



The USAID Polio Eradication Initiative

1997 Report to Congress

- PN-ACC-727 -



Polio-Free by the Year 2000



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Executive Summary

In 1997, the world moved a step closer to polio eradication—giving hope that future generations will not know the perils of this crippling and potentially deadly disease. With support from the United States Congress, the United States Agency for International Development (USAID), through its Child Survival Program, launched an expanded effort in April 1996: the Polio Eradication Initiative (PEI). This initiative demonstrates America's strong commitment to saving the world's children from unnecessary illness and death from polio. PEI is part of an ongoing effort to eradicate polio worldwide by the year 2000. To achieve this goal, children everywhere must be vaccinated and every remaining chain of transmission interrupted.

Once polio is eradicated,
global savings can equal
more than U.S. \$1.5 billion
each year.

The global eradication campaign is already showing impressive results. Four out of every five children are now immunized against polio during their first year of life—a significant change from the early 1970s when only one in 20 was immunized. Many children in developing countries are being immunized against polio during National Immunization Days (NIDs). Approximately 300 million children in 32 countries were immunized against polio during NIDs in 1995; that number rose to 420 million in 69 countries in 1996, and to an estimated 450 million in 75 countries in 1997.

Through the initiative, USAID has taken a more active role in the global polio eradica-

tion effort. Working with host countries and its Polio Partners—the World Health Organization (WHO), Rotary International, United Nations Children's Fund (UNICEF), the U.S. Centers for Disease Control and Prevention (CDC), and others, the Agency has channeled funds, technical assistance, training, and other resources into this collaborative initiative. USAID has also been working with the Government of Japan through the *US-Japan Common Agenda* to coordinate financial and technical support to the eradication effort.

To raise awareness of polio eradication activities and spread the news of the benefits of immunization at the community level, USAID and the Voice of America (VOA) joined forces in November 1997 in a targeted media campaign. By late February 1998, VOA reporters had broadcast more than 100 reports in 13 African countries and six Asian countries in local languages. In addition, the Associated Press and regional and local news services have been running the VOA reports and independently reporting on polio eradication activities in Africa, Asia, Eastern Europe, and the New Independent States (NIS).

USAID works through CDC, WHO, and UNICEF, and directly with governments in Africa, Asia and the Near East (ANE), and Europe and the NIS (ENI), where the poliovirus is still transmitted. The Agency also serves as an advocate for the PEI in meetings with foreign governments and other donors, and works to leverage available resources.

On the research front, USAID is funding studies through U.S. universities and other institutions to further knowledge of the poliovirus. Determining if immunodeficient individuals continue to shed the virus remains a critical question for the eradication effort. Determining if communication messages are reaching the hard-to-reach and identifying barriers to reporting on polio cases are also key issues.



USAID is also promoting routine immunization for all vaccine-preventable diseases, including polio. The Agency is examining why routine immunization has not increased in some areas as the PEI has developed and been implemented by most developing countries.

With funding and resources from USAID, other donors, governments, and private voluntary organizations (PVOs), the number of countries conducting NIDs has increased sharply in recent years. By the beginning of 1998, 111 countries had conducted at least one round of NIDs, including all the polio endemic countries of Asia and Europe. As of January 1998, only four countries in Africa had not yet held NIDs. Two of these, the Democratic Republic of Congo and Somalia, have conducted sub-national immunization days (SNIDs) and plans are being made to hold full national campaigns in 1998.

NIDs have also been the motivating factor for a number of remarkable displays of international cooperation, bringing together people at all levels to ensure that all children under the age of five are immunized. The successful 1997 NIDs in India, for example, were the focal point of a \$60 million campaign that involved ministry of health staff, UNICEF, USAID and other donors, Rotary International, and 10 million volunteers. In its third year of NIDs, India was able to immunize 130 million children on December 7, 1997, and again on January 18, 1998—two of the largest public health events in history. NIDs have been synchronized in south and central Asia, the Caucasus, and the Middle East. Because immunizing nomadic and other mobile groups is very difficult, regionally coordinated NIDs provide a maximum effect in reaching the target group.

As a result of this global effort, the number of countries with functioning surveillance systems for a limited number of diseases is also growing. These systems are helping to both

strengthen the health infrastructure in many developing countries and identify remaining reservoirs of the poliovirus. These are areas where USAID funding has made a difference.

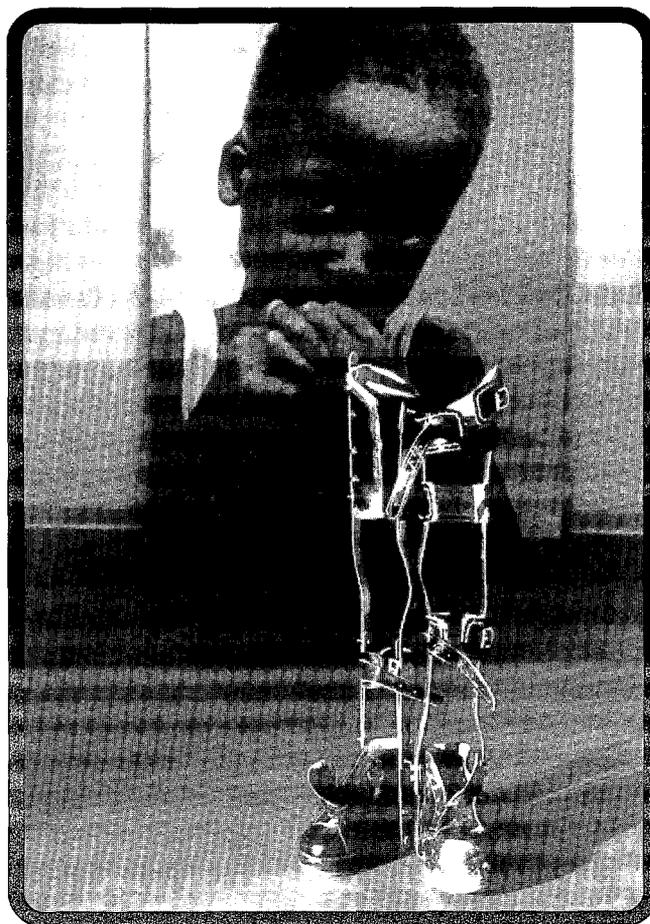


Photo by J.F. Cretien/WHO

This Report to Congress presents a summary of PEI activities and the initiative's impact on the world's children in 1997.

Through the PEI, USAID is striving to leave a legacy for the world's children. This will be a legacy of polio eradication, global cooperation, greater confidence in our ability to achieve public health goals, and stronger health systems to monitor, track and prevent the spread of diseases in developing countries.



ACRONYMS

AAWH	American Association for World Health
AFP	Acute Flaccid Paralysis
ANE	Asia and Near East (USAID Regional Bureau)
BASICS	Basic Support for Institutionalizing Child Survival (a USAID Project)
CDC	U.S. Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CPHA	Canadian Public Health Association
DANIDA	Danish International Development Assistance
ENI	Europe and New Independent States (USAID Regional Bureau)
EPI	Expanded Program on Immunization
EU	European Union
FY	Fiscal Year
G/PHN	Global Bureau, Center for Population, Health, and Nutrition (of USAID)
ICC	Interagency Coordinating Committee
IDB	International Development Bank
INCLEN	International Clinical Epidemiology Network
JOCV	Japan Overseas Cooperation Volunteers
LAC	Latin America and the Caribbean (USAID Regional Bureau)
MECACAR	Middle East, Caucasus, Central Asia Republics
NGO	Non-Governmental Organization
NID	National Immunization Day
NIS	New Independent States
OPV	Oral Polio Vaccine
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PEI	Polio Eradication Initiative
PVO	Private Voluntary Organization
SNID	Sub-national Immunization Day
UNICEF	United Nations Children's Fund
UNICEF/AFR	UNICEF/Africa Region
USAID	United States Agency for International Development
VOA	Voice of America
WHO	World Health Organization
WHO/AFRO	World Health Organization/Africa Regional Office
WHO/EURO	World Health Organization/Europe Regional Office
WHO/SEARO	World Health Organization/South East Asia Regional Office
WHO/WPRO	World Health Organization/Western Pacific Regional Office



I. Introduction

A. The Global Effort to Eradicate Polio by the Year 2000

In 1988, the U.S. government joined with other member nations of the World Health Assembly to adopt a global resolution to eradicate polio by the year 2000. Together, the signatories are working to strengthen the Expanded Program on Immunization (EPI), and its routine activities, and develop sustainable health care systems.

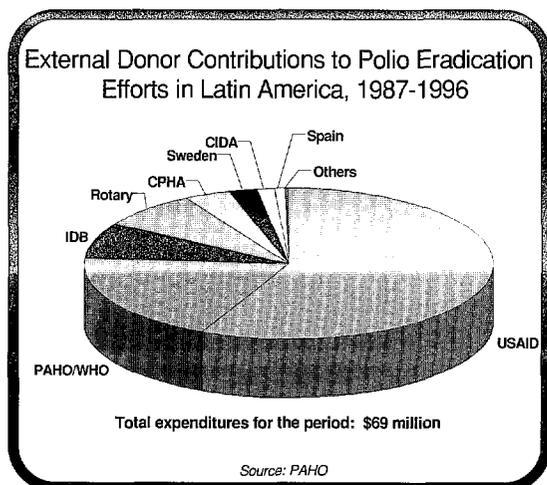


Figure 1

Initially, USAID assistance for polio eradication focused on Latin America and the Caribbean (LAC), where it was the major external donor (see Figure 1). After the Americas were certified polio-free in 1994, the U.S. shifted its geographic focus. In 1996, with the encouragement and support of Congress, USAID launched an expanded eradication initiative, the USAID PEI. To carry out this initiative, USAID in collaboration with its partners, developed a strategy incorporating the many lessons learned from 10 years of support to the LAC region. For example, the importance of establishing functioning Interagency Coordination Committees (ICCs) at the country and regional levels, the value of establishing, mea-



Photo by N. Ward/WHO

suring, and regularly monitoring indicators of program success, and the benefits of harnessing the enthusiasm and confidence of those involved in eradication efforts were all recognized and replicated in the PEI strategy.

With \$20 million for the PEI in 1996, USAID was able to take a more active role in the effort to wipe out polio. Resources were focused in Africa, South Asia, and the New Independent States of the former Soviet Union (NIS), which continue to be major polio endemic areas.

In both FY 1997 and FY 1998, USAID set aside \$25 million for the PEI, reflecting a continuing political commitment to polio eradication in developing countries.



B. Polio Partners

USAID and its Polio Partners—WHO, Rotary International, UNICEF, and CDC—are working collaboratively with host country governments in Africa and Asia to closely monitor routine immunization coverage year-round, provide rapid feedback to countries, and report on coverage at country, regional, and international meetings. USAID is also supporting the development of a standard set of EPI sustainability indicators and exploring long-term vaccine financing issues.

USAID provides technical assistance and financial support for polio eradication efforts. The Agency administers most of its support through grants to WHO and UNICEF. USAID also draws on the skills and experience of its technical cooperating agencies.

USAID and its Polio Partners



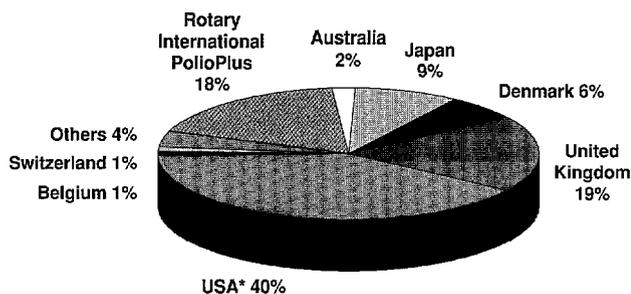
An estimated \$150 million in funding was provided by the Polio Partners in 1997 (see Figure 2). Together the partnerships provide developing countries with funding, technical expertise, leadership, advocacy, and volunteers.

The Polio Partners use a Polio Eradication Strategy that is simple and has proven effective in the Americas. It calls for interrupting poliovirus transmission through:

- High levels of routine immunization;
- NIDs—a short-term activity that involves organizing two rounds of highly visible, concentrated supplemental vaccination days a year, one month apart, over a period of at least three years. NIDs target all children under five with oral polio vaccine (OPV) regardless of their prior vaccination status;
- Adequate surveillance systems to isolate and identify all polio cases;
- “Mop-up” activities (initiated after NIDs cease) to immunize children in a house-to-house effort in high-risk areas where the final pockets of wild poliovirus remain; and,
- A certification process to verify the reported polio-free status of countries.

Estimated Polio Partner Contributions To Polio Eradication: 1997

(Total = US\$150 million)



USA contributes 60% through CDC and 40% through USAID. USAID distributes most of its funds through WHO or UNICEF.

Source: WHO

Figure 2

Other important Polio Partners are host countries, community groups, PVOs, and other bilateral donors, including the governments of Australia, Canada, Denmark, Japan, Sweden, and the United Kingdom.



II. The USAID Polio Eradication Initiative

A. Overview

The Agency's PEI strategy is designed to eradicate polio within the context of strong and sustainable routine immunization systems—an essential foundation for childhood immunization and basic primary health care services in the developing world. This is the legacy that the Agency hopes to leave for the 21st century.

The Results Framework that USAID developed with its partners in May 1996, remains the guiding document for USAID funding. It is also proving to be an effective management tool.

B. PEI Strategy and Results Framework

The USAID PEI focuses on the five elements articulated in the PEI Results Framework (see Figure 3). These are:

1. Build effective partnerships

USAID supports partnerships at both regional and national levels, particularly through ICCs.

2. Strengthen systems

USAID supports activities to enhance a country's capacity to provide high-quality polio vaccine through routine immunization systems delivery. This includes improved training, supervision, logistics, cold chain assessment and management, and program management for polio and other childhood illnesses.

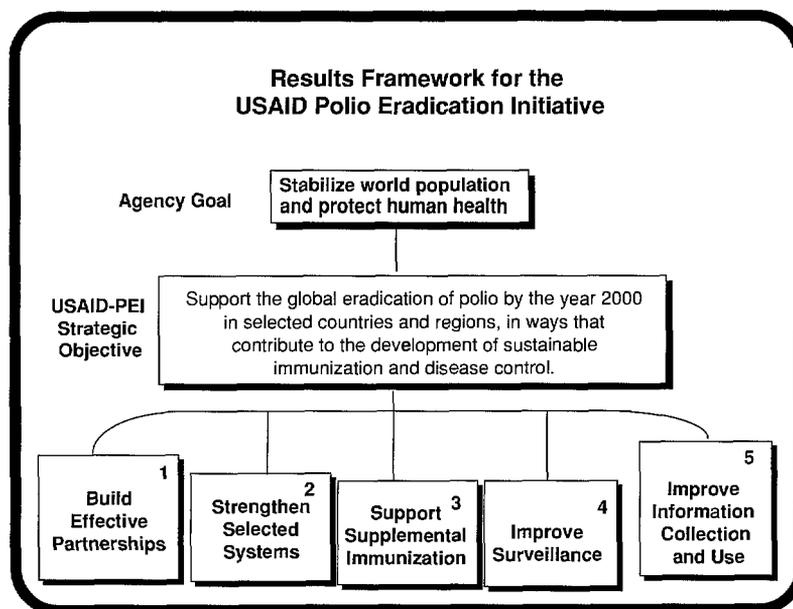


Figure 3

3. Ensure effective supplemental immunization through NIDs and mop-up campaigns

USAID funds are used to assist in planning and implementing supplemental polio immunization and intensive immunization campaigns in high-risk areas.

4. Improve Acute Flaccid Paralysis (AFP) surveillance¹ and laboratory investigation

USAID funds are used to strengthen existing surveillance systems and support development of new surveillance systems that are needed to detect, report, and respond to outbreaks of polio and other infectious diseases.

¹Acute Flaccid Paralysis (AFP) Acute refers to the rapid progression of the poliovirus, usually in 1 to 3 days. Flaccid (i.e., floppy) paralysis is the condition where polio is suspected. A case of suspected polio is defined as any child under 15 years of age with AFP, including Guillain-Barré syndrome, or any paralytic illness at any age when polio is suspected. AFP surveillance is a system to identify suspected polio cases. Its purpose is to reliably detect areas where poliovirus transmission is occurring or likely to occur. Once an area is identified, supplementary immunization can be targeted to that area.



5. Improve information collection and use

USAID supports data and information collection to monitor, evaluate, and continually improve the quality of PEI activities.

C. PEI Funding

USAID has been supporting polio eradication activities through the EPI since 1978. In April 1996, USAID added to its ongoing EPI activities by joining the global polio eradication effort. The lion's share of the 1996 \$20 million in funding went to the Africa region (\$9.7 million) and ANE region (\$7.6 million),



Photo by D. Henrioud/WHO

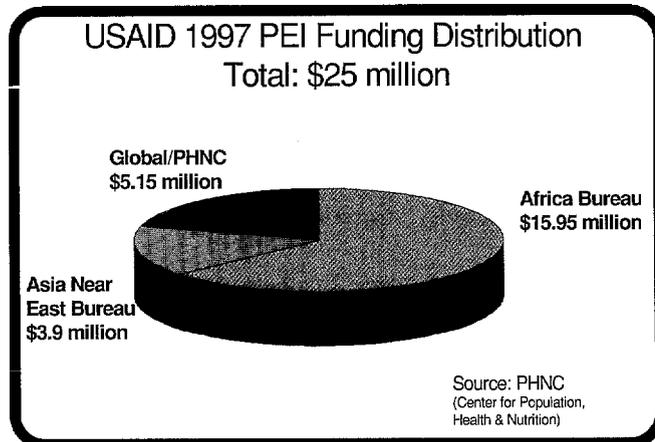


Figure 4

to strengthen health infrastructure and surveillance systems.

In FY 1997, USAID's \$25 million PEI contribution was allocated as follows (see Figure 4):

- **\$15.95 million for the Africa region**, implemented through WHO, UNICEF, and the USAID-funded BASICS project, to support ministries of health in host countries to help plan and strategize for their polio eradication activities. Funds were also used to purchase cold chain equipment and provide monitoring and evaluation activities.

- **\$5.15 million through the USAID Global Bureau, Center for Population, Health and Nutrition (G/PHNC)** for research, monitoring and evaluation initiatives, and specific activities in the ANE and ENI regions to improve polio surveillance and strengthen immunization systems. Also funded were efforts to: identify barriers to effective immunization and case reporting; conduct data collection and use verification methodologies; develop methods to assess PEI's impact on health systems; disseminate information; and conduct communication and training activities.

- **\$3.9 million for the ANE region** through grants to UNICEF and WHO to strengthen planning and training systems, conduct NIDs, and improve polio surveillance systems in India, where about 25 percent of all reported polio cases occur.



D. The U.S.-Japan Common Agenda: A Successful Partnership

In 1993, the governments of the United States and Japan launched the *Common Agenda for Cooperation in a Global Perspective*, (also known as the "U.S.-Japan Common Agenda," or "Common Agenda"). The objective was to jointly provide financial and technical support to address critical global challenges. Today the Common Agenda has emerged as one of the world's most successful bilateral partnerships. It has grown to include more than 20 initiatives that tackle worldwide issues in health, population, and environmental degradation. Polio eradication is considered one of the highlights of the U.S.-Japan Common Agenda—where we continue to find ways to maximize our collaboration.



Photo by D. Darbois/WHO

Polio eradication is considered one of the highlights of the U.S.-Japan Common Agenda.

Polio Eradication

Japan joined other member nations in signing the World Health Assembly resolution to Eradicate Polio by the Year 2000. While most Common Agenda activities are implemented bilaterally, the unique nature of the polio eradication effort dictates that it be carried out as a global partnership. While the U.S. government directs its polio eradication funds to USAID and CDC, the Japanese government directs its funds to its Ministry of Foreign Affairs. Because the U.S. and Japan provided about half of the external funding for polio eradication for the past two years, these countries are in a position to help shape the eradication effort by supporting individual country activities (see figure 2, page 2).

From 1988 to 1995, the U.S. focused its efforts in the LAC region, while Japan focused on the western Pacific. In 1996, both countries began to coordinate their financial and technical support to eradication activities in Asia and Africa. This has included increasing collaboration and information exchange between U.S. and Japanese technical staff on country programs, OPV procurement, and advocacy issues. In 1997, Japan and the U.S. coordinated efforts in six countries: Bangladesh, India, Kenya, Malawi, Nepal, and Tanzania. Recently, the U.S. and Japan began promoting the participation of U.S. Peace Corps volunteers and Japan Overseas Cooperation volunteers in polio activities and began a joint dialogue with U.S. and Japanese PVOs and non-governmental organizations (NGOs) working in developing countries.



E. USAID and Voice of America

In 1997, to increase the participation of communities and families in immunization and



Voice of America reporter Cole Mallerd takes time to pose with children from Ghana during the NIDs in December 1997.

Photo by K. Ofori/VOA

Rotary International and USAID briefed VOA reporters on the technical eradication strategy at a kick-off meeting in November 1997. The Agency encouraged reporting in a variety of formats: call-in shows, progress reporting, interviews with volunteers/Rotarians/local ministry of health staff/U.S. government staff, radio dramas, the use of VOA fan clubs, etc. Reporters were also instructed to contact the local ICC partners to ensure technical accuracy and appropriateness, and coordinate with in-country social mobilization plans. Most of the VOA reports will be available to other radio affiliates free of charge. The Africa NIDs were the first to be reported on under this new agreement. Thousands of VOA fan clubs are starting to promote polio and EPI activities.

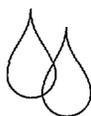
surveillance efforts, USAID signed an inter-agency agreement with VOA. Through this agreement, VOA now provides year-round reporting on various aspects of polio eradication to millions of listeners in South Asia, Africa, and Central Asia in local languages.

"In Africa, hearing reports on the eradication initiative in the international media reinforces the seriousness of the global effort. Hearing Africans in these reports strengthens the credibility of our health experts, and increases the level of participation."

Dr. J.M. Okwo-Bele
Regional Advisor EPI, WHO/AFRO

The Agency is working with VOA to:

- Maintain interest in polio eradication at the local level where polio exists, until global certification is achieved;
- Emphasize routine immunization;
- Announce the NIDs and broadcast to hard-to-reach groups;
- Explain the need for supplemental immunization;
- Inform the public about the importance of reporting AFP cases to a health facility; and,
- Help counter any misinformation.



III. Progress in 1997²

A. Overview: Status Report on Polio Immunization Efforts

1. Routine Polio Immunization

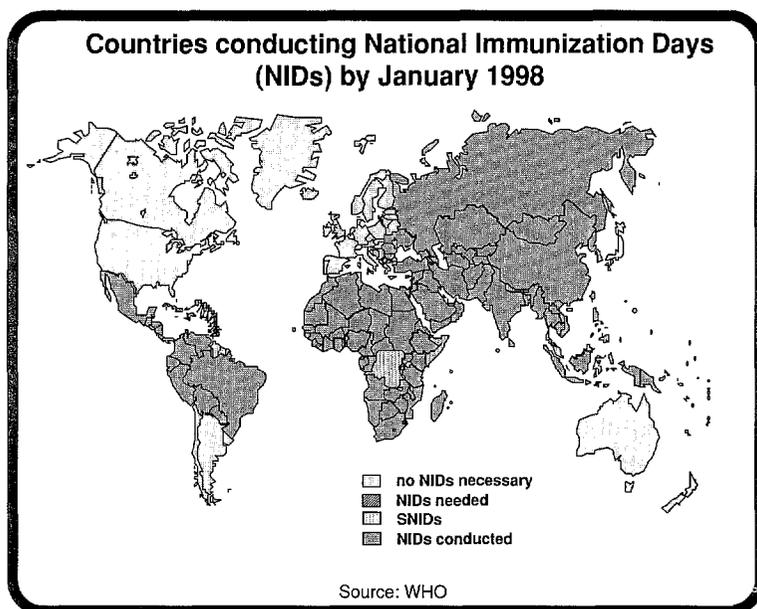
While progress by USAID and its Polio Partners has been remarkable in increasing coverage through supplemental immunizations, worldwide routine polio immunization coverage (3 doses of OPV) peaked at 83 percent in 1990 and has remained static; it is currently at 82 percent. This indicates that additional rounds of NIDs and more widespread mop-up campaigns are needed in some countries to wipe out polio. More attention also needs to be directed to areas where routine immunization coverage has decreased. Declines in routine immunization coverage are worrisome. USAID is monitoring the situation and working with its partners to find ways for PEI efforts to further support and accelerate routine immunization coverage.

2. Supplemental Immunization

The number of countries conducting NIDs has increased sharply in recent years. At the beginning of 1998, 111 countries had conducted at least one round of NIDs. NIDs have now been conducted by all the polio endemic countries of Europe and Asia. As of January 1998, only four countries in Africa had not yet started their NIDs: the Democratic Republic of Congo, Liberia, Sierra Leone, and Somalia. The Democratic Republic of the Congo and Somalia conducted sub-national immunization days (SNIDs) and are making plans to conduct full national campaigns in 1998.

Since 1995, the number of children who are immunized against polio has grown steadily. Approximately 300 million children were immunized during NIDs in 1995, and in

²Using best available data at press time (March 1998).



Map 1

1996, 420 million were immunized. In 1997, 75 countries conducted NIDs, protecting 450 million children against polio.

NIDs have provided the opportunity for a number of remarkable displays of international cooperation. To prepare for the NIDs, USAID and its Polio Partners work with host country governments, regional entities, PVOs, other community groups, and volunteers to organize and mobilize the population to support these large-scale efforts. The level of cooperation and dedication among the groups and volunteers has been gratifying, and the result has been success in reaching more and more of the targeted group, children under the age of five.

3. Surveillance Systems

As the number of immunized children has increased, the number of confirmed polio cases has declined. Polio cases are reported through a growing worldwide network of surveillance systems that track circulation of wild polioviruses and play an important role in certifying polio eradication. Since AFP can be caused by agents other than polio, specimens from these cases must be examined by competent virological labs. Laboratories support disease and AFP surveillance by testing stool samples for



the wild poliovirus. AFP reporting systems have been established in most polio endemic coun-

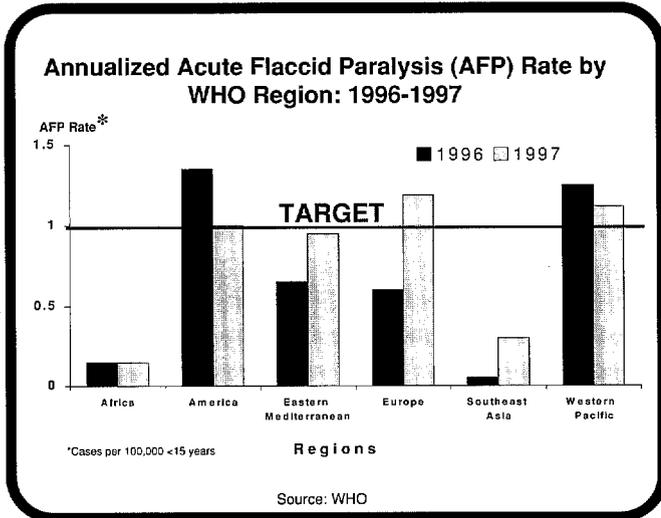


Figure 5

tries and are being improved with the needed equipment and training. WHO reports that a network of 87 laboratories with special capability in enterovirus isolation has been established. By mid-1997, WHO began implementing a polio network laboratory accreditation process to ensure that labs meet WHO criteria for a satisfactory surveillance standard. By early 1998, 35 labs were accredited and another four had provisionally passed WHO criteria.

A surveillance system is deemed adequately sensitive if it can identify about one case of non-polio AFP per 100,000 persons under 15 years of age. Satisfactory standards for surveillance are being achieved in the regions where AFP surveillance has been established for several years, the western Pacific and the Americas (see Figure 5). The systems in Africa and southeast and central Asia are beginning to be established. Additional support to rapidly bring surveillance to adequate levels is needed to confirm that wild poliovirus transmission has ended.

When the global polio eradication goal was set in 1988, approximately 35,000 cases of polio were reported worldwide. In 1996, 4,074 cases were reported, a 90 percent decline. Incomplete 1997 data indicate that 2,426 polio cases were reported (see Figure 6). While these trends are encouraging, it should be noted that many polio cases are not reported in part because they are difficult to detect.³ WHO estimates that the reported total represents only 10 percent of the cases that actually occur.

Before it can be certified as "polio-free," a country must meet strict criteria for three consecutive years. The criteria include the absence of confirmed polio cases and of detectable wild poliovirus; the presence of an adequate surveillance system; on-site evaluation by a national certification commission; and establishment of appropriate measures to deal with importations. **No countries outside of the Americas have met these criteria. This is a matter of concern to USAID and its partners, given the target year 2000. USAID is working with its partners to accelerate improvements in surveillance capacity.**

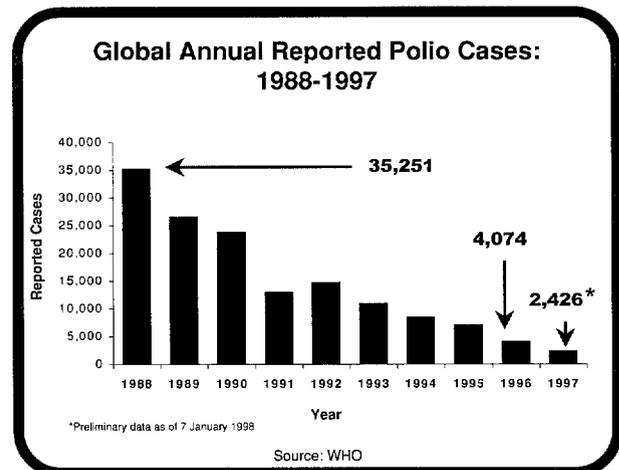


Figure 6

³While paralysis is the most visible sign of polio infection, less than one percent of all polio cases ever result in paralysis. Most cases either produce very mild flu-like symptoms or no symptoms at all. Polio can infect more than 200 individuals "silently" before the first case of paralysis emerges. This is why one case of AFP is considered a potential polio outbreak.



B. Africa: Overview & Success Stories



The 1997 drive to “Kick Polio Out of Africa” was highly successful. Many African countries reported preliminary results well above the targeted 80 percent polio immunization of all children younger than five years of age.⁴ Championed by South African President Nelson Mandela, the continent-wide campaign vaccinated 70 million children. Despite economic and political difficulties, 36 African countries conducted NIDs or SNIDs between March 1997 and March 1998, an increase from the previous year. About 100 million children below the age of five were expected to be immunized with the two supplemental doses of oral polio vaccine during this period.

Nearly 2,000 polio cases have been reported in Africa over the period of 1996-97. In 1995, 2,192 polio cases were reported. Countries with no reported polio cases are beginning to emerge in both northern and southern Africa. As of October 1997, no wild poliovirus had been identified in east and southern Africa. More important, since 1993, no wild poliovirus has been found in continental southern Africa, and several countries are close to meeting the first year’s certification criteria.

Surveillance systems are now being put in place in 31 African countries and plans for regional expansion of the lab network are under way (see section III. B. 4).

USAID Funding: In Africa, USAID provided \$15.95 million in 1997 funding through grants to WHO/AFRO, UNICEF/AFR, and the BASICS Project. These funds were used to: strengthen partnerships, immunization systems, planning, and training; provide effective supplementary immunization; assist in social mobili-

zation; improve surveillance systems and information collection; and provide program support in 24 countries.

1. Increased Coordination of Advocacy and Social Mobilization Efforts

Recognizing the growing need to engage communities in this effort, an Advisory Group on Social Mobilization for Polio Eradication in the Africa Region was formed in February 1997, with strong USAID support. The group now serves as a working group of the Task Force on Immunization in Africa and the African Region ICC and closely coordinates with both groups. Four key Polio Partners—WHO, UNICEF, Rotary International, and USAID; and rotating country officials—are members of the Advisory Group. The group is providing advice on strategic planning and reviewing progress at all levels for social mobilization activities in Africa.

The Advisory Group is also engaging in media advocacy to raise general public awareness, regional advocacy for high-level political commitment, and national social mobilization to strengthen community participation. A coordinated strategic use of advocacy and communication for behavior change, and social mobilization will strengthen local participation in NIDs, reinforce community reporting, improve the use of routine immunization, and increase PEI resources.

2. ICC Partnerships

The national ICCs and African regional ICCs are involved in planning NIDs and have added social mobilization activities to their agendas. Beginning in February 1997, the national point persons for social mobilization attended EPI manager meetings in southern and west Africa. As a result, a core group of African experts is now forming. The experience gained

⁴WHO Regional Office for Africa. “1997 Progress Report on the Implementation of the EPI in Africa.”



in the past year should help to improve the effectiveness of social mobilization efforts in each country.

3. Democratic Republic of the Congo (formerly Zaire)

After years of conflict, in 1997, USAID sent one of the first international teams to the Democratic Republic of the Congo to plan for the revitalization of the immunization system. The Agency was the only donor to support immunization in Kinshasa, the capital city; the Belgian Rotary provided funding for other cities



Photo by K. Ofori/VOA

and regions. With complementary funds, USAID was able to add vitamin A to the first round and measles vaccination to the second round of NIDs. Working through UNICEF, WHO/AFRO and BASICS, the first round was highly successful, resulting in immunization coverage of 97 percent, with a total of 721,940 children vaccinated. For the second round, reported coverage was close to 96 percent for OPV, and 91 percent for measles. A positive evaluation of the 1997 effort has set the stage

for countrywide NIDs in 1998. Progress in polio eradication in the Democratic Republic of the Congo will be crucial to the region as a whole because it is considered the main remaining reservoir of wild poliovirus in central Africa. Planned 1998 immunization activities will be coordinated with neighboring countries. WHO/AFRO has received funding to start crucial surveillance activities.

4. Southern Africa Surveillance Progress

In September 1997, the "Kick Polio Out of Africa" campaign entered its second year with growing numbers of children immunized. At that time, the American Association for World Health (AAWH) which serves as the U.S. Committee to WHO, announced its support of a critical next step: Expanding the polio surveillance network in southern Africa, where the disease is still a major threat. The network and other AAWH polio eradication activities are being funded by a \$1 million grant from Wyeth-Lederle Vaccines and Pediatrics. USAID worked closely with Wyeth-Lederle as they developed their donation plans. AAWH stated that through the expanded polio surveillance network in southern Africa, it will be possible to "quickly pinpoint locations of wild poliovirus outbreaks, alert local organizations to conduct massive immunization campaigns, and verify areas where polio has been eradicated."

In a related effort to mobilize resources and people in Africa, the Committee for a Polio-Free Africa participated in the following social mobilization activities:

- President Nelson Mandela, the committee's chair, sent letters to the Secretary General of the European Union (EU) to mobilize resources; in response, the EU passed a resolution to support polio eradication in Africa.



- The first ladies of Congo, Ghana, and Nigeria mobilized resources and involved local communities during NIDs.
- Heads of state launched NIDs in many countries, and in some cases, participated in social mobilization throughout the immunization days.



Photo by WHO/EPI

An Ethiopian doctor who participated in administering the polio vaccines described the first day as a joyous occasion. “Children cheered and sang joyfully, possibly foreseeing their healthy future, while their peers hurriedly swallowed the two drops of vaccine, and even some asking for more of it! The concerted effort of all those involved to make this hope come true was commendable.”

5. “A Day of Hope” in Ethiopia

To “Kick Polio Out of Ethiopia,” the Government of Ethiopia held two rounds of successful NIDs in November and December 1997, targeting 8.5 million children younger than five years of age. The Addis Ababa Regional Health Bureau declared the NIDs a great success. A nearly 90 percent national achievement rate was reported after the first round. Ethiopia has 500 to 1,000 new polio cases each year, according to WHO estimates, making it one of the largest reservoirs of wild poliovirus in the world.

The Ethiopia NIDs involved 25,000 vaccination posts or mobile teams, staffed by 75,000 regional health bureau staff, health workers, and many volunteers. The 1997 NIDs followed the successful 1996 SNIDs that were held in selected municipalities.

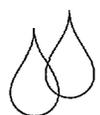
A coalition of partner agencies—USAID/Ethiopia, CDC, Rotary International and the Ethiopia Rotary Office, UNICEF, and WHO—provided approximately US\$4.8 million in funding for the NIDs. The BASICS Project provided technical assistance to help the government prepare for the NIDs. Swiss tennis player Martina Hingis contributed US\$75,000 to the Ethiopian campaign.

6. Madagascar Launches Successful NIDs for Polio Eradication

Following almost a year of planning and preparation by a National NIDs Steering Committee composed of officials from the Ministry of Health, UNICEF, USAID, WHO, Rotary International, and German, Japanese, and French governments, Madagascar’s polio eradication campaign was launched nationwide in October 1997. The campaign marked the start of a four-year effort by the Malagasy people to eradicate polio, and was the first time that the entire population was successfully mobilized around a health issue. Preliminary data showed average coverage rates of 85 percent, with some health districts recording 100 percent coverage.

7. Guinea

In late 1997, USAID provided about \$200,000 through UNICEF to the Government of Guinea for social mobilization and evaluation. In addition, USAID and the Government of Japan supported the October 1997 NID. The Guinean prime minister presided over the launch with all the ministers in attendance. The USAID mission director participated and administered the first polio dose at a health clinic.



C. Asia and Near East: Overview & Success Stories

1. Overview

Asian countries have made tremendous progress in 1997 in both supplemental immunizations and surveillance. Surveillance systems are now in place in all 10 WHO/SEARO member countries, up from two countries in 1996. Active, case-based AFP surveillance and reporting are proceeding well in Asia. In early 1997, Indonesia was the first country in the region to report AFP cases weekly to WHO. Subsequently, Bangladesh, Burma (Myanmar), India, Nepal, Sri Lanka, and Thailand followed. Non-endemic countries, Bhutan and Maldives, are now reporting weekly to WHO with negative reports (no AFP cases).

Building on the regional synchronization strategy, the first round of NIDs was launched in December 1997 in Bangladesh, Bhutan, Burma, India, the Maldives, Nepal, Thailand, Viet Nam, and China's border provinces. These followed the December 1996 NIDs coordinated by seven South Asian nations—Bangladesh, Bhutan, Burma, India, Nepal, Pakistan and Thailand—when approximately 181 million children were immunized.

The number of reported polio cases increased from 1,116 in 1996 to 1,347 in 1997. The increase reflects an expanded surveillance system designed to identify cases.

USAID Funding: USAID provided nearly \$5 million to India in 1997 through grants to WHO, UNICEF, and INCLIN.



These grants were used to: strengthen immunization systems, planning, and training; provide effective supplementary immunization; assist in social mobilization; and improve surveillance systems, information collection, and program support.

Through the BASICS Project in Bangladesh, USAID funded social mobilization activities to increase demand for polio immunization, and provided technical assistance to improve surveillance. A program review found that BASICS played "a critical role in the success of the 1997 polio program." Bangladesh also successfully linked AFP case reporting with the reporting of other vaccine-preventable diseases, particularly neonatal tetanus.

2. PVOs in India: A Large Volunteer Corps Makes the NIDs a Success

A nation of about 1 billion people, India has made important progress in polio eradication. A decade ago, India accounted for more than half of the global polio cases; now it accounts for about 25 percent. The successful NIDs in India were the focal point of a \$60 million, three-year campaign that involved CDC, DANIDA, UNICEF, USAID, WHO, other donors, ministry of health staff, Rotary International, and 10 million volunteers. Doctors, health workers, teachers, students, soldiers, policemen, and volunteers from private and state organizations administered the polio vaccine.

Reported polio cases in India dropped from 24,257 in 1988 to 946 in 1996. Some under-reporting is suspected, however. In the first 10 months of 1997, 700 polio cases were reported.



Photo by J. Corash/ UNDP



In December 1997 and January 1998, India conducted two well-publicized NIDS, immunizing 130 million children in two of the largest public health events in history. Over 96 percent of eligible children were immunized during each NID. Pakistan, Bangladesh, and six other Asian countries coordinated NIDs with India so as to achieve the maximum effect over the entire region.

India now has 50 medical surveillance officers in place and has changed its reporting requirements to be consistent with global eradication criteria. USAID support to Rotary/India helped to persuade thousands of private medical doctors to report weekly on AFP. USAID/India provided additional funding for cold chain and laboratory equipment.

3. Indonesia's Three-Year Campaign to Eradicate Polio

Indonesia, a country with the world's fourth largest population, entered a decisive stage when it began the final phase of a three-year national campaign to wipe out polio in late 1997. The health minister launched the final NIDs in early October. During the three-day drive, 286,000 immunization posts were set up at public locations such as health centers, bus stations, kindergartens, and child care centers. Indonesia has completed five national polio immunization campaigns and no wild poliovirus has been detected since 1995.

In December 1997, an international team, consisting of participants from WHO, USAID, CDC, and the Indonesian government, conducted an assessment of the polio surveillance system. The team found the system in place nationwide, with active weekly AFP reporting. The program also has two laboratories providing excellent virological support. Given the consistency and quality of AFP reporting and case investigation, the team recommended the cessation of NIDs and the development of mop-

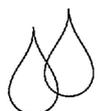
up campaign plans. The keys to the success of the Indonesia eradication effort are strong commitment by government at the national and local levels, and equally strong community participation and awareness.

4. Successful NIDs in Egypt

Two successful NIDs were conducted in Egypt in 1997. A WHO/CDC team confirmed a high coverage rate of nearly 100 percent nationwide for both rounds, with more than 6.7 million children vaccinated. The NIDs also helped to strengthen the routine EPI.

Political commitment was high at all levels. Mrs. Mubarak, the first lady of Egypt, inaugurated the campaign. Television, radio, and newspaper reporters covered the nationwide effort. The Ministry of Health and Population used its primary health facilities as fixed vaccination sites and provided additional vaccination through mobile teams and house-to-house visits in high-risk areas. USAID and other donors provided assistance and the ministry covered the vaccine costs.

For 1997, the preliminary reported number of confirmed polio cases was 14 with 217 AFP cases, evidence of a decline from the 100 confirmed polio cases and the 309 confirmed AFP cases in 1996.



D. Operation MECACAR Shows Results in ENI (WHO/EURO) Region

Most of the nations in the ENI region (also referred to as the WHO/EURO region) have not identified any new polio cases since the early 1980s. However, in a number of countries, either endemic transmission of poliovirus or outbreaks have continued well into the 1990s. Therefore, coordinated NIDs and SNIDs were organized in countries at high-risk for polio transmission beginning in 1995. As many as 19 bordering nations (from the Middle East and Caucasus to the Central Asian Republics) synchronized their immunization efforts in 1995 - 1997, reaching 95 percent of the targeted child population in all three years. The "Operation MECACAR" mass immunization campaign has been deemed a success, virtually eliminating polio from the 19 contiguous countries. The operation's success is due to well-established coordination among national health authorities, the Polio Partners, and field staff. In addition, in 1996 - 1997, the governments of Denmark, Finland, France, Norway, Sweden, Switzerland, and the United Kingdom contributed valuable support.

MECACAR 1997 included 15 countries in the WHO/EURO region, where over 18 million children were immunized, and eight countries in the eastern Mediterranean region. This is an increase from the 16.7 million children immunized in 10 WHO/EURO region countries in 1996. In 1995, there were 679 reported polio cases in the countries that participated in Operation MECACAR. In 1997, WHO reported that seven polio cases were confined to Tajikistan and Turkey—representing a significant decline in a two-year period.

By 1996, all 16 WHO/EURO states with reported epidemic or endemic cases of polio and 15 states with non-endemic status had



established AFP surveillance systems. By the end of 1997, two additional states instituted surveillance activities.

The rate of identified non-polio AFP cases is also improving. WHO/EURO is in the process of standardizing its surveillance reporting criteria; once revised, this should allow for rapid acceleration and increased quality of AFP reporting. The proportion of AFP cases with adequate specimens increased from 68 percent in 1996 to 79 percent (as of October 1997).

USAID Funding: USAID/G/PHN provided WHO/EURO with \$450,000 in incremental funds, out of a \$1 million grant for FY 1997 and FY 1998. The grant was to: strengthen immunization systems by improving cold chain and reverse cold chains; improve surveillance systems through training, assessment, and laboratory support; improve donor coordination by supporting the regional ICC; and increase information dissemination, including translation of a how-to guide for certification. USAID provided \$172,000 to BASICS for FY 1997-98 to support vaccine logistics, cold chain management, social mobilization, mop-up activities, and AFP surveillance in central Asia.

Through the BASICS Project, USAID supported improved vaccine logistics and cold chain management training programs for the ministries of health in Kyrgyzstan, Turkmenistan, and Uzbekistan. Similar training activities are planned in Tajikistan in 1998. The BASICS Project also supported country-led initiatives: to improve surveillance (including AFP surveillance) and health information systems; and increase demand for polio immunization in Kazakstan, Kyrgyzstan, and Moldova. Preliminary data indicate that these republics achieved 94 percent or greater coverage in the 1997 first and second rounds of NIDs.



USAID/Ukraine provided approximately \$60,000 in funding to a joint effort by the Program for Appropriate Technology in Health (PATH), CDC, and BASICS for the strengthening of disease surveillance and health information systems in Ukraine. (This is not funded under the PEI budget.)

Despite the immensely difficult political, social and geographic circumstances under which the Tajik Ministry of Health has been working, the rate of poliovirus transmission has been slashed in recent years. Prior to Operation MECACAR, in 1994, the Tajik Ministry of Health reported 29 polio cases; by 1997, Tajikistan reported only one polio case. The ministry's staunch efforts have led to cease-fires for polio NIDs, the effective mobilization of physicians and health workers, and the organization of oral polio vaccine and cold chain shipment to hard-to-reach mountainous areas on the backs of donkeys. The BASICS Project assisted in planning the social mobilization component of the NID. Despite these efforts, wild poliovirus circulation, exportation to neighboring countries, and importations from Afghanistan are still likely to occur. As a result, WHO is planning immunization campaigns for war-affected zones in 1998.

E. Latin America and the Caribbean

Although the LAC region was certified as having eradicated polio in 1994, USAID provided limited funding in 1997, to monitor the status of AFP surveillance in the region through an agreement with the Pan American Health Organization. (This is not funded under the PEI budget.) Decreases in the quality of AFP surveillance are being monitored closely. Maintaining high quality surveillance is key to retaining certification status.



F. Western Pacific Region

In 1997, reported polio cases in the western Pacific were confined to the Mekong Delta of Cambodia and Viet Nam, with no cases reported after mid-1997. USAID monitors this closely, although no PEI funds are provided to this region. The agency also coordinates with other donors on cross-border issues in Southeast Asia.



G. Global Projects

USAID/Global/PHNC supports activities that are designed to strengthen selected health systems, improve information collection and use, and build effective partnerships.

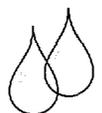


USAID and Donor Partners

In discussions with other donor countries, USAID advocates for increased financial and technical polio eradication support. USAID also consults with donor countries on the best funding strategy to avoid duplicating efforts, promotes the efficient use of funds, and is working to build a legacy of strengthened health systems.

On the global front, USAID is supporting:

- The development of a PEI communications and evaluation strategy to take full advantage of the technical, logistical, and financial inputs provided by the Polio Partners;



- A study to identify additional data collection mechanisms to verify immunization coverage and surveillance data in difficult-to-reach areas;
- Research on immunodeficient persons who may “shed” the poliovirus for a prolonged time, potentially requiring a new strategy for ceasing all polio vaccination; and
- The development of information kits for field staff, PVOs/NGOs and volunteers that inform and promote further collaboration in PEI activities.

IV. Next Steps—1998

A. Summary

With the improvement of transportation systems, it is clear that polio can spread to almost anywhere in the world in a matter of days. Until all countries are certified polio-free, ev-

the world; the industrialized, polio-free countries will reap significant economic benefits, and the poorer countries that now are endemic will be freed from the disease. Accordingly, the work of eradication should be shared by all countries, with the richest providing economic assistance to the poorest.

The progress achieved to date has been the result of extraordinary international cooperation. If that cooperation can be continued and expanded, polio will join smallpox in the history books. USAID is actively working to ensure that positive benefits will last beyond polio eradication, and establish a foundation for other disease control efforts.

With FY 1998 support of \$25 million, USAID will continue to follow the PEI strategy; however, the Agency will shift some of the focus from NIDs to AFP case detection and reporting activities.

B. USAID’s Shift in Focus

A combination of routine immunization and NIDs has led to a 90 percent reduction of reported polio cases. The greatest challenge today for USAID and its Polio Partners is to rapidly strengthen AFP surveillance, with a focus on detecting all AFP cases and chains of transmission. Community awareness and involvement in this effort will be essential to its success, so social mobilization campaigns must be increased. The surveillance phase of the eradication effort will be the most difficult and will require greater commitment and collaboration at all levels.

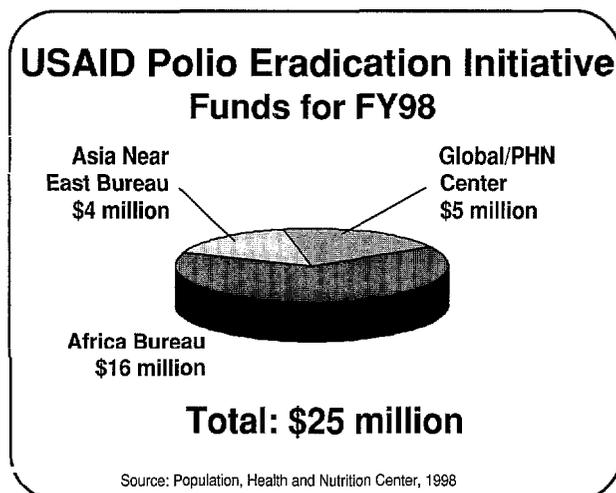


Figure 7

ery nation will need to continue to vigilantly vaccinate all of its children. The benefits of polio eradication will accrue to all countries of



1. Improving AFP Surveillance Systems

The PEI strategy calls for holding two rounds of NIDs for three consecutive years, while establishing and strengthening AFP surveillance systems, to identify where and how the poliovirus is circulating. After NIDs have been conducted for three years if an adequate surveillance system is in place, it should be possible to detect the remaining pockets of poliovirus. At this stage, smaller mop-up campaigns are initiated to wipe out the final vestiges of transmission. Switching from the larger-scale and costlier NIDs to the more focused smaller-scale mop-up campaigns reflects confidence in the surveillance system and recognition that a country is close to wiping out polio.

An effective surveillance system is essential to the eradication effort and the certification process. Reporting systems for AFP, including access to the global network of laboratories that provide testing for the presence of wild poliovirus, have now been established in most polio endemic countries. USAID is committed to focusing on improving the quality and in some cases the quantity of surveillance systems, particularly in high-risk areas.

The faster an effective AFP surveillance system can be established, the quicker a country reduces its dependence on NIDs. **USAID, along with other major donors, is shifting and increasing resources to focus on surveillance.**

The global strategy to increase detection includes establishing a strong system for notification and investigation. This includes weekly visits to hospitals to search for AFP cases, weekly reporting even if no AFP cases are detected, and reviewing hospital records for retrospective cases.



Photo by E.Schwab/WHO

This facility-based approach has proven effective under good infrastructure conditions in LAC and in certain African countries. However, it is fragile at best in large parts of Africa where only 53 percent of the population has access to

health services and 50 percent live farther than 10 kilometers from a health facility.

To supplement reliance on facilities that are needed to collect and transport specimens, USAID is supporting additional efforts to engage grassroots, community-based organizations and people willing to report weekly on the situation in their local area. Through UNICEF, the Agency is exploring the use of the existing Guinea worm eradication network in several countries. In Bangladesh, with the assistance of the BASICS Project, a network of “key informants” is reporting weekly and making a valuable contribution to local polio detection efforts. USAID is also exploring the potential of working with PVO and volunteer organization networks to identify key informants or “health guardians” in other regions.



USAID supports WHO in their efforts to provide consistent and reliable sources of lab reagents and cell lines required to isolate poliovirus at national and regional labs. In addition, USAID supports the development of high quality laboratories through the use of proficiency exams and training.

2. Increasing Social Mobilization Efforts

In 1998, USAID will continue to support and improve social mobilization activities to achieve high levels of political commitment, public awareness, and community participation for polio eradication and for the routine EPI. Advocacy and social mobilization are particularly important to educate the public about the importance of immunization and encourage parents to immunize their children. Social mobilization is also critical to sustaining interest and participation in all aspects of EPI, especially surveillance.

Surveillance is particularly difficult to keep in the public eye, because it is an ongoing activity and not a "news event," such as NIDs that have immediate and measurable results. Motivating people to report weekly, an essential but mundane activity, is one of the lessons that USAID hopes to capture and share with its partners.

USAID has taken the lead in emphasizing social mobilization as a means to improve surveillance and AFP reporting. The Agency is working with WHO/Geneva in its effort to coordinate a global communications strategy and sustain interest in the PEI through the certification process. USAID will continue to study and document the role of PEI communication and social mobilization efforts. As part of this activity, USAID plans to develop a standard monitoring and evaluation plan that partners such as UNICEF, WHO, and host countries can adapt to meet local needs.

This plan will incorporate issues relating to NIDs, surveillance, and the means of disseminating information to health workers on lessons learned to improve the next NIDs or improve surveillance. The plan will also include an evaluation of the barriers to immunization that exist for the hard-to-reach population or in those areas with low immunization rates. Also covered will be instructions on assessing local level polio eradication activities.

USAID is committed to creating an archive of communication messages and activities, a review or critique of messages, and lessons learned. This information will undoubtedly be beneficial to ongoing immunization efforts, such as the EPI.

3. Building on PVO Networks

The Agency is encouraging PVOs to take a larger role in the eradication effort by using their knowledge of the localities where they work, acceptance in the community, and extensive networks to fill critical gaps in community involvement in surveillance and improve the rapid identification of polio cases.

USAID already works with many PVOs and NGOs on polio-related and other activities and is currently engaged in a dialogue with them to find ways to increase collaboration. The Agency is also working to involve additional PVOs in PEI activities.

4. Developing Information Kits

USAID is developing information kits to inform current and potential collaborators about USAID's PEI programs and plans, and encourage greater participation, and increase support for polio eradication partnerships. The first kit, the *USAID Mission Information Kit*, was released in December 1997 and provided USAID mission staff with current information on polio eradication activities and the roles that missions can play. The kit included a worldwide directory of PEI part-



ner organizations. USAID is now developing similar information kits for PVOs and for volunteer groups, with a specific focus on U.S. Peace Corps volunteers and Japan Overseas Cooperation Volunteers.

C. Remaining Challenges: Routine EPI and Sustainability

While great strides are being made in polio eradication, many challenges still loom:

- Declines in routine immunization;
- Waning interest and enthusiasm in NIDs;
- Difficulty of reaching individuals in war-torn areas and other hard-to-reach places; and
- Achieving polio eradication and the sustainable delivery systems to support it.

1. Static Routine Immunization Coverage

All immunization programs are based on the maintenance and achievement of a consistently high level of routine immunization coverage. This is certainly true for routine immunization services and PEI. In the case of polio, consistently high coverage reduces the incidence of the poliovirus and increases the feasibility of eradication.

While global polio immunization coverage has increased dramatically since 1988, it has since plateaued at 82 percent. In some countries—especially poor areas, those with undeveloped health infrastructure, areas in conflict,

and regions with large migrant populations—immunization coverage is much lower.

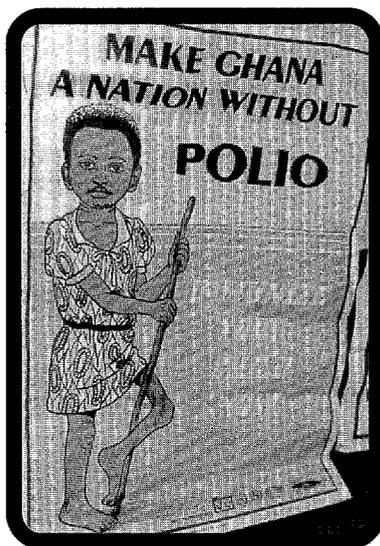


Photo by K. Ofori/VOA

In Africa, where health infrastructure is the weakest, vaccination coverage has leveled off or dropped even as successful rounds of NIDs have been conducted. Today, 14 of the 15 countries that are unable to immunize even half of their infants are in Africa. According to WHO/AFRO, the static rates are due in part to the impact of Angola, Democratic Republic of the Congo, and Nigeria—three populous countries low routine immunization coverage that are now beginning to conduct NIDs. WHO/AFRO maintains that

while overall average rates for routine immunization in Africa are static, rates for some African countries are improving. USAID is monitoring the situation and identifying barriers to immunization. The Agency will continue to work with its partners to find ways for PEI efforts to further support and accelerate routine immunization coverage.

There are encouraging signs. Routine immunization and AFP case reporting are now being promoted on NIDs in Ghana, Namibia, and Tanzania, in response to a perceived drop in routine immunization in the months leading up to the NIDs. Other African nations need to begin this practice and focus more attention on social mobilization for routine immunization and the control of other diseases, such as tetanus and measles.

USAID has worked with its Polio Partners, particularly in Africa and Asia, to closely monitor routine immunization coverage year-round, provide rapid feedback to countries, and report on routine immunization coverage at country, regional, and international meetings. Over



the next several years, the Agency will fund studies to assess the impact of polio activities on health systems and use the results to strengthen our efforts, particularly for routine EPI.

2. War-Torn and Other Hard-To-Reach Areas

Wars and civil unrest destroy health systems and infrastructure, and cause immunization coverage to fall, creating fertile ground for polio epidemics. Infected individuals can quickly transport the poliovirus over long distances and spread it to polio-free areas. WHO and UNICEF have brokered cease-fires and truces to allow polio immunization campaigns to be conducted in several countries.

Many of the most difficult countries to reach are those that USAID is unable to currently support, such as Afghanistan, Angola, Burundi, Central African Republic, Congo, the Democratic Republic of Congo, Liberia, Rwanda, Sierra Leone, Somalia, and Sudan. USAID and its Polio Partners are exploring ways to support polio eradication efforts in these critical areas where the virus continues to circulate. The Agency plans to identify possible mechanisms to increase support to these areas over the next few years. USAID will also work with its Polio Partners and the government of Japan, to increase efforts in these countries.

Monitoring the geographic distribution of polio cases is of great importance in the ENI region because of the proximity to high-risk areas in Asia and the relatively large groups of nomadic people living in hard-to-reach mountainous areas, such as Afghanistan, Iran, Iraq, Pakistan, and Tajikistan. Therefore, a continuation of Operation MECACAR Plus is planned for 1998-2000, focusing on continuing coordination of efforts with other donors that work in these difficult areas.

Peace — A Side Benefit to PEI Activities

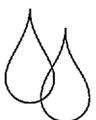
While war is one of the most significant obstacles to polio eradication, an important, but ironic, benefit of polio eradication is peace. NIDs have been the stimulus for a number of ceasefires for immunization including truces declared in Afghanistan, El Salvador, the Philippines, Sri Lanka, Sudan, and Tajikistan. In El Salvador and the Philippines, the ceasefires for immunization were an important early step in the process that led to peace.

In November 1997, WHO and UNICEF called for \$35 million to combat polio in Asian and African nations affected by war. In their joint appeal, WHO and UNICEF noted, "Whenever armed conflicts erupt in the world, young children are among the first innocent victims." The two agencies said that in these cases, "getting vaccines to children is an urgent priority."

3. Sustainability

It is difficult for poor countries to improve their health systems. By providing technical assistance and training, USAID is contributing to host country capacity to plan, implement, and evaluate a large public health effort.

Through the PEI, USAID is also helping to strengthen existing health systems. By improving surveillance systems and laboratory networks, the PEI is helping to build the health infrastructure needed to fight polio and other infectious diseases. USAID's PEI also contributes to the long-term sustainability of immuni-



zation by replacing and refurbishing cold chain equipment, which is necessary for keeping the vaccine cold and potent. Replaced cold chain equipment can be used for OPV and other vaccines for the next 10 years.

Achieving a seamless surveillance system involves strengthening laboratory networks and surveillance activities. This includes improving each laboratory's independent proficiency, testing procedures, and quality of analysis, as well as using laboratory results to initiate follow-up mass immunization or mop-up campaigns. These activities will help to institutionalize the use of a functioning laboratory network for disease control activities.

PEI efforts help to enhance the EPI's foundation by applying the skills developed through the polio effort—such as vaccine forecasting, regular disease reporting and response, district level planning for routine health services and immunization campaigns, and mobilizing people to reach a common goal—to other major health initiatives. Lessons learned from the PEI can serve as a model for future initiatives and other health interventions.

To ensure that PEI inputs contribute to the long-term benefits and sustainability of immunization, USAID will continue to advocate for greater commitment and funding from host governments, private foundations, partnerships for polio, and within the context of other EPI and child health interventions.

The success achieved to date establishes the technical feasibility of polio eradication. Despite some obstacles, it now appears that most chains of transmission will have been interrupted by the year 2000, if the current level of participation is maintained. Surveillance continues to lag in Africa, and most countries do not expect to be certified polio-free before 2005. The chal-

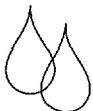
lenges ahead are primarily political and financial. Commitment remains weak in a number of polio-endemic countries. Although many countries have borne a significant percentage of polio eradication costs, virtually all the supplemental costs need to be financed by external sources in the poorest and most difficult countries. WHO estimates that about \$1 billion in total supplemental funding is needed to finish the job. No new donors have joined the effort, and levels from the current Polio Partners are constant or declining.

The challenges are significant, but the benefits are many. The eradication of wild polioviruses will eliminate the disease and prevent the consequent crippling of children, reducing demands on the health care systems. Following eradication, polio immunization will no longer be necessary. Not only will all parents be free of the fear that their children could be paralyzed by polio, but global savings can equal \$1.5 billion per year—most of which will accrue to developed countries. An additional legacy of polio eradication will be improved primary health care systems, particularly in the field of immunization and infectious disease control.



Annex to the Polio Eradication Initiative 1997 Report to Congress

- **Table 1: Planned Budget for FY 97 by Result**
- **Table 2: Planned Budget for FY 97 by Region**
- **Polio Eradication Initiative Regional Summaries**



POLIO ERADICATION INITIATIVE BUDGET SUMMARIES

**TABLE 1: PLANNED BUDGET FOR FY 97 BY RESULT (\$25 MILLION)
(\$000's)**

	Africa					ANE				G/PHNC						Total	
	WHO/ AFRO	BASICS/ AFR	UNICEF/ AFR	To be deter- mined	Sub total	WHO/ India	UNICEF/ India	INCLN	Sub total	WHO/ HQ	WHO/ EURO	WHO/ SEARO	WHO/ ANE Countries*	WHO Sub total	G/PHNC Projects	Sub total	FY 97 PEI Funds
Result 1: Partnerships	344	0	0		344	0	0	0	0	0	0	5	11	16	750	766	1,110
Result 2: Strengthening Immunization Systems Planning and Training	2,637	375	836	25	3,873	460	353	0	813	0	0	35	31	66	1,425	1,491	6,177
Result 3: Effective Supplementary Immunization, Social Mobilization	6,898	75	1,612	400	8,985	0	1,382	0	1,382	0	65	120	24	209	250	459	10,826
Result 4: Surveillance	1,777	50	250	25	2,102	1,215	34	200	1,449	65	308	283	258	914	550	1,464	5,015
Result 5: Use of Information	344	0	212		556	175	15	0	190	65	25	2	11	103	700	803	1,549
Program Support	0	0	90		90	0	66	0	66	20	52	55	40	167	0	167	323
Total	12,000	500	3,000	450	15,950	1,850	1,850	200	3,900	150	450	500	375	1,475	3,675	5,150	25,000

* Bangladesh, Indonesia, Nepal

TABLE 2: PLANNED BUDGET FOR FY 97 BY REGION AND MAJOR PARTNERS

By Region and Major Partners	FY 97 PEI Funds	Additional FY 97 (Non-PEI) Funds	Total FY97 Funds
Africa			
WHO/AFRO Grant	12,450,000		12,450,000
UNICEF Grant	3,000,000		3,000,000
BASICS	500,000		500,000
Subtotal	15,950,000	2,148,000	18,098,000
Asia & Near East			
WHO/India	1,850,000		1,850,000
UNICEF/India	1,850,000		1,850,000
INCLN/India	200,000		200,000
Subtotal	3,900,000	998,000	4,898,000
Global / PHNC			
WHO / SEARO	500,000		500,000
WHO / Bangladesh	125,000		125,000
WHO / Indonesia	125,000		125,000
WHO / Nepal	125,000		125,000
WHO / EURO *	450,000	60,000	510,000
WHO / HQ-RO	150,000		150,000
G/PHNC Projects **	3,675,000		3,675,000
Subtotal	5,150,000	60,000	5,210,000
Total	25,000,000	3,206,000	28,206,000

* WHO/EURO covers the New Independent States (NIS) including: Armenia, Georgia, Kazakstan, Kyrgystan, Moldova, Russia, Tajikistan, Turkmemistan, Ukraine, Uzbekistan
** The G/PHN contractors have various country-specific activities.



POLIO ERADICATION INITIATIVE REGIONAL SUMMARIES

(\$000's)

ASIA/NEAR EAST

	INCLN	USAID WHO / SEARO		UNICEF (Rotary PolioPlus = 400)	Total FY 97 PEI Funds	Bilateral (non-PEI) Funds
		Grant	See also G/PHNC			
Bangladesh			X		0	
Egypt					0	500
India	200	1,850	X	1,850	3,900	400
Indonesia			X		0	
Jordan						
Morocco					0	98
Nepal			X		0	
Philippines					0	
Sri Lanka					0	
Yemen					0	
Regional			X		0	
Totals	200	0		1,850	3,900	998

GLOBAL

USAID/G/PHNC ACTIVITIES THROUGH WHO	FY 97 PEI Funds	Additional FY 97 (non- PEI) Funds
WHO/ SEARO	500	
WHO / Indonesia, Nepal, Bangladesh (125 each)	375	
WHO / Headquarters and Regional Offices	150	
WHO/ EURO	450	
Subtotal	1,475	0
USAID/G/PHNC PROJECTS		
BASICS	300	
Child Health Research (a) (Harvard Institute for International Development)	275	
Child Health Research (b) (John Hopkins School of Public Health)	300	
Partnership for Health Reform		
Quality Assurance II Project	400	
Rational Pharmaceutical Management (a) (Management Science for Health)	75	
Rational Pharmaceutical Management (b) (U.S. Pharmacopeia Convention, Inc.)	75	
Health Technical Services Project	300	
Monitoring and Evaluation to Assess and Use Results (MEASURE)	100	
Center for International Health Information	600	
Voice of America	250	
Technical Advisors in AIDS and Child Survival	300	
Fellow in South Asia	300	
Subtotal	3,675	0
OTHER ACTIVITIES		
Path/CD/BASICS		60
Totals	5,150	60

AFRICA

	USAID Grant to WHO / AFRO				USAID Grant to UNICEF					USAID Funds to BASICS	FY 97 PEI Funds	Addtl. (non-PEI) Funds	
	NIDS	Surveil- lance	ROS*	Sub- total	NIDS	Social Mobilzn.	Plan & Trng	Eval.	Surveil- lance				Sub- total
Angola	878	98		976	100	150	75			325		1,301	
Benin	126	31		157						55		212	
Burkina Faso	179	45		224					48	48		272	
Burundi				0						0		0	
Cameroon	231	33		264		143	55			198		462	
C.A.R				0						0		0	
Chad	302	75		377					50	50		427	
Congo, D.R.				0						0		0	2,083
Cote d'Ivoire				0					80	80		80	
Eritrea				0		59	10	2		71		71	
Eq. Guinea				0		5	15	15		35		35	
Ethiopia	1,580	176		1,756		100				100		1,856	
Gabon				0		40				40		40	
Ghana	520	130		650		30	70			100		750	
Guinea	127	32		159		125		72		197		356	
Kenya	878	107		985						0		985	
Madagascar	473	76		549		180	30			210		759	
Malawi	218	55		273	100					100		373	
Mali	286	72		358		110	56		50	216		574	
Mozambique	322	81		403	100			75		175		578	
Namibia				0		25				25		25	
Niger				0						0		0	
Nigeria	702	78		780						0		780	
Senegal				0		70			30	100		100	
Tanzania	1,242	107		1,349						0		1,349	
Togo	122	31		153						0		153	
Uganda	735	107		842					40	40		882	
Zambia	297	67		364						0		364	65
To be determined after discussion				0	177	177	177	177	127	835	500	1,335	
Totals	9,218	1,401	1,831	12,450	477	1,214	543	389	377	3,000	500	15,950	2,148

*Regional Office Support

