

NOW, MORE THAN EVER: STOP POLIO FOREVER.



Partners in the Global Polio Eradication Initiative

Polio Eradication Situation Report – June 2005

All data refers to end-May

For latest polio case data by country, updated every week: www.polioeradication.org

Headlines

- **World Health Assembly re-affirms polio eradication goal.** Member States note the progress made in Asia and the intense response to the outbreak in Africa and urge for sustainable funding to continue activities, especially against the backdrop of the most recent importations. Additionally at the WHA, **polio is included as a reportable disease** in new International Health Regulations.
- **Somalia carries out preventive campaigns in April and June** due to the outbreak in Ethiopia and the threat to the polio-free status of the rest of the Horn of Africa.
- **Funding gap critical to emergency response and planned activities.** Because of the risk of further spread to polio-free areas, it is more important than ever to rapidly fill the US\$250 million funding gap for 2005-06, with US\$ 50 million urgently needed by July 2005. Failure to do so will compromise immunization activities and threaten the entire eradication effort.

The state of polio eradication in 2005

- **Members states at the World Health Assembly in May expressed overwhelming confidence in the success of the programme.** The target-date of stopping transmission by end-2005 will be reviewed in October.
- **There are 6 countries with endemic indigenous polio** (Nigeria, India, Pakistan, Niger, Afghanistan and Egypt) **and 6 countries where transmission has been re-established** (Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Mali and Sudan).
- **Success depends on reaching the groups of children that remain under-immunized.** In every country, these children are poor, young and living in communities that get little or no basic healthcare.
- **The greatest threats to a polio-free world are:**
 1. **A failure to reach all children** in the remaining endemic districts (especially in India, Pakistan and Nigeria), combined with ongoing insecurity in some countries with re-established transmission (particularly Côte d'Ivoire and Sudan)
 2. **Gaps in surveillance of the disease** (particularly in West, Central and Horn of Africa).
 3. **Low routine immunization rates** which help the virus spread.
 4. **A funding gap** of US\$50 million for the latter half of 2005 (needed by July) and a need for multi-year pledges, the most pressing of which is \$200 million for 2006.

More than the end of a disease is at stake. Polio eradication would validate a US\$4 billion, 17-year global investment and prove the world can work together to reach a shared public health goal.

Asia

India and Pakistan

- A joint mid-year review was held in Geneva on 30 May, refining plans for the remainder of the year and bringing together senior administrators from the federal level and key states and provinces (India: Uttar Pradesh and Bihar; Pakistan: Punjab, Northwest Frontier Province, Balochistan and Sindh). The successful involvement of the civil administration needs to be encouraged and strengthened as it has led to improved access and high-quality rounds.
- The Indian Federal Railway Ministry adopted a plan to vaccinate children while they are travelling on trains. This comes in addition to the vaccinations taking place since earlier this year at transit points such as bus and train stations.
- May immunization rounds in India used monovalent oral polio vaccine-1 (mOPV1) in high-risk areas and trivalent in the rest of the country.
- In Pakistan, an informal consultation on polio eradication took place on 10-12 May. Experts concluded that Pakistan can stop wild poliovirus transmission in 2005, as the past year has seen marked improvements in the ability of immunization campaigns to reach every child and in the surveillance of polio. Pakistan's cases are half what they were in the same period last year, and are all due to wild poliovirus type 1. It is encouraging that cases are falling even though the

surveillance system is performing better: 50% more AFP cases were reported in the first four months of 2005 as compared to the same period in 2004. The presence of only type-1 virus led the consultation to advise the use of mOPV1 for campaigns in the latter part of the year, to speed up interruption of this virus type.

Afghanistan

- Two type-3 cases were reported, from Helmand and Oruzgan provinces, a reminder that type 3 continues to circulate in this reservoir. A mop-up vaccination campaign was conducted in 13 districts on 21-23 May.

Indonesia

- Indonesia ended the month with 16 imported cases, all in or bordering West Java, where the index case was reported. The sub-national immunization days started at the end of the month, targeting 6.4 million children.

Africa

- A third round of synchronized National Immunization Days (NIDs) continued the continent's strong response to the outbreak, and is showing positive results. In western Africa, only Cameroon, Niger and Nigeria had cases in 2005.
- Stopping transmission by the end of 2005 will require extraordinary and rapid improvement in the quality of immunization campaigns, especially in northern Nigeria and countries with armed conflict.
- The further spread of polio is a continuing risk, particularly to the Democratic Republic of Congo, Djibouti, Eritrea and Somalia.

Nigeria

- Transmission of wild poliovirus is becoming more focused. To date in 2005, 71% of the wild poliovirus cases are concentrated in 6 states (Jigawa, Kaduna, Kano, Kebbi, Sokoto and Zamfara) in the northwest of Nigeria. This focalization reflects improved quality of vaccination campaigns. One of the factors contributing to this improvement is the increased ownership of political, traditional and religious leaders at the federal, state, Local Government Areas and ward levels.
- Strong progress is notable in the quality of vaccination campaigns: the number of missed children dropped to 7% during the May 2005 campaign. Compared to 68% of children under-immunized in 2004, 41% of children have fewer than 4 doses of OPV in 2005.
- Completely interrupting wild poliovirus transmission in Nigeria now requires special attention to the high risk areas where quality of supplementary immunization activities (SIAs) is still low. The highest priority must be to enhance micro-planning, close supervision and local advocacy, in addition to having more independent monitors.

Niger

- No new cases were reported in May. Synchronized NIDs took place in mid-May.

Egypt

- No positive environmental samples have been reported since 13 January 2005, and no clinical cases since 3 May 2004. Initial reports from the May NIDs using mOPV1 are very encouraging in terms of quality and coverage.

West and central Africa

- Synchronized NIDs took place between 13-17 May in Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, Guinea, Mali, and Chad (in addition to Nigeria and Niger).

East Africa and the Horn of Africa

- In Somalia, an analysis of the immunization status suggests that 69% of children are un- or under-immunized (<3 doses of OPV). While the nationwide AFP rate is 2.8, sub-national surveillance gaps remain, particularly in Mogadishu and the north of the country. An additional NID round is planned for June.

Middle East

Yemen

- NIDs began 30 May, using 6 million doses of mOPV1 to interrupt transmission more quickly, in house-to-house rounds with 32,000 vaccinators.
- The case numbers from the outbreak in Yemen reached 179 by the end of May. Yemen suffered multiple importations into Hodaidah governorate, a port-town with frequent population movements across the Red Sea. The relatively low routine immunization in Yemen- is behind the rapid spread of the virus.
- Twelve of the 22 governorates of the country have reported cases, 75% in Hodeidah. This focalization suggests that the preventive campaign in April helped prevent even further spread. The next SIAs in Yemen are planned for 11 July.