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PROGRESS REPORT

ERADICATION OF POLIOMYELITIS

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1. INTRODUCTION

In May 1988 the Forty-first World Health Assembly committed Member States and the World Health Organization (WHO) to the global eradication of poliomyelitis by the year 2000 with the goal of certification by the year 2005 (WHA41.28). Extraordinary progress towards poliomyelitis eradication has been made since 1988. Poliomyelitis transmission has been interrupted in the American, European and Western Pacific regions. More than 180 countries are now poliomyelitis free. Worldwide, the number of cases has declined by more than 99% since the beginning of the initiative. In line with the World Health Assembly (WHA) resolution, poliomyelitis eradication activities have been implemented in ways which strengthen immunization programmes, health infrastructure and the capacity to tackle other diseases. A broad coalition spearheaded by WHO, Rotary International, Centers for Disease Control and Prevention (CDC) and UNICEF has been established to achieve the goal of poliomyelitis eradication.

Following the WHA resolution for poliomyelitis eradication, the Regional Committee for the Eastern Mediterranean adopted the target in resolution EMR/RC36/R.6 in October 1988, and the next year adopted the regional plan of action for poliomyelitis eradication. Since then, remarkable progress has been achieved towards the goal of eradication. Large parts of the Region have now become poliomyelitis-free with 16 Member States reporting zero cases, 14 of them for 3 or more consecutive years under conditions of improving surveillance.

2. STATUS OF POLIOMYELITIS TRANSMISSION IN THE REGION

Progress towards poliomyelitis eradication has continued in the Eastern Mediterranean Region through implementation of the main eradication strategies which are: maintaining high routine immunization coverage of infants with three oral poliovaccine (OPV) doses; conducting supplementary immunization activities to provide all children aged under 5 years with extra doses of OPV; and establishing effective surveillance systems for acute flaccid paralysis (AFP) and laboratories for isolation and characterization of polioviruses.

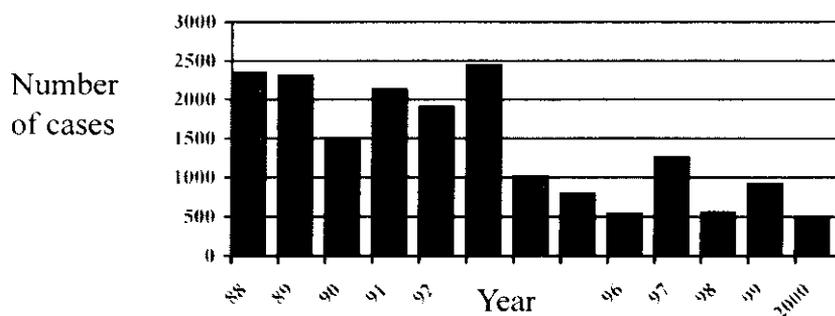


Figure 1. Reported poliomyelitis cases, Eastern Mediterranean Region, 1988–2000

Compared to 1999, the number of confirmed cases of poliomyelitis reported during 2000 in countries of the Region has decreased by about 45% from 914 to 505 despite substantial improvement in AFP surveillance. (Figure 1). The number of countries reporting zero poliomyelitis cases has increased to 16 compared with 14 in 1999. Only 6 countries (Afghanistan, Egypt, Iraq, Pakistan, Somalia and Sudan) have reported cases with indigenous strains of wild poliovirus. Countries with ongoing circulation of poliovirus are shown in Figure 2.

Through multiple rounds of national immunization days (NIDs) and mopping up campaigns it was possible to end the poliomyelitis outbreak in Iraq, with the last virologically confirmed case in January 2000. Since late 1999, wild poliovirus transmission in Egypt has been localized to a few districts in Upper Egypt. Expansion of surveillance in south and central Somalia has led to identification of an outbreak of poliomyelitis in Mogadishu. During 2000, Pakistan continued to report the largest number of cases. However, for the year 2000, the total number of virologically-confirmed cases declined by nearly 40% in Pakistan compared with 1999. Similarly, in Afghanistan there has been a great reduction in the numbers of isolated polioviruses and in the number of districts from which wild viruses have been isolated. Although the number of poliomyelitis cases reported from Sudan has increased, most of these cases were confirmed on clinical grounds with only 4 virologically-confirmed cases.

Importation of wild polioviruses from Afghanistan and Pakistan to the Islamic Republic of Iran continued to occur during 2000, and as in 1999, 3 cases associated with imported poliovirus strains were reported.

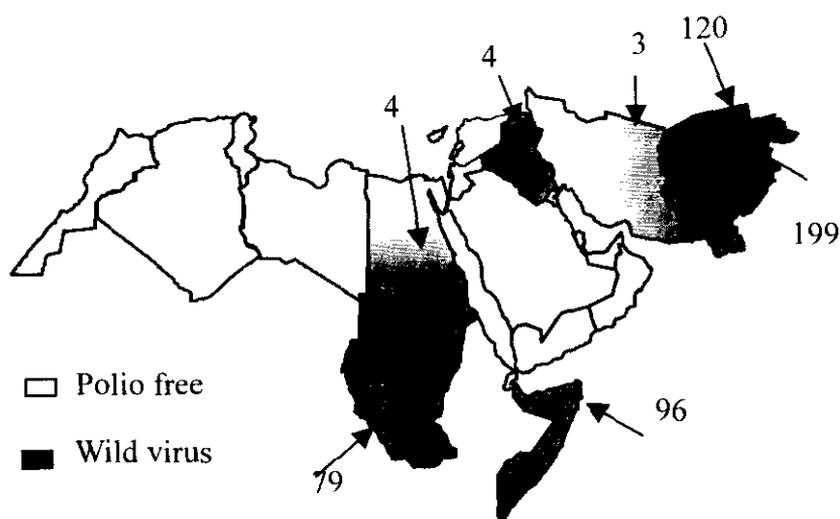


Figure 2. Reported poliomyelitis cases, Eastern Mediterranean Region, 2000

In 2000, wild polioviruses were detected in 7 countries, 4 of which (Afghanistan, Egypt, Somalia and Pakistan) detected types 1 and 3 and the others (Islamic Republic of Iran, Iraq and Sudan) detected type 1 (Figure 3). There has been almost a 50% decline in the isolation of wild polioviruses from laboratory-investigated AFP cases in 2000 compared to 1999. In 1999, wild viruses were isolated from 17% of 2802 laboratory-investigated AFP cases, and in 2000 wild viruses were isolated from only 9% of 3166 AFP cases with virology investigation. Genetic characterization of wild viruses continues to provide useful information on the transmission links among cases from different countries, and the decreasing genetic diversity of viruses in several countries points to the significant progress being made towards achieving the poliomyelitis eradication goal.

Up to end May 2001, only 39 cases of poliomyelitis were reported in the Region; 17 from Pakistan, 16 from Afghanistan, 3 from Egypt and 3 from Sudan. In 2000 there were 221 reported cases; 65 from Afghanistan, 56 from Somalia, 51 from Sudan, 42 from Pakistan, 4 from Iraq and 3 from Egypt.

3. IMPLEMENTATION OF THE BASIC POLIOMYELITIS ERADICATION STRATEGIES IN THE REGION

3.1 Routine immunization

Achieving and sustaining high routine immunization coverage of infants with at least 3 doses of OPV is given high priority in the Region. Since 1996, the regional coverage has slightly improved after a decline during 1993–1995. Based on reports received from Member States in 2000, the average regional OPV3 coverage rate is 79%.

In 2000, 15 countries achieved and sustained a coverage rate of 90% and above. However, in Afghanistan, Djibouti, Iraq, Pakistan, Somalia, Sudan, and the Republic of Yemen, that together comprise more than half of the total regional population, OPV3 coverage has remained lower than the targeted coverage.



Figure 3. Distribution of wild poliovirus types, Eastern Mediterranean Region, 2000

In Afghanistan, Somalia and parts of south Sudan where long-standing conflicts have destroyed the health infrastructure, innovative strategies have been developed to immunize women and children. EPI acceleration initiatives using mobile and outreach teams and/or local mass campaigns have been initiated to reduce morbidity and mortality due to measles, neonatal tetanus and poliomyelitis.

Plans have been developed in Afghanistan, Pakistan, Sudan and Republic of Yemen with assistance from WHO, UNICEF and other partners to restore the EPI infrastructure and services and improve routine immunization coverage through rehabilitation of the cold chain and programme acceleration initiatives. These plans have been partly funded by WHO, UNICEF and the Governments of the United Kingdom, Japan and Denmark.

Among countries lagging behind with respect to routine immunization, Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Republic of Yemen are eligible for the Global Alliance for Vaccine and Immunization (GAVI) support and can benefit from the Global Fund for Children's Vaccines. Pakistan received approval for strengthening immunization services support and introducing of new vaccines. As well, Afghanistan and Republic of Yemen succeeded in obtaining GAVI support for immunization services strengthening. WHO is providing support to Djibouti and Somalia to fulfil the basic prerequisites for GAVI support, including the formulation of multi-year action plans, conducting an EPI assessment as well as establishment of functioning interagency coordination committee. Support is also being provided to the Republic of Yemen for finalization of the application for introduction of new vaccines.

3.2 National immunization days and other supplementary immunization activities

During 2000, all Member States except Cyprus, Oman and United Arab Emirates conducted supplemental immunization activities. Several countries that have been poliomyelitis-free have scaled down the scope of supplementary immunization activities from NIDs to sub-NIDs or local campaigns targeting provinces at risk of poliovirus importation and/or with suboptimal immunization coverage.

To ensure interruption of virus transmission on time, endemic countries of the Region undertook acceleration of eradication activities, particularly mass immunization campaigns and surveillance for AFP. An essential element of acceleration was to ensure improvement in the quality of campaigns to reach all children, particularly the hardest-to-reach among high-risk groups. Thus, these countries conducted intensified NIDs and other mass campaigns characterized by detailed microplanning, multisectoral involvement, intensified supervision, social mobilization and, most importantly, vaccinating children house-to-house in large parts of the target area. These intensified campaigns have been very effective in reaching all children. Moreover, recognizing that two rounds of NIDs, especially in endemic countries with low routine immunization coverage, are not sufficient to stop wild poliovirus transmission by the target date, extra immunization campaigns were conducted in the remaining endemic countries during 2000. Sudan (including war-affected parts of southern

Sudan) conducted two pairs of NIDs plus subnational campaigns. Afghanistan and Pakistan, conducted two pairs of intensified NID rounds, and Djibouti and Somalia conducted subnational campaigns in addition to 3 rounds of NIDs. The Republic of Yemen continued to conduct one pair of NIDs. Egypt and Iraq also conducted two pairs of NIDs, plus subnational campaigns. Extraordinary difficulties have been surmounted in Afghanistan, Somalia and Sudan to reach children living in war-affected and remote areas.

The Regional Office has stepped up its technical assistance in all aspects of NID planning, implementation and evaluation, particularly to programmes in Afghanistan, Iraq, Pakistan, Somalia, Sudan and the Republic of Yemen by appointing large numbers of professional staff in the programme.

The experience gained by national and district level staff in planning immunization campaigns, including cold chain logistics, workforce, transportation and social mobilization has contributed significantly to human resources development in all countries, and particularly in countries faced with difficult circumstances. The mass immunization campaigns have been used also to deliver other health interventions, particularly vitamin A supplements, to reduce childhood morbidity and mortality from malnutrition and complications of measles. The experience gained from planning mass campaigns and accessing children in high-risk areas will be invaluable when delivering other health services and for the control and elimination of other vaccine-preventable diseases.

3.3 Surveillance for acute flaccid paralysis

All countries of the Region have established a system of AFP surveillance, which has also improved the capacity for detection and reporting of other EPI target diseases. AFP surveillance continued to improve all over the Region and the required level of sensitivity (non-poliomyelitis AFP rate of 1 or more per 100 000 children under 15 years) that was reached for the first time in 1999 (1.10) was maintained during 2000 (1.41) (Figure 4). AFP rates of 1 or more per 100 000 children under 15 years were reported from 16 Member States, including those endemic for poliomyelitis. Rates between 0.5 and 1 per 100 000 children under 15 years were reported from 6 countries. Most of these countries are reporting a rate close to 1 per 100 000. No AFP cases were reported from Cyprus in 2000. Further improvement was noted in 2001 where the annualized non-poliomyelitis AFP rate was 1.55 (up to the end of May 2001).

Another important criterion for the quality of AFP surveillance is that at least 80% of all AFP cases should have adequate¹ stool specimens collected. In 2000, 11 countries met or exceeded this criterion and in 4 other countries, adequate specimens were collected from more than 60% of cases. Compared to 67% of AFP cases with adequate stool specimens in 1999, 69% of AFP cases had adequate stool specimens collected in 2000 (Figure 5). Data up to the

¹ Adequate specimens: 2 stool specimens collected at least 24 hours apart within 14 days of the onset of paralysis and arriving at the laboratory in good condition.

end of May 2001 indicate further improvement with more than 80% of AFP cases having adequate stool specimens.

As part of the acceleration efforts, active AFP surveillance was initiated and strengthened in most of the countries with recruitment of sufficient national surveillance officers and provision of required supplies and equipment and technical support from the Regional Office.

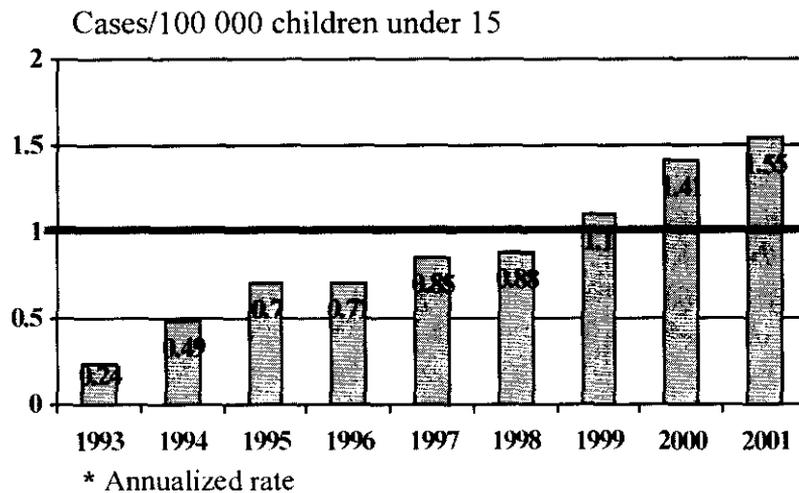


Figure 4. Regional non-polio AFP rate, 1993–2001

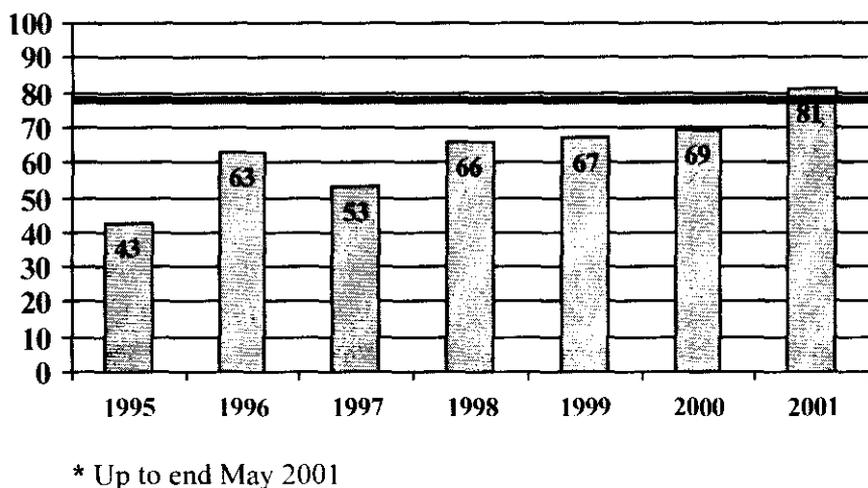


Figure 5. Percentage of AFP cases with adequate stool specimens, Eastern Mediterranean Region, 1995–2001

With most Member States making significant progress in AFP surveillance, it is hoped that all countries will reach certification standard surveillance before the end of 2001.

Establishment of AFP surveillance has provided an opportunity for training of national staff in communicable disease surveillance and has helped strengthen capacity and infrastructure for disease reporting. Moreover, in some countries, AFP surveillance has been the first disease-reporting system ever established and it is being used as the first step towards phased development of a communicable diseases surveillance system in the country. The AFP surveillance system in Afghanistan has been expanded to include reporting of other vaccine-preventable diseases, such as measles and neonatal tetanus.

Laboratory-based surveillance, the core component of AFP surveillance, also made substantial progress in 2000. Each of the 12 network laboratories was accredited during 2000. Virological investigations were performed on 3166 of the 3256 AFP cases reported in the Region during the year 2000. The network laboratories tested 7369 stool samples, of which 6284 stools were from AFP cases, and 1085 were from contacts, environmental samples and other sources. Only 52% of stool samples were received in laboratories within 3 days of collection from the patients but 96% were received in good condition. Results were reported within 28 days for 80% of samples, and non-polio enteroviruses were isolated from 12% of samples. All indicators of laboratory performance showed an upward trend when compared to previous years. However, long delays in referral of specimens from the field to the laboratories is a persistent problem.

WHO efforts to strengthen network laboratories include provision of on-site training, close coordination of activities, ensuring of adequate human resources, timely provision of supplies and equipment and improvement of means of communication.

It is gratifying to note that weekly reporting of surveillance data, including laboratory results, is continuing efficiently and the weekly *PolioFax* is regularly issued by the Regional Office and immediately communicated by fax and e-mail to all responsible officers in ministries of health and to more than 200 institutions and individuals in the Region and around the world.

4. CONTAINMENT OF LABORATORY STOCKS OF WILD POLIOVIRUS AND POTENTIALLY INFECTIOUS MATERIAL

High priority is being given to achieve containment of laboratory stocks of wild polioviruses. A regional plan for containment has been developed and endorsed by the Regional Committee. WHO is providing support to countries to develop and implement the national plans through visits of consultants. Also, a meeting was held in the Regional Office for all national containment coordinators. In addition, a guideline has been developed to help countries to formulate the national plans. National containment plans have been developed in 17 countries.

The first phase of the plan requires that each country makes a national inventory of laboratories that handle or store poliovirus isolates or potentially infectious material and ensures that biosafety requirements are met. The second phase, to be implemented 1 year after the detection of the last case resulting from natural infection with the wild poliovirus, requires all laboratories to destroy the remaining stocks or place them in a maximum containment laboratory where essential scientific work can continue. The third phase of the containment plan, to be implemented after global cessation of OPV immunization, requires destruction of OPV stocks.

The first phase is currently being implemented in Jordan, Morocco, Saudi Arabia, Syrian Arab Republic and Tunisia. Oman has completed the first phase of the plan and has submitted a national inventory of laboratories storing poliovirus infectious or potentially infectious materials. Thus far, 11 of 12 WHO-designated poliovirus network laboratories have provided inventories of stored materials.

Some common concerns have been expressed by countries implementing the first phase of the containment plan. First, it is hard to obtain the collaboration and cooperation of laboratories working in the non-health sectors of government. Second, the systematic and thorough search of laboratories in some countries will require the provision of resources and designation of the task to individuals with sufficient time and authority to complete the job. Third, in some countries, a national list of biomedical laboratories is not readily available and time and resources are needed to develop one. Finally, it is evident that strong political commitment is necessary to achieve laboratory containment of poliovirus, and mechanisms must be established for interministerial collaboration to complete the job. All countries will be required to provide evidence that the containment issue has been appropriately addressed before they can be certified as poliomyelitis-free.

5. CERTIFICATION OF POLIOMYELITIS ERADICATION

The regional activities for certification of poliomyelitis eradication are gaining momentum. According to the recommendations of the Global and Regional Commissions for Certification of Poliomyelitis Eradication (RCC), most Member States have now established National Certification Committees (NCC) with appropriate membership. The revised manual for the preparation of certification reports is being used by Member States. With assistance from the Regional Office, NCCs of 12 Member States submitted reports to the RCC. These reports were reviewed by the RCC, which provided appropriate feedback to the countries. The commission also approved the format of an annual report which is expected from all countries whose initial reports were found to be satisfactory until regional certification is achieved.

6. STRENGTHENING PROGRAMME CAPACITY

Acceleration efforts have demanded the provision of additional technical support to priority countries. In order to meet this demand, a detailed personnel plan has been developed

to ensure closer coordination and adequate support to the programmes at the operational level. Potential consultants have been briefed and additional national and international staff have been placed at the national and subnational levels in all priority countries that have not yet achieved interruption of poliovirus transmission. The programme is currently supported by 19 long-term professional staff placed at the regional and country level. In addition, during 2000, 81 short-term professionals and consultants were deployed to priority countries and about 400 national staff were recruited to support poliomyelitis eradication activities, particularly AFP surveillance.

Considerable supplies and equipment have been provided to the priority countries according to their needs. These include mainly vehicles and other means of transport as well as communication equipment to ensure proper and timely exchange of information and ensure security and safety of staff in the field.

7. REGIONAL AND GLOBAL PARTNERSHIP AND ADVOCACY

During 2000, countries of the Eastern Mediterranean Region remained committed to poliomyelitis eradication and continued large-scale eradication activities in close collaboration with the Regional Office. In 2000, the Regional Office further strengthened its partnership with international agencies and governments supporting poliomyelitis eradication, particularly Rotary International, CDC, USAID and the governments of Japan, United Kingdom and Canada. Countries of the Region have benefited immensely from a new and strong partnership between WHO, the United Nations Foundation and the Bill and Melinda Gates Foundation. Through this coordination and the preparation of well documented plans of action, it has been possible to secure all the required resources for 2000 in support of countries where the virus is still circulating. Of these resources over US\$ 30 million were channelled through WHO. In addition, the Regional Office is playing a key role in facilitating bilateral support to countries and in raising funds for the purchase of vaccines through UNICEF to several countries. It is noted with appreciation that the Health Ministers' Council for the Gulf Cooperation Council has agreed to provide US\$ 1.5 million in support of poliomyelitis eradication in the Region, of which the Government of Oman has already provided US\$ 100 000. It is hoped that other contributions from regional agencies and organizations will follow.

Several advocacy efforts have been made for poliomyelitis eradication. Heads of State and Prime Ministers continued to demonstrate national commitment to poliomyelitis eradication. Efforts are being made to achieve days of tranquillity in war-affected countries to ensure implementation of NIDs. In 2000, the Regional Director headed a multi-agency mission to Pakistan, the main reservoir of poliomyelitis in the Region, during which successful efforts were made with all governors and senior government officials to promote immunization in general and poliomyelitis eradication in particular. This was followed early in 2001 by another visit with the Director-General during which they met with Ministry of Health and WHO officials and field staff. The Regional Director also visited Sudan and had meetings with the President and many ministers during which poliomyelitis eradication was

the main subject discussed. Other advocacy efforts have been made through continuous contact with national authorities during meetings of WHO governing bodies and in other forums.

8. PROGRAMME REVIEW

The Regional Office together with UNICEF and other partners has conducted technical and managerial reviews of the poliomyelitis eradication programmes in the remaining endemic countries of the Region (Afghanistan, Pakistan, Somalia and Sudan). The reviews addressed many areas required for interruption of virus transmission. These included adequacy of technical and managerial leadership in the programme, staffing, funding, logistical capacity and administrative support. The teams also reviewed the planning and implementation of the eradication strategies, namely supplementary immunization activities and AFP surveillance. Furthermore, the level of coordination between different partners, including WHO, UNICEF and other nongovernmental organizations was assessed. The review teams concluded that if high-level commitment to achieve poliomyelitis eradication is continued with enhanced strategy implementation, it is likely that poliovirus transmission in the Region will cease before the end of 2002.

9. SUPPORT AND COORDINATION FROM THE REGIONAL OFFICE

WHO/EMRO has played a central role in providing assistance to countries in preparing national strategic and operational plans of action and budgets. The Regional Office has facilitated bilateral funding support to priority countries. Ongoing support has been provided to national programmes through training, regular country visits, close monitoring and regular feedback and periodic programme evaluations. WHO/EMRO continues to play a key role in coordinating eradication activities between countries through regular exchange of information and planning meetings. Coordinated poliomyelitis eradication activities between 8 neighbouring countries of the Region and 12 countries of the European Region continued as part of Operation MECACAR. Specially coordinated immunization and surveillance activities continued in selected border areas of Iraq, Islamic Republic of Iran, Syrian Arab Republic and Turkey as well as between Afghanistan, Islamic Republic of Iran and Pakistan. In addition, coordination of activities has been initiated with the Regional Office for Africa, particularly targeting countries in the Horn of Africa. Most importantly, activities were initiated to identify and cover all the gap areas between the areas under government control and those under the control of rebels in south Sudan. Issues related to cross-border management of poliomyelitis eradication are now being reviewed in south Asia among member countries of the SAARC, including Pakistan and India.

The Regional Laboratory Network is supported by WHO/EMRO through training, monitoring, supervision, provision of supplies and equipment. The Regional Office is playing a central coordinating role in ensuring that as part of the certification of poliovirus eradication, all laboratory stocks of poliovirus and infectious material stored in laboratories

within Member States are properly contained. In addition, activities for certification of eradication are also coordinated and supported by the Regional Office.

All the efforts and achievements have been made possible because of the priority given to the poliomyelitis eradication programme in the Regional Office. The programme has been under the direct supervision of the Regional Director since 1997. The Regional Director has also established a regional task force that has ensured the provision of all the managerial and administrative support required by giving high priority to the recruitment of personnel, procurement of supplies and flexibility in financial aspects of the programme. All correspondence related to poliomyelitis are marked urgent and dealt with in the same spirit.

10. REMAINING CHALLENGES

Despite significant developments and achievements, there are some constraints that must be overcome in order to implement the different components of the strategic plan and thus achieve poliomyelitis eradication. The Region includes 4 of the 10 global priority countries. These are Pakistan, as one of the global reservoirs, and Afghanistan, Somalia and Sudan, as countries in conflict. Moreover, the Region borders 3 of the remaining 6 endemic or war-affected countries that represent global priorities for poliomyelitis eradication. The problems in war-torn countries are not only obstructing routine immunization efforts but are also affecting supplementary immunization efforts and surveillance. These countries pose a unique challenge to the eradication effort and require extraordinary efforts from the United Nations and other agencies and also human and financial resources and multi-agency coordination in order to secure access to all children for effective implementation of immunization and surveillance activities. The reservoir countries have one or more of the factors that facilitate continued transmission of the wild poliovirus, namely low routine immunization coverage, high population density and poor sanitary conditions that lead to both an accumulation of a large number of susceptible children and difficulties in achieving necessary standards of quality in supplemental immunization and surveillance.

The eradication effort has now entered its final and most difficult phase, which will require consolidation of political commitment within countries and globally and a concerted effort from all governments, international partners and United Nations agencies to ensure access to difficult areas and the availability of human and financial resources. Political and financial commitment must be translated into effective action to solve persistent gaps in management and implementation at the local level. In polio-free countries, political commitment is needed for maintaining high routine immunization coverage and supplementary immunization activities to protect against importation of wild poliovirus, for attaining certification-standard surveillance and for achieving laboratory containment of poliovirus stocks.

The global shortage of OPV is another challenge which was faced in 1999 and 2000 because of the acceleration of poliomyelitis eradication activities and production problems by vaccine manufacturers. The uncertainty of vaccine delivery for planned NIDs adversely

affects the planned activities and results in cancellation of some rounds and postponement of others. Stronger efforts will be needed to increase public- and private-sector support, particularly from within the Region.

The financial support required to implement the regional plan for eradication through 2005 must be secured in order to ensure that the acceleration plan is not delayed and certification of eradication is achieved on time.

11. COMPONENTS OF THE STRATEGIC PLAN 2001–2005

A five-year strategic plan 2001–2005 was prepared and includes the following elements.

Intensified NIDs and mop-up

During 2001 and 2002, the primary focus will be on intensifying NIDs and mop-up immunization to interrupt virus transmission in the remaining endemic countries. The focus will be on ensuring high quality supplementary immunization activities (SIAs) through house-to-house immunization, multisectoral support, better planning, closer monitoring and supervision, increased human resources and logistic support. SIAs will continue on a smaller scale from 2003 to 2005.

AFP surveillance

Efforts to improve AFP surveillance will continue. All countries in the Region are expected to achieve 'certification-standard' by mid-2001 and all laboratories to maintain full accreditation. All countries will move to virological case classification before the end of 2001 and will maintain surveillance through global certification

Certification

From 2002 to 2005, certification activities will accelerate to provide documentation of the absence of wild poliovirus for the RCC. The RCC will continue to review national documentation and each country will be visited by a member of the Commission to validate data.

Strengthening EPI

EPI strengthening has already been started through advocacy, social mobilization and capacity-building for poliomyelitis eradication. From 2001 to 2005 and beyond, the initiative will work in partnership with GAVI to strengthen routine EPI, ensuring maximum use of the infrastructure and lessons learned from poliomyelitis eradication.

Containment of laboratory stocks

A regional plan for containment of laboratory stocks of wild poliovirus and potentially infectious materials has been developed based on the policies and strategies in the global containment plan.

External resource requirements, available funds and shortfalls

Following coordinated budgetary planning with country programmes, WHO headquarters and UNICEF, a detailed budget is prepared annually for each of the priority countries that require external financial assistance as well as for activities undertaken for technical support and overall coordination by the Regional Office. Country level budgets include cost of OPV, operational costs for immunization campaigns and surveillance, and national staff. The Regional Office coordinates eradication activities in the Region and supports the laboratory network, certification and containment of laboratory stock of poliovirus and deployment of international staff and consultants (Figure 6). Each of these elements is described below.

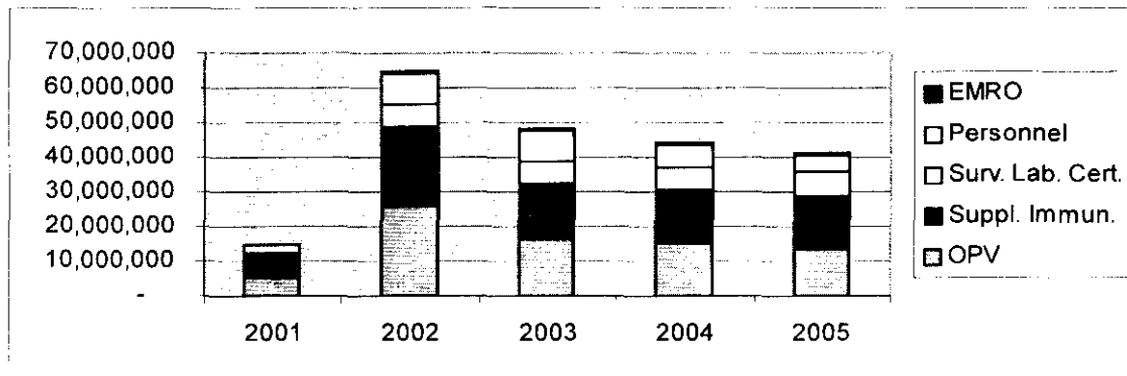


Figure 6. Shortfall (US\$) in external resource requirements for poliomyelitis eradication, Eastern Mediterranean Region, January 2001–December 2005

Priority actions for 2001–2002

Wild poliovirus continues to circulate widely in Afghanistan, Pakistan and Sudan. Somalia has been faced with a massive outbreak of poliomyelitis, and virus circulation has persisted in parts of Egypt. Extraordinary efforts are needed to meet the challenge of the final and most difficult phase of eradication in the Eastern Mediterranean Region. The accelerated eradication activities will reach their peak in 2001 and 2002 with attention being focused on the following actions.

- Further strengthen the programme ownership and national commitment at all levels.
- Continue the acceleration of eradication efforts in endemic and war-affected areas of the Region, including continued coordinated efforts from the United Nations and other agencies to ensure safe access to all areas to deliver immunization and implement surveillance.
- Further improve the quality of NIDs with adequate microplanning, house-to-house immunization and intensified supervision, particularly in high-risk areas. Afghanistan and Pakistan will conduct 5 NID rounds (3 in spring and 2 in autumn) in addition to mopping up in high-risk districts. During 2001, Iraq and Somalia will again conduct two pairs of NID rounds. In addition to two pairs of NIDs, Sudan will conduct two rounds of mopping up campaigns. The mopping up in these countries will target 30%–50% of the total number of children under 5 years of age. NIDs and mopping up will include coordinated cross-border immunization activities in border areas. In 2002, Afghanistan, Pakistan, Somalia and Sudan will be conducting 4 rounds of NIDs in addition to targeted mopping up campaigns. Iraq will scale down the activity to one pair of NIDs plus mopping-up. It is expected that by mid-2002, all countries in the Region will have succeeded in interrupting wild poliovirus transmission and from 2003 to 2005 these priority countries will be conducting one pair of NIDs plus subnational campaigns in some countries. The Republic of Yemen will continue to conduct one pair of NIDs during 2001, and will phase down to sub-NIDs from 2002 to 2005. These plans will be revised and updated annually after review of the situation.
- Rigorously implement active AFP surveillance and appropriate laboratory support in order to reach certification standard surveillance in all countries. Following the recommendations of the Global Technical Consultative Group, the major focus will be on further improving the timeliness of obtaining critical surveillance data and rapidly responding to it.
- Provide sufficient guidance and support to the programme in Egypt to interrupt poliovirus transmission.
- Consider the unique situation of the Islamic Republic of Iran and its exposure to repeated importation of poliovirus from neighbouring countries. It is important to maintain high population immunity and vigilant surveillance. Every effort should be made to ensure availability of the required OPV vaccine and to resume vaccine

production in the country. Cessation of transmission after the importation in 2000 should be proven and documented.

- Provide appropriate technical and operational support by ensuring sufficient financial and human resources to accelerate eradication activities and meet the goal of eradication as soon as possible.
- Further consolidate the partnership of international agencies and governments.
- Ensure implementation of the first phase of the plan for containment of polioviruses.
- Ensure that all polio-free countries develop the national plan and capacity for preparedness for early detection and appropriate response for any wild poliovirus importation.
- Continue RCC review of country documentation for certification.