WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD **EB115/28**
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Eradication of poliomyelitis

Report by the Secretariat

BACKGROUND

1. Resolution WHA41.28 established the goal of global eradication of poliomyelitis. When that resolution was adopted in 1988, wild-type poliovirus was endemic in more than 125 countries. In 1999, the Health Assembly, in resolution WHA52.22, called on all Member States to accelerate eradication activities. On 15 January 2004, the Director-General, the spearheading partners of the Global Polio Eradication Initiative and health ministers of the six countries remaining endemic for poliomyelitis signed the Geneva Declaration for the Eradication of Poliomyelitis committing themselves to interrupting the final chains of poliovirus transmission through intensified immunization campaigns.

2. As of 10 November 2004, the intensified eradication activities were making good progress in Asia. An increase in the quality and quantity of poliomyelitis campaigns in Afghanistan, India and Pakistan reduced the geographical distribution of wild-type poliovirus in those countries, with altogether just 120 cases reported (see Figure) compared with 266 for the same period in 2003. In Egypt, poliovirus transmission fell to its lowest level ever as the quality of poliomyelitis campaigns improved further. In contrast, sub-Saharan Africa experienced epidemic poliomyelitis as a result of a suspension (from August 2003 to 31 July 2004) of immunization against the disease in the state of Kano, Nigeria, and low routine immunization coverage in some neighbouring countries. Consequently, reported cases of poliomyelitis in Niger and Nigeria increased to 699 by 10 November 2004 compared with 242 at the same time in 2003, and 98 cases occurred in 10 previously poliomyelitis-free countries due to imported wild-type polioviruses. In four of these countries (Burkina Faso, Chad, Côte d'Ivoire and the Sudan) endemic transmission of the imported polioviruses was re-established, and, as of 16 November 2004, a fifth country, Central African Republic, is experiencing increasingly intense transmission of poliovirus.

3. International support for poliomyelitis eradication grew in 2004. In June 2004, G8 leaders renewed their pledge to finance eradication activities. In the same month, a second resolution on poliomyelitis eradication was adopted by the Islamic Conference of Foreign Ministers at its 31st Session (Istanbul, Turkey, 14-16 June). In October 2004 Heads of State or Government of the African Union launched the Synchronized Pan-African Immunization Campaign against Poliomyelitis in 23 countries of central and western Africa.

4. In response to the Executive Board's consideration of the thematic evaluation undertaken in 2001,[1] the oversight mechanisms for poliomyelitis eradication have been revised. Technical advisory groups have been established to guide each of the remaining countries endemic for the disease, with the Ad Hoc Advisory Committee on Polio Eradication providing global advice on the strategic priorities for poliomyelitis eradication and the eventual synchronous cessation of oral poliomyelitis vaccine use.

ISSUES

5. **Interrupting the final chains of wild-type poliovirus transmission worldwide.**

- In Egypt and India the transmission of polioviruses is particularly efficient. Consequently, mass campaigns are needed to reach more than 95% of children with oral poliomyelitis vaccine in the infected areas, every six weeks until transmission stops.

- Afghanistan and Pakistan share two reservoirs of poliovirus, requiring very high immunization coverage during large-scale, synchronized mopping-up activities, in addition to ongoing nationwide poliomyelitis eradication campaigns in both countries.

- Niger and Nigeria have had very low poliomyelitis immunization coverage. Stopping poliovirus transmission requires rapid rebuilding of community confidence in the safety of the poliomyelitis vaccine and raising coverage substantially during at least six rounds of immunization campaigns in 2005.

- Burkina Faso, Chad, Côte d'Ivoire and the Sudan need a marked increase in the number and quality of immunization campaigns, particularly during the series of synchronized national immunization days planned for 23 countries of central and western Africa in 2005.

6. **Strengthening surveillance for polio cases and polioviruses.** The detection in 2004 in central Africa of type 1 and type 3 polioviruses that were genetically related to those viruses thought to have been eliminated three years earlier demonstrated that surveillance that does not meet certification standards could fail to detect ongoing poliovirus transmission in some circumstances. Surveillance for acute flaccid paralysis must be enhanced in all countries recently endemic for the disease, particularly in central Africa and the Horn of Africa, to ensure that no chains of poliovirus transmission escape detection and to prepare for regional certification of eradication.

7. **Preparing for the synchronous cessation of oral poliomyelitis vaccine use.** The Ad Hoc Advisory Committee on Polio Eradication recommended synchronous cessation of use of the oral vaccine as early as three years after interruption of wild-type poliovirus transmission worldwide, as continued use of the live attenuated polioviruses contained in that vaccine would ultimately be incompatible with eradication. Ceasing the use of the oral vaccine will decrease the risk of future poliomyelitis outbreaks due to circulating vaccine-derived polioviruses and also eliminate the risk of vaccine-associated paralytic poliomyelitis. Safely stopping use of oral poliomyelitis vaccine will require: (i) appropriate containment of *all* poliovirus strains (wild-type, vaccine-derived and *Sabin*) in laboratories and vaccine-production facilities, (ii) a WHO/UNICEF-managed stockpile of monovalent oral poliomyelitis vaccines with internationally agreed mechanisms for their use, (iii) continued

[1] See document EB109/2002/REC/2, summary record of the tenth meeting, section 3.

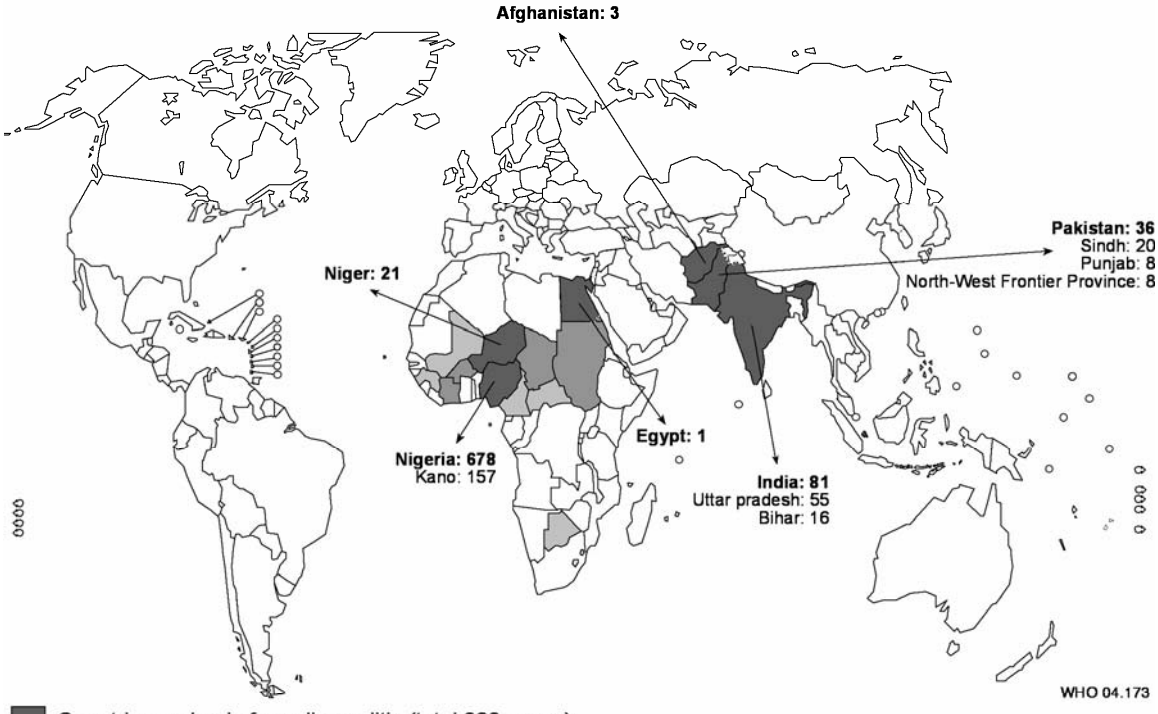
poliovirus surveillance and notification capacity that meet international standards globally, (iv) processes for synchronously stopping use of oral poliomyelitis vaccine globally, and (v) decisions by all countries using oral poliomyelitis vaccine on their long-term poliomyelitis immunization policy for the period following cessation of use of oral vaccine. Recommendations on these issues will be proposed to the Executive Board in the near future to ensure country and global preparedness.

8. **Ensuring sufficient financing.** Owing to the international spread of wild-type poliovirus in central and western Africa, planned supplementary poliomyelitis immunization activities were markedly expanded for 2005 and extended through to the end of 2006. These additional activities have increased the costs to the end of 2005 of interrupting wild-type poliovirus transmission globally by US$ 200 million. Closing the financing gap, identifying funds for the certification activities required to the end of 2008, and ensuring funding for eventual cessation of the use of oral poliomyelitis vaccine, especially the building of a stockpile of monovalent oral vaccine, will require the realization of existing pledges in full, new pledges by current partners for poliomyelitis eradication, and the participation of other international development donors.

ACTION BY THE EXECUTIVE BOARD

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

Countries with reported cases of poliomyelitis due to wild-type poliovirus, 2004



Countries endemic for poliomyelitis (total 820 cases)
Countries with re-established transmission of wild-type poliovirus (total 59 cases)
Countries with imported cases (total 39 cases)

Data received in WHO headquarters as of 10 November 2004.

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