

EPI Newsletter

Expanded Program on Immunization in the Americas

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June 1995

Southern Cone: Measles Elimination

The tenth meeting of the "Asunción Group" was held in Santiago, Chile, from 18 to 20 April 1995, and included representatives of the countries of the Southern Cone, Brazil and Cuba. This meeting comes after the Symposium on Children, part of the Summit of the Americas held in December 1994 in Miami, where the First Ladies of the Region made the commitment to support the campaign for measles elimination in the Americas. The focus of the two conferences was on evaluating the progress made in the countries toward the goal to eliminate measles by the year 2000, which was set by the Pan American Sanitary Conference in 1994. In Chile the following subjects were also discussed:

- Maintaining the surveillance levels for acute flaccid paralysis

necessary for the Region to continue free of poliomyelitis,

- Measures for the control of neonatal tetanus, and
- Use of the vaccines against hepatitis B and *Haemophilus influenzae* type b.

The following is a summary of the discussions and conclusions reached in the meeting.

Measles Elimination by the Year 2000

The impact of national vaccination campaigns can be

seen in Table 1, which shows the decrease in number of confirmed cases of measles. Brazil and Chile conducted vaccination campaigns in 1992, Argentina in 1993, and Uruguay in 1994. More than 95% of the population between 1 - 14 years of age were vaccinated in these countries. Paraguay is organizing a national vaccination campaign for this year, and Brazil will conduct a follow-up campaign to reach children between the ages of one and three who were not vaccinated in the 1992 campaign.

Argentina, Brazil, and Chile have set up surveillance systems for rash and fever illnesses (RFIs) together with networks of laboratories to support diagnosis of these cases. In Brazil, 70% of cases were confirmed by laboratory testing. Paraguay and Uruguay have not

yet intensified their epidemiological surveillance activities for RFIs.

To facilitate the surveillance of RFIs, the definition of a "probable case of measles" was changed in October 1994 to include cases in which there is fever for at least two days. This will help increase the number of cases that enter the surveillance system. The importance of participation by the private sector in RFI surveillance was underscored during the presentation of the country reports.

Table 1
Confirmed Cases of Measles
Southern Cone and Brazil, 1992 - 1994*

COUNTRIES	NUMBER OF CONFIRMED CASES OF MEASLES								
	1992			1993			1994		
	NOTI- FIED	COMPA- TIBLES	CON- FIRMED	NOTI- FIED	COMPA- TIBLES	CON- FIRMED	NOTI- FIED	COMPA- TIBLES	CON- FIRMED
ARGENTINA	20551	-	20551	5048	-	5048	1160	612	134
BRAZIL	7934	-	209	6251	1932	273	2269	381	38
CHILE	777	62	1*	283	23	1	210	13	0
PARAGUAY	864	-	864	2066	-	2066	142	20	122
URUGUAY	187	-	187	16	-	16	12	-	12
TOTAL	30313	62	21812	13664	1955	7404	3793	1026	306

*Following Campaign of April 1992

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Conclusions and Recommendations

The countries that have launched measles elimination programs must maintain high vaccination coverage in each cohort of infants less than one year old. The coverage rates should be periodically examined not only at the national level, but also at the state or municipal level.

Every country, upon initiating a national measles vaccination campaign, must maintain both a surveillance system capable of detecting all cases of RFIs and the ability to carry out the control measures recommended in the PAHO *Measles Elimination Field Guide*. Immediate notification of suspected cases of measles should be instituted.

Brazil should look for ways to properly monitor surveillance of RFIs at the national level and to coordinate surveillance and control operations between border states and the adjacent countries.

Countries should use a definition of a "probable measles case" which is sensitive enough to avoid possible surveillance errors that could prevent the prompt detection of outbreaks. This could, in turn, endanger the progress made during national vaccination campaigns. In addition, it is important to involve the private sector in the notification of RFIs. The universities can play an important part in training the health personnel employed in the public and private health sectors.

Upon the occurrence of a **probable measles case** immediate steps should be taken to determine whether it is the result of any of the following system flaws: the patient's vaccination history, his or her place of origin, and the possibility of the patient's having visited other areas of possible transmission, and to identify the vaccination status of the populations exposed to the risk of an outbreak. In the event that vaccination measures are required (e.g. if the coverage has been less than 95%), the decision on which geographic area and which age group to vaccinate will be based upon the analysis of the local epidemiological information.

The countries should document measles outbreaks and examine their epidemiological variables. Adjustments to elimination strategies can be made based upon the information collected. Also, when suspected cases occur in border areas, the neighboring countries must be notified so that joint surveillance operations may be launched. PAHO can facilitate these exchanges of information.

Paraguay should carry out a national vaccination campaign for children between the ages of 1 and 14 as soon as possible. Therefore, progress towards the control and elimination of measles will be at similar levels throughout the Southern Cone.

It is apparent that in the countries which have conducted vaccination campaigns targeting children between the ages

of 9 months and 14 years, even in those still using 2-dose vaccination schedule, a population of susceptibles is growing, which could eventually lead to an outbreak of measles. This buildup is expected because the efficacy of the vaccine is not 100%, and even in the best programs the coverage rates can fall short of 100%. The rate of accumulation of susceptibles varies with the levels of coverage attained in the different countries.

Therefore, it is necessary to carry out periodic vaccination campaigns in those age groups determined by the variables of coverage and immunity over time. In general, it is recommended that a campaign be conducted when the number of accumulated susceptibles amounts to a cohort of live births. In a country that maintains vaccination coverage rates of 90% among infants under one year of age this number of susceptibles will be reached in six years. In such case, a campaign must be carried out at 5-year intervals among the population aged one to five years regardless of previous vaccination status. This holds true even in countries that administer the 2-dose measles vaccine in their routine program.

The following indicators should be the minimum required for the evaluation of RFI surveillance, however they are not yet being used in the countries:

- % of weekly negative notification
- % of cases with complete epidemiological records
- % of cases with adequate response and documented investigation
- % of notified cases that meet the definition of "probable case"
- % of cases with proper serum samples

Data should be collected in a uniform manner through the Regional Measles Elimination Surveillance System (MESS) so that epidemiological analysis can be standardized at the national and hemispheric levels.

The lack of a laboratory test that is sufficiently sensitive and specific constitutes a major obstacle for surveillance. The diagnostic techniques used in the different countries must be standardized as soon as possible as a provisional measure until a simple, rapid test for immediate diagnosis in the field is available. PAHO will promote a meeting of virologists in May 1995 to consider this matter.

The First Ladies should be kept informed by the Ministers of Health of their respective countries as to the progress of the program in order to facilitate the support they may be able to give to the measles elimination program.

Consolidation of the Eradication of Poliomyelitis

The last case of poliomyelitis caused by wild poliovirus in the Americas occurred in Junin, Peru, on August 31, 1991. Three years later the International Commission for the Certification of Poliomyelitis Eradication concluded that the transmission of wild poliovirus had been interrupted in the Region. The Commission also noted the importance of

maintaining the coverage rates and surveillance of cases of acute flaccid paralysis (AFP) at high levels to avoid the importation of wild poliovirus. It can be seen in Table 2 that the levels of surveillance of AFP cases has deteriorated in some countries.

Table 2
Indicators of AFP Surveillance for Certification
Southern Cone Countries and Brazil, 1994

COUNTRY	% NEGATIVE NOTIFICATION	AFP RATE > 1/100,000 CHILDREN <15 YRS	% CASES INVESTIGATED WITHIN 48 HOURS OF NOTIFICATION	% 2 STOOL SAMPLES TAKEN WITHIN 15 DAYS OF ONSET OF PARALYSIS
ARGENTINA	82	1.2	87	52
BRAZIL	89	1	91	53
CHILE	94	2	98	84
PARAGUAY	92	1.6	100	95
URUGUAY	85	0.6	100	87

Conclusions and Recommendations

The deterioration of AFP surveillance in some of the countries present at the meeting, especially in regard to collecting stool samples, is a source of concern. It is of utmost importance that appropriate measures be taken in each of these countries to restore previous surveillance levels and meet the conditions required to keep the Region polio-free. It would be tragic if after the effort made by these countries to eradicate this disease, setting an example for the whole world, an importation from another region were to reintroduce the wild poliovirus and establish indigenous transmission all over again.

Each country must meet all the criteria required by the International Commission for the Certification of Poliomyelitis Eradication (ICCPE) to maintain the Americas polio free. The responsibility for this lies with Ministries of Health, and the national epidemiological surveillance systems should be responsible for carrying out the tasks.

Each country should pay special attention towards ensuring that each case of AFP (regardless of the preliminary clinical diagnosis) is investigated within 48 hours, and that 2 stool samples are taken within 15 days of the onset of paralysis. As a rule stool samples taken from contacts of the AFP case are not always necessary. However this decision should be made by the investigating epidemiologist.

The emphasis in surveillance must be placed on the proper collection and transportation of stool samples from cases of AFP. This requirement cannot be properly satisfied without a good surveillance system in place, within which every case of AFP is detected quickly, reported, and brought into the surveillance system.

The surveillance indicators must be evaluated periodically in each country, taking care to analyze them at all levels, from the national level to the smallest geographical district.

The weekly PAHO Polio Surveillance Bulletin should be used by the countries as a source of feedback. It is important that any data which does not agree with the information managed in each country be reported to PAHO Headquarters as soon as possible so that they may be corrected.

Each country should keep a record of the conditions in which the samples are transported, and arrangements should be provided for their proper shipment to laboratories so that they will arrive well identified, with the necessary quantity of ice or refrigerant.

The countries must make sure that their laboratories have the staff, equipment and supplies required to ensure the quality of their results.

Control of Neonatal Tetanus

In order to reach the goal of neonatal tetanus (NNT) elimination by the end of 1995, the vaccination campaigns for neonatal tetanus (NNT) have been concentrated in High-Risk Areas (HRAs). These control measures have had a noticeable impact on the incidence of the disease; in Brazil, for example, where most of the cases occur in HRAs in the northern and west-central parts of the country, the incidence dropped almost 50% between 1990 and 1994 (see Table 3).

Table 3
Number of Cases of Neonatal Tetanus by Country and year

COUNTRY	1990	1991	1992	1993	1994
ARGENTINA	8	18	7	5	11
BRAZIL	298	272	229	214	151
CHILE	0	3	3	1	1
PARAGUAY	38	38	18	28	18
URUGUAY*	0	0	0	0	0

* Last case occurred in 1982

In Argentina control measures have been launched in the HRAs, and expanded to cover all the districts in which at least one case has occurred in the last ten years.

Conclusions and Recommendations

Adequate supplies of TT should be guaranteed in order to administer 2 doses of vaccine to every woman of child-bearing age (WCBA) living in an HRA.

Paraguay should accelerate the pace of WCBA vaccination in HRAs.

It is important that the countries regularly report the cumulative coverage rates of WCBAs living in HRAs.

Polio Surveillance

Indicators for Evaluating Poliomyelitis Surveillance in Latin America, 1995*

	1	2	3	4
El Salvador				
Honduras				
Paraguay				
Venezuela				
Bolivia				
Chile				
Colombia				
Ecuador				
Mexico				
Nicaragua				
Peru				
Brazil				
Cuba				
Dominican Republic				
Guatemala				
Panama				
Argentina				
Costa Rica				
Uruguay				
Haiti				

1 - 80% Weekly Reporting Units 3 - 80% of Cases with 2 adequate stool samples take
 2 - 80% Investigated within 48 hours 4 - AFP Rate

N.R. No Report Received  Meet criteria

- Countries reporting zero cases

* Data as of 25 May

Source: EPI/PAHO (PESS)

The Americas, the first Region in the world to eradicate polio, must maintain high vaccine coverage and surveillance as long as wild poliovirus is circulating elsewhere. Importations present the risk of producing a polio outbreak, particularly in areas with low vaccine coverage. Surveillance of cases of Acute Flaccid Paralysis (AFP) is one of the most effective tools for detecting the possible importations of wild poliovirus from outside the Americas. Documented, effective AFP surveillance must be maintained in every country if the Region is to be considered free of polio by the Global Commission for the Certification of the Eradication of Poliomyelitis (GCCPE) by the year 2000.

The graph left shows that only four countries in Latin America are performing well with regards to the surveillance of cases of AFP as required by the ICCPE. Therefore, those countries which are not meeting these criteria should evaluate the impediments hindering effective surveillance, and ensure that resources will be targeted towards the timely investigation of all probable cases of AFP.

Measles In Canada, 1994-1995 (as of February 14)

From January 1 to December 31, 1994, a provisional total of 518 measles cases (1.80 per 100,000 population) was reported in Canada. This is 2.5 times greater than the total of 204 cases reported for 1993, but substantially lower than those reported for 1991 (6,178) and 1992 (3,011). The lowest annual number of cases ever recorded in Canada was in 1993. Figure 1 shows the trend in reported incidence, by month, from January 1991 to January 1995. During the past four years, the lowest measles activity (three cases) was reported in December 1994. In 1995, as of January 31, a total of nine cases has been reported.

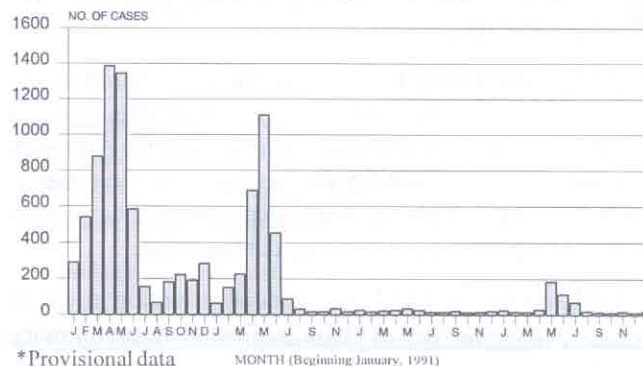
Table 1 (see page 5) shows the distribution of cases by province and territory for 1994. Ontario accounted for 61.6% (319 cases or 2.97 per 100,000 population) of the total, followed by Quebec with 24.7% (128 cases or 1.77 per 100,000). Nine of the 10 provinces reported measles, and the number of cases ranged from one each in Manitoba, New Brunswick and Nova Scotia to 319 cases in Ontario. No cases were reported from Prince Edward Island, the Yukon and the Northwest Territories.

In 1994, a total of four outbreaks were reported in Canada: two in Ontario and two in Quebec. The outbreaks in Ontario peaked in May, while both the outbreaks in Quebec peaked in June and July. Brief descriptions of these outbreaks were published in previous issues of *Measles Update*.

Approximately 25% of the 1994 cases have been serologically confirmed.

In general, the epidemiologic characteristics, i.e., the age distribution, preventability status, immunization status,

Figure 1
Reported Cases of Measles by Month, Canada 1991 - 1995 (January)*



*Provisional data

etc., of measles cases reported in this issue remain the same as those presented in the previous issue.

During January 1995, a small outbreak involving eight cases was reported from the Peel Regional Health Unit in Ontario. All of the cases were students from one secondary school and had a history of receiving measles vaccine after the first birthday. Five of these cases were laboratory confirmed for IgM; the other cases were clinically diagnosed. With the exception of one clinical case from another health region in Ontario, no additional cases have been reported to date from other provinces or territories.

Editorial Comment: The reported measles activity across Canada in recent months suggests that the virus is confined to a specific geographic area in Ontario. However, the possibility of introducing the virus to other communities

within or outside this province is feasible because of population mobility and other common activities.

Constant surveillance and timely reporting at all levels of government is essential to achieve measles elimination.

In view of the low measles incidence in Canada, it is important that each case receives specific attention and a thorough epidemiologic investigation.

In order to comply with the WHO/PAHO request for weekly notification, and as outlined in the Measles Consensus Conference, we are seeking your assistance in the timely reporting of all unusual incidents or outbreaks of measles, including epidemiologically linked clinical cases, to your provincial/territorial health authorities for subsequent notification to the Childhood Immunization Division, LCDC (Tel: 613-957-1344 or Fax: 613-998-6413).

We also welcome photographs of clinical presentation, including a brief note, for inclusion in upcoming issues of *Measles Update*.

Acknowledgement: The assistance and co-operation of all provincial and territorial epidemiologists, medical officers of health and other health care personnel, and staff from LCDC, is greatly appreciated.

Table 1

Reported Cases of Measles, Canada, 1994

Province/Territory	(Preliminary Data)		
	No. of Cases	%	Rate/100,000
Newfoundland	5	1	0.9
Prince Edward Island	0	0	0
Nova Scotia	1	0.2	0.1
New Brunswick	1	0.2	0.1
Quebec	128	24.7	1.8
Ontario	219	61.6	3
Manitoba	1	0.2	0.1
Saskatchewan	4	0.8	0.4
Alberta	31	6	1.2
British Columbia	38	5.4	0.8
Yukon	0	0	0
Northwest Territories	0	0	0
Canada	518	100	1.8

Source: Paul Varughese, Childhood Immunization Division, Bureau of Communicable Disease Epidemiology, LCDC, Ottawa. *Measles Update* 1995;3(1)1-2.

Update: Measles Elimination in England

As reported in the December 1994 issue of the EPI Newsletter (Vol. XVI, No. 6), the United Kingdom launched a national measles campaign in November 1994. Mathematical models constructed by two independent groups, combined with the fact that measles notifications in 1994 were rising (Figure 1) predicted an epidemic of measles which could cause an estimated 150,000 cases with up to 50 deaths.

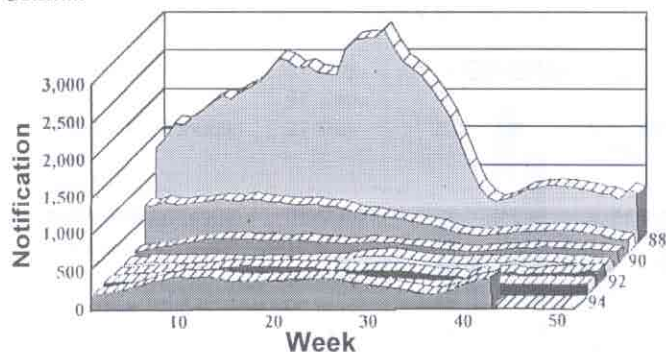


Figure 1. Measles notifications in England & Wales, 1988 to 1994 (OPCS data).

Laboratory confirmation of measles showed that the distribution of cases was shifting to older groups. Figure 2 provides an estimate of probability that notified cases were correctly diagnosed. When this probability was applied to the notified cases according to their age, it could be seen that the group at highest risk of measles was not the group from whom most notifications were coming (<1-9 years), but older children (10-14 years, Figure 3).

The Joint Committee on Vaccination and Immunization (JCVI) recommended that a nation-wide school based

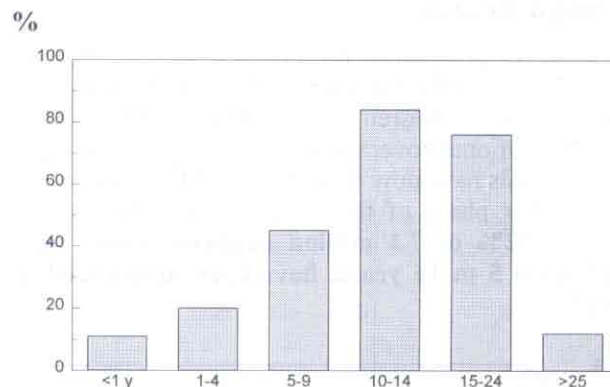


Figure 2. Proportion of notified measles cases confirmed by laboratory testing (PHLS data).

immunization campaign should be carried out using the MR vaccine. The target population, all school children aged 5 to 16, was chosen on the basis of age specific sero-epidemiology that identified that this was the group that would benefit most from immunization. It also matched well the planned immunization of school children up to 6th grade.

The results of cost benefit analyses showed that the most effective use of resources was to implement an intensive school health service delivered campaign targeted at all children aged 5 to 16 years, irrespective of previous history of measles or immunization. The cost of the campaign (vaccine, publicity, and operational costs) was estimated at £20 million—one third of the estimated cost of an epidemic.

Publicity for the campaign began in October, 1994, with national advertisements about the benefits of the

campaign and reminders to parents to complete the consent forms distributed through the schools. Around 12 million doses of vaccine were issued in advance of the campaign, with every district appropriately resourced for vaccine and consumables (syringes, needles, sharps' boxes). Most Health Authorities ran their campaigns during November with mop-up activities in December. In some cases, the campaign ran through December with mopping-up being completed by early February, 1995.

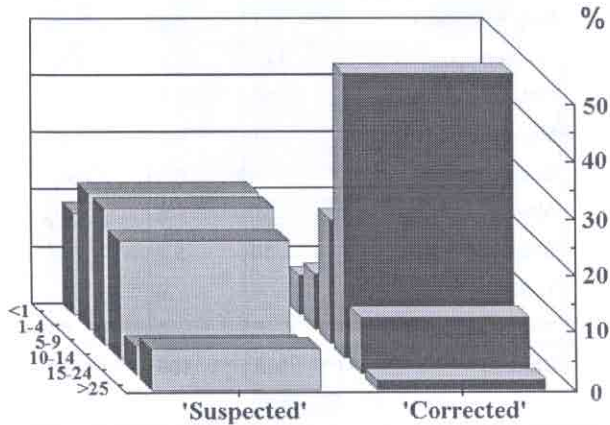


Figure 3. Left: Age specific notifications of measles E & W 1993-1994, not corrected. Right: as left, corrected for probability of correct diagnosis for each age band (as at Fig 2).

Campaign Results

The target population for England was 7.1 million children. The first information return from Districts reported on the number of children immunized during November alone. The national coverage was around 90%. Districts and NHS Trusts have now submitted their final returns for the November phase of the campaign and the mop-up activities. **92% of 7.1 million children, whose ages ranged from 5 to 16 years, have been immunized in England.**

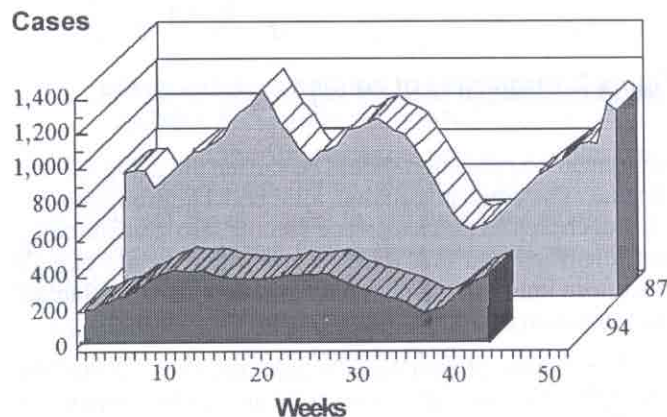


Figure 4. Measles notifications E&W 1987 and 1994 (OPCS reports).

In 1994, notifications of measles had been rising in line with those seen in 1987, the lead-in phase to the 1988 measles epidemic. In 1988, the last epidemic year, there were 86,000 notifications and 15 deaths (Figure 4).

The predictions for 1995 had suggested an epidemic of the order of 150,000 cases. Because more cases would occur in older individuals than previously and measles case fatality rates increase with advancing age, approximately 50 deaths were anticipated.

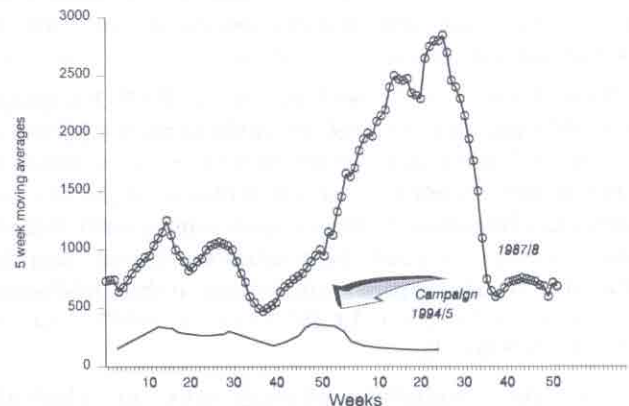


Figure 5. Measles notifications E&W 1987/8 and 1994/5 (OPCS reports).

Previous experience has demonstrated that measles notification data shows useful trends but individual notifications are highly unreliable, especially in younger children; here the specificity of notification in the under 5s is considerably less than 20%. Since the beginning of November 1994, the Public Health Laboratory Service has been able to use **salivary antibody diagnosis** to confirm measles in suspected cases (Figures 5 and 6). There were more than 100 positive reports in November and December 1994. In 1995, despite more than 800 samplings having been tested, there have been only 21 confirmed measles cases. Only one case occurred in a child whose age was covered by the campaign; that child's parents had withheld consent. All other cases were in children under the age of routine immunization, those under 5 years who had received one dose of MMR vaccine previously, or who were over 17 years.

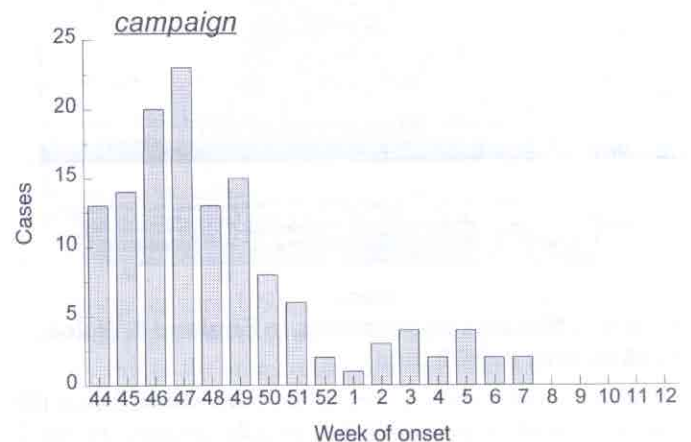


Figure 6. Cases of measles (E&W) confirmed by salivary antibody testing. (PHLS data).

Since 24 February 1995, there have been no confirmed cases of indigenous measles in England Wales and Northern Ireland.

Source: Dr. D. M. Salisbury MB FRCP MFPHM, Principal Medical Officer, Department of Health, London, United Kingdom

Reported Cases of Selected Diseases

Number of reported cases of measles, poliomyelitis, tetanus, diphtheria, and whooping cough, from 1 January 1995 to date of last report, and the same epidemiological period in 1994, by country.

Subregion and country	Date of last Report	Measles				Poliomyelitis		Tetanus				Diphtheria		Whooping Cough	
		Reported		Confirmed		1995	1994	Non Neonatal		Neonatal		1995	1994	1995	1994
		1995	1994	1995	1994			1995	1994	1995	1994				
LATIN AMERICA															
Bolivia	27 May	17	0	0	0	0	0	0	...	...	...	...	...	...	...
Colombia	13 May	1417	352	134	50	0	0	...	...	...	...	...	...	...	...
Ecuador	13 May	680	...	...	830	0	0	...	...	...	13	...	165	...	148
Peru	27 May	109	191	...	191	0	0	27	13	25	10	1	1	340	118
Venezuela	27 May	291	8 204	27	8 204	0	0	...	...	5	3	0	0	75	279
Southern Cone															
Argentina	1 Apr	57	88	8	160	0	0	...	1	...	3	...	2	...	247
Chile	27 May	84	...	0	0	0	0	...	1	...	0	...	0	...	20
Paraguay	27 May	12	66	1	50	0	0	...	9	...	6	...	1	...	18
Uruguay	27 May	...	...	...	1	0	0	...	2	...	0	...	0	...	3
Brazil	20 May	440	...	0	272	0	0	...	180	...	28	...	47	...	431
Central America															
Belize	27 May	6	9	0	0	0	0	...	...	...	...	...	...	...	...
Costa Rica	27 May	145	106	14	10	0	0	...	...	...	...	...	...	...	...
El Salvador	27 May	143	4 667	0	0	0	0	...	...	...	...	...	...	...	...
Guatemala	6 May	33	133	25	117	0	0	...	...	...	6	...	...	...	33
Honduras	27 May	8	27	0	2	0	0	...	0	...	5	...	0	...	2
Nicaragua	20 May	62	1 203	1	11	0	0	...	...	...	...	...	...	...	...
Panama	27 May	46	22	1	0	0	0	0	1	0	2	0	0	3	48
Mexico	27 May	323	550	15	96	0	0	0	37	0	26	0	0	0	78
Latin Caribbean															
Cuba	27 May	23	...	0	0	0	0	...	2	...	0	...	0	...	0
Haiti	07 Jan.	...	...	...	...	0	0	...	...	...	...	...	...	...	...
Dominican Republic	27 May	22	295	0	295	0	0	...	...	...	4	...	1	...	8
CARIBBEAN															
Antigua & Barbuda	27 May	1	2	0	0	0	0	0	0	0	0	0	0	0	0
Bahamas	27 May	1	4	0	0	0	0	0	0	0	0	0	0	0	0
Barbados	27 May	8	22	0	0	0	0	0	0	0	0	0	0	0	0
Dominica	27 May	8	4	0	0	0	0	...	...	...	...	...	...	...	...
Grenada	27 May	3	4	0	0	0	0	...	...	...	...	...	...	...	...
Guyana	27 May	8	1	0	0	0	0	...	...	...	...	...	...	...	...
Jamaica	27 May	87	38	0	0	0	0	...	...	...	...	...	...	...	...
St. Kitts/Nevis	27 May	1	2	0	0	0	0	...	...	...	...	...	...	...	...
St. Vincent	27 May	0	2	0	0	0	0	...	...	...	...	...	...	...	...
Saint Lucia	27 May	5	13	0	0	0	0	...	...	...	...	...	...	...	...
Suriname	27 May	5	7	0	0	0	0	...	...	...	...	...	...	...	...
Trinidad & Tobago	27 May	13	12	0	0	0	0	0	0	0	0	0	0	0	1
NORTH AMERICA															
Canada	27 May	401	117	401	117	0	0	...	1	...	...	...	0	899	1 878
United States	20 May	153	515	153	515	0	0	4	14	...	...	0	0	625	1 162

... Data not available.

Global Commission for the Certification of Polio Eradication

On 16-17 February 1995, the Global Commission for the Certification of the Eradication of Poliomyelitis (GCCEP) met for the first time to discuss what criteria would be used to define and certify global eradication of polio. Serving as a model were the criteria established by the International Commission for the Certification of Polio Eradication in the Americas (ICCPE), which, in September 1994, certified the Region of the Americas polio free—the first region to achieve this goal.

Global polio eradication is defined as the complete cessation of transmission of the wild poliovirus.

The GCCEP decided that preliminary certification should be done on a regional and sub-regional basis. The guidelines for certifying polio eradication will be based upon the assessment of documented evidence focusing on effective surveillance levels for AFP and wild poliovirus. Final certification will not be considered until three years have passed since the last confirmed case of paralytic polio caused by wild poliovirus.

Effective surveillance will be of paramount importance in judging whether or not to certify a region as polio-free. Because infection with wild poliovirus does not necessarily result in clinical infection, there needs to be strict guidelines regarding AFP case surveillance and surveillance for wild poliovirus transmission.

The guidelines for surveillance of AFP are as follows:

- Timely reporting of at least 80% of AFP cases, including zero reporting and documentation of the reasons for late reporting or non-reporting
- Identification of a rate of AFP per 100,000 children under 15 years of age as an indicator of adequate surveillance systems

The *EPI Newsletter* is published every two months, in Spanish and English by the Special Program for Vaccines and Immunization (SVI) of the Pan American Health Organization (PAHO), Regional Office for the Americas of the World Health Organization (WHO). Its purpose is to facilitate the exchange of ideas and information concerning immunization programs in the Region, in order to promote greater knowledge of the problems faced and their possible solutions.

References to commercial products and the publication of signed articles in this *Newsletter* do not constitute endorsement by PAHO/WHO, nor do they necessarily represent the policy of the Organization.

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- At least 80% of reported AFP cases should be investigated within 48 hours

- Detailed investigation—clinical, epidemiological and virological—of suspected polio cases; final case classification should be made on the basis of the examination results by a committee of experts convened for this purpose.

The guidelines for wild poliovirus surveillance are as follows:

- High levels of competency by labs certified as part of global/regional networks
- Validation of specimen collection, transport and testing procedures
- No wild poliovirus will be identified from two stool samples collected within 14 days of onset from at least 80% of cases for at least three years
- No wild poliovirus isolated from stool samples collected from contacts of AFP cases for at least three years

After careful documentation and review by the national commissions, the data collected will be sent to the regional commissions who will have the authority to certify that polio eradication has occurred. Certification of global eradication will be announced only when all regional Commissions have certified polio eradication within their respective areas. During this period, it will be necessary to continue vaccination campaigns and immunization efforts, to maintain strict surveillance for all cases of AFP, and to be in readiness for possible importations of wild poliovirus. The GCCEP will meet again in 1997 to review the progress made towards the goal of global eradication of polio.



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