POLIO GLOBAL ERADICATION INITIATIVE

ANNUAL REPORT

ON THE THRESHOLD OF A POLIO-FREE WORLD...

2014

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Cover photo: A child proudly displays his fingermark, proving he has been vaccinated against polio. © Rotary International/J.M. Giboux
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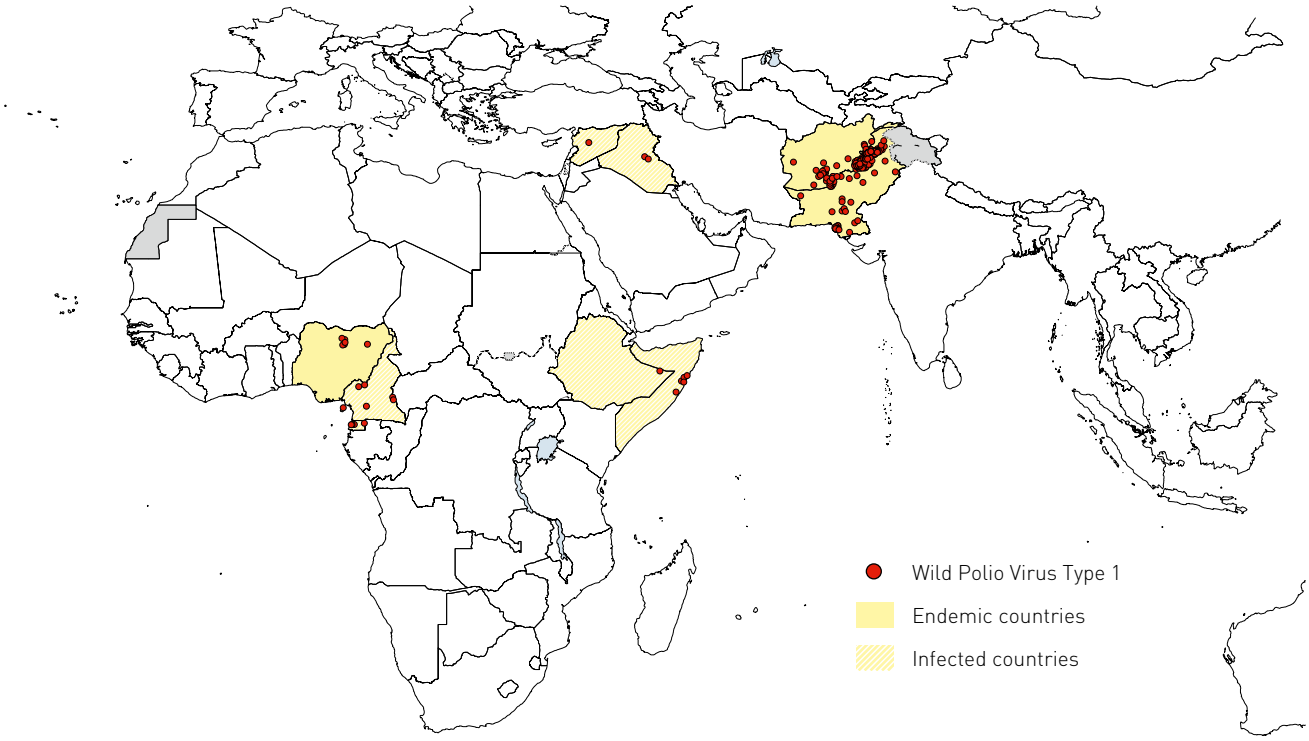
EXECUTIVE SUMMARY

By the end of 2014, significant progress had been made towards each of the objectives of the Polio Eradication & Endgame Strategic Plan 2013-2018 (Endgame Plan); the world has never been in a better position to eradicate polio. As the Global Polio Eradication Initiative (GPEI) enters 2015, efforts are being intensified to build on this progress and stop polio once and for all.



Capitalizing on progress in Nigeria, against outbreaks in central Africa and the Horn of Africa, and against two out of three strains of wild poliovirus

In Nigeria, no new cases due to wild poliovirus (WPV) occurred from July 2014 to the end of the year as a result of the improved quality of immunization campaigns. Subnational surveillance gaps in some areas remain, however, and the country continues to be affected by a persistent circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreak. The second half of 2014 also saw the two-year mark of the most recent case of wild poliovirus type 3 (WPV3), which was last detected anywhere in the world in November 2012, in Nigeria. This allows cautious optimism that this strain may have been eradicated. It would be a historic milestone for the GPEI and would leave only one wild serotype – wild poliovirus type 1 (WPV1) – in circulation (wild poliovirus type 2 - WPV2 - has not been detected anywhere since 1999).

In the second half of 2014, the outbreaks in the Horn of Africa, central Africa and the Middle East that spanned 2013 and the first half of 2014 were brought to the verge of being stopped. Thanks to regionally-coordinated outbreak responses in all three regions, one case was reported in this six-month period, in Somalia on 24 August. No case has been reported from any of the outbreaks since then. Risks remain across all three outbreak zones, however, such as residual surveillance gaps, which could hide undetected transmission, so none of the outbreaks has been considered closed.At the same time, the Middle East is considered at high-risk of renewed reinfection, given the intense virus transmission in Pakistan and further deterioration of immunization

systems in the Syrian Arab Republic and Iraq due to the conflict and security situation.

To minimize the risks of renewed international spread of wild poliovirus, on 5 May the Director-General of WHO declared the international spread of wild poliovirus to be a public health emergency of international concern under the International Health Regulations, and issued temporary recommendations to polio-infected countries, such as declaring polio as national public health emergencies and vaccinating international travellers.

Preparing the world for the phased removal of oral polio vaccines

In October 2014, the Strategic Advisory Group of Experts on immunization (SAGE) reviewed global readiness for the planned phased removal of oral polio vaccines (OPVs), beginning with a switch from trivalent OPV to bivalent OPV in April 2016. This readiness includes the introduction of inactivated polio vaccine (IPV) into all countries that currently use only OPV by end-2015, to continue to provide protection against all strains following the switch in 2016. Reviewing all evidence, the SAGE concluded that preparations for the switch are on track and urged countries to further intensify efforts.

A critical factor to assure a successful switch will be the containment of type 2 polioviruses in laboratories, as well as certification that WPV2, last detected in 1999, has indeed been globally eradicated. In late 2014, a new and updated global containment action plan was endorsed by the SAGE, and progress towards WPV2 verification continued.

The trigger for the global, phased withdrawal of OPVs will be to ensure that all persistent circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks are fully stopped. At end-2014, persistent cVDPV2s endured in Nigeria and Pakistan.

Ensuring the legacy of polio eradication

In late 2014, work continued to ensure the legacy of polio eradication can be secured, in other words that the investments made in the GPEI will continue to benefit other development goals in the long term through the documentation and transition of knowledge, lessons and assets. Ongoing consultations with Member States, major partners and stakeholders, as well as detailed pilot evaluations, reinforced the conclusions of the regional committees in 2013 that legacy planning should benefit existing health priorities and be driven by countries. Its success will require establishing a formal process in all countries where substantial assets for polio eradication were financed through external resources.

In 2015, finalization of the Global Legacy Framework will ensure that the essential functions of the GPEI's programme of work will be transitioned to other priorities. The Democratic Republic of the Congo (DR Congo), India, Nepal and Nigeria have initially been selected for focused legacy transition planning support in 2015, with other countries with significant polio resources to be prioritized.

Urgent epidemiological priority - stopping polio in Afghanistan and Pakistan

In 2014, Pakistan accounted for 85% of all WPV cases worldwide, and in the second half of 2014 continued to export virus internationally. This intense virus transmission across the country is now the greatest epidemiological risk to achieving a polio-free world, as too many children remain under-immunized (due to a number of factors, including operational challenges, insecurity, targeted attacks on health workers and hampered access). Mass population movements from previously inaccessible areas present both a risk and an opportunity. The risk is that virus continues to be exported from these areas, but the opportunity is that for the first time in more than two years, populations can be reached at transit points as they move out of these areas.

Recognizing the risks Pakistan poses to the global effort, end-2014 saw a build-up in government commitments at all levels. Following initial strategic planning, an emergency meeting convened the political leadership from the high-risk provinces and districts to prepare a robust 'low season emergency plan' with consensus from all key levels. This low season plan focuses on overcoming clearly identified, area-specific challenges in the early part of 2015 (the 'low season' for polio transmission). The plan has all the necessary elements in place to rapidly eradicate polio; its success, however, hinges on its full implementation at all levels. To facilitate implementation, a national task force reporting directly to the Prime Minister's office has been established; a cabinet committee formed on security for immunization; and close collaboration is being fostered to secure the assistance of the army and the Ministry of the Interior for polio eradication. Emergency Operations Centres established at federal and provincial levels will oversee implementation, assure real-time monitoring and guide corrective actions as necessary.

In neighbouring Afghanistan, efforts focused on holding ground against the virus in the face of importations from Pakistan. While the bulk of WPV cases are linked to cross-border transmission with neighbouring Pakistan, evidence of residual endemic virus circulation persists and access challenges remain in some areas.

Looking to 2015

At end-2014, much epidemiological evidence justified cautious optimism, with Africa on the verge of being polio-free and the possible eradication of WPV3. However, major challenges remain to be overcome. The GPEI will focus on five key areas of work in the first half of 2015, to maximize the opportunity that presents itself and to urgently overcome barriers preventing all children from being reached with life-saving polio vaccine.

1. Further intensifying surveillance – to rapidly detect any residual transmission, in particular in parts of Nigeria, central Africa, the Horn of Africa and the Middle East.
2. Securing a polio-free Africa and Middle East – by fully implementing emergency measures to urgently interrupt residual virus transmission, reducing the risk of international spread and developing stronger outbreak response capacity.
3. Providing surge support to Pakistan (and Afghanistan) – to help implement and evaluate the 'low season' plan in Pakistan, while further building on progress in neighbouring Afghanistan (which is epidemiologically linked to Pakistan).
4. Preparing for phased removal of OPVs – by continuing to support countries in introducing IPV and preparing the world for the planned switch from trivalent OPV to bivalent OPV in early 2016.
5. Engaging with routine immunization – with particular focus on 10 priority countries with the bulk of GPEI staff and infrastructure, to ensure immunity levels to all vaccine-preventable diseases can be boosted.

2015 marks the mid-term point of the Endgame Plan 2013-2018, and provides the opportunity for the GPEI to carry out a mid-term review of the Polio Endgame Plan. This review will assess progress to date and identity operational, financial and technical adjustments, as needed.

Financing the Endgame Plan

By end-2014, the GPEI had received US$ 2.23 billion in contributions and was tracking an additional US$ 2.85 billion in pledges, against the overall 2013-2018 budget of US$ 5.5 billion. Full and rapid realization of all pledges would result in a remaining funding gap of US$ 451 million against the Endgame Plan.

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2014 HIGHLIGHTS

JANUARY

Most recent WPV1 case in Syria, following comprehensive regional outbreak response

FEBRUARY

Islamic leaders from around world call for access to vaccinate children

MARCH

UNICEF and Gavi announce outcomes of landmark tender making IPV accessible to children in world's poorest countries

APRIL

Most recent WPV1 case in Iraq

MAY

Polio declared 'public health emergency of international concern', urging infected countries to vaccinate international travellers

JUNE

Polio campaigns resume in Bara, Pakistan, after 5 years of inaccessibility

JULY

Most recent WPV1 case in Nigeria

AUGUST

Most recent WPV1 case in Somalia

SEPTEMBER

Nepal becomes first Gavi-eligible country to introduce IPV

The first baby immunized with IPV in Nepal at a launch ceremony in Kathmandu on 18 September 2014.

OCTOBER

Rotary leads a global awareness-raising movement, marking World Polio Day

SAGE concludes preparations are on track for global switch from trivalent to bivalent OPV

NOVEMBER

2 years since WPV3 was last detected anywhere in the world

DECEMBER

Urgent re-vamped Pakistan programme launched, overseen by Prime Minister's office

Pakistan Prime Minister Nawaz Sharif vaccinates a child against polio.

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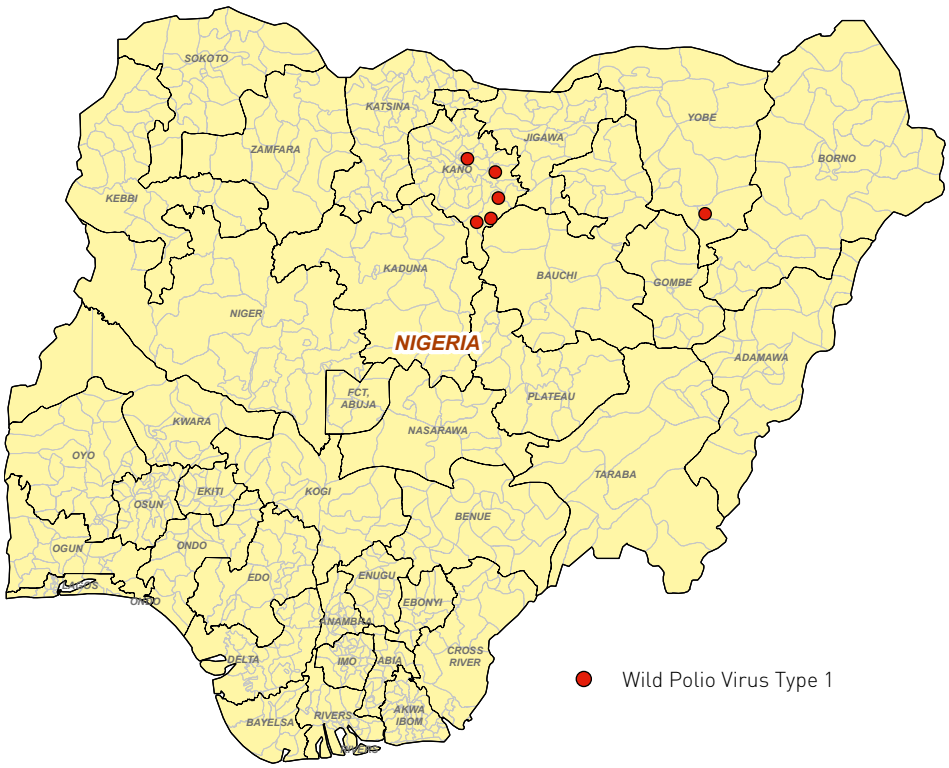
OBJECTIVE 1 | POLIOVIRUS DETECTION AND INTERRUPTION

ENDEMIC COUNTRIES

NIGERIA



Situation analysis:

Nigeria has made major progress towards achieving polio-free status. The decrease in global cases is largely associated with progress achieved in Nigeria, which saw only one case of WPV1 in the second half of 2014, on 24 July. This led to a total of six cases in 2014, a significant decrease from 53 in 2013.

In September 2014, the Expert Review Committee on Polio Eradication and Routine Immunization (ERC) identified Kano as the remaining place with persistent WPV transmission in the country. An analysis of strategic approaches began in high-risk states such as Borno and Yobe, including for areas with compromised access to populations, and based on its outcomes, strategies were targeted to inform ward-specific plans. Vaccine mix was optimised, to address both WPV and cVDPV transmission. Identification of any subsequent polioviruses (detected through acute flaccid paralysis - AFP - or environmental surveillance) will trigger an aggressive outbreak response consisting of a series of vaccination mop-up campaigns at 2-3 week intervals.

While access to children has improved substantially during the past year, access continues to be limited in many areas and supplementary immunization activity

(SIA) quality remains inadequate in areas that are accessible. The north of Nigeria continues to face substantial security challenges and gaps in surveillance that the region is attempting to address.

Focus for 2015:

- Ensuring a strong and reliable surveillance system, through identification of residual subnational gaps in AFP surveillance and continued expansion of environmental surveillance.
- Further strengthening political commitment at all levels, and ensure that national elections in early 2015 do not disrupt programme performance.
- Continuing to optimize vaccine mix, to simultaneously and effectively address both WPV1 and cVDPV2 transmission, including through use of IPV during campaigns.
- Introducing IPV into the country's routine immunization programme, in advance of the planned global switch from trivalent to bivalent OPV in early 2016.
- Scaling-up efforts to implement temporary recommendations issued under the auspices of the International Health Regulations, in the context of the Public Health Emergency of International Concern (PHEIC).
- Continuing to explore innovative ways to reach children, and sensitive surveillance, in areas where access is hampered due to insecurity, in particular in high-risk areas of the north-east (Borno and Yobe states).
- In Kano, urgently addressing residual gaps in SIA quality to increase vaccination coverage, in particular in very young children.
- Integrating the polio network into broader routine immunization, training health workers more efficiently and establishing health camps where additional antigens and health interventions are offered to communities over and beyond polio vaccine.
- Development of a National Emergency Outbreak Response Plan, to ensure immediate, large-scale mop-up activities to any detection of residual transmission.
- Rolling out of a comprehensive national legacy plan, to document lessons learned and plan for the future contribution of the innovations associated with the polio programme to other public health and development goals.

Environmental surveillance activities in Kano, Nigeria

AFGHANISTAN

Situation analysis:

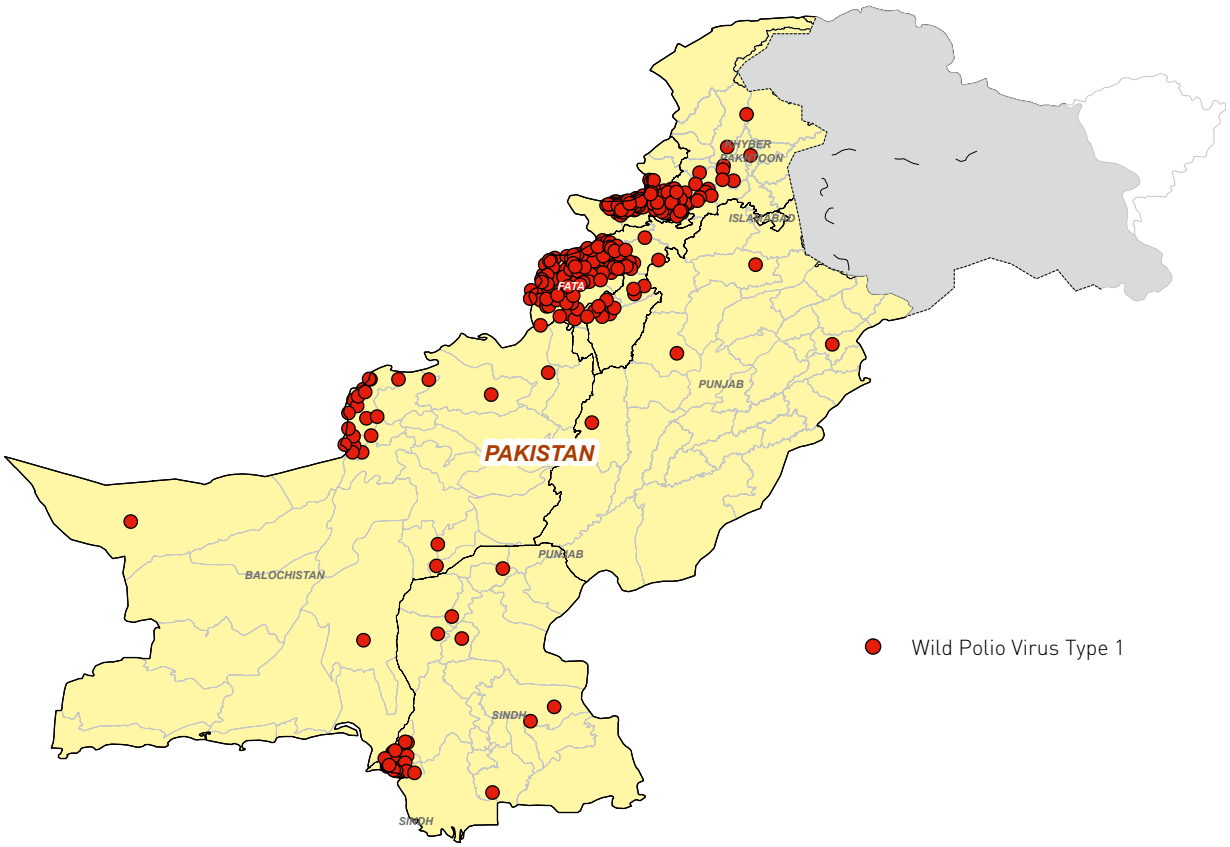
The bulk of Afghanistan's cases in 2014 were linked to cross-border transmission with neighbouring Pakistan. No cVDPV2 cases have been reported in the country since March 2013. This stresses the fact that Afghanistan's progress towards eradication is inextricably connected to progress against the virus in Pakistan. The country succeeded in keeping numbers relatively low when considering the population movement across the porous border between the two. However, low-level endemic transmission and secondary spread of imported viruses demonstrates remaing vaccination coverage gaps that must be filled, including in low-performing districts of Southern Region and Eastern Region. Twice in 2014, local leaders suspended immunizations in high-risk areas of Helmand province. Ongoing and local level negotiations resolved both suspensions, by highlighting the importance of maintaining the neutrality of public health efforts.

Focus for 2015:

- Intensifying high-quality SIA schedule, with particular focus on maximising technical and other resources to low-performing districts of Eastern Region and Southern Region.
- Optimising vaccine mix, to boost immunity to type 1 and type 2 poliovirus (given persistent cVDPV2 transmission in neighbouring Pakistan), including through IPV in key areas.
- Continuing to expand environmental surveillance, which in 2014 proved an invaluable surveillance tool to supplement AFP surveillance and ascertain a clearer epidemiological picture (allowing for targeted strategic approaches). In particular, the focus is on known areas with gaps in Southern Region.
- Continuing to reduce 'missed' children in accessible areas of Southern Region, through ongoing engagement with communities (creating demand) and improving service delivery.
- Introducing IPV ahead of the planned global switch from trivalent OPV to bivalent OPV.

- Building on programmatic innovations from 2014, including rolling-out comprehensive re-visit strategy, revising microplans, improving supervision and enhancing communications.
- Engaging local level access negotiators, to ensure access to all populations.
- Analysing evolving security situation and adapting strategies accordingly.
- Establishing Permanent Polio Teams (PPTs), in particular at entry-exit points of inaccessible areas and at key border crossings.
- Coordinating SIA and surveillance activities (including sharing of data) with neighbouring Pakistan.
- Strengthening monitoring of activities, including through use of non-traditional partners, and supplementing independent monitoring by increased use of Lot Quality Assurance Sampling (LQAS).
- Tracking performance in low-performing districts.
- Increasing oversight, accountability and transparency at all levels, through engagement of political leaders at national, provincial and district levels.
- Expanding implementation of temporary recommendations associated with PHEIC.

PAKISTAN



Situation analysis:

In 2014, Pakistan accounted for 85% of all WPV cases worldwide, and was affected by transmission of both WPV1 and persistent cVDPV2.

Too many children in Pakistan continue to be under-immunized, due to a number of factors, including operational challenges during immunization campaigns, and in some areas insecurity, targeted attacks on health workers and hampered access.

Despite the serious polio situation in Pakistan, there have been positive developments last year which bring hope for significant progress in 2015. According to polling data by Harvard in 2014, vaccine acceptance rates are at the highest levels ever recorded in Pakistan. Vaccine acceptance rates reach 99% in many areas in Pakistan, meaning that parents' desire to vaccinate their children is high, even in inaccessible and insecure areas. Further, the displacement of persons from North and South Waziristan meant that as populations from this area moved out, they received the polio vaccine for the first time since 2012. Access to both areas also improved for the first time since 2012.

In 2015, Pakistan has the opportunity to reverse the current spike in cases and in so doing to take the world over the finish line of eradication. Recognizing both the risk and the opportunity which presents itself in 2015, end-2014 saw a build-up in government commitments at all levels. In November, an emergency meeting convened leaders from all high risk provinces and districte to prepare a 'low season emergency plan' with concensus from all levels, that focuses on overcoming operational and security challenges in the early half of the 2015 (the 'low season' for polio transmission). This plan has all the necessary elements in place to rapidly eradicate polio from Pakistan; its success hinges on its full implementation.

To ensure this, implementation will be directly overseen by the Office of the Prime Minister, which will monitor progress on a regular basis and redirect the plan as needed based on evolving epidemiology. It is the only social programme overseen in Pakistan by the Prime Minister. Emergency Operations Centres will be set up at the federal and provincial levels in Pakistan. These will be supported by Polio Eradication Committees at the district and union-council levels. This will ensure real-

time monitoring of activities, enabling rapid response to changes and the needs of local areas. In addition, the combination of vaccines given to children will be optimised in order to address both WPVs and cVDPVs. Close collaboration is being fostered to secure the assistance of the army and the Ministry of the Interior for polio eradication.

Focus for 2015:

- Identifying area-by-area reasons for missing children during SIAs and adapting strategies accordingly.
- Estabishing Emergency Operations Centres (EOCs) at federal and provincial levels, and ensure they are functioning to monitor and coordinate strategic implementation.
- Improving performance and morale of frontline health workers, in particular by increasing the security measures being implemented to protect health workers.
- Expanding innovations to reach mobile populations.
- Rolling out IPV to selected areas during campaigns.
- Addressing both WPV1 and cVDPV2 transmission, by ensuring optimised vaccine mix.
- Increasing the quality of independent monitoring, coupled with scaled-up LQAS in key areas.
- Strengthening AFP surveillance and continuing to scale up environmental surveillance.
- Negotiating local-level access to all areas.
- Implementing comprehensive outbreak response in polio-free areas, to detection of any poliovirus from any source.
- Monitoring performance and increasing accountability at all levels.
- Ensuring oversight and review of programme implementation through:

  a. the Prime Minister's Task Force and the Prime Minister's Focus Group for Polio Eradication as well as the National Steering Committee headed by the Prime Minister's Focal Person for Polio Eradication at the national level,

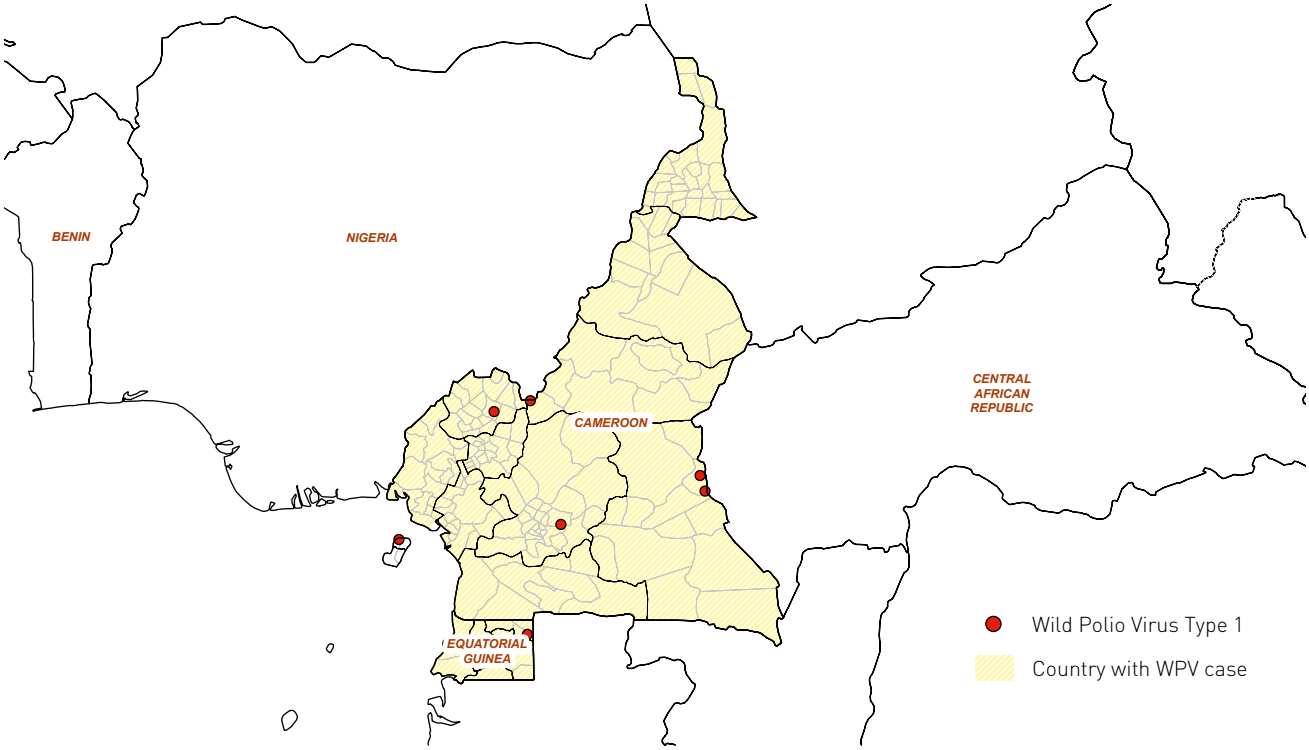
  b. the Provincial Task Forces headed by the Chief Secretaries and Security Coordination Committees at the provincial level

  the District Polio Eradication Committees headed by the Deputy Commissioners (Civil Military Coordination Committee headed by Political Agent in FATA).

Mrs Saira Afzal Tarar, Minister of State for National Health Services Regulations and Coordination and Mrs Ayesha Raza Farooq, Prime Minister's Focal Person for Polio Eradication, oversee the country's eradication effort in the federal Emergency Operations Centre in Islamabad.

OUTBREAKS

CENTRAL AFRICA



Situation analysis:

In central Africa, two WPV1 cases were reported in August 2014, the first in the region since February, from a refugee camp near the border with the Central African Republic. Detection of these cases alerted officials of the risk of residual, low-level transmission associated with this regional outbreak that was first detected in 2013 in Cameroon.

An international outbreak assessment conducted in September highlighted that the response was significantly strengthened throughout 2014, including by focusing on addressing major operational gaps and surveillance deficits. This progress continued to be further built on throughout the last quarter of 2014, including through strengthened engagement with routine immunization systems, and UNHCR and NGOs to ensure both surveillance and campaigns are improved in formal and informal refugee camps, recognizing the ongoing risk of international spread. Particular focus is being given on areas with high risk of undetected transmission, including Lake Chad, northern Cameroon and Central African Republic. Activities are being coordinated regionally.

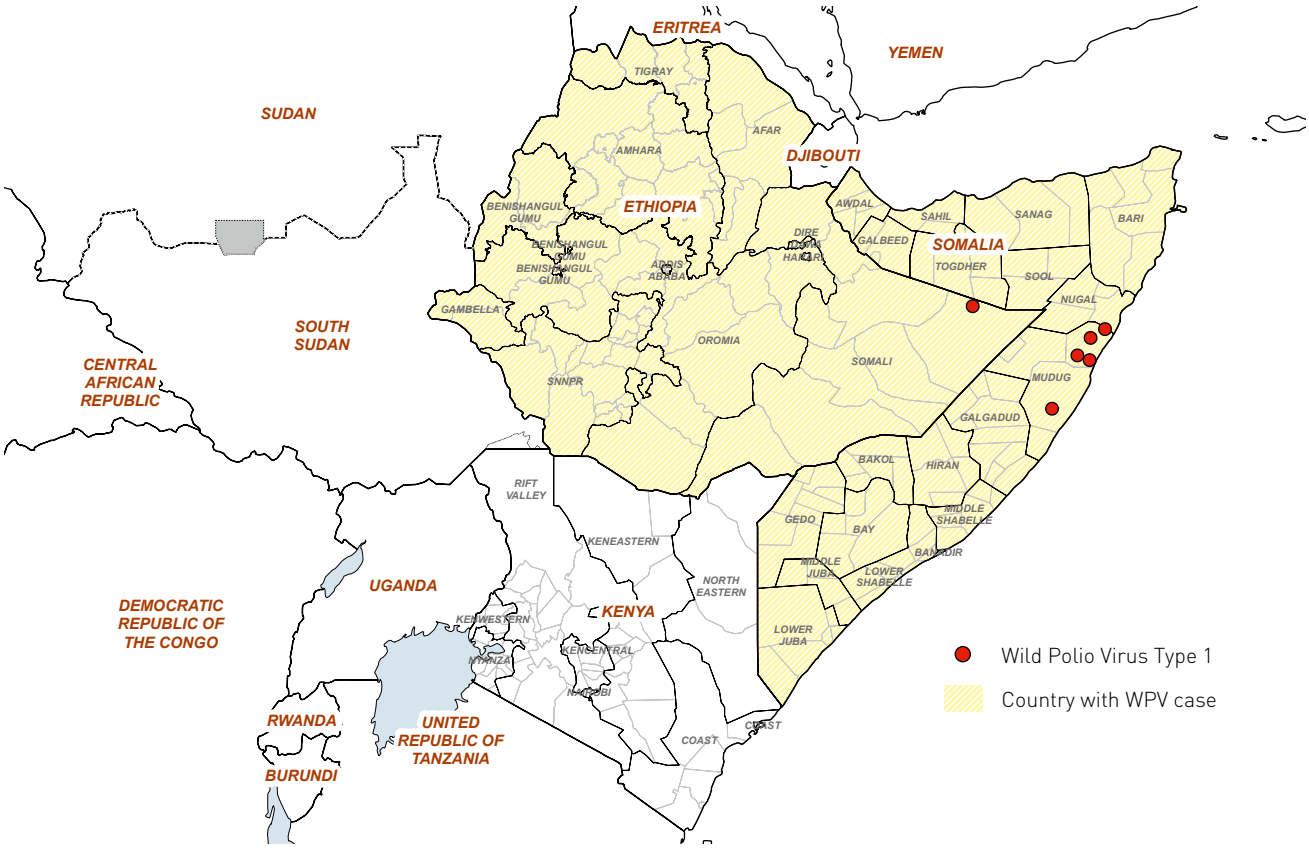
Focus for 2015:

- Regionally coordinate all activities across countries
- Focus in particular on known high-risk areas, including Lake Chad
- Fill residual surveillance gaps to detect any eventual undetected virus transmission
- Continue to implement regional emergency outbreak response to vaccinate more than 8.6 million children across four countries considered at highest risk, with multiple doses

Public Health Emergency of International Concern - PHEIC

On 5 May 2014, on the advice of an Emergency Committee under the International Health Regulations (2005) convened at the request of the Executive Board, the Director-General declared the international spread of WPV to be a Public Health Emergency of International Concern (PHEIC) and issued Temporary Recommendations for 'states currently exporting wild poliovirus' and 'states infected with wild poliovirus but not currently exporting'. The Temporary Recommendations contain advice on measures to reduce the risk of international spread of wild poliovirus, such as declaring and managing the event as a national public health emergency and vaccinating travellers from affected countries against poliomyelitis. On the advice of the Emergency Committee, the Director-General extended the original temporary recommendations on 3 August 2014 and again on 13 November 2014. On 13 November, the Temporary Recommendations were supplemented with specific measures for Pakistan because of escalating wild poliovirus transmission in that country and the ongoing cross-border exportation of the virus into Afghanistan, including recommending Pakistan restrict at the point of departure the international travel of any resident lacking documentation of appropriate polio vaccination. In the second half of 2014, all polio-affected countries continued to scale up and implement the Temporary Recommendations, however to variable success and extent. Additionally, polio-free countries are increasingly taking additional steps to minimise the risk and consequences of a potential virus importation, including requiring travellers from polio-affected countries to show proof of vaccination as a visa requirement and/or administering an additional dose of polio vaccine upon arrival in the country.

HORN OF AFRICA



Situation analysis:

The WPV1 outbreak in the Horn of Africa has significantly declined, however confirmation of a case in Somalia in August 2014 underscores the dangers of ongoing, low-level residual transmission in the region. Regional outbreak response activities are continuing, and efforts are being made to strengthen and fill residual subnational surveillance gaps.

Two cases of cVDPV2 emerged in South Sudan in September, in a refugee camp area of Unity state. Immediate outbreak response was conducted, with the objective to rapidly stop the cVDPV2 in the infected area, while further boosting immunity to type 1 polio to minimise the risk posed by any potential residual transmission of this strain in the region. A total of 130 million doses of OPV have been administered to more than 27 million children across four countries.

Focus for 2015:

- Regionally coordinate all activities across the Horn of Africa
- Fill residual surveillance gaps, particularly in key areas of Somalia and Somali region of Ethiopia, including through increased sampling of healthy children in high-risk areas
- Increase vaccination coverage among nomadic and pastoral communities
- Implement SIADs in newly-accessible areas and continue permanent vaccination post strategy
- Expand independent monitoring and LQAS to ascertain a clearer picture of programme performance
- Systematically use polio staff and infrastructure to support strengthening of routine immunization

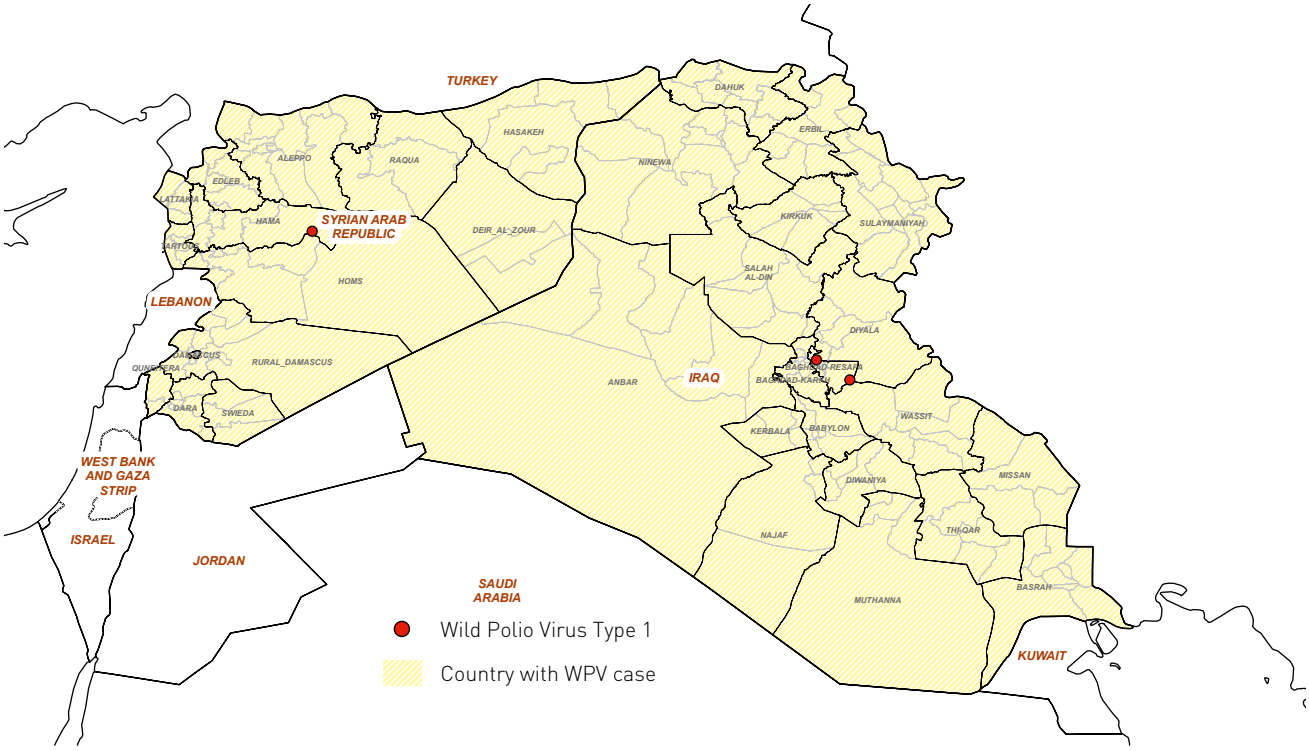
New outbreak response guidelines issued

In 2006, the World Health Assembly issued international outbreak response guidelines, with specific measures countries should take upon detection of a polio outbreak in any polio-free area. Full implementation of these guidelines reduced the extent (in time and number of cases) of new outbreaks by 50%, compared to previous outbreaks. Outbreak response is now more critical than ever, as the world is now closer than ever to being polio-free and the phased removal of oral polio vaccines (OPV) is beginning. That is why the GPEI has issued revised, international outbreak response guidelines to countries, building on those from 2006. The key elements of the guidelines are:

- to strengthen surveillance for all polioviruses;
- to declare any detection of poliovirus as a national public health emergency by the top level of government;
- to appoint a senior government focal person to oversee implementation of the outbreak response;
- to mobilize an 'all of government' response and resources, both financial and human (multisectoral); and,
- to fully implement recommendations issued through the International Health Regulations (2005).

The revised and strengthened outbreak response guidelines were subsequently endorsed by the 2015 World Health Assembly.

MIDDLE EAST



Situation analysis:

2014 saw the continuation of the phase II Middle East regional outbreak response across seven countries. Despite major disruptions to health and transport infrastructure, no new cases have been detected in Iraq since April, and in Syria since January. It is a remarkable achievement that has drawn on the commitment of the governments of the region, health workers, and the desire of parents to access the vaccines for their children. A total of more than 140 million doses of OPV have been administered to nearly 30 million children across 8 countries of the region.

In a complex political and security environment, governments and administrators, with the assistance and partnership of UN organizations and local and international nongovernmental organizations, outbreak response is continuing across the lines of conflict to reach all children.

Focus for 2015:

- Implement Phase III of the outbreak response, building on progress achieved in 2014 and late 2013
- Focus is on identifying remaining undervaccinated population groups
- Filling residual surveillance gaps
- Maintain high population immunity, given ongoing risk of further international spread of poliovirus across the region from Pakistan

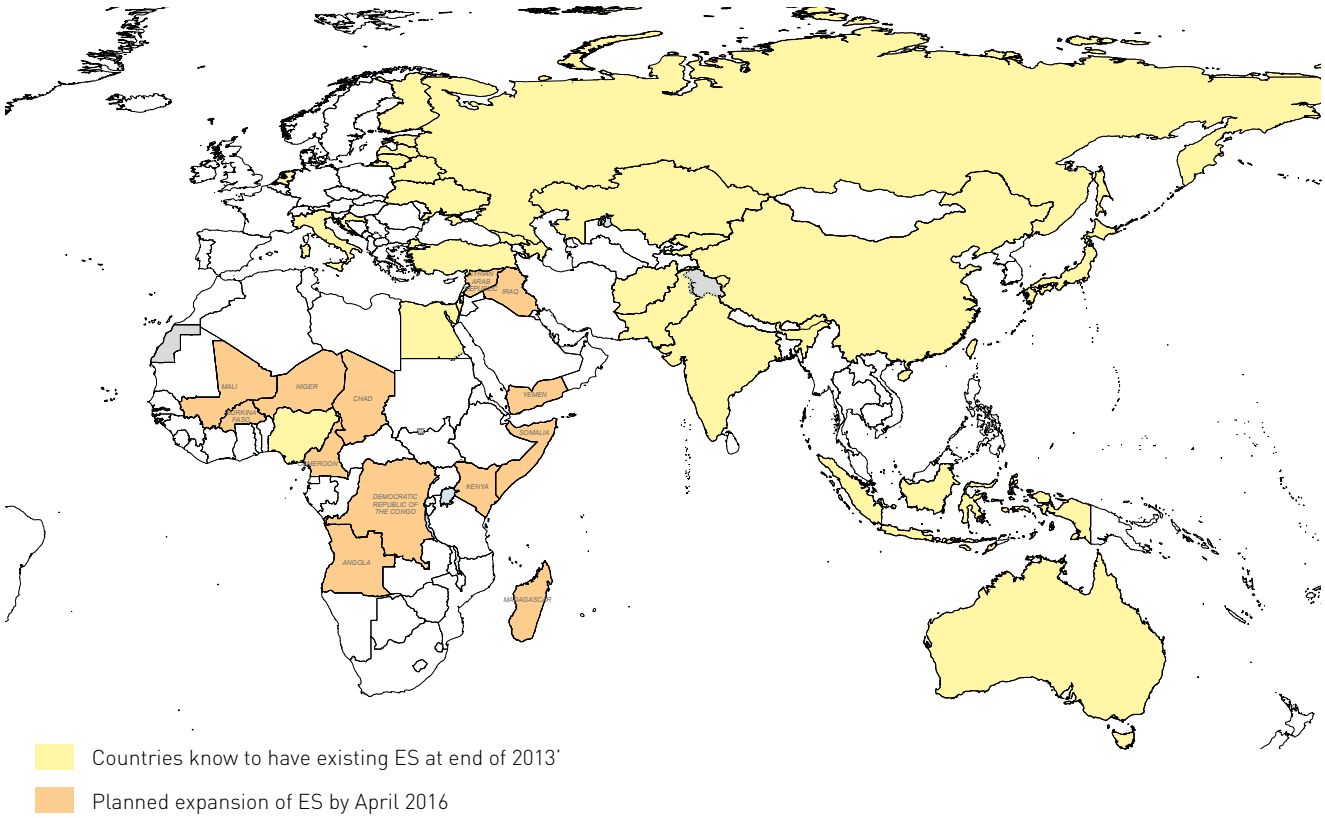
STRENGTHENING SURVEILLANCE

Across all infected countries and high-risk areas, efforts continued in the second half of 2014 to rapidly identify and fill residual subnational surveillance gaps. This is particularly true in all three outbreak zones, the Middle East, the Horn of Africa and central Africa.

Through guidance by regional technical advisory bodies, particular attention is being given to strengthen active surveillance for acute flaccid paralysis (AFP) cases in marginalized and at-risk population groups. Targeted and active AFP community searches are being conducted during vaccination campaigns, to further complement existing AFP surveillance activities. Detailed analyses at country, regional and global levels of surveillance indicators are aimed at highlighting critical gap areas, and field visits organized in response to develop and implement corrective measures.

Rapidly identifying any polio transmission is critical, as it enables a full and comprehensive outbreak response. Filling surveillance gaps is a programmatic priority for the programme in 2015. Environmental surveillance is being further expanded, to supplement active surveillance for AFP cases.

Environmental surveillance for polioviruses



Global polio surveillance 2014

REGION	AFP CASES REPORTED	NON-POLIO AFP RATE	% ADEQUATE STOOL COLLECTION
AFRICA	22 447	5.64	92%
THE AMERICAS	2 001	0.85	77%
EASTERN MEDITERRANEAN	12 546	5.86	91%
EUROPE	1 593	1.03	88%
SOUTH-EAST ASIA	58 672	10.88	87%
WESTERN PACIFIC	6 876	1.88	90%
GLOBAL TOTAL	**104 135**	**5.46**	**89%**

THE RISK OF POLIO TO HIGH-RISK COUNTRIES OF WEST AFRICA – THE IMPACT OF EBOLA

West Africa has historically been one of the highest-risk areas for polio re-infection and outbreaks, given its geographic proximity to Nigeria and large-scale population movements across the region. The devastating Ebola outbreak affecting the region has further raised the spectre of renewed spread of polio across the region.

The polio programme is monitoring the situation across the region closely. In the three Ebola-affected countries, Guinea, Liberia and Sierra Leone, population immunity has declined, as has surveillance for AFP as the Ebola outbreak has limited the ability to conduct activities. However, poliovirus transmission levels are at a historic low in Nigeria (from where virus would spread into West Africa), and population movements *into* the three Ebola-affected countries are limited. At the same time, the programme continues to conduct immunization campaigns across other countries of West Africa, to build an immunity wall to minimise the risk of polio spreading again into the region. The programme is prepared to immediately implement large-scale SIAs in the three Ebola-affected countries as soon as the situation allows.

Polio staff and infrastructure across the region continue to support Ebola outbreak response measures, by conducting surveillance, contact tracing, data management, logistics and supply distribution, and outbreak management. **In Nigeria, the assets and experience of the dedicated polio emergency operations centres and staff were instrumental in helping stop the Ebola outbreak in that country.**

Polio staff and infrastructure across West Africa support Ebola outbreak response measures.

Polio staff – first responders in emergencies

The polio staff in West Africa have been an integral part in the Ebola outbreak response. Polio staff and infrastructure are often front and centre in emergency relief efforts following natural or other disasters. Polio staff from the country have been deployed to help conduct rapid assessments of the most urgent needs. A rise in infectious diseases often poses a threat to people living with weakened or destroyed sanitation and health systems. Polio staff from both the World Health Organization (WHO) and UNICEF support the Ministries of Health in planning, implementing and monitoring vaccination campaigns for measles, rubella and other diseases in the affected areas. At the same time, staff gear up surveillance capacity, to actively look for other communicable diseases, including cholera. The drive to eradicate polio has always been about more than polio alone. The polio network routinely conducts surveillance for other diseases of public health importance, including measles, yellow fever, neonatal tetanus and avian influence. With local knowledge of communities, health systems and government structures, the polio network's technical capacity in disease surveillance and planning of large-scale operations often helps sustain international and national relief efforts. The extensive polio eradication network at country-level has proved itself repeatedly to be uniquely equipped to provide immediate support during emergencies or other disease outbreaks. Following the October 2005 earthquake on the Pakistan-India border areas, more than 50 medical officers from the Pakistani polio eradication programme arrived within a day after the earthquake, equipped with vaccines, medications, potable water and sleeping bags, in addition to critical logistics support such as 15 vehicles and radio and satellite equipment. The medical officers conducted the initial rapid assessment of the disaster and communicated their observations to the capital to allow effective relief planning. They also provided emergency medical care during the following days, setting up treatment camps and transporting patients, while planning and implementing mass vaccination campaigns against measles, polio and tetanus. In the days and weeks immediately following the Indian Ocean tsunami in December 2004, polio staff were deployed by the government of India to the worst-affected areas of southern India to cope with health needs. At headquarters level, polio staff were immediately involved in resource mobilisation and staff coordination activities. In affected countries, polio staff arrived on the scene equipped with vehicles and medicines, including oral rehydration salts and co-trimoxazole paediatric tablets to help prevent deaths due to pneumonia. Polio staff also organised and helped implement large-scale, preventive immunisation campaigns, reaching more than 150 000 children with measles and polio vaccine, as well as Vitamin A supplements. Similar support was given during the Sahel drought in 2013 and the Horn of Africa drought in 2011-2012, and is currently being provided to the Ebola outbreak response across western Africa. Polio staff at country level spend, on average, 50% of their time working on broader public health efforts, over and beyond polio eradication. They provide a critical contribution to strengthening health systems. Ensuring that the infrastructure built up to eradicate polio continues to support broader health services, even after the disease has been eradicated, is now one of the highest priorities for the programme. An extensive 'legacy planning' process is underway with partners and governments to ensure that the experience and expertise of polio staff continue to support people in the aftermath of emergencies.

OBJECTIVE 2 | IMMUNIZATION SYSTEMS STRENGTHENING AND OPV WITHDRAWAL

Situation analysis:

As part of the Endgame Plan, OPV use worldwide will eventually end, starting with the removal of type 2 poliovirus vaccine (OPV type 2) through the switch from trivalent OPV to bivalent OPV. A first step in this process is the introduction of at least one dose of inactivated polio vaccine (IPV) into all routine immunization programs by the end of 2015. This will boost immunity against type 2 polioviruses and will also:

- reduce the risk of re-emergence of wild- or vaccine-derived type 2 polio virus
- facilitate the containment of outbreaks
- accelerate WPV eradication by boosting immunity against poliovirus type 1 and 3 in children who have previously received OPV.

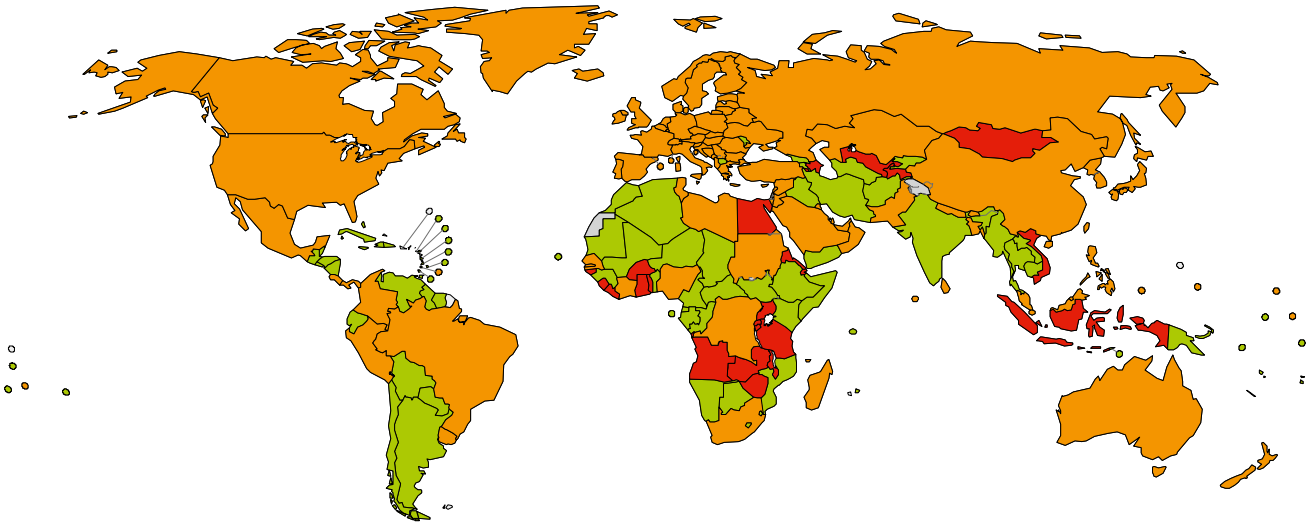
In October 2014, the Strategic Advisory Group of Experts on immunization (SAGE) reviewed progress towards global readiness for the coordinated, phased removal of OPVs, and concluded that preparations are on track for a switch from trivalent OPV to bivalent OPV in April 2016. In particular, the group noted the progress achieved with regard to IPV introduction, with virtually all countries committing to introducing the vaccine by end-2015.

In conjunction with IPV introduction, Objective 2 of the Endgame plan also includes efforts to strengthen routine immunization in ten 'focus' countries where there are significant polio resources and assets. A joint programme of work was initiated with Gavi, the Vaccine Alliance, to support this work. To date, six of these countries – Chad, Democratic Republic of Congo, Ethiopia, India, Nigeria and Pakistan – have developed annual national immunization plans that leverage polio assets to improve broader immunization goals. In Pakistan, for example, a pilot project first evaluated in 16 districts is being expanded across all provinces, in close collaboration with high-level provincial political leadership, to take steps to rapidly increase vaccination coverage among children. In addition, work is ongoing to assess and quantify the contribution of polio-funded staff to routine immunization activities across the 10 focus countries.

Focus for 2015:

- Continue to support countries worldwide in their efforts to introduce IPV into their routine immunization programmes by end-2015
- Ensure polio staff and infrastructure are systemtically engaging to support routine immunization strengthening in ten priority countries
- Monitor evolving epidemiology of persistent cVDPV2s in Pakistan and Nigeria, which must be fully stopped before the planned switch from trivalent OPV to bivalent OPV
- Prepare for global switch from trivalent OPV to bivalent OPV, planned for April 2016

Countries using IPV vaccine to date and formal decision to introduce



- Introduced* to date *(97 countries or 50%)*
- Formal commitment to introduce in 2015 *(74 countries or 38.1%)*
- Intend to introduce in 2015 *(0 country or 0%)*
- Formal commitment to introduce in 2016 *(23 countries or 11.9%)*
- Not available
- Not applicable

Since January 2013, the following countries have introduced IPV: Kazakhstan & Peru (July 2013); Micronesia (August 2013); Libya (April 2014); Albania & Panama (May 2014); Nepal & Tunisia (September 2014); Philippines (October 2014); China (December 2014); Comoros, Senegal & Serbia (January 2015); Colombia & Nigeria (February 2015); Bangladesh & Maldives (March 2015); DR Congo, DPR Korea & The Gambia (April 2015); Madagascar (May 2015); Cote d'Ivoire, Kiribati, St Vincent and the Grenadines & Sudan (June 2015); Bhutan, Cameroon, Niger, Pakistan & Sri Lanka (July 2015)

* Includes introductions in some parts of the country only

Data source: WHO/IVB Database, as of 03 August 2015
Map production Immunization Vaccines and Biologicals (IVB), World Health Organization

IPV introduced in DR Congo. Copyright: Gavi/Phill Moore

OBJECTIVE 3 | CONTAINMENT AND CERTIFICATION

Situation analysis:

National laboratory survey and inventory activities for materials infected or potentially infected with wild polioviruses were completed in all countries of the WHO Western Pacific, European and American Regions by 2008. In 2009, the third version of GAP assumed concomitant eradication of all three WPV types and required the containment of all WPV to be in place before the containment of all OPV/Sabin-derived polioviruses, expected at the time of OPV cessation. The renewed discussions on OPV cessation that were prompted by the confirmation of cVDPVs in turn led to the revision of the third edition of GAP. The new Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of OPV use (GAPIII) outlines biorisk management requirements and other critical safeguards for handling wild-, Sabin- and Sabin-derived polioviruses following eradication and eventual OPV cessation.

In the second half of 2014, the strategic approach and plan to fully align GAPIII with the major milestones and timelines of the Endgame Plan were finalized and endorsed by SAGE. Importantly, the revised GAPIII describes timely and specific requirements for polio type 2 containment, critical for the successful switch from trivalent to bivalent OPV. Additionally, it sets the general parameters for the long-term containment of polioviruses following the cessation of all OPV use expected sometime after 2019.

Focus for 2015:

- Ensure the verification of eradication of wild poliovirus type 2 through the Global Commission for Certification of the Eradication of Poliomyelitis (GCC)
- Implement appropriate containment of type 2 polioviruses in essential facilities, in preparation for the phased removal of OPV beginning with the switch from trivalent OPV to bivalent OPV in 2016.

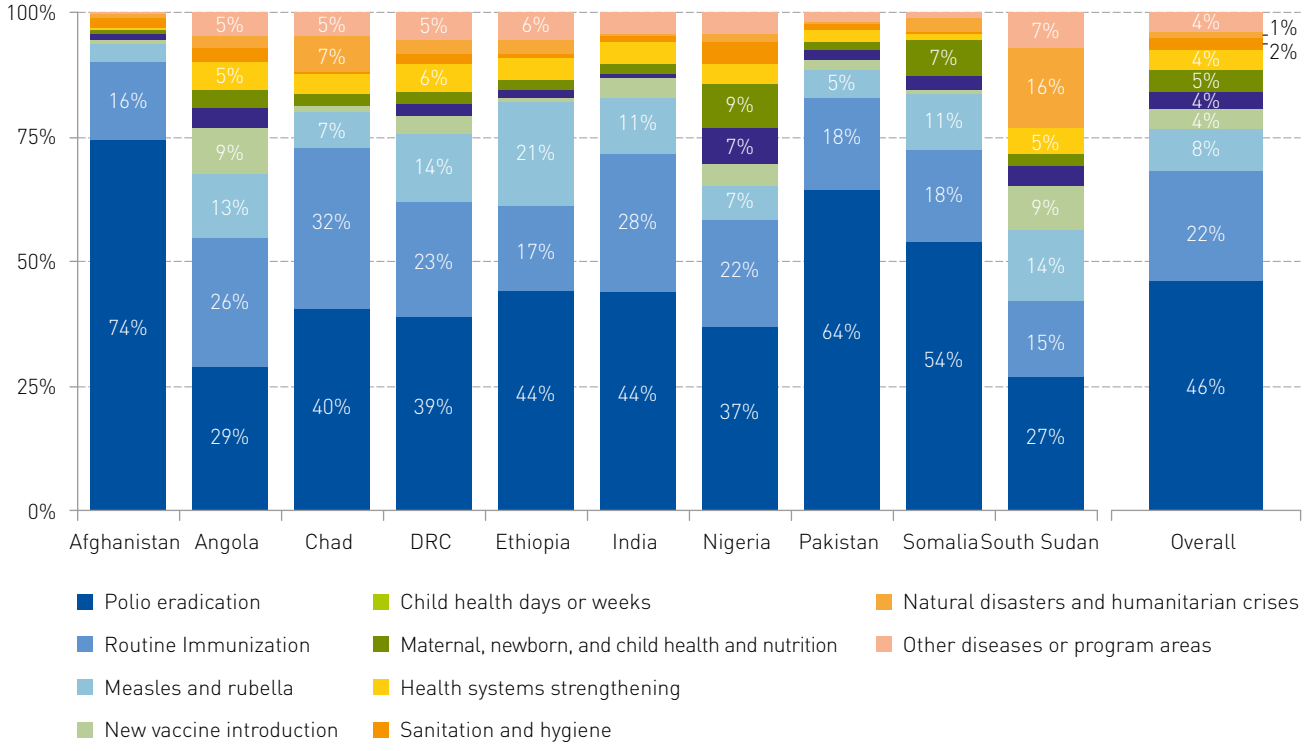
OBJECTIVE 4 | LEGACY PLANNING

Situation analysis:

The principle objective of the legacy planning work is to ensure that the investments made in the cause of polio eradication are built on to benefit other development goals, through a comprehensive programme of work to document and transition the GPEI's knowledge, lessons learned and assets. As an example, the infrastructure used in polio eradication is helping to support the response to the Ebola outbreak in west Africa, by providing staff for surge support, conducting disease surveillance, contact tracing, data management, logistics and supply distribution, and outbreak management. In Nigeria, the assets and experience of the dedicated polio eradication emergency operations centre and staff were instrumental in helping to stop the Ebola outbreak in that country.

The polio network routinely conducts surveillance for other diseases of public health importance, including measles, yellow fever, neonatal tetanus and avian influence. With local knowledge of communities, health systems and government structures, the polio network's technical capacity in disease surveillance and planning of large-scale operations often helps sustain international and national relief efforts. The extensive polio eradication network at country-level has proved itself repeatedly to be uniquely equipped to help support broader public health goals. Polio staff at country-level spend on average 50% of their time working on strengthening routine immunization services. In Africa, this has helped reduce the burden of measles deaths by half over the past ten years. During this time, the number of children in the least developed areas of Africa and Southeast Asia who were reached with a wide range of lifesaving vaccines nearly doubled. As a result of the systematic administration of Vitamin A during polio vaccination campaigns, more than an estimated 1.5 million childhood deaths have been averted. The polio programme provides a critical contribution to strengthening routine health and immunization systems.

Estimated time allocation of polio personnel by country



1: RI-related activities are: RI, M&R, NVI, CHD, MNCH+N, HSS
Source: RI IMG Polio Survey; Polio Legacy Survey

In 2013, the GPEI established the legacy planning working group to manage the development of legacy planning, including to ensure the consultations and evidence base development necessary to inform the Global Legacy Framework. A draft of the Framework was approved by the Polio Oversight Board in December 2014.

Throughout 2014, stakeholder input was sought into the overall direction of the legacy planning work, to understand better the capabilities of the programme and its knowledge and to steer the legacy working group in directions that could be of benefit to other health priorities.

An evidence database continues to be compiled, definitively outlining the capabilities, functions, assets and contributions of the GPEI to other priorities. Other programmes already benefiting from the GPEI infrastructure in particular are disasters and crises systems, maternal and child health, sanitation and hygiene, child health days and new vaccine introductions. Critical activities polio staff are contributing to these areas include supporting routine immunization, disease surveillance, supply chain management and overall resource and capacity support. Detailed pilot planning missions were conducted in the Democratic Republic of the Congo and Nepal, to initiate legacy planning and to learn how transition planning could function in different settings.

It is anticipated that legacy planning will be conducted on a national basis following development of the Global Legacy Framework but that global priorities (e.g. emergency response capacity) will also be up for discussion.

Focus for 2015:

- Develop guidelines to help countries in the development of legacy plans.
- Finalize Global Legacy Framework.
- Ensure engagement with Member States, including through discussions at relevant policy bodies, notably the World Health Assembly and the Regional Committees. Plan a three-staged country-level process, focused on: planning and decision making, preparation and execution
- Provide focused legacy planning support to countries with significant polio resources (initial countries selected: India, Nepal, DR Congo and Nigeria)

Ebola outbreak control measures in Nigeria. Copyright: WHO /Andrew Esiebo

STRENGTHENING THE MANAGEMENT OF THE ENDGAME PLAN

Thanks to continued, generous support from the international development community, the GPEI has by end-2014 received US$ 2.23 billion in contributions, and was tracking an additional US$ 2.85 billion in pledges, against the overall 2013-2018 budget of US$ 5.5 billion. Full and rapid realization of all pledges would result in a remaining funding gap of US$ 451 million against the Endgame Plan.

Globally, the GPEI underwent significant management and administrative changes in the second half of 2014, following a comprehensive management review. Based on the findings of the review, the Polio Oversight Board adopted a number of recommendations to more rapidly and effectively achieve eradication. Of note is that a new finance and accountability committee is being established to ensure more rapid, comprehensive and transparent financial reporting for all stakeholders.

The GPEI is carrying out a mid-term review of the Polio Endgame Plan, which will assess progress to date and identity adjustments as needed, including budgetary adjustments. 2015 marks the mid-term point of the Endgame Plan 2013-2018, and therefore provides an important opportunity to review the Endgame Plan against the current situation and take steps to ensure polio can be eradicated as rapidly as possible. The purpose of the midterm review is to evaluate lessons learned, risks and priorities, and make recommendations on what strategic shifts are needed in order to reach eradication. Based on analysis against all four objectives and financing, the process will entail interviewing key stakeholders as well as representatives from the Polio Partners Group (PPG), the Independent Monitoring Board (IMB) and the Strategic Advisory Group of Experts on immunization (SAGE).

FINANCING THE ENDGAME PLAN

The achievements of 2014 in polio eradication have been made possible by the generous contributions of a wide range of donors, including: affected countries, individuals, donor governments and multilateral organizations. During 2014, donors continued to convert the pledges made at the Global Vaccine Summit in 2013 while new donors joined the GPEI with contributions totaling US$ 956 million. Donors and other stakeholders continued their strong engagement in the programme through the Polio Partners Group (PPG), co-chaired by the Canadian Ambassador and Permanent Representative to the United Nations in Geneva and the United Nations Foundation. The PPG continued to play a critical role in engaging development partners to ensure the necessary political commitment and financial resources to reach the goal of polio eradication. Two PPG meetings were held in 2014 at the Ambassadorial level, and one technical workshop where stakeholders provided input into the ongoing legacy planning process.

Contributions

The Arab Gulf Program for Development (AGFUND) provided US$ 36 000 as part of a three year grant to strengthen surveillance in Ethiopia.

Australia disbursed US$ 12.54 million and approved the release of the last tranche of its 2011-2014 commitment of AU$ 50 million at the end of 2014[1]. This took place a few months after the Rotary International Convention in Sydney in June 2014, where Prime Minister Tony Abbott confirmed Australia's AU$ 100 million pledge for polio eradication activities from 2014-2018.

The **Bill & Melinda Gates Foundation** provided an additional US$ 250 million in 2014 funding. US$ 80 million was also provided through a match grant to Rotary International as part of the ongoing fundraising partnership between the two organizations.

In 2014, the **Government of Canada** continued to deliver the C$ 250 million commitment made at the 2013 Vaccine Summit, disbursing approximately US$ 39 million for Afghanistan, the Democratic Republic of Congo, Nigeria, Pakistan[2] and global support for the implementation of GPEI Endgame Strategic Plan. Above and beyond its Vaccine Summit commitment, an additional US$ 1.8 million in humanitarian funding was contributed for Somalia to respond to the Horn of Africa outbreak. In May 2014, Prime Minister Harper hosted the Toronto Summit "Saving Every Woman Every Child: Within Arm's Reach", highlighting GPEI`s role in improving children's lives and highlighted the importance of immunization.

In addition to its role as a spearheading partner, the **US Centers for Disease Control and Prevention (CDC)** provided funding for OPV, operational costs and programme support to UNICEF and WHO. In December 2011, CDC activated its Emergency Operations Center (EOC) to scale-up CDC polio eradication activities in an emergency response mode for increased technical and management assistance in polio eradication priority countries. CDC continues to dispatch its epidemiologists, virologists and technical officers to assist polio-affected countries in implementing polio eradication activities. US Congressional appropriations to CDC for polio eradication in its 2014 fiscal year totaled US$ 151 million, of which US$ 87 million was allocated to WHO and UNICEF.

Chile made its first contribution to GPEI in 2014, donating US$ 30 000 to WHO in support of polio eradication activities in Egypt in the context of the Middle East outbreak response.

Estonia made a contribution of US$ 24 907 to UNICEF to support activities in Afghanistan bringing its total support to GPEI to US$ 186 853.

The **European Union** contributed US$ 6.79 million to UNICEF and WHO to respond to the Horn of Africa outbreak through DEVCO and US$ 4.08 million to the Middle East Outbreak through ECHO.

The **International Finance Facility for Immunization (IFFIm)** provided US$ 12.91 million for the establishment of a monovalent OPV stockpile.

Germany released $15.6 million dollars to UNICEF and WHO for polio eradication in Nigeria as as part of their 2013-2017 € 105 million commitment. An additional US$ 5.1 million dollars was provided to UNICEF for the Middle East outbreak response.

Further to the US$ 227 million loan taken by the Government of Pakistan to fund its eradication programme, the **Islamic Development Bank** disbursed US$ 69.11 million to WHO and UNICEF,

1 Payment received in Q1 2015
2 Payment received on 12 December 2013.

which helped support OPV procurement, campaign operations, surveillance and social mobilization in 2014, representing the single-largest source of support for the Pakistan programme.

At the Vaccine Summit and under its EU Presidency, **Ireland** announced €5 million in support of the Strategic Plan, demonstrating its renewed commitment to a polio-free world. Ireland disbursed €1 million in 2014/2015, bringing its disbursements under the present pledge to €3.9 million.

Japan continued to demonstrate its strong commitment to polio eradication. In 2014, Japan provided nearly US$ 10 million via UNICEF for polio eradication efforts in six countries: Afghanistan, Chad, Egypt, Niger, Pakistan and Somalia. The Government of Japan, together with JICA and the Bill & Melinda Gates Foundation, signed a JICA loan conversion for Nigeria of US$ 70.28 million in September 2014, following the successful introduction of a similar funding mechanism for Pakistan in 2011.

The **Korean Foundation for International Healthcare (KOFIH)**, a specialized organization under the South Korean Ministry of Health and Welfare, remains fully engaged in polio eradication efforts in Nigeria. In 2014, KOFIH provided US$ 1 million to WHO towards acute flaccid paralysis (AFP) surveillance activities in Nigeria. This grant was made possible by the Community Chest of Korea.

The **Principality of Liechtenstein confirmed its commitment to polio eradication efforts worldwide,** providing US$ 53 562.

Luxembourg contributed US$ 668 449 to WHO in support of polio eradication operations worldwide and donated $341 997 to WHO for polio activities in the context of the Middle East outbreak response.

Monaco released US$ 206 327 for activities in Niger and as well as US$ 27 360 for polio eradication operations worldwide. Monaco's total funding for polio eradication activities in Niger is over US$ 1.4 million.

Private philanthropists provided a total of US$ 50 million in 2014, US$ 48.4 million through the **National Philanthropic Trust,** and US$ 1.5 million to polio eradication operations in Yemen through the Swiss Philanthropy Foundation/Shefa Fund.

Nigeria provided over US$ 50 million in domestic resources in 2014, nearly 18% of the total financial resource requirements for polio eradication activities in the country.

Norway continued to provide critical, unspecified contributions to the GPEI. In 2014, the country provided US$ 7.33 million to WHO for polio eradication operations worldwide. As part of their pledge to GPEI, Norway also finalised an agreement with the Gavi, the Vaccine Alliance, for US$ 190 million for the introduction of IPV in Gavi-eligible countries.

H.E. Dr Ahmed bin Mohamed bin Obaid Al Saidi, Minister of Health of **Oman,** announced a US$ 5 million pledge to polio eradication efforts at the EMRO Regional Committee in October 2013. In February 2014, Oman disbursed US$ 3 million to WHO as a first contribution under this pledge.

Rotary International, in addition to being a spearheading partner of the GPEI, is also the second-largest private-sector donor. In June 2013 at its annual convention, Rotary International announced a pledge of up to US$ 175 million to be matched two-to-one by the Bill & Melinda Gates Foundation, which could raise an additional US$ 350 million. In 2014, Rotary disbursed US$ 123 million to the GPEI. By 2015, Rotary International will have contributed more than US$ 1.3 billion to the global effort.

In 2013, WHO and UNICEF signed agreements with the **Saudi Fund for Development** (SFD) for US$ 15 million, the final tranche of the Kingdom of **Saudi Arabia's** US$ 30 million commitment to ending polio in the Horn of Africa, Afghanistan, Pakistan and Yemen. In 2014, SFD released US$ 6 million. Saudi Arabia's support to the GPEI through 2015 totals US$ 34.16 million.

Switzerland continued to provide critical support to strengthen surveillance for poliovirus and management training in Chad, Democratic Republic of Congo and Ethiopia. Switzerland released US$ 630 000 as part of its US$ 1.9 million commitment over three years.

For the first time, **Turkey** contributed US$ 60 000 to polio eradication efforts worldwide.

At the Vaccine Summit, the **United Kingdom** announced a pledge of up to £ 300 million for polio eradication over 2013-2018. As part of that pledge, WHO signed a multi-year agreement for £ 238 million with the United Kingdom's Department for International Development (DFID), bringing essential, flexible funding to the programme. For 2014/2015, DFID disbursed £ 50 million to GPEI following a successful annual performance review. Also, as part of the Vaccine Summit pledge to GPEI, DFID provided funding of £ 30 million to Gavi, the Vaccine Alliance, to support the introduction of IPV in Gavi-eligible countries, as part of Gavi's

complementary role in the Endgame Plan. Finally, DFID supported WHO and UNICEF for the Middle East outbreak response with an additional £ 2 million in 2014.

In 2014, spearheading partner **UNICEF** provided significant funding to its country offices. In total, UNICEF provided more than US$ 17 million for polio eradication activities from core funding and UNICEF National Committees.

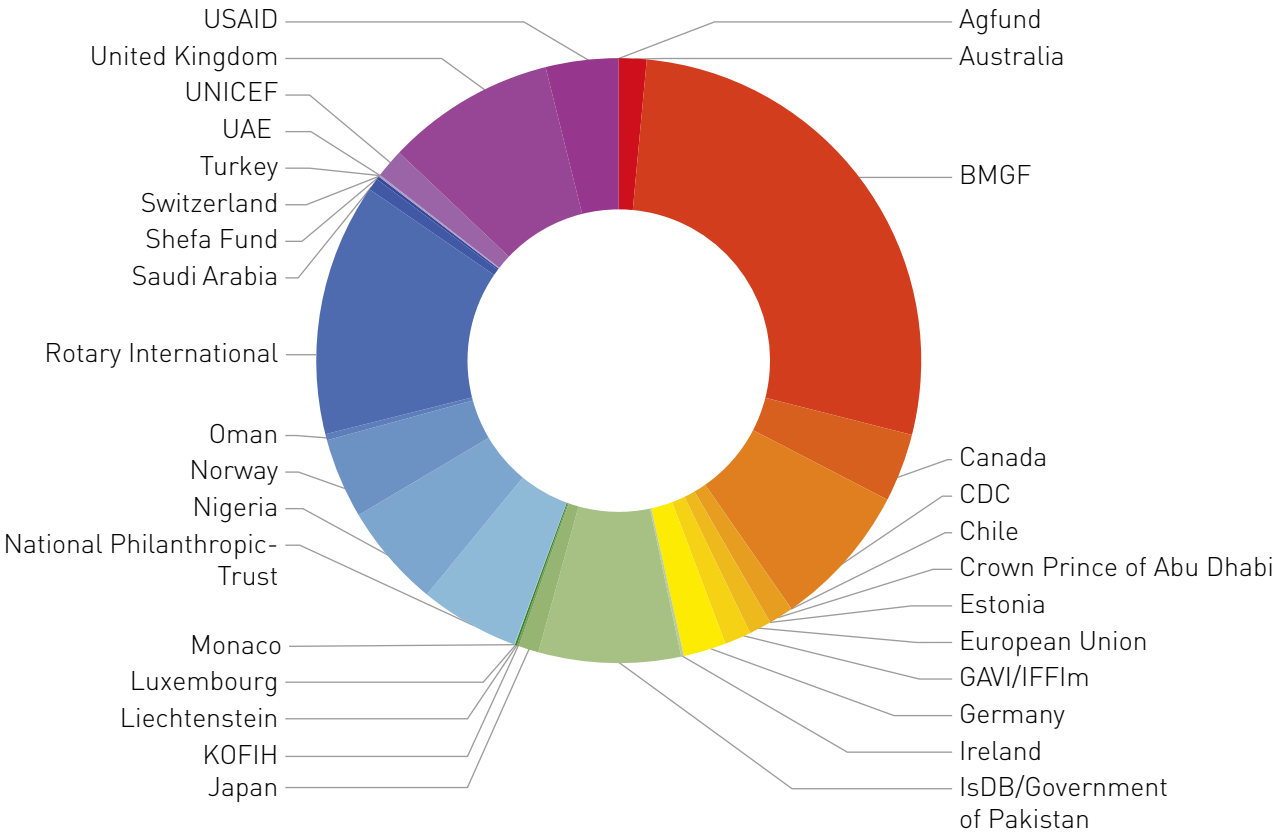
The US Congress in its fiscal year 2014, allocated US$ 59 million to the **United States Agency for International Development (USAID)** for polio eradication activities, of which US$ 35.4 million was disbursed to WHO and UNICEF to support social mobilization, surveillance and laboratory activities, outbreak response and monitoring in priority countries.

At the Vaccine Summit, the Crown Prince of Abu Dhabi, **Sheikh Mohammed bin Zayed al-Nahayan,** pledged a donation of AED 440 million (US$ 120 million) to support efforts to eradicate polio over the next five years, half of which benefits the GPEI directly. US$ 12 million was disbursed for Ethiopia, Kenya and Somalia, to support the Horn of Africa outbreak response in 2014. Overall, the Crown Prince has provided US$ 41 million to the GPEI, including US$ 17 million in 2011 for Afghanistan. Furthermore, under the Crown Prince's leadership, an innovative UAE Pakistan Assistance Programme has been set up, which complements WHO and UNICEF's efforts in some of the most difficult to reach areas in Pakistan.

The United Arab Emirates supported the Middle East outbreak response in Syria with US$ 317 860.

The GPEI provides regular updates on the status of pledged funds and new commitments both through the FRR publication and through its website, www.polioeradication.org.

External contributions 2014



ANNEX: EXPENDITURES 2014

In 2014, the expenditures of the GPEI programme were 12% below the budget set in July 2014. This pattern is largely similar to what was observed in 2013, and the drivers are mostly the same. By decreasing order of impact, the main factors were:

- A large part of the response to the Middle East outbreak, notably in Syria and Iraq was funded from humanitarian sources, which reduced the budgetary impact on GPEI.
- Late in 2014, the favourable evolution of exchange rate with the US dollar, either against currencies pegged to the Euro (e.g. CFA Francs used in many west and central African countries), or against currencies of commodity exporters affected by commodity price drops (e.g. Nigeria), reduced some of the programme's operational costs in some countries.
- A sizeable percentage of unfilled positions across the programme. The GPEI budget reflects full funding for all approved positions. Various partner agencies experience a vacancy rate that typically ranges from 5% to 15%. Given that the locations where GPEI deploys its staff are some of the most challenging, it is not unusual to observe vacancy rates of more than 20% in some geographies. This factor mostly affects the technical assistance and social mobilization elements of the budget, but also impacts campaigns, surveillance and other activities with a significant personnel component.
- Campaign delays or campaign scope reduction: GPEI sets a provisional calendar for supplementary immunization activities (SIAs) twice a year, based on an epidemiological risk assessment and budgets for its implementation. Planned campaigns can be delayed for a variety of decisions, ranging from governments' decision on timing (e.g. Ethiopia), delays in arrival of funds at the local level (e.g. Somalia), security concerns (e.g. Central African Republic), or, notably in 2014, the Ebola outbreak in West Africa (planned campaigns delayed in Guinea, Liberia, Sierra Leone, Mali and Senegal).

Summary of external resource requirements and expenditure by major category of activity, 2014

(all figures in US$ millions)		WHO	UNICEF	OTHERS *
IMMUNIZATION ACTIVITIES	**2014 EXPENDITURE TOTAL**	**EXPENDITURE**	**EXPENDITURE**	**EXPENDITURE**
Planned OPV Campaigns (OPV)	$196		$196	
Planned OPV Campaigns (WHO - Operational Cost)	$301	$269		$32
Planned OPV Campaigns (UNICEF - Operational Cost)	$35		$35	
Planned OPV Campaigns (Social Mobilization)	$51		$40	$11
Complementary OPV Campaigns				
IPV in Routine Immunization	$68			$68
Sub-Total	**$651**	**$269**	**$271**	**$111**
SURVEILLANCE AND RESPONSE CAPACITY				
Surveillance and Running Costs (incl. Security)	$62	$62		
Laboratory	$6	$6		
Environmental Surveillance				
Emergency Response (WHO)				
Emergency Response (UNICEF)				
Stockpiles for Emergency Response				
Sub-Total	**$68**	**$68**		
CONTAINMENT AND CERTIFICATION				
Certification and Containment	$8	$8		
Surveillance and Lab enhancement for Certification				
Sub-Total	**$8**	**$8**		
CORE FUNCTIONS AND INFRASTRUCTURE				
Ongoing QI, surge capacity,etc...	$151	$131		$20
Technical Assistance (WHO)				
Technical Assistance (UNICEF)	$26		$26	
Community Engagement and Social Mobilization	$46		$46	
R&D and Technology Transfer	$3	$3		
Sub-Total	**$225**	**$133**	**$72**	**$20**
SUBTOTAL DIRECT COSTS	**$952**	**$478**	**$343**	**$131**

** CDC, GAVI, GoN*

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