Meeting Report

Sixteenth Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region

Manila, Philippines
27 to 30 October 2010

World Health Organization
Western Pacific Region

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC

REPORT

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NOTE

The views expressed in this report are those of the participants of the sixteenth meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region and do not necessarily reflect the policies of the World Health Organization.

Keywords:

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This report has been printed by the Regional Office for the Western Pacific of the World Health Organization for the participants of the sixteenth meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region, which was held in Manila, Philippines, from 27 to 30 October 2010.

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OF POLIOMYELITIS ERADICATION IN THE WESTERN PACIFIC REGION
DIAMOND HOTEL
MANILA, PHILIPPINES
28 - 29 OCTOBER 2010

1. INTRODUCTION

The Regional Commission for the Certification of Poliomyelitis Eradication (RCC) in the Western Pacific Region continues to meet on an annual basis in order to review and support maintenance of poliomyelitis-free status and certification standard quality requirements and to fulfil its reporting mandate to the Global Certification Commission (GCC).

1.1 Objectives

The objectives of the RCC at its sixteenth meeting were:

(1) to review progress reports from all countries and areas on maintaining their poliomyelitis-free status and make recommendations on required action for maintaining the Region's poliomyelitis-free status;

(2) to advocate with National Certification Committees (NCC) and other relevant partners for requirements for keeping the Region poliomyelitis-free; and

(3) to encourage traditional and new key partners to ensure the necessary resource requirements are met, as part of an interagency coordinating mechanism.

1.2 Organization

In order to have closer direct interactions with the National Certification Committees (NCC) in key countries and to allow RCC members to observe activities for maintaining poliomyelitis-free status, the 16th RCC meeting was held at the WHO Western Pacific Regional Office in Manila, the Philippines. Field activities for a targeted review of the acute flaccid paralysis (AFP) surveillance system were conducted immediately after the meeting and the main conclusions and recommendations presented to the National Immunization Programme (NIP) by the RCC Rapporteur. Holding the meeting in the Philippines also presented advocacy opportunities regarding the significance of and requirements for maintaining the country's poliomyelitis-free status and subsequently support for the NIP.

The meeting was attended by six of the seven commission members, a temporary adviser, 16 NCC members and designates, 54 observers from 15 partner agencies and 27 WHO staff from Headquarters, the Western Pacific Regional Office and country offices. Annex 1 includes the meeting timetable, and Annex 2 contains a list of participants.

1.3 Opening ceremony

The WHO Regional Director for the Western Pacific, Dr Shin Young-soo, welcomed the Honourable Secretary of Health of the Philippines, Dr Enrique Ona, members of the RCC and the NCCs, and representatives of partner agencies. He recognized the important role of the RCC, which has been rigorous in its oversight and monitoring. Likewise, NCCs have provided invaluable oversight to national poliomyelitis programmes to sustain both high-quality surveillance and population immunity.

The Regional Director reiterated that high alert needs to be maintained, as global poliomyelitis eradication is still an unfinished story. Despite new vaccines and hundreds of thousands of health workers vaccinating millions of children many times each year, the virus is still a threat. In Afghanistan, India, Nigeria and Pakistan, wild poliovirus transmission has never

been stopped. As long as there is poliomyelitis anywhere in the world, any child who has not been fully vaccinated is vulnerable.

The Regional Director reminded participants that the WHO European Region had also been certified as poliomyelitis-free, but had faced virus importations in 2010 from a poliomyelitis-endemic area, causing outbreaks in Tajikistan, Turkmenistan, Kazakhstan and the Russian Federation, and paralyzing nearly 500 persons. Some of those cases had been close to countries in the Western Pacific Region, namely China and Mongolia. Both those countries had reacted quickly and decisively, alerted health workers, stepped up surveillance, and conducted careful risk assessments. All young children in Mongolia were given additional vaccine and China did the same for those in at-risk areas.

He also noted that there had been two episodes of wild poliovirus importation in the Western Pacific Region: the first in 2006, from Nigeria into Singapore, and the second in 2007, from Pakistan into Australia. Fortunately, there had been no secondary cases. Recognizing the ongoing risks, everybody in the Region should worry about the falling rates of vaccination coverage and increasing surveillance gaps observed in some countries.

The Regional Director noted that the number of poliomyelitis cases reported worldwide as of October 2010 was 793, compared with 1198 in the same period for 2009, representing a reduction of over 30%. In India, the number of reported cases was less than 10% of the number in 2009. Progress in Nigeria appeared even more impressive — only eight cases notified in 2010, compared with 381 in the whole of 2009. However, there are also disturbing challenges, with Pakistan having more cases than the other three endemic countries combined. In addition, in the previous 12 months, 51% of all poliomyelitis cases globally had been reported from WHO's European Region, most of them in Tajikistan.

The Regional Director gave his commitment that WHO would do whatever required to support the eradication of poliomyelitis in those parts of the world where it still exists. He concluded by thanking everyone for their hard work and commitment over the past 10 years to keep poliomyelitis out of the Region, expressing particular appreciation to Rotary International, the Bill and Melinda Gates Foundation and the United States Centers for Disease Control for making poliomyelitis eradication their priority.

2. PROCEEDINGS

2.1 Global poliomyelitis status

2.1.1 Endemic countries

As of 28 September, there have been 706 cases globally in 2010 (635 type 1 and 71 type 3), compared with 1126 cases by the same date in 2009 (387 type, 1735 type 3 and 4 type 1/3 mixtures). A total of 17 countries have reported cases in 2010, compared with 21 by the same time in 2009. One hundred and fifty-one districts have been infected with wild poliovirus in 2010, an almost 65% reduction compared with the 408 districts infected by the same time in 2009. In September 2010, Sierra Leone and Liberia came off the active outbreak list (no cases in the past six months) while Russia and Turkmenistan were added to the list. There has been a 90% decrease in the number of wild poliovirus type 3 (WPV3) cases globally in 2010 (71 cases compared with 735 by the same time in 2009). In Africa, in the past four months, only Nigeria, Angola and the Democratic Republic of the Congo have reported cases.

In Afghanistan, 17 cases have been reported (nine WPV1, eight WPV3) compared with 22 cases by the same time in 2009 (15 WPV1, seven WPV3). The most recent supplementary immunization activity (SIA) was a mop-up in the northern states from 3 to 5 September, using monovalent oral poliovirus vaccine type 1 (mOPV1). The next national immunization days (NIDs) were conducted from 3 to 5 October, using bivalent oral poliovirus vaccine (bOPV), Afghanistan reported its first case in Kunduz in the far north of the country since 2002. Widely expected to be related to the Tajikistan outbreak across the border, genetic sequencing showed that the case was in fact related to transmission in Khyber Pakhtunkhwa (North West Frontier Province) in Pakistan. A surveillance review for AFP held in all regions except the Southern Region found that poliovirus transmission in the review areas was "very unlikely" to go undetected. In preparation for the October NIDs, staff from the regional to the community levels were trained on interpersonal communication skills. New communications materials and mass media spots were produced to incorporate information about the addition of de-worming tablets, to be administered to children aged 24–59 months during the October NIDs.

In India, 39 cases have been reported in 2010 (16 WPV1, 23 WPV3) compared with 395 cases by the same time in 2009 (51 WPV1, 343 WPV3, 1 WPV1/3). The most recent subnational immunization days (SNIDs) were held from 19 September onwards in Bihar, UP, Delhi and parts of Jharkhand, West Bengal and Maharashtra. The next SNIDs were planned from 3 October onwards in Bihar. Dozens of highly experienced surveillance medical officers were deployed to Malegaon (Nasik), Pakur (Jharkhand) and Murshidabad (West Bengal) to assist with training, microplan revision, and monitoring during the SNIDs, and more than 700 volunteers were mobilized by UNICEF to conduct social mobilization activities in Murshidabad and two other high-risk districts. Reports from Pakur and Murshidabad revealed that the quality of the most recent immunization activity had shown improvement. A partners meeting, attended by the WHO- National Polio Surveillance Project (NPSP), UNICEF and Rotary International was held in Nasik to finalize and implement a coordinated plan to improve SIA quality in Malegaon. A surveillance review was scheduled to take place in southern West Bengal from 4 to 11 October 2011.

In Nigeria, eight cases have been reported to date in 2010 (four WPV1 and four WPV3) compared with 382 cases by the same time in 2009 (73 WPV1, 307 WPV3 and 2 WPV1/3). The most recent SIAs were conducted from 18 to 21 September, with the next NIDs to be carried out from 23 to 26 October in high-risk northern states, using bOPV. The most recent meeting of the national Expert Review Committee on Polio Eradication and Routine Immunization (ERC) was held from 4 to 5 October. The group discussed strategies to capitalize on the current positive epidemiological situation. The Rotary International PolioPlus Summit, held in Abuja on 21 September, declared a "zero-tolerance policy for poliomyelitis". Rotary International President, Ray Klinginsmith, and Rotary Foundation Trustee Vice-Chair, John Germ, attended the Summit to recognize Nigeria's 99% reduction in poliomyelitis cases in 2010 compared with 2009 and to encourage Rotarians and government officials to finish the job.

In Pakistan, to date 69 cases have been reported in 2010 (50 WPV1 and 19 WPV3) compared with 62 cases by the same time in 2009 (40 WPV1, 21 WPV3 and 1 WPV1/3). The most recent NIDs were conducted from 27 September onwards, with the next SNIDs carried out from 11 to 13 October, using bOPV. With the large-scale population movements and expected intensified transmission of poliovirus due to flooding, concerns are growing over widespread poliomyelitis transmission. More than nine million children in the 36 districts worst-affected by the recent flooding have been reached and immunized with monovalent oral poliovirus vaccine (mOPV1) and measles vaccine since 15 September. All poliomyelitis-funded technical staff and 60% of administrative staff were mobilized to assist with the response to the flood emergency, which has devastated health facilities and the vaccine cold chain. The Federal Ministry of Health has contacted key administrative officials in the Federally Administered Tribal Areas (FATA) to

highlight the sharp increase in poliomyelitis cases and urge the full implementation of the operational plan developed by the civil and military Polio Crisis Taskforce.

2.1.2 Countries with re-established transmission

In Angola, to date 25 WPV1 cases have been reported in 2010 compared with 26 WPV1 cases by the same time in 2009. Recent SIA were conducted from 6 to 8 August, using bOPV, followed by NIDs from 1 to 3 October, using bOPV. Efforts have been underway to urgently address the operational gaps in immunization activities — with upwards of 20% of children regularly missed during SIAs, particularly in Luanda, Kuanza Sul and Kuanza Norte — by strengthening microplans and vaccinator selection and training. Key to ultimate success, however, will be strengthened engagement by provincial and district-level leadership.

In Chad, to date 14 WPV3 cases have been reported in 2010 compared with 24 WPV3 cases by the same time in 2009. The next NIDs are to be conducted in October and November, using bOPV.

In the Democratic Republic of Congo (DRC), to date 24 cases have been reported in 2010 (23 WPV1 and 1 WPV3) compared with three WPV3 cases by the same time in 2009. The most recent SIA were conducted from 23 to 25 September, followed by NIDs from 21 to 30 October. The Democratic Republic of Congo experienced a severe outbreak in Kasai Occidental, the result of poliomyelitis transmission from across the Angolan border. Such expanding outbreaks in Angola and Democratic Republic of Congo threaten progress in Africa; in the past four months, only three countries in Africa — Angola, Democratic Republic of the Congo and Nigeria — have recorded any poliomyelitis cases. Chad recorded its most recent case on 10 May, while the most recent case from the 2009–2010 West African outbreak was in Mali on 1 May. However, expanding outbreaks in Angola and the Democratic Republic of Congo are seriously undermining progress. As a result, WHO has alerted the Member States of the increasing risk associated with these outbreaks through the International Health Regulations mechanism. Angola has conducted a staggering 29 immunization activities since its outbreak began in April 2007, clearly indicating that urgent action is required to improve the quality of campaigns.

2.1.3 Importation countries

The large outbreak of wild poliovirus type 1 in Tajikistan in 2010 (456 of 581 WPV1 cases globally in 2010) has slowed dramatically, but not before poliovirus from Tajikistan spread to infect Turkmenistan and the Russian Federation. The most recent case in Tajikistan had onset of paralysis on 4 July. While two cases were reported in Tajikistan in September, both cases had onset of paralysis in May and had already been covered by two immunization activities. Turkmenistan's three cases are clustered together in Lebap Province in the far south-east, with infection of all three cases occurring within eight days of each other in June. These cases have already been covered by three immunization activities.

A total of 12 cases have been reported in the Russian Federation, with seven of these cases attributed to separate unique importations from neighbouring poliomyelitis-infected countries. Three cases in Chechnya represent a significant risk of further international spread. Countries of the Caucasus have been recommended to ensure all children under five are fully immunized against poliovirus. Uzbekistan is to immunize nine million children under 15 with mOPV1 from 25 to 31 October. Kazakhstan held NIDs from 6 September, while Kyrgyzstan has conducted two rounds of NIDs.

The outbreak in Nepal continues, with a new case reported with onset of paralysis on 30 August. All cases have occurred in two of eight high-risk districts bordering India (Rautahat,

with five cases and Mahottari with one case). It is from Rautahat district that this outbreak spread to re-infect northern Bihar. Rautahat district remains at risk of ongoing transmission or re-infection due to high levels of population movement to and from the now-infected East Champaran of Bihar, India. Recognizing the ongoing outbreak, the Government of Nepal has called for emergency measures in the high-risk district and has added an additional SIA at the end of October. Three SNIDs are being held in a six-week period in the high-risk areas in order to raise immunity rapidly.

In West Africa, preparations for an 11-country synchronized immunization campaign to be held from 29 October are ongoing, targeting 29 500 000 children under five in Benin, Burkina Faso, Cote d'Ivoire, Gambia, Guinea, Liberia, Mali, Mauritania, Niger, Senegal and Sierra Leone. Focus is on improving the quality of campaigns based on lessons learnt in previous activities through strengthening microplans, maximizing capacity in identified high-risk border areas, and introducing strategies to access all difficult-to-reach populations.

2.2 Regional status of maintaining poliomyelitis-free status

At its 15th meeting in December 2009, the RCC concluded that the Western Pacific Region remained free of poliomyelitis during 2009, despite the persisting risk of wild poliovirus importation from endemic areas, and despite of the existence of sub-areas in the Region where insufficient immunity levels may allow wild poliovirus spread, subsequent to an importation.

The overall quality of immunization and surveillance activities, including the performance of the regional poliomyelitis laboratory network, remains commendable in most Member States, but subnational performance gaps continue in several countries. With poliomyelitis gone from the Region for over a decade, other disease control and public health efforts are being given priority. Limited resources do not allow special efforts beyond the minimum routine activities, particularly for preventive SIAs and comprehensive AFP surveillance reviews.

The large 2010 poliomyelitis outbreak in Tajikistan, following an importation of wild poliovirus circulating in India, highlighted the grave risks for poliomyelitis-free countries; it is eight years since the WHO European Region was certified. Wild poliovirus has further spread from the outbreak into Kazakhstan, Turkmenistan and the Russian Federation. Close geographical proximity to the Member States in the Western Pacific Region (China and Mongolia) requires enhancement of importation preparedness in all countries.

As of 14 October, there were 453 laboratory-confirmed poliomyelitis cases in Tajikistan, 69% of them aged 0–5 years. The last confirmed poliomyelitis case had a date of onset of 4 July (>15 years of age). The most relevant of the 14 poliomyelitis cases in the Russian Federation were from Irkutsk (near the border with Mongolia) and from Khabarovsk (near the border with Heilongjiang Province in China).

The case in Irkutsk was a nine-month-old girl, with onset on 4 May 2010, who arrived in Russia on 1 May 2010 on a flight from Tajikistan. Vaccination with oral poliovirus vaccine (tOPV) was conducted for 24 close domestic contacts, 51 persons in the hospital where the child was admitted (including medical staff) and 234 children under 15 years of age in the settlement. Micro-district Severnyi is a small part of the Irkutsk city, with defined borders.

The case from Khabarovsk was a five-month-old girl, with onset on 2 July 2010. The child was born in Khabarovsk, her parents arrived from Uzbekistan two years ago and she is living in a household with two more families from Uzbekistan (total 28 household contacts, some of them arrived in late April from Uzbekistan). Stool samples were collected from 28 household contacts and 45 health workers in the hospital; all were immunized afterwards. One healthy

carrier of wild poliovirus type 1 was detected among household contacts of the case (a boy, born in 2000); this contact arrived from Uzbekistan on 20 April 2010. Local supplemental immunization with tOPV has been organized for children aged three months to 15 years.

The following main activities have been undertaken and supported:

- Risk assessment was carried out for Xinjiang and Heilongjiang provinces in China.
- A workshop was held for provincial and prefecture staff from Xinjiang, Tibet and Yunnan provinces to enhance wild poliovirus importation preparedness (13–15 July).
- Shandong and Heilongjiang provinces provided +OPV for children under the age of five simultaneously during nationwide measles SIAs from 11 to 20 September 2010.
- Two rounds of national tOPV SIAs for all children aged five months to five years in Mongolia were scheduled for early October and November 2010; the WHO Regional Office for the Western Pacific supported the planning process.
- Importation preparedness plans have been updated in Cambodia, China, Malaysia, the Philippines and Viet Nam, as well as the generic protocol for the Pacific and the Regional Plan.
- A resource mobilization strategy for the Region has been developed, in addition to resource requirements stipulated in the Regional Strategic Plan 2008–2012.
- Regular updates on the Tajikistan outbreak and subsequent virus spread have been distributed to all countries concerned.
- Intensified surveillance and an immunization data review have been carried out at the WHO Regional Office for the Western Pacific to improve the alert systems for countries with low performance.
- A risk assessment protocol has been developed.
- There has been active participation in enhancing coordination between poliomyelitis-free regions.

2.2.1 Immunization against poliomyelitis

While importations of wild poliovirus cannot be prevented, the spread of the virus can, with high population immunity. The minimum requirement is at least 80%, as agreed at the World Health Assembly in 2006, which should be universally reached throughout a country. The Global Immunization Vision and Strategy (GIVS) calls for at least 90% routine immunization coverage for all EPI antigens.

In 2009, five countries in the Region reported coverage below 80% (Fiji, the Lao People's Democratic Republic, Palau, Papua New Guinea and Samoa). In some countries (e.g. Cambodia and Papua New Guinea) coverage gains may also be influenced by adjusted denominators, based on recent census data.

Further data analysis suggests that the range of subnational performance levels behind satisfactory national coverage can be large; e.g. from 51%–136% at operational district (OD) level in Cambodia (annual progress report to RCC 2008) and 18%–90% at the provincial level in

Papua New Guinea (annual progress report to RCC 2008). Likewise, analysis of groups of districts with certain coverage brackets reveals in some countries (e.g. the Philippines) that less than 80% of districts achieve at least 80% coverage.

Likewise, analysis of the immunization status of AFP cases that represent a decent sample of the general population suggests coverage problems in some countries as well as incomplete case investigation, as no information about immunization status is available.

In the past 12 months, SIAs were only conducted in China targeting 20.8 million children under four years of age with two rounds in high-risk areas of 22 provinces. Reported coverage was 98%. Papua New Guinea is adding one dose of tOPV to the currently ongoing measles SIAs. Any further preventive SIAs are limited by the lack of resources.

2.2.2 AFP/poliomyelitis surveillance

Complete and timely investigation of AFP cases remains essential to reliably detect polioviruses. In terms of key aspects of AFP surveillance quality, two countries did not reach the minimum non-poliomyelitis AFP rate of 1 per 100 000 children under 15 years in 2009 (Mongolia and Papua New Guinea), while adequate stool specimen collection rates of at least 80% were not reached by several countries, including Cambodia, the Lao People's Democratic Republic, Papua New Guinea, the Philippines and the Pacific island countries. Reporting of AFP cases in 2010 (as of 24 October 2010) is very low in Cambodia and Papua New Guinea.

2.2.3 Wild poliomyelitis importation preparedness

The World Health Assembly adopted a resolution stating that poliovirus importation into a poliomyelitis-free area constitutes a potential international health threat, as stipulated under International Health Regulations (IHR) 2005. The resolution focuses on appropriate response to the importation of wild polioviruses and essential indicators, including conduct of an initial investigation, conduct of a complete risk assessment within 72 hours of confirmation of the index case, and establishing an emergency action plan based on the existing poliomyelitis preparedness plan. In the implementation of a minimum of three large-scale immunization rounds, the first SIA should take place within four weeks of confirmation of the index case, with an interval of four weeks between subsequent rounds. This requirement highlights the need for an active and current national plan to be in place and widely distributed before an importation event. Currently, several countries still have to finalize their updated importation preparedness plans, awaiting recommendations from the RCC, including Cambodia, China, Malaysia, the Philippines and Viet Nam.

While immediate and comprehensive risk assessment is a key component in an importation event, routine risk assessment should be conducted by all countries and for relevant subnational levels (mainly dependent on population size). Proposed risk criteria to be considered for scoring points include AFP surveillance indices for the past three years, subnational surveillance gaps, best estimate of national coverage, percentage of susceptible accumulated children for the past five years, subnational coverage gaps, AFP cases with less than three doses of OPV, population movements (to/from poliomyelitis affected areas, international and domestic), and development of local indicators as appropriate. Due to small populations in most Pacific island countries and areas, the standard approach needs to be modified. Capacity-building for NIP and subnational-level health staff is still required.

2.2.4 Poliomyelitis laboratory network

For the rapid detection of wild polioviruses or vaccine-derived polioviruses (VDPVs), the global poliomyelitis laboratory network introduced the new algorithm and real-time (reverse transcription polymerase chain reaction) RT-PCR for intratypic differentiation (ITD) and VDPV screening. The Region has gradually shifted to the new algorithm since 2007. To implement the real time RT-PCR for ITD and VDPV screening in the Region, a hands-on training course was held in the Victorian Infectious Diseases Reference Laboratory (VIDRL), Australia for five poliomyelitis laboratories with ITD function in August 2009. As of August 2010, four steps to implement real-time RT-PCR have been successfully completed by five ITD laboratories in Australia, China, Japan, Malaysia and Singapore.

The poliomyelitis laboratories in the Region met during the second meeting on Vaccine Preventable Diseases Laboratory Networks in the Western Pacific Region, held in Manila, the Philippines, from 22 to 23 February 2010, to identify the challenges facing network laboratories and ways to strengthen the quality of performance to maintain poliomyelitis-free status, and also to monitor the implementation of recommendations from the first laboratory network meeting in July 2008. The meeting concluded that the performance of the regional poliomyelitis laboratory network was being sustained at poliomyelitis-free certification standard and that AFP surveillance activities were being efficiently supported. The network provides critical evidence in support of the continued poliomyelitis-free status of the Region. The network's activities to implement new test algorithms and real-time RT-PCR procedures were all on track. WHO should continue its advocacy with national authorities and partner agencies for continued support to the regional poliomyelitis laboratory network. Recommendations for the poliomyelitis laboratory network include: the implementation of the new algorithm for virus isolation and the new real-time PCR technique for ITD of polioviruses and VDPV screening to reduce laboratory reporting time, timely sharing of cell sensitivity testing results, and tackling of data management issues.

2.2.5 Post-eradication activities

With the current situation of the Global Polio Eradication Initiative (GPEI) still focused on interrupting wild poliovirus transmission, only limited activities are being conducted in the post-eradication era. Phase III clinical trials have started for Sabin-based IPV production in China and work is also going on in Japan. China and the Philippines continue to participate in the WHO lead multi-country study on iVDPV detection in persons with primary immune deficiency (PID), while Australia is preparing its own study for detection of chronic poliovirus infection in persons with a PID. Environmental surveillance will be expanded in China and introduced in Malaysia. With the recent complete shift from OPV to inactivated polio vaccine (IPV) in Malaysia, the possibility of conducting a special study on the persistence of poliovirus isolation is being explored.

3. CONCLUSIONS

3.1 General

The RCC again appreciates the timely assembly and submission of quality update reports by the NCCs and their Secretariats. The delay in reporting the conclusions was due to the fact that one country report had to be revised and re-submitted to the RCC. After reviewing the resubmission, the RCC was able to conclude that the Western Pacific Region had remained free of circulating poliovirus during the period covered by the country reports.

Being able to commemorate on 29 October 2010 that the Western Pacific Region had been certified poliomyelitis-free for 10 years was an achievement that was probably comparable to reaching elimination itself. The RCC expresses gratitude to everybody in all countries who helped to make this happen.

Nonetheless, the RCC also reiterates that there is no room for complacency, as reminded by events in the WHO European Region — a region which had been certified poliomyelitis-free in 2002. In 2010, following an importation of wild poliovirus from India, a large poliomyelitis outbreak occurred in Tajikistan (458 confirmed cases, 26 deaths) with subsequent spread to at least three other countries in the Region. This was a stark reminder of vulnerability as long as poliovirus transmission continues in other parts of the world, no matter how long a country has remained poliomyelitis-free.

Risk assessment conducted in 2010 for all countries in the Western Pacific Region on the potential spread of imported wild poliovirus classified three countries as being at high risk and four countries as being at medium risk. While a range of activities for risk mitigation is being implemented, the quality of surveillance and immunization activities is not yet universally at the level required to have good protection against poliomyelitis reintroduction. Performance gaps remain, leaving high-risk populations vulnerable.

Following a 2010 World Health Assembly recommendation, an Independent Monitoring Board (IMB) was established to monitor and guide the work of the 2010–2012 Strategic Plan of the GPEI. While the key focus is on the plan's main strategic objectives, the RCC appreciates the attention given by the IMB to poliomyelitis-free regions. In its April 2011 report, the IMB commented that, although maintaining poliomyelitis-free areas has no global milestone to be monitored, it is critical that these areas maintain their poliomyelitis-free status. The IMB welcomes the work on risk assessment of poliomyelitis-free countries, and, at each future meeting, will ask to receive updates from each WHO region, as well as a synopsis of actions planned for countries that this process highlights as being ‘high-risk’.

The RCC has requested the WHO Secretariat to regularly update risk assessment and mitigation plans for the Western Pacific Region. However, the RCC also encourages countries to conduct their own risk assessment exercises, including, where appropriate, risk assessment at subnational levels. The RCC recommends that, in addition to the assessment of population immunity and surveillance quality, other key risk indicators, like the presence of specific high-risk groups, population movements and systems components, should be used for national and subnational risk assessments. The RCC requests that the outcomes of countries' own risk assessments should be discussed in the next annual progress reports.

Risk assessments must be followed by appropriate mitigation measures. In high-risk populations, where inadequate vaccination coverage for poliomyelitis cannot be immediately improved by strengthening routine immunization, supplementary immunization is required and

OPV should ideally be added to SIAs for other antigens, Child Health Days and other service delivery as appropriate.

The RCC urges all partners involved in poliomyelitis eradication to ensure that the required resources for risk mitigation are available, as another poliomyelitis outbreak in a poliomyelitis-free region would be a devastating set-back for the GPEI, cause unnecessary suffering for its victims and families, and be far more costly than prevention measures. In this context, the RCC welcomes the proactive resource mobilization approach the WHO Secretariat is pursuing.

While the RCC gratefully acknowledges that the majority of countries still manage to keep surveillance performance at certification levels, the Committee is deeply concerned about continued low levels in some countries and serious declines in others.

The RCC is disappointed that its targeted AFP surveillance reviews in Cambodia and the Philippines apparently did not provide the expected encouragement and impetus, and requests specific feedback from the respective NCCs and NIPs on why recommendations made do not support performance improvements.

In terms of high-quality surveillance, timely detection and identification of wild polioviruses and VDPV among the poliomyelitis network laboratories remains crucial for maintaining the poliomyelitis-free status by allowing rapid response and preventing further spread of viruses.

In this context, the RCC highly commends the excellent performance of the 43 poliomyelitis laboratories in the regional network, all fully accredited by WHO.

The RCC welcomes the fact that the new WHO algorithm for poliovirus isolation and identification has already been introduced into 11 network laboratories to provide results of primary isolation within 14 days of receipt of samples in the laboratory, a reduction from 28 days.

The RCC likewise appreciates that results of characterization as wild-type or vaccine-strain poliovirus by ITD testing procedure are now available within seven days, reduced from 14 days.

The RCC encourages the WHO Secretariat to explore opportunities to upgrade provincial laboratories in China to perform PCR-based ITD.

The RCC considers it paramount that national governments actively support their national poliomyelitis laboratories and that, through efficient partner coordination, the required resources are made available.

The RCC commends all countries that have updated their wild poliovirus importation preparedness plans. The RCC considers the availability of plans that are current and fully endorsed by all parties concerned as essential, and urges countries that have not yet done so to complete them as a matter of priority.

The experience of wild poliovirus importation in Australia in 2007 taught a very valuable lesson on how, even without secondary spread, investigation, information, coordination and response requirements are very demanding, also in view of IHR 2005. In this context, the RCC highlights the need to also include an 'emergency surge capacity' component for the Regional Reference Laboratories in Australia and Japan in terms of human resources, transportation and operational requirements.

The RCC welcomes the work of the WHO Secretariat on systematically analysing importation preparedness plans and providing feedback to countries. The RCC requests this work to be completed as soon as possible in order to receive improved plans, where required, with the next annual progress report.

Finally, the RCC concurs with the IMB on the highly important contribution the poliomyelitis-free regions make to the GPEI in pursuing its key goals as laid out in the 2010–2012 global strategic plan. The continued efforts made by Members States in the Western Pacific and their partners cannot be valued highly enough.

3.2 Country-specific conclusions and recommendations

Australia

The RCC appreciates the detailed presentation of activities conducted to improve and supplement the quality of poliomyelitis surveillance in Australia. The RCC likewise acknowledges efforts to prevent the build up of susceptible populations by specifically targeting areas with low vaccination coverage. The RCC considers Australia's current surveillance and immunization strategies adequate to stay poliomyelitis-free.

The RCC acknowledges once more the substantial support the poliomyelitis laboratory at Victorian Infectious Diseases Reference Laboratory (VIDRL) is providing to the regional poliomyelitis laboratory network and the laboratory's continued high performance.

The RCC appreciated Australia's presentation at the 16th RCC meeting on the response to wild poliovirus importation in 2007, which provided useful lessons for other countries on the specific reporting and response requirements under IHR 2005, even if an importation does not result in secondary cases.

Brunei Darussalam

The RCC appreciates the continued active oversight of the NCC and its comprehensive post-certification terms of reference.

The RCC commends the integration of AFP and measles surveillance, in view of required maintenance of quality poliomyelitis surveillance for several more years.

The RCC appreciates the risk-assessment exercise included in the report and the national importation preparedness plan being updated regularly accordingly. The RCC concurs with the risk assessment and suggests that, in terms of travel to and from poliomyelitis-affected areas, consideration should also be given to potential adult virus carriers.

The RCC concludes that the performance of all programme components to maintain Brunei Darussalam's poliomyelitis-free status remained of a high quality.

The RCC notes the planned shift from OPV to IPV and looks forward to receiving updates in the next progress report.

Cambodia

The RCC appreciates the continued active oversight of the NCC and agrees with the assessment of the situation and recommendations.

The RCC remains very concerned about the further deterioration of AFP surveillance performance and notes that case-reporting from provincial hospitals did not improve, while there were fewer cases reported from the Kunta Bopha hospitals.

The RCC urges the national programme to immediately develop an activity plan for rapidly improving AFP surveillance to at least minimum certification quality standards and to ensure that clear roles, responsibilities, timeframes and resource requirements are agreed upon by all concerned partners.

The RCC finds the reported overall oral polio vaccine type 3 (OPV3) coverage satisfactory but notes the considerable variance at subnational levels and encourages the NIP to use the findings of the 2010 EPI review in its efforts towards achieving universally high OPV3 coverage. The RCC supports the plan of adding OPV to the 2011 measles SIAs in high-risk areas.

The RCC concurs with the regional assessment of Cambodia as being at high-risk for the spread of an imported wild poliovirus and requests the NCC and NIP to present an updated risk assessment, also for the subnational level, in the next annual progress report.

China

The RCC continues to consider regular reviews of the poliomyelitis component to be part of the work of NIP and encouraged active oversight and advocacy by China's NCC.

The RCC acknowledges again the continued excellent support given by the Regional Reference Laboratory at China CDC to the regional poliomyelitis laboratory network, particularly the systematic work to identify emerging VDPVs.

The RCC also encourages the timely reporting of epidemiological investigation results of VDPVs to WHO.

The RCC welcomes the ongoing work on the national wild poliovirus importation contingency plan and strongly encourages its finalization (in collaboration with WHO).

Hong Kong (China)

The RCC appreciates the leadership of the NCC and concurs with the conclusions at the end of the report that the quality of both AFP surveillance and immunization activities remains high.

The RCC commends the ongoing efforts to improve AFP surveillance indicators through involvement of key physicians and regular re-sensitization of clinicians.

The RCC also acknowledges the important role of enterovirus surveillance in poliomyelitis surveillance in Hong Kong and commends the very high performance of the designated national poliomyelitis laboratory.

Macao (China)

The RCC commends the fact that the quality of performance of all programme components to maintain Macao’s poliomyelitis-free status remained high.

Japan

The RCC acknowledges once more the substantial support the poliomyelitis laboratory at the National Institute of Infectious Diseases, Tokyo, is providing to the regional and global poliomyelitis laboratory networks, and the laboratory's continued high performance.

The RCC appreciates the detailed discussions on poliomyelitis vaccination as it continues to note that, due to the bi-annual vaccination schedules, there is the possibility that a relatively large proportion of young infants receive poliomyelitis vaccine during the second half of life only. This is confirmed by serological results, which indicate relatively low seroprevalence in young infants.

The RCC wishes to receive a copy of the national wild poliovirus importation preparedness plan with the next annual progress report as experience has shown (as in Australia) that even a single isolated case has complex response requirements and implications for the whole Region.

Lao People's Democratic Republic

The RCC continues to appreciate the active work of the NCC and finds the recommendations made both practical and data-based.

The RCC commends the NIP for its efforts to address the recommendations made in 2009 and particularly welcomes the subnational risk assessment work. The RCC looks forward to learn in the next annual progress report which follow-up activities have been undertaken to manage and reduce the risks identified.

The RCC congratulates the NIP for successfully integrating OPV into other early childhood interventions and strongly encourages that any future SIA should contain OPV.

The RCC realizes that AFP surveillance remains a challenge, mainly due to other priorities, and recommends that activities be focused, for example, on large provinces with underreporting, and that local resources are used to regain surveillance sensitivity in underperforming areas.

Malaysia

The RCC commends the NCC for its comprehensive review of relevant implementation and performance quality aspects of the national poliomyelitis programme and notes the range of activities undertaken to address challenges to AFP surveillance. The RCC welcomes the planned introduction of environmental surveillance in areas where the performance of AFP surveillance is not yet satisfactory, but reminds the NCC that this can only be a supplemental activity. The underreporting of AFP cases in Selangor, Kuala Lumpur, Sabah and Sarawak remain a concern.

The RCC appreciates the NCC discussions on high-risk populations and encourages the national programme to perform a systematic risk assessment at the subnational level to guide the planned supplementary immunization activities.

The RCC welcomes the dialogue of the national programme with WHO in finalizing the national wild poliovirus importation contingency plan and looks forward to receiving a copy with the next annual progress report.

Mongolia

The RCC commends the continued very active oversight of the NCC and the regular meetings being held.

The RCC is very impressed by Mongolia's proactive and comprehensive response to the threat of poliomyelitis outbreaks in neighbouring countries.

The RCC commends the updating of the national wild poliovirus importation preparedness plan.

New Zealand

The RCC commends the fact that the quality of performance of all programme components to maintain New Zealand’s poliomyelitis-free status remains high.

The RCC appreciates the fact that there had been a response to its request for further immunization coverage data. In the future, the RCC would welcome poliomyelitis coverage being presented for (at least) three doses and full calendar years.

Pacific island countries and areas

The RCC appreciates the continued commitment and oversight of the Subregional Certification Committee (SRCC) and concurs with the conclusions and recommendations made.

The RCC considers the SRCC 2010 workplan comprehensive and appropriate and recommends particular focus on four areas:

(a) re-affirming support to countries with good poliomyelitis surveillance;

(b) continued efforts in larger countries with chronic under-reporting of acute flaccid paralysis cases;

(c) advocacy for at least 90% OPV3 coverage; and

(d) current national wild poliovirus importation preparedness plans, at least in Fiji.

The RCC recommends discussions with the WHO on how current risk-assessment approaches could be adjusted to the particular characteristics of Pacific countries and areas.

Papua New Guinea

The RCC appreciates the continued active oversight of the NCC and agrees with the assessment of the situation and recommendations.

The RCC remains concerned about declining AFP surveillance performance and endorses the NCC's recommendations on improving AFP surveillance quality, particularly the plan to sensitize the National Department of Health on the increased risk of importation due to increased industrial activity.

The RCC encourages implementation of a comprehensive activity plan for rapidly improving AFP surveillance to at least minimum certification quality standards. In this context, the RCC commends the recently conducted AFP surveillance review in Morobe Province.

The RCC welcomes the inclusion of OPV in the 2010 measles SIA, but recommends a second round should be conducted, at least in Port Moresby, but ideally nationwide.

The RCC concurs with the regional assessment of Papua New Guinea as being at high risk for an imported wild poliovirus to spread and requests the NCC and Department of Health to present an updated risk assessment, also for the subnational level, in the next annual progress report.

Philippines

The RCC continues to urge the Department of Health to review and strengthen the NCC membership to function as a strong independent oversight body for the national poliomyelitis programme. In this context, the RCC welcomes the Department's participation in the quarterly meetings of the Expert Review Panel.

The RCC encourages the Department of Health to fully implement the recommendations made at the end of the targeted AFP surveillance review conducted in November 2010, and looks forward to receiving updates on performance improvements.

In the context of the WHO risk assessment of the potential of imported wild poliovirus to spread, the RCC requests a respective subnational exercise to be conducted and the results, including risk-mitigation actions, to be presented in the next annual progress report.

Based on results of such risk assessment and other immunization coverage reviews and validations, integration of OPV into other supplementary immunization activities should be considered, as appropriate, and the national programme and relevant partners should ensure the required resources.

The RCC urges the Department of Health to complete an updated national wild poliovirus importation preparedness plan and ensure its wide endorsement and distribution.

Republic of Korea

The RCC appreciates the thoughtful and good report and commends the fact that the quality of performance of all programme components to maintain the Republic of Korea's poliomyelitis-free status remains high.

The RCC notes that increasing emphasis is being placed on the enterovirus surveillance network for poliomyelitis surveillance and considers this acceptable given the conditions in the Republic of Korea.

Singapore

The RCC appreciates the continued active oversight of the NCC and its updates on post-certification terms of reference.

The RCC concludes that the quality of performance of all main programme components to maintain Singapore's poliomyelitis-free status remains high.

The RCC notes the references to the generic wild poliovirus importation preparedness plan used as basis for the national plan, recommendations made by the World Health Assembly and the former Advisory Committee on Polio Eradication (ACPE) and compliance with IHR 2005.

However, the RCC still wishes to receive a copy of the current national plan as it has requested the WHO Secretariat for systematic analysis of all plans.

Viet Nam

The RCC commends the continued leadership and oversight of the NCC and notes that its meeting minutes are sent directly to the Minister of Health.

The RCC welcomes the development of an updated, well prepared wild poliovirus importation plan, as well as the intention to conduct supplementary immunization activities for poliomyelitis in high-risk areas in 2012.

The RCC appreciates the opportunity to hold its next meeting in Viet Nam and looks forward to gaining direct insights into programme service delivery during the planned site visits.

ANNEX 1

SIXTEENTH MEETING OF THE REGIONAL COMMISSION FOR THE CERTIFICATION OF POLIOMYELITIS ERADICATION IN THE WESTERN PACIFIC REGION

Manila, 28-29 October 2010

25 October 2010
English only

TIMETABLE

Time	Thursday, 28 October 2010	Time	Friday, 29 October 2010
0800-0830	**REGISTRATION**	0800-0830	**REGISTRATION**
0830-0850	**1. Opening** • Opening speech • Self-introduction • Election of officers: Chairperson, Vice-Chairperson and Rapporteur • Administrative announcements • Group photo	0830-0840	**Opening remarks** **9. The Western Pacific Region certified polio free for 10 years**
		0840-0850	(a) Certification process – oversight after achieving polio-free status (b) Maintaining high population immunity
		0850-0930	- Innovative ways to strengthen routine immunization - Conducting supplementary immunization activities with other health interventions
		0930-1010	(c) Quality surveillance for polio - The challenge of diversity - The laboratory network
		1010-1040	***COFFEE BREAK***
0850-0920	**2. Global polio eradication – overview of current situation**	1040-1100	(d) Securing polioviruses in laboratories – phase 1 containment
0920-0950	**3. Polio outbreak in Tajikistan and subsequent spread to other European countries**	1100-1140	(e) When polio returns - Responding to wild poliovirus importation - Responding to circulating vaccine-derived poliovirus (cVDPV)
0950-1010	**4. Global Polio Strategic Plan 2010–2012 and implications for the Western Pacific Region**	1140-1200	(f) Post eradication work
1010-1030	**5. New WHO position paper on polio vaccine**	1200-1220	(g) Risk assessment to stay polio free: a practical framework
1030-1050	***COFFEE BREAK***	1220-1330	***LUNCH BREAK***
1050-1110	**6. The work of the Regional Certification Commission (RCC) 2009–2010**	1330-1400	**The Face of Polio: a feature presentation**
1110-1230	**7. Country summaries on maintaining poliomyelitis-free status:** - Current main challenges - Mid-term plans to keep the status - Support required from RCC, WHO and other partners (a) Australia (c) Cambodia (b) Brunei Darussalam (d) China (e) Japan	1400-1430	**Keynote addresses** - WHO Regional Director - Philippines Secretary of Health
		1430-1450	**10. Wild poliovirus importation in the WHO European (EURO) – lessons to be learnt from other polio-free regions**
		1450-1510	- How to respond to a polio importation threat
		1510-1530	**11. Reaching the ultimate goal of global eradication – the contribution of polio-free regions**
		1530-1550	**12. Key challenges and ensuring adequate resources**
		1550-1630	- The voices of partners - The way forward
		1630-1640	
		1640	**13. Closing ceremony**

1230-1330	***LUNCH BREAK***	**1700**	***RECEPTION***
1330-1500	**Country summaries on maintaining poliomyelitis-free status (*continued*)** (f) Lao People's Democratic Republic (i) New Zealand (g) Malaysia (j) Pacific island countries and areas (h) Mongolia (k) Papua New Guinea		
1500-1520	***COFFEE BREAK***		
1520-1635	**Country summaries on maintaining poliomyelitis-free status (*continued*)** (l) Philippines (m) Republic of Korea (n) Singapore		
1635-1700	**Discussion with Expert Panel on aspects of keeping the Western Pacific polio free**		
1700-1715	**8. Recommendations from the 19th Meeting of the Technical Advisory Group (TAG) on Immunization and Vaccine Preventable Diseases in the Western Pacific Region**		

ANNEX 2

W O R L D H E A L T H ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

SIXTEENTH MEETING OF THE REGIONAL COMMISSION FOR THE CERTIFICATION OF POLIOMYELITIS ERADICATION IN THE WESTERN PACIFIC REGION

WPR//DCC/EPI(7)/2010/IB/2
27 October 2010

Manila, Philippines
28-29 October 2010

ENGLISH ONLY

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ANNEX 3

Speech Delivered by Dr Steve Wassilak, United States Centers for Disease Control and Prevention During the 16th Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region, Celebrating 10 Years of Polio-Free Status 29 October 2010, Manila, Philippines

CDC Partner Statement

CDC is honored to stand here today with our partners to celebrate this historic occasion. We have been partners in the fight against polio in this region since the beginning. The journey toward polio eradication in the Western Pacific had many challenges. However, these were overcome, one by one, until the last polio case in Cambodia in 1997. The result of these enormous and unprecedented efforts is that polio eradication now stands as one of the greatest achievements in health in this Region. We achieved this lofty goal together through cooperation, focus, and pure hard work, and it has given all of us the confidence to tackle other worthy goals such as measles elimination, hepatitis B control, and so on.

On behalf of CDC, I would like to thank Dr. Sigi Roesel and the other organizers of this meeting for making it possible for us to mark this historic occasion by coming together with our partners, and reminding ourselves of what can be accomplished when we all work together for a common cause.

The Way Forward

As this meeting to celebrate the 10th Anniversary of Certification of Polio Eradication in the Western Pacific Region draws to a close, it is time to reflect on what we have been discussing over the past 2 days and think about the way forward. Firstly, I want to thank all of you for the sustained commitment, diligence, and hard work that you and your organization and governments have displayed over the years to eradicate polio. You have made it possible for us to be here today to celebrate this wonderful and historic occasion. It is a remarkable accomplishment!

However, you know and I know that our work is not done. We know that we must continue to guard and protect the fruits of this work by maintaining the Region's polio-free status……and we must be on guard and prepared against the threat of importation of poliovirus into this Region. The recent events in Tajikistan, with poliovirus spread to other Central Asian Republics and to the Russian Federation, are a stark lesson and reminder to us all of what can happen if we are not vigilant, prepared, and proactive. The eradication of polio from this Region is a gift to the children of this Region and to future generations. We cannot allow this gift to be taken away. All of us need to think about how we can contribute to the cause. We must move forward with the resolve to find the energy and the human and financial resources to sustain our victory over polio, and maintain a safety net of protection for the children of the Western Pacific Region. Think about what you can do to contribute, as you return to your homes, your families, and your communities. I wish you safe travels—thank you!

Speech delivered by Dr Sigekazu Miyazaki, Ex-Regional Rotary Foundation Coordinator, Rotary International District 2650 During the 16th Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region
Celebrating 10 years of Polio-free Status
29 October 2010, Manila, Philippines

Honourable Dr Shin Young-soo, Regional Office Regional Director, World Health Organization Western Pacific; Honourable Undersecretary Enrique T. Ona MD, Department of Health Philippines; Honourable Mr Akio Isomata, Minister, Embassy of Japan to Philippines; distinguished guests and officials; ladies and gentlemen.

Good afternoon!

It is a great honor and pleasure for us, Rotary International District 2650, to be with you all in today's occasion to commemorate the 10th anniversary of maintaining the Western Pacific Region Polio free.

We, as the Chief Delegation of RID 2650, would like to express our heartfelt congratulations to you all for successfully maintaining Polio free status for ten years.

I remember clearly, just as it happened yesterday that Kyoto meeting on Poliomyelitis Eradication in the Western Pacific Region has been organized on 29 October 2000, and during this meeting "Polio free status in the Western Pacific Region" was declared to all over the world. RID 2650 was got honor opportunity to co-organize this meeting with WHO, and The Government of Japan

We are pleased to announce that in the long history of RID 2650 continuous support to the Poliomyelitis Eradication Program.

We provided a total of four million US dollars to Global poliomyelitis eradication program through Rotary International Polio-Plus foundation and have provided directly also around four million US dollars into this Region including other support to EPI program.

All these supports have been taken place under close consultation with WHO WPRO and coordination with Japan International Cooperation Agency (JICA)

We wish to commit that RID 2650 will continue providing support to the poliomyelitis eradication program, especially for maintaining "polio-free status" in this Region until declaration of global poliomyelitis eradication.

We must be facing additional threats and difficulties in the future of maintaining "Polio-Free" in this Region. However, we believe we are able to clear any crisis if we could maintain strong fighting spirits and partnership as we have at the former decade.

Thank you very much for your attention.

Speech Delivered by Ms Diana Chang-Blanc, United Nations Children's Fund
During the 16th Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region, Celebrating 10 Years of Polio-Free Status
29 October 2010, Manila, Philippines

Firstly, I'd like to express gratitude to WHO WPRO not only for organising this important meeting of the RCC each year, but also for providing this opportunity to UNICEF to reinforce its commitment to the Global Polio Eradication Initiative.

As one of the four spearheading partners of the Global Polio Eradication Initiative (GPEI), UNICEF is proud to be part of this initiative and continues to be fully committed to finishing the job.

We have come a long way since 1988, with more than 99% reduction in polio cases -- and when there were more than 125 polio-endemic countries -- to only four remaining today. The achievements have been great and the journey to this point arduous; so we cannot trip up now on the path to the finish line.

At the highest levels, UNICEF is engaged in this initiative. UNICEF's Executive Director Tony Lake co-hosted with WHO Director General Margaret Chan the launch of the new GPEI Strategic Plan (2010-2012), as conducted in Geneva in June earlier this year. UNICEF's senior management, under the leadership of Executive Director Tony Lake, remains directly involved in overseeing the progress made against the milestones articulated in this plan, and supports any corrective actions needed.

A cornerstone of UNICEF's support is to assure a safe and secure global supply of oral polio vaccines for routine programmes and supplementary immunization campaigns. To meet the needs of the Strategic Plan 2010-2012, it is estimated that over 5 billion doses of vaccine will be needed. In 2009 alone, UNICEF procured over 2.3 billion doses of OPV. Coordinating and balancing the global supply and demand picture of 4 different formulations -- trivalent, monovalent OPV type 1, monovalent OPV type 3 and most recently bivalent – is a complex responsibility that the agency takes very seriously.

Furthermore, UNICEF leads communication and social mobilisation efforts to keep polio eradication on the political and public agenda, working closely with ministries of health, partners and local communities. Through our country offices and national counterparts, we collaborate with local NGOs and civil society to access hard to reach places, involve religious leaders to increase vaccine acceptance, and use local community volunteers to find defaulters -- not only to prevent polio but to prevent other vaccine-preventable diseases that afflict mothers, children and families.

At the operational level, UNICEF allocates its expertise and resources where possible, as in the case of emergency vaccine procurement mobilised for Tajikstan or in contributions made to support the cost of Mongolia's OPV SIAs.

As we've heard these past two days, the risk of a poliovirus importation in our region is a real, not theoretical, threat. Staying polio-free is our joint responsibility and a game of endurance. We cannot collectively afford to be overtaken by fatigue or indifference.

UNICEF reaffirms its commitment to supporting Governments, in close collaboration with WHO, to strengthening routine delivery systems to achieve and sustain high OPV3 coverage, preparing and implementing supplementary activities where needed to keep protection levels high, and continuing its advocacy to leverage resources and political will in the final push to achieve polio eradication by the end of 2012.

Permit me to conclude with a statement recently made by our Executive Director Tony Lake: Let's act and let's act with an eye to results. We must all dedicate ourselves to writing this final chapter and closing the book on polio forever. For every child.

Speech Delivered by Mr Seiji Kato, Adviser, Japan International Cooperation Agency During the 16th Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region, Celebrating 10 years of Polio-Free Status 29 October 2010, Manila, Philippines

Honourable Dr Shin Young-soo, World Health Organization Western Pacific Regional Office, Regional Director; Honourable Dr Tony Adams, RCC Chairman;
Honourable Undersecretary Enrique T. Ona, MD, Department of Health, Philippines;
Distinguished guests and officials.

It is a great pleasure and honor to say a few words on this special occasion, and I would like to extend to all participants my wholehearted appreciation for letting me have this opportunity today.

As all the participants here may know, in October 2000 at the Kyoto conference on polio eradication in the Western Pacific Region, the World Health Organization in the Western Pacific, announced that the circulation of indigenous wild polio virus has been terminated.

I remember that day 10 years ago, as I was one of those who attended the Kyoto conference, sitting in the middle back of large conference room, with the audiences exceeding a thousand people gathered from all over the Region and the world, listening to "the Region has been certified as polio-free."

The scene at that moment still remains in my memory as if it were the event of yesterday - cheers and shout with joy, a flood of applause, WHO members who became so moved to tears, and the presence of many country representatives.

JICA cooperated with the organizers of Kyoto conference, and one of the boards then, Mr. Abe, spoke some words as a representative of JICA, with the text I drafted. Today, I am honored and truly grateful to speak as a representative of JICA, at the RCC 10 years after the announcement of polio-free. The only thing which disappointed me was that the text of my speech had to be drafted by myself, once again.

Advocate for the eradication of polio was initiated at the 41st WHO general conference in 1988, and since then Japan has provided firm support to achieve this goal. The announcement of polio-free in the Western Pacific Region is counted as one of the most successful cases in which assistance of Japan, as the largest donor country in the Region, has generated remarkable progress.

The anti-polio project in China, which began in 1990, made a pioneering and significant contribution to the eradication of polio in the Region. In addition, we have implemented technical cooperation projects in Laos and Mongolia. In 1989 through 1996, Indonesia tackled on the fundamental technology transfer project for production of live attenuates with support of JICA, and transferred production technology for polio and measles vaccines. Pleasant to say, now Indonesia has become one of the export countries producing polio vaccines.

JICA also have provided equipment and supplies including vaccines and cold chain for countries in Asia and Africa. The total amount of assistance which contributed to the reduction of polio patients summed up to 310 million dollars in 2000.

As a result of such cooperation, the Western Pacific Region enjoyed less and less need for funding to combat polio compared to the massive input before, and more budgets began to fall into the other relevant and significant challenges.

However, there still are cases of wild polio virus, reported constantly in several countries in Africa such as Nigeria, and in some countries in South and East Asia including India. We also need to pay attention to Western Pacific Region as well, in order to maintain the polio-free status.

That is why Japan will continue its effort to support countries with wild polio virus, and to maintain the polio-free status in the Western Pacific Region.

I would like to hand over to the next session by making two remarks at last.

The first one is my strong suggestion for sharing your knowledge, efforts and achievements in this Western Pacific Region, globally. I hope for even more efforts among WHO members at Geneva, and colleagues who work on combating polio in the countries of other regions.

Second and lastly, as JICA is willing to continue its support as much as possible, it expects the worldwide effort to be made with any kind of involvement. We would like to hear this announcement, “the Region has been certified as polio-free,” on and on in the other regions, followed by the cheers and shout with joy, as we have already experienced before.

Thank you for your attention.

Speech Delivered by Ernesto "Ernie" Y. Choa, Director General of Rotary International District 3810 During the 16th Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region, Celebrating 10 Years of Polio-Free Status
29 October 2010, Manila, Philippines

WHO Regional Director, Dr Shin Young Soo; Department of Health Secretary Dr Enrique Ona; Dr Tony Adams, Chairman, Regional Certification Commission; distinguished delegates and participants to this conference; my colleagues in Rotary.

Good Afternoon,

We thank you for the opportunity to present our organization this afternoon and also to show how we have participated in the polio eradication effort. Rotary is an organization of business and professional leaders united worldwide to provide humanitarian service, encourage high ethical standards in all vocations, and help build goodwill and peace in the world. There are at present 1.2 million Rotarians in nearly 33 000 clubs in over 200 countries worldwide.

Rotary started in February 23, 1905 by our founder, Paul Harris and it became an International Organization in 1911. In 1917 during the Rotary International Convention in Atlanta, Georgia, the 6th R.I. President, Arch Klumph proposed the creation of an endowment fund for Rotary and in 1928 the fund was renamed The Rotary Foundation.

Surely, RI President Arch Klumph did not realize in 1917 the extent by which the Rotary Foundation would affect the world, more so with its global initiative to eradicate polio from the face of the earth.

Yes, it all started here in the Philippines on September of 1979 when RI President James Bomar came to the Philippines to sign a Memorandum of Agreement with the Philippine government represented by the Department of Health Secretary Enrique Garcia to conduct a national polio immunization project where Rotary would provide US $760 000 for the purchase of oral polio vaccine (OPV) for six million children under one year of age over a five year period. Past RI President Mat Caparas, and Past RI Director Paing Hechanova, the district Governor then of District 380 facilitated this historic event. It was also the initiative of Past RI Director Benny Santos who requested the Rotary Foundation to make the Philippines the site of a National Pilot Immunization Program. Carlos Canseco, RI President in 1984-1985 accepted this challenge and renamed Polio 2005 to Polio Plus as an official partner of the World Health Organization (WHO) in its fight against six preventable childhood diseases namely: diphtheria, pertussis, tetanus, tuberculosis, measles, and poliomyelitis. Since 1985, much has been accomplished!

Polio Plus has drawn support from all over the world. The US $555 million fund agreement between Rotary and the Bill and Melinda Gates Foundation marks another milestone in Rotary's 25 year legacy of polio eradication work. You all know that the Bill and Melinda Gates Foundation gave US$ 355 million for polio and they challenged us Rotarians to match US $200 million of that. To date, we have already surpassed the halfway mark with contributions of nearly US$ 146 million.

Locally, Philippine Rotarians and friends have consistently done their part in fund development for Polio Plus and the Rotary Foundation. Contributions have come in from as small as US $100 to large one time contributions such as the US $250 000 given by Mr. Angelo King through his foundation and just last Rotary year, PRID Paing and spouse.

Mely Hechanova turned over a check of US $100 000 for Polio Plus and another US $100 000 was donated last June to bring their total lifetime contributions to the Rotary Foundation at US $280 000.

Rotary made a commitment to immunize the world's children against polio in 1985 and became a spearheading partner in the Global Polio Eradication Initiative three years later.

To date, Rotary has already contributed more than US$ 900 million to the polio eradication effort. Rotary reaches out to national governments worldwide to generate crucial financial and technical support for polio eradication. Since 1995, the advocacy efforts of Rotary and its partners have helped raise more than US$ 3 billion in vital funding from donor countries.

Rotary clubs also provide "Sweat Equity" on the ground in polio-affected communities, which helps ensure that leaders at all levels remain focused on the eradication goal. Over the years, Rotary club members have volunteered their time and resources to reach more than 2 billion children in 122 countries with oral polio vaccine. In fact, our District 3810 will partner will WHO-WPRO together with District 2650 of Japan who are also represented here this afternoon by past district governors Miyazaki and Hashimoto and by District Governor-Elect Imanishi. A Global Grant amounting to US$ 221,000 has already been filed with the Rotary Foundation and is currently under review, and another Global Grant may be obtained next Rotary Year to strengthen Routine Immunization in the Philippines.

Rotary and our partners like the World Health Organization (WHO), the US Centers for Disease Control and Prevention, and UNICEF knows that the final stretch will be the most difficult and expensive to prevent resurgence due to a variety of reasons including geographical isolation, worker fatigue, armed conflicts, and cultural barriers. That is why it is so important to generate the funds needed to finish the job. To ease up now would be to invite a polio resurgence that would condemn millions of children to life long paralysis in the years ahead. Rotary estimates that its total contribution to the effort would reach US$ 1.2 Billion by the year 2012.

During the 2009 Rotary International Birmingham Convention, UN Secretary General Ban Ki Moon said and I quote "I am with you in this great campaign ….

Now is the time to finish the job!" Rotarians made a commitment in 1985 to eradicate polio, the commitment continues, and we shall all see it through!

LET US END POLIO NOW!!!

Thank you!

Speech Delivered by Dato' Mustapha Ma, Polio Plus National Advocacy Advisor, Rotary International Polio Plus Committee During the 16th Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region, celebrating 10 years of Polio-Free Status
29 October 2010, Manila, Philippines

Dr. Shin, Honourable Ministers of Health, distinguished colleagues and guests: I am delighted to represent Rotary International at this meeting where you are discussing progress and collaboration on the many public health challenges we face as a regional community.

I would like to take a moment to highlight a success story that offers hope and inspiration for us to continue to face the many complex public health demands of our countries – and one which had its beginning right here in the Philippines.

In 1979 Rotarians in the Philippines developed a project to buy and help distribute polio vaccine to 6.3 million children in the Philippines – a country that had one of the highest rates of polio cases in the Western Pacific Region. On 29 September of that year, then-Rotary International President James L. Bomar Jr. put the first drops of vaccine into a child's mouth, ceremonially launching the Philippine poliomyelitis immunization effort, Rotary's first Health, Hunger and Humanity (3-H) Grant project.

Hundreds of Philippine Rotarians and community members were on hand as Enrique M. Garcia, the country's minister of health, joined with Bomar to sign the contract committing Rotary International and the government of the Philippines to the joint five-year effort to immunize about six million children against polio in a US $760 000 immunization drive.

The success of the project ultimately led to the Global Polio Eradication Initiative, of which Rotary is a spearheading partner, created in 1988 by a unanimous vote of the World Health Assembly.

Fast forward more than thirty years to 2010. Today, the countries of the Western Pacific Region celebrate a decade-free from polio. Ten years without a single child among the billions who live in this Region needlessly suffering a fate of a life crippled by a disease that once claimed thousands every year.

Some of you in this room may remember the difficult work entailed in this accomplishment. For those of you who are younger and earlier in your career, perhaps you have only read about polio in a textbook and have, fortunately, never had the heavy task of telling a mother and father that their child will be forever crippled by a disease that could have been prevented through the simple, painless act of immunization.

You are fortunate. Your colleagues in neighbouring Southeast Asian countries, the Eastern and Mediterranean Region, and Africa, are still working to eliminate this dread disease. As the Western Pacific Region celebrates a decade free from polio, your colleagues in the European Region are facing an outbreak of polio that accounts for 70% of the global burden of polio for 2010.

While this outbreak is being rapidly controlled and polio again will be eradicated from the Region, it is a tragic and painful reminder that no child is safe until polio has been completely

eradicated. I urge you to remain vigilant, to not be lulled into a false sense of security. As a Region we must maintain high levels of acute flaccid paralysis surveillance and ensure that our children continue to be routinely immunized against polio.

In addition, we must help our brothers and sisters in the remaining polio affected countries. It has taken global collaboration and an investment of more than US $8 billion to bring us to the point where only four countries have never stopped transmission of wild polio. Polio has been defeated even in the most challenging places, and progress in the remaining polio endemic countries of Afghanistan, India, Nigeria, and Pakistan inspires confidence that we can finish the job. We must continue to work together to ensure these countries, and those suffering from outbreaks, have the resources needed to conquer polio once and for all since this accomplishment will benefit all children, everywhere, in perpetuity.

As a Rotarian, I am one of more than 1.2 million men and women in clubs around the world who are committed to freeing every child in every Region from this crippling disease. We have provided more than US $900 million and countless hours of volunteer service toward this goal. We were proud to have contributed US $36 million to support polio eradication activities in the countries of the Western Pacific Region.

I congratulate you on the accomplishment of a decade free from polio. Please be assured that Rotarians in this Region and around the world are committed to protecting this accomplishment, and to expanding it so that we fulfil the promise of a polio free world for all children.

Thank you.