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Agenda item 14

POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

PROGRESS REPORT

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POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

PROGRESS REPORT

Agenda item 14

1. Introduction

In 1988, the Forty-first World Health Assembly adopted resolution WHA41.28 calling for the eradication of poliomyelitis by the year 2000, and in May 1993, the Forty-sixth World Health Assembly reaffirmed that this goal was achievable and confirmed WHO's commitment to the eradication of poliomyelitis as one of its highest priorities at the global level. In 1988, in pursuit of the World Health Assembly's resolution, the Regional Committee for the Eastern Mediterranean adopted a resolution for poliomyelitis eradication (resolution EM/RC35/R.14) and endorsed a regional plan for this purpose. In 1989, through resolution EM/RC36/R.6, Member States were urged to prepare national plans for poliomyelitis eradication to aim for high immunization coverage, to develop effective surveillance, outbreak investigation and control, and to establish diagnostic laboratory facilities. The same resolution urged that the necessary resources and budget should be mobilized.

This report gives an overview of the progress achieved in the Region in poliomyelitis eradication since 1989, and addresses various issues and problems facing this campaign.

2. Planning

Considerable progress has been achieved since 1989 in the development of national plans for poliomyelitis eradication. Sixteen Member States have developed national plans of action for poliomyelitis eradication with WHO assistance, through the provision of services of consultants and WHO staff Members. In the light of the global and regional experiences gained, six of these countries (Djibouti, Egypt, Jordan, Oman, Pakistan and Syrian Arab Republic) have updated their national plans to incorporate the latest WHO-recommended strategies and approaches as appropriate to their national situation.

Of the remaining six Member States and the Palestinian people under the administrative care of UNRWA that have *not* yet developed polio eradication plans, Cyprus, Kuwait, the Libyan Arab Jamahiriya, the United Arab Emirates and the Palestinian people have been "polio-free" for sometime, or have had a very low incidence of cases, and thus were under the impression that national poliomyelitis eradication plans were not necessary for them.

However, with the occurrence of an outbreak of poliomyelitis in Jordan in 1991-1992, which included three cases from among the Palestinian population, and the discovery of one case in Cyprus in 1991, after nearly two decades of a polio-free status, these countries are now convinced of the necessity to develop plans, based on surveillance of acute flaccid paralysis (AFP) and monitoring of the environment and high-risk population groups.

In Lebanon and Yemen, where the indigenous transmission of the wild poliovirus still exists, there is an urgent need to develop national eradication plans, to establish national strategies, and to set priority activities to reach the eradication goal. WHO/EMRO will assist these countries in 1993 to develop national plans.

At regional level, poliomyelitis eradication activities have been implemented under the auspices of the regional plan endorsed by the Regional Committee in 1988. A five-year plan for 1992-1996, with detailed financial requirements, was prepared and endorsed by the Ninth Inter-country Meeting for EPI National Managers and the Fifth EPI Regional Technical Advisory Group, which met in Teheran in May 1992.

3. Poliomyelitis incidence

The regional annual *reported* incidence of poliomyelitis cases since 1980 is shown in **Figure 1**, which reveals a significant decreasing trend from the above 12 000 cases reported in 1980 to less than 2000 cases in the 1990s. This is associated with the progressive increase in immunization coverage of infants with three doses of oral polio vaccine (OPV).

The number of *reported* poliomyelitis cases since 1988 are presented in **Table 1**. Data in the table indicate that since 1988, the number of reported cases has shown a slightly decreasing trend in spite of the significant improvement in surveillance resulting in the identification of more cases than previously. In addition, poliomyelitis outbreaks in Jordan and Pakistan also contributed to the rise in 1991. The reported cases for 1992 amounted to 1889, which was slightly less than in 1991. Considering the continued improvement in surveillance activities, this can be interpreted as a decline, although moderate.

About 90% of the cases reported were from two countries, Egypt and Pakistan. In both countries, the number of reported cases has levelled off during the last five years, despite the steady increase in both countries of immunization coverage of children in the first year of age with three doses of OPV, indicating that probably there had been significant under-reporting in the past. Fortunately, the number of cases of poliomyelitis in Egypt has shown a significant decrease since the beginning of 1993.

The number of countries reporting no cases in 1992 reached eight, reflecting significant progress towards polio eradication in the Region.

Figure 1. Number of Poliomyelitis cases occurring and percentage of OPV3 coverage in the EMR, 1980-1992

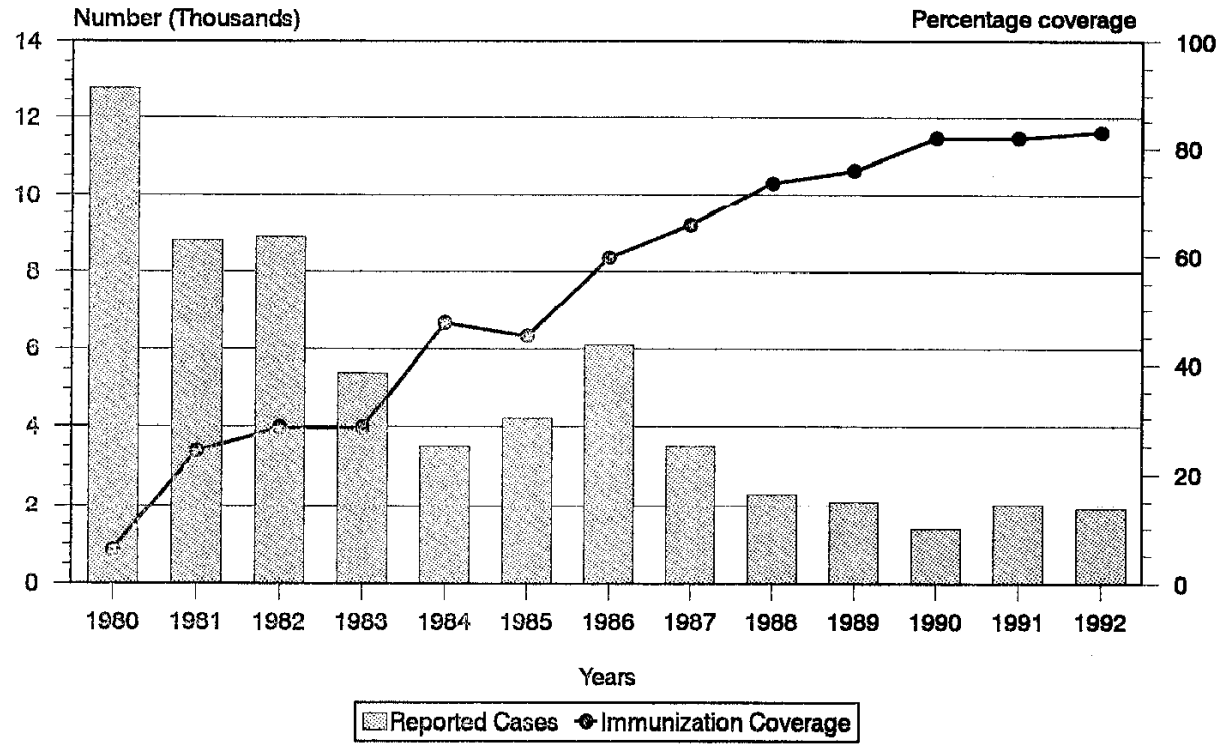


Table 1. Number of reported poliomyelitis cases in the EMR, 1988-1992

Member States	1988	1989	1990	1991	1992
Afghanistan	307	55	48	2	..
Bahrain	0	0	0	0	0
Cyprus	0	0	0	1	0
Djibouti	3	10	7	0	3
Egypt	550	474	565	625	575
Iran, Islamic Republic of	36	13	15	55	44
Iraq	69	10	..	92	120
Jordan	2	0	0	14	15
Kuwait	0	0	0	0	0
Lebanon	0	..	..	5	0
Libyan Arab Jamahiriya	10	4	5	6	0
Morocco	0	2	0	0	0
Oman	118	5	0	4	0
Pakistan	935	811	777	1147	1046
Qatar	0	0	1	0	0
Saudi Arabia	3	3	5	1	2
Somalia	54	0	..	..	..
Sudan	93	51	4	27	10[a/]
Syrian Arab Republic	37	13	12	24	22
Tunisia	2	0	0	3	4
United Arab Emirates	9	0	0	0	2
Yemen	99	674	..	27	45
UNRWA	0	0	0	2	1
Total	2327	2125	1439	2035	1889

.. = Data not available.

[a/] January to June 1992 only.

4. Immunization coverage

The development of immunization services throughout most of the Region, through existing health systems, was one of the greatest public health successes of the 1980s.

The estimated regional immunization coverage of children in the first year of age with three doses of OPV showed a slight change in 1991 and 1992, compared with 1990. During this period, the Programme was affected by the Gulf crisis, the continued prevailing situation in Afghanistan, Lebanon, Somalia, southern Sudan and Yemen, and heavy floods in Pakistan in 1992. These conditions affected the immunization coverage achieved.

The *reported* immunization coverage with three doses of OPV in the Member States in 1992 is shown in **Figure 2.** The data in this figure demonstrate that despite a stationary trend in the regional average of immunization coverage in 1991-1992, the majority of Member States achieved at least an 80% coverage rate. Immunization coverage in Somalia, Afghanistan and southern Sudan was believed to be below 50%, and needless to say, special efforts will be needed to improve the coverage levels in these countries.

5. Poliomyelitis laboratory network

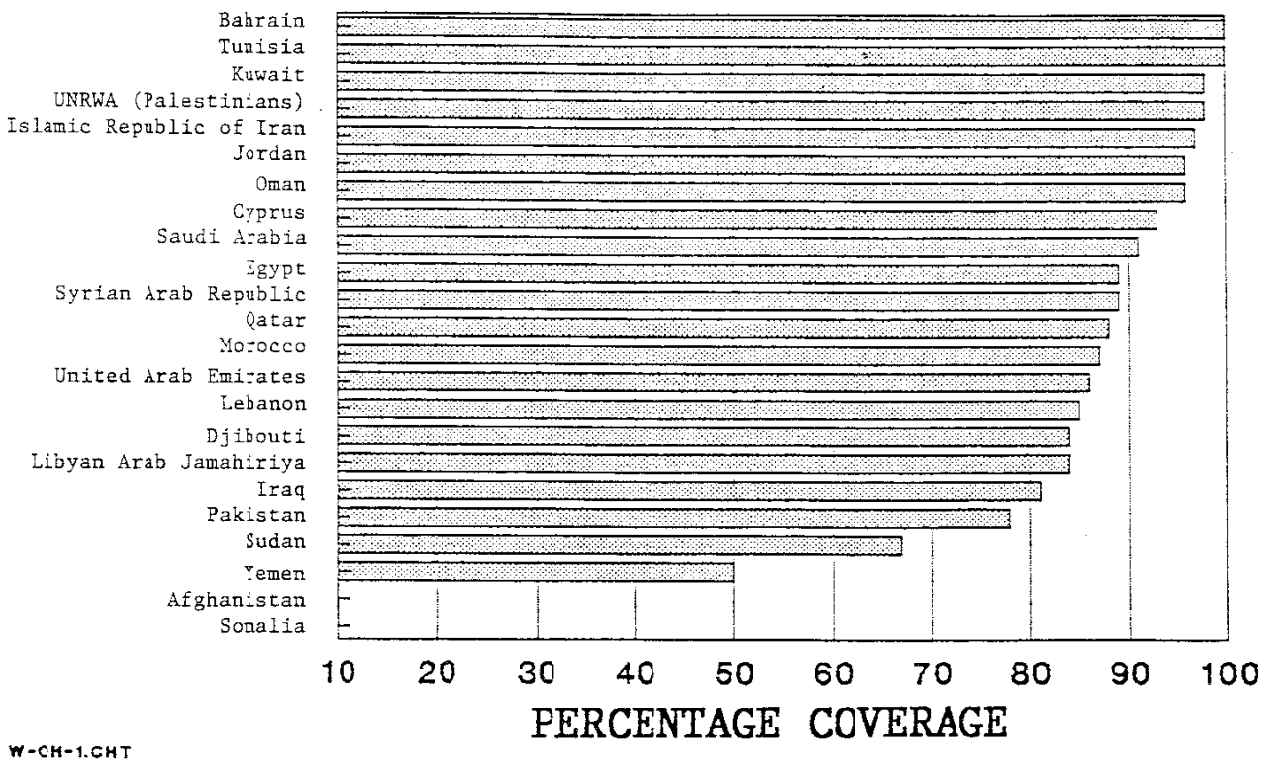
Laboratory services play an essential role in poliomyelitis eradication activities. They are becoming increasingly more important as the polio eradication initiative progresses towards its target. Laboratory services are essential for: (a) confirmation of the diagnosis by isolating polio viruses from faecal specimens, and (b) ensuring that vaccines used are potent and meet WHO standards.

The regional plan of action for developing laboratory services needed for poliomyelitis eradication includes several phases, which are being implemented. Within the first phase of the plan, four regional reference laboratories were designated (in Egypt, Kuwait, Pakistan and Tunisia) and six national reference laboratories were identified (in the Islamic Republic of Iran, Iraq, Jordan, Morocco, Saudi Arabia and Sudan). Recently, the Central Public Health Laboratory, Ministry of Health, Egypt, has been included in the network as a national reference laboratory. There is potential for further expansion of the network by certifying the laboratories in Oman and the Syrian Arab Republic.

WHO continues to actively collaborate to help strengthen this network of regional and national reference laboratories through the provision of consultants and WHO staff services, standard reagents, disposables and some basic equipment and training. Two intercountry courses, one on basic laboratory techniques and poliomyelitis vaccine potency testing (4-13 June 1991), and the other on poliomyelitis virus isolation and typing (11-20 January 1993), were held at the WHO Collaborating Centre at the Egyptian Organization for Biological Products and Vaccine (VACSERA), in Cairo. Staff from the regional laboratory network participated in these courses.

Figure 2.

Reported Immunization Coverage with DPT3/OPV3, in the EMR, 1992



The regional reference laboratory in VACSERA, Egypt, meets national needs and is extending diagnostic services to other countries, as required. The regional reference laboratories in Pakistan and Tunisia are serving national needs for the time being. Efforts are under way to designate another reference laboratory in one of the Arab Gulf countries.

Limited available data indicate that the majority of poliomyelitis cases (65%) is caused by poliovirus type 1. There is also evidence that all three poliovirus types are present and circulating in the Region.

One of the important needs implicit in poliomyelitis eradication is the development of a system through which collected stool specimens from suspected cases can be stored and transported to the laboratory under refrigerated conditions. This is often referred to as "reverse cold chain". To assist Member states in developing reverse cold chains, more than 500 reusable and disposable specimen carriers have been distributed to Member States in the Region.

However, to achieve a functioning regional laboratory network capable of fulfilling national and regional requirements, significant funds are still needed.

6. Strategies for poliomyelitis eradication

The main poliomyelitis eradication strategies include achieving more than 90% immunization coverage in all districts; supplementary immunization activities designed to interrupt circulation of the wild polio virus; and strengthening the surveillance system, including laboratory support services. These strategies have been actively promoted by the WHO Regional Office and are at different stages of implementation in most Member States.

6.1 Achieving high immunization coverage

Achieving high immunization coverage through the routine immunization system remains the first priority and is the national policy in all Member States. It is also realized that achieving and sustaining more than 90% coverage is a difficult task and will need strengthening of the Expanded Programme on Immunization (EPI) infrastructure in general. Therefore, priority is being given by national authorities and by WHO to staff training, including improved supervision. Efforts are also being made to use every contact between infants and health services to complete immunization.

Experience has shown that the high national averages of immunization coverage do not guarantee that coverage is high in *all* areas and among *all* population groups. National coverage is increasingly being monitored at district and even peripheral levels. Such an approach has shown that there are certain population groups and even whole districts where immunization coverage is much lower than the national average. This has been seen in countries with very high national immunization coverage rates (e.g., in Egypt and Jordan). When investigating an outbreak of poliomyelitis in Jordan in 1991-1992, it was found that the immunization coverage among children of certain minority populations (e.g., Pakistanis, Gypsies and Bedouins) was much lower than the national average. Indeed, in

almost all the countries, there are population groups with coverage levels significantly lower than the national average.

6.2 Supplementary immunization activities

To overcome the problem of low immunization coverage achieved through routine immunization, the policy of additional mass administration of two doses of OPV, through national or local vaccination days, has been adopted in many countries of the Region. During the last few years, this strategy has been implemented successfully in many countries, including Egypt, and as a coordinated activity in Maghrebian countries.

"Mopping-up" immunization is being used by an increasing number of countries as a strategy to interrupt the wild poliovirus circulation. This strategy is being used on a large scale in Egypt and Oman, where two doses of OPV are administered through house-to-house visits to children under five years of age, during the low-transmission season in the areas of high risk for wild poliovirus transmission.

Also, an aggressive response to poliomyelitis outbreaks is becoming the routine strategy in many countries in the Region. The number of doses of OPV administered as an outbreak response depends on the national policy. In Jordan, for example, as an outbreak response, a national immunization campaign was conducted where 90% of 600 000 children under five years of age were given two doses of OPV, one month apart. In Egypt, for each case of poliomyelitis, an average of 2000 children under five years of age are given two doses of OPV regardless of their previous immunization status.

It is increasingly being realized by countries in the Region that the poliomyelitis eradication initiative requires additional doses of OPV to achieve *and* sustain routine immunization coverage of 90% and to implement supplementary immunization strategies (i.e., national, sub-national vaccination days, "mopping-up" operations and aggressive outbreak response). It is estimated that the proper implementation of the supplementary immunization activities alone may at least double the national requirement of OPV. Therefore, vaccine supply if not properly planned, based on national resources and donor support, may become a serious obstacle to the poliomyelitis eradication initiative. In 1992, for example, Pakistan faced a significant shortfall in OPV needed for its national two-dose urban immunization campaign, and the planned activity had to be called off at the last moment in view of the vaccine shortage.

The regional self-reliance in EPI vaccines and in their quality control is an important issue and was addressed at the Regional Consultative Meeting on Vaccine Production and Quality Assurance, held in Alexandria, September 1992. All the major vaccine producers in the EMR (Egypt, Islamic Republic of Iran, Jordan, Pakistan, Tunisia) actively participated in the meeting.

As a follow-up of this consultation, EMRO has arranged, in collaboration with the **Children's Vaccine Initiative** (CVI), visits of teams of experts to the main national vaccine production companies in the Region to assess their production capacities in the light of national

vaccine demands. These teams also assess the extent of application of good manufacturing practices and the quality control procedures to assure vaccine potency. Plans of action and recommendations on the necessary steps to boost production and quality control, including funding are also considered by these missions. Two visits have already been completed, one to the Egyptian producer of biological products and vaccines (VACSERA) in December 1992, and the other to the National Institute of health, Pakistan, in April 1993. It is planned to visit the Razi and Pasteur Institutes in the Islamic Republic of Iran later in 1993, so that the three main producers of vaccines in the Region will be covered. Visits to other vaccine producers in the Region are also planned for the future.

EMRO is making efforts to ensure the implementation of the recommendations of these missions and is closely working with national authorities, the United Nations Children's Fund (UNICEF) and other international agencies in securing the needed support.

Regional polio eradication achievements related to the steady increase in immunization coverage, have been achieved through the exclusive use OPV, which as recommended by the WHO Technical Consultative Group Meeting, held in Geneva, 1992, remains the vaccine of choice for poliomyelitis eradication. The Ninth Intercountry Meeting for EPI Managers and Fifth EPI Regional Technical Advisory Group Meeting (Teheran, May 1992) reaffirmed the use of OPV in a formulation of 10:1:6 instead of the previous formulation 10:1:3, as the vaccine of choice. Both meetings also endorsed the WHO-recommended four dose initial immunization schedule to be accomplished in the first year of life. EMRO actively encourages the implementation of the four dose schedule and the use of the new formulation of OPV by all Member states. The idea of a combined schedule of IPV/OPV (inactivated poliovirus vaccine/live oral poliovirus vaccine) has been the subject of discussion in Egypt, which it has been implementing for the last two years. A trial to study the effectiveness of such a combination is under way in Oman, and results are expected in the near future.

It is essential, in this regard, to ensure the quality of the vaccine used, as well as to achieve optimum storage and transport through a reliable cold chain, from the drug manufacturer to the most peripheral vaccination site. It is satisfying to note that the basic cold chain, as an essential part of EPI, has been established in all Member States and, in general, is functioning effectively.

6.3 Strengthening the surveillance system

From the beginning of the 1990s, the regional EPI has increasingly focussed on developing an effective and efficient surveillance system, able to monitor and evaluate disease eradication-elimination-control targets in the Region. The poliomyelitis surveillance system has always been considered as an integral part of the EPI surveillance system.

The main directives and policy elements of the regional surveillance system can be summarized as follows.

(a) *Further strengthening national routine reporting systems, which remain the main source of data.* It is realized, by all

concerned, that this source is inadequate, and so efforts to strengthen this routine system are being carried out through:

- decentralization of data-handling and monitoring, this means expansion of surveillance activities to cover all geographical areas and population groups;

- special emphasis on high-risk areas and population groups;

- instituting monthly, including zero, reporting;

- monitoring surveillance performance, especially with regard to completeness and timeliness. This is done through the use of appropriate quantified performance indicators, which have been introduced in many countries and are being adopted increasingly by national authorities;

- ensuring that surveillance data lead to timely and aggressive action; and

- ensuring feedback to the originators of the data through modalities such as monthly bulletins and other systems to exchange information.

(b) *Broadening the sources of data through active involvement of the private sector*, since in many countries, this sector plays an important role in the delivery of health care. In this regard, and to identify all cases of acute flaccid paralysis (AFP) as rapidly as possible, efforts are being made to include private health providers in national poliomyelitis surveillance systems. One of the Member States actively pursuing this aspect is Egypt. Increasing involvement of the private sector in the poliomyelitis surveillance system is documented by the fact than in two years, the percentage of cases of AFP reported through the private sector increased from 2% in 1990 to 20.4% in 1992. The experience of the national programme in Egypt, in this regard, is worth being studied by other national programmes.

(c) *Monitoring the occurrence of AFP by early detection, immediate notification and prompt expert investigation*. This system has been established in Bahrain, Djibouti, Egypt, Jordan, Morocco, Oman, Syrian Arab Republic and UNRWA, and is being accepted and introduced in an increasing number of other countries. Control measures are being implemented in response to AFP cases without waiting for laboratory confirmation. The introduction of this system prompted the discovery of cases in some countries that had long thought themselves to be polio-free.

(d) *Exchange of information*. Reporting from some countries in the Region to WHO has been very deficient. Monthly reporting is not being received regularly, except from a few countries, and even annual reporting is being delayed for several months.

Since March 1992, the Regional Office, in collaboration with UNICEF's Middle East and North Africa Regional Office (MENARO), has issued a monthly bulletin called *Polio Fax*, which is being sent to all Ministries of Health on the first day of each month (see section 9). In addition to a brief technical write up, it contains a table with the number of cases of poliomyelitis by country. It shows Member States who are late in reporting to WHO, and the period of this late reporting. Since the start of this bulletin, there has been considerable improvement in reporting, and it is hoped that the timeliness of reporting will improve as well. Reporting of AFP cases has been included also, and hopefully this will soon be reported regularly in the *Polio Fax*.

(e) *Training*. One of the important elements in the success of surveillance has been trained human resources. To this effect, since 1991, several subregional and national workshops have been held. National key surveillance staff from 19 Member States have been trained through participation in the following workshops:

- First Subregional Workshop for Maghrebian Countries (Morocco, Tunisia) (Casablanca, 29 July - 1 August 1991). Algeria and Mauritania (AFRO) participated also;

- Second Subregional Workshop for Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya, Sudan, Syrian Arab Republic, Yemen and UNRWA (Amman, Jordan, 4-7 November 1991). Turkey (EURO) participated also;

- Third Subregional Workshop for Gulf Countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates) (Manama, Bahrain, 2-4 December 1991). Cyprus (EMRO) participated also;

- National workshop - Egypt (Cairo, 8-13 June 1991);

- Two national workshops - Pakistan (one held in Lahore, 7-10 October 1991 and the other in Swat, 18-22 April 1992);

- National workshop - Islamic Republic of Iran (Teheran, 30-31 May 1992);

- National workshop - Qatar (2-4 November 1992);

- National workshop - Damascus, Syrian Arab Republic (15-18 November 1992); and

- National workshop - Khartoum, Sudan (25-29 April 1993).

It is hoped that the EPI surveillance system, when effectively developed and functional, will play a catalytic role in epidemiological surveillance of communicable diseases in general in the Region.

6.4 Rehabilitation of cases

The poliomyelitis eradication initiative provides an excellent opportunity to strengthen national rehabilitation services for children and adults stricken with poliomyelitis and for persons disabled by other diseases.

Poliomyelitis rehabilitation services are not yet at the required level of development in many countries of the Region. WHO is promoting community-based rehabilitation for poliomyelitis victims, which will create better awareness of the potential benefits and needs of polio eradication and will mobilize resources in support of programme activities.

At national level, EMRO is promoting community-based rehabilitation, using the *WHO Guidelines for the prevention of deformities in polio*, which has been translated into Arabic. The main objective of community based rehabilitation is to provide physical, social, psychological and occupational rehabilitation for the disabled to allow them to lead well-integrated, happy and productive lives. To implement community-based rehabilitation during 1993-1994, key personnel will be trained in the national workshops. It is expected that eventually each district will have one to two individuals trained in this activity who will monitor services at community level.

7. Development of polio-free zones

Under the revised (1992) global and regional plans of action for poliomyelitis eradication, high priority has been given to creating and expanding polio-free zones within the Region. This strategy was discussed at the Ninth Intercountry Meeting for EPI Managers and the Fifth EPI Regional Technical Advisory Group Meeting, which were held in Teheran in May 1992, and both meetings strongly supported this principle and recommended the development of two such zones in the Region, one for Gulf countries and other for Maghrebian countries. In view of the closeness of Algeria and Mauritania with Morocco, Tunisia and the Libyan Arab Jamahiriya, the Maghrebian initiative was done in collaboration with the Regional Office for Africa (AFRO).

As a first step, evaluation of the national surveillance systems for EPI diseases, with emphasis on poliomyelitis eradication, was conducted in early 1993 in all countries in these zones (i.e., Bahrain, Kuwait, Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Saudi Arabia, Tunisia, and the United Arab Emirates) as a joint activity between national authorities and WHO. These national programme evaluations were followed by two coordination meetings, one for Gulf countries (Muscat, 13-15 April 1993) and the other for Maghrebian countries (Tunis, 25-27 April 1993). As an outcome of in-depth discussions on a wide range of activities and strategies of subregional interest, the participants at these meetings concluded that poliomyelitis eradication is achievable by the mid-1990s. Several valuable recommendations were made to achieve close cooperation and coordination of activities of each group of countries in their efforts to achieve and sustain a polio-free zone status by 1995 in Gulf countries, and by 1996 in Maghrebian countries.

The two meetings stressed the necessity to strengthen national systems for acute flaccid paralysis surveillance and establish a system of immediate and regular exchange of surveillance data among countries and also with WHO. In this regard, concomitant development of diagnostic laboratory services, at national and regional levels, was considered a priority.

The meetings also emphasized the need to ensure the quality of vaccines used in the national immunization programmes, and called for the development of vaccine quality control facilities in the Region.

8. Research and development

Research and development has a key role to play if poliomyelitis eradication is to succeed reliably and within the target year. In operational research, WHO coordinated a number of research projects in the area of integration of services, community involvement, epidemiological studies on disease trends, seroconversion levels, missed opportunities for immunization, and others. A large WHO-sponsored randomized clinical trial was conducted in Oman, the Gambia and Thailand. Children in this trial received either OPV alone or IPV alone, or OPV and IPV administered simultaneously, at 6, 10, and 14 weeks of age. Children in the OPV only group and the OPV/IPV group also received, at birth, a dose of OPV. Serum specimens are being tested in triplicate for antibodies for all three types of polio virus. Faecal excretion of the vaccine virus will also be documented in all three groups, following monovalent type 1 OPV at six months of age as an indirect measure of intestinal immunity. Results of this trial are expected by the end of 1993.

WHO is also actively pursuing the development of reliable national reverse cold-chains for appropriate handling of stool specimens. During 1992-1993, WHO staff visited Egypt and Pakistan and introduced national field studies. Study results will be shared with other countries. WHO is testing a new fluorescent antibody method for detecting polio viruses in stool isolates in Pakistan.

9. Exchange of information among Member States

One of the most important managerial tools for surveillance is the exchange of information among all levels.

As mentioned earlier, to facilitate the exchange of information among Member States of the Region on the poliomyelitis eradication initiative, EMRO, in collaboration with UNICEF/MENARO, has been issuing a two-page monthly bulletin on poliomyelitis surveillance reporting, called *Polio Fax*, which is designed for direct distribution by facsimile to promote rapid and effective information distribution.

The bulletin has been well received by the Ministries of Health and other interested parties, and it is hoped it will play a positive role not only in promoting the exchange of information among countries, but in timely reporting to WHO/EMRO.

10. Main areas of concern in poliomyelitis eradication

1. In some countries, poliomyelitis eradication activities are not given sufficiently high priority. It is necessary to translate the accepted goal of poliomyelitis eradication by national authorities into action plans, and to secure the necessary human resources and financial commitments for implementation.

2. There is an increased demand for the oral polio vaccine (OPV), as a result of increased immunization coverage and adoption of supplementary immunization strategies. Some countries are already facing an acute vaccine shortage even for routine immunization. It is anticipated that this problem will increase with the increasing need for vaccines and the withdrawal of some of the usual donors of vaccines from continued support to developing countries.

3. WHO regular budget allocations available are very modest for collaborative activities in the poliomyelitis eradication initiative, at a time when significant funds are needed for the development of the regional polio laboratory network, strengthening national surveillance systems, appropriate staff training and other priority activities.

4. The epidemiological surveillance system in many countries, is relatively weak, which does not permit early identification and timely investigation and effective containment of suspected cases, including cases of acute flaccid paralysis.

5. The regional polio laboratory network has not been developed to the stage needed to fulfil national and regional requirements in the laboratory support services.

6. Exchange of information among countries and with WHO is still far from being adequate for coordination of activities related to poliomyelitis eradication.

11. Recommendations

1. Member States should reaffirm their commitment to the national eradication of poliomyelitis and make available the staff and resources necessary to implement their national plans.

2. All efforts should be made, through national resources and donor support, to obtain sufficient quantities of OPV, meeting WHO quality standards for both routine and supplementary immunization. In case of a vaccine shortage, the priority should be on guaranteeing vaccine for routine immunization.

3. The national programmes, through monitoring immunization coverage by district, should identify high-risk areas or population groups not reached by immunization services. Accelerated immunization activities such as increasing out-reach services, national/local vaccination days, etc., should be targeted to strengthen the infrastructure for routine service delivery and to bring coverage levels in these areas up to, or above, the national average.

4. Countries should give high priority to surveillance of EPI disease, especially those targeted for eradication and elimination. Poliomyelitis surveillance should be based on surveillance of cases of acute flaccid paralysis (AFP).

5. Where the surveillance system shows that none of the cases of AFP are poliomyelitis, and in preparation for eradication certification, countries should implement a system of surveillance sensitive enough to detect whether the wild poliovirus is circulating in the environment or not.

6. Recognizing the basic role of laboratory services in surveillance and case investigation, necessary resources to support developing and strengthening of national laboratories for the diagnosis of poliomyelitis should be included in the plans and budgets of national immunization programmes.

7. Member States should strengthen rehabilitation services for children disabled by poliomyelitis and other paralytic illnesses through existing national rehabilitation services, and introduce community-based rehabilitation.

8. All national programmes should develop and strengthen mechanisms for the timely (i.e., monthly) exchange of information within their countries, between various levels, on the incidence of cases of poliomyelitis and activities carried out for control purposes. This monthly information should also be sent to WHO/EMRO.

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

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October 1993

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Agenda item 14

POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

Summary of Recommendations

It is recommended that Member States:

1. reaffirm their commitment to the eradication of poliomyelitis and make available the staff and resources necessary to implement their national plans;

2. ensure the availability of sufficient quantities of OPV that meets WHO's quality standards for both routine and supplementary immunization;

3. through monitoring of immunization coverage by district, identify high-risk areas or population groups not reached by immunization services and introduce accelerated immunization activities, such as increasing outreach services, national/local vaccination days, to strengthen the infrastructure for routine services delivery and to bring coverage levels in these areas up to, or above, the national average;

4. give high priority to the surveillance of EPI diseases, especially those targeted for eradication and elimination;

5. ensure necessary resources for developing and strengthening of national laboratories for the diagnosis of poliomyelitis;

6. Strengthen existing national rehabilitation services for children disabled by poliomyelitis and other paralytic illnesses, and introduce community-based rehabilitation; and

7. develop and strengthen timely exchanges of information between various levels on the occurrence of cases of poliomyelitis and control activities, and report these to the Regional Office on a monthly basis.

It is also recommended that WHO:

1. continue its support to countries in obtaining sufficient quantities of OPV that meets WHO's quality standards for both routine and supplementary immunization, including local bulk production or bottling of vaccine, as appropriate;

2. cooperate with Member States in determining their other needs with regard to implementing nationally planned activities to achieve poliomyelitis eradication, including those related to laboratory services and surveillance;

3. coordinate with other organizations of the United Nations system, intergovernmental agencies and governmental and nongovernmental organizations to mobilize sufficient funds for vaccine supply and to meet other requirements for the eradication of poliomyelitis;

4. continue to monitor progress through monthly reports of detected cases of acute flaccid paralysis, confirmed cases of poliomyelitis and indicators of the effectiveness of surveillance; and

5. keep the Regional Committee informed regularly of progress towards the eradication of poliomyelitis from the Region.

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POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

Summary for the Report

Since 1988 the regional poliomyelitis eradication initiative has made encouraging progress towards achieving the goal of eradication by the year 2000.

Most notably, the high immunization coverage achieved has resulted in a significant drop in the number of cases of poliomyelitis reported by Member States. Increasing number of countries are reporting zero or very low incidence of the disease.

A regional polio diagnostic laboratory network has been established and efforts are being made to strengthen it in order to enable it to meet fully the regional requirements of laboratory support services.

Since the early 1990s, Member States have been focusing their efforts on implementing the main strategies aimed at eradication of wild poliovirus transmission, namely supplementary immunization activities, monitoring of acute flaccid paralysis cases and aggressive case/outbreak investigation and response. One of the innovative strategies introduced recently in the Region is the subregional (zonal) approach to the eradication initiative. Two such zones have been established--one for Arab countries of the Gulf region, and another for the Union of Maghreb Countries. It is expected that the eventual eradication of poliomyelitis from the Region by the year 2000 will be accomplished through the expansion of these zones.

However, the progress towards the eradication of poliomyelitis from the Region is threatened by shortages of resources to procure vaccines, support laboratories, train national staff and provide technical assistance where needed.

DRAFT RESOLUTION

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

EM/RC40/R.
October 1993

Fortieth Session

ORIGINAL: ARABIC

Agenda item 14

POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

The Regional Committee,

Having reviewed the Regional Director's progress report* on "Poliomyelitis Eradication in the Eastern Mediterranean Region";

Appreciating the progress being made towards the goal of poliomyelitis eradication in the Region;

Noting with satisfaction that all Member States have set national targets for the eradication of poliomyelitis by the year 2000;

Recognizing with concern, however, that some countries have not maintained the immunization coverage of poliomyelitis achieved during 1991-1992;

Being fully aware that the goal of the eradication of poliomyelitis from the Region will not be achieved unless there is a continuing acceleration of national immunization programmes;

1. **COMMENDS** the Regional Director for the efforts made to achieve the regional goal of poliomyelitis eradication;

2. **ACKNOWLEDGES** the Regional Director's initiative towards achieving regional self-sufficiency in production and quality control of vaccine;

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* Document EM/RC40/12.

3. **URGES** Member States:

3.1 to reaffirm their commitment to eradicating poliomyelitis and to make available the staff and resources necessary to implement their national plans;

3.2 to ensure the availability of sufficient quantities of OPV that meets WHO's quality standard for both routine and supplementary immunization;

3.3 to give high priority to the surveillance of EPI diseases, especially those targeted for eradication and elimination;

3.4 to ensure the availability of the necessary resources for developing and strengthening national laboratories for the diagnosis of poliomyelitis.

4. **REQUESTS** the Regional Director:

4.1 to continue his efforts to achieve regional self-sufficiency in vaccine production and quality control, and to support countries in obtaining sufficient quantities of OPV;

4.2 to coordinate with other organizations of the United Nations system, intergovernmental agencies and governmental and non-governmental organizations to mobilize sufficient funds for vaccine supply and to meet other requirements for the eradication of poliomyelitis;

4.3 to continue to monitor progress by suitable means, including monthly by Poliofax;

4.4 to continue to keep the Regional Committee informed about progress towards eradication of poliomyelitis from the Region.

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

EM/RC40/12
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POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

Introductory Paragraph

The regional poliomyelitis eradication initiative is based on the resolutions of the Forty-first World Health Assembly (1988) and of the Regional Committee for the Eastern Mediterranean, EM/RC35/R.14 (1988) and EM/RC36/R.6 (1989).

In May 1993, the Forty-sixth World Health Assembly, through its resolution WHA46.33, reaffirmed its commitment to the eradication of poliomyelitis by the year 2000 and called attention to the urgent need for all countries to continue to accelerate national immunization programmes and to participate actively in the eradication efforts.

To achieve this goal, additional resources and coordinated efforts will be required, particularly for achieving and sustaining high immunization coverage and developing a strong and action-oriented disease surveillance system in all Member States of the Region.

The subject of poliomyelitis eradication has been included in the agenda in response to the resolution of the Regional Committee at its Thirty-sixth Session (EM/RC36/R.6) that it should be kept informed of the status of this initiative.