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Progress Report

# POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

**CONTENTS**


| | | page |
|---|---|---|
| 1. | INTRODUCTION | 1 |
| 2. | PROGRESS TOWARDS POLIO ERADICATION AND RESPONSE TO THE REGIONAL COMMITTEE RESOLUTIONS | 2 |
| | 2.1 Reaffirming national commitments to polio eradication | 2 |
| | 2.2 Ensuring the availability of OPV that meets WHO quality standards | 5 |
| | 2.3 Strengthening surveillance of acute flaccid paralysis (AFP) and other immunizable diseases | 5 |
| | 2.4 Promotion of effective participation of the different medical sectors and the community in all activities of the programme | 8 |
| | 2.5 Strengthening laboratory support for the diagnosis of poliomyelitis | 8 |
| 3. | OTHER REGIONAL INITIATIVES IN POLIO ERADICATION | 9 |
| | 3.1 Polio-free zones | 9 |
| | 3.2 Exchange of information | 9 |
| | 3.3 Certification of polio eradication | 10 |
| 4. | CONSTRAINTS | 11 |
| 5. | CONCLUSIONS AND RECOMMENDATIONS | 11 |

## 1. INTRODUCTION

The initiative to eradicate poliomyelitis from the world by the year 2000 was launched as a response to the WHA resolution in May 1988. The Regional Committee for the Eastern Mediterranean responded immediately and adopted the target during its meeting in October 1988 (EM/RC35/R.14). In the following year the regional plan of action for polio eradication was discussed and adopted by the Regional Committee (EM/RC36/R.6). Four years later, in 1993, at its Fortieth Session, the Regional Committee reviewed the progress achieved in the march towards polio eradication and adopted resolution EM/RC40/R.8. The resolution urged Member States to:

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

2) ensure the availability of sufficient quantities of oral polio vaccine (OPV) that meets WHO quality standards for both routine and supplementary immunization;

3) give high priority to surveillance of acute flaccid paralysis (AFP) as well as to other immunizable diseases;

4) promote effective participation of the different medical sectors and the community in all the activities of the programme; and

5) ensure the availability of the necessary resources for strengthening national laboratories for the diagnosis of poliomyelitis.

The resolution also requested the Regional Director to:

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

2) coordinate with other United Nations Organizations, inter-governmental agencies and governmental and nongovernmental organizations to mobilize sufficient funds to meet all requirements for the eradication of poliomyelitis, in particular for vaccine supply;

3) to continue to monitor progress by various means; and

4) to keep the Regional Committee regularly informed about the progress being made towards eradication of poliomyelitis from the Region.

The purpose of this report is to provide an update on the status and progress of the polio eradication initiative in the EMR, particularly in relation to last year's resolution (EM/RC40/R.8). This report also summarizes the remaining constraints facing the goal of polio eradication by the year 2000 in the region and the necessary actions to be taken to overcome them.

## 2. PROGRESS TOWARDS POLIO ERADICATION AND RESPONSE TO THE REGIONAL COMMITTEE RESOLUTIONS

### 2.1 Reaffirming national commitments to polio eradication

At the time of the Regional Committee of 1993 there was evidence that the regional average immunization coverage of infants by 3 doses of OPV in 1993 would be lower than in 1992 because of the significant decline in immunization coverage in Djibouti, Pakistan, Sudan and Yemen. These declines were generally attributed to managerial problems, decreasing support for immunization both by the donors and countries, civil unrest and inadequate political commitment. In addition, in two countries which have suffered complete disruption of health care services for several years (Afghanistan and Somalia), the immunization coverage is far below 50% despite efforts being made in initiating immunization activities in accessible population groups. Thus, while the immunization goals for the 1990s are to achieve and sustain 90%+ coverage in all sectors of the community, coverage among half of the Regional infant population was still below 80% for the reasons mentioned above.

EMRO has continued its efforts to support national authorities in overcoming this problem and reversing the pattern. The Regional Committee resolution of 1993 has been timely and has pushed and enforced various efforts. It is encouraging to note that an increasing number of countries are implementing National Immunization Days (NIDs) during which 2 doses of OPV are given to all children under 5 year of age. They are also implementing other supplementary immunization activities such as mopping-up and outbreak response, raising the hope that children will be protected against the wild polio viruses which are still widespread throughout the Region and in neighbouring countries in other WHO Regions. Since the last Regional Committee meeting 12 countries either have already conducted the national two-dose OPV campaigns (Egypt, Islamic Republic of Iran, Pakistan, Sudan, Syrian Arab Republic) or are planning to do so (Gulf countries and Yemen). For comparative purposes, it is to be noted that only two countries (Egypt and Syrian Arab Republic) conducted NIDs in 1992.

The successful experiences of some Member States in conducting the NIDs are presented below:

**Egypt**

National Immunization Days were first conducted in 1990 and 1991. During these campaigns a single dose of OPV was administered to all

children under 5 years of age. In 1993 and 1994, 2 doses of OPV were administered to all children under 5 years of age. About 8 million children received 2 doses of OPV during each campaign. In addition, national authorities are also implementing other supplementary immunization strategies recommended by WHO (mopping-up and case-response immunization). These have resulted in a dramatic decrease in the number of reported polio cases from around 500 cases annually during the last 5 years to 150 cases in 1993.

Islamic Republic of Iran

Despite a very high (over 95%) national immunization coverage of infants with 3 doses of OPV through routine immunization services, cases of poliomyelitis continued to be reported in Iran. During 1993, with improved surveillance and introduction of surveillance of AFP, the number of cases of confirmed poliomyelitis was 103. This picture prompted the committed national authorities to consider supplementary immunization efforts.

In April and May 1994, NIDs targeted children under the age of 5 years through house-to-house visits during one day. A total of 9 021 917 children under 5 received 2 doses of OPV. Immunization coverage was estimated to be close to 100%.

This activity was well planned, implemented and monitored and its success was due to considerable political commitment and support. A written directive was issued by the country's spiritual leader and the President, emphasizing the importance of the NIDs. One week prior to and during the NIDs, prominent national figures, including the Minister of Health, the Under-Secretary of Health, and many religious leaders, provided regular daily messages on TV and radio and in newspapers emphasizing the importance of NIDs.

Syrian Arab Republic

NIDs were first conducted in 1993. Two doses of OPV were administered to all children under 5 years of age during February and March. This activity was repeated during March and April of 1994. The NIDs were widely promoted in the mass media, especially on television. NIDs were conducted over a period of one week for each round. The number of fixed and mobile teams employed during the NIDs increased considerably to meet the additional vaccination demands. In the second round, an estimated coverage level of above 95% was achieved. There is strong evidence that the persistent circulation of the wild polio virus was interrupted by conducting these NIDs in addition to the routine immunization programme. This is reflected in no cases reported during 1993 and this situation has continued throughout the early months of 1994.

Pakistan

After an evident increase in the number of cases of poliomyelitis during 1991 and 1992 which accompanied the over all decrease in

coverage of children with EPI vaccines in Pakistan, national authorities in collaboration with WHO planned to implement urban NIDs in October 1992. After the plans were finalized and all the preparatory work of community sensitization was completed and only one week before the date of implementation, the national authorities called the campaign off because of fear that this would exhaust most of their vaccine reserve used in routine immunization. The repercussions were significant and were most evident in a continued increase in the number of cases of polio until they reached over 1800 cases recorded by the health authorities in 1993. The Regional Committee resolution of 1993 stimulated the authorities to reconsider the situation and revitalize the plan of NIDs. The updated plan called for 2 doses of OPV, one in April and the other in May 1994. This plan was again almost called off except for considerable pressure from WHO to secure the needed doses of OPV from Canada (27 million doses of OPV donated), supplemented by inputs from EMRO, the Asian Development Bank and the United Arab Emirates. The NIDs were a success in achieving almost 95% coverage of all children under 5 years of age with 2 doses of OPV. It is sincerely hoped that this will have an impact on decreasing the cases of polio. There is a national plan to repeat these days for three consecutive years 1995-1997 with the required doses of OPV procured largely from national funds.

**Sudan**

The epidemic spread of poliomyelitis during 1993 and the Regional Committee resolution of 1993 triggered the development of a national plan for immunization days to cover children under 5 years of age. WHO support was instrumental in convincing the usual donor of OPV vaccine to EPI/Sudan to increase its input to cover the needs for the NIDs. The plan was successful in reaching children in accessible areas. In addition, it is hoped that the initiative supported by UNICEF for days of tranquility for vaccination will be successful in order to reach those children in areas undergoing civil unrest in south Sudan.

**Gulf countries**

The intercountry coordination meeting on polio eradication for the Gulf countries, during its last meeting in January 1994, recommended concomitant implementation of National Immunization Days for November and December 1994. The plans are well advanced and several countries are seeking WHO technical views on issues related to this initiative.

National authorities have allocated considerable funds to finance these supplemental immunizations. The Islamic Republic of Iran covered all the expenses involved in its NIDs. The Government of Pakistan released 30 million Rupees to cover the implementation cost and under the 5-year plan (1995-1999), Rs2.2 billion have been allocated for EPI. This includes the cost of OPV for National Immunization Days for the years 1995-1997. The Government of Sudan released LS35 million for local expenses and LS350 million for procurement of OPV and related equipment through UNICEF.

Although those achievements are very encouraging, they should not be considered a replacement for the essential target of achieving high levels (above 90%) of immunization coverage with three doses of OPV through routine immunization.

2.2 Ensuring the availability of OPV that meets WHO quality standards

As the EPI moves towards eradication of polio, the elimination of Neonatal tetanus and measles control, large quantities of vaccine of high quality are needed. This situation has encouraged a regional initiative for self-sufficiency of vaccines that meet WHO quality standards. The Regional consultation held in September 1992 set the stage for further action to assess the needs of the region for vaccines and sought ways of promoting vaccine production and quality assurance. Multidisciplinary teams of experts visited the major vaccine-producing agencies in the region through a collaborative effort between national authorities, EMRO and the children vaccine initiative (CVI). These missions were instrumental in identifying the needs of these vaccine-producing agencies in the region to boost their production and ensure high quality products.

Positive steps have already been taken. WHO and UNICEF together with bilateral agencies are supporting these national initiatives towards less dependence on importation of vaccines.

The development of national quality control authorities is a cause of great concern. Reliance on quality control by the production authority still prevail among major vaccine producers in the region. Some authorities have tried to partially solve the problem by placing the control authorities under separate administrative authorities, although they still function at the production laboratories and use the latter's facilities. Until national authorities develop their own quality control facilities, efforts will still be needed to establish a regional network of quality control laboratories relying on existing facilities in the Region.

2.3 Strengthening surveillance of acute flaccid paralysis (AFP) and other immunizable diseases

In 1993, 2438 cases of acute poliomyelitis were reported in 9 countries within the Region, the largest number of cases reported since 1988. It represents a 28% increase over cases reported in 1992. This increase was due to two large outbreaks of poliomyelitis, one in Pakistan, the other in Sudan. Pakistan reported 1803 cases in 1993, a 72% increase over the 1046 cases reported in 1992. Sudan reported 243 cases as compared to only 10 cases in 1992. The increase in both countries has overshadowed the overall Regional decrease in 1993, especially in Egypt where the incidence of poliomyelitis decreased sharply to 150 cases in 1993 (from 584 cases in 1992). Available date for 1994 indicate that there is a significant decrease in the number of cases of poliomyelitis in the Region.

**Table 1. Reported incidence of poliomyelitis**
Eastern Mediterranean Region, 1988-1993

| Member States | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 |
|---|---|---|---|---|---|---|
| Afghanistan | 307 | 55 | 48 | 2 | ... | ... |
| Bahrain | 0 | 0 | 0 | 0 | 0 | 2 |
| Cyprus | 0 | 0 | 0 | 1 | 0 | 0 |
| Djibouti | 3 | 10 | 7 | 0 | 3 | 0 |
| Egypt | 550 | 474 | 565 | 625 | 584 | 150 |
| Iran, Islamic Republic of | 36 | 13 | 15 | 55 | 44 | 107 |
| Iraq | 69 | 10 | 56 | 186 | 120 | 75 |
| Jordan | 2 | 0 | 0 | 14 | 18 | 0 |
| Kuwait | 0 | 0 | 0 | 0 | 0 | 0 |
| Lebanon | 0 | ... | 2 | 5 | ... | 0 |
| Libyan Arab Jamahiriya | 10 | 4 | 5 | 6 | 0 | 0 |
| Morocco | 0 | 2 | 0 | 0 | 0 | 0 |
| Oman | 118 | 5 | 0 | 4 | 0 | 2 |
| Pakistan | 935 | 811 | 777 | 1147 | 1046 | 1803 |
| Qatar | 0 | 0 | 1 | 0 | 0 | 0 |
| Saudi Arabia | 3 | 3 | 5 | 1 | 2 | 2 |
| Somalia | 54 | 155 | ... | ... | ... | ... |
| Sudan | 93 | 51 | 4 | 27 | 10 | 252 |
| Syrian Arab Republic | 37 | 13 | 12 | 24 | 22 | 0 |
| Tunisia | 2 | 0 | 0 | 3 | 4 | 0 |
| United Arab Emirates | 9 | 0 | 0 | 0 | 2 | 0 |
| Yemen | 114 | 701 | ... | 37 | 45 | 58 |
| UNRWA | 0 | 0 | 0 | 2 | 1 | 0 |
| Total | 2342 | 2307 | 1497 | 2129 | 1901 | 2451 |

... = Data not available.

Reported cases of poliomyelitis by country since 1988 are presented in **Table 1**. This data indicates that since 1988, the number of reported cases remained in the range of 1800-2400 in spite of the improved national epidemiological surveillance systems in many countries. This indicates that there is probably a real decrease in the incidence of poliomyelitis in the Region. However, considerable under-reporting is still believed to be a major problem in a number of endemic countries (Pakistan, Sudan, Yemen).

In 1993, 11 countries (Cyprus, Djibouti, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Qatar, Syrian Arab Republic, Tunisia, United Arab Emirates, and the Palestinian population under the administrative care of UNRWA) reported no cases of polio as compared to 7 countries in 1992. Three countries in the Region reported no cases of polio for three or more years, namely Kuwait, Morocco and Qatar.

To achieve polio eradication, national programmes must be able to detect all cases of the disease at an early stage. Therefore, developing effective and efficient national surveillance systems which are able to monitor and evaluate EPI disease eradication-elimination-control targets was one of the main points emphasized by the Regional Committee last year. This remains a priority activity for both national authorities and WHO.

Since December 1992, recognizing the critical role of surveillance in polio eradication, and in collaboration with national authorities, in December 1992 EMRO initiated assessment of national disease surveillance systems. By the end of 1994, 19 of the 22 countries will have been visited. The joint WHO/national teams conducted a review of the national surveillance system to determine the sensitivity of the system in detecting cases of poliomyelitis and its capacity to confirm diagnosis and conduct case/outbreak response in a timely manner. Except for very few countries, the reviews showed that AFP surveillance is not being implemented comprehensively and that the existing surveillance systems are not sufficiently sensitive for detecting low levels of wild polio virus transmission. However more Member States are reporting cases of AFP. During 1993, the number of countries increased to 15 as compared to only 6 in 1992.

At least one case of non-polio AFP occurs annually for every 100 000 children under 15 years of age. An effective AFP surveillance should be able to detect such a number of cases. At present only three countries, namely Bahrain, Oman and Qatar have reached the required level of sensitivity of the system and are reporting more than one case of AFP/100 000 population under 15 years of age.

The global programme for polio eradication has developed poliomyelitis surveillance performance indicators to evaluate immediate reporting and monitoring of AFP cases. These include zero reporting and use of laboratory support services. Such indicators are routinely used in Bahrain, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Morocco, Oman, Qatar, Syrian Arab Republic, Tunisia and others. However, analysis of the data at the national level must still be improved in many countries.

2.4 Promotion of effective participation of the different medical sectors and the community in all activities of the programme

Although there is evidence of the effective participation of the community in activities for polio eradication as demonstrated, evident in the very high response to NIDs and the continued increase in the immunization coverage, the response of the different medical sectors, especially in surveillance of polio, is not clear. However, there is evidence of such participation. In Egypt the percentage of cases of AFP/polio reported by private practitioners is increasing. Another example is the fact that many national authorities are publishing monthly EPI bulletins. These are a good tool for feedback and are felt to be an important step towards achieving greater participation of the medical sector in polio eradication activities. Other initiatives include the establishment of a prize for timely reporting of AFP cases to national authorities.

2.5 Strengthening laboratory support for the diagnosis of poliomyelitis

As the Region moves closer to the target of polio eradication, the use of laboratory services to detect wild polio viruses becomes increasingly important. In collaboration with national authorities WHO has actively pursued the establishment of a regional laboratory network to serve the dual purpose of assisting the diagnoses of polio infection among children with acute flaccid paralysis and to conduct surveillance for the wild polio viruses in the environment.

The Regional network consists of 13 laboratories in 12 countries (Egypt (2), Islamic Republic of Iran, Iraq, Jordan, Kuwait, Morocco, Oman, Pakistan, Saudi Arabia, Sudan, Syrian Arab Republic and Tunisia). Four of these are Regional reference laboratories and nine are national laboratories.

During the year since the Regional Committee meeting in 1993, all regional reference laboratories and most national laboratories have been certified following staff training, provision of reagents and proficiency testing. Additional equipment and training is still needed for some national laboratories. Staff from the regional reference laboratories in Egypt, Kuwait and Tunisia have been trained in intratypic differentiation technics in a WHO workshop held in the Netherlands, in December 1993. WHO consultants visited national laboratories in Jordan, Morocco, Saudi Arabia, Sudan and Syrian Arab Republic, to assist the laboratory staff in initiating and/or upgrading diagnostic work and to assess requirements for staff training, supplies and equipment to ensure reliable results. The laboratory requirements of supplies and equipment and essential reagents have also been assessed and WHO support has been extended as possible. Visits were made to the regional reference laboratories in Egypt, Kuwait and Tunisia, to review polio virus culturing practices and results, and to assess the laboratories' requirements.

In order to achieve coordination between the laboratory and surveillance activities the WHO Regional Office ensures participation of laboratory staff in the subregional coordination meetings for polio eradication.

It is believed that further strengthening of the Regional laboratory network will be stimulated, to a great extent, by the development of national surveillance systems and hence the increasing demands for laboratory confirmation of suspected polio cases.

## 3. OTHER REGIONAL INITIATIVES IN POLIO ERADICATION

### 3.1 Polio-free zones

Poliomyelitis eradication is going very well in both the sub-regional polio-free zones, namely those of the Gulf countries and the Maghreb. During 1993, no cases of polio were reported from EMR Maghreb countries. The 6 cases detected in the Gulf countries (Bahrain:2, Oman:2, and Saudi Arabia:2) were detected early and immediate aggressive response was initiated; therefore, no further wild polio virus transmission occurred.

The 2nd Intercountry coordination meetings in both subregions were held in Manama, Bahrain, from 24 to 26 January 1994 for the Gulf countries in which Yemen also participated, and in Tunis, Tunisia, from 25 to 26 June for the Maghreb Union countries. In addition to reviewing progress in implementing the recommendations of the first meetings, the responsible officers discussed coordinated activities and made recommendations for their implementation. Of special importance is the conduct of national immunization days during the 1994/1995 low seasons of polio virus transmission in all countries of the zone at the same time.

In addition to the approach of subregional zones, efforts in support of all countries not included in these zones continued. Efforts are already underway to establish a third subregional polio-free zone which will include Islamic Republic of Iran, Iraq, Jordan, Lebanon, Palestine and Syrian Arab Republic. As a first step, joint WHO/national teams assessed the surveillance for the EPI target diseases with main emphasis on poliomyelitis eradication in Islamic Republic of Iran, Jordan and Syrian Arab Republic. Plans are underway for similar assessments in other countries of this third zone. Following these individual country surveillance assessments, the First Intercountry subregional meeting on coordination of poliomyelitis eradication strategies/activities will be held in Amman, Jordan, from 19 to 21 September 1994.

### 3.2 Exchange of information

The monthly bulletin "Polio Fax", issued by WHO since February 1993, has had a remarkable effect on the timely reporting of both AFP and polio. By the end of January 1994, 96% of the expected

reports for 1993 had been received in EMRO. However, updating of the national data by some countries continued until April 1994, due mainly to the recommended 60-day follow-up visits of suspect cases. In the near future, this Polio Fax initiative will be expanded to cover other immunizable diseases.

3.3 Certification of polio eradication

In May 1994, the Regional Director initiated the first step in a series of activities to be accomplished for eventual certification of polio eradication from the Region, i.e., establishment of national commissions as well as a Regional certification commission.

The experiences of the Americas show that it is extraordinarily difficult to demonstrate with certainty that no wild polio viruses are circulating in a given country, or in the Region as a whole. Therefore, the primary goal of the national commissions is to oversee pre-certification activities and prepare the national programme for certification by the regional and global commissions.

The first meeting of a working group to review processes leading to the certification was held in Geneva in March 1993. The working group defined the following five principles on which certification of polio eradication should be based:

1. Certification will be on a regional or subregional basis, by commissions convened for the purpose. In this sense, regional will mean a geographic area and not necessarily a WHO Region.

2. A Global Commission for the certification of wild polio virus eradication will be established to provide guidelines for regional commissions to ensure uniformity in the criteria used for certification and to establish a timetable leading to eventual certification of global wild polio virus eradication.

3. Certification of eradication will be based on convincing documented evidence, particularly of effective surveillance for wild polio viruses.

4. Global eradication will be certified only when all Regions, and therefore all countries, have been certified as having achieved wild polio virus eradication.

5. Final certification of eradication will not be considered until a full three years have elapsed since the last detected and culture-confirmed occurrence of the wild polio virus. Until eradication is certified, and in preparation for the certification process, AFP surveillance, data collection and its documentation must continue following the occurrence of the last confirmed case.

To fulfil the above criteria, much remains to be done by the national, regional and global authorities. WHO will convene regular

meetings of the certification commissions and will ensure timely dissemination of relevant information of global and regional interest to make the final certification of polio eradication possible.

## 4. CONSTRAINTS

Although steps taken towards poliomyelitis eradication in the Region are encouraging, several constraints remain which, if not tackled properly and in a timely manner, may affect early eradication from the Region.

The main areas of concern in polio eradication presented to the Fortieth Session of the Regional Committee for the Eastern Mediterranean (Resolution EM/RC40/R.8) in October 1993, still remain partially unsolved in some countries. They are:

1. inadequate translation of political commitment into action. This is reflected in insufficient funding for purchase of OPV for both routine and supplementary immunization activities and also for other resources such as laboratory support services.

2. insufficient acceptance by some national decision-makers that polio eradication requires additional coordinated strategies between countries, such as timely and coordinated NIDs.

3. still inadequate epidemiological surveillance in some countries which does not permit early identification and timely investigation of all AFP cases or effective response to suspect cases.

4. war and social unrest in some countries which are threatening the Regional polio eradication initiative.

5. Exchange of information between countries and with WHO is still far from adequate for timely coordination of the activities involved in polio eradication. This exchange of information is not yet immediate, widespread or comprehensive.

## 5. CONCLUSIONS AND RECOMMENDATIONS

Conclusion

In the six years since the polio eradication initiative was launched, the Eastern Mediterranean Region has been able to develop and implement comprehensive programme strategies which include achievement and maintenance of high immunization coverage, implementation of the supplementary immunization strategies including NIDs and mopping-up immunization, effective surveillance based on AFP detection and aggressive response to the occurrence of new cases in most countries of the Region. National immunization days are being conducted in an increasing number of countries.

Although no evident decline in the number of reported cases of polio has been seen since 1988, this can be explained by improved surveillance systems. AFP surveillance with laboratory investigation is being implemented in an increasing number of countries and its sensitivity is reaching the globally established standards of at least one case per 100 000 children under 5 years of age in some of them.

However, without special efforts directed at the countries where wild polio viruses are widespread, the eradication of poliomyelitis from the Eastern Mediterranean Region will not be easily achieved by the target date of the year 2000. The success of the programme will depend on additional financial support from both national and external sources.

Recommendations

1. National authorities should translate their commitment to the national eradication of polio into actions by providing the staff and resources necessary to implement national plans.

2. All efforts should be made to ensure timely supply of sufficient quantities of OPV which meet WHO quality standards for both routine and supplementary immunization.

3. WHO should continue to improve surveillance and give high priority to surveillance for AFP as the basis for early identification of all suspected cases.

   National programmes should monitor immunization coverage by district, identify areas of low coverage and address their needs by strengthening basic immunization and supplementary immunization activities such as National Immunization Days, mopping-up and immediate response to occurrence of case(s).

4. Efforts should continue to strengthen laboratory services for case investigation and quality assurance of polio vaccines.

5. National programmes should develop and strengthen mechanisms for the timely exchange of information at the national level and between countries and ensure feedback to the sources of information.

6. The initiative of establishing and extending polio-free zones in the Region should be continued.

7. National authorities should establish national commissions for polio eradication and WHO should establish a Regional commission. These should begin functioning as soon as possible.

8. A regional effort should be made to raise funds to meet unprecedented needs in support of national programmes and to undertake intercountry activities.

REGIONAL COMMITTEE FOR THE
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# POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

## Summary of Recommendations

It is recommended that Member States:

1. Ensure that there is strong national commitment to polio eradication at all levels of the administrative structure to guarantee the provision of local leadership, resources and personnel;

2. Ensure mandatory reporting of all cases of acute flaccid paralysis (AFP) in children aged less than 15 years, with expert clinical, epidemiological and virological investigation and 60-day follow up;

3. Conduct national immunization days with oral polio vaccine in those countries where there is evidence or risk of wild poliovirus transmission;

4. Coordinate the timing of national immunization days among countries in the emerging polio-free zones and their adjacent countries;

5. Ensure sufficient quantities of oral polio vaccine meeting WHO quality standard for both routine and supplementary immunization;

6. Regularly and rapidly exchange information on AFP/polio cases between countries and through WHO;

7. Strengthen rehabilitation services for children disabled by poliomyelitis and introduce community-based rehabilitation; and

8. Establish national commissions for polio eradication to monitor the epidemiological situation and document actions taken in preparation for certification of polio eradication.

It is recommended that WHO:

1. Continue to provide support to countries in obtaining sufficient quantities of oral polio vaccine meeting WHO requirements for both routine and supplementary immunization, including local production or bottling of bulk vaccines, as appropriate;

2. Provide additional support to those countries that are not yet pursuing polio eradication, so that by the end of 1995 all Member States would have plans of action to achieve the regional target of eradication by 1998;

3. Continue to provide technical leadership to the Polio Eradication Initiative and to actively coordinate and encourage the involvement of all agencies concerned;

4. Establish effective contact with other Regions to coordinate inter-regional polio eradication activities;

5. Establish a regional commission for polio eradication to monitor the situation and coordinate activities of national commissions;

6. Continue to seek additional resources required to achieve polio eradication in the Region by the year 1998;

7. Keep the Regional Committee regularly informed of the progress towards the eradication of poliomyelitis.

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EASTERN MEDITERRANEAN

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# POLIOMYELITIS ERADICATION IN THE EASTERN MEDITERRANEAN REGION

## Summary for the Report

In pursuance of the resolutions of the Regional Committee (1988, 1989 and 1993), as well as the resolutions of the World Health Assembly (1988 and 1993), the regional poliomyelitis eradication initiative has made remarkable progress, at both national and regional levels.

In order to implement WHO eradication strategies recommended by WHO, the Regional Office has introduced several key initiatives/activities, namely, assessment of national disease surveillance systems, followed by workshops on disease surveillance; annual sub-regional meetings to coordinate key activities among neighbouring Member States; and a rapid exchange of information between Member States through a regional monthly bulletin (PolioFax).

The principal strategy to interrupt circulation of wild poliovirus--conducting national immunization days (NIDs)--was implemented in two countries in 1993, and five in 1994. It is expected that 11 countries will conduct NIDs in late 1994 and early 1995, during the low polio virus transmission season. In 1997, all countries will be conducting NIDs, so that by 1998, the regional goal of zero polio can be achieved, allowing three years for certification of polio-free status of countries in the Region.

The Regional Office actively promoted the development and the strengthening of national surveillance systems through surveillance assessments and workshops, which have already been conducted in 18 countries. As a result, all the essential elements of high-quality polio surveillance, namely the reporting of all cases of acute flaccid paralysis (AFP), case-investigations, laboratory-based diagnosis and 60-day follow-up examinations for residual paralysis, have been

established. In addition, the quality and sensitivity of AFP surveillance in these countries are monitored with standard WHO performance indicators, which suggest substantial improvements since the assessments were conducted.

An important landmark in the efforts to achieve polio eradication in the EMR is the establishment of three sub-regional polio-free zones: one for the Arab countries in the Gulf, one for the Arab Maghreb Union, and one in the Middle East. Annual sub-regional meetings are held in each zone to exchange information and coordinate activities, such as the simultaneous conduct of national immunization days, in order to interrupt circulation of wild polio virus over a large zone.

Despite these activities and progress in 1993, 2451 cases of poliomyelitis have been reported to WHO from nine Member States--the largest number reported since 1988 (2432). This increase is attributable to an overall improvement in surveillance for polio and to large outbreaks in Pakistan (~~1180~~ 1803 cases) and Sudan (252 cases). With NIDs already conducted in five countries, including Pakistan and Sudan, during 1994, it is strongly believed that the number of polio cases reported will substantially decrease in 1994, while surveillance continues to improve in the Region. This decrease in cases is already evident, based on the reports for the first half of 1994.