POLIO GLOBAL ERADICATION INITIATIVE

2021 ANNUAL REPORT

World Health Organization · unicef · Rotary · CDC Centers for Disease Control and Prevention · Bill & Melinda Gates foundation · Gavi The Vaccine Alliance

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Global Polio Eradication Initiative: annual report 2021

ISBN 978-92-4-005893-4 (electronic version)

ISBN 978-92-4-005894-1 (print version)

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

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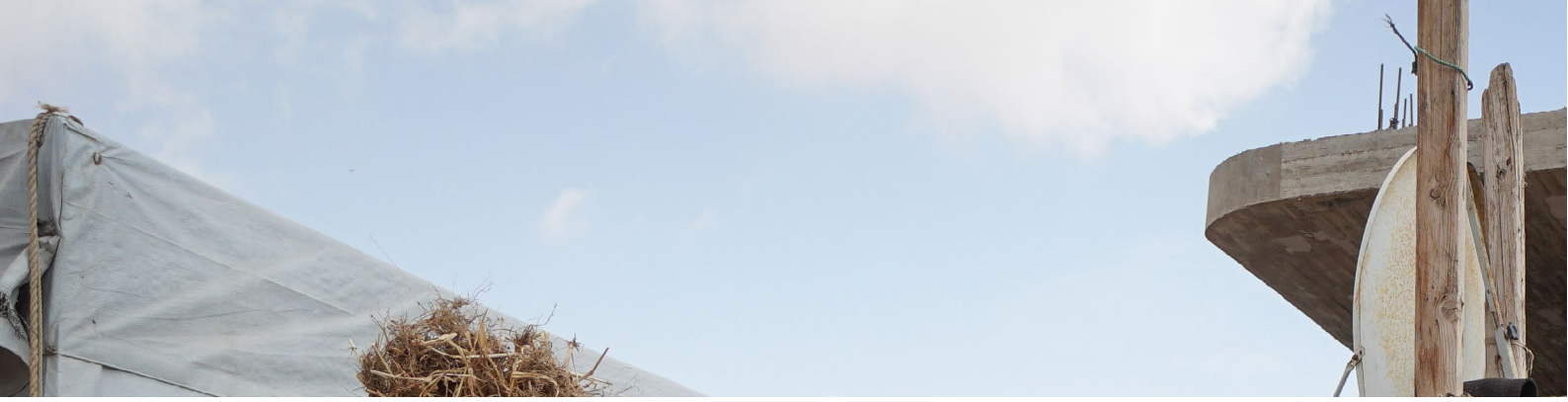
ACRONYMS

AFP	Acute flaccid paralysis
cVDPV	Circulating vaccine-derived poliovirus
cVDPV2	Circulating vaccine-derived poliovirus type 2
EUL	Emergency Use Listing
GPEI	Global Polio Eradication Initiative
NID	National Immunization Days
nOPV2	Novel oral polio vaccine type 2
NPAFP	Non-polio acute flaccid paralysis
OPV	Oral polio vaccine
PHEIC	Public Health Emergency of International Concern
SIA	Supplementary immunization activity
UNICEF	United Nations Children's Fund
WHO	World Health Organization



EXECUTIVE SUMMARY

The year 2021 may go down in history as the turning point in the global effort to eradicate polio.

With the ongoing COVID-19 pandemic, continued wild polio transmission in the remaining endemic countries and spreading outbreaks of circulating vaccine-derived poliovirus type 2 (cVDPV2), the year began with many challenges facing polio eradication efforts. WHO Member States and partners of the Global Polio Eradication Initiative (GPEI) had to show rapid adaptability in their efforts to protect children from lifelong paralysis.

In June, the GPEI launched the new Polio Eradication Strategy 2022–2026, which lays out the roadmap to achieving a world forever free of all forms of poliovirus through stronger community engagement, a renewed focus on gender equity and the roll-out of new tools and approaches.

These new tools included the novel oral polio vaccine type 2 (nOPV2), which began deployment under the Emergency Use Listing procedure as part of the GPEI's broader polio vaccine repository to curb cVDPV2 transmission. Notable among the new approaches were more deliberate partnering with essential immunization services, pandemic and outbreak response and preparedness, and – where impactful – coordination with broader health and sanitation sectors. In August, the WHO African Region celebrated one year since it was certified free of wild poliovirus (WPV), and countries recommitted to strong cVDPV2 outbreak response across the continent with the support of the GPEI.

Further critical progress took place in Afghanistan despite political upheaval. For the first time in more than three years, nationwide polio immunization campaigns resumed across Afghanistan, reaching 9.9 million children, including 2.6 million children[1] who were previously inaccessible. This is one illustration of the GPEI's commitment to the focus on zero-dose children of the Immunization Agenda 2030.

These developments unfolded against the backdrop of continued support to the COVID-19 pandemic response by GPEI health workers on the front line doing contact tracing, delivering vaccines, mobilizing communities and countering misinformation, among other activities. The use of GPEI infrastructure for health emergency response and recovery has provided critical lessons for integrating polio resources into broader health systems as polio-free countries work towards the transition and the GPEI looks ahead to the post-certification period.

[1] Poliomyelitis eradication – Report by the Director-General, 75th World Health Assembly, A75/23, 6 May 2022

Following dire predictions at the end of 2020, the GPEI once again proved its ability to adapt to programmatic, epidemiological and political developments. At the end of the first half of 2022, there was cause for cautious optimism: WPV transmission had slowed drastically, and cases of cVDPV2 had also declined compared to the previous year, except in northern Nigeria, eastern Democratic Republic of the Congo, south-central Somalia and northern Yemen. As the impact of cVDPVs on children and their families is the same as the impact of WPVs, political urgency and focus must treat circulating vaccine-derived poliovirus (cVDPV) outbreaks in the same manner as WPV outbreaks. Confirmation in early 2022 of WPV in south-east Africa, with cases confirmed in Malawi and subsequently Mozambique, genetically-linked to virus circulation in Pakistan, and cVDPV in Israel and Ukraine, as well as VDPV detected in London, United Kingdom of Great Britain and Northern Ireland and New York, United States of America, further underscored the fragility of the progress witnessed in 2021.

Importantly, commitment to achieving a lasting polio-free world remained evident at all levels, by core GPEI partners, including among the Polio Oversight Board, whose members travelled to Pakistan twice in 2021; by health workers, communities and parents; and by country leaders worldwide who helped champion this year's milestones. With the new strategy, new tools and adapted approaches, the stage was set to achieve permanent success.

To stop all forms of polio for good, the GPEI aimed to capitalize on the positive epidemiological situation that led into 2022, by focusing on known and infected geographies with the highest proportion of zero-dose children, and ensuring a more rapid, larger-scale and, critically, higher-quality response.

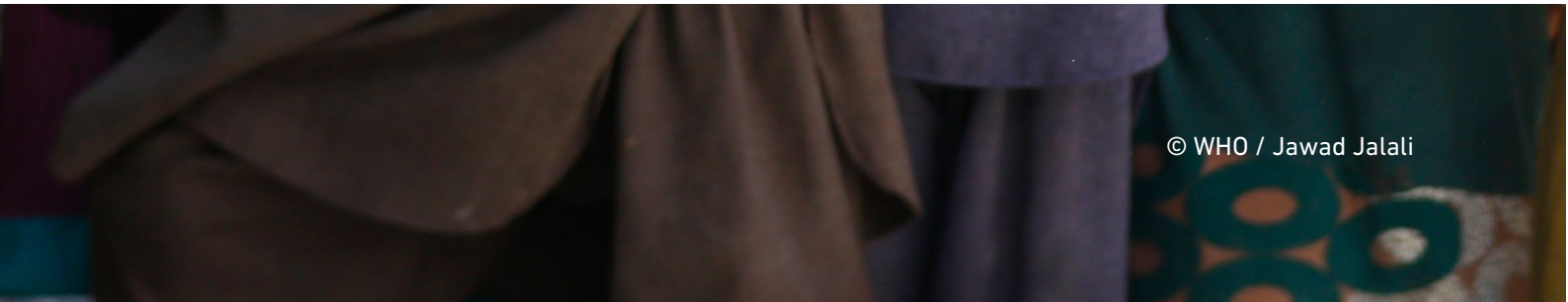
In 2021, thanks to the support of the GPEI, more than 370 million children were vaccinated multiple times in 30 countries using more one billion doses of oral polio vaccine.[2]

GPEI partners planned a renewed and intensified outreach across the broader international development community to secure the necessary financial resources to achieve success, including by publishing the strategic plan's sister document – the Global Polio Eradication Initiative Investment Case 2022–2026 – and preparing for a global pledging moment in late 2022.

[2] Data in WHO HQ, 2022; Poliovirus Weekly Update, 27 July 2022, World Health Organization, available at: https://polioeradication.org/polio-today/polio-now/this-week/

THE POLIO ERADICATION STRATEGY 2022–2026: GOAL I

PERMANENTLY INTERRUPT ALL POLIOVIRUS TRANSMISSION IN ENDEMIC COUNTRIES



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WILD POLIOVIRUS AT EXTREMELY LOW LEVELS: A UNIQUE OPPORTUNITY FOR SUCCESS THAT MUST BE SEIZED

In 2021, a unique epidemiological situation emerged that presents in 2022 the world's best-ever opportunity to rid itself of all remaining wild polioviruses (WPV) anywhere. Six children were paralysed by wild poliovirus type 1 (WPV1) in 2021, five in the two remaining endemic countries (Pakistan and Afghanistan) and one in Malawi in November, linked to a virus strain originating in Pakistan[3]. These levels of transmission present a unique epidemiological opportunity that must be capitalized on in 2022, to eradicate WPV once and for all and prevent global re-emergence.

AFGHANISTAN AND PAKISTAN – A FOCUS ON REACHING ZERO-DOSE CHILDREN

Afghanistan and Pakistan are today the last remaining endemic WPV bastion in the world. Both countries are also co-affected by circulating vaccine-derived poliovirus type 2 (cVDPV2).

Despite the record-low levels of cases reported, the dangers of residual transmission were underlined by the ongoing detection of WPV1 in environmental samples in both countries. The risk of ongoing transmission of WPV anywhere was further underscored by the confirmation of a WPV1 case in February 2022 in Malawi (the child had onset of paralysis in November 2021), and further detection in Mozambique, genetically linked to the virus from Pakistan.

In Afghanistan, the GPEI continued to work within the broader relief effort, as the humanitarian crisis in the country deepened. WPV transmission was largely focused in the southern and eastern regions, and efforts were further complicated by increased mass displacements of people, continued limited access for house-to-house vaccinations in some areas, the compromised safety of forefront health workers and continuing operational challenges due to the COVID-19 pandemic. As a result, while overall national polio vaccination coverage was high (upwards of 90%), subnational immunity gaps persisted, and a significant number of children under age 5 remained unvaccinated (zero-dose children).

[3] All case data in this Annual Report in WHO HQ as of 17 August 2022. Data are updated on a weekly basis and available at: https://polioeradication.org/polio-today/polio-now/this-week/

Polio eradication in Afghanistan: Adapting operations to complex environments

The GPEI has a long-standing history of adapting its strategies and operations to local realities, including in areas of insecurity or humanitarian emergencies. Nowhere has this been more evident over recent years than in Afghanistan.

A complex geopolitical environment culminated in 2018 in local-level bans on house-to-house polio vaccination activities, significantly complicating the effort to reach every single child with polio vaccine. The situation was further compounded in 2020. With the emergence globally of COVID-19, polio vaccination activities were temporarily paused amid fears that such close-contact activities could contribute to the transmission of the virus, putting at risk the health and safety of forefront health workers and the communities they are meant to serve. The overriding operational principle of polio eradication has always been to ensure the health and safety of its workforce as the programme's top priority.

Amid these complexities, the programme adapted. Local-level negotiations, including through neutral third parties, intensified to secure access where possible. Operations were adapted to make service delivery more culturally appropriate, including moving from a house-to-house to a mosque-based, fixed site approach where acceptable to local leaders. At the same time, surveillance was strengthened in all areas to more clearly ascertain virus circulation, and immunizations intensified in all accessible areas. In response to COVID-19, additional operational requirements were implemented to resume activities in a safe manner, including by equipping vaccinators with face masks and hand sanitizers.

The result of these efforts was that surveillance – in 2021 and the first half of 2022 – was stronger than ever before, including at critical subnational levels, with active searches for acute flaccid paralysis supported by the ever-increasing roll-out of environmental surveillance and virus transmission kept in check in known high-risk endemic areas of the country without it establishing footholds outside those areas.

Following geopolitical developments in August 2021, two nationwide polio immunization activities were conducted back to back, the first in more than three years to target, among others, more than 2.6 million children previously living in inaccessible areas. At the start of 2022, WPV transmission was at its lowest level in history in the country, and Afghanistan – together with Pakistan – has a very real and achievable opportunity to end WPV once and for all.

Experiences from Afghanistan are further evidence of the programme's ability to reach all children everywhere, no matter where they live or under what circumstances. Polio eradication is a truly equitable intervention, and the GPEI's experiences are also helping to inform and support the implementation of other health programmes around the world.

The GPEI therefore continued to adapt its operational approaches as the challenges evolved, with the overriding priority being to reach remaining zero-dose children. Filling the residual vaccination gap among these unreached children holds the key to a polio-free Afghanistan. Particularly encouraging was the fact that the country implemented two back-to-back nationwide immunization campaigns, targeting 9.9 million children in November and December 2021, including in the southern region (where 2.6 million children were vaccinated for the first time in almost three years).

In Pakistan, activities were sharply focused on the remaining low-level but persistent transmission of both WPV1 and cVDPV2 in close cross-border coordination with Afghanistan.

The programme continued to operate under the auspices of the National Emergency Action Plan implemented through the National Emergency Operations Centre, with the overarching goal of reaching remaining zero-dose children during supplementary immunization activities. The programme focused on prioritizing the highest-risk areas with the highest proportion of zero-dose children, notably in areas of southern Khyber Pakhtunkhwa; effectively implementing community engagement strategies; integrating with broader public health programmes, in particular to help strengthen immunization systems; and fully engaging federal and provincial leadership to support and oversee programme implementation. Confirmation in 2022 of 14 newly-detected WPV1 cases, the first reported from the country in 15 months, underscored the sense of urgency. While all cases were reported from two Union Councils of North Waziristan, Khyber Pakhtunkhwa, the risk that this transmission would spread to other areas of the country remained high and efforts focused on ring-fencing the area to prevent expansion, while of course implementing urgent outbreak response to stop transmission.

The Ministerial Regional Subcommittee on Polio Eradication and Outbreaks, established by the WHO Regional Director for the Eastern Mediterranean, met for the first time in March 2021. The subcommittee signals the greater engagement of government leadership and provides additional support and guidance to Afghanistan and Pakistan. At the same time, operations in both countries were affected by the COVID-19 pandemic, as polio eradication staff, expertise and infrastructure continued to support national and local COVID-19 response efforts,

including vaccine roll-out. The GPEI Hub in Amman continued to optimize timely and expert support to the countries' eradication efforts in a cross-partnership manner. With a wide set of expertise, ranging from logistics to data analysis to social mobilization, the right support could rapidly be deployed to the appropriate areas to fill the most urgent support needs.

RISK OF INTERNATIONAL SPREAD UNDERSCORED BY THE DETECTION OF WPV1 IN SOUTH-EAST AFRICA

In February 2022, the GPEI received confirmation that a child was paralysed by WPV1 in Malawi in November 2021, linked to a virus strain originating in Pakistan. It is the first WPV1 on the continent since 2016, and a subsequent case in Mozambique linked to the same strain was reported in May 2022. While the detected virus is not endemic to the region and hence does not currently affect the region's WPV certification status, it does underscore the risk any poliovirus anywhere poses to children everywhere.

Immediately following confirmation of the initial case, planning was under way for an urgent, high-quality multicountry response to stop this outbreak, underpinned by high levels of government ownership and supported by the WHO African Region's Rapid Response Team.

Such international spread will continue to occur until all remaining strains of poliovirus are eradicated everywhere, which is why the International Health Regulations Emergency Committee on polio eradication continues to assess the situation as a Public Health Emergency of International Concern, despite record-low levels of WPV cases globally.

CIRCULATING VACCINE-DERIVED POLIOVIRUS: RIDDING THE WORLD OF ALL FORMS OF POLIOVIRUS

The goal of the global effort is to eradicate all forms of poliovirus and thereby ensure that no child, anywhere, will ever again be paralysed by any form of polio. This also includes circulating vaccine-derived polioviruses, better known as cVDPVs.

The impact of cVDPVs on children and their families is the same as WPVs and therefore must be addressed with the same sense of political urgency as WPV outbreaks.

In 2021, countries continued to respond to cVDPVs. Most notably, activities were urgent and intense in Nigeria, which accounted for more than two thirds of all cVDPV cases during the year, and Yemen, where transmission continued to intensify. Outbreak response in 2020 and 2021 led to a nearly 50% decline in cases globally compared to the previous year, but cVDPVs continued to be detected in 20 non-endemic countries in three regions, including in Ukraine.

In the first half of 2022, the primary areas of concern remained outbreaks in northern Nigeria, eastern Democratic Republic of the Congo, south-central Somalia and northern Yemen. It is these areas that also have the highest proportion of zero-dose children, underscoring the risk any poliovirus strain (be it wild or vaccine-derived) poses to children in under-immunized communities. Special focus must be placed on these areas throughout 2022.

At the same time, while the Polio Eradication Strategy 2022–2026 outlines the need and approaches for timely detection of viruses as well as the need for rapid, large-scale and high-quality outbreak response, in some instances 2021 saw delayed responses for a variety of reasons, including insufficient vaccine supply, inaccessibility/insecurity, the ongoing COVID-19 pandemic and other public health emergency priorities. Continued efforts in 2022 will focus on strengthening outbreak response and surveillance performances.

To support the outbreak response to cVDPVs in Africa, on the margins of the Regional Committee for Africa in August 2021, Member States recommitted to intensifying their efforts to eradicate all remaining strains of cVDPV2 on the continent, while continuing to transition the assets, functions and expertise established by the GPEI to benefit broader public health efforts and ensure long-term sustainability. Efforts in Africa continued to be supported by the cross-partnership Africa Rapid Response Team.

THE POLIO ERADICATION STRATEGY 2022–2026: GOAL II

STOP cVDPV TRANSMISSION AND PREVENT OUTBREAKS IN NON-ENDEMIC COUNTRIES

NOVEL ORAL POLIO VACCINE TYPE 2 – AN ADDITIONAL TOOL IN THE GLOBAL GPEI VACCINE REPOSITORY

A major success was achieved for the GPEI in 2021 when the novel oral polio vaccine type 2 (nOPV2) was introduced as an additional tool in the global GPEI vaccine arsenal.

This new tool was introduced in March 2021, as the first-ever vaccine to receive WHO Emergency Use Listing (EUL), to more effectively and sustainably stop cVDPV2. A new-generation oral polio vaccine (OPV), it offers the same benefits as the traditional OPV, with the added benefit of increased genetic stability, which makes it less likely to be associated with the emergence of new cVDPVs. The experience and knowledge gained through the EUL process also proved invaluable in helping secure licences for COVID-19 vaccines globally, a further example of the broader benefits of polio eradication.

Following an initial use period, in October 2021, nOPV2 graduated to broader use and, by the end of the year, more than 100 million doses of this revolutionary new tool had been successfully administered[4]. However, as with any vaccine, nOPV2 is only as good as the proportion of children that it reaches – hence, high-quality and rapid response campaigns are critical to successfully stopping any outbreak. At the same time, nOPV2 supply continued to be managed alongside other vaccines, and countries were strongly encouraged to respond rapidly to outbreaks with the most appropriate, available vaccine. A timely and high-quality outbreak response is the most critical factor to rapidly stopping outbreaks.

[4] Data in WHO HQ, 2022; nOPV2 roll-out: monthly update, published in Poliovirus Weekly Update, World Health Organization, available at https://polioeradication.org/polio-today/polio-now/this-week/

Polio in Ukraine: Adapting operations to the reality on the ground

In 2021, confirmation was received of a cVDPV2 in Ukraine, resulting in two cases (the most recent in December 2021). Outbreak response was implemented in late 2021, but the tragic situation emerging in the country in February 2022 severely disrupted response and surveillance capacity. While the cold winter climate in the country is not conducive to poliovirus transmission, undetected circulation cannot be ruled out.

The GPEI has a long history of working in a variety of complex environments and will continue to adapt its operations to the reality on the ground, to the degree possible, without compromising the safety and security of health workers. Immunization and surveillance continued to be assessed in neighbouring countries to minimize the risk and consequences of any potential infectious disease emergence or spread resulting from large-scale population movements. The GPEI strengthened synergies with broader immunization provision for displaced persons, including by ensuring that polio vaccines were included in the package of health interventions and by using polio surveillance to help detect other vaccine-preventable diseases.

The situation in Ukraine is a further stark reminder that the opportunity to eradicate polio must be capitalized on. It is never possible to know when the next global crisis will emerge (be it due to insecurity or a pandemic). The successful eradication of polio will give the world one less infectious disease to worry about once and for all.

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DELIVERING ON A PROMISE: THE ENABLING FACTORS

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The Polio Eradication Strategy 2022–2026 lays out the roadmap to achieving and sustaining a world free of all polioviruses, in perpetuity. Successful implementation requires a number of critical enabling success factors.

THE IMPORTANCE OF GENDER, INTEGRATION, TRANSITION AND POST-CERTIFICATION

The GPEI continued its trailblazing work to ensure gender equality across its operations at all levels. The eradication strategy revision process in 2020 and 2021 allowed the Gender Equality Strategy 2019–2023 and the Polio Eradication Strategy 2022–2026 to become fully aligned, including through gender-sensitive and gender-specific key performance indicators and other gender metrics as well as dedicated resources. Further to the GPEI management review and to ensure gender work is mainstreamed across the programme and partnership, a Gender Mainstreaming Group was established within the Global Programme Support Group. The Gender Mainstreaming Group will focus on coordination, knowledge sharing, the promotion of best practices and lessons learned, technical work, and advocacy and communications.

During 2021, despite the challenges of the COVID-19 pandemic, the GPEI continued to make progress in areas to improve women's meaningful engagement and in sex-disaggregated data collection and analysis to inform programming. Efforts were also made to enhance advocacy and the gender equality capacity of GPEI staff and partners. Highlights from 2021 include:

- The cross-partnership Gender Data Working Group acted throughout the year to strengthen the analysis of surveillance sex-disaggregated data to investigate any potential gender discrepancies among zero-dose children.
- Gender was mainstreamed in technical GPEI documents and guidelines (Global Polio Surveillance Action Plan 2022–2024 and Standard Operating Procedures: Responding to a polio event or outbreak).
- For the first time, the 2021 Afghanistan and Pakistan Technical Advisory Groups included specific gender recommendations in their programmes to ensure they are more gender-responsive in their planning and implementation, based on dedicated technical support to Technical Advisory Group members.
- New Champions joined the Gender Champion for Polio Eradication initiative: H.E. Carole Lanteri, Ambassador and Permanent

Representative of the Principality of Monaco to the United Nations Office at Geneva, and Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean.

- Gender Champions continued to communicate and advocate. One example is an op-ed entitled "The future of public health depends on women" by former Minister of Foreign Affairs, European Union and Cooperation of Spain, Arancha González Laya, after her visit to a health centre in Chad.
- To commemorate World Polio Day, on 25 October 2021, UNICEF hosted an online event on the "Role of Women in Polio Eradication" to showcase the work, lives and voices of women around the world directly involved in or supporting polio eradication.
- During the year, the GPEI continued to provide technical support to integrate gender into the WHO Scholar certification course on Immunization Agenda 2030 and to ensure inter-agency collaboration at all stages of development and implementation of programme strategies through an inclusive and consultative process across the partnership. The GPEI is a founding member of the Alliance Gender Equality and Immunization.

A statistical analysis of zero-dose children was performed in 2021 using 2016–2020 sex-disaggregated surveillance data for children aged 0–36 months. It was conducted through an intra-cluster correlation coefficient and adjusted multiple regression analysis to calculate risk at the province and district levels in endemic countries (Afghanistan and Pakistan). Age and sex were used as risk variables to calculate the risk of children being among those who do not receive any dose and to calculate if this risk was equally distributed across the countries. The results were mapped to showcase the districts in which children had a higher risk of not receiving any doses. In Afghanistan, some districts showed a higher risk for girls to receive zero doses and, in Pakistan, both boys and girls were at higher risk of receiving zero doses in certain districts. The Gender Data Working Group validated these results with additional data, including post-campaign sex-disaggregated data[5].

Cross-programmatic integration has been accelerated by the COVID-19 pandemic, during which the GPEI has worked closely with other health programmes. In places where the polio programme has the largest presence, polio staff have contributed to the COVID-19 pandemic response and immunization recovery efforts through the

[5] Data in WHO HQ, 2022; Eradication of poliomyelitis: Report by the Director-General; 152nd Executive Board (January 2023) – in print

introduction and roll-out of COVID-19 vaccines. A newly published WHO report documents the extent of this work in 2021, with the polio workforce contributing in areas such as surveillance, capacity building, community engagement, data management, logistics and coordination for COVID-19 vaccine roll-out. These contributions, which extend beyond eradicating polio, demonstrate the transferable skills of the polio staff and their added value for broader public health, in the context of polio transition.

For polio eradication to succeed, chronically low immunization coverage and vaccine hesitancy in key geographies and populations must be addressed. Integration provides targeted solutions to tackle these challenges. At the same time, integration must be seen as a step towards the long-term, sustainable transition of GPEI functions and assets to other health programmes and national health systems as the world nears polio eradication. The GPEI therefore continues to align its priorities with key global vaccine and immunization strategies, such as the Immunization Agenda 2030 and the Gavi Strategic Plan 5.0 (2021–2025), focusing particularly on identifying and reaching zero-dose communities.

INTERNATIONAL SUPPORT FOR THE GLOBAL ERADICATION EFFORT

To ensure that assets, tools and knowledge from eradicating polio are sustainably integrated into national health systems, polio transition efforts are in progress alongside eradication. By the end of 2021, more than 50 polio-free countries transitioned out of GPEI support[6], which shows the success of the programme in eradicating polio in some of the world's toughest geographies. In these countries, critical functions have been integrated into WHO's immunization and health emergency programmes to sustain capacities for immunization, disease detection, and outbreak preparedness and response that need to be maintained until and even beyond eradication. Transition is the eventual pathway for all countries currently receiving GPEI support.

ONCE POLIO IS ERADICATED, ENSURING IT WILL *REMAIN* ERADICATED

The last two deaths ever to be associated with smallpox – the only human disease to have been globally eradicated – were associated with an inadvertent laboratory containment failure. The GPEI takes this as a stark reminder of the need to put in place all necessary safeguards to minimize the risk of polio re-emergence in a post-polio world.

Containing polioviruses in laboratories and vaccine manufacturing sites is a key component of this area of work. In 2021, work continued to implement the WHO Global Action Plan to minimize poliovirus facility-associated risk in designated poliovirus-essential facilities and, in 2022, the aim is to further provide guidance to Member States.

Following the successful eradication of WPV globally, the use of all remaining OPV from routine immunization programmes will end in order to eliminate the long-term risk of vaccine derived polioviruses. This cessation of OPV use is planned for one year after the certification globally of WPV eradication, and planning is already starting now, including through continued strategic guidance from groups such as the Global Commission for the Certification of the Eradication of Poliomyelitis and the Strategic Advisory Group of Experts on immunization. Much was learned from the switch from the trivalent OPV to a bivalent OPV in April/May 2016, and the lessons for final OPV

[6] Polio transition planning and polio post-certification – Report by the Director-General, 75th World Health Assembly, A75/24, 12 April 2022

cessation will be incorporated. Additionally, an OPV Cessation Team, consisting of wider-than-GPEI stakeholder participation, will be formed to ensure the appropriate planning, coordination and implementation of all OPV cessation aspects.

In 2021, financial support for the global eradication effort was strong, led first and foremost by Rotary International and Rotarians, as well as by donor governments, domestic contributions and private-sector engagement.

The Polio Eradication Strategy 2022–2026: Delivering on a promise lays out the roadmap to achieving not just a sustained polio-free world, but one in which the polio infrastructure will continue to contribute to stronger health systems – and thereby to a more stable and functioning civil society – long after the disease is gone.

The Polio Eradication Strategy 2022–2026 must be fully financed and, to this effect, the GPEI published its Investment Case 2022–2026 in April 2022, detailing the economic and humanitarian benefits of polio eradication. Germany generously agreed to host a global pledging moment in late 2022, giving the international development community the opportunity to publicly recommit to the effort.

CONTRIBUTIONS IN 2021

The GPEI thanks all donors who helped immunize more than 370 million children worldwide against polio and who helped the polio infrastructure support broader public health initiatives, including global COVID-19 pandemic response efforts[7].

[7] Financing the Global Polio Eradication Initiative, https://polioeradication.org/financing/

DONORS	AMOUNT
G7 COUNTRIES	
USA*	US$ 125 610 000
Germany	US$ 42 120 000
Canada	US$ 32 480 000
United Kingdom	US$ 6 990 000
Japan	US$ 100 000
Sub-total:	**US$ 207 300 000**
NON-G7 OECD COUNTRIES	
Norway	US$ 5 820 000
Australia	US$ 5 400 000
Luxembourg	US$ 610 000
Spain	US$ 110 000
Türkiye	US$ 20 000
Sub-total:	**US$ 11 960 000**
OTHER DONOR COUNTRIES	
United Arab Emirates	US$ 15 030 000
Monaco	US$ 60 000
Liechtenstein	US$ 30 000
Sub-total:	**US$ 15 120 000**
PRIVATE SECTOR / NON-GOVERNMENTAL DONORS	
Bill & Melinda Gates Foundation	US$ 300 650 000
Rotary International	US$ 150 590 000
His Highness Sheikh Mohamed Bin Zayed Al Nahyan	US$ 13 000 000
National Philanthropic Trust / Private Philanthropists	US$ 10 700 000
United Nations Foundation	US$ 1 650 000
Al Ansari Exchange	US$ 500 000
Sub-total	**US$ 477 090 000**
MULTILATERAL SECTOR	
Islamic Development Bank Loan / Government of Pakistan	US$ 60 000 000
UNICEF Regular and Other resources	US$ 3 130 000
Sub-total:	**US$ 63 130 000**
DOMESTIC RESOURCES	
Egypt	US$ 4 400 000
Sudan	US$ 4 900 000
Tajikstan	US$ 530 000
Sub-total:	**US$ 9 830 000**
GRAND - TOTAL	**US$ 784 430 000**

* WHO and UNICEF received US$ 126.61 million in 2021 from CDC and USAID. For FY21, the US Congress appropriated US$ 176 million for the polio eradication activities of theCDC and US$ 65 million for USAID. For more information, please see https://polioeradication.org/financing/donors/historical-contributions/

ANNEXES

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KEY PERFORMANCE INDICATORS* OF THE POLIO ERADICATION STRATEGY 2022–2026: DELIVERING ON A PROMISE

OBJECTIVE	KEY PERFORMANCE INDICATORS	2022 RESULTS Q1	Q2
Goal 1	Stop WPV transmission for outbreak countries	at risk	at risk
Goal 2	Stop cVDPV transmission, prevent outbreaks	off track	off track
1. Political will	1.1.1. PHEIC declaration for outbreak countries	at risk	at risk
	1.1.2. Inaccessible districts	at risk	at risk
	1.1.3. High level meetings of national task force	at risk	at risk
	1.2.1. Domestic medical / vax vacant positions	unavailable	at risk
	1.2.2. Post NID meetings, provincial level	unavailable	on track
	1.2.3. Domestic contributions to outbreak response	off track	off track
2. Vaccine acceptance	2.1.1. SIAs caregiver awareness	off track	off track
	2.2.2. Female healthworker at the forefront	off track	off track
	2.2.3. Missed children	unavailable	at risk
	2.3.1. Innovation in community engagement	at risk	unavailable
3. Intergration and partnership	3.1.1. Zero dose children	unavailable	at risk
	3.2.1. GPEI-Gavi joint investment	unavailable	unavailable
	3.2.2. Integrated campaigns	unavailable	on track
	3.3.2. Contributions to COVID-19 response	at risk	unavailable
4. Campaign operations	4.1.1. Enhanced microplanning	unavailable	unavailable
	4.1.3. Sex desagregated SIA results (0 dose AFP cases, F vs M)	unavailable	on track
	4.1.4. Outbreaks stopped within 28 days	off track	off track
	4.2.1. Round 1 of outbreak within 28 days	off track	off track
	4.2.2. Funds availability 72h before outbreak SIAs	off track	unavailable
	4.3.1. Countries verified for nOPV use	on track	on track
	4.3.2. nOPV2 use vs total type 2	on track	on track
5. Sensitive surveillance	5.1.1. Non-polio acute flaccid paralysis rate	at risk	on track
	5.1.2. Environment Sites sensitivity	off track	off track
	5.2.1. Stool adequacy by sex	at risk	on track
	5.2.2. WPV isolates result within 35 days	on track	off track
	5.2.3. cVDPV isolates result within 35 days	off track	off track

* KPIs available only since 2022. In 2021, process for new KPIs was being finalized, alongside publication of new Polio Eradication Strategy 2022-2026

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

ENDEMIC COUNTRIES

AFGHANISTAN					
Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
		Female	Male	Female	Male
Equal reach in immunization campaigns	% F/M vaccinated	93.1	93.5	92.5	93.3
Equal doses received	Median # doses F/M	5	6	5	4
	% F/M 0-dose	5.72	7.17	6.02	5.02
	% F/M 3+ doses	88.56	88.35	87.43	87.08
Equal timeliness of disease notification	Median # days disease notification	3	3	3	3
	% F/M <= 3 days	54.02	56.65	55.35	54.16
Women's participation in immunization campaigns	% F/M frontline workers	>50%	41%	59.30%	68.4%

PAKISTAN					
Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
		Female	Male	Female	Male
Equal reach in immunization campaigns	% F/M vaccinated	96.44	96.81	96.12	96.28
Equal doses received	Median # doses F/M	8	8	8	8
	% F/M 0-dose	0.43	0.71	0.36	0.6
	% F/M 3+ doses	99.15	98.75	98.96	98.89
Equal timeliness of disease notification	Median # days disease notification	3	3	3	3
	% F/M <= 3 days	53.18	53.75	51.36	53.83
Women's participation in immunization campaigns	% F/M frontline workers	>80%	60	59	41

GENDER SENSITIVE INDICATORS - OUTBREAK COUNTRIES

WHO REGIONAL OFFICE FOR THE AFRICA

	Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
			Female	Male	Female	Male
ALGERIA	Equal doses received	Median # doses F/M	3	3	0	0
		% F/M 0-dose	0	0	0	0
		% F/M 3+ doses	86.11	96.77	92	86
	Equal timeliness of disease notification	Median # days disease notification	0	0	0	0
		% F/M <= 3 days	100	100	100	100
ANGOLA	Equal doses received	Median # doses F/M	1	0	0	0
		% F/M 0-dose	4.55	9.8	14	14.71
		% F/M 3+ doses	70.45	70.59	66	64.71
	Equal timeliness of disease notification	Median # days disease notification	6	5	5	5
		% F/M <= 3 days	26.97	35.59	38.46	35.48
BENIN	Equal doses received	Median # doses F/M	1	0	0	0
		% F/M 0-dose	4.55	9.8	14	14.71
		% F/M 3+ doses	70.45	70.59	66	64.71
	Equal timeliness of disease notification	Median # days disease notification	6	5	5	5
		% F/M <= 3 days	26.97	35.59	38.46	35.48
BURKINO FASO	Equal doses received	Median # doses F/M	4	4	3	3
		% F/M 0-dose	3.74	2.92	3.1	4.07
		% F/M 3+ doses	89.72	91.67	92.04	91.11
	Equal timeliness of disease notification	Median # days disease notification	4	3	3	3
		% F/M <= 3 days	47.87	53.51	58.73	52.68
CAMEROON	Equal doses received	Median # doses F/M	3	2	3	3
		% F/M 0-dose	3.19	1.55	2.44	0.7
		% F/M 3+ doses	81.91	88.37	86.59	86.71
	Equal timeliness of disease notification	Median # days disease notification	4	6	5.5	4
		% F/M <= 3 days	39.58	35	36.62	40.61
CENTRAL AFRICAN REPUBLIC	Equal doses received	Median # doses F/M	2	0	3	3
		% F/M 0-dose	4.17	3.57	3.23	0
		% F/M 3+ doses	87.5	89.29	80.65	85.29
	Equal timeliness of disease notification	Median # days disease notification	5	5	4.5	5
		% F/M <= 3 days	36.96	26.79	36.54	33.33

	Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
			Female	Male	Female	Male
CHAD	Equal doses received	Median # doses F/M	3.5	3	4	4
		% F/M 0-dose	6.35	5.42	3.33	2.73
		% F/M 3+ doses	83.33	76.51	84.29	85.91
	Equal timeliness of disease notification	Median # days disease notification	5	6	6	6
		% F/M <= 3 days	30.11	29.28	26.6	26.85
CONGO	Equal doses received	Median # doses F/M	0	0	0.5	0
		% F/M 0-dose	18.18	25.81	11.76	22.22
		% F/M 3+ doses	40.91	51.61	70.59	61.11
	Equal timeliness of disease notification	Median # days disease notification	6	4	5	4
		% F/M <= 3 days	39.53	43.64	32.26	37.84
COTE D'IVOIRE	Equal doses received	Median # doses F/M	3	3	4	3
		% F/M 0-dose	2.41	3.88	0.8	0
		% F/M 3+ doses	72.29	74.76	80.8	87.72
	Equal timeliness of disease notification	Median # days disease notification	4	4	4	4
		% F/M <= 3 days	45.45	41.9	44.39	46.73
DEMOCRATIC REPUBLIC OF THE CONGO	Equal doses received	Median # doses F/M	3	3	3	3
		% F/M 0-dose	8.87	6.1	10.18	9.38
		% F/M 3+ doses	75.28	75.18	75.66	79.29
	Equal timeliness of disease notification	Median # days disease notification	5	5	4	5
		% F/M <= 3 days	34.99	34.35	40.55	36.01
ERITREA	Equal doses received	Median # doses F/M	0	0	3	3
		% F/M 0-dose	0	0	0	3.7
		% F/M 3+ doses	100	100	100	92.59
	Equal timeliness of disease notification	Median # days disease notification	3.5	3	4	4
		% F/M <= 3 days	50	48.21	43.9	33.33
ETHIOPIA	Equal doses received	Median # doses F/M	3	0	1	1
		% F/M 0-dose	1.04	3.02	7.88	3.38
		% F/M 3+ doses	89.06	84.91	60.1	67.67
	Equal timeliness of disease notification	Median # days disease notification	4.5	5	5	5
		% F/M <= 3 days	35.01	36.21	28.27	27.24
GAMBIA	Equal doses received	Median # doses F/M	1.5	0	3	0
		% F/M 0-dose	0	0	0	0
		% F/M 3+ doses	100	100	100	100
	Equal timeliness of disease notification	Median # days disease notification	1.5	8	2	3
		% F/M <= 3 days	75	40	80	55.56

	Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
			Female	Male	Female	Male
GHANA	Equal doses received	Median # doses F/M	3	3	3	3
		% F/M 0-dose	0.81	0	0	1.69
		% F/M 3+ doses	94.31	95.24	95	93.22
	Equal timeliness of disease notification	Median # days disease notification	5	4	4	3
		% F/M <= 3 days	40.91	44.32	40.45	52.36
GUINEA	Equal doses received	Median # doses F/M	2	3	2	2
		% F/M 0-dose	7.89	4.23	6.78	0
		% F/M 3+ doses	60.53	77.46	54.24	66.67
	Equal timeliness of disease notification	Median # days disease notification	4	4	3	3
		% F/M <= 3 days	41.41	44.76	50.57	56.41
GUINEA - BISSAU	Equal doses received	Median # doses F/M	0	2	4	3
		% F/M 0-dose		0	0	0
		% F/M 3+ doses		100	100	100
	Equal timeliness of disease notification	Median # days disease notification	2	6	9.5	7
		% F/M <= 3 days	66.67	33.33	25	14.29
LIBERIA	Equal doses received	Median # doses F/M	2	3	1	1
		% F/M 0-dose	0	0	0	0
		% F/M 3+ doses	78.95	80.56	66.67	41.18
	Equal timeliness of disease notification	Median # days disease notification	6.5	5.5	5	5
		% F/M <= 3 days	25	30	47.06	37.5
MADAGASCAR	Equal doses received	Median # doses F/M	3	3	4	3
		% F/M 0-dose	4.12	3.54	2.88	3.74
		% F/M 3+ doses	75.26	85.84	88.46	87.85
	Equal timeliness of disease notification	Median # days disease notification	3	3	2	2
		% F/M <= 3 days	54.11	53.5	62.07	67.31
MALAWI	Equal doses received	Median # doses F/M	0	0	0	0
		% F/M 0-dose	0	0	0	0
		% F/M 3+ doses	80	100	94.12	88.89
	Equal timeliness of disease notification	Median # days disease notification	5	6	4.5	8
		% F/M <= 3 days	26.32	24.24	40.35	29.41
MAURITANIA	Equal doses received	Median # doses F/M	0	2	0	2
		% F/M 0-dose	0	0	0	3.45
		% F/M 3+ doses	100	80	94.12	86.21
	Equal timeliness of disease notification	Median # days disease notification	2	2	6	3
		% F/M <= 3 days	63.64	55.56	38.78	50

	Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
			Female	Male	Female	Male
MOZAMBIQUE	Equal doses received	Median # doses F/M	3	3	3	3
		% F/M 0-dose	1.23	0	0	1.59
		% F/M 3+ doses	87.65	79.17	93.48	74.6
	Equal timeliness of disease notification	Median # days disease notification	8	6	6	7
		% F/M <= 3 days	14.93	23.81	28.57	29.7
NIGER	Equal doses received	Median # doses F/M	5	4	4	5
		% F/M 0-dose	2	0.82	1.68	1.83
		% F/M 3+ doses	97	87.7	84.87	85.37
	Equal timeliness of disease notification	Median # days disease notification	9	9	8	7
		% F/M <= 3 days	12.2	16.55	17.5	20.1
NIGERIA	Equal doses received	Median # doses F/M	8	8	8	8
		% F/M 0-dose	0.38	0.07	0.06	0.05
		% F/M 3+ doses	99.25	99.49	99.74	99.85
	Equal timeliness of disease notification	Median # days disease notification	5	5	5	5
		% F/M <= 3 days	33.31	33.84	34.97	31.89
SENEGAL	Equal doses received	Median # doses F/M	2	2.5	0	3
		% F/M 0-dose	0	0	0	0
		% F/M 3+ doses	78.12	89.58	100	100
	Equal timeliness of disease notification	Median # days disease notification	4	4	3	5
		% F/M <= 3 days	43.28	43.3	49.43	42.34
SIERRA LEONE	Equal doses received	Median # doses F/M	3	3	3	3
		% F/M 0-dose	0	2.27	0	0
		% F/M 3+ doses	83.33	84.09	96	92.86
	Equal timeliness of disease notification	Median # days disease notification	5	4	6	5
		% F/M <= 3 days	37.78	43.4	35.48	40
SOUTH SUDAN	Equal doses received	Median # doses F/M	3.5	3	3	2
		% F/M 0-dose	8.6	7.69	0	3.81
		% F/M 3+ doses	74.19	71.43	79.31	65.71
	Equal timeliness of disease notification	Median # days disease notification	4	4	4	3
		% F/M <= 3 days	42.06	32.85	44.96	49.06
TOGO	Equal doses received	Median # doses F/M	3	0	2	3
		% F/M 0-dose	0	9.09	0	2.99
		% F/M 3+ doses	96.3	84.85	87.5	95.52
	Equal timeliness of disease notification	Median # days disease notification	5.5	6	3	4
		% F/M <= 3 days	37.04	30.88	50	41.84

	Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
			Female	Male	Female	Male
UGANDA	Equal doses received	Median # doses F/M	0	0	2	3
		% F/M 0-dose	0.79	0	1.99	2.65
		% F/M 3+ doses	86.51	92.62	86.09	87.61
	Equal timeliness of disease notification	Median # days disease notification	6	5	4	5
		% F/M <= 3 days	33.59	30.09	41.37	35.97

GENDER SENSITIVE INDICATORS - OUTBREAK COUNTRIES

WHO REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

	Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
			Female	Male	Female	Male
DJIBOUTI	Equal doses received	Median # doses F/M	5	5	4	0
		% F/M 0-dose	0	0	0	
		% F/M 3+ doses	100	100	100	
	Equal timeliness of disease notification	Median # days disease notification	3	7	6	2
		% F/M <= 3 days	100	0	0	66.67
EGYPT	Equal doses received	Median # doses F/M	8	9	9	10
		% F/M 0-dose	0.51	0.43	0	0.4
		% F/M 3+ doses	99.49	99.57	100	99.6
	Equal timeliness of disease notification	Median # days disease notification	2	2	2	3
		% F/M <= 3 days	81.06	78.99	76.21	69.51
SOMALIA	Equal doses received	Median # doses F/M	4	4	4	6
		% F/M 0-dose	18.97	12.64	8.33	10.67
		% F/M 3+ doses	79.31	74.71	72.92	82.67
	Equal timeliness of disease notification	Median # days disease notification	3	3	3	3
		% F/M <= 3 days	59.49	59.46	63.49	59.38
SUDAN	Equal doses received	Median # doses F/M	4	4	2.5	3
		% F/M 0-dose	3.61	0	4.71	3.81
		% F/M 3+ doses	92.77	95.74	90.59	92.38
	Equal timeliness of disease notification	Median # days disease notification	3	3	2	2
		% F/M <= 3 days	57.86	50.64	62.99	65.78
YEMEN	Equal doses received	Median # doses F/M	3	2	2	1
		% F/M 0-dose	10.34	5.93	17.2	14.74
		% F/M 3+ doses	77.59	78.52	65.61	70
	Equal timeliness of disease notification	Median # days disease notification	4	4	4	4
		% F/M <= 3 days	44.57	45.87	39.91	43.14

GENDER SENSITIVE INDICATORS – OUTBREAK COUNTRIES

WHO REGIONAL OFFICE FOR EUROPE

	Outcome	Indicator	Jan-Jun 2021		Jul-Dec 2021	
			Female	Male	Female	Male
ISRAEL	Equal doses received	Median # doses F/M	4	0	1.5	6
		% F/M 0-dose	0		0	0
		% F/M 3+ doses	100		100	100
	Equal timeliness of disease notification	Median # days disease notification	6	10	12	5.5
		% F/M <= 3 days	14.29	0	25	25
UKRAINE	Equal doses received	Median # doses F/M	0	3	2	0
		% F/M 0-dose	0	0	0	0
		% F/M 3+ doses	75	83.33	92.31	100
	Equal timeliness of disease notification	Median # days disease notification	2.5	2	1	1
		% F/M <= 3 days	61.11	73.68	89.29	83.02

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