WORLD HEALTH ORGANIZATION

FIFTY-SIXTH WORLD HEALTH ASSEMBLY A56/20
Provisional agenda item 14.12 28 March 2003

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. At that time, it was estimated that more than 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.

2. As a result of the consequent acceleration, only seven countries were still endemic for wild-type poliovirus at the end of 2002 (see Annex, Figure 1).[1] 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. In the remaining WHO regions endemic for poliomyelitis, the absence of cases from countries recently considered as major reservoirs of wild-type poliovirus, particularly Bangladesh, Democratic Republic of the Congo, Ethiopia and Sudan, demonstrates the soundness of the eradication strategies.

3. Despite the further geographical restriction of poliovirus transmission in 2002, the total of 1919 cases reported last year is four times greater than in 2001, owing to an epidemic in northern India (83% of all cases in the world in 2002) and a combination of intense transmission and heightened surveillance in northern Nigeria (10% of all cases).

4. 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. In terms of progress towards laboratory containment of poliovirus, 146 Member States had initiated a national survey of laboratories by the end of 2002, with 79 of them having submitted an inventory of facilities holding wild-type polioviruses and potentially infectious materials.

5. Increasing attention has been 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. Specific milestones have been established and indicators developed for monitoring progress. Collaborative mechanisms have been created to share the lessons learned from this initiative with the Global Alliance for Vaccines and Immunization within WHO and with participants in the "Human Resources for Health Equity: A Joint Learning Process" programme coordinated by the Rockefeller Foundation.

[1] Afghanistan, Egypt, India, Niger, Nigeria, Pakistan and Somalia.

6. Despite endorsement of the Global Polio Eradication Initiative in 2002 by participants at such important international forums as the G8 Summit at Kananaskis (Canada) and the second Africa-Europe Ministerial meeting (Ouagadougou), eradication activities were curtailed in the first half of 2003 owing to an acute shortfall in expected funding. As of February 2003, the shortfall in funding for the period 2003-2005 was US$ 275 million, US$ 85 million of which is required for activities that must be funded in 2003.

7. In response to the further geographical restriction of areas with intense transmission of poliovirus, and the acute funding shortfall at the end of 2002, the strategic approach for eradication of poliomyelitis has been revised for the period 2003-2005. Additional resources will be directed toward improving the quality of supplementary immunization activities in the remaining endemic areas and, if appropriate, increasing the number of mass poliomyelitis immunization rounds conducted each year in these places. Increased attention will be given to enhancing the quality of global surveillance to detect poliovirus and to accelerating containment activities worldwide to minimize the risk of an inadvertent release of wild poliovirus from laboratory stocks. Scheduled preventive campaigns in poliomyelitis-free areas will be substantially reduced and replaced with an emergency-response approach consisting of enhanced surveillance and large-scale house-to-house mop-up immunization campaigns when necessary.

ISSUES

8. In India, Nigeria, Pakistan, Egypt, Niger, Afghanistan and Somalia multiple additional rounds of large-scale supplementary poliomyelitis immunization activities will be needed in 2003-2004. Of particular importance will be improving the quality of these activities so that all children receive oral poliomyelitis vaccine. Global eradication will require an especially intense effort in India because of the intensity of transmission in the states of Uttar Pradesh and Bihar, and the re-establishment of transmission in 2002 of multiple other states which had recently become poliomyelitis-free.

9. In areas affected by armed conflict, heightened collaboration will be required with other organizations of the United Nations system, humanitarian organizations and nongovernmental organizations to ensure effective implementation and monitoring of poliomyelitis eradication activities. In areas bordering countries endemic for poliomyelitis, large-scale supplementary poliomyelitis immunization activities may be required to maintain high levels of population immunity against possible importations of wild-type poliovirus.

10. For all WHO regions to be in the process of poliomyelitis-free certification by 2005, the quality of surveillance for cases of acute flaccid paralysis must be raised to certification standard, especially in 24 countries and territories in the WHO regions of Africa (16), the Eastern Mediterranean (6) and South-East Asia (2) (see Annex, Figure 2). In addition, all countries will have to have submitted an inventory of laboratories holding wild-type poliovirus and potentially infectious materials and ensured that any retained materials are handled in appropriate biosafety conditions.

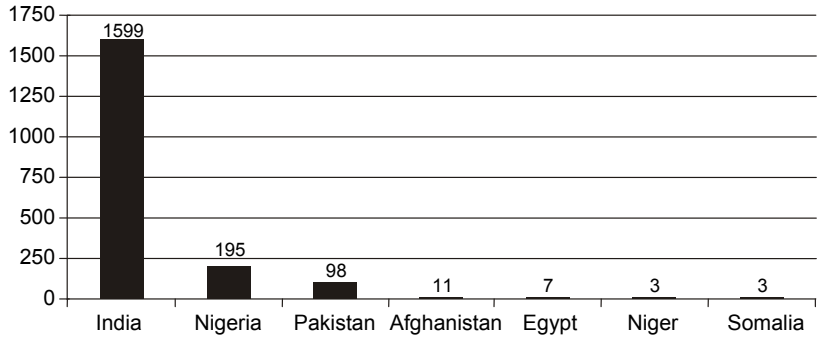
11. The revised strategic approach aims to reduce the risks to global eradication of poliomyelitis caused by the acute shortfall in funding in early 2003. Until such time as transmission of poliovirus is stopped globally, however, the vulnerability of areas free from poliomyelitis to the reintroduction of poliovirus will actually increase owing to the scaling back of supplementary immunization activities in those areas. The extent to which these risks can be managed depends on the amount of additional financial resources available from mid-2003.

ACTION BY THE HEALTH ASSEMBLY

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

ANNEX

Figure 1. Reported cases of poliomyelitis due to indigenous wild-type poliovirus, by country, in 2002*
(data as of 3 March 2003)



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

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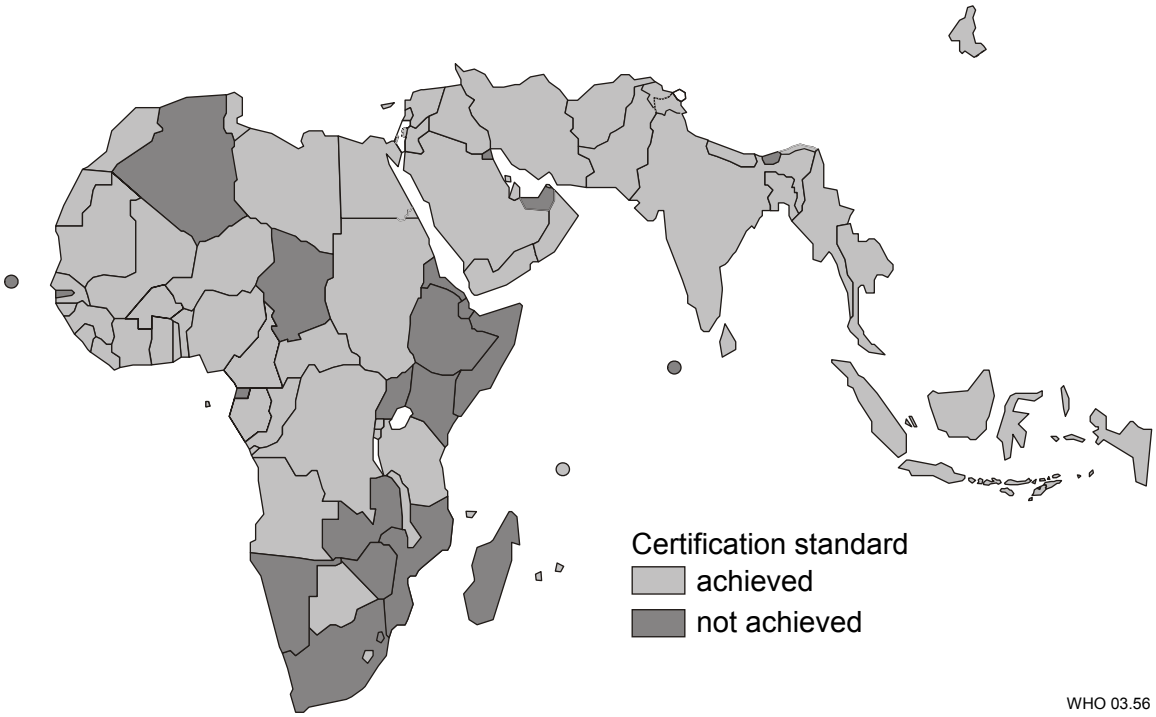
Figure 2. Performance of acute flaccid paralysis surveillance in 2002 in the three WHO regions yet to be certified free of poliomyelitis
(data as of 3 March 2003)



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