



## **Eradication of poliomyelitis**

### **Report by the Director-General**

#### **BACKGROUND**

1. In 1988 the Health Assembly established a goal to eradicate poliomyelitis globally by the year 2000.<sup>1</sup> Recognizing that a focused eradication goal could facilitate the development of health care systems, the Health Assembly specified that poliomyelitis eradication should be conducted within the Expanded Programme on Immunization (EPI) and the context of primary health care.
2. Routine immunization systems are now delivering poliomyelitis vaccine and other EPI antigens to 80% of the world's infants. National immunization days for poliomyelitis eradication have been conducted in all endemic countries with the exception of the Democratic Republic of the Congo and Sierra Leone. Eighty-nine countries will conduct national immunization days in 1998, targeting an estimated 470 million children, approximately three-quarters of the world's population aged less than five years. Many immunization days are being internationally coordinated either within or between WHO regions, including the "Kick Polio Out of Africa" campaign, Operation MECACAR (Eastern Mediterranean and European regions), and the simultaneous immunization days among countries of the South Asian Association for Regional Cooperation. Surveillance of acute flaccid paralysis has been established in all poliomyelitis endemic countries, fully integrated in a global network of 133 poliomyelitis laboratories. Truces have been declared for immunization campaigns in Afghanistan, El Salvador, Peru, Philippines, Sri Lanka, Sudan, and Tajikistan.
3. If the current rate of progress is maintained, poliomyelitis can be eradicated globally by the year 2000 or shortly thereafter. Since 1988 the number of cases reported by WHO Member States has fallen by 85%. Poliomyelitis eradication was certified in the Region of the Americas in 1994, three years after the last case occurred in Peru. In the Western Pacific Region the last case occurred in Cambodia in March 1997. As of mid-1998, only 50 countries were still considered to be poliomyelitis-endemic, mainly in South Asia and sub-Saharan Africa (Annex).
4. Eradication of poliomyelitis will benefit the world by preventing hundreds of thousands of cases of paralysis each year, and producing direct savings of US\$ 1.5 thousand million each year after immunization is stopped. The eradication initiative has already revitalized immunization programmes in many countries, helping to re-establish the cold chain and improve routine coverage. Improved integrated surveillance systems, trained health staff and the global virology laboratory network are additional legacies. In 43 countries, the distribution of vitamin A during national immunization days has prevented blindness

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<sup>1</sup> Resolution WHA41.28.

and reduced deaths from measles and other infectious diseases. Because of the “slack” in many health systems, combined with the availability of new funding, there has not been a major disruption in other health services or diversion of funds. The eradication of poliomyelitis in the Western Hemisphere has led the Region of the Americas to adopt a measles elimination target.

## **ISSUES**

5. The poliomyelitis eradication initiative is now in a crucial phase, with some of the most difficult countries still remaining endemic. Six countries (Bangladesh, Ethiopia, India, Nepal, Nigeria and Pakistan) are major reservoirs of poliomyelitis, where large populations, high birth rates, crowded areas with poor sanitation and insufficient routine immunization facilitate poliovirus transmission. Implementing eradication activities is especially challenging in seven countries affected by conflict (Afghanistan, Angola, Liberia, Sierra Leone, Somalia, Sudan and Tajikistan). The Democratic Republic of the Congo is a unique challenge, a major reservoir affected by conflict.

6. During the initial phases of poliomyelitis eradication, countries paid 80% to 90% of the total cost. However, the lower levels of infrastructure and health resources available in the remaining poliomyelitis-endemic countries mean that a high percentage of the eradication cost has to be paid from external sources. Political will and financial resources are urgently needed to accelerate the eradication initiative and to avoid delays that would both threaten the success to date and substantially increase the overall cost. Such support also needs to continue in those countries that are now poliomyelitis-free, as the quality of surveillance and immunization has already started to decline in some areas.

7. As more countries become free of the disease, the risk posed by laboratory stocks of wild poliovirus increases substantially. If wild poliovirus were inadvertently released after immunization is stopped, circulation could be re-established. WHO has drawn up a global action plan and timetable for safe handling and maximum laboratory containment of wild polioviruses and potentially infectious materials. This plan calls for countries to inventory laboratory stocks of wild polioviruses, destroy stocks of no scientific value and move the remaining stocks to interim repositories starting in 1999.

## **FUTURE ACTION**

8. Eradication activities must be accelerated in the 14 most difficult countries, with additional rounds during national immunization days in many areas. Data deriving from surveillance of acute flaccid paralysis must be improved in order to identify accurately areas where wild polioviruses continue and to target large-scale house-to-house “mopping-up” immunization to halt transmission. Truces for immunization need to be secured in countries affected by conflict. All countries must ensure that high-quality immunization days reach all children aged less than five years.

9. WHO’s advocacy is needed to secure the political support and funds necessary to conduct these activities. WHO estimates that a total US\$ 850 million is needed from external sources over the next three years, the current shortfall being US\$ 370 million. An emergency fund is needed to permit a rapid and effective response when windows of opportunity open in countries that are affected by conflict or are politically isolated.

10. Implementation of WHO’s plan of action for containment of wild polioviruses should start in 1999. A coordinating group needs to be set up, with the authority to oversee the process, provide guidance to

WHO, and report formally to the Global Commission for the Certification of the Eradication of Poliomyelitis.

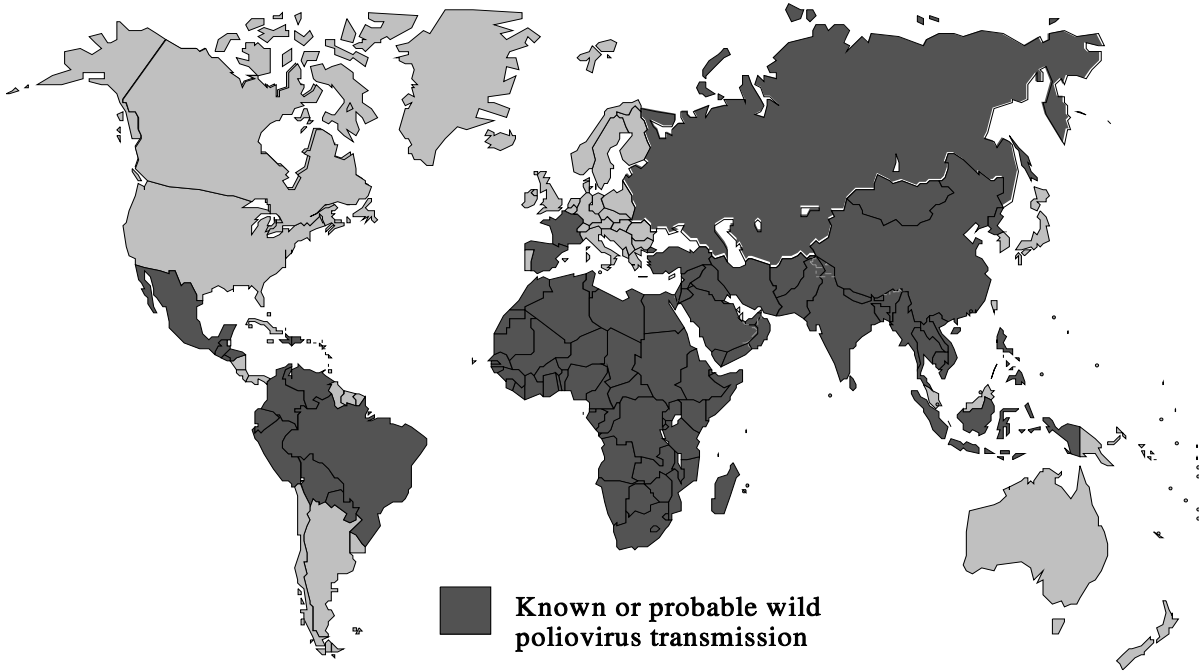
**ACTION BY THE HEALTH ASSEMBLY**

11. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB103.R10.

ANNEX

COMPARISON OF “KNOWN OR PROBABLE” WILD POLIOVIRUS TRANSMISSION IN 1988 AND BY JANUARY 1998

Wild poliovirus 1988



Wild poliovirus 1998

