Global Polio Eradication Initiative

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

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, 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

- 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

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.

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