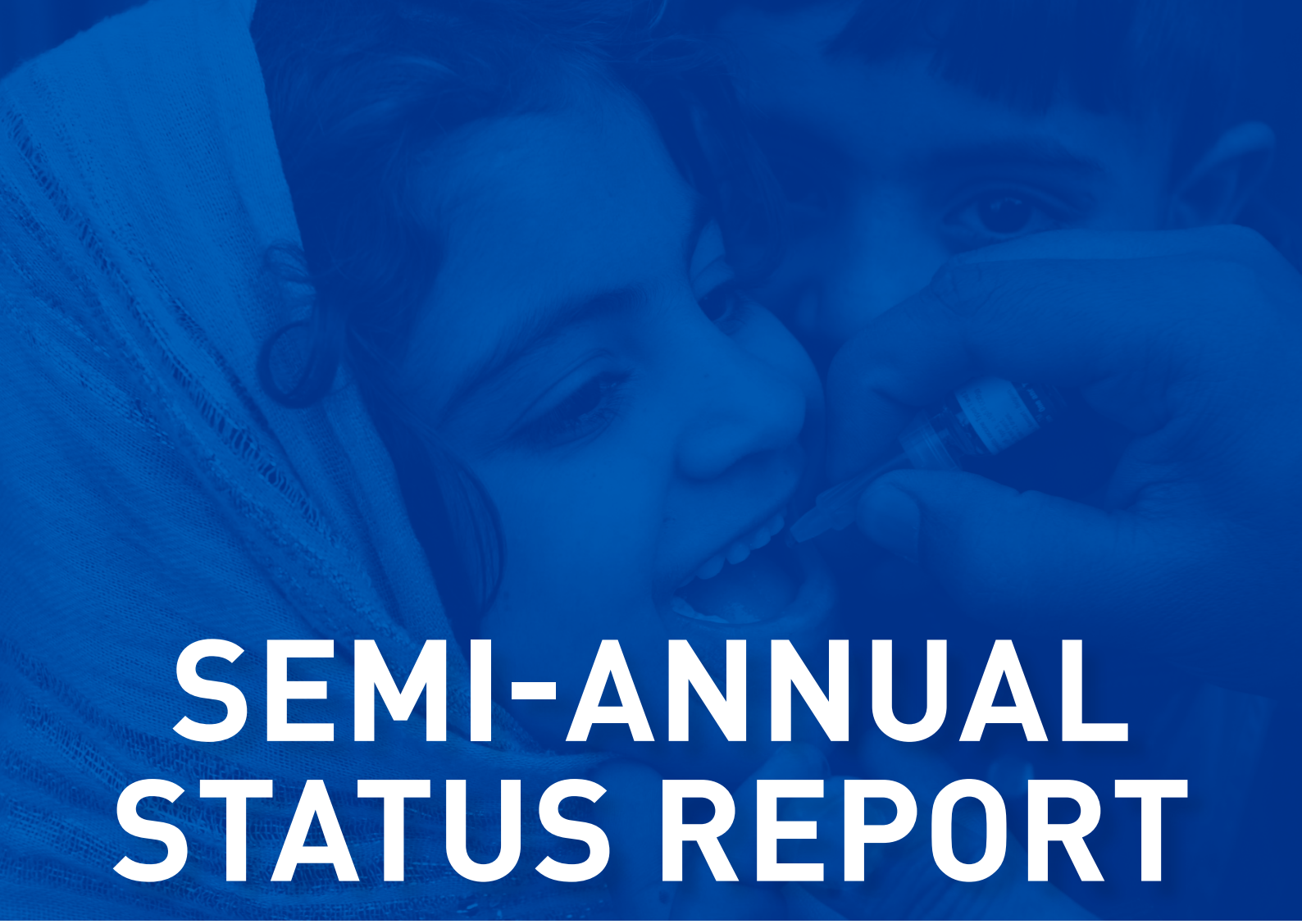


SEMI-ANNUAL STATUS REPORT

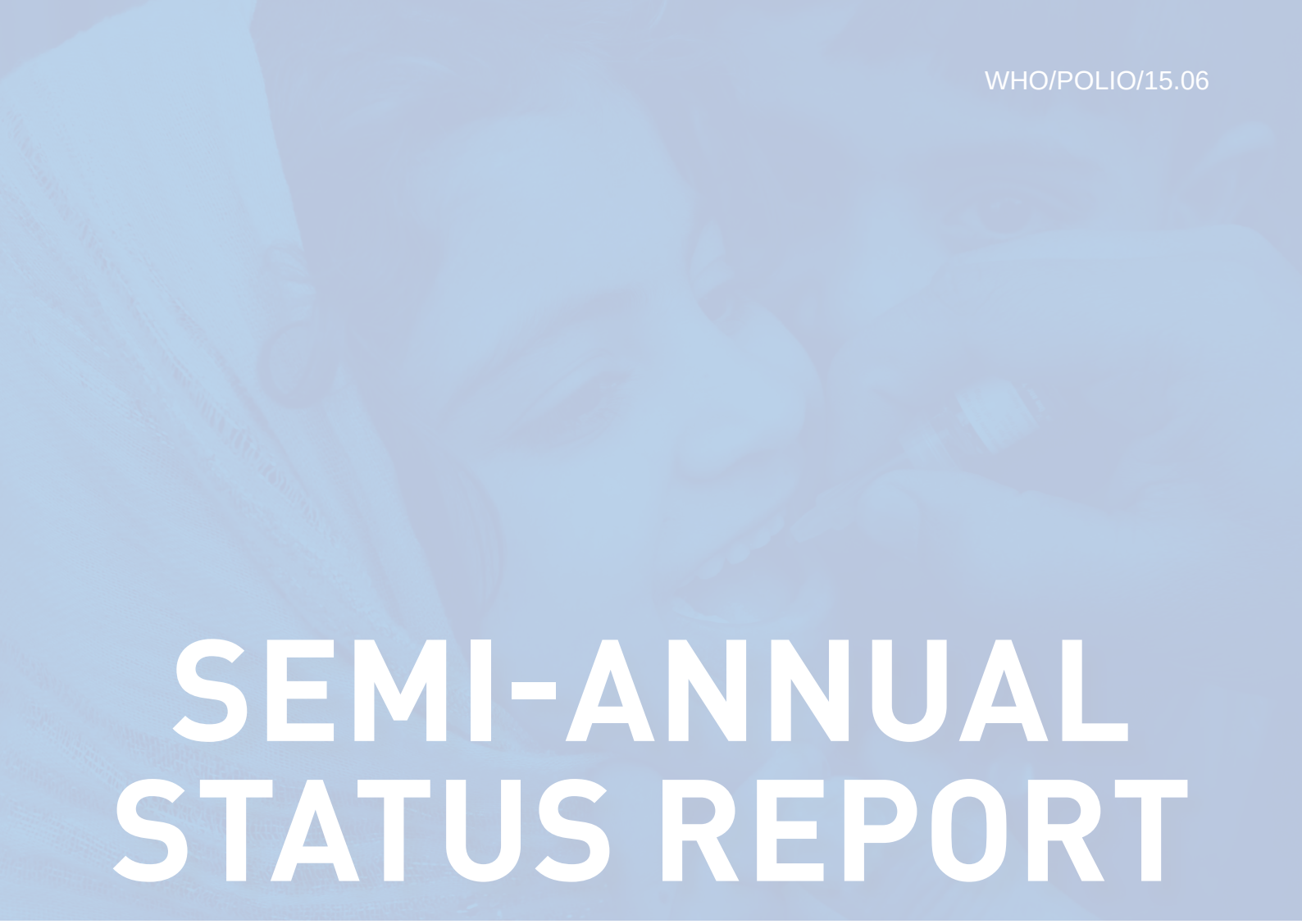
JANUARY TO JUNE 2015

PROGRESS AGAINST THE POLIO ERADICATION AND ENDGAME STRATEGIC PLAN 2013-2018

POLIO GLOBAL ERADICATION INITIATIVE

Design by Paprika (Annecy, France)

WHO/POLIO/15.06



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POLIO GLOBAL ERADICATION INITIATIVE

TABLE OF CONTENTS

ACRONYMS

cVDPV	Circulating vaccine-derived poliovirus
cVDPV1	Circulating vaccine-derived poliovirus type 1
cVDPV2	Circulating vaccine-derived poliovirus type 2
CDC	Centers for Disease Control and Prevention
GAP	Global Action Plan
GAPIII	Third edition of the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use
GPEI	Global Polio Eradication Initiative
IMG	Immunization Systems Management Group
IPV	Inactivated polio vaccine
OPV	Oral polio vaccine
OPV2	Oral polio vaccine type 2
PHEIC	Public health emergency of international concern
SAGE	Strategic Advisory Group of Experts on immunization
SIA	Supplementary immunization activity
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPV	Wild poliovirus
WPV1	Wild poliovirus type 1
WPV2	Wild poliovirus type 2
WPV3	Wild poliovirus type 3

HIGHLIGHTS

Objective 1: Poliovirus detection and interruption

- **Endemic countries**: Strong progress continues in Nigeria, with no wild poliovirus case since 24 July 2014, as efforts intensify in Pakistan and Afghanistan.
- **Outbreaks**: In the Horn of Africa, Middle East and central Africa, outbreaks appear close to being stopped, with regional emergency outbreak response continuing. In Madagascar, a circulating vaccine-derived poliovirus type 1 (cVDPV1) outbreak from 2014 is detected in 2015, and a cVDPV1 strain emerges in Ukraine.
- **Midterm review**: Halfway through the Polio Eradication & Endgame Strategic Plan 2013-2018, a midterm review evaluates progress and identifies gaps that need to be filled.
- **World Health Assembly resolution on polio**: In May, the World Health Assembly adopts a landmark resolution on polio eradication, urging full implementation of emergency plans and endorsing new international outbreak response guidelines.

Objective 2: Immunization systems strengthening and OPV withdrawal

- The Strategic Advisory Group of Experts on immunization (SAGE) concludes global preparations are on track to switch from trivalent oral polio vaccine (OPV) to bivalent OPV in April 2016. The World Health Assembly resolution on polio further urges all countries to ensure global readiness for the switch.
- The SAGE notes progress achieved with regard to inactivated polio vaccine (IPV) introduction worldwide.
- Efforts intensify in 10 priority countries (with the bulk of Global Polio Eradication Initiative infrastructure) to use the infrastructure in support of routine immunization systems strengthening. The Polio Oversight Board issues a statement to the GPEI network urging the network to work closely with broader routine immunization programmes.

Objective 3: Containment and certification

- **Certification**: Certification of the conclusive global eradication of wild poliovirus type 2 (WPV2) is on track for 2015.
- **Containment**: The Global Action Plan (GAP) to minimize post-eradication poliovirus facility-associated risks (GAPIII) is updated and aligned with Polio Eradication & Endgame Strategic Plan timelines, particularly with regard to the phased removal of OPVs, and is endorsed by the World Health Assembly.

Objective 4: Legacy planning

- A draft Global Legacy Framework is under development by a legacy planning working group, following outcomes from a Boston Consultancy Group evaluation. Legacy planning is to be guided by national priorities at the country level, with strong linkages to global priorities. Planning missions are conducted in the Democratic Republic of the Congo and Nepal. A practical example of legacy in action is support to the Ebola outbreak in west Africa.

INTRODUCTION

The Global Polio Eradication Initiative (GPEI) Polio Eradication & Endgame Strategic Plan 2013-2018 (the Endgame Plan) aims to make polio the second-ever disease to be eradicated from the world. At the time of the Endgame Plan's launch, the GPEI was 25 years old and had succeeded in reducing the incidence of polio globally to less than 1% of what it was in 1988 when the GPEI began. Just three countries – Nigeria, Pakistan and Afghanistan – still remained endemic (down from more than 125 countries in 1988). The Endgame Plan set out four objectives: to complete the elusive 1%, to start to withdraw OPV from use, to certify polio's eradication and to plan the GPEI's broader legacy.

Following the request by GPEI stakeholders to update the monitoring framework for the Endgame Plan, the framework has been revised to conform with the results-based approach to polio eradication outlined in the Endgame Plan, and to ensure that progress against the Endgame Plan is reflected through programme indicators across all four of its objectives.

The structure of this document includes a high-level summary, followed by a more detailed narrative for each of the strategic objectives, broken down by geography where appropriate. The narrative is followed by a series of annexes that contain the monitoring framework indicators for endemic countries, outbreak countries and high-risk countries, and global indicators.

EXECUTIVE SUMMARY

By the middle of 2015, strong progress had continued towards each of the Endgame Plan's four objectives. The world has never been in a better position to eradicate polio, as the virus is more geographically limited than ever before and there are fewer cases than at this point in 2014. As the GPEI enters the second half of 2015, it is more important than ever that the momentum be maintained to strengthen and build upon the gains made in the first half of the year.

Recognizing the progress made towards interrupting transmission and to prepare for the phased removal of OPVs, the World Health Assembly in May 2015 adopted a landmark resolution urging Member States still infected by poliovirus to further intensify their emergency efforts, and recommending all countries prepare their efforts for the planned switch from trivalent OPV to bivalent OPV, planned in April 2016. The resolution was a clear signal of global commitment to ensure a lasting polio-free world is rapidly achieved.

Continued success in Nigeria

In Nigeria, no new cases of wild poliovirus type 1 (WPV1) have occurred since 24 July 2014. This is the longest period Nigeria has had with no case of WPV. Final laboratory results from all acute flaccid paralysis case samples, expected in September 2015, are required to confirm interruption of transmission for the full 12 months in Nigeria. If negative, Nigeria will be removed from WHO's list of endemic countries. Three years with no polio cases and certification-standard surveillance are required before the Africa Regional Certification Commission determines whether the WHO African Region can be certified polio-free.

However, regional insecurity has led to some subnational gaps in surveillance in Nigeria, and despite the increase in number of children reached with the oral polio vaccine (OPV) through campaigns, pockets of un- or under-immunized children still exist. These significant challenges must be addressed in the country.

Inactivated polio vaccine (IPV) was introduced into routine immunization activities in February 2015 in preparation for the trivalent OPV to bivalent OPV switch. A circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreak that emerged in 2014 was found in Abuja, with onset of paralysis on 16 May 2015. An aggressive outbreak response is being implemented to urgently stop this outbreak.

Cautious progress in Afghanistan and Pakistan

Both Afghanistan and Pakistan saw progress in the first half of 2015 due to a shift from a focus on the children reached with vaccines to a focus on those missed for whatever reason. Due to transmission of the virus across the border in both directions in 2014, Afghanistan and Pakistan this year are being treated as a single epidemiological block with greater coordination between the two to stop transmission.

In the first half of 2015, six cases of WPV1 were reported in Afghanistan: one in Helmand and three in Farah. While this represents an improvement over last year (down from six cases in the same period in 2014), it suggests endemic transmission continues to be of concern. Around 500 000 children aged under 5 years remained unvaccinated, 25% of whom live in areas that are inaccessible to vaccinators. No circulating vaccine-derived poliovirus (cVDPV) cases have been reported since March 2013. Progress has been hindered in some areas of the south, where suspicion regarding vaccination programmes remains.

Pakistan appears to be moving back on track, with a total of 29 cases reported in the first half of 2015, compared to 88 over the same period last year. The programme was aided by the use of IPV in hard-to-reach areas to

rapidly build immunity. An increase in political commitment resulted in the implementation of a national emergency action plan, focused on identifying areas in which children are missed and ensuring practices are adapted to local areas in order to maximize coverage.

Continued progress in central Africa, the Horn of Africa and the Middle East

The outbreaks of WPV in central Africa, the Horn of Africa and the Middle East appear to have stopped. Despite this encouraging progress, insecurity, gaps in surveillance and low levels of immunity in some areas mean that these countries remain vulnerable.

In Madagascar, eight cases of cVDPV1 were confirmed with onset between 22 April and 29 May 2015, linked to cVDPV1 first detected in 2014. The outbreak response has been intensified with a view to ending the outbreak by the end of 2015. In Ukraine, a cVDPV1 strain emerged in the south-western part of the country.

Preparation for the withdrawal of oral polio vaccines and the strengthening of immunization systems

The Strategic Advisory Group of Experts on immunization (SAGE) met in April 2015 and concluded that preparations for the global switch from trivalent OPV to bivalent OPV in April 2016 are on track. This was strongly endorsed by the World Health Assembly in May 2015, where global commitment to the switch and IPV introduction were reinforced. As part of the switch, all countries currently using only OPV in their routine immunization systems are introducing at least one dose of IPV in the coming year. Fifteen countries introduced IPV between January and June, including Nigeria.

The SAGE recommended establishing a global stockpile of monovalent OPV type 2 to facilitate the response to any potential cVDPV2 following the switch. The United Nations Children's Fund (UNICEF) has contracted WHO prequalified suppliers to establish a global stockpile of 500 million doses.

WHO and GAVI, the Vaccine Alliance, have partnered with national governments to strengthen routine immunization in 10 key countries. Six have since developed national immunization plans to optimize their leverage of polio resources.

Containment and certification

The World Health Assembly endorsed plans pertaining to the containment of poliovirus type 2 during the Endgame Plan. The *WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use* addressed the need to contain both wild and attenuated poliovirus type 2 following eradication.

Preparations are under way to formally declare the eradication of WPV2, with the last WPV2 case occurring in India in 1999.

Legacy

In 2015, work continues to ensure that investments made in polio eradication are used as a foundation for the advancement of other development goals. This came to the forefront in controlling the Ebola outbreak, at which time the polio team provided staff support for disease surveillance, contact tracing, data management and outbreak management, as well as logistical support.

Throughout 2015, stakeholders have continued to contribute to legacy planning. A comprehensive series of documents is

in production to profile GPEI knowledge, the lesson learnt from the programme and its assets. Legacy planning will be conducted on a national level according to the Global Legacy Framework.

Financing the Endgame Plan

As of June 2015, the GPEI received US$ 2.84 billion in contributions with a further US$ 2.18 billion pledged. If all funds were made available immediately, a funding gap of US$ 496 million would remain.

In the first half of 2015, on the recommendations of a management review, the Polio Oversight Board formed a new finance and accountability committee to ensure transparency to all stakeholders. In close consultation with stakeholders, the GPEI partners conducted a midterm review to take stock of progress towards the implementation of the Endgame Plan and to provide recommendations on any needed course corrections and the related financial implications. The Polio Oversight Board will meet in September 2015 to review eradication scenarios, including associated budget implications, and to approve a plan to implement the proposed recommendations.

Looking to the future

Progress reported in the first half of 2015 justifies cautious optimism. Africa is closer than ever to being polio-free, but vigilance remains essential to avoid and, if necessary, contain outbreaks. The absence of wild poliovirus type 3 (WPV3) outbreaks since November 2012 provides confidence that WPV3 is on the verge of eradication. The GPEI will focus on four key areas in the second half of 2015 to further advance the cause of polio eradication:

1. further intensifying surveillance systems to rapidly detect residual transmission, particularly in the endemic and outbreak countries;
2. securing a polio-free Africa and Middle East by implementing emergency measures to urgently interrupt residual poliovirus transmission, reducing the risk of international spread;
3. providing surge support to Pakistan and Afghanistan to help them cross the finishing line to a polio-free world;
4. continuing preparations for the withdrawal of OPVs by supporting countries in introducing IPV and preparing the world for the planned switch from trivalent OPV to bivalent OPV in April 2016.

OBJECTIVE 1: POLIOVIRUS DETECTION AND INTERRUPTION

Endemic countries

Strong progress in Nigeria

As it has been more than 12 months since the last child was paralysed by WPV, Nigeria has made important headway towards achieving polio-free status. The decrease in global cases is largely associated with progress achieved in this country. In 2014, Nigeria had just six cases, a significant decrease from 53 in 2013. The most recent case due to WPV in Nigeria was on 24 July 2014.

In January 2015, the Expert Review Committee on Polio Eradication & Routine Immunization, the independent technical advisory group guiding the effort in the country, urged vigilance in light of this tentative progress. Twelve months with no detection of WPV is necessary before Nigeria can be removed from the World Health Organization's list of polio endemic countries, and three years must pass before the country can be certified polio-free along with the rest of the WHO African Region. Both of these would be dependent on certification-standard surveillance being in place.

In the lead-up to the elections in February and March, political commitment to polio eradication slowed but the engagement of partners and civil society organizations prevented this from impacting too heavily on campaign quality. Following the elections, Nigeria has received support and oversight from the incumbent government.

While access to children improved substantially between January and April, it continues to be limited in many areas, and supplementary immunization activity (SIA) quality remains inadequate in areas that are accessible. The north of Nigeria continues to face substantial security challenges and gaps in surveillance that the region is attempting to address. All states achieved the two main surveillance indicators (stool adequacy and the non-polio acute flaccid paralysis rate). Bridging surveillance gaps continued to be a challenge, as was insecurity.

IPV was introduced into routine immunization systems in February 2015 as part of the Endgame Plan, in preparation for the global switch from trivalent OPV to bivalent OPV in April 2016.

At the same time, an extensive outbreak response is continuing to stop a persistent cVDPV2 outbreak, which emerged in 2014 and continued in 2015, with a case from Abuja confirmed in May. In October 2015, the SAGE will review the evolving epidemiology of persistent cVDPV2, to determine if such strains potentially impact the upcoming planned switch from trivalent OPV to bivalent OPV.

Nigeria wild poliovirus and cVDPV – January to June 2015

Progress but challenges in Afghanistan

Afghanistan began making adjustments to its programme after a period of relatively limited progress, following strengthened commitment from the Government of Afghanistan during the first half of 2015.

Between January and June, four cases were reported in Afghanistan, down from six during the same period in 2014. One case was reported in Helmand and three in neighbouring Farah. Whereas between July and December 2014 most of the 20 cases were linked to cross-border transmission with neighbouring Pakistan, the first half of 2015 proved that endemic transmission continues to be a concern, with the bulk of the cases caused by a virus that has been circulating within Afghanistan for some time. The Farah virus's close relation to a virus from Kandahar demonstrates the ease with which the virus can spread if a microscopic focus is not used to reach pockets of under-immunized children. In 2015, so far the eastern region has remained polio-free despite insecurity.

In spite of constant efforts to obtain and sustain access to children, in May 2015, 500 000 children aged under 5 years remained unvaccinated. Around 75% of them live in areas that vaccinators should be able to reach, yet 120 000 children are being missed as they live in areas with varying degrees of inaccessibility. The major reasons accessible children are being missed are unavailable children, insufficiently detailed microplans or inadequate supportive supervision and monitoring systems.

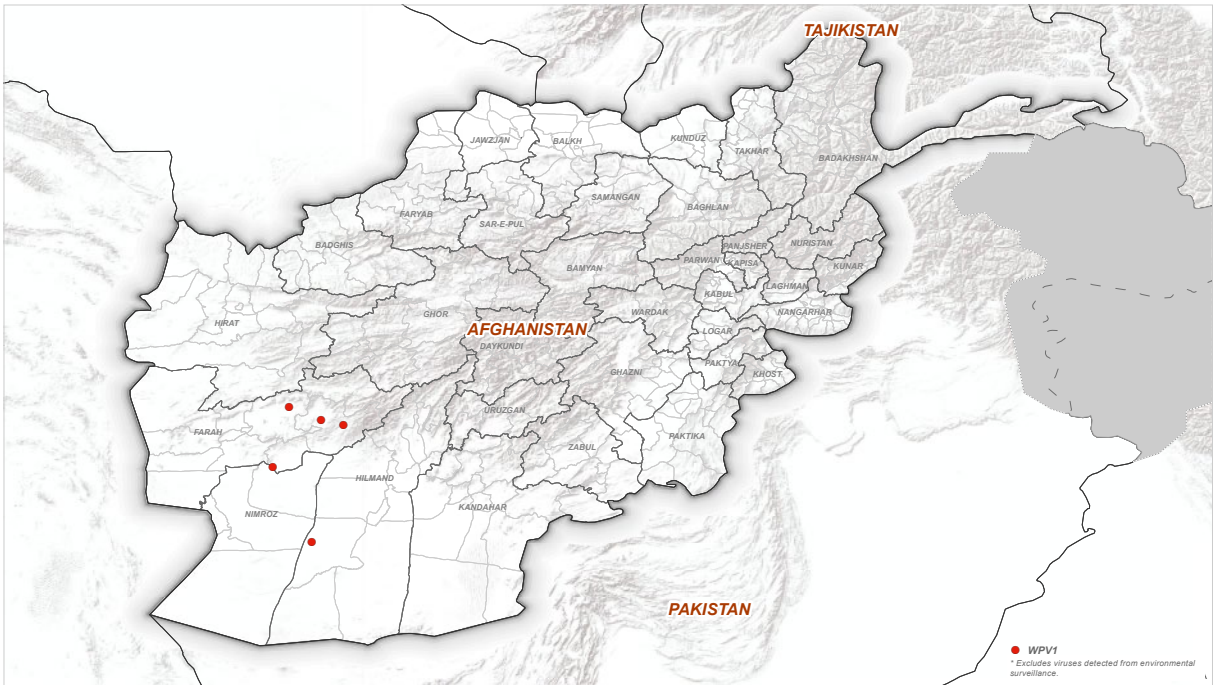
Afghanistan's progress towards eradication remains connected to progress made against the virus in Pakistan. Following the discovery that virus from Afghanistan had spread into Pakistan, the two countries are increasingly being treated as a single epidemiological block. Several cross-border coordination meetings were held to strengthen efforts along the border between Pakistan and Afghanistan.

No cVDPV2 cases have been reported in the country since March 2013. However, the country

must remain vigilant as there was evidence of cVDPV2 in Pakistan in June 2015.

Local leaders in some areas of the southern region in 2015 halted vaccinations in high-risk areas. Ongoing and local-level negotiations resolved the suspension by highlighting the importance of maintaining the neutrality of public health efforts.

Afghanistan wild poliovirus – January to June 2015



Paradigm shift in Pakistan

Following the high number of cases in 2014, Pakistan has been moving back on track, due to renewed commitment and energy on the part of the Government of Pakistan. The drop in the recent number of confirmed WPV cases in Pakistan was significant in the first half of 2015, with 29 cases this year compared to 88 in 2014 for the same period.

The low-season emergency plan, which was put in place by the government at the end of 2014 in recognition of the risk and opportunities presented by 2015, has been instrumental in this shift of pace. A National Emergency Action Plan was finalized, which must be implemented fully to be of benefit to all stakeholders. The progress made towards establishing strong emergency operations centres at the national and provincial levels began to bear fruit. The implementation of the programme was overseen directly by the office of the prime minister, the only social programme in Pakistan to be supervised at this level, ensuring a high degree of accountability. As a result, the programme's operational deficits are increasingly being addressed, and access continues to improve in previously inaccessible areas.

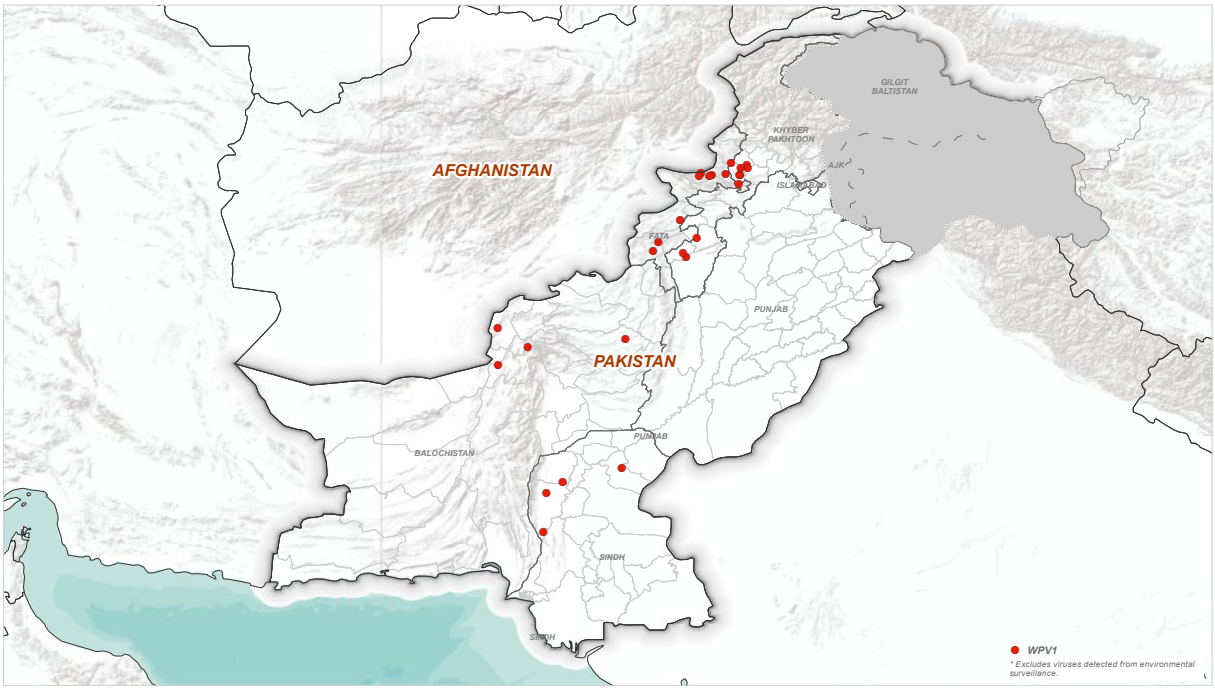
Despite this progress, Peshawar, Khyber Pakhtunkhwa, as well as Khyber Agency and North and South Waziristan in the Federally Administered Tribal Areas remain of special concern, with continued transmission or factors keeping their populations at high risk. Northern Sindh and key areas of Balochistan are also areas of concern.

The reasons for continuing to miss children vary by area. As part of the national emergency plan, efforts are focusing on clearly identifying the area-specific explanations for missing children and devising appropriate strategies to address these reasons.

Innovations, such as IPV use in campaigns in hard-to-reach areas to more rapidly build immunity, have also helped the programme in Pakistan to improve. The vaccine mix continues to be optimized, to address known WPV1 transmission and further boost immunity to type 2 poliovirus (in response to last year's cVDPV2 outbreak).

The upcoming high season for poliovirus transmission (in the second half of 2015) will provide crucial epidemiological data on how intensively polioviruses continue to circulate in the country. Epidemiologists will closely analyse these data and adapt strategies accordingly.

Pakistan wild poliovirus – January to June 2015



Outbreaks

Regional wild poliovirus outbreaks in central Africa, the Horn of Africa and the Middle East

No cases due to WPV in any of the three outbreak zones have as yet been reported in 2015. Regional outbreak response efforts are continuing in all three areas – central Africa, the Horn of Africa and the Middle East – to ensure each outbreak is definitively and fully stopped and to prevent the risk and consequences of further reinfection. Activities are in particular being intensified in South Sudan, following confirmation of a cVDPV2 in the country in the second half of 2014.

As part of regional efforts, subnational surveillance sensitivity continues to be strengthened to detect any residual transmission associated with these outbreaks.

Reconvening in February and May 2015, the International Health Regulations Emergency Committee concluded that the risk of the international spread of WPV continued to constitute a "public health emergency of international concern" (PHEIC), and extended its Temporary Recommendations accordingly. This decision was reaffirmed by delegates at the World Health Assembly in May.

Ongoing cVDPV outbreak in Madagascar

In Madagascar, eight cases due to a cVDPV1 outbreak were confirmed, with dates of onset ranging between 22 April and 29 May 2015. These new cases are genetically linked to cVDPV1 isolated from a case with onset on 29 September 2014, which indicates that the circulation of cVDPV1 first detected in September 2014 continues and is geographically widespread.

Since the detection of the September case, outbreak response activities have been conducted throughout the country, including subnational immunization days and national immunization days held in December and April, respectively. Nevertheless, the extent, timeliness and quality of the outbreak response to date have been insufficient to interrupt the circulation of this strain, with efforts further complicated by flooding affecting the country. More than 25% of children across Madagascar remain un- or under-immunized. The emergency outbreak response has recently been further intensified.

The emergence of cVDPV strains underscores the importance of maintaining high levels of routine vaccination coverage. Multiple cVDPV strains have emerged in Madagascar over the last 15 years; their transmission has been interrupted following the implementation of supplementary immunization campaigns. The outbreak response across the country is now being intensified, with the aim of fully stopping this strain's circulation by the end of 2015.

As this strain is caused by type 1 (rather than the more commonly occurring type 2), it will not affect the planned switch from trivalent OPV to bivalent OPV in early 2016.

Madagascar cVDPV – January to June 2015

New cVDPV outbreak in Ukraine

In Ukraine, cVDPV1 was confirmed, with two reported cases from Zakarpatskaya Oblast (located in south-western Ukraine, close to Romania to the south, Hungary to the south-west, Slovakia to the west and Poland to the north). The cases had onset of paralysis on

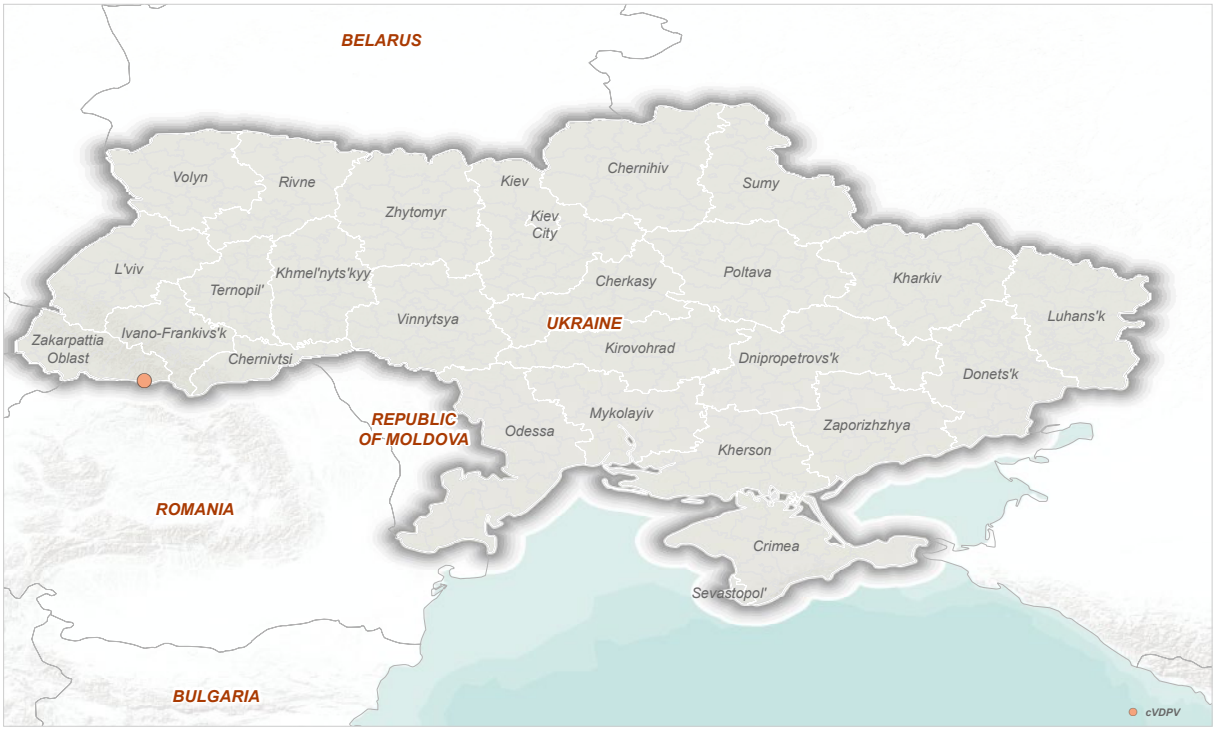
30 June 2015 and 7 July 2015, respectively (in a 4-year-old and a 1-year-old).

Immediately following notification of the outbreak, the Government of Ukraine and national and international public health authorities took a number of unprecedented steps:

1. The Minister of Health of Ukraine held a press briefing to announce the outbreak and the need for a full and comprehensive emergency outbreak response.
2. The National Security Council was briefed on the occurrence to ensure an all-government, all-civil society approach to the outbreak.
3. The health committee in the affected area convened an extraordinary session to begin emergency outbreak response planning; an intensive surveillance plan was initiated through active searches and the collection of specimens from healthy contacts across the community.
4. A joint ministry of health-WHO-UNICEF national task force was established to prepare the outbreak response plan, oversee implementation and conduct monitoring.
5. A national/international team of experts conducted an in-depth investigation in the affected area.

Following a significant decline in vaccination coverage, this outbreak and its response are considered by national and subnational public health authorities to be an urgent opportunity to bolster the country's immunization programme (not just against polio, but for all vaccines), to re-establish a broad and well-functioning supply chain, and to engage communities in strengthening confidence in the safety and importance of vaccines.

Ukraine cVDPV – January to June 2015



OBJECTIVE 2: IMMUNIZATION SYSTEMS STRENGTHENING AND OPV WITHDRAWAL

As part of the Endgame Plan, OPV use worldwide will eventually end, starting with the removal of oral poliovirus vaccine type 2 (OPV2) through the switch from trivalent OPV to bivalent OPV. A first step in this process is the introduction of at least one dose of IPV in all routine immunization programmes by the end of 2015. This will boost immunity against type 2 polioviruses and will also:

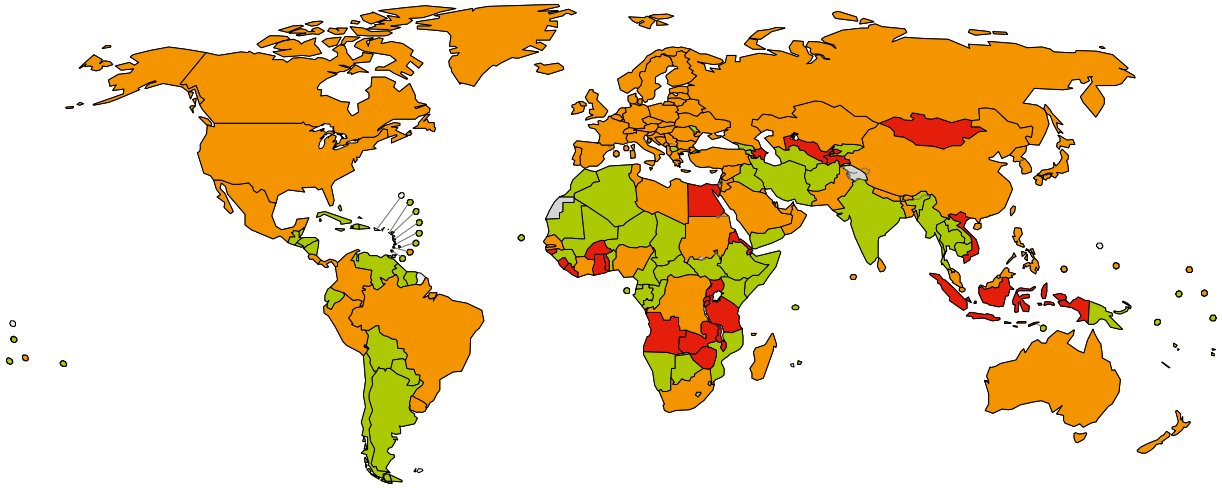
- reduce the risk of re-emergence of WPV2 or cVDPV2;
- facilitate the containment of outbreaks;
- accelerate WPV eradication by boosting immunity against poliovirus types 1 and 3 in children who have previously received OPV.

In April 2015, the SAGE reviewed progress towards global readiness for the coordinated, phased removal of OPVs and concluded that preparations are on track for a switch from trivalent OPV to bivalent OPV in April 2016. The World Health Assembly in May 2015 subsequently endorsed this approach. To prepare, all countries have committed to IPV introduction prior to the switch.

The SAGE further reinforced that a stockpile of monovalent OPV type 2 should be established and maintained, to facilitate outbreak response should it be needed. The World Health Assembly endorsed an approach for its global management and release. UNICEF has contracted two manufacturers of WHO-prequalified product to establish a global stockpile of 500 million doses by end-2015.

In conjunction with IPV introduction, Objective 2 of the Endgame Plan also includes efforts to strengthen routine immunization in 10 "focus" countries where there are significant polio resources and assets. A joint programme of work was initiated with GAVI, the Vaccine Alliance, to support this work. To date, six of these countries – Chad, Democratic Republic of the Congo, Ethiopia, India, Nigeria and Pakistan – have developed annual national immunization plans that leverage polio assets to improve broader immunization goals. In Pakistan, for example, a pilot project first evaluated in 16 districts is being expanded across all provinces, in close collaboration with the high-level provincial political leadership, to take steps to rapidly increase vaccination coverage among children. In addition, work is progressing to assess and quantify the contribution of polio-funded staff to routine immunization activities across the 10 focus countries.

Countries using IPV vaccine to date and formal decision to introduce



Introduced* to date *(97 countries or 50%)*

Formal commitment to introduce in 2015 *(74 countries or 38.1%)*

Intend to introduce in 2015 *(0 country or 0%)*

Formal commitment to introduce in 2016 *(23 countries or 11.9%)*

Not available

Not applicable

Since January 2013, the following countries have introduced IPV: Kazakhstan & Peru (July 2013); Micronesia (August 2013); Libya (April 2014); Albania & Panama (May 2014); Nepal & Tunisia (September 2014); Philippines (October 2014); China (December 2014); Comoros, Senegal & Serbia (January 2015); Colombia & Nigeria (February 2015); Bangladesh & Maldives (March 2015); DR Congo, DPR Korea & The Gambia (April 2015); Madagascar (May 2015); Cote d'Ivoire, Kiribati, St Vincent and the Grenadines & Sudan (June 2015); Bhutan, Cameroon, Niger, Pakistan & Sri Lanka (July 2015)

* Includes introductions in some parts of the country only

Data source: WHO/IVB Database, as of 03 August 2015
Map production Immunization Vaccines and Biologicals (IVB), World Health Organization

OBJECTIVE 3: CONTAINMENT AND CERTIFICATION

In 2014, the strategic approach and plan for fully aligning the containment of polioviruses with the milestones and timelines of the Polio Eradication & Endgame Strategic Plan 2013-2018 were finalized and endorsed by the SAGE and the World Health Assembly. The *WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use* establishes specific measures for the poliovirus type 2 containment period of the Endgame Plan, addresses the need to contain both wild type and Sabin polioviruses, and sets general parameters for the final containment of polioviruses following the certification of eradication.

At the same time, preparations are continuing for the Global Commission for Certification of the Eradication of Poliomyelitis to formally declare that WPV2 was eradicated more than 15 years ago. Countries are currently submitting formal documentation on the last detection of WPV2, if any, to their regional certification commissions, which the Global Commission for Certification is expected to review in September 2015.

OBJECTIVE 4: LEGACY PLANNING

The principal objective of the legacy planning work is to ensure that the investments made in the cause of polio eradication are built upon to benefit other development goals, through a comprehensive programme of work to document and transition the GPEI's knowledge, lessons learnt and assets. The staff and facilities funded through the GPEI are substantially involved in the delivery of non-polio functions, particularly in the areas of immunization and surveillance. Transition planning is crucial to ensure that these critical functions can be sustained after GPEI funding ceases. As an example, the infrastructure used in polio eradication is helping to support the response to the Ebola outbreak in west Africa, by providing staff for surge support and by conducting disease surveillance, contact tracing, data management, logistics and supply distribution, and outbreak management. In Nigeria, the assets and experience of the dedicated polio eradication emergency operations centre and staff were instrumental in helping to stop the Ebola outbreak in that country.

In 2013, the GPEI established a legacy planning working group to manage the development of legacy planning, including to ensure the consultations and evidence-based development necessary to inform the Global Legacy Framework. A draft plan of the Framework was approved by the Polio Oversight Board in December 2014.

Throughout 2014 and so far in 2015, stakeholder input continues to be sought into the overall direction of the legacy planning work, to better understand the capabilities of the programme and its knowledge and to steer the legacy planning working group in directions that could be of benefit to other health priorities.

An evidence database continues to be compiled, definitively outlining the capabilities, functions, assets and contributions of the GPEI to other priorities. Other programmes already benefiting from the GPEI infrastructure in particular are in the areas of disaster and crisis response, maternal and child health, sanitation and hygiene, child health days and new vaccine introductions. Critical activities polio staff are contributing to these areas include supporting routine immunization, disease surveillance, supply chain management and overall resource and capacity-building. Detailed pilot planning missions were conducted in the Democratic Republic of the Congo and Nepal, to initiate legacy planning and to learn how transition planning could function in different settings. To help guide countries in the development of legacy transition plans, guidelines are under development.

It is envisaged that legacy planning will be conducted in a phased manner, beginning with an initial small group of countries. Critical to success will be Member State and country-level donor engagement, including through discussions in upcoming relevant policy bodies, notably at the World Health Assembly and regional committees. A three-stage country-level planning and implementation process is envisaged, focusing on:

1. planning and decision-making
2. preparation
3. execution.

It is anticipated that legacy planning will be conducted on a national basis according to the Global Legacy Framework but that global priorities (e.g. emergency response capacity) will be open to discussion. In 2015, finalization of the Global Legacy Framework will facilitate the programme of work for transitioning the polio eradication infrastructure to other priorities. Legacy planning will be supported in specific countries, including those that have already initiated transition planning and those with substantial resources for polio eradication.

Strengthening the management of the Polio Eradication & Endgame Strategic Plan 2013-2018

Thanks to continued, generous support from the international development community, by June 2015 the GPEI had received US$ 2.84 billion in contributions and was tracking an additional US$ 2.18 billion in pledges, against the overall 2013-2018 budget of US$ 5.5 billion. The full and rapid realization of all pledges would result in a remaining funding gap of US$ 496 million against the Endgame Plan.

Globally, the GPEI underwent significant management and administrative changes in the first half of 2015, following a comprehensive management review. Based on the findings of the review, the Polio Oversight Board adopted a number of recommendations to more quickly and effectively achieve eradication. Of note is that a new finance and accountability committee has been established to ensure more rapid, comprehensive and transparent financial reporting for all stakeholders. It held its first meeting on 12 June 2015.

In the first half of 2015, in close consultation with stakeholders, the GPEI partners conducted a midterm review to take stock of progress towards the implementation of the Endgame Plan and to provide recommendations on any needed course corrections and the related financial implications.

The review concluded that the key strategic elements required to reach polio eradication are in place. However, it also identified gaps that require a refocusing of priorities and strengthened implementation. The review also evaluated the overall financial situation and outlined future expenditures based on potential timelines for interrupting transmission.

The midterm review was presented to major partners, stakeholders and donors at the Polio Partners Group meeting in June. The Polio Oversight Board is expected to review the proposed eradication scenarios and associated budgetary implications in September 2015. Subsequently, a comprehensive plan will be developed to operationalize the recommendations.

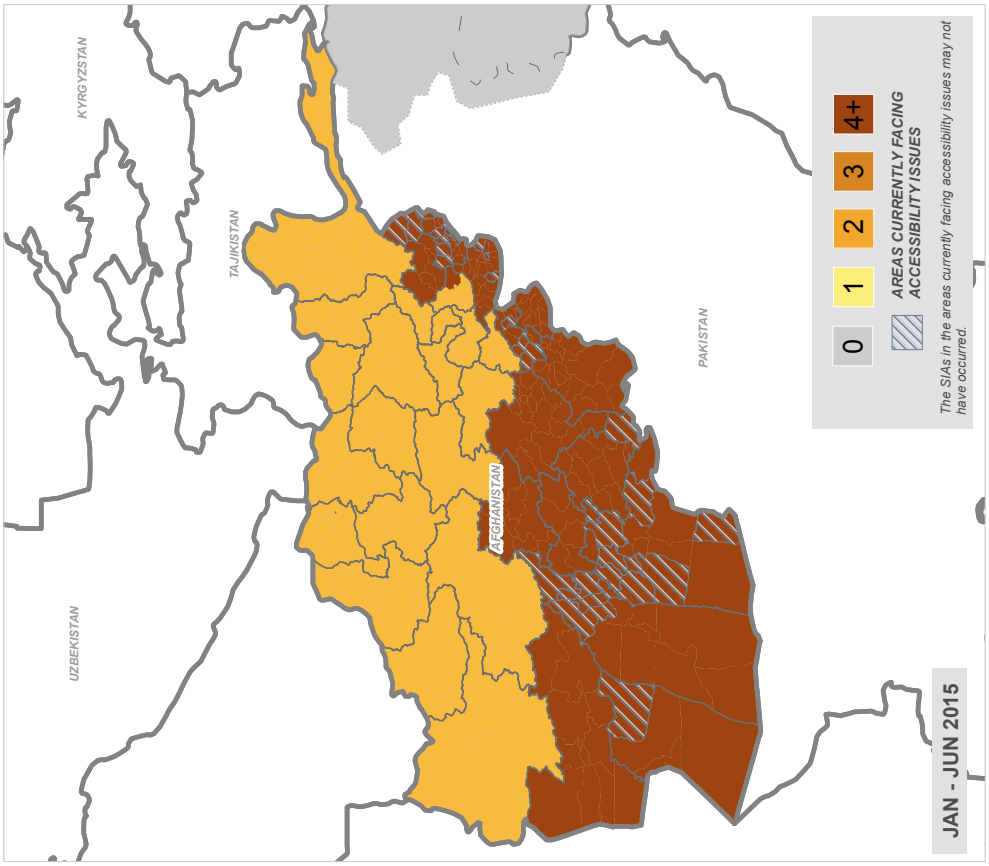
More information on the revised management structures and the midterm review can be found at www.polioeradication.org.

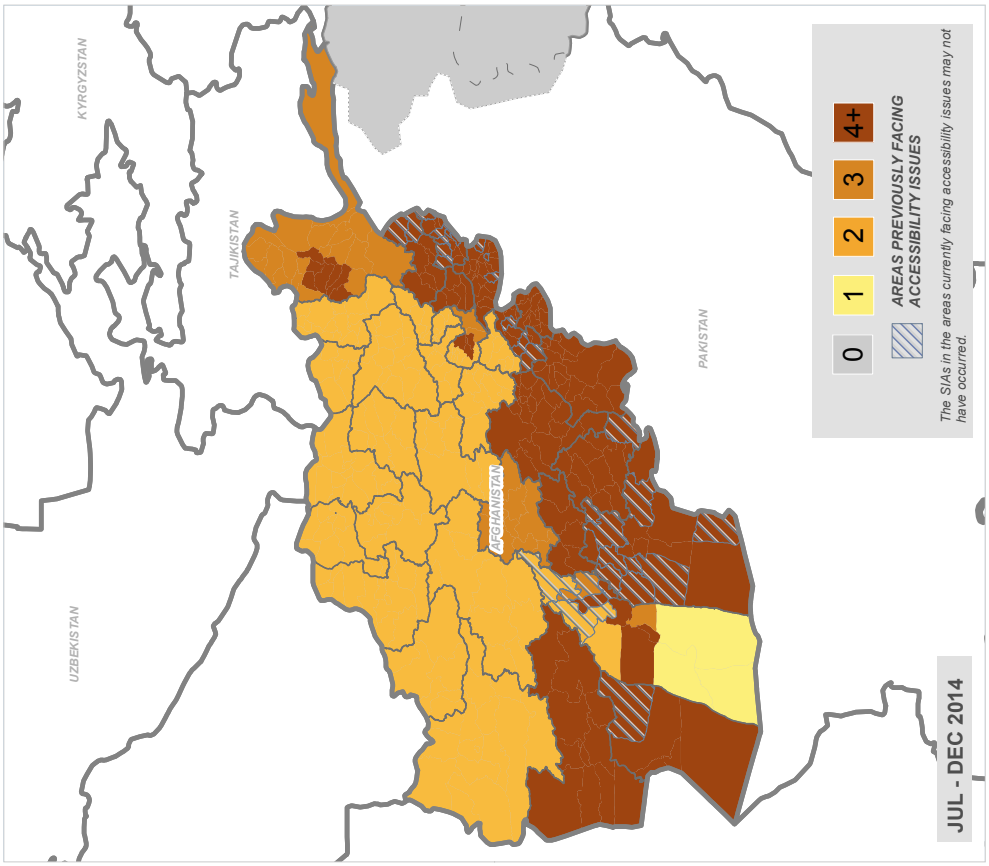
Annex 1 – Definition and significance of indicators

Indicator	Definition
0-dose	Percent of children between 6 and 59 months of age who have never received a dose of polio vaccine
LQAS	Lot Quality Assurance Sampling (LQAS) – a methodology, which classifies geographic areas (corresponding to 'lots') as having 'acceptable' or 'unacceptable' levels of vaccination coverage; based on sampling of individuals in a given geographic area against a pre-set decision value. Ideal methodology to detect areas with low vaccination coverage
Independent monitoring	Real-time independent monitoring of SIAs to assess levels of vaccination coverage achieved during a given SIA
% inaccessible	Percent of children missed during an SIA due to inaccessibility
% children missed due to child not being seen	Percent of children missed during an SIA due to house not visited or child not at home
% children missed due to refusal	Percent of children missed during an SIA due to caregiver refusal to allow vaccination
Number and type of activity	Number and type of SIAs conducted (ie National Immunization Days, Subnational Immunization Days)
Non-polio AFP rate	Non-polio AFP rate (npAFP) refers to surveillance sensitivity. Target is to achieve npAFP rate of 2/100.000 population aged <15 years
Stool adequacy	Further indicator to assess surveillance sensitivity. Target is to achieve 80% stool adequacy rate
IPV introduction	Indicator tracking progress in introducing IPV into routine immunization programmes of OPV-only using countries by end-2015
Primary isolation at the laboratory upon receipt of stool specimens	Virus isolation results available within 14 days of receipt of stool specimens at the laboratory
Routine immunization strengthening	Indicator to monitor progress against improving routine immunization in ten priority countries through use of GPEI infrastructure (Afghanistan, Angola, Chad, Democratic Republic of Congo, Ethiopia, India, Nigeria, Pakistan, Somalia and South Sudan), as measured through percent reduction in un-immunized children year-on-year, with DTP3-containing vaccine
Financial resources	Indicators to measure availability of funds to implement Polio Endgame Plan: -Proportion of 2014 required funds received -Proportion of 2013-2018 committed funds received
Human resources	Percent of positions vacant
OPV supply	Indicator tracking adequacy of available OPV supply for planned SIAs and type-specific buffer stock

Endemic Country	State/Area	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Afghanistan	Southern (Kandahar, Helmand)	Interrupt transmission	Number of cases	0 case	15	1
		High population immunity	% 0-dose	<10%	0,71%	0,70%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	2.74 start (Q3) 6.6 end (Q4)	24.9 start (Q1) 20.5 end (Q2)
			Number and type of activity	per plan	2 NIDs, 12 SNIDs	1 NID, 8 SNIDs
			% children missed due to no visit/child absent (in 11 LPDs)		5.5% start 7.2% end	0.5% start 0.6% end
			% children missed due to refusal (in 11 LPDs)		1.3% start 2.4% end	0.2% start 0.3% end
		High virus detection	AFP rate	> 2 per 100 000	17,9	21,3
			Stool adequacy	> 80%	87,63	91,59
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases	0 case	5	5
		High population immunity	% 0-dose	<10%	0,34%	0,26%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 8 SNIDs	1 NID, 6 SNIDs
		High virus detection	AFP rate	> 2 per 100 000	13,0	15,1
			Stool adequacy	> 80%	95,86	97,27
			Lab receipt to virus isolation result (median)	< 14 days	11	12
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	17% reduction (2014 vs 2013)	N/a
	All of country		Number of polio cases from families refusing OPV	0 case		N/a
			IPV introduction	intro by 2015	N/a	Yes (Sep-15)

SIAs in Afghanistan

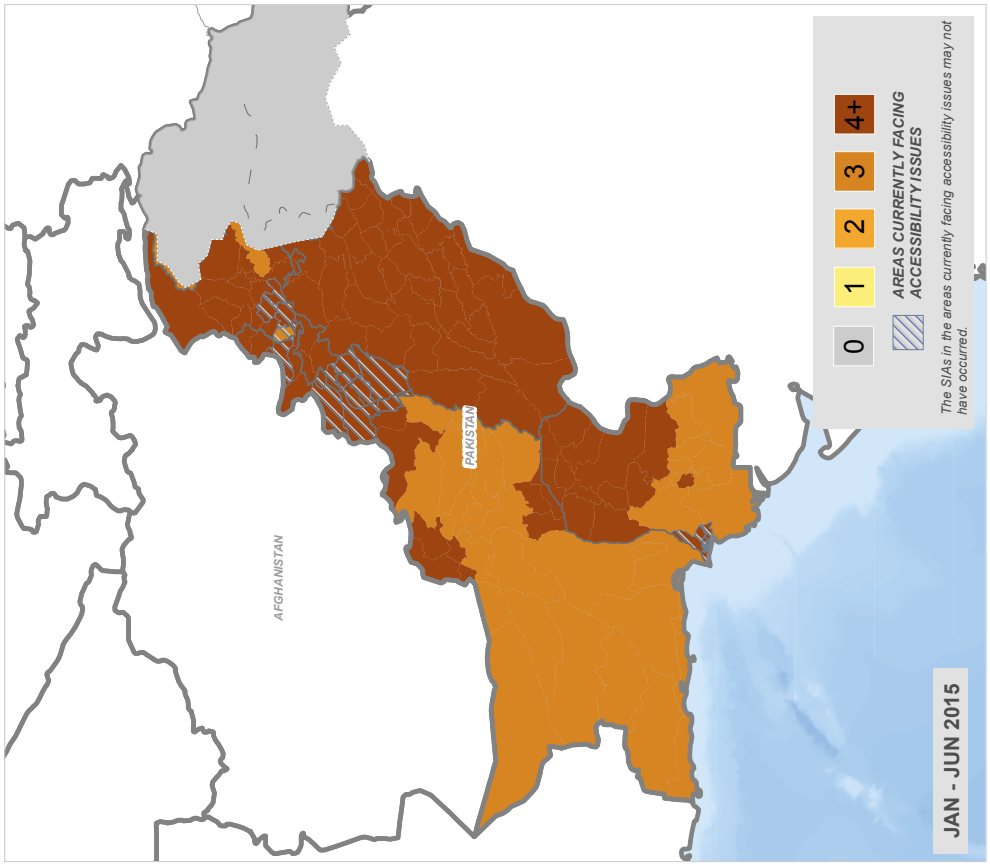


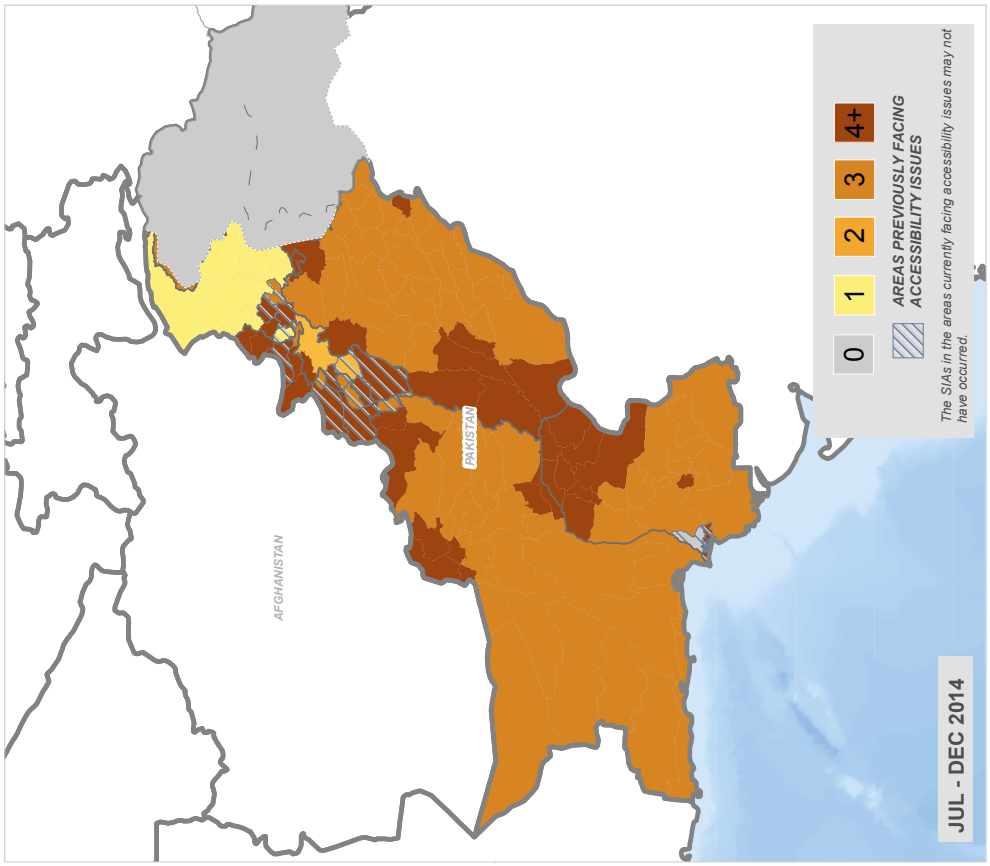


Endemic Country	State/Area	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Pakistan	KP (Peshawar, Nowshera, Swabi, Charsaddah, Mardan, Bannu, Tank, Lakki Marwat)	Interrupt transmission	Number of cases (WPV1 only)	0 case	51	13
		High population immunity	% 0-dose	<10%	3,22%	1,72%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	42%	66%
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 8 SNIDs	3 NIDs, 4 SNIDs
			% children missed due to no visit/child absent		2.3% start 1.4% end	2% start 1% end
			% children missed due to refusal		1.3% start 0.7% end	0.03% start 0.04% end
		High virus detection	AFP rate	> 2 per 100 000	9,53	9,43
			Stool adequacy	> 80%	81,87	87,37
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	FATA	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	106 (105+1)	8 (8+0)
		High population immunity	% 0-dose	<10%	37,96%	6,35%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	15.9 start (Q3) 11.3 end (Q4)	5.0 start (Q1) 4.8 end (Q2)
			Number and type of activity	per plan	2 NIDs, 4 SNIDs	3 NIDs, 4 SNIDs
			% children missed due to no visit/child absent		2.1% start 2.9% end	1% start 1% end
			% children missed due to refusal		0.1% start 0.1% end	0% start 0% end
		High virus detection	AFP rate	> 2 per 100 000	18,85	10,23
			Stool adequacy	> 80%	85,98	79,78
			Lab receipt to virus isolation result (median)	< 14 days	10	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

Endemic Country	State/Area	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Pakistan	Karachi (SINDH)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	WPV: 14 in Karachi (20 in Sindh)	0
		High population immunity	% 0-dose	<10%	0,57%	3,23%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	33%	28%
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 7 SNIDs	3 NIDs, 6 SNIDs
			% children missed due to no visit/child absent		0.7% start 1.3% end	0.05% start 0.07% end
			% children missed due to refusal		0.6% start 0.5% end	0.01% start 0.03% end
		High virus detection	AFP rate	> 2 per 100 000	5,6	5,5
			Stool adequacy	> 80%	92,37	93
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases (WPV1 only)	0 case	35	8
		High population immunity	% 0-dose	<10%	0,83%	0,82%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 7 SNIDs	3 NIDs, 6 SNIDs
		high virus detection	AFP rate	> 2 per 100 000	5,12	5,47
			Stool adequacy	> 80%	92	91,2
			Lab receipt to virus isolation result (median)	< 14 days	12	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	0% reduction (2014 vs 2013)	N/a
	All of country		Number of polio cases from families refusing OPV	0 case		N/a
			IPV introduction	intro by 2015	N/a	Yes (Aug-15)

SIAs in Pakistan

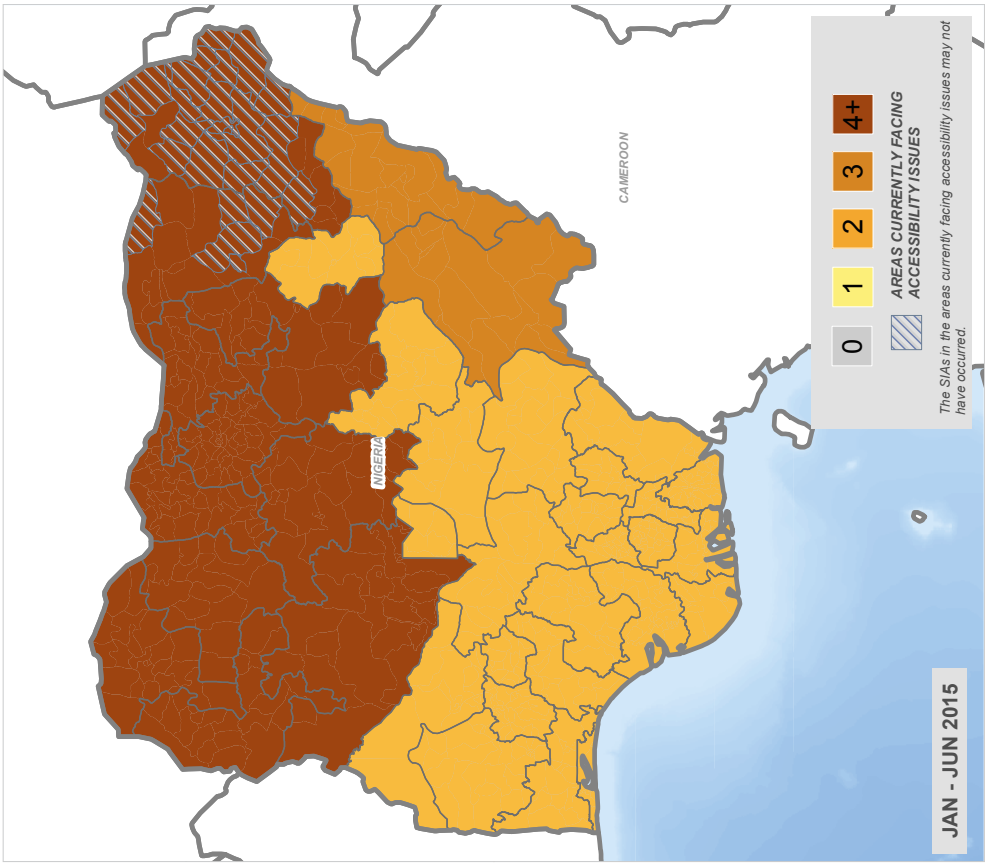


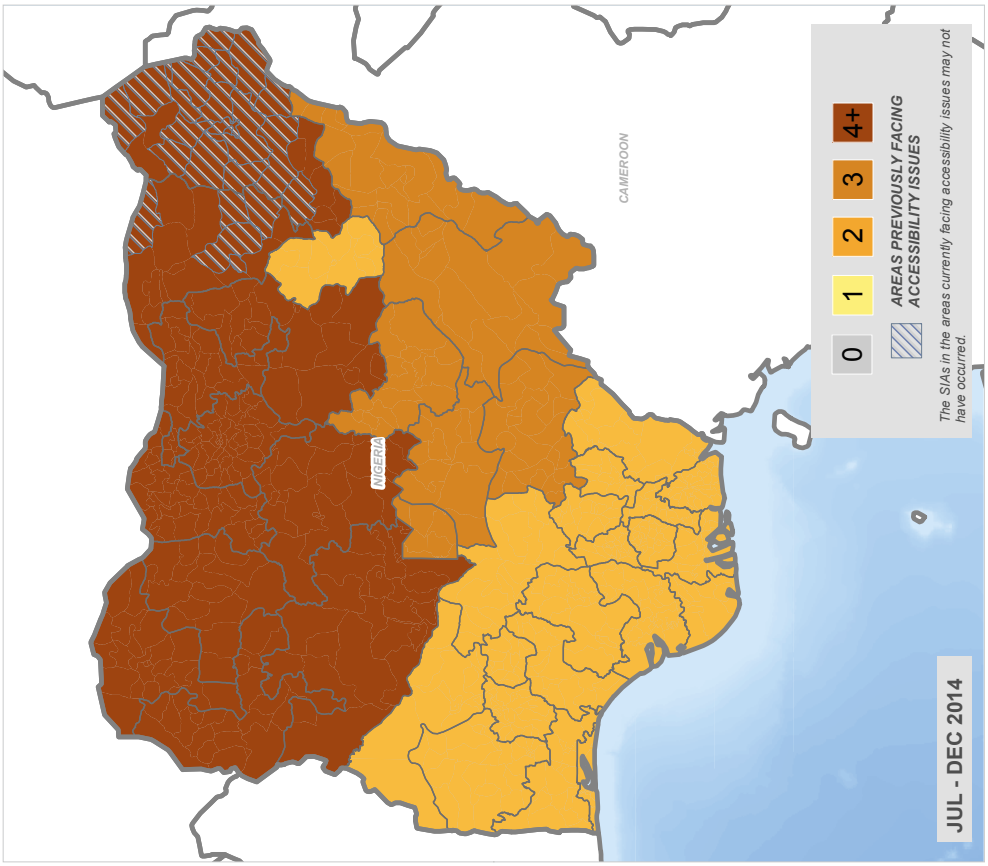


Endemic Country	State/Area	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Nigeria	North Central (Kano, Katsina, Jigawa, Kaduna)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	7 (1+6)	0
		High population immunity	% 0-dose	<10%	0,35%	0,35%
			LQAS	>= 90%	99 start 98 end	98 start 94 end
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	8 SNIDs	2 NIDs, 3 SNIDs
			% children missed due to no visit/child absent		1.9% start 1.3% end	1% start 1% end
			% children missed due to refusal		0.3% start 0.2% end	0.3% start 0.2% end
		High virus detection	AFP rate	> 2 per 100 000	15,21	21,28
			Stool adequacy	> 80%	96,3	98
			Lab receipt to virus isolation result (median)	< 14 days	14	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Northeast (Borno, Yobe)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	2 (0+2)	0
		High population immunity	% 0-dose	<10%	1,23%	1,56%
			LQAS	>= 90%	74 start 96 end	86 start 86 end
			% inaccessible	<5%	17.7 start 52.9 end (Borno only)	56.3 start 54.2 end (Borno only)
			Number and type of activity	per plan	6 SNIDs	2 NIDs, 2 SNIDs
			% children missed due to no visit/child absent		3.2% start 3.2% end	0.3% start 0.3% end
			% children missed due to refusal		1.2% start 1.2% end	0.01% start 0.01% end
		High virus detection	AFP rate	> 2 per 100 000	10,58	21,59
			Stool adequacy	> 80%	97,41	100
			Lab receipt to virus isolation result (median)	< 14 days	12	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

Endemic Country	State/Area	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Nigeria	Rest of North (Sokoto, Kebbi, Zamfara)	Interrupt transmission	Number of cases	0 case	0	0
		High population immunity	% 0-dose	<10%	0%	0%
			LQAS	>= 90%	98 start 98 end (Kebbi not incl.)	95 start 89 end (Kebbi not incl.)
			% inaccessible	<5%	n/a	n/a
			Number and type of activity	per plan	4 SNIDs	2 NIDs, 2 SNIDs
			% children missed due to no visit/child absent		1.7% start 1.3% end	0.2% start 0.1% end
			% children missed due to refusal		0.2% start 0.2% end	0% start 0% end
		High virus detection	AFP rate	> 2 per 100 000	28,56	37,32
			Stool adequacy	> 80%	99,48	100
			Lab receipt to virus isolation result (median)	< 14 days	13	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases (cVDPV2 only)	0 case	0	1
		High population immunity	% 0-dose	<10%	0,30%	0,40%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	6 SNIDs	2 NIDs, 2 SNIDs
		High virus detection	AFP rate	> 2 per 100 000	11,25	14,13
			Stool adequacy	> 80%	99,28	99,29
			Lab receipt to virus isolation result (median)	< 14 days	13	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	6% reduction (2014 vs 2013)	N/a
	All of country		Number of polio cases from families refusing OPV	0 case		N/a
			IPV introduction	intro by 2015	N/a	Yes (Feb-15)

SIAs in Nigeria





Outbreak	Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Central Africa	**Cameroon** (Most recent case 9 July 2014)	Interrupt transmission within 6 months of confirmation of outbreak	Number of cases	0 case after 6 months	2	0
		High population immunity	% 0-dose	<10%	8,94%	2,60%
			LQAS or IM out-of-house result	>= 90% or <5%	5.5% (IM O-H)	6.8% (IM O-H)
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	4 NIDS, 3 SNID	2 NIDs, 2 SNIDs
		High virus detection	AFP rate (national)	>2	8,93	4,87
			AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
			Stool adequacy (national)	>=80%	77,08	89,17
			Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	30%	100%
			Lab receipt to virus isolation result (median)	< 14 days	13	9
			Environmental surveillance	Yes or No	No	Yes (May-15)
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	20% increase (2014 vs 2013)	N/a
			IPV introduction	intro by 2015	N/a	Yes (Jul-15)
	Equatorial Guinea (Most recent case 3 May 2014)	Interrupt transmission within 6 months of confirmation of outbreak	Number of cases	0 case after6 months	0	0
		High population immunity	% 0-dose	<10%	0%	0%
			LQAS or IM out-of-house result	>= 90% or <5%	5.0% (IM O-H)	9.0% (IM O-H)
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	4 NIDs	2 NIDS
		High virus detection	AFP rate (national)	>2	5,93	3,28
			AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	86%	43%
			Stool adequacy (national)	>=80%	77,78	60
			Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	43%	14%
			Lab receipt to virus isolation result (median)	< 14 days	18	11
			Environmental surveillance	Yes or No	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	20% reduction (2014 vs 2013)	N/a
			IPV introduction	intro by 2015	N/a	Yes (Oct-15)

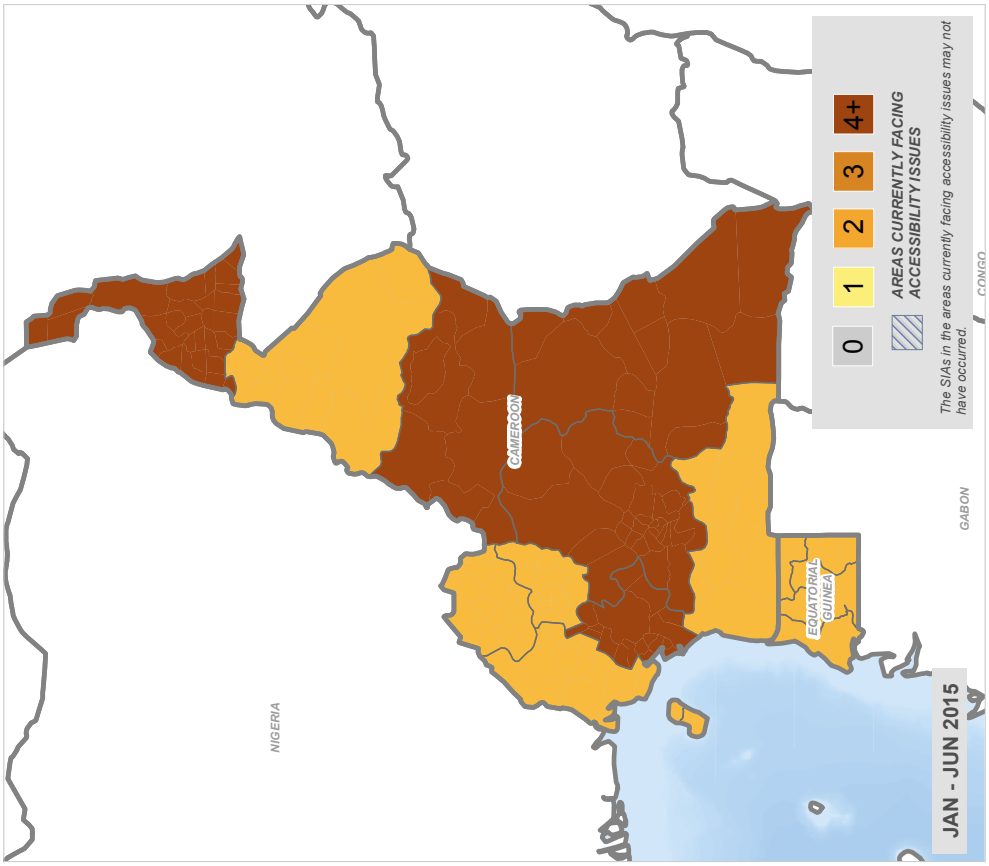
Outbreak	Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Horn of Africa	**Somalia** (Most recent case 11 August 2014)	Interrupt transmission within 12 months of confirmation of outbreak	Number of cases	0 case after 12 months	1	0
		High population immunity	% 0-dose	<10%	19,08%	16,06%
			LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 6 SNIDs	3 NIDS, 6 SNIDs
		High virus detection	AFP rate (national)	>2	6,77	6,33
			AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
			Stool adequacy (national)	>=80%	97,7	98,78
			Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	89%	100%
			Lab receipt to virus isolation result (median)	< 14 days	11	11
			Environmental surveillance	Yes or No	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	2% increase (2014 vs 2013)	N/a
			IPV introduction	intro by 2015	N/a	Yes (Oct-15)
	Ethiopia (Most recent case 5 January 2014)	Interrupt transmission within 6 months of confirmation of outbreak	Number of cases	0 case after 6 months	0	0
		High population immunity	% 0-dose	<10%	7,43%	4,74%
			LQAS or IM out-of-house result	>= 90% or <5%	12.0% (IM O-H)	12.0% (IM O-H)
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	1 NID, 2 SNIDs	1 NID, 2 SNIDs
		High virus detection	AFP rate (national)	>2	2,8	2,99
			AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	82%	73%
			Stool adequacy (national)	>=80%	91,1	95,23
			Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	73%	100%
			Lab receipt to virus isolation result (median)	< 14 days	12	9
			Environmental surveillance	Yes or No	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	17% reduction (2014 vs 2013)	N/a
			IPV introduction	intro by 2015	N/a	Yes (Oct-15)

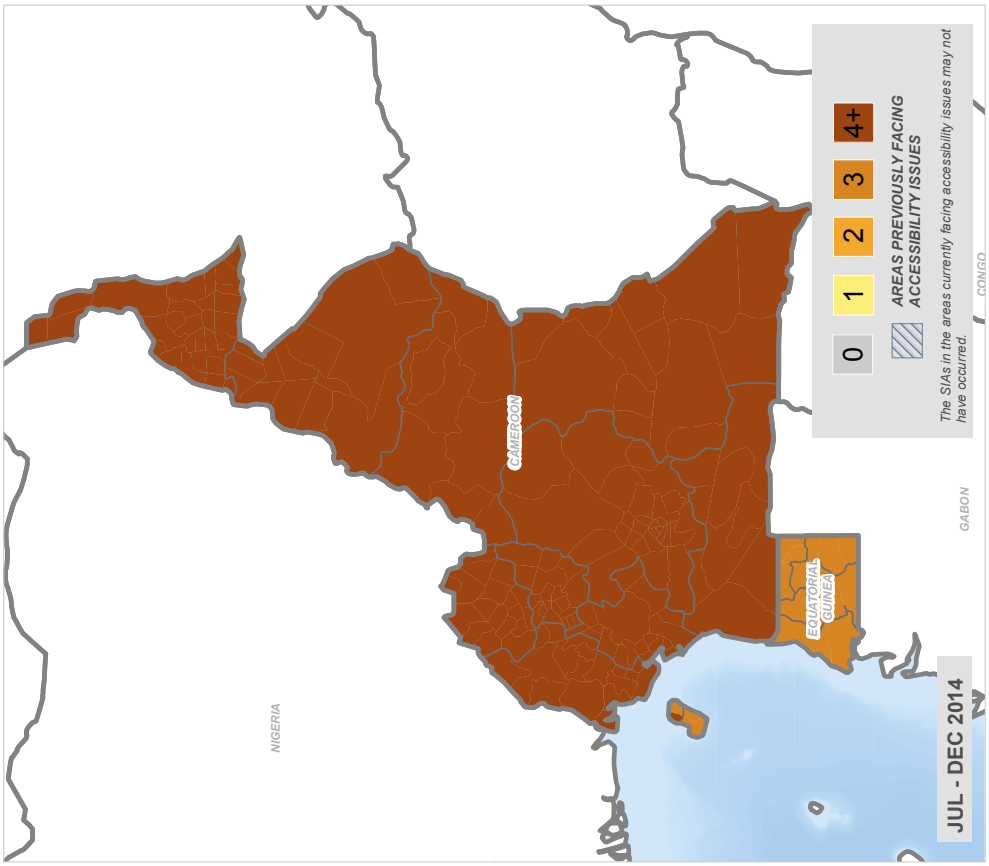
Outbreak	Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Middle East	Syria (Most recent case 21 January 2014)	Interrupt transmission within 12 months of confirmation of outbreak	Number of cases	0 case after 12 months	0	0
		High population immunity	% 0-dose	<10%	1,82%	4,41%
			LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDS, 1 SNID	2 NIDs, 1 SNID
		High virus detection	AFP rate (national)	>2	2,83	3,18
			AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	79%	57%
			Stool adequacy (national)	>=80%	91,74	93,39
			Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	79%	79%
			Lab receipt to virus isolation result (median)	< 7 days	12	12
			Environmental surveillance	Yes or No	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	3% reduction (2014 vs 2013)	N/a
			IPV introduction	intro by 2015	N/a	Yes (<2015)
	Iraq (Most recent case 7 April 2014)	Interrupt transmission within 12 months of confirmation of outbreak	Number of cases	0 case after 12 months	0	0
		High population immunity	% 0-dose	<10%	0%	0%
			LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 4 SNIDs	3 NIDs
		High virus detection	AFP rate (national)	>2	3,35	3,58
			AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	84%	79%
			Stool adequacy (national)	>=80%	93,13	91,57
			Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	84%	79%
			Lab receipt to virus isolation result (median)	< 14 days	11	11
			Environmental surveillance	Yes or No	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	14% increase (2014 vs 2013)	N/a
			IPV introduction	intro by 2015	N/a	Yes (Oct-15)

Outbreak	Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
	Madagascar (Most recent case 29 May 2015)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days	N/a	N/a
			Timing of 1st response	=<4 weeks	N/a	⩽11 weeks
			SIAs plan execution	=>3 campaigns within first 3 months	N/a	1 SIA within first 3 months
		Follow-on response	Interim assessment	Conducted at 3 months	N/a	No (Jul-15)
			Final assessment	Conducted at 12 months	N/a	N/a
		Interrupt transmission within 6 months of confirmation of outbreak	Number of cases (cVDPV1 only)	0 case after 6 months	1	8
		High population immunity	% 0-dose	<10%	0%	3,64%
			LQAS or IM out-of-house result	>= 90% or <5%	7.0% (IM O-H)	9.0% (IM O-H)
			% inaccessible	<5%		n/a
			Number and type of activity	per plan	2 NIDs, 4 SNIDs	1 NID
		High virus detection	AFP rate (national)	>2	3,35	3,37
			AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	64%	64%
			Stool adequacy (national)	>=80%	93,13	79,03
			Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	64%	32%
			Lab receipt to virus isolation result (median)	< 14 days	11	8
			Environmental surveillance	Yes or No	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	6% increase (2014 vs 2013)	N/a
			IPV introduction	intro by 2015	N/a	Yes (May-15)

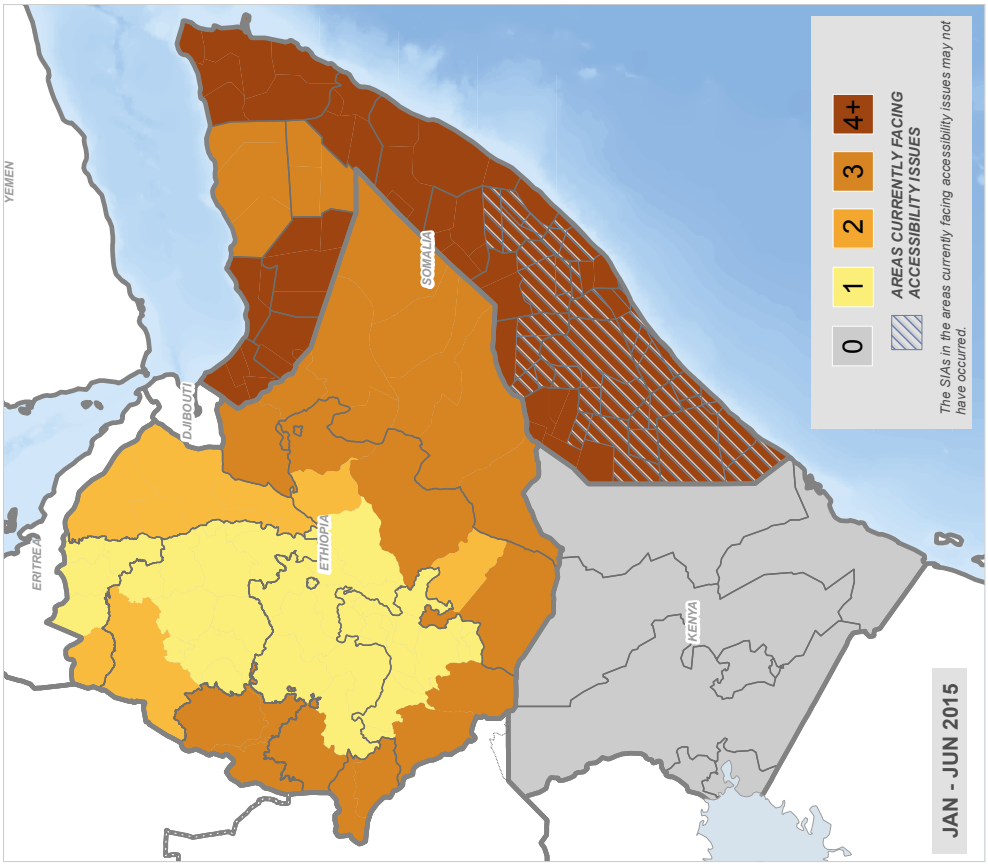
Outbreak	Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
	Ukraine (Most recent case 30 June 2015)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days	N/a	N/a
			Timing of 1st response	=<4 weeks	N/a	N/a
			SIAs plan execution	=>3 campaigns within first 3 months	N/a	N/a
		Follow-on response	interim assessment	conducted at 3 months	N/a	N/a
			final assessment	Conducted at 12 months	N/a	N/a
		Interrupt transmission within 6 months of confirmation of outbreak	number of cases (cVDPV1 only)	0 case after 6 months	N/a	1
		High population immunity	% 0-dose	<10%	N/a	0,00%
			LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Freqency and type of activities	per plan	N/a	N/a
		High virus detection	AFP rate	>2 (national)	N/a	2,31
			AFP rate	>2 (% of states/provinces meeting indicator)	N/a	65% (15/23)
			stool adequacy	>=80% (national)	N/a	97%
			stool adequacy	>=80% (% of states/provinces meeting indicator)	N/a	100%
			lab receipt to virus isolation result (median)	< 14 days	N/a	11
			Environmental surveillance	Yes or no	N/a	Yes
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015	N/a	N/a

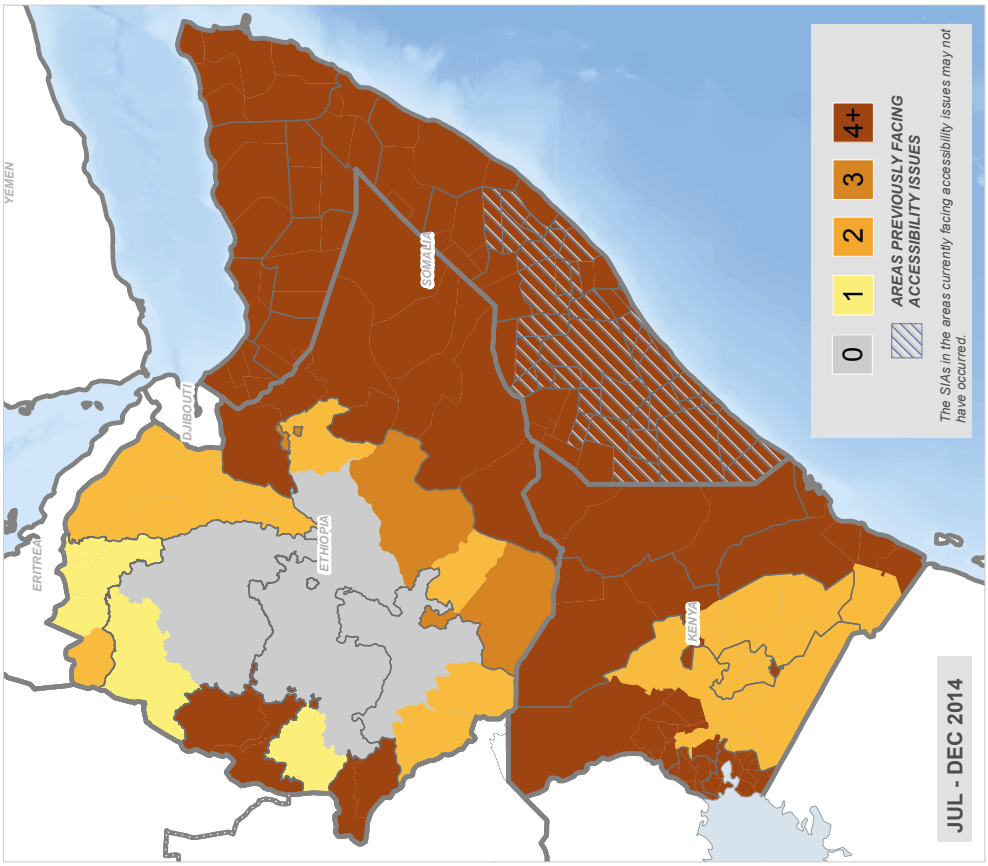
SIAs in Central Africa



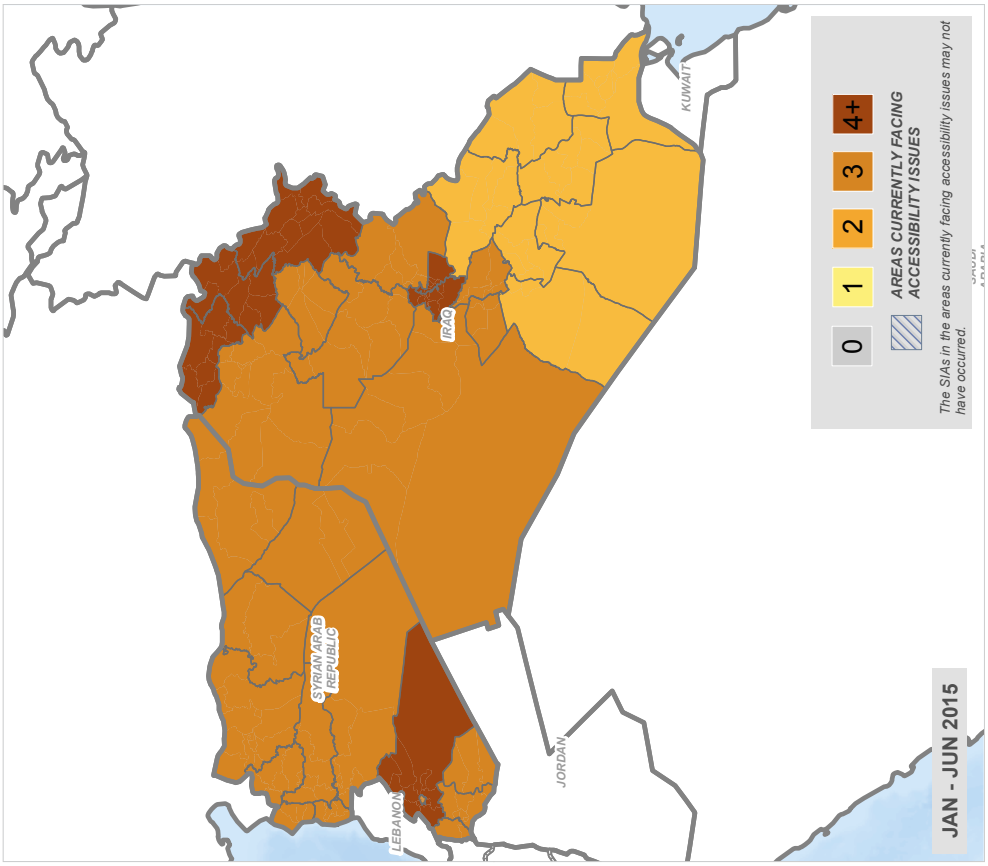


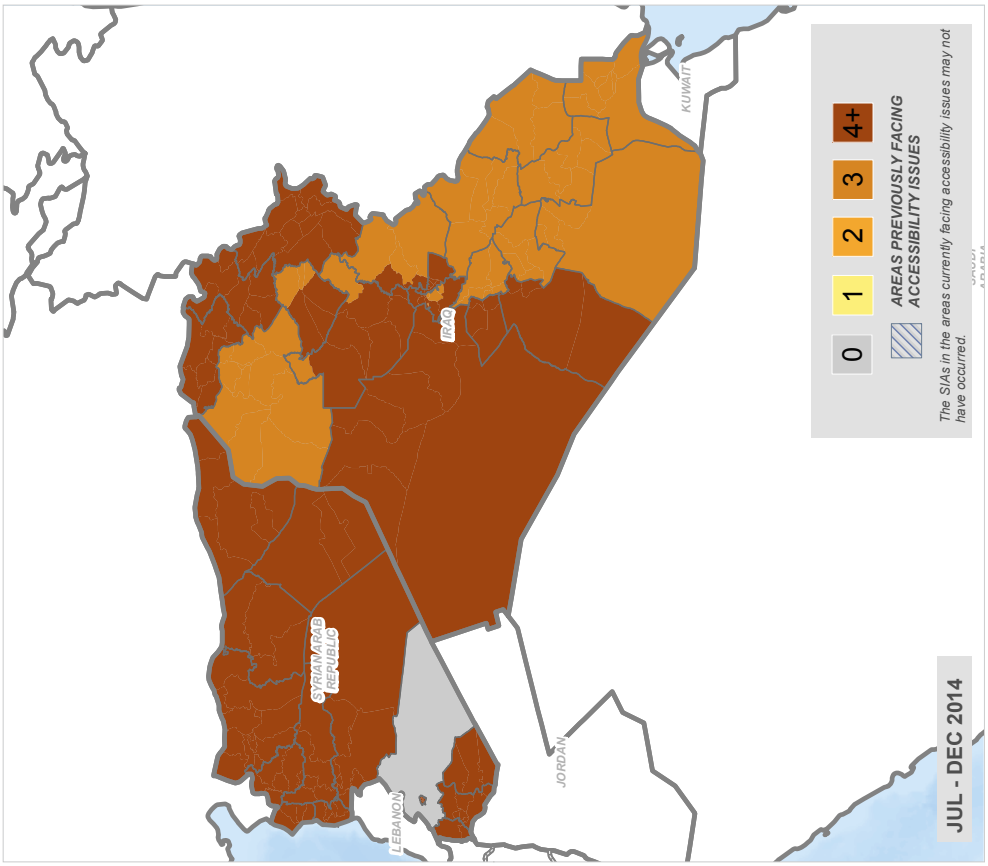
SIAs in Horn of Africa





SIAs in Middle East





Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Angola	High population immunity	% 0-dose	<10%	2,61%	0,81%
		LQAS or IM out-of-house result	>= 90% or <5%	13.0% (IM O-H)	no SIA
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NIDs, 1 SNIDs	no SIA
	High virus detection	AFP rate (national)	>2	3,32	3,95
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	89%	94%
		Stool adequacy (national)	>=80%	94,35	94,76
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	89%	100%
		Lab receipt to virus isolation result (median)	< 14 days	18 (median days)	9
		Environmental surveillance	Yes or No	No	Yes (2014)
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	191% increase (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	No (Jan-16)
Benin	High population immunity	% 0-dose	<10%	0%	2,22%
		LQAS or IM out-of-house result	>= 90% or <5%	5.0% (IM O-H)	4.5% (IM O-H)
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	2 NIDS
	High virus detection	AFP rate (national)	>2	2,78	3,52
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	50%	58%
		Stool adequacy (national)	>=80%	80,95	98,75
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	50%	92%
		Lab receipt to virus isolation result (median)	< 14days	19 (median days)	8
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	2% reduction (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Aug-15)

Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Central African Republic	High population immunity	% 0-dose	<10%	6 SNIDs	6,67%
		LQAS or IM out-of-house result	>= 90% or <5%	13.8% (IM O-H)	9.8% (IM O-H)
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	6 SNIDs	1 NID, 2 SNIDs
	High virus detection	AFP rate (national)	>2	5,33	3,64
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	57%	71%
		Stool adequacy (national)	>=80%	82,69	88,24
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	57%	71%
		Lab receipt to virus isolation result (median)	< 14 days	12 (median days)	8,5
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	30% reduction (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Sep-15)
Chad	High population immunity	% 0-dose	<10%	5,45%	0,71%
		LQAS or IM out-of-house result	>= 90% or <5%	5.5% (IM O-H)	5.5% (IM O-H)
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID, 1 NID	2 NIDS, 1 SNID
	High virus detection	AFP rate (national)	>2	5,64	6,93
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	96,69	93,75
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	100%	100%
		Lab receipt to virus isolation result (median)	< 14 days	18 (median days)	10
		Environmental surveillance	Yes or No	No	Yes (June)
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	6% increase (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Sep-15)

Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Congo	High population immunity	% 0-dose	<10%	30,00%	3,33%
		LQAS or IM out-of-house result	>= 90% or <5%	7.7% (IM O-H)	no data
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	3 NIDs	1 NID
	High virus detection	AFP rate (national)	>2	5,73	5,28
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	83,93	96,15
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	73%	100%
		Lab receipt to virus isolation result (median)	< 14 days	14 (median days)	8
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	32% reduction (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Oct-15)
Côte d'Ivoire	High population immunity	% 0-dose	<10%	0,89%	4,29%
		LQAS or IM out-of-house result	>= 90% or <5%	5.5% (IM O-H)	7.0% (IM O-H)
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	1 NID
	High virus detection	AFP rate (national)	>2	4,05	3,26
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	65%	65%
		Stool adequacy (national)	>=80%	85,14	90,78
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	76%	76%
		Lab receipt to virus isolation result (median)	< 14 days	12 (median days)	9
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	68% increase (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Jun-15)

Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Democratic Republic of the Congo	High population immunity	% 0-dose	<10%	2,40%	4,26%
		LQAS or IM out-of-house result	>= 90% or <5%	7.3% (IM O-H)	8.0% (IM O-H)
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID, 4 SNIDs	1 SNID
	High virus detection	AFP rate (national)	>2	5,59	5,3
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	86,89	89,81
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	91%	100%
		Lab receipt to virus isolation result (median)	< 14 days	14 (median days)	8
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	22% reduction (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Apr-15)
Gabon	High population immunity	% 0-dose	<10%	25,00%	5,56%
		LQAS or IM out-of-house result	>= 90% or <5%	9.0% (IM O-H)	no data
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	1 NID
	High virus detection	AFP rate (national)	>2	8,45	8,42
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	80%	100%
		Stool adequacy (national)	>=80%	75	92,86
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	40%	80%
		Lab receipt to virus isolation result (median)	< 14 days	18 (median days)	11
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	45% increase (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Dec-15)

Country	Outcome	Indicator	Target	Jul-Dec 2014	Jan-Jun 2015
Mali	High population immunity	% 0-dose	<10%	1,39%	0%
		LQAS or IM out-of-house result	>= 90% or <5%	4.0% (IM O-H)	3.0% (IM O-H)
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID	2 NIDS, 1 SNID
	High virus detection	AFP rate (national)	>2	3,23	1,77
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	89%	44%
		Stool adequacy (national)	>=80%	95,08	98,33
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	67%	78%
		Lab receipt to virus isolation result (median)	< 14 days	20 (median days)	19
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	18% reduction (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Oct-15)
Niger	High population immunity	% 0-dose	<10%	3,06%	0,95%
		LQAS or IM out-of-house result	>= 90% or <5%	7.0% (IM O-H)	4.5% (IM O-H)
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID, 3 SNIDs	2 NIDS, 1 SNID
	High virus detection	AFP rate (national)	>2	2,43	2,92
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	86%	86%
		Stool adequacy (national)	>=80%	87,93	92,14
		Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	86%	86%
		Lab receipt to virus isolation result (median)	< 14 days	23 (median days)	36
		Environmental surveillance	Yes or No	Yes	Yes (2014)
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	1% increase (2014 vs 2013)	N/a
		IPV introduction	intro by 2015	N/a	Yes (Jul-15)

Annex 5 – Analysis of OPV costs by region, July-December 2014 vs January-June 2015

Operational cost ($) per child (to reach and vaccine 1 child with 1 dose)	Jul - Dec 2014	Jan-Jun 2015
Global	0.32	0.31
Regional Office for Africa	0.43	0.36
Regional Office for the Eastern Mediterranean	0.16	0.20
Regional Office for South-East Asia	0.10	0.10
Regional Office for Europe	0.30	0.30

Outcome	Indicator	Target	January-June 2015
All	**Financing:** 12-month cash gap		US$ 271 million
	Financing: Strategy funding gap		US$ 4.86 billion of US$ 5.5 billion committed (US$ 2.84 billion in contributions; US$ 2.18 billion in pledges. Realization of all pledges would result in remaining funding gap of US$ 496 million against Endgame Plan.)
	Staffing: Vacant approved posts	<10%	WHO Headquarters: 13.33% WHO Afghanistan: 14.39% WHO Nigeria: 8.00% WHO Pakistan: 13.29% WHO All: 12.48% CDC Headquarters: 13.10% CDC Nigeria: 5.90% CDC All: 7.30%
High population immunity	**Vaccine supply:** Weeks forecast below buffer in next 6 months	<10%	0 weeks
Low risk of virus reintroduction	Number of OPV-only using countries introducing IPV	**Per IMG**	All countries have committed to IPV introduction ahead of the switch from trivalent OPV to bivalent OPV in April 2016.
	Plan in place to support routine immunization strengthening in 10 priority countries	**Per IMG**	Six countries – Chad, Democratic Republic of the Congo, Ethiopia, India, Nigeria and Pakistan – have developed annual national immunization plans that leverage polio assets to improve broader immunization goals.
	Reduction in the international spread of polio		The declared PHEIC continues; countries extend the implementation of the Temporary Recommendations.
	Containment	**Per GAPIII**	GAPIII is updated and aligned with the polio Endgame Plan timelines, and is endorsed by the SAGE and World Health Assembly.
	Certification		Progress continues on WPV2 eradication verification, expected by September 2015.
Legacy planning	Consultations inputs into plan	**By end 2015**	Progress continues on consultations to develop the Global Legacy Framework in 2015, endorsed by the Polio Oversight Board.

objective 1	objective 2
objective 3	objective 4

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