

Independent  
Monitoring Board  
of the  
Global Polio  
Eradication Initiative

Report

October 2011

# Independent Monitoring Board of the Global Polio Eradication Initiative

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The Independent Monitoring Board was convened at the request of the World Health Assembly to monitor and guide the progress of the Global Polio Eradication Initiative's 2010-12 Strategic Plan. This plan aims to interrupt polio transmission globally by the end of next year.

This third report follows our fourth meeting, held in London from 28 to 30 September 2011. We will meet in London from 30 January to 1 February 2012, and will issue our next report thereafter.

We continue to benefit from the time, energy, and support of many partners of the Global Polio Eradication Initiative. We are grateful to each of them. We continue to invite comments from all readers of our reports. These can be directed to our independent secretariat – [IMBSecretariat@polioeradication.org](mailto:IMBSecretariat@polioeradication.org). Independence remains at the heart of our role. Each of us sits on the board in a personal capacity. As before, this report presents our findings frankly, objectively, and without fear or favour.

Sir Liam Donaldson (Chair)  
Former Chief Medical Officer, England

Dr Nasr El Sayed  
Assistant Minister of Health, Egypt

Dr Jeffrey Koplan  
Vice President for Global Health, Director,  
Emory Global Health Institute

Professor Ruth Nduati  
Chairperson, Department of Paediatrics  
and Child Health, University of Nairobi

Professor Michael Toole  
Head, Centre for International Health,  
Burnet Institute, Melbourne

Dr Ciro de Quadros  
Executive Vice President, Sabin Vaccine  
Institute

Dr Sigrun Mogedal  
Special Advisor, Norwegian Knowledge  
Centre for the Health Services

Dr Arvind Singhal  
Marston Endowed Professor of  
Communication, University of Texas at El  
Paso

## CONTENTS

Executive Summary	4
Introduction	6
Country by country findings	8
Cross-Programme findings	18
Conclusion: End-2012 milestone	26
Recommendations	27

1. Every country with persistent polio transmission, with the exception of India and Angola, has had more cases so far in 2011 than they had by the same time last year. Chad, Afghanistan and DR Congo have already exceeded their entire 2010 total.
2. The rate of occurrence of new outbreaks serves as an ongoing reminder that many countries in the world are under threat from the ease with which polio could be imported across their borders.
3. The 2010-12 Strategic Plan set out four intermediate milestones. Just two are on track. One is highly unlikely to be attained within the planned timeframe. One has missed its deadline and remains elusive.
4. The GPEI is not on track to interrupt polio transmission by the end of 2012 as it planned to. Indeed, unless the fundamental problems highlighted in this report can be addressed, there is a substantial risk that stopping transmission will take far longer than the 15 months that remain between now and the end of 2012.
5. Polio eradication could still be achieved by the end of 2012 if the weaknesses of the Programme at both country and global level can be swiftly corrected, and if political commitment and financial support for the GPEI can be bolstered.
6. This report assesses progress in each of the countries with persistent transmission. With the exception of India, none of the endemic countries is making progress at the rate it needs to:
  - India has a good chance of interrupting transmission this year
  - Afghanistan's programme is strongly managed and innovative, but is still unable to reach one-third of children in 13 high-risk districts
  - Nigeria has slipped back on progress made in 2010; it needs to demonstrably regain the commitment of political and traditional leaders
  - Pakistan has made little tangible advance over the last 18 months; a fundamental strategy review is needed.

Case numbers are rising in five of the seven key countries

Outbreaks - unwelcome surprises continue

As many milestones are being missed as are being met

The Programme is not on track for its end-2012 goal, or for any time soon after unless fundamental problems are tackled

But if problems are tackled, imminent success is entirely feasible, even for the end of 2012

India is alone amongst the four endemic countries in being on track to stop transmission in 2011

Pakistan and Nigeria are of major concern, particularly Pakistan

7. Having missed their end-2010 goal, the three countries with re-established transmission are now showing some progress, though the end is not in sight for any of them yet:
  - Angola is making good progress, but Luanda remains a real vulnerability
  - Chad now has the technical capacity that it desperately needed, and must now deploy this to good effect
  - Indicators in DR Congo remain off-target but are moving in the right direction; the potential for election-related disruption is of great concern
8. The surprises of unexpected outbreaks continue to undermine confidence in the Programme. China had been free of polio for a decade until its current outbreak. The detection of a case in Kenya is particularly alarming, because it represents a failure to deal with long-standing transmission between Kenya and Uganda since 2009. The Horn of Africa remains at particular risk of further outbreaks.
9. In addition to our country-specific findings, we describe five problems that run as common threads through the global Programme, reducing its chances of success. They relate to culture and approach. Tackling each will require challenging introspection for the Programme, but will produce great gains. The style and approach to management of the global Programme needs reorientation.
10. Our view remains that polio eradication needs to be treated as a global health emergency. It needs more funding, and broader, more engaged global political commitment – particularly from non-affected countries. The challenge remains great, but the other option is to allow this terrible disease to resurge.

There is some positive news from each of Angola, Chad and DR Congo but, nine months after their original deadline, none of them is nearing completion

Too many surprises

The culture and approach of the global Programme is not currently matched to what is required

This Programme needs greater global priority and funding. Failure would be a disaster

This is the third report of the Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative (GPEI). The IMB has spent a great deal of time: reviewing data (both qualitative and quantitative); listening to country leaders and Programme managers, experts, donors and commentators; reading, discussing, learning and taking account of feedback on our reports.

At its meetings, which precede the production of the reports, the IMB has met with health ministers and programme leaders from each of the affected countries, with representatives of the spearheading partners, with donors and with a wide range of others.

Over this time, the IMB has gained a deeper understanding of the strengths and weaknesses of the GPEI. We have benefited greatly from the growing frankness of many of those whom we have met. Few now give presentations to put on a good show. Instead, they know that the IMB can be of most help if they hear a “warts and all” account.

When we sent our last report to the Heads of the spearheading agencies – WHO, UNICEF, CDC, Rotary International – and to the Bill & Melinda Gates Foundation – we identified in the covering letter a number of developments that, if they happened, would be important straws in the wind that eradication was on track. These were:

- No recurrence of cases in India by end-2011
- Interruption of transmission in Kano and the surrounding north-west areas of Nigeria by end-2011
- Interruption of type 3 poliovirus globally by end-2011
- Major expansion in capacity and expertise in Chad and DR Congo, with independent monitoring, surveillance data and case numbers clearly reflecting the impact of this expansion by end-October 2011
- A clear decline in the number of cases in Pakistan in the second half of 2011, compared to the equivalent period in 2010, with particular evidence that the National Emergency Action Plan is working in Sindh province
- No more ‘surprises’ with re-emergence of the disease in polio-free countries
- A decline in field reports suggesting poor or variable quality of vaccination campaigns and surveillance, and/or inadequate local leadership

Following in-depth review of the GPEI, this is the IMB's third report

Three months ago, we identified seven ‘straws in the wind’ that would indicate eradication to be on track

There is a broad consensus amongst the many we have talked to that only the first of these (India) is likely to materialize. These are not goals that we have unilaterally created. They simply describe progress that would be consistent with the Programme's stated ambition of stopping polio transmission globally by the end of 2012.

In this, our third report, we:

- Assess the progress being made in stopping polio transmission country by country
- Adopt a broader view of the Programme as a whole, to present our observations on some systemic issues; dealing with these cross-Programme issues would fortify the GPEI's ability to reach its important goal

Our major findings are clear and unambiguous. We present these findings frankly. We are convinced that polio can – and must – be eradicated. We are equally convinced that it will not be eradicated on the current trajectory. Important changes in style, commitment and accountability are essential. This report explains this conclusion, offers many observations and makes five recommendations.

Only one of these seven looks set to materialize

This report examines progress country by country, and also describes important cross-Programme findings

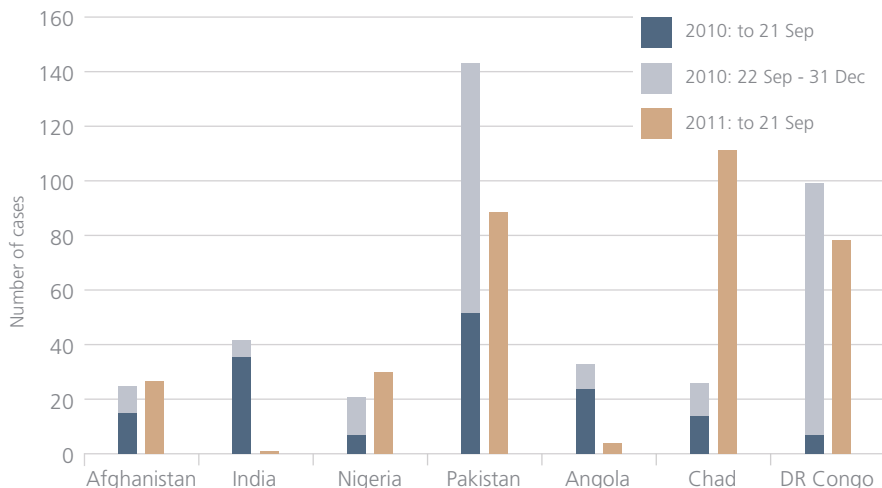
Seven countries have persistent polio transmission:

- Four countries with endemic transmission – Afghanistan, India, Nigeria and Pakistan
- Three countries with ‘re-established’ transmission – Angola, Chad and DR Congo

With the exception of just Angola and India, each of these countries has had more cases to date in 2011 than it had by this time last year (figure 1). Three countries have, after nine months of 2011, already exceeded the number of cases reported in the whole of 2010.

We assess the progress being made in each of these countries. We then assess the progress being made in dealing with outbreaks in other countries.

**Figure 1: Every country except Angola and India has had more cases in 2011 than it had by this time last year. Chad, Afghanistan and Nigeria have already exceeded their entire 2010 total.**



### ENDEMIC COUNTRIES

The GPEI is very unlikely to attain its end-2011 goal of stopping transmission in at least two of the four endemic countries. India is making great progress, and appears on track to stop polio transmission this year. Nigeria made strong progress in 2010, but has slipped backwards in 2011. Afghanistan continues to makes slow but steady progress. Pakistan’s programme is failing.

Five of the seven countries with persistent polio transmission have had more cases in 2011 than they had by this point last year

**END-2011 MILESTONE**  
 Cessation of all poliovirus transmission in at least 2 of 4 endemic countries  
**AT RISK**



## Afghanistan

Afghanistan is a highly mountainous country with a dispersed population. Routine vaccination coverage is as low as 20% in some areas. But the greatest challenge to polio eradication is conflict, which renders thousands of children inaccessible to vaccinators. On average, each of its 13 high risk districts reached just two-thirds of children in the July 2011 vaccination round. Just one reached more than 90% of children. Virological evidence also makes it clear that there are gaps in surveillance, not just vaccination.

The programme's primary problems are at district and local level rather than national or regional. That said, there are strong commonalities between areas. They face problems with coordination of, and commitment to, polio eradication activities, as well as with funding flows. But success in Afghanistan particularly hinges on finding ways to gain access to more children at each successive vaccination round. Fighting in Afghanistan has traditionally being cyclical. The forthcoming winter season offers an important opportunity to reach more children.

Afghanistan was the only country to seize upon our recommendation of setting out intermediate milestones en route to interrupting transmission. Each of these five milestones is clear and appropriate. Each has a clear set of actions associated with it, and indicators defined to track its success.

Afghanistan also stands out for its openness to innovation. At both micro and macro levels, there are examples of ingenuity. Not all innovations will succeed but some will, and this 'can do' mindset will help the country's programme to navigate the challenges ahead. Its establishment of permanent vaccination outreach teams in the high risk districts is a particularly welcome innovation.

We are impressed with the management of Afghanistan's programme, in the face of considerable challenges. But this is not to say that all is going well. The country is far from achieving the end-2011 milestones set out in the 2010-12 Strategic Plan. It will not succeed in eradicating polio until the problem of inaccessibility is more roundly overcome. The programme's ingenuity and innovation must continue, supported by a real drive to continuously enhance commitment and quality at the district and local levels.

Afghanistan faces many challenges, the greatest of which is conflict-related inaccessibility

There are major gaps in both surveillance and vaccination

Fighting usually diminishes during the winter months, offering greater access opportunities

Afghanistan's disciplined programme management approach is reflected by its five defined milestones

Its programme is strengthened by its ingenuity; it innovates around problems

This is a strong programme but it is not yet one capable of stopping polio transmission

## India

This is a promising time for India. Just two years ago, some would have found it inconceivable that India could get this close to eradicating polio. The sheer force of polio transmission in its stubborn reservoirs was immense. The sanitary conditions amongst the densely packed populations of Uttar Pradesh and Bihar presented a towering challenge to the effectiveness of any vaccination campaign. India has more individuals migrating at any one time than some countries have as their entire populations. But these challenges have been understood, and seemingly overcome.

India dealt well with its single 2011 case (in West Bengal). The response was fast and effective. It has achieved and maintained strong surveillance and impressive vaccination levels. Further cases may arise, but the country seems ready to deal with them. India stands a good chance of interrupting polio transmission by the end of 2011.

India has been through a long and relentless learning process. Its programme is highly sophisticated, and has many experts. India is now considering how it can deploy this expertise in support of other countries. We strongly urge it to do so.

The prospect of interrupting transmission in India raises a difficult question for the country, and for the global Programme as a whole: Can India maintain the intensity of campaigns needed to remain polio-free whilst it remains threatened by the presence of the disease in other countries?

## Nigeria

Nigeria is strategically vital to polio eradication. Its southern states have been free of polio for a decade, but persistent transmission in the north has repeatedly seeded infection across a band of surrounding countries. Stopping polio in Nigeria should be a top priority – for the sake of protecting Nigerian children, and to put a stop to exportations of the virus, which are sapping valuable resources from the global Programme.

Nigeria made impressive progress in 2010, achieving a 95% reduction in polio case numbers. Our April report highlighted the window of opportunity that this provided to stop polio transmission for good. Despite our warnings, the subsequent elections caused the programme to lose momentum. In the first nine months of 2011, Nigeria has already reported more cases than in the whole of 2010. Quite simply, immunization day coverage remains too low across whole swathes of the north. Almost 30% of the highest risk wards have been missing more than 10% of children. This is embarrassing and unacceptable performance.

India has pushed through barrier after barrier to reach a very favourable position

India is on track to interrupt polio transmission in 2011

India has a great deal to offer other polio-affected countries

Can India maintain the required intensity of campaigns until global eradication removes the threat of re-infection?

Northern Nigeria is the unrelenting source of polio transmission across much of northern Africa

Nigeria has slipped back on progress made in 2010, to the dismay of everyone who had commended their programme leadership

Instituted in February 2009, the Abuja commitments were held up as the keystone of Nigeria's programme, a valuable mechanism for achieving the all-important active commitment of governors. It is very worrying to see that adherence to these commitments has dropped precipitously. Unfortunately the challenges in Nigeria have also been exacerbated by a deteriorating security situation in a number of northern states over recent months.

There is no shortage of high-level advocacy and commitment in Nigeria. The challenge, as elsewhere, is in aligning the actions of state and local leaders with this. Both political and traditional leaders need to be involved. Whatever other advances the programme is making will be fruitless without this. Earlier this year, Nigeria had gained credibility as having a programme on the right trajectory to stop polio transmission. That credibility has slipped. Nigeria must show that it can achieve the sustained commitment of political and traditional leaders if it is to regain its footing as a programme able to stop polio transmission soon.

## Pakistan

In 2010, three of the four endemic countries each achieved a 60% or greater reduction in their annual number of polio cases. The fourth endemic country, Pakistan, stood out for the wrong reasons. It suffered 50% more cases in 2010 than in 2009. In 2011, the situation has worsened further.

Nine months ago, the President of Pakistan launched an emergency action plan intended to get the situation under control. The plan looked good on paper. It assigned responsibility for polio eradication to the district and Union Council levels. It established a national polio monitoring cell, overseen by the Prime Minister.

The plan has almost entirely failed to gain traction. At the top, the President and Prime Minister are committed to eradicating polio. But the actions of thousands of workers beneath are not in line with this commitment, and little is being done to bring them into line. The disbandment of Pakistan's Ministry of Health has weakened the programme's grip, and any chain of responsibility or authority, still further.

The challenge is not a technical one. It is one of people management. Success in stopping polio depends on the thousands of individuals involved in vaccinating, supervising and managing. Many are committed to their work – they take pride in what they do, they toil to rid their communities of polio. But many are not. At best, they are indifferent. Some district leaders seem to feel that polio vaccination has little bearing on their relationship with the electorate or with their

The Abuja commitments have been much trumpeted as key to the country's programme, but have now collapsed

Active involvement of both political and traditional leaders remains as important as it ever was, and needs urgent revitalization

Nigeria is at risk of losing everything it had gained

The number of polio cases in Pakistan is worsening year on year; the situation is dire

Pakistan's emergency action plan made sense on paper, but is not being meaningfully translated into action

Pakistan's programme contains too many individuals who do not support it

own political masters. There is no shortage of task forces and committees, but accountability cannot be properly enforced through a committee.

In too many areas of Pakistan administration is weak, there are low levels of interest in and ownership of polio eradication, teams cannot reach children because of security concerns and health generally does not have a high priority compared to other seemingly more pressing concerns.

It is absolutely apparent that the governance of Pakistan's polio eradication programme is deeply dysfunctional. Commitments made at the top are simply not resulting in effective action at the front-line. Pakistan certainly faces other challenges, from recent flooding to conflict-related inaccessibility. But the lack of alignment and accountability remains the diseased core of the programme. The strategic management of the GPEI is achieving very limited control over these matters, so the eradication effort is sliding towards a precipice. The question that arises is a fundamental one: what more can federal government do when provincial structures are not delivering?

Some parts of Pakistan run against the trend. In the Punjab, for example, polio transmission is low. One reason is that there are clear district and sub-district plans, and the Chief Minister takes a keen interest in ensuring that accountability is clearly set out.

Our last report earmarked Sindh as a barometer of progress in improving governance, as the province was not affected by fighting. Sindh has since suffered devastating floods. Balochistan is now a more pure barometer, although reporting may be unsatisfactory. We will watch progress there closely.

Pakistan's progress now lags far behind every other country in the world. Without urgent and fundamental change, it is a safe bet that it will be the last country on earth to host polio, its children and those of its neighbours remaining vulnerable to otherwise preventable paralysis long beyond the time that they should. The problems are absolutely clear. Focus now must be on generating real – and different – solutions. We recommend that Pakistan fundamentally re-thinks its national emergency action plan, focusing on what can be done to enhance meaningful accountability. We also recommend that it consider outsourcing elements of the programme away from government, for management by non-governmental organisations.

**The programme in Pakistan is riddled with dysfunction**

**Pakistan lacks a federal-level leader who can bring Presidential authority to bear in poor-performing districts**

**Polio eradication in Pakistan is sliding towards a precipice**

**The Punjab shows that it is possible to achieve results in Pakistan**

**Balochistan and Sindh are key barometers of future progress**

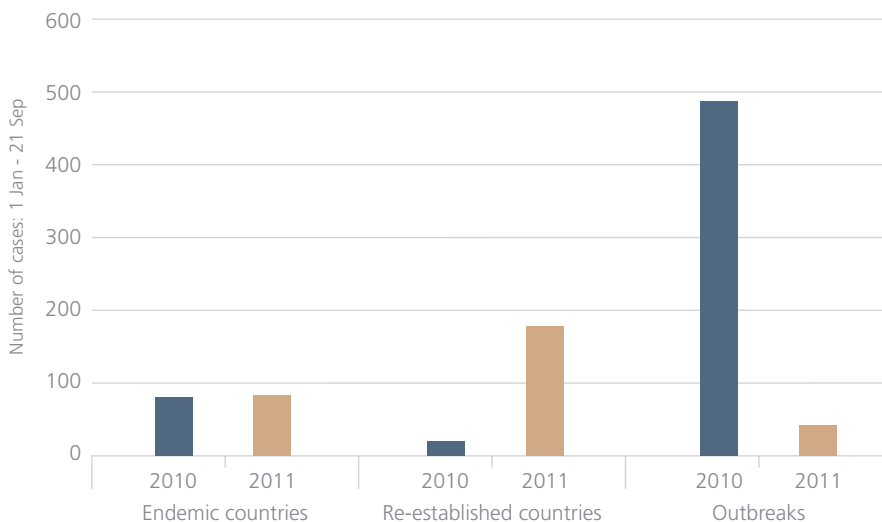
**Pakistan's response to polio is the weakest in the world**

**A fundamental strategic re-think is urgently needed**

## COUNTRIES WITH RE-ESTABLISHED TRANSMISSION

When the 2010-12 Strategic Plan was launched, four countries had 're-established' polio transmission. The plan aimed to stop this transmission by the end of 2010. This failed in three of the four countries – Angola, Chad and DR Congo. So far in 2011, almost half of all detected polio cases have occurred in one of these countries (figures 2 and 3).

**Figure 2: Compared to the same period to 2010, there have been many more cases in re-established countries so far in 2011, many fewer attributable to outbreaks, and approximately the same number in endemic countries**



### Angola

Polio became re-established in Angola in 2005, after four polio-free years. The country has re-infected six others since that time, and progress in stopping transmission again has been slow to come. There is now apparent good news. Angola has detected no polio cases for the last seven months – the longest interval since 2005.

The programme has performed well in 2011, maintaining a frantic pace of activity. The government has given considerable financial backing. We are increasingly optimistic about progress.

The programme has a good sense of the substantial challenges remaining, and must not lose pace in tackling them. The seven-month plan for Luanda is a vital development. An outbreak in Luanda could readily spread within the province and beyond. Surveillance here is still too patchy - we cannot be sure that cases are not currently occurring. The community-based strategy has had

#### END-2010 MILESTONE

Cessation of all 're-established' polio transmission

**MISSED**

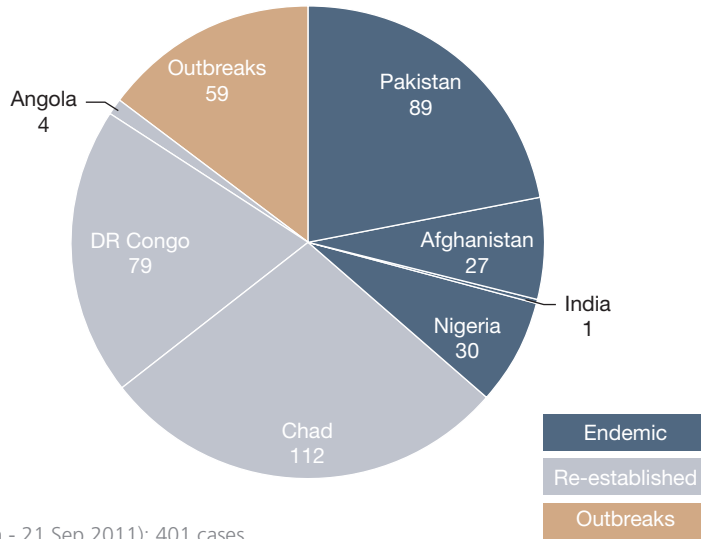
We are increasingly optimistic about progress in Angola, but substantial challenges remain

Both surveillance and vaccination performance in Luanda remain dangerously weak

some positive impact, but most districts in Luanda continue to miss more than 10% of children in vaccination rounds. This is poor performance. The engaged leadership of provincial governors and municipal and local administrators is key to success, but this engagement is variable. The new system of indicators to monitor commitment needs to be used to celebrate those leading the charge against polio, and to hold poor performers to account.

If this seven-month hiatus is real, it represents an opportunity that Angola must seize. The Major Process Indicators of the 2010-12 Strategic Plan provide some clear goals for vaccination and surveillance quality – goals that have not yet been attained. Their attainment would substantially increase the chances of permanent polio interruption. We congratulate Angola on having come this far, but relentless determined work is still needed to overcome the remaining challenges, achieve these goals, and secure true success.

**Figure 3: So far in 2011, 48% of cases have been in re-established countries, 37% in endemic countries, and 15% in outbreak countries**



## Chad

Chad has the highest number of cases of polio in Africa and accounts for over a quarter of cases worldwide. It has no organized and accessible healthcare system and so is reliant on campaigns that have faced formidable logistic, financial and technical challenges. As a result, the response to the need to eradicate polio in Chad has been weak and ineffective.

Angola’s end-2011 Major Process Indicator goals are some way from being attained; more is needed to complete the job

The number of cases in Chad is the highest in Africa

The IMB was so alarmed about the situation in Chad that we characterized it as a public health emergency and called for an urgent and substantive mobilization of commitment, capacity and capability. In the six months since then, the level and tempo of action has improved.

The President of Chad has strongly committed his leadership to eradication. Some 80 additional polio staff have been placed in the programme and training has commenced. However, a group of around 20 other government-employed staff appear not to be integrated into the programme and this situation needs to be remedied. Another major deficit is still the lack of any skilled professional leader for the programme nationally.

Crucial to the programme in Chad will be the frequency and quality of vaccination rounds over the next few months. A campaign is planned for late October but will not benefit fully from the extra capacity that is still being integrated. A campaign is also planned for November. This must be of a different order than anything Chad has seen in the past, or the new plan will face very public and humiliating failure. Evaluation must recognize that the end of the year is a low-transmission period, so any apparent successes need to be judged cautiously.

## Democratic Republic of Congo

Our previous assessments of DR Congo have revealed a country with a dysfunctional healthcare system, struggling to mount the additional response needed to stop polio transmission. Surveillance was so weak that a chain of transmission was missed for two years. From a number of sources, we heard of multiple problems on the ground, with vaccination rounds as well as with surveillance.

Despite its large number of cases so far this year, there are some more positive signs that the programme in DR Congo is strengthening. We previously underscored the importance of gaining the President's active involvement in the programme. The fact that he used a meeting in August to hold each of his governors to account for actions that they are taking against polio was a welcome development. We ask that this continues. Nearer the front-line, there is evidence that vaccination coverage is steadily improving.

Despite the noticeable improvements, we retain concerns. Closer investigation is needed of UNICEF's adverse evidence that overt and covert refusal rates in Katanga may be exceptionally high. The country set a target of interrupting transmission by the end of September 2011, which it will miss. It also looks

Six months ago, weak commitment, non-existent capacity, dysfunctional vaccination performance and massive logistic difficulties meant there was no prospect of eradication

Heightened commitment from the top and additional staff have strengthened the position

Chad needs a strong professional leader for the programme

The quality of the campaign in November will need to be superior to anything seen in the country before

Until recently, DR Congo has not been able to mount a credible response to ongoing polio transmission

More positive signs are beginning to emerge, including a strong leadership signal from the President

Vaccination coverage rates are too low in many provinces; the programme is far from meeting the targets that will allow it to interrupt transmission

set to miss its end-2011 Strategic Plan targets. Despite improvements, too few provinces are consistently achieving coverage rates of over 90% in their vaccination rounds. The country's 'weak' surveillance rating is due to a significant problem with specimen adequacy. Other indicators suggest a reasonably robust system, although there are some 'silent' zones that are not detecting any cases of paralysis. This may or may not be explained by their relatively small populations.

DR Congo now needs to drag itself free of the "boom and bust" cycle of progress that has too often been seen in the GPEI. The country's forthcoming elections hang over the programme, giving us deep concern given what happened to polio eradication when Nigeria had elections. This is too crucial a time in the programme's evolution for such harm to be tolerated and contingency plans must be formulated to insulate the programme from disruption.

## OUTBREAKS

In addition to the seven countries with persistent transmission, polio outbreaks have occurred in seven other countries in 2011. Six of these are in Africa. The other is China.

The 2010-12 Strategic Plan set two milestones in relation to outbreaks. The first was that all 2009 outbreaks should be stopped by mid-2010. The second was that all subsequent outbreaks should be stopped within six months.

The Programme has continued to be successful in achieving these milestones, when an outbreak is defined on a country-specific basis. However, one recently detected case demonstrates that the reality of polio transmission is more complex than these milestones immediately suggest. A case of polio detected in Kenya in July 2011 was found to be genetically related to a case in Uganda in 2010. That Uganda case was, in turn, related to a case in Kenya in 2009. This does not necessarily mean that the Programme failed to stop the 2009 outbreak in Kenya. There is population movement across the Kenya-Uganda border. The action taken to stop transmission in Kenya clearly failed to prevent spread to Uganda. Likewise, in 2010, the action taken to stop transmission in Uganda clearly failed to stop transmission to Kenya. It is vital that the action now taken in Kenya and Uganda should be sufficient to stop any further transmission in both of these countries. This means national campaigns. This instance also offers an important general reminder to the Programme about the importance of cross-border working.

DR Congo has now gained a foothold in the struggle against polio; explicit arrangements must be made to insulate the programme from disruptions to its governance

### MID-2010 MILESTONE

Cessation of all polio outbreaks with onset in 2009  
**ON TRACK**

### ONGOING MILESTONE

Cessation of new outbreaks within 6 months of confirmation of index case  
**ON TRACK**

China is now on the polio radar for the wrong reasons and is at risk of further infection from Pakistan

The detection of a case in Kenya, related to previous outbreaks in Uganda and Kenya, indicates a real failing

Both countries need to act definitively to stop this worrying ongoing transmission



Technically speaking, milestones relating to outbreaks have been defined as country-bound. However, the fact that a multi-country outbreak has persisted for two years is a clear failing of the Programme. Polio does not respect country borders. In effect, Kenya and Uganda have together had re-established polio transmission for the last two years. It needs to be stopped.

The Horn of Africa remains at risk of further polio outbreaks. Famine and political turmoil are disrupting entire populations. Somalia is of particular concern, with one million children unreachable by vaccinators – though the work of WHO's surveillance officers in this area is to be applauded. WHO's responsibility for supporting the Horn of Africa is split between the AFRO and EMRO regional offices. These offices need to ensure that their collaboration is optimal.

**The Horn of Africa remains at high risk of further outbreaks, with an unreachable pocket of one million children in Somalia being of particular concern**

Every country has its own context, its own challenges. But examining the GPEI in the round, a number of features stand out. These relate in particular to culture and approach.

It is no surprise to find these common threads. Every programme, business and group in the world develops a particular way of doing things over time. The GPEI has had more than 20 years to do so. Many common threads are positive – but some are problematic.

These findings are important. Making improvements to the overarching approach of the global Programme clearly has benefits that are not confined to one country. These observations that we make as outside observers may not be so readily visible to people within the Programme. For those steeped in polio eradication day-to-day, the culture and approach of the GPEI become just the way things are. Although some of these findings may provoke discomfort, the Programme would benefit from taking them as seriously as our country-level findings.

### **1. People are the crucial ingredient in this Programme, and need to be viewed as such**

Polio eradication will succeed if its vast array of individuals are motivated, organized, well-linked, and well-led. At its heart, this is a challenge of change management. It is common for change management programmes to pay too little attention to the human factors, to over-orientate themselves to the technical elements of a challenge. The GPEI risks doing the same:

- How can it be that individuals known to be tired and ineffective are allowed to remain in key leadership positions?
- How can it be that front-line positions in some countries remain so under-rewarded that they are not attractive to the kind of workforce that the GPEI needs?
- How can it be that some people are not held accountable for poor performance?
- How can it be that some vaccinators are not paid the money that they are promised?
- How can it be that some team leaders are not capable of quality assuring the work they are supervising?

A Programme of this longevity inevitably evolves a particular way of doing things

Whilst many of the Programme's common threads are positive, some are impeding success

These findings may not be easy for the Programme to take on board, but are vital to its fate

Change management programmes commonly perceive technical challenges to be more important than people challenges, but it is the people who will succeed or fail to eradicate polio

Several features of the GPEI suggest that it risks making the same mistake

The Programme puts a great deal of emphasis on the technical elements of polio eradication – on finding cases, on organizing vaccination campaigns. It puts emphasis on communicating with people outside the immediate Programme – parents, key politicians, partners. But does it put enough emphasis on human factors within the Programme? We suggest not. We are in no doubt that the Programme would perform more strongly if this could be tackled. These are central issues, not peripheral ones. The Programme needs to systematically look out for and deal with these issues with the same vigour that it approaches cases of polio.

## 2. The Programme's prominent data and reports do not suggest an obsession with improving quality and with delivering on plans

This Programme cannot be about delivering more and more vaccination campaigns, on responding to polio as it arises. It needs to be relentlessly focused on improving the quality of vaccination campaigns and of surveillance. It needs to consistently focus beyond data that show *where* coverage is poor, towards a deep understanding of *why* it is poor. It needs to be disciplined in making and following through on plans that address these problems at their most essential level. All of these elements are present in the GPEI, but they are not always clearly expressed. They are often vague. They are discussed, but they do not sit at the heart of the Programme in the way that they need to. Some of our criticism relates to the way in which the Programme uses data.

In simple terms, the process of improving vaccination campaign coverage in a country involves four steps:

### Step 1. Highlight under-performing locations

The Programme does this well. It uses data to identify which places are not achieving the required vaccination coverage. These data – chiefly describing polio cases and vaccination levels – dominate the Programme's reports.

### Step 2. Understand the problems underlying under-performance

The reasons behind the gaps in performance are less well described. Typically, we see some data describing this, but it is drowned out by data that go no deeper than showing where the problems are. There may be a number of factors – parental refusals, conflict-related inaccessibility, poor quality microplanning, and more. To excel, programmes would use data to gain a precise idea of the problems behind under-performance at their deepest level. We do not see these data being integrated into the Programme or tracked as they might be.

People are central to the Programme – they need to be seen as such

If one word could be used to illustrate the areas of Programme weakness it would be lack of systems of 'accountability'

Improving vaccination campaign and surveillance quality needs to receive relentless focus

Elements that are key to quality improvement are somewhat under-developed in the GPEI – present, but more vague than they should be

The GPEI is good at using data to identify places with quality problems

The GPEI is less good at using data to really understand these quality problems; to precisely define and describe them; to communicate them

### Step 3. Plan to tackle the problems

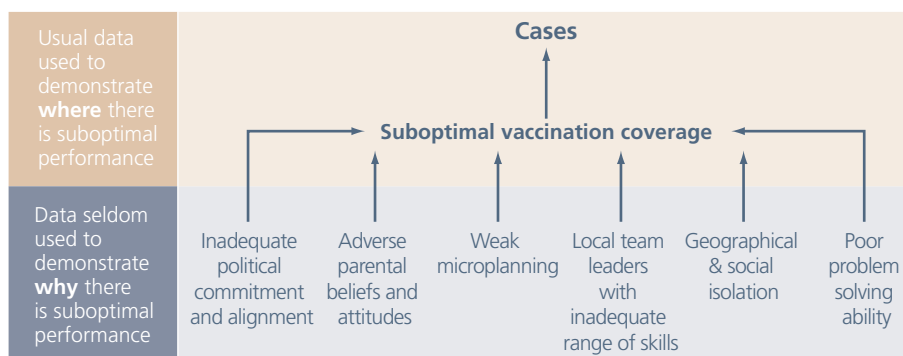
Some of the Programme’s planning documents are good, but many are weakened because they do not precisely define what actions need to be taken, because they assign accountability so broadly that it is meaningless, or because they lack timelines. It would be possible to set a number of quantified goals – perhaps to reduce parental refusals to 3%, to quality assure 95% of microplans, or to gain access to 10% more children. Few plans do so, diminishing their power.

### Step 4. Visibly track the plan’s implementation

We have not yet seen a single example of a document that tracks the implementation of the actions set out in a country’s plan. Perhaps they exist, but they are certainly not prominent. We see occasional indicator data, but we do not see these being systematically tracked and reported. This misses the opportunity to maintain focus, to accelerate implementation by holding countries, teams and individuals to account.

Most of the data that we see being used within the Programme describe where the gaps are, but say far less about why they are there or what is being done about them (figure 4). This is true of the country summaries presented at our September meeting. It is true of the national and global summaries at the heart of the GPEI’s weekly reporting mechanism. The Programme’s most visible reports are important, because they set the tone for the Programme as a whole.

**Figure 4: The GPEI predominantly focuses on data that can only describe where performance is suboptimal, not why**



Many GPEI plans are weakened through simple mistakes in design and allowing accountability to remain ill-defined and unenforced

The implementation of plans is not routinely tracked – it remains vague, rather than highly visible

Major reports from the Programme say a lot about ‘where’ but little about ‘why’ or about what is being done; they need to forcefully shift this emphasis

The Programme would benefit from more thoroughly following these simple approaches. Importantly, the Programme would benefit from doing so very visibly, indicating to all that this is a disciplined and data-driven programme focused on quality improvement.

Data are also not shared as well as they might be. Country programmes do not appear to be using the quarterly reports that the IMB receives from CDC and from UNICEF. Some tell us that they do not receive them, giving the impression that they are for the eyes of global managers only. This enhances the feeling that globally the Programme is watching and waiting rather than using data for accountability and judgement. At global level, the data are not being inter-linked to present a unified analysis of the key problems facing each country.

### 3. The GPEI's spirit of optimism risks it ducking the really difficult problems essential to eradication

Traditionally the GPEI has presented a very positive view of the Programme, emphasizing successes and downplaying challenges. The positive energy and optimism within the Programme is in many ways laudable. It represents an unyielding drive to eradicate polio. But over-optimism has real downsides.

At any given time, there is a mixture of positive and negative signs to be found within the Programme. In any one country, progress is made on some fronts as problems accumulate on others. The same is true across the global Programme. It is in the optimist's nature to see the successes more prominently than the challenges – to seize on the good news, rather than dwell on the bad. As a result, at any given time absolute success seems within imminent reach.

The Programme has an established narrative of positivity – a pervading sense of “nearly there”. The danger comes in how the Programme deals with information that does not sit well with this narrative. We have observed that the Programme:

- Is not wholly open to critical voices, perceiving them as too negative – despite the fact that they may be reporting important information from which the Programme could benefit
- Tends to believe that observed dysfunctions are confined to the particular geography in which they occur, rather than being indicative of broader systemic problems
- Displays nervousness in openly discussing difficult or negative items

These are simple but important points

The Programme also needs to move from unconnected data streams to generating a unified view using its many inputs

There is an optimism about the GPEI that has wholly positive roots and intentions, but risks not addressing some of the realities and intractable dysfunctions

The Programme has an established narrative of positivity – inputs that do not fit within this narrative risk receiving insufficient attention

Optimism and positivity is an asset to the Programme in many ways, but the GPEI would have a healthier chance of success if:

- Critical voices were sought out – to understand the reasons for them, to really consider the content of what they are saying rather than risk writing them off as being negative. Polio eradication is an ambitious endeavor. The Programme cannot afford to limit the scope of inputs from which it learns
- The GPEI actively considered the possibility of systemic implications when dysfunctions arise that initially appear confined to a local area. Although each country is different, there are powerful linkages across the Programme. Difficulties in one place may indicate more widespread issues.
- All partners were more profoundly engaged with the highs and lows of the Programme, resulting in an ongoing open dialogue and a sense of multilateral responsibility for the Programme.

There are several geographical areas in which progress is clearly lagging behind plan. In each of these places, the Programme has an important judgement to make. Is the current strategy broadly working, though slower than had been hoped? Or is the current strategy basically failing? If it appears that the current approach is broadly working, the right thing to do is to maintain it, heighten it, iteratively enhance it, give it more funding and more time. If the strategy is basically failing, though, these are precisely the wrong actions to take. Instead, these instances need the Programme to fundamentally review its strategy – to deeply re-examine the technical, the operational, and the human elements that are impeding progress; to challenge all of the assumptions that have become implicit within the struggling part of the Programme.

This raises particular problems for an optimistically-inclined Programme. The Programme may be slow to truly appreciate that a strategy is not working. It will tend to under-appreciate the depth of problems. It will be uncomfortable with the idea of engaging in the kind of process required to fundamentally re-think a broken strategy – a process that should welcome critical voices into the fold, incorporating their inputs constructively rather than dismissing them as destructive; a process that should question every assumption about the previous strategy; a process that should publicly lay bare the uncertainties and painful challenges of the Programme. This process would result in a stronger strategy and a broader consensus to support its implementation, but it presents a tough challenge to the established way in which the Programme is conducted.

The Programme would more likely succeed if it could welcome criticism, see the systemic implications of apparently local dysfunctions, and be entirely open with partners, thus giving them greater ownership and responsibility

The GPEI needs to make sharper judgements at strategic level about places where more of the same will never work

A Programme desperate to maintain positivity will find it painful to deconstruct and reconstruct strategy at a sufficiently fundamental level

We are not challenging optimism in itself. A Programme populated by pessimists would have given up long ago. The sense of positivity is impressive and must not be lost. There is also a difficult balance to maintain, because it is right and necessary that achievements are celebrated, publicized, and shared with those who fund the Programme. But the Programme must recognize that a culture of positivity can impede its ability to deal with difficult truths. Recognising this tendency, the Programme must strive to be as objective as possible, and to overcome what has become a deeply ingrained 'need' to maintain a positive narrative. The ideal was perhaps best expressed by the Italian Antonio Gramsci: "Optimism of the will, pessimism of the intellect".

#### **4. National Immunisation Days (NIDs) or Sub-national Immunisation Days (SNIDs)? The policy is unclear**

There seems to be no clear policy across the Programme about the optimum balance between National Immunisation Days (NIDs) and Sub-National Immunization Days (SNIDs). Some say that NIDs became less prominent at a time when the Programme faced financial hardship, and have not been fully reinstated. Some say that SNIDs are preferable to NIDs because they allow energies to be focused on the highest risk areas. Others say that SNIDs may target yesterday's high-risk areas, missing areas of the country that could pose tomorrow's highest risk of an outbreak. We simply observe that there seem to be fewer NIDs than in earlier times of the Programme, that this may represent a risk, and that a clearer definitive policy is necessary.

#### **5. The Programme does not do enough to foster innovation**

Imagine any programme whose established approaches have fallen short of achieving a goal. One might expect to find within that programme a culture in which new ideas are welcomed if they might help reach the elusive goal, in which such ideas are systematically encouraged and tested, and the successful ones implemented across the programme. This is not the case in the GPEI. The relative paucity of innovation is striking.

We hear of historic resistance to innovation. The idea of a bivalent vaccine took years to gain mainstream acceptance within the Programme, and therefore to be trialed. This technology is now central to the GPEI.

Optimism is helpful in many ways, but the Programme does need to realize the implications of its "positive narrative" tendency

"Optimism of the will, pessimism of the intellect" (Gramsci)

There is no clear policy about what the optimum balance is between National and Subnational Immunisation Days

The GPEI would be stronger if it really valued exploring innovative solutions to its obstinate challenges

There are some recent examples of innovation, such as Lot Quality Assurance Sampling (LQAS) and the use of satellite technology to track vaccinators. But the Programme lacks a thriving stream of innovations. Innovation is not cherished. It is sometimes not even welcomed, too readily condemned to death-by-bureaucracy. Our July report acknowledged that there is a range of views, but recommended that piloting the combined use of IPV and OPV should at least be given serious consideration. This recommendation was met by a response that suggested it was unwelcome – a technical working group has been asked to examine the use of IPV in general, as part of a broader mandate. The specific suggestion has been diluted, perhaps lost. There is no urgency, no sense of seriously wanting this innovation to be considered.

We also recommended the creation of twinning mechanisms between countries. The idea was that, at ministerial level, a polio-free country would pledge support to a country trying to rid itself of polio. This support would be both financial and technical. There would be a more direct and meaningful relationship between the pair of countries than exists when finances follow complex channels and technical expertise is pooled from many countries to many others. If it worked, twinning could go some way to enhancing global public awareness and political commitment, as well as bolstering financial and technical support. At its heart, the twinning suggestion offers something different from how the Programme currently operates.

We are told in response that various countries are already deploying technical expertise to various others. We are rebuffed with vague statements like ‘the politics are very difficult’. The point is missed. Life moves busily on, and the essence of what is different about this suggestion risks being lost.

Perhaps none of these innovations would amount to anything of value in any case, even if properly trialled. We cannot know if they are not tried. But if the Programme tries enough innovations, it will find some real gems that will catalyse success.

Innovations that do exist in the programme need to be consistently recognized, documented, and shared. Our previous recommendations about the need to encourage and amplify micro-innovations have not yet received the full attention that they need. Programmatic innovations will be as important as technical innovations, if not more so.

Perhaps the reluctance to innovate comes from a belief that the Programme already has what it needs, that innovation is a distraction from the task of implementing what is known. Perhaps it comes from a slightly fatigued

Judgement is passed too early on suggestions that may have promise if given a chance

The spark of an innovative idea is too easily extinguished if it is not nurtured



sense that everything has already been tried. We would not suggest that all efforts should be diverted, that the Programme should be over-run by a free-for-all of untested practices. But we would suggest that a strand of systematized innovation should be more prominent – to encourage and to test out new ideas. Innovations do not have to consume substantial resources or divert significant energy. They should be trialled on a small scale, properly evaluated, and implemented more widely if successful.

**If the Programme could systematize innovation, it would benefit from breakthroughs**

The GPEI planned to stop polio transmission globally by the end of 2012. To judge whether this is on track to be achieved, we draw on several strands of data and intelligence:

- Of the Strategic Plan's four intermediate milestones, one has been missed and remains unattained; a second is highly likely to be missed at the end of 2011. Just two are on track;
- Most countries are not on track to achieve the end-2011 Major Process Indicators targets set out in the Strategic Plan. Most of these were also missed at the end of 2010;
- We continue to hear of dysfunctions at ground level across the Programme, which we do not yet see being escalated and dealt with systemically;
- India stands alone as the country that has demonstrably made consistent progress over a prolonged period of time. Others have waxed and waned, undermining optimism when we see a spurt of progress. Progress in Pakistan and Nigeria is of particular concern;
- Viewed as a whole, the global Programme has a number of features that are eroding its chances of success
- The Programme remains threatened by a major funding gap

Given all of the above, it is impossible to conclude that the Programme is on track to achieve its end-2012 goal.

Fifteen months remain. We continue to genuinely believe that this is long enough – that success could still be attained. But this will not happen through more of the same, nor will it happen by sharpening performance here and there. It will only happen if the Programme seizes on the most fundamental problems that this report identifies and deals with them as real organizational, national and global priorities.

Some of the problems identified in this report run so deep that nobody should believe that 'more time' is the solution to them. The focus needs to be on solving the problems themselves. More time may be a requirement, but is not the answer in itself.

Polio simply will not be eradicated unless it receives a higher priority – in many of the polio-affected countries, and across the world. The funding gap needs to be filled, and polio eradication needs to achieve greater ownership and attention in the global political sphere. We continue to believe that polio eradication should be treated as a global health emergency. This report illustrates that the challenges are great, but the GPEI is a vital endeavor. To fail now would unleash widespread suffering and death on the world's most vulnerable children.

Viewed from a number of different angles, it is clear that the Programme is not yet on track to interrupt transmission by the end of 2012

Success is not out of the question: 15 months remain; it can be done on time if the fundamental issues are dealt with

'More time' is not the answer when fundamental problems exist

Great improvement would be catalyzed by polio receiving higher priority focus. It is a global health emergency. Failure would be a disaster.

## RECOMMENDATIONS

- We recommend that the heads of the spearheading partner agencies consider each of our cross-Programme findings, and lead in tackling the problems identified
- We recommend a small number of pilot schemes where local management of vaccination campaigns is outsourced by governments to suitable non-governmental organisations
- We recommend that a high-level representative from each of the spearheading partners and the Bill and Melinda Gates Foundation meet together with the leadership of Pakistan to agree on urgent solutions to the huge dysfunctions in that country's programme
- We recommend that India and Nigeria move forward their informal agreement for public health leaders from the former to visit and help the latter
- We recommend that the GPEI fundamentally examines accountability and its enforcement at all levels in the programme