11th Meeting of the South-East Asia Regional Certification Commission for Polio Eradication (SEA-RCCPE)

Paro, Bhutan, 15-16 November 2018
Tenth Meeting of the South-East Asia Regional Certification Commission for Polio Eradication (SEA-RCCPE)
SEA-Immun-125

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Contents

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Opening</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Global progress in polio eradication and implementation of the Endgame Plan</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Regional update on maintaining polio-free status</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Conclusions, observations and general recommendations</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Country specific conclusions and recommendations</td>
<td>15</td>
</tr>
</tbody>
</table>

Annexes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agenda</td>
<td>23</td>
</tr>
<tr>
<td>2</td>
<td>List of Participants</td>
<td>24</td>
</tr>
</tbody>
</table>
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFP</td>
<td>acute flaccid paralysis</td>
</tr>
<tr>
<td>bOPV</td>
<td>bivalent oral poliovirus vaccine</td>
</tr>
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<td>CCS</td>
<td>containment certification scheme</td>
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<td>CES</td>
<td>coverage evaluation survey</td>
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<tr>
<td>cVDPV</td>
<td>circulating vaccine-derived poliovirus</td>
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<tr>
<td>cVDPV1</td>
<td>circulating vaccine-derived poliovirus type 1</td>
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<tr>
<td>cVDPV2</td>
<td>circulating vaccine-derived poliovirus type 2</td>
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<td>DHS</td>
<td>demographic health survey</td>
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<td>DPR Korea</td>
<td>Democratic People’s Republic of Korea</td>
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<td>DQA</td>
<td>data quality assessment</td>
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<td>Endgame Plan</td>
<td>Polio Eradication &amp; Endgame Strategic Plan 2013-2018</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>ES</td>
<td>environmental surveillance</td>
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<td>EURO</td>
<td>World Health Organization Regional Office for Europe</td>
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<td>GAPIII</td>
<td>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</td>
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<td>GCC</td>
<td>Global Certification Commission</td>
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<td>GPEI</td>
<td>Global Polio Eradication Initiative</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>IMB</td>
<td>Independent Monitoring Board (of the GPEI)</td>
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<td>IPV</td>
<td>inactivated poliovirus vaccine</td>
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<td>NAC</td>
<td>national authority for containment</td>
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<td>NCCPE</td>
<td>National Certification Committee for Polio Eradication</td>
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<td>NCTF</td>
<td>National Containment Taskforce</td>
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<td>OPV</td>
<td>oral poliovirus vaccine</td>
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<td>OPV3</td>
<td>the third dose of oral polio vaccine</td>
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<td>PEF</td>
<td>poliovirus essential facility</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PIM</td>
<td>potentially infectious materials</td>
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<td>RCCPE</td>
<td>Regional Certification Commission for Polio Eradication</td>
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<td>RPNL</td>
<td>Regional polio laboratory network</td>
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<td>RRL</td>
<td>regional reference laboratory</td>
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<td>SAGE</td>
<td>Strategic Advisory Group of Experts on Immunization</td>
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<td>SEA</td>
<td>South-East Asia</td>
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<td>SEARO</td>
<td>World Health Organization Regional Office for South-East Asia</td>
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<td>SIA</td>
<td>supplementary immunization activity</td>
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<td>sIPV</td>
<td>Sabin IPI</td>
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<td>SIMO</td>
<td>surveillance and immunization medical officer</td>
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<td>SMO</td>
<td>surveillance medical officer</td>
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<td>SOP</td>
<td>standard operating procedure</td>
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<tr>
<td>tOPV</td>
<td>trivalent oral poliovirus vaccine</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VDPV</td>
<td>vaccine-derived poliovirus</td>
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<td>VDPV2</td>
<td>vaccine-derived poliovirus type 2</td>
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<tr>
<td>VPD</td>
<td>vaccine preventable disease</td>
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<td>WHA</td>
<td>World Health Assembly (of the WHO)</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPV</td>
<td>wild poliovirus</td>
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<td>WPV1</td>
<td>wild poliovirus type 1</td>
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<tr>
<td>WPV2</td>
<td>wild poliovirus type 2</td>
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<td>WPV3</td>
<td>wild poliovirus type 3</td>
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1. Introduction

The strife towards global polio eradication continues under the framework of the Global Polio Eradication and Endgame Strategic Plan 2013-2018 (Endgame Plan); approved by the Executive Board in January 2013 and endorsed by the World Health Organization’s (WHO) World Health Assembly (WHA) in May 2013. The Endgame Plan has certification and poliovirus facility containment as one of its four objectives which requires continued active oversight by the Regional Certification Commission for Poliomyelitis Eradication (RCCPE) and National Certification Committees for Poliomyelitis Eradication (NCCPEs).

The polio resolution 71.16 of the 2018 WHA urges (among other aspects) all Member States and requests WHO to provide the respective support

(1) to fully implement all strategic approaches outlined in the Endgame Plan;

(2) to intensify efforts to accelerate the progress of poliovirus containment certification as outlined in national requirements as well as 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

(3) to complete inventories for type 2 polioviruses, destroy unneeded type 2 materials and to begin inventories and destruction of unneeded type 1 and 3 materials in accordance with the latest available published WHO guidance.

Based on the NCCPE reports received and presentations made at its 10th meeting in November 2017, the RCCPE concluded that the Region had maintained its polio-free status during the period of review. The RCCPE commented that wild poliovirus (WPV) importation remains a risk as long as there is WPV circulation in some parts of the world. Noting the global situation of polio outbreaks due to circulating vaccine derived poliovirus (cVDPV), the RCCPE considered emergence of cVDPV in areas of low coverage to be at least as great a risk to polio-free status as an outbreak due to imported WPV. While the RCCPE commended the Region for steady progress towards meeting the requirements and the substantial capacity
In this context the 11th RCCPE meeting was held from 15-16 November 2018 in Paro, Bhutan; with a closed session with RCCPE members on 14 November 2018 with the following objectives:

1. to review update reports from each Member State on maintaining polio-free status, including poliovirus laboratory containment, as per requirements of the Endgame Plan and relevant WHO resolutions with focus on:
   - national and regional risk assessments in order to highlight gaps in the levels of immunity and the quality of surveillance at national and sub-national levels,
   - national polio outbreak preparedness, and
   - poliovirus containment requirements as per the GAPIII;
2. to review the implementation status of the recommendations made at the 10th meeting of the SEA-RCCPE; and
3. to update the Global Certification Commission (GCC) on the polio-free certification status and Polio Endgame implementation of the South-East Asia (SEA) Region.

The agenda of the meeting is included in annex 1 and the list of participants in annex 2. The meeting was attended by seven RCCPE members, chairpersons and representatives of 10 NCCPEs, officials of the Ministry of Health of Bhutan and a WHO Secretariat.

2. Opening

The 11th meeting of the SEA-RCCPE was opened by the WHO Representative to Bhutan, Myanmar, Dr Stephan Jost, on behalf of Dr Poonam Khetrapal Singh, WHO Regional Director for SEA.

The Regional Director sincerely thanked the Government of Bhutan for hosting this RCCPE meeting and noted that at the time of the meeting it had been three decades since the adoption of the historic WHA resolution.
calling for polio’s eradication, and significant milestones have been achieved together since then.

At the global level, these milestones include eradicating type 2 wild poliovirus (WPV2); keeping type 3 wild poliovirus (WPV3) cases to zero since 2013; and eliminating indigenous type 1 wild poliovirus (WPV1) from all but three countries. In addition, the type 2 component of the oral poliovirus vaccine (OPV) was successfully withdrawn in April 2016. She congratulated all countries in the Region for contributing to these outcomes and stressed the importance of now strengthening poliovirus containment in facilities and laboratories and preparing for the period after global certification.

Dr Khetrapal Singh noted that despite progress towards eradication in the world’s three remaining endemic countries, in 2018 transmission of the virus continued. When reviewing the most recent report of the Independent Monitoring Board (IMB) – of the Global Polio Eradication Initiative (GPEI), she noted many cross-cutting findings, both positive and negative, in several areas. These areas include dynamic operating environments; access and security; management and oversight; human resources; monitoring; meeting basic needs such as water and sanitation and access to health care; community perception; the performance of routine immunization and surveillance; and financing and transition planning.

Overall, the Regional Director says, the IMB report highlighted once more the primary hurdle faced in eradicating polio, which remains reaching children who are unreached by health systems because of difficult terrain, conflict, security-compromised access, urban sprawl or large-scale population movements. Dr Khetrapal Singh noted that this hurdle affects our broader mission to control vaccine-preventable diseases (VPD) and said that addressing them is vital to maintaining the polio-free status of the Region.

The Regional Director emphasized that focusing on that outcome is crucial given that as of 16 October, in 2018 there were 20 WPV1 cases in two countries, with 130 positive samples from environmental surveillance (ES). At the same time 68 polio cases due to cVDPV were detected in five countries.
Dr Khetrapal Singh noted that a cVDPV type 1 outbreak was occurring in Papua New Guinea at the time of the meeting, near the border of Indonesia, while four other countries in Africa have experienced cVDPV 2 outbreaks more than two years after the global switch from trivalent to bivalent OPV. The Regional Director said that this is of great concern, especially given many young children are unprotected against type 2 poliovirus due to the recent global shortage of inactivated poliovirus vaccine (IPV).

While Dr Khetrapal Singh commended all countries in the SEA Region for their continued commitment to staying polio-free, meeting the requirements of the global Endgame Plan, and pioneering new programme strategies while pursuing research and innovation, she also recognised the challenges health and immunization systems continue to encounter.

As such, the Regional Director greatly valued the commitment and continued work of the RCCPE and NCCPEs and emphasized how these bodies are much-needed to promote vigilance and support national immunization programmes in their efforts to keep countries polio-free.

Dr Khetrapal Singh was pleased to note the Region’s progress in several key areas. These include expanding polio surveillance capacities, especially for environmental surveillance; restructuring our risk assessments at all levels; adjusting oversight mechanisms such as the RCCPE and NCCPEs to meet the new requirements for polio eradication; enhancing outbreak preparedness; and focusing on poliovirus facility containment.

The Regional Director acknowledged the outstanding leadership that Dr Supamit Chunsuttiwat has provided as RCCPE Chairperson since 2012. She stated that Dr Chunsuniwat’s tireless work, clear analytic mind, attention to detail, respect for opinions and promotion of teamwork have been tremendously appreciated, and vital to the collective success and wished Dr Chunsuttiwat the very best in his future endeavours.

3. Global progress in polio eradication and implementation of the Endgame Plan

Wild poliovirus transmission: The last WPV2 case was reported in 1999, and WPV2 was officially certified as eradicated in September 2015. Wild poliovirus type 3 has not been detected globally since November 2012, when the last polio case due to this strain was reported in Yobe State,
Nigeria. Since that time, all cases of paralytic polio due to wild poliovirus (WPV) have been caused by WPV1, which continues to circulate in three countries in which the disease is endemic: Afghanistan, Nigeria and Pakistan. In Nigeria, no new polio case due to WPV1 has been confirmed since the detection in the State of Borno of cases in August 2016 and the detection of the virus in a healthy child in September 2016. However, because of continuing gaps in surveillance in areas at high risk of polio and inaccessible areas, undetected and continued circulation of this strain cannot be ruled out.

Afghanistan and Pakistan continue to be treated as a single epidemiological block. In 2018, four cases of paralytic polio due to WPV1 have been reported in Pakistan (as at end-September 2018), compared with five for the same period in 2017; in Afghanistan, 15 cases have been reported, compared with six for the same period in 2017.

**Circulating vaccine-derived poliovirus transmission:** In 2018, outbreaks due to cVDPV type 2 newly emerged or continued in the Democratic Republic of the Congo (19 cases), the Horn of Africa (6 cases) (where the virus has been detected in Somalia and environmental samples in Kenya), Niger (8 cases) and Nigeria (27 cases). There were no new cases in Syrian Arab Republic that reported an outbreak in September 2017. In 2018, Somalia also reported 7 cases of cVDPV type 3. In June 2018, cVDPV type 1 outbreak was confirmed in Papua New Guinea (25 cases, as of November 2018).

**cVDPV type 1 outbreak in Papua New Guinea:** Following confirmation of cVDPV type 1 outbreak the Government of Papua New Guinea declared the outbreak as a national public health emergency and launched a comprehensive emergency outbreak response. Papua New Guinea shares porous border with Indonesia with multiple ‘traditional border crossings’, but low volume foot traffic. Indicators in Indonesia’s Papua and West Papua indicate risk of undetected transmission. Indonesia and Papua New Guinea are collaborating through cross border meetings, sharing surveillance information, synchronizing supplementary immunization activities (SIA) across border districts, mapping key border crossings and markets and establishing vaccination booths. This outbreak is a wake-up call for OPV using countries with poor population immunity and surveillance.
The declaration in 2014 of the international spread of wild poliovirus as a **public health emergency of international concern** and the temporary recommendations promulgated under the International Health Regulations (IHR; 2005) remain in effect. All countries currently affected by circulation of either wild or vaccine-derived polioviruses have declared such events to be national public health emergencies and are implementing national emergency action plans.

**Phased removal of OPV:** The first phase of OPV removal took place with the switch from trivalent (tOPV) to bivalent oral polio vaccine (bOPV) between 17 April and 1 May 2016. Once all remaining foci of WPV transmission have been eradicated and the world is certified as polio-free, all use of remaining OPV will be stopped. Until then, countries are encouraged to minimize the risks and consequences of potential vaccine-derived polioviruses (VDPV) by ensuring high routine immunization coverage, conducting surveillance for any emergence of cVDPV, and maintaining strong outbreak response capacity.

**New GPEI Strategy 2019-2023:** The GPEI is developing a new strategy to cover the period 2019-2023. The strategy will highlight which activities need to be undertaken and what the GPEI needs to do differently to certify the eradication of polio, particularly in the context of recent detections of circulating vaccine-derived poliovirus.

### 4. Regional update on maintaining polio-free status

The WHO SEA Region was certified polio-free on 27 March 2014 and has maintained its polio-free status in 2017-18. No WPV was detected in the Region and no VDPVs were detected in acute flaccid paralysis (AFP) cases. One VDPV2 in 2017 and one VDPV3 in 2018, were detected in sewage samples in India. There was no evidence of circulation and adequate response measures were taken by the country. However, risk of importation of polioviruses from areas with current circulation and risk of emergence of cVDPVs remain. There is also a risk of re-introduction of poliovirus type 2 into community following a breach in facility / laboratory containment.

The factors that could potentially accentuate the risks are sub-optimal population immunity against polioviruses, population movements (migrants, refugees), surveillance gaps leading to delayed detection of polioviruses, weaknesses in containment of polioviruses, inadequate preparedness to respond to a poliovirus leading to delayed or inadequate response and
transition following ramp-down of global polio funding in five large countries may result in programme deficiencies.

**Population immunity:**

As per WHO and United Nations Children’s Fund (UNICEF) estimates of national immunization coverage (July 2018) six countries in the Region (Bangladesh, Bhutan, the Democratic People’s Republic of Korea / DPR Korea, Maldives, Sri Lanka, and Thailand) had a routine OPV third dose (OPV3) coverage of >90%, India, Indonesia, Myanmar, and Nepal had coverage between 80% and 90% and Timor-Leste had a coverage of < 0%. India, Myanmar and Nepal conducted SIAs in 2017 to increase coverage of OPV. Indonesia and Myanmar had a high proportion of under-immunized non-polio AFP cases.

The IPV first dose coverage was < 50% in seven countries of the Region. IPV supply has been restored for routine immunization in countries that had stockouts; Bangladesh, Bhutan, DPR Korea and Nepal, following global shortage. India, Sri Lanka, Bangladesh and Nepal are administering intradermal IPV as a dose sparing method following Strategic Advisory Group of Experts on Immunization (SAGE) recommendations.

**Surveillance performance:**

All countries in the Region maintained certification standard non-polio AFP rates of at least 1 per 100,000 children under 15 years of age, in 2017 (as of 12 November 2018). Eight countries, namely Bangladesh, Bhutan, DPR Korea, India, Indonesia, Myanmar, Nepal and Sri Lanka, had adequate stool specimen collection of > 80%. However, for both performance indicators there is considerable subnational variance in several countries.

AFP surveillance is being complemented by environmental surveillance (ES) in six countries of the Region. In 2017, ES activities in the Region were expanded to include additional sites in Indonesia and India and were initiated in Myanmar and Nepal. A total of 63 sites in 23 provinces of six countries, namely Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, are currently conducting ES. Bangladesh operates four temporary sites in Cox’s Bazaar. ES data provided important evidence for the disappearance of Sabin like poliovirus type 2, following the switch from tOPV to bOPV during 2016.
There are 16 polio laboratories in seven countries that perform intratypic differentiation. Three of these laboratories also perform sequencing. There is one global specialized laboratory and two regional reference laboratories in the Region. All laboratories, except the national polio laboratory of DPR Korea, are accredited.

**Poliovirus laboratory containment**

Activities to contain type 2 polioviruses in facilities under GAPIII requirements are progressing in the Region. Three poliovirus essential facilities (PEF) have been identified to store/handle type 2 polioviruses in two countries of the Region, namely India (research facility) and Indonesia (vaccine manufacturer). National authorities for containment (NAC) have been established in both countries and processes to undertake certification of these facilities as per the global containment certification scheme (CCS) have commenced.

Special trainings on GAPIII requirements for national containment taskforces (NCTF), PEFs, NAC and vaccine manufacturers were successively conducted in 2016 – 2017 (with participation from other WHO Regions) and more capacity building activities are planned in early 2019. ACCS auditors’ training was held in January 2017 for India and Indonesia (jointly with Australia and Republic of Korea). The series of trainings began with a Regional orientation meeting in November 2015 and progress was reviewed during a Regional meeting in April 2017.

The Regional Polio Laboratory Network (RPLN) has conducted several bio-risk management capacity building activities and network laboratories are conducting self-assessments against GAPIII requirements.

All Member States are completing new surveys of biomedical laboratories and facilities to meet requirements outlined in GAPIII. Countries are being supported with direct technical assistance to implement their activity plans for containment of Sabin2/OPV2 infectious and potentially infectious materials. One of the challenges in GAPIII implementation are involvement of facilities that collect, handle and store clinical and environmental samples for purposes other than polio research. These specimens also present a poliovirus transmission risk if samples were collected in a place and time where wild poliovirus or VDPV were circulating or OPV was being used. These facilities are at a disadvantage in that the potential presence of an infectious poliovirus in such samples is both undesirable and uncertain. To support such laboratories, WHO has
developed ‘Guidance for non-poliovirus facilities to minimize risk of sample collections potentially infectious for polioviruses (PIM)’ which were pilot tested in Bangladesh in December 2017 in a workshop with high risk laboratories. All materials identified in Bangladesh can be stored outside a PEF as per the PIM guidance.

**Risk assessment and outbreak response preparedness:**

The WHO Regional Office for SEA (SEARO) is updating the regional risk assessment tool for national analysis. The tool is further modified after inputs from RCCPE, NCCPEs and other stakeholders to guide countries to perform subnational risk analysis. Similarly, the tool is also being modified for countries with small population size.

All countries have national outbreak preparedness and response plans in place. However, updates may be required based on risk assessment and current global guidelines. The global guidelines for response to poliovirus event or outbreak are being revised and will soon be available. A systematic review of outbreak preparedness and response plans is needed and minimum guidance to conduct simulation exercises is required.

**Transition planning:**

With the GPEI funding ramp-down and its imminent cessation in the post-eradication era, countries with significant polio funded infrastructure are developing transition plans. Five countries in the Region; Bangladesh, India, Indonesia, Myanmar and Nepal; have significant workforce, systems and processes dependent on the polio funded assets. Polio infrastructure in these countries supports essential polio functions that must be maintained beyond certification. Polio infrastructure also supports non-polio programmes like measles elimination, routine immunization, vaccine preventable diseases surveillance, new vaccines introduction, neglected tropical diseases, emergencies and disasters. These five countries have developed transition plans and these plans are in various stages of review by the respective governments. The transition plans are focused on mechanisms to transfer the capacity to government (to the extent possible), identifying alternate sources of funding to sustain the polio infrastructure once GPEI funding stops and building capacity of polio teams to support ‘new public health programmes’. Leadership provided by national
governments and funding by donors are critical for the smooth implementation of the transition plans.

5. Conclusions, observations and general recommendations

**Overall**

Based on the reports received by NCCPEs and presentations made at the 11th RCCPE meeting, the RCCPE concluded that the WHO SEA Region has remained polio-free during the period of review. As such almost eight years have passed since the last WPV case was detected (January 2011). This is on one hand very commendable in terms of efforts undertaken by countries but also bears the risk that complacency may increase and resources be moved to other health programmes.

While acknowledging various areas of progress in global polio eradication efforts, the RCCPE remained concerned about continued WPV1 transmission and the ongoing and new outbreaks of cVDPV, especially type 2.

The RCCPE was particularly concerned about the recent cVDPV type 1 outbreak in Papua New Guinea and its risks and possible implications for the Region, especially Papua Province of Indonesia. The RCCPE considered emergence of cVDPV or transmission of imported VDPV 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 SEAR as imported WPV. Virus spread would be further facilitated by gaps in surveillance and inadequate outbreak preparedness.

The RCCPE noted the outlook of the GCC on global certification options and recommended that countries report data on their last WPV1 and WPV type 3 (WPV3) to NCCPEs.

**Work of the NCCPEs**

In this situation of continued risks the active role of NCCPEs becomes more important than ever, especially in view of the increasing relevance of detailed risk assessments which need to be included in NCCPE reports with deliberations on population immunity, surveillance, poliovirus facility containment, and outbreak preparedness and response.
Active oversight requires ensuring adequately updated terms of reference, diversity of relevant expertise in NCCPE members (where possible) and regular meetings, also involving representatives of the relevant national programme sectors, other national advisory bodies and key partners. WHO should provide respective guidance based on latest GCC and GPEI oversight requirements which expand NCCPE responsibilities compared to pre-certification. NCCPE capacities should also allow for targeted participation in programme performance assessments. WHO participation in NCCPE meetings is encouraged to provide latest updates relevant to polio eradication; this could in smaller countries also be used as opportunity to support capacity building for public health physicians and selected clinicians.

The RCCPE recommended that NCCPEs meet at least 3 times per year; for reviewing outcomes of the RCCPE meeting and developing an activity plan, mid-term performance review and preparing the annual progress report.

The RCCPE noted the high quality of the annual progress reports and appreciated efforts made by the NCCPEs to use a more analytical approach in answering the four key questions on immunization, surveillance, laboratory containment and outbreak response preparedness. The GCC recommendation on future electronic NCCPE reports was recognized.

**Immunization**

- The RCCPE commended the national programmes in the Region for their efforts to maintain their polio-free status for many years (sometimes decades) and initiatives being taken to improve OPV and IPV coverage.
- The RCCPE noted that four countries of the Region are providing intradermal IPV (Bangladesh, India, Nepal, Sri Lanka).
- The RCCPE also noted that IPV supplies were restored 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 some countries have already provided IPV to cohorts that had missed IPV due to stock-outs and others are planning to carry out catch up immunization to reduce susceptibility to type 2 poliovirus resulting from IPV stock-outs. It
should be noted that catch up vaccination has two components; children/birth cohorts missed during the vaccine shortage as well as children missed during routine immunization when vaccine is/was available.

- The RCCPE was concerned that the global supply is projected as remaining tight in 2019 and not all catch up vaccination activities planned/required may be possible.

- The RCCPE recommended a joint analysis by national programmes/WHO on the scope of susceptibility for type 2 poliovirus and planning for efficient use of constrained IPV supplies. WHO should extend its regular sharing on global polio vaccine supply updates to RCCPE and NCCPEs.

**Surveillance**

- The RCCPE noted that AFP surveillance continues to be conducted in all countries and is supplemented with ES in six countries (Bangladesh, India, Indonesia, Myanmar, Nepal, Thailand).

- While the overall quality indicators remain good, surveillance performance issues continued in several countries and are being addressed in country specific recommendations.

- The RCCPE acknowledged that the polio laboratory network in the Region remains strong and was satisfied with its performance. The RCCPE, however, remained concerned about the situation of the national laboratory of the DPR Korea.

**Poliovirus facility / laboratory containment**

The RCCPE commended the ongoing work in GAPIII implementation but concurs with the 2018 resolution by the WHO WHA that activities need to be accelerated; in terms of

- Submitting certificate of participation (CP) applications for designated PEFs by respective NACs; this currently applies to India while Indonesia needs to provide additional information to the containment working group (CWG) of the GCC on application submitted.

- Completing of poliovirus type 2 inventories; with destruction of unneeded PV2 materials and applying the ‘WHO Guidance to
minimize risks for facilities collecting, handling or storing materials potentially infectious for polioviruses’. The current time line for completion of April 2019 should be noted.

➢ Applying external quality assurance to PV2 surveys already completed.

➢ Reporting status of PV2 inventories to the RCCPE by National Poliovirus Containment Coordinators (NPCC)/NCTF through NCCPEs.

➢ Beginning inventories for WPV1 and WPV3 infectious materials.

Risk assessment

➢ The RCCPE took note of the GCC recommendations on risk assessment and requested all countries and WHO Secretariat to give high priority to regular and detailed risk assessments.

➢ The RCCPE appreciated the work by WHO South-East Asia Regional Office (SEARO) to update the regional risk assessment tool and include recommendations for subnational analysis which should be completed as soon as possible and applied at appropriate levels. Based on feedback from national programmes and NCCPEs the tool should be further refined and a description provided on rationale for risk points, cut-offs, thresholds and weights.

➢ National programmes should flexibly extend risk assessment to implementation levels; as feasible and appropriate (while being mindful of additional work load for front line health service staff).

➢ Annual risk assessment exercises should be built into the programme reporting system and outcomes as well as mitigation activities included in the 2019 NCCPE progress reports.

➢ WHO SEARO should facilitate risk assessment in border areas between countries (within the SEAR and with neighbouring WHO Regions).

➢ The RCCPE requested SEARO to conduct a comparison analysis of risk assessment outcomes presented by NCCPEs, RCCPE and the updated draft Regional model.
Outbreak preparedness

➢ The RCCPE noted that while countries have developed outbreak preparedness and response plans, a mechanism needs to be developed to assess their quality and usefulness during real poliovirus events/outbreak situations.

➢ The RCCPE welcomed the development of a checklist that would be completed by NCCPEs as well as WHO-SEARO and guide the assessment where national plans need to be updated by the national programmes; applying the respective current WHO global standard operating procedures (SOPs).

➢ While there needs to be some flexibility for countries in designing their preparedness plans as outbreaks may be addressed in different ways in different areas minimum requirements and principles must be met as per global WHO SOP.

➢ Preparedness plans need to include – where applicable – how border areas are being dealt with and which coordination mechanisms are required with neighbouring countries; this must also be included in simulation exercises.

➢ Developing outbreak preparedness should also take lessons from other disaster preparedness programmes into consideration and specify on collaboration in the International Health Regulations (IHR 2005) context.

➢ Containment breaches need to be added to national preparedness plans; further guidance is expected from Strategic Advisory Group of Experts (SAGE) in 2019 when commenting on the WHO draft protocol for containment breach preparedness.

➢ The RCCPE reminded that per WHA resolution 71.16 countries are urged to ensure that any confirmed event associated with a breach in a poliovirus facility containment is immediately reported to the National IHR Focal Point. The NCCPE should also be informed at the appropriate timing and subject to confidentiality aspects.

➢ Risk assessment should guide development / updating of plans and be tested in different simulation exercises.

➢ The RCCPE noted that several countries have conducted simulation exercises in country individual approaches. The
RCCPE supported development of minimum guidance to conduct these exercises using the polio outbreak simulation exercise (POSE) materials of the WHO European Regional Office (EURO) and other available models. The RCCPE expected updates of enhancing outbreak preparedness quality including simulation at its 12th meeting in 2019.

6. Country specific conclusions and recommendations

**Bangladesh**

- The RCCPE commended the continued strong immunization and surveillance supported by the WHO surveillance and immunization medical officers (SIMO) network.

- The 2016 coverage evaluation survey (CES) suggested lower coverage rates than the reported administrative coverage; with issues particularly in some urban areas/city corporations. With the national programme recognizing these challenges, a national/international Expanded Programme on Immunization (EPI) and vaccine preventable disease (VPD) surveillance review was conducted in August 2018 and the RCCPE would like in the next NCCPE report to have a status update on implementation of recommendations relevant for maintaining polio-free status.

- Immunization should be strengthened in two main areas; that is
  - continued focus on addressing coverage gaps in urban areas/city corporations and
  - ensuring maximum catch up of children missed during IPV stock out with two intradermal IPV doses and report coverage to the NCCPE.

- The RCCPE commended the Government of Bangladesh for providing routine immunization services to the refugees in Cox’s Bazar and for conducting special supplementary immunization activities (SIAs). They should apply these measures to future refugees also.
➤ The RCCPE commended the NCTF and NCCPE on having organized the PIM guidance workshop in December 2017 and recommended the following follow-up:
   - Implementation of risk mitigation action points needs to be recorded and reported to NCCPE.
   - Documentation of destruction of PIM and measures taken as per PIM guidance.

**Bhutan**

➤ Following the change in position of the NCCPE chairperson, the membership should be updated and expanded as guided by the RCCPE in earlier meetings.

➤ The RCCPE supported plans for conducting risk assessment with focus on area with pockets of low coverage, particularly highlighted during recent measles outbreaks; this may benefit from doing a cross border analysis with neighbouring state(s) in India, requiring coordination support by SEARO.

➤ The RCCPE encouraged a simulation exercise when Regional guidance has become available.

➤ To ensure surveillance quality the RCCPE recommended timely shipment of stool samples from the field to Thimpu and onwards to the Regional Reference Laboratory (RRL).

**India**

➤ The RCCPE commended the national programme for innovative strategies to strengthen routine immunization and noted the continued high level of commitment to maintaining the polio-free status, also expressed by continued resolve to conduct polio SIAs.

➤ Efforts need to continue focusing on coverage gaps in high risk areas and populations, especially for IPV. While IPV coverage is increasing it is still not high enough; leaving many children susceptible to PV2.

➤ While overall surveillance remains adequate, the RCCPE noted that there are districts where surveillance needs to be strengthened. Focus should be particularly where other indicators such as OPV3 coverage and SIA performance are also
subpar. In general, capacity building and ownership of government immunization/surveillance officers should be increased. The WHO surveillance medical officer (SMO) network should be maintained for technical assistance and capacity building.

- Laboratory containment of polioviruses as per GAPIII should continue to be a priority and the certification process with the designated PEF be accelerated. While the NAC reports directly to the CWG of the GCC, the NCCPE should also be kept informed about developments.
  - CP application for the PEF currently designated should be accelerated.
  - As additional PEF designations can be expected clarity should be obtained from the NAC about the status of Sabin IPV (sIPV) manufacturers and other potential developers in the pipeline that potentially are manipulating PV2 for their research and development.

- The RCCPE appreciated the early detection and comprehensive investigation of a Sabin 2 “contamination” of bOPV but is concerned about the extent, cause and implications of the event. This poliovirus 2 contamination should be considered a containment breach; thus certain requirements from the WHA on the IHR (2005) mechanism have to be involved.
  - Once the P2 contamination investigation report is prepared it should be shared with the RCCPE.
  - The date/period of Sabin2/OPV2 occurrence in terms of potentially infectious materials should be changed and considered for survey updates to be conducted.

**Indonesia**

- The RCCPE concurred with the NCCPE conclusion of considering the country as high risk and shares the concerns about continued coverage gaps in routine immunization, limited SIAs and very low IPV coverage. The risk is largest from high density islands (big population communities) with low population immunity and considerable in the border areas with Papua New Guinea and as guided by risk assessment. Hence,
the RCCPE encouraged the programme to focus on these high-risk areas.

➢ The RCCPE concluded that risk is further aggravated by continued limited active surveillance and gaps in subnational AFP surveillance performance.

➢ The RCCPE was concerned that GAPIII implementation is delayed; while the NAC has been established and the CP application process for the designated PEF has started the oversight mechanism for the PIM survey has yet to be decided. As such, Indonesia is the country in the Region where survey activities have not yet started.

➢ The RCCPE noted that risk mitigation strategies recommended for several years have not yet shown significant impact. Hence, different approaches have to be identified for lowering risk towards global certification.

➢ The RCCPE urged strengthening of immunization service delivery for both, bOPV and IPV and especially in areas of suboptimal coverages; based on risk assessment and prioritization of high population areas. The RCCPE equally urged to improve AFP surveillance by conducting more frequent active surveillance visits in priority areas combined with other monitoring activities. Programme strengthening activities should be supported by regular and frequent supervisory visits by central and provincial level staff.

➢ The RCCPE highlighted that activities to strengthen immunization and surveillance performance are of particular urgency in border areas with Papua New Guinea and comprehensive risk mitigation measures must be implemented in good coordination with all key stakeholders.

➢ The RCCPE was encouraged by efforts to increase outbreak preparedness by conducting simulation exercises and requested to receive updates on their outcomes.

➢ The RCCPE urged that facility containment of WPV2/VDPV2 and of Sabin 2/OPV2 infectious or potentially infectious materials should be taken on priority and the national oversight / implementation responsibility needs to be decided as soon as possible.

➢ The RCCPE supported that the certification process of the designated PEF should be accelerated. While the NAC reports
directly to the CWG, the NCCPE should also be kept informed about developments.

**Maldives**

- The RCCPE appreciated the continue high performance of polio immunization; for coverage report validation the RCCPE requested to receive the results of the recent demographic health survey (DHS) once available.

- As some persistent issues with AFP surveillance continue (for example lack of human resource capacities for active surveillance, low stool specimen collection rates and delayed shipment to the RRL) the planned EPI and VPD surveillance review - when taking place - should also aim at increasing capacity for AFP surveillance.

- Risk assessment should be done once the WHO tool has been adapted for countries with small population followed by simulation exercises under WHO guidance.

**Myanmar**

- The RCCPE commended the continued programme performance improvements resulting in increasing polio vaccine coverage and quality AFP surveillance in most areas, including at subnational levels.

- The RCCPE encouraged the national programme to continue its approach of innovative strategies and collaborations to reach at risk populations for immunization service delivery for bOPV and IPV, especially in areas of sub optimal coverages, which should include ensuring maximum catch up of children missed during IPV stock out.

- The RCCPE also noted evidence of increasing outbreak preparedness through simulation exercises but remains concerned about the risks in Rakhine State in view of population movements and that they should be well accounted for. Reported coverage of the 2017 SIA was high but in view of denominator challenges the figures may be considered with caution.
➢ The RCCPE commended the catch-up immunization SOP for repatriating population and considers systematic implementation as critical.

➢ The RCCPE commended the efforts in PV facility containment and recommended quality assessment (QA) to document the completion for PV2 infectious and potentially infectious materials.

**Nepal**

➢ The RCCPE was encouraged with country decision and GPEI agreement to deliver an add-on bOPV dose in 2019 along with the MR immunization campaign to ~60% of the under-5 population at high risk. The RCCPE recommends that high SIA quality should be ensured in delivering this dose.

➢ The RCCPE commended that surveillance quality has been maintain at good quality levels in a well-structured system.

➢ The RCCPE noted that IPV immunization has restarted and encouraged efforts to also aiming at high coverage in catch-up immunization of children missed during IPV stock out.

➢ As Nepal is in governance transition and reorganizing health and other services, efforts should be made to orient the federal and provincial ministers about the global polio eradication status and requirements; for their continued support.

➢ The RCCPE noted that laboratory containment still in progress and encouraged completion of survey activities before the current 2019 timeline.

➢ Risk assessment should particularly focus on southern border areas with high population density and consider the subnational risk situation in bordering districts of India, with support from SEARO. Results should be considered when updating the national outbreak preparedness plan (also in view of new federal structure) and conducting simulation exercises.

➢ The RCCPE welcomed the plan for EPI and VPDS review in 2019 and requested to be updated about the outcomes.
Sri Lanka

➢ The RCCPE commended the continued high performance of polio immunization with OPV and IPV, with convincing outcomes of the recent serosurvey.

➢ The RCCPE concurred with the NCCPE conclusions of the low risk but encouraged the programme to continue focusing on keeping subnational AFP surveillance performance at least at certification quality levels.

➢ The RCCPE commended the efforts in PV facility containment and recommends quality assurance of the survey to document the completion for PV2 infectious and potentially infectious materials, once achieved.

Thailand

➢ The RCCPE noted the continued strong immunization but also persistent gaps in AFP surveillance performance which need to be addressed on a priority basis.

➢ The RCCPE commended efforts for improving outbreak preparedness by conducting risk assessment (not homogenously low for the whole country), updating the national preparedness plan and conducting a table top exercise on polio outbreak preparedness.

➢ The RCCPE noted the progress in the PV2 infectious and potentially infectious materials and encourages completion with application of the PIM guidance; this may be supported by a similar workshop as recently conducted in Bangladesh. Risk mitigation activities for facilities with PIM needs to be monitored by the NCTF and reported to the NCCPE for inclusion in the next progress report.

Timor-Leste

➢ The RCCPE acknowledged the various initiatives being taken to increase access to immunization as well as the 2018 SIA (in conjunction with measles rubella vaccine National Immunization Day).
➢ The RCCPE noted the recently conducted CES and the results will be important to validate the significant increase in reported vaccination coverage in 2017 (resulting from using a different denominator based on the 2015 census). The RCCPE requested outcomes of the DQA (data quality audit) to be included in next NCCPE report.

➢ The RCCPE noted the IPV coverage improvements but still encouraged ensuring maximum catch up of children still missed for reducing susceptibility.

➢ The programme needs to further evaluate why there were no AFP cases yet reported in 2018.

➢ The RCCPE noted that PV2 laboratory containment has been completed.

➢ Risk assessment should be done once the WHO tool has been adapted for countries with small population followed by simulation exercises under WHO guidance. Areas in the western border need to be assessed for risk situation in Indonesia; with support from SEARO.
Annex 1

Agenda

(1) Opening session

(2) Global updates on polio eradication and implementation of the Endgame Strategic Plan 2013-2018

(3) Global progress in type 2 poliovirus laboratory containment

(4) Introduction to minimizing risks for facilities collecting, handling or storing materials potentially infectious for polioviruses

(5) Update on global certification aspects

(6) Updates by National Certification Committees for Polio Eradication on maintaining polio-free status

(7) Regional summary on maintaining polio-free status in the WHO South-East Asia Region

(8) Regional summary on implementation of 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)

(9) Conclusions and recommendations

(10) Closing
Annex 2

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