

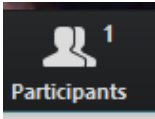
# Welcome!

We will begin at 6 am PST/9 am EST/3 pm CET

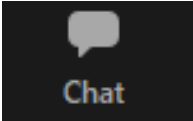
# Welcome to the Polio Partners Group Meeting

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*

**15:10 – 15:25:** Polio Eradication Situation Update (Aidan O’Leary) – *15 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



Rotary

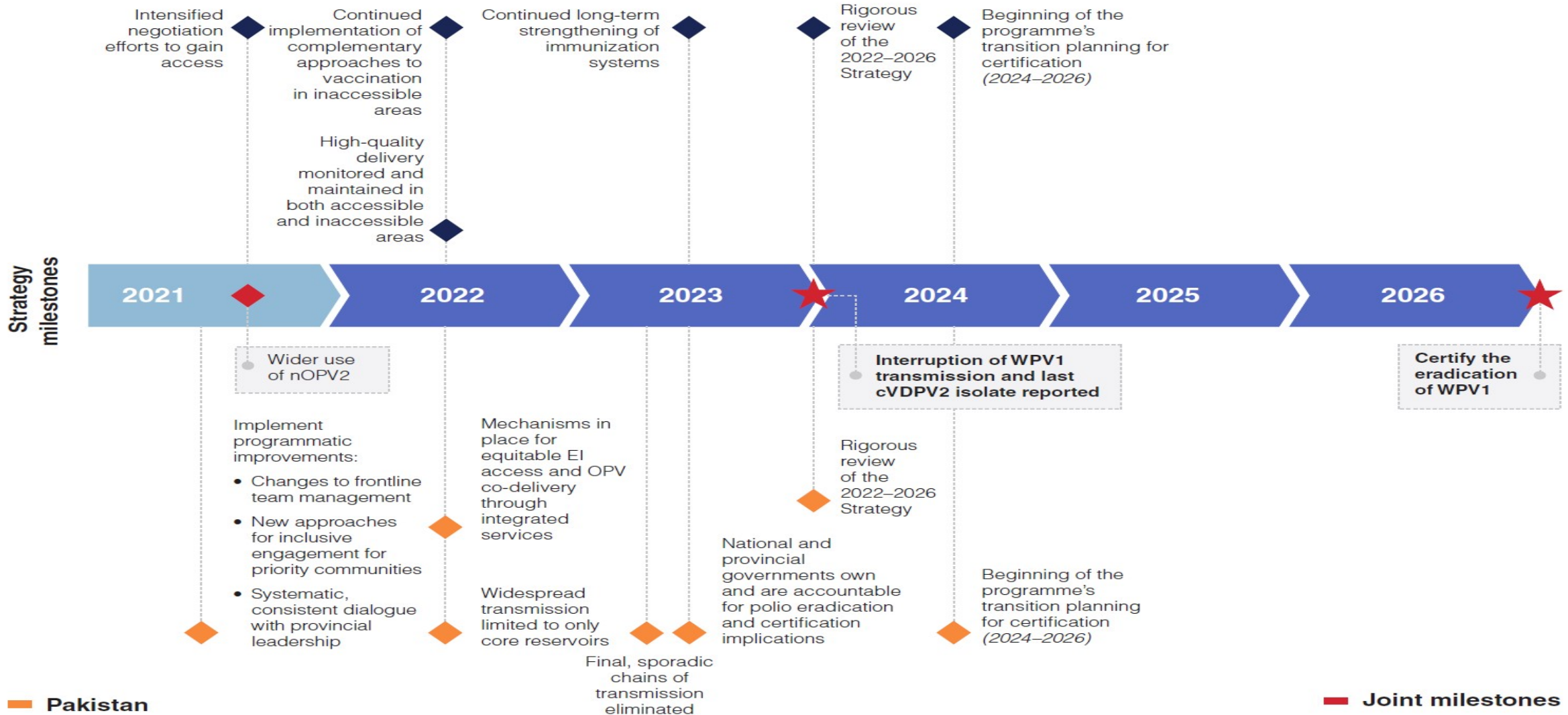


BILL & MELINDA  
GATES foundation



# Goal One milestones for interrupting poliovirus transmission in Afghanistan and Pakistan

## ■ Afghanistan

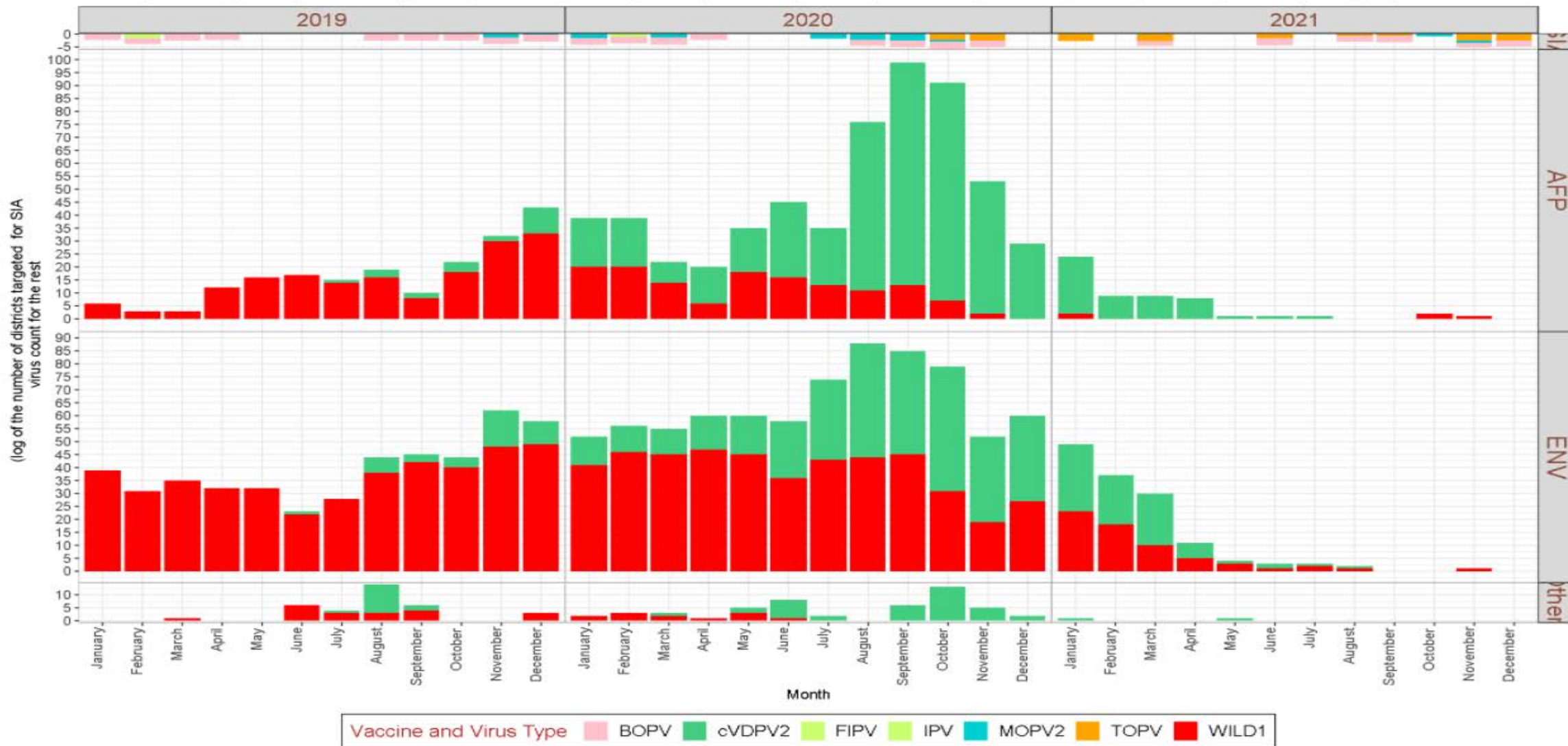


# Pakistan-Afghanistan

## Epi-Curve: AFP Cases, ENV, others(Human) and SIAs

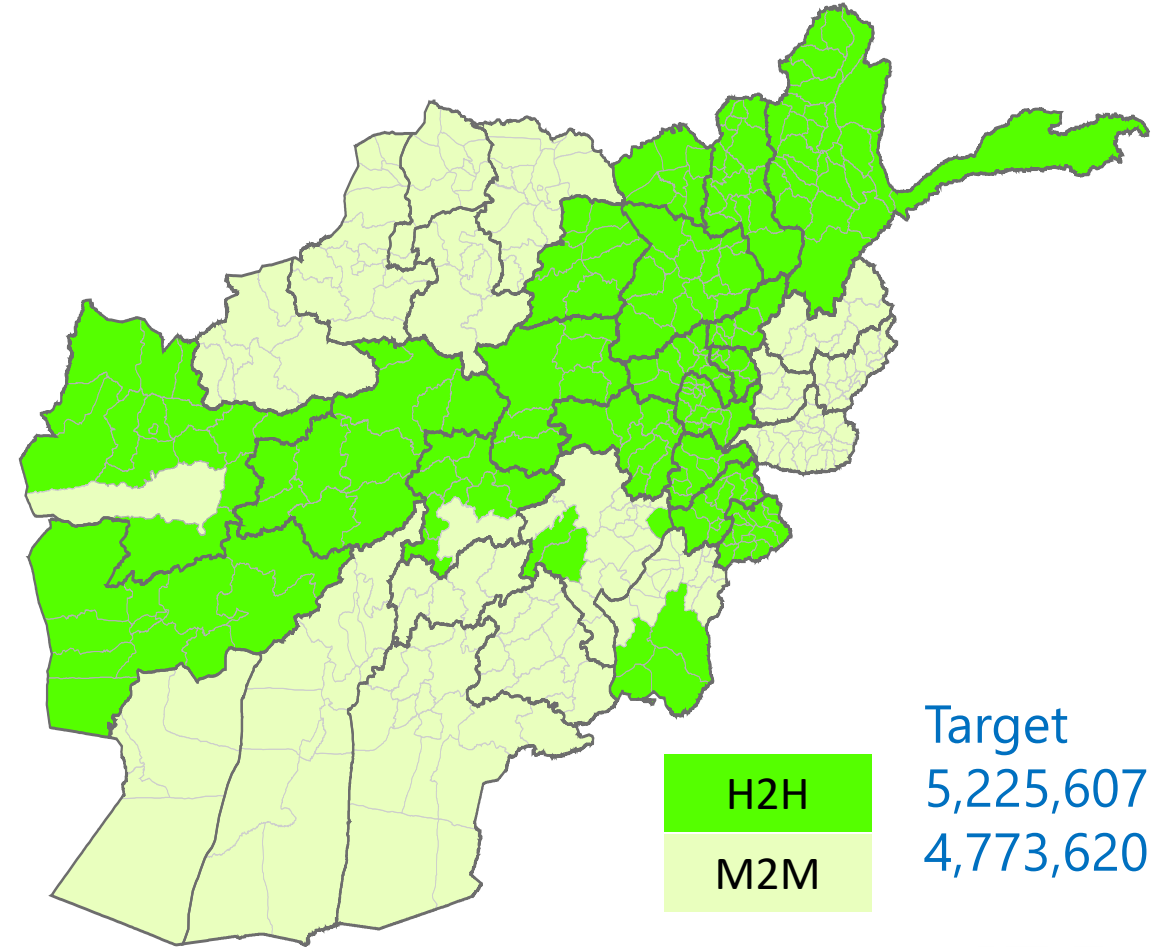
Country: AFGHANISTAN, PAKISTAN,

Province(s): BADAKHSHAN, BADGHIS, BAGHLAN, BALKH, BAMYAN, DAYKUNDI, FARAH, FARYAB, GHAZNI, GHOR, HILMAND, HIRAT, JAWZJAN, KABUL, KANDAHAR, KAPISA, KHOST, KUNAR, KUNDUZ, LAGHMAN, LOGAR, NANGARHAR, NIMROZ, NURISTAN, PAKTIKA, PAKTYA, PANJSHER, PARWAN, SAMANGAN, SAR-E-PUL, TAKHAR, URUZGAN, WARDAK, ZABUL, AJK, B





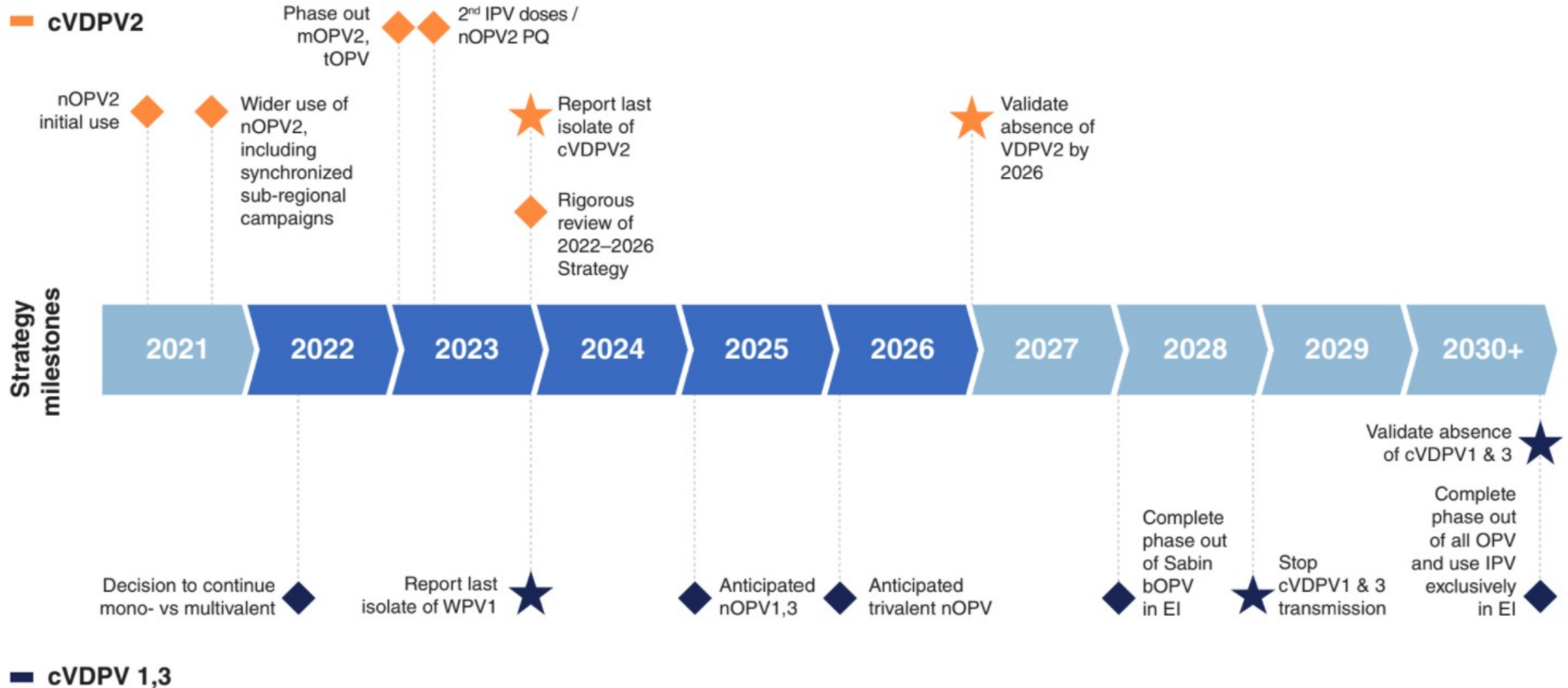
- Nationwide polio campaign conducted in November – *outstanding accomplishment with no security incidents and communities very supportive of vaccination*
- Reached 2.4 million children who were inaccessible for more than three years
- The recent campaign gives confidence to prepare well for the December 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.



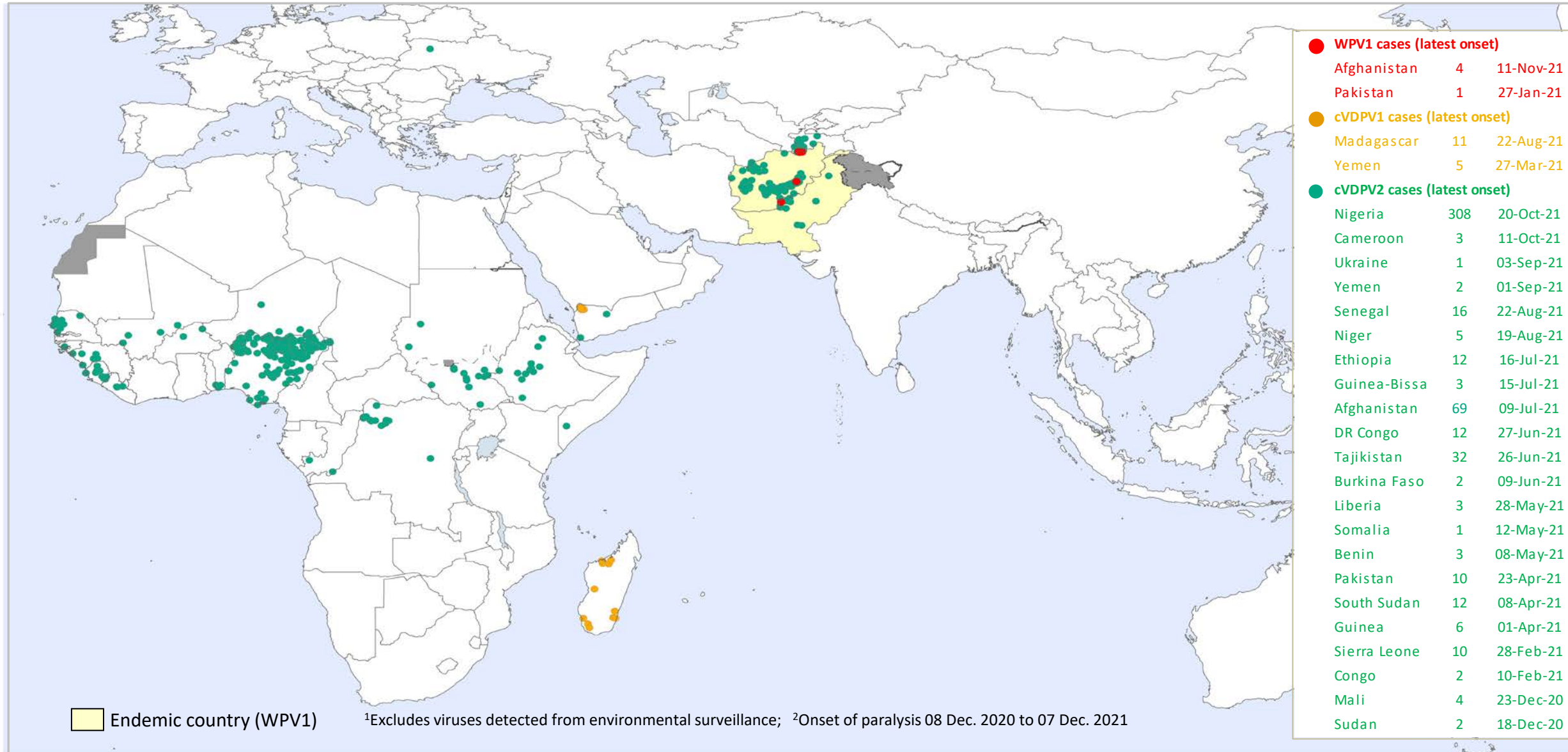
# Highlights of PCM Nov. NIDs Afghanistan

- 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 achieved 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

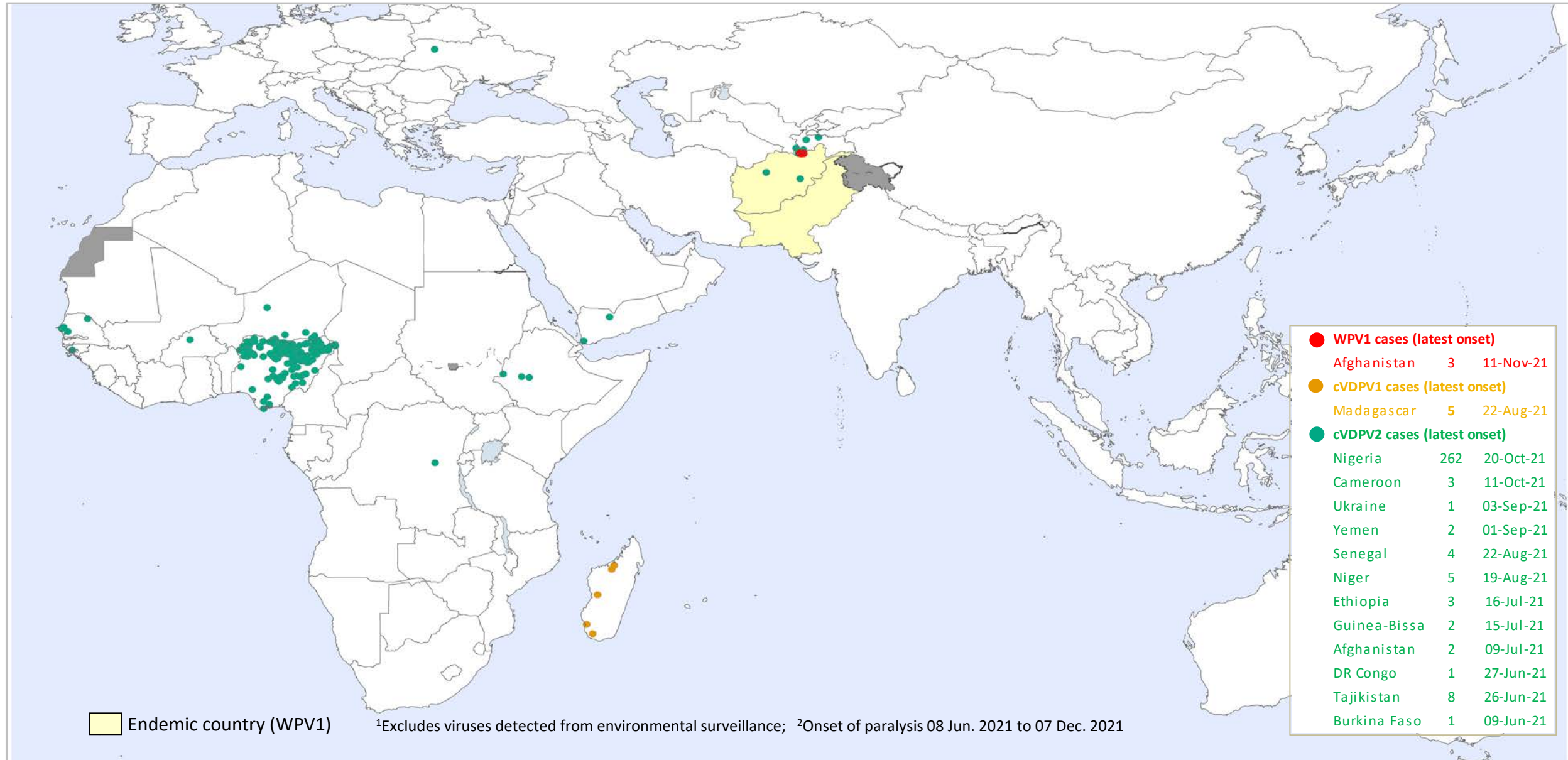
# Goal Two milestones for interrupting cVDPV transmission in outbreak and at-risk countries



# Global WPV1 & cVDPV Cases<sup>1</sup>, Previous 12 Months<sup>2</sup>



# Global WPV1 & cVDPV Cases<sup>1</sup>, Previous 6 Months<sup>2</sup>



<span style="color: red;">●</span>	<b>WPV1 cases (latest onset)</b>
Afghanistan	3 11-Nov-21
<span style="color: orange;">●</span>	<b>cVDPV1 cases (latest onset)</b>
Madagascar	5 22-Aug-21
<span style="color: green;">●</span>	<b>cVDPV2 cases (latest onset)</b>
Nigeria	262 20-Oct-21
Cameroon	3 11-Oct-21
Ukraine	1 03-Sep-21
Yemen	2 01-Sep-21
Senegal	4 22-Aug-21
Niger	5 19-Aug-21
Ethiopia	3 16-Jul-21
Guinea-Bissa	2 15-Jul-21
Afghanistan	2 09-Jul-21
DR Congo	1 27-Jun-21
Tajikistan	8 26-Jun-21
Burkina Faso	1 09-Jun-21

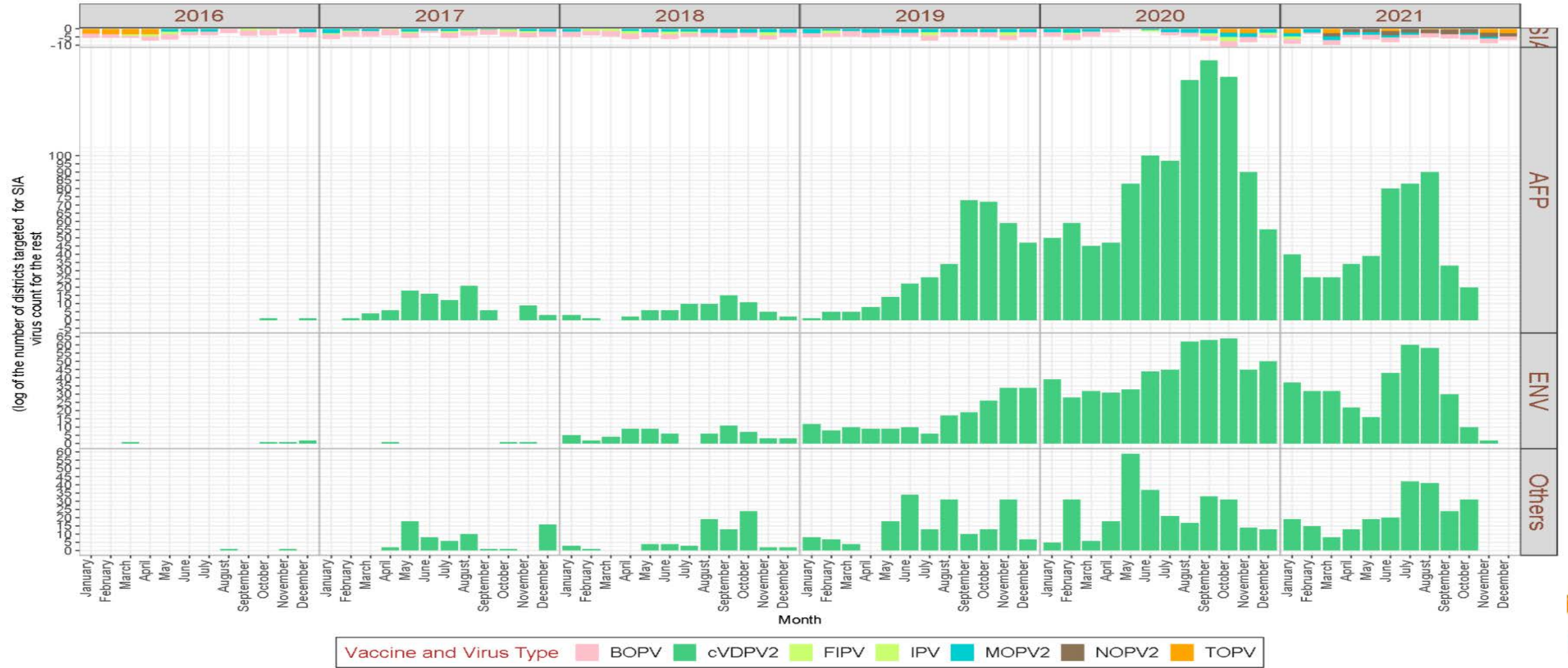
Endemic country (WPV1)

<sup>1</sup>Excludes viruses detected from environmental surveillance; <sup>2</sup>Onset of paralysis 08 Jun. 2021 to 07 Dec. 2021

# Global, post switch cVDPV2 trend between 2016-2021

## Epi-Curve: AFP Cases, ENV, others(Human) and SIAs

Country: AFGHANISTAN, ANGOLA, BANGLADESH, BENIN, BURKINA FASO, CAMEROON, CENTRAL AFRICAN REPUBLIC, CHAD, CHINA, CONGO, CÔTE D'IVOIRE, DEMOCRATIC REPUBLIC OF THE CON  
 Province(s): BADAQSHAN, BADGHIS, BAGHLAN, BALKH, BAMYAN, DAYKUNDI, FARAH, FARYAB, GHAZNI, GHOR, HILMAND, HIRAT, JAWZJAN, KABUL, KANDAHAR, KAPISA, KHOST, KUNAR, -  
 KUNDUZ, LAGHMAN, LOGAR, NANGARHAR, NIMROZ, NURISTAN, PAKTIKA, PAKTYA, PANJSHER, PARWAN, SAMANGAN, SAR-E-PUL, TAKHAR, URUZGAN, WARDAK, ZABUL, BENGU



- **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

Country	Response zone	Date of Outbreak/ Breakthrough Confirmation	Date country Verified for nOPV2 use	Dose Release approval date	Planned R1	Duration till dose release (Ideally < 7)	Duration till <b>planned</b> first round (Ideally < 28 )
Uganda	Whole Country	21-Jul-21	6-Jul-21	10-Aug-21	14- Jan 22	20	177
Egypt	Whole Country	25-Jun-21	16-Aug-21	7-Sep-21	5-Dec-21	74	163
Senegal	Whole Country	15-Mar-21	30-Aug-21	11-Oct-21	17-19 Dec-21	210	277
Mauritania	Whole Country	23-Aug-21	12-Oct-21	14-Oct-21	17-19Dec-21	52	102
Nigeria (7 states BT)	10 states & FCT	24-Aug-21	12-Feb-21	28-Oct-21	Waiting vaccine availability	65	99+ Till 01 Dec 21

Ethiopia R2 remain uncertain due to insecurity

# Pending responses, decision made to use Sabin OPV2

(As of 01 December 2021)

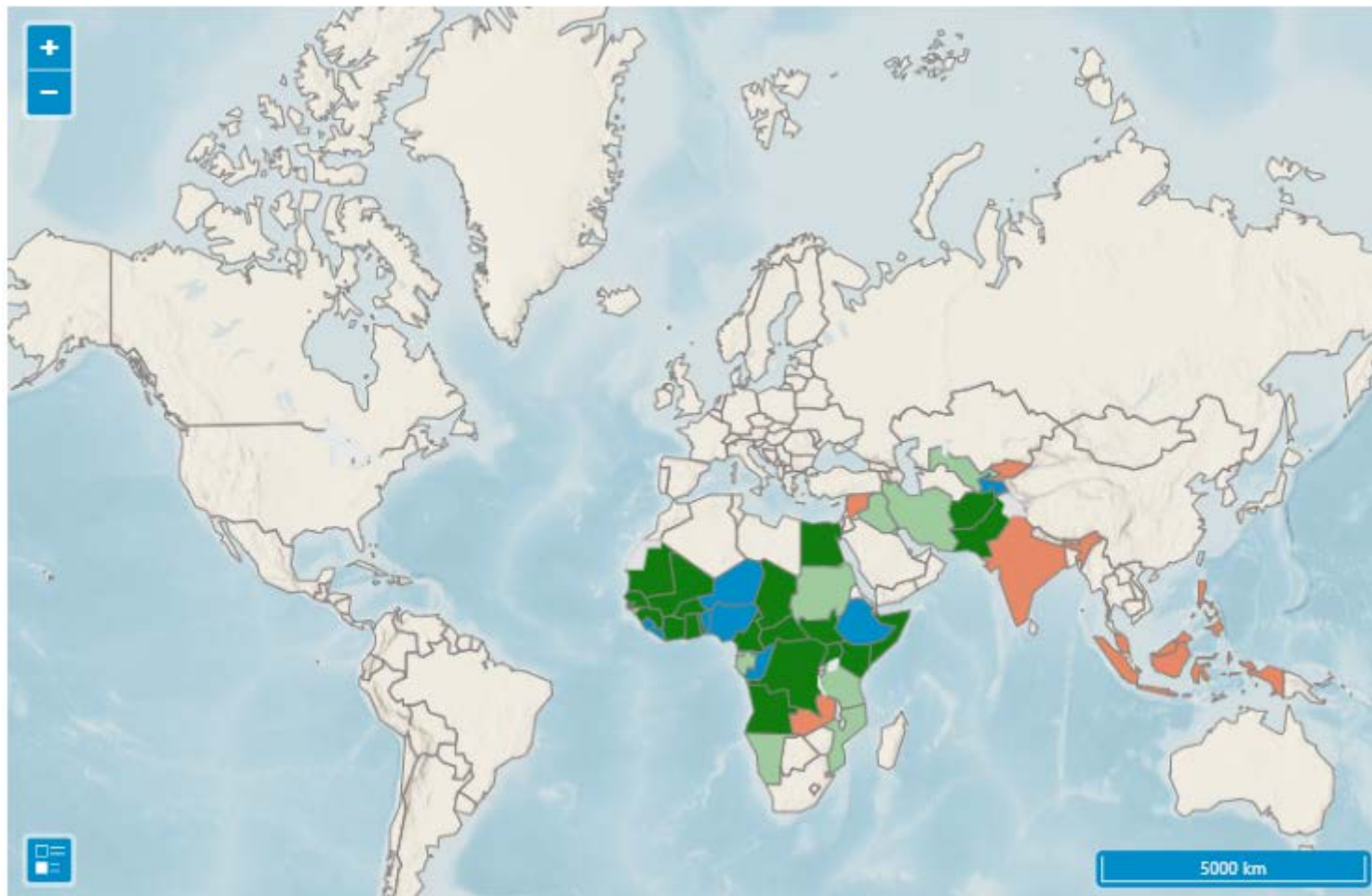
Country	Date of Outbreak/ Breakthrough Confirmation	Duration since confirmation till today	Remarks
Ukraine	05-Oct-21	57+	Use of mOPV2/tOPV under discussion
Somalia	06-Oct-21	56+	mOPV2 authorized by DG
Yemen (cVDPV2)	22-Nov-21	9+	tOPV authorized by DG





# Pending responses waiting for nOPV2 Readiness Verification/Vaccine Availability As of 01 December 2021

Country	Date of Outbreak/ Breakthrough Confirmation	Date country Verified for nOPV2 use	Duration since confirmation till today	Expected delay till nOPV2 become available (end Q1 2022)
Burkina Faso	24-May-21	01-Oct-21	191+	311
Guinea Bissau	22-Oct-21	Pending	40+	160
DRC	26-Oct-21	25-Jun-21	36+	156
Niger	27-Oct-21	28-Apr-21	35+	155
Cameroon	28-Oct-21	12-Oct-21	34+	154
Nigeria (middle belt states)		12-Feb-21		

# 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*



-  Discussions ongoing (7)
-  Verification in progress (11)
-  Verified, but have not conducted campaigns (21)
-  Verified and nOPV2 campaign conducted (8)

# nOPV2

Overview of stock levels based on WHO DG

Global stockpile balance after WHO DG release is – 100,821,500 doses

nOPV2	Authorised by WHO DG	Stockpile Balance 25 Nov	Released by ORPG	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Stockpile replenishment		35,671,000		21,742,500	39,600,000	75,600,000	64,800,000	46,800,000	54,000,000		82,800,000
<b>Released by ORPG</b>											
Egypt R1			20,800,000								
Nigeria R1			28,847,500								
<b>DG authorised pending ORPG distribution</b>											
Uganda R2	10,997,500										
Ethiopia R2	21,215,000										
Egypt R2	20,800,000										
Senegal R2	3,505,000										
Gambia R2	480,000										
Mauritania R2	1,000,000										
Nigeria R2	28,847,500										
<b>Total authorised by DG</b>	<b>86,845,000</b>										
<b>Balance after ORPG Release</b>		<b>35,671,000</b>	<b>-13,976,500</b>	<b>7,766,000</b>	<b>47,366,000</b>	<b>122,966,000</b>	<b>187,766,000</b>	<b>234,566,000</b>	<b>288,566,000</b>	<b>288,566,000</b>	<b>371,366,000</b>

### nOPV2 weekly release schedule:

- Week of 29<sup>th</sup> November – 21,742,500 doses
- Week of 6<sup>th</sup> December – 32,400,000 doses
- Week of 27<sup>th</sup> December – 7,200,000 doses

**Overview of mOPV2 actual stock levels based on WHO DG**

**Global stockpile balance after WHO DG release is 225,933,400 doses**

<b>mOPV2</b>	Stockpile Balance 18 Nov	November	December	January	February	March	April	May	June	July	August	September
Stockpile replenishment		107,744,200		37,803,400			10,000,000	10,000,000	10,000,000			20,000,000
Country Requests												
<b>Balance after DG</b>	<b>225,933,400</b>	<b>333,677,600</b>	<b>333,677,600</b>	<b>371,481,000</b>	<b>371,481,000</b>	<b>371,481,000</b>	<b>381,481,000</b>	<b>391,481,000</b>	<b>401,481,000</b>	<b>401,481,000</b>	<b>401,481,000</b>	<b>421,481,000</b>



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

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

# 2022 budget prioritization table

Line	Category	Geography	Function	2022 critical activities w/indirect cost	Cumulative Total
A	Endemics <sup>1</sup>	Pakistan	SIAs, surveillance, integration, EOC	\$ 251	
B	Endemics <sup>1</sup>	Afghanistan	SIAs, surveillance, integration, EOC	\$ 70	
C	Immunization	Non-endemics	Outbreak response	\$ 168	
D	Vaccines	Global	Vaccine procurement for outbreaks (nOPV2)	\$ 88	
E	Surveillance, Infrastructure	AFRO 10 + Somalia	TA (surv + non-surv), surv running costs, labs	\$ 83	
F	Surveillance	Global	Lab - expand sequencing, direct detection	\$ 10	
G	Surveillance	HQ & RO	Surveillance TA, running costs, labs	\$ 48	
H	Infrastructure	HQ & RO	Non-Surveillance TA	\$ 45	
I	Gender (Infrastructure)	Global	Gender mainstreaming strategy/activities TBD	\$ 7	\$ 771
J	Immunization	Non-endemic Higher risk	bOPV campaigns (Q1/Q2 multi-antigen or stand alone)	\$ 33	
K	Community Engagement (Immunization)	Nigeria + Somalia	Social mobilization network	\$ 9	
L	Infrastructure	AFRO 10 + Somalia	EOCs	\$ 3	
M	Immunization	RO	Digital Tools/Tracking	\$ 3	\$ 819
N	Vaccines	Global	Vaccine procurement for outbreaks (nOPV2)	\$ 35	
O	Immunization	Non-endemic Higher risk	bOPV campaigns (Q3/Q4 multi-antigen and stand alone)	\$ 33	
P	Immunization	Global	bOPV Buffer Stock	\$ 26	
Q	Endemics	Afghanistan	SIAs, surveillance, integration	\$ 19	\$ 932

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

Aligned with projected available resources

<sup>1</sup>Budget set in line with historical implementation capacity






# **The Secretariat Model Core Group Polio Project**

Polio Partners Group Meeting  
December 16, 2021

# History of the CORE Group Polio Project

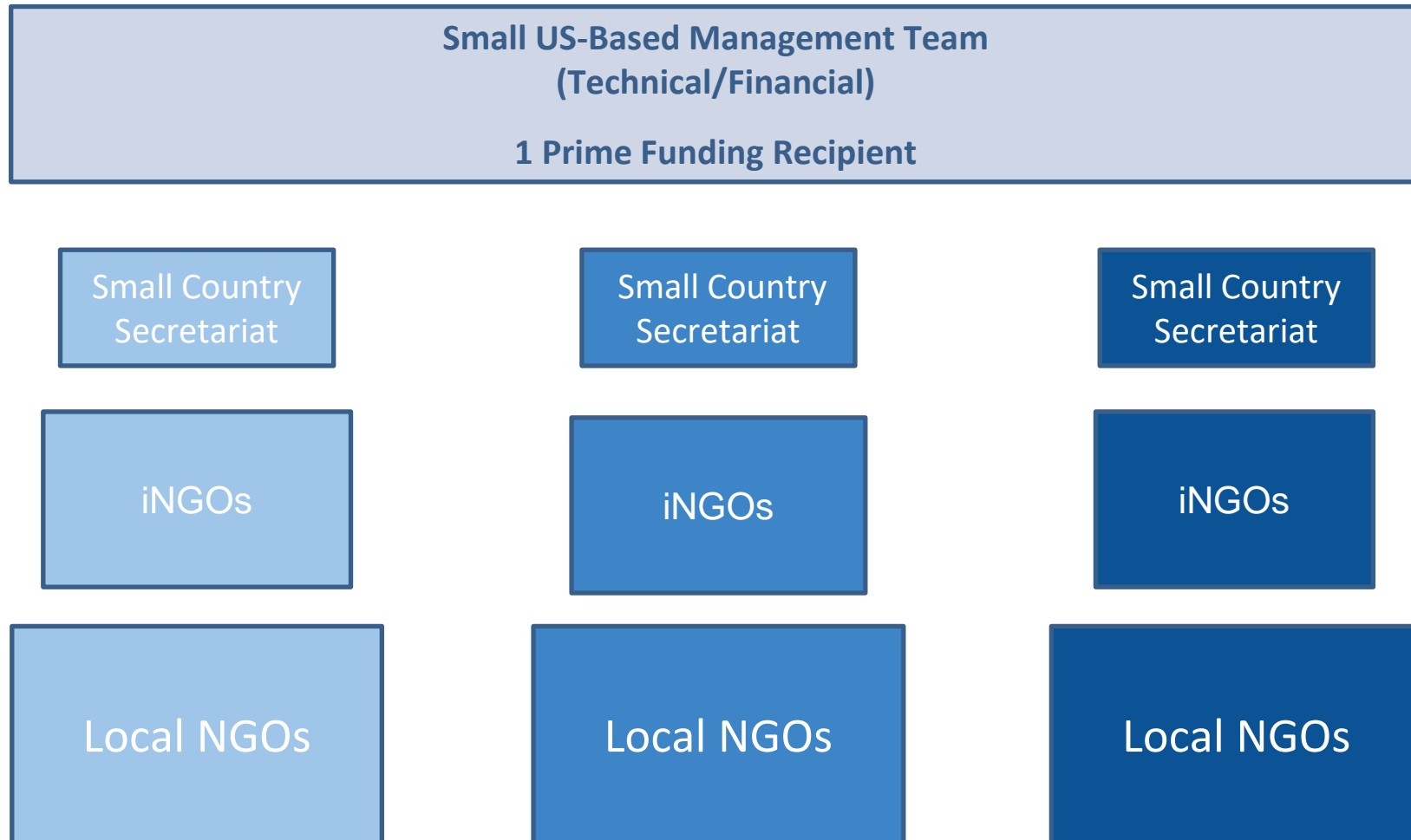
- Initiated to complement facility-based surveillance, reach children beyond the reach of government and UN services, build on networks of NGOs with experience in child survival and to streamline management in support of Polio Eradication.
- The Secretariat Model was launched in 1999 with grants to international 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



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

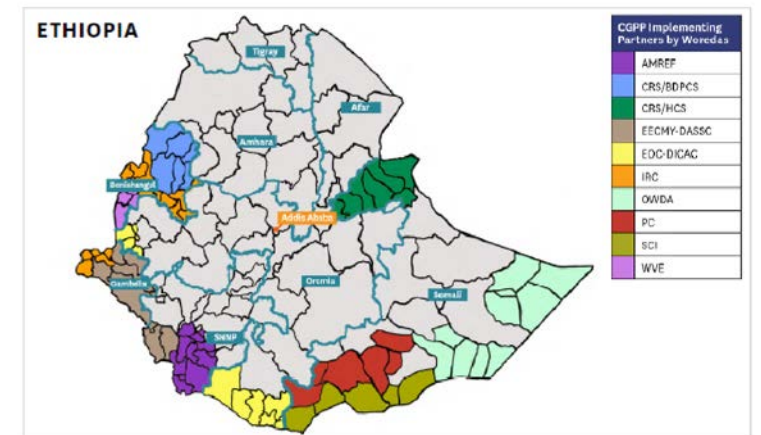
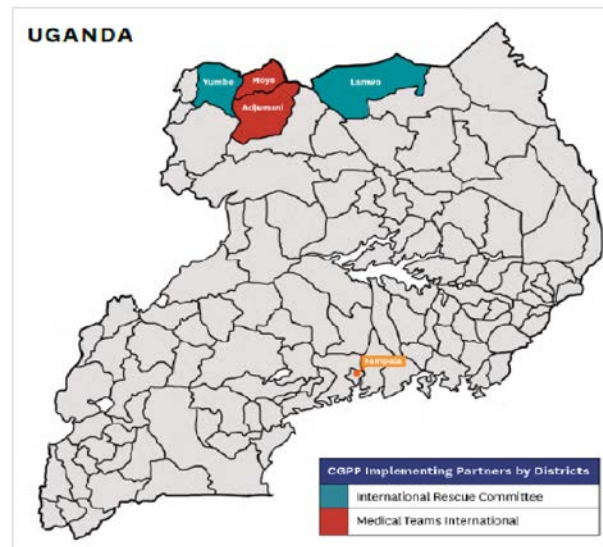
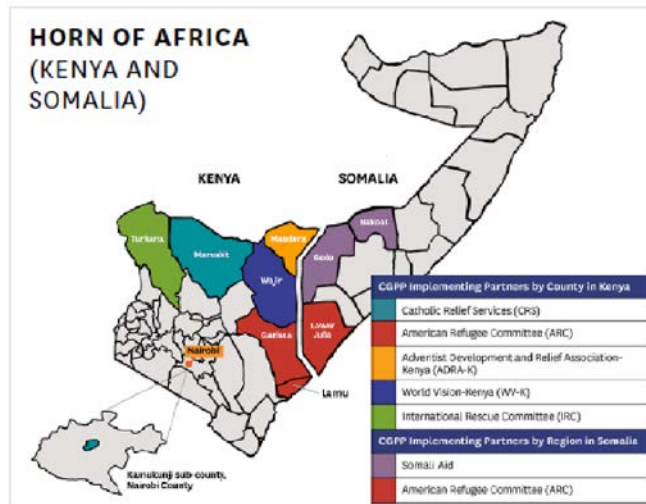
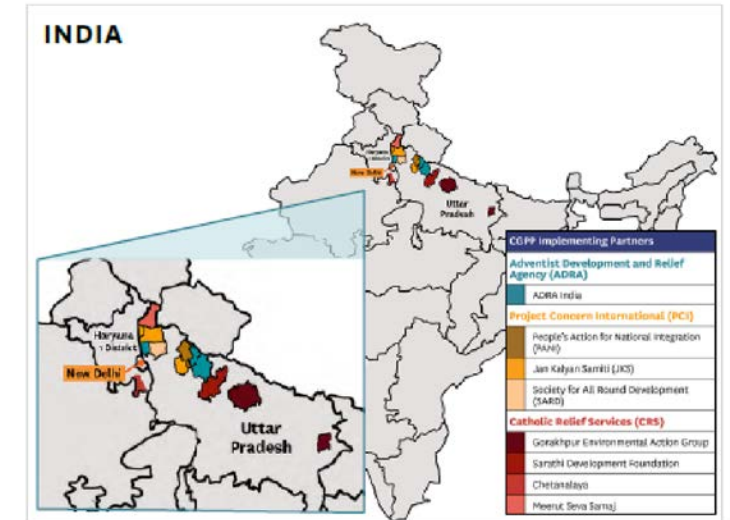
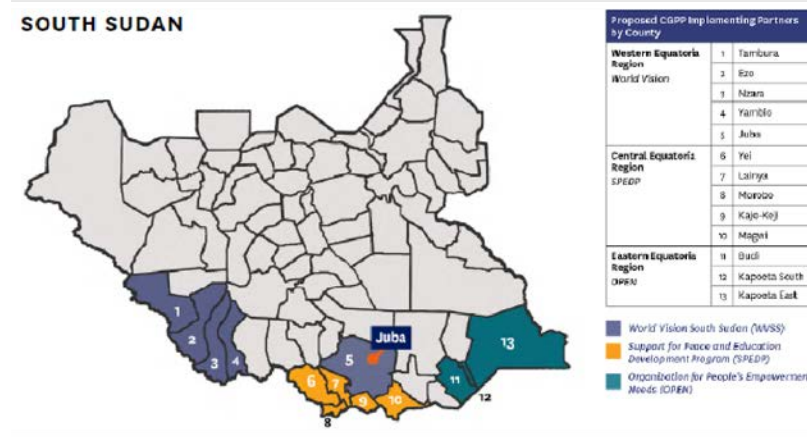
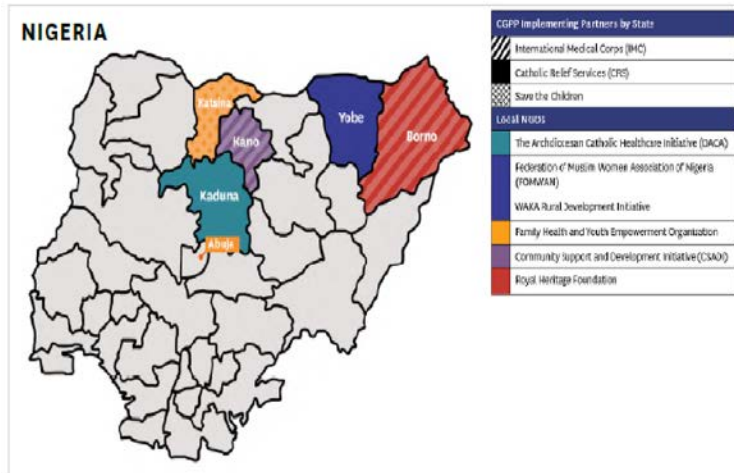
# Collaboration And Innovation

- 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

Change Clock Type  
Digital

Duration: 00 10 00

TimeUp Reminder (Optional): -- -- --

Choose Sound Effect None

Choose TimeUp Sound None

Enable Count Up  Combine With Bar Clock

# 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

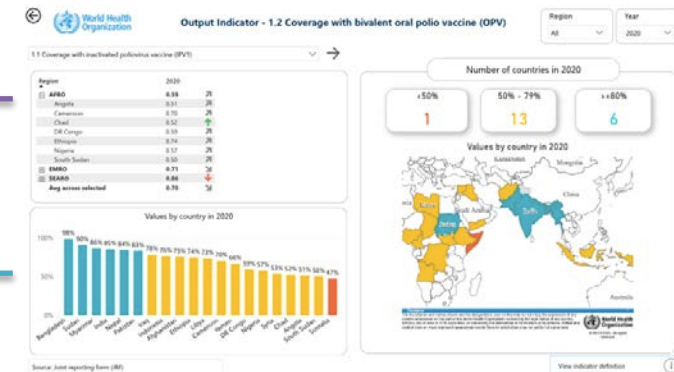
Close engagement of civil society

Strong M&E framework to ensure high programmatic performance

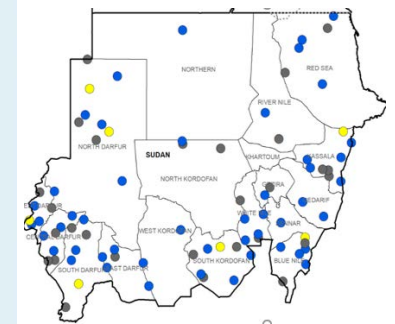


**POLIO WORLD CAFÉ: SPOTLIGHTING CIVIL SOCIETY ACTION**  
Hosted by the Polio CSO Integration and Transition Working Group

FRIDAY, OCTOBER 22



Polio Transition Plan for Somalia, 2021-2024



# Challenges

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COVID-19 continues to slow down efforts

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Ongoing WPV and cVDPV circulation

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National commitment and ownership

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Sustainable financing (domestic and external)

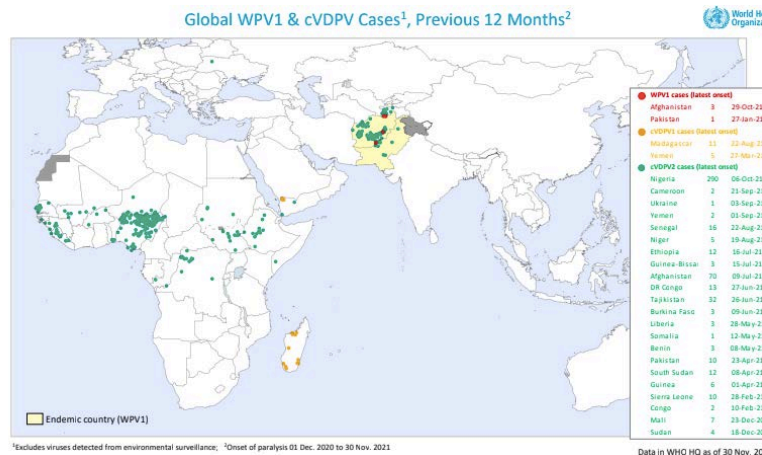
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Need for long term partner support in fragile and conflict-affected settings

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# Opportunities

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Integration is an opportunity to reach and sustain eradication

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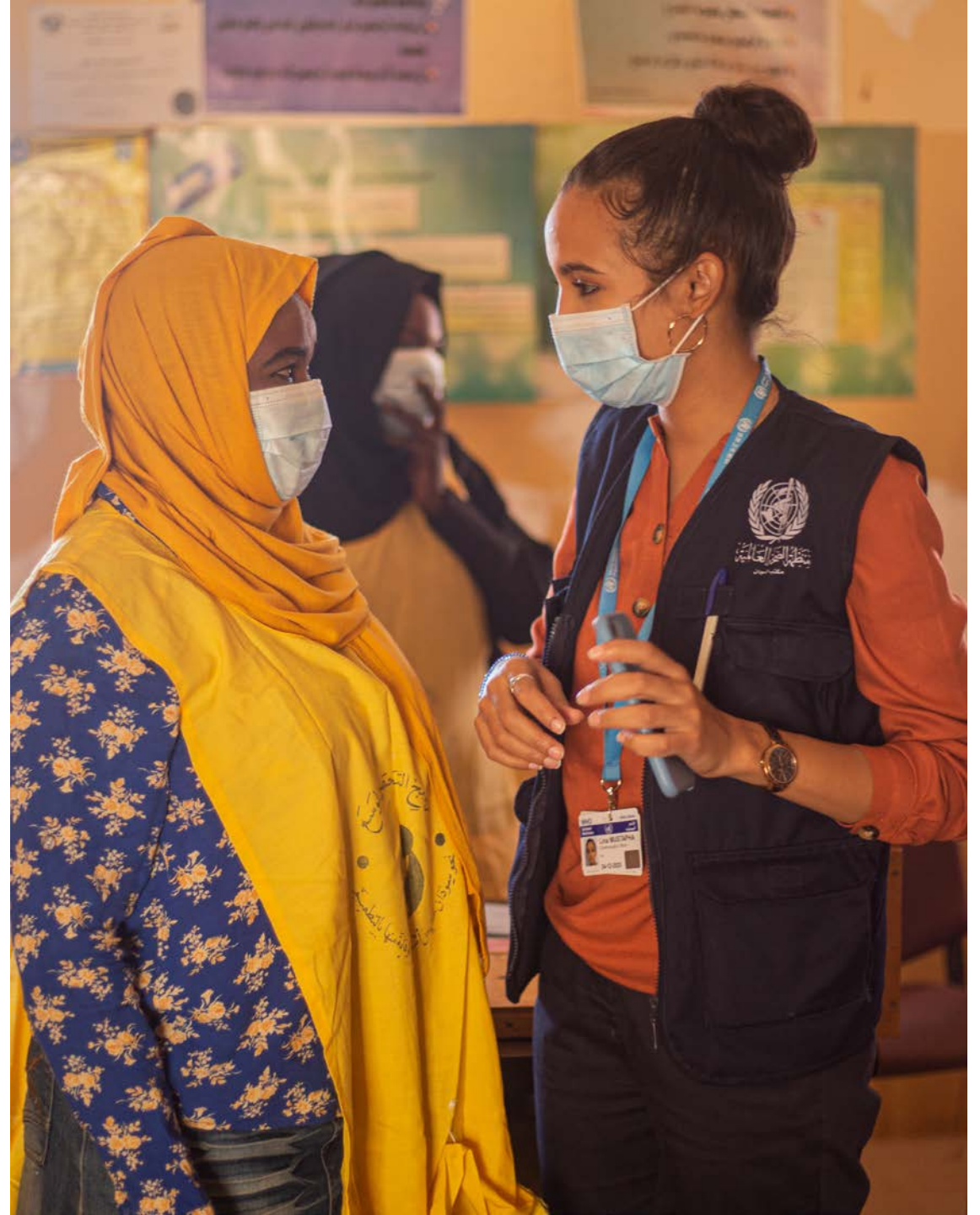
Transferable skills of the polio workforce - demonstrated again during the pandemic response and COVID-19 recovery and vaccine rollout

---

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**

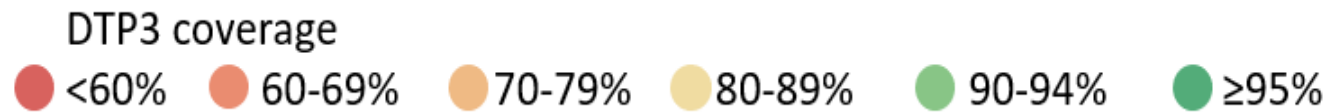
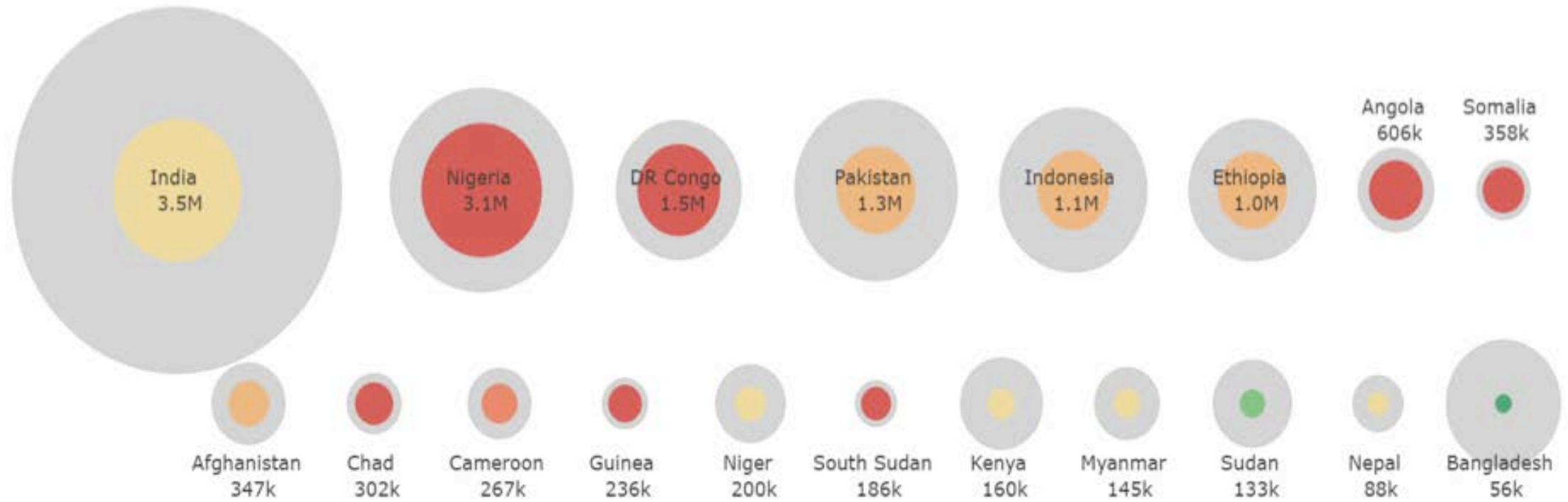
Zero-dose communities often have no regular health services



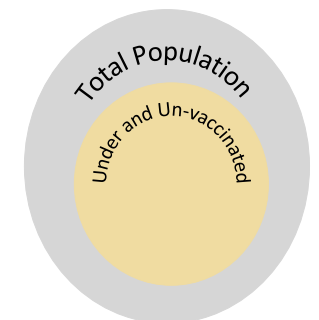
**Health Security**

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

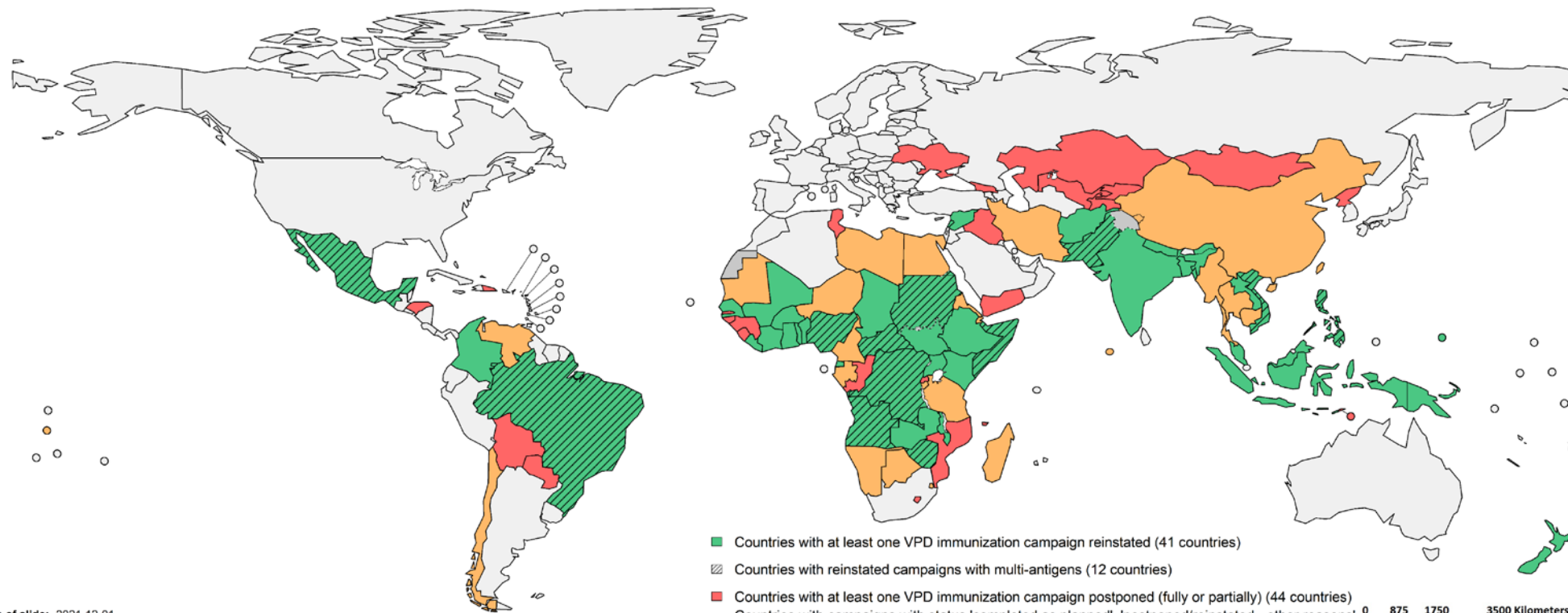


\* Priority countries for polio eradication / transition are those included in the new GPEI Strategy (AFG, PAK, AFRO 10 and Somalia), along with the rest of the countries prioritized for polio transition (5 SEARO countries + Sudan)

# 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, 1<sup>st</sup> December 2021

**Angola, Brazil, CAR, DR Congo, Mexico, Nigeria, Pakistan, Philippines, Somalia, Sudan, Viet Nam and Zimbabwe** have re-instated campaigns with multi-antigens.



**Date of slide:** 2021-12-01  
**Map production:** Immunization, Vaccines and Biologicals (IVB), World Health Organization (WHO)  
**Data source:** WHO/IVB Repository, 1st December 2021

**Disclaimer:**

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area nor of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. World Health Organization, WHO, 2021. All rights reserved



The largest single MR catch-up campaign ever to be conducted – led to the protection of over 93 Mn children.

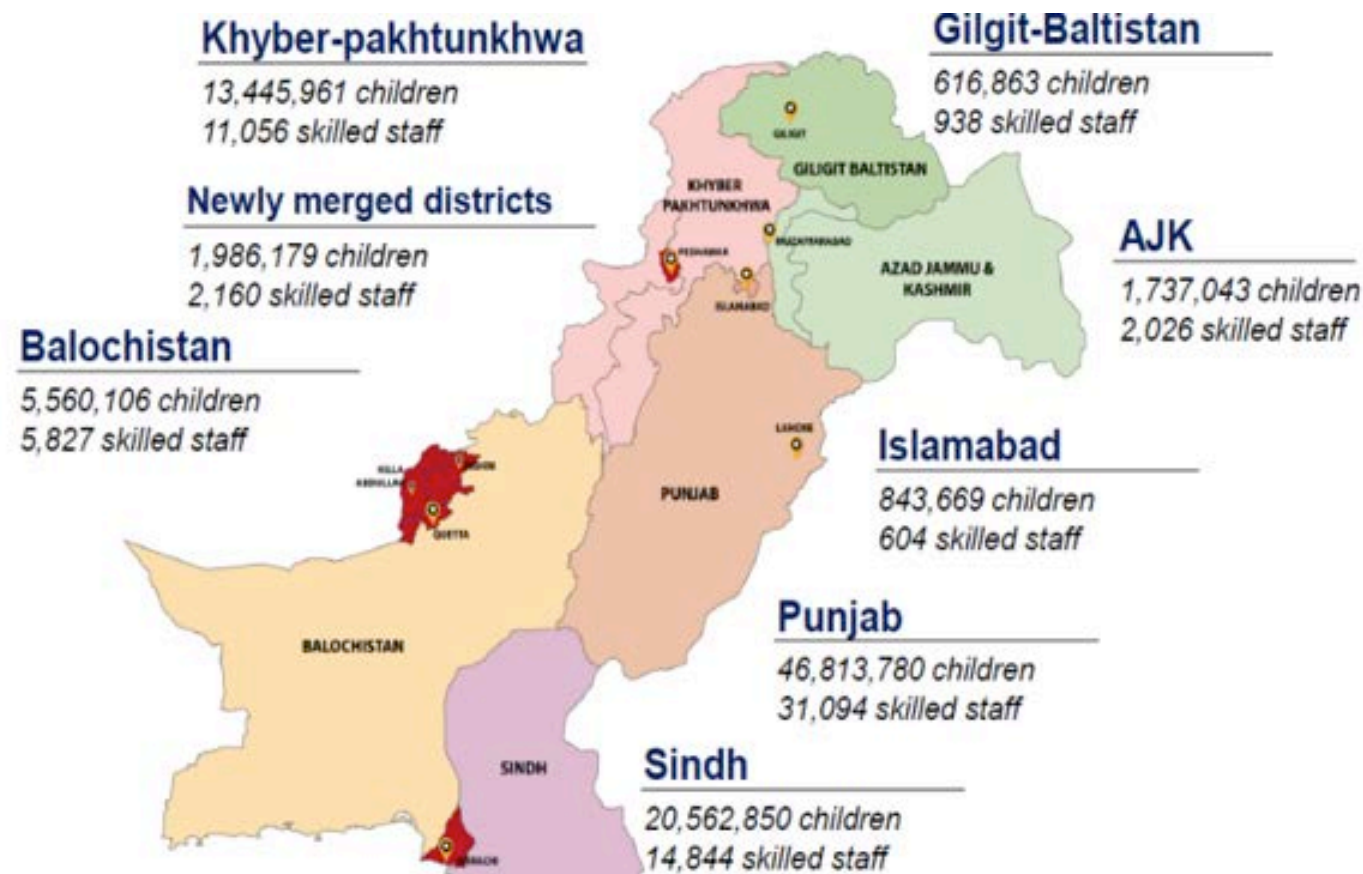
Over 31 Mn under-5s received co-delivery of bOPV.

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

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

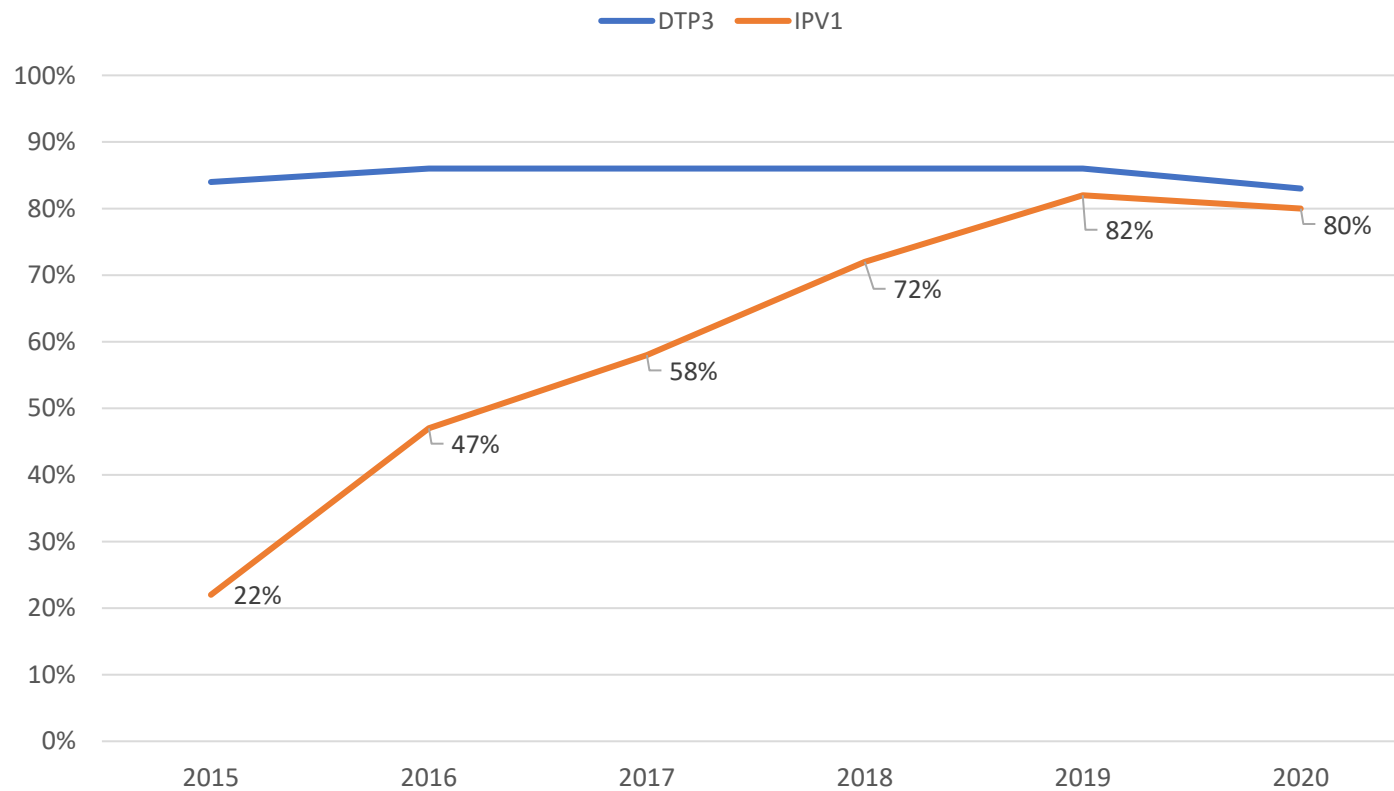
- Ensuring data sharing for developing micro-plans
- Field validation of micro-plans by polio staff, esp. addressing planning for high-risk populations
- Identifying and reaching persistently missed children using polio assets and community knowledge

## PAKISTAN: COORDINATION FOR THE INTEGRATED bOPV & MR CAMPAIGN, 15–27 Nov 2021



# High population immunity against polio is critical to sustain eradication

Global IPV coverage estimates 2016-2020 (WUENIC)



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.

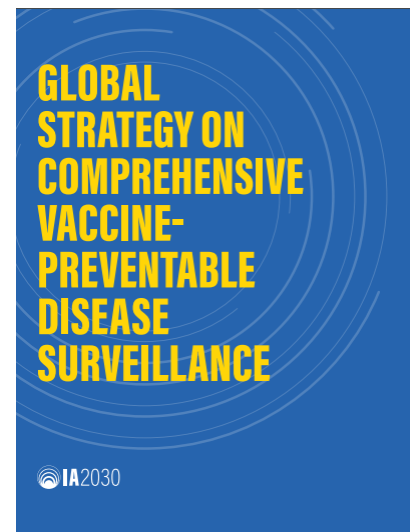
Global health security concerns have catalyzed greater synergies between the WHO programmes (WHE, IVB & POL), in collaboration with others (TB, HIV and external stakeholders).

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



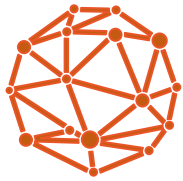
SMO supporting COVID-19 case investigation



Lab network for polio and MR leveraged for COVID-19



# 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