WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE

Forty-eighth session
Sydney
22-26 September 1997

WPR/RC48/6 Rev.1

30 July 1997

ORIGINAL: ENGLISH

Provisional agenda item 11

ERADICATION OF POLIOMYELITIS IN THE REGION: PROGRESS REPORT

This annual progress report details the current status of the regional poliomyelitis eradication campaign. Intensive measures are being made to ensure that the Region will be completely free of wild poliovirus transmission from 1998 onwards.

In 1996, a total of 5305 cases of acute flaccid paralysis (AFP) were reported in the Region (data as at 25 April 1997). Of these, 4192 (79%) had two stool specimens collected within two weeks of onset of paralysis. Wild poliovirus could be isolated from only 21 of these cases. Three wild poliovirus-associated cases were detected in China and are believed to have been imported from Myanmar. The other 18 wild-poliovirus associated cases were found in the area surrounding the Mekong River and Delta in Cambodia, the Lao People's Democratic Republic and Viet Nam.

As at 19 June 1997, eight wild poliovirus associated poliomyelitis cases with onset of illness in 1997 have been reported from Cambodia, and one case has been reported from the central region of Viet Nam. Among other actions, two rounds of focused supplementary immunization were conducted in May and June 1997 in high-risk districts of Cambodia, the Lao People's Democratic Republic and Viet Nam.

The certification process is underway, starting with the non-endemic countries and areas which have formed national certification committees, or are represented by the subregional committee for Pacific island countries and areas. They are developing progress reports and national plans of action which will be presented to the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region at its second meeting in November 1997.

All countries and areas are asked to continue to provide the highest level of support for poliomyelitis eradication, especially as the efforts needed in the final stages of the campaign to eradicate wild poliovirus are even more intensive than those required at the beginning of the initiative.

1. INTRODUCTION

At its thirty-ninth session in September 1988, the Regional Committee for the Western Pacific adopted resolution WPR/RC39.R15 on the eradication of poliomyelitis in the Region by 1995. Resolution WPR/RC41.R5 called for an annual report on eradication, and WPR/RC42.R3 and WPR/RC44.R4 proposed ways to accelerate the programme. Rapid progress has since been made towards the eradication of poliomyelitis in the Region.

2. PROGRAMME ACTIVITIES

2.1 Strengthening of routine EPI activities

Routine immunization activities continue to be the foundation of the poliomyelitis eradication initiative. Routine oral poliovirus vaccine (OPV) coverage remained at over 90% during 1996 (Figure 1).

2.2 Supplementary immunization activities

A total of 23 national immunization days (NIDs) have been conducted or are planned in the Region from 1992 to 1997 (see Table 2). In the last two low transmission seasons of 1995–1996, and 1996–1997, countries have improved the quality of NIDs by focusing on areas at high risk for continued poliovirus transmission and by developing approaches to reach previously unimmunized children. A particularly successful strategy has been the use of mobile teams on the waterways of the Mekong River.

In addition to the NIDs, special efforts were made in May and June 1997 to eradicate the transmission of wild poliovirus by conducting two rounds of high-risk response immunization (HRRI) in areas of recent poliovirus circulation. Over two million children in Cambodia, the Lao People's Democratic Republic and Viet Nam were given oral poliovirus vaccine (OPV) by mobile teams of health workers going from house to house, and from boat to boat, in districts which

surveillance data had shown to be at high risk of poliovirus transmission. At the same time, an active search for unreported AFP cases was carried out.

2.3 Poliomyelitis surveillance

In 1996, 5305 cases of acute flaccid paralysis were reported throughout the Region (data as at 25 April 1997). Of these, 79% had two stool samples taken within 14 days of onset of illness. However, after stool analysis in accredited laboratories, only 21 of the 5305 cases were confirmed as poliomyelitis by wild virus isolation (virological confirmation). This contrasts with 6000 poliomyelitis cases reported in 1990 (see Figure 2).

In 1996, China and Viet Nam had already reached a level of AFP and laboratory surveillance quality which enabled them to confirm as poliomyelitis only those AFP cases where wild poliovirus was detected in the stool samples. Other countries confirmed cases that met the clinical classification criteria for poliomyelitis (clinical confirmation). Therefore the 141 poliomyelitis cases reported in 1996 (data as at 25 April 1997) are a mixture of cases reported by virological and clinical confirmation criteria (see Table 1). Surveillance quality has continued to improve, and in 1997 all countries reporting poliomyelitis cases are expected to reach surveillance standards that will enable them to confirm poliomyelitis based upon virological rather than clinical confirmation.

In 1996 and 1997, the improvements in quality of surveillance, particularly for laboratory analysis, have enabled rapid location of areas where the wild poliovirus continues to circulate, followed by focused immunization response .

2.4 Certification of poliomyelitis eradication

The Subregional Committee for Certification of Poliomyelitis Eradication in Pacific Island Countries and Areas met for the first time in December 1996 and prepared a plan of action. The 20 Pacific Island countries and areas concerned are now improving AFP surveillance in accordance with this plan.

During 1997, the other eight countries and areas in the Region that are considered non-endemic for poliomyelitis have established national certification committees for poliomyelitis eradication and are preparing national plans of action for certification. These plans of action will describe the surveillance and immunization activities that will be undertaken by each country in order

to meet the standards recommended by the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region.

2.5 Vaccine quality

Further progress has been made in strengthening local vaccine production and national capabilities in quality control, in line with the regional plan of action for achieving self sufficiency in vaccine production and supply. Technical support for vaccine production and quality control is being provided to China, the Philippines and Viet Nam. Regional and national workshops in quality control were held in 1996 and 1997.

2.6 Resource requirements

Despite the fact that countries in the Region are becoming more and more self-sufficient in vaccine supply, a very significant proportion of the resources required for vaccines and operational costs for surveillance and supplementary immunization activities is still provided by international partners. The many partners involved in funding the programmes to eradicate poliomyelitis are gratefully acknowledged, particularly UNICEF, the governments of Australia, Japan, the Republic of Korea, and the United States of America through the Centers for Disease Control and Prevention in Atlanta, and Rotary International and Rotary International District 2650 of Japan. Ensuring that poliovirus circulation is finally eradicated is very resource-intensive and the HRRI carried out in Cambodia, the Lao People's Democratic Republic and Viet Nam in May and June 1997 has required major additional external support. Until global eradication is certified, the generosity of international partners will remain a critical factor.

2.6.1 Vaccine

From 1992 to 1996, US$ 37.1 million was provided by international partners for the purchase of oral poliovirus vaccine for supplementary immunization (see Figure 3).

2.6.2 Operational support

In addition to the provision of vaccine, from 1992-1996, US$ 12 million was committed by partners for staff, supplies and equipment, and operational costs for surveillance and national immunization days.

2.7 Major issues in poliomyelitis eradication and actions being taken

The major issues facing the poliomyelitis eradication campaign and actions being taken are presented in Table 3.

3. FUTURE ACTIVITIES

3.1 Supplementary immunization

Using high-quality surveillance data to rapidly detect high-risk areas, urgent HRRI will be carried out in areas where any single wild poliovirus may be detected, and in communities that are considered to be at risk of continued transmission. National and subnational immunization days will continue, using strategies that have been developed to reach previously unimmunized children. Efforts will continue to be made to coordinate control activities in the border areas, both within the Western Pacific Region, and those shared with the South-East Asia Region. The aim will be to ensure synchronized supplementary immunization rounds in the 1997–1998 low transmission season.

3.2 Laboratory and acute flaccid paralysis surveillance

All laboratories in the network will continue to be monitored for performance, particularly for the timeliness of specimen processing and for coordination with AFP surveillance. Improvements are being introduced into all national laboratories to increase sensitivity for poliovirus isolation. Timely information from laboratories will be a decisive factor in taking prompt action in high-risk areas.

3.3 International Vaccine Institute

The establishment of an International Vaccine Institute (IVI) was approved by resolution WHA50.12 at the Fiftieth World Health Assembly (see Annex). The IVI will be based in the Region, in a research park on the campus of Seoul National University, Republic of Korea. The study by UNDP which examined the feasibility of an international institute decided to focus on the Asia-Pacific because of its expanding economic resources and progress in vaccine sciences. The IVI will focus on research and development. It will undertake laboratory, clinical and field studies of new

and improved vaccines of particular concern to developing countries. The IVI will also engage in collaborative projects with institutions in developing countries, provide technical services, organize training and disseminate information on vaccines.

Table 1. Total AFP cases reported, showing cases meeting clinical criteria for poliomyelitis and cases associated with wild poliovirus, 1992-1996*

Western Pacific Region

Country	Total AFP cases reported					Cases meeting clinical criteria for poliomyelitis (including virologically confirmed cases)					Wild poliovirus isolated				
	1992	1993	1994	1995	1996	1992	1993	1994	1995	1996	1992	1993	1994	1995	1996
Cambodia	146	135	301	183	140	146	135	297	130	71	0	4	33	17	15
China	2488	1818	3096	4802	4372	1191	538	307	165	3	0	101	6	1*	3*
Lao P.D.R.	10	9	11	16	41	7	7	6	8	20	0	0	0	0	1
Malaysia	0	1	17	13	32	3	0	0	0	0	0	0	0	0	0
Mongolia	**	**	**	0	21	1	2	0	0	0	**	**	**	0	0
Papua New Guinea	73	16	13	13	20	0	0	2	1	0	0	0	0	0	0
Philippines	47	88	126	153	175	13	15	11	40	45	8	7	0	0	0
Pacific island countries	0	0	1	3	6	0	0	0	0	0	0	0	0	0	0
Viet Nam	653	607	353	467	495	557	452	121	137	2	26	157	35	13	2
Others	0	1	1	0	3	0	0	0	0	0	0	0	0	0	0
Western Pacific Region	**3417**	**2675**	**3919**	**5650**	**5305**	**1918**	**1149**	**744**	**481**	**141**	**34**	**269**	**74**	**31**	**21**

Source: Latest available data from Regional Office AFP Surveillance System as at 25 April 1997. All cases reported by year of onset.
*Imported cases.
**Data not available.

Table 2. National immunization days and high-risk response immunization, 1992-1997*

Western Pacific Region

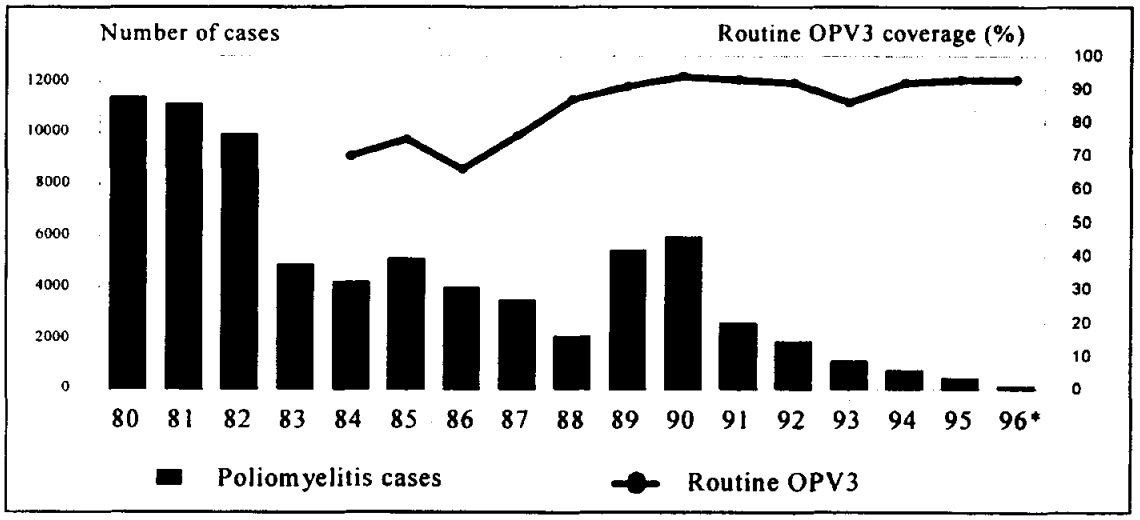
Country	Subnational immunization days	National immunization days		Coverage	Other antigens	High-risk response immunization days	Number immunized
	Total	Total	Average number immunized per NID			Dates	
Cambodia	1	3	1.9 million	95%	Vitamin A	May/June 1997	1 million
China	2	3	83 million	>80%	-		
Lao P.D.R.	2	4	650 000	80%	Vitamin A, measles, DPT***	May/June 1997	75 000
Mongolia	0	3	424 000	97%	Diphtheria, tetanus toxoid, measles		
Papua New Guinea	1	1**	NA	-	-		
Philippines	0	5	9.9 million	>90%	Vitamin A, tetanus toxoid, measles		
Viet Nam	1	4	9.7 million	>90%	Vitamin A, tetanus toxoid, measles	May/June 1997	1 million
TOTAL	7	23	106 million				

*Figures as at 25 April 1997.
**Scheduled for September/October 1997.
***Diphtheria, pertussis, tetanus triple antigen.

Table 3. Major issues in poliomyelitis eradication and actions being taken

MAJOR ISSUES	ACTIONS BEING TAKEN
Quality of supplementary immunization – Wild virus transmission among non-immunized children despite several NIDs – Wild virus transmission persists in focal areas along Mekong Delta waterways	– More detailed planning, mobile teams and additional fixed posts are improving the quality of NIDs – HRRI synchronized in May and June 1997 in Cambodia, the Lao People's Democratic Republic and Viet Nam focused on house-to-house and boat-to-boat immunization in areas at risk of continued transmission
Acute flaccid paralysis and laboratory surveillance – Problems of coordination between epidemiology laboratory, surveillance components and within the laboratory network	– Standard format for laboratory reporting has been instituted – Computerized data transfer is being improved – All network laboratories directed to report through WHO
– Insufficient surveillance activity in countries where poliomyelitis was recently endemic	– Active surveillance for acute flaccid paralysis has been introduced through regular visits to health facilities
– Need to improve cross-border coordination	– International and interregional meetings are being held to improve cross-border coordination – Synchronized supplementary immunization activities are taking place on both sides of border areas during NIDs and HRRI
Resource availability – Resources for surveillance and supplementary immunization will be required until global eradication is certified	– Continued funding support for surveillance, staff posts, and OPV is being sought from partner agencies

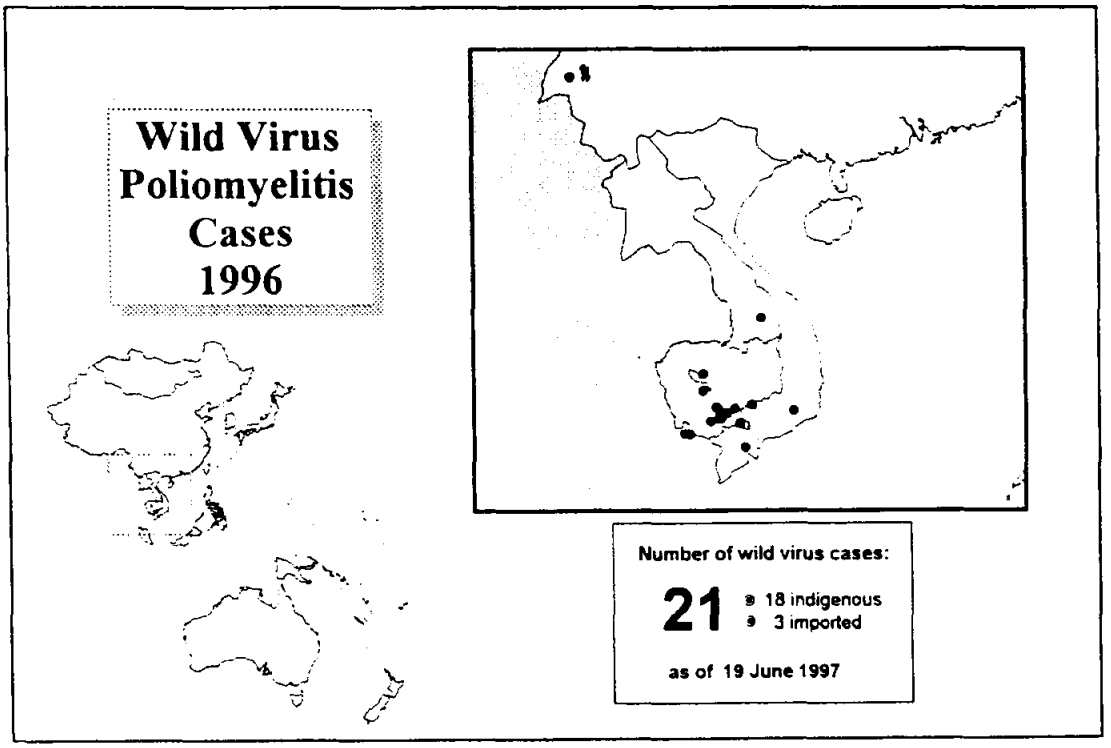
Figure 1. Reported poliomyelitis cases and OPV3 coverage 1980-1996, Western Pacific Region

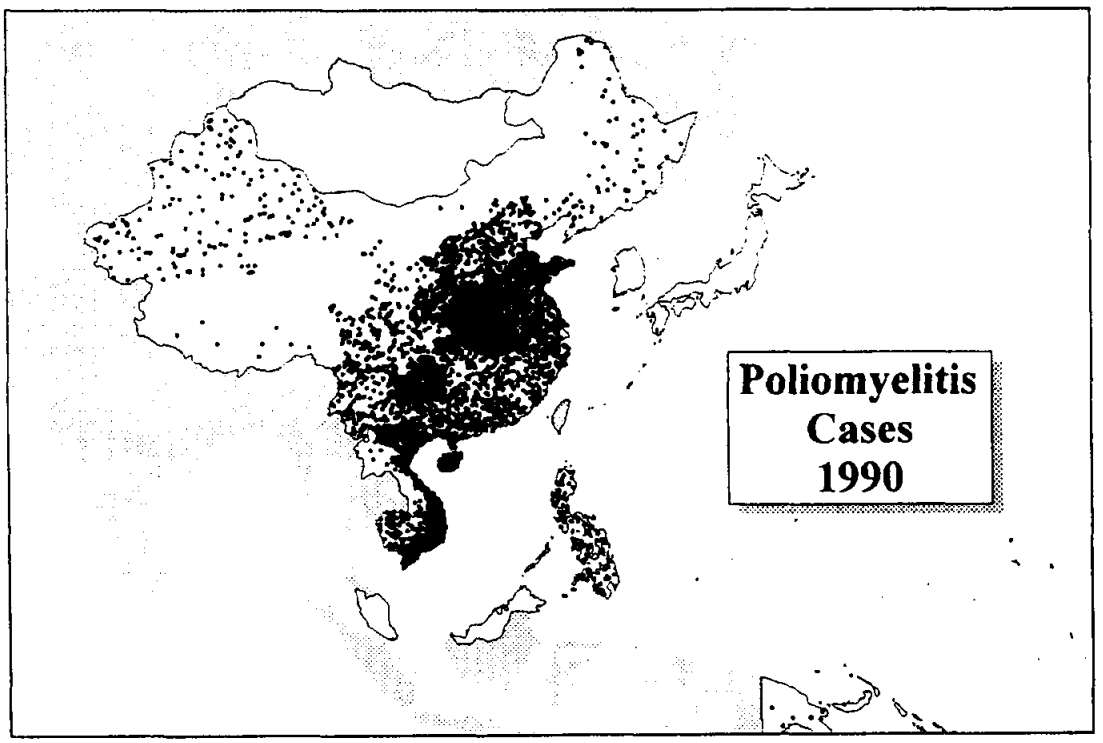


* 1996 data provisional. *Source*. Regional Office CEIS and poliomyelitis surveillance reports, 25 April 1997.

Figure 2. Geographical distribution of poliomyelitis cases in 1996 compared with 1990

Western Pacific Region

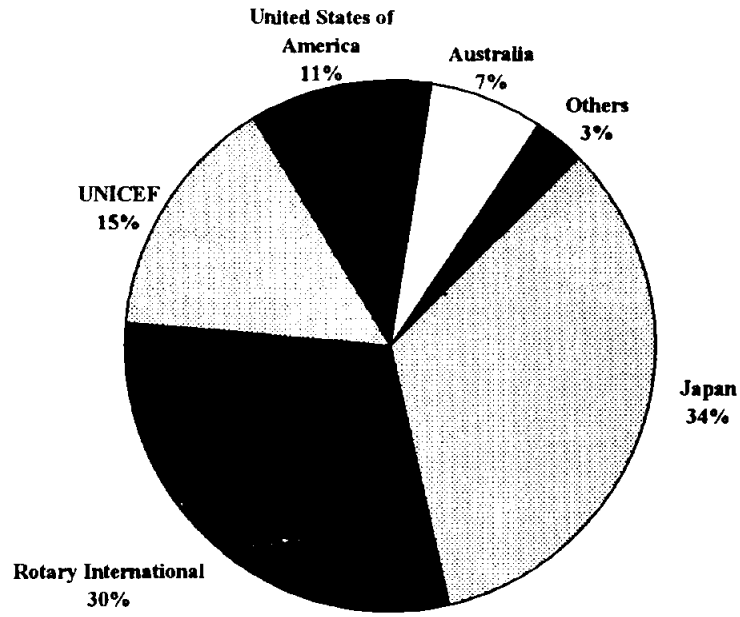




*Cases meeting clinical criteria for poliomyelitis (includes virologically confirmed cases).

Figure 3. Partner support for oral poliovirus vaccine requirements, 1992-1996, Western Pacific Region

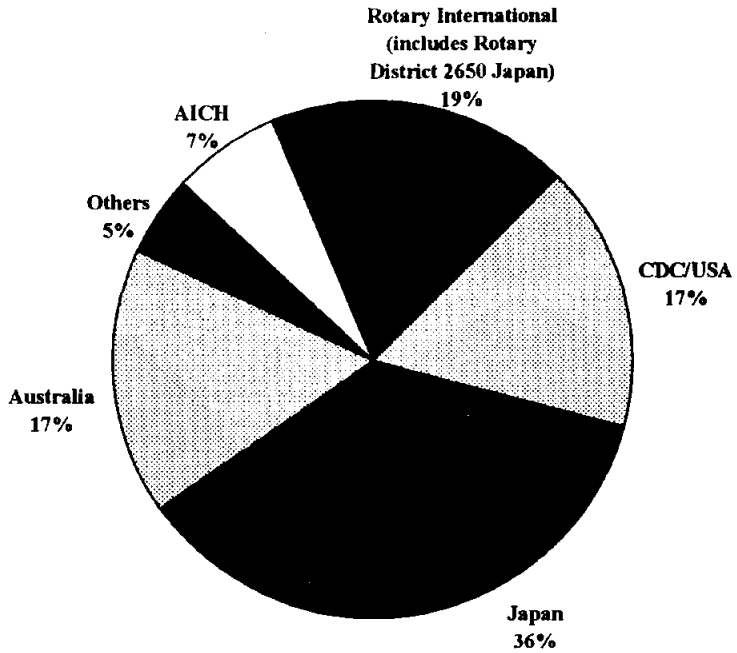
Total: US$ 37.1 million



Source: Data as at 31 January 1997. Includes committed as well as received funds.

Figure 4. Partner support for other operational and surveillance requirements, 1992-1996, Western Pacific Region

Total: US$ 12 million



Source: Data as at 31 January 1997. Includes committed as well as received funds.
Note: Total does not add up to 100% due to rounding.

ANNEX

世界衛生大會 決議 قرار جمعية الصحة العالمية

RESOLUTION OF THE WORLD HEALTH ASSEMBLY
RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ
РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ
RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

FIFTIETH WORLD HEALTH ASSEMBLY — WHA50.12

Agenda item 27.1 — 12 May 1997

Establishment of the International Vaccine Institute

The Fiftieth World Health Assembly,

Having considered the report of the Director-General on the establishment of the International Vaccine Institute (document A50/16 Add.1), and in accordance with Article 18(l) of the Constitution of the World Health Organization,

1. APPROVES the Agreement on the Establishment of the International Vaccine Institute;

2. AUTHORIZES the Director-General to deposit WHO's instrument of approval of the Agreement with the Secretary-General of the United Nations.

Eighth plenary meeting, 12 May 1997
A50/VR/8

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