Global Polio Eradication Initiative

The Global Polio Eradication Initiative — led by WHO, Rotary International, the US Centers for Disease Control and Prevention (CDC) and UNICEF — was launched in 1988 when the World Health Assembly adopted a resolution to eradicate polio. At the time, more than 350 000 children were paralysed by the disease each year, and polio was endemic in more than 125 countries. Since then, tremendous progress has been made and the disease burden has been reduced by more than 99%. In 2006, four countries remain polio endemic — Afghanistan, India, Nigeria and Pakistan — and fewer than 600 cases were reported worldwide by 21 June 2006.

David Heymann

- — Scientific evidence must be validated and used as basis for policies
- — Establish strong surveillance mechanisms, performance monitoring and effective planning
- — Well-defined partnership capitalizes on complementary strengths

David Heymann, Representative of the WHO Director-General for Polio Eradication, said he expects that all countries will be able to interrupt polio transmission in 2006, except Nigeria, where at least a further 12 months are needed to finish the job.

Q: Which practices helped to make this programme a success?

A: Polio eradication follows two major strategies: routine immunization with oral polio vaccine and mass vaccination campaigns to top off that routine coverage. These strategies are underpinned by networks of medical personnel and laboratories: field medical officers to identify persons with polio through surveillance of acute flaccid paralysis and to support countries in planning and implementation of immunization activities; and laboratories to confirm and analyse the presence of poliovirus. Practices that have worked are: the integration of micro-planning (including community mapping) with the planning of vaccination campaigns; monitoring the performance of vaccination campaigns using pre-established performance indicators; and assessing their impact through surveillance. Additional practices that have ensured strong and valid surveillance include weekly assessment of the performance of surveillance using quantitative reporting indicators, and annual certification of laboratory quality through external quality assessment.

Q: What were the lessons you learned when implementing this programme?

A: The first lesson is that scientific evidence must be validated and used as the basis for policies. When difficulty occurred, for example, in interrupting transmission in high population density countries, scientific evidence was used to find the solution — a monovalent oral polio vaccine that is now available to countries in the final stage of eradication. The second and possibly most important lesson is that a well-defined partnership brings complementary strengths to the table. Polio eradication depends on collaboration between four leading partners: WHO, Rotary International, CDC and UNICEF, and on the implementation of programmes by countries with guidance from WHO's regional and country offices. Frequent and regular communication is necessary, whether it be phone conferences to discuss advocacy or fundraising between the four core partners, or within each organization to discuss planning, budgeting and implementation among staff at headquarters and those in regional and country offices. Each partner, with its comparative advantage, has made the polio eradication initiative a success: Rotary — because of its capacity to raise funds and advocate at all levels of government; UNICEF — with its strength in social mobilization and vaccine supply; CDC — with its provision of technical experts, and WHO — by ensuring eradication norms, standards and policies, global monitoring and technical support to governments. ■

WHO's strategy on Integrated Management of Childhood Illness

Elizabeth Mason, Director of WHO's Department of Child and Adolescent Health and Development (CAH), says that since WHO launched the Integrated Management of Childhood Illness (IMCI) strategy in 1995 it has been implemented in more than 100 countries. In some countries it has already led to improvements in child survival and health. The programme started in response to a request from countries to expand the remit of the management of diarrhoeal diseases and acute respiratory infections to cover all the major life-threatening conditions of childhood. It is based on the idea that health workers need to look at the child as a whole.

Elizabeth Mason

- — Empower health workers (providers) and educate parents (clients)
- — All programmatic tools need to be ready before implementation
- — Be quick to present positive results for advocacy purposes

Q: What are the practices that helped to make IMCI a success?

A: IMCI is a very simple tool based on evidence, and it simplifies the approach to managing the child while at the same time considering the child as a whole. It also includes communications skills between the health worker and the mother, so that the health worker feels empowered to advise parents better, so that the parents are more likely to understand and adhere to the advice. A lot of the feedback on IMCI has been on health worker skills and confidence: confidence in their decision-making, and skills to make the best decision for that child. Whether the best decision is to give or not give an antibiotic, or to refer or counsel the mother — health workers actually have a systematic review process to follow. They can make a decision based on a clear set of well-defined instructions, and that decision leads them to the correct action. IMCI guidelines and materials are adapted to the epidemiological, political, and social environment of a country. The guidelines thus meet a country's specific needs in terms of illnesses (e.g. malaria or HIV), drug policy (which drugs are available at which level of health facility) and organizational structure. The fact that it has been essential to build from the beginning and continually nurture partnerships with other principal actors in child health creates a stronger technical and funding base, and helps develop harmonious assistance to countries.

Q: What lessons did you learn for the future, when implementing this programme?

A: One key lesson was that you need to have the programmatic tools at the same time as the training tools. One of the initial criticisms was that IMCI was just a training programme, since the other programmatic areas were not developed well enough initially. Another key lesson was in our presentation of IMCI to countries. For example, the training of health workers is done in a fairly intensive 11-day course. For the health worker, it is a short time to learn a great deal of material. For the decision-makers, it is a long time to take health workers from their posts. For the funders, it is expensive. Overall, you have a mixture of interests. In the packaging, we were focused more on the content than on an explanation of why that length of time is necessary. Having all programmatic tools ready may have been a more successful way of ensuring agreement among the decision-makers and the funders. In addition, we need to be quicker to present positive results. Although we embarked on a very comprehensive multi-country evaluation of IMCI, we didn't pay sufficient attention to more punctual evaluation and feedback that would give results we could communicate to the ministries of health and to partners. I would do that differently in future. ■

Recent news from WHO

- WHO welcomed the **focus on infectious diseases** and **detailed health commitments made by the G8** countries in a final statement at 15–17 July summit in St. Petersburg, Russia. "The G8 spoke together on the essential need to tackle infectious diseases, because of their health, social, security and economic impacts," said WHO Acting Director-General Anders Nordström. "The commitments are detailed and specific, and represent another step forward in G8 leadership on public health." The G8 pledged to improve the ways in which the world cooperates on surveillance for infectious diseases, including improving transparency by all countries in sharing information. The G8 also committed to continued support to fight HIV/AIDS, tuberculosis, malaria, and to eradication of polio. Nordström led a senior WHO team at the summit to contribute to discussions on infectious disease, and he addressed G8 leaders, in the presence of heads of state or government officials from Brazil, China, the Congo, Finland, India, Kazakhstan, Mexico and South Africa, as well as UN officials who had been invited.
- The Codex Alimentarius Commission has adopted new standards on the maximum allowable levels of a number of key contaminants and food additives in order to protect the health of consumers. At its latest session, which ended on 7 July, the Commission set standards for the maximum allowable amounts of contaminants such as lead and cadmium in certain foods. Additionally, newly adopted codes of practice will give guidance to governments on how to prevent and reduce dioxins and aflatoxins in food.
- WHO issued updated guidelines on 28 June for the airline industry to reduce the risk of tuberculosis (TB) and other infectious diseases being passed from passenger to passenger on board aircraft. The ***Tuberculosis and Air Travel*** **guidelines** stipulate that people with infectious TB must postpone long-distance travel, while those with multidrug-resistant tuberculosis (MDR-TB) must postpone any air travel.
- WHO launched the world's first-ever international guidelines on **safe places to swim and bathe** on 27 June. The guidelines aim to protect people from the health risks associated with swimming pools, spas and other recreational bathing areas.
- Indonesia hosted an international expert consultation on **avian influenza** from 20 to 22 June. During the meeting, experts reviewed the status of the H5N1 virus in humans and animals. The group made recommendations on improving control of the virus in animals and humans, and it reviewed the lessons learned for rapid response and containment.
- WHO and the United Nations Population Fund pledged to step up efforts to address the increasing levels of **sexual and reproductive ill-health** after a 16 June meeting on the issue. The move follows two World Health Assembly resolutions on the issue in 2005 and 2006. Inadequate sexual and reproductive health services have resulted in maternal deaths and rising numbers of sexually transmitted infections, particularly in developing countries. WHO estimates that 340 million new cases of sexually transmitted bacterial infections, such as syphilis and gonorrhoea, occur annually in people aged 15–49 years. Many are untreated because of lack of access to services.

For more about these and other WHO news items please see: http://www.who.int/mediacentre/events/2006/en/index.html