Meeting Report

TWENTY-SECOND MEETING OF THE REGIONAL COMMISSION FOR THE CERTIFICATION OF POLIOMYELITIS ERADICATION IN THE WESTERN PACIFIC

15–17 November 2016

Sydney, Australia

World Health Organization
Western Pacific Region


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WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC

RS/2016/GE/60(AUS) English only

MEETING REPORT

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Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Sydney, Australia
15–17 November 2016

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

May 2017

NOTE

The views expressed in this report are those of the participants of the Twenty-second Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Twenty-second Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific in Sydney, Australia from 15 to 17 November 2016.

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Keywords:

Poliomyelitis – prevention and control / Immunization / Poliovirus vaccines / Vaccination

ABBREVIATIONS

AFP	acute flaccid paralysis
bOPV	bivalent oral polio vaccine
cIPV	conventional inactivated polio vaccine
cVDPV	circulating vaccine-derived poliovirus
cVDPV1	type 1 circulating vaccine-derived poliovirus
cVDPV2	type 2 circulating vaccine-derived poliovirus
EPI	Expanded Programme on Immunization
GAP III	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
IPV	inactivated polio vaccine
mOPV	monovalent oral polio vaccine
NAC	national authority for containment
NCC	national certification committee
OPV	oral polio vaccine
RCC	Regional Commission for the Certification of Poliomyelitis Eradication
SIA	supplementary immunization activity
sIPV	Sabin inactivated polio vaccine
SIREP	Special Integrated Routine EPI Strengthening Programme
SRCC	Subregional Committee for the Certification of Poliomyelitis Eradication in Pacific Island Countries and Areas
tOPV	trivalent oral polio vaccine
VDPV	vaccine-derived poliovirus
VPD	vaccine-preventable disease
WPV	wild poliovirus
WPV1	wild poliovirus type 1
WPV2	wild poliovirus type 2

SUMMARY

The Twenty-second Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication (RCC) in the Western Pacific was held in Sydney, Australia on 15–17 November 2016. The RCC meets annually to review and evaluate progress reports on maintaining polio-free status submitted by the national certification committees (NCCs) and by the Subregional Committee for the Certification of Poliomyelitis Eradication in Pacific Island Countries and Areas (SRCC). The NCC and SRCC reports also include updated information on the status of implementing recommendations from the 2015 RCC meeting.

During the meeting, the RCC reviewed the status of each Western Pacific Member State's polio eradication programme in the context of the polio endgame strategy with special emphasis on achieving and maintaining sensitive acute flaccid paralysis (AFP) surveillance and high population immunity through routine and supplemental polio immunization activities. The RCC commended the success of the switch from trivalent (tOPV) to bivalent oral polio vaccine (bOPV) during the globally synchronized period from 17 April to 1 May 2016.

After thorough discussion and deliberation, the RCC concluded that the Region remains free of wild polioviruses (WPVs) and thus retains its status as polio-free. Key general recommendations to all Member States included the following:

- The RCC urges that type 2 polioviruses, WPVs and vaccine-derived polioviruses (VDPVs) from any source (AFP surveillance, environmental surveillance, stool surveys, etc.) be reported to WHO immediately.

- The RCC encourages Member States to continue consideration of fractional inactivated polio vaccine (IPV) use to mitigate the global IPV supply constraint.

1. INTRODUCTION

1.1 Meeting organization

The Twenty-second Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication (RCC) in the Western Pacific was held in Sydney, Australia on 15–17 November 2016. The RCC meets annually to review the maintenance of poliomyelitis-free status, the quality of acute flaccid paralysis (AFP) surveillance against standard indicators, and population immunity based on coverage of routine and supplemental polio vaccination. This annual meeting fulfils the RCC's mandate to assess progress and achievements every year, which are then reported to the Global Certification Commission.

In attendance were three members of the RCC, 17 chairpersons of national certification committees (NCCs) or delegates, one temporary adviser, and six observers. The meeting was supported by staff from World Health Organization (WHO) headquarters and regional offices, including the WHO Regional Office for the Western Pacific.

Professor Anthony Adams was appointed Chairperson, Dr Nobuhiko Okabe served as Vice-Chairperson, and Dr Aida Salonga served as Rapporteur. The list of participants and meeting timetable are available in Annex 1 and Annex 2, respectively.

1.2 Meeting objectives

The objectives of the meeting were:

1) to update the RCC and NCC chairpersons on the global and regional status of poliomyelitis eradication and recent activities in other regions;

2) to review and evaluate NCC progress reports, including implementation status of 2015 RCC recommendations; and

3) to recommend actions for countries to sustain polio-free status and for the timely implementation of polio endgame activities.

2. PROCEEDINGS

2.1 Opening session

Dr William Schluter delivered the opening remarks on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific. Dr Shin called attention to the recent eradication of indigenous wild poliovirus type 2 (WPV2), the globally synchronized withdrawal of type 2 oral polio vaccine (OPV) and the introduction of inactivated polio vaccine (IPV) in 105 countries' national immunization schedules. However, the recent wild poliovirus (WPV) cases in Nigeria and the global shortage of IPV continue to pose risks of outbreaks.

First Assistant Secretary Sharon Appleyard delivered remarks on behalf of the Department of Health of the Australian Government. She noted the challenge to eliminate the final 1% of polio cases, with Australia continuing to provide resources for the polio eradication effort. She also acknowledged RCC Chairperson Professor Anthony Adams, who is Australian, for his valuable contribution to the eradication of polio.

Professor Anthony Adams commented that much progress has been made to achieve and sustain polio-free status in the Western Pacific Region. He noted that with new polio cases in north-east Nigeria and continued cases in Pakistan and Afghanistan, it will require a minimum of 3–4 years

before global certification of polio eradication can be declared. He also stressed the importance of containment and acknowledged the successful switch from trivalent (tOPV) to bivalent oral polio vaccine (bOPV) and the response to the circulating vaccine-derived poliovirus (cVDPV) outbreak in the Lao People's Democratic Republic. He announced he will step down as RCC Chairperson at the end of December, with Dr Okabe assuming the role.

2.2 Global update

With 32 WPV cases reported from Pakistan, Afghanistan and Nigeria in 2016 (as of 20 November), the level of reported wild poliovirus type 1 (WPV1) polio cases is lower than in any previous year. The only reported cVDPV cases in 2016 were from the Lao People's Democratic Republic (type 1 or cVDPV1, last case 11 January 2016) and Nigeria (type 2 or cVDPV2, last case 21 August 2016). The situation in the Afghanistan–Pakistan epidemiological bloc – the main remaining endemic area globally – has further improved, with the number of cases and WPV1-positive samples decreasing. Polio emergency operations centres in both countries continue to implement the detailed national emergency action plans approved by the Technical Advisory Group on Immunization and Vaccine-Preventable Diseases in the Western Pacific Region to overcome remaining weaknesses in supplementary immunization activity (SIA) and AFP surveillance quality in Pakistan, as well as the impact of continuing problems of reaching children for vaccination, particularly in north-eastern Afghanistan (Kunduz). Nigeria, which had celebrated one year of absence of WPV1 in August 2015, experienced a setback with the renewed isolation in 2016 of both WPV1 and cVDPV2, with genetic features indicating prolonged circulation without detection, in conflict-affected areas of Borno state in the north-east. A multicountry, multi-SIA "Lake Chad response" activity is currently under way, which also includes the use of monovalent oral polio vaccine (mOPV) type 2. While the tOPV–bOPV switch was implemented globally according to plan, country teams should be on the alert to detect and fully investigate any isolations of Sabin virus type 2. Sabin 2 was found after August 2016 in India and in Afghanistan, with investigations revealing that tOPV had continued to be used in some health facilities. The Global Polio Eradication Initiative also has started to work with selected Member States to assure that so-called polio transition plans are in place, to assure a successful transition of key polio eradication assets (i.e. AFP surveillance) to benefit other national public health efforts in the future.

2.3 Regional update

Efforts to maintain polio-free status continue in the Western Pacific Region. Average reported coverage with the third dose of polio vaccines in 2015 was over 90% in the Region. Well-performing sensitive surveillance for AFP is in place and a risk assessment of the poliovirus spread in case of importation WPV or emergence of cVDPV is completed annually. The countries are equipped with national polio outbreak preparedness and response plans. However, challenges still exist in the Region, including population immunity gaps and suboptimal performance of AFP surveillance both at the national and subnational levels. To close these gaps, countries, supported by the WHO Regional Office for the Western Pacific, are strengthening national immunization programmes, implementing SIAs and improving AFP surveillance.

2.4 Update on regional laboratory network and Global Action Plan (GAP III) implementation

An update was provided of the performance and activities of the regional polio laboratory network and GAP III implementation with focus on the 2015–2016 period. The regional polio laboratory network has sustained certification standard and supports AFP surveillance activities. Performance indicators for timeliness of reporting of virus isolation and intratypic differentiation of polioviruses for all national polio laboratories have achieved high levels. All network laboratories are participating in the quality control programme with outstanding results. Regional laboratory network meetings, trainings and on-site visits are being conducted to ensure the continued high quality of laboratory testing and close monitoring of laboratory performance. Expansion of environmental surveillance is being considered in line with global guidelines to supplement AFP surveillance for prompt detection

of polioviruses. In compliance with requirements for laboratory containment, all countries in the Region are finalizing preparations for destruction and/or containment of all WPV2 isolates.

2.5 Recommendations of the 2016 Technical Advisory Group on Immunization and Vaccine-preventable Diseases

Dr Robert Hall summarized the polio-specific conclusions and recommendations of the Twenty-fifth Meeting of the Technical Advisory Group on Immunization and Vaccine-Preventable Diseases in the Western Pacific Region that was conducted on 26–29 July 2016 in Manila, Philippines. The Technical Advisory Group recommended that all countries analyse and fill population immunity gaps by strengthening routine vaccination with polio vaccines and conducting SIAs. This should include prioritization of IPV allocation to high-risk areas, and exploration of the programmatic feasibility of using IPV as a fractional dose via intradermal administration. In addition, all countries were recommended to improve surveillance for AFP cases and conduct active surveillance, especially in underperforming areas. All countries and areas were recommended to notify in a comprehensive and timely manner all type 2 polioviruses detected from all sources, including environmental surveillance. Advanced authorization for the importation and use of mOPV type 2 based on WHO prequalification and/or by providing an emergency waiver should be in place to allow the use of the vaccine for emergency response. Countries were recommended to ensure the completion of a national policy for the timely and comprehensive response to polio events/outbreaks in line with the Global Polio Eradication Initiative guiding documents and to comply with the requirements of GAP III.

2.6 tOPV–bOPV switch and IPV introduction

All 16 countries in the Western Pacific Region using any OPV in 2016 switched from tOPV to bOPV during 17 April–1 May 2016. To validate the withdrawal of tOPV from the cold chain, about 16 170 sites were monitored across the Region. Around 160 186 OPV vials in nine countries and 36 318 169 OPV doses in China were disposed. Starting from 1 May 2016, all 16 countries have been using bOPV in the national immunization schedule.

Fifteen of the 17 countries and areas in the Region that were using an all-OPV schedule introduced at least one dose of IPV in their national immunization schedules in 2015. China and the Philippines are continuing with a phased rollout of IPV. Due to the global shortage of supply, Mongolia and Viet Nam will be able to introduce IPV vaccine no earlier than the fourth quarter of 2017. Eight Pacific islands (Cook Islands, Fiji, Kiribati, Nauru, Samoa, Solomon Islands, Tonga and Vanuatu) that introduced IPV will not receive additional supplies before the fourth quarter of 2017 and therefore may experience stock-outs of IPV. Affected countries are encouraged to consider introduction of dose-sparing strategies like using two fractional doses of IPV (a fifth of the full dose) via the intradermal route instead of one full dose.

2.7 Laboratory containment

Progress towards implementing GAP III for poliovirus containment continues. For Phase I part 1, the reduction of the number of poliovirus facilities holding wild or vaccine-derived type 2 polioviruses, 194 reports have been received from 205 WHO Member States and associated territories. Twenty-four WHO Member States have expressed their intention to designate a total of 58 facilities (diagnostic or research laboratories or vaccine production facilities) as poliovirus-essential facilities (PEFs). Provided that they are certified as having complied with all containment requirements as prescribed by GAP III, PEFs will be allowed to retain WPV2 or Sabin 2 materials. For Phase Ipart 2 of GAP III, all WHO Member States are expected to identify and report all facilities holding potentially infectious poliovirus type 2 materials. WHO headquarters is about to publish the long-awaited guidance document to provide advice to countries on the completion of this phase. The Global Certification Commission for polio eradication will have an important role in final approval of the certification of PEFs as fully compliant with GAP III. For Phase II, the reduction of risk in PEFs, WHO is currently establishing a containment working group that will work closely with and advise

the Global Certification Commission.

2.8 Country presentations

2.8.1 Lao People's Democratic Republic

Chronically low routine coverage with polio vaccine resulted in an outbreak of cVDPV1 in 2015 in the Lao People's Democratic Republic. As of 1 November 2016, 11 cVDPV1 cases and 25 positive contacts were confirmed, all from the Hmong ethnic minority population which has historically had low vaccination coverage rates for polio and other routine vaccines. Up to July 2016, the Ministry of Health of the Lao People's Democratic Republic has conducted eight rounds of subnational or national polio SIAs targeting more than 15 million people in various age groups. Two more nationwide rounds of polio SIA (for children under 5 years of age) combined with other preventive public health interventions will be conducted in November 2016 and January 2017. The future plan of the national immunization programme is to sustain outbreak response achievements and to strengthen communication and cooperation with nongovernmental organizations and local authorities to increase population compliance with the national immunization schedule.

2.8.2 Cambodia

Cambodia's national polio programme continues to perform well, as demonstrated by national indicators for coverage with three doses of polio vaccine, AFP surveillance and stool adequacy. Subnational indicators, however, demonstrated underperforming AFP surveillance and routine immunization in hard-to-reach communities. A cross-border meeting is planned for 2017 between the Greater Mekong Subregion countries to integrate Expanded Programme on Immunization (EPI) and vaccine-preventable diseases (VPD) surveillance. The programme successfully completed the tOPV–bOPV switch. IPV was introduced in December 2015, although stock-outs were reported in 2016.

2.8.3 China

Most of the last RCC recommendations were implemented in China. The National Health and Family Planning Commission issued a contingency plan for responding to imported WPV outbreaks and VDPV-related events (WBJK 2011-60); updated polio diagnostic criteria and reclassified the definition of VDPV2 in alignment with global standards (WS 294-2016); and drafted a national plan for detecting and responding to VDPV2 or type 2 vaccine virus. No poliovirus type 2 was identified through surveillance of AFP patients, and residual poliovirus type 2 was isolated from environmental surveillance in one of nine provinces (Xinjiang) between June and August 2016 with a dramatically decreasing trend. No tOPV reuse was confirmed.

Great efforts were made to meet the GAP III recommendations and timelines, such as updating the inventory of WPV and potentially infectious materials; drafting the guideline on destruction of WPV/transferring to PEFs; drafting the guideline for a survey of facilities containing Sabin 2; designating two staff members responsible for GAP III implementation; and nominating EPI managers as containment coordinators. mOPV2 will not be considered in the national stockpile; if it is needed, China will apply for it from WHO according to the regulations. China has also decided on the facilities in the Chinese Center for Disease Control and Prevention to act as PEFs for the containment of WPV.

China successfully switched from tOPV to bOPV during 1–14 May 2016. During 2015–2016, China continued to raise the immunity of its population and improve the performance of its AFP surveillance system by implementing the OPV SIA and immunization check-up in the country's high-risk provinces and autonomous regions, including Tibet, and upgrading the AFP online real-time surveillance system software to meet the needs of the polio vaccine switch.

A robust laboratory network exists at the national and provincial levels with good laboratory performance and high level of quality assurance. Three VDPV cases were detected in 2015: type 2 immunodeficiency-associated VDPV (or iVDPV) case from Guangdong, type 2 ambiguous VDPV (or aVDPV) case from Liaoning, type 1 aVDPV case from Zhejiang. One type 3 VDPV (or VDPV3) case is still pending final classification. Nine provinces are involved in the environmental surveillance in the country. The number of Sabin 2 viruses decreased after the vaccine switch and no type 2 polioviruses have been detected after August 2016.

Challenges to maintaining polio-free status in China still exist. These include the continued potential importation of WPV from bordering and other polio-endemic countries, the potential continued emergence and circulation of VDPVs or iVDPVs; sustaining high levels of routine and SIA coverage, particularly for hard-to-reach populations; sustaining high-quality AFP surveillance in all parts of the country to quickly detect and respond to imported WPV and circulation of VDPVs; the shortage of IPV for the routine immunization schedule; the complexities of poliovirus containment in China; frequent changes in staff of epidemiology facilities and/or laboratories and subsequent need to train new staff; and the need for funds to support polio laboratories.

Follow-up activities include: sustaining high coverage of polio vaccine; sustaining the high quality of AFP surveillance and sentinel environmental surveillance; responding to importation of WPV and emergence of VDPVs; conducting a risk assessment of WPV importation and VDPVs; continuing the sentinel environmental surveillance in the nine provinces; increasing the IPV supplements; and continuing to implement poliovirus containment according to GAP III.

2.8.4 Papua New Guinea

Professor John Vince provided an update on the polio programme in Papua New Guinea. He noted that the Government of Papua New Guinea conducted a high-profile event in August 2015 stressing the importance of the EPI. The National Department of Health has also upgraded the EPI as one of two top priorities for the country, although no specific funding for the activities has been linked to the status change. One of the major constraints in addressing immunity gaps is the lack of budget allocation for the EPI at the provincial and district levels. Official estimates for the third dose of OPV show an improvement of national coverage from 52% in 2013 to 63% in 2015. The Special Integrated Routine EPI Strengthening Programme (SIREP) is still ongoing in an effort to improve immunization coverage and to introduce new vaccines. Strategies to close surveillance gaps included encouraging the designation of surveillance focal points at provincial hospitals, conducting workshops in 2014 and 2015 for provincial disease control officers and family health officers, and conducting VPD surveillance for paediatricians and paediatric nurses.

2.8.5 Philippines

The Philippines non-polio AFP rate improved from 0.71 in 2014 to 1.07 in 2015, only to slide to 0.8 in January–August 2016. Stool adequacy improved from 61% in 2015 to 67% in 2016, but is still far from the 80% target. Coverage of routine immunization with three doses of OPV remains low: 79% in 2015 and no substantial improvement in the 2016 data. The establishment of environmental surveillance is proceeding with 19 collection sites selected for a two-phase approach in 2016–2017. Noteworthy is the disconnect between the private and public sectors, with private sector data not accounted for or reported to the Department of Health.

Vaccine procurement is a challenge with EPI vaccine stock-outs (including IPV) happening from the second quarter of 2016.

The Philippines has not yet updated its national polio preparedness and response plan. The Department of Health managed to comply with the switch from tOPV to bOPV, but switch validation has not looked at the private sector. All regions have introduced IPV in routine immunization with

demonstrated improvements, but more granular data show that the extent of IPV introduction within each region has been limited.

A total of 77 provinces were assessed as high risk in 2016 in comparison with 94 in 2015, but this still represents a very high percentage and efforts should be pursued.

The quarantine programme addresses only the people leaving the Philippines going to infected countries, but not incoming workers from infected countries.

Two major polio-related risks have been identified in the Philippines: importation from endemic countries, but more importantly a major risk of VDPV emergence.[1]

In terms of potential opportunities, a new Secretary of Health has been appointed and advocacy is of paramount importance to continue efforts towards maintaining polio-free status in the Philippines.

2.8.6 Viet Nam

In 2015 the polio programme in Viet Nam continued its efforts to maintain polio-free status. In 2015–2016 the programme conducted a retrospective record review to find missed AFP cases. Use of tOPV stopped on 1 May 2016 and use of bOPV in the routine immunization schedule started on 1 June 2016. According to the national regulations, however, some doses of tOPV are still kept at the manufacturer's sites. Due to global supply constraints, the introduction of IPV has been postponed until at least the fourth quarter of 2017. To address immunity gaps, two rounds of polio SIAs were conducted in 2015 and 2016 for the population in high-risk areas. The coverage in both rounds was more than 95%. Viet Nam has also made good progress in complying with GAP III requirements. To sustain the achievements, the Ministry of Health has adopted a national plan to respond to an outbreak of poliovirus type 2 for 2016–2020.

2.8.7 Australia

By strengthening engagement with reporting practitioners, AFP surveillance continues to improve, although stool adequacy indicators have not yet met certification standards. Routine immunization with poliovirus vaccines remains very high. Environmental surveillance continues to include major metropolitan areas like Melbourne. The national programme has successfully implemented GAP III requirements by designating a national laboratory containment coordinator and designating the National Enterovirus Reference Laboratory at the Victorian Infectious Diseases Reference Laboratory as a PEF.

2.8.8 Brunei Darussalam

Brunei Darussalam has maintained very strong AFP surveillance and immunization coverage. To ensure consistently high coverage figures, the vaccination coverage monitoring system has been further refined to include subnational coverage. Since 2011, Brunei has been providing IPV to foreign-born residents who fail to provide valid immunization records upon arrival. Preparedness and response plans have been developed and in view of challenges posed by the substantial number of travellers from the country for the Hajj pilgrimage.

2.8.9 Hong Kong SAR (China)

Professor Yu-lung Lau provided an update on the polio programme in Hong Kong SAR (China). The last polio case was in 1983 and AFP surveillance has been in place since 1997. IPV has been used in

[1] It should be noted that the most recent case was type 1 VDPV.

the routine immunization programme since 2007. At present, the routine immunization schedule includes a four-dose primary series followed by two booster doses given at primary 1 and primary 6. Coverage with at least three doses has been close to 100% since 2008. All surveillance performance standards are being met. Hong Kong SAR (China) does not plan to establish PEFs and is waiting for additional guidance on containment issues. The biggest risk may come from heavy international tourist traffic with more than 59 million visitors each year. Future plans include maintaining a sensitive surveillance system, a high-quality fully accredited laboratory, regular monitoring to ensure high population immunization coverage, and an up-to-date and comprehensive polio importation preparedness and response plan.

2.8.10 Japan

Japan has not experienced any cVDPV cases, the last WPV case was in 1993 and the last vaccine-associated paralytic polio (VAPP) case was in 2012. Japan has a stand-alone IPV product and combined products with diphtheria, pertussis and tetanus, such as DPT-IPV. Domestic manufacturers are producing combined vaccines of conventional IPV such as with diphtheria, tetanus and acellular pertussis (DTaP-cIPV), but also those containing Sabin-derived IPV product originating from attenuated Sabin vaccine polioviruses (DTaP-sIPV). The Bill & Melinda Gates Foundation has approached one Japanese company to produce at least 50 million doses of sIPV products every year to make available for more than 70 developing countries.

Shortly before the introduction of IPV in 2012, routine OPV coverage declined in part due to public concern over the risk of vaccine-associated paralytic polio, raising serious concerns about an emerging immunity gap during the OPV–IPV transition period. Those children who should have been immunized during the OPV–IPV transition are carefully monitored. Strong social mobilization was able to turn around vaccination hesitancy.

Nationwide immunization coverage data for 2015 and 2016 will be officially available in 2017, but are thought to be satisfactorily high as in previous years. A sero-epidemiological survey in 2015 showed no particular high-risk populations in the young age groups (6 months–30 years old), at least for type 1 and type 2 polioviruses (over 90% seropositivity rate). Higher seropositivity rates against type 3 poliovirus (over 95% seropositivity rate) were observed in children 6 months–3 years old than those in the previous years, suggesting a high IPV vaccination coverage and higher efficacy of IPV for type 3 poliovirus than tOPV.

Although no surveillance system exists for enterovirus D68 (EV-D68), Japan has analysed characteristics of EV-D68 detected cases in the country and suggests cyclic epidemics. Further research is ongoing to assess the AFP status among the nine paralytic cases that have been identified since 2006 based on clinical case definition.

After introduction of IPV, nationwide environmental surveillance started in 2013 and the environmental surveillance network consisted of 18 public health institutes in 2015. No poliovirus was isolated in Japan in 2015.

2.8.11 Macao SAR (China)

Macao has a very strong national immunization programme maintaining high performance standards. High protection of the population with three doses of polio vaccine and high-quality surveillance for AFP cases make it possible for Macao SAR (China) to maintain its polio-free status. Despite such a well-performing programme, challenges still exist, the main one being the large number of visitors which might be a potential source of importation of the poliovirus from endemic countries. However, plans are in place to mitigate possible negative consequences resulting from the high volume of international travel. Specifically, efforts are being made to sustain high coverage with polio vaccine, to maintain the high quality of AFP surveillance, and to further enhance knowledge and awareness of polio among health-care professionals and the population.

2.8.12 Malaysia

Performance of surveillance for AFP and collection of adequate stool samples is of high quality and coverage with three doses of polio vaccine is very high. Compared to 2014, collection of rectal swabs for AFP surveillance has been discontinued. Despite high coverage with polio vaccine, some issues and challenges remain. The national programme discontinued the use of tOPV in May 2015 and currently uses a four-dose IPV schedule. The risk of spread of WPV in case of importation is high due to migrants (at least 2 million documented migrants) who have financial constraints to access vaccination. The programme is in the process of documenting GAP III requirements for destruction of all poliovirus type 2 specimens.

2.8.13 Mongolia

Mongolia continues to maintain high levels of immunization coverage (98%) across all provinces with increased efforts directed to identify high-risk populations in border areas. Improvements were made in strengthening AFP surveillance and routine immunization by means of increased training, rolling out a communications strategy and other targeted activities. Mongolia has fully switched nationwide from tOPV to bOPV and will introduce IPV in the fourth quarter of 2017 due to lack of supply of IPV. One ongoing problem is that of high turnover of subnational EPI staff which may cause potential problems in monitoring surveillance.

2.8.14 New Zealand

Professor Stephen Chambers presented New Zealand's annual progress report on maintaining polio-free status. He noted that active surveillance for childhood AFP is undertaken by the New Zealand Paediatric Surveillance Unit, with monthly zero reporting from essentially all practicing paediatricians in New Zealand (91% response rate) in 2015 and 2016. Nevertheless, the rate of reporting children with AFP is below the recommended threshold and stool adequacy is also below the 80% threshold. To evaluate the system, an audit of AFP hospital discharges was undertaken in 2015. Eight children with Guillain-Barré syndrome and four with acute polyneuropathy were identified and reviewed. A neurology nurse from the main referral paediatric hospital was engaged to identify possible cases in order to improve reporting and adequacy of specimen collection. Arrivals from polio-endemic countries are monitored by the refugee health programmes upon arrival and missed vaccinations are provided. AFP surveillance is supplemented with laboratory-based enterovirus surveillance. New Zealand has a comprehensive national immunization registry that helps maintain high coverage even among ethnic minority populations.

2.8.15 Republic of Korea

The Republic of Korea continues to maintain high performance in surveillance and immunization coverage. IPV1 and IPV3 coverage was 99.9% and 99.4%, respectively, in 2014. Among children (12 months), IPV1 and IPV3 coverage was 99.6% and 98.8%, respectively, in 2012, and 99.8% and 99.4%, respectively, in 2013. The share of children who completed all three doses of IPV during 2011–2014 was over 95% in all districts. IPV4 coverage for children aged 4–6 years in 2014–2016 was over 98% among all elementary school students (school entry requirement). The free immunization also covers all foreigners 12 years and below who reside in the Republic of Korea (including illegal immigrants).

The country has had no outbreak or imported case of polio for more than 30 years. The risk of VDPV has been very low since the switch from OPV to IPV in 2004, and high immunization coverage has been maintained. As for polio surveillance, the Republic of Korea runs AFP surveillance complemented by enterovirus surveillance and an entry screening programme following the experience with Middle East respiratory syndrome (MERS).[2] Regular seroprevalence studies (the last one in 2012) are also performed. No poliovirus has been detected by any of the systems in recent years.

The current challenges are the implementation of GAP III at the national level and formation of a nati onal authority for containment (NAC). A domestic pharmaceutical company plans to produce Sabin I PV. The country's main plans are to update the national action plan for detection of and response to importation of WPV and cVDPV, to identify a NAC by early 2017, and finally to conduct a new sero-epidemiological study.

2.8.16 Singapore

In 2015–2016, Singapore maintained its polio-free status with its high-performance polio programme. High-quality, sensitive AFP surveillance is in place with the main indicators exceeding the established international standards. Population coverage with polio vaccine is above 95%. The risk of spread of poliovirus through importation is not high due to the well-functioning effective polio programme, high standards of environmental hygiene and sanitation, and small number of visitors from polio-endemic countries. On 30 April 2016, Singapore stopped using tOPV and started using bOPV in the national immunization schedule. The challenges include maintaining awareness of polio importance among health-care workers and ensuring vaccination of visiting children. A number of activities are planned to address these challenges, including updating the national outbreak preparedness and response plan.

2.8.17 Pacific island countries and areas

The Pacific island countries and areas successfully maintained polio-free status in 2015. However, quality of AFP surveillance, coverage with polio vaccine, programmatic strengths, and external threats and emergencies vary among the 21 countries and areas. Three countries have no reported coverage data, and there are multiple silent areas for AFP surveillance. In April 2015, bOPV was discontinued, and all countries had introduced IPV by the end of 2015.

2.9 Update on regional laboratory network and GAP III implementation

Dr Shin closed the meeting by acknowledging all Member States for their commitment and dedication to polio eradication. He also thanked the governments of Australia and Japan for making the meeting possible and expressed appreciation for the work of retiring chair Anthony Adams.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

3.1.1 General

1) The RCC concludes that the Region remains polio-free and congratulates all the Member States for their continued dedication.
2) The RCC notes the timely introduction of IPV and successful coordinated execution of the tOPV–bOPV switch.
3) The RCC commends Member States on the considerable progress made on poliovirus type 2 containment.

[2] Passengers and crew from polio-affected countries have been monitored at the port of entry since 2011.

4) The RCC commends ongoing and proposed efforts in the Region for IPV manufacture.

3.1.2 Country-specific conclusions

Australia

1) The RCC commends Australia's strong commitment to meeting polio performance indicators including more effective AFP surveillance.
2) The RCC commends Australia's actions towards containment.

Brunei Darussalam

The RCC commends Brunei Darussalam's strong surveillance and immunization programme.

Cambodia

The RCC notes Cambodia's continued progress in AFP surveillance and routine immunization performance.

China

1) The RCC commends China's continued outstanding commitment to maintaining polio-free status.
2) The RCC commends the country's efforts to increase IPV supply for its EPI.

China, Hong Kong SAR

The RCC commends the strong surveillance and immunization programme, especially in light of challenges with mass population movements.

China, Macao SAR

The RCC commends the strong surveillance and immunization programme.

Japan

The RCC congratulates Japan for their high performance in surveillance and immunization coverage.

Lao People's Democratic Republic

1) The RCC commends the country's timely and comprehensive response to the cVDPV1 outbreak.
2) The RCC notes the effective implementation of new vaccination and communication strategies in hard-to-reach populations including production of information, education and communication (IEC) materials in multiple languages.
3) The RCC notes that despite improvements in AFP surveillance, performance varies by province.

Malaysia

1) The RCC commends Malaysia for its continued commitment to meeting surveillance performance indicators and high immunization coverage.
2) The RCC notes the global supply chain shortage of IPV and possible consequences to Malaysia.
3) The RCC notes that unvaccinated migrants in the country pose a risk for VDPV emergence and transmission.

Mongolia

The RCC commends Mongolia on the high reported immunization coverage rates both nationally and at the provincial level.

New Zealand

1) The RCC commends New Zealand's strong commitment to meeting polio performance indicators.
2) The RCC commends the high coverage achieved, including among the Maori population.

Pacific island countries and areas

1) The RCC commends the Subregional Committee for the Certification of Poliomyelitis Eradication in Pacific Island Countries and Areas and the Pacific island countries and areas for their continued progress despite the complexity of managing a disparate group of countries over a vast area.
2) The RCC notes that programmatic performance varies among the 21 countries and areas.
3) The RCC recognizes the impact of external health emergencies on programme performance.

Papua New Guinea

1) The RCC acknowledges the increased priority given to EPI by the country.
2) The RCC acknowledges the increase in the number of provincial sentinel surveillance sites.

Philippines

1) The RCC notes that the Philippines, with its high population, remains the country of highest concern for polio importation, cVDPV emergence and transmission in the Region.
2) Despite continued efforts, the polio and VPD programmes remain severely under-resourced.
3) AFP surveillance standards are not yet met and routine immunization coverage remains chronically low.
4) The RCC commends the frank, comprehensive and objective report from the NCC.

Republic of Korea

The RCC commends the country's high performance in surveillance and immunization coverage.

Singapore

The RCC commends the strong surveillance and immunization programme.

Viet Nam

1) The RCC commends the SIAs done in high-risk districts with high coverage.
2) The RCC is pleased that steps are being taken to manufacture IPV within the country, thus easing shortages.
3) The RCC notes the presence of a number of silent provinces.

3.2 Recommendations

3.2.1 General recommendations

1) The RCC urges that type 2 polioviruses, WPVs and VDPVs from any source (AFP surveillance, environmental surveillance, stool surveys, etc.) be reported to WHO immediately.
2) The RCC encourages Member States to continue consideration of fractional IPV use to mitigate the global IPV supply constraint.

3.2.2 Recommendations to specific Member States

Australia

The RCC recommends continuing efforts to improve AFP reporting and the collection of adequate stool specimens.

Brunei Darussalam

The RCC recommends continuing to maintain high performance standards to contribute to the regional polio-free status.

Cambodia

The RCC recommends continuing to maintain and strengthen the recent improvements in surveillance and coverage.

China

The RCC recommends the following:

1) continuing to sustain high coverage of polio vaccine;
2) continuing to sustain high-quality AFP surveillance and supplemental environmental surveillance;
3) continuing to implement poliovirus containment;
4) designating a NAC with NAC members who are independent from PEFs;
5) reporting results of environmental surveillance to WHO at least quarterly; and
6) sharing results of updated national polio risk assessments.

China, Hong Kong SAR

The RCC recommends continuing to maintain high performance standards to contribute to the regional polio-free status.

China, Macao SAR

The RCC recommends maintaining high performance standards to contribute to the regional polio-free status.

Japan

The RCC recommends reporting the results of environmental detection of poliovirus type 2 and any WPV/VDPV to WHO immediately; otherwise complete zero reporting of polioviruses on a quarterly basis.

Lao People's Democratic Republic

The RCC recommends the following:

1) sustaining improvements in routine immunization coverage;
2) continuing efforts to improve AFP surveillance in low-performing provinces;
3) overcoming barriers to increase the utilization of IPV; and
4) making proper preparations for the upcoming SIAs to ensure high coverage of target populations with special attention to reaching missed children; and
5) supporting proposed cross-border coordination meetings with Viet Nam and Cambodia.

Malaysia

The RCC recommends the following:

1) providing polio vaccination to all migrant children at no cost to prevent cVDPV emergence and polio outbreaks;
2) improving subnational surveillance performance; and
3) reporting the results of environmental surveillance to WHO at least quarterly.

Mongolia

The RCC recommends the following:

1) continuing to maintain and achieve high programme performance standards;
2) giving IPV to children eligible after the switch as soon as vaccine becomes available;
3) providing full risk assessment findings; and
4) updating the timeline for the virus isolation indicator from 28 days to 14 days.

New Zealand

The RCC recommends continuing efforts to improve AFP reporting and the collection of adequate stool specimens.

Pacific island countries and areas

The RCC recommends identifying children who will be impacted by IPV stock-outs and to vaccinate them once IPV becomes available.

Papua New Guinea

The RCC supports the following:

1) recommendations of the NCC and the development of provincial health authorities as a mechanism to increase availability of funding for EPI activities; and
2) the continued deployment of Stop Transmission of Polio (STOP) volunteers as a mechanism to improve AFP surveillance quality.

Philippines

The RCC recommends the following:

1) urgently strengthening routine immunization coverage (bOPV and IPV) with priority allocation of available IPV given to highest-risk areas as identified in the national risk assessment;
2) supporting the NCC's recommendation to address gaps in vaccine procurement;
3) urgently addressing AFP surveillance shortfalls;
4) finalizing the implementation of the environmental surveillance system to complement AFP surveillance; and
5) updating polio preparedness and outbreak response plans according to global guidelines.

Republic of Korea

The RCC recommends the following:

1) continuing to maintain high performance standards to contribute to the regional polio-free status;
2) identifying a NAC; and
3) completing a risk assessment at the provincial or district level.

Singapore

The RCC recommends continuing to maintain high performance standards to contribute to the regional polio-free status.

Viet Nam

The RCC encourages the country to improve AFP surveillance performance.

3.2.3 Recommendations for WHO

The RCC recommends the following:

1) that WHO work with manufacturers developing IPV products to encourage clinical trials that would allow labelling for the use of fractional dose administration;
2) that WHO develop clear guidance on containment of potentially infectious materials; and
3) that WHO and partners summarize existing data from serosurveys on the immunogenicity and duration of protection provided from OPV and IPV for presentation to the Strategic Advisory Group of Experts.

ANNEX 1

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ANNEX 2

MEETING TIMETABLE

Time	Tuesday, 15 November 2016	Time	Wednesday, 16 November 2016	Time	Thursday, 17 November 2016
08:00–08:30 08:30–09:00	Registration Opening ceremony • Welcome remarks by the Responsible Officer • Opening remarks of the Regional Director • Opening remarks of the Department of Health • Self-introduction, Election of Officers (Chair, Vice-Chair, Rapporteur) • Remarks by the Regional Certification Commission (RCC) Chairperson • Administrative announcements	08:30–10:00	Country presentations *(continuation)* • Australia • Brunei Darussalam • Hong Kong SAR (China)	08:30–10:00	Closed working session
09:00–09:30	*GROUP PHOTO AND COFFEE BREAK*	10:00–10:30	*COFFEE BREAK*	10:00-10:30	*COFFEE BREAK*
09:30–10:00 10:00–10:20 10:20–10:40 10:40–10:55 10:55–11:10 11:10–11:25 11:25–11:40 11:40–12:00	1. Global update 2. Regional update 3. Update on regional laboratory network and GAP III implementation Discussion 4. Recommendations of the 2016 Technical Advisory Group on Immunization and Vaccine-preventable Diseases 5. Trivalent oral polio vaccine-bivalent oral polio vaccine switch and inactivated polio vaccine introduction 6. Laboratory containment Discussion	10:30–12:00	Country presentations *(continuation)* • Japan • Macao SAR (China) • Malaysia	10:30–12:00	Closed working session (*continuation*)
12:00–13:00	*LUNCH BREAK*	12:00–13:30	*LUNCH BREAK*	12:00–13:00	*LUNCH BREAK*
13:00–15:00	7. Country presentations • The Lao People's Democratic Republic • Cambodia • China	13:30–15:00	Country presentations *(continuation)* • Mongolia • New Zealand • The Republic of Korea	13:00–14:00 14:00–14:30	8. Regional Certification Commission conclusions and recommendations Closing session
15:00-15:30	*COFFEE BREAK*	15:00–15:30	COFFEE BREAK	14:30–15:00	COFFEE BREAK
15:30–17:00	Country presentations (*continuation)* • Papua New Guinea • The Philippines • Viet Nam	15:30–16:30	Country presentations *(continuation*) • Singapore • Pacific island countries and areas		
18:00–19:30	Regional Director's reception				

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