ANNUAL REPORT

2015

POLIO GLOBAL ERADICATION INITIATIVE

ERADICATION WITHIN REACH...

World Health Organization

Rotary

CDC

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Cover photo: A child proudly displays her fingermark, proving she has been vaccinated against polio. © WHO Afghanistan

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ACRONYMS

bOPV	Bivalent oral polio vaccine
CCS	Containment certification scheme
CDC	US Centers for Disease Control and Prevention
cVDPV	Circulating vaccine-derived poliovirus
DFID	UK Department for International Development
EOC	Emergency Operations Centre
GAPIII	WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use
GCC	Global Commission for the Certification of the Eradication of Poliomyelitis
GPEI	Global Polio Eradication Initiative
IPV	Inactivated polio vaccine
OPV	Oral polio vaccine
OPV2	Oral polio vaccine type 2
PPG	Polio Partners Group
SAGE	Strategic Advisory Group of Experts on immunization
tOPV	Trivalent oral polio vaccine
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAPP	Vaccine-associated paralytic poliomyelitis
VDPV2	Vaccine-derived poliovirus type 2
WHO	World Health Organization
WPV	Wild poliovirus
WPV2	Wild poliovirus type 2

EDITOR'S NOTE
September 2016

The GPEI Annual Report 2015 provides a historical record and epidemiological summary of the global polio eradication effort during the calendar year 2015. As referenced in the report, Nigeria was removed from the list of endemic countries in September 2015, following no detection of wild poliovirus cases since July 2014.

In August 2016, three new cases due to wild poliovirus type 1 (WPV1) were detected from Borno state, Nigeria. Genetic sequencing of the isolated viruses indicate they are most closely linked to WPV1 last detected in Borno in 2011, indicating the strain has been circulating without detection since that time. The Government of Nigeria immediately launched an aggressive outbreak response and declared the outbreak a national public health emergency. At the same time, additional measures are being implemented to strengthen subnational surveillance sensitivity. The response is part of a broader regional outbreak response within the context of the humanitarian emergency in the region, coordinated with neighbouring countries, in particular the Lake Chad sub-region, including Chad, northern Cameroon, southern Niger and parts of Central African Republic. At the Regional Committee for Africa on 21 August 2016, Health Ministers declared the polio outbreak to be a regional public health emergency for countries in the Lake Chad sub-region. Detection of these cases underscores the risk posed by low-level undetected transmission, and of the urgent need to strengthen subnational surveillance everywhere.

Although confirmation of these cases falls outside of the 2015 reporting period of this report, the editors felt its importance warranted an editorial note, placing the epidemiological situation in 2015 in the context of 2016. For more and up-to-date information on the evolving situation, please visit www.polioeradication.org.

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WHAT WE WANT YOU TO TAKE AWAY FROM THIS REPORT...

Global Polio Eradication Initiative – The worldwide eradication of a disease

- Polio is a devastating disease, which paralyses children for life.
- There is no cure for polio – but a simple and effective vaccine protects a child for life.
- In 1988, a global movement was started to ensure that every child is vaccinated against polio.
- At that time, every year more than 350 000 children were paralysed by the disease, in more than 125 countries.
- In 2015, only 74 cases were reported, from just 2 countries: Pakistan and Afghanistan.
- The world has never been closer to being polio-free. But if we do not succeed, polio will come roaring back. Within ten years, 200 000 children could again be paralysed all over the world – every single year!
- Please help us eradicate polio once and for all. For just US$ 0.50, you can protect a child for life against this terrible disease.

Together, let's achieve something historic!

Let's make sure that no child will ever again be paralysed by polio.

EXECUTIVE SUMMARY

ANOTHER YEAR CLOSER TO A POLIO-FREE WORLD

Progress in 2015 laid the groundwork for a final push towards a polio-free world.

Looking back on 2015, that year may well be seen as the time the tide irreversibly turned on polio. From the removal of Nigeria from the list of polio endemic countries, to the declaration of wild poliovirus type 2 (WPV2) eradication, to the closure of several outbreaks, progress against polio has accelerated in its remaining strongholds. The finishing line is in sight.

Wild poliovirus (WPV) is more geographically constrained than it has been at any point in recorded history. In 2015, 74 WPV cases were reported from the only two remaining polio endemic countries, Pakistan and Afghanistan, compared to 359 cases reported in nine countries in 2014.

POLIO-FREE NIGERIA

In 2015, the three remaining polio endemic countries were reduced to two.

Nigeria reached one year without WPV on 24 July 2015 and was removed from the endemic country list in September. August 2015 marked one year without any WPV across the entire African continent (the most recent case occurred in Somalia). The hard work must continue if Africa is to remain polio-free; in Nigeria and other at-risk countries in Africa, the focus must shift from stopping transmission to building resilience. The risk of reinfection remains high until the remaining endemic reservoirs in the world also achieve success.

PROGRESS IN AFGHANISTAN AND PAKISTAN

Cases in Afghanistan remained low in 2015, with a total of 20 cases compared to 28 in 2014.

While in 2014 most cases in Afghanistan came from cross-border transmission from Pakistan, this year saw endemic cases in areas of the south and east. Vast improvements were seen in Pakistan, with more than 80% fewer cases in the country than in 2014. In part, this is thanks to the establishment of Emergency Operations Centres (EOCs) at all levels, operating under the auspices of the National Emergency Action Plan overseen by the Prime Minister's office, and which serves as a platform for increased government ownership of the polio programme.

POLITICAL COMMITMENT

In May, the Sixty-eighth World Health Assembly adopted a landmark resolution to end polio once and for all. This puts into place all the necessary building blocks to complete the Polio Eradication & Endgame Strategic Plan 2013-2018 (the Endgame Plan) and urges all Member States to fully implement and finance it.

SECURING A LASTING POLIO-FREE WORLD

THE SWITCH

To reach a polio-free world, all types of polioviruses must be stopped. While WPV cases are at an all-time low, circulating vaccine-derived polioviruses (cVDPVs) are increasingly significant in the Endgame Plan.

In 2015, WPV2 was declared eradicated; no case had been reported anywhere in the world since 1999. However, the type 2 virus continues to paralyse children – not due to the wild virus, but to the vaccine-derived strain.

This was one of the factors that enabled the Strategic Advisory Group of Experts on immunization (SAGE) to give the go-ahead for the globally synchronized switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) in April 2016. The switch plays an important role in preventing the emergence of new cVDPVs.

In 2015, six countries were affected by cVDPV outbreaks: Guinea, Lao People's Democratic Republic, Madagascar, Myanmar, Nigeria and Ukraine. These outbreaks underline the fact that populations continue to be under-immunized. In the same year, more countries were affected by cVDPVs than by WPVs, giving them a greater precedence and illustrating the importance of the 2016 tOPV to bOPV switch.

CONTAINING POLIOVIRUSES

With WPV2 officially declared eradicated, countries continue to intensify efforts to implement the appropriate containment of polioviruses in facilities that need to retain them. As type 2 is an eradicated pathogen, the priority is to ensure the containment of this strain, but countries are implementing containment requirements for all strains as outlined in the *WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use* (GAPIII).

TRANSITIONING THE GLOBAL POLIO ERADICATION INITIATIVE

Planning also continued to ensure that the polio infrastructure will pay dividends for other health programmes once polio has been eradicated. Over the last 26 years, the Global Polio Eradication Initiative (GPEI) has mobilized and trained millions of health-care workers and volunteers, accessed households untouched by other health initiatives and established a global surveillance and response capacity that has huge potential to contribute to future health objectives. Countries with a strong polio eradication presence have begun to plan for the transition of the polio infrastructure to other programmes; at the same time, the polio infrastructure has already strengthened routine immunization and reached remote children with other health services, and it was integral in fighting Ebola in western Africa.

LOOKING AHEAD

In the home stretch, it is more important than ever to maintain the momentum that has brought such achievement. To fully eradicate poliovirus and remove the burden of polio from all future generations, high immunization coverage is essential. Surveillance must be improved even further to ensure polio is rooted out from all existing reservoirs. Funding must continue until every last case is found.

The year 2015 saw remarkable progress in the fight against polio. With continued drive and commitment, even more can be achieved in 2016.

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STOPPING POLIO TRANSMISSION

STOPPING POLIO TRANSMISSION

CURRENT SITUATION – PROGRESS IN 2015 LAID THE GROUNDWORK FOR A FINAL PUSH TOWARDS A POLIO-FREE WORLD.

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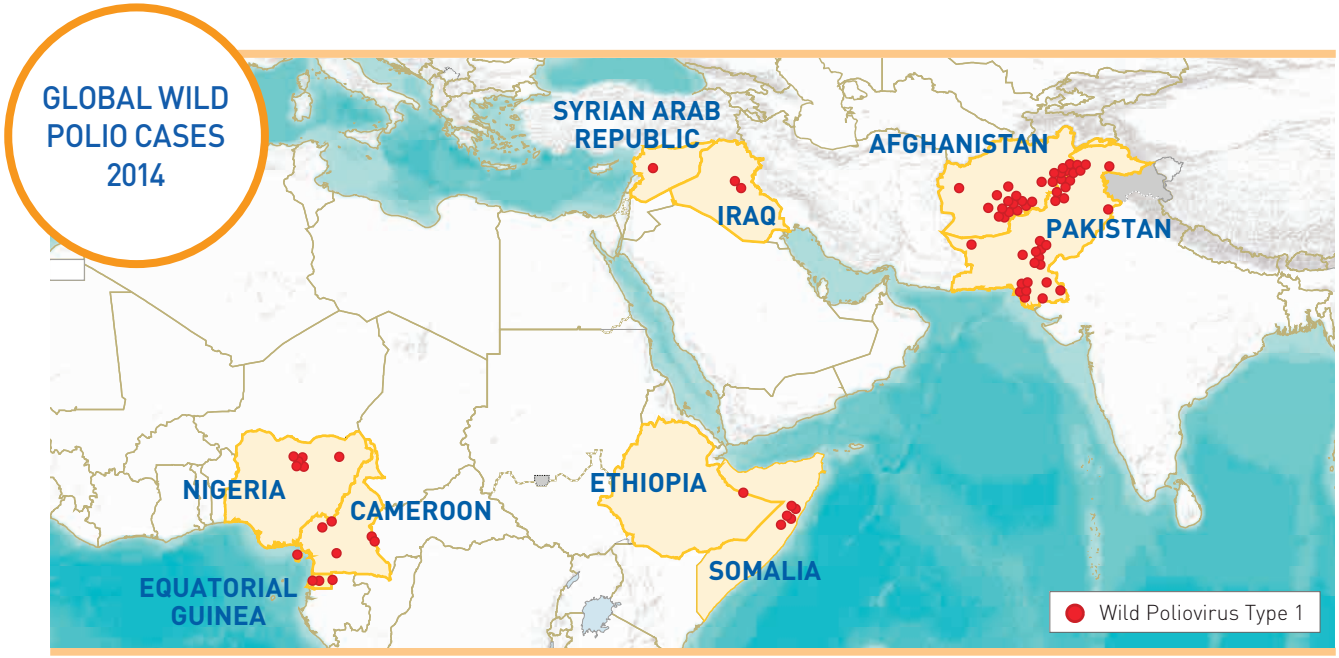

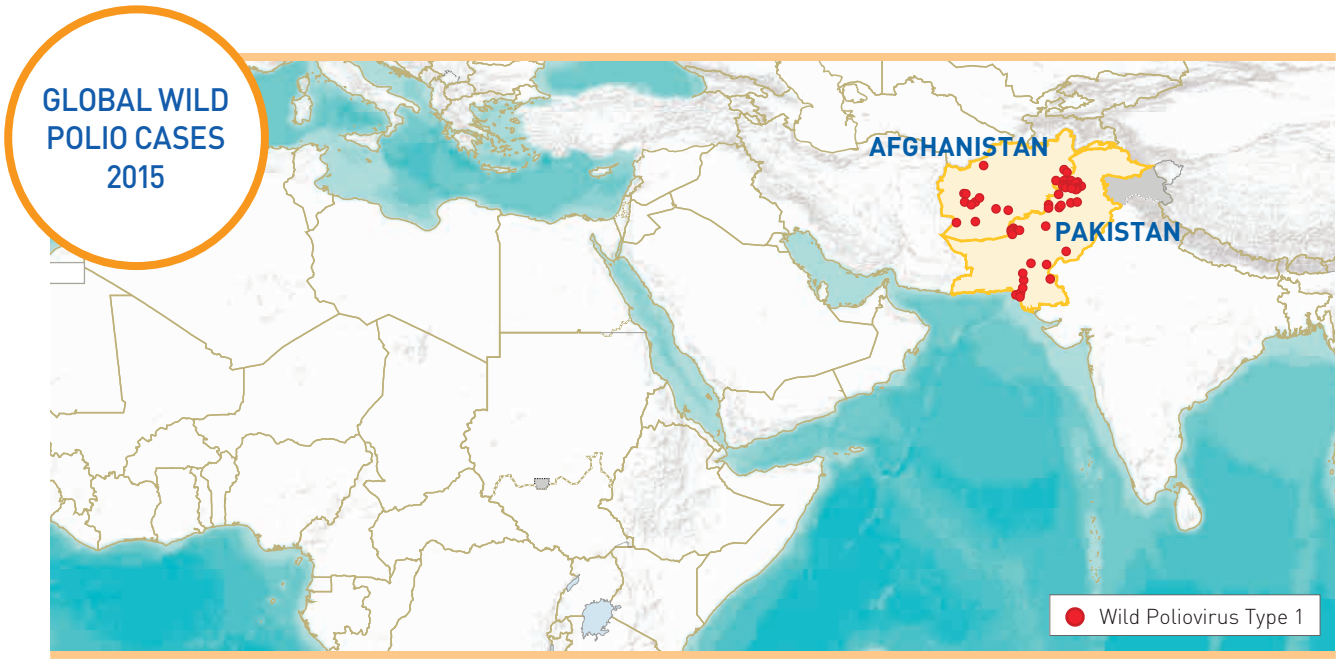

POLIO-FREE NIGERIA

In 2015, the three remaining polio endemic countries were reduced to two.

After many years of determination and hard work, Nigeria reached one year without WPV on 24 July 2015 and was removed from the endemic country list in September. With large populations in remote, hard-to-reach areas, as well as regional insecurity, success in Nigeria was achieved thanks to renewed political commitment and attention to detail at every level of the programme.

August 2015 marked one year without any WPV across the entire African continent (the most recent case occurred in Somalia). The hard work must continue if Africa is to remain polio-free; in Nigeria and other at-risk countries in Africa, the focus must shift from stopping transmission to building resilience. The risk of reinfection remains high until the remaining endemic reservoirs in the world also achieve success.

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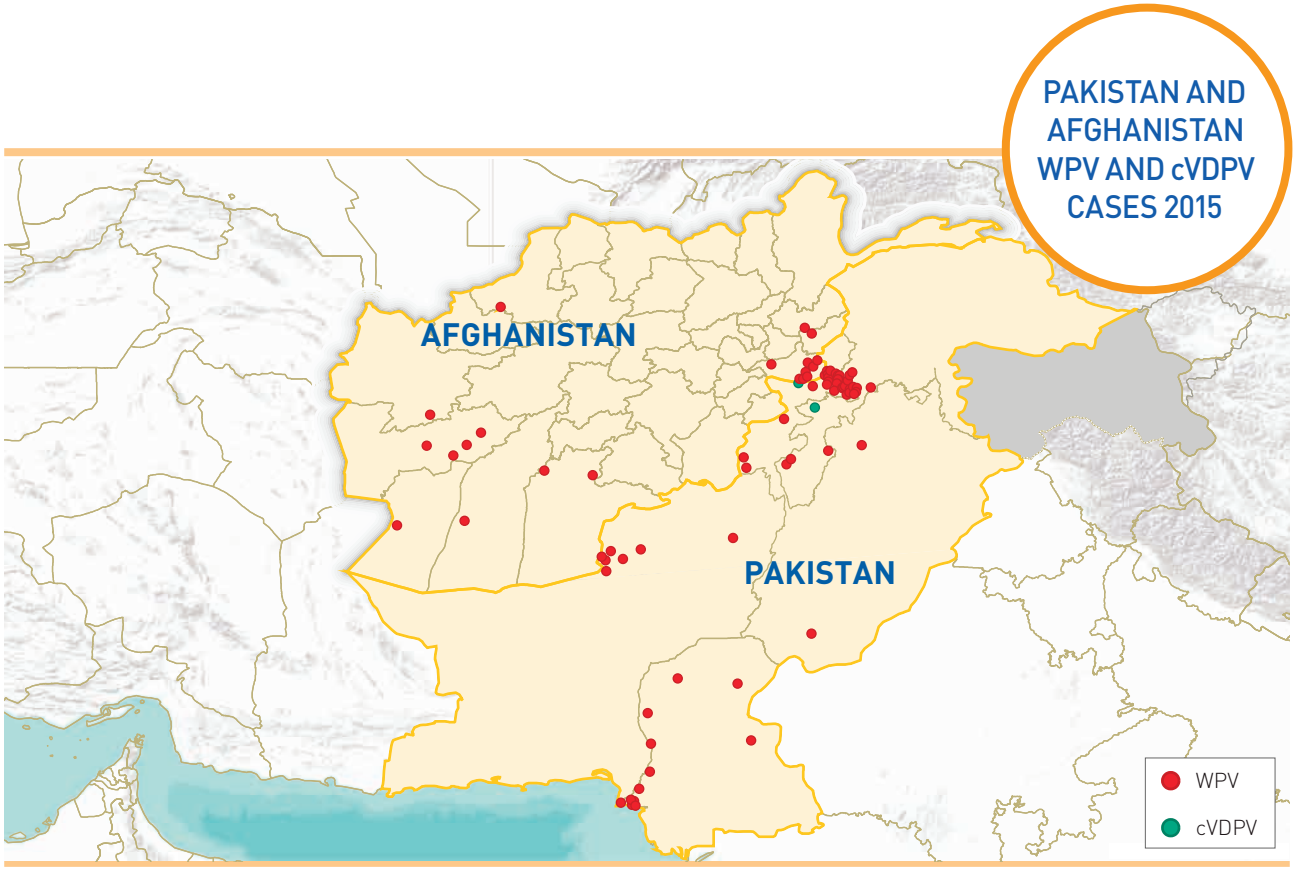

PROGRESS IN AFGHANISTAN AND PAKISTAN

Cases in Afghanistan remained low in 2015, with a total of 20 cases compared to 28 in 2014. While in 2014 most cases in Afghanistan came from cross-border transmission from Pakistan, this year saw endemic cases in areas of the south and east. Security threats continued to pose a threat to reaching children with vaccines in some areas of the country, but health-care workers and volunteers continued to work tirelessly to protect children everywhere.

Vast improvements were seen in Pakistan, with more than 80% fewer cases in the country than in 2014. In part, this is thanks to the establishment of Emergency Operations Centres (EOCs) at all levels, operating under the auspices of the National Emergency Action Plan overseen by the Prime Minister's office, and which serves as a platform for increased government ownership of the polio programme. The EOCs have played an important role in the implementation of new strategies, such as health camps, which have reached almost 350 000 people in high-risk areas, with additional health services alongside polio vaccines in 2015. Encouragingly, the number of inaccessible children declined to 35 000 in comparison with 300 000 in 2014. While this gives much cause for optimism, environmental surveillance showed widespread transmission continues in several provinces. Pakistan must leverage the low season to the best of its ability if it is to succeed in eliminating transmission in 2016.

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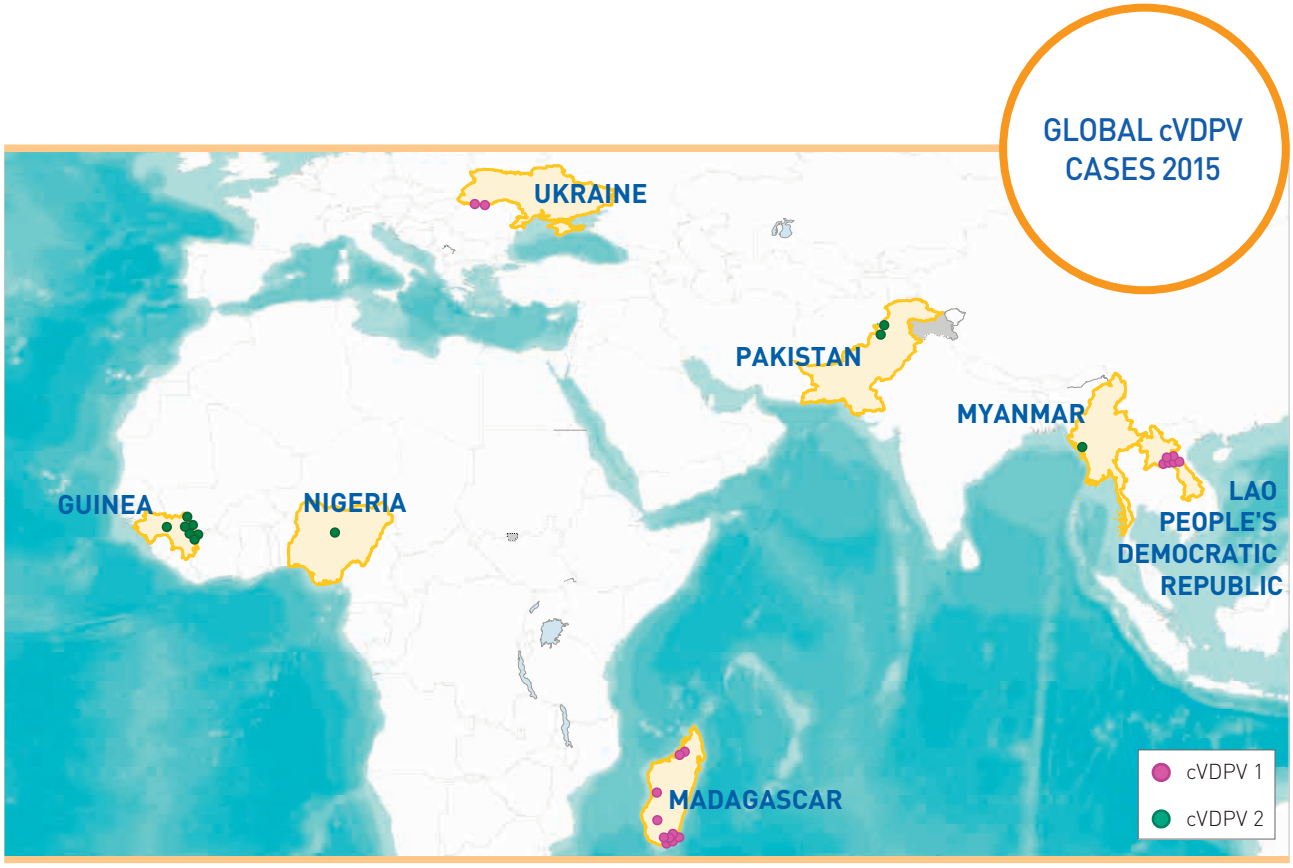
In both countries, innovative approaches are focusing on identifying area-specific reasons for continued 'missed children', and implementation of area-specific solutions in particular in tier 1 (high risk) districts of Pakistan and low-performing districts (LPDs) of Afghanistan. Community-based volunteer strategies such as use of field community volunteers (FCVs) in Afghanistan and continuous community-protected vaccination (CCPV) in Pakistan help ensure that polio vaccinations and other health interventions reach communities in the most relevant and culturally-appropriate manner.



THE INCREASING IMPORTANCE OF CIRCULATING VACCINE-DERIVED POLIOVIRUSES

To reach a polio-free world, all types of polioviruses must be stopped. While WPV cases are at an all-time low, circulating vaccine-derived polioviruses (cVDPVs) are taking on an increasing importance with more countries affected by cVDPV than WPV in 2015.

In 2015, wild poliovirus type 2 (WPV2) was declared eradicated; no case had been reported anywhere in the world since 1999. However, the type 2 virus continues to paralyse children – not due to the wild virus, but to the vaccine-derived strain.

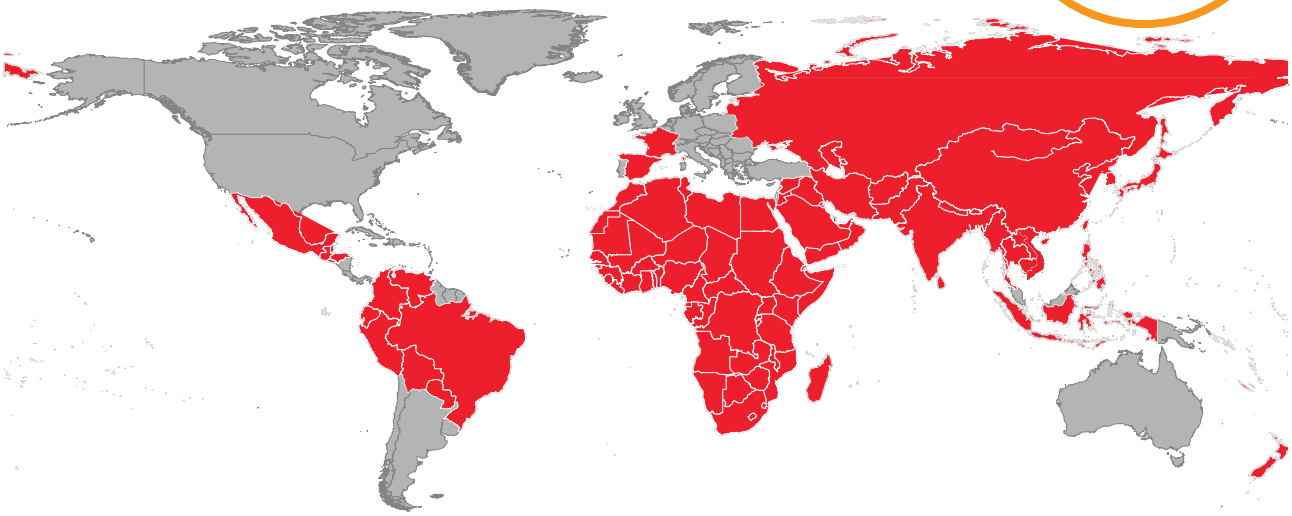
This was one of the factors that enabled the Strategic Advisory Group of Experts on immunization (SAGE) to give the go-ahead for the globally synchronized switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) in April 2016. The switch plays an important role in preventing the emergence of new cVDPVs.

In 2015, six countries were affected by cVDPV outbreaks: Guinea, Lao People's Democratic Republic, Madagascar, Myanmar, Nigeria and Ukraine. These outbreaks underline the fact that populations continue to be under-immunized. In the same year, more countries were affected by cVDPVs than by WPVs, giving them a greater precedence and illustrating the importance of the 2016 tOPV to bOPV switch.

Recognizing the growing importance of cVDPVs in the Endgame Plan, the temporary recommendations issued in 2014 through the Public Health Emergency of International Concern, previously limited to countries with WPV, were extended to countries also affected by cVDPVs.

SUMMARY OF GLOBAL PROGRESS SINCE 1988

GLOBAL POLIO ENDEMIC COUNTRIES 1988



GLOBAL POLIO ENDEMIC COUNTRIES 2015

In 1988, at the annual World Health Assembly, the Global Polio Eradication Initiative (GPEI) was formed by Rotary International, World Health Organization (WHO), US Centers for Disease Control and Prevention (CDC) and UNICEF.

At the time, more than 125 countries around the world were endemic to polio and every year more than 350 000 children were paralysed for life by the virus. Today, only two countries remain endemic (Pakistan and Afghanistan) and, in 2015, 74 cases of polio were reported worldwide. Only one wild serotype continues to be detected (WPV type 1); WPV2 was officially declared eradicated and no case of polio due to WPV type 3 has been detected anywhere in the world since 2012. The world stands on the brink of being polio-free, with fewer cases reported from fewer areas in fewer countries than ever before.

The GPEI has become the world's largest internationally-coordinated public health initiative in history. Thanks to it, more than 16 million people are walking today who otherwise would have been paralysed. An estimated 1.5 million childhood deaths have been prevented through the systematic administration of vitamin A during polio immunization activities. A global network of more than 20 million volunteers administer polio vaccines and other life-saving medicines to more than 400 million children worldwide every year. Over the next 20 years, more than US$ 50 billion will be saved (most in developing countries) as a result of the GPEI. Most importantly, no child will ever again be affected by lifelong paralysis from this terrible disease.

ORAL POLIO VACCINE WITHDRAWAL AND ROUTINE IMMUNIZATION STRENGTHENING

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ORAL POLIO VACCINE WITHDRAWAL AND ROUTINE IMMUNIZATION STRENGTHENING

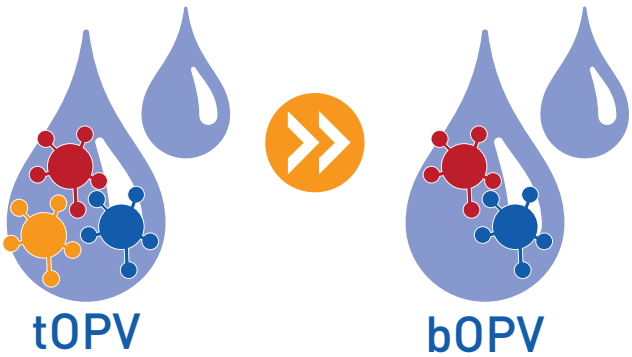
SITUATION ANALYSIS

In 2015, preparations accelerated for the globally synchronized switch from tOPV to bOPV, in which 155 countries are to change the vaccine administered in their routine immunization programmes. In October 2015, SAGE reaffirmed that the switch should proceed as planned in April 2016. All countries selected a date between 17 April and 1 May on which to make the switch.

RATIONALE FOR THE SWITCH

There are two major reasons for the global switch. First, as long as the oral polio vaccine (OPV) remains in use in the world, the risk of generating new cVDPVs exists. These are exceptionally rare strains of poliovirus that occur when the vaccine virus has been able to circulate unimpeded in a community long enough for it to mutate and reacquire pathogenicity. This is only possible if there are a sufficiently high number of unimmunized or under-immunized individuals in a community to allow the virus to survive during this time. As such, cVDPVs are not due to a problem with the vaccine, but to the low coverage of the vaccine. As eradication of the wild virus approaches, cVDPVs become increasingly important, not because they are increasing in number, but because WPV cases are decreasing, with the consequence that the proportion of cases that are vaccine-derived increases.

The switch



The second reason for the switch is to mitigate cases of vaccine-associate paralytic poliomyelitis (VAPP). While OPV is regarded as highly safe and effective, in extremely rare cases (approximately 1 in every 2.7 million first doses) the vaccine can cause paralysis. Around 30% of cases of VAPP are associated with the type 2 component of OPV. As such, these cases should decrease following the withdrawal of this component in the tOPV to bOPV switch.

INACTIVATED POLIOVIRUS VACCINE INTRODUCTIONS

A total of more than 100 countries had introduced inactivated polio vaccine (IPV) into their routine immunization systems by the end of 2015. Importantly, by the end of the year all of the highest risk countries had introduced IPV, including Nigeria in February, Pakistan in July and Afghanistan in September.

The globally constrained supply of IPV was aggravated yet further in 2015, owing to increased difficulties in scale-up. This means some lower-risk countries will be delayed in introducing IPV until late 2016 and 2017. While not optimal, IPV plays a limited role in stopping the transmission of poliovirus due to the fact that it infers relatively poor mucosal immunity. The main role of IPV is to prevent paralysis in the event of an outbreak. Transmission will be controlled via the release of a global stockpile of monovalent oral polio vaccine type 2, authorized by the Director-General of WHO, should an outbreak of type 2 poliovirus occur after the switch.

Additionally, the GPEI is continuously reviewing the global supply situation and prioritizing available supply for allocation to the highest risk areas. Mechanisms to instigate dose-sparing strategies continue to be explored, including fractional dose IPV to optimize available supply. Research published in 2015 further contributed to the body of evidence that suggests two fractional doses of intradermal IPV infer better immunity than one full dose of IPV.

OPERATIONAL IMPLICATIONS OF THE SWITCH

In 2015 in the run up to the switch, countries managed their vaccine inventories to forecast demands for tOPV to minimize wastage following the switch. The bOPV has been approved for use in all countries with global supply of this vaccine secured.

NIGERIA – POLIO ERADICATION AND ROUTINE IMMUNIZATION STRENGTHENING

A joint programme of work with Gavi, the Vaccine Alliance, aims to strengthen routine immunization in 10 priority countries with significant polio resources and assets. One of these countries is Nigeria that, since its last case of polio reported in 2014, continues to benefit from the broader impacts of its polio eradication initiative. Prior to the joint programme of work with Gavi, challenges to achieving high routine immunization coverage included poor planning, the poor implementation of planned activities, inadequate supportive supervision, inadequate community involvement in immunization and poor funding of routine immunization activities.

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Intervention of the polio programme resulted in an improvement in diphtheria–tetanus–pertussis vaccine third dose coverage in 107 high-risk local government authorities from 33% to over 74%. What's more, the polio programme identified many remote, hard-to-access villages that had previously been chronically missed during vaccination rounds.

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CONTAINMENT AND CERTIFICATION

CONTAINMENT AND CERTIFICATION

SITUATION ANALYSIS

In September 2015, the GCC declared the global eradication of WPV2. © WHO

In September 2015, a landmark in the polio eradication effort was reached when the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC) declared that WPV2 had been eradicated. The last case of WPV2 was reported in India in 1999. In addition, WPV type 3 has not been detected worldwide since November 2012, raising hopes that this serotype has also been eradicated.

At the regional level, four out of six WHO regions have been certified polio-free. The African Region has not reported any case of WPV since August 2014 and is making progress towards polio-free certification. Regions can consider certification only when all countries in the area demonstrate the absence of WPV transmission for at least three consecutive years while surveillance meets certification standards.

The GCC's declaration that WPV2 is an eradicated agent paved the way for its appropriate containment in facilities that need to retain it, including polio vaccine production sites and research laboratories. Containment requirements are specified in the *WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use* (GAPIII), endorsed by the World Health Assembly in May 2015.

The deadline for completion of Phase I of GAPIII for WPV2 or VDPV2 materials was set for the end of December 2015. By then Member States had to:

- identify all facilities that handle or store WPV2 or VDPV2 materials;
- encourage facilities to destroy all unneeded WPV2 or VDPV2 materials and report on this destruction;
- designate facilities retaining needed WPV2 or VDPV2 materials and certify them against the containment requirements described in GAPIII.

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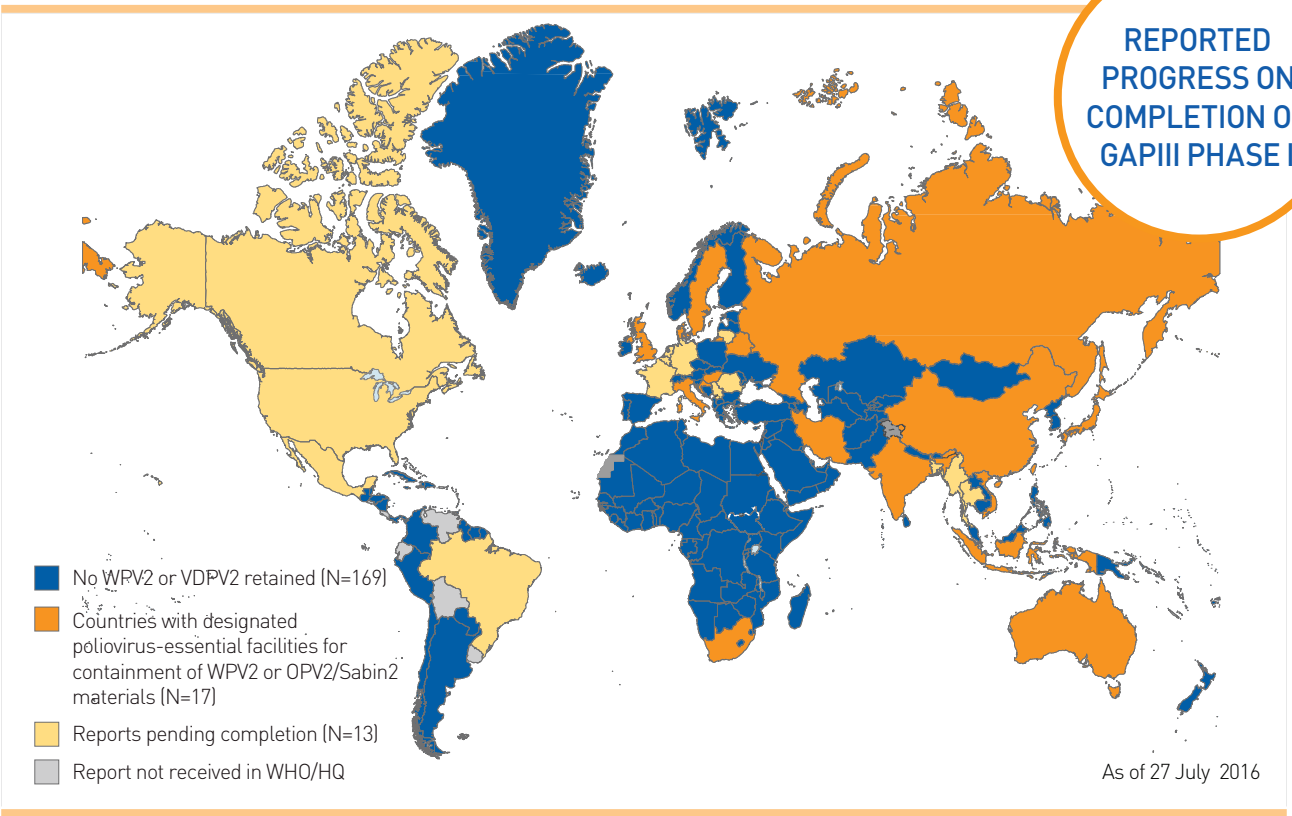
Countries are ensuring that polioviruses in laboratory settings are either destroyed, or – if they are needed – secured under appropriate containment levels.



Some territories administered by sovereign states may be at a different completion stage of containment.

As of 25 May 2016, 169 countries and territories reported that they no longer held any WPV2 or VDPV2 materials, and 20 countries designated 55 facilities to retain poliovirus type 2 materials. In addition, 17 submitted reports for which more information is still being collected (including three that have designated facilities to retain poliovirus type 2 materials).

Reducing the number of facilities retaining WPV2 materials is a primary measure to decrease the risk of release of polioviruses from these facilities. The risk of release of poliovirus from facilities is further reduced when facilities implement appropriate containment, and their hosting countries ensure the population's adequate immunization coverage and sanitary conditions in the area where the facilities are located, as described in GAPIII.

A newly developed GAPIII containment certification scheme (CCS) will guide countries towards the enactment of robust, transparent and equitable mechanisms for the containment certification of facilities retaining polioviruses.

The CCS also introduces a new option of interim containment certification that allows such important activities as vaccine production and critical research to continue, while the complete set of containment measures is being implemented.

FOCUS FOR 2016

By July 2016, Member States must:

- identify all facilities that handle or store OPV2/Sabin2 materials;
- encourage facilities to destroy all unneeded OPV2/Sabin2 materials and report on this destruction;
- designate facilities retaining needed OPV2/Sabin2 materials and certify them against the containment requirements described in GAPIII.

Just as for the containment of WPV2 or VDPV2 described earlier, the risk of release of poliovirus from facilities is further reduced when facilities retaining Sabin2 materials implement appropriate containment, and countries ensure the population's adequate immunization coverage and sanitary conditions in the area where the facilities are located.

National authorities for containment are responsible for certifying facilities against GAPIII. The adoption of the CCS will allow them to define adequate recording and reporting mechanisms to ensure confidence in the certification process and its ability to provide the required level of assurance to stakeholders that containment is appropriately addressed. The GCC will oversee the certification process at the global level.

SECURING THE LEGACY OF THE GPEI THROUGH TRANSITIONING ITS INFRASTRUCTURE

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SECURING THE LEGACY OF THE GPEI THROUGH TRANSITIONING ITS INFRASTRUCTURE

After polio eradication is certified, the GPEI will cease to exist, having achieved its goal. Building on the opportunity to use the investments made in the polio infrastructure and the lessons learned over the past three decades to strengthen other health programmes in the future is at the core of the transition planning objective (previously referred to as 'legacy' planning). In addition, incorporating essential polio functions, such as vaccination, containment and surveillance, into other programmes after the GPEI will be essential to maintain a polio-free world. The broader benefits that can be achieved with the human and technical infrastructure of the polio eradication Endgame Plan are already in evidence; in countries with strong polio programmes, polio staff and systems are supporting other global health needs, such as surveillance, routine immunization, maternal and child health requirements, and emergency and outbreak response. For example, during the October polio campaigns in Iraq, essential messaging was distributed about the cholera outbreak, and the EOC in Nigeria is playing a key role in the response to an outbreak of Lassa fever.

Progress towards transition planning ramped up in 2015, building on increased stakeholder input into transition planning work established since 2014. The Polio Partners Group (PPG) was used as a platform for engaging partners, including donors, in the discussion. In October, a programmatic workshop on transition planning and implementation was held, followed by an update at the PPG's December meeting. These meetings were an important opportunity for stakeholders to provide advice and input into the three core channels of transition planning: ensuring the mainstreaming of polio-essential functions into other programmes; documenting and sharing lessons learned; and identifying and planning opportunities for transitioning capacity and systems from polio eradication to other health programmes.

Vitamin A is given to a child during a polio vaccination campaign.

Polio-funded infrastructure supporting maternal and neonatal health projects and routine immunization services in Kano, Nigeria

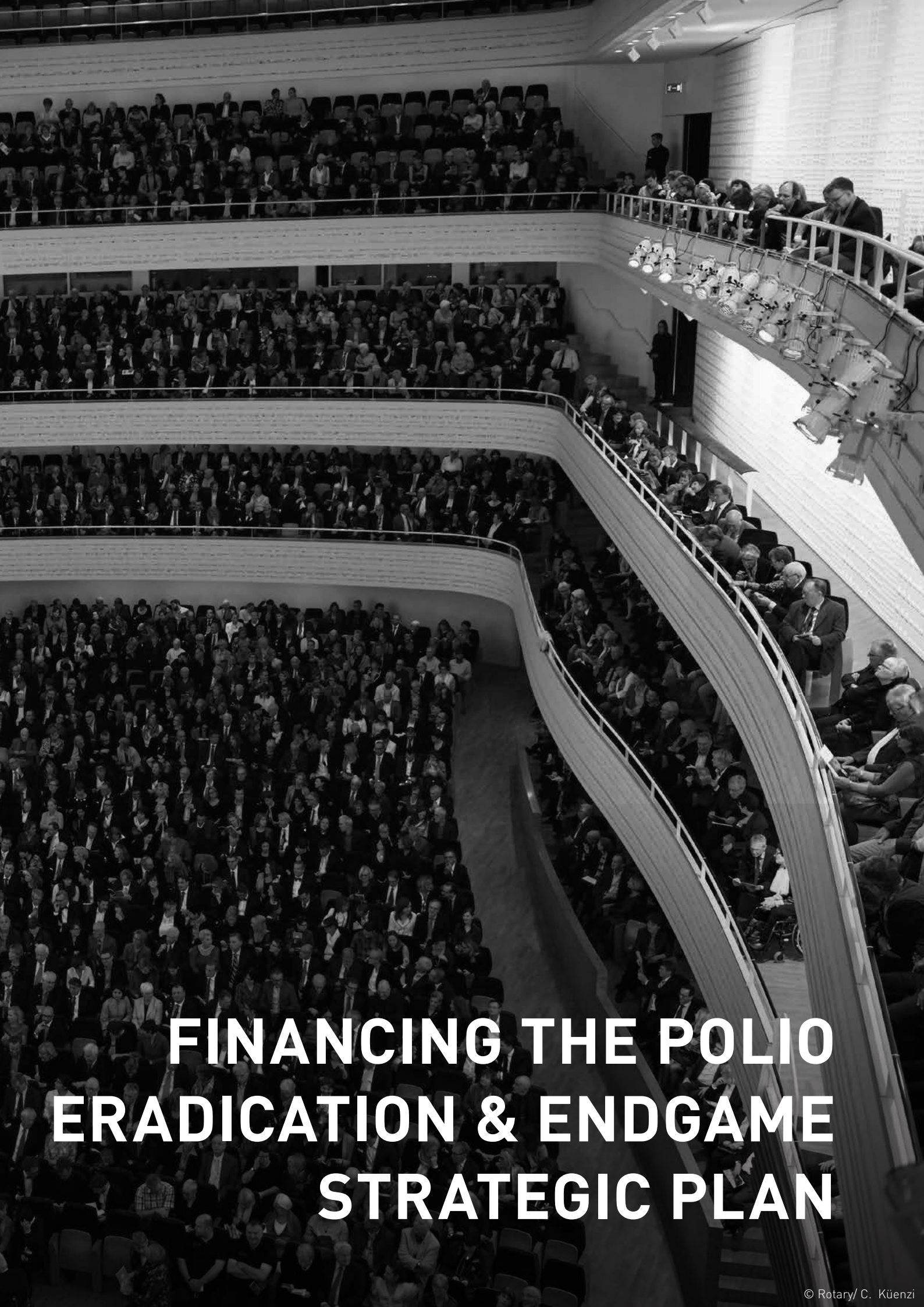
With over a year since the last case of WPV was reported on the African continent, 2016 is the year in which the transition planning process is to begin in earnest. Sixteen countries where polio infrastructure is significant have been selected as priorities for transition planning (Afghanistan, Angola, Bangladesh, Chad, the Democratic Republic of the Congo, Egypt, Ethiopia, India, Indonesia, Myanmar, Nepal, Nigeria, Pakistan, Somalia, South Sudan and Sudan). By the end of 2016, 14 of these countries (all except Afghanistan and Pakistan, where the focus remains squarely on interrupting transmission) should have finalized transition plans based on a mapping of the polio eradication assets in each country. These plans will ensure that polio-essential functions are mainstreamed and will identify opportunities for transitioning the infrastructure to other health programmes after eradication. Afghanistan and Pakistan will begin transition planning once they have interrupted transmission.

To help countries develop transition plans and to document and share lessons learned, the GPEI produced guidelines and distributed them to countries undergoing transition. In 2015, it was confirmed that the GPEI will also provide technical assistance to the priority countries. Though modest in relation to overall GPEI spending, this activity is important and is reflected in the GPEI budget for 2016–2019. The focus is on supporting country-level planning.

As transition planning primarily needs to occur at a national level, the leadership of heads of government and the engagement of GPEI and non-GPEI partners, donors, civil society organizations and many others are crucial. Responsibility for transition planning cannot lie in the hands of the GPEI alone.

As transition planning picks up speed, the importance of monitoring and guiding the process increases. Plans for a Polio Legacy Independent Monitoring Board were developed in the latter half of 2015. This body aims to independently monitor the progress of transition planning processes, timeliness and quality, and the role of GPEI and non-GPEI partners in building on the opportunity to make a significant and sustainable contribution to global health programmes.

END
POLIO
NOW



FINANCING THE POLIO ERADICATION & ENDGAME STRATEGIC PLAN

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FINANCING THE POLIO ERADICATION & ENDGAME STRATEGIC PLAN

Thanks to the strong and continued support of the international development community, the GPEI's 2015 budgetary requirements were fully met.

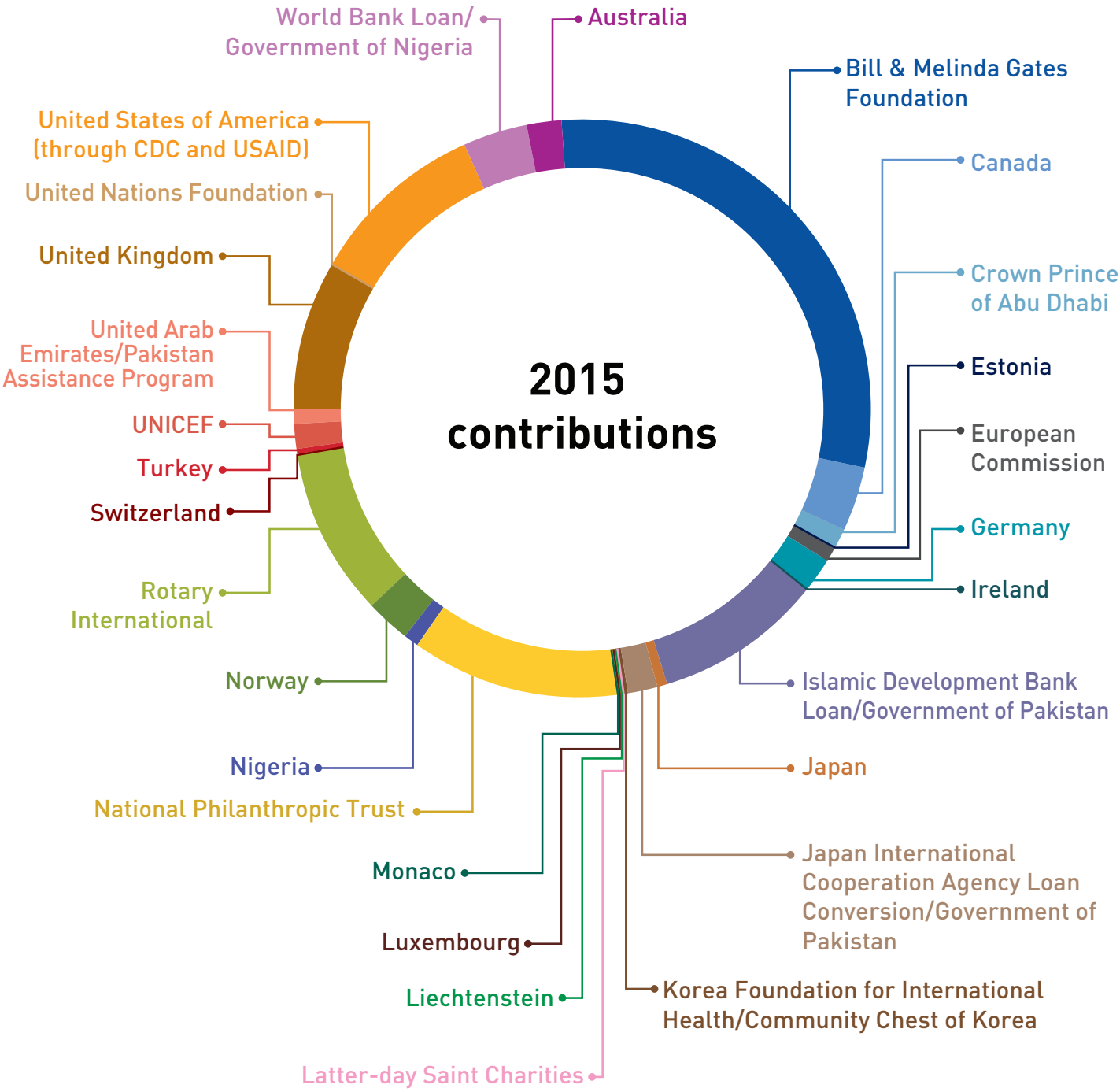
In 2015, a midterm review assessed progress against the Endgame Plan at its halfway point, and as part of this process evaluated the GPEI's future financial needs. Presented with the outcomes of this review, the Polio Oversight Board endorsed a revised financial scenario at its meeting in September 2015. The delay in achieving the interruption of WPV transmission has resulted in an additional year of intense polio eradication activities. This has increased the budgetary requirements by US$ 1.5 billion.

In addition to the significant humanitarian benefits associated with polio eradication, the effort is also associated with substantial economic benefits. A polio-free world will reap savings of more than US$ 50 billion, funds that can be used to address other pressing public health and development needs. Critical to achieving a lasting polio-free world is the rapid mobilization of the additional funds needed.

The GPEI published the *Investment Case* for polio eradication, clearly summarizing the economic and humanitarian rationale for continued investment into the GPEI. The document is available at www.polioeradication.org

The GPEI thanks the following generous donors for their contributions to the initiative in 2015, which helped ensure that all planned activities summarized in this Annual Report were implemented during the year, including most directly the vaccination of more than 430 million children multiple times during 264 supplementary immunization activities, using more than 2 billion doses of different formulations of polio vaccine. This long-standing and generous support by the international development community is a critical success factor, which has brought the world to the threshold of being polio-free.

CONTRIBUTORS TO THE GPEI, 2015



Australia disbursed US$ 26 million, as part of a multi-year commitment to support the Endgame Plan through 2018, made after the Rotary International Convention in Sydney in June 2014.

The **Bill & Melinda Gates Foundation** provided US$ 354 million in 2015 funding, and continues to match funds raised by Rotarians two to one as part of the ongoing fundraising partnership between the two organizations.

In 2015, the Government of **Canada** continued to deliver on the Can$ 250 million commitment made at the 2013 Vaccine Summit, disbursing approximately US$ 43 million for the global implementation of the Endgame Plan.

The **Crown Prince of Abu Dhabi** disbursed US$ 12 million, bringing the Crown Prince's commitment to achieving a lasting polio-free world to more than US$ 50 million.

Estonia continued its support to polio eradication, providing US$ 20 000 to the effort, bringing its total contribution to more than US$ 220 000.

The **European Commission** contributed US$ 13 million to the GPEI; its total support over the years to a polio-free world now totals more than US$ 250 million.

Germany continued its multi-year support to polio eradication in Nigeria and Afghanistan, contributing US$ 22 million to the effort. Germany is a long-standing partner, having contributed more than US$ 500 million. Germany also announced it would extend its support to Pakistan's eradication effort, to supplement its ongoing support to Nigeria and Afghanistan.

The Government of **Ireland** provided US$ 440 000 to polio eradication, bringing its multi-year support to the effort to more than US$ 27 million.

The **Islamic Development Bank**, through a Loan Agreement with the **Government of Pakistan**, disbursed US$ 113 million to support the National Emergency Action Plan of Pakistan. Support by the **Government of Pakistan** through Islamic Development Bank loans now totals more than US$ 225 million.

Japan continued to demonstrate its strong commitment to polio eradication. In 2015, Japan provided more than US$ 6 million to the effort, bringing its total contribution over the years to more than US$ 500 million. Additionally, through a **Japan International Cooperation Agency Loan Conversion** with the **Government of Pakistan**, an additional US$ 21 million was disbursed to support the country's efforts to implement its National Emergency Action Plan.

The **Korea Foundation for International Healthcare**, a specialized organization under the South Korean Ministry of Health and Welfare, remains fully engaged in polio eradication efforts. It provided more than US$ 1 million to the Endgame Plan. This grant is made possible by the **Community Chest of Korea** and brings its total contribution over the years to US$ 3 million.

Latter-day Saint Charities has a long history of supporting immunization initiatives and provided its first contribution of US$ 220 000 to the GPEI.

Liechtenstein continued its annual support to the GPEI providing approximately US$ 30 000, underscoring the Principality's commitment to see the world polio-free.

Luxembourg contributed US$ 1 million in support of polio eradication operations worldwide, which brings its support to the GPEI over the years to more than US$ 17 million. This support equates to each inhabitant of the country having contributed more than US$ 30 to the effort.

In addition to serving as co-chair of the Polio Partners Group (PPG), **Monaco** contributed nearly US$ 190 000 solidifying its long standing commitment to polio eradication.

Private philanthropists provided a total of US$ 144 million in 2015, through the **National Philanthropic Trust**. Almost US$ 290 million has now been contributed by private philanthropists worldwide through this mechanism.

Nigeria provided over US$ 11 million in domestic resources in 2015. The country has now contributed more than US$ 180 million in direct budget resources to the effort. Domestic resources are an increasingly important funding source to the global eradication effort.

Norway continued to provide critical contributions to the GPEI. In 2015, the country provided US$ 30 million for polio eradication operations worldwide, bringing its total contributions to more than US$ 300 million as part of the pledge it made at the Global Vaccine Summit.

Rotary International, in addition to being a spearheading partner of the GPEI, is also the second largest private-sector donor. The more than 1.2 million Rotarians worldwide have personally contributed more than US$ 1.5 billion to the effort; they provided more than US$ 116 million in 2015 alone. Additionally, Rotarians continue to advocate with both donor governments and governments of countries that remain affected or at high risk of polio. This helps ensure critical, ongoing political support for polio eradication at all levels. Thank you Rotary!

Switzerland continued to provide essential support to strengthen poliovirus surveillance and management training in Chad, the Democratic Republic of the Congo and Ethiopia. Switzerland released US$ 630 000 as part of its US$ 1.9 million commitment through 2015. Additionally, Switzerland announced it would continue its multi-year support to the GPEI beyond 2015.

Turkey continued its support to eradicate polio by providing an additional US$ 60 000 in 2015 bringing its total to over US$ 1 million.

In 2015, spearheading partner **UNICEF** provided significant funding to its country offices. In total, UNICEF contributed more than US$ 18 million for polio eradication activities from regular resources and UNICEF National Committees.

Complementing the direct support of the Crown Prince of Abu Dhabi, the **United Arab Emirates** through its Pakistan Assistance Program provided almost US$ 10 million for campaign operations in high risk districts in Pakistan. Critical support as the country works to become polio-free.

At the Global Vaccine Summit in 2013, the **United Kingdom** announced a pledge of up to £300 million for polio eradication between 2013 and 2018. As part of that pledge, WHO signed a multi-year agreement for £270 million with the UK Department for International Development (DFID), bringing essential flexible funding to the Endgame Plan. In 2015, DFID disbursed more than US$ 100 million to the GPEI following a successful annual performance review. The United Kingdom is the second largest public-sector contributor with total commitments of US$ 1.5 billion until 2018.

The **United Nations Foundation** continued its critical support by providing an additional US$ 730 000 to the global effort. The United Nations Foundation is an important and long-standing partner, having contributed more than US$ 44 million over the years.

The **United States of America** remains the largest public-sector donor to the GPEI. It has committed more than US$ 2.6 billion to the effort, including US$ 118 million in 2015 out of the US$ 218 million allocated by Congress. Funds are channelled through the CDC and USAID, providing crucially needed support to eradication efforts, including the increased provision of technical and management assistance in priority countries.

The **World Bank**, through a Loan Agreement with the **Government of Nigeria**, disbursed US$ 43 million to support Nigeria's Emergency Action Plan. World Bank contributions now total nearly US$ 1 billion through various direct, credit and loan mechanism partnerships.

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

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POLITICAL COMMITMENT

In May, the Sixty-eighth World Health Assembly adopted a landmark resolution to end polio once and for all. This puts into place all the necessary building blocks to complete the Polio Eradication & Endgame Strategic Plan 2013-2018 (the Endgame Plan) and urges all Member States to fully implement and finance it.

YOUR NOTES

EVERY LAST CHILD

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