

POLIO GLOBAL ERADICATION INITIATIVE

ANNUAL REPORT
2018



TO ACHIEVE LASTING SUCCESS



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Rotary



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GLOBAL POLIO ERADICATION INITIATIVE

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Published by the World Health Organization (WHO) on behalf of the Global Polio Eradication Initiative.

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Suggested citation. Suggested citation. Global Polio Eradication Initiative: annual report 2018. Geneva, Switzerland: World Health Organization; 2018 (WHO/Polio/19.07). Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

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ACRONYMS

AFP	Acute flaccid paralysis
bOPV	Bivalent oral polio vaccine
cVDPV	Circulating vaccine-derived poliovirus
cVDPV1	Circulating vaccine-derived poliovirus type 1
cVDPV2	Circulating vaccine-derived poliovirus type 2
cVDPV3	Circulating vaccine-derived poliovirus type 3
GCC	Global Commission for the Certification of the Eradication of Poliomyelitis
GPEI	Global Polio Eradication Initiative
IPV	Inactivated polio vaccine
OPV	Oral polio vaccine
RCC	Regional Commission for the Certification of Polio Eradication
RI	Routine immunization
UNICEF	United Nations Children’s Fund
VDPV	Vaccine-derived poliovirus
VPD	Vaccine-preventable disease
WHO	World Health Organization
WPV	Wild poliovirus



1988

350 000 | 125
cases | countries

2018

33 | 2
cases | countries

EXECUTIVE SUMMARY

In the 30 years since the 1988 World Health Assembly adopted a resolution for the worldwide eradication of polio, the Global Polio Eradication Initiative (GPEI) has reduced the number of wild polio cases from 350 000 across 125 countries to 33 in just two countries in 2018. This scale and progress across global health and disease eradication efforts were only possible thanks to the polio eradication community's perseverance and continuous learning and innovation.

The ability to adjust and amend the approach to succeed has been a cornerstone of the polio eradication programme, and 2018 was another year demonstrating the GPEI's flexibility.

Wild poliovirus

The Polio Eradication & Endgame Strategic Plan 2013–2018 came close to polio eradication and set the stage for a final assault. Wild poliovirus (WPV) was cornered in the cross-border area of Afghanistan and Pakistan, and both countries continued to work in close coordination to ensure that all strategies and tools remain aligned, and all major activities are synchronized. Special attention was paid to the cross-border transmission corridors, continuing to bring a better understanding of the different challenges and to ensure cross-border transmission can be curbed.

The footprint of WPV is receding each year. A major milestone of global certification of WPV type 3 eradication is nearing, after eradication of WPV type 2, leaving just one strain of WPV in the world. At the same time, Africa is on the verge of regional certification of WPV eradication.

The Global Commission for the Certification of the Eradication of Poliomyelitis established clear criteria for certifying the global eradication of WPVs, which will be followed by the cessation of oral polio vaccine (OPV) to eliminate long-term vaccine-derived poliovirus risks.

Circulating vaccine-derived polioviruses

The same proven strategies that are being used to stop WPV transmission have also been used to respond to circulating vaccine-derived polioviruses (cVDPVs). In December 2018, an international group of public health experts determined that the 2017 outbreak of cVDPV type 2 (cVDPV2), which had occurred in the Syrian Arab Republic, had been brought to a halt. That news followed 18 months of intensive vaccination and surveillance efforts in conflict-affected, previously inaccessible, areas. Since the confirmation of a cVDPV type 1 outbreak in Papua New Guinea in June 2018, the polio eradication programme conducted five rounds of polio vaccination campaigns with integrated vitamin A supplements and human papillomavirus vaccination for girls. A multimedia approach was used, maximizing traditional and social media and interpersonal communication through health workers and church organizations.

Elsewhere, however, notably in Africa, despite progress in curbing WPVs, cVDPV2 continues to expand across parts of the Lake Chad region, central Africa and the Horn of Africa.

A historic resolution on poliovirus laboratory containment was adopted at the Seventy-first World Health Assembly to ensure that the number of polioviruses in labs and vaccine manufacturing plants is minimized, and that those that remain are fully contained.

New tactics

As the world moves forward on the last mile towards the anticipated goal of polio eradication, the new GPEI Polio Endgame Strategy 2019–2023 defines what changes will be introduced and what innovations will be needed to reach 0.1% of the poorest and most marginalized children.

To strike while the iron is hot, the new worldwide vision and strategy focus on crossing the finishing line, while taking steps to ensure sustainability. Building on lessons learned and tools and tactics established through the Polio Eradication & Endgame Strategic Plan 2013–2018, the new strategy builds on a compelling, country-centric vision with responsive and nimble support. An Afghanistan–Pakistan hub, dedicated rapid response teams for outbreaks, and a new partnership with Gavi, the Vaccine Alliance, are among several new tactics to seize the moment for polio eradication.

Protecting the future

The broader assets of the polio infrastructure, including the human resources and expertise, are critical to reach children through routine immunization and basic health, nutrition and water, and sanitation services. Polio and other immunization and health services need each other to achieve and sustain eradication. The intricate polio surveillance network is constantly expanding and is unique in scale and capability, simultaneously detecting cases of polio paralysis as well as positive samples in the environment. The labs provide benefits beyond polio eradication, detecting and responding to other public health threats, including measles, yellow fever, neonatal tetanus and avian influenza.

Cross-cutting approaches

The GPEI's work on cross-border coordination improves migrant health and ensures people on the move need not miss out on basic health services. Its gender-conscious approaches accelerate progress against polio and advance women's and children's overall wellness. Once eradication is achieved, valuable infrastructure, data and tools can remain in affected countries, strengthening their health systems and ensuring inclusive human security. These assets will help generations to come to better detect and respond to other disease outbreaks.

The world has a new opportunity to achieve success. The starting point is different than in 2013: today, the South-East Asia Region is certified as polio-free, the African Region is on the verge of certification, a Public Health Emergency of International Concern has been declared, WPV has been curbed to a cross-border area of just two countries, the phased removal of OPVs is under way and clear laboratory containment guidelines have been established. Governments, communities and partners have a chance to use this springboard to unite behind a shared goal, to take control, learning from the successes.

Polio has tested our scientific ingenuity and now it is testing our perseverance. Polio eradication is an effort that cannot be sustained indefinitely. It is resource intensive and puts tremendous pressure on the affected countries, on donors and on communities. A good strategy with an optimistic and critical mindset coupled with meticulous implementation and full financing will finish the job, and the contributions to this effort will be remembered as helping to making history.

Achieving a polio-free world will generate an estimated US\$ 14 billion in cumulative cost savings by 2050, compared to the cost countries would incur to control the virus indefinitely. In financial terms, the global effort to eradicate polio has already saved more than US\$ 27 billion in health costs since 1988. The benefits of success of the next chapter of polio eradication will be shared equally by all countries and people around the world. This incredible achievement will be a perfect example of a sustainable and equitable global public good and of universal health care – as all humans will have benefitted equally from polio vaccines and from a polio-free world.



ERADICATION

Éradication
Erradicación

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Afghanistan and Pakistan: The final global wild poliovirus type 1 bastion

In 2018, wild poliovirus (WPV) cases were reported from just two countries: Pakistan and Afghanistan. In Nigeria, the third WPV-endemic country, no WPV has been detected since 2016.

Both countries continued to be treated as a single epidemiological block as the same virus strains are shared across their joint border. They coordinated both vaccination and surveillance activities, including at the provincial level and along border areas. While overall national immunization coverage was high, pockets of local under-immunized populations remained. National emergency action plans focused on identifying the reasons for persistently missed children in specific areas and implementing operational plans.

Virus transmission was primarily restricted to two cross-border corridors: the first linking eastern Afghanistan with Khyber Pakhtunkhwa and Federally Administered Tribal Areas in Pakistan, and the second linking southern Afghanistan (Kandahar and Helmand) with the Quetta Block, Balochistan province in Pakistan and Karachi (Pakistan). Environmental surveillance in both countries continued to detect virus in other parts, but without re-establishing local transmission.

While both countries were affected by various difficulties in different areas, including insecurity, challenging terrain, the lack of infrastructure or inadequate activity planning, the overriding issue affecting them was reaching populations on the move. Implementing specific high-risk mobile population strategies aimed to fill the remaining vaccination coverage gaps among these groups. The two countries share a border that is more than 2400 km long, which more than 50 000 children cross every day, either at formal border crossings or at unofficial crossings. Populations travel for a variety of reasons and include nomads, seasonal and economic migrants, agricultural or migrant labourer families, or refugees. Specific tactics to reach them included engaging with leaders of populations on the move, establishing vaccination points at key border areas and gathering sites, using mobile vaccination groups on roads and at bus and rail terminals, and organizing special vaccinations at destination and arrival sites.

Africa and polio eradication: An unfinished success story

Africa has not detected any WPV from any source from north-eastern Nigeria since September 2016. And although surveillance gaps in some parts of that area remain, surveillance (and immunity levels) is significantly stronger today than in 2016, when the surveillance system did manage to detect the virus.

Africa stands on the cusp of a historic public health success: the potential certification of WPV eradication, which could occur as early as 2020.

This success would be a tribute to the tremendous efforts achieved by political leaders across the continent as well as by traditional, religious and community leaders, public health systems, front-line health workers and, most importantly, parents. They all dedicated themselves to a single and common goal: to find and vaccinate every child against WPV, no matter where they live. All heeded the call issued by Nelson Mandela in 1996 – at a time when WPV paralysed more than 75 000 children every year across every country on the continent – to “kick polio out of Africa”.

The certification of Africa would also highlight what can be achieved when all levels of public and civil society are mobilized towards a common goal. Already, the polio effort on the continent has helped to address other urgent public health challenges.

But this success is only half the story. In fact, it is an unfinished success story. To finish it, the increasing threat of circulating vaccine-derived polioviruses (cVDPVs) on the continent must also be addressed.

Ongoing emergency outbreak response to cVDPVs in Africa

In 2018, Nigeria was affected by two genetically distinct cVDPVs type 2 (cVDPV2). In Sokoto state, four genetically related viruses were isolated from environmental samples, collected between April and May 2018. No associated cases of acute flaccid paralysis (AFP) were detected. Separately, the country was affected by a different outbreak originating in

Jigawa state, with subsequent spread both nationally to other states and internationally to neighbouring Niger. After detection of the original outbreak in Jigawa, 42 cases were reported, including 33 from six Nigerian states and nine from Niger. Of particular concern was the detection of a case associated with this outbreak in Kwara, Nigeria in the second half of 2018, a state immediately bordering Benin, magnifying the risk of further international spread.

In the Democratic Republic of the Congo, four different cVDPV2 outbreaks continued, in the provinces of Haut-Katanga, Mongala, Maniema and Haut-Lomami/Tanganyika/Haut-Katanga/Ituri. In total, 42 cases were confirmed in the country after detection of the first outbreak in June 2017, including 20 cases in 2018. Operational gaps in the response continued to hamper the full implementation of protocols, as high-risk populations remained under-immunized; the response did not control the outbreaks or prevent geographic spread. Polio outbreak response was conducted simultaneously to an ongoing Ebola outbreak affecting North Kivu province, in the east of the country (close to provinces affected by cVDPV2). As in the past, the polio teams coordinated efforts closely with the broader humanitarian emergency network to address both outbreaks in a coordinated manner (as was the case during the 2017 Ebola outbreak in Equateur province, which was successfully stopped).

The Horn of Africa was affected by outbreaks due to cVDPV2 and cVDPVs type 3 (cVDPV3). The cVDPV2 was isolated from cases of AFP as well as environmental samples in Mogadishu (Somalia) and from environmental samples in Nairobi (Kenya). Genetic sequencing of this strain suggested it had been circulating without detection since 2016, underscoring the dangers of gaps in subnational surveillance. In addition to cVDPV2, cVDPV3 was isolated from AFP cases and environmental samples in Mogadishu. Regional outbreak response activities for both strains were implemented, in line with internationally agreed guidelines. Somalia, Kenya and Ethiopia all declared these outbreaks to be national public health emergencies.

Cross-regional, cross-border emergency response to two unrelated cVDPVs on the border of Papua New Guinea and Indonesia

Both Papua New Guinea (in WHO's Western Pacific Region) and Indonesia (in WHO's South-East Asia Region) continued to implement a coordinated, cross-regional, cross-border outbreak response to two separate and genetically distinct cVDPV type 1 (cVDPV1) outbreaks that affected their respective border areas.

In Papua New Guinea, a cVDPV1 outbreak was confirmed in June 2018; the virus was initially isolated from an AFP case and two healthy community contacts. The government immediately declared the outbreak as a national public health emergency, and launched a comprehensive emergency outbreak response. After the initial confirmation of the virus in June, additional cases were confirmed in other areas, prompting the government to extend the response to nationwide campaigns. Given the proximity of the cases to the border with Indonesia, both countries implemented cross-border vaccinations to minimize the risk of this strain's international spread.

In January 2019, a genetically distinct cVDPV1 outbreak was confirmed in Indonesia, in Papua province bordering Papua New Guinea. The virus was isolated from a child with AFP, as well as from a healthy community contact. A district-level outbreak response was immediately launched following the detection, with further outbreak response planned in high-risk provinces.



Providing support to polio survivors in Papua New Guinea... a model for the rest of the world?

Public health authorities in Papua New Guinea and key partners are exploring concrete ways to more comprehensively support children affected by the current outbreak and their families. Although polio paralysis is not curable, in some instances certain treatments can alleviate symptoms or provide increased comfort. The provision of prosthetics and wheelchairs as well as increased social, vocational or educational assistance can also greatly improve the quality of life of survivors.

Using the experiences of similar work in countries like Pakistan as a model, local health authorities are coordinating more closely with universal health care infrastructures and specialized agencies that provide support to persons requiring increased rehabilitation services. By critically evaluating the precise needs and treatment options of each patient, a targeted, patient-centred approach to their care can be provided. This approach can be made a part of the current outbreak response strategy and could well serve as an operating model moving forward, as the world nears polio eradication.

Syrian Arab Republic: An outbreak response success story

In June 2017, reports emerged of an explosive cVDPV2 outbreak in the eastern part of the Syrian Arab Republic. Confirmation of the outbreak was soon received and an extraordinary outbreak response was launched, amidst extremely challenging and dangerous circumstances and within the context of a broader humanitarian aid response. The response was successfully implemented throughout the rest of 2017 and 2018, involving a broad range of partners and humanitarian actors, and the outbreak was successfully stopped as no new cases were detected in the country after September 2017.

Gender and polio eradication

Gender equality and equity are core values for the GPEI, and the programme recognizes that gender-responsive approaches further strengthen polio eradication interventions. Gender, along with other factors such as socioeconomic background, age and ethnicity, is an important social determinant of health and, as such, also has an impact on vaccination outcomes and the overall effectiveness of the programme. The GPEI also recognizes that gender-equitable, gender-balanced and diverse organizations produce better results.

A Gender Equality Strategy and Implementation Plan are being finalized, and a gender perspective has been integrated into the new GPEI Polio Endgame Strategy 2019–2023.

INTEGRATION

Intégration
Integración

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積分

интеграция



END
POLIO
NOW

The GPEI continued to expand the delivery of integrated services, with polio at the forefront. Its integration approach focuses on systematic collaboration with other health actors to leverage the capacities and contributions and help to achieve and sustain eradication.

Delivering polio services in a more integrated manner will channel the GPEI's human and physical assets, systems and expertise to protect populations by supporting the public health system and emergency response.

The key areas of GPEI expertise include policy and strategy development; planning; management and oversight; implementation and service delivery; monitoring and evaluation; communications and community engagement; disease surveillance and data analysis; capacity building; and partnerships and coordination.

Collaboration with routine immunization (RI), surveillance and emergencies groups will ensure that core capacities are maintained and strengthened during the transition to a post-polio world. This union will contribute to providing necessary advocacy support to ensure the implementation of country plans and help with knowledge and staff to mitigate the risks of new outbreaks in areas of inadequate RI.

Delivering polio vaccinations in a more integrated way earns the trust of communities and politicians. Knowing that polio is the reason that other services are being provided gives the communities confidence in the eradication programme and helps foster engagement and participation.

The 2018 cVDPV1 outbreak in Papua New Guinea is a strong example of the impact the GPEI collaboration with other partners can bring; systematically ensuring this happens should be a priority in all polio outbreak countries. The response operation was led by the National Department of Health, with technical support from WHO, UNICEF, the US Centers for Disease Control and Prevention, Gavi, the Vaccine Alliance, and other partners.

Following confirmation of the outbreak, five rounds of polio vaccination campaigns were conducted in

2018. But over and beyond addressing the immediate outbreak, partners worked collectively to address the root cause of the outbreak: inadequate RI levels in marginalized areas. Viewing improving RI as an emergency activity is key in eradicating polio and stopping outbreaks. The effort hence focused on administering other public health interventions alongside polio vaccine, such as vitamin A and other vaccinations, while ensuring that the infrastructure built up to stop the outbreak could be sustained in the longer term.

Polio staff on the ground spend approximately 50% of their time working on other health intervention areas, such as conducting surveillance for other diseases, supporting outbreak responses, helping respond to natural disasters, and much more.

Approximate average yearly delivery of broader health interventions through polio:

Oral polio vaccine – 450 million

Vitamin A – 82 million

Measles – 64 million

Deworming tablets – 34 million

Yellow fever – 7 million

Tetanus toxoid – 5 million

Insecticide-treated bednets – 4 million

Integration is one of the three main pillars of the new GPEI Polio Endgame Strategy 2019–2023. The integration goal was envisioned to provide the impetus for (a) strengthening immunization/health systems to facilitate attaining and sustaining a polio-free world; (b) expanding the AFP/polio surveillance system to support vaccine-preventable diseases (VPDs) and communicable disease surveillance systems; and (c) expanding preparedness and response to future polio outbreaks and emergencies in such a way that they support health security. At a strategic level, the ground will thus be set for using GPEI assets to benefit the greater public health good.

At a technical level, the GPEI launched the following key intervention areas to institutionalize integration into routine operations: implementing multi-antigen supplementary immunization activities; expanding AFP surveillance to broader VPD surveillance; and using polio outbreak preparedness and response to support immunization systems recovery in line with the WHO Emergency Response Framework.

The GPEI and Gavi, the Vaccine Alliance: Working together for the well-being of all

- ◆ As joint advocates for immunization and global health, the GPEI and Gavi, the Vaccine Alliance, have historically worked together, with Gavi lending expertise to support 73 countries in their efforts to introduce the inactivated polio vaccine (IPV) used in national immunization programmes. This milestone in the fight against polio and the mission to support routine immunization programmes worldwide was achieved at an unprecedented pace only seven years after it began, and it is a testament to the strength of the partnership between Gavi and the GPEI.
- ◆ The collaboration between the GPEI and Gavi has now entered a new era as both move into their next strategic periods. In June 2018, the Gavi Board decided to use its core resources to support IPV for the 2019–2020 period. The Gavi Board also approved support for IPV as part of its next strategic phase (the 2021–2025 period, also called “Gavi 5.0”), subject to the availability of resources following the Gavi replenishment. And in March 2019, at its invitation, the Gavi CEO joined the Polio Oversight Board. Gavi and the GPEI are currently working to define the modalities of this important and enhanced collaboration, which will be at the centre of the integration pillar of the GPEI Polio Endgame Strategy 2019–2023. The unique benefits that this multipartner collaboration offers were seen recently in a joint effort in Papua New Guinea, where together the GPEI and Gavi were able to optimize outbreak response while also aiming to address some of the root causes of the outbreak and integrating other health interventions for some of the most removed and vulnerable populations on earth.
- ◆ This partnership promises to bring the comparative advantages of both organizations into full focus on health system and immunization strengthening. It is also an example of how health initiatives can work together to align and accelerate impact as part of the Sustainable Development Goals, in particular the third goal to ensure healthy lives and promote well-being for all.



CONTAINMENT AND CERTIFICATION

Confinement et certification

Contención y certificación

الاحتواء وإصدار الشهادات

遏制和認證

Сдерживание и сертификация

Planning for success— ensuring that once polio is eradicated, it will **remain** eradicated

What does planning for success in the context of ensuring a lasting polio-free world actually mean?

It means, in the first instance, independently verifying that all poliovirus transmission has actually been successfully interrupted globally.

It means minimizing the risk of poliovirus re-emergence or reintroduction in a post-polio world.

It means maintaining the functions needed to sustain a polio-free world, such as disease surveillance, ongoing immunization and outbreak response capacity.

It means ensuring that the GPEI infrastructure, which currently does much more than simply eradicate polio, will continue to contribute to broader public health and development goals, long after the disease is gone.



27 February 2019, WHO, Geneva, Switzerland – WHO Director-General Dr Tedros Adhanom Ghebreyesus (centre) with members of the GCC (from left to right): Dr Nobuhiko Okabe (Chair of Western Pacific RCC), Professor Yagoub Al-Mazrou (Chair of Eastern Mediterranean RCC), Professor Mahmudur Rahman (Chair of South-East Asia RCC), Professor David Salisbury (Chair of the GCC and Chair of European RCC), Dr Arlene King (Chair of Americas RCC and Chair of the GCC Containment Working Group) and Professor Rose Leke (Chair of African RCC).

Certification: The independent stamp of approval for polio eradication

In 2018, the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC) continued to intensify its work and review the criteria that will need to be met to achieve the global certification of WPV eradication. Within this context, the GCC recommended a process of sequential certification of WPV eradication (following the global certification of WPV type 2 eradication in 2015), and confirmation of the absence of vaccine-derived polioviruses (VDPVs), which would occur after the global certification of WPVs and subsequent oral polio vaccine (OPV) withdrawal globally.

While the operational and programmatic aspects of achieving and sustaining a world free of all polioviruses – be they wild or vaccine-derived – are well established, the GCC focused its discussions on the necessary verification processes associated with this eventual achievement. Following the certification that WPV transmission has been stopped – and after OPV has been withdrawn – the absence of VDPVs will also need to be validated. The assessment that all WPV transmission has been interrupted globally is the critical step that will mark the launch of preparations for the cessation of all OPV use.

The importance of effective containment

At the World Health Assembly in May 2018, a resolution was passed calling for strong Member State commitment to accelerate containment. The importance of effective poliovirus containment is perhaps best illustrated by recalling that the last infection due to smallpox virus – the only human pathogen to have been eradicated globally thus far – occurred as a result of an accidental laboratory containment failure.

In a limited number of facilities, poliovirus will continue to be retained to serve critical national and international functions, such as the production of polio vaccine or research. It is crucial that this

poliovirus material be appropriately contained under strict biosafety and biosecurity handling and storage conditions to ensure that virus is not released into the environment, either accidentally or intentionally, to again cause outbreaks of the disease in susceptible populations. That is why the resolution on the containment of polioviruses adopted by the World Health Assembly is so important.

As the day draws near when WPV transmission is interrupted, planning for the future and securing this success are essential. Too much has been invested globally to risk jeopardizing a polio-free world by not fully containing polioviruses.

Preparing for global OPV cessation

To eliminate the long-term risks of VDPVs and vaccine-associated paralytic polio, OPVs continued to be phased out. The first removal phase took place with the switch from trivalent OPV to bivalent OPV (bOPV) between 17 April and 1 May 2016. Once all remaining foci of WPV transmission have been eradicated and the world is certified as WPV-free, all remaining OPV use will be stopped. Until OPV cessation has been completed, Member States are encouraged to minimize the risks and consequences of potential VDPVs by ensuring high RI coverage, conducting surveillance for any emergence of cVDPV and maintaining strong outbreak response capacity.

To prepare for the switch to bOPV, all countries had committed to introducing at least one dose of IPV into their RI programmes. Global supply constraints emerged owing to technical difficulties manufacturers had encountered to scale up production, which had resulted in some countries experiencing delays in supply. The supply situation was largely resolved, thanks also to Member States increasingly adopting dose-sparing strategies, such as administering intradermal fractional-dose IPV as recommended by the Strategic Advisory Group of Experts on immunization. The GPEI and its partners continued to explore new IPV approaches to ensure an affordable and sustainable supply following certification, including through the use of vaccine manufactured from Sabin strains or non-infectious materials such as virus-like particles.



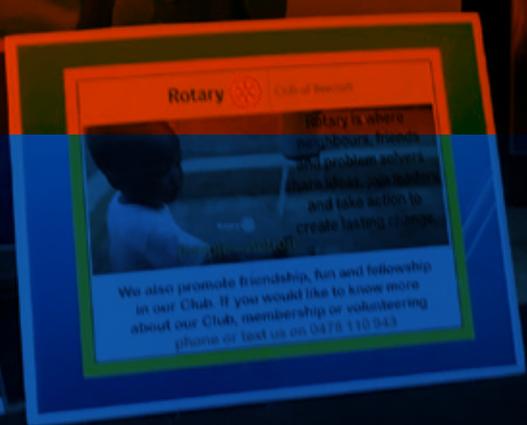
FINANCING

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2018 donor update

Thanks to the generous continuing support of the international development community, including Member States (both those where poliovirus remains endemic and those that are donors to the GPEI) as well as multilateral and bilateral organizations, development banks, foundations and Rotary International, the budget for planned activities for 2018 was fully financed.

Moreover, public- and private-sector partners continued to fulfil pledges made at the Rotary International convention in June 2017 that ensured the programme will be financed through 2019. The Polio Oversight Board adopted new financial scenarios at its meeting in September 2018. The global budget to implement the activities of the GPEI Polio Endgame Strategy 2019–2023 was projected to be US\$ 4.2 billion, of which US\$ 3.27 billion must still be mobilized. Therefore, continued support will be needed from polio eradication’s long-standing partners, along with ministers and leaders of the G7, the Commonwealth and G20 countries to ensure the uninterrupted programme operations necessary to achieve eradication by 2023. The GPEI continued to demonstrate value for money and its sound financial management practices were confirmed in positive programme reviews and audits.

The GPEI Polio Endgame Strategy 2019–2023

The new GPEI Polio Endgame Strategy 2019–2023, developed in broad consultation for presentation to the World Health Assembly in May 2019, builds on the tools, lessons and tactics of the Polio Eradication & Endgame Strategic Plan 2013–2018. It optimizes the proven approaches that have been shown to work and strengthens the tactics in those areas where they need sensitizing, including by reaching out to new partners and reinforcing collaboration with other sectors. Its operating principle is clear: to identify clearly why a child is missed, and then to implement the proven approaches to overcome that reason. Critical to its success is to ensure that it is fully financed and implemented at all levels.

The regularly published *Semi-Annual Status Report* had as its aim to report out against the Polio Eradication & Endgame Strategic Plan 2013–2018. The GPEI will continue to publish status reports throughout the life of the Polio Endgame Strategy 2019–2023. More regular reporting will of course continue through the ongoing publication of the weekly global polio update, featuring an overview of the latest reported viruses and narratives of country-level activities.

As the GPEI plans for the future and its final push to “finish the job”, it is clear that political and financial efforts need to intensify in this increasingly steep last mile. To this effect, His Highness Sheikh Mohamed bin Zayed Al Nahyan, Crown Prince of Abu Dhabi, and the United Arab Emirates – a long-time supporter of the polio programme – will host a GPEI pledging event in November 2019 at the Reaching the Last Mile forum in Abu Dhabi, a gathering of leaders from across the global health space held every two years.

The international development community’s **long-standing support** is critical to bringing the world to the threshold of being **polio-free**.

Contributors to the GPEI – 2018

The GPEI thanks the following donors for their generous contributions to the initiative in 2018, which helped ensure that the activities described in this Annual Report were implemented during the year. The international development community's long-standing support is critical to bringing the world to the threshold of being polio-free. The GPEI is grateful for the extraordinary commitment to polio eradication by the generous donors across the world listed below.

Australia – US\$4.28 million

Bill & Melinda Gates Foundation – US\$256 million

Canada – US\$42.19 million

Crown Prince of Abu Dhabi – US\$12 million

EasyJet – US\$880,000

European Commission – US\$17.18 million

Italy – US\$2.41 million

Germany – US\$32.68 million

Government of Nigeria – US\$3.29 million

Japan – US\$12.40 million

Korean Foundation for International Healthcare / Community Chest of Korea – US\$500,000

Liechtenstein – US\$40,000

Luxemburg – US\$590,000

Monaco – US\$120,000

National Philanthropic Trust – US\$124.01 million

Norway – US\$25.83 million

Republic of Korea – US\$2 million

Rotary International – US\$150.64 million

Spain – US\$60,000

UNICEF Regular and Other Resources – US\$53,000

United Arab Emirates – US\$21.81 million

United Kingdom – US\$66.40 million

United Nations Foundation – US\$2.37 million

USA – US\$235 million

World Bank Loan/Government of Nigeria – US\$57.41 million

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