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Polio News

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A Newsletter for the Global Polio Eradication Initiative
Expanded Programme on Immunization
Department of Vaccines and other Biologicals
World Health Organization

1998 Review

1998 has been a very successful year for polio eradication. Existing polio eradication partners renewed their commitment, virtually all National Immunization Days (NIDs) were carried out according to plan, rapid progress in Acute Flaccid Paralysis (AFP) surveillance was made in key areas, and extensive social mobilization increased the visibility and awareness of the initiative.

Administering OPV (AFR)

Photo ©WHO/AFR

Achievements

- Almost all endemic countries have carried out at least one set of double-round NIDs.
- The three endemic countries where NIDs have not yet been conducted will do so in December 1998 / January 1999 - Sierra Leone and Liberia; the Democratic Republic of Congo also hopes to conduct NIDs in early 1999, covering as much of the target population as possible.
- NIDs were carried out for the first time in Southern Sudan and Somalia (Northern and Southern Somalia) in 1998.
- A record 134 million children were immunized during 1998 NIDs in India.
- A cease-fire was obtained in Sri Lanka to ensure that NIDs could occur as planned.
- An extensive inter-regional 'mopping-up' immunization activity between the European and Eastern Mediterranean Regions carried out in Iran, Iraq, Syria and Turkey.
- AFP surveillance has dramatically improved in several countries of the Indian sub-continent and sub-Saharan Africa.
- Surveillance improvements were particularly impressive in India and Nigeria. In India, improvements occurred as soon as AFP surveillance medical officers had been deployed in many districts in 1997/98. In a similar development, new regional surveillance officers in Nigeria helped to dramatically increase surveillance quality.
- Over 7 500 health care institutions in India have been enrolled in a weekly AFP reporting network.
- Planning began for a marked acceleration of the global eradication initiative in 1999 and 2000.

Challenges

- NIDs in the Democratic Republic of Congo were planned for September 1998 but had to be postponed due to renewed civil conflict.
- The NIDs planned in Afghanistan had to be scaled down to Subnational Immunization Days (SNIDs) due to continued internal strife; full NIDs are planned for May/June 1999.
- While surveillance has begun officially in most countries with endemic wild poliovirus, surveillance quality is still very variable from country to country.
- The wide distribution of type 1 virus strains in South Asia and West/Central Africa demonstrates that supplementary immunization activity will need to be substantially enhanced to achieve polio eradication by the year 2000.
- Of the estimated US$ 700 million required for 1999-2001, there is a continued, significant funding shortfall of US$ 325 million. ◆

The Greatest Hurdle

"…the campaign risks running critically short of money. That is not acceptable – this is a combat we simply cannot afford to lose in the last stretch".

Dr. Gro Harlem Brundtland

As the global effort to eradicate polio enters the peak years of activity in 1999 through 2001, the technical feasibility of the goal is apparent. By early 1998, polio had already been eradicated from areas as diverse as Brazil and Cambodia. When the peoples of Somalia and southern Sudan overcame tremendous difficulties to demonstrate that they could immunize nearly 1 million of their children during NIDs in each of those areas, the biggest challenge to polio eradication shifted even further from logistics to financing.

The new Director General of WHO, Dr. Gro Harlem Brundtland, has indicated on several occasions that "…the campaign risks running critically short of money. That is not acceptable – this is a combat we simply cannot afford to lose in the last stretch".

With the introduction of the polio eradication strategies into virtually all remaining polio-endemic countries during 1998, it has been possible to develop increasingly precise estimates as to the cost of the entire initiative. Approximately US$700 million in external resources are needed to fully implement the eradication strategies in the critical period 1999-2001. By late 1998, over half of that amount (US$375m), had already been pledged by the principal polio eradication partners (see figure).

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Dr Brundtland asked existing donors and governments "to go the extra mile with us and rid the world of polio and its tragic toll on death and disability."

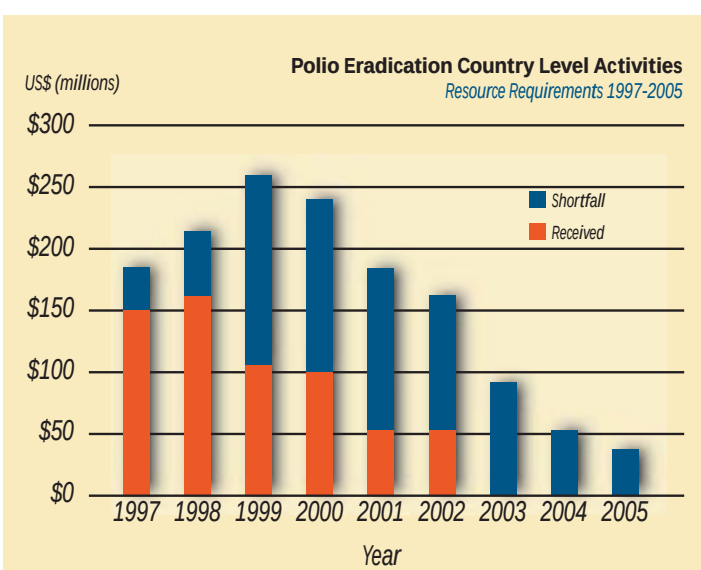
The resources needed for polio eradication fall into three general categories:

- operational costs for NIDs and "mopping-up" immunization rounds;
- oral polio vaccine (OPV);
- support for AFP surveillance and polio laboratories.

Of the three areas, the overall need is largest for operational costs, while the shortfall is greatest for AFP surveillance and laboratory needs. Historically, it has been easiest to find the external resources needed for vaccines. Six countries account for over 50% of the estimated resources required: India, Pakistan, Bangladesh, Democratic Republic of the Congo, Ethiopia and Nigeria.

While substantial external support is needed for polio eradication, most of the resources come from the polio endemic countries themselves, either in cash or in kind. Due to the myriad of sources and levels from which these country-level funds are received, it is virtually impossible to put a dollar figure on the actual amount contributed. However, information from Latin America, sub-Saharan Africa and the Western Pacific suggests that the endemic countries cover 60-80% of the costs. In some countries, such as China and Indonesia, that percentage has been in excess of 90%. Even in the poorest countries, contributions in the form of personnel, transport and communications cover a substantial proportion of the resources needed.

Recognizing the need for additional resources to complete polio eradication, the World Health Organization is teaming up with its partner agencies, especialy Rotary International, to accelerate fundraising activities. The current strategy calls for a two pronged approach: reaching out to traditional health sector donors which are not yet part of the polio eradication initiative, and establishing new partnerships with 'non-traditional' donors.◆



NID Calendar: January to March 1999

National Immunization Days and other supplementary OPV immunization

This calendar reflects information known to WHO/HQ at the time of print. Some NID dates are preliminary and may change; please contact WHO/HQ for up-to-date information.

Month of 1st round	Country	Type of Activity	Date 1st round	Date 2nd round	Target Population
OCTOBER	Benin	NID	Oct-98	Nov-98	1 358 422
	Guinea	NID	23 Oct-98	Nov-98	1 389 371
	Lesotho	SNIDS	12-23 Oct-98	16-27 Nov	308 000
	Iraq	MopUp	5 Oct-98	5 Nov-98	400 000
	Iran	MopUp	5 Oct-98	5 Nov-98	*NA
	Syria	MopUP	5 Oct-98	5 Nov-98	600 000
	Libya	NID	Oct-98	Nov-98	1 000 000
	Morocco	NID	Oct-98	Nov-98	3 500 000
	Tunisia	NID	Oct-98	Nov-98	1 030 000
	Yemen	NID	Oct-98	Nov-98	3 600 000
	Armenia	MopUp	Oct-98	Nov-98	22 600
	Russian Federation	MopUp	Oct-98	Nov-98	300 000
	Tajikistan	MopUp	Oct-98	Nov-98	282 000
	Turkey	MopUp	Oct-98	Nov-98	150 000
	Turkmenistan	MopUp	Oct-98	Nov-98	93 000
	Uzbekistan	MopUp	Oct-98	Nov-98	300 000
	Yugoslavia	SNID	Oct-98	Nov-98	125 000

*NA: Information not available at the time of going to press.

Polio eradication partners

Government of Canada/CIDA

The Government of Canada, through the Canadian International Development Agency CIDA, has committed to provide a series of annual grants of 10 million Canadian Dollars over five years (total of 50 million Canadian Dollars) to support immunization programmes in Asia and Africa, with an emphasis on polio eradication and the development of surveillance for Acute Flaccid Paralysis.

Canada, through CIDA, is also supporting the conduct of National Immmunization Days in Senegal with a grant of 500.000 Canadian Dollars.

Rotary International

In November 1998, the Board of Trustees of Rotary International has approved new grants for global polio eradication totaling US$ 20.2 million, with US$ 12 million for the African Region, US$ 2.9 million for the South East Asian Region, US$ 3.9 million for the Eastern Mediterranean Region, US$ 0.85 million for the European Region and US$ 0.5 million for support at the global level.

Fifty-three percent of Rotary Districts (280 out of 527 districts) are currently participating in the PolioPlus Partners Programme, and have raised a total of 8.8 million US$.

As of November 1998, Rotary International has given a cumulative total of US$ 334 million towards the global eradication of poliomyelitis.

The United States Agency for Development/USAID

The United States Agency for International Development (USAID) has approved a new grant of US$ 5.6 million to support polio eradication activities in the South East Asian and European Regions of WHO, and at the global level.

Department for International Development, UK/DFID

DFID, the Department for International Development in the United Kingdom, is providing a grant (UK£1.4 million) to procure oral poliovaccine for the upcoming National Immunization Days in Pakistan.

DFID will also provide substantial support to WHO to implement polio eradication activities in East Africa through a grant of more than UK£17.5 million over a period of three years.

Centers for Disease Control and Prevention/CDC

The Atlanta-based CDC (Centers for Disease Control and Prevention), in preparation of a new project to support field surveillance for AFP and wild poliovirus, plans to field additional technical staff for 3 - 6 month missions to countries in greatest need. CDC will use a cadre of medical officers currently enrolled in its prestigious two-year field epidemiology training programme, EIS (Epidemic Intelligence Service). Following a short introductory course, volunteer 'EIS officers' will join polio eradication teams in countries where additional support to develop surveillance is required, working under the direction of national EPI managers and country epidemiologists. Up to 25 EIS officers will be available for short-term missions every year.

OPEC

The OPEC Fund donated US$ 150,000 for polio eradication in countries affected by conflict.

UN Foundation

The UN Foundation approved a three million US$ grant to UNICEF to support polio eradication in countries affected by conflict (Afghanistan, Liberia, Sierra Leone, Somalia, Southern Sudan).

Japanese International Cooperation Agency

The Japanese International Cooperation Agency will support up to 25 Japanese Overseas Volunteers to be deployed in critical countries to support field surveillance for AFP. The first countries to receive Japanese volunteers will be NIger, Kenya and Bangladesh. ◆

From Regions and Countries

African Region

AFP surveillance in Tanzania

Tanzania has become another 'success story' in developing surveillance in Africa. Following a concerted effort to train and sensitize public health workers and clinicians at provincial and district level, AFP surveillance quality in Tanzania rapidly improved during the second half of 1998. AFP cases are now reported from all areas of the country, and virological specimens are collected from more than half of all cases. While the national laboratory undergoes rehabilitation, specimens from Tanzania are temporarily processed at the Zambia national laboratory. In 1998, no wild poliovirus has yet been isolated in Tanzania.

South-East Asia Region

Polio eradication review in India

A large-scale review of polio eradication activities, focusing on AFP surveillance in particular, was conducted in India in September 1998. The review confirmed that dramatic improvements had occurred in AFP surveillance following the deployment of 59 designated AFP surveillance medical officers to areas all over India in September 1997. Molecular analysis of viral genomes from a number of areas has shown that the biodiversity of polioviruses is decreasing, indicating that NIDs have already decreased the intensity of virus transmission. The review team recommended additional OPV immunization rounds in several high-risk states and areas, such as Bihar and Uttar Pradesh.

Eastern Mediterranean Region

EPI review in Afghanistan

A comprehensive review of EPI services and polio eradication was conducted in Afghanistan in June 1998. Facilitated by UNICEF and WHO, an international team, including representatives of major partners and donors to the Afghanistan programme, visited five. EPI coverage surveys were conducted in all regions visited. Despite continuing civil unrest and unstable political conditions, Afghanistan has made significant progress in establishing AFP surveillance. Supplementary OPV immunization, particularly the 1997 NIDs, was very successful. However, the 1998 NIDs did not reach 30% of the target population in the north, due to ongoing civil unrest. The review made detailed recommendations on how to rehabilitate and improve the routine EPI, in close coordination with polio eradication efforts.

Photo caption please.

Photo ©WHO/SEAR

Eastern Mediterranean and European Region

Cross-border immunization

A great step forward has been made in eliminating a major multicountry reservoir of wild poliovirus in the bordering areas of Turkey, Iraq, Islamic Republic of Iran and Syria. This unique inter-regional collaboration between the European (EUR) and the Eastern Mediterranean (EMR) Regions of WHO targeted 2.3 million children under five years of age in adjoining areas of these four countries in a house-to-house mopping up campaign. The campaign, which took place over one week in October and one week in November, covering eleven provinces in Turkey, four provinces in Iran, nine governorates in Iraq and the border governorates of Syria. Preliminary reports suggest high coverage in all areas.

European Region

AFP surveillance reviews

Since February 1998, international reviews of AFP surveillance have been carried out in Albania, Bulgaria, Georgia, Kazakhstan, Kyrgizstan, Moldova, Turkey, the Russian Federation, Turkmenistan, Ukraine and the Federal Republic of Yugoslavia. The planned review in Tajikistan could not yet be conducted due to continued civil unrest. The reviews showed an improvement in the quality of AFP surveillance in most countries, and also helped to highlight problems which need to be resolved to ensure the eventual certification of polio eradication. ◆

Accrediting the Global Polio Laboratory Network

THE global polio lab network provides crucial services to the eradication effort. Detection and laboratory evaluation of acute flaccid paralysis (AFP) cases is the standard for certifying polio eradication for all countries. Only laboratory confirmation of absence of wild poliovirus can support surveillance quality data.When AFP cases are reported in the field, stool samples are taken and sent to the national laboratory, which must isolate the virus and determine if it is type 1,2 or 3.

Photo caption please.

Photo ©WHO/SEAR

Once the virus is identified, the isolate is then sent to the Regional Reference Laboratory for intratypic differentiation to determine if the virus is a wild strain or a Sabin (vaccine) strain. If the virus is a wild poliovirus, the sample is sent to a specialised laboratory to confirm the wild strain and genetically sequence the virus. Virus sequencing allows the tracking of the chains of transmission by genetic epidemiology, or history, of the virus, which in turn helps to determine future immunization strategies for the country or region where the wild virus originated.

This year has seen significant progress in introducing the process of accreditation of laboratories within the Global Polio Laboratory Network. The accreditation process is used to assure that all laboratories in the network perform at acceptable quality levels and use standardized procedures. For the first time ever, all but 15 of the 133 laboratories in the network have undergone assessment for accreditation over the past 12 months. 80% of the labs are either fully or provisionally accredited.

To verify that the laboratories within the Global Polio Laboratory Network meet these high standards, and ensure accuracy of results, WHO in co-ordination with technical laboratory experts, has developed six key criteria to assess laboratory performance and form the basis for accreditation:

1. On-site review of laboratory facility and practices;
2. Proficiency in testing for and recognition of a panel of enteroviruses including poliovirus;
3. Confirmation of results by a regional reference laboratory;
4. Timeliness of reporting results after receipt of stool samples (i.e. within 28 days of receiving the sample);
5. Rate of non-polio enterovirus identification;
6. Number of virologic tests performed annually.

Accredited laboratories must fulfill all six criteria. As the network of accredited laboratories grows, other disease areas will benefit from the capacity-building and professionalism of each individual laboratory. In the Region of the Americas, this network is already playing a central role in the Regional measles elimination initiative. ◆

Global Laboratory Network for Polio Eradication — 1998

Polio eradication in countries in conflict

Southern Somalia

Photo caption please.

Photo ©WHO/SEAR

IN August and September 1998 more than 1 million children in Southern and Central Somalia received two doses of OPV during a campaign that lasted over a period of five days. The teams administering the vaccine used a highly simplified "cold chain" (keeping the vaccine cold from production to delivery), using individual Vaccine Vial Monitors (VVMs). It was decided that this "fast cold chain" would be the cheapest and most flexible strategy for National Immunization Days. The vaccine was transported in carriers that can maintain the vaccine at a proper temperature for 48 hours; health workers were told that if they ran out of ice they should keep the vaccine as cool as possible and monitor the VVM.

While Somalia has a relatively well developed cold chain, the health workers did not need to use it extensively. The VVMs gave health workers the flexibility to reach people that had not been in touch with a health service for years. It was easier to reach people in even the most remote areas, as the health workers did not have to worry about ice supplies.

The VVM, when used properly, can become a tool to manage and plan NIDs cost-effectively, while still reaching more children. As one supervisor commented, "I arrived at an immunization site at the same time as the team. I saw them put the vaccine carrier in the shade, wet a piece of cloth, and cover the carrier with it. Upon my question as to what the purpose of this was, I was told that the team was instructed to handle the vaccine like a child with malaria. And that is what they did!" The VVM gives health workers the confidence they need and allows them to find specific solutions for problems they encounter. It is an option that can be used in many more countries, not only in those countries with cold chain or other logistic problems. ◆

AFP and polio reporting, 1997 and 1998, by WHO Region, as of December 1998

	1997			1998			
	Non-polio AFP rate	Confirmed polio cases	Wild poliovirus	Projected non-polio AFP rate	AFP cases with adequate specimens (%)	Confirmed polio cases	Wild poliovirus
African Region	0.16	1087	31	0.38	33%	13	21
Region of the Americas	1.01	0	0	0.67	78%	0	0
Eastern Mediterranean Region	0.97	1069	261	0.73	54%	131	134
European Region	1.12	7	6	1.02	74%	5	5
South East Asian Region	0.31	2988	435	0.45	51%	923	155
Western Pacific Region	1.35	9	9	1.12	86%	0	0
Global Total	0.72	5160	742	0.86	60%	1072	315

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