Welcome!

We will begin at 6 am PST/9 am EST/3 pm CET
Welcome to the Polio Partners Group Meeting
16 December 2021 from 15:00-17:30 CET

As you join the meeting

- Please ensure you are muted unless speaking to avoid background noise
- So that we know who is who, please make sure your name follows the ‘ORGANIZATION / FIRST NAME LAST NAME’ naming convention.
  - To change your name, click on the “Participants” button at the top of the Zoom window.
  - Next, hover your mouse over your name in the “Participants” list on the right side of the Zoom window. Click “Rename.”
  - Enter your ‘ORGANIZATION / FIRST NAME LAST NAME’ (e.g., “WHO / John Doe”) and click “OK.”

During the meeting

- **Use the chat feature** to ask questions and communicate with your fellow participants. You can make your questions “to everyone” or send them privately to the Moderator.
- **Use the raise your hand button, if you’d like to ask a question**
  - Click on the icon labelled “Participants” at the bottom centre of your screen
  - At the bottom of the window on the right side of the screen, click the button labelled “Raise hand”
  - If you want to lower your hand, lower it by clicking on the same button, now labelled “Lower hand”
Polio Partners Group Meeting Agenda
(all times in Central European Time)

15:00 – 15:05: Welcome and introductory remarks (PPG Co-Chairs, Henrietta Fore, Steven Lauwerier) – 10 minutes


15:25 – 16:00: Supporting Polio Eradication and Strengthening Surveillance at the County Level (Ellyn Ogden and Lee Losey) + Discussion – 35 minutes

16:00 – 16:10: Health break – 10 minutes

16:10 – 16:25: Programmatic and strategic updates (Ebru Ekeman & Kate O’Brien) – 15 minutes

16:25 – 16:40: Programmatic and strategic updates (Sir Liam Donaldson) – 15 minutes

16:40 – 17:20: Discussion – 40 minutes

17:20 – 17:30: Closure of meeting (PPG Co-Chairs) – 10 minutes
Video from ED Fore
Presentations
Delivering on a Promise
Polio Eradication Strategy 2022-2026

Polio Eradication Update
16 December 2021
Goal One milestones for interrupting poliovirus transmission in Afghanistan and Pakistan

**Afghanistan**
- Intensified negotiation efforts to gain access
- Continued implementation of complementary approaches to vaccination in inaccessible areas
- High-quality delivery monitored and maintained in both accessible and inaccessible areas
- Continued long-term strengthening of immunization systems
- Rigorous review of the 2025–2026 Strategy
- Beginning of the programme’s transition planning for certification (2024–2026)

**Strategy milestones**

- **2021**
  - Wider use of nOPV2

- **2022**
  - Implement programmatic improvements:
    - Changes to frontline team management
    - New approaches for inclusive engagement for priority communities
    - Systematic, consistent dialogue with provincial leadership

- **2023**
  - Mechanisms in place for equitable E1 access and OPV co-delivery through integrated services
  - Widespread transmission limited to only core reservoirs

- **2024**
  - Interruption of WPV1 transmission and last cVDPV2 isolate reported

- **2025**
  - Rigorous review of the 2025–2026 Strategy
  - National and provincial governments own and are accountable for polio eradication and certification implications

- **2026**
  - Beginning of the programme’s transition planning for certification (2024–2026)
  - Certify the eradication of WPV1

**Pakistan**
- Final, sporadic chains of transmission eliminated

**Joint milestones**
- Final, sporadic chains of transmission eliminated
• Nationwide polio campaign conducted in November – *outstanding accomplishment with no security incidents and communities very supportive of vaccination*

• Reached 2.4 million children who were inaccessible for more than three years

• The recent campaign gives confidence to prepare well for the December round to be synchronized with Pakistan and implemented in best possible modality

• This campaign is a massive step in the right direction; however, we need to sustain and step-up efforts to prevent a resurgence of polio and the likelihood of international spread.
Highlights of PCM Nov. NIDs Afghanistan

- Nov. 2021 SIAs in AFG is an encouraging development, that marks the first nationwide campaign in about 3 years
  - 2.4 million inaccessible children reached for the first time since early 2018
- Post campaign assessment in 399 Districts, across AFG
  - 206 (52%) implemented SIAs by H2H strategy; 193 (48%) implemented by M2M strategy
  - Among 182 M2M districts for which PCM data is available, only 14% were assessed to have 90% or higher coverage
  - Among 98 H2H districts for which PCM data is available, 93% were assessed to have 90% or higher coverage
  - Both core reservoir regions (East & South) implemented by M2M modality; 16% & 4% districts could reach 90% coverage mark, respectively
- Following the recent WPV-1 detection, heightened focus on Kunduz province yielded good results through H2H strategy
  - 6/7 districts achieved >90% coverage (one district 89%)
- PCM analysis shows that overall coverage achieve through M2M modality is much lower than what’s required to stop poliovirus transmission
  - This underscores the importance of expanding H2H strategy for future campaigns
Goal Two milestones for interrupting cVDPV transmission in outbreak and at-risk countries
Global WPV1 & cVDPV Cases\(^1\), Previous 12 Months\(^2\)

WPV1 cases (latest onset)
- Afghanistan 4 11-Nov-21
- Pakistan 1 27-Jan-21

cVDPV1 cases (latest onset)
- Madagascar 11 22-Aug-21
- Yemen 5 27-Mar-21

cVDPV2 cases (latest onset)
- Nigeria 308 20-Oct-21
- Cameroon 3 11-Oct-21
- Ukraine 1 03-Sep-21
- Yemen 2 01-Sep-21
- Senegal 16 22-Aug-21
- Niger 5 19-Aug-21
- Ethiopia 12 16-Jul-21
- Guinea-Bissau 3 15-Jul-21
- Afghanistan 69 09-Jul-21
- DR Congo 12 27-Jun-21
- Tajikistan 32 26-Jun-21
- Burkina Faso 2 09-Jun-21
- Liberia 3 28-May-21
- Somalia 1 12-May-21
- Benin 3 08-May-21
- Pakistan 10 23-Apr-21
- South Sudan 12 08-Apr-21
- Guinea 6 01-Apr-21
- Sierra Leone 10 28-Feb-21
- Congo 2 10-Feb-21
- Mali 4 23-Dec-20
- Sudan 2 18-Dec-20

Endemic country (WPV1) \(^1\)Excludes viruses detected from environmental surveillance; \(^2\)Onset of paralysis 08 Dec. 2020 to 07 Dec. 2021
Global WPV1 & cVDPV Cases\(^1\), Previous 6 Months\(^2\)

Endemic country (WPV1)

\(^1\)Excludes viruses detected from environmental surveillance; \(^2\)Onset of paralysis 08 Jun. 2021 to 07 Dec. 2021

Data in WHO HQ as of 07 Dec. 2021
Global, post switch cVDPV2 trend between 2016-2021
Outcome of implemented outbreak responses in Nigeria

• After 2 rounds of nOPV2 responses:
  – cVDPV2 transmission **not detected in 14 states**
  – Continued **transmission in 7 seven states**

• Peculiarities in areas with continued transmission:
  – **Persistent low quality** of response rounds **with data falsification**
  – **Intense transmission** before implementation of the outbreak responses
  – **Huge population movements** and migratory patterns
  – **Weak oversight (political and technical)** during preparedness and implementation
Next Steps following roundtable on 18-19 November

• **Conduct planned outbreaks responses:**
  - Immediate **localized nOPV2 responses** from 1 – 3 Dec. 2021 using available vaccines in country
  - Additional **two nOPV2 response rounds** from 14 – 17 Dec. 2021; and 14 – 17 Jan. 2022

• **Boosting population** immunity through:
  - Phased **fIPV +bOPV rounds** from Feb. – May 2022
  - Introduction of **second dose IPV** through routine immunization

• Mobilize resources to **re-instate human resource surge capacity** to fully implement the planned activities
## nOPV2 responses: authorized pending implementation

<table>
<thead>
<tr>
<th>Country</th>
<th>Response zone</th>
<th>Date of Outbreak/Breakthrough Confirmation</th>
<th>Date country Verified for nOPV2 use</th>
<th>Dose Release approval date</th>
<th>Planned R1</th>
<th>Duration till dose release (Ideally &lt; 7)</th>
<th>Duration till planned first round (Ideally &lt; 28 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uganda</td>
<td>Whole Country</td>
<td>21-Jul-21</td>
<td>6-Jul-21</td>
<td>10-Aug-21</td>
<td>14- Jan 22</td>
<td>20</td>
<td>177</td>
</tr>
<tr>
<td>Egypt</td>
<td>Whole Country</td>
<td>25-Jun-21</td>
<td>16-Aug-21</td>
<td>7-Sep-21</td>
<td>5-Dec-21</td>
<td>74</td>
<td>163</td>
</tr>
</tbody>
</table>

Ethiopia R2 remain uncertain due to insecurity
Pending responses, decision made to use Sabin OPV2  
(As of 01 December 2021)

<table>
<thead>
<tr>
<th>Country</th>
<th>Date of Outbreak/Breakthrough Confirmation</th>
<th>Duration since confirmation till today</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ukraine</td>
<td>05-Oct-21</td>
<td>57+</td>
<td>Use of mOPV2/tOPV under discussion</td>
</tr>
<tr>
<td>Somalia</td>
<td>06-Oct-21</td>
<td>56+</td>
<td>mOPV2 authorized by DG</td>
</tr>
<tr>
<td>Yemen (cVDPV2)</td>
<td>22-Nov-21</td>
<td>9+</td>
<td>tOPV authorized by DG</td>
</tr>
</tbody>
</table>
### Pending responses waiting for nOPV2 Readiness Verification/Vaccine Availability  As of 01 December 2021

<table>
<thead>
<tr>
<th>Country</th>
<th>Date of Outbreak/Breakthrough Confirmation</th>
<th>Date country Verified for nOPV2 use</th>
<th>Duration since confirmation till today</th>
<th>Expected delay till nOPV2 become available (end Q1 2022)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>24-May-21</td>
<td>01-Oct-21</td>
<td>191+</td>
<td>311</td>
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<tr>
<td>Guinea Bissau</td>
<td>22-Oct-21</td>
<td>Pending</td>
<td>40+</td>
<td>160</td>
</tr>
<tr>
<td>DRC</td>
<td>26-Oct-21</td>
<td>25-Jun-21</td>
<td>36+</td>
<td>156</td>
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<tr>
<td>Niger</td>
<td>27-Oct-21</td>
<td>28-Apr-21</td>
<td>35+</td>
<td>155</td>
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<tr>
<td>Cameroon</td>
<td>28-Oct-21</td>
<td>12-Oct-21</td>
<td>34+</td>
<td>154</td>
</tr>
<tr>
<td>Nigeria (middle belt states)</td>
<td></td>
<td>12-Feb-21</td>
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</tbody>
</table>
Preparations for nOPV2 use are completed or ongoing in 85% of countries at high-risk for cVDPV2s

62% are verified for nOPV2; and 23% are in the midst of preparing
**Global stockpile balance after WHO DG release is – 100,821,500 doses**

**nOPV2**

**Overview of stock levels based on WHO DG**

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<tbody>
<tr>
<td>Stockpile replenishment</td>
<td>35,671,000</td>
<td>21,742,500</td>
<td>39,600,000</td>
<td>75,600,000</td>
<td>64,800,000</td>
<td>46,800,000</td>
<td>54,000,000</td>
<td>82,800,000</td>
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<td>Released by ORPG</td>
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<td>Egypt R1</td>
<td>20,800,000</td>
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<td>Nigeria R1</td>
<td>28,847,500</td>
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<td>DG authorised pending ORPG distribution</td>
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<td>Uganda R2</td>
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<td>Ethiopia R2</td>
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<tr>
<td>Egypt R2</td>
<td>20,800,000</td>
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<td>Senegal R2</td>
<td>3,505,000</td>
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<td>Gambia R2</td>
<td>480,000</td>
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<tr>
<td>Mauritania R2</td>
<td>1,000,000</td>
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<td>Nigeria R2</td>
<td>28,847,500</td>
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<tr>
<td>Total authorised by DG</td>
<td>86,845,000</td>
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<tr>
<td>Balance after ORPG Release</td>
<td>35,671,000</td>
<td>-13,976,500</td>
<td>7,766,000</td>
<td>47,366,000</td>
<td>122,966,000</td>
<td>187,766,000</td>
<td>234,566,000</td>
<td>288,566,000</td>
<td>288,566,000</td>
<td>371,366,000</td>
</tr>
</tbody>
</table>

**nOPV2 weekly release schedule:**

- Week of 29th November – 21,742,500 doses
- Week of 6th December – 32,400,000 doses
- Week of 27th December – 7,200,000 doses
Global stockpile balance after WHO DG release is 225,933,400 doses

<table>
<thead>
<tr>
<th>mOPV2</th>
<th>Nov</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
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<tbody>
<tr>
<td></td>
<td>Stockpile replenishment</td>
<td>107,744,200</td>
<td>37,803,400</td>
<td>10,000,000</td>
<td>10,000,000</td>
<td>10,000,000</td>
<td>20,000,000</td>
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<td></td>
<td></td>
<td>20,000,000</td>
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<tr>
<td>Country Requests</td>
<td>225,933,400</td>
<td>333,677,600</td>
<td>333,677,600</td>
<td>371,481,000</td>
<td>371,481,000</td>
<td>371,481,000</td>
<td>381,481,000</td>
<td>391,481,000</td>
<td>401,481,000</td>
<td>401,481,000</td>
<td>421,481,000</td>
</tr>
</tbody>
</table>
### tOPV Overview of actual stock levels based on WHO DG

Global stockpile balance after WHO DG release is 4,358,000 doses

<table>
<thead>
<tr>
<th>tOPV</th>
<th>Stockpile Balance 18 Nov</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
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</thead>
<tbody>
<tr>
<td>Stockpile replenishment</td>
<td>15,332,000</td>
<td>34,800,000</td>
<td>33,350,000</td>
<td>33,350,000</td>
<td>5,800,000</td>
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<tr>
<td><strong>Country Requests</strong></td>
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<tr>
<td>Pakistan</td>
<td>-</td>
<td>2,033,000</td>
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<tr>
<td>Afghanistan</td>
<td>-</td>
<td>11,700,000</td>
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<tr>
<td><strong>Balance after DG</strong></td>
<td><strong>18,091,000</strong></td>
<td><strong>19,690,000</strong></td>
<td><strong>54,490,000</strong></td>
<td><strong>87,840,000</strong></td>
<td><strong>121,190,000</strong></td>
<td><strong>126,990,000</strong></td>
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</table>
2022 budget prioritization table

<table>
<thead>
<tr>
<th>Line</th>
<th>Category</th>
<th>Geography</th>
<th>Function</th>
<th>2022 critical activities w/indirect cost</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Endemics¹</td>
<td>Pakistan</td>
<td>SIAs, surveillance, integration, EOC</td>
<td>$251</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Endemics¹</td>
<td>Afghanistan</td>
<td>SIAs, surveillance, integration, EOC</td>
<td>$70</td>
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<tr>
<td>C</td>
<td>Immunization</td>
<td>Non-endemics</td>
<td>Outbreak response</td>
<td>$168</td>
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<tr>
<td>D</td>
<td>Vaccines</td>
<td>Global</td>
<td>Vaccine procurement for outbreaks (nOPV2)</td>
<td>$88</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Surveillance, Infrastructure</td>
<td>AFRO 10 + Somalia</td>
<td>TA (surv + non-surv), surv running costs, labs</td>
<td>$83</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Surveillance</td>
<td>Global</td>
<td>Lab - expand sequencing, direct detection</td>
<td>$10</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Surveillance</td>
<td>HQ &amp; RO</td>
<td>Surveillance TA, running costs, labs</td>
<td>$48</td>
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<tr>
<td>H</td>
<td>Infrastructure</td>
<td>HQ &amp; RO</td>
<td>Non-Surveillance TA</td>
<td>$45</td>
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<tr>
<td>I</td>
<td>Gender (Infrastructure)</td>
<td>Global</td>
<td>Gender mainstreaming strategy/activities TBD</td>
<td>$7</td>
<td>$771</td>
</tr>
<tr>
<td>J</td>
<td>Immunization</td>
<td>Non-endemic Higher risk</td>
<td>bOPV campaigns (Q1/Q2 multi-antigen or stand alone)</td>
<td>$33</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Community Engagement (Immunization)</td>
<td>Nigeria + Somalia</td>
<td>Social mobilization network</td>
<td>$9</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Infrastructure</td>
<td>AFRO 10 + Somalia</td>
<td>EOCs</td>
<td>$3</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Immunization</td>
<td>RO</td>
<td>Digital Tools/Tracking</td>
<td>$3</td>
<td>$819</td>
</tr>
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<td>N</td>
<td>Vaccines</td>
<td>Global</td>
<td>Vaccine procurement for outbreaks (nOPV2)</td>
<td>$35</td>
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<td>O</td>
<td>Immunization</td>
<td>Non-endemic Higher risk</td>
<td>bOPV campaigns (Q3/Q4 multi-antigen and stand alone)</td>
<td>$33</td>
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<tr>
<td>P</td>
<td>Immunization</td>
<td>Global</td>
<td>bOPV Buffer Stock</td>
<td>$26</td>
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</tr>
<tr>
<td>Q</td>
<td>Endemics</td>
<td>Afghanistan</td>
<td>SIAs, surveillance, integration</td>
<td>$19</td>
<td>$932</td>
</tr>
</tbody>
</table>

¹Budget set in line with historical implementation capacity

AFG budget to be closely monitored and adjusted based on need/ability to implement

Aligned with projected available resources
The Secretariat Model
Core Group Polio Project

Polio Partners Group Meeting
December 16, 2021
History of the CORE Group Polio Project

- Initiated to complement facility-based surveillance, reach children beyond the reach of government and UN services, build on networks of NGOs with experience in child survival and to streamline management in support of Polio Eradication.
- The Secretariat Model was launched in 1999 with grants to international and country-based national NGOs to support polio eradication.
- Currently working in Nigeria, India, Ethiopia, South Sudan, Kenya, Somalia, Uganda, and Niger
- Supports 40 sub-grants to NGOs working in the target countries
- Funded by primarily by USAID. BMGF co-funded efforts in South Sudan for nine years.
What are the key components of the Secretariat Model?

- Collaboration between networks of NGOs/Civil Society, government, UN Agencies and other Partners
- A network of international and national NGOs working in unison to support polio eradication or other health intervention
- Coordination of NGO partners by a central secretariat with a director and technical support team facilitating engagement with government
- Representation of NGO partners in National and Sub-National planning committees
- Two-way communication of national and global polio eradication strategies and policies to NGO partners to ensure a collaborative value added
- Fosters innovation and local problem solving
- Supervised engagement of NGOs/civil society in polio eradication following national guidelines assures capacity building and high quality
Overall Management Structure

- Small US-Based Management Team
  (Technical/Financial)
  1 Prime Funding Recipient

- Small Country Secretariat
- iNGOs
- Local NGOs

Simplified, cost-effective management and learning structure:

- Funder manages one agreement with the ‘prime’ recipient.
- Small, virtual, HQ team reduces costs.
- 90% of funding goes to program implementation.
- Cross-country learning
Collaboration And Innovation

- No lead NGO
- Transparent approach to budgets
- Neutral Secretariat
- Training uses more adult learning approaches, develops coaches and mentors, interactive
- Integrated programming
- Identify and reach zero-dose and under-immunized
- Unified training, supervision and
- Independent campaign monitoring
- Community-based surveillance
- Integrated Disease Surveillance One Health
- Focus on cross-border coordination
Community-Based Surveillance

- Network of Community Informants
- Unpaid key community members
- Adds Sensitivity in areas with weak facility-based surveillance or coverage
- Linked to the national systems for polio and in Ethiopia/Kenya/Nigeria/South Sudan GHSA and COVID
- AVADAR reporting system would facilitate CBS
Emphasis on High-Risk Areas and Local NGOs
Why invest in Community-Based Approaches?

* Reaches high-risk, hard-to-reach Communities
* Success at identify and tracking zero dose children and defaulters
* Increased efficiency and effectiveness in a large network of NGOs
* Early detection and response to polio and other diseases of public health importance.
* Innovation and local problem solving encouraged
* Trust of Communities
* Simplified and cost-effective strategy to receive, distribute and manage funding.
Discussion

Note: Gavi requirements of $122.2 million are not included in this slide
Health Break (10 minutes)

We will reconvene in:

00:10:00
Presentations
Polio Transition: A Strategic Overview

Ebru Ekeman
Polio Transition Team
Lead a.i
Progress

Some countries will completely transition out of GPEI in 2022. Programmatic integration in these countries facilitates transition.

Implementation of country plans underway, with lessons learned for the future (e.g. Angola, Bangladesh, India)

Countries are reviewing their plans to align with the COVID-19 context (e.g. Nigeria, Chad, South Sudan, Somalia)

“Integrated public health teams” are moving from concept to reality

Better coordination between GPEI and WHO governance structures

Close engagement of civil society

Strong M&E framework to ensure high programmatic performance
Challenges

COVID-19 continues to slow down efforts

Ongoing WPV and cVDPV circulation

National commitment and ownership

Sustainable financing (domestic and external)

Need for long term partner support in fragile and conflict-affected settings
Integration is an opportunity to reach and sustain eradication

Transferable skills of the polio workforce - demonstrated again during the pandemic response and COVID-19 recovery and vaccine rollout

GPEI support to 11 high risk countries needs to be a “bridge” to lay the grounds for transition

The mid-term review of the Strategic Action Plan is an opportunity to adapt to evolving context
How can the PPG help move forward the transition agenda?

1. **Support advocacy for action at country level**, with a focus on programmatic and financial sustainability

2. Provide **bilateral funding** to countries and implementing partners, and help **identify funding levers**

3. **Focus on the country voice** (e.g. invite a priority country to present at the PPG)

4. Facilitate **targeted and more intentional outreach** to CSOs
Integration as an opportunity to reach and sustain eradication

Dr Kate O’Brien
WHO Director, Department of Immunization, Vaccines and Biologicals
Focus on “zero dose children” in the core reservoirs is critical in this final phase of eradicating polio

Equity
Zero-dose children in most marginalized communities in different settings: *Urban, Remote Rural, Conflict*

Primary Healthcare
Zero-dose communities often have no regular health services

Health Security
Zero-dose children live in communities most vulnerable to outbreaks
Majority of “zero-dose” children live in countries prioritized for polio eradication / transition*

DTP3 coverage according to legend, bubbles sized to total population and number of un/under protected children

* Priority countries for polio eradication / transition are those included in the new GPEI Strategy (AFG, PAK, AFRO 10 and Somalia), along with the rest of the countries prioritized for polio transition (5 SEARO countries + Sudan)
Resumption of immunization activities for polio and other VPDs offer opportunities for integration

VPD campaigns postponed in 44 countries due to COVID-19, with 12 countries conducting multi-antigen campaigns, 1st December 2021

Angola, Brazil, CAR, DR Congo, Mexico, Nigeria, Pakistan, Philippines, Somalia, Sudan, Viet Nam and Zimbabwe have re-instated campaigns with multi-antigens.
The largest single MR catch-up campaign ever to be conducted – led to the protection of over 93 Mn children.

Over 31 Mn under-5s received co-delivery of bOPV.

Unprecedented coordination between EPI & Polio at national and sub-national level.

Integration can be further enhanced at lower levels, such as:

- Ensuring data sharing for developing micro-plans
- Field validation of micro-plans by polio staff, esp. addressing planning for high-risk populations
- Identifying and reaching persistently missed children using polio assets and community knowledge
High population immunity against polio is critical to sustain eradication

SIAs have been the main platform to increase population immunity against polio, especially in countries with weak or fragile health systems.

Moving forward, essential immunization needs to be strengthened to reach and sustain high coverage.

99 countries need to introduce IPV2. Of the 63 Gavi countries, so far only 9 have introduced IPV2.

Gavi Board will review IPV co-financing in 2022. Changes can have significant financial implications.

Availability of Hexa-IPV presents opportunities, but product and schedule changes could lead to programmatic risks.
Integration is a “two-way” street:

1) Polio networks have provided support to VPD surveillance and immunization services often going beyond polio.

2) Moving forward, sustainability of sensitive polio surveillance will necessitate integration with other VPDs.

Integration has progressed on different tracks in countries of the three priority regions.

VPD lab network and trained human resource capacity has been leveraged for COVID-19.

Global health security concerns have catalyzed greater synergies between the WHO programmes (WHE, IVB & POL), in collaboration with others (TB, HIV and external stakeholders).

A minimum of US$300 Million/year external funding will be needed in 2021-30 to strengthen surveillance (living estimate as new VPDs are added and/or new goals developed).

We have an opportunity to move from siloed to integrated surveillance to achieve multiple health objectives.
Through IA2030, we can take the necessary actions to reach and sustain global eradication, while strengthening immunization.

- Delivering comprehensive PHC services in targeted geographies
- Generating demand for vaccines through context-specific community engagement
- Reaching zero dose communities with targeted, gender sensitive delivery strategies
- Expanding integration through unified partnerships
- Using emergency capacities to stop cVDPVs and prevent future outbreaks
- Sustainable transition out of GPEI and other donor support
- Fostering research and programmatic innovations