Report on implementation of June 2012 IMB recommendations

October 2012

1. An emergency meeting of the Global Polio Partners Group is held to mobilise urgent funding to reinstate cancelled campaigns.

- July conference call held to discuss resource mobilization plans
- As of October
  - 2012 gap is effectively closed
  - 2013 gap reduced to US$340.76 m (including 75% likely prospects)
  - Impact: high priority campaigns rescheduled for end 2012
- Two major contributors to filling the gap:
  - WHA declaration of eradication as a programmatic emergency
  - UNGA polio event characterizing eradication as a “once-in-a-generation” opportunity
- A robust long-term strategy, more strategic collaboration of partners (task force for resource mobilization), concrete progress, and UNGA momentum, planning for the Vaccine Summit in April 2013 should result by mid-2013 in a majority of the long-term funding needed

2. The Polio Oversight Board should continuously review the effectiveness of the Programme to achieve improvement; ten transformative activities are set out for this purpose.

- Polio Oversight Board has met twice (June and Sept) since last IMB report
- Visits by Heads of Agencies &/or senior staff:

Country	Number of visits
CDC	2 visits to Nigeria
Rotary	1 visit to Nigeria by Rotary President (July 2012)*
UNICEF	1 visit to Chad by Executive Director (April 2012)
WHO	2 visits to Pakistan and 1 visit to Afghanistan by Regional Director, WHO EMRO 2 visits to Nigeria, 2 visits to Pakistan, and 1 visit to Afghanistan by WHO Assistant Director General

*Afghanistan, Nigeria and Pakistan have all been visited by Rotary Senior Leaders, with visits to Heads of State in the last 7 months.

3. A polio 'end-game and legacy' strategy should be urgently published for public and professional consultation.

- Consultant hired in July 2012
- Input from WHO Regional and Country Offices, the polio donor and stakeholder community, the Polio Partnership Group, the SAGE polio working group, and spearheading partners
- Draft transmitted to the IMB on 18 October; input expected on final version (due end-2012)

- Key strategy milestones identified:
  - end-2014: interruption of WPV transmission
  - 2015-16: tOPV-bOPV switch
  - end-2018: global certification
- 2013-2018 budget developed: US$5.5 b
- Broad 2013 consultations on program legacy planned to ensure polio investments/assets are secured for broader global health benefits

4. A plan to integrate polio vaccination into the humanitarian response to the food crisis & conflict in W Africa should be rapidly formulated & implemented. Alliances with all possible programmes must be urgently explored, to make every contact count.

- Challenges: nutrition/food crises, insecurity, flooding, and cholera
- Actions:
  - Country plans developed to integrate nutrition, health (including OPV), and WASH
  - Cross-border meetings held to strengthen collaboration (Niger and Nigeria; Mali, Burkina Faso, and Cote d'Ivoire; Lake Chad - Cameroon, Chad, Niger, and Nigeria; and Cameroon and Chad) and focus on nomadic and other mobile populations (Burkina Faso, Mali, Niger, Chad, and Mauritania)
  - Refugees and IDPs targeted in all SIAs (e.g., IDPs in Mali and Malian refugees in Burkina Faso, Niger and Mauritania)
  - Additional synchronized SIA conducted in Niger (all regions except Agadez), Mali (the 6 regions accessible in South), Burkina Faso (all regions neighboring Niger and Mali), and Guinea (Conakry and Kankan) due to increased mobility in these areas
  - Synchronized SIAs Oct & Nov in Benin, Burkina Faso, Cameroon, CAR, Chad, Cote d'Ivoire, DRC, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria and Sierra Leone

5. We recommend that environmental surveillance should be much expanded in its use, and that, if feasible, a positive environmental sample should trigger a full outbreak response. We recognize the feasibility and the logistics of this need to be looked into but this should be done rapidly.

- Environmental surveillance workshop held May 2012
  - By end-2012: Strategy/guidance developed (e.g., risk areas for undetected WPV importation/circulation, cVPDV emergence)
- Funds sought to support optimization of sample collection/concentration. RFP to use funds expected in 2012-Q4; work to commence in early 2013
- While new technologies are developed, expansion priorities are:
  - 2012-Q4: Add/change collection sites in the Kano metro area
  - 2013-Q1: Start collection in Luanda for local concentration and remote testing
  - 2013-Q2 or later: Initiate collection at sites in Maiduguri (lab capacity must be increased to accommodate this)
  - 2013-Q4: Consider new sites in major transport hubs of sub-Saharan Africa
- By end-2015: 15-20 new sites globally to help monitor OPV2 cessation, elimination of Sabin 2, facility containment (vaccine manufacturing sites) (Endgame 2013-18)

6. Contingency plans should be drawn up now to activate the International Health Regulations to require travellers from polio-affected countries to carry a valid vaccination certificate; this measure should be implemented when just two affected countries remain.

3 options considered (with Department of Global Capacities Alert and Response):

1. Amendment to the IHR
    - only way to "require" vaccination prior to travel
    - NOT favored as : 1) process is long (>2 years); 2) rejected in 2008 by WHA; and 3) countries can opt out
2. DG/WHO to issue a 'Temporary Recommendation' under the IHR
    - NOT favored as "considerable administrative effort and related processes", including declaration of a "public health emergency of international concern", the establishment of an "IHR Emergency Committee," review every 3 months, and duration < 24 months
3. DG/WHO to issue a 'Standing Recommendation' under the IHR
    - Favored by WHO as could potentially include vaccination or review of proof of vaccination and exit screening
    - Process could begin late 2012 or early 2013

7. The number of missed children (those with 0 doses of vaccine, those with <3 doses, and those missed in each country's most recent vaccination campaign) should henceforth be the predominant metric for the Programme; a sheet of paper with these 3 numbers should be placed on the desk of each of the Heads of the Spearheading Agencies at the beginning of each week. This should commence immediately.

- Consensus on best metric – triangulation of independent data on missed children over time
  - LQAS conducted in high-risk/worst-performing areas immediately after SIA rounds
  - OPV immunization status of non-polio AFP cases
  - post-campaign market surveys and 'independent monitoring'
- Other data improvements
  - house-based monitoring of missed children during the SIAs to enable immediate correction
  - 'results monitoring frameworks' showing outcome (SIA quality, OPV status of non-polio AFP cases) and impact data (polio cases, environmental isolates) for highest-risk areas
  - partner calls to optimize quarterly SIA planning based on best data and modeling
  - re-designed computerized data platform at WHO/HQ to receive, process, and share data
  - data sharing agreements (with appropriate safeguards) between WHO/HQ and partners