WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY A57/8
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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 global eradication of poliomyelitis by the end of the year 2000. At the time the resolution was adopted, wild-type poliovirus was endemic in over 125 countries and on five continents, paralysing more than 350 000 children each year. In 1999, the Fifty-second World Health Assembly, in resolution WHA52.22, called on Member States to accelerate eradication activities and to introduce laboratory containment of the virus.

2. The WHO regions of the Americas, Europe, and Western Pacific, comprising more than 3000 million people, have been certified free of poliomyelitis. To date, endemic wild-type poliovirus transmission has been interrupted in all but six countries in the three remaining regions (see figure). Nigeria (355 cases), India (225) and Pakistan (101) account for 93% of all cases, although the geographical extent of transmission has been substantially reduced in India and Pakistan. In Niger (39 cases) and Afghanistan (8), epidemiological and virological data demonstrate highly focal endemic transmission, with repeated importations from the "global reservoir" with which they share a border (Pakistan and Nigeria, respectively). In Egypt (one case) endemic transmission is highly localized.

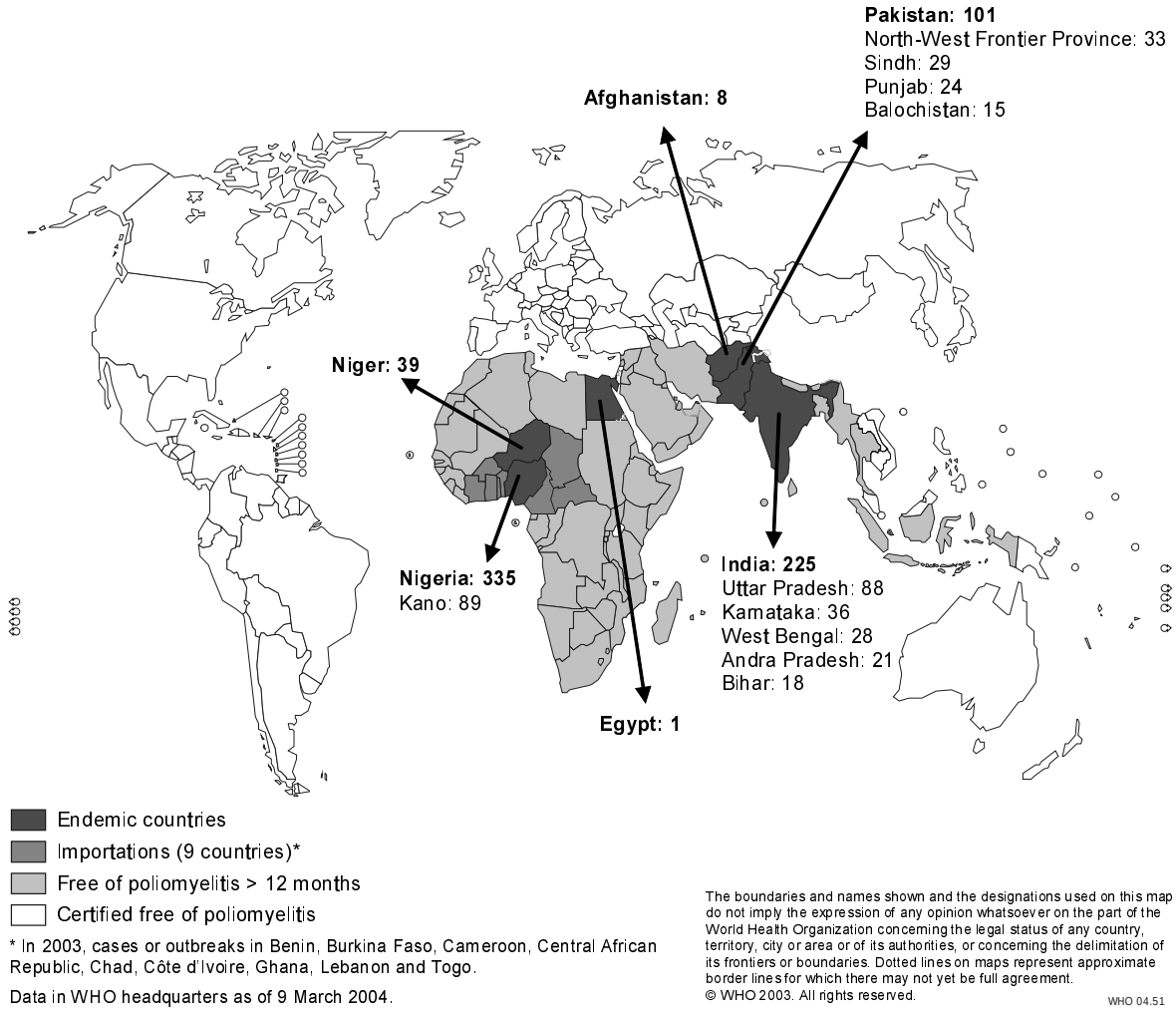
3. At an emergency meeting on eradication of poliomyelitis (Geneva, 15 January 2004), health ministers or their representatives from the remaining affected countries established a comprehensive plan to intensify activities in a "final push" to interrupt poliovirus transmission by the end of 2004. The Geneva Declaration signed by the ministers and spearheading partners at the meeting expresses the national and international commitment to this goal. After consideration by the Health Assembly, it is hoped that Heads of State will report on progress at the forthcoming session of the United Nations General Assembly.

4. The emergency meeting reflected the increase in international support for eradication of poliomyelitis. At the G8 Summit (Evian, France, June 2003) leaders reaffirmed their pledge to close the funding gap for activities in 2003 to 2005 to eradicate poliomyelitis. At the African Union Summit (Maputo, July 2003), Heads of State resolved to break the final chains of poliomyelitis transmission in Africa and ensure that the required funds for 2003 to 2005 are mobilized. Leaders of the Organization of the Islamic Conference endorsed a resolution on eradication of poliomyelitis at their Summit Conference (held in Putrajaya, Malaysia, October 2003) and called on Member States to accelerate efforts to eradicate the disease and allocate the resources necessary to ensure that children in all countries of the Islamic Conference are protected.

5. Following wide consultation among the partners of the Global Polio Eradication Initiative, a new Global Polio Eradication Strategic Plan for the period 2004 to 2008 was launched in January 2004. The Plan lays out the programme of work to be performed and the milestones to be reached for each of the Initiative's four major objectives: namely, interruption of poliovirus transmission in the

final reservoir areas; global certification of poliomyelitis eradication; preparing for the cessation of oral poliovirus vaccine use; and mainstreaming of the poliomyelitis eradication initiative. The Plan reflects the major tactical revisions that were introduced in 2003 to stop poliovirus transmission, the revised time-frame for global certification (2008), the specific goal of ceasing oral poliovirus vaccination soon thereafter, and plans for sustaining the long-term elements of poliomyelitis eradication work.

Wild poliovirus, July to December 2003



6. In terms of laboratory containment of poliovirus, all 135 countries in the three WHO regions that are certified free of poliomyelitis have initiated a survey of facilities. Of the countries concerned, which include several large industrialized nations, 82 (or 61%) have submitted an inventory of facilities holding wild-type poliovirus and infectious or potentially infectious materials. In the South-East Asia and Eastern Mediterranean regions, all Member States that are free of poliomyelitis have initiated containment activities. In the African Region, Botswana has completed the survey and inventory. Other countries in poliomyelitis-free areas of eastern and southern Africa plan to begin containment activities before the end of 2004.

ISSUES

7. Wild-type poliovirus transmission must be interrupted in the six remaining countries where poliomyelitis is endemic to exploit the "one-time opportunity" that exists to stop transmission by the end of 2004 (see figure). It is particularly important to make a rapid improvement in the quality of mass poliomyelitis immunization campaigns in key reservoir states or provinces of Nigeria (e.g. Kano), India (e.g. Uttar Pradesh), and Pakistan. Reaching every child during poliomyelitis eradication campaigns in these areas in 2004 will require the direct oversight of high-level political and health authorities at national, state and district levels. This is needed to mobilize fully the civil administration and address gaps in such key programme areas as vaccinator transport and public information. All religious, traditional and local community leaders will need to be fully involved to ensure that every community is included and all its children fully immunized.

8. In 2003 Nigeria accounted for 48% of the world's cases of poliomyelitis. Because of concerns expressed by public figures regarding the safety of oral poliovirus vaccine, government officials in the state of Kano and a number of surrounding states suspended immunization campaigns, beginning in August 2003. To interrupt poliovirus transmission in Nigeria by the end of 2004, high-quality immunization campaigns that reach every child must be implemented nationwide during the low season for poliovirus transmission, early in 2004. This will require rebuilding confidence in the safety of the vaccine at community level, improving the quality of community-level micro-planning, and maintaining close political oversight during each round of activities.

9. For the first time in history in 2003, more countries recorded imported cases of poliomyelitis than were endemic for the disease. Most notably, in 2003, poliovirus from northern Nigeria reinfected Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Ghana, Togo, and part of Niger, as well as Nigerian states that were previously free of poliomyelitis, such as Lagos. The international immunization responses to importations cost over US$ 20 million. To minimize the risk of further importations, all areas that are free of poliomyelitis must maintain high immunization coverage through routine programmes; sustain certification-standard surveillance; and establish standard operating procedures to enable massive "mop-up" immunization campaigns within 28 days following confirmation of the presence of wild-type poliovirus.

10. Insufficient financing continues to be the greatest threat to the Global Polio Eradication Initiative. In 2003, for the first time in the history of the Initiative, activities had to be cancelled or postponed as a result of an acute financing gap – severely compromising the quality of surveillance and supplementary immunization, particularly in sub-Saharan Africa. In mid-January 2004, the Initiative reduced the funding gap for 2004 to 2005 to US$ 130 million from US$ 275 million at the end of 2002. As high-quality, worldwide surveillance must be maintained up to global certification and cessation of oral poliovirus vaccination, additional resources will be required until 2008.

11. In September 2003, a WHO informal consultation on identification and management of vaccine-derived polioviruses concluded that outbreaks caused by vaccine-derived polioviruses pose a real threat to the global goal of eliminating paralysis induced by circulating polioviruses; and that this threat would continue as long as oral poliovirus vaccine is used, particularly in areas of low immunization coverage. The Global Polio Eradication Strategic Plan 2004-2008 includes the explicit goal of stopping routine immunization with oral poliovirus vaccine as soon as possible after eradication, while surveillance sensitivity and population immunity are still high. By that time, stocks of wild-type poliovirus will need to have been placed at an appropriate level of bio-containment, and the current stockpile of poliomyelitis vaccines will need to have been expanded in terms of the number

of doses and types of vaccine included. WHO is preparing guidelines for national policy makers to underpin the decisions they will need to make upon cessation of oral poliovirus vaccination.

ACTION BY THE HEALTH ASSEMBLY

12. The Health Assembly is invited to note the report.

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