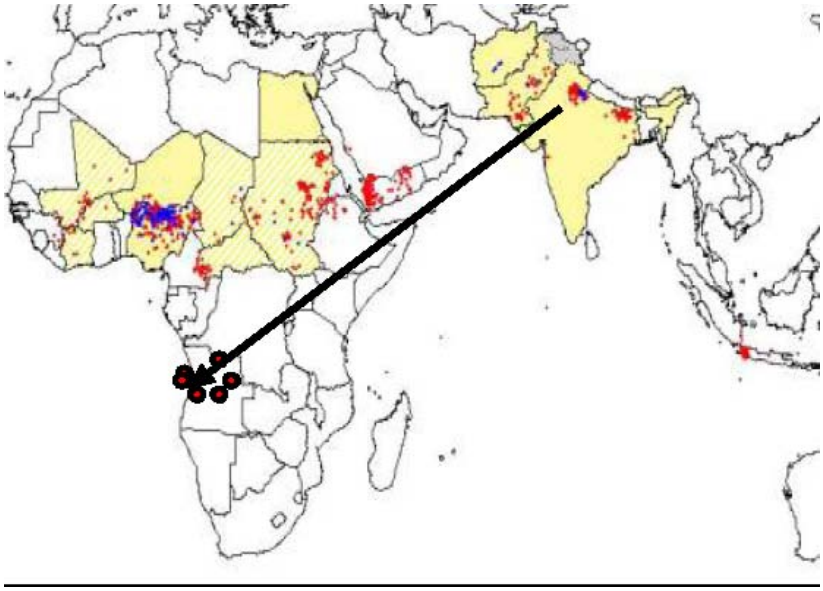
Polio Outbreak in Angola:
Situation report (as of 13 October 2005)

Outbreak Situation

24 June 2005: one polio case is confirmed.
13 October 2005: total rises to 8 cases.

On 24 June 2005, the Ministry of Health of Angola reported its first polio case since 2001. A 17-month old girl with a previous history of oral polio vaccine (OPV) developed fever and paralysis in both legs on 25 April, in the metropolitan area of the capital, Luanda. Genetic sequencing of the type-1 wild poliovirus shows that it originated in India. Virological and epidemiological evidence suggest a recent importation.

Eight cases of wild polio-virus have been reported and confirmed between May and August 2005 in four provinces in the country i.e. Luanda, Benguela, Lunda Sul and Moxico. The importation of poliovirus constitutes a major threat to the country, especially as routine vaccination coverage is around 45%. Failure to halt transmission in Angola could also lead to spread of virus to neighbouring countries such as the Republic of Congo, Democratic Republic of Congo, Namibia and Zambia.



Emergency Outbreak Response

Since 1996, supplemental immunization activities (SIAs) have been conducted on a regular basis. In response to a massive poliovirus outbreak in 1999, a national house-to-house vaccination strategy was introduced. Confirmed cases of wild virus dramatically declined from over 1000 in 1999 to just 55 in 2000, 1 case in September 2001 and zero cases since 2002. Following the outbreak, Angola implemented at least two rounds of nation-wide polio eradication SIAs on an annual basis between 2001 and 2004. In 2001 and 2002, three rounds of national immunization days (NIDs) and two rounds of sub-national NIDs (SNIDs) were conducted. In 2003 and 2004, two rounds of NIDs were conducted.

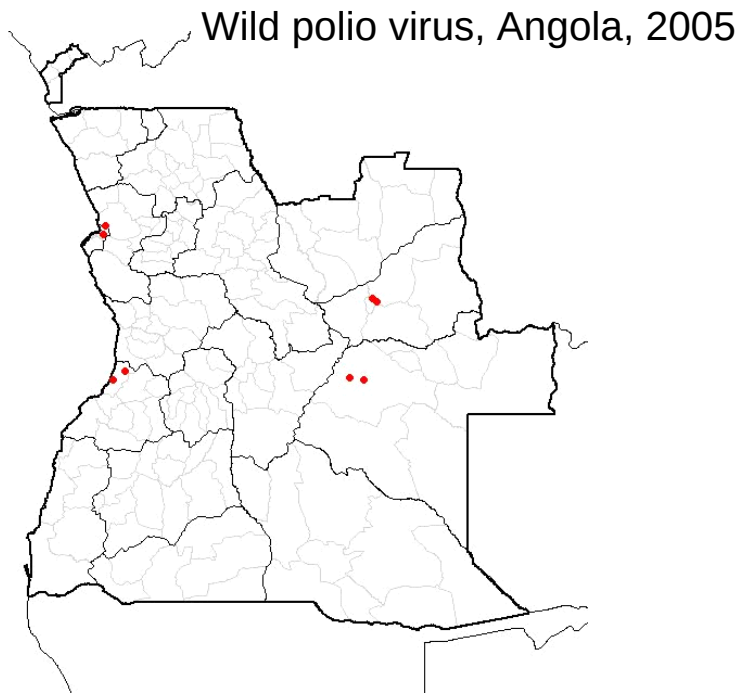
Before the imported case was reported, two NIDS for July and August, targeting 5.4 million children, had already been planned to protect Angola's polio-free status. The July and August house-to-house campaigns reached national administrative coverage of over 90%. Additionally. monovalent oral polio vaccine type 1 (mOPV1) was used in the 2 infected provinces of Benguela and Luanda, as well as in the town of Moxico, in order to increase population immunity against type 1 poliovirus, the strain causing Angola's outbreak.

In response to the importation, an additional NID was conducted in September. mOPV1 was used nationwide and the number of vaccination teams was increased in an effort to vaccinate children in hard-to-reach areas. Preliminary results indicate a slight increase in national coverage.

Plans for a fourth NID in November are being finalized. Urgent improvements in immunization campaign quality must urgently be attained to reach all children under 5 years of age. This is particularly important given low routine OPV immunization coverage and weak health systems. Experience in polio eradication demonstrates that outbreaks can be quickly contained with high quality immunization campaigns which reach every child under five years of age.

Since the confirmation of wild poliovirus in mid-2005. Acute Flaccid Paralysis (AFP) surveillance activities have been intensified in all provinces in the country, including neighboring countries. Activities include sensitization of all health workers, traditional healers and other key community informants regarding the importance of immediate reporting and investigation of all AFP cases as well as the inclusion of smaller health facilities into the active surveillance network.

Location of polio cases



Data in WHO HQ as of 11 Oct 2005

Financial situation

US$ 5.4 million provided for OPV and operational costs of the first three campaigns of 2005 was made available through WHO and UNICEF, from donors including US Centers for Disease Control and Prevention, the Canadian International Development Agency (CIDA), the European Commission, DFID, USAID and the governments of France and New Zealand. The Government of Angola also contributed over US$470,000 to the first three campaigns. Spain, Portugal and USAID provided funding to support the surveillance and laboratory network.

The external funding requirement for the November campaign is US$ 2.51 million (OPV + operational costs + surveillance), with a funding gap of US$ 1.37 million.