

Interim Quick Reference on Strengthening Polio Surveillance during a Poliovirus Outbreak

March 2021



GPEI's Standard Operating Procedures for responding to a poliovirus event or outbreak makes it clear that a robust and sensitive polio surveillance system capable of detecting virus transmission in a timely manner is essential to interrupting poliovirus transmission and closing outbreaks.¹ Data are used to 1) inform and guide further response activities including SIAs beyond the original outbreak-affected area and 2) provide evidence of the successful interruption of virus transmission. Generally, the geographic scope for response activities (i.e., outbreak-affected and high-risk areas) are identified through a detailed country risk assessment with input from technical experts.¹ In the event these outbreak-affected and high-risk areas are subnational areas, the aim for surveillance strengthening should remain nationwide as poliovirus anywhere in a country can travel everywhere in a country.

This document is intended as a quick reference guide that summarizes current globally recommended polio surveillance (acute flaccid paralysis (AFP), environmental, and laboratory) activities to achieve a sensitive system, much of it available in GPEI's Global Polio Surveillance Action Plan (GPSAP) 2018-2020.² Many of these activities should already be operational in countries and attention should be given to 1) verify they are functioning as intended, and 2) modify activities to respond to the needs presented by the outbreak. National and subnational polio outbreak response plans should incorporate these recommended activities to address identified gaps in surveillance to achieve and maintain a high level of sensitivity. Technical and financial resources needed to implement activities, including dedicated surveillance staff at all levels, should be identified and also included in plans.

This guide is intended for individuals involved in poliovirus surveillance activities during outbreaks, at all levels within a country. To make this document user-friendly,

- a checklist that summarizes recommended activities is included in Annex 1.
- a high-level summary is provided for each activity and references are included at the end of the guide. Readers are encouraged to review references. When necessary, further details are included in Annex 2.
- activities included in this document are comprehensive but not exhaustive, highlighting the most critical surveillance activities to conduct during outbreaks.
- information is current as of March 2021 and supersedes any previous publications. In the event of conflicting recommendations among other documents, this document should be followed.

I. Acute Flaccid Paralysis (AFP) Surveillance

1. Immediately notify surveillance and laboratory personnel upon polio outbreak confirmation

Use the quickest means of communication to reach personnel at all levels to avoid delays. Informal communication may be necessary until a formal communication can be made. Use the notification as an opportunity to remind personnel of the importance to conduct active surveillance, ensure passive surveillance (and Zero-reporting) is conducted, and review surveillance data and indicators to take corrective action.

2. Increase the annualized target for the NPAFP rate to > 3 per 100,000 children <15 years old per year

During polio outbreaks, the annualized target for the non-polio AFP (NPAFP) rate is increased in outbreak-affected and polio high-risk areas

Outbreak Target: AFP Surveillance Indicators

NPAFP rate: ≥ 3 per 100,000 children <15 years old per year
Stool adequacy: $\geq 80\%$

to increase the sensitivity of poliovirus detection.¹ The target for stool adequacy^a remains at $\geq 80\%$. These targets are to be met for ≥ 12 months after the last case or isolate; data are used for outbreak response assessments.

3. All districts and provinces should review and update (if necessary) their polio surveillance reporting network, including prioritization of reporting sites for active surveillance visits

- Review and verify that the reporting network^b is robust and contains reporting sites that accurately reflect *current* health service providers within the jurisdiction, including public and private health facilities (e.g., hospitals, clinics, health centers), non-governmental organizations (NGOs), and refugee camps.
 - Based on the epidemiology of the outbreak and the health-seeking behavior of populations at high risk for poliovirus, expand the reporting network to include other health service entities such as traditional healers, veterinarians, pharmacists, and key community informants.
- Update the prioritization of reporting sites for active surveillance visits based on 1) the revised reporting network and 2) epidemiology of the outbreak. Refer to Annex 2 for further details.
 - Outbreak-related factors that should inform prioritization include reporting sites that border an outbreak-affected area, provide health services to polio high risk populations, etc. All changes made to the prioritization scheme should be documented.

4. Ensure *prospective* active surveillance visits are conducted regularly and monitored nationwide

Verify that *prospective* active surveillance^c is being conducted nationally; prioritize outbreak-affected and high-risk areas first if human resources are limited. Verification includes working with the local surveillance team to confirm the availability of a prioritized list of reporting sites, and a schedule and plan for visits. At the reporting site, verify that the surveillance officer visits and reviews medical records and logbooks at all appropriate units, wards, and departments; interviews and sensitizes medical staff on polio and AFP reporting (refer to Section I.A.2); and there is regular supervision and documentation of active surveillance visits.

5. Ensure that passive surveillance is performing optimally

Verify that passive surveillance^d (also known as Zero-reporting) is being conducted nationally. Upon outbreak notification, surveillance officers across the country should review their data to verify that targets for completeness and timeliness of reporting are met including Zero-reporting.³ If national and subnational resources are limited, prioritize outbreak-affected and polio high-risk areas for immediate corrective steps if targets are not met and expand nationwide thereafter. Refer to Section I.A on sensitization activities to improve reporting.

6. Conduct facility-based, ad hoc active case searches to identify any unreported AFP cases

Facility-based, ad hoc active case searches (also known as retrospective medical records reviews, ad-hoc records reviews) are a one-time visit to a health facility. Activities to be completed are the same as active surveillance visits with the exception that records should be reviewed for the 6 months prior to the date of the visit

^a Stool adequacy: two stool specimens collected ≥ 24 hours apart, both within 14 days of paralysis onset, and specimens arrived in good condition at a WHO-accredited laboratory.

^b Reporting network: comprehensive list of sites that report suspected AFP cases to public health authorities within an administrative unit. The network is comprised of formal and informal health care providers and facilities, private and public sector, community-based surveillance (where available), and other key reporters such as veterinarians and pharmacists.

^c Active surveillance: routine visits by surveillance officers to priority reporting sites to identify unreported AFP cases. This entails physical review of medical records and registers as well as interviews with healthcare providers to identify suspected AFP cases.

^d Passive surveillance: reporting sites notify surveillance officers of suspected AFP cases. Reporting sites also send weekly AFP surveillance reports to surveillance officers documenting the number of suspect AFP cases detected during the week, including if no suspect cases were detected (i.e., Zero-reporting).

- In outbreak-affected and polio high-risk areas, visit high-priority health facilities and then expand to medium- and low- priority health facilities. Due to population movement, health facilities in the Capital/Capital region should also be prioritized even if not within the outbreak-affected or high-risk areas.
- Investigate all unreported AFP cases identified during the visit. Further details on investigation activities are included in Annex 2.
- Use visits as opportunities to sensitize staff on AFP reporting (refer to Section I.A.2).

7. Use all engagement opportunities to conduct community-based, ad hoc active case searches to identify unreported AFP cases

Community-based, ad hoc active case searches is a valuable complement to facility-based, ad hoc active case searches and should be pursued during all community engagement opportunities.

- Ask community members and leaders about individuals with AFP symptoms during every visit, whether for AFP or polio case investigations, conducting community sensitization activities, and other purposes.
- Include active case search in trainings for vaccination teams so they can ask households and individuals about any individual with AFP symptoms as they move from house-to-house and community-to-community.

8. Verify that special populations within the outbreak-affected and high-risk areas are included in surveillance activities and implement tailored approaches as necessary

Surveillance officers should work with government and non-government partners to identify special populations (e.g., mobile populations, hard to reach populations, inaccessible populations, etc) within their jurisdictions, understand their health-seeking behaviors, and develop tailored approaches to engage and include these populations in surveillance activities. Refer to *GPEI’s Guidelines for Implementing Polio Surveillance in Hard-to-Reach Areas & Populations* for suggested approaches.⁴

9. Ensure supportive supervision and monitoring of surveillance officers is conducted

- Focus resources on supportive supervision and monitoring of surveillance officers, especially in the outbreak-affected and polio high risk areas. This may require pulling resources from around the country, including national resources, to ensure a knowledgeable and responsive workforce that can effectively and efficiently implement surveillance activities to bring the outbreak to a timely end.
- Documentation of supervisory activities is necessary to facilitate corrective actions and the use of electronic tools are encouraged. In some WHO regions, such as the Africa Region, use of the electronic tool Esurv is required. Refer to Annex 8 of GPEI’s GPSAP for indicators that can be used to monitor supervisory visits.

10. Monitor surveillance performance and use data for action

- Monitor the performance of the surveillance system by regularly reviewing the NPAFP rate, stool adequacy, and process indicators to identify and correct surveillance gaps that negatively affect poliovirus detection. For example, delays in notification from health facilities to public health, and delays in specimen transport from point of collection to the national laboratory. Refer to WHO’s Vaccine-Preventable Disease Surveillance Standards for indicators and calculations.³
- Assess the demographic characteristics of reported AFP cases to investigate potential gaps in surveillance, including age, member of a special population (if documented), and accessibility status of residence. For example, a larger percentage of male AFP cases or no AFP cases reported from inaccessible areas suggest that surveillance is not capturing all children in all areas. Findings should be investigated to identify the reason(s) and corrective steps taken to address them, such as sensitization (refer to Section I.A).
- Regularly monitor the epidemiology of the outbreak to inform outbreak response efforts, including age distribution of polio cases, geographic distribution of polio cases, and clusters of AFP cases that may suggest

undetected poliovirus circulation. Findings may suggest a need to expand vaccination campaigns demographically and geographically.

11. Prioritize investigation of silent districts and provinces within outbreak-affected and polio high-risk areas

Immediately investigate the reasons for silent districts and provinces within outbreak-affected and polio high-risk areas, especially those with >50,000 children <15 years old because this represents a critical gap in poliovirus detection. Refer to the GPSAP 2018-2020 on recommended activities and corrective steps for silent districts.

12. Establish regular mechanisms of communication with AFP surveillance partners

Regular communication with local AFP surveillance partners such as other governmental groups, NGOs, key health facilities and key community leaders is a critical activity to maintain partner engagement and support.

- Establish regular surveillance review meetings (minimum every two weeks) to discuss how to further optimize surveillance performance, including challenges and possible solutions. Meetings should include representatives from groups who are engaged in AFP surveillance within the jurisdiction.
- Provide regular feedback (preferably weekly) to colleagues in the field on surveillance activities as well as the larger outbreak response activities to keep them informed and knowledgeable on response efforts.

AFP CASE INVESTIGATION

13. Collect key information that may not be included in the AFP case investigation form

During polio outbreaks, the following information should be collected from all AFP cases nationwide to better understand the epidemiology of the outbreak (*if not already routinely collected*):

- Recent travel history of AFP case and household members (e.g., location, dates, people met)
 - visitors before and after the paralysis onset date
 - polio vaccination received from routine immunization documented separately from campaign vaccination
 - date(s) of mOPV2 and nOPV2 vaccination was received
- Countries planning to use nOPV2 should refer to *GPEI's field and laboratory surveillance requirements in the context of nOPV2* for specific modifications to the AFP case investigation form.⁵

14. Verify that AFP contact sampling for all AFP cases with inadequate stool specimens is conducted and consider expanding AFP contact sampling for all AFP cases in certain outbreak and polio high risk settings

Verify that the globally recommended practice of AFP contact sampling for *all AFP cases with inadequate stool specimens* is being conducted throughout the country

- During outbreaks, AFP contact sampling may be expanded to **all** AFP cases (i.e., AFP cases with adequate and inadequate stool specimens collected). Refer to *GPEI's Job Aid: Use of AFP contact sampling* for further details on expanding AFP contact sampling during outbreaks.⁶ *Note: any decision to expand AFP contact sampling should be made in close coordination and collaboration with national surveillance and laboratory personnel.*

15. Prioritize completion of 60-day follow-up investigations for AFP cases with inadequate stool specimens

The practice of conducting 60-day follow-up investigations varies from country to country. During outbreaks, prioritization should be given to AFP cases with inadequate stool specimens collected to enable the quick review and final classification of pending AFP cases by the National Expert Review Committee or equivalent committee.

I.A Sensitization Activities as part of AFP surveillance

1. Conduct re-fresher trainings on polio and polio surveillance for surveillance officers and teams

Formal trainings that include practical, hands-on exercises are encouraged and resources are available through WHO country, regional, and national offices. However, informal trainings such as sensitization during supervisory visits should also be conducted to make sure there is a knowledgeable workforce until a formal training can be conducted.

2. Conduct AFP surveillance sensitization activities among healthcare providers

Awareness of healthcare providers to report the **syndromic acute flaccid paralysis** and **not the diagnosis of polio** is essential. In addition to conducting formal sensitization activities, it is important to use every interaction, including active surveillance visits and other meetings, to continue to increase awareness of AFP, polio, and the need for immediate reporting to public health. Provide posters, job aids, and list of phone numbers for easy reference materials and include sensitization activities for medical professional networks, too.

3. Conduct polio and AFP surveillance sensitization activities among communities

During outbreaks, increasing awareness among community members who serve as polio volunteers, community informants, and community health workers, as well as community leaders and the broader community, is an important and effective way to increase AFP reporting. However, this supplements health-facility based surveillance and efforts for detecting AFP cases through sensitization of healthcare providers and active surveillance should be the primary focus.

- In outbreak-affected and polio high-risk areas in which a formal, structured community-based surveillance system operates because health facility-based surveillance cannot or is not functioning, prioritize sensitization of these communities and associated volunteers before other communities.

4. Conduct polio and AFP surveillance sensitization activities among governmental and non-governmental organizations and engage their support

Other governmental groups or non-governmental organizations (NGOs) may provide health-related and other services (e.g., housing, veterinary) to communities and special populations, such as refugee camps, so it is important that they are made aware of the outbreak and engaged to support efforts to detect and report AFP cases. Furthermore, some groups may have established relationships or access to certain geographic areas that the government does not. Their support and engagement in reporting AFP cases can extend the reach of polio surveillance in the country.

II. Environmental Surveillance

A *Standard Operating Procedures (SOP) for polio environmental surveillance (ES) enhancement following investigation of a poliovirus event or outbreak* is available on the GPEI website.⁷ Refer to the SOP for detailed steps to be taken as part of outbreak response activities; the two primary activities as listed on pages 4-5 are:

1. Determine the adequacy of existing ES sites
2. Identify high-risk areas for ES expanding during an outbreak, including ad hoc ES sites

Note that oversight and management of ES varies from country to country but at a minimum, all discussions about ES should include both surveillance and laboratory personnel to ensure discussions on the need and ability to collect, transport, and test ES samples includes key relevant groups.

III. Laboratory Surveillance

1. Establish regular, ongoing communication mechanisms among surveillance and laboratory personnel at all levels

Increased storage and testing of stool specimens and sewage samples can overwhelm laboratory resources and staff if advance notification is not provided for planning. It is critical for surveillance and laboratory personnel to routinely communicate with one another, at a minimum weekly, on the changing demand for laboratory resources. Routine communication is also critical for data harmonization.

2. Prioritize testing of stool specimens and sewage samples from outbreak-affected and polio high-risk areas

Testing of stool specimens and sewage samples from outbreak-affected and polio high-risk areas should be prioritized as results will 1) inform the need for additional vaccination campaigns in the outbreak-affected area should poliovirus continue to be detected after completion of planned vaccination campaigns, and 2) guide expansion of the zone of outbreak response if poliovirus is detected in high-risk areas. Surveillance officers should indicate on stool specimen and sewage sample submission forms that these should be prioritized for testing and laboratory personnel should put these at the top of the queue for testing.

3. Verify that stool specimens and sewage samples are collected as recommended and reverse cold chain is maintained from point of collection to arrival at a WHO-accredited laboratory

Isolation of poliovirus is essential to confirm polio diagnosis in an AFP case and poliovirus transmission in a community. Make sure supplies to collect, store, and transport stool specimens and sewage samples can meet the increased demand for testing. Maintaining reverse cold chain optimizes isolation of poliovirus therefore efforts should be taken to verify that reverse cold chain is maintained throughout the surveillance system, especially samples from remote or difficult to access areas within outbreak-affected and high-risk areas.

4. Adjust stool and sewage sample transport networks, as necessary, to ensure a well-coordinated and rapid delivery system is maintained

The effect of the COVID-19 pandemic on the movement of population and goods has steadily improved but bottlenecks persist. Surveillance and laboratory personnel should work together to identify and investigate any bottleneck issues, and identify alternative transport means and routes to get samples to the laboratory as soon as possible. This may necessitate engaging new partners to use their transport network.

5. Ensure laboratory resources are available to meet the demand of increased testing, and have a contingency plan available just in case it cannot

During the early phase of an outbreak, laboratory personnel and resources (e.g., personnel, reagents, supplies, etc.) may be able to handle the increased workload. However, the tipping point can come quickly when demand for testing outweighs available laboratory capacity. Ensure that a contingency plan for testing samples is available and can be readily implemented, if necessary.

IV. Additional Considerations

1. Polio surveillance should be strengthened ahead of novel oral poliovirus vaccine type 2 (nOPV2) use

Until nOPV2 meets WHO's vaccine prequalification criteria, use of the new nOPV2 will only be permitted when certain criteria are met, including polio surveillance. Refer to the GPEI's field and laboratory surveillance requirements in the context of nOPV2 use for detailed information on the polio surveillance criteria in

preparation for nOPV2 use as well as after nOPV2 use.⁵ General information about nOPV2 can be found on the GPEI website (<https://polioeradication.org/nopv2/>).

2. Targeted healthy children stool sampling has limited use for strengthening polio surveillance

Targeted healthy children stool sampling (THCSS) is of limited use once a polio outbreak is confirmed because it is most useful in confirming community-wide transmission (i.e., outbreak).⁶ THCSS may be considered for children coming from inaccessible areas where poliovirus transmission is occurring.² However, it is not recommended as part of overall efforts to strengthen surveillance performance and in particular, THCSS is **not recommended** during investigations of silent districts and provinces. *Note: any decision to conduct THCSS should be made in close coordination and collaboration with national surveillance and laboratory personnel.*

3. Include surveillance updates in the national Polio Outbreak Situation Report (SitRep)

Include up-to-date surveillance information in the SitRep, using maps and figures to quickly orient key individuals on the scope of the outbreak and surveillance performance. Interpretation of findings as well as next steps on any corrective actions should be documented.

4. Prepare for GPEI's Outbreak Response Assessment (OBRA)

Surveillance staff at the national-level, and selected provincial and district surveillance teams within the outbreak-affected and polio high-risk areas, should be prepared to provide a comprehensive summary of polio surveillance performance as part of GPEI's Outbreak Response Assessments (OBRA).⁸ When closing a polio outbreak, it is vital to assess and determine that the overall polio surveillance system is of high quality such that the absence of virus detection indicates interruption of virus transmission, and not the inability to detect virus. An outbreak cannot be closed if the polio surveillance system is deemed not sensitive.

References

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Annex 1. Checklist of Poliovirus Surveillance Strengthening Activities during a Poliovirus Outbreak

I. AFP SURVEILLANCE

- Immediately notify surveillance and laboratory personnel upon polio outbreak confirmation
- Increase the annualized target for the NPAFP rate to > 3 per 100,000 children <15 years old per year
- All districts and provinces should review and update (if necessary) their polio surveillance reporting network, including prioritization of reporting sites for active surveillance visits
- Ensure **prospective** active surveillance visits are conducted regularly and monitored nationwide
- Ensure that passive surveillance is performing optimally
- Conduct facility-based, ad hoc active case searches to identify any unreported AFP cases
- Use all engagement opportunities to conduct community-based, ad hoc active case searches to identify unreported AFP cases
- Verify that special populations within the outbreak-affected and high-risk areas are included in surveillance activities and implement tailored approaches as necessary
- Ensure supportive supervision and monitoring of surveillance officers is conducted
- Monitor surveillance performance and use data for action
- Prioritize investigation of silent districts or provinces within the outbreak-affected or high-risk areas
- Establish regular review meetings among AFP surveillance partners

AFP case investigation

- Collect key information that may not be included in the AFP case investigation form
- Verify that AFP contact sampling for all AFP cases with inadequate stool specimens is conducted and consider expanding AFP contact sampling for all AFP cases in certain outbreak and polio high risk settings
- Prioritize completion of 60-day follow-up investigations for AFP cases with inadequate stool specimens

I.A SENSITIZATION ACTIVITIES

- Conduct re-fresher trainings on polio and polio surveillance for surveillance officers and teams
- Conduct AFP surveillance sensitization activities among healthcare providers
- Conduct polio and AFP surveillance sensitization activities among communities
- Conduct polio and AFP surveillance sensitization activities among governmental and non-governmental organizations and engage their support

II. ENVIRONMENTAL SURVEILLANCE

- Determine the adequacy of existing ES sites
- Identify high-risk areas for ES expansion during an outbreak, including ad hoc ES sites

III. LABORATORY SURVEILLANCE

- Establish regular, ongoing communication mechanisms among surveillance and laboratory personnel at all levels
- Prioritize testing of stool specimens and sewage samples from outbreak-affected and polio high-risk areas
- Verify that stool specimens and sewage samples are collected as recommended and reverse cold chain is maintained from point of collection to arrival at a WHO-accredited laboratory
- Adjust stool and sewage sample transport networks, as necessary, to ensure a well-coordinated and rapid delivery system is maintained
- Ensure laboratory resources are available to meet the demand of increased testing, and have a contingency plan available just in case it cannot

IV. ADDITIONAL CONSIDERATIONS

- Polio surveillance should be strengthened ahead of novel oral poliovirus vaccine type 2 (nOPV2) use
- Targeted healthy children stool sampling has limited use for strengthening polio surveillance
- Include surveillance updates in the national Polio Outbreak Situation Report (SitRep)
- Prepare for GPEI's Outbreak Response Assessment (OBRA)s

Annex 2. Further details on recommended surveillance activities

Section I.3: All districts and provinces should review and update (if necessary) their polio surveillance reporting network, including prioritization of reporting sites for active surveillance visits

Prioritization of reporting sites for active surveillance visits is based on sites (e.g., facilities) that are most likely to provide care for AFP patients. Additional prioritization criteria may be recommended by the WHO regional and national offices, such as proximity to inaccessible areas and a site located within a high-risk population, such as a refugee camp. The frequency of active surveillance visits reflects the priority classification of the reporting site. For example, high priority sites are often major hospitals, large pediatric clinics, and physiotherapy centers and are therefore recommended for weekly active surveillance visits. The table to the right is a recommended classification tier and corresponding frequency of active surveillance visits. Of note, active surveillance is key to timely detection of AFP cases and is complemented by **passive surveillance by all reporting sites**. The last row in the table reflects the absence of active surveillance visits for a subset of reporting sites and reliance on passive surveillance, which may be classified as “Zero-reporting” by countries.

Priority classification	Frequency of visits
High	Weekly
Medium	Every 2 weeks
Low	Monthly
Passive surveillance/ Zero-reporting	No active surveillance

Section I.6 Conduct facility-based, ad hoc active case searches to identify any unreported AFP cases

The figure below summarizes activities to be taken for unreported AFP cases that are identified. Refer to Annex 4 in GPEI’s GPSAP 2018-2020 for more details on facility-based, ad hoc active case searches.²

