory of biomedical laboratories.
- (4) Section 5.4.2: the Commission notes that the sub national immunization activities carried out during 2000 – 2001 reached less than 50% of the target population. Please clarify this and provide an explanation.

- (5) Section 5.2.5: Please clarify OPV dose and accuracy of numbers.
- (6) Page 3: The Commission recommends that the National Certification Committee membership includes an additional professional independent of the responsible programme.
- (7) Section 1.1: Please address the concern of importation of wild polio to Maldives via movement patterns and travel of residence and visitors to and from India.
- (8) Section 1.1.3: Please insert or attach appropriate country maps
- (9) Section 2.2.2: Last Case of poliomyelitis details need to be elaborated upon and a report of the investigation and response included in the document as an annex.
- (10) Please include a line listing of all AFP cases from 1997 onwards.

DPR Korea

Please note that Annex 4 through 11 is not attached to the current report. Please forward this at your earliest convenience.

- (1) Section 3.4.2: In 2001, all 64 AFP cases were discarded. Please clarify why the National Expert Review Committee reviewed 47 cases.
- (2) Can DPR Korea be certified along with South Korea?
- (3) Section 3.4.4; A sensitive and specific AFP surveillance system should be detecting a greater percentage of GBS and transverse-myelitis cases. Refer to Manual of WHO for diagnosis of AFP.

- (4) Section 2.2.4: No VAPP cases have been reported, given the population and number of doses given, you should expect to see VAPP cases.
- (5) The NCC chairperson should attend the next ICCPE meeting so that clarification can be provided. Some of the data is confusing and will need explanation at the next meeting.
- (6) Section 3.2.5: the Commission notes the high number of active surveillance sites. Please provide an explanation of the activity and the frequency of active record reviews.
- (7) The Commission notes the discrepancy in the number of reporting sites in 3.2.2 and the number of active reporting sites in 3.2.5. Please clarify this information.
- (8) Section 4.2.1: Please provide a map of geographic location of specimens collection.
- (9) Section 4.2.2 Please provide rationale for collecting specimens from 18 healthy children.
- (10) Section 6.1.1: Please describe the technical component of the National Task Force for Containment and the laboratory personnel who are responsible for technical guidance.

Bangladesh

- (1) Please include an Executive Summary with a critical assessment and a firm statement of confidence regarding the status of wild poliovirus circulation in Bangladesh. The Commission notes that the AFP surveillance indicators meet the globally established target, but there is considerable variability across the country. The NCC must be confident

that surveillance standards are being met and maintained at all levels.

- (2) Section 3.4.4: A sensitive and specific AFP surveillance system should detect a large proportion of GBS and transverse-myelitis cases. Refer to Manual of WHO for diagnosis of AFP. The commission will request a final diagnosis on all AFP cases that are discarded.
- (3) Section 1.3.6. Please provide a description of the strategies used to encourage compliance of reporting by private practitioners.
- (4) Section 3.5.2 D. Please provide information pertaining to the number of cases found within each disease classification.
- (5) Section 5.2.6: The Commission notes with concern the number of districts with dangerously low OPV coverage.
- (6) Section 2.2.4: Summary of confirmed polio cases: In 2001, only one compatible case reported to date and no VAPP cases reported.
- (7) Section 1.2.1 Please provide an organogram of the structure of the National Polio Eradication Initiative.
- (8) Section 1.2.1 Please provide a summary of the long term strategic plan for sustainability of IOCH and WHO activities in polio eradication in Bangladesh
- (9) Section 5.3.4: The NCC chair of Bangladesh and Myanmar proposed synchronizing NIDs across borders in an effort to reduce missed opportunities of families crossing borders.

They also proposed a cross-border meeting to discuss this and similar issues.

- (10) Please provide clarification of Table 3.2.2 and 3.2.5.
- (11) Section 3.4.2. Pending case – need expert review.
- (12) Section 3.3.2 Total AFP and total non-polio AFP should be the same, please clarify.
- (13) Section 4.2.2: In 2001, 2,586 stools received more than twice the no. of AFP case, but only 79% had two stools. Please clarify to ensure that the NCC can have confidence in the numbers presented.

Nepal

The Commission is pleased to review the first draft of the Country Document for Certification of Polio Eradication in Nepal. In future updated documents must be supplemented with much more detail of the status of activities in polio eradication.

- (1) Please add an Executive Summary with critical assessment of the current status and a firm statement of confidence.
- (2) Section 1.2.1: Please include an organogram of the location of the polio eradication programme within the Government of Nepal.
- (3) Section 2.2.6: Wild P3 cluster of cases could be considered an outbreak. Please provide more detailed information pertaining to these cases. The Commission also notes that the last four cases of wild polio are poliovirus type 3. Could these be considered as imported with the last indigenous case reported being P1 in 1999?

- (4) Section 2.2.4: No VAPP cases: given the population and number of doses given you should expect to see VAPP cases.
- (5) Section 3.4.4: A sensitive and specific AFP surveillance system should be detecting a large proportion of GBS and transverse–myelitis cases. Refer to Manual of WHO for diagnosis of AFP. The Commission will request a final diagnosis on all AFP cases that are discarded.
- (6) Section 3.2.5: Active surveillance visits conducted were only 43% for the expected. Please provide evidence to convince the ICCPE that despite this low level of active surveillance, you are confident that there is no continuing virus circulation. Silent areas are not necessarily disease–free areas.
- (7) Annex: Please provide a map and include the details of the border area with India, especially the high risk areas bordering Uttar Pradesh and Bihar.
- (8) Sections 2.2.4 and 2.2.6 do not match. Please clarify total confirmed polio cases and clinically confirmed polio cases. Please explain why there are no polio compatible cases.
- (9) Section 2.2.2: Please provide more epidemiologic details of the last case of wild poliovirus. Please include the date that Nepal changed to a virologic classification scheme.
- (10) Sections 3.3.2 and 3.4.2: Please explain why total AFP cases and total non–AFP cases do not tally.
- (11) Section 6: Containment activities, the Commission notes that no containment activity has been carried out. By the next annual update, containment should be given priority.

Myanmar

To ensure that Myanmar is able to provide timely and consistent follow up, the Commission would like to request that continuity of the NCC Chair person be maintained to the extent possible.

- (1) Section 2.2.2: Please provide age of the child.
- (2) Section 2.2.4: Given the population and number of doses of OPV given you should expect to see VAPP cases, none are, however, reported.
- (3) Section 3.5.2: Please provide the results of the retrospective review that was conducted.
- (4) Section 4.2.6: Please note that two of these results in 2000 were wild poliovirus.
- (5) Section 2.1.4: Please provide genetic sequencing results of the imported case of wild poliovirus.
- (6) Section 2.1.5: Please provide the epidemiologic data pertaining to this VAPP case, as well as the sequencing data.
- (7) Section 3.3.4: Please provide more information regarding AFP surveillance in high-risk border areas and in areas where AFP rates are lower than expected.

Indonesia

The Commission notes the decline in AFP surveillance indicators during 1999 to 2001. The NCC executive summary must provide convincing evidence that surveillance indicators are being closely monitored and that the expected incline in AFP surveillance is carefully documented.

- (1) Section 2.1.2: Please clarify the definition of compatible polio.

- (2) Sections 3.2.2 and 3.2.5: Please provide further information regarding quality and completeness of active AFP surveillance. You need convincing evidence that you do have consistent reporting at province level and that reports are received on time.
- (3) Section 3.4.4: Please provide a breakdown of final diagnosis of AFP cases.
- (4) Section 4.2.4: Please provide source of non-AFP stools specimens collected.
- (5) Section 4.1.2: Please include three separate tables, one for each of the three National Polio Laboratories.
- (6) Section 3.3.4: Please provide more information regarding AFP surveillance in high-risk area of East Timor and in areas where AFP rates are lower than expected.

India

The Commission notes the added value of the analysis of polio compatible cases and finds the data reassuring. The Commission also discussed how to most efficiently handle the analysis of data for the purpose of certification of polio eradication in India and asks the NCC to consider the possible value of state by state analysis.

- (1) The Commission notes the very low EPI coverage in some states and suggests the inclusion of an analysis of the problem by individual state.

- (2) Section 2.3.1. Information from Mumbai ERC should be included.
- (3) Section 3.3.2. Please verify the population figures.
- (4) Table 3.4.4 Please provide a detailed breakdown of the fifth column, "Other"
- (5) In addition to programme indicators, socio-demographic indicators should be used when comparing states such as Kerala and UP. Large cities and urban areas as well as the states of Uttar Pradesh and Bihar are at high risk for wild poliovirus transmission and more detailed information should be provided.

The Commission also wishes to thank the NCC chairpersons from Thailand and Sri Lanka for submitting updated documentation of their progress towards polio eradication.

Annex 4

ICCPE TENTATIVE TIME LINE FOR THE CERTIFICATION PROCESS FOR POLIO ERADICATION IN THE SOUTH-EAST ASIA REGION

December 2005	ICCPE certification of SEAR as a polio-free region
September 2005	Presentation to the SEAR Regional Committee.
August 2005	Eighth Meeting of ICCPE: Review of final country documentation from every Member State with NCC Chair.
September 2004	Seventh Meeting of ICCPE: Review of final country documentation with the NCC Chairperson.
September 2003 documentation	Sixth Meeting of ICCPE: Review of country documentation from all Member States.
31 March 2003 format	Interim progress report by NCCPE as per format
April 2002- February 2003	Participation in surveillance reviews
5-8 March 2002	Fifth Meeting of ICCPE: Review of country documentation from: Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal. Sri Lanka, and Thailand.