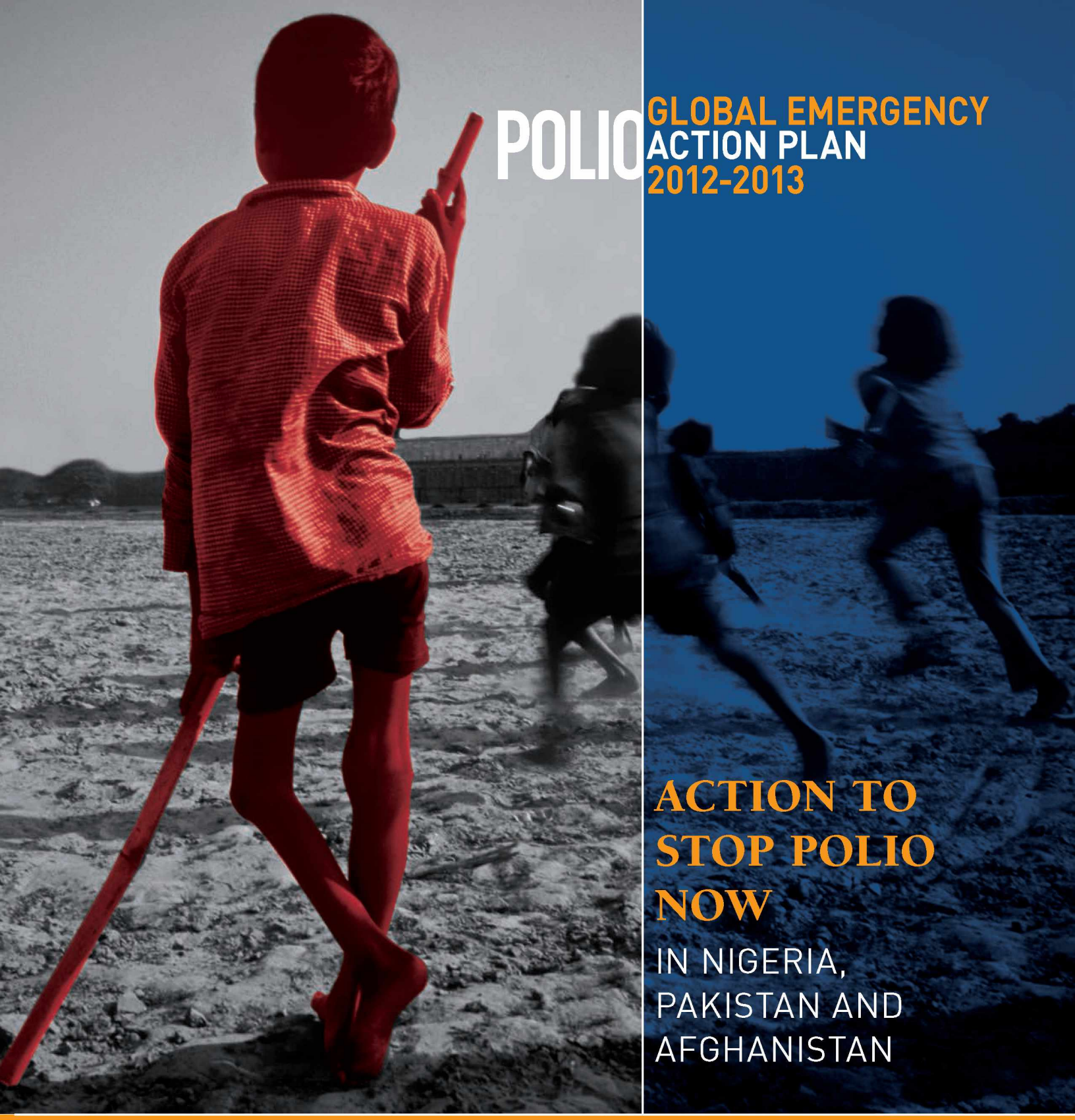

POLIO GLOBAL EMERGENCY ACTION PLAN 2012-2013

ACTION TO STOP POLIO NOW

IN NIGERIA, PAKISTAN AND AFGHANISTAN

Developed by the Governments of Nigeria, Pakistan and Afghanistan

With the support of

World Health Organization

CDC

unicef

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ACTION TO STOP POLIO NOW

IN NIGERIA, PAKISTAN AND AFGHANISTAN

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Executive Summary

The emergency

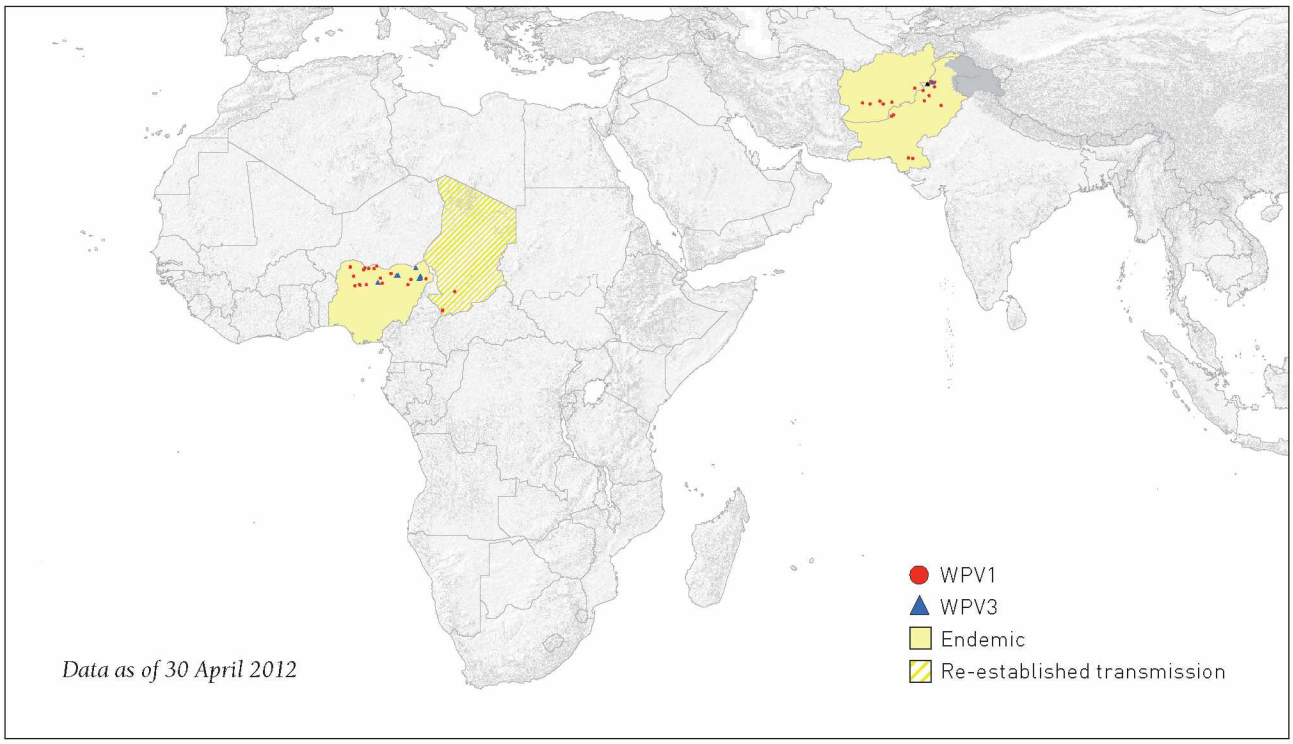
An unprecedented intensity of polio eradication activities in 2010-11 resulted in several landmark successes. India became polio-free and global cases decreased by 52%; of the four countries with re-established poliovirus transmission, South Sudan and Angola have not recorded a case since June 2009 and July 2011, respectively, while cases fell substantially in the second half of 2011 in Chad and the Democratic Republic of the Congo. All importation-associated outbreaks in eight previously polio-free countries in 2011 were stopped, all but one (in Mali) within six months.

In the three remaining polio-endemic countries, however, polio cases soared from 2010 to 2011 (in Afghanistan by 220%, in Nigeria by 185% and in Pakistan by 37%), with the most dramatic rise in the second half of 2011. Polio also spread internationally from Nigeria and Pakistan, underscoring the risk that endemic poliovirus transmission continues to pose globally.

In addition, recent polio outbreaks on three continents highlighted the unacceptable consequences of failure. In China, Tajikistan and Congo, explosive outbreaks following importations affected both adults and children, due to the changing susceptibility patterns; in some areas, the adult case fatality rates approached 50%.

Polio eradication is at a tipping point (Figure 1). If immunity is not raised in the three remaining countries to levels necessary to stop poliovirus transmission, polio eradication will fail. All three countries still face a variety of barriers to reaching each child with the oral polio vaccine (OPV) including weak public infrastructure and health systems, insecurity, large-scale population movements, corruption, political change, and insufficient accountability.

Figure 1: Global cases of wild poliovirus, 2012



The consequences of failure are both immediate and long-term. Poliovirus will again spread rapidly from polio-affected countries, sparking large polio outbreaks in areas with weak immunity, potentially with high fatality rates. Within a decade, the disease could re-establish itself globally, paralysing over 200 000 children again every year and precluding financial benefits estimated at a minimum of US$40-50 billion by 2035[1], for low-income countries alone. Failure of the polio effort would also threaten all global immunization programmes which aim to save the lives of millions of children in this decade.

The goal

The over-riding goal of the Global Polio Emergency Action Plan (EAP) is to help the remaining polio-infected areas of Nigeria, Pakistan and Afghanistan get back on track for eradication through an emergency approach with appropriate leadership, oversight and accountability, and bolstered by an extensive surge of technical assistance down to the subnational level. The emergency activities are driven by the national governments of the endemic and re-established transmission countries, with support from international partners.

The EAP represents an urgent escalation of national and international efforts using a wide range of new targeted and cross-cutting initiatives to eradicate polio, and enhanced resource mobilization to bridge the campaign's funding gap of US$945 million against an overall budget of US$2.19 billion for 2012-2013. This shortfall has already necessitated the cancellation or reduction of polio vaccination campaigns in 24 high-risk polio-free countries.

The EAP was developed in response to the WHO Executive Board's declaration in January 2012 that the completion of polio eradication must now be treated as a "programmatic emergency for global public health". The EAP builds upon the approaches outlined in the GPEI Strategic Plan 2010-2012 and is designed to accelerate progress towards the realization of its milestones. The EAP will also serve as a precursor to the Polio Eradication and Endgame Strategy 2014-2018.

The plan

The specific objectives of the EAP are to:

1. Accelerate and intensify support to poorly-performing areas of Nigeria, Pakistan and Afghanistan to increase, by end-2012, vaccination coverage to the levels needed to interrupt transmission of all remaining polioviruses;

2. Sustain momentum in Chad, the Democratic Republic of the Congo and Angola to complete the interruption of poliovirus transmission in 2012 and to respond rapidly and effectively to stop within six months any new outbreaks in polio-free countries;

3. Heighten GPEI partner accountability, coordination and oversight to improve subnational outcomes in polio-affected countries;

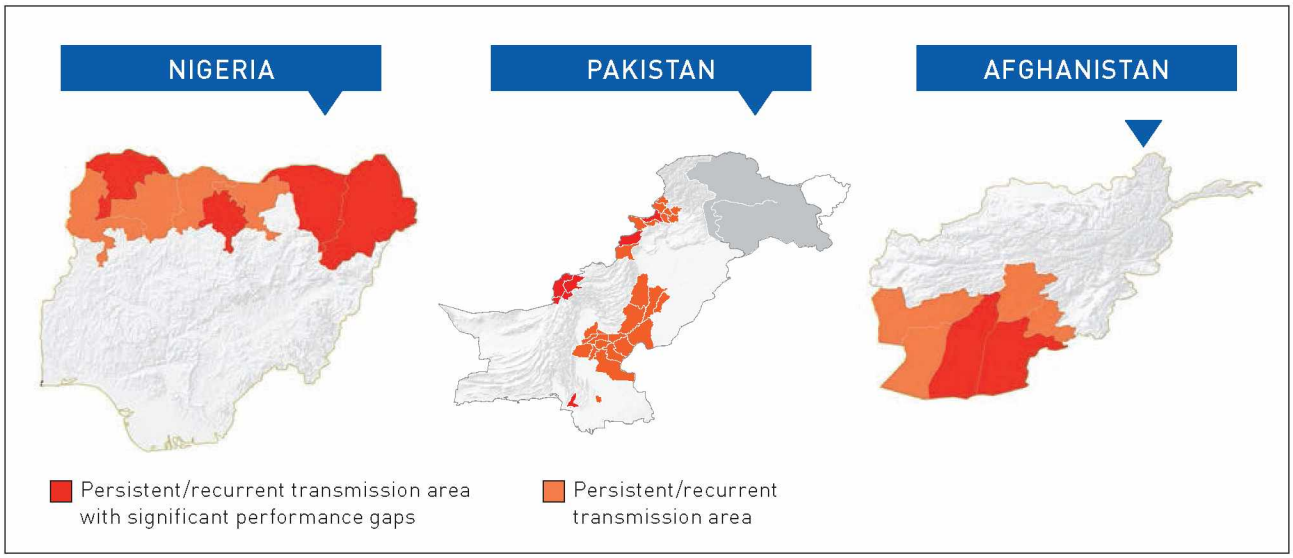
4. Close the US$945 million funding gap for eradication activities in 2012-2013 and develop a long-term plan to ensure funding and political will for the Polio Eradication and Endgame Strategy 2014-2018.

The EAP is built on the new 2012-2013 national emergency plans of the three remaining endemic and two remaining re-established transmission countries, and the joint commitments of the four spearheading partners of the Global Polio Eradication Initiative - Rotary International, WHO, the U.S. Centers for Disease Control and Prevention, and UNICEF. Also supporting the EAP is the Bill & Melinda Gates Foundation. To optimize international and national collaboration, a new emergency programme coordination architecture has been put in place, overseen by governments of affected countries and leadership of partner agencies, with support by technical expert groups and other stakeholders. The new Global Polio Partners Group (PPG) will enhance the voice of stakeholders in the development and implementation of plans, and foster greater engagement of existing and new donors and partners in both the emergency action plan and, eventually, the "endgame" strategy through 2018.

Geographically, the EAP focuses on the historically "worst-performing" districts in Nigeria, Pakistan and Afghanistan, in terms of the polio eradication activities (Figure 2).

1 Economic analysis of the global polio eradication initiative. Tebbens RD et al. Vaccine. Vol 29, Issue 2, 16 December 2010

Figure 2: Worst-performing areas for polio eradication activities in the three remaining endemic countries



The EAP incorporates a combination of actions that address systemic problems in polio campaign performance, have been proven to rapidly improve coverage and have been validated during 2010-2011 in polio-affected countries, especially India. These include: rapid detection of poliovirus in all areas and communities; immediate responses to local problems and risks based on quality monitoring data; complete and accurate micro-planning; greater community support and demand for polio vaccination; enhanced political commitment and accountability at all levels; and, improved selection, motivation and performance of vaccinators.

The EAP also emphasizes a number of approaches that have been tailored to the specific circumstances of each country such as:

- **New vaccinator team composition** - in Nigeria, selected teams are being restructured on a trial basis to to heighten flexibility of deployment, achieve better-balanced workloads, improve supervision and ensure availability of more teams. Pilots suggest this approach can reduce the number of missed children.

- **Improved access in insecure areas** - in Afghanistan, low-visibility "permanent polio teams" are conducting house-to-house vaccination in conflict-affected districts on an ongoing basis, to provide every eligible child in the catchment area with at least one dose of OPV every three months.

- **Better micro-planning and maps** - in Nigeria, new micro-planning templates, supplemented by new GIS maps, are helping to solve the problem of incorporating locations that in the past have been completely missed.

- **Enhanced attention to routine immunization** - synergies with the polio planning, social mobilization and supervision activities are being exploited; in Pakistan routine immunization is also being boosted in health camps.

- **Closer tracking of vaccinators** - in Nigeria, GIS/GPS technology is being used to monitor vaccination activities more accurately and help identify gaps where teams are not visiting areas or communities.

- **Scale-up of strategies for special populations** - In Pakistan and Nigeria, special mapping and tracking strategies have been developed to reach migrant, mobile and nomadic populations.

- **New communications tactics** - in Pakistan, a Nomadic Children's Festival and in Nigeria a Volunteer Community Mobilizer Network are increasing community participation and building trust among parents to vaccinate their children against polio.

Implementation and oversight

In the first three months of 2012, steps were taken to reconfigure the GPEI at all levels to operate in an emergency mode. In each endemic country, the Head of State established an oversight mechanism to monitor local polio campaign performance in infected areas. This enhanced oversight was reinforced with accountability frameworks that clarified responsibility down to the district and subdistrict levels. Programme implementation at the district and subdistrict level was supported with the initial deployments of what will eventually be thousands of additional personnel through international partner agencies. The partner agencies also set up Heads of Agency oversight bodies, activated emergency operations centres and procedures, and tightened inter-agency programme performance monitoring.

By April 2012, polio cases were declining in all remaining polio-infected countries with the exception of Nigeria. The latter represents an imminent risk to west and central Africa, amplified by the cancellation of polio vaccination campaigns in 24 polio-free countries in Africa and Asia due to the shortage of funds.

Progress against the Global Polio Emergency Action Plan will be tracked by the Independent Monitoring Board and reported to each session of the WHO Executive Board and the World Health Assembly.

1. Purpose

On 21 January 2012, the World Health Organization's Executive Board declared the completion of polio eradication a "programmatic emergency for global public health"[2] and requested the WHO Director-General to develop an intensified plan through 2013 to interrupt wild poliovirus (WPV) transmission globally.

In response, the Global Polio Eradication Initiative (GPEI) has developed a *Global Polio Emergency Action Plan 2012-13*. Its goal is to support transformational change leading to eradication in the three remaining polio-endemic countries: **Nigeria, Pakistan and Afghanistan**.

Such change will be achieved through an emergency approach that focuses on developing appropriate leadership, oversight, accountability and surge capacity at global, national and subnational levels. The emergency approach will be driven by the endemic and re-established transmission countries, with support from donors and partners.

This Plan builds upon the strategic approaches outlined in the GPEI Strategic Plan 2010-2012 and introduces new approaches intended to accelerate progress towards its milestones. The Plan will also serve as a critical precursor to the Polio Eradication and Endgame Strategy 2014-18.

2 WHO Executive Board Resolution 130.R10 Poliomyelitis: intensification of the global eradication initiative. Available at: http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_DIV3-en.pdf

2. Context

Today, the world is closer than it has ever been to polio eradication. Due to vaccination efforts, cases have been reduced by a remarkable 99.8% since the GPEI began in 1988. As a result, an estimated quarter of a million children are now alive and another five million children are walking who otherwise would have been paralyzed.

Cases are at the lowest level in history. Since the launch of the GPEI Strategic Plan 2010-12, the incidence of polio has fallen by up to 50%, and there are only the three remaining endemic countries mentioned above.

With the recent confirmation of India's polio-free status, another 172 million children are now protected from this debilitating disease, marking the highest-ever global immunity against it. While the impact of this achievement is impressive, it also signifies that the world is now at the greatest risk of compromising this protection unless transmission is stopped everywhere.

The GPEI is redoubling its efforts to accomplish this. It is laying the foundation for a better public health system that can continue to enable critical health services for children in the poorest and most inaccessible places. Polio eradication is an early milestone in the Decade of Vaccines, and a resolution will be voted on during the 65th World Health Assembly to ensure that the world community supports access to vaccines in order to save the lives of millions more children in this decade.

There is also encouraging progress in re-established transmission countries. In South Sudan and Angola there have been no reported cases, respectively, since June 2009 and July 2011. While Chad and the Democratic Republic of the Congo (DR Congo) experienced extensive outbreaks in early 2011, transmission has been geographically restricted and clear signs of progress have been seen since. With the exception of Mali, outbreaks in all previously polio-free countries have been successfully stopped within six months of onset.

Despite the tremendous progress in India, and improvements elsewhere, these gains are at risk. In 2011 there was an upsurge of cases in **Nigeria** and **Pakistan**, where the continued circulation of two WPV serotypes[3] was accompanied by international spread. In **Afghanistan** cases also increased, with the national programme unable to reach enough children in insecure areas.

The common denominator that has thrown the three endemic countries off track for eradicating polio has been "performance of variable quality that has consistently fallen below best practice in polio affected areas."[4] As a result the end-2010 and end-2011 milestones of the GPEI 2010-12 Strategic Plan were missed.

To maintain the highest level of immunity, as eradication draws closer and cases continue to fall, the GPEI needs to ensure that political will and funding do not falter. The programme currently faces a 50% gap in financing for 2012-13. This gap has required a scale-back in February 2012 of critical activities aimed at reducing the risk of WPV spread.

The *Global Polio Emergency Action Plan 2012-13*, and the revised national emergency action plans that underpin it, are critical to ensuring that polio-affected countries and the partners collaborating with them bring about the necessary changes in approach and implementation, and the political commitment and funding that will achieve polio eradication.

3 Nigeria was also unable to stop the transmission of circulating vaccine-derived poliovirus two (cVDPV2).

4 Independent Monitoring Board of the Global Polio Eradication Initiative. Report, October 2011. Available at: www.polioeradication.org

3. Risks

GEOGRAPHICAL

Nigeria, Pakistan and **Afghanistan** represent the gravest risk to global polio eradication.

The principal threat to global polio eradication resides in:

- Borno, Kano, Jigawa and Sokoto States (Nigeria);
- Quetta Block, Karachi City and the Federally-Administered Tribal Areas - FATA (Pakistan);
- Hilmand and Kandahar provinces (Afghanistan).

OPERATING ENVIRONMENT

Strengthening of political commitment, management, accountability and operational capacity in the endemic countries will lead to transformative change. Also critical is increased international support in the endemic countries. Progress, however, will continue to be threatened by:

- Weak systems;
- Geographical barriers to access;
- Insecurity;
- Corruption;
- Political change.

PROGRAMMATIC

Key programmatic risks include:

- Poorly planned and managed SIA campaigns (including inadequate understanding of **refusals**) leading to **chronically-missed children**;
- Inability to overcome the limitations of **poor quality supervision** and **oversight**;
- Failure to reach **migrant** and **neglected populations**;
- Suboptimal **training quality** and **motivation of vaccinator**s;
- Weak and declining **Routine Immunization** coverage;
- Continued **OPV vaccine insecurity**.

FINANCIAL

The GPEI is faced with a **US$ 945 million (50%) shortfall** in its 2012-13 budget.

Insufficient financing has forced the programme to **cancel and substantially scale back polio vaccinations** in 24 countries in 2012.

The GPEI does not have sufficient funding, particularly in relation to core costs, to commence key activities in 2013.

4. Objectives

The specific **objectives** of the Plan are to:

1. Accelerate and intensify support to poorly-performing areas of Nigeria, Pakistan and Afghanistan to ensure that the coverage levels needed to stop transmission of all polioviruses are reached by end 2012;

2. Sustain momentum in Chad, DR Congo and Angola to interrupt transmission in 2012 and respond rapidly and effectively to stop any new outbreaks within six months;

3. Heighten GPEI partner accountability, coordination and oversight to improve sub-national outcomes in these countries;

4. Close the US$ 945 million funding gap for eradication activities in 2012-13 and develop a long-term plan to ensure funding and political will for the Polio Eradication and Endgame Strategy 2014-18.

5. An emergency approach

In the first three months of 2012 significant steps were taken to restructure the GPEI as a **public health emergency**:

- National emergency plans in Nigeria, Pakistan and Afghanistan (as well as other priority countries[5]) were updated, augmented and strengthened (See details in Section 7). All polio-affected countries have already announced, or will announce, that polio is an emergency and they will develop national and subnational communication plans to drive home the message that these are country priorities of utmost urgency.

- Implementing partners have moved their operations onto an emergency footing:
  - WHO has established a change management task force at Headquarters (HQ) and Regional Office levels (Africa, Eastern Mediterranean and South-East Asia) to drive the implementation of a seven-pronged emergency approach[6] to polio eradication activities;

5 Chad and the Democratic Republic of the Congo.

6 The components are: Activation of emergency operations in HQ Strategic Health Operations Centre; change communications; GPEI architecture; programme performance monitoring; personnel accountability; in-country capacity and surge support; and innovation.

- UNICEF has established an Inter-Divisional Polio Emergency team operating under the Deputy Executive Director;
- the U.S. Centers for Disease Control and Prevention (CDC) has activated its Emergency Operations Center (EOC) and mobilized staff across the organization;
- the Rotary Foundation has reaffirmed that polio eradication is the urgent organizational priority and is making available the full resources of the organization to support the effort.

The following fundamental principles have been proposed for the GPEI by the Independent Monitoring Board,[7] and they mirror various aspects of the emergency approach being taken by the endemic and re-established countries and partners:

- All involved in the GPEI give the emergency a very high level of priority over other issues;
- Zero tolerance of chronic poor performance, including falsification of data and misuse of funds/resources;
- Fair, transparent and practical processes to reward good performance;
- People at the top of every involved organization pay close personal attention to the emergency and its resolution, including providing the necessary people and resources rapidly when and where needed;
- Time is of the essence, requiring rapid actions for all activities;
- Barriers that impede work to resolve the emergency are unacceptable, and are resolved rapidly;
- The task at hand is more important than sensibilities; the emergency requires that organizational tensions are resolved and concerns about who gets credit or blame are set aside;
- Anything that might help to bring the emergency to a close should be tried; there is no place for 'business as usual';
- The front line is all-important; those not working on the front line will work to support those who are.
- All data that shows why polio persists should be used rapidly to adapt strategies, activities and resource allocation.

7 Independent Monitoring Board of the Global Polio Eradication Initiative. Report, October 2011. Available at: www.polioeradication.org

6. Best practices and innovations to address systemic problems

The Plan builds on the GPEI Strategic Plan 2010-12, incorporating lessons learnt and insights from affected countries, **especially India** [see Web Annex 1, at www.polioeradication.org], which are as follows:

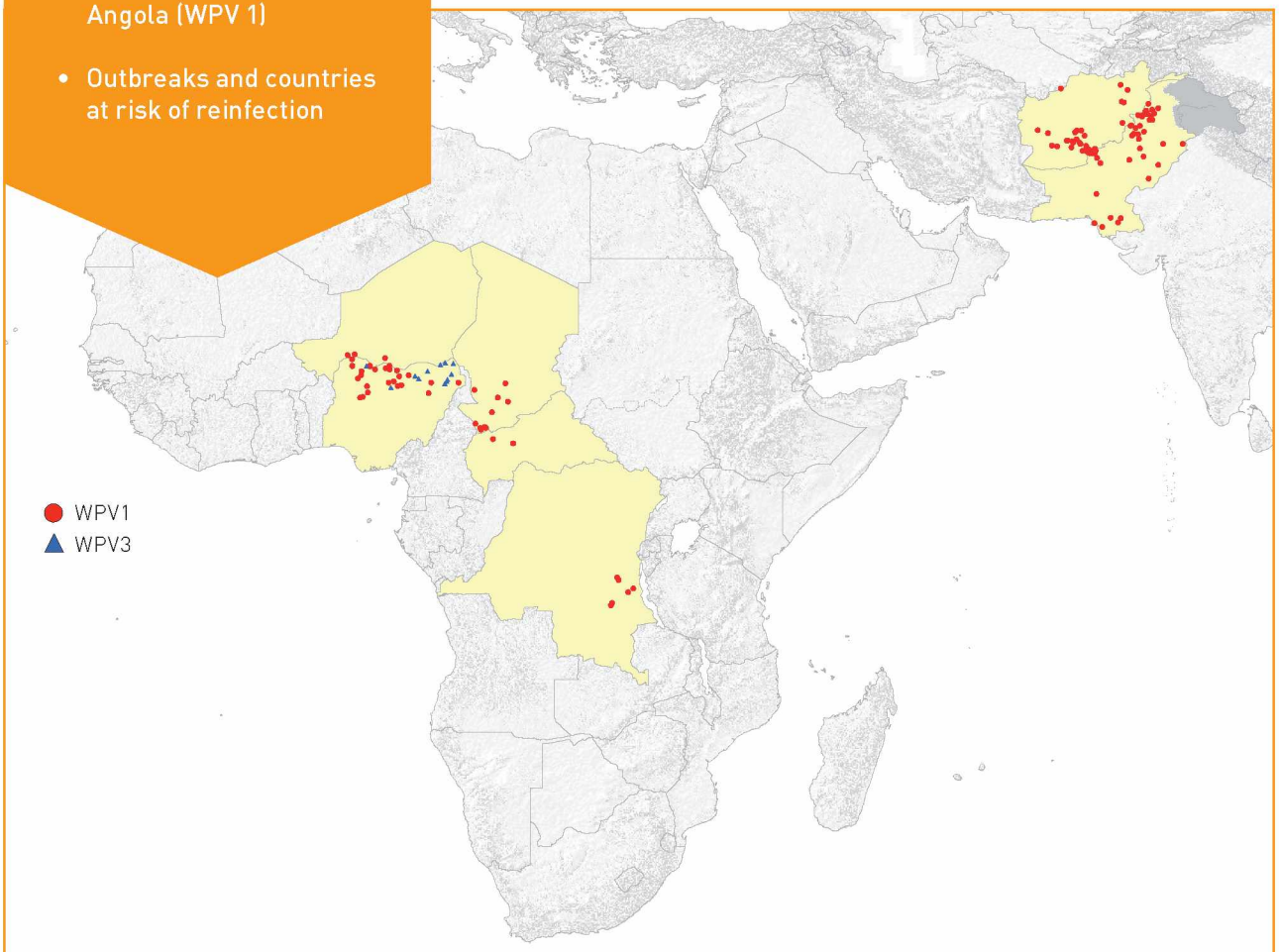
ACTIVITY*	MAJOR LESSON*
National and subnational Accountability and Oversight	Corrective actions and their impact depend on oversight and accountability of subnational leaders.
Monitoring of Supplementary Immunization Activities	Independent monitoring has poor sensitivity to detect areas that fail to achieve minimum coverage levels.
Quality of Supplementary Immunization Activities	The intensive scale-up of technical assistance is fundamental to enhancing SIA performance rapidly in chronically-weak areas.
Outbreak Prevention and Response	New, innovative response tactics (e.g. extended age groups for OPV rounds) can stop outbreaks in even less than six months. Targeted SIAs based on risk assessment can be used to prevent substantial immunity gaps from developing.
Surveillance	Gaps can persist in subnational areas with high performance indicators due to subpopulations and other factors requiring constant monitoring and supervision.
Routine Immunization	Routine immunization coverage can and should be improved substantively while intensive eradication activities are ongoing.
Vaccines	Research has indicated that bivalent OPV and inactivated polio vaccine provide new opportunities to enhance vaccine impact.
Communication and social mobilization	Community-level communication and social mobilization focusing on high risk areas/populations needs to be intensified and scaled-up to help secure local engagement, address community concerns and create demand to improve overall quality of activities.
Resource Mobilization	Sustained progress and a credible programme plan are critical elements to achieve funding for the GPEI, which also must be complemented by an expanded and engaged donor base and a longer-term approach.

**See Annex 1 for related Emergency Actions and Expected Outcomes*

7. Programmatic priorities by Geographic/Strategic area

KEY GEOGRAPHIC PRIORITY AREAS:

- Nigeria (WPV1, WPV 3, cVDPV2), Pakistan (WPV 1, WPV3) and Afghanistan (WPV 1)
- Chad, DR Congo and Angola (WPV 1)
- Outbreaks and countries at risk of reinfection



Wild poliovirus cases, 25 October 2011 – 24 April 2012

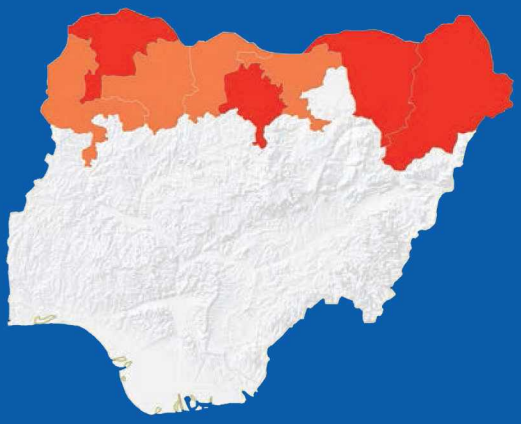
7. A

Putting endemic countries back on track to reach the coverage levels needed to stop transmission of all polioviruses and achieve eradication.

Nigeria

Situational Analysis

Polio cases, 2011	• 62 WPV cases (47 WPV1 and 15 WPV3) • 33 cVDPV2 cases	Threefold increase in WPV cases compared to 2010
Worst performing areas, 2011	Borno, Kano, Sokoto and Yobe States	



In 2011 Nigeria reported 62 cases due to wild poliovirus (47 due to WPV1 and 15 to WPV3), a three-fold increase over 2010. In addition, 33 cases due to circulating vaccine derived poliovirus type 2 (cVDPV2) were reported. Transmission of all three types was restricted to the endemic northern states, particularly Kano, Jigawa, and Borno, with significant transmission also in Sokoto, Zamfara, and Kebbi. In 2011 Nigeria continued to export virus to neighbouring countries (Niger and Cameroon).

While the immunization status of children in northern Nigeria has continued to improve slowly in 2011, both the number and geographical extent of cases are increasing. In four infected states, <65% of children have >4 OPV doses (Borno, Kano, Sokoto and Yobe). Nearly one third of WPV cases in 2011 were in children who had never received a single dose of OPV. Case investigations suggest that 50% of children with WPV were not vaccinated because of parental refusal.

The low-quality routine services are deteriorating; 55% more infants were not vaccinated with DPT3 in 2011 than in 2010, and there were central stock-outs of four of the eight childhood vaccines. Children are missed due to a mixture of operational and social factors, and these programme gaps must be addressed if more children are to be reached.

Viruses with genetic evidence of long periods of circulation without detection are still being found, indicating both surveillance gaps, and the strong likelihood that population subgroups, especially nomadic groups and other migrants, are not being adequately covered by immunization or surveillance activities. Recent insecurity in the north is a further factor affecting programme quality.

Although polio has been declared an emergency by His Excellency the President, in the first quarter of 2012, only half of the 12 northern states convened their State Task Force to address problems.

However, the **new National Emergency Plan 2012** finalized in April [see Web Annex 2, at www.polioeradication.org] is promising, and if well-implemented can achieve a rapid jump in campaign coverage. Data from recently-conducted

pilots[8] prove the Intensified Ward Communication Strategy (IWCS) can tackle the issue of parents refusing to vaccinate their children. Restructuring the vaccination team strategy should help address the issue of insufficient teams. Pilots designed to improve vaccinator selection/performance and reduce refusals are showing promise. Application of the new micro planning templates, supplemented by Global Information System (GIS) mapping, could solve the problem of missed communities. Special population strategies, as for nomadic populations, prove these important groups can now be reached. It will be crucial to take these innovations to scale rapidly in the worst-performing LGAs and districts, through the planned surge support.

Additionally, optimizing the Accountability Framework of the Presidential Task Force on Polio Eradication, as well as the State Task Forces, and continued public reporting of the Abuja Commitments to hold states and LGAs accountable, are essential to ensure the Plan's full application, reward leadership, and sanction those who stand in its way.

The National Emergency Plan 2012 provides specificity (activities, targets, deadlines, accountability framework and performance metrics etc.) in each of the following areas.

Improving national ownership, oversight and accountability

On 1 March 2012 the President inaugurated a Polio Eradication Task Force, chaired by the Minister of State for Health, to oversee implementation of the National Emergency Action Plan. The issue of accountability of all levels of government is one of the key thematic elements of the plan, in particular the implementation and close monitoring of the Abuja Commitments. The country's Expert Review Committee meets at least twice a year to provide strategic advice to the Ministry of Health on polio eradication and to review progress on implementation of the Emergency Plan.

SIA and vaccine plans for 2012-13

Nigeria is planning for a minimum of two national and five large-scale subnational supplementary immunization rounds in 2012, and a minimum of two national and four large sub-national rounds in 2013. A combination of bOPV and tOPV will be used to stop transmission of the cVDPV2 as well as WPV1 and WPV3. Subnational rounds will target, at a minimum, the eight key endemic states of the north.

Improving SIA quality and monitoring

Under its Emergency Action Plan the interim biannual programme performance target set for SIA coverage in Nigeria is >90%.[9] The Plan will target levels surpassing this in high-risk, mobile population subgroups. Performance against these targets will be assessed by LQAS.

The Emergency Action Plan elaborates key thematic elements for improving the quality of immunization activities, including:

- **Heightened LGA accountability and advocacy:** intensifying advocacy at LGA level while re-enforcing leadership in key high risk states, closely linked to the monitoring of critical steps outlined in the Abuja Commitments;
- **Improved SIA quality and innovations:** the review and refinement of basic strategies for supplementary immunization, including a thorough review of current guidelines, training practices and materials, and the micro planning process, and incorporating new approaches including GIS technology;
- **Improved SIA planning:** developing and implementing a system of indicators to assess preparations for each SIA round at LGA level, coupled with a process for delaying implementation in any LGA/ward failing to meet satisfactory preparation;
- **Human resource surge:** the identification and deployment of adequate human resources to the highest-risk states and areas (government and partner resources) from the level of vaccination teams and community mobilizers up to state level management;
- **Reaching chronically-missed children:** introducing and scaling up new interventions to reach chronically-missed children, including a process of in-depth

8 Presentation of the national Expert Review Committee, Nigeria, 28 March 2012

9 These targets for priority countries are based on experience in India and internal data and are *interim targets*. The ultimate aim for all priority countries is to reach higher effective vaccination coverage that goes over the "threshold" as quickly as possible. Further refinements and data from ongoing studies and surveillance will assist in deriving more valuable models of critical target immunity levels in Q2 and Q3 2012, which could lead to revisions of these targets.

investigation of identified wards or populations (including nomadic populations) where children are being missed, to develop a package of appropriate operational and social interventions;

- **Enhanced routine immunization:** intensifying routine immunization activities through the 'reaching every ward' strategy in the high-risk states and incorporating lessons learnt in polio, including micro planning to ensure all communities are reached, monitoring of service delivery, and communications strategies to build community demand.

- **Strengthened communication response** in key priority areas to address vaccine resistance: Establishing the Volunteer Community Mobilizer (VCM) initiative in poor performing settlements in Kano, Kebbi, Sokoto, Zamfara and Jigawa. Following-up on the Polio Free Torch campaign with media engagement and organizing state level events to engage Governors. Intensifying engagement of religious clerics and launching an anti-rumour campaign in northern Nigeria.

- **Focusing on the front-line workers and vaccinators:** improving interpersonal communication training for vaccinators, their supervisors and ward focal points; rewarding well-performing volunteers; and rewarding settlements who continue to have 0% missed children and 0% non-compliance (refusals).

Enhancing Surveillance

The Emergency Plan outlines a process for strengthening surveillance, including the continued use of rapid assessments linked to action plans to address gaps, a full national surveillance review, a series of processes for the better engagement of medical and health workers, and expanded environmental surveillance.

Additionally, mobile phone SMS prompting to increase and improve active surveillance, especially in difficult access areas (e.g. Borno) will be piloted, with a view to wider scale-up.

Highlight of key achievement signposts and targets[10]

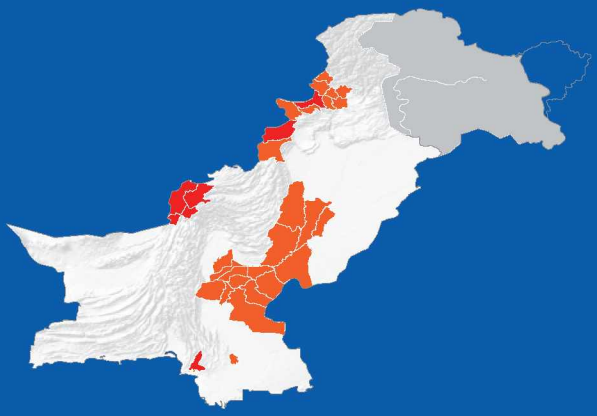
Area	Achievement/Target	Date (2012)
SIA Coverage	> 80% LGAs in high-risk states (HRS) achieve 90% coverage in at least 1 IPD (Immunization Plus Day) round.	End June
	> 90% LGAs in the HRS achieve 90% coverage in 2 IPDs.	End September
	> 90% LGAs in the HRS achieve 90% coverage in at least 4 IPDs.	End December
Surveillance	90% of LGAs meet the 2 main surveillance indicators.	End December
	Zero orphan virus detection.	End December
Routine Immunization	Achievement of at least 50% OPV3 coverage in all high-risk LGAs.	End December
Communication & social mobilization	Ensure 80% of high-risk States and LGAs achieve quarterly Abuja Commitments.	End December
	80% of LGAs implement 80% of social mobilization activities in national EAP.	End December

10 See Annex 2 for additional highlights

Pakistan

Situational Analysis

Polio cases, 2011	198 cases (196 WPV1 and 2 WPV3)	40% increase in WPV cases compared to 2010
Worst performing areas,2011	Baluchistan, FATA and Karachi	



In 2011 Pakistan reported 198 cases due to wild poliovirus (196 due to WPV1 and two due to WPV3), an increase of nearly 40% compared with 2010. In the first half of the year transmission was heavily concentrated in the known, poor-performing transmission zones in Baluchistan, FATA, and Karachi, but during the high transmission season virus spread more widely out of these zones, including into areas that had been polio-free. Nonetheless the worst- performing areas, which have been identified by the national programme for several years now, carry by far the largest burden of disease.

It is continued transmission in these areas that threatens the achievement of polio eradication in Pakistan. Children are being missed during immunization activities because of a range of operational and social factors, and in some areas due to ongoing insecurity (although access to children in FATA has improved significantly in Q4 2011/Q1 2012).

Programme performance is complicated further by the presence of minority groups in some of the key zones, including in Karachi and Quetta block, which require special strategies to be reached. Achieving well-supervised, high-quality immunization rounds in the key transmission zones remains the major issue for the programme in Pakistan.

However, despite these very real challenges, there have been several encouraging developments in the national programme over the last six months particularly in the areas of programme oversight and accountability at district/agency level (with District Coordination Officers now being held directly accountable and in turn holding health authorities accountable); the ongoing scale-up of technical assistance to the subdistrict level by UN agencies, particularly in the worst-performing areas of Karachi and the Quetta block; and tighter programme performance monitoring, with campaigns being suspended in districts not meeting standard preparedness indicators until corrective action is taken.

Pakistan's **Augmented National Emergency Plan 2012** [see Web Annex 3, at www.polioeradication.org], provides credible solutions to many of the problems identified and covers each of the following areas.

Improving national ownership, oversight and accountability

In November 2011, the Government of Pakistan announced major new changes to the country's polio eradication effort, as part of urgent measures to address the drastic rise in polio in 2011. At the same time, the National Task Force on Polio Eradication, which meets quarterly and is chaired by the Prime Minister, launched a strengthened and reinvigorated National Emergency Plan for polio. The Prime Minister also appointed his special assistant on the social sector as his National Polio Focal Point.

The Augmented National Emergency Action Plan 2012, which was endorsed by the National Technical Advisory Group in March 2012, focuses strongly on accountability and performance issues at district and subdistrict levels,

particularly in the high-risk areas. Under the Plan, each province will also appoint a Focal Point for polio, reporting directly to the Chief Minister or Governor.

The national Technical Advisory Group (TAG) has been reconstituted and will meet twice a year (the first meeting was held in March 2012) to provide strategic advice to the Government and to review progress against implementation of the Emergency Plan.

SIA and vaccine plans for 2012-13

Pakistan is planning a minimum of four national and four large-scale subnational supplementary immunization rounds in 2012, and a similar schedule in 2013. Both trivalent and bivalent OPV will be used (trivalent in at least two national rounds per year), to ensure that protection against WPV2 is maintained while WPV1 and WPV3 are being eradicated. The TAG proposed a pilot study on the use of IPV as a supplement to OPV in the second half of 2012 to develop experience on its potential wider use.

Improving SIA quality and monitoring

Under its Emergency Plan the interim bi-annual programme performance target set for SIA coverage in Pakistan is >95%.[11] The national Plan will target levels surpassing this in high-risk, mobile population subgroups. Performance against these targets will be assessed by lot quality assurance sampling (LQAS).

The Augmented National Emergency Plan 2012 identifies key actions for improving the quality of immunization activities, including:

- **Heightened subnational accountability:** ensuring that responsibility for the quality of activities in districts is borne by the head of the civil administration in the district, and that the District and Union Council Polio Eradication Committees are both functioning and empowered;

- **Improved SIA planning:** developing and implementing a system of assessing preparations for each SIA round at district and subdistrict level, coupled with a process for delaying implementation in any district failing to meet satisfactory preparation;

- **Improved SIA quality:** coupling the surge deployment at district and sub-district level in high risk areas with the review of basic implementation strategies for supplementary immunization, including vaccination team selection, training, and supervision, the micro planning process, and incorporating approaches on vaccinator payment including the introduction of direct payment mechanisms; exploring the much greater engagement of local partners in the implementation of SIAs in key areas with persistent quality problems;

- **Human resource surge:** deploying adequate human resources to the poorest-performing districts (government and partner resources) from the level of vaccination teams up to provincial level management;

- **Reaching chronically-missed children:** introducing and scaling up new interventions to reach chronically-missed children, including a process of in-depth investigation of identified areas or populations (such as migrant and minority populations) where children are being missed, to develop a package of appropriate operational and social interventions.

The most under-vaccinated children in Pakistan live in parts of the Federally Administered Tribal Areas (FATA), particularly in the Khyber and North Waziristan Agencies. These populations are the main engine for the continued transmission of polio in Pakistan. Children in these areas have not been vaccinated for several years due to armed conflict, insecurity, and gaps in quality of SIA implementation. Access to children in FATA has improved recently and the programme has taken a multi-pronged approach to vaccinate children living in FATA, and those moving or displaced from these areas. In addition to ongoing efforts to negotiate access and improve quality of implementation in accessible areas, special strategies to rapidly increase population immunity include the following:

  - Application of the short interval additional dose (SIAD) in which children are given two doses of OPV with a very short interval of a few days only;
  - Vaccination of children up to 15 years of age in specific settings, for example in camps and other settlements of displaced populations;

11 These targets for priority countries are based on experience in India and internal data and are *interim targets*. The ultimate aim for all priority countries is to reach higher effective vaccination coverage that goes over the "threshold" as quickly as possible. Further refinements and data from ongoing studies and surveillance will assist in deriving more valuable models of critical target immunity levels in Q2 and Q3 2012, which could lead to revisions of these targets.

  - Constant vigil for opportunities to vaccinate, for example following major population displacements to accessible areas and camps;
  - Tracking and mapping for vaccination of settlements in periurban areas or camps especially in Karachi, Peshawar, and around other major cities where migrants and the displaced from FATA reside;
  - A targeted transit strategy in which special vaccination teams are deployed along major movement corridors used by the mobile populations from FATA.

- **Enhanced routine immunization:** accelerating routine immunization activities in key poorly-performing districts and subdistricts, including special approaches in areas such as FATA, where immunization will be coupled with multi-intervention health camps;
- **Enhanced communications:** developing a national communications strategy to enhance acceptance of vaccine and create demand for immunization with special emphasis on areas and populations at highest risk; expand the polio Communication Network (COMNet) to cover all poorly- performing areas down to Union Council and community level to support polio communication and social mobilization planning and implementation.

Enhancing surveillance

The surge of Government and partner agency staff will be coupled with an intensive process of strengthening surveillance in the key target areas. Rapid assessments linked to action plans to address gaps will be a key component of the strategy to identify and close surveillance gaps; in particular any "orphan" viruses will trigger a rapid assessment. Environmental surveillance will continue in all current sites as a supplement to AFP surveillance.

Highlight of key achievement signposts and targets[12]

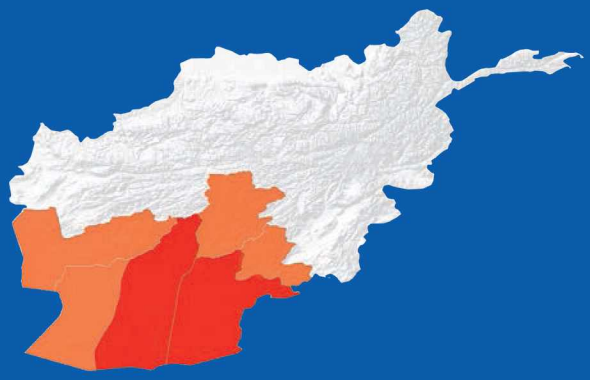
Area	Achievement/Target		Date (2012)
SIAs, Surveillance, Communication & Social Mobilization	●	Data on preparation and implementation indicators for SIAs available at district, province and national level.	End January
		Enhanced partnership implementation of SIAs introduced in persistently under-performing areas.	
		Launch of media campaign to mobilize wide-spread national and localized support for the eradication effort.	
	●	Minimum 90% of all LQAS lots in key under-performing districts (Quetta, Killa Abdullah, Pishin in Baluchistan; Gulshan Iqbal, Gadap, and Baldia in Karachi; Thatta in Sindh) will be accepted at greater than 90% coverage.	End March
		Poliovirus transmission interrupted in Punjab and northern Sindh.	
	●	Minimum 80% of all LQAS lots assessed nationally in every SIA accepted at greater than 95% coverage.	End July
		Poliovirus transmission interrupted in KP, all accessible areas in FATA, and southern Sindh (except Karachi).	
		WPV3 transmission interrupted nationally.	
		Refusals in Khyber Pakhtunkhwa (KP), FATA and southern Sindh are <5% of missed children.	
		At least 85% of caregivers in key under-performing districts of Balochistan and Sindh believe that OPV is safe.	
	●	Poliovirus transmission interrupted in Karachi and in Quetta block.	End October
		Mechanisms in place to access > 90% of children in SIAs in FATA.	
		Environmental and AFP surveillance demonstrate both genetic and geographical restriction of WPV1 in the high transmission season.	
		Refusals in Quetta Block and Karachi are <5% of missed children.	
	●	Cessation of all WPV transmission in Pakistan.	TBC

12 See Annex 2 for additional highlights

Afghanistan

Situational Analysis

Polio cases, 2011	80 cases of WPV1	Threefold increase in WPV cases compared to 2010
Worst performing areas,2011	Hilmand and Kandahar provinces	



A major setback for polio eradication in Afghanistan occurred in 2011, when 80 cases due to wild poliovirus type 1 were reported - a more than three-fold increase compared to the 25 cases reported in 2010. The majority of cases in 2011 (85%) occurred again in the south-western endemic zone comprising the Southern Region and Farah province of the Western Region. As in Pakistan, some spread of WPV out of the endemic zone occurred during the high transmission season of 2011, with 13 cases reported from nine previously polio-free provinces.

However, as of March 2012 it appears that transmission did not continue in any area outside of the south-western endemic zone. A major factor in ensuring that re-introductions of virus into polio-free areas of Afghanistan do not lead to extensive spread or re-establishment of transmission is that programme performance outside the endemic zone continues to be better compared to endemic areas. In the south-western endemic zone, the quality of SIAs has been declining over the last three years, and the immunization status of children in this area is now worse than it was in 2008. In the endemic zone, the percentage of young children (6-23 months) with Acute Flaccid Paralysis (AFP) not due to polio who had never before received any OPV ("zero dose") increased from 9% in 2010 to 21% in 2011. Nationally, this percentage was 2.5% in 2010, increasing to 7% in 2011.

Afghanistan will not reach the eradication goal unless the trend of programme performance is reversed and the quality of SIAs in the south-western endemic zone can be considerably improved.

SIA and vaccine plans for 2012-13

Afghanistan is planning a minimum of four national and four large-scale subnational SIAs in 2012, followed by a similar schedule in 2013. Both trivalent and bivalent OPV will be used extensively (trivalent in at least two national rounds per year), to ensure that protection against WPV2 is maintained while WPV1 and WPV3 are being eradicated.

Improving SIA quality: the 2012 Afghanistan Polio Emergency Action Plan

In light of the worsening polio situation, the Government of Afghanistan and its polio eradication partners have developed a **Polio Eradication Emergency Action Plan (EAP)**, which will be revised by the TAG in May 2012 [see Web Annex 4, at www.polioeradication.org].

The EAP defines and addresses the following root causes for which too many children are still missed during SIAs, particularly in the highest risk districts of the south-western endemic zone:

- problems in gaining access to and vaccinating children in conflict areas;
- serious gaps in polio eradication management and accountability; and,
- "social reasons" related to failure to inform parents and communities sufficiently.

Addressing access problems in conflict areas

The main contributing reasons hampering access include active conflict, obstruction and blockage of SIAs by anti-government elements (AGE), as well as the absence of law and order and the wide-spread "climate of fear" in both accessible and in-accessible areas. SIA field workers may not cover a particular area for fear of being harassed or attacked by one of the parties to the conflict.

To overcome the negative impact of conflict, the EAP calls for renewed efforts in the highest-risk districts to engage more fully local leadership and stakeholders, to negotiate access using well-supervised local-level access negotiators, and to continue to work with international humanitarian organizations which are active in the conflict areas.

In addition, the EAP also highlights the urgent need to:

- improve the monitoring and documentation of reasons for and magnitude of inaccessibility in each affected SIA operational area ("cluster"), and to conduct small-scale campaigns as soon as an area becomes accessible;
- in AGE-controlled areas, to coordinate more closely the selection of SIA field staff, directly or indirectly, with the AGE; and,
- to expand the use of low-visibility "permanent polio teams" conducting house-to-house vaccination in conflict-affected high-risk districts on an ongoing basis, to provide every eligible child in the catchment area with at least one dose of OPV every three months. The new "permanent polio team" strategy was launched in March 2012 in Kandahar city, southern Afghanistan.

Improving polio eradication management and accountability

The main challenges in this area include the lack of permanent oversight, support and accountability for SIA implementation, particularly at district and cluster levels in conflict-affected inaccessible areas and also in accessible areas. The Afghanistan Ministry of Public Health (MoPH) is not represented at the district level, but contracts with health NGOs to provide basic primary health services, including immunization, in the districts. In particular, changing the poor performance of district coordinators and cluster supervisors has been very difficult.

Provincial polio teams (government and partners) coordinate polio SIA planning and implementation at the district level using temporary local staff who often have only limited knowledge and capacity. Other unresolved managerial issues include continued delays in disbursement of polio eradication funds, as well as lack of transparency in the distribution of funds.

The EAP highlights the following priority strategies to improve management and accountability:

- Strengthening programme capacity at district and cluster levels by appointing a dedicated full-time district polio manager to lead the district polio team in each of the 28 highest-risk districts in the endemic zone;
- Close monitoring and assessment of district performance by provincial polio teams (MoPH and partners) and scaled-up levels of UN staff, who will ensure accountability also by conducting reviews of campaign preparedness, implementation and outcomes jointly with district polio teams. The commitment of key players in the Government to sanction poor performance, including replacing incompetent staff, will be crucial;
- Conducting learning and training needs assessments, followed by management training of province and district level polio managers;
- Strengthening post-campaign monitoring, particularly in areas with access problems, by exploring new approaches including remote monitoring through telephonic surveys, and use of LQAS methodology in selected areas.

Enhancing communication support for polio eradication

Direct refusal of vaccine, or non-compliance, by child caretakers is not a main reason for which children are missed during SIAs in Afghanistan (5% of missed children). However, post-SIA monitoring continues to show that up to 30% of children are missed for reasons such as being newborn, sick or sleeping at the time of the team visit, indicating that parents were not sufficiently informed that there is no reason to exempt such children, and that vaccinators failed to identify and correct the problem.

Much of the latter problem is caused by the fact that male vaccinators cannot enter homes and compounds; women work in only a small percentage of vaccination teams in Afghanistan. Efforts to change the composition of vaccination teams have yielded some progress in urban areas and these will be continued, but progress in rural settings is expected to remain a challenge.

To address the communication needs of the programme, a new communications strategy will be introduced to build demand for immunization. This includes a new multimedia communication campaign, the better integration of existing communication and operational networks at the subdistrict (cluster) level and the enhanced engagement of community influencers.

The EAP also highlights the importance for polio eradication of activities to strengthen routine immunization. To achieve this, MoPH (National EPI and Grant and Contract Management Unit) and partners will collaborate to supervise more closely and hold accountable the health NGOs contracted by MoPH to provide primary health care at the district level, based on quarterly performance reviews.

Highlight of key achievement signposts and targets[13]

Area	Achievement/Target		Date (2012)
SIAs, Surveillance, Communication & Social Mobilization	◎	Coverage of >90% in high risk districts in at least 4 of the 8 planned SIAs (national and sub-national).	TBC[14]
	◎	Less than 5% of children are inaccessible in each high-risk district.	TBC
	◎	Polio awareness to increase local engagement, address community concerns and create demand increased to 90% (baseline 50%).	TBC
	◎	Zero dose AFP cases reduced by 50%.	TBC
	◎	Among all unvaccinated children <10% missed due to "no team visit, sleeping or sick".	TBC

13 See Annex 2 for additional highlights.

14 Timeline to be confirmed based on final National Emergency Action Plan.

7.B

Sustaining momentum in re-established transmission countries

Chad

Situational Analysis

Polio cases, 2011	132 cases (129 WPV1 and 3 WPV3)	75% decrease in WPV cases in Q3/Q4 2011 compared to Q1/Q2
Worst performing areas,2011	See map below	

Chad reported a total of 132 cases in 2011, 129 due to WPV1 and three due to WPV3, the most cases of any re-established transmission country and the second highest in the world after Pakistan. Following intensive transmission in the first half of 2011, the epidemiological situation in Chad has improved in the third and fourth quarters; the number of cases declined by 75% in the second half of the year. Transmission in the last six months has been much more focal following a series of SIAs in the fourth quarter of 2011 and the first quarter of 2012. The principal reasons for children being missed in Chad remain operational, although social and communication issues are also important, particularly in key high-risk areas. Nomadic communities and remote populations are at relatively higher risk of being missed than the general community.

The national programme in Chad has now finalized an Emergency Action Plan for 2012 which aims to address the operational and social constraints to achieving higher coverage.

Chad's **Emergency Action Plan for 2012** [see Web Annex 5, at www.polioeradication.org], provides specificity in each of the following areas.

National oversight and accountability

Since August 2011, at the direction of the President, a monthly meeting on health issues has been held at national level, with polio as a standing agenda item. Under the Emergency Plan, the Minister of Health will also convene a monthly meeting, to which the heads of UN and other partner agencies will be invited, to review progress under the Plan. At provincial level the responsibility for polio eradication has been assigned to the Governors. The National Technical Advisory Group meets at least twice a year to provide specific strategic advice and recommendations to the national programme.

SIA and vaccine plans

Chad is planning six national and two large-scale subnational rounds in 2012, and four national rounds in 2013. Trivalent OPV will be used in at least two national rounds each year, with the remaining rounds using bivalent OPV, to ensure good immunity against all three poliovirus serotypes.

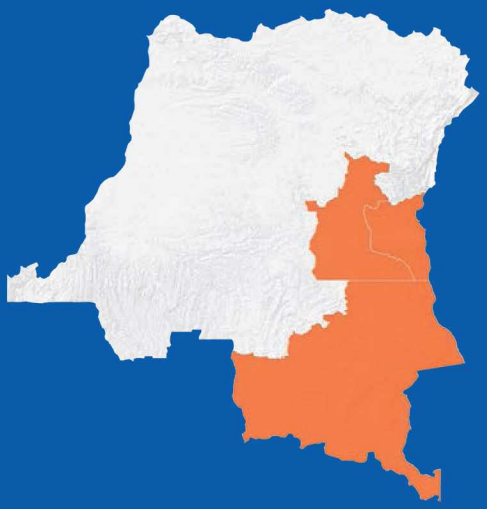
Key activities to sustain momentum

The key issue for Chad in 2012 will be to sustain the momentum the programme is beginning to achieve following corrective actions in 2011, especially increased national oversight and deployment of close to 100 partner staff. The Emergency Plan outlines a series of steps to strengthen implementation at district and subdistrict levels, including the deployment of human resource surge capacity (which began in 2011); the re-training and re-orientation of government health staff in the provinces; the engagement of nongovernmental agencies active in the provinces; enhanced communications and social mobilization; careful attention to selection and training of vaccination teams and the integration, at all levels, of communication activities. In 2012 Chad plans to introduce GPS technology to improve micro planning in key high- risk areas.

Democratic Republic of the Congo

Situational Analysis

Polio cases, 2011	93 cases (WPV1)	70% decrease in WPV cases in Q3/Q4 2011 compared to Q1/Q2
Worst performing areas,2011	Katanga, Maniema and South Kivu	



DR Congo reported 93 cases due to wild poliovirus in 2011, all due to WPV1. As in Chad, transmission was most intense in the first half of the year, declining significantly in the third and fourth quarters; DR Congo reported a drop of over 70% in the second half of the year compared with the first half. In addition to case numbers dropping, transmission became much more focal, and at the end of 2011 the only remaining active transmission zone appeared to be in the south-east of the country, in Katanga and neighbouring areas of Maniema. The poor immunization status in Katanga is also evidenced by an outbreak of cVDPV2 in the province in late 2011.

The ongoing transmission in this area is due to the usual operational factors, particularly significant logistical constraints; suboptimal management and supervision of activities are further complicated by pockets of rejection of immunization by a small number of religious communities.

An **Emergency Action Plan** [see Web Annex 6, at www.polioeradication.org] has been completed by the national programme, with a particular focus on stopping transmission in the east through addressing the operational and social barriers to immunization. The Plan provides specificity in each of the following areas.

National oversight and accountability

A National Coordination Committee has been established to oversee implementation of the Emergency Plan, which is convened by the Minister of Health and includes the heads of key partner agencies. An external evaluation of the implementation of the Plan will be held in 2012.

SIA and vaccine plans

DRC is planning to conduct two national and six subnational rounds in 2012 and two national and two subnational rounds in 2013. Trivalent OPV will be used in at least one national and one subnational round each year; in areas of recent cVDPV circulation, tOPV will be used in multiple rounds. Remaining rounds will be conducted with bOPV to ensure high levels of immunity against the two WPV serotypes.

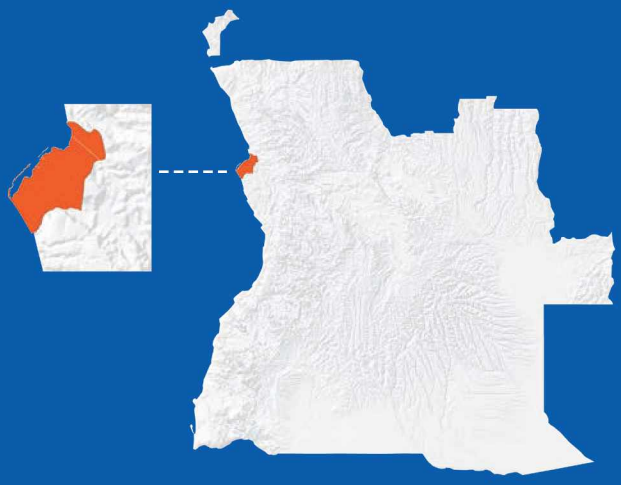
Key activities to sustain momentum

The Emergency Plan outlines a series of key steps to improve the implementation of polio eradication activities, particularly in eastern DR Congo. These include sustained government and human resource surge for technical support in high risk areas; special investigations on reasons why children are being missed, including anthropological surveys and direct contact with religious and community leaders to inform them about the benefits of immunization. A heavy emphasis is placed on communication strategies to build demand for immunization; the targeting of wider age groups in key high-risk areas; the intensive review of micro plans; special attention to the selection, training, and supervision of immunization teams; and improved AFP surveillance.

Angola

Situational Analysis

Polio cases, 2011	5 cases (WPV1)	85% decrease in WPV cases compared to 2010
Worst performing areas,2011	Luanda	



Angola has reported only five cases due to wild poliovirus in 2011, a significant decrease from the 33 reported in 2010. In the first quarter, transmission of the re-established WPV1 in the south-east of the country accounted for four cases; however, that particular lineage has not been detected since March 2011. In July a single case was reported from Uige province in the north, bordering the then active transmission zone of Bandundu and Bas Congo in DR Congo, and representing a re-introduction of WPV1 from that zone.

National oversight and accountability

Angola has not detected WPV for more than six months to date. However, it remains at high risk, with the possibility that low-level circulation is continuing in some parts of the country, in addition to the constant threat of re-introduction.

The national programme has developed a **National Polio Emergency Plan for 2012** [see Web Annex 7, at www.polioeradication.org] focusing on surveillance in the capital city of Luanda and in the northern bordering districts and on improving supplementary and routine immunization services to mitigate these risks. The Plan provides specificity in each of the following areas:

- Increasing active search for AFP cases in the high risk districts particularly in Luanda and the six bordering provinces with the Democratic Republic of the Congo involving community leaders and local NGOs;
- Intensification of routine immunization services with increase of outreach and mobile activities in high risk districts;
- Improving the quality of supplementary immunization activities through ensuring local recruitment of vaccinators and supervisors, and involvement of administrative leaders in the preparation, implementation and evaluation of the polio campaigns;
- Ensuring effective communication messages to the communities and adequate social mobilization activities.

SIA and vaccine plans

Angola is currently planning three national immunization rounds in 2012 and two subnational rounds, depending on the evolving epidemiology. Two national and two subnational rounds are currently envisaged for 2013.

7.C

Outbreaks and countries at risk of re-infection

Situational analysis

The GPEI Strategic Plan 2010-2012 aimed to stop any new outbreaks within six months. Since 2010 just one outbreak in previously polio-free areas (in Mali) has lasted longer than six months. In order to mitigate the risk that all countries face until polio is eradicated globally, further improvements are planned to the GPEI's approach to outbreak response. In addition, all countries need to regularly assess outbreak risk, maintain high levels of population immunity through routine and supplementary immunization and conduct vigilant surveillance for AFP cases.

Key enhancements to outbreak response approach

Building on the experience of 2010-11, which suggests that outbreaks can be stopped in less than six months, key steps will be taken to strengthen outbreak response under this Emergency Plan, as follows:

- Immediate deployment of national and international support teams for the initial investigation and assessment of the outbreak and the planning of the response;
- Deployment of support for the duration of the outbreak to ensure high-quality immunization response activities, including effective communication and social mobilization; and to enhance rapidly surveillance quality in outbreak and at-risk areas;
- Extended age group for first two OPV response rounds (i.e. at least 15 years of age). Broader target age groups have been vaccinated in response to the epidemiology of outbreaks (in Tajikistan, Republic of Congo, and China) and to margins of risk (in DR Congo and Central African Republic) in the last two years. The approach appears to have value in rapidly increasing overall population immunity where there are significant immunity gaps in older children and adults.

Systematic joint national/international rapid assessment at three and six months after the occurrence of the most recent case. Specifically, the main interventions will be based on the following approach:

The *first assessment* after response (three-month assessment) will focus on:

i. Speed and quality of initial response (including case investigation, response plan, first SIA, etc.);
ii. Speed and quality of initial response (including case investigation, response plan, first SIA, etc.);
iii. SIA quality (which should ideally include field work in the form of SIA monitoring, especially in high risk areas);
iv. Surveillance (very rapid review - desk and field, in high risk areas);
v. Other aspects that affect quality of response (government engagement; engagement of NGOs); transfer of funds to country e.g. Ministry of Health; other).

Subsequent assessments will be repeated quarterly and will entail, depending on the epidemiological situation and in consultation with national and other partners, a "rapid assessment" (joint/international team), focusing on:

i. Surveillance quality;
ii. SIA response;
iii. Support (human resources, technical, logistics, other).

A *"close-of-outbreak assessment"* will occur six months after onset of the last case, focusing on validating that the outbreak is really over.

8. Enhanced international support to the Emergency Action Plan

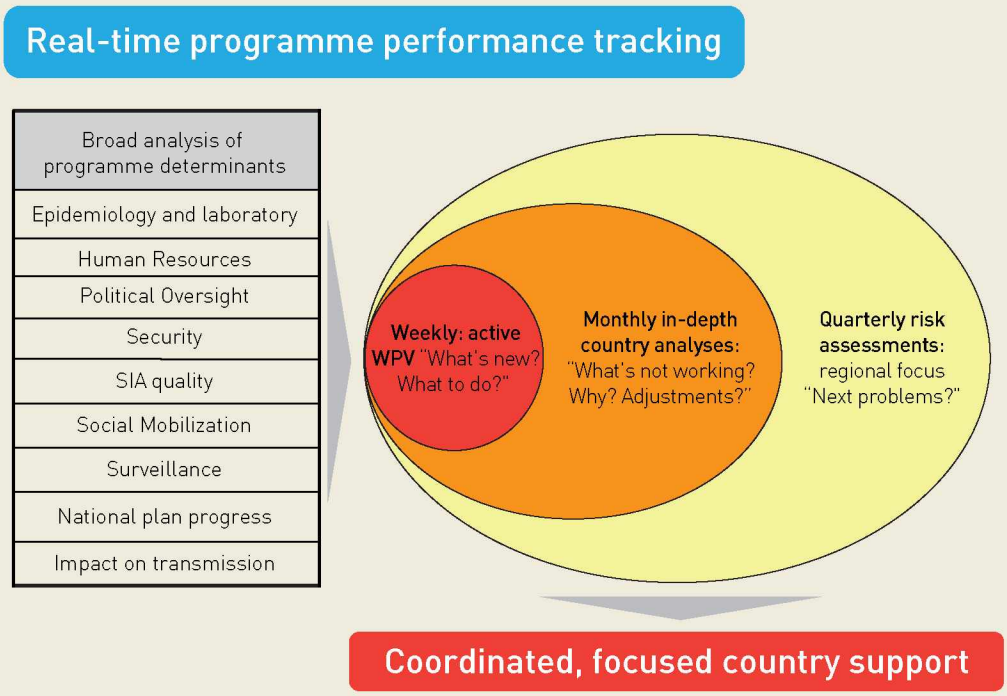
8.1 New structures and processes for international support, coordination and interagency leadership for the Emergency Action Plan

The urgent need to exploit fully the relative strengths of the spearheading partners and the Bill & Melinda Gates Foundation (BMGF) is recognized. This means that the strategic oversight to countries' polio eradication efforts, and in particular those of Nigeria, Pakistan and Afghanistan, will now be driven by an inter-agency *Polio Emergency Steering Committee* (PESC) composed of senior representatives (management and technical) from the five key agencies. It will convene monthly by teleconference and bi-annually in person, and aim to ensure cross-agency alignment in priority-setting and support to countries. It will direct three new inter-agency groups as described as follows.

Inter-agency international support groups

- **Inter-Agency Country Support Group** (ICSG) (an expansion of WHO's current country support group) to coordinate support to countries' eradication efforts, especially Nigeria, Pakistan, Afghanistan, Chad, DR Congo, and outbreak countries. The ICSG will have a critical role in programme performance monitoring and risk management. WHO will lead a weekly global conference call of all GPEI partners represented in the ICSG, supported by the active participation of Regional Office colleagues, to review epidemiology, risks, campaign performance, and key actions required in HR, monitoring, finance, advocacy and communications. Specific action points will be captured and reviewed in every call, progress or challenges closely monitored, and solutions identified. Key activities are detailed in Web Annex 8a, at www.polioeradication.org.

Real-time programme performance tracking and cross-agency polio analytical products



Central to the emergency agenda will be drilling down to data that shows why polio persists, and rapidly adapting strategies, activities and resource allocation based on that information. The new inter-agency country support team will be charged with ensuring that the wealth of polio data is fully exploited to guide the programme in identifying obstacles and tracking progress in overcoming those obstacles, on a weekly basis. The team will work with country teams, particularly in key endemic countries, to analyze available information to identify the problems, develop solutions, and track implementation across all levels of the partnership. In parallel, all partners will assist governments and priority national polio programmes to improve data management, accuracy, and analytical capacity so that information is rapidly available to those who need it most.

A set of cross-agency analyses will incorporate subnational data, including communications data. This will allow the programme to go beyond the current analyses that clearly identify where children are being missed; move to more systematic analyses that reveal the various operational, social and political reasons why children are being missed; and track progress and effectiveness in addressing the "whys".

A weekly epidemiological and programmatic report will serve as the centerpiece of a series of analytical products to drive decision-making. The weekly analyses will be complemented by monthly in-depth analyses of each polio priority area and quarterly risk assessments that scan the broader horizon to identify potential future problems and actions that can be taken to prevent their occurrence.

The analyses will be made available publicly and to national polio programmes, the Polio Emergency Steering Committee, the Polio Oversight Board (see Section 9 for details on these new bodies) and the IMB, to assess the programme and guide decision-making.

- **Inter-Agency Innovation Working Group** (IIWG) to identify systemic challenges and root causes and drive innovations to improve operations. Key activities are detailed in Web Annex 8b, at www.polioeradication.org.

- **Polio Advocacy Group** (PAG) to mobilize resources to close the 2012-13 funding gap and develop long-term funding and support for the programme. This group has reconstituted previous, siloed groups to ensure innovative, strategic approaches to building support and funding, and to ensure closer alignment of strategy and implementation. It includes spearheading partners, BMGF, UN Foundation and integrates with other Organizations working in vaccine advocacy (See Section 10 for details on 2012-13 funding gap).

Additionally, a **Global Polio Partners Group** (PPG) has been constituted: (1) to serve as the stakeholder voice for GPEI in the development and implementation of short-term and long-term polio eradication strategic plans and emergency action plans; and (2) to foster greater engagement among polio-affected countries, donors and other partners with the objective of utilizing their political, communications, programmatic and financial capabilities to ensure GPEI has the necessary political commitment and financial resources to reach the goal of polio eradication.

PPG membership is inclusive and will be comprised of senior representatives of the PESC agencies, donors and prospective donors, polio-affected countries and other NGOs and foundations working in polio eradication. The PPG will meet every six months, with the possibility of ad-hoc conference calls or meetings in between.

8.2 Enhanced technical assistance: standing and surge capacity

A key lesson learnt from 2011-12 has been the need to increase substantially external technical assistance to accelerate eradication and build capacity in the worst -performing and persistent transmission areas. Consequently, standing capacity and surge capacity for technical support to countries is being significantly supplemented in the following settings (see Figures 2 and 3 for details).

- Nigeria and Pakistan

Intensified technical assistance will be provided all the way to the subdistrict levels as was done in India.

- Afghanistan, Chad, DR Congo and Angola

Intensified technical assistance will be provided to the state/provincial levels.

For both endemic and re-established transmission countries such technical assistance will comprise:

- Long-term support in key transmission zones to strengthen the capacity of agency teams and to achieve high quality immunization, communication and social mobilization, field monitoring and surveillance activities;

- Operations management support to agency teams;

- Epidemiological and data support to national agency teams;

- Support for specific activities, including surveillance assessments, quality reviews, assessment of innovations, management reviews, etc.

- New outbreak situations[15]:

In outbreak situations, both short- and medium-term surge support to country programmes will be provided. The objective is to support national programmes and partner agency teams in-country to cover both the initial response stage (detailed investigation, planning of response, and immunization and surveillance response) and the phase of consolidation when interruption of transmission is ensured. Outbreak managers are designated at regional and global level to support country programmes and effectively coordinate partner agency teams. WHO, UNICEF, and CDC maintain rosters of staff that can be dispatched at short notice in response to outbreaks.

- Countries and areas at high risk of importation and outbreaks as identified by regular (three-monthly) risk assessments[16]

The following short- to medium-term support will be provided to this category of countries:

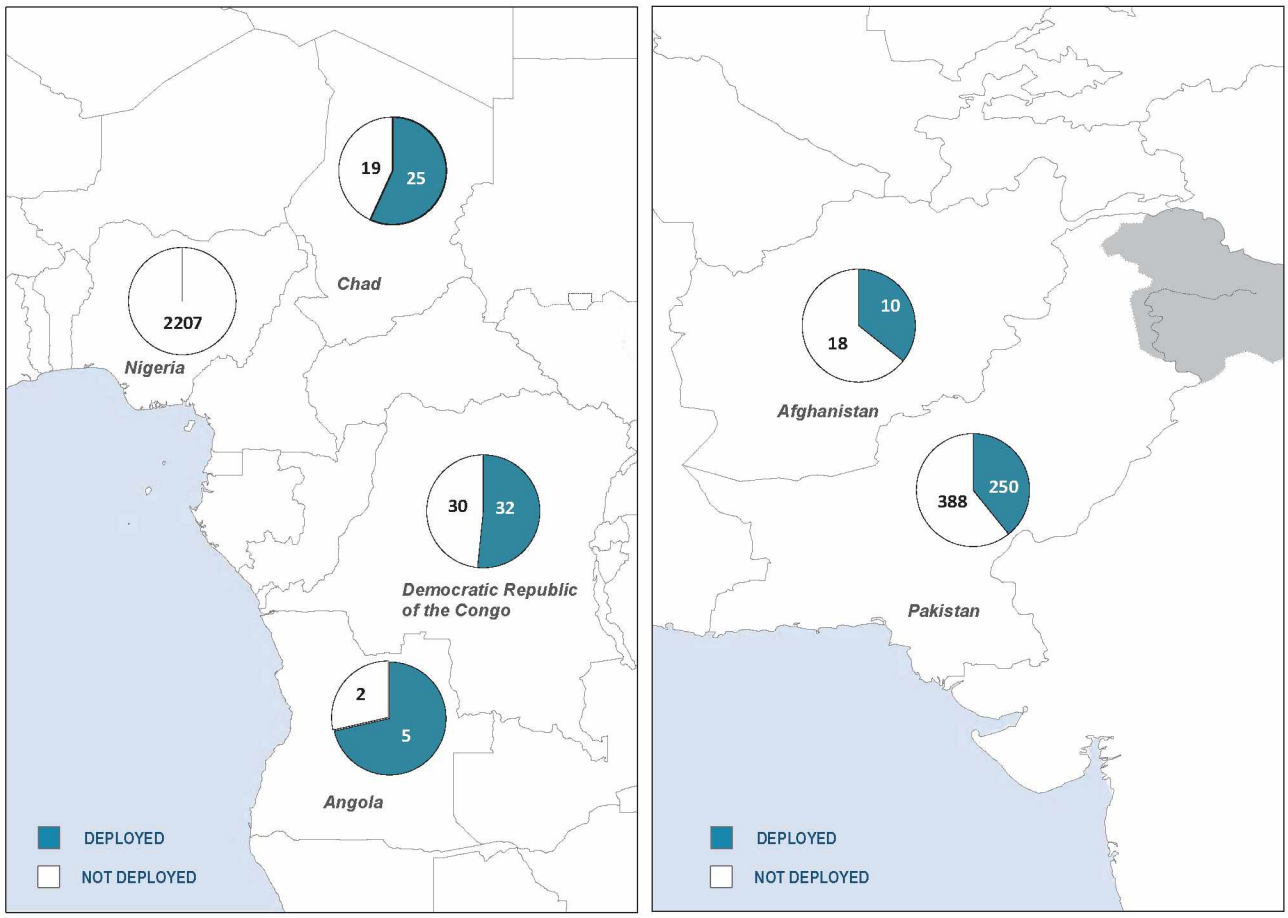
15 Which can be in polio-free countries or polio-free areas of currently infected countries.

16 Including those countries/areas that suffered outbreaks in 2011.

- support to Regional teams for risk assessment, and planning and prioritization of surveillance, communication and immunization activities;
- support to enhance and maintain extremely high surveillance quality at minimum in outbreak and at-risk areas and populations;
- support for achieving high quality in any supplementary or routine immunization activities in outbreak and at-risk areas and populations;
- The ICSG is the main mechanism for partners to improve surge capacity to establish rapidly an effective partnership country support response.

Figure 3 maps current and targeted deployments of national and international staff funded by WHO and UNICEF in the endemic and re-established transmission countries.

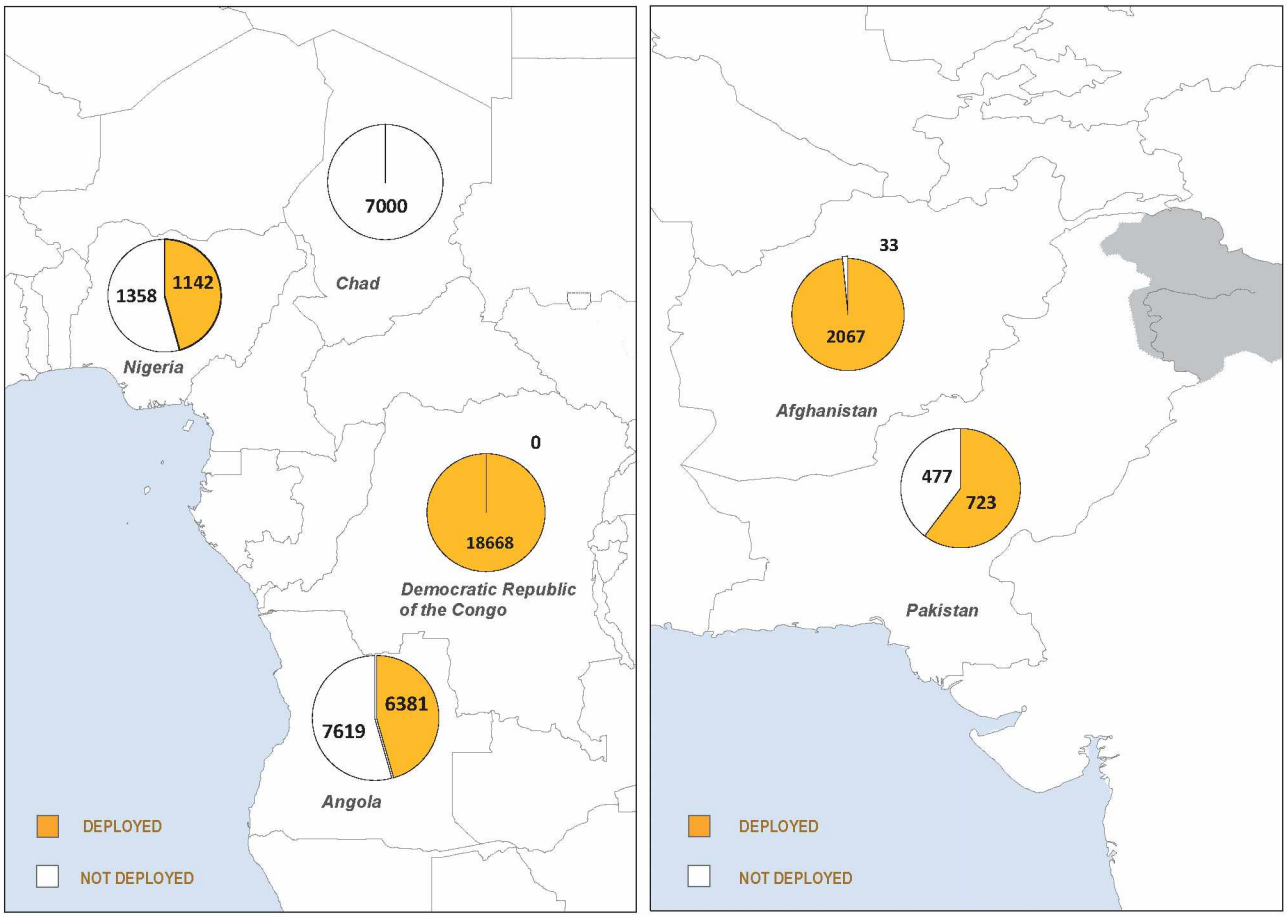
Figure 3: Human resource deployments by WHO and UNICEF (National and International staff), 2012-13



NOT DEPLOYED = Denotes human resource deployments that are pending. The deployment map is dynamic and will be updated quarterly on the GPEI website.

Learning lessons from India, another significant area of rapid scale-up driven by UNICEF is the building or strengthening of volunteer social mobilization networks across the six priority countries. Figure 4 maps current and targeted deployments of volunteer social mobilizers.

Figure 4: Deployments of front-line volunteer social mobilizers, 2012-13



NOT DEPLOYED = Denotes volunteer social mobilizer deployments that are pending. The deployment map is dynamic and will be updated quarterly on the GPEI website.

8.3 Improved GPEI partner accountability and management

All implementing partners and BMGF are reviewing their existing accountability frameworks to improve programmatic and personnel performance and management.

WHO

WHO has established a Polio Change Management Taskforce that includes senior representatives from Headquarters, Regional and Country Offices. This Taskforce is leading a change management programme to review critically and improve: (a) programme performance monitoring; (b) personnel accountability; (c) stakeholder engagement; (d) innovation; and (e) surge support to priority areas.

With respect to programme performance monitoring and personnel accountability, WHO has conducted a rapid review of all performance monitoring processes/tools in its major programmes (especially India, Nigeria, Pakistan, Angola, Chad, and DR Congo) and developed a "best-practices" model for implementation across all priority countries with the assistance of consultants. Training programmes are being rolled out in Nigeria and Pakistan in March 2012. The country teams are being staffed by senior experts to enhance the overall management capacity and to ensure implementation of best practices and supervision of the human resource surge. [Key activities for all improvement areas are detailed in Web Annex 9, Table 1, at www.polioeradication.org]

UNICEF

In countries where management systems need to be strengthened, UNICEF is making the necessary adjustments to its staffing and management structures in order to be able to deliver. Additionally, UNICEF has established the inter-divisional polio emergency team which includes senior-level management from the different divisions and levels of the organization. It reviews performance management issues and identifies bottlenecks as well as the means to address them more systematically.

Following a significant scale-up of staff at all levels, UNICEF HQ has initiated an internal programme review guided by a standardized tool targeting key polio priority countries (Nigeria, Pakistan, Afghanistan, Chad, DR Congo, Angola and India) to review the current status of the programme, available resources and capacities and help identify priority gaps (technical, operational, financial and managerial). UNICEF is also part of the inter-agency working group on Management and Accountability [See further details in Web Annex 9, Table 2, at www.polioeradication.org]

Centers for Disease Control and Prevention

The CDC Emergency Operations Centre (EOC) has been activated and the Global Immunization Division has moved polio eradication activities and staff into the EOC operational structure. This will ensure maximum use of CDC resources to support polio eradication activities, and to scale up timely technical expertise and support for polio-affected countries (Chad, DR Congo, Nigeria, Afghanistan, Pakistan) and for countries at risk of polio outbreaks (at-risk countries), in coordination with GPEI partners. [Key activities are detailed in Web Annex 9, Table 3, at www.polioeradication.org]

Rotary International

Rotary is expanding its advocacy efforts through specialized regional training and the appointment of additional global coordinators to support the current network of representatives in donor and polio-affected countries to encourage policy makers, Rotary club members, and the public to support global polio eradication efforts. Rotary continues to recruit new voices to the cause of polio eradication to further amplify the message of the importance of the campaign. [Key activities are detailed in Web Annex 9, Table 4, at www.polioeradication.org]

Bill & Melinda Gates Foundation

The BMGF established a Polio Task Team in 2011 to coordinate efforts across various departments of the organization tasked with pursuing global polio eradication. The team includes staff working on vaccines and tools, programme implementation, advocacy and communication, and innovative financing. The task team meets weekly on strategy execution. The Foundation's own performance is measured against a monthly scorecard that includes reaching epidemiological and programme goals, as well as resource mobilization and communication targets. As the number one priority of the Foundation, key barriers and hurdles are reviewed with the Foundation's leadership on a monthly basis.

9. GPEI Architecture to Improve Oversight, Accountability and Coordination

9.1 Governance

The WHO Executive Board (EB), World Health Assembly (WHA) and WHO Regional Committees will provide strategic global governance of the GPEI and this Plan including recommendations on policies further to reduce international risks (e.g., through revised guidance and decision(s) on the vaccination of travellers). These WHO governing bodies will monitor and respond to progress against EB Resolution EB130.R10 and a 65th WHA Resolution on intensification of the GPEI.

9.2 Oversight, Coordination and Implementation

Within the core partner agencies, the polio emergency is now being overseen at the highest levels. A new Polio Oversight Board (formalizing the existing Heads of Agencies meetings/calls on a quarterly basis) will provide operational oversight of the GPEI, ensure high-level accountability and fully exploit each agency's resources, with representation from the heads of WHO, Rotary International, CDC, UNICEF and BMGF.

Informing this operational oversight will be regular review and coordination of partner support of the Emergency Action Plan by the Polio Emergency Steering Committee (PESC). The PESC will provide strategic, technical and operational oversight for the GPEI and ensure accountability for the Interagency Country Support Group, Polio Advocacy Group, and Innovation Working Group. The Interagency Country Support Group will interface with country processes, including National Polio Task Forces, National Polio Operations Groups, and Inter-Agency Coordinating Committees.

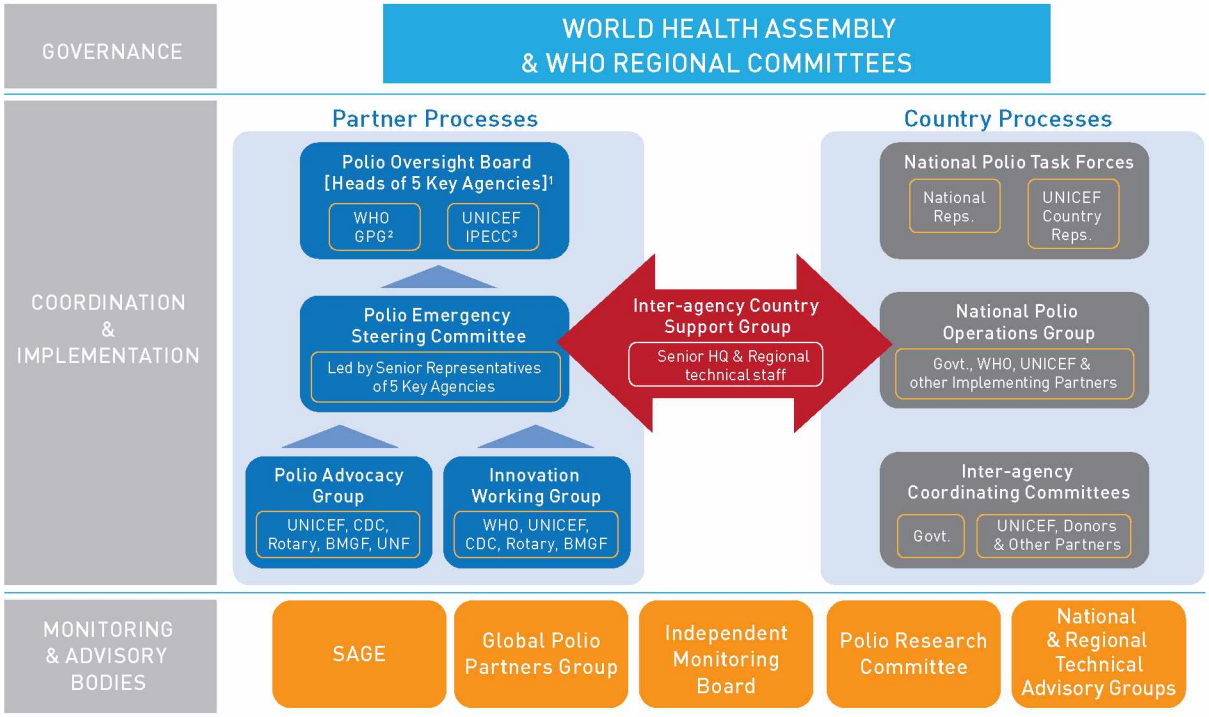
9.3 Monitoring and Advisory Bodies

The Independent Monitoring Board (IMB) will continue to monitor and guide the progress of the GPEI Strategic Plan and the contributions of this Emergency Plan to enhancing efforts towards polio eradication. The IMB convenes on a quarterly basis to evaluate independently progress towards each of the major milestones of the GPEI Strategic Plan 2010-2012 as "on track", "at risk" or "missed", on the basis of polio epidemiology, standard performance indicators and other programme data. The IMB also evaluates the quality, implementation and impact of any corrective action plans that are introduced based on its recommendations. Additionally, the IMB provides assessments of the risks posed by existing funding gaps. This Emergency Plan includes activities based on recommendations in the October 2011 and February 2012 IMB reports and, as a dynamic Plan, it will be augmented as needed based on subsequent IMB reports in 2012 and updates of the National Emergency Action plans of priority countries.

The Strategic Advisory Group of Experts on immunization (SAGE) acts as the principal technical advisory group to WHO for vaccines and immunization, and will provide technical oversight to the implementation of this Plan. SAGE oversight will be complemented by inputs from the Polio Research Committee (PRC), which provides guidance to the GPEI on long-term risk management for the post-eradication era, as well as on identifying, developing and evaluating new tools and tailored eradication tactics to interrupt more rapidly wild poliovirus transmission. Additionally, the national and regional Technical Advisory Groups (TAGs) and Interagency Coordination Committees, National Polio Operations Groups, and National Polio Task Forces operating in the priority countries, will play a crucial supporting role to the national oversight functions of Governments (leadership task forces) and international partners.

The Global Polio Partners Group will ensure stakeholder voice in GPEI, including endorsing workplans and budgets developed by countries for the PESC, and undertaking diplomatic and advocacy interventions to mitigate risks, in particular financing.

Figure 5: GPEI architecture to improve oversight, accountability and coordination[17]



1 WHO, UNICEF, CDC, Rotary and BMGF
2 WHO Global Policy Group, which comprises the Director-General, the Deputy Director-General and the six Regional Directors.
3 UNICEF Inter-divisional Polio Emergency Coordinating Committee.

10. Funding for polio eradication

10.1 Resource requirements

The polio eradication programme is in urgent need of funding. As of March 2012, GPEI faces a US$945 million funding gap against a budget of US$2.19 billion[18] for planned activities in 2012-2013 and has long-term funding requirements estimated at US$3-5 billion. An increasing budget, which is needed to scale-up and accelerate successful work in the field, has been accompanied by declining donor commitments. The substantial funding gap has meant that activities for 2012 have already started to be cut or scaled back. Although the GPEI is approaching polio eradication as an emergency and is building on lessons from the recent success in eliminating polio in India, some donors are yet to reinstate their funding to the programme.

17 Details of the GPEI architecture, including membership and objectives are provided in Annex 3.

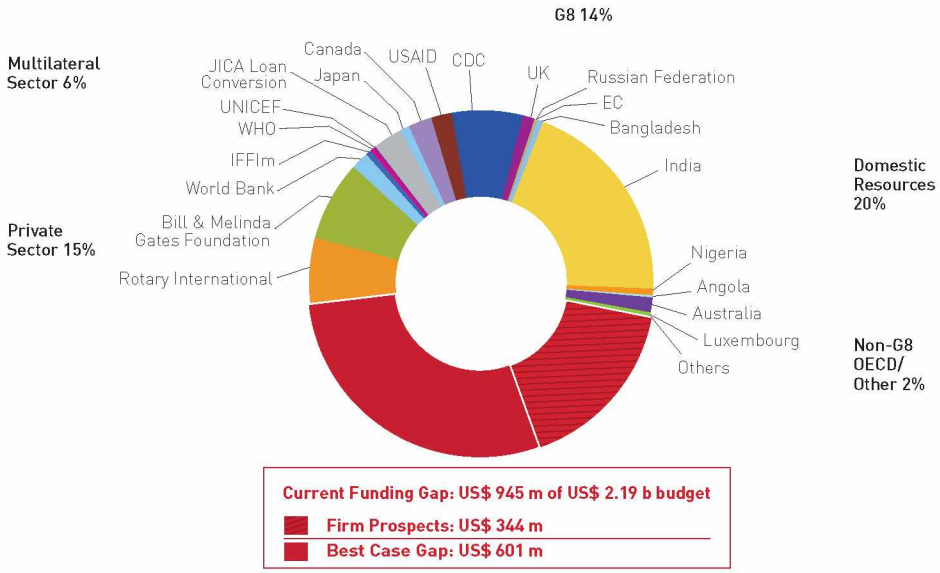
18 The budget figure does not include firm prospects and the cost of IPV campaigns. This component of the budget is currently under development.

Table 1: Summary of external resource requirements by major category of activity, 2012-13 (US$ millions)

Core Costs	2012	2013	2012-2013
Emergency Response (OPV)	$16.50	$20.00	$36.50
Emergency Response (Ops)	$40.00	$25.00	$65.00
Emergency Response (Soc Mob)	$4.50	$6.00	$10.50
Surveillance and Running Costs (Incl. Security)	$61.82	$64.36	$126.18
Surge Capacity	$35.00	$0.00	$35.00
Laboratory	$11.08	$11.23	$22.31
Technical Assistance (WHO)	$134.04	$136.57	$270.61
Technical Assistance (UNICEF)	$35.62	$37.31	$72.94
Certification and Containment	$5.00	$5.00	$10.00
Product Development for OPV Cessation	$10.00	$10.00	$20.00
Post-eradication OPV Stockpile	$12.30	$0.00	$12.30
Supplementary Immunization Activities	**2012**	**2013**	**2012-2013**
Oral Polio Vaccine	$301.73	$285.63	$587.36
NIDs/SNIDs Operations (WHO-Bilateral)	$323.44	$248.39	$571.83
NIDs/SNIDs Operations (UNICEF)	$28.33	$28.15	$56.48
Social Mobilization for SIAs	$87.63	$93.68	$181.32
Subtotal	**$1'107.00**	**$971.32**	**$2'078.32**
Programme Support Costs (estimated)*	**$56.98**	**$52.49**	**$109.47**
GRAND TOTAL	**$1'163.98**	**$1'023.81**	**$2'187.79**
Contributions	**$891.70**	**$349.11**	**$1'240.81**
Funding Gap	**$272.28**	**$674.70**	**$946.98**
Funding Gap (rounded)	**$270.00**	**$675.00**	**$945.00**

* Programme Support Cost (PSC) estimates are calculated based on sources and channel of funds

Figure 6: Financing 2012-13: US$ 1.24 billion contributions



'Other' includes: Austria, Brunei Darussalam, Finland, Monaco, Nepal, Central Emergency Response Fund (CERF), Common Humanitarian Fund (South Sudan), and Google Foundation/Matching Grant.

10.2 New fundraising strategies

Between 1988 and 2013, donors will have invested over US$ 9.5 billion in polio eradication. More than 52 donors have contributed (21 of which have given more than $25 million each), an almost unparalleled number of different donors to a major global public health partnership. Nevertheless, new strategies are critical to increase confidence and secure the funds necessary to realize the goal of a polio-free world. These include:

- Shifting the *fundraising approach* to a long-term plan that re-engages donors, increases commitments of traditional donors, cultivates new donors, and incorporates innovative financing mechanisms;
- *Enhancing advocacy* through increasing voices and the integration of polio eradication within a wider framework of vaccines and immunization systems;
- Developing a more *coordinated and strategic communications* plan;
- *Increasing engagement* of global partners and widening the circle of partners active in resource mobilization;
- *Ensuring cost efficiencies* in the global programme.

Fundraising Approach

The primary objective of the Polio Advocacy Group will be to close the immediate funding gap and develop a long-term plan to ensure funding and political will for the polio endgame. Key activities are already underway, including:

- A **systematic analysis of the donor landscape**, including mapping past histories, current trends, available windows of support (e.g. at country/mission level or global level for bilateral donors), and key influencers for more than four dozen bilateral and multilateral public donors, development banks and private philanthropies.
- The **development of Donor Task Teams** for more than a dozen major potential or existing donors: Task Teams will draw from the collective knowledge of resource mobilization, advocacy and communications specialists from a range of partners, including those outside the core partners who have an intimate knowledge of a particular donor market. Insights and information from the task teams will be used to develop an over-arching resource mobilization strategy for global polio eradication.
- **Exploration of innovative financing mechanisms:** a review of innovative funding instruments is underway to help narrow the funding gap in the short and medium/long-term, recognizing the limitations of significant new funding to cover the near-term funding gap.
- **Increased focus on domestic resources:** ensure that where possible, resources from affected countries are secured to help offset programme costs and potentially stimulate increased country commitment.
- **Re-engaging lapsed and traditional donors:** through a collaborative approach, rebuild confidence in the programme, safeguard previous donor commitments, and appeal for additional resources to support the emergency plan.
- **Bringing in new donors:** Building on the success with Australia, Saudi Arabia, and the United Arab Emirates in 2011, fundraising efforts will build interest in supporting polio among new donors, and expand outreach to include emerging market donors and high net worth individuals.

Enhancing Advocacy

Since polio and other vaccine advocates target the same donors and funding sources, the global polio eradication partnership is in the early stages of working with the global constituency for vaccines. In addition to fostering a much closer relationship with GAVI, collaboration with the broader set of vaccine advocacy partners will help increase public attention, policy-maker action and accountability in key donor markets and affected countries. A compelling, evidence-based storyline connecting polio with a broader vaccine strategy will be developed, and help demonstrate that vaccines (and thus polio eradication) are sound, cost-effective foreign aid investments.

Strategic Communications

A more coordinated and strategic communications plan is being developed by the core partners to help create a conducive environment for fundraising. This plan will engage a broader audience and communicate the

significance of the opportunity to eradicate polio and improve global health for the long term. The communications work will also bolster existing efforts among national, regional and local leaders, and among vaccination teams, to increase the effectiveness of polio campaigns.

Key activities will focus on the following:

- Instilling donor country confidence in global polio eradication efforts, beginning with the launch of the Global Polio Emergency Action Plan 2012-13 during the World Health Assembly;
- Energizing the global community and strengthening momentum around the opportunity for maximizing polio immunity worldwide;
- More effectively communicating, through new tools and outreach channels, that funding polio eradication supports broader public health goals including strengthening routine immunization systems, promoting health-seeking behaviour and enhancing surveillance;
- Supporting media and related efforts to galvanize new and existing donors;
- Continuing effective social mobilization efforts to create demand for the polio vaccine;
- Praising and energizing vaccinators and their role in making polio history;
- Minimizing the perceptions around setbacks in the polio programme;
- Explaining the broad, negative ramifications of failure;
- Full integration of communications, operations and planning activities at all levels.

Increasing Engagement

Given the need to enhance both support and funding for polio, it is more important than ever that the world re-commits to the polio programme. There are promising signals, such as the UN Secretary General declaring the eradication of polio to be one of his top five health priorities during his second five-year term, and the WHO Executive Board recommending that the World Health Assembly declare polio eradication a "programmatic emergency for global public health." The GPEI must help ensure that high-level commitments are translated into effective and sufficient funding.

The PPG will call for inputs and endorse plans and budgets; track epidemiological and programme data to identify areas for interventions; and undertake diplomatic and advocacy interventions to mitigate risks, including those related to financing and advocacy for polio eradication.

These strategies must also widen the circle of partners active in resource mobilization and accountability for polio eradication. It is important that existing donors and polio-affected countries support the appeals from partners and civil society organizations. Everyone must play a role in ensuring that the ultimate goal of ending polio forever is realized.

Cost Efficiencies

GPEI continually evaluates costs throughout the programme and seeks opportunities for cost savings. In recent years, reviews of costs associated with SIAs in countries such as Chad and DR Congo have led to substantial reductions in operational costs. GPEI and partners are considering other ways to optimize costs and ensure maximum value for money. An evaluation of the key drivers of cost and performance is underway to identify where better results can be delivered with more efficiency.

GPEI and partners will also continue to look to innovative financing and procurement mechanisms for OPV supply to help bring costs down. Providing volume guarantees and multi-year commitments have allowed OPV suppliers to lower their prices, sometimes considerably. In 2010, such commitments, along with continued advocacy by GPEI and partners, reduced the average weighted price of OPV to US$ 0.13 per dose, saving over US$ 60 million in OPV procurement costs for 2011-2012. As we move closer to eradication and the demand for polio vaccines becomes less certain, these mechanisms will play an important role in reducing or maintaining prices as well as ensuring stable vaccine supply.

11. Polio Eradication and Endgame Strategy 2014-18

On 21 January 2011, WHO's Executive Board, reviewing the evidence and recommendations by SAGE, adopted Resolution EB130.R10, in which it requested the Director-General to finalize rapidly a comprehensive **Polio Eradication and Endgame Strategy 2014-18**, including a timeline for the switch from trivalent to bivalent OPV for all routine immunization programmes.

The polio endgame strategy is based on new diagnostic tests for cVDPV, the availability of bOPV, new low-cost approaches for the introduction and use, as appropriate, of IPV, as well as supplementary surveillance and mass immunization activities.

The SAGE in November 2011 endorsed the central premise of the new strategy: in summary, the removal of Sabin polioviruses from immunization programmes should be phased, beginning with the particularly problematic Sabin type 2 poliovirus in the near term (responsible for upwards of 97% of new cVDPVs), followed by the remaining serotypes after certification of WPV eradication globally.

After interruption of WPV transmission, the polio endgame will be driven by the costs of maintaining surveillance and laboratory capacity, and the costs of outbreak response capacity for cVDPV. These costs will stop once use of OPV has stopped and vaccine-derived polioviruses have been eliminated.

The Polio Eradication and Endgame Strategic Plan 2014-18 will be finalized, based on SAGE advice, for the 66th World Health Assembly in May 2013.

ANNEX 1:
Emergency actions for 2012-13 and expected outcomes

ACTIVITY 1: National and Subnational Accountability and Oversight	
Major Lesson	Corrective actions and their impact depend on oversight and accountability of subnational leaders.
Emergency Actions for 2012-13	**Expected outcomes**
• Programme focal point answering directly to Head of Government. • National Task Force to appraise district/Local Government Area (LGA) performance on a monthly or quarterly basis. • Introduce standard criteria to grade district/LGA supplementary immunization activity (SIA) performance. • State and district-level polio taskforce established and work monitored at national level. • District leaders to be accountable for vaccinator selection/supervision and outcomes (including strong leadership and deployment of adequate capacity at sub-district level).	• Elimination of political interference and associated protection of poor performers. • Poor performers strictly held accountable. • Improved staff motivation and performance.

ACTIVITY 2: Monitoring of Supplementary Immunization Activities	
Major Lesson	Independent monitoring has poor sensitivity to detect areas that fail to achieve minimum coverage levels.
Emergency Actions for 2012-13	**Expected outcomes**
• Correct gaps in how independent monitoring is conducted to improve reliability, collect social data and "grade" local SIA and communications performance, rather than estimate coverage. • Refine Lot Quality Assurance Sampling (LQAS) and expand to all infected areas. • Identify means of community feedback if vaccinator teams do not visit as planned. • Complement SIA monitoring with annual seroprevalence data. • Triangulate data sources; disagregate data at the lowest possible level. • Separate monitoring and implementation functions and establish objective third-party monitoring systems.	• Real time, objective SIA preparedenss and implementation indicators linked with accountability and corrective action. • Campaigns deferred in areas of inadequate preparations for 7-10 days to allow for additional preparation. • More objective and robust estimates to track SIA coverage. • Direct evidence of enhanced coverage among young children in high risk areas. • Reduction in zero-dose children in chronically -missed populations and sub-groups.

ACTIVITY 3: Quality of Supplementary Immunization Activities	
Major Lesson	The intensive scale-up of technical assistance is fundamental to enhancing rapidly SIA performace in chronically weak areas.
Emergency Actions for 2012-13	**Expected outcomes**
• Intensify partner technical assistance (TA) to subdistrict level in endemic areas and district level in re-established virus areas, to improve micro-planning, vaccinator selection and more rigorous monitoring during campaigns. • Establish quicker and more sensitive monitoring networks at the subnational level to understand social data and better address refusals. • Establish a "think tank" at global level to examine and develop solutions for systemic issue of insecure areas. • Realign vaccinator density to actual workloads in all infected areas. • Introduce or scale-up use of Global Information System (GIS) mapping to enhance microplans and Global Positioning System (GPS) tracking of vaccinators. • Implement special strategies to identify, track and immunize migrant/neglected populations e.g. the strategies used in Uttar Pradesh and Bihar, India. • Direct payment to vaccinators in key endemic areas. • Use of mobile phones and other technologies for monitoring vaccinator performance, identifying missed areas, etc. • District leaders to be accountable for vaccinator selection/supervision and outcomes (including demonstration of strong leadership and deployment of adequate capacity at sub-district level).	• Clear local understanding of why children are missed. • Relevant and innovative solutions to local problems. • Improved performace with a rational team workload. • Up-to-date and validated microplans. • Increase in proportion of vaccinator teams for which performance is found to be acceptable.

ACTIVITY 4: Outbreak Prevention and Response	
Major Lesson	New, innovative response tactics (e.g. extended age groups for OPV rounds) can stop outbreaks in even less than six months.
Emergency Actions for 2012-13	**Expected outcomes**
• Respond immediately with short interval rounds to rapidly increase immunity. • Expanded age group for first two oral poliovirus (OPV) rounds (i.e. at least 15 years of age) for all new outbreaks. • Systematic joint national/international rapid assessment at three and six months. • Technical support tailored to polio experience and health system, including promotion of better coordination with other health efforts to reduce the number of susceptibles. • Prevent substantial immunity gaps from developing using targeted SIAs based on risk assessment.	• Immediate vigorous response tailored to local situation and risks. • Substantial reduction in duration of outbreaks, numbers of polio cases and polio vaccination rounds. • Risk of future outbreaks reduced.

ACTIVITY 5: Surveillance	
Major Lesson	Gaps can persist in subnational areas with high performance indicators due to subpopulations and other factors requiring constant monitoring and supervision.
Emergency Actions for 2012-13	**Expected outcomes**
• Targeted surveillance among key population subgroups. • Systematic "rapid assessments" in areas of "orphan" viruses and insecurity. • Moblie phone SMS prompting for active surveillance in priority areas. • Expanded environmental sampling (including outbreak settings and along recognized transmission routes). • Expansion of community-based surveillance.	• Poliovirus rapidly detected in all areas and communities. • Gaps in surveillance promptly detected and addressed.

ACTIVITY 6: Routine Immunization	
Major Lesson	Routine immunization coverage can and should be improved substantively while intensive eradication activities are ongoing.
Emergency Actions for 2012-13	**Expected outcomes**
• Systematically engage with GAVI on routine immunization (RI) synergies and coverage targets in priority areas. • Use polio SIA monitoring mechanisms to identify gaps in RI systems in high risk areas. • Extend the detailed microplanning and mapping for polio SIAs to RI, utilizing polio-funded personnel (including at district/sub-district levels). • Utilize the polio infrastructure to identify, monitor and address RI bottlenecks in key areas. • Ensure the polio communications and social mobilization strategies, capacities and activities are used systematically to promote RI. Opportunities for collecting social data/research for polio to inform EPI communications strategies. • Apply to RI the lessons on identifying and reaching missed children, especially among underserved, mobile and minority populations.	• Improved planning and monitoring of RI sessions in polio poorly-performing areas. • High-risk and difficult-to-access and underserved populations systematically included in RI microplanning and outreach. • Stronger synergies and collaboration between polio eradication and RI that mitigates risks associated with VDPVs.

ACTIVITY 7: Vaccines	
Major Lesson	Research has indicated that bivalent OPV and fractional-dose inactivated poliovirus provide new opportunities to enhance vaccine impact.
Emergency Actions for 2012-13	**Expected outcomes**
• Estimated timeframe for replacing tOPV with bOPV for routine/supplementary use. • Estimated affordable IPV option of one IPV dose, 6 months before a tOPV-bOPV switch. • IPV campaign pilots in key endemic areas to assess feasibility/impact. • Increase availability of quality-assured vaccines i.e. ensure sufficient number of producers of OPV and IPV. • Consider expanded age group SIAs in selected populations and areas in endemic countries.	• Eventual elimination of risk of type 2 cVDPV (> 90% reduction in overall risk of cVDPV). • Eventual reduction in the risk of VAPP (approx. 40% of all VAPPs). • OPV vaccine supply security is ensured. • Optimized use of IPV to achieve and sustain polio eradication.

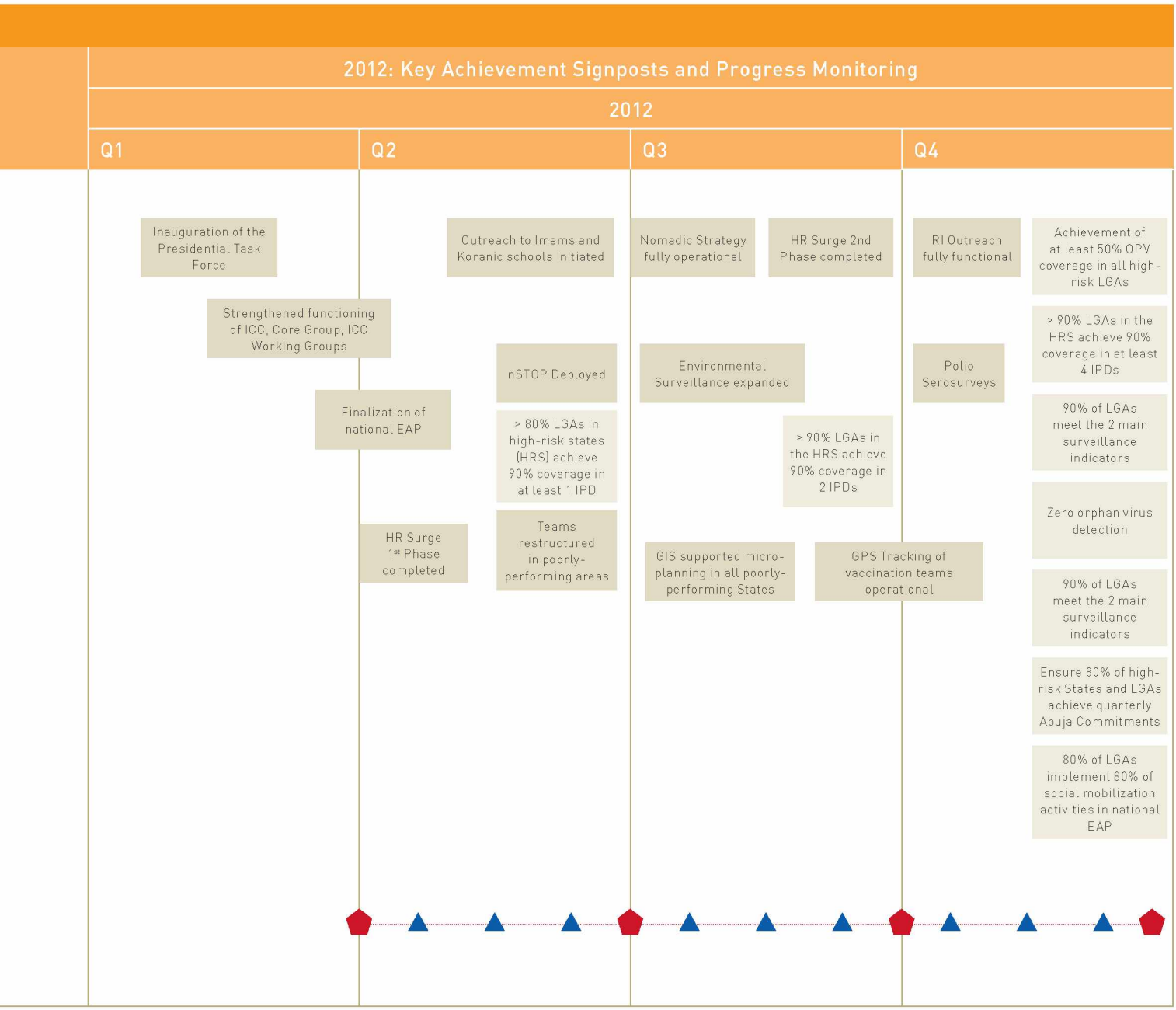
ACTIVITY 8: Communication and social mobilization	
Major Lesson	Community-level communication and social mobilization focusing on high-risk areas/populations needs to be intensified and scaled-up to help secure local engagement, address community concerns and create demand to improve overall quality of activities.
Emergency Actions for 2012-13	**Expected outcomes**
• Establish/scale-up social mobilization networks at community level in high-risk areas with evidence of social barriers to immunization c.f. SMNet in India (>6 500 to be delpoyed in high-risk areas). • Intensify the mapping, engagement and mobilization of community leaders, e.g. traditional and religious leaders in Nigeria. • Undertake systematic research/monitoring to identify and understand the social reasons for chronically-missed children. • Apply best practices for reaching high-risk and chronically missed-children (e.g. migrant and underserved strategies). • Improve interpersonal skills of vaccinators and mobilizers to enhance performance and build trust, including addressing reticence and refusal. • Ensure vaccination teams are from that geographical area and work closely with community authority structures. • Harness mass-media to re-energize public support and ownership, motivate vaccinators, enhance ownership of key stakeholders (e.g. media, medical staff, NGOs) and increase local leader accountability. • Train front-line personnel to respond quickly to misinformation or crisis. • Focus on integration of the two arms of the programme: communication and operations, to ensure effective coordination, harmonization and streamlining of activities.	• All communities understand, trust, support and demand polio vaccination. • No child is missed due to vaccine refusal. • Any vaccine refusal is immediately assessed and addressed. • Increase in motivation of vaccinators.

ACTIVITY 9: Resource Mobilization	
Major Lesson	Sustained progress and a credible programme plan are critical elements to achieve funding for the GPEI, which also must be complemetned by an expanded and engaged donor base and a longer-term approach.
Emergency Actions for 2012-13	**Expected outcomes**
• Establish country task teams to bridge communication, advocacy and resource mobilization in key markets to enhance public and political engagement. • Enhance involvement of key stakeholders in the programme through the new Global Polio Partners Group. • Re-engage lapsed donors and rebuild the trust of the traditional donors by ensuring that programme strategies and evidence address donor concerns. • Explore innovative financing mechanisms linked to a new multi-year integrated eradication and endgame strategy. • Increase domestic funding so affected countries are more committed to on-the-ground results. • Enhance outreach to Brazil, Russia, India and China (BRICs), middle-income countries and Organization of Islamic Cooperation countries. • Identification of private sector partners to support GPEI.	• The Global Emergency Action Plan is fully financed for unimpeded implementation in 2012-13. • A broader range of donors provides stable multi-year funding through the "endgame". • Renewed confidence, enthusiasm and accountability among donors and partners.

ANNEX 2:

High-level Achievement Signposts and Progress Monitoring of the Global Polio Emergency Action Plan 2012-13

GLOBAL POLIO ERADICATION INITIATIVE - EMERGENCY ACTION PLAN		
Focus Area	**Key new interventions**	
Programmatic priorities by Geographic/ Strategic Area	**NIGERIA**	1. GIS/GPS mapping introduced in eight worst performing states 2. HR Surge: Scale up of WHO technical assistance and UNICEF community network 3. Restructured vaccination teams deployment 4. nSTOP rolled out in high-risk states 5. Initiation of outreach strategy to imams and Koranic schools 6. Nomadic strategy scale-up 7. Expansion of environmental surveillance 8. RI outreach initiative (cVDPVs) 9. Seroprevalence studies Quarterly joint Federal-State review of EAP progress ⬟ Monthly progress review: Presidential Task Force ▲


2012: Key Achievement Signposts and Progress Monitoring
2012
Q1
Q2
Q3
Q4
Inauguration of the Presidential Task Force
Strengthened functioning of ICC, Core Group, ICC Working Groups
Finalization of national EAP
HR Surge 1st Phase completed
Outreach to Imams and Koranic schools initiated
nSTOP Deployed
> 80% LGAs in high-risk states (HRS) achieve 90% coverage in at least 1 IPD
Teams restructured in poorly-performing areas
Nomadic Strategy fully operational
HR Surge 2nd Phase completed
Environmental Surveillance expanded
> 90% LGAs in the HRS achieve 90% coverage in 2 IPDs
GIS supported micro-planning in all poorly-performing States
GPS Tracking of vaccination teams operational
RI Outreach fully functional
Polio Serosurveys
Achievement of at least 50% OPV coverage in all high-risk LGAs
> 90% LGAs in the HRS achieve 90% coverage in at least 4 IPDs
90% of LGAs meet the 2 main surveillance indicators
Zero orphan virus detection
90% of LGAs meet the 2 main surveillance indicators
Ensure 80% of high-risk States and LGAs achieve quarterly Abuja Commitments
80% of LGAs implement 80% of social mobilization activities in national EAP

GLOBAL POLIO ERADICATION INITIATIVE - EMERGENCY ACTION PLAN

Focus Area	Key new interventions	
Programmatic priorities by Geographic/ Strategic Area	PAKISTAN	1. Concentration of resources, efforts and monitoring and LQAS in key persistent transmission and underperforming zones: FATA; Quetta, Pishin, Killa Abdullah in Balochistan; Gulshan Iqbal, Gadap and Baldia in Karachi; Thatta in Sindh. 2. LQAS target: >80% of LQAS lots in key transmission zones outside FATA accepted at 90% or more coverage; Q3 onwards >80% accepted at >95% coverage. 3. A comprehensive Transit Strategy rolled out. 4. Enhanced Strategy to cover migrant populations initiated. 5. WHO and UNICEF (COMNET) human resource surge in key union councils of transmission zones. 6. Strategies for key zones and special population groups, particularly in FATA and migrant or displaced groups from FATA: a) Short Interval Additional Dose (SIAD) of OPV; b) vaccination of older age groups; c) focused efforts in Pashtun settlements; d) vigilance and preparedness for access and opportunities to vaccinate. 7. Overhaul of team composition and performance in Quetta block and Gadap and other poor performing towns of Karachi. 8. Expansion of environmental surveillance. 9. Direct disbursement of funds for campaigns and vaccinator honorarium. 10. Local accountability for quality of SIAs shifted to DCOs and UC Medical Officer

Meeting of the National Task Force

Monthly Meetings of the Provincial Task Force (at provincial and regional levels)

2012: Key Achievement Signposts and Progress Monitoring

2012

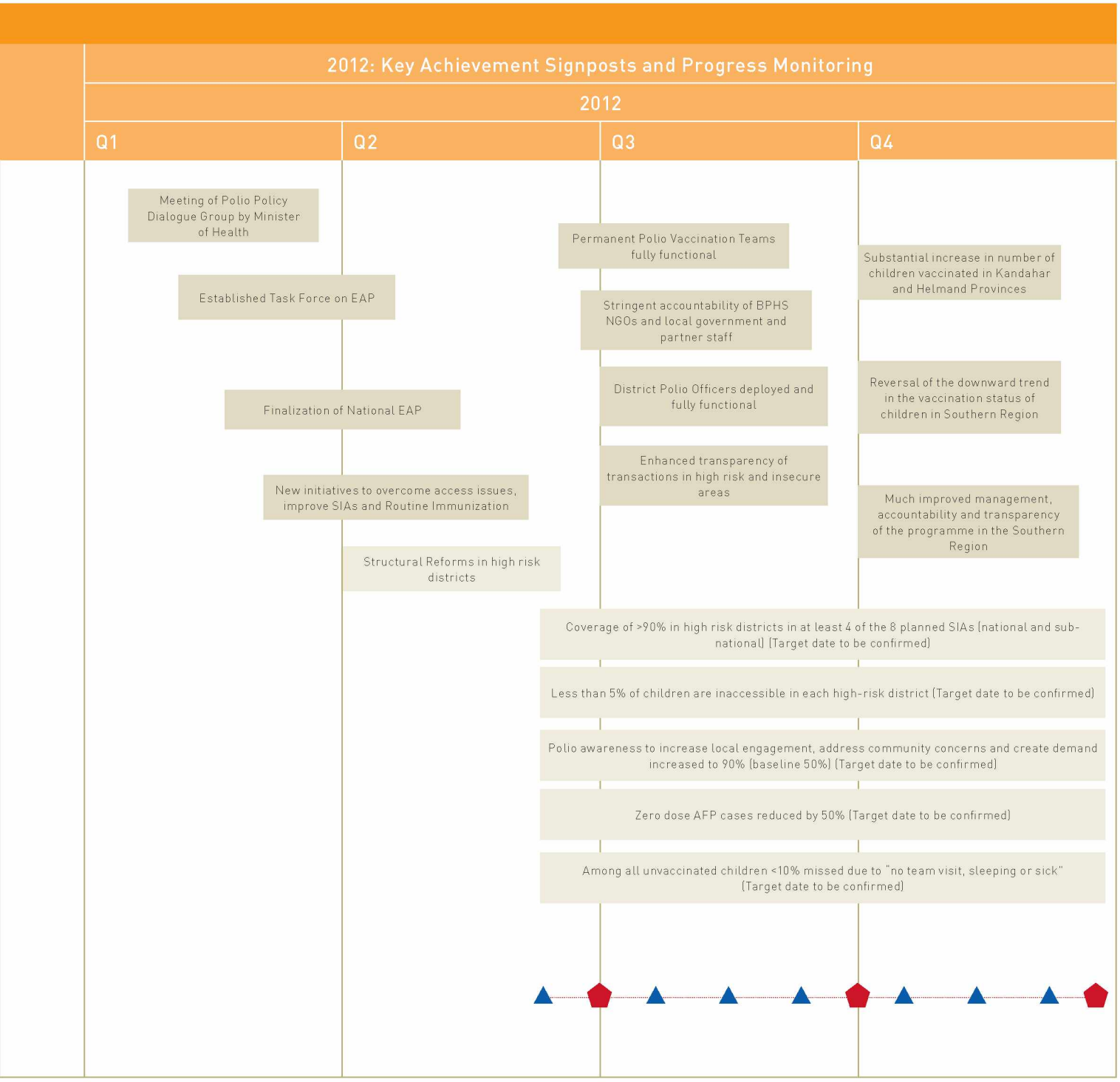
Q1	Q2	Q3	Q4
More than 90% lots accepted at more than 90% coverage levels in all districts of Karachi	Transit Strategy rolled out	>80% of all LQAS lots assessed nationally in every SIA accepted at greater than 95% coverage.	Mechanism in place to access >90% of children in SIAs in FATA and Refusals in Quetta Block and Karachi are <5% of missed children
Launch of the Augmented National Emergency Action Plan (NEAP)	Enhanced strategies for migrant populations initiated	Direct disbursement of payment to the vaccination teams	SIADS in the low transmission season
Establishment of the Polio Control Rooms at the Provincial and District Levels	Expansion of Environmental Surveillance		
Abolishment of the Zonal Supervisory tier and problematic paramedic positions	1st Phase of HR surge completed	2nd Phase of HR surge completed	
DCOs and UC Medical Officers accountable for quality of SIAs	Expansion of LQAS	Vaccination Teams fully revamped in Quetta Block and poorly- performing towns of Karachi, including Gadap	
Training of staff on Management and Accountability	New website (www.polioalert.info) for regular updates to the media		
COMNET staff recruitment initiated	Planning for the three successive passages in the last month of low transmission season targeting the critical areas		
WHO and UNICEF UC level staffing recruitment initiated			
Enhanced media and communications drive			
Enhanced involvement of parliamentarians and religious leaders			
Enhanced SIADS in high risk areas , vaccination of older age age groups among special population groups - full use of access and all opportunities to vaccinate children from FATA			
Nomination of the Provincial Focal Persons for PE and formation of special provincial committees			

GLOBAL POLIO ERADICATION INITIATIVE - EMERGENCY ACTION PLAN

Focus Area	Key new interventions	
Programmatic priorities by Geographic/ Strategic Area	AFGHANISTAN	1. Oversight by the office of H.E President, engaging members of Cabinet for inter-ministerial coordination on PEI. 2. Structural Reforms at district level to constitute "District EPI/PEI Management Team" with the aim to improve service delivery, management and accountability. This will be complemented by a surge of WHO, UNICEF and MoPH staff in high-risk districts of Southern Region. 3. Additional interventions to strengthen post-campaign monitoring through telephonic surveys and also introducing LQAS. 4. Introduction of a new strategy of "Permanent Polio Teams" in the poorly-performing districts. 5. Use of "Short Interval Additional Dose strategy" (SIAD) wherever possible in inaccessible areas. 6. Use of "high-risk cluster" approach to analyze, list and focus the interventions at sub-district levels. 7. Rolling out an integrated communication network (ICN) with focus on increasing the awareness and demand for vaccination in poorly-performing districts. 8. Introduction of an intensified three-month plan to strengthen routine immunization and monitoring progress through Grant and Contract Management Unit (GCMU) of MoPH.

Quarterly joint review of EAP progress

Monthly progress review: Polio Policy Dialogue Group


2012: Key Achievement Signposts and Progress Monitoring
2012
Q1
Q2
Q3
Q4
Meeting of Polio Policy Dialogue Group by Minister of Health
Established Task Force on EAP
Finalization of National EAP
New initiatives to overcome access issues, improve SIAs and Routine Immunization
Structural Reforms in high risk districts
Permanent Polio Vaccination Teams fully functional
Stringent accountability of BPHS NGOs and local government and partner staff
District Polio Officers deployed and fully functional
Enhanced transparency of transactions in high risk and insecure areas
Substantial increase in number of children vaccinated in Kandahar and Helmand Provinces
Reversal of the downward trend in the vaccination status of children in Southern Region
Much improved management, accountability and transparency of the programme in the Southern Region
Coverage of >90% in high risk districts in at least 4 of the 8 planned SIAs (national and sub-national) (Target date to be confirmed)
Less than 5% of children are inaccessible in each high-risk district (Target date to be confirmed)
Polio awareness to increase local engagement, address community concerns and create demand increased to 90% (baseline 50%) (Target date to be confirmed)
Zero dose AFP cases reduced by 50% (Target date to be confirmed)
Among all unvaccinated children <10% missed due to "no team visit, sleeping or sick" (Target date to be confirmed)

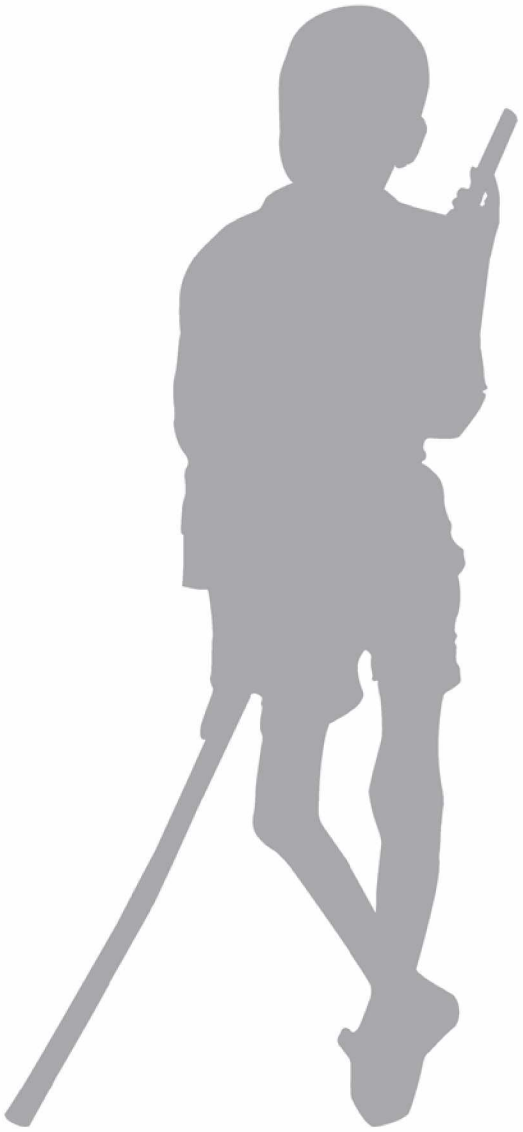
ANNEX 3:
Global Polio Eradication Initiative Architecture

Entity	Membership	Objectives
COORDINATION AND IMPLEMENTATION: PARTNER PROCESSES		
Polio Oversight Board Secretariat: same as chair agency.	Heads of five key agencies (WHO, UNICEF, CDC, Rotary, BMGF) informed by the WHO Global Policy Group and UNICEF Inter-divisional Polio emergency Steering Committee.	• Receive IMB reports. • Provide oversight of the GPEI and ensure high-level accountability. • Fully exploit agency resources.
Polio Emergency Steering Committee Chair: rotating Secretariat: WHO or UNICEF.	One senior representative (with access to the Head of Agency) from each of WHO, UNICEF, CDC, Rotary, BMGF.	• Provide strategic, technical and operational oversight for the GPEI, including issuing recommendations on implementation of tactics for accelerating polio eradication. • Ensure cross-agency alignment on priority setting and support to countries. • Set six-monthly global priorities to guide and direct the work of the Inter-Agency working groups. • Prepare strategy options for SAGE endorsement. • Clear budgets and work plans developed by countries for Polio Global Partners' Group endorsement. • Guided by monthly risk analysis "dashboard" compiled by Inter-Agency Country Support Group.
Inter-Agency Country Support Group (aligns country support of five Steering Committee agencies). Chair: WHO. Secretariat: CDC and WHO.	HQ and Regional, where applicable, technical leads on polio eradication. Participation includes priority country focal points from WHO, UNICEF, CDC, Rotary, BMGF, ROSA, WCARO, ESARO. Monthly Ministerial level participation of Nigeria and Pakistan in teleconference, together with country teams and Polio Emergency Steering Committee.	• Coordinate inter-agency support to countries; one HQ/RO voice. • Improve speed, alignment and effectiveness of country support. • Generate weekly epidemiology/programme situation analyses to guide operations. • Generate detailed monthly risk analyses to inform/HoA "dashboard".

Entity	Membership	Objectives
COORDINATION AND IMPLEMENTATION: PARTNER PROCESSES		
Inter-Agency Innovation Working Group Chair: BMGF & CDC. Secretariat: CDC.	Innovation focal points from BMGF, CDC, WHO, UNICEF and Rotary.	• Identify systemic challenges and root causes, evaluate potential solutions, assess the effectiveness of innovation, make recommendations to Steering Committee. • Improve operations in ongoing transmission areas: operations/ management, monitoring/ communications/social mobilization, vaccine strategies/programme management.
Polio Advocacy Group (brings together and expands cross-agency resource mobilization, communications and advocacy work). Co-Chairs: Rotary and BMGF. Secretariat: WHO.	External relations focal points from UNICEF, Rotary, BMGF, WHO, CDC, UNF, participation also by new advocates.	• Exploit comparative advantages of agencies to mobilize required financial resources to implement Global Polio Emergency Action Plan 2012-13 and the Polio Eradication and Endgame Strategy 2014-18. • Align communications, advocacy and resource mobilization efforts, recruit new advocacy partners for greater impact. • Guided by Global Polio Emergency Action Plan 2012-13, Financial Resource Requirements, funding gap tracker.
COORDINATION AND IMPLEMENTATION: COUNTRY PROCESSES		
National Polio Task Forces Chair: High-level Government official e.g. President, Minister of Health.	Varies from country to country but generally comprises senior government officials from the relevant ministries of health and WHO and UNICEF heads of country office.	Oversee the implementation of the national polio emergency action plans, including progress monitoring and adherence to national accountability frameworks.
National Polio Operations Group Chair: Senior Ministry of Health official e.g. Director-General of Health, Secretary of Health or equivalent.	Government officials, WHO and UNICEF staff, staff of other implementing agencies, donor agencies and NGOs.	Improve coordination among national partners on financing for polio eradication activities.

Entity	Membership	Objectives
MONITORING AND ADVISORY PROCESSES		
Independent Monitoring Board (IMB) Chair: Sir Liam Donaldson. Secretariat: Paul Rutter.	Nine members, international experts in disciplines relevant to the IMB ToRs, appointed by WHO DG, in consultation with heads of UNICEF, CDC, Rotary, BMGF).	• Independently evaluate progress toward GPEI Strategic Plan 2010-2012 milestones. • Identify areas where corrective action plans are required. • Evaluate the quality of corrective action plans. • Advise on additional measures needed to achieve milestones.
Global Polio Partners Group Chair: Elected member other than from WHO and UNICEF. Secretariat: WHO.	Inclusive. Senior representatives from donor/prospective donor agencies, foundations, NGOs, polio-affected countries, Steering Committee agencies.	• Ensure stakeholder voice in GPEI. • Provide input/guidance on development/implementation of strategic and action plans and polio "endgame" plan. • Review and endorse work plans and budgets. • Track epidemiologic/program data and assess progress, risks, and gaps to identify areas for interventions. • Undertake diplomatic and advocacy interventions to mitigate political/ programmatic risks and to mobilize short-term/long-term financial resources.
Strategic Advisory Group of Experts on immunization (SAGE) Chair: Helen Rees. Secretariat: WHO (IVB Department).	Fifteen members, representing a broad range of immunization and vaccines disciplines. Representation of professional affiliation, areas of expertise, three major areas of WHO's immunization-related work. Nominated by WHO's Director of Vaccines and Biologicals in consultation with WHO departments and regional offices. Public call for nominations. Reports to WHO D-G.	• Principal advisory group to WHO for development of policy related to vaccines and immunization. Advises WHO on overall global policies and strategies for control of vaccine-preventable diseases. • Through the SAGE polio working group, development of policies related to polio eradication and the endgame strategy.

EVERY LAST CHILD



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