WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD
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Eradication of poliomyelitis

Report by the Secretariat

1. In 1988, the Forty-first World Health Assembly (resolution WHA41.28) established the goal of the global eradication of poliomyelitis by the end of the year 2000. At the time the resolution was adopted, an estimated 350 000 poliomyelitis cases were occurring each year, and at least 125 countries were endemic for poliovirus. In 1999, the Fifty-second World Health Assembly, in resolution WHA52.22, called on Member States to accelerate eradication activities to interrupt the chains of transmission of wild-type poliovirus and to introduce laboratory containment of wild-type poliovirus.

2. As a result of this acceleration, only 10 countries[1] were still endemic for wild-type poliovirus at the end of 2001, and just 483 laboratory-confirmed cases of poliomyelitis were reported in those countries. The absence of cases during that year from countries historically considered as major reservoirs of wild-type poliovirus, particularly Bangladesh and the Democratic Republic of the Congo, also demonstrates that the eradication strategies are sound. On 21 June 2002, the independent Regional Certification Commission certified the WHO European Region poliomyelitis-free, bringing the total number of such certified regions to three, with a total population of more than 3000 million people in 134 countries, areas and territories. By 12 November 2002 the number of countries affected by poliomyelitis was the lowest ever, with only seven known to be endemic.

3. In 2001-2002, a framework for assessing and managing the risks of poliomyelitis in the post-certification era was created, drawing on extensive research results, in order to facilitate national and international deliberations on future poliomyelitis immunization policy. Planning is under way for extensive consultations with Member States to determine how these risks may influence national policy on the use of poliomyelitis vaccines after global certification.

4. Increasing attention is being given to optimizing and documenting the role of the infrastructure of the Global Polio Eradication Initiative in contributing to the attainment of other health goals. In 2001, for example, a survey of 1015 WHO staff funded by the Global Polio Eradication Initiative found that 91% of international staff and 100% of national staff are devoting an average of 44% and 22%, respectively, of their time to strengthening routine immunization and surveillance systems. Specific milestones have been established and indicators developed to monitor progress in this area.

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[1] Afghanistan, Angola, Egypt, Ethiopia, India, Niger, Nigeria, Pakistan, Somalia, and the Sudan.

ISSUES

5. Over the next 12 months an intensive global effort will be required to eradicate poliomyelitis from the remaining endemic areas. Of particular importance will be to close the gaps in the quality of supplementary immunization activities to ensure that all children receive oral poliomyelitis vaccine in India, Nigeria and Pakistan, which, as of 12 November, accounted for 98% of cases in 2002 (90% of these cases are found in nine of the 76 states or provinces of those three countries) (see Annex, Figure 1). Concerted action will be needed to stop the low-level but geographically extensive transmission of poliovirus in Egypt and Niger.

6. In Afghanistan, the Mogadishu area of Somalia, and eastern Angola, continued improvements in access to immunization of all children are crucial to interrupting the final chains of poliovirus transmission in these "low transmission" areas.

7. For all the WHO regions to be in the process of poliomyelitis-free certification by 2005, the quality of surveillance of acute flaccid paralysis must be raised to certification standard, especially in 33 countries in the WHO regions of Africa (23 countries), the Eastern Mediterranean (7) and South-East Asia (3) (see Annex, Figure 2).

8. In terms of progress toward laboratory containment of poliovirus, by August 2002, 122 Member States had initiated a national survey, and, of those, 76 had completed and submitted an inventory of laboratories holding wild-type polioviruses and potentially infectious materials. Global certification will require that all countries complete these activities to ensure that any retained materials are handled in appropriate biosafety conditions.

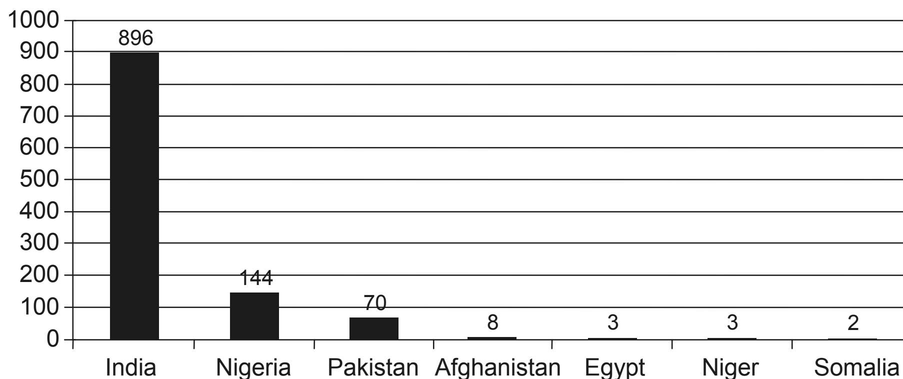
9. Implementing the necessary eradication, surveillance, certification and containment activities largely depends on whether the shortfall in funding of US$ 275 million for the period 2003-2005 is met.

ACTION BY THE EXECUTIVE BOARD

10. The Executive Board is invited to note the report.

ANNEX

Figure 1. Reported cases of poliomyelitis due to transmission of indigenous wild-type poliovirus, by country, in 2002*
(data as of 12 November 2002)



* In addition to the countries referred to in this Figure, the isolation of wild-type poliovirus from Angolan refugees in Zambia suggests ongoing transmission in Angola during 2002.

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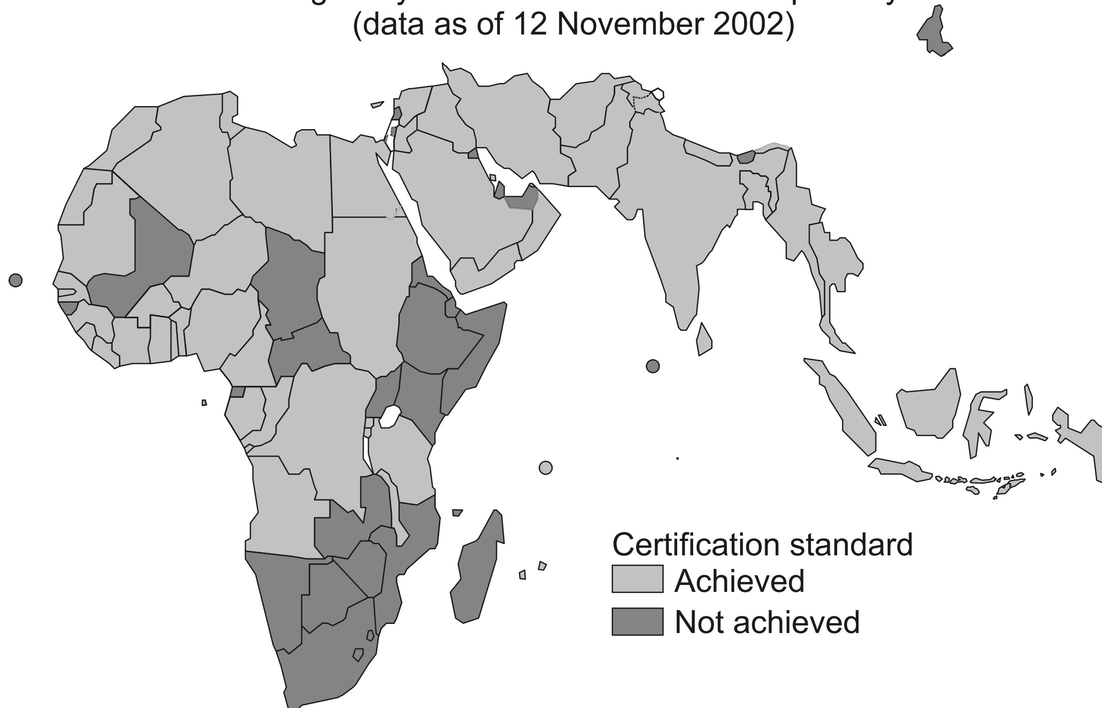
Figure 2. Performance of acute flaccid paralysis surveillance for the eradication of poliomyelitis in 2002 in the three WHO regions yet to be certified as free of poliomyelitis
(data as of 12 November 2002)



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