



WORLD HEALTH ORGANIZATION

FIFTY-EIGHTH WORLD HEALTH ASSEMBLY
Provisional agenda item 13.7

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7 April 2005

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. Health ministers from countries in Africa and Asia affected by poliomyelitis reconvened on 13 January 2005 and 4 February 2005, respectively, to assess progress in completing the activities set out in the Geneva Declaration and to identify the actions needed to interrupt poliovirus transmission in 2005.

2. In 2004, the intensified eradication activities made 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 194 cases reported (see Figure) compared with 336 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 814 by 8 March 2005 compared with 395 at the same time in 2003, and 254 cases occurred in 12 previously poliomyelitis-free countries due to imported wild-type polioviruses. In five of these countries (Burkina Faso, Central African Republic, Chad, Côte d'Ivoire and the Sudan) endemic transmission of the imported polioviruses was re-established.

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. African leaders attending the Fourth African Union Summit (Abuja, 24-31 January 2005) adopted a decision "to ensure that every child receives polio immunization in 2005".

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 requiring mass campaigns to reach more than 95% of children with oral poliomyelitis vaccine in the infected areas, every six weeks until transmission stops. To interrupt the remaining chains of transmission of type 1 poliovirus, an intensive project was launched to develop and licence a new monovalent oral poliomyelitis vaccine for use as early as possible in 2005.
- 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 raising coverage substantially during at least six rounds of synchronized immunization campaigns in more than 20 countries across central and west Africa in 2005.
- Burkina Faso, Central African Republic, 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 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, especially in those areas recently or currently affected by conflict and/or with uncertain population figures.

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 eventually eliminate poliomyelitis outbreaks due to circulating vaccine-derived polioviruses and vaccine-associated paralytic poliomyelitis. Safely stopping use of oral poliomyelitis vaccine will require: (i) confirmation of interruption of transmission of wild-type poliovirus globally, (ii) appropriate containment of *all*

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

poliovirus strains (wild-type, vaccine-derived and *Sabin*) in laboratories and vaccine-production facilities, (iii) a WHO/UNICEF-managed stockpile of monovalent oral poliomyelitis vaccines with internationally agreed mechanisms for their use, (iv) continued poliovirus surveillance and notification capacity that meet international standards globally, (v) processes for synchronously stopping use of oral poliomyelitis vaccine globally, and (vi) 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. As of 18 March 2005, the funding gap for activities in the second half of the year was US\$ 75 million and the gap for activities in 2006 was US\$ 200 million. Closing these gaps, 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 confirmation of multi-year pledges for 2004-2008 and the participation of other international development donors.

9. At its 115th session in January 2005, the Executive Board noted the report on progress towards eradicating poliomyelitis and restated its commitment to that goal.¹

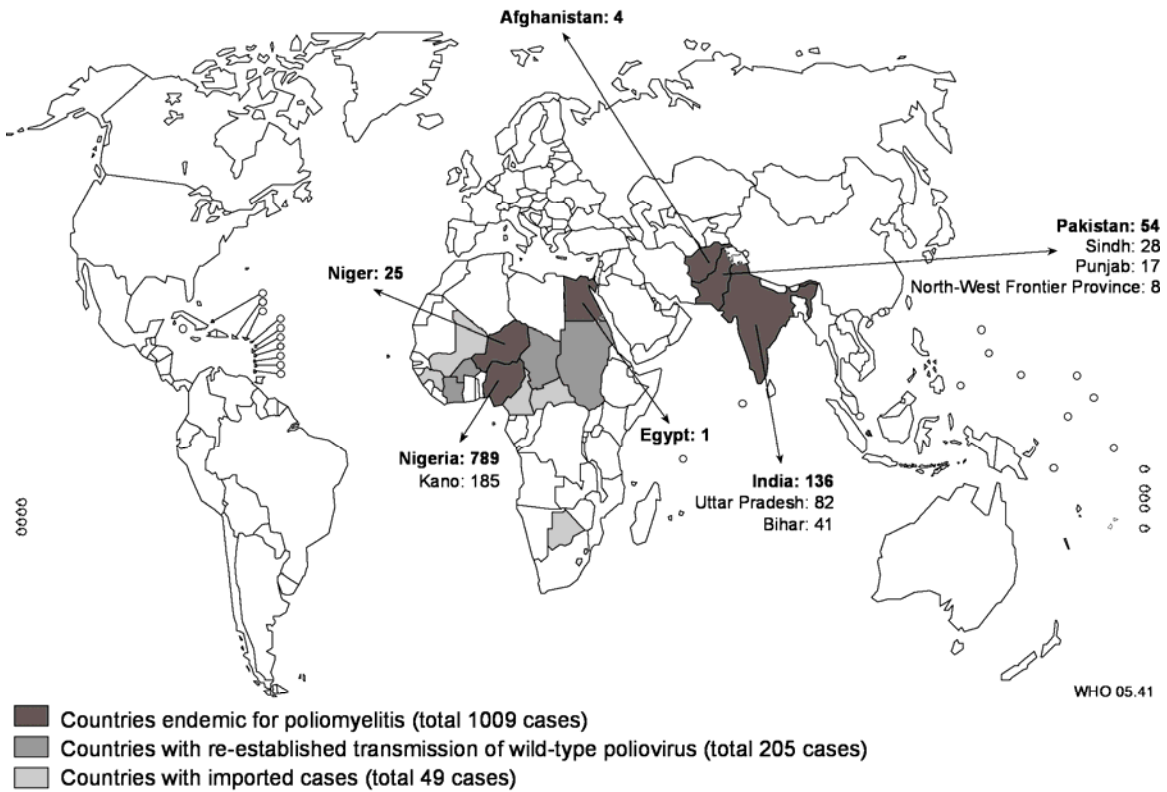
ACTION BY THE HEALTH ASSEMBLY

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

¹ See document EB115/2005/REC/2, summary record of the twelfth meeting, section 4.

Figure

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



Data received in WHO headquarters as of 8 March 2005.

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

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