



Global Polio Emergency Action Plan 2012-13
Getting Nigeria, Pakistan and Afghanistan back on track

DRAFT (Version 2)

This working draft (**version 2**) of the global Polio Emergency Action Plan (EAP) is based on inputs from the national emergency plans of the endemic and re-established transmission countries; the four spearheading partners of the Global Polio Eradication Initiative (WHO, UNICEF, CDC and Rotary International) and the Bill and Melinda Gates Foundation; the Strategic Advisory Group of Experts on Immunization (SAGE); the Polio Advocacy Group; and the Global Partners' Group (GPG), which includes donors, polio-affected countries and other stakeholders.

WHO HQ is requesting these stakeholders to provide feedback on this draft in writing and/or during the meetings of the GPG (April 11) and SAGE (April 10-12). The final version of the Global Polio EAP will be completed by 27 April, for submission to the 65th World Health Assembly (21-26 May 2012)



Global Polio Emergency Action Plan 2012-13 *Getting Nigeria, Pakistan and Afghanistan back on track*

1. Purpose

On 21 January 2012, WHO's Executive Board declared the completion of polio eradication a "programmatically emergency for global public health"¹ and requested the Director-General to develop a plan through 2013, for the intensified implementation of existing strategies and the introduction of new tactics and innovations to interrupt wild poliovirus (WPV) transmission globally.

In response to this emergency situation the Global Polio Eradication Initiative (GPEI) has developed a *Global Polio Emergency Action Plan 2012-13*. The **goal** of this Plan is to get the GPEI back on track through an emergency approach, concentrated in **Nigeria, Pakistan and Afghanistan**, that focuses on developing appropriate leadership, oversight, accountability and surge capacity at global, national and sub-national level to support a transformational change. The emergency approach will be driven by the endemic and re-established transmission countries, with support from international partners.

This Plan builds upon the strategic approaches outlined in the GPEI Strategic Plan 2010-2012 and is intended to accelerate progress towards the realization of its milestones. The Plan will also serve as a critical precursor to the *Polio Eradication and Endgame Strategy 2013-18*.

2. Context

Since the launch of the GPEI Strategic Plan 2010-12, the incidence of polio has fallen by >50%. India, one of the four endemic countries, has not reported a case since early 2011. In addition, there has been encouraging progress in the re-established transmission countries. In South Sudan and Angola there have been no reported cases, respectively, since June 2009 and July 2011 and while Chad and the Democratic Republic of Congo (DR Congo) have experienced extensive outbreaks in early 2011, transmission has been geographically restricted since then, with clear signs of progress seen in the latter half of last year. In all cases but one², outbreaks in previously polio-free countries have been successfully stopped within 6 months of onset.

However, in 2011 there was an upsurge of cases in **Nigeria and Pakistan**, where the continued circulation of two WPV serotypes³ was accompanied by international spread, despite the introduction of national emergency polio eradication plans. In **Afghanistan** cases also increased, with the national programme unable to reach enough children in insecure areas. The common denominator that has thrown the three endemic countries off track for eradicating polio has been "performance of variable quality that has consistently fallen below best practice in polio affected

¹ WHO Executive Board Resolution 130.R10 Poliomyelitis: intensification of the global eradication initiative. Available at: http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_DIV3-en.pdf

² Mali

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



areas”⁴ resulting in the end-2010 and end 2011 milestones of the GPEI 2010-12 Strategic Plan being missed.

Compounding this epidemiological emergency is a 50% gap in financing for 2012-13 and the lack of a long term business plan for funding the program. This has already necessitated a scale-back of critical activities thought necessary to reduce the risk of WPV spread, which began to take effect in February 2012.

Given that the current Strategy has not been successful in putting the GPEI on a clear trajectory towards polio eradication by the end of 2012, the *Global Polio Emergency Action Plan 2012-13*, and the revised national emergency action plans that underpin it, will be critical to ensuring that polio affected countries and the partners collaborating with them, realize the fundamental change in approach and structure that will ultimately bring about polio eradication.

3. Risks

GEOGRAPHIC	OPERATIONAL
<p>The end 2011 milestones of the GPEI 2010-12 Strategic Plan related to cessation of transmission in countries with endemic or re-established polio transmission <i>have been missed</i>. Nigeria and Pakistan represent the gravest risk to global polio eradication.</p> <p>Although other areas also present great challenges, the poor performing areas of these two endemic countries pose a disproportionate risk to the likelihood of success for the entire world, through international spread of wild poliovirus.</p> <p>The principal threat to global polio eradication resides in six sanctuaries: Kano and Borno states (Nigeria); Quetta City, Killah Abdullah District, Pishin District (Balochistan, Pakistan); Karachi City (Sindh, Pakistan).</p>	<p>Strengthening of political commitment, management, accountability and operational capacity, as well as ramped up international support in the endemic countries, can bring about transformative change but progress will continue be threatened by geographical barriers to access, insecurity, corruption, political change, poor infrastructure and missed sub-populations.</p> <p>Extraordinary measures will need to be taken to ‘sustain the gains’ in the face of these operational challenges.</p>
PROGRAMMATIC	FINANCIAL
<p>Key programmatic risks include:</p> <ul style="list-style-type: none"> ▪ Inadequate understanding of refusals; ▪ Continued oral poliovirus vaccine insecurity; ▪ Reaching migrant/neglected populations; ▪ Failure of governments and partners to effectively integrate and translate data into action; ▪ Inability to overcome the limitations of campaign monitoring; ▪ Achieving gains at the strategic political and national level without translating this into front line gains e.g. improved SAI quality; ▪ Successful pilots regarded as an end in themselves without subsequent or sufficient scale-up e.g. related to improved micro planning, vaccinators selection, refusals. 	<p>The GPEI is faced with a > US\$ 1 billion shortfall in its 2012-13 budget. Insufficient financing has forced the program to cancel or substantially scale back polio vaccination during the first half of 2012. A continued funding crisis will preclude the full implementation of national emergency plans, particularly the critical human resource surge.</p> <p>Without the required funding to achieve the goals of this Plan and ultimately the strategic eradication and endgame plan, the consequences will be dire both from a public health and economic perspective. The failure to eradicate polio puts the world at significant risk of resurgence of this disease, leading to over 200,000 children paralysed annually within a decade and would preclude the financial benefits of eradication estimated at US\$ 40-50 billion.</p>

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



4. Objectives

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

1. Accelerate and intensify support to poor performing areas of Nigeria, Pakistan and Afghanistan to ensure that the coverage levels needed to eventually stop transmission of all polioviruses are reached by end 2012;
2. Sustain momentum in Chad, DR Congo and Angola to interrupt transmission in 2012 and respond rapidly and effectively to stop any new outbreaks within 6 months;
3. Heighten GPEI partner accountability, coordination and oversight to improve sub-national outcomes in these countries;
4. Close the US\$ 1.09 billion funding gap for eradication activities in 2012-13 and develop a long-term plan to ensure funding and political will for the Polio Eradication and Endgame Strategy.

5. An emergency approach

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

- National emergency plans in Nigeria and Pakistan (as well as other priority countries⁵) were updated, augmented and strengthened (See details in Section 7). All polio affected countries will publicly and appropriately announce that polio is an emergency and develop a national and sub-national communication plan to drive home the message that these are country priorities of utmost urgency.
- Implementing partners have moved their operations onto an emergency footing: WHO established a change management task force at Headquarters (HQ) and Regional Office levels (Africa, Eastern Mediterranean and South East Asia) to drive the implementation of a seven-pronged emergency approach⁶ to polio eradication activities; UNICEF has established an Inter-Divisional Polio Emergency team operating under the Deputy Executive Director; the Centres for Disease Control and Prevention (CDC) has activated its Emergency Operations Centre (EOC) and mobilized staff across the organization; and the Rotary Foundation declared polio eradication an urgent organizational priority and is making available the full resources of the organization to the support the effort.

⁵ Chad and the Democratic Republic of Congo.

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



The emergency approach of affected countries and collaborating partners in the GPEI is based on the following fundamental **principles**:⁷

- All involved in the GPEI give the emergency a very high level of priority over other issues.
- National programmes require all who receive funds under the GPEI to follow a 'Code of Conduct'.
- Zero tolerance for chronic poor performance, including falsification of data and misuse of funds/resources.
- Fair, transparent and practical processes to reward good performance.
- People at the top of every involved organization pay close personal attention to the emergency and its resolution, including availing the necessary people and resources rapidly when and where needed.
- Time is of the essence, necessitating rapid actions for all activities.
- Barriers that impede work to resolve the emergency are unacceptable, and are resolved rapidly.
- The task at hand is more important than sensibilities.
- If something might help to bring the emergency to a close it should be tried; there is no place for 'business as usual'.
- The front line is all important; those not working on the front-line will work to support those that are.

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



6. Best practices and innovations to address systemic problems

The Plan builds on the GPEI Strategic Plan 2010-12, incorporating lessons learnt from affected countries, **especially India** [see [Web Annex 1](#)], which are as follows:

ACTIVITY 1: National and sub-national Accountability and Oversight	
Major Lesson	The impact of corrective action plans depends on oversight and accountability of sub-national leaders.
Emergency Actions for 2012-13	Expected outcomes
<ul style="list-style-type: none"> Programme focal point answering directly to Head of Government. National Task Force to appraise district/Local Government Area (LGA) performance on a monthly or quarterly basis. Introduce standard criteria to grade district/LGA supplementary immunization activity (SIA) performance. State and district-level polio taskforce established and work monitored at national level. District leaders to be accountable for vaccinator selection/supervision and outcomes (including strong leadership and deployment of adequate capacity at sub-district level). 	<ul style="list-style-type: none"> Elimination of political interference and associated protection of poor performers. Poor performers strictly held accountable. Improved staff motivation and performance.

ACTIVITY 2: Monitoring of Supplementary Immunization Activities	
Major Lesson	Independent monitoring has poor sensitivity to detect areas that fail to achieve minimum coverage levels.
Emergency Actions for 2012-13	Expected outcomes
<ul style="list-style-type: none"> Correct gaps in how independent monitoring is conducted to improve reliability, collect social data and 'grade' local SIA and communications performance, rather than estimate coverage. Refine Lot Quality Assurance sampling (LQAS) and expand to all infected areas. Identify means of community feedback if vaccinator teams do not visit as planned. Complement SIA monitoring with annual seroprevalence data. Triangulate data sources; disaggregate data at the lowest possible level. Separate monitoring and implementation functions and establish objective 3rd party monitoring systems. 	<ul style="list-style-type: none"> Real time, objective SIA preparedness and implementation indicators linked with accountability and corrective action. Campaigns deferred in areas of inadequate preparations. More objective and robust estimates to track SIA coverage. Direct evidence of immunity among young children in high risk areas.



ACTIVITY 3: Quality of Supplementary Immunization Activities

Major Lesson

The intensive scale-up of technical assistance is fundamental to rapidly enhancing SIA performance in chronically weak areas.

Emergency Actions for 2012-13

- Intensify partner technical assistance (TA) to sub-district level in endemic areas and district level in re-established virus areas, to improve micro-planning, vaccinator selection and more rigorous monitoring during campaigns.
- Establish quicker and more sensitive monitoring networks at the sub-national level to understand social data and better address refusals.
- Establish a 'think tank' at global level to examine and develop solutions for systemic issue of insecure areas.
- Re-align vaccinator density to actual workloads in all infected areas.
- Introduce or scale-up use of Global Information System (GIS) mapping to enhance microplans and Global Positioning System (GPS) tracking of vaccinators.
- Implement special strategies to identify, track and immunize migrant/neglected populations e.g. the strategies used in Uttar Pradesh and Bihar.
- Direct payment to vaccinators in key endemic areas.
- Use of mobile phones and other technologies for monitoring vaccinator performance, identifying missed areas etc.
- District leaders to be accountable for vaccinator selection/supervision and outcomes (including demonstration of strong leadership and deployment of adequate capacity at sub-district level).

Expected outcomes

- Clear local understanding of why children are missed.
- Relevant and innovative solutions to local problems.
- Improved performance with a rational team workload.
- Up-to-date and validated microplans.
- Increase in quality and motivation of vaccinators.

ACTIVITY 4: Outbreak Prevention and Response

Major Lesson

More aggressive response tactics can stop outbreaks in even less than 6 months.

Emergency Actions for 2012-13

- Respond immediately with short interval rounds to rapidly increase immunity.
- Extended age group for first two oral poliovirus (OPV) rounds (i.e. at least 15 years of age) for all new outbreaks.
- Systematic joint national/international rapid assessment at 3 and 6 months.
- Technical support tailored to polio experience and health system, including promotion of better coordination with other health efforts to reduce the number of susceptibles.

Expected outcomes

- Immediate vigorous response tailored to local situation and risks.
- Substantial reduction in duration of outbreaks, numbers of polio cases and polio vaccination rounds.
- Risk of future outbreaks reduced.



ACTIVITY 5: Surveillance

Major Lesson	Gaps can persist in subnational areas with high performance indicators due to sub-populations and other factors.	
Emergency Actions for 2012-13	Expected outcomes	
<ul style="list-style-type: none"> Targeted surveillance among key population sub-groups. Systematic 'rapid assessments' in areas of orphan viruses and insecurity. Mobile phone SMS prompting for active surveillance in priority areas. Expanded environmental sampling (including outbreak settings and along recognized transmission routes). Expansion of community-based surveillance. 	<ul style="list-style-type: none"> Poliovirus rapidly detected in all areas and communities. Gaps in surveillance promptly detected and addressed. 	

ACTIVITY 6: Routine Immunization

Major Lesson	Routine immunization coverage can and should be improved substantively while intensive eradication activities are ongoing.	
Emergency Actions for 2012-13	Expected outcomes	
<ul style="list-style-type: none"> Systematically engage with GAVI on routine immunization (RI) synergies & coverage targets in priority areas. Use polio SIA monitoring mechanisms to identify gaps in RI systems in high risk areas. Extend the detailed microplanning and mapping for polio SIAs to RI, utilizing polio-funded personnel (including at district/sub-district levels). Utilize the polio infrastructure to identify, monitor and address RI bottlenecks in key areas. Ensure the polio communications and social mobilization strategies, capacities and activities are used systematically to promote RI. Opportunities for collecting social data/research for polio to inform EPI communications strategies. Apply to RI the lessons on identifying and reaching missed children, especially among underserved, mobile and minority populations. 	<ul style="list-style-type: none"> Improved RI coverage in high risk and difficult to access and underserved populations. Increasingly strong synergies between polio eradication and RI that sustain polio eradication and mitigate risks associated with the global switch from trivalent OPV (tOPV) to bi-valent OPV (bOPV) and ultimate cessation of all OPV. 	



ACTIVITY 7: Vaccines

Major Lesson	Research has indicated that bivalent OPV and fractional-dose inactivated poliovirus provide new opportunities to enhance vaccine impact.	
Emergency Actions for 2012-13		Expected outcomes
<ul style="list-style-type: none"> Consider replacing tOPV with bOPV for routine/supplementary use. Introduce one IPV dose at DPT3, 6 months before a tOPV-bOPV switch. IPV campaign pilots in key endemic areas to assess feasibility/impact. Increase availability of quality assured vaccines i.e. ensure sufficient number of producers of OPV and IPV. 		<ul style="list-style-type: none"> Risk of type 2 cVDPV eliminated, > 90% reduction in overall risk of cVDPV Nearly 40% reduction in the risk of VAPP OPV vaccine supply security is ensured IPV becomes affordable and available to complete polio eradication.

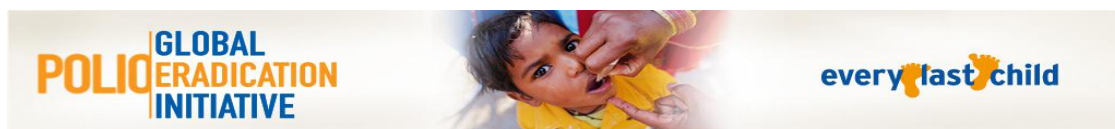
ACTIVITY 8: Communication and social mobilization

Major Lesson	Intensified community level communication and social mobilization focusing on high risk areas/populations help secure local engagement, address community concerns and create demand to improve overall quality of activities.	
Emergency Actions for 2012-13		Expected outcomes
<ul style="list-style-type: none"> Establish/scale-up social mobilization networks at community level in high risk areas with evidence of social barriers to immunization c.f. SMNet in India (>6,500 to be deployed in high-risk areas). Intensify the mapping, engagement and mobilization of community leaders e.g. traditional and religious leaders in Nigeria. Undertake systematic research/monitoring to identify and understand the social reasons for chronically missed children. Apply best practices for reaching high risk and chronically missed children (e.g. migrant and underserved strategies). Improve interpersonal skills of vaccinators and mobilizers to enhance performance and build trust, including addressing reticence and refusal. Ensure vaccination teams are from that geographic area and work closely with community authority structures. Harness mass-media to re-energize public support, motivate vaccinators, enhance ownership of key stakeholders (e.g. media, physicians, NGOs) and increase local leader accountability. Train front-line personnel to respond quickly to misinformation or crisis. 		<ul style="list-style-type: none"> All communities understand, trust, support and demand polio vaccination. No child is missed due to vaccine refusal. Any vaccine refusal is immediately assessed and addressed.



ACTIVITY 9: Resource Mobilization

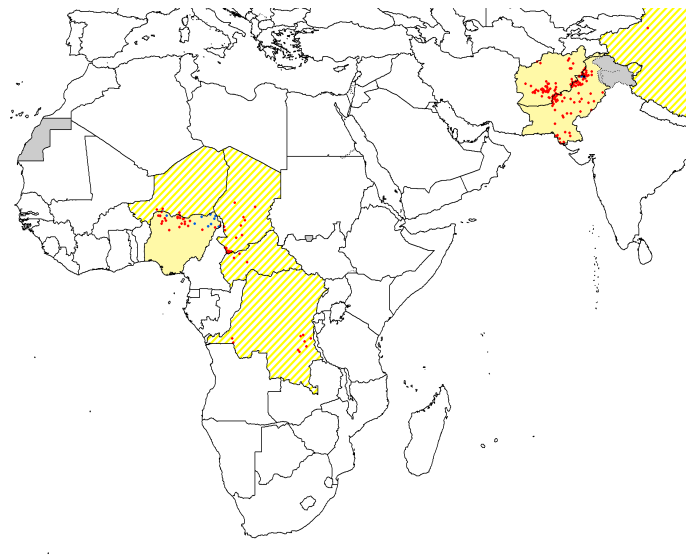
Major Lesson	Financing must be complemented by an expanded and engaged donor base and a longer-term approach.	
Emergency Actions for 2012-13	Expected outcomes	
<ul style="list-style-type: none"> ▪ Establish country task teams to bridge communication, advocacy and resource mobilization in key markets to enhance public and political engagement. ▪ Enhance involvement of key stakeholders in the programme through the new Global Partners Group (see Section 8 for details). ▪ Re-engage lapsed donors and re-build the trust of the traditional donors by ensuring program strategies and evidence are linked to donor needs. ▪ Explore innovative financing mechanisms linked to a new multi-year integrated eradication and end-game strategy. ▪ Increase domestic funding so affected countries are more committed to on-the-ground results. ▪ Enhance outreach to Brazil, Russia, India and China (BRICs), Middle-Income Countries and Organization of Islamic Cooperation countries. ▪ Re-invigorate Rotary's National Advocacy Advisory network. 	<ul style="list-style-type: none"> ▪ The Global Emergency Action Plan is fully financed for unimpeded implementation in 2012-13. ▪ A broader range of donors provides stable multi-year funding through the 'endgame.' ▪ Renewed confidence and enthusiasm among donors and partners. 	



7. Programmatic priorities by Geographic/Strategic area⁸

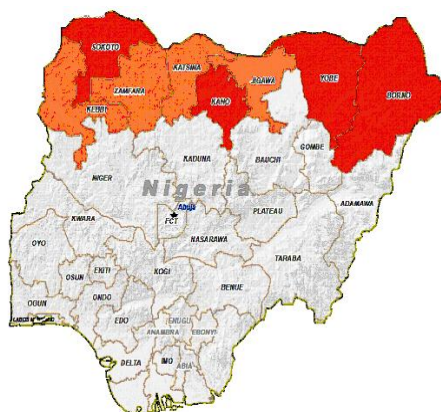
i Key geographic priority areas:

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



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

NIGERIA



See Annex 2 for detailed map of areas of priority focus

Situational Analysis

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

While the immunization status of children in northern Nigeria has continued to slowly improve in 2011, both the number and geographical extent of cases are increasing. In four infected states, <65% of children have >4 OPV doses (Borno, Kano, Sokoto and Yobe).

⁸ Wild poliovirus previous 6 months; excludes viruses detected from environmental surveillance and vaccine derived polioviruses (Data in WHO HQ as of 20 March 2012)



The low quality routine services are deteriorating; 55% more infants were not vaccinated with DPT3 in 2011 than 2010 and there were central stock-outs of 4 of the 8 childhood vaccines. Children are missed due to a mixture of operational and social factors, and these programme gaps must be addressed if more children are to be reached.

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

Although polio has been declared an emergency by H.E. the President, in Quarter one 2012 only half of the 12 northern states convened their State Task Force to address problems.

However, the **new National Emergency Plan 2012** finalized in April [[see Web Annex 2](#)] is promising, containing the tools and tactics to achieve a rapid jump in campaign coverage. Hard data prove the Intensified Ward Communication Strategy (IWCS) can reconcile most non-compliance. Restructuring of the vaccination team strategy should help address the issue of insufficient teams. Pilots designed to improve vaccinator selection/performance and reduce refusals are showing promise. Application of the new micro planning templates, supplemented by GIS mapping, could solve the problem of missed places. Special population strategies, as for nomadic populations, prove these important groups can now be reached. Taking these innovations to scale rapidly in the worst performing LGAs and districts, through the planned surge support, will be crucial.

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

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

Improving national ownership, oversight and accountability

On 01 March 2012 the President inaugurated a Polio Eradication Task Force, chaired by the Minister of State for Health, to oversee implementation of the National Emergency Action Plan. The issue of accountability of all levels of government is one of the key thematic elements of the plan, in particular the implementation and close monitoring of the Abuja Commitments. The national Expert Review Committee meets at least twice a year to provide strategic advice to the Ministry of Health on polio eradication and to review progress on implementation of the Emergency Plan.



SIA and vaccine plans for 2012-13

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

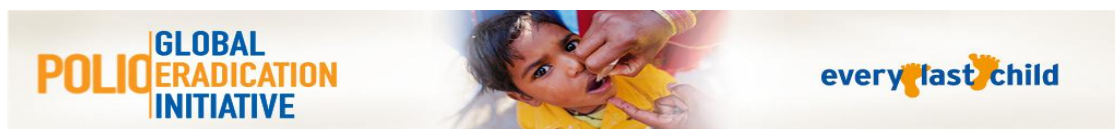
Improving SIA quality and monitoring

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

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

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

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



- **Enhanced Routine immunization:** intensifying routine immunization activities through the 'reaching every ward' strategy in the high risk states and incorporating lessons learned in polio including micro planning to ensure all communities are reached, monitoring of service delivery, and communications strategies to build community demand.
- **Strengthened communication response** in key priority areas to address vaccine resistance: Establishing the Volunteer Community Mobilizer (VCM) initiative in poor performing settlements in Kano, Kebbi, Sokoto, Zamfara and Jigawa. Following-up on the Polio Free Torch campaign with media engagement and organizing state level events to engage Governors. Intensifying engagement of religious clerics and launching an anti-rumour campaign in the Northern Nigeria.
- **Focusing on the front line workers and vaccinators:** improving IPC training for vaccinators, their supervisors and ward focal points. Linkage of VCM to LGA Chairmen, awarding well performing volunteers and rewarding settlements who remain 0% MC and 0 % NC.

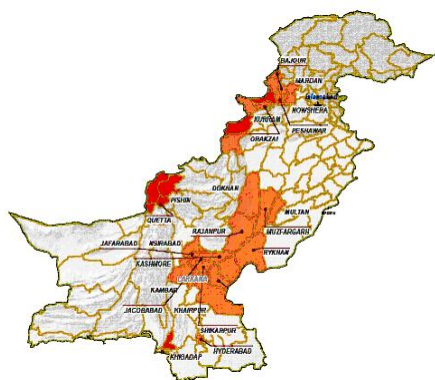
Enhancing Surveillance

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

Environmental surveillance will be expanded to include Maiduguri (Borno) in 2012, and the number of sampling sites in Kano will be increased.

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

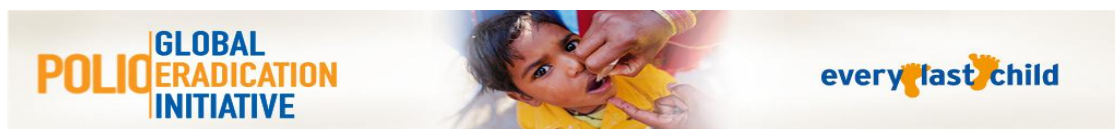
PAKISTAN



See Annex 2 for detailed map of areas of priority focus

Situational Analysis

In 2011 Pakistan reported 198 cases due to wild poliovirus (196 due to WPV1 and 2 due to WPV3), an increase of nearly 40% compared with 2010. In the first half of the year transmission was heavily concentrated in the known, poor performing transmission zones in Baluchistan, FATA, and Karachi, but during the high transmission season virus spread more widely out of these zones, including into areas that had been polio free. Nonetheless the worst performing areas, which have been identified by the national programme for several years now, carry by far the largest burden of disease.



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

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

However, despite these very real challenges, there have been several encouraging developments in the national programme over the past 6 months particularly in the areas of programme oversight and accountability at district/agency level (with DCOs now being held directly accountable and in turn holding health authorities accountable); the ongoing scale-up of technical assistance to the sub-district level by UN agencies, particularly in the worst performing areas of Karachi and the Quetta block; and tighter programme performance monitoring, with campaigns being suspended in districts not meeting standard preparedness indicators until corrective action is taken.

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

Improving national ownership, oversight and accountability

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

The Augmented National Emergency Action Plan 2012, which was endorsed by the National Technical Advisory Group in March 2012, focuses strongly on accountability and performance issues at the district and sub-district level, particularly in the high risk areas. Under the Plan, each province will also appoint a Focal Point for polio, reporting directly to the Chief Minister/Governor.

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



SIA and vaccine plans for 2012-13

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

Improving SIA quality and monitoring

Under its Emergency Plan the interim bi-annual programme performance target set for SIA coverage in Pakistan is >95%.¹⁰

The national Plan will target levels surpassing this one in high-risk, mobile population subgroups. Performance against these targets will be assessed by LQAS.

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

- **Heightened sub-national accountability:** ensuring that responsibility for the quality of activities in districts is borne by the head of the civil administration in the district, and that the District Polio Eradication Committee is both functioning and empowered;
- **Improved SIA planning:** developing and implementing a system of assessing preparations for each SIA round at district and sub-district level, coupled with a process for delaying implementation in any district failing to meet satisfactory preparation;
- **Improved SIA quality:** coupling the surge deployment at district and sub-district level in high risk areas with the review of basic implementation strategies for supplementary immunization, including vaccination team selection, training, and supervision, the micro planning process, and incorporating approaches on vaccinator payment; exploring the engagement of local partners much more in the implementation of SIAs in key areas with persistent quality problems;
- **Human resource surge capacity:** deploying adequate human resources to the poorest performing districts (government and partner resources) from the level of vaccination teams up to provincial level management;
- **Reaching chronically missed children:** introducing and scaling up new interventions to reach chronically missed children, including a process of in-depth investigation of identified areas or populations where children are being missed, to develop a package of appropriate operational and social interventions;

¹⁰ These targets for priority countries are based on experience in India and internal data and are *interim targets*. The ultimate aim for all priority countries is to reach higher effective vaccination coverage that goes over the “threshold” as quickly as possible. Further refinements and data from ongoing studies and surveillance will assist in deriving more valuable models of critical target immunity levels in Q2 and Q3 2012, which could lead to revisions of these targets.

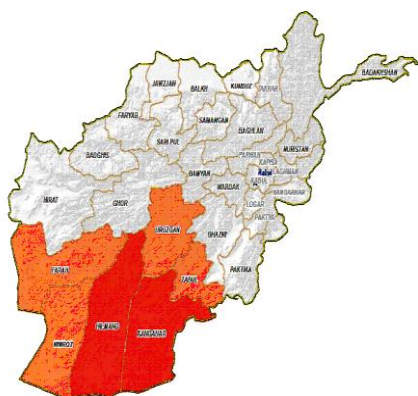


- **Enhanced Routine immunization:** accelerating routine immunization activities in key poor performing districts and sub-districts, including special approaches in areas such as FATA, where immunization will be coupled with multi-intervention health camps;
- **Enhanced communications:** developing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

Enhancing Surveillance

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

AFGHANISTAN



See Annex 2 for detailed map of areas of priority focus

Situational Analysis

A major setback for polio eradication in Afghanistan occurred in 2011, when 80 cases due to wild poliovirus type 1 were reported - a more than three times increase compared to the 25 cases reported in 2010. The majority of cases in 2011 (85%) occurred again in the south-western endemic zone comprising the Southern Region and Farah province of the Western Region. As in Pakistan, some spread of WPV out of the endemic zone occurred during the high transmission season of 2011, with 13 cases reported from 9 previously polio-free provinces.

However, as of March 2012 it appears as if transmission did not continue in any area outside of the south-western endemic zone. A major factor in ensuring that re-introductions of virus into polio-free areas of Afghanistan do not lead to extensive spread or re-establishment of transmission is that programme performance outside the endemic zone continues to be better compared to endemic areas. In the south-western endemic zone, the quality of SIAs has been declining over the past 3 years, and the immunization status of children in this area is now worse than it was in 2008. In the endemic zone, the percentage of young children (6-23 months) with AFP not due to polio who had never before received any OPV ('zero dose') increased from 9% in 2010 to 21% in 2011. Nationally, this percentage was 2.5% in 2010, increasing to 7% in 2011.



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

SIA and vaccine plans for 2012-13

Afghanistan is planning a minimum of four national and four large-scale sub-national SIAs in 2012, followed by a similar schedule in 2013. Both trivalent and bivalent OPV will be used extensively (trivalent in at least 2 national rounds per year), to ensure that protection against WPV2 is maintained while WPV1 and WPV3 are being eradicated.

Improving SIA quality: the 2012 Afghanistan Polio Emergency Action Plan

In light of the worsening polio situation, the Government of Afghanistan and its polio eradication partners are currently developing a **Polio Eradication Emergency Action Plan (EAP)** [[see Web Annex 4](#)]

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

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

Addressing access problems in conflict areas

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

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

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

- improve the monitoring and documentation of reasons for and magnitude of inaccessibility in each affected SIA operational area ('cluster'), and to conduct small-scale campaigns as soon as an area becomes accessible;
- in AGE-controlled areas, to more closely coordinate the selection of SIA field staff, directly or indirectly, with the AGE;
- and to expand the use of low-visibility 'permanent polio teams' conducting house-to-house vaccination in conflict-affected high-risk districts on a



permanent basis, to provide every eligible child in the catchment area with at least one dose of OPV every three months. The new 'permanent polio team' strategy was launched in March 2012 in Kandahar city, southern Afghanistan.

Improving polio eradication management and accountability

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

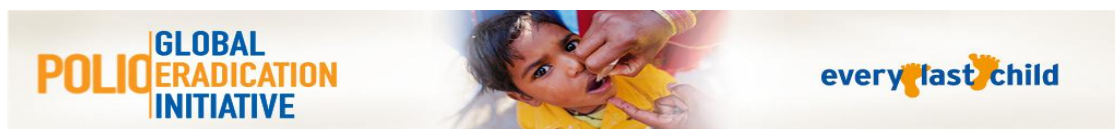
Provincial polio teams (government and partners) coordinate polio SIA planning and implementation at the district level using temporary local staff who often have only limited knowledge and capacity. Other unresolved managerial issues include continued delays in disbursement of polio eradication funds,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

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

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

Enhancing communication support for polio eradication

Direct refusal of vaccine, or non-compliance, by child caretakers is not a main reason for which children are missed during SIAs in Afghanistan (< 5% of missed children). However, post-SIA monitoring continues to show that up to 30% of children are missed for reasons such as being new-born, sick or sleeping at the time of the team visit, indicating that parents were not sufficiently informed that there is no reason to exempt such children, and that vaccinators failed to identify and correct the problem. Much of the latter problem is caused by the fact that male vaccinators cannot enter homes and compounds; women work in only a small percentage of vaccination teams in Afghanistan.



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

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

B. Sustaining momentum in re-established transmission countries

CHAD



See Annex 3 for detailed map of areas of priority focus

Situational Analysis

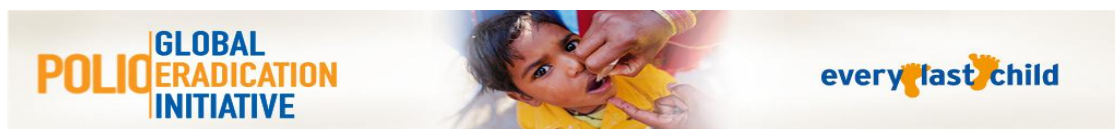
Chad reported a total of 132 cases in 2011, 129 due to WPV1 and 3 due to WPV3, the most cases of any re-established transmission country and the second highest in the world after Pakistan. Following intensive transmission in the first half of 2011, the epidemiological situation in Chad has improved in the third and fourth quarters; the number of cases declined by 75% in the second half of the year. Transmission in the last 6 months has been much more focal following a series of SIAs in the fourth quarter of 2011 and the first quarter of 2012. The principal reasons for children being missed in Chad remain operational, although social and communication issues are also important, particularly in key high risk areas.

Nomadic communities are at relatively higher risk than the general community. The national programme in Chad has now finalized an Emergency Action Plan for 2012 which aims to address the operational and social constraints to achieving high coverage.

Chad's **Emergency Action Plan for 2012** [[see Web Annex 5](#)], provides specificity in each of the following areas.

National oversight and accountability

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



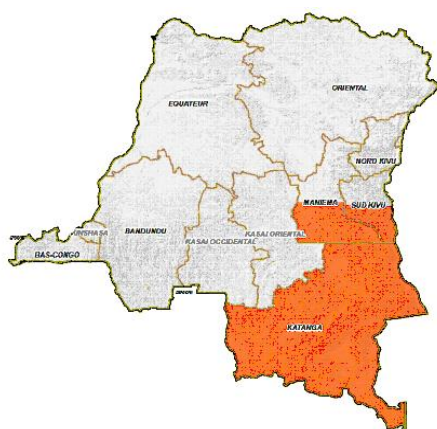
SIA and vaccine plans

Chad is planning six national and two large scale sub-national rounds in 2012, and 4 national rounds in 2013. Trivalent OPV will be used in at least 2 national rounds each year, with the remaining rounds using bivalent OPV, to ensure good immunity against all three poliovirus serotypes.

Key activities to sustain momentum

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

DR CONGO



See Annex 3 for detailed map of areas of priority focus

Situational Analysis

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

The reasons for ongoing transmission in this area are due to the usual operational factors; sub-optimal management and supervision of activities are further complicated by localized rejection of immunization by a small number of religious communities.

An **Emergency Action Plan** for the first half of 2012 [[see Web Annex 6](#)] has been completed by the national programme, with a particular focus on stopping transmission in the east through addressing the operational and social barriers to immunization. The Plan provides specificity in each of the following areas.

National oversight and accountability



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

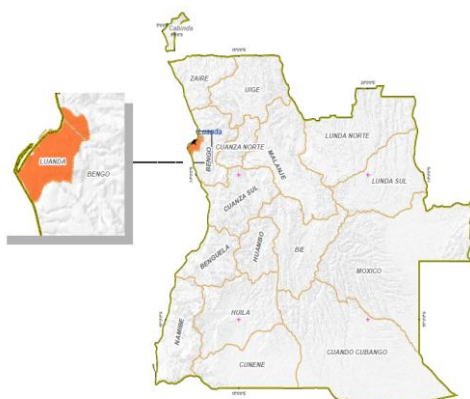
SIA and vaccine plans

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

Key activities to sustain momentum

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

ANGOLA



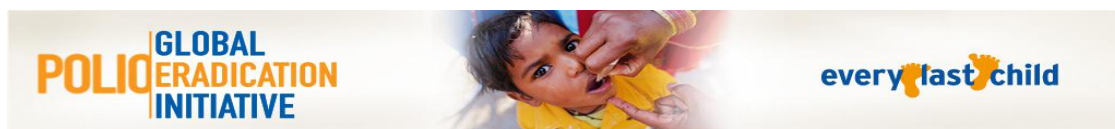
See Annex 3 for detailed map of areas of priority focus

Situational Analysis

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

National oversight and accountability

For more than 6 months now, Angola has not detected WPV. Despite the absence of WPV, Angola remains at high risk, with the possibility that low level circulation is continuing in some parts of the country, in addition to the constant threat of re-introduction.



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

- Increasing active search of AFP cases in the high risk districts particularly in Luanda provinces and the 6 bordering provinces with the Democratic republic of Congo involving community leaders and local NGOs;
- Intensification of routine immunization services with increase of outreach and mobile activities in high risk districts;
- Improving the quality of supplementary immunization activities through ensuring local recruitment of vaccinators and supervisors and involvement of administrative leaders in the preparation, implementation and evaluation of the polio campaigns;
- Ensuring effective communication messages to the communities and adequate social mobilization activities.

SIA and vaccine plans

Angola is currently planning three national immunization rounds in 2012 and two sub-national rounds, depending on the evolving epidemiology. In 2013 two national and two sub-national rounds are currently envisaged. A decision by the Ministry of Health on the introduction of tOPV is expected to be made by mid-2012.

C. Outbreaks and countries at risk of re-infection

Situational analysis

The GPEI Strategic Plan 2010 - 12 aimed to stop any new outbreaks within six months. Since 2010 just one outbreak in previously polio-free areas (in Mali) has lasted longer than this. In order to mitigate the real risk that all countries face until polio is eradicated globally, further improvements are planned to the GPEI's approach to outbreak response.

Key enhancements to outbreak response approach

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

- Immediate national and international support teams for the initial investigation and assessment of the outbreak and the planning of the response;
- Deployment of support for the duration of the outbreak to ensure high quality in immunization response activities, including effective communication and social mobilization; and to rapidly enhance surveillance quality in outbreak and at-risk areas;



- Extended age group for first two OPV response rounds (i.e. at least 15 years of age). Broader target age groups have been identified in response to the epidemiology of outbreaks (Tajikistan, Congo, China) and to margins of risk (DR Congo, Central African Republic) in the past 2 years. The approach appears to have value in rapidly increasing overall population immunity where there are significant immunity gaps in older children and adults.
- Systematic joint national/international rapid assessment at 3 and 6 months. Specifically, the main interventions will be based on the following approach:

The *first assessment* after response (3-month assessment) will focus on:

- i. Speed and quality of initial response (including case investigation, response plan, first SIA, etc.)
- ii. SIA quality (which should ideally include field work in the form of SIA monitoring, especially in high risk areas)
- iii. Appropriateness/adequacy of additional human resources support
- iv. Surveillance (very rapid review - desk and field, if travel is organized around SIA monitoring, in high risk areas)
- v. Other aspects that affect quality of response (Government engagement; engagement of non-governmental organizations (NGOs); transfer of funds to country e.g. Ministry of Health; other)

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

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

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

8. Enhanced international support to the Emergency Action Plan

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

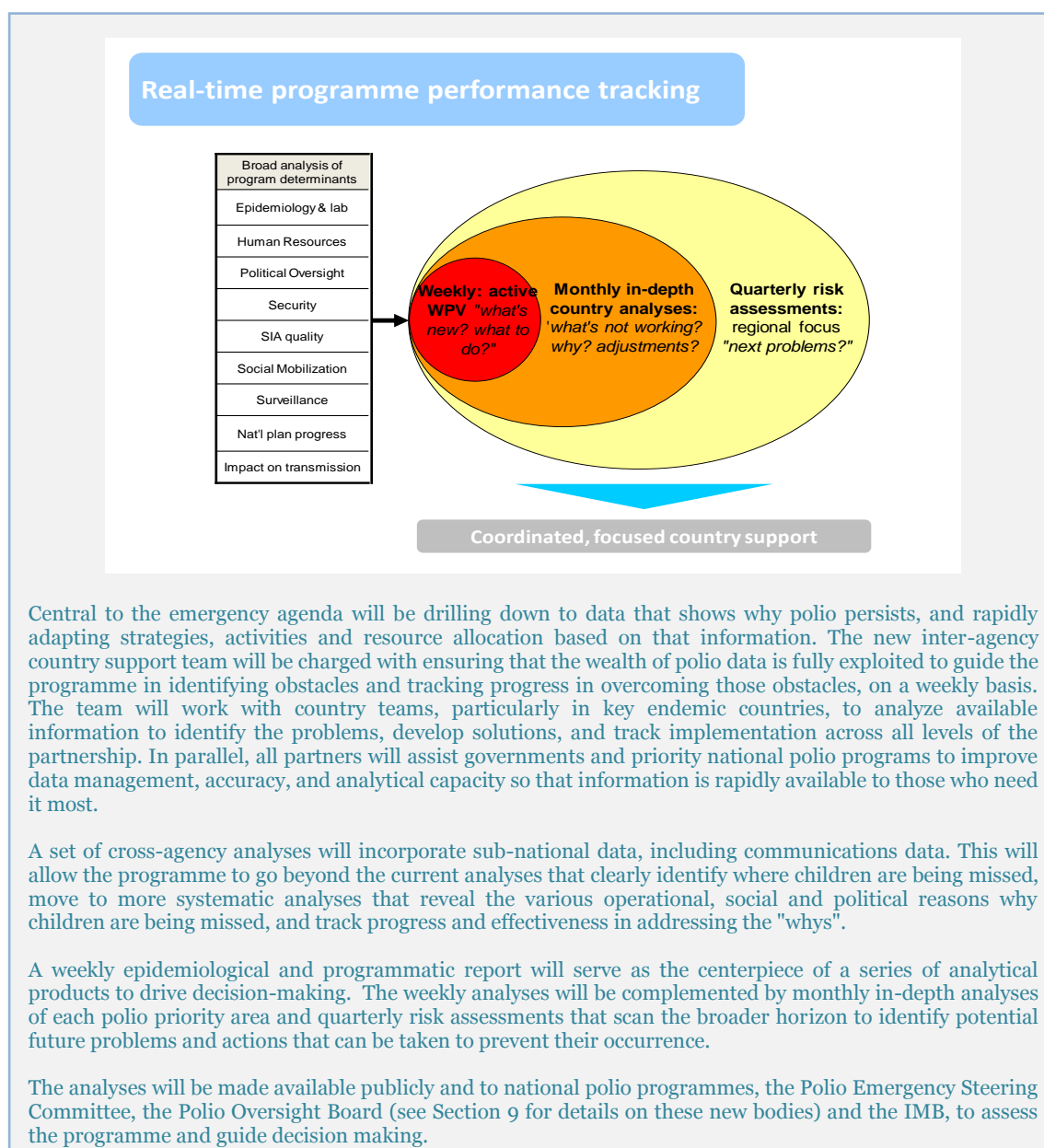
Recognizing the urgent need to fully exploit the relative strengths of the spearheading partners and the Bill & Melinda Gates Foundation (BMGF), strategic oversight to countries' polio eradication efforts, and in particular those of Nigeria, Pakistan and Afghanistan, will now be driven by a *Polio Emergency Steering Committee* composed of senior executives from the five key agencies. It will aim to ensure cross-agency alignment in priority-setting and support to countries. It will direct three new inter-agency groups as described below.

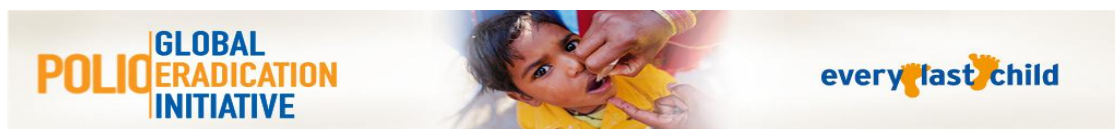


Inter-agency international support groups

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

Figure 1: Real-time programme performance tracking and cross-agency polio analytical products





- ❖ **Inter-Agency Innovation Working Group (IIWG)** to identify systemic challenges and root causes and drive innovations to improve operations. Key activities are detailed in [Web Annex 8b](#).
- ❖ **Polio Advocacy Group (PAG)** to mobilize resources (merging the existing Polio Advocacy and Global Polio Communications groups for closer alignment of strategy and implementation) to close the 2012-13 funding gap (See Section 10 for details on 2012-13 funding gap). This group will also engage country specific task teams which will include the spearheading partners, BMGF and UN Foundation, but also organizations based in countries, and can provide additional value and new thinking to advocacy and resource mobilization efforts.

Additionally, a **Global Partners' Group (GPG)** has been constituted to (1) ensure a GPEI stakeholder voice in the development and implementation of the Polio Emergency Action Plan 2012-13 and the Polio Eradication and Endgame Strategy 2013-18 and, (2) to foster greater engagement across the donor, polio-affected country and partnership landscape, with the objective of fully exploiting the resources of all members for polio eradication.

GPG membership is inclusive and will be comprised of senior representatives of Inter-agency Steering Committee agencies (WHO, Rotary, CDC, UNICEF, BMGF), donors/prospective donors, polio-affected countries and key non-governmental organizations/foundations working in polio eradication. The GPG will meet every six months, with the possibility of ad-hoc conference calls or meetings in between.

Enhanced technical assistance: standing and surge capacity

A key lesson learnt from 2011-12 has been the need to substantially increase external technical assistance to accelerate eradication and build capacity in areas of particularly weak systems. Consequently, standing capacity and surge capacity for technical support to countries is being significantly supplemented in the following settings.

Nigeria and Pakistan

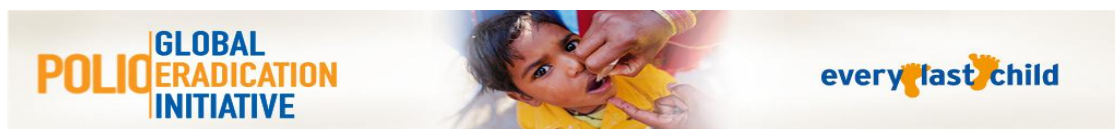
Intensified technical assistance will be provided all the way to the sub district levels as was done in India.

Afghanistan, Chad, DR Congo and Angola

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

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

- Long-term support in key transmission zones to strengthen the capacity of agency teams and to achieve high quality immunization, communication and social mobilization, field monitoring and surveillance activities.
- Operations management support to agency teams.
- Epidemiological and data support to national agency teams.
- Support for specific activities, including surveillance assessments, quality reviews, assessment of innovations, management reviews, etc.



New outbreak situations¹¹:

- Immediate support for the initial investigation and assessment of the outbreak and the planning of the response;
- Support for achieving high quality in the immunization response activities, including effective communication and social mobilization;
- Support to rapidly enhance surveillance quality in outbreak and at-risk areas;
- Assessment at 3 and 6 months, of progress and remaining risks.

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

Countries and areas at high risk of importation and outbreaks as identified by regular (3 monthly) risk assessments¹²

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

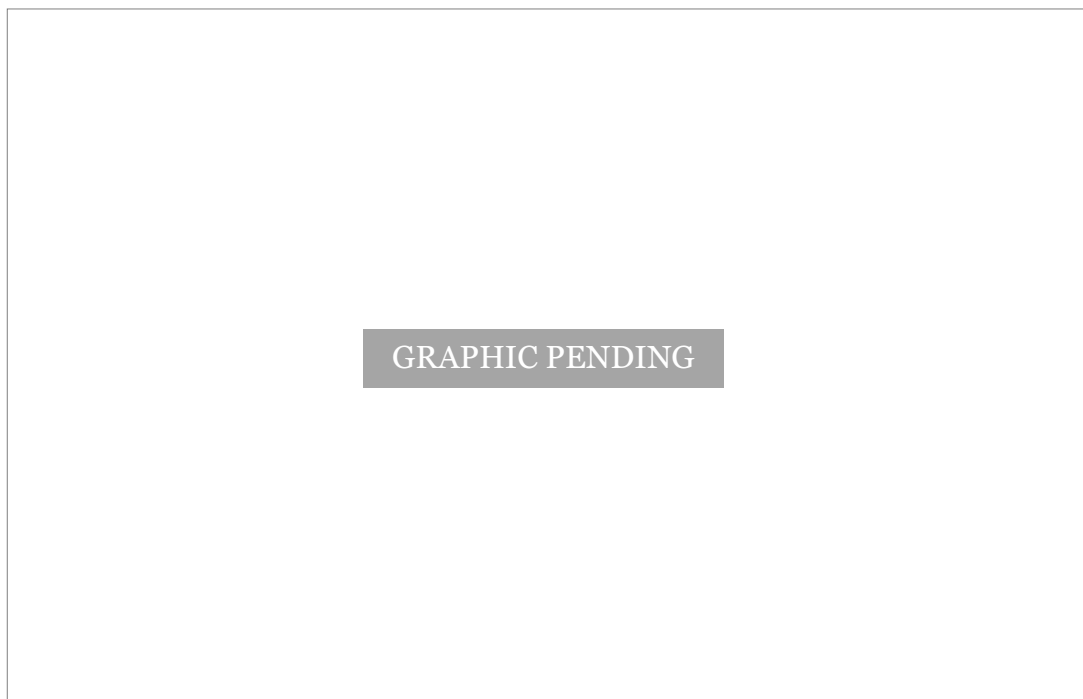
- support to Regional teams for risk assessment, and planning and prioritization of surveillance and immunization activities;
- support to enhance and maintain extremely high surveillance quality at minimum in outbreak and at-risk areas and populations;
- support for achieving high quality in any supplementary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

¹¹ Which can be in polio-free countries or polio-free areas of currently infected countries.

¹² Including those countries/areas that suffered outbreaks in 2011.



Figure 2: Mapping of human resource deployments, levels of deployment, key activities and timelines, 2012-13



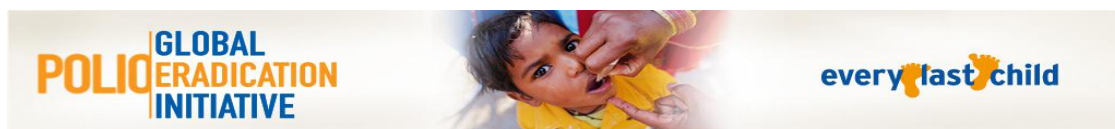
Learning lessons from India, another significant area of rapid scale-up driven by UNICEF is the building or strengthening of volunteer social mobilization networks across six of the priority countries. This will mean 2,000 communication workers are expected to be in the field in Pakistan by 2012; in Afghanistan 2,100 workers in the high-risk Southern and Eastern Regions; in Nigeria, 2,457 community mobilizers in 3 priority northern states; in DR Congo, 13,000 Government mobilizers in place with UNICEF-supported technical assistance. The system is still under development in Chad but could potentially harness up to 7,000 community ‘relais’ supporting polio in 2012. Finally Angola is working with faith-based groups to build a network of 14,000 religious leaders in border areas, as well as in densely populated slums in Luanda.

8.2 Improved GPEI partner accountability and management

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

WHO

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



With respect to programme performance monitoring and personnel accountability, WHO has conducted a rapid review of all performance monitoring processes/tools in its major programmes (especially India, Nigeria, Pakistan, Angola, Chad, and DR Congo) and developed a "best-practices" model for implementation across all priority countries with the assistance of consultants. Training programmes are being rolled out in Nigeria and Pakistan in March. [Key activities for all improvement areas are detailed in [Web Annex 9, Table 1](#)]

UNICEF

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

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

Centres for Disease Control and Prevention

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

Rotary International

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



Bill & Melinda Gates Foundation

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

9. Oversight and monitoring

9.1 Oversight

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

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

9.2 Milestone monitoring and assessment

The Independent Monitoring Board (IMB) will continue to monitor and guide the progress of the GPEI Strategic Plan and the contributions of this Emergency Plan to enhancing efforts towards polio eradication. The IMB convenes on a quarterly basis to independently evaluate progress towards each of the major milestones of the GPEI Strategic Plan 2010-2012 as 'on track', 'at risk' or 'missed', on the basis of polio epidemiology, poliovirus virology, standard performance indicators and other programme data. The IMB also evaluates the quality, implementation and impact of any corrective action plans that are introduced based on its recommendations. Additionally, the IMB provides assessments of the risks posed by existing funding gaps.

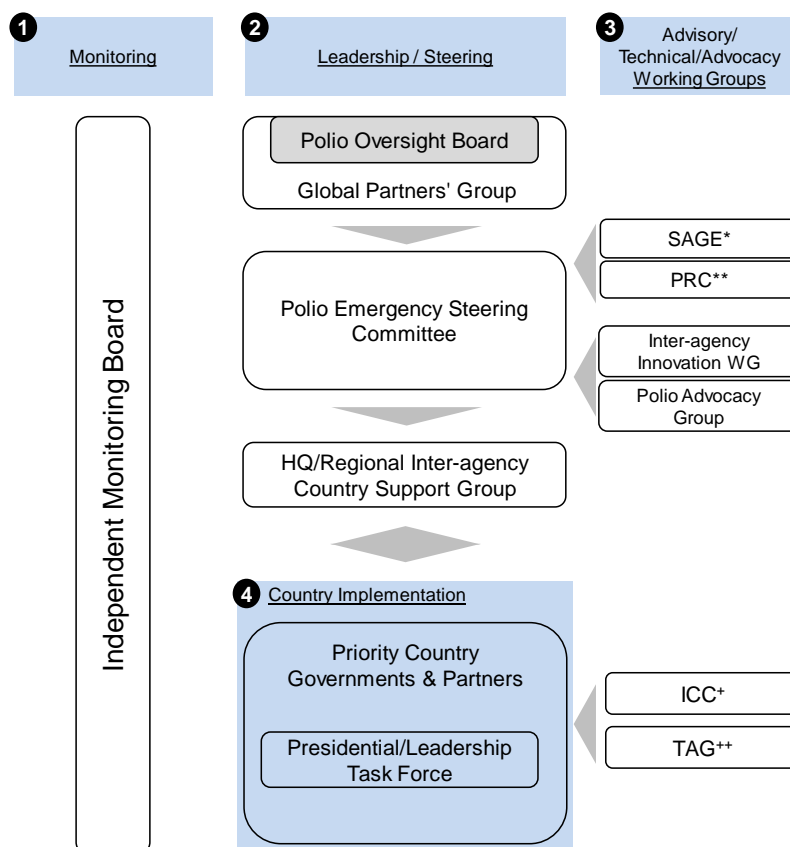
This Emergency Plan includes activities based on recommendations in the October 2011 and February 2012 IMB reports and, as a dynamic Plan, it will be augmented as needed based on subsequent IMB reports in 2012.



9.3 Technical oversight

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

Figure 3: Global Polio Eradication Initiative architecture to improve oversight, accountability and coordination



* Strategic Advisory Group of Experts on Immunization

** Polio Research Committee

+ Interagency Coordinating Committee

++ Technical Advisory Group



10. Funding for polio eradication

10.1 Resource requirements

The polio programme is in urgent need of funding. As of March 2012, GPEI faces a US\$1.09B funding gap¹³ against a budget of US\$2.23B¹⁴ for planned activities in 2012-2013 and has long-term funding requirements estimated at US\$3-5B. An increasing budget, which is needed to scale-up and accelerate successful work in the field, has been accompanied by declining donor commitments. The substantial funding gap has meant that activities for 2012 have already started to be cut or scaled-back. Equally important is the political will to finish the job, which must compete with other health, development and economic priorities. Although the GPEI is approaching polio eradication as an emergency and is building on lessons from the recent success in eliminating polio in India, some donors still lack confidence in the programme.

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

Core Costs	2012	2013	2012-2013
Emergency Response (OPV)	\$22.00	\$20	\$42.00
Emergency Response (Ops)	\$40.00	\$25.00	\$65.00
Emergency Response (Soc Mob)	\$12.00	\$6.00	\$18.00
Surveillance and Running Costs (Incl. Security)	\$62.42	\$64.36	\$126.78
Laboratory	\$11.03	\$11.23	\$22.26
Technical Assistance (WHO)	\$148.07	\$136.57	\$284.64
Technical Assistance (UNICEF)	\$38.68	\$37.31	\$76.00
Certification and Containment	\$5.00	\$5.00	\$10.00
Product Development for OPV Cessation	\$10.00	\$10.00	\$20.00
Post-eradication OPV Stockpile	\$12.30	\$0.00	\$12.30
Supplementary Immunization Activities	2012	2013	2012-2013
Oral Polio Vaccine	\$313.85	\$285.63	\$599.49
NIDs/SNIDs Operations (WHO-Bilateral))	\$344.76	\$248.39	\$593.15
NIDs/SNIDs Operations (UNICEF)	\$31.49	\$28.15	\$59.64
Social Mobilization for SIAs	\$96.92	\$93.68	\$190.60
Subtotal	\$1'148.53	\$971.32	\$2'119.85
Programme Support Costs (estimated)	\$59.76	\$52.49	\$112.25
GRAND TOTAL	\$1'208.29	\$1'023.81	\$2'232.10
Contributions	\$803.00	\$340.00	\$1'143.00
Funding Gap	\$405.29	\$683.81	\$1'089.10
Funding Gap (rounded)	\$405.00	\$685.00	\$1'090.00

¹³ Not including 75% likely prospects

¹⁴ The budget figure does not include the cost of IPV campaigns. This component of the budget is currently under development.

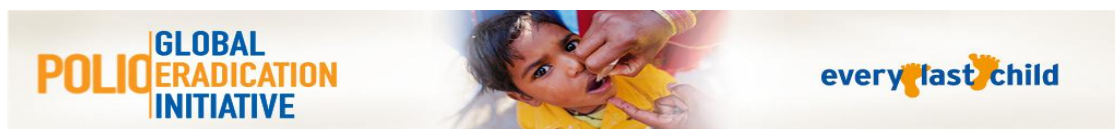
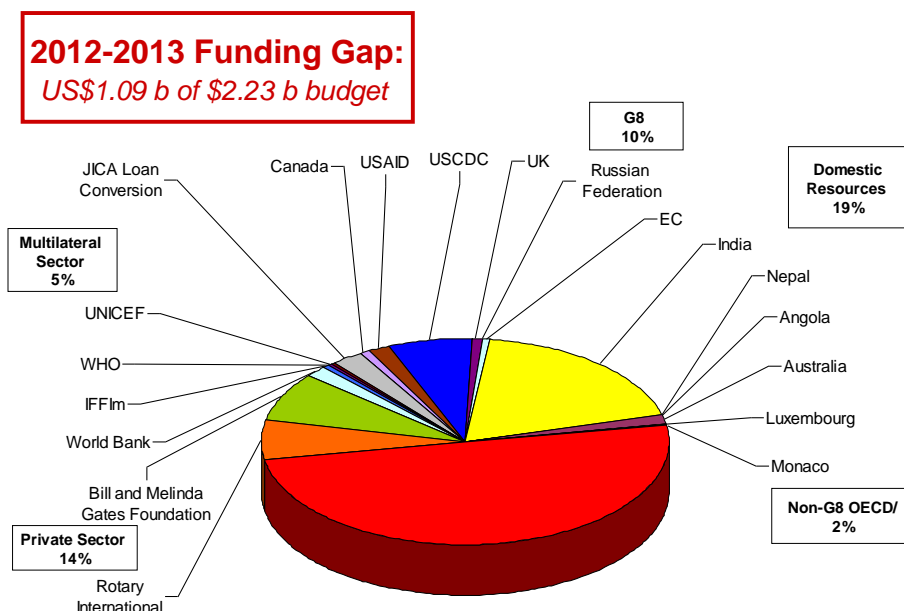


Figure 4. Financing 2012-13: US\$ 1.14 billion contributions



10.2 New fund raising strategies

New strategies are critical to increase confidence and secure the funds necessary to realize the goal of a polio-free world. These include:

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

Fundraising Approach

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

- The **development of Donor Task Teams**: Task Teams will draw from the collective knowledge of resource mobilization, advocacy and communications specialists from a range of partners, including those outside the core partners who have an intimate knowledge of a particular donor market. Insights and information from the task teams will be used to develop an over-arching resource mobilization strategy for global polio eradication.



- **Exploration of innovative financing mechanisms:** a review of innovative funding instruments is underway to help narrow the funding gap in the short and medium/long-term.
- **Increased focus on domestic resources:** ensure that where possible, resources from affected countries are secured to help off-set programme costs and potentially stimulate increased country commitment.
- **Re-engaging lapsed and traditional donors:** through a collaborative approach, re-build confidence in the programme, safe-guard previous donor commitments, and appeal for additional resources to support the emergency plan.
- **Bringing in new donors:** Building on the success with Australia, Saudi Arabia, and the United Arab Emirates in 2011, fundraising efforts will build interest in supporting polio among new donors, and expand outreach to include emerging market donors and high-net worth individuals.

Enhancing Advocacy

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

Strategic Communications

A more coordinated and strategic communications plan is being developed by the core partners to help create a conducive environment for fundraising. This plan will engage a broader audience and communicate the significance of the opportunity to eradicate polio and improve global health for the long term. The communications work will also bolster existing efforts among national, regional and local leaders, and among vaccination teams, to increase the effectiveness of polio campaigns.

Key activities will focus on the following:

- Instilling donor country confidence in global polio eradication efforts, beginning with the launch of the Global Polio Emergency Action Plan 2012-13 during the World Health Assembly;
- Energizing the global community and strengthening momentum around the potential for a global health 'win';
- Supporting media and related efforts to galvanize new and existing donors;
- Continuing effective social mobilization efforts to create demand for the polio vaccine;
- Praising and energizing vaccinators and their role in making polio history;
- Minimizing the perceptions around setbacks in the polio programme;
- Explaining the broad, negative ramifications of failure.



Increasing Engagement

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

The GPG, will involve in a new way donors and prospective donors; polio-affected countries; key intergovernmental organizations, non-governmental organizations and foundations working in polio eradication; and the GPEI Inter-agency Emergency Steering Committee. It will call for inputs into plans and budgets, track epidemiologic and programme data to identify areas for interventions; and undertake diplomatic and advocacy interventions to mitigate risks, including those related to financing and advocacy for polio eradication.

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

Cost Efficiencies

GPEI continually evaluates costs throughout the programme and seeks opportunities for cost savings. In recent years, reviews of costs associated with SIAs in countries such as Chad and DR Congo have led to substantial reductions in operational costs. GPEI and partners are considering other ways to optimize costs and ensure maximum value for money.

In recent years, GPEI and partners have looked to innovative financing and procurement mechanisms for OPV supply to help bring costs down. Providing volume guarantees and multi-year commitments have allowed OPV suppliers to lower their prices, sometimes considerably. In 2010, such commitments, along with continued advocacy by GPEI and partners, reduced the average weighted price of OPV to US\$.13 per dose, saving over US\$60M in OPV procurement costs for 2011-2012. As we move closer to eradication and the demand for polio vaccines becomes less certain, these mechanisms will play an important role in reducing or maintaining prices as well as ensuring stable vaccine supply.



11. Polio eradication and end-game strategy, 2013-18

On 21 January 2011, WHO's Executive Board, reviewing the evidence and recommendations by SAGE, adopted Resolution EB130.R10, in which it requested the Director-General to rapidly finalize a comprehensive **Polio Eradication and Endgame Strategy 2013-18**, including a timeline for the switch from trivalent to bivalent OPV for all routine immunization programmes.

To this end a new, more efficient polio eradication strategy will be developed, which combines the eradication of residual WPV transmission with the 'Polio Endgame' strategy. The polio endgame strategy is based on new diagnostic tests for cVDPV, the availability of bOPV, new low-cost approaches for the introduction and use, as appropriate, of IPV, as well as supplementary surveillance and mass immunization activities.

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

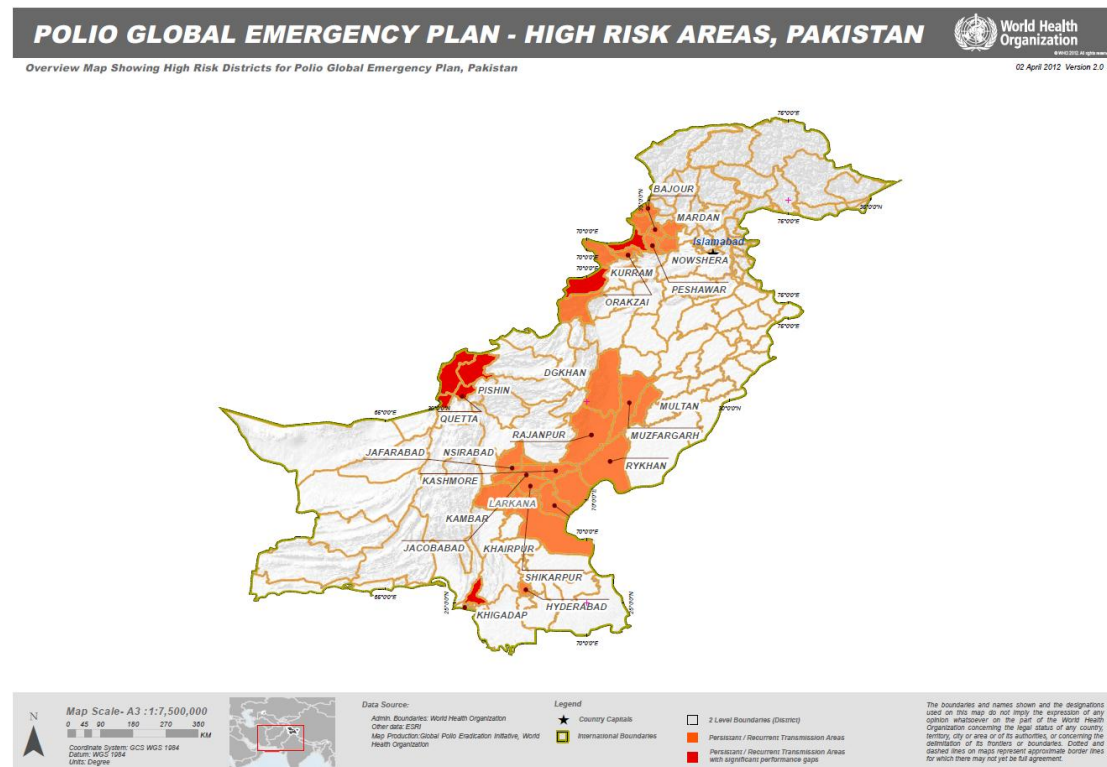
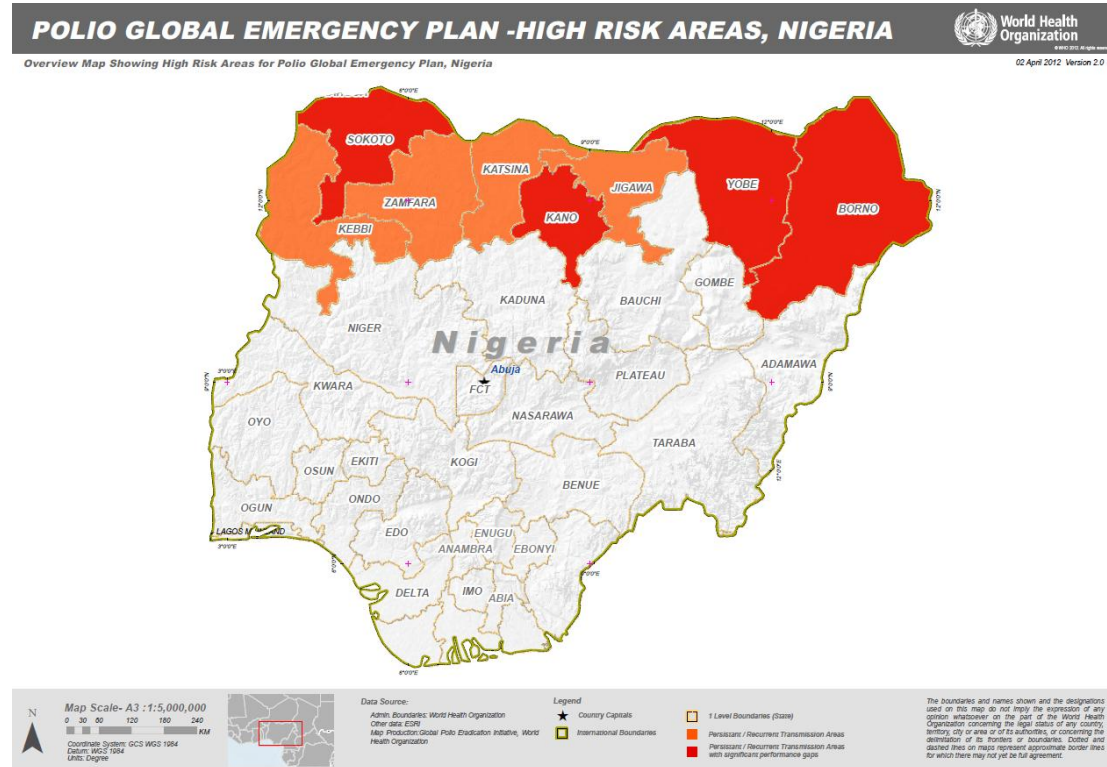
After interruption of WPV transmission, the polio endgame will be driven by the costs of maintaining surveillance and laboratory capacity, and the costs of outbreak response capacity for cVDPV. These costs will stop once use of OPV has stopped and vaccine-derived polioviruses have been eliminated.

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

GLOBAL POLIO ERADICATION INITIATIVE - EMERGENCY ACTION PLAN 2012-13									
Focus Area	Key expected outcomes	Milestones							
		2012		2013					
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Geographic/Strategic Area	NIGERIA								
	PAKISTAN								
	AFGHANISTAN								
Enhanced International support									
Funding									
Oversight and Monitoring									
Key									



ANNEX 2: Areas of priority focus for the Global Polio Emergency Action Plan 2012-13 in the endemic countries.



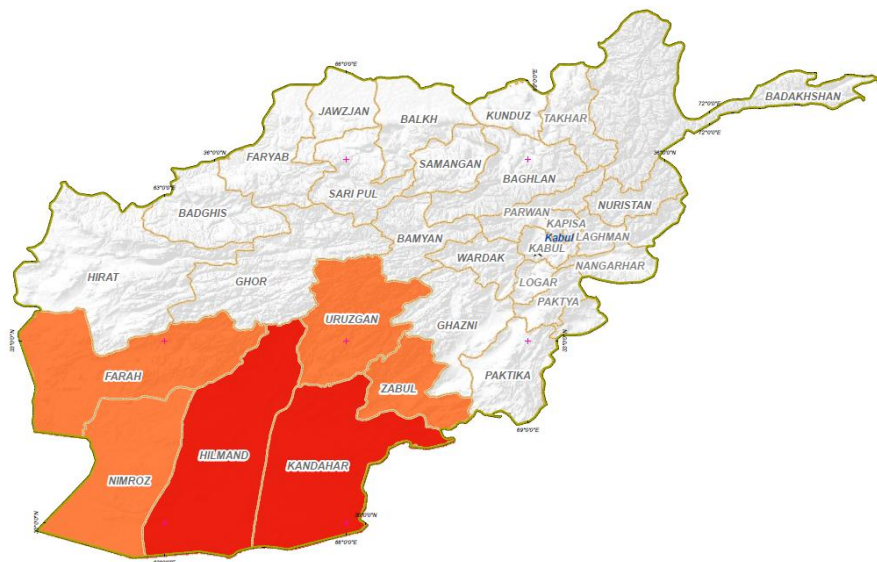


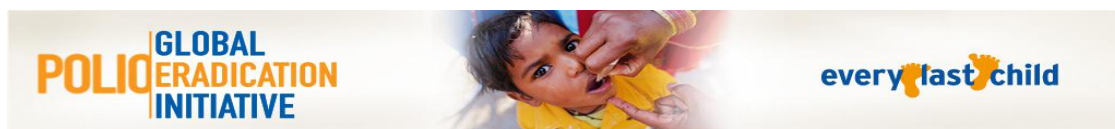
POLIO GLOBAL EMERGENCY PLAN - HIGH RISK AREAS, AFGANISTAN



Overview Map Showing High Risk Provinces for Polio Global Emergency Plan, Afghanistan

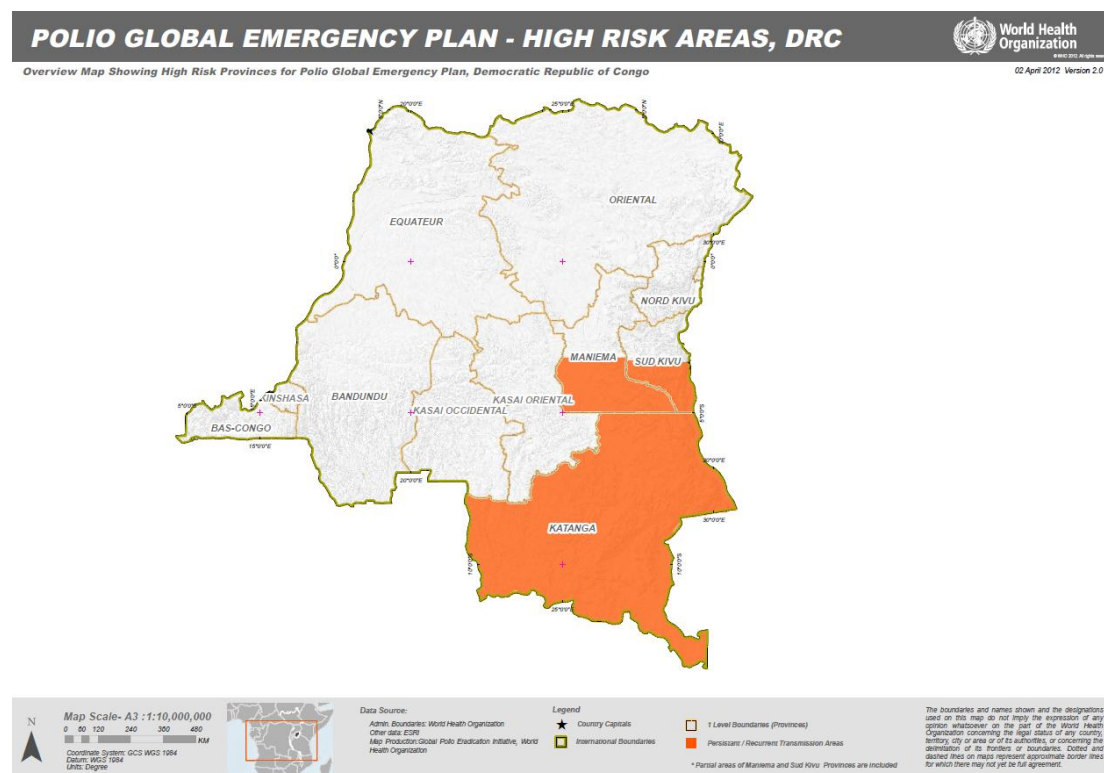
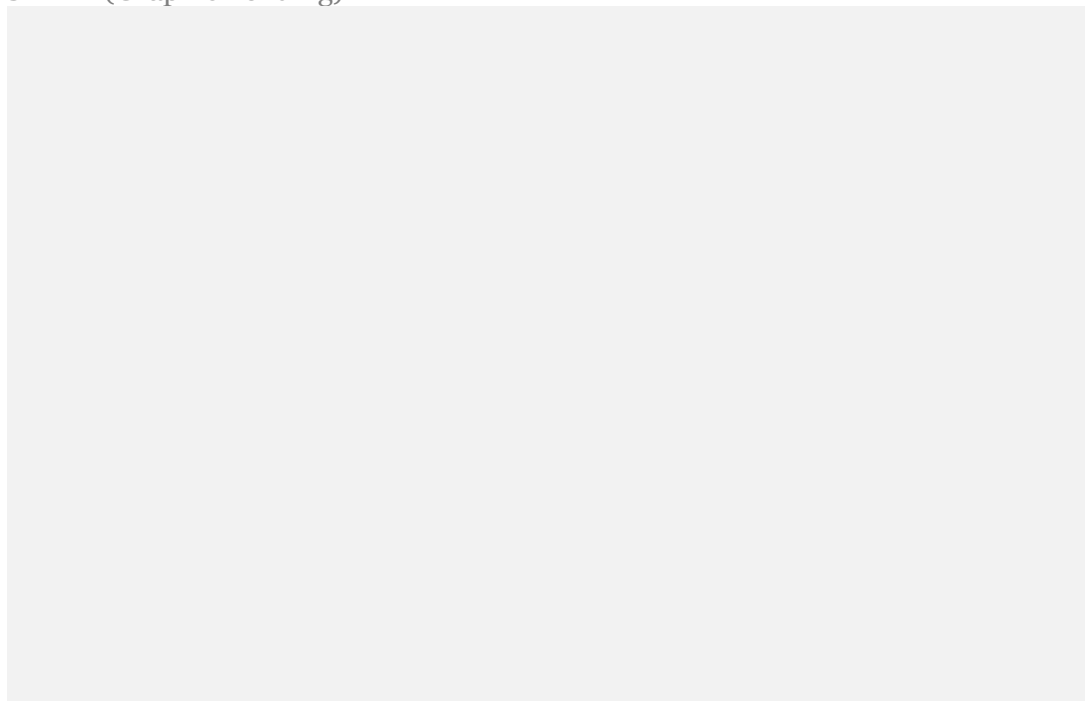
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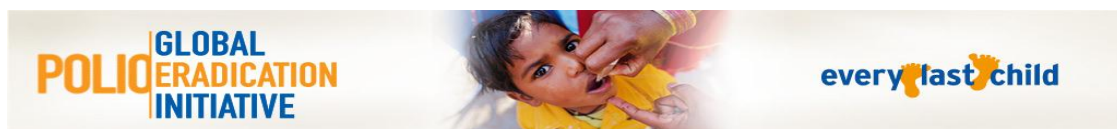




ANNEX 3: Areas of priority focus for the Global Polio Emergency Action Plan 2012-13 in the re-established transmission countries

CHAD (Graphic Pending)





POLIO GLOBAL EMERGENCY PLAN - HIGH RISK AREAS, ANGOLA



Overview Map Showing High Risk Provinces for Polio Global Emergency Plan, Angola

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