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ADDRESSING THE RESURGENCE OF WILD POLIOVIRUS TRANSMISSION IN THE AFRICAN REGION

Information Document

EXECUTIVE SUMMARY

1. In 1988, when the World Health Assembly adopted a resolution to eradicate polio, all countries in the African Region were polio-endemic. By the end of 2002, only two countries in the Region were polio-endemic. Since 2003, there has been a major increase in wild poliovirus transmission in the remaining endemic countries, with spill over into nine previously polio-free countries.

2. This resurgence in wild poliovirus transmission is attributed to a failure to vaccinate at least 90% of all susceptible children in the most endemic areas in Niger and Nigeria. Persistent gaps in the quality of supplemental immunization activities (SIAs) in these areas as well as the suspension of all immunization activities in Kano State, which is the epicentre of this transmission, have contributed to the current massive increase in wild poliovirus transmission in these areas.

3. To address the observed resurgence of wild poliovirus transmission in the African Region, efforts have been made to improve the quality of vaccination campaigns in Nigeria, while advocacy to ensure that Kano State resumes vaccination is being intensified. Several rounds of very high quality mop up vaccination campaigns have been conducted in the countries that experienced importations in 2003 and 2004.

4. Three rounds of nationwide SIAs are planned for Niger and Nigeria in 2004. These rounds aim at reaching at least 90% of all susceptible children so as to interrupt the remaining chains of indigenous transmission. Polio-free countries at risk for importations due to geographical proximity or commercial and other links with Niger and Nigeria will conduct two rounds of SIAs to boost population immunity before the end of 2004. All polio-free countries should strengthen routine immunization coverage, achieving and sustaining certification standard acute flaccid paralysis surveillance and importation plans.

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Introduction

1. In 1988, the World Health Assembly adopted Resolution WHA 41.28 to rid the world of poliomyelitis. At that time, over 125 countries were polio-endemic, including all 46 countries of the WHO African Region.

2. Implementation of the recommended polio eradication strategies in the WHO African Region began in earnest following the 1996 African Heads of State Yaounde Declaration on polio eradication in Africa (AHG/Decl.1.XXXII). Since 1996, Heads of State and ministers of health throughout Africa have overseen polio eradication activities that at their peak immunized over 100 million African children annually.

3. Four sessions of the WHO Regional Committee for Africa adopted resolutions (AFR/RC39/R3, AFR/RC42/R4, AFR/RC44/R7, AFR/RC45/R5) on polio eradication activities. By 2003, 44 of the 46 countries in the Africa Region had interrupted indigenous wild poliovirus transmission and were therefore no longer considered polio-endemic.

4. Failure to vaccinate all susceptible children in the most endemic parts of northern Nigeria and southern Niger has resulted in a massive resurgence in wild poliovirus transmission. This situation represents a threat to polio eradication in the African Region.

Situation analysis

5. *Wild poliovirus transmission in the Africa Region*: By the end of June 2004, Africa had reported five times as many polio cases as compared to the same period in 2003.

6. *Endemic transmission*: There continues to be endemic wild poliovirus transmission in Niger and Nigeria. These countries account for 353 (92%) of the 383 confirmed polio cases in the Africa Region between 1 January and 7 July 2004. This more than fivefold increase in cases in both countries since 2003 is a result of the failure to vaccinate a significant proportion of susceptible children in the most endemic areas. The suspension of vaccination activities in Kano State, the epicentre of the epidemic in northern Nigeria, and the sub-optimal quality of vaccination campaigns in the other endemic areas in Niger and northern Nigeria have led to the increased intensity of wild poliovirus transmission in both countries.

7. *Imported transmission*: In 2003, genetic sequencing confirmed that wild poliovirus from the Niger-Nigeria reservoir had re-infected eight west and central African countries (Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Ghana and Togo). In 2004, six countries in west, central and southern Africa (Benin, Botswana, Burkina Faso, Central African Republic, Chad and Côte d'Ivoire) were re-infected.

8. *Acute flaccid paralysis surveillance*: Polio surveillance as monitored by acute flaccid paralysis (AFP) reporting improved between April 2003 and March 2004, particularly in the southern and eastern African epidemiological blocs. As of the end of May 2004, gaps in AFP

surveillance were evident in 11 countries in the Region: Algeria, Burkina Faso, Burundi, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Lesotho, Namibia and Sierra Leone.

9. *Routine immunization*: In 2003, 29 of the 46 countries reported DPT3 coverage of at least 70%. At the same time, 12 countries in the Region reported DPT3 less than 60%.

10. *Certification*: The African Regional Certification Commission (ARCC) reviewed documentation from eight countries (Burundi, Cameroon, Gambia, Guinea, Malawi, Rwanda, Senegal and Tanzania) that have fulfilled the criteria for certification. The work of the ARCC has been substantially complicated by the importation of wild poliovirus to countries such as Botswana which are of considerable distance from the Niger-Nigeria epicentre of transmission.

11. *Mainstreaming polio interventions*: Many countries in the Region have used the opportunities provided by polio eradication to improve routine immunization coverage, accelerate measles control, and advance maternal and neonatal tetanus elimination. Polio vaccination campaigns have offered opportunities for interventions which focus on vitamin A, antihelminths and insecticide-treated materials. About 75% of the countries in the Region have used AFP surveillance resources to support integrated disease surveillance, and experiences from the Regional Polio Laboratory Network have been used to establish networks for measles and yellow fever.

12. *Polio eradication financing*: The Global Polio Eradication Initiative faces a funding gap of approximately US$ 100 million for planned activities in 2004–2005. Of this, US$ 50 million is required for Africa. The emergency response being planned by 21 west and central African countries is estimated to require an additional US$ 100 million over the next two years. Resource mobilization efforts internationally as well as in endemic and high-risk countries are being intensified.

Interventions to date

13. *Supplemental immunization activities*: Between 1996 and 2002, most countries in the Region conducted high quality SIAs. As a result, indigenous wild poliovirus transmission was interrupted in all countries except Niger and Nigeria. In 2003, SIAs were only conducted in endemic and high-risk countries. SIAs in several of the most endemic states in northern Nigeria were suspended in the second half of 2003 as a result of unfounded fears about the safety of the oral polio vaccine. SIAs have since been resumed in all states except Kano.

14. *Activities in Nigeria*: The focus has been on resuming SIAs in all states in the country and ensuring that at least 90% of susceptible children are reached during these campaigns. The following efforts have been undertaken:

(a) WHO has provided expert advice to the Federal Government of Nigeria on the testing of vaccines for steroid hormones, and the interpretation of such test results.

(b) High-level advocacy discussions have taken place with the president of Nigeria, the governor of Kano State and federal health authorities. The UN secretary-general, president of the Africa Union and ambassadors of the Organization of the Islamic Conference, among others, have been involved in these advocacy efforts.

(c) WHO and partners have facilitated *fatwas* and other edicts by senior Muslim religious leaders and scholars of Egypt, Saudi Arabia and Qatar which indicate that immunization does not contradict any Islamic teachings.

(d) WHO and UNICEF have assisted local and international media in better understanding the background to the suspension of polio immunization activities in northern Nigeria, as well as the nature and safety of the oral poliovirus vaccine.

15. *Mopping-up immunization activities*: In an effort to stop transmission of imported poliovirus in re-infected countries in Africa, a total of 63 million children were vaccinated during campaigns conducted in October, November and December of 2003. These campaigns resulted in additional costs of US$ 25 million. Botswana and Ghana contributed domestic resources to cover a significant portion of the costs of these campaigns.

Proposed interventions

16. Mass polio immunization campaigns will be restarted across northern Nigeria. The proportion of children reached will be improved to greater than 90% in each campaign in both Niger and Nigeria. This is crucial to ensuring interruption of the persistent endemic wild poliovirus transmission in these countries.

17. At least two rounds of high quality nationwide immunization campaigns will be conducted in 21 west and central African countries to interrupt wild poliovirus transmission in the subregion.

18. Angola and the Democratic Republic of Congo need to conduct two rounds of high quality immunization campaigns in high-risk areas.

19. Countries need to utilize every opportunity to conduct immunization campaigns to boost population immunity and pre-empt wild poliovirus importations in the polio-free countries.

20. Countries need to develop preparedness plans to ensure rapid response to importation in all countries. Importations will remain a risk until polio is eradicated everywhere, and they should be treated as an urgent public health threat.

21. All countries need to intensify efforts to strengthen routine immunization and polio surveillance as the best defense against importations of poliovirus.

Implementation process

22. To continue the implementation process, countries should:

(a) ensure the highest political commitment and leadership at all levels to facilitate quality implementation of the appropriate polio eradication strategies;

(b) ensure national ownership and leadership of the polio eradication initiative and pursue this in a manner that is beneficial to strengthening national health systems;

(c) advocate and support activities aimed at ensuring high quality polio eradication activities in the remaining polio-endemic reservoirs in the WHO African Region;

(d) utilize the Inter-Agency Coordination Committee mechanisms to mobilize financial, material and human resources in-country to ensure implementation of priority polio eradication activities;

(e) advocate with partners for the additional resources required for the implementation of planned polio eradication activities until Africa is certified polio-free.

23. The role of WHO is to:

(a) provide technical assistance in response to requests from Member States to support planning, implementation and evaluation of polio eradication activities;

(b) continue to mobilize financial and material support required for the implementation of planned polio eradication activities.

24. Partner agencies are invited to scale up their technical, financial and material support for the defined priority activities aimed at interrupting wild poliovirus transmission.

Monitoring

25. Each country should implement monthly monitoring of the status of polio eradication.

26. The WHO Regional Office for Africa should report annually to the Regional Committee on the progress made in polio eradication in the Region.

Conclusion

27. The tremendous progress and experience in Africa since the launch of the “Kick polio out of Africa Campaign” at the Organisation of African Unity (OAU) Summit in Yaounde in 1996 clearly demonstrates that a polio-free Africa is achievable. Africa’s emergency response to the spread of poliovirus in west and central Africa will preserve this progress and the considerable investment made to eradicate this crippling disease from the continent. Achieving this important public health success in Africa depends on the leadership and support of governments, donors and international organizations working together in the final push to eradicate polio transmission by the end of 2004.