

# Global Polio Eradication Initiative (GPEI) Status Report

28 September 2015

World Health Organization  
Geneva, Switzerland

Rotary International  
Evanston, Illinois USA

Bill and Melinda Gates Foundation  
Seattle, Washington USA

Centers for Disease Control and Prevention  
Atlanta, Georgia USA

UNICEF  
New York, New York USA

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# Global Assessment

## Summary of progress and risks

- Type 1 wild virus transmission is limited to specific districts of Pakistan and Afghanistan. Nigeria has been removed from the list of endemic countries. Afghanistan has not seen a decline in the number of WPV cases in 2015 compared with 2014. WPV outbreaks in the Horn of Africa, the Middle East and Central Africa have stopped.
- WPV type 3 not seen anywhere for nearly three years. The Global Commission for the Certification of Poliomyelitis Eradication has concluded that wild poliovirus type 2 has been eradicated worldwide. The programme is seeing exciting strides towards ending polio for good.
- Reaching missed children through improving SIA quality and mitigating the risks of inaccessibility is a major programme priority requiring further intensified and focused effort in both endemic and non-endemic countries.
- The withdrawal of type 2 OPV in April 2016 is on track and IPV will be introduced in 85% of the 126 countries using OPV only. Implementation of Phase I of Global Action Plan for Containment (GAP III) is being intensified.
- Weak routine immunization programmes remain a cause of cVDPV emergence and a leading cause of cVDPV outbreaks.
- Although the program has expanded deployment of technical support through STOP teams and consultants, substantial challenges remain in identifying, and recruiting talented human resources at all levels of the GPEI.
- Addressing the funding gap and maintaining consistent cash flow is a further challenge.

# **ENDEMIC COUNTRIES**

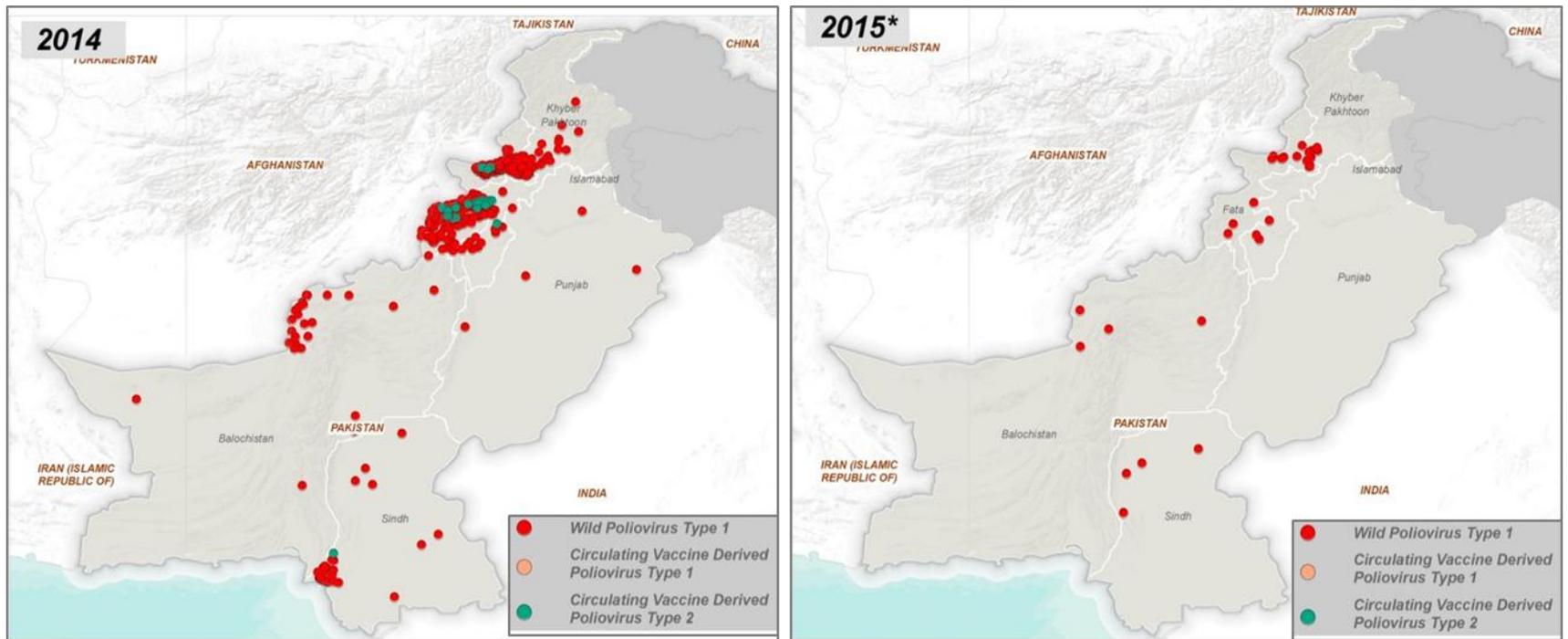
# Topline Messages

1. Endemic transmission of type 1 polio continues in just Pakistan and Afghanistan.
2. Pakistan has transformed its polio program with strong political commitment and large strides towards improving access, starting to address delays in payments, refining SIA schedule and strategies and training and motivation of frontline worker. It is too early to assess impact on performance and reaching missed children. Sustained momentum is required to stop transmission in 2016.
3. Afghanistan is moving toward implementation of its emergency plan for improved collaboration to enhance SIA quality and accessibility, but the main coordination mechanism remains to be operationalized.

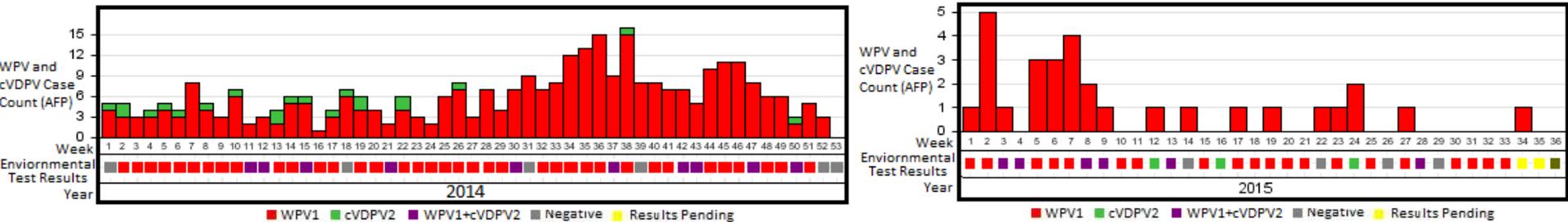
**PAKISTAN**

# Pakistan: reduction in WPV cases but increase in orphan viruses in first half of 2015 compared to first half 2014

WPV, and cVDPV cases, 2014 and Jan 2015 to Aug 2015

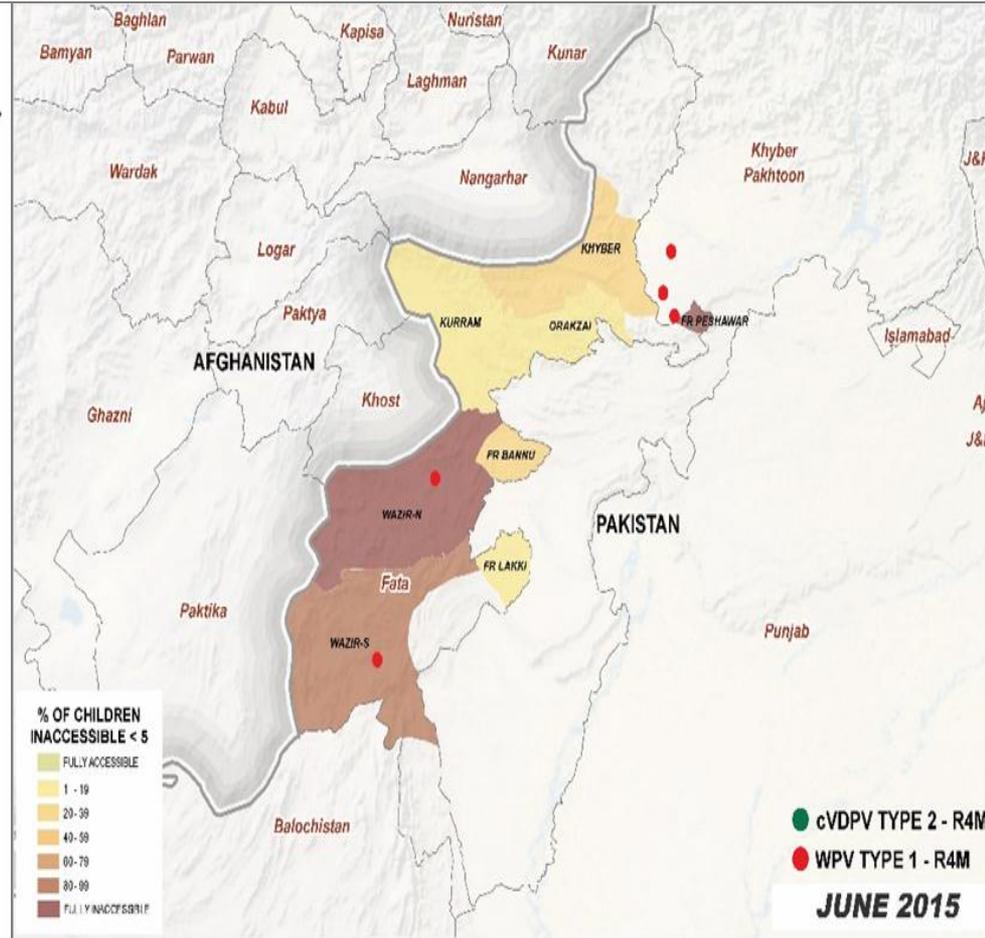
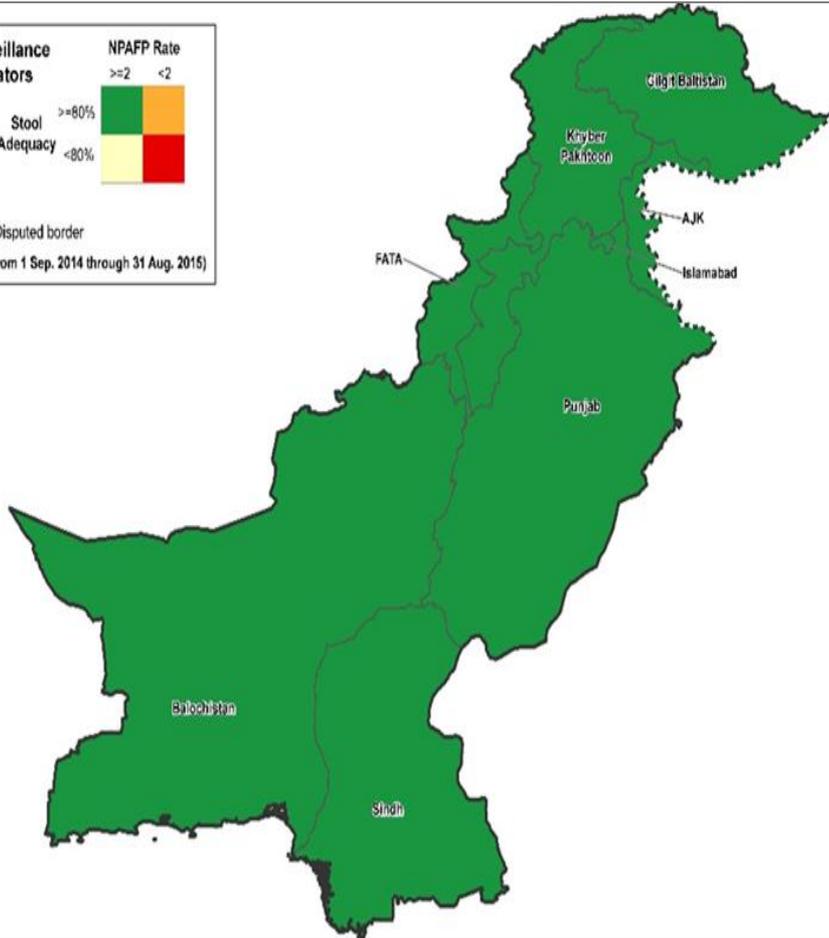
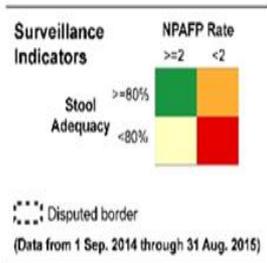


WPV, and cVDPV cases, environ. results by weeks of Onset, 2014 and Jan 2015 to Aug 2015



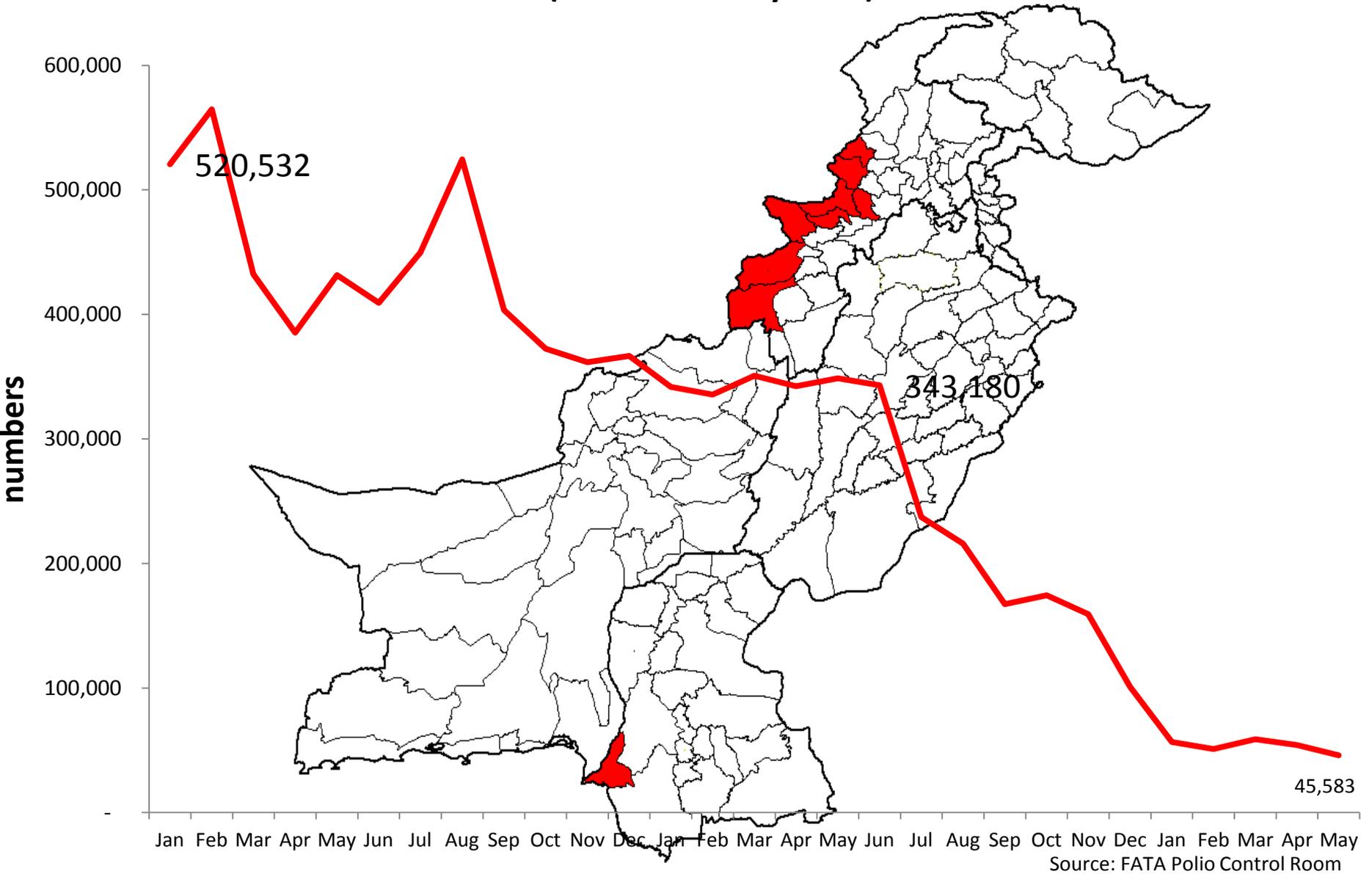
# Good surveillance, but increased orphan virus

## Surveillance and Accessibility



# Access has transformed

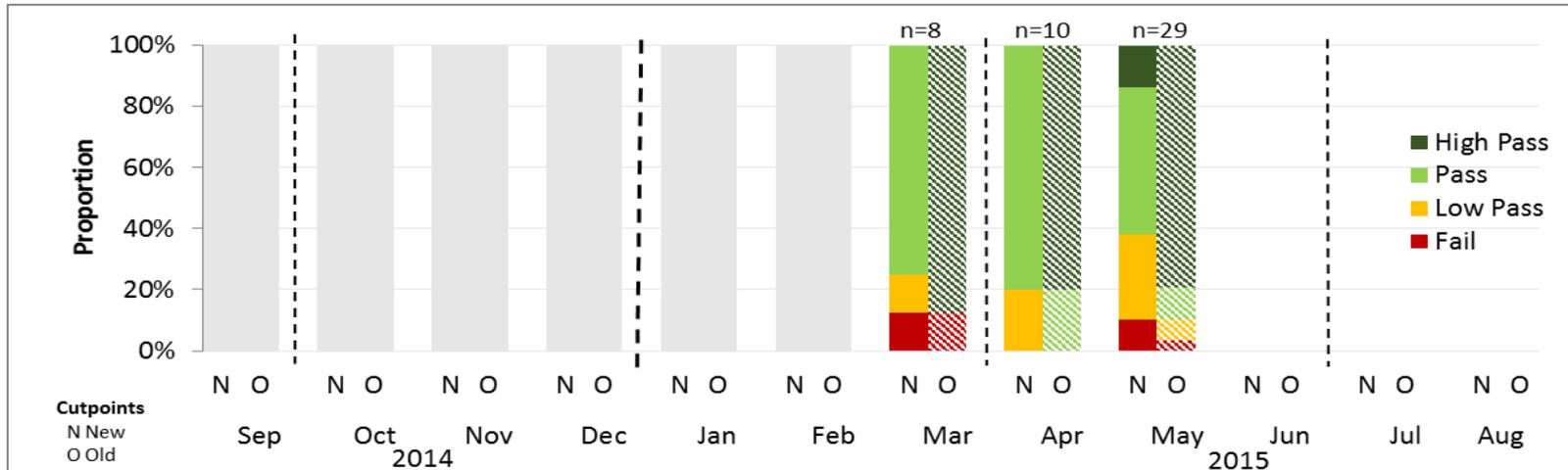
Reduction in children in insecure/inaccessible areas  
(Jan 2013 – May 2015)



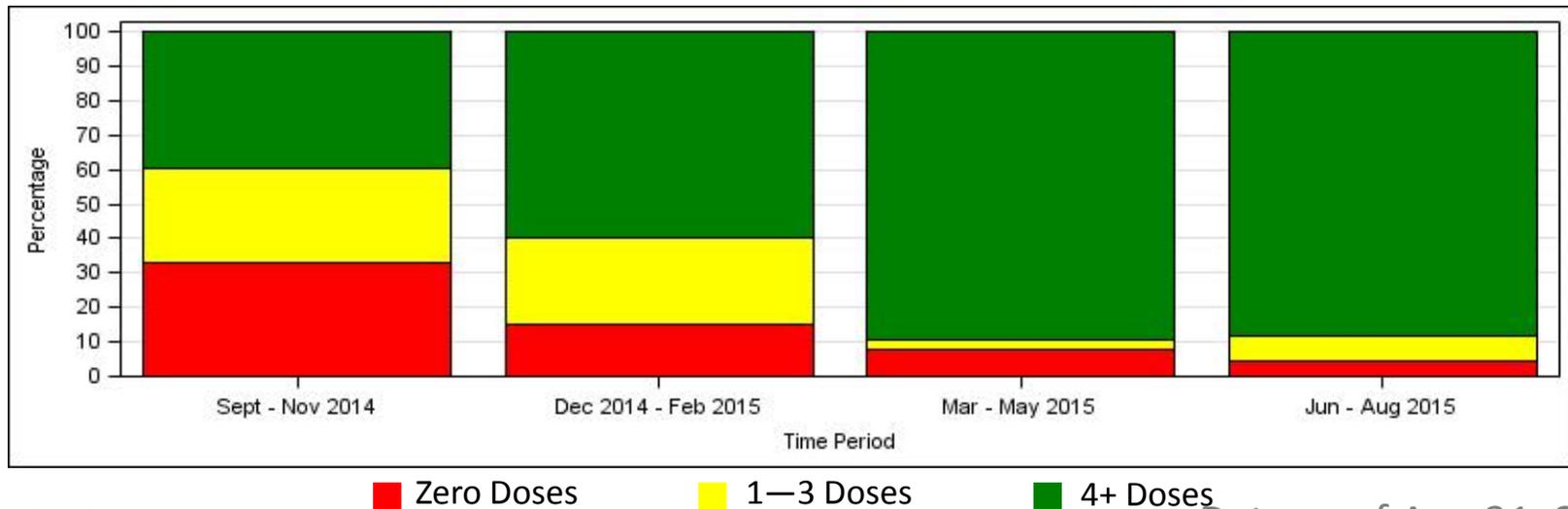
# Immunity is improving in FATA, but risks remain especially in Khyber Agency

Sept 2014 – August 2015

LQAS Survey Results by SIA



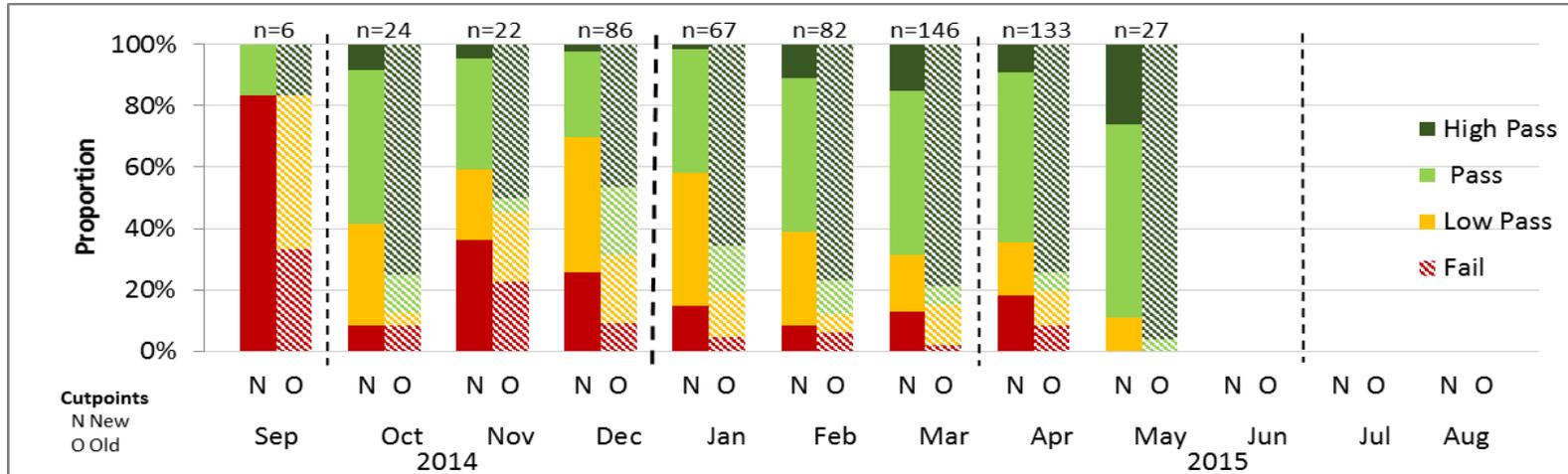
Percentage of NPAFP cases 6-35 months, by OPV status



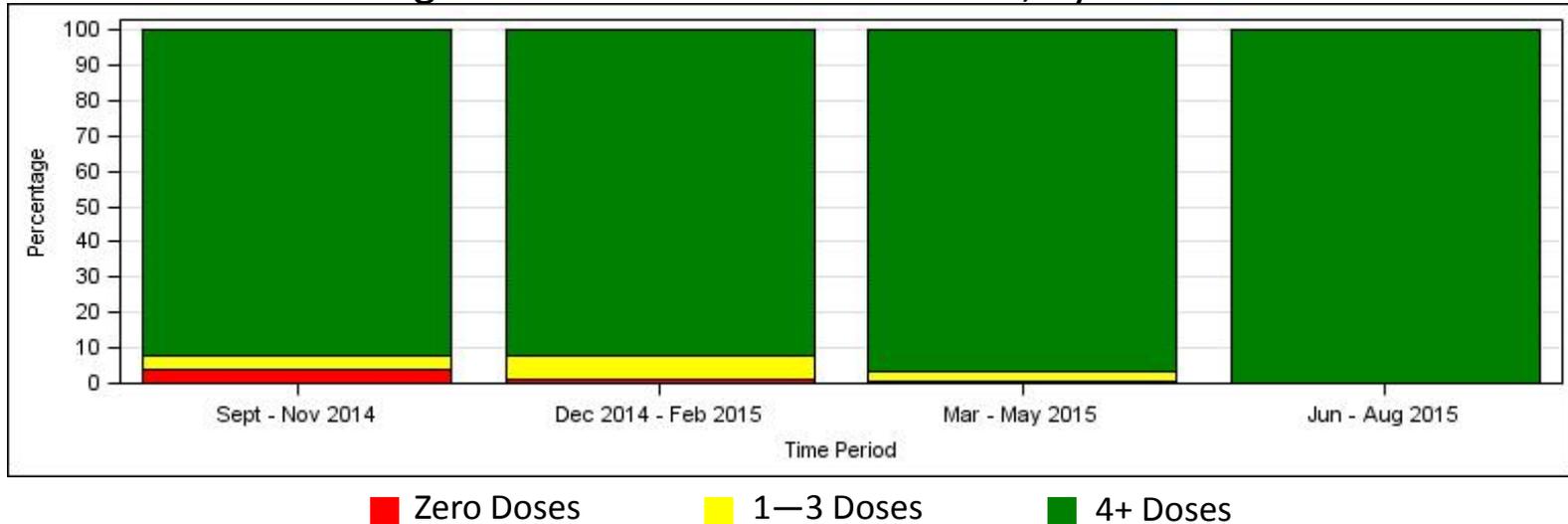
# Substantial improvement in KP immunity

Sept 2014 – August 2015

LQAS Survey Results by SIA



Percentage of NPAFP cases 6-35 months, by OPV status



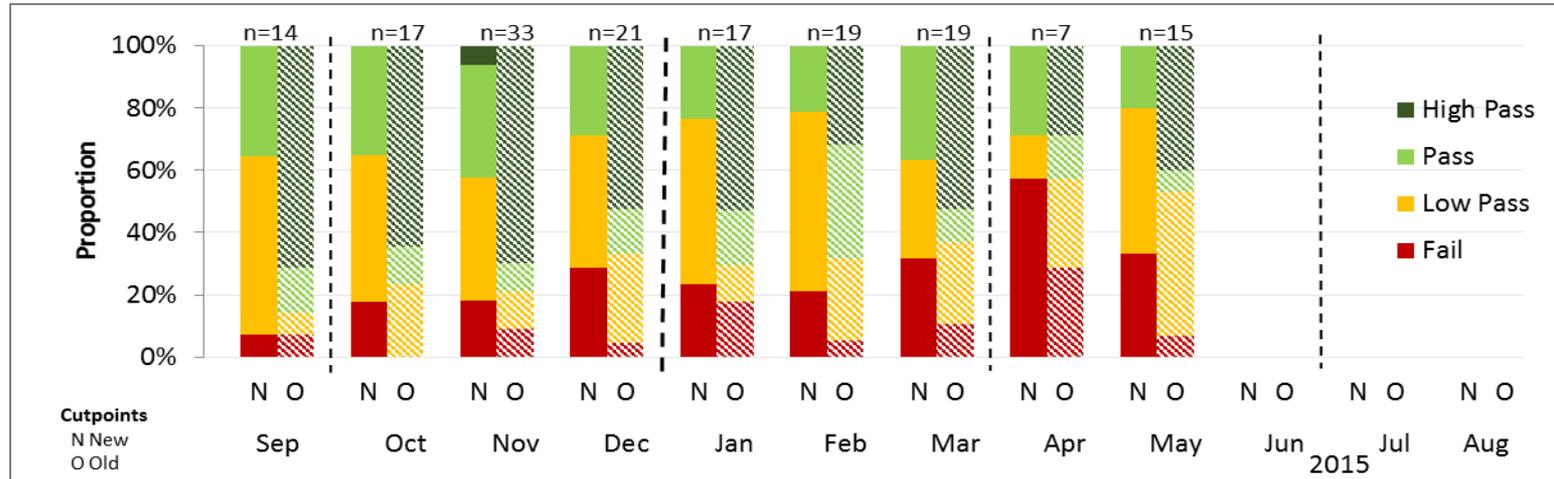
Zero Doses

1-3 Doses

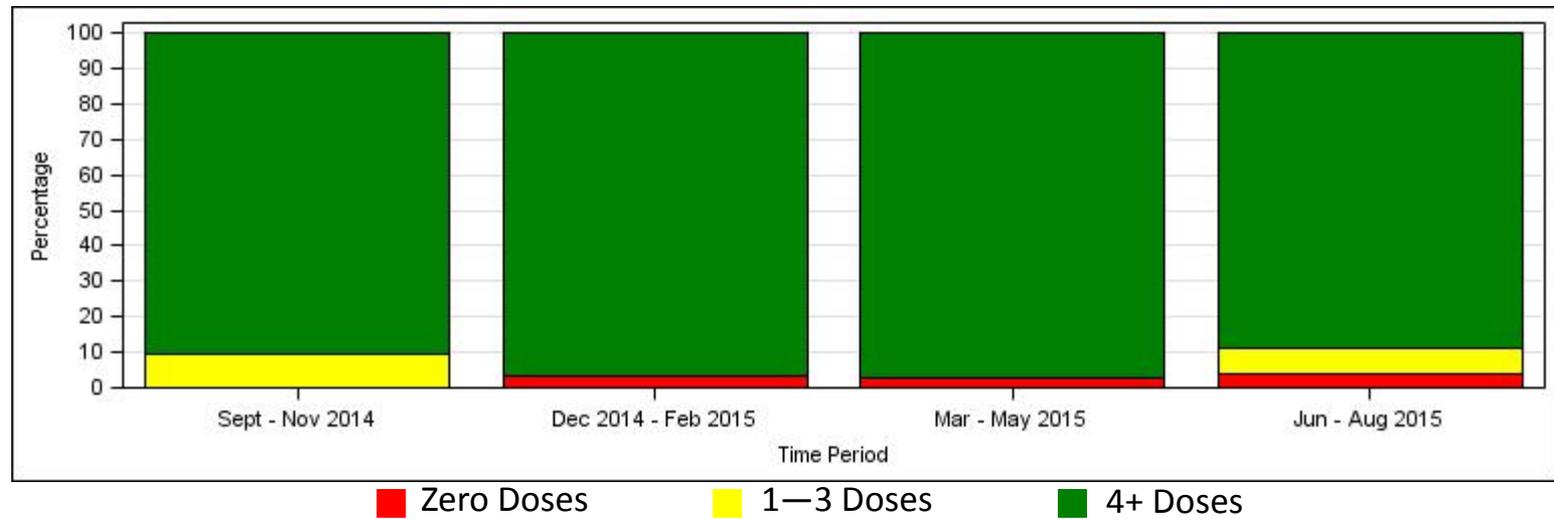
4+ Doses

# Volatile progress in Karachi

## LQAS Survey Results by SIA

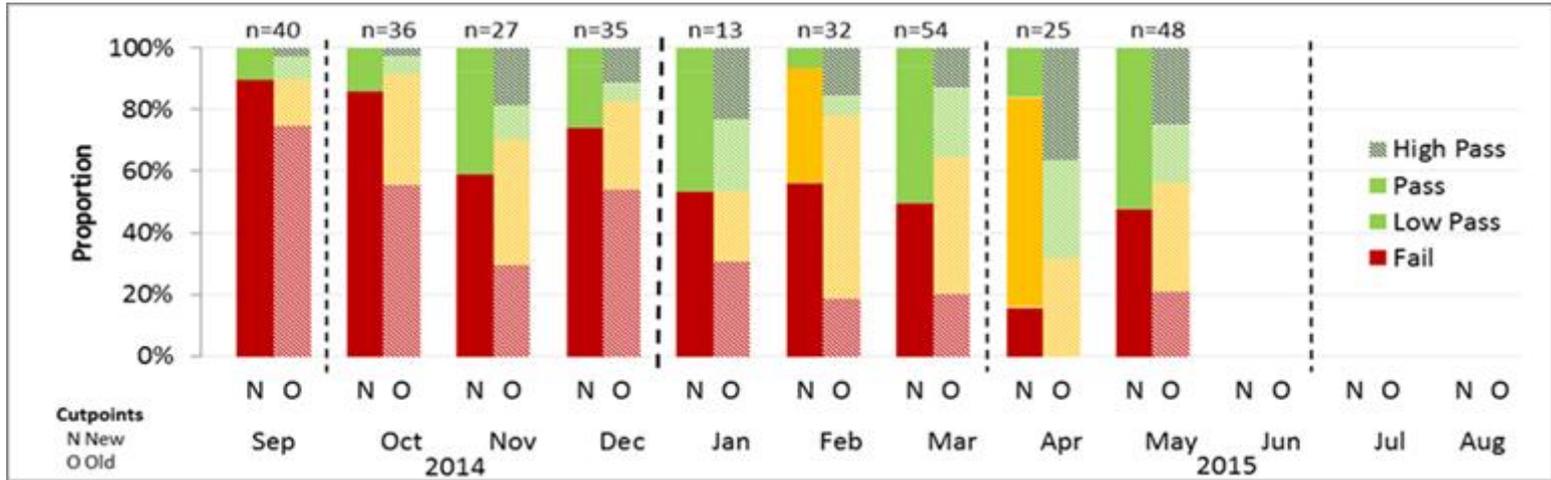


## Percentage of NPAFP cases 6-35 months, by OPV status

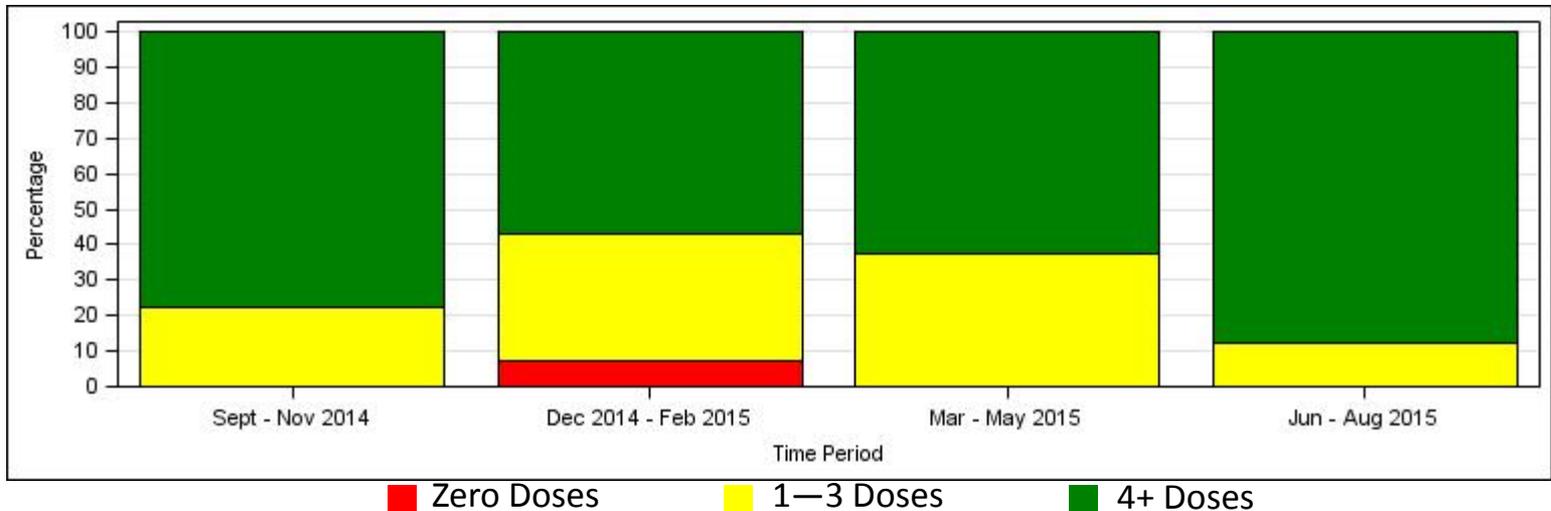


# Low SIA quality in Quetta but improved immunity

LQAS Survey Results by SIA

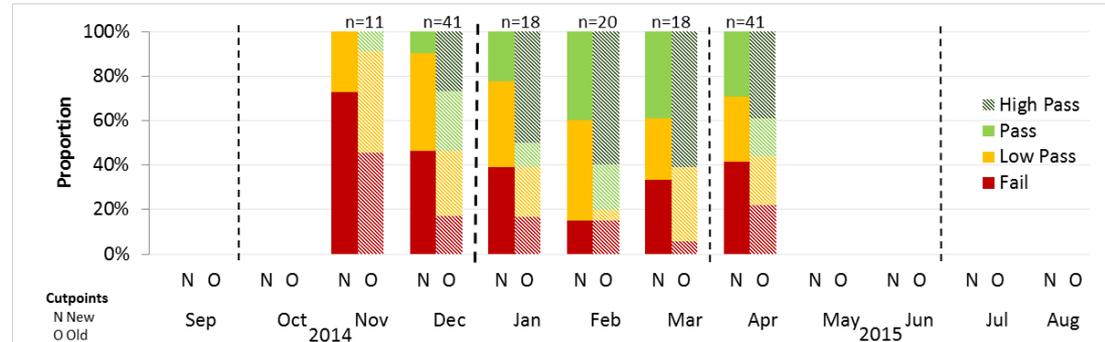


Percentage of NPAFP cases 6-35 months, by OPV status

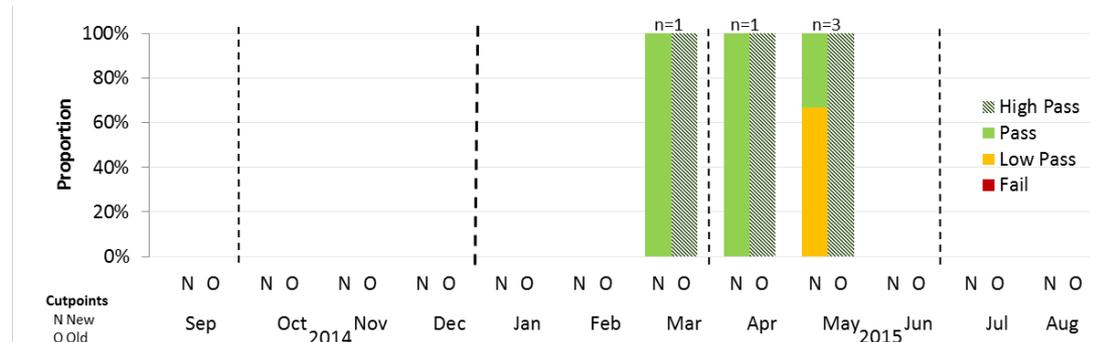


# SIA quality in endemic reservoir areas of Pakistan

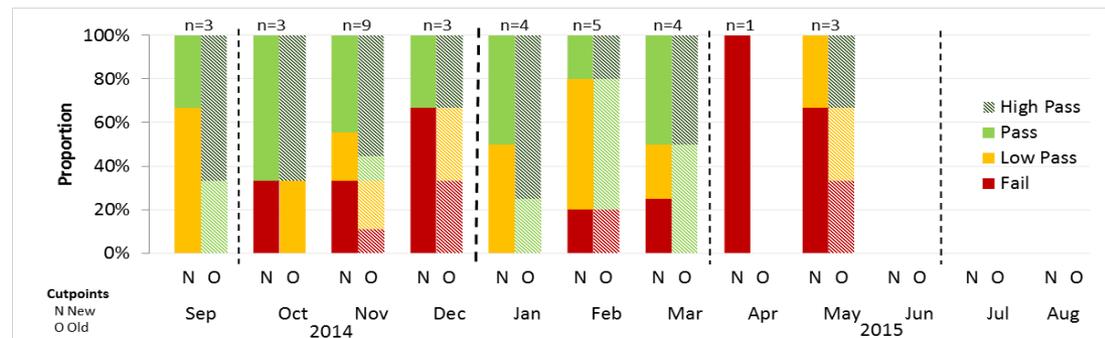
Peshawar



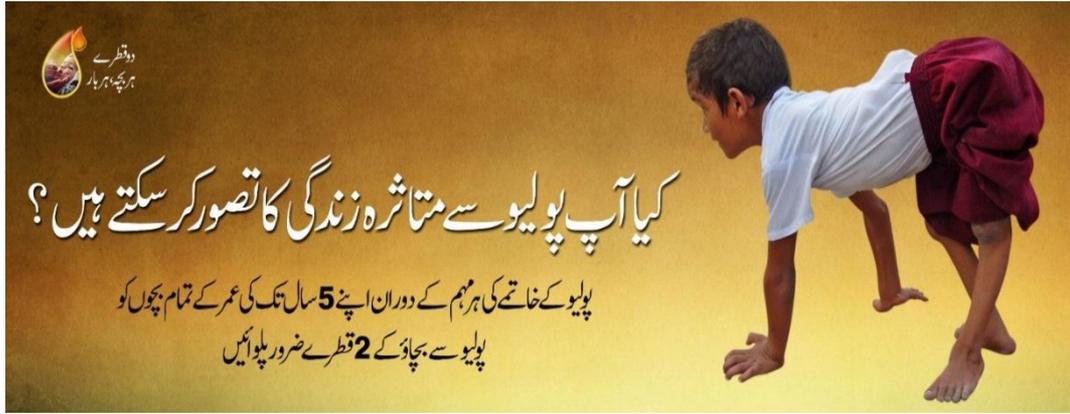
Khyber



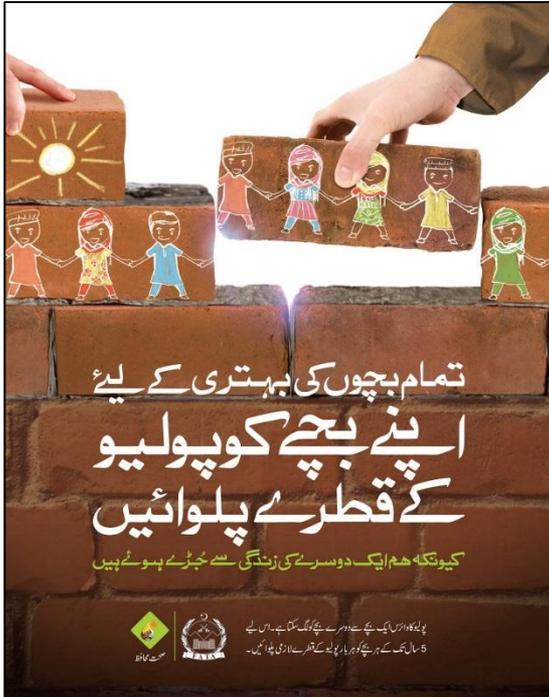
High Risk  
Karachi Towns



# Communications - then and now



Shift from a generalized focus on risk and fear to positive, targeted communications leveraging cultural/social beliefs and practices to build trust and promote vaccination as a social norm



# Promotion of the frontline worker as a friend to the community aims to support reality on the ground



Over 4,00 Continuous Community Protected Volunteers (CCPV) newly recruited in highest risk areas who are:

- Selected by local communities
- Female (except in FATA)
- Permanent – to build trust
- Paid on time
- Supervised by an independent structure
- Promote other health practices beyond OPV



# Programmatic Priorities and Innovations

Priorities/Innovation	Progress and Impact
Missed Children	<ul style="list-style-type: none"><li>• Estimated 1 million under-immunized children in Pakistan</li><li>• Identification, tracking and vaccination of missed children now embedded in all phases of SIAs</li></ul>
Front line workers	<ul style="list-style-type: none"><li>• 4,700 (96%) of front-line supervisors in tier 1-2 districts received enhanced 2-day training, with 23,000 polio teams to follow</li><li>• PKR 2 billion in payment arrears cleared and revamped DDM</li></ul>
Communications	<ul style="list-style-type: none"><li>• Redesigned, re-branded and re-packaged to increase trust and empowering and equipping FLW to succeed on the door-step</li></ul>
Access & Security	<ul style="list-style-type: none"><li>• Inaccessible children now below 46,000</li><li>• Security protection for mobile teams much improved</li></ul>
Continuous Community Protected Vaccination	<ul style="list-style-type: none"><li>• Expanded from Karachi and now rolled out in KP/FATA/Balochistan</li><li>• Covering 40% of target population in Tier1 districts</li></ul>
Health Camps	<ul style="list-style-type: none"><li>• 2,000 camps targeted (95%) to highest risk areas</li><li>• 500K beneficiaries/100K u5/ 10K zero dose</li></ul>
IPV-OPV	<ul style="list-style-type: none"><li>• IPV-OPV targeted Campaigns reaching 1.7 million children.</li><li>• IPV now being rolled out in EPI</li></ul>
Surveillance	<ul style="list-style-type: none"><li>• Surveillance reviews and improvement plans in all provinces</li></ul>

# Pakistan: Summary

## Progress

- Clear and strong Government engagement at all levels, including from PM
- Functioning EOCs at national and provincial levels
- Strengthened district staff: over 5,000 surge at district & UC level since January
- Sharp geographic focus led to investment in right areas: 12 HRDs
- Detailed EOC workplans in place **before Low Season**
- PKR 2 billion delayed payment to vaccinators cleared
- Nearly all Tier 1-2 district front-line supervisors and polio teams received revamped 2-day training, with focus on communication, motivation & security
- Communications focused to resonate and build trust with Pashtun communities
- IPV campaigns implemented with over 1.6 million doses used including in Tier 1 districts.

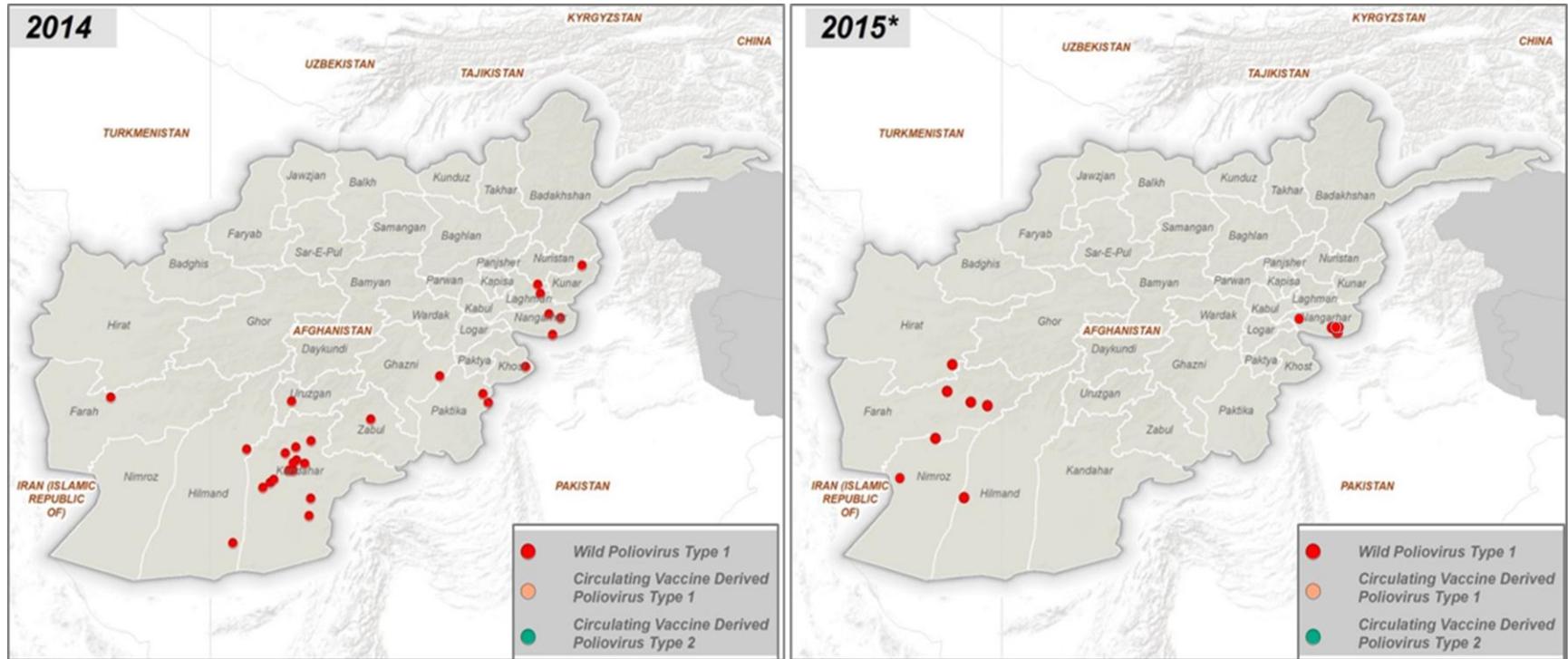
## Challenges

- Consistently reaching children in Peshawar, Khyber & high risk towns of Karachi will be critical to eradication in Pakistan
- Improved payment system for all vaccinators
- Translation of innovative strategies to high quality implementation at district and sub-district level during low transmission season
- Coverage in IPV campaigns is variable. Most IPV campaigns lack quality monitoring and evaluation.

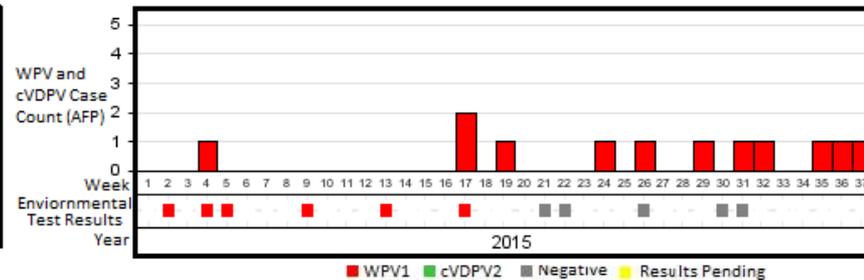
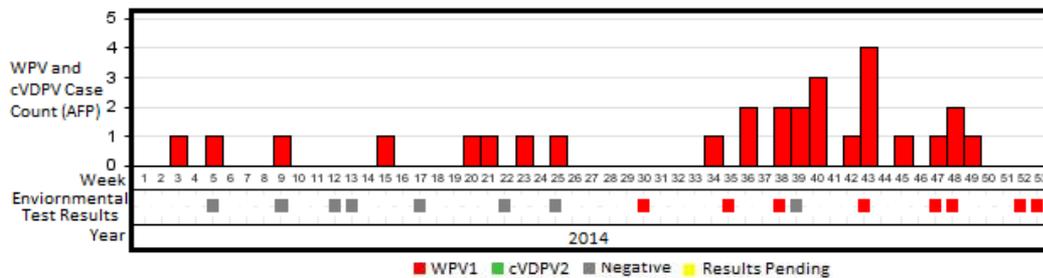
**AFGHANISTAN**

# Afghanistan:

WPV and cVDPV cases, 2014 and Jan 2015 to Aug 2015



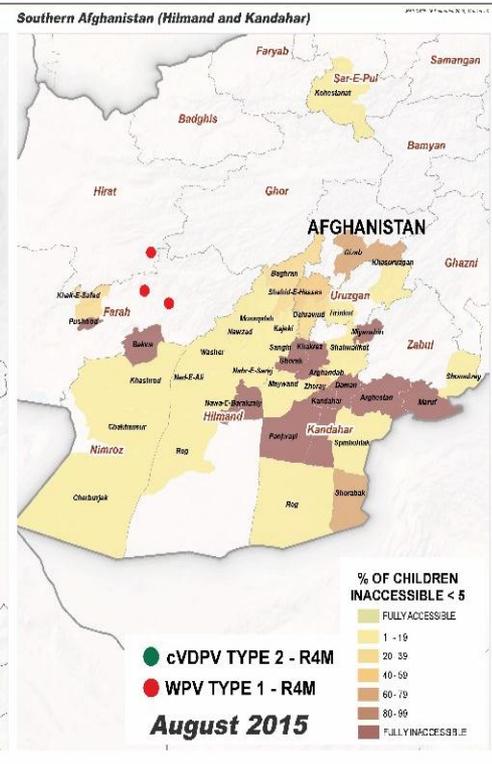
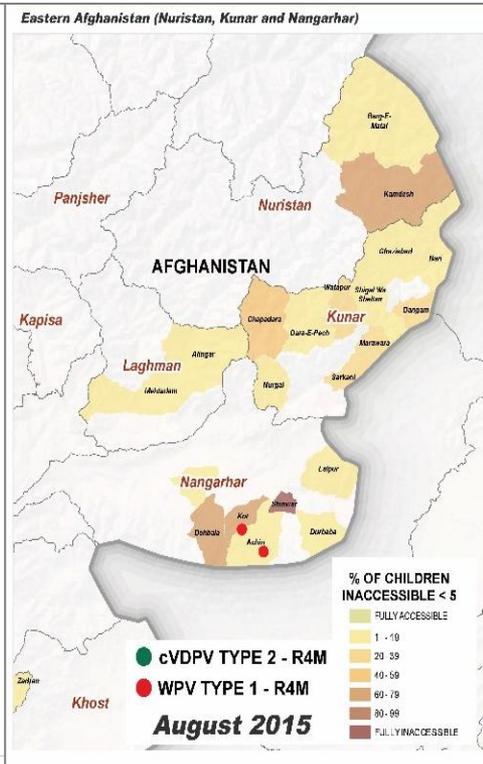
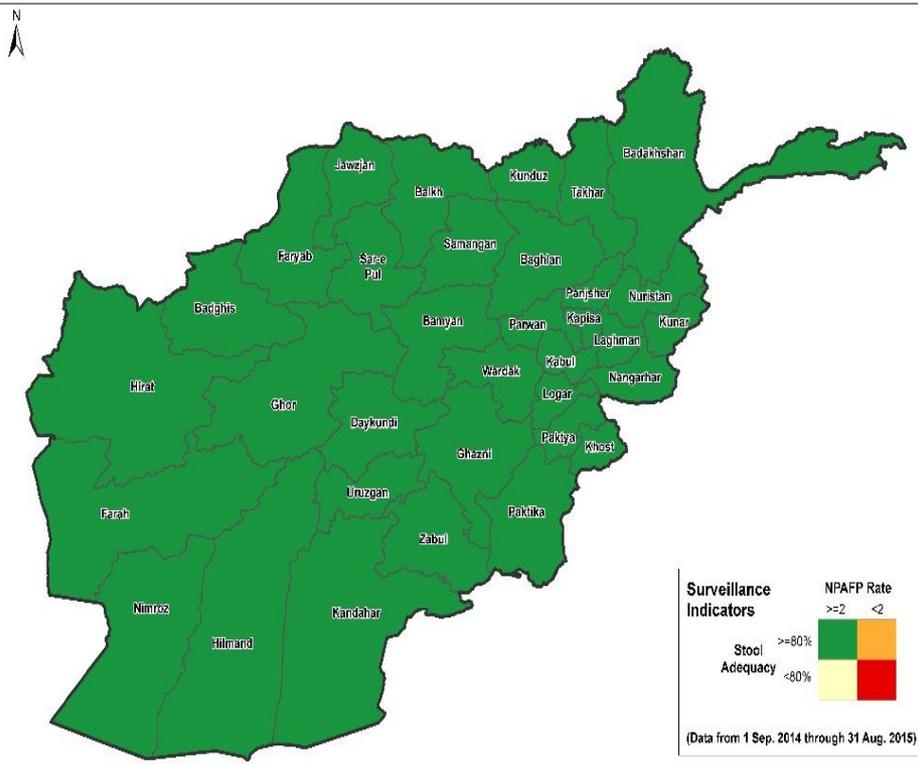
WPV and cVDPV cases, enviro. results by weeks of onset, 2014 and Jan 2015 to Aug 2015



# Good surveillance, but volatile access to children across Eastern & Southern Regions

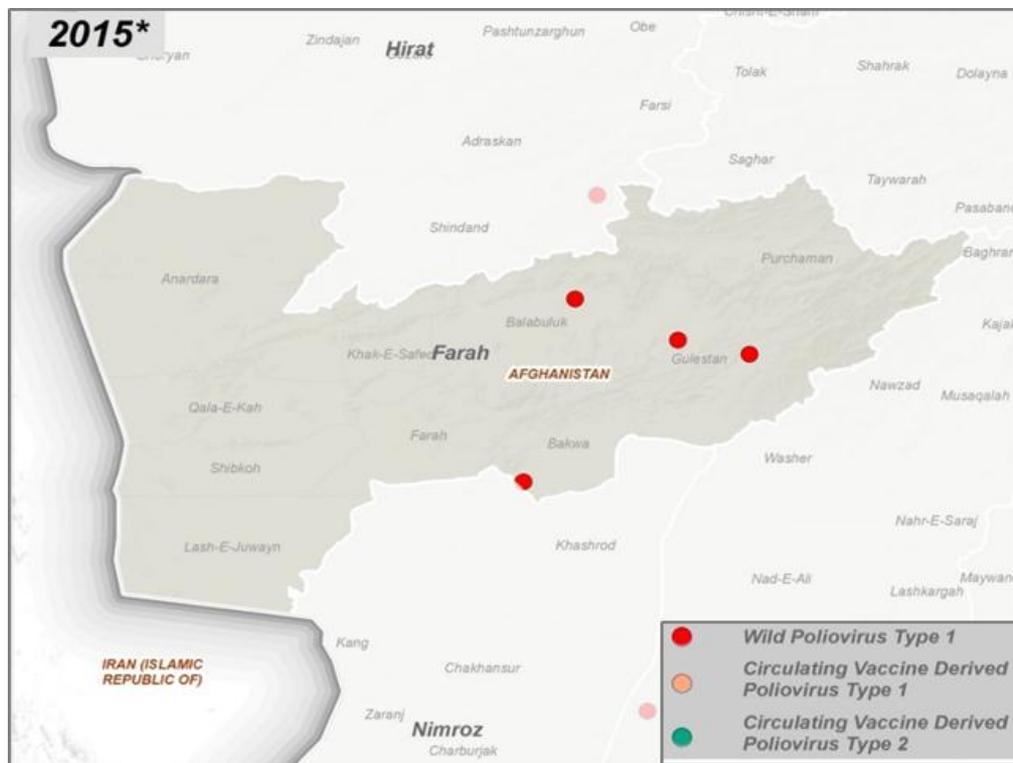
## Surveillance

## Accessibility



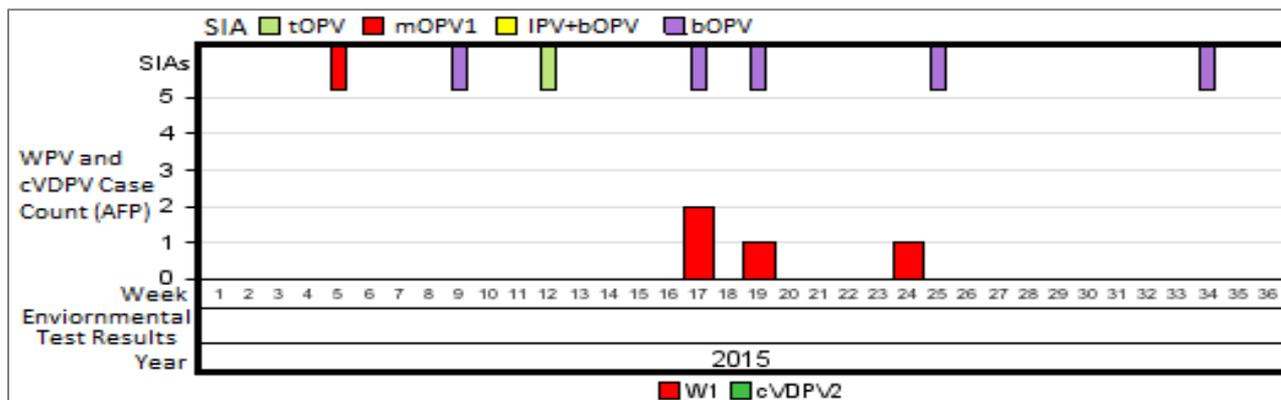
# Farah Province: Epicentre of Western Outbreak

WPV and cVDPV cases, Jan 2015 to Aug 2015



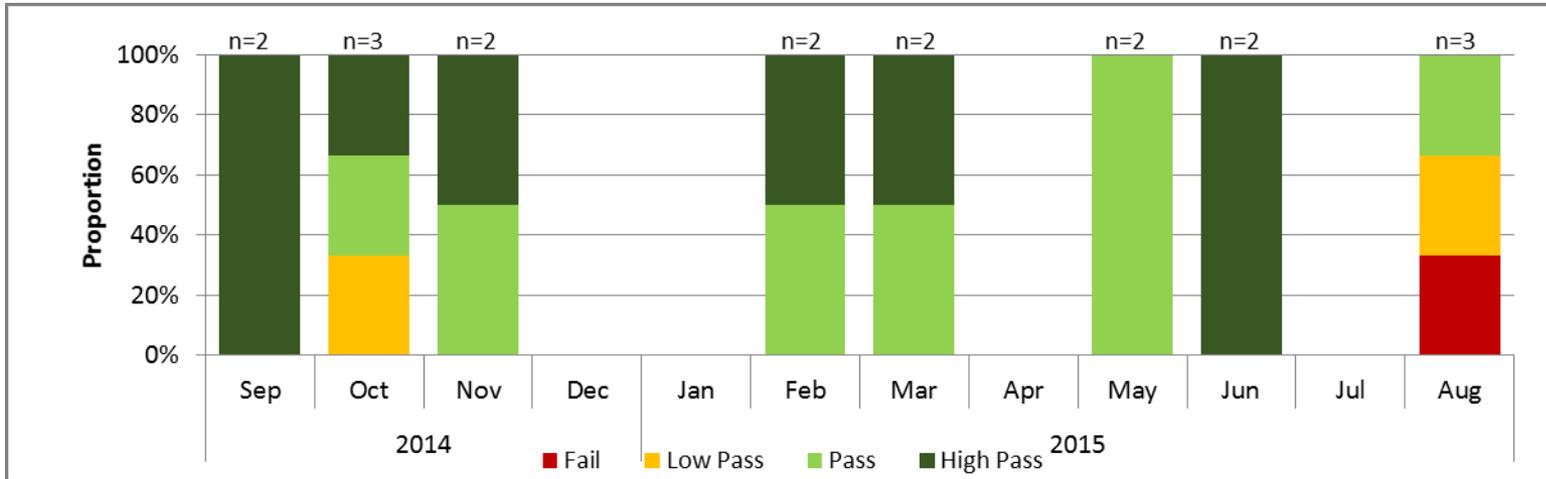
- Circulation in Farah and Herat represent the same WPV1 lineage of R4B5C circulating in Helmand and Kandahar.
- No orphan viruses have been detected in Afghanistan in 2015.

\*map excludes environmental samples

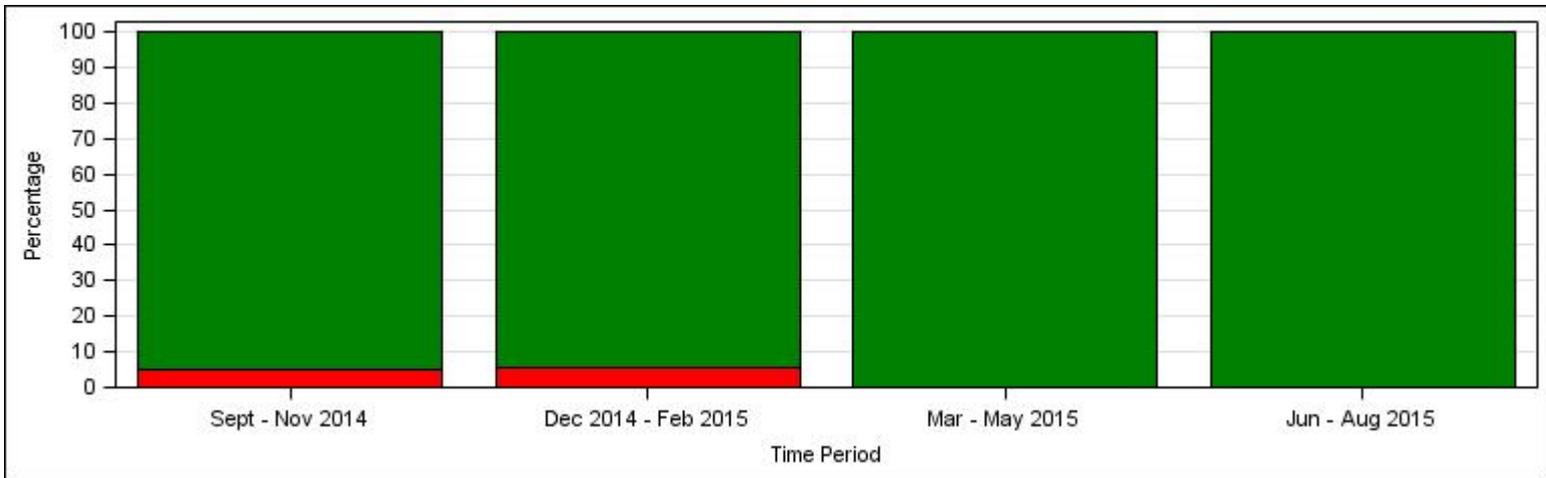


# Farah: Positive LQAS, but small sample masks risk

LQAS Survey Results by SIA

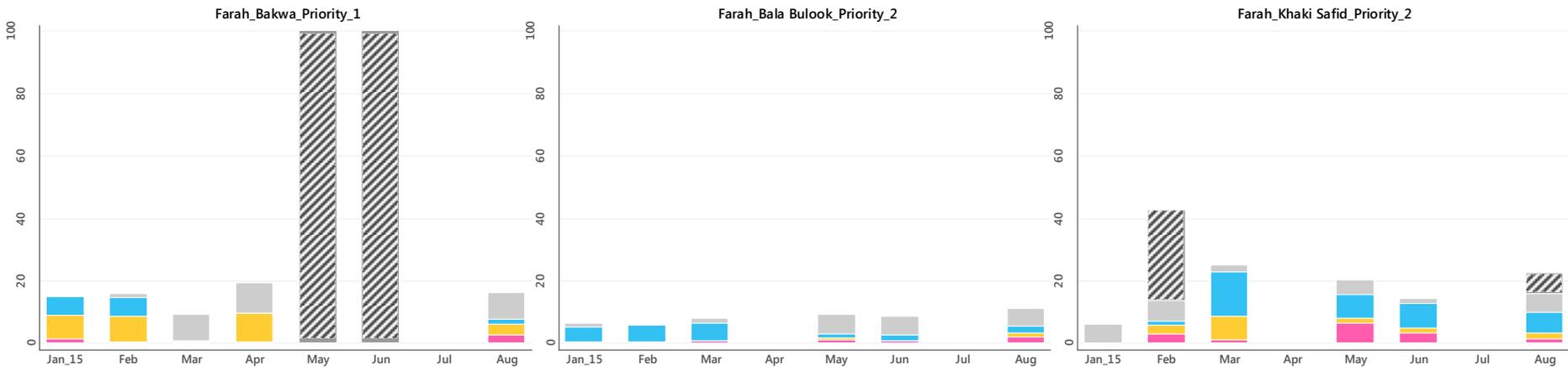
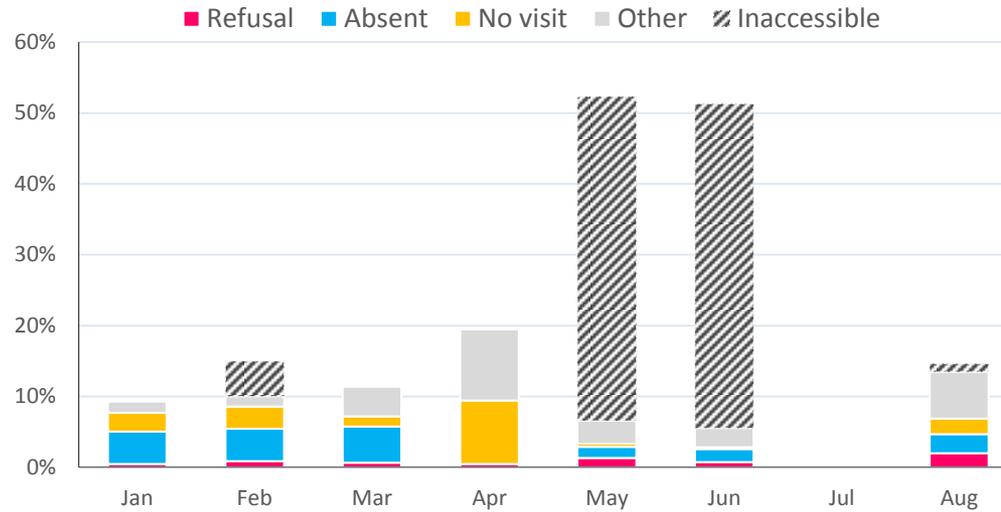


Percentage of NPAFP cases 6-35 months, by OPV status



Zero Doses      1-3 Doses      4+ Doses

# Trends of Missed Children in Priority Districts, Farah Province, Afghanistan, 2015

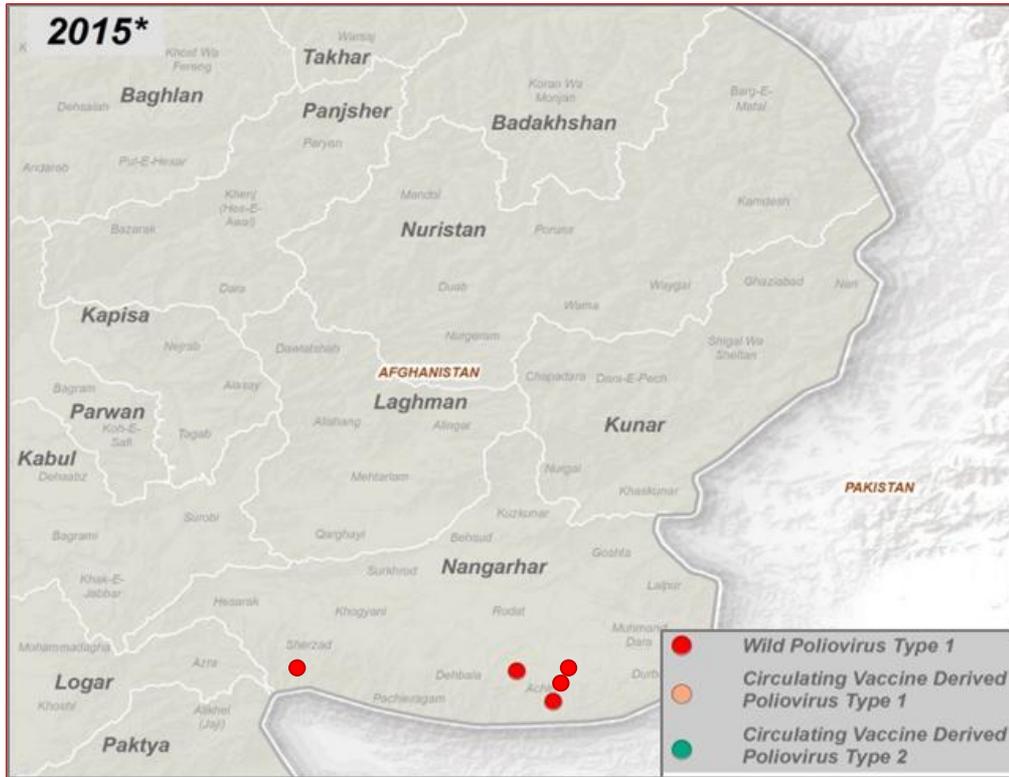


Source: Independent Monitoring

Note: Aggregate based on data from three districts – Bakwa (Priority 1), Bala Bulook (Priority 2) and Khaki Safid (Priority 2)

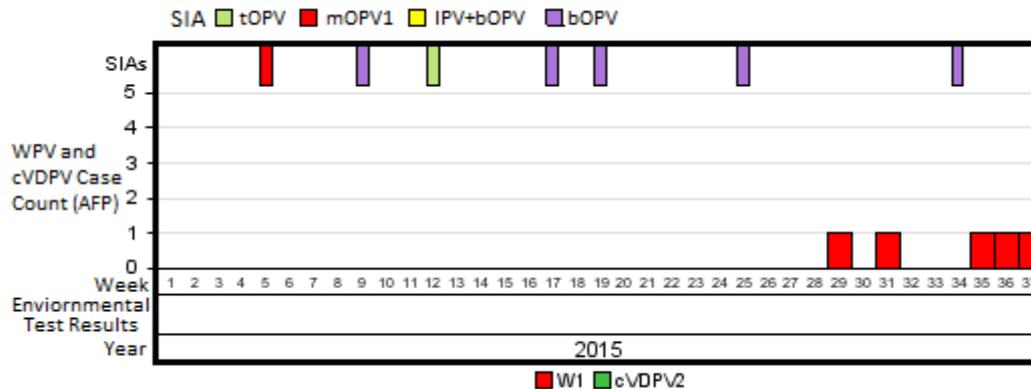
# Nangarhar: Epicenter of Eastern Outbreak

WPV and cVDPV cases, Jan 2015 to Sep 2015



- Isolates from two AFP cases in Nangarhar are genetically linked to WPV1 isolated circulating in Khyber/Peshawar, Pakistan of one lineage of the R4B5C cluster

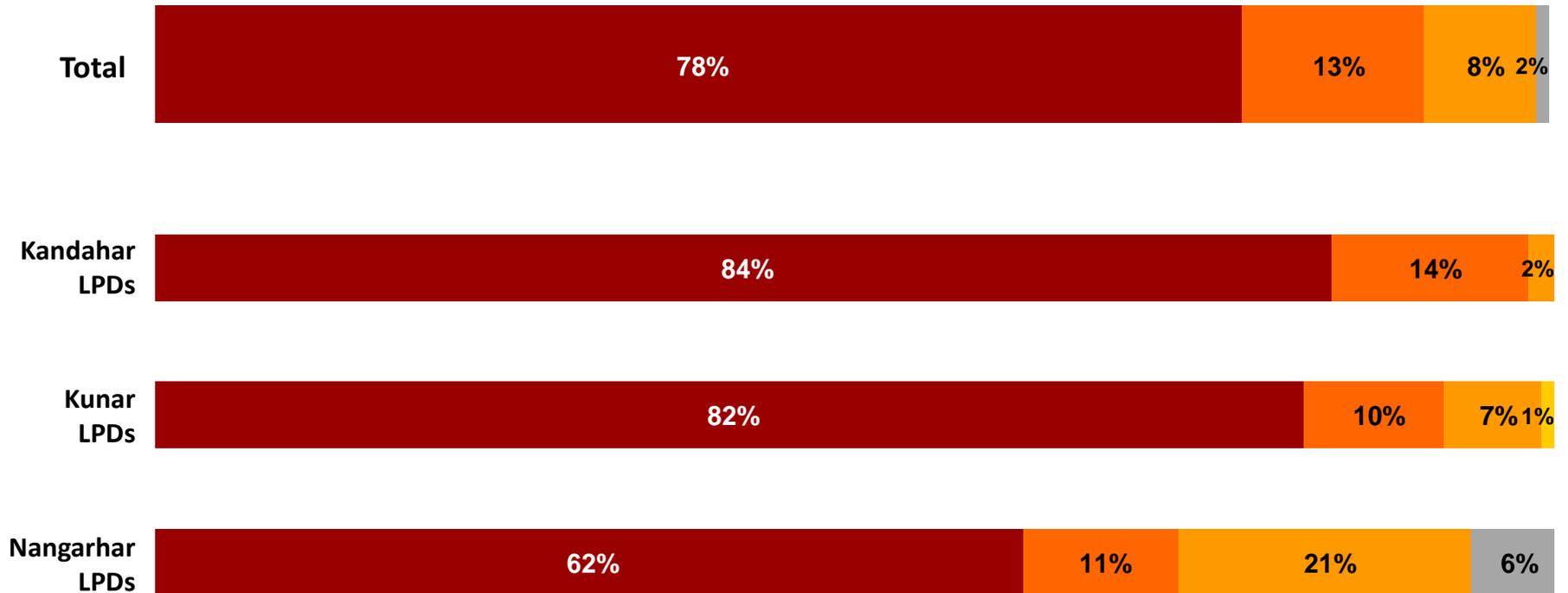
\*map excludes environmental samples



# Parents in Nangarhar have the lowest intent to give their children OPV every time it's offered. Even if quality improves, demand challenges may limit vaccination coverage.

*% caregivers saying they intend to give their child polio drops...*

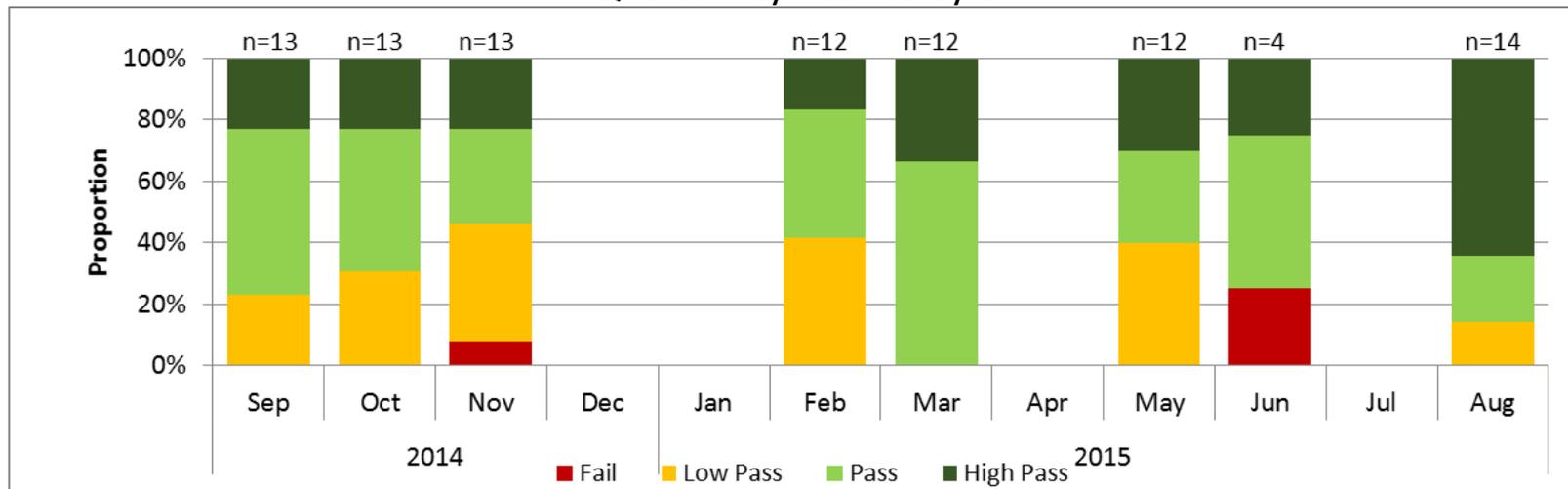
■ Every time ■ Most of the time ■ Just a few times ■ Only once ■ Never ■ Have not heard of polio



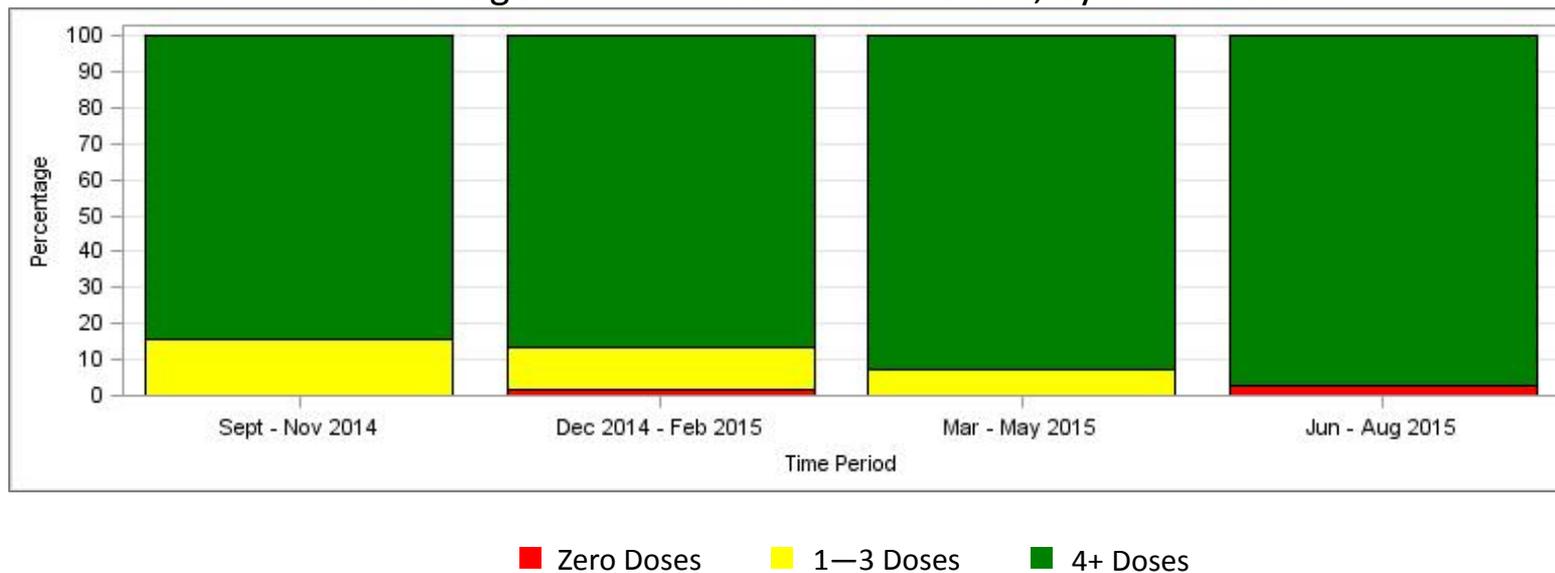
Total n=2025; Kandahar n=675; Kunar n=675; Nangarhar n=675

# Southern Afghanistan: varying quality

LQAS Survey Results by SIA

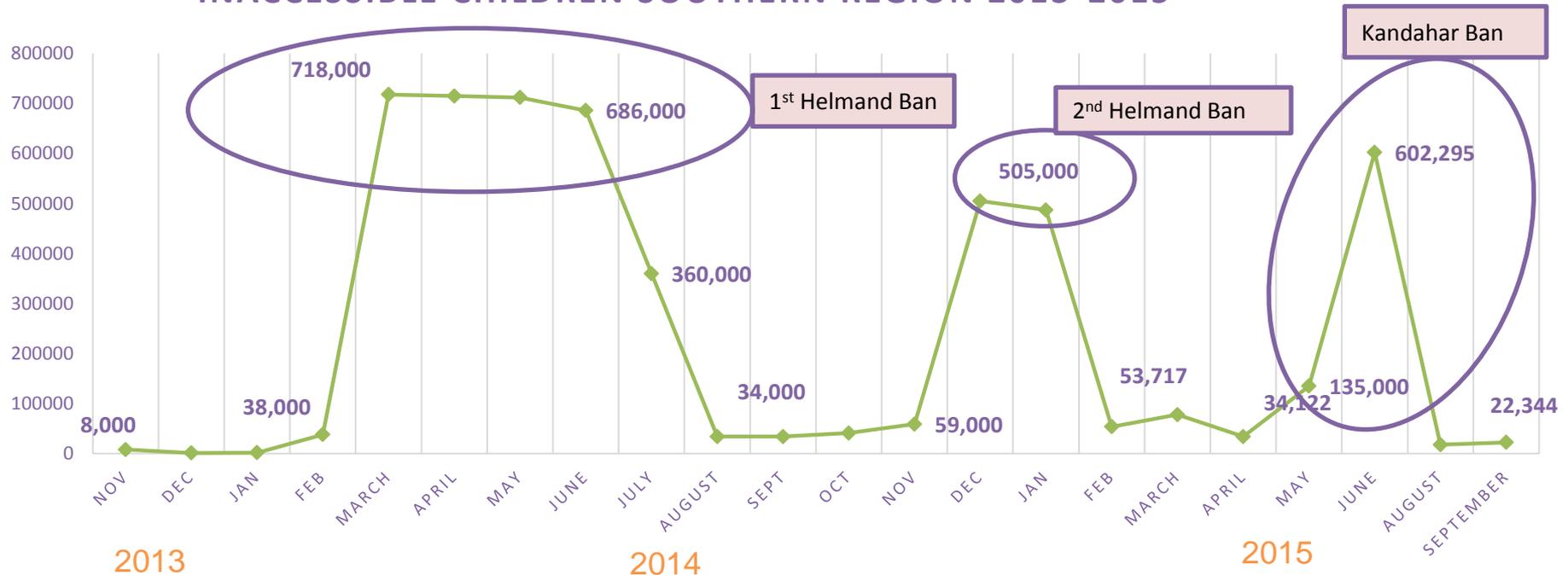


Percentage of NPAFP cases 6-35 months, by OPV status



# Bans in the Southern Region remain a challenge

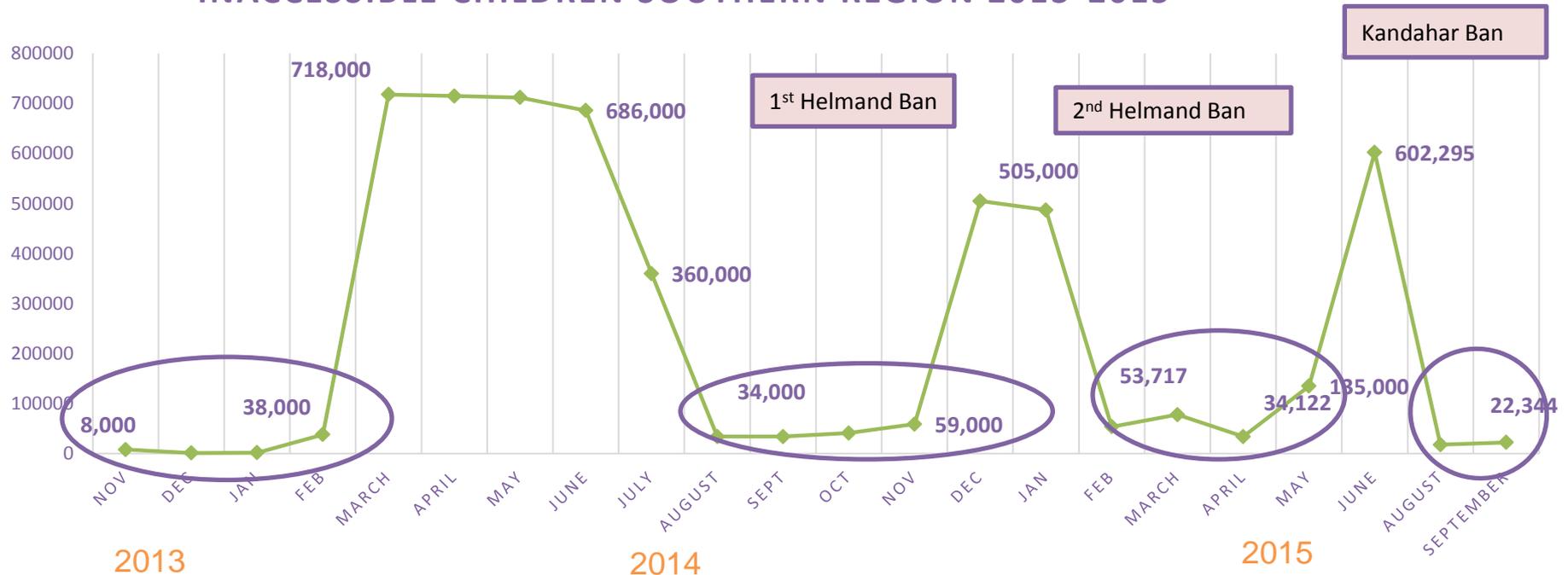
## INACCESSIBLE CHILDREN SOUTHERN REGION 2013-2015



- Large bans on polio campaigns have occurred in Helmand and Kandahar over the past two years with greater than 500,000 inaccessible each time
- These bans are extremely detrimental to the program creating wide gaps in population immunity
- An intense partner effort has been required to get each of the bans resolved
- District-specific, chronic inaccessibility issues have also plagued the program – *specific districts in Helmand, Kandahar, Farah, Urozgan, Kunar, and Nangarhar have experienced lengthy periods of inaccessibility in the past year*
- Very close correlation between areas of inaccessibility, location of cases, and areas of low population immunity

# But large windows of opportunity exist to vaccinate children when bans are not in place

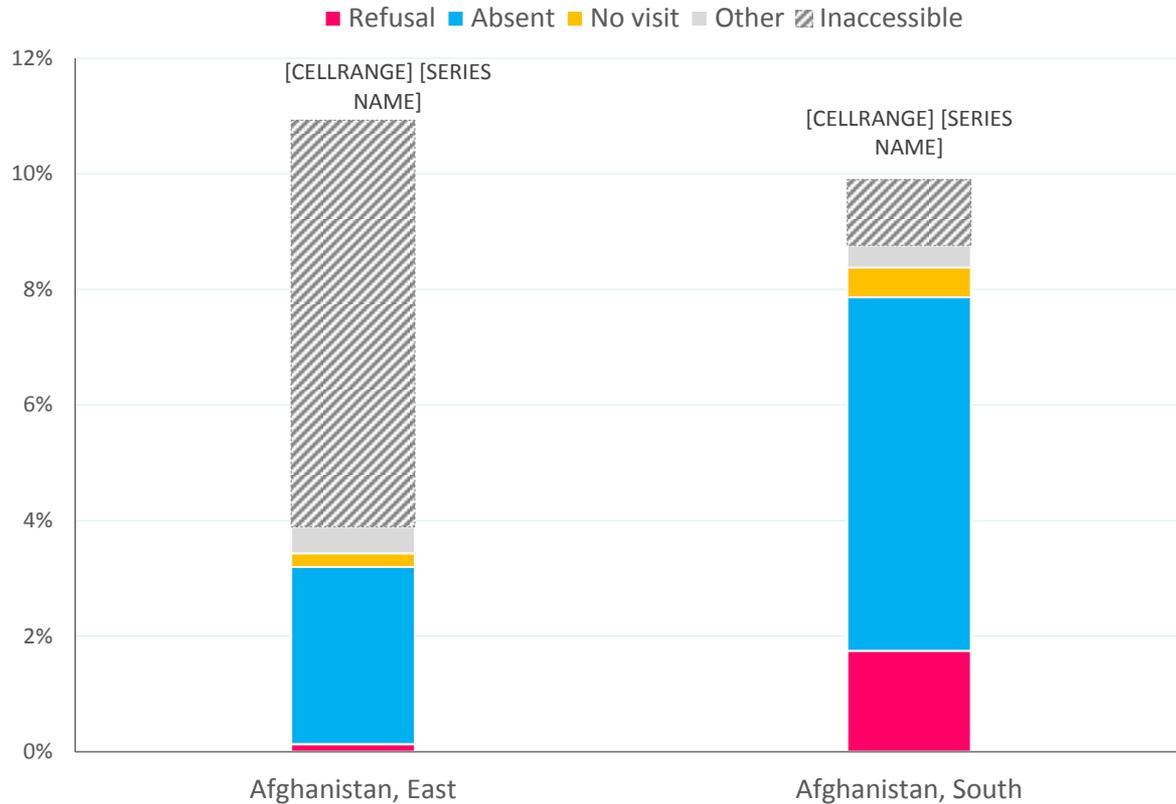
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# However, when bans are not in place, SIA quality in the South is poor

All reasons of missed children in high-risk areas, Afghanistan, NID August 2015

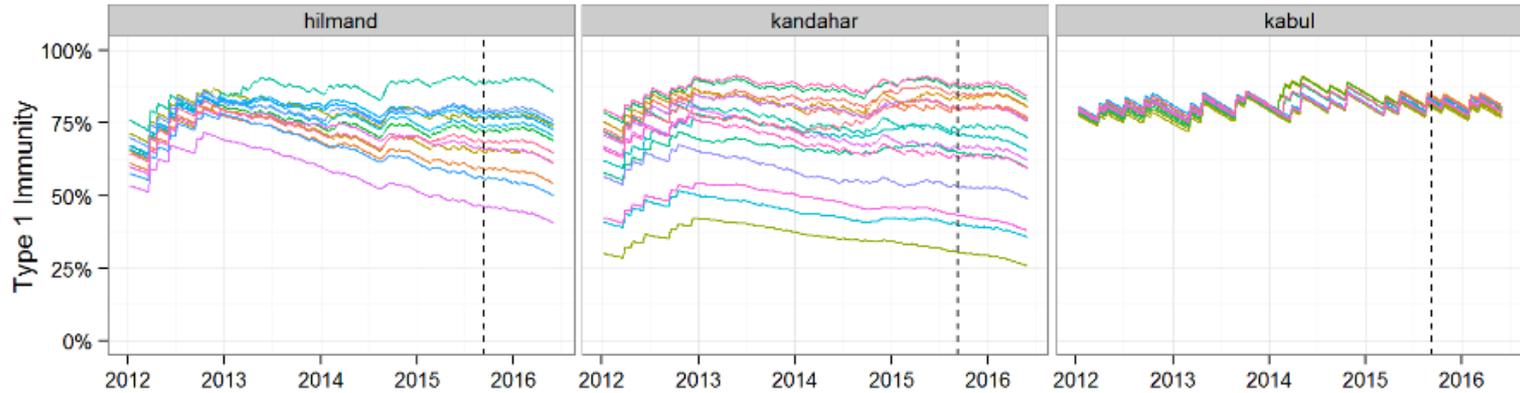


Source: Post campaign assessment

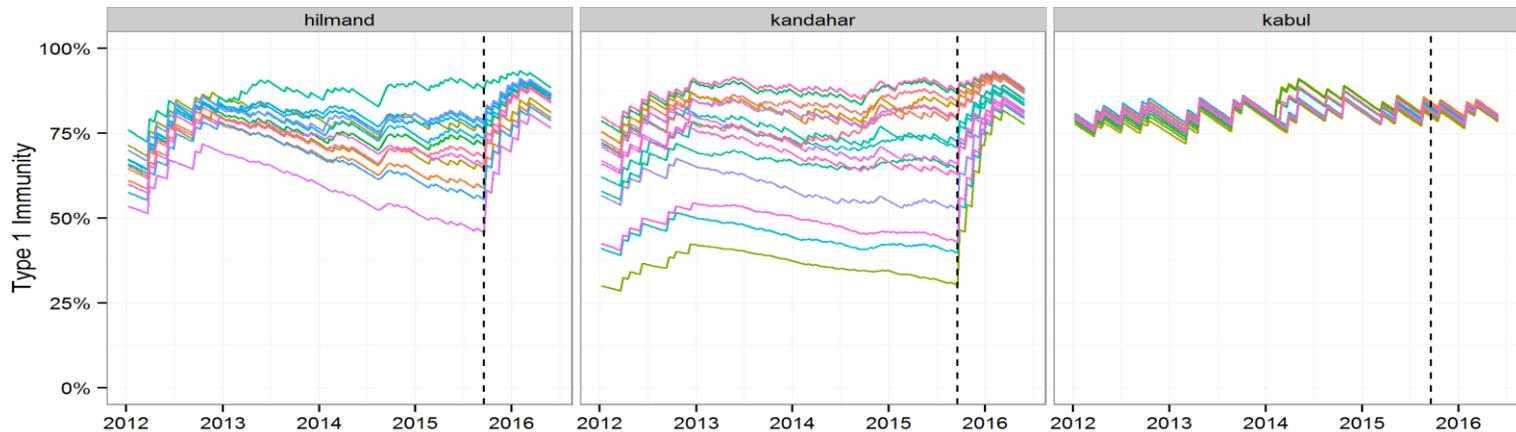
Note: High risk areas refer to *Priority 1&2 districts* in Afghanistan

# High immunity in Southern Region is achievable with current campaign calendar, but only if access and campaign quality improves immediately

Projected district immunity in Hilmand, Kandahar, and Kabul if inaccessibility and campaign quality continue in the same pattern as last few years: suboptimal immunity levels in Hilmand and Kandahar in the coming years



Projected district immunity if all children are accessed and campaign quality immediately improves to 80% coverage in each round: immunity profile dramatically improves in the coming year



# Afghanistan: Summary

## Progress

- Leadership and oversight at Presidential and MOH levels established
  - Key advisors to President and Minister of Health appointed and engaged, and all GPEI partners now meeting weekly
- Access successfully renegotiated in most of South and West
- New NEAP has been developed, with proposed approaches to reduce missed children
- Indigenous virus last seen in October 2014 and multiple chains of transmission stopped since beginning of 2014

## Challenges

- Requisite transformational shift has not yet taken place: EOCs not fully functioning. Urgent need to make EOCs operational with clearly defined TORs, and daily coordination among Government and all GPEI partners
- More children are missed children due to SIA quality than inaccessibility in the South. Gaps in SIA quality is a challenge that must be addressed to succeed.
- Increasing access issues in East due to AGEs and conflict
- Unclear communications strategy and approach to address critical KAP data

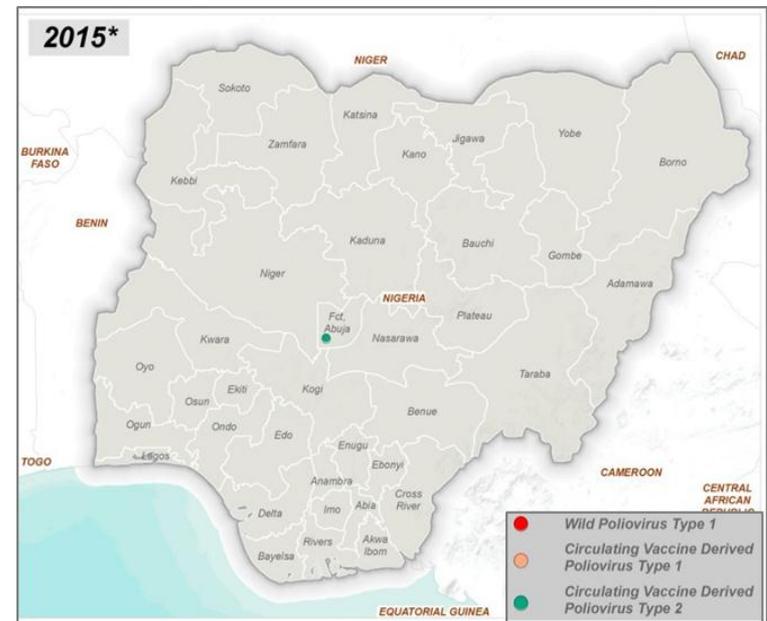
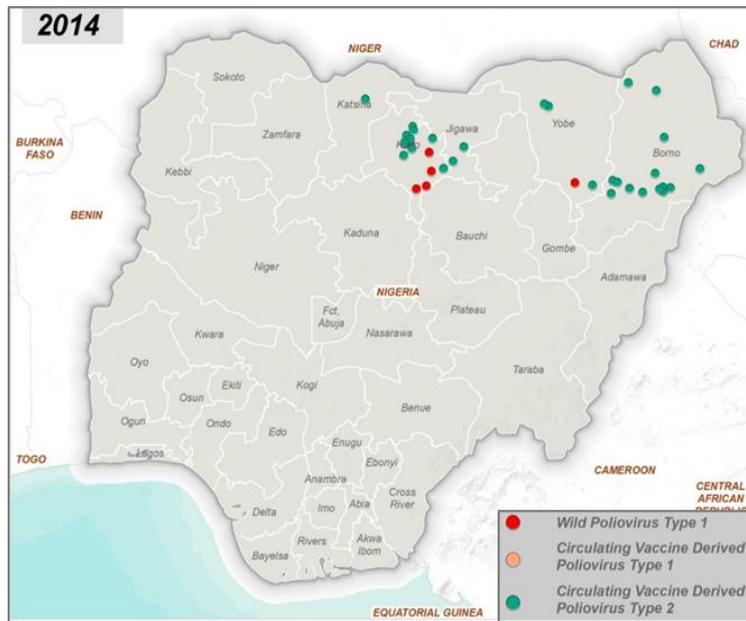
**NIGERIA**

# Topline Messages

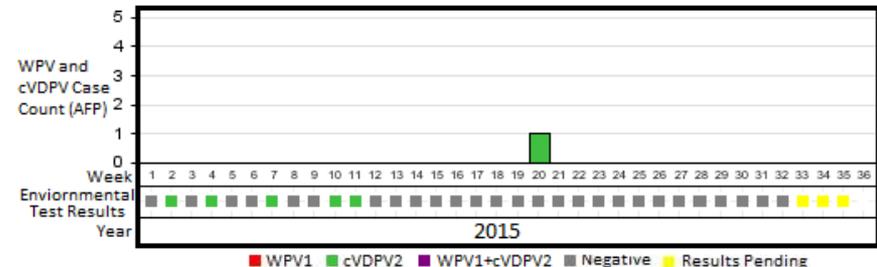
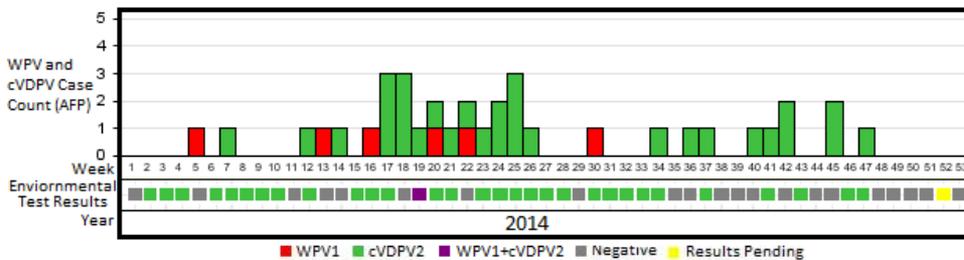
1. Africa has stopped transmission of indigenous wild polio virus this year – a tremendous achievement. Nigeria has been taken off the list of endemic countries but continues to face significant risks.
2. Unwavering political commitment, vigilance and risk mitigation in high-risk countries remain essential in order to improve SIA quality, surveillance and outbreak preparedness and response.
3. GPEI must immediately and rapidly adapt to meet the challenge of emerging vaccine-derived polioviruses before and after withdrawal of type 2 oral polio vaccine. Africa is proving to be a key battleground and performance is variable.

# Nigeria – on track to eradication, but with key risks to manage before the job is done

WPV, and cVDPV cases, 2014 and Jan 2015 to Aug 2015

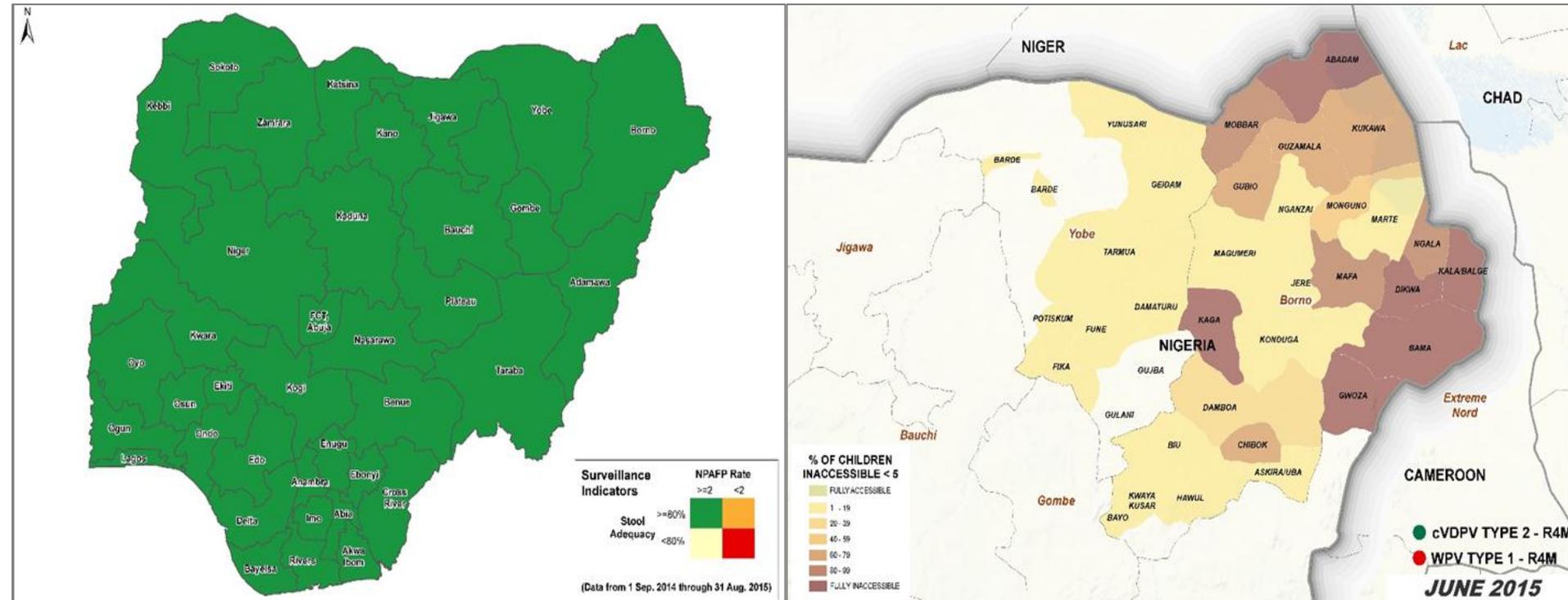


WPV, and cVDPV cases by weeks of Onset, 2014 and Jan 2015 to Aug 2015



# Nigeria – virus circulation unlikely to be missed; but children being missed for immunization in NE

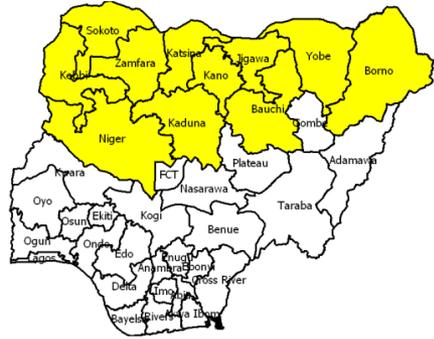
## Surveillance and Accessibility



- Primary surveillance indicators continue to be met by all States; sub-State surveillance gaps being addressed through reviews, re-training and closer monitoring; environmental surveillance being reported from 38 sites in 11 states
- 250-300,000 children in Borno State being missed due to insecurity; >60% of all communities in Borno not reached this year during SIAs; ongoing intensive efforts to reach those children through 'hit and run' campaigns, at IDP camps, border areas

# Nigeria – top priority is to stop cVDPV transmission with aggressive use of tOPV

Jan'15



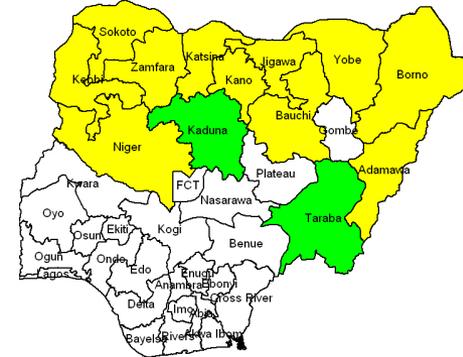
Mar'15



Apr'15



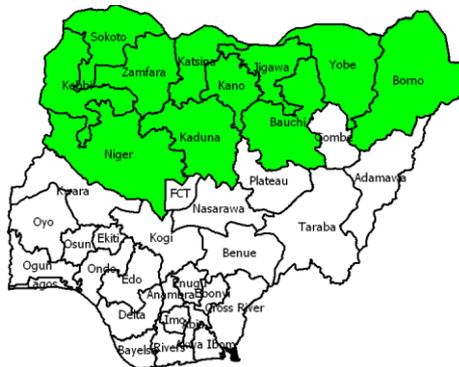
Jun'15



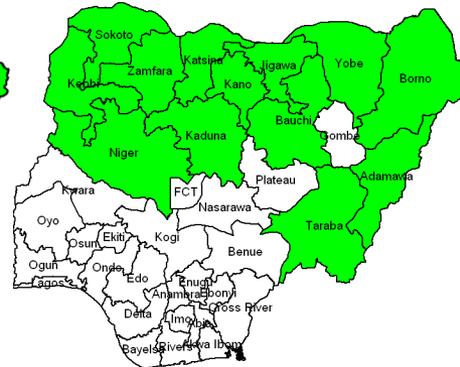
Dec'15



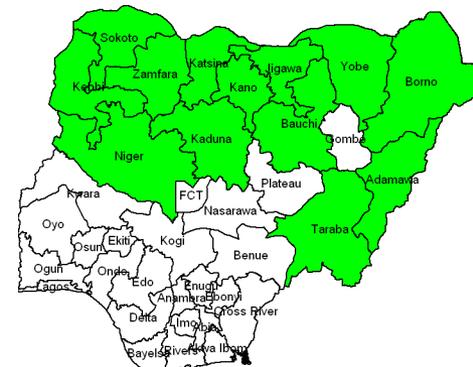
Oct'15



Sep'15

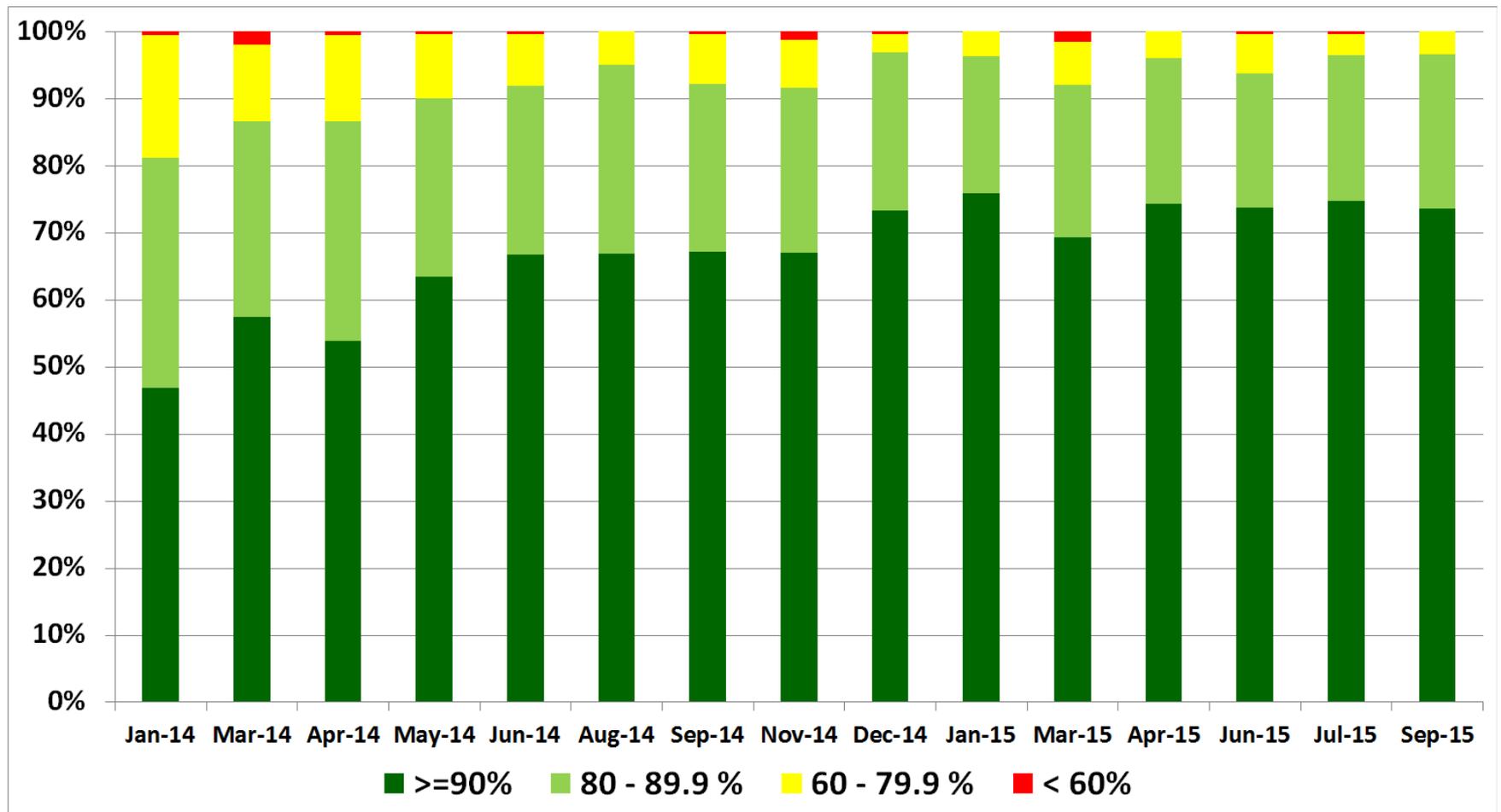


Jul'15



# Nigeria - Quality of immunization activities is being maintained, with strong EOC overview

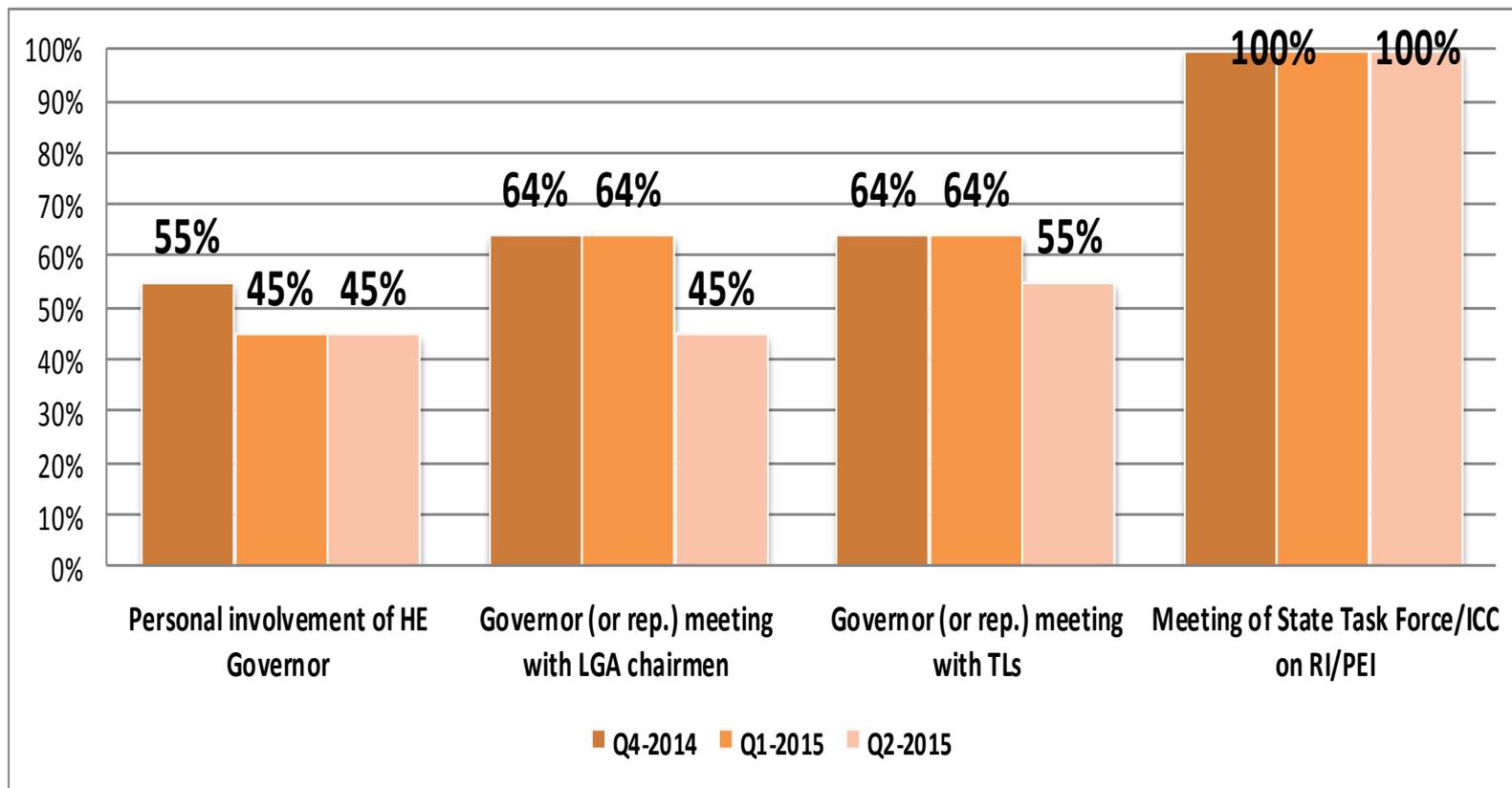
% of LGAs at 90%+ coverage increased from 67% to 75% in past year



# Nigeria's 2015 election pushed polio to the back burner; yet to recover in many States and LGAs

## State Level Abuja Commitment Indicators

Performance in the **11 High Risk States**, Q4 2014 – Q2 2015



**11 HR States: Katsina, Kano, Kaduna, Borno, Sokoto, Zamfara, Bauchi, Jigawa, Niger, Yobe, and Kebbi**

# Nigeria - summary

- Nigeria is no longer on the list of endemic countries - a definite breakthrough for the global program
- cVDPV transmission persisted in 2015 with a case in FCT in May; multiple aVDPVs detected in 2015 in northern states; aggressive use of tOPV and a strong outbreak response was implemented – but vigilance is needed and a continued focus on improving program quality at the sub-district level before we can be confident circulation is stopped
- AFP and environmental surveillance is robust – but some sub-State gaps remain, and need continual attention
- Borno remains a weak link in the program, with an estimated quarter of a million missed children, low type 1 and 2 immunity and a lack of political attention
- President Buhari and some key State Governors have been visible and vocal on polio; but polio is yet to regain the attention it needs, including increased domestic funding and strengthened local government oversight

# OUTBREAKS

# Outbreaks / VDPV2 events- 2015

- **Equatorial Guinea and Cameroon outbreaks** have been closed, though gaps remain in political commitment, quality immunization activities, and surveillance
- **Middle East and Horn of Africa outbreaks** have also apparently ended but both continue to have highly vulnerable areas/communities
- As of 24<sup>th</sup> of September 2015 immunization responses **to 5 cVDPV outbreaks and 1 VDPV2 event** have been planned or already carried out in 6 countries in two regions (AFRO and EURO).
- **cVDPV outbreaks** – yet to be fully contained in Madagascar, with slowly increasing political will and sub-optimal programme operations. While political commitment has increased following intense advocacy efforts in Ukraine, attempts to launch the outbreak response are slowed down due to in-country political processes and obstacles. Uncertain whether transmission is stopped in South Sudan, which has substantial security limitations. Prompt response to cVDPV2 case had been launched in Mali with Guinea following suit. Quality of planning and implementation of response, especially in Guinea raises concerns.
- **VDPV2 events** – swift response to a confirmed VDPV2 case in Katanga with first SIA round covering the province and adjacent areas of DRC and Zambia planned for the week of 28<sup>th</sup> of September

# Experience with VDPV2, 2014-15

- VDPV emergence indicates serious gaps in routine immunization
- 15 countries detected 46 separate emergences of VDPV2 in AFP and environmental surveillance
- Of the 46 strains, only 4 progressed to become circulating VDPV2 (cVDPV2)
- Emergences in Pakistan, Nigeria, South Sudan and Guinea evolved into cVDPV2
- Most new VDPV2 emergences do not continue as cVDPV2 but serve as early warning

# **GPEI approaches to management of Polio outbreaks and VDPV2 events**

The GPEI response to polio outbreaks and VDPV2 events is guided by the following guidance documents

- SOPs for responding to a poliovirus outbreak in a polio free country (Feb 2015. under revision)
- Interim Guidelines on Response to type 2 vaccine-derived polioviruses prior to global tOPV withdrawal (July 2015)

# Responses to a 2014 cVDPV2 outbreak and new VDPV2 event in South Sudan continue today

2015\*



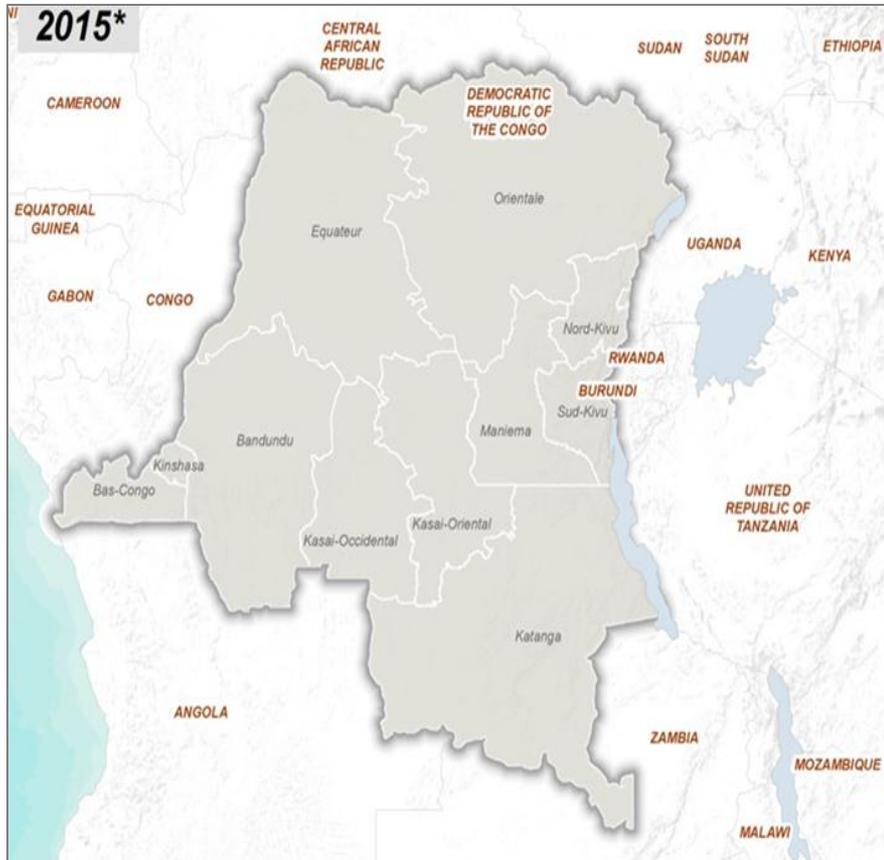
- 2 cVDPV2s reported in September 2014, not detected since then
- 1 VDPV2 notified on 11 June 2015 (date of onset 19th April 2015), Mayom county, Unity state
- The 2015 VDPV2 is not genetically linked to the 2014 VDPVs and is classified as an aVDPV2.
- Swift planning followed by quick launch of SIA campaigns:
- Outbreak response strategy not fully implemented in some areas due to access and security challenges
- Surge support fell short of SOP standards
- Surveillance and SIA quality and coverage are compromised in conflict affected areas
- Large capacity gaps persist with a number of international and local staff positions vacant

WPV and cVDPV cases, Jan 2015 to Aug 2015



# Recent VDPV2 emergence in Democratic Republic of Congo

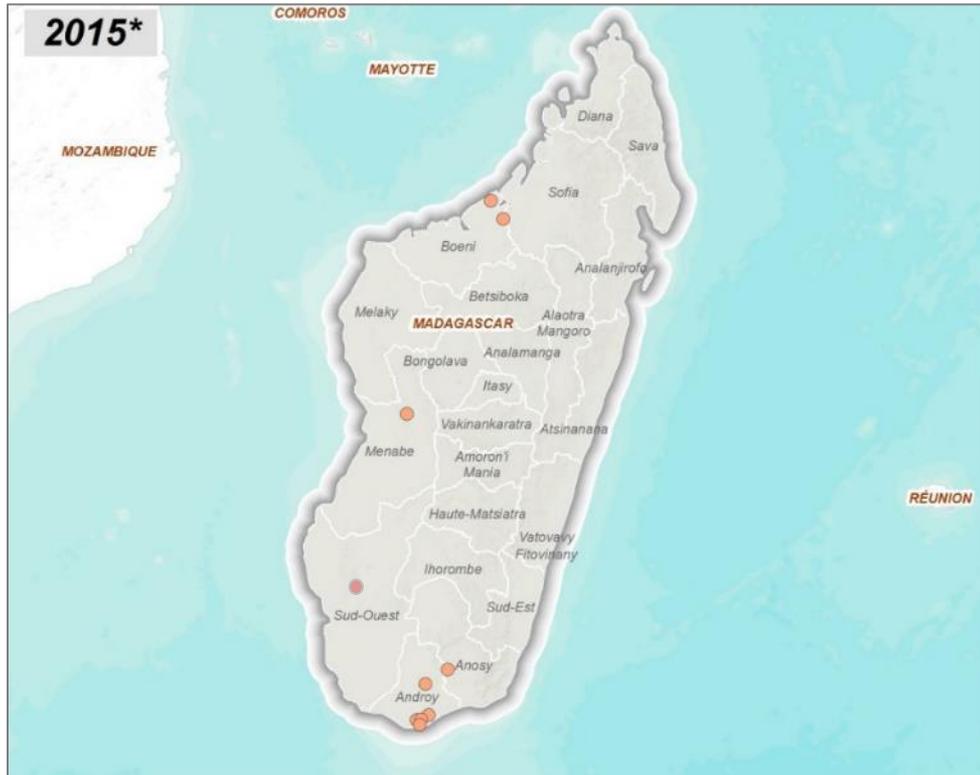
WPV and cVDPV cases, Jan 2015 to Aug 2015



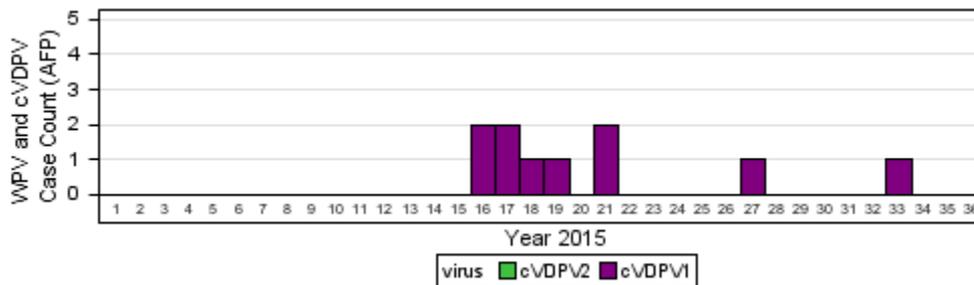
- A VDPV2 event confirmed in Katanga, Village of Kisangwe, in September
- virus isolated from 18 month old boy. Onset of paralysis: 18/07/2015
- Variation from Sabin2: 7 nucleotide difference
- Number of OPV doses received: 1 dose during Polio SIA in 28-30/04/2015
- Immunization response will commence per new guidelines

# **cVDPV1 Outbreaks**

# The response to the cVDPV1 outbreak in Madagascar is gradually improving, and needs to accelerate



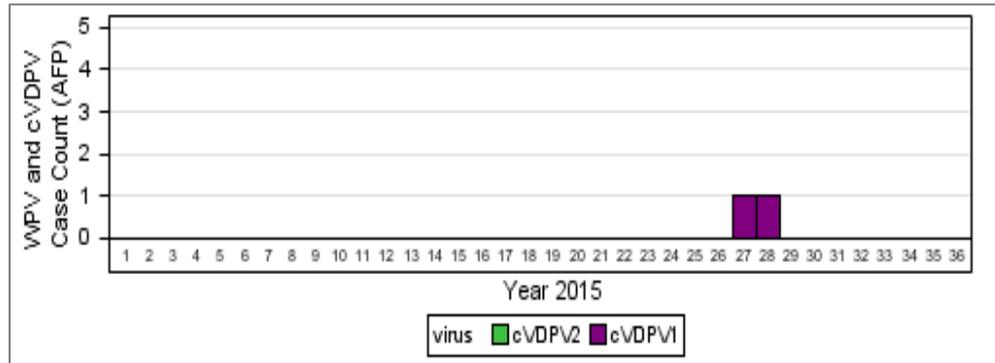
WPV and cVDPV cases, Jan 2015 to Aug 2015



- VDPV1 detected in Madagascar in late September 2014; evidence of ongoing circulation
- VDPV1 has since been detected in multiple regions and districts of Madagascar (February-July 2015). The initial outbreak response, though slow to start, gained force in mid 2015 with unprecedented political backing from the country's top leadership.
- The quality of the campaigns and surveillance have progressively improved but still fail to reach outbreak control standards.
- cVDPV1 isolated from contact of AFP case with date of onset 22 August, 2015
- If SIAs and surveillance do not continue to improve, the outbreak will continue.

# Response to new cVDPV1 outbreak in Ukraine hampered by variety of issues

WPV and cVDPV cases, Jan 2015 to Aug 2015



- Two cVDPV1 cases confirmed by RRL on August 28
- Onset of paralysis in the two children - 30 June and 7 July 2015
- Children from Zakarpattia Oblast in the far west of the country
- A number of AFP cases from the same and neighboring oblasts pending classification
- Field investigation and active case search finds no evidence of missed AFP cases
- Immunization coverage of children less than one year with 3 doses of polio vaccine within Zakarpattia Oblast is only 18% in 2015.
- Immunization coverage throughout Ukraine is estimated to have fallen from about 90% in 2008 to under 50% in 2014
- \*map excludes environmental samples

# Highlights of the response to cVDPV1 outbreak in Ukraine

- Strong support of WHO EURO, UNICEF and GPEI partners in planning the outbreak response and advocacy with the Government of Ukraine.
- Outbreak Manager and multi-discipline Team A deployed
- National Polio Task Force established and Six Month Outbreak Response Plan is with Cabinet of Ministers for endorsement
- Significant resistance from "expert community" and lobby groups to use OPV, with fear of VAPP and subsequent VDPV emergence
- Health personnel fear political backlash if something goes wrong
- Fragile trust in vaccination following the widely reported death of a child in 2008 incorrectly attributed to MR vaccine. Well organized, funded and active anti-vaccination groups effectively slowing down preparations for the outbreak response.
- Questioning of the quality of the OPV doses which have already been delivered to the country and reluctance to using these doses due to freezing/thawing despite confirmation from WHO and manufacturers that the vaccine remains effective

# Summary slide on outbreaks

## What's going well

- Normative guidance and tools in place to support planning and management of polio outbreaks and VDPV2 events
- Strong technical expertise for polio outbreak control and management of VDPV2 emergence
- Global coordination in place (OPRTT)
- Strong advocacy capacity across GPEI

## What's not going well

- GPEI operational capacity weaknesses - limited pool of qualified personnel for immediate response from within the partners as well as externally;
- Limited national preparedness and slow response and weak oversight by national authorities

## Key priorities moving ahead

- Build capacity for polio outbreak preparedness and response at the country, IST and regional levels
- Strengthen timely deployment of qualified GPEI HR to support outbreak responses
- Continued high level advocacy efforts

# **GPEI MANAGEMENT & RESOURCE REQUIREMENTS**

# Topline Messages

1. The management review and MTR provided a path for better optimization of GPEI to “finish the job.” Critical issues now being addressed include– human and financial resource capacity and management, accountability, and coordination.
2. Improved credibility with donors and other stakeholders, greater public confidence in GPEI’s ability to finish.
3. Strong overall global commitment and support from countries to complete the Polio Endgame

# Mid-Term Review Recommendations

## Objective 1:

1. Increase surveillance quality and capacity
2. Improve SIA quality with focus on missed children and intensified social mobilization
3. Increase global and national capacity for outbreak preparation and aggressive response to cVDPV and WPV

## Cross-Cutting:

8. Strengthen management capacity and accountability
9. Increase advocacy at sub-national levels and improve communication with external and internal stakeholders
10. Increase data standardization, monitoring capacity and analysis
11. Update resource mobilization and allocation strategy

# GPEI Joint Approach to addressing three main MTR recommendations

- Work on strengthening polio programme in the highest priority countries is guided by the EOMG's concept notes outlining a joint approach to improving SIA quality, strengthening AFP Surveillance and Polio Outbreak Preparedness and Response.
- Brazzaville meeting held on August 18-19 with EOMG, WHO AFRO, UNICEF WCARO and ESARO
- Target countries in AFRO: CAR, Cameroon, Niger, Mali, Gabon, Liberia, Sierra-Leone and potentially Guinea, South Sudan and Madagascar
- Plans developed for the WHO AFRO IST Central and West focusing on polio program strengthening at the regional and country level
- \$2 million out of \$4.6 million USD for implementation of the plans allocated, finalizing preparations for operationalization of the plans
- Engagement with EMRO to agree on target countries for the initiative is underway

# **Joint approach to strengthening AFP surveillance in the highest priority countries:**

West and Central Africa plans focusing on:

- Strengthening intercountry polio surveillance coordination systems in Lake Chad area
- Conducting surveillance reviews, development and streamlining of the country surveillance strengthening plans
- Strengthening field supervision and programme management
- Expansion of environmental surveillance
- Training and capacity building
- Purchase of equipment for data collection and management
- Recruitment of additional program support personnel
- Deployment of technical and program management support from the HQ and Regional Levels

# AFRO Strengthening SIA quality in the highest priority countries

West and Central Africa plans focusing on:

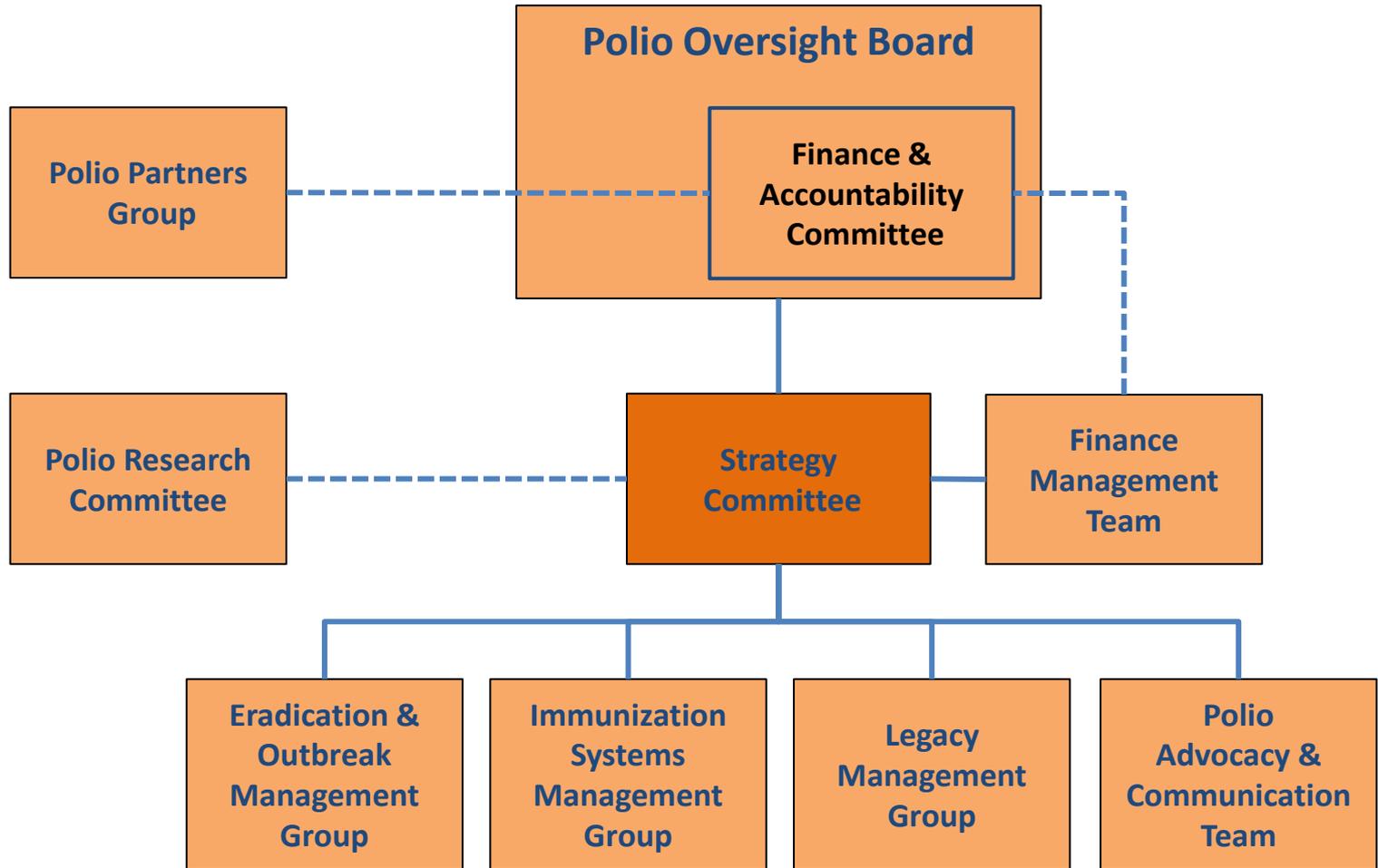
- Joint SIA quality reviews, development of country specific SIA quality plans
- Recruitment of national and international SIA campaign coordinators, operations officers and additional field personnel
- National review and updating microplans for priority districts
- Development and operationalization of plans for cross border immunization of population in high risk areas between Cameroon, CAR and Nigeria, establishment of additional permanent vaccination posts in CAR
- Training and capacity building
- Strengthening field supervision and programme management

# Strengthening outbreak response and preparedness capacity in the highest priority countries

IST West and Central plans focusing on:

- Conducting regional Outbreak Response SOP trainings and outbreak simulations for the national personnel from the highest priority countries: for francophone countries Senegal 13-16 October, for English speaking countries TBD in Nov
- Strengthening national systems for coordination of polio outbreak response and preparedness planning: setting up national polio outbreak preparedness committees
- Development, testing and updating of polio outbreak preparedness and response plans in the highest priority countries
- Facilitating outbreak response simulation in Gabon in Nov-Dec 15

# MTR 8: GPEI Management - Revised Structure



# MTR 8: EOMG - what's working, what needs improvement

- **Required capacity for supporting EOMG and TTs:** almost all members have competing responsibilities between their agency and EOMG/TT roles especially EOMG withing **secretariat** and Outbreak Preparedness and Response Task Team
  - Progress: updating SIA calendar, 2 trainings on global roll-out of the outbreak SOPs -> global roster of consultants and capacity
  - Challenges:
    - Timely and effective deployment for outbreak response varies
    - Increasing technical capacity dedicated to EOMG: need to improve alignment & engagement of GPEI partner staff with EMOG and TT responsibilities and priorities
    - Regular monitoring of SIA quality and improving coverage
- **Engaging with Country and Regional Offices**
  - RO: Challenges related to regional capacity and buy-in of global initiatives. Opportunities with new leadership in AFRO, good start with the roll-out of concept notes on SIA quality, surveillance and outbreak preparedness in response to IMB and MTR recommendations.
  - CO: Afghanistan country TT has not yet become functional, the support of GPE to Afghanistan is yet to be fully optimized.

# MTR 8: Strategy Committee - what's working, what needs improvement

## What's working

- Mid-term review process provided more strategic clarity
- Strengthened relationships, working and openness between agencies

## What needs improvement

- Strategy Committee's current focus is on making decisions and providing guidance in response to management group requests. Needs to take an increasingly proactive role in setting and communicating program direction.
- The fast-changing program makes forward planning a challenge – but forward planning needs to be prioritised, whilst allowing flexibility to respond to changing circumstances.

# MTR 8: On the Frontlines - managing workers & quality of operations

## **Nigeria:**

- Performance Management System in place for all frontline workers. Revamped training and motivation for frontline workers will be a critical component of Nigeria's maintenance plan in 2015-2016.
- EOC Dashboard in place to monitor campaign quality. Data sharing and use is optimized among the partners

## **Pakistan:**

- New training, payment and motivation system rolled out for all frontline workers in the 12 Highest Risk Districts.
- Payment arrears cleared in the amount of 2 billion PKR
- Innovative, inter-active new training implemented for all FLWs in September
- EOC Dashboard in process; data sharing and use still not optimized among the partners

## **Afghanistan**

- Joint WHO-UNICEF Training assessment conducted August 2015
- Gaps identified in curriculum design, training cascade, master trainers capacity, integration of communications and operations, tools
- No EOC Dashboard or comprehensive common shared system of monitoring quality of operations

## **MTR 10: Data standardization, monitoring capacity and analysis**

- Data working group among GPEI partners established within the EOMG to align key performance indicators, data sharing and analytical processes
- One face to face meeting has taken place - limited movement from decisions to action
- At country level, joint data collection, data sharing and cohesive analysis remains a critical cap.
- Final feedback analyses trickles down to district and sub-district levels – microplans, rapid data for action and missed children are impacted
- Nigeria is a best practice model for data collection, use and analysis amongst the GPEI and at all levels

# MTR 11: Financial Scenarios 2 endorsed by the POB

Scenario:	1	2	3	4				
	Low	Intermediate (A)	Intermediate (B)	High				
Nigeria interrupts:	2014	2014	2014	2015				
Pak/Afg. interrupt:	2015	2016	2017	2017				
All other assumptions:	Optimistic	Intermediate	Intermediate	Pessimistic				
Global interruption:	2015	2016	2017	2017				
Global certification:	2018	2019	2020	2020				
Post-certification costs:	2019-2025	2020-2026	2021-2027	2021-2027				
	'13 – cert.	Post-cert.	'13 – cert.	Post-cert.	'13 – cert.	Post-cert.	'13 – cert.	Post-cert.
	\$5.7B	\$0.8B	\$7.0B	\$0.8B	\$7.8B	\$0.8B	\$8.8B	\$1.2B

→ Additional funding of \$1.5 billion needed for scenario 2

# GPEI management summary

- **GPEI has established more functional governance structure at global level**, with task teams identified for all major components of programme delivery. Some task teams more effective than others; timely decision making efficiency and capacity improved but issues remains a challenge in some cases.
- **Global teams in WHO, UNICEF and CDC are about to embark on major transitions.**
- **Some progress made with deployment of short term support** through expanded STOP and intensified consultant deployments including surge in Pakistan for both WHO and UNICEF. All WHO short term contract holders have been transferred to a stronger HR management system under UNOPs. Blanket approval of zero cost WHO consultant contracts for experts contracted by GPEI partners
- GPEI continues to face **challenges with retention of qualified staff and filling key management positions:** getting the right people to the right (most difficult places) at the right time.
- **Nigeria and Pakistan have made greater investments in payment, motivation, accountability and training of frontline workers.** This is making a difference. Are lessons being applied in other contexts?
- **A coordinated resource mobilization strategy for Pakistan FRR 2016-18**
- **Substantial funding gaps remain to be filled for 2016**