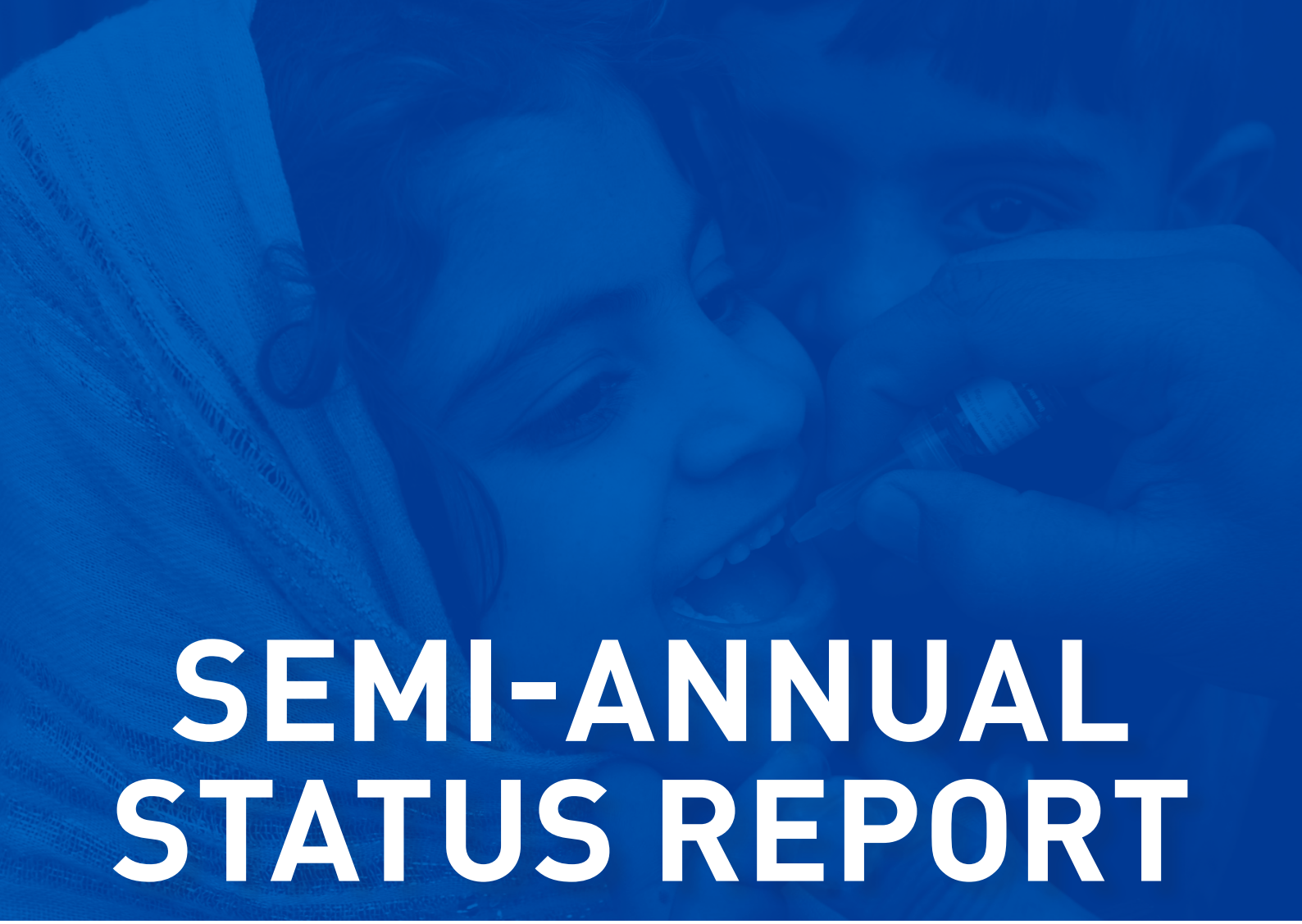


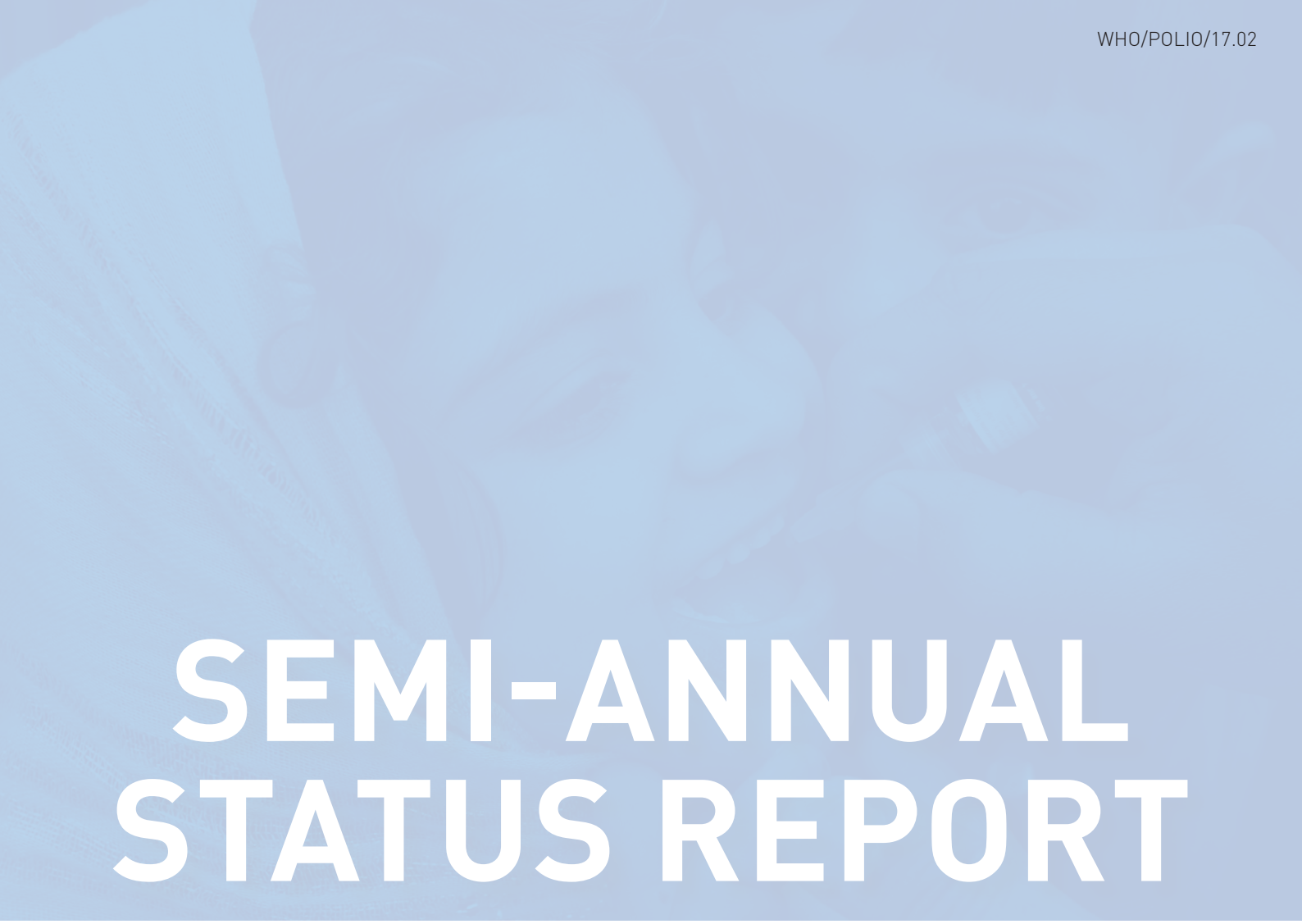
SEMI-ANNUAL STATUS REPORT

JULY TO DECEMBER 2016

PROGRESS AGAINST THE POLIO ERADICATION & ENDGAME STRATEGIC PLAN

POLIO GLOBAL ERADICATION INITIATIVE

WHO/POLIO/17.02



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PROGRESS AGAINST THE POLIO ERADICATION & ENDGAME STRATEGIC PLAN

POLIO GLOBAL ERADICATION INITIATIVE

Design by Paprika (Annecy, France)

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ACRONYMS

bOPV	Bivalent oral polio vaccine
cVDPV	Circulating vaccine-derived poliovirus
cVDPV1	Circulating vaccine-derived poliovirus type 1
cVDPV2	Circulating vaccine-derived poliovirus type 2
GAPIII	Third edition of the WHO Global Action Plan to minimize poliovirus facility associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use
GPEI	Global Polio Eradication Initiative
IPV	Inactivated polio vaccine
mOPV2	Monovalent oral polio vaccine type 2
OPV	Oral polio vaccine
OPV2	Oral polio vaccine type 2
SAGE	Strategic Advisory Group of Experts on immunization
tOPV	Trivalent oral polio vaccine
VDPV2	Vaccine-derived poliovirus type 2
WPV	Wild poliovirus
WPV1	Wild poliovirus type 1
WPV2	Wild poliovirus type 2

INTRODUCTION

The Global Polio Eradication Initiative (GPEI) Polio Eradication & Endgame Strategic Plan (Endgame Plan) aims to make polio the second-ever human disease to be eradicated from the world. At the time of the GPEI's founding in 1988, polio was endemic in more than 125 countries and paralysed 350 000 children every year. Since then, the GPEI has overseen a 99% reduction in annual cases of polio, with only 37 wild poliovirus (WPV) cases reported in 2016 from just three countries.

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

EXECUTIVE SUMMARY

By the end of 2016, progress continued towards each of the Endgame Plan's four objectives. The world has never been closer to eradicating polio, with fewer cases in fewer areas of fewer countries than at any time in the past. The virus is now more geographically constrained than at any point in history.

In the second half of 2016, Pakistan and Afghanistan continued to intensify eradication efforts and implement their respective national emergency action plans, overseen by each country's head of state. They continued to treat the virus transmission as a single epidemiological block and focused on coordinating activities in both countries.

In August, wild poliovirus type 1 (WPV1) was detected in Borno, Nigeria, the first WPV detected in the country since 2014, a sobering reminder of the fragility of global progress and of the dangers of any subnational surveillance gap and low-level residual virus transmission. The outbreak was immediately declared a regional public health emergency, and an emergency outbreak response across Nigeria and the Lake Chad subregion was launched.

Although falling outside the reporting period of this report, the first case in 2017 was reported, from Afghanistan, with onset of paralysis on 13 January. With confirmation of transmission into early 2017, global certification of poliomyelitis eradication will now occur at the earliest in 2020.

Following the successful globally coordinated switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) in April, surveillance and response for type 2 polioviruses continued to be intensified in the second half of the year. Outbreak response to previously detected circulating vaccine-derived poliovirus type 2 (cVDPV2) continued in Guinea, Lao People's Democratic Republic and Madagascar, with no new cases reported during the reporting period. In Nigeria, the regional outbreak response to the detected WPV1 also addressed two separate cVDPV2s, in Borno and Sokoto states.

A global supply constraint of inactivated polio vaccine (IPV) continued to be managed carefully, allocating available supply to areas deemed at highest risk of cVDPV2 emergence. Increasing clinical evidence indicates that fractional dose IPV provides equal (and in a two-dose schedule, even superior) protection to full dose IPV, and this approach could substantially stretch limited supply further. India, Bangladesh and Sri Lanka successfully maintained this approach, ensuring their national supply could meet their respective population needs. In October, the Strategic Advisory Group of Experts on immunization (SAGE) urged countries to adopt this approach, in lieu of full dose IPV, in their routine immunization programmes. The GPEI continued to work with other partners and manufacturers to further alleviate the supply constraint. The primary outbreak response tool, should it be needed, remained the global stockpile of monovalent OPV type 2 (mOPV2), which is not affected by a global supply constraint.

To minimize the risk of accidental release of polioviruses into the environment, which could lead to outbreaks, countries intensified their efforts to ensure the identification, destruction or safe handling and containment of polioviruses in vaccine manufacturing or research facilities. Priority was given to containing the type 2 polioviruses in such facilities.

The overriding priority remained to eradicate the final strains of poliovirus transmission and to ensure that the full capacity to do so was in place. At the same time, a comprehensive transition planning process intensified in the latter half of 2016. In 16 priority countries,

accounting for 95% of GPEI assets, national transition planning was under way to ensure that the capacity to continue supporting other health programmes remains in place, even after polio has been eradicated from the world. A comprehensive strategic road map towards polio transition and the development of a post-certification strategy will be presented to the World Health Assembly in 2017.

Fully implementing all Endgame Plan strategies requires an additional US$ 1.3 billion. Securing a lasting polio-free world will not only be associated with significant humanitarian benefits but also with economic advantages, as eradicating polio worldwide will result in global savings of US$ 50 billion.

The world is closer than ever to being polio-free. Now is the time to redouble efforts and step over the finish line once and for all. It has been said of Edward Jenner, the medical doctor from rural England who in 1796 pioneered the world's first vaccine (against smallpox), that no other single human being who has ever lived has saved more lives in history. That is the power of vaccination and disease eradication. By securing a polio-free world, it is possible to show what can be achieved when everyone unites towards a common goal.

Together with GPEI partners Rotary International, the US Centers for Disease Control and Prevention (CDC), UNICEF and the Bill & Melinda Gates Foundation, the GPEI stands ready to support all stakeholders, partners and countries in their final push to secure a polio-free world once and for all.

OBJECTIVE 1: POLIOVIRUS DETECTION AND INTERRUPTION

At the beginning of 2016, polio was more geographically constricted than ever before, as only two endemic countries remained: Afghanistan and Pakistan. Despite Nigeria returning to the list following the detection of WPV1 in August 2016, this year saw the lowest number of polio cases in recorded history – just 37, down from 74 in 2015.

Polio in Nigeria

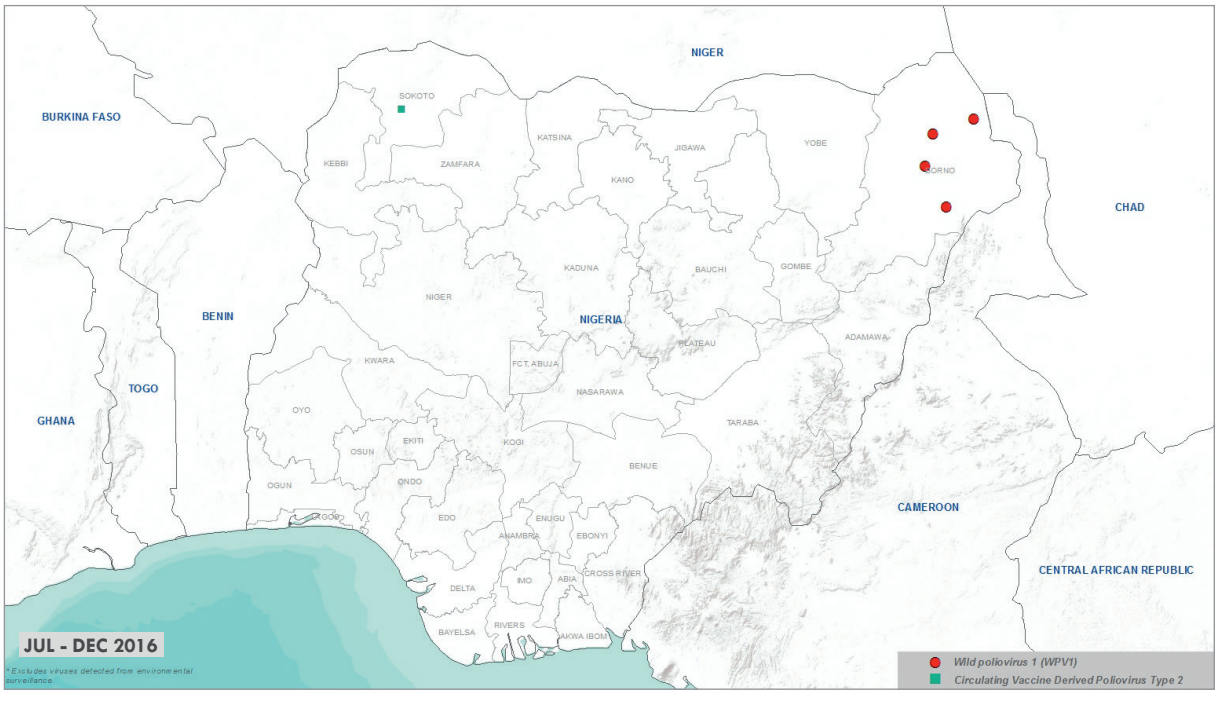
In August 2016, four new cases of paralysis due to WPV1 were detected from Borno state. Genetic sequencing of the isolated viruses suggested they were most closely linked to WPV1 last detected in Borno in 2011, indicating the strain had circulated without detection since that time. The Government of Nigeria immediately launched an aggressive outbreak response, conducting several rounds of supplementary immunization activities using bOPV. The outbreak was declared a national public health emergency, and Nigeria was put back on the list of polio endemic countries. Furthermore, health ministers at the WHO Regional Committee for Africa declared the polio outbreak to be a regional public health emergency for countries in the Lake Chad subregion, generating a wider outbreak response covering Cameroon, Central African Republic, Chad, Niger and Nigeria.

Improved access in some conflict-affected areas was used to rapidly raise the immunity of newly accessible populations. Additional measures were implemented to strengthen the sensitivity of subnational surveillance.

The outbreak response was coordinated within the context of the humanitarian emergency affecting north-eastern Nigeria.

Nigeria continued to have strong immunity to the virus in most locations, but the detection of these cases underscored the risk posed by low-level undetected transmission, and the urgent need to strengthen subnational surveillance everywhere.

Nigeria wild poliovirus and cVDPV – July to December 2016



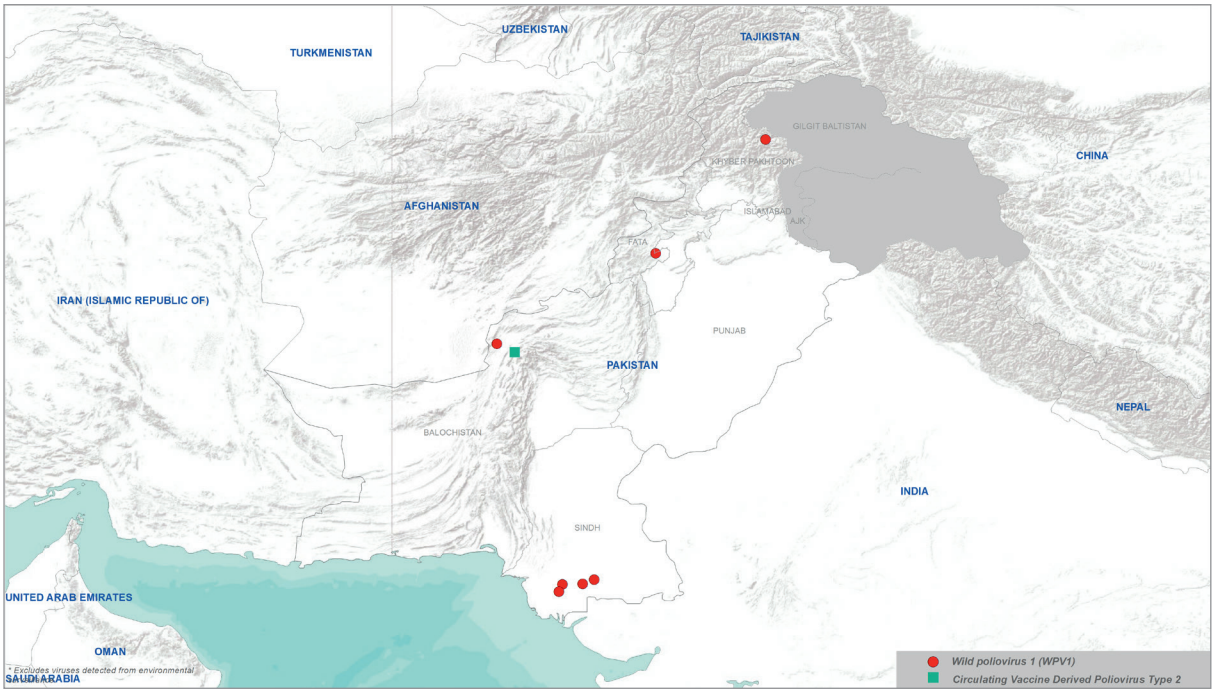
Progress in Afghanistan and Pakistan

Cases in Afghanistan remained low in 2016; 12 cases were reported compared to 20 the year before. Most of the country remained polio-free, with no cases from the traditional reservoirs. The virus was mainly confined to two small areas: Kunar and Paktika in the east and south-east, and in the northern parts of Helmand and Kandahar in the south. The programme continued to operate and adapt in the midst of a fluctuating security situation to reach the maximum number of children possible while maintaining its neutrality. The primary challenges in Afghanistan throughout 2016 remained access and programme quality.

Significant improvements continued to be made throughout 2016 in Pakistan, with case numbers falling from 54 in 2015 to 20. It was the lowest-ever annual number of polio cases in the country, but poliovirus continued to be isolated through environmental surveillance over a wide geographical area, indicating ongoing transmission. Significantly, two of the three core polio reservoirs (Karachi and Peshawar) demonstrated encouraging progress in 2016. Of particular note, Karachi had not reported a polio case for almost one year, and detected only three positive environmental samples since March 2016. The situation in the reservoir of Quetta Block caused concern as the local transmission of WPV continued, together with the emergence of cVDPV2 since June 2016.

The National Emergency Action Plan of Pakistan focused on identifying chronically missed children and the reasons they were missed, and on implementing area-specific approaches to overcome these challenges. As a result, innovative community-based strategies were implemented, the programme's operational weaknesses continued to be corrected, and access to previously inaccessible areas continued to be improved. Vaccination coverage rates were increased in the Peshawar-Khyber corridor and Karachi. Concerted efforts were applied to improve programme operations and to strengthen supervision and monitoring mechanisms in Quetta Block and Interior Sindh.

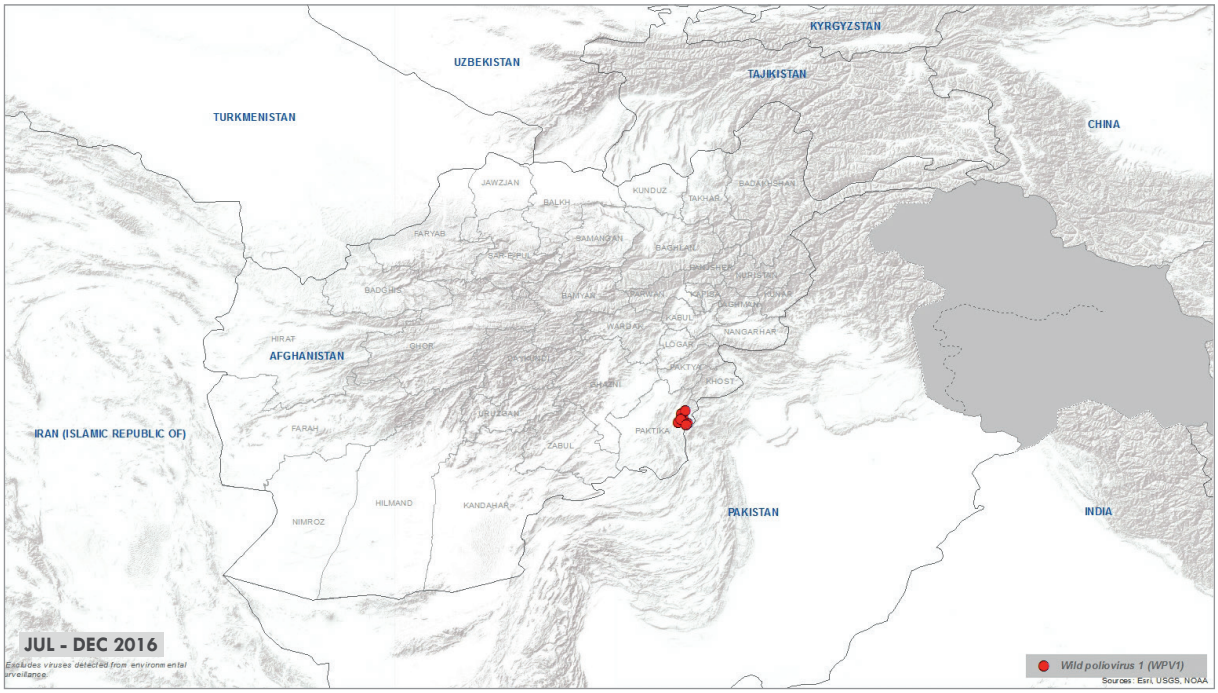
Pakistan wild poliovirus and cVDPV – July to December 2016



Emergency operations centres continued to strengthen collaboration and government ownership within both countries, with strong national emergency action plans setting priorities. Emergency operations centres in Afghanistan and Pakistan also worked together to reach high-risk groups along the border in response to increasing evidence that mobile populations were the main route by which the virus moved around the country. The number of permanent transit points was increased, and cross-border teams, permanent transit teams and special nomadic teams helped to reach children on the move.

While the progress in 2016 was heartening, the risk of backsliding in these countries and elsewhere is real if the programme's performance does not continue to improve in 2017.

Afghanistan wild poliovirus – July to December 2016



Update on circulating vaccine-derived polioviruses

This year marked a historic step forward towards the eradication of all polioviruses.

An important part of the Endgame Plan is stopping circulating vaccine-derived polioviruses (cVDPVs), which has increased in significance for the GPEI as cases of WPV drop. An important step forward in the fight against cVDPVs took place in 2016, with the withdrawal of the type 2 component of the oral polio vaccine (OPV). In April, 155 countries and territories – all those still using tOPV – carried out the switch to bOPV on one single day within a two-week period.

The removal of OPV type 2 (OPV2) was the first stage in the longer-term withdrawal of all types of OPV, which will happen once WPV has been globally certified as eradicated. A stockpile of mOPV2 was compiled for use in case of any type 2 poliovirus outbreak, released from the global stockpile, for the implementation of response activities in Cameroon, Chad, Mozambique, Niger, Nigeria and Pakistan.

In 2016, three cases of cVDPV1 were reported from Lao People's Democratic Republic in January. Both Nigeria and Pakistan remained affected by cVDPV2. In Nigeria, two separate strains circulated, in Sokoto and Borno states. In Pakistan, a cVDPV2 emerged centred around Quetta, Balochistan.

The detection of type 2 polioviruses at this time was not unusual or unexpected, although it was important to ensure that any such virus was rapidly detected, and its public health risk assessed and, if needed, responded to.

OBJECTIVE 2: IMMUNIZATION SYSTEMS STRENGTHENING AND OPV WITHDRAWAL

Between 17 April and 1 May 2016, 155 countries and territories switched from tOPV to bOPV, a historic milestone representing the largest-ever withdrawal of one vaccine and the associated roll-out of another. This achievement is a tribute to the extraordinary commitment, leadership and engagement of all Member States. The switch was the first stage of the eventual phased removal of all OPVs, which will be completed following the global certification of poliomyelitis eradication worldwide. The cessation of OPV is necessary to eliminate the very rare but long-term risks of vaccine-derived polioviruses associated with its use; it is a key strategy of the polio Endgame Plan, endorsed by the SAGE and the World Health Assembly.

To prepare for the switch to bOPV, all countries had committed to introducing at least one dose of IPV into their routine immunization programmes. The level of commitment from countries to meet this goal was exceptional.

At its meeting in October 2016, the SAGE noted the continued reduction in IPV supply caused by technical difficulties manufacturers have encountered to scale up production, and the global vaccine supply was expected to remain fragile through 2017 and 2018. The available supply of this vaccine continued to be prioritized to areas at highest risk of cVDPV2 and endemic countries.

All efforts were under way to ensure that all remaining low-risk countries receive IPV supplies as soon as they are available. With WHO regions and Member States, the GPEI explored the feasibility of instituting dose-sparing strategies, such as using intradermal fractional dose IPV. Countries, including India, Bangladesh and Sri Lanka, are already using such approaches in their routine immunization programmes. Reviewing the increasing body of data demonstrating that two fractional doses of IPV administered intradermally are more effective than a single full dose administered intramuscularly, the SAGE urged countries to adopt this approach, in lieu of full dose IPV, in their routine immunization programmes.

At the same time, surveillance for type 2 polioviruses from any source was expanded and intensified. Detection of type 2 polioviruses for a certain period of time following the switch was anticipated, as children who received tOPV up to May 2016 would excrete the type 2 strain for a limited period of time. Every type 2 poliovirus detected is investigated to determine if it presents a health risk to populations and if an immunization response is needed with mOPV2.

OBJECTIVE 3: CONTAINMENT AND CERTIFICATION

In September 2015, the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC) declared that wild poliovirus type 2 (WPV2) has been eradicated. However, the virus is still retained in laboratories and facilities worldwide, for activities such as vaccine production and research. The handling and storage of any poliovirus type 2 materials[1] in facilities poses a potential risk of release and reintroduction of the virus into the populations, to again cause paralysis and death.

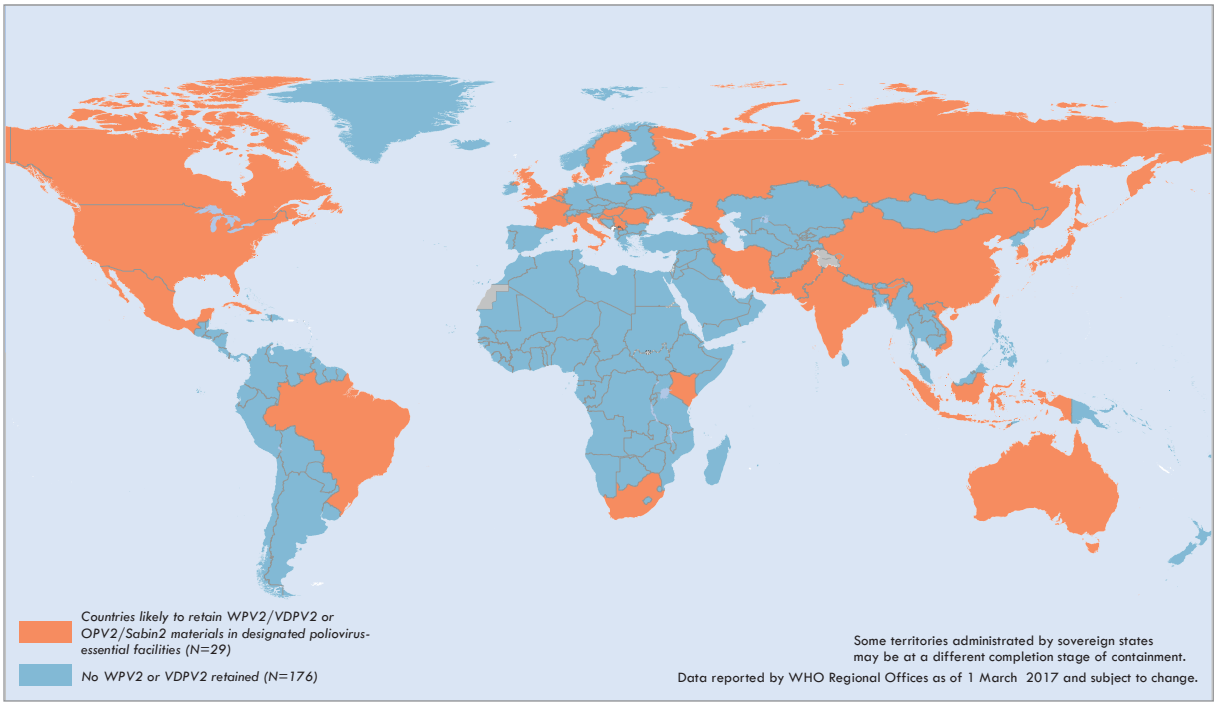
The GPEI is supporting countries to implement the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine (GAPIII). Key measures for minimizing risk include: destroying poliovirus type 2 materials, or containing materials in a certified poliovirus-essential facility that adheres to the requirements in GAPIII.

In 2016, countries continued activities to prepare for the containment of poliovirus type 2 materials (Phase I of GAPIII). In this phase, countries reported on inventories of facilities that handle or store poliovirus type 2 materials, the destruction of unneeded materials, and the designation of poliovirus-essential facilities to retain needed materials.

As of 17 January 2017, 175 countries and territories reported that they no longer have any WPV2 or VDPV2; 30 countries have designated poliovirus-essential facilities to retain poliovirus type 2 materials.

In 2016, countries with designated poliovirus-essential facilities started conducting activities in Phase II of GAPIII. Of the 30 countries with designated poliovirus-essential facilities, 17 have nominated a national authority

Reported progress on completion of GAPIII Phase I (WPV2/VDPV2)



[1] Includes all materials containing or potentially containing WPV2, vaccine-derived poliovirus type 2 (VDPV2), oral polio vaccine type 2 (OPV2) or Sabin type 2 (Sabin 2) viruses.

for containment, which is responsible for containment certification of facilities. In Phase II, designated poliovirus-essential facilities must demonstrate the implementation of the biorisk management requirements as described in GAPIII. Since February 2015, WHO has conducted 17 workshops, involving over 300 participants from facilities, national authorities for containment, and other stakeholders in all regions, to help countries strengthen their capacity for GAPIII implementation and certification.

To guide the certification process, WHO developed the Containment Certification Scheme to support the WHO Global Action Plan for Poliovirus Containment (GAPIII-CCS), endorsed by SAGE in October 2016. Since January 2017, WHO has been conducting workshops to train auditors to conduct audits against GAPIII using the mechanism described in the GAPIII-CCS.

OBJECTIVE 4: TRANSITION PLANNING

In 2016, the acceleration of polio transition planning (formerly known as "legacy planning") continued. Transition planning should serve three purposes. First, it ensures that the functions needed to maintain a polio-free world after eradication (for example, immunization, surveillance, outbreak preparedness and response, and facility containment of polioviruses) are brought into the mainstream of continuing national public health programmes. Second, it ensures that the knowledge generated and lessons learnt from polio eradication activities are shared with other health initiatives. Third, where feasible and appropriate, it assures the transfer of capabilities, assets and processes to support other health priorities.

Polio transition planning primarily needs to occur at the national level. The leadership of Member States is crucial to ensure this process. If polio transition planning is well executed, investments in polio eradication will benefit other development goals in the long term. Human resources, facilities and processes funded through the GPEI are substantially involved in the delivery of non-polio eradication functions, particularly in the areas of immunization, surveillance and emergency response. To support Member States in the process of polio transition planning, the GPEI developed guidelines for preparing a transition plan.

The 16 countries with the greatest polio-funded infrastructure proceeded to draw up their transition plans. As a result of the detection of WPV1 in Nigeria, transition planning may not happen at the same speed in the countries of the Lake Chad subregion. The momentum should not be interrupted, however, and planning should continue in the other countries, in close cooperation with the relevant stakeholders, including donors.

In tandem, WHO and other GPEI partners launched a process to develop their agency-specific transition plans for polio-funded assets at the regional and global levels. In 2016, a new Transition Independent Monitoring Board was established to monitor and guide both the national and global aspects of transition planning, reporting on progress and engagement.

As requested by Member States, including at the WHO Executive Board session in January 2017, the GPEI will present a strategic road map towards polio transition and the development of a post-certification strategy at the World Health Assembly in May 2017.

Financing the Polio Eradication & Endgame Strategic Plan

Thanks to the generous continuing support of the international development community, including Member States (comprising the endemic countries), multilateral and bilateral organizations, development banks, foundations and Rotary International, the budget for planned activities in 2016 was fully financed. Efforts continued to mobilize the additional US$ 1.3 billion to fully implement the Endgame Plan and secure a lasting polio-free world. A key event in 2017 will be the Rotary International convention in June, in Atlanta, USA, marking the 100th anniversary of the Rotary Foundation.

In addition to the significant humanitarian benefits associated with polio eradication, the effort is also associated with substantial economic benefits. A polio-free world will reap savings of more than US$ 50 billion, funds that can be used to address other pressing public health and development needs. Critical to achieving a lasting polio-free world is the rapid mobilization of the additional funds needed.

Annex 1 – Endemic and recently endemic country monitoring

AFGHANISTAN

Endemic Country	State/Area	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Afghanistan	Southern (Kandahar, Helmand)	Interrupt transmission	Number of cases	0 case	2	0
		High population immunity	% 0-dose	<10%	0.60%	0.74%
			LQAS (% lots with "High Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 5 SNIDs	2 NIDs, 5 SNIDs
			% children missed due to no visit/child absent (in 11 LPDs)		N/a	5.91%*
			% children missed due to refusal (in 11 LPDs)		N/a	1.85%*
		High virus detection	AFP rate	> 2 per 100 000	23,8	19,5
			Stool adequacy	> 80%	87.08	86.39
			Lab receipt to virus isolation result (median)	< 14 days	11	12
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases	0 case	4	7
		High population immunity	% 0-dose	<10%	0.45%	1.27%
			LQAS (% lots with "High Pass")	>= 90%	13,9%	
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 5 SNIDs	2 NIDs,4 SNIDs
		High virus detection	AFP rate	> 2 per 100 000	15,7	16,3
			Stool adequacy	> 80%	94	94,5
			Lab receipt to virus isolation result (median)	< 14 days	11	12
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	13% reduction (2015 vs 2014)	13% reduction (2015 vs 2014)
	All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a
			IPV introduction	intro by 2015	Yes (Sep-15)	Yes (Sep-15)

*Indicator refers to assessment of December campaign, aggregated over 11 LPD1 districts

Endemic Country	State/Area	Outcome	Indicator	Target	Jan-Jun 2016	Jul - Dec 2016
Pakistan	KP (Peshawar, Nowshera, Swabi, Charsaddah, Mardan, Bannu, Tank, Lakki Marwat)	Interrupt transmission	Number of cases (WPV1 only)	0 case	7	1
		High population immunity	% 0-dose	<10%	0.00%	0.63%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 7 SNIDs	2 NIDs, 4 SNIDs
			% children missed due to no visit/child absent		N/a	0.8%*
			% children missed due to refusal		N/a	0.1%*
		High virus detection	AFP rate	> 2 per 100 000	10.55	17.55
			Stool adequacy	> 80%	89,7	80.04
			Lab receipt to virus isolation result (median)	< 14 days	10	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	FATA	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	1	1
		High population immunity	% 0-dose	<10%	1.67%	0.91%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 5 SNIDs	2 NIDs, 4 SNIDs
			% children missed due to no visit/child absent		N/a	0.9%**
			% children missed due to refusal		N/a	0.5%**
		High virus detection	AFP rate	> 2 per 100 000	22.02	38.34
			Stool adequacy	> 80%	86.63	88.41
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

* Indicator refers to assessment of December campaign, aggregated over specified districts
** Indicator refers to assessment of December campaign, aggregated over ALL districts

Endemic Country	State/Area	Outcome	Indicator	Target	Jan-Jun 2016	Jul - Dec 2016
Pakistan	Karachi (SINDH)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	4	4
		High population immunity	% 0-dose	<10%	0.27%	0.00%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 6 SNID (and mop ups)	2 NIDs, 5 SNIDs
			% children missed due to no visit/child absent		N/a	1.8%**
			% children missed due to refusal		N/a	0.4%**
		High virus detection	AFP rate	> 2 per 100 000	6.72	10.13
			Stool adequacy	> 80%	89.57	90,7
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases (WPV1 only)	0 case	1	1
		High population immunity	% 0-dose	<10%	0.23%	0.32%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 5 SNID (and mop ups)	3 NIDs, 4 SNIDs
		high virus detection	AFP rate	> 2 per 100 000	8.08	10,3
			Stool adequacy	> 80%	90,1	89.41
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	0% reduction (2015 vs 2014)	0% reduction (2015 vs 2014)
	All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a
			IPV introduction	intro by 2015	Yes (Jul-15)	Yes (Jul-15)

** Indicator refers to assessment of December campaign, aggregated over ALL districts

Endemic Country	State/Area	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Nigeria	North Central (Kano, Katsina, Jigawa, Kaduna)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	0	0
		High population immunity	% 0-dose	<10%	0.05%	0.11%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 4 SNIDs	5 NIDs
			% children missed due to no visit/child absent		N/a	0.9%*
			% children missed due to refusal		N/a	0.2%*
		High virus detection	AFP rate	> 2 per 100 000	36.88	32.12
			Stool adequacy	> 80%	98.46	97.96
			Lab receipt to virus isolation result (median)	< 14 days	9	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Northeast (Borno, Yobe)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	0	4
		High population immunity	% 0-dose	<10%	0.67%	0.93%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 5 SNIDs	9 SNIDs
			% children missed due to no visit/child absent		N/a	2.1%*
			% children missed due to refusal		N/a	0.4%*
		High virus detection	AFP rate	> 2 per 100 000	38.49	21.65
			Stool adequacy	> 80%	99.84	88.51
			Lab receipt to virus isolation result (median)	< 14 days	9	9
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

* Indicator refers to assessment of November (NID) campaign, aggregated over specified states

Endemic Country	State/Area	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Nigeria	Rest of North (Sokoto, Kebbi, Zamfara)	Interrupt transmission	Number of cases	0 case	0	0
		High population immunity	% 0-dose	<10%	0%	0%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 2 SNIDs	5 NIDs
			% children missed due to no visit/child absent		N/a	0.8%*
			% children missed due to refusal		N/a	0.1%*
		High virus detection	AFP rate	> 2 per 100 000	47.05	36.31
			Stool adequacy	> 80%	100	99.79
			Lab receipt to virus isolation result (median)	< 14 days	9	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases (cVDPV2 only)	0 case	0	0
		High population immunity	% 0-dose	<10%	0.09%	0.28%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 3 SNIDs	7 SNIDs
		High virus detection	AFP rate	> 2 per 100 000	19.75	18.58
			Stool adequacy	> 80%	99.63	98.98
			Lab receipt to virus isolation result (median)	< 14 days	9	8
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	14% reduction (2015 vs 2014)	14% reduction (2015 vs 2014)
	All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a
			IPV introduction	intro by 2015	Yes (Feb-15)	Yes (Feb-15)

* Indicator refers to assessment of November (NID) campaign, aggregated over specified states

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Angola	High population immunity	% 0-dose	<10%	4.04%	7.55%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	N/a	N/a
	High virus detection	AFP rate (national)	>2	3.37	3.48
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	94%	94%
		Stool adequacy (national)	>=80%	94.05	97.93
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	94%
		Lab receipt to virus isolation result (median)	< 14 days	9	10
		Environmental surveillance	Yes or No	Yes	Yes
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	2% increase (2015 vs 2014)	2% increase (2015 vs 2014)
		IPV introduction	intro by 2015	N/a	N/a
Benin	High population immunity	% 0-dose	<10%	1.96%	3.03%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	No NIDs/SNIDs
	High virus detection	AFP rate (national)	>2	5.57	3.69
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	93.08	94.25
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	92%	92%
		Lab receipt to virus isolation result (median)	< 14days	9	8
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	17% decrease (2015 vs 2014)	17% (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Aug-15)	Yes (Aug-15)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Burkina Faso	High population immunity	% 0-dose	<10%	0.81%	0.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	N/a
	High virus detection	AFP rate (national)	>2	4.33	2.16
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	83%	54%
		Stool adequacy (national)	>=80%	92,7	92.22
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	83%	85%
		Lab receipt to virus isolation result (median)	< 14 days	10	9
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015	N/a	N/a
Cameroon	High population immunity	% 0-dose	<10%	0.46%	1.95%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs, 1 SNID	6 SNIDs
	High virus detection	AFP rate (national)	>2	7.13	8.46
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	87.53	89.86
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	80%	100%
		Lab receipt to virus isolation result (median)	< 14 days	9	10
		Environmental surveillance	Yes or No	Yes	Yes
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	20% increase (2015 vs 2014)	20% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes	Yes

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Central African Republic	High population immunity	% 0-dose	<10%	3.13%	3.23%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NIDs	5 SNIDs
	High virus detection	AFP rate (national)	>2	7.46	6.65
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	94.37	89.71
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	86%	100%
		Lab receipt to virus isolation result (median)	< 14 days	9	8
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	1% increase (2015 vs 2014)	1% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Sep-15)	Yes (Sep-15)
Chad	High population immunity	% 0-dose	<10%	1.24%	1.12%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	6 SNIDs
	High virus detection	AFP rate (national)	>2	7.38	6.97
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	98.38	88.51
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	83%
		Lab receipt to virus isolation result (median)	< 14 days	11	10
		Environmental surveillance	Yes or No	Yes	Yes
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	17% decrease (2015 vs 2014)	17% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Aug-15)	Yes (Aug-15)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Congo	High population immunity	% 0-dose	<10%	0.00%	10.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	N/a
	High virus detection	AFP rate (national)	>2	4.44	3.02
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	82%	90%
		Stool adequacy (national)	>=80%	97.78	97,1
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	91%	71%
		Lab receipt to virus isolation result (median)	< 14 days	9	8
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	50% increase (2015 vs 2014)	50% increase (2015 vs 2014)
		IPV introduction	intro by 2015	N/a	N/a
Côte d'Ivoire	High population immunity	% 0-dose	<10%	1.45%	0.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	N/a
	High virus detection	AFP rate (national)	>2	4,9	3.42
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	76%	70%
		Stool adequacy (national)	>=80%	95.41	94.16
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	94%	94%
		Lab receipt to virus isolation result (median)	< 14 days	9	8
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	38% decrease (2015 vs 2014)	38% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Jun-15)	Yes (Jun-15)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Democratic Republic of the Congo	High population immunity	% 0-dose	<10%	3.78%	2.31%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs 1 SNID	2 NIDs
	High virus detection	AFP rate (national)	>2	5.49	4.77
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	96%	88%
		Stool adequacy (national)	>=80%	90.55	91.30
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	92%	96%
		Lab receipt to virus isolation result (median)	< 14 days	9	9
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	3% decrease (2015 vs 2014)	3% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Apr-15)	Yes (Apr-15)
Equatorial Guinea	High population immunity	% 0-dose	<10%	N/a	N/a
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID	N/a
	High virus detection	AFP rate (national)	>2	0.64	1.26
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	14%	29%
		Stool adequacy (national)	>=80%	100	0
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	14%	0%
		Lab receipt to virus isolation result (median)	< 14 days	11	11
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	6% increase (2015 vs 2014)	6% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Apr-16)	Yes (Apr-16)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Ethiopia	High population immunity	% 0-dose	<10%	0.43%	0.56%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID, 1 SNIDs	3 SNIDs
	High virus detection	AFP rate (national)	>2	2.71	2.32
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	73%	92%
		Stool adequacy (national)	>=80%	92.32	91.53
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	73%	92%
		Lab receipt to virus isolation result (median)	< 14 days	9	9
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	62% decrease (2015 vs 2014)	62% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Dec-15)	Yes (Dec-15)
Gabon	High population immunity	% 0-dose	<10%	6.67%	9.09%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID	1 NID
	High virus detection	AFP rate (national)	>2	6.44	5.80
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	90%	95%
		Stool adequacy (national)	>=80%	95.45	91,3
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	80%	90%
		Lab receipt to virus isolation result (median)	< 14 days	8	11
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	48% decrease (2015 vs 2014)	48% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Dec-15)	Yes (Dec-15)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Guinea	High population immunity	% 0-dose	<10%	1.65%	2.24%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	3 NIDs, 1 SNID	2 NIDs
	High virus detection	AFP rate	>2 (national)	20.37	19.55
		AFP rate	>2 (% of states/provinces meeting indicator)	100%	100%
		stool adequacy	>=80% (national)	90.84	95.57
		stool adequacy	>=80% (% of states/provinces meeting indicator)	88%	100%
		lab receipt to virus isolation result (median)	< 14 days	10	9
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	1.6% increase (2015 vs 2014)	1.6% (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Nov-15)	Yes (Nov-15)
Iraq	High population immunity	% 0-dose	<10%	3.11%	0.56%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	1 NID
	High virus detection	AFP rate (national)	>2	4.65	3.78
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	84%	89%
		Stool adequacy (national)	>=80%	87.05	80.88
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	63%	68%
		Lab receipt to virus isolation result (median)	< 14 days	11	11
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	16% increase (2015 vs 2014)	16% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Jan-16)	Yes (Jan-16)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Lao PDR	High population immunity	% 0-dose	<10%	9.50%	3.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	5 NIDs	N/a
	High virus detection	AFP rate	>2 (national)	4.00	5.90
		AFP rate	>2 (% of states/provinces meeting indicator)	89%	100%
		stool adequacy	>=80% (national)	73%	74%
		stool adequacy	>=80% (% of states/provinces meeting indicator)	39%	84%
		lab receipt to virus isolation result (median)	< 14 days	N/a	N/a
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	8% decrease (2015 vs 2014)	8% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Oct-15)	Yes (Oct-15)
Liberia	High population immunity	% 0-dose	<10%	7.69%	0.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	2 NIDs
	High virus detection	AFP rate (national)	>2	3.21	3.89
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	66%	87%
		Stool adequacy (national)	>=80%	90.32	68.42
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	66%	58%
		Lab receipt to virus isolation result (median)	< 14 days	7	9
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015	N/a	N/a

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Madagascar	High population immunity	% 0-dose	<10%	0.00%	0.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	1 SNID
	High virus detection	AFP rate (national)	>2	6.72	8.40
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	95%	95%
		Stool adequacy (national)	>=80%	80.17	91.99
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	64%	91%
		Lab receipt to virus isolation result (median)	< 14 days	10	9
		Environmental surveillance	Yes or No	Yes	Yes
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	15% increase (2015 vs 2014)	15% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (May-15)	Yes (May-15)
Mali	High population immunity	% 0-dose	<10%	2.53%	8.33%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	N/a
	High virus detection	AFP rate (national)	>2	3.99	3.65
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	78%	100%
		Stool adequacy (national)	>=80%	86.16	95.24
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	78%	90%
		Lab receipt to virus isolation result (median)	< 14 days	9	9
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	29% increase (2015 vs 2014)	29% increase (2015 vs 2014)
		IPV introduction	intro by 2015	N/a	N/a

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Myanmar	High population immunity	% 0-dose	<10%	2.94%	6.06%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID, 2 SNIDs	N/a
	High virus detection	AFP rate	>2 (national)	2.54	4.58
		AFP rate	>2 (% of states/provinces meeting indicator)	76%	94%
		stool adequacy	>=80% (national)	95%	97%
		stool adequacy	>=80% (% of states/provinces meeting indicator)	94%	100%
		lab receipt to virus isolation result (median)	< 14 days	N/a	N/a
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	0.6% decrease (2015 vs 2014)	0.6% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Dec-15)	Yes (Dec-15)
Niger	High population immunity	% 0-dose	<10%	2.04%	1.79%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	6 SNIDs
	High virus detection	AFP rate (national)	>2	2.85	4.16
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	71%
		Stool adequacy (national)	>=80%	94.52	85.65
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	75%
		Lab receipt to virus isolation result (median)	< 14 days	10	9
		Environmental surveillance	Yes or No	Yes	Yes
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	11% increase (2015 vs 2014)	11% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Jul-15)	Yes (Jul-15)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Sierra Leone	High population immunity	% 0-dose	<10%	1.65%	0.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs	2 NIDs
	High virus detection	AFP rate (national)	>2	2.76	2.43
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	75%	75%
		Stool adequacy (national)	>=80%	81	81.25
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	75%	100%
		Lab receipt to virus isolation result (median)	< 14 days	10	9
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015	N/a	N/a
Somalia	High population immunity	% 0-dose	<10%	12.24%	15.08%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	2 NIDs, 1 SNID	2 NIDs, 1 SNID
	High virus detection	AFP rate (national)	>2	6.29	5.51
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
		Stool adequacy (national)	>=80%	99,4	98.66
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	100%
		Lab receipt to virus isolation result (median)	< 14 days	9	7
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	2% increase (2015 vs 2014)	2% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (Nov-15)	Yes (Nov-15)

Country	Outcome	Indicator	Target	Jan-Jun 2016	Jul-Dec 2016
Syria	High population immunity	% 0-dose	<10%	2.53%	0.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NID, 2 SNIDs	1 NID, 1 SNIDs
	High virus detection	AFP rate (national)	>2	.3.76	4.11
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	71%	64%
		Stool adequacy (national)	>=80%	91.67	85.53
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	79%	71%
		Lab receipt to virus isolation result (median)	< 7 days	12	12
		Environmental surveillance	Yes or No	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	1% increase (2015 vs 2014)	1% increase (2015 vs 2014)
		IPV introduction	intro by 2015	Yes (<2015)	Yes (<2015)
Ukraine	High population immunity	% 0-dose	<10%	0.00%	0.00%
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	N/a	N/a
	High virus detection	AFP rate	>2 (national)	3.09	3.00
		AFP rate	>2 (% of states/provinces meeting indicator)	88%	N/a
		stool adequacy	>=80% (national)	98	98%
		stool adequacy	>=80% (% of states/provinces meeting indicator)	86%	86%
		lab receipt to virus isolation result (median)	< 14 days	11	N/a
		Environmental surveillance	Yes or no	Yes	Yes
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	0.6% decrease (2015 vs 2014)	0.6% decrease (2015 vs 2014)
		IPV introduction	intro by 2015	Yes	Yes

Annex 3 – Analysis of cost per child by region, January-June 2016 vs July-December 2016

Operational cost (US$) per child (to reach and vaccinate 1 child with 1 dose)	Jan – June 2016	Jul – Dec 2016
Global	0.34	0.35
Regional Office for Africa	0.35	0.36
Regional Office for the Eastern Mediterranean	0.32	0.33
Regional Office for South-East Asia	0.10	0.10
Regional Office for Europe	0.30	0.30
Regional Office for the Western Pacific	0.27	0.27

Outcome	Indicator	Target	July – December 2016
All	**Financing:** 12-month cash gap		US$273 million (through December 2017)
	Financing: Strategy funding gap		US$1.1 billion
	Staffing: Vacant approved posts	<10%	UNICEF HQ/RO: 10% UNICEF Afghanistan: 14% UNICEF Pakistan: 14% UNICEF Nigeria: 7% UNICEF Total: 12% CDC HQ: 31% CDC Afghanistan: 0% CDC Pakistan: 0% CDC Nigeria: 5.9%
High population immunity	**Vaccine supply:** Planned SIAs cancelled due to vaccine shortage		Q3/4 planned SIAs in the following countries were cancelled, postponed or scaled-back, to re-direct OPV needs to support outbreak response in Lake Chad subregion: Benin, Mauritania, Mali, DR Congo, South Sudan.
Low risk of virus reintroduction	Number of OPV-only using countries	**Per IMG**	All countries committed to IPV introduction ahead of the switch from trivalent OPV to bivalent OPV in April 2016. However due to a global IPV supply constraint, some countries continue to experience delays in receiving supply. By end-2016, 105/126 countries had introduced IPV. All 155 trivalent OPV-using countries successfully switched to bivalent OPV by May 2016.
	Plan in place to support routine immunization strengthening in 10 priority countries	**Per IMG**	Six countries (Chad, Democratic Republic of Congo, Ethiopia, India, Nigeria and Pakistan) have developed annual national immunizaiton plans that leverage polio assets to improve broader immunization goals.
	Reduction in the international spread of polio		Declared PHEIC remains in place
	Containment	**Per GAPIII**	GAPIII aligned with Polio Endgame timelines
	Certification		WPV2 eradication declared by Global Commission for the Certification of Poliomyelitis Eradication (GCC) in September 2015
Transition planning	Consultations inputs into plans		Consultations with countries and stakeholders ongoing

objective 1	objective 2
objective 3	objective 4

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