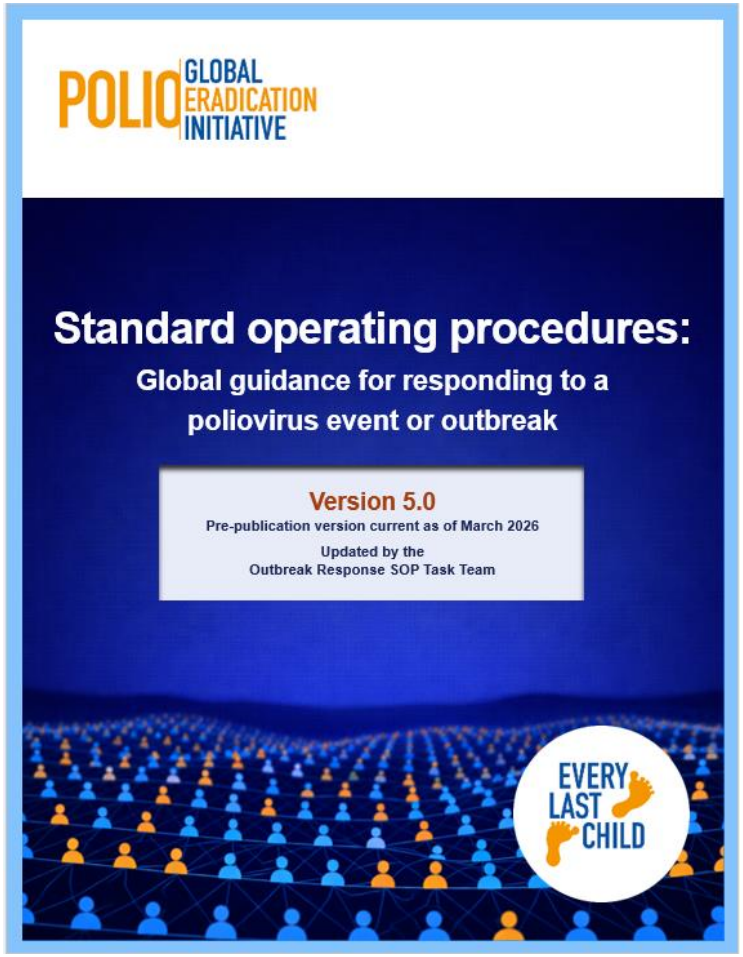
Standard Operating Procedures: Global Guidance for Responding to a Poliovirus Event or Outbreak

Webinar

23 June 2026

Overview of the Outbreak Response (OBR) Standard Operating Procedures (SOPs) Version 5



- Background
- Process for updating the SOPs
- Overview and Highlights
- Way forward

BACKGROUND

Standard Operating Procedures: Why an update now?

- Since **2015**, the Global Polio Eradication Initiative (GPEI) has published SOPs for responding to a poliovirus outbreak
  - Last updated in 2022, OBR SOP Version 4.0

- Since **2022**:
  - Updated SAGE recommendations for vaccine use in outbreaks
  - OBR SOP 4.0 addendum released in 2025
  - GPEI Strategy 2022-2026 extended through 2029
  - nOPV2 shifted from EUL to PQ and became the vaccine of choice to respond to type 2 outbreaks
  - Findings from analytical work highlighted where improvements could be made
  - Need to clearly define and shift response approaches for “new” outbreaks versus “persistent” outbreaks

The OBR SOPs Version 5….

IS

- an Update
- a high-level overview of key fundamentals, activities, and timelines to respond to a polio outbreak
- applicable to most polio outbreak situations
  - rare or specific situations may not be addressed in this SOPs and will be taken up separately on a case-by-case basis by GPEI technical experts to provide further guidance and clarity on next steps.

IS NOT

- an Overhaul
- detailed on “how to” conduct activities
  - references existing documents and tools that provide details to operationalize activities
- guidance to operationalize the GPEI Action Plan 2026
  - guidance and recommendations in the SOPs are from the perspective of what it will take to interrupt transmission and confirm with high confidence that virus transmission as been interrupted.

Outbreak Response SOP Task Team Composition & Responsibilities

	Led by GPEI's Subgroup on Analysis & Modeling (SAM) Co-chairs Project secretariat	Stephanie Kovacs, Corey Peak Feyrouz Kurji, Sasha Zvejnieks
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	Project coordinators and Editor	Cindi Snider, Claire Chauvin Deborah Kimmey

- The OBR SOP Task Team was formed in Aug 2025 to update the SOPs
- Members and liaisons divided into small writing groups to update 19 topical areas
  - Writing groups brought in additional technical experts
- Project coordinators led overall writing process and ensured technical accuracy
- Editor finalized language, style, layout, and ensured unified voice for the SOP

OVERVIEW AND HIGHLIGHTS

Overview of the SOP

Introductory Section

- Acknowledgements
- Acronyms
- Glossary
- Executive Summary
- Context: About GPEI and SOPs

Section 1. Response Fundamentals

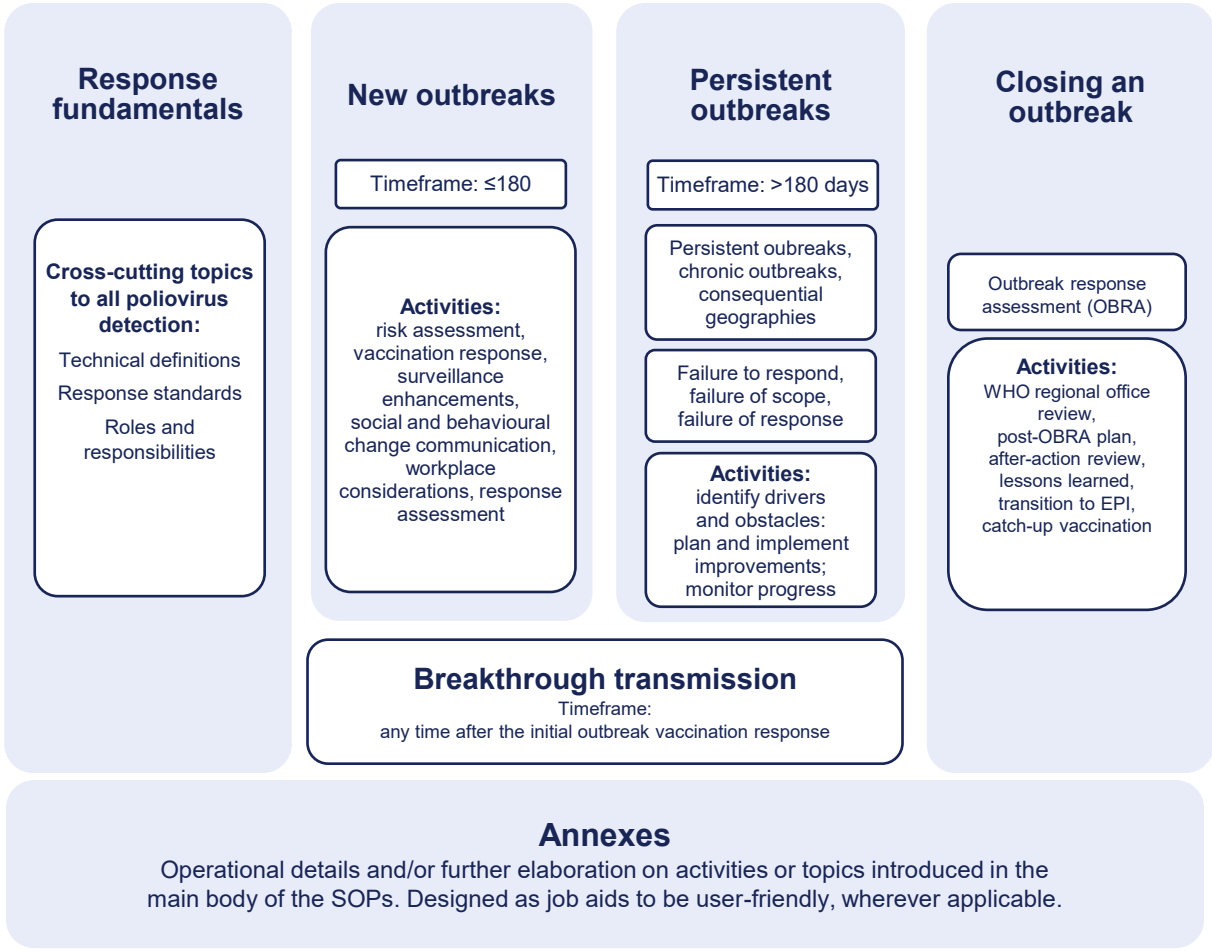
Section 2. New outbreaks: after Day 0

Section 3. Persistent outbreaks: beyond Day 180

Section 4. Closing an outbreak

Annexes

Fig. 1. Overview of the outbreak response SOPs (2026)



EPI = Essential Programme on Immunization; OBRA = outbreak response assessment; SOPs = standard operating procedures; WHO = World Health Organization.
Source: WHO

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Introductory Section

Standard introductory content included in GPEI documents including an Executive Summary and context for the SOPs

Executive Summary

- Two-page summary
- High-level overview of
  - Priority actions and standards for a polio outbreak
  - Topics addressed in the SOPs
  - New and revised guidance since the last OBR SOP

EXECUTIVE SUMMARY

Since its first publication in 2015, *Standard operating procedures: Global guidance for responding to a poliovirus event or outbreak* has provided guidance to countries on how to respond in a timely, effective manner to a high-risk event or outbreak of poliovirus. With the release of a new and revised fifth version, the Global Polio Eradication Initiative (GPEI) has updated this essential tool to reflect the latest developments within broader epidemiological, virologic and operational contexts.

These standard operating procedures (SOPs) outline priority actions that must urgently be taken by national governments in collaboration with the GPEI for any high-risk polio event or outbreak. In the context of an outbreak, the SOPs set a goal of stopping poliovirus transmission within 120 days (or four months).

Snapshot of priority actions and standards for a poliovirus outbreak

Initiate an investigation.	*within 24 hours*
Conduct a risk assessment and grade the outbreak.	*within 72 hours*
Begin developing (or update) a national polio outbreak response plan (NPORP).	*within 72 hours*
Declare an outbreak (or high-risk event) as a national public health emergency.	*within 7 days*
Plan and submit a finalized vaccination response plan.	*within 14 days*
Launch the initial outbreak vaccination response.	*within 28 days*
Complete three large-scale vaccination campaigns.	*within 84 days*

Country ownership, GPEI support: Ultimate ownership and accountability for a robust, comprehensive response rests with national authorities, whose strong leadership must be maintained throughout the response effort. Poliovirus high-risk events and outbreaks bring national governments and the GPEI into active collaboration and coordination. Depending on the scope and scale of the outbreak and the country's capacity to respond, the GPEI will provide support that can include technical assistance, response coordination, advocacy or financial and logistical support. In cases of weak country capacity or a high risk of international spread, the GPEI may also quickly deploy a technical liaison and arrange for the longer-term deployment of a multidisciplinary team of regional and global experts whose specialized skillsets can strengthen the response. Outbreak response efforts at the global level are led by the GPEI Outbreak Response and Preparedness Group (ORPG), in close coordination with the relevant regional offices and regional outbreak response mechanisms.

The SOPs provide guidance on topics that include:

- When is a vaccination response warranted for a poliovirus detection?
- Which vaccines should be used and how can they be requested?
- Which vaccines should be administered in outbreaks with the co-circulation of multiple types?
- What is required to complete a successful initial vaccination response to a poliovirus outbreak?
- How does a gender-responsive approach to vaccination campaigns create a stronger response?
- How does surveillance need to be enhanced to support detection and inform response plans?
- How does social and behavioural change improve response quality and reach?
- Why do some outbreaks persist? How can underlying issues and failures be resolved?
- What tools help to assess whether the outbreak is on the path to interruption?
- What criteria must be met to declare the closure of a poliovirus outbreak?
- How can population immunity continue to be strengthened to prevent a future risk of outbreaks?

Version 5.0: new and revised guidance

This fifth version of the SOP, published in 2026, includes new and revised guidance that will be critical for all polio-outbreak countries to consult, regardless of what point they are at in their response efforts.

Revised standard of practice

The recommended number of major large-scale

Latest vaccine guidance

Guidance is provided on when the inactivated polio vaccine (IPV) can be used in conjunction with the oral polio vaccine (OPV). For countries with outbreaks of more than one type, guidance is also provided on concomitant administration of the bivalent oral polio vaccine (bOPV) and the novel oral polio vaccine type 2 (nOPV2).

Failures in response efforts

To more effectively respond to outbreaks, new guidance is provided to support countries in identifying the underlying failures that contribute to a persistent outbreak. These include: a failure of response, a failure of scope and a failure to respond. More than one type of failure may be contributing to persistent transmission. Added guidance is also provided on conducting in-depth reviews to uncover drivers or root causes.

Expanded guidance for all countries

In recognition of recent detections in countries that exclusively use IPV in routine immunization programmes, the SOPs now include guidance for IPV-only countries. Recommendations cover which detections warrant investigation, when OPV may be recommended, and how countries should investigate detections of type 1 or type 3 in settings where bOPV has not been administered in the preceding four months.

responding to a poliovirus event or outbreak, referred
ent." The SOPs undergo review every six months with
required. To ensure response efforts incorporate the
a range of materials on topics covered by the SOPs
companion document, available on the GPEI website,
utbreak response strategies.

About the OBR SOPs Version 5

1

Purpose: To provide guidance to countries to respond in a timely and effective manner to a poliovirus event or outbreak with the specific objective of interrupting poliovirus transmission within 120 days of confirmation.

2

Audience: National governments and public health decision-makers who coordinate responses to poliovirus events and outbreaks so they may take quick and decisive actions.

The SOP will also be useful for their country-level, regional and global partners.

3

Scope: Establishes response standards and timelines for responding to:

- WPV1 importation in a non-endemic country

- outbreaks of any type of circulating vaccine-derived poliovirus (variant poliovirus Type 1, 2 or 3) detected anywhere

- vaccine-derived poliovirus (VDPV) events

Out of scope: WPV1 due to local transmission in an endemic context

How to use the OBR SOPs Version 5

- As a global guidance, contains a wealth of information but not all sections may be relevant to a particular outbreak.
- The different approach for a “new” outbreak versus one that “persists” is clearly defined and mapped in the SOP.
- Refer to Table 2 on sections to review based on your country’s outbreak status.

Table 2. Relevant sections based on a country’s current polio status

Current polio status	Section(s) to read
Poliovirus detected, yet to be classified as an event or outbreak	*Response fundamentals*
Newly classified outbreak or high-risk event	*Response fundamentals* *New outbreaks: after Day 0*
Ongoing outbreak (≤180 days)	*Response fundamentals* (refresher) *New outbreaks: after Day 0*
Ongoing outbreak (>180 days) *Persistent outbreak*	*Response fundamentals* (refresher) *Persistent outbreaks: beyond Day 180*

Structure of Most Chapters

Start of each chapter

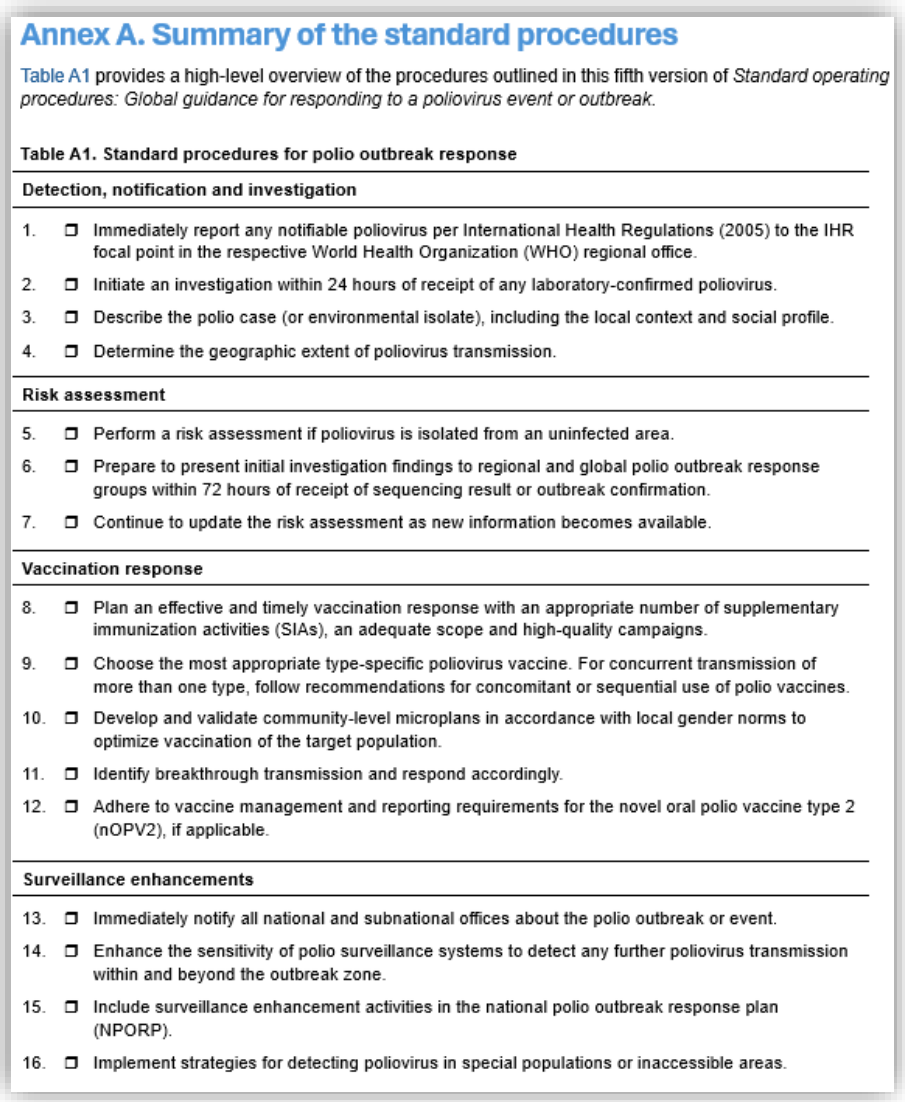
- Procedures (i.e., key action items) are listed.

What actions must immediately be taken in a new outbreak

Procedures

→ Immediately report any notifiable poliovirus per International Health Regulations (2005) to the IHR focal point in the respective WHO regional office.
→ Initiate an investigation within 24 hours of receipt of any laboratory-confirmed poliovirus.
→ Describe the polio case (or environmental isolate), including the local context and social profile.
→ Determine the geographic extent of poliovirus transmission.

- A checklist of all chapter procedures is summarized and included in Annex A (image to right)



Annex A. Summary of the standard procedures

Table A1 provides a high-level overview of the procedures outlined in this fifth version of *Standard operating procedures: Global guidance for responding to a poliovirus event or outbreak.*

Table A1. Standard procedures for polio outbreak response

Detection, notification and investigation		
1.	❒	Immediately report any notifiable poliovirus per International Health Regulations (2005) to the IHR focal point in the respective World Health Organization (WHO) regional office.
2.	❒	Initiate an investigation within 24 hours of receipt of any laboratory-confirmed poliovirus.
3.	❒	Describe the polio case (or environmental isolate), including the local context and social profile.
4.	❒	Determine the geographic extent of poliovirus transmission.
Risk assessment		
5.	❒	Perform a risk assessment if poliovirus is isolated from an uninfected area.
6.	❒	Prepare to present initial investigation findings to regional and global polio outbreak response groups within 72 hours of receipt of sequencing result or outbreak confirmation.
7.	❒	Continue to update the risk assessment as new information becomes available.
Vaccination response		
8.	❒	Plan an effective and timely vaccination response with an appropriate number of supplementary immunization activities (SIAs), an adequate scope and high-quality campaigns.
9.	❒	Choose the most appropriate type-specific poliovirus vaccine. For concurrent transmission of more than one type, follow recommendations for concomitant or sequential use of polio vaccines.
10.	❒	Develop and validate community-level microplans in accordance with local gender norms to optimize vaccination of the target population.
11.	❒	Identify breakthrough transmission and respond accordingly.
12.	❒	Adhere to vaccine management and reporting requirements for the novel oral polio vaccine type 2 (nOPV2), if applicable.
Surveillance enhancements		
13.	❒	Immediately notify all national and subnational offices about the polio outbreak or event.
14.	❒	Enhance the sensitivity of polio surveillance systems to detect any further poliovirus transmission within and beyond the outbreak zone.
15.	❒	Include surveillance enhancement activities in the national polio outbreak response plan (NPORP).
16.	❒	Implement strategies for detecting poliovirus in special populations or inaccessible areas.

Structure of Most Chapters

End of each chapter

- Additional resources for presented topics is listed.
- Documents are hyperlinked.
  - Simply clink on the title to be directly connected to the external resource.

Resources

- Microplanning for Polio Supplementary Immunization Activity
- GPEI Resource Hub – Supplementary Immunization Activities
- Field Manual: Assessing Vaccination Coverage Levels Using Clustered Lot Quality Assurance Sampling
- Best Practice for Monitoring the Quality of Polio Eradication Campaign Performance
- Microplanning for immunization service delivery using the Reaching Every District (RED) strategy.
- Briefing Note: Considerations for Integrating Multi-Antigens & Other Health Interventions to Support Polio Eradication
- Catch-Up Institutionalization Assessment Tool
- Missed Opportunities for Vaccination **(series)**
  - Planning Guide to Reduce Missed Opportunities for Vaccination
  - Methodology for the Assessment of Missed Opportunities for Vaccination
  - Intervention Guidebook for Implementing and Monitoring Activities to Reduce Missed Opportunities for Vaccination

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1 Section 1. Response Fundamentals

Definitions and cross-cutting topics that are relevant to all poliovirus detections, including outbreaks

1 Technical Definitions

- Definitions of poliovirus types, poliovirus outbreak and events included in tables
- Slight changes to make definitions clearer
- One change to note: outbreaks are now specific to the poliovirus type, not emergence group.
  - Aim is to simplify understanding and communication of “outbreak”
  - A country may have up to four polio outbreaks at one time: WPV1, Variant Poliovirus Type 1, 2, or 3
  - Wild-type and circulating vaccine-derived polioviruses outbreaks are classified separately despite the same serotype

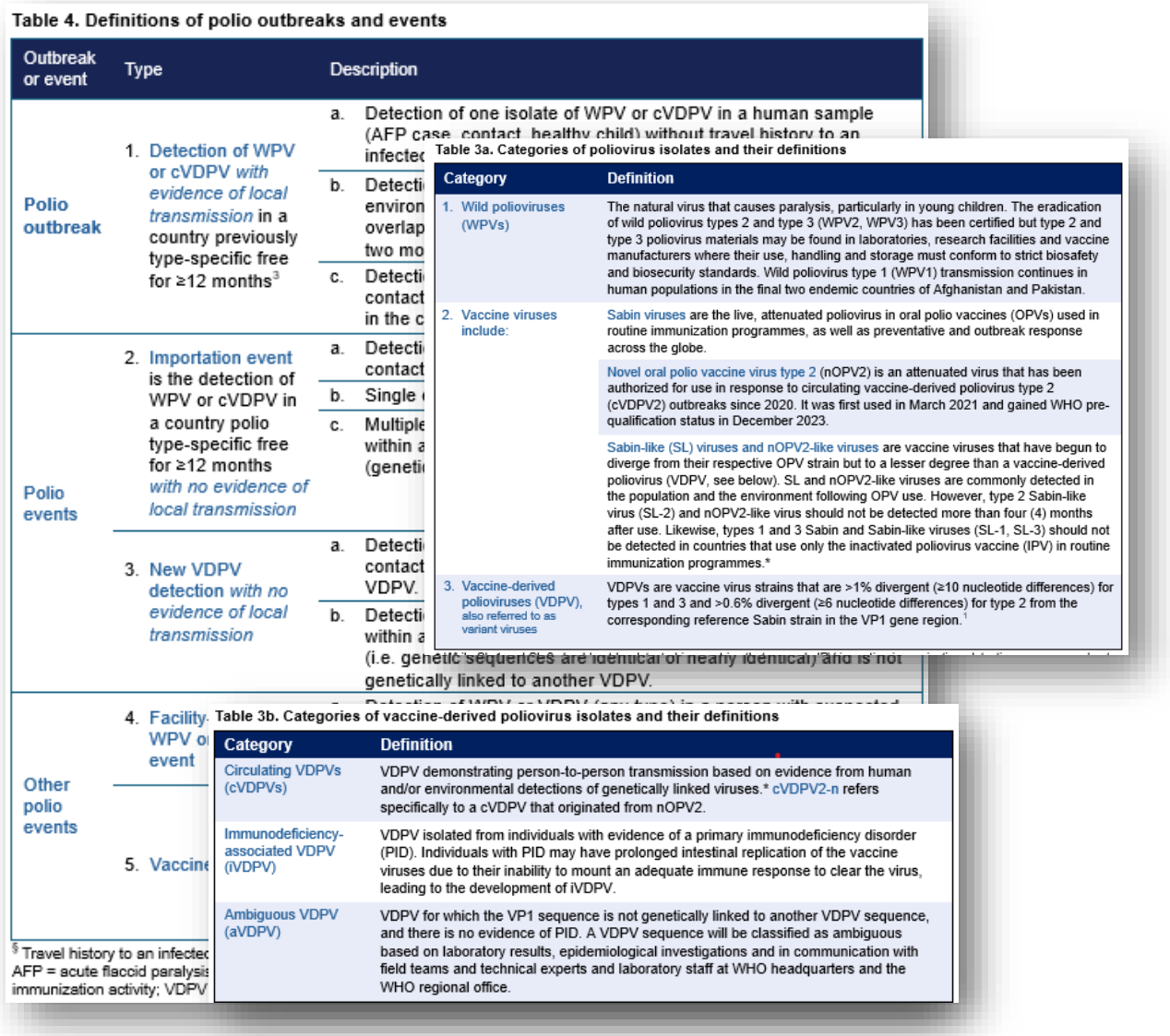


Table 4. Definitions of polio outbreaks and events

Outbreak or event	Type	Description
Polio outbreak	1. Detection of WPV or cVDPV *with evidence of local transmission* in a country previously type-specific free for ≥12 months[3]	a. Detection of one isolate of WPV or cVDPV in a human sample (AFP case, contact, healthy child) without travel history to an infected b. Detecti environ overlap two mo c. Detecti contact in the c
Polio events	2. Importation event is the detection of WPV or cVDPV in a country polio type-specific free for ≥12 months *with no evidence of local transmission*	a. Detecti contact b. Single c. Multiple within a (genetic
	3. New VDPV detection *with no evidence of local transmission*	a. Detecti contact VDPV. b. Detecti within a (i.e. genetic sequences are identical or nearly identical) and is not genetically linked to another VDPV.
Other polio events	4. Facility WPV o event	
	5. Vaccine	

§ Travel history to an infected
AFP = acute flaccid paralysis
immunization activity; VDPV

Table 3a. Categories of poliovirus isolates and their definitions

Category	Definition
1. Wild polioviruses (WPVs)	The natural virus that causes paralysis, particularly in young children. The eradication of wild poliovirus types 2 and type 3 (WPV2, WPV3) has been certified but type 2 and type 3 poliovirus materials may be found in laboratories, research facilities and vaccine manufacturers where their use, handling and storage must conform to strict biosafety and biosecurity standards. Wild poliovirus type 1 (WPV1) transmission continues in human populations in the final two endemic countries of Afghanistan and Pakistan.
2. Vaccine viruses include:	Sabin viruses are the live, attenuated poliovirus in oral polio vaccines (OPVs) used in routine immunization programmes, as well as preventative and outbreak response across the globe.
	Novel oral polio vaccine virus type 2 (nOPV2) is an attenuated virus that has been authorized for use in response to circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks since 2020. It was first used in March 2021 and gained WHO pre-qualification status in December 2023.
	Sabin-like (SL) viruses and nOPV2-like viruses are vaccine viruses that have begun to diverge from their respective OPV strain but to a lesser degree than a vaccine-derived poliovirus (VDPV, see below). SL and nOPV2-like viruses are commonly detected in the population and the environment following OPV use. However, type 2 Sabin-like virus (SL-2) and nOPV2-like virus should not be detected more than four (4) months after use. Likewise, types 1 and 3 Sabin and Sabin-like viruses (SL-1, SL-3) should not be detected in countries that use only the inactivated poliovirus vaccine (IPV) in routine immunization programmes.*
3. Vaccine-derived polioviruses (VDPV), also referred to as variant viruses	VDPVs are vaccine virus strains that are >1% divergent (≥10 nucleotide differences) for types 1 and 3 and >0.6% divergent (≥6 nucleotide differences) for type 2 from the corresponding reference Sabin strain in the VP1 gene region.[1]

Table 3b. Categories of vaccine-derived poliovirus isolates and their definitions

Category	Definition
Circulating VDPVs (cVDPVs)	VDPV demonstrating person-to-person transmission based on evidence from human and/or environmental detections of genetically linked viruses.* cVDPV2-n refers specifically to a cVDPV that originated from nOPV2.
Immunodeficiency-associated VDPV (iVDPV)	VDPV isolated from individuals with evidence of a primary immunodeficiency disorder (PID). Individuals with PID may have prolonged intestinal replication of the vaccine viruses due to their inability to mount an adequate immune response to clear the virus, leading to the development of iVDPV.
Ambiguous VDPV (aVDPV)	VDPV for which the VP1 sequence is not genetically linked to another VDPV sequence, and there is no evidence of PID. A VDPV sequence will be classified as ambiguous based on laboratory results, epidemiological investigations and in communication with field teams and technical experts and laboratory staff at WHO headquarters and the WHO regional office.

1 Polio Response Standards

- Response standards summarized in a table
- Shift from a met/not met to a stoplight coloring scheme to better assess response performance and/or raising the alarm.

Table 5. Outbreak response standard indicators

Indicator	Definition	Optimal	Caution	Failed to meet	Critically failed to meet
Time to complete (or partially complete) risk assessment	Time from Day 0 to risk assessment received by ORPG	≤3 days	>3 days and ≤7 days	>7 days	Not applicable; tiering only goes to "Failed to meet."
Time to declare outbreak a national public health emergency (PHE)	Time from Day 0 to declaration of PHE	≤7 days	>7 days and ≤14 days	>14 days and ≤28 days	>28 days
Initial response time *Standard of practice is 3 SIAs but may be 2 SIAs per risk assessment (RA)*	Time from Day 0 to completion of SIA3 *(or SIA2 per RA)*	3 SIAs ≤84 days from Day 0 *(2 SIAs ≤56 days per RA)*	3 SIAs completed >84 and ≤180 days from Day 0 *(2 SIAs >56 days per RA)*	<3 SIAs completed within 180 days of Day 0 *(<2 SIAs completed within 180 days of Day 0 per RA)* **FAILURE TO RESPOND**	No SIAs completed >365 days of Day 0 with ongoing virus detections **CONTINUED FAILURE TO RESPOND**
Breakthrough transmission response time	Time from Day 0 of breakthrough transmission detection to start of second breakthrough SIA	2 SIAs ≤56 days from Day 0 of breakthrough transmission	2 SIAs completed >56 and ≤180 days from Day 0 of breakthrough transmission	<2 SIAs completed within 180 days of Day 0 of breakthrough transmission **FAILURE TO RESPOND**	No SIAs completed >365 days of Day 0 of breakthrough transmission **CONTINUED FAILURE TO RESPOND**
Effective spacing of SIAs	Time from start of SIA1 to start of SIA2, and start of SIA2 to start of SIA3	>1 week and ≤4 weeks	>4 weeks and ≤8 weeks	>8 weeks and ≤26 weeks	>26 weeks
Time to interrupt transmission	Time from Day 0 to the last virus detection of the outbreak	≤120 days from Day 0	>120 days ≤180 days from Day 0	>180 days and ≤365 days from Day 0 **PERSISTENT OUTBREAK**	>365 days from Day 0 **PERSISTENT OUTBREAK (CHRONIC OUTBREAK)**
Effective outbreak vaccination response	Time from completion of the initial outbreak vaccination response to last virus detection *The initial outbreak vaccination response is composed of an optional Round 0, major vaccination response campaigns (SIAs) and mop-up campaign used to respond to a new polio outbreak.*	No virus detections for >365 days after completion of initial outbreak vaccination response	No virus detections for >365 days after completion of initial outbreak vaccination response and breakthrough SIAs	Virus detection >21 and ≤365 days after initial outbreak vaccination response *and two breakthrough SIAs* **FAILURE OF RESPONSE**	Virus detection >21 and ≤365 days after initial outbreak vaccination response *and four breakthrough SIAs* **CONTINUED FAILURE OF RESPONSE**

Day 0 = date of laboratory confirmation; IHR = International Health Regulations; ORPG = Outbreak Response and Preparedness Group; PHE = public health emergency; RA = risk assessment; Round 0 = rapid response round; SIA = supplementary immunization activity; SIA1 = first supplementary immunization activity; SIA2 = second supplementary immunization activity; SIA3 = third supplementary immunization activity.

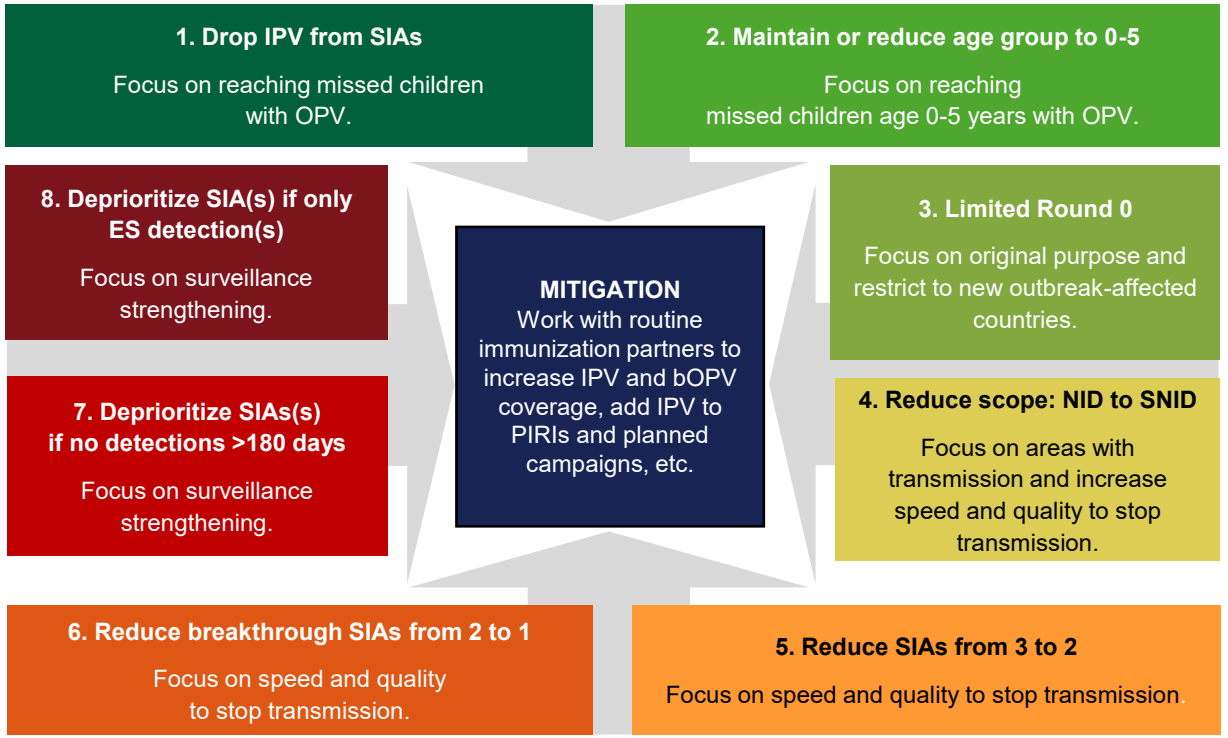
1 Roles and Responsibilities

- The SOP articulates the roles and responsibilities:
  - Ownership and accountability for a robust and comprehensive response to a poliovirus outbreak belongs with the national authorities of a polio outbreak country
  - GPEI undertakes a range of activities to support country-led response, in alignment with its mandate, technical expertise and available resources
  - Areas of collaboration and coordination include political advocacy, response coordination, budgets and financing, and vaccine cost

1 Prioritization of outbreak response activities in a resource constrained environment

- The SOPs provide guidance designed to interrupt transmission and does not take into consideration resource limitations.
- General considerations for prioritizing limited resources are provided in Annex D.
- The prioritization scheme is ordered from 1 to 8 based on lowest to highest anticipated impact on interruption

Fig. D1: Prioritization of outbreak response activities in resource constrained environment



bOPV = bivalent oral polio vaccine; ES = environmental surveillance; IPV = inactivated polio vaccine; NID = National Immunization Day; OPV = oral polio vaccine; PIRI = periodic intensification of routine immunization; SIA = supplementary immunization activity; SNID = Subnational Immunization Day.
Source: WHO.

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2 Section 2. New outbreaks: After Day 0

Science-based and data-driven guidance and recommendations with the best practices to interrupt poliovirus transmission with 120 days.

2 Actions that must be immediately taken

- Guidance on the three critical steps to be taken upon detection of a poliovirus
  1. Detection
  2. Notification
  3. Investigations

Table 7. Investigation of poliovirus isolates from humans and environmental surveillance

Part	Investigation components	Objectives
Part A Analyze the case or environmental isolate and the local context	1. Detailed case investigation of a poliovirus isolate from an AFP case, AFP contact or healthy child. 2. Investigation of the site of an isolate from environmental surveillance. 3. Description of the community context for any detected isolate, regardless of source: • population immunity; • recent SIA performance; • population characteristics, movement •	• Gather information to confirm the event/outbreak and associated risks. • Identify possible source of infection/causes of the event or outbreak. • Determine the number and characteristics of cases and the local context for environmental isolates. • Formulate control measures (immunization and surveillance) to interrupt transmission and prevent spread.
Part B Determine the geographic extent of transmission	1. • • •	

Table 6. IHR notifiable polioviruses and poliovirus detections that must be investigated

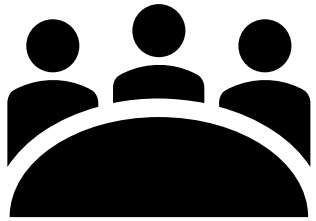
Poliovirus detections that must be notified under IHR (2005) as amended in 2014, 2022 and 2024	Poliovirus detections that must be investigated
✓ WPV	✓ WPV
✓ VDPV (type 1, 2 or 3)	✓ VDPV (type 1, 2 or 3)
✓ Sabin2 / SL-2 viruses* from areas where Sabin OPV2 has not been used in the previous four months.	✓ Sabin2, SL-2 vaccine virus in an area where mOPV2 has not been used in the four months prior to detection.
	✓ Novel, and novel-like type 2 vaccine virus in an area where nOPV2 has not been used in the four months prior to detection.
	✓ Type 1 or type 3 vaccine virus in an area where bOPV** has not been used in routine immunization or SIAs in the four months prior to detection.***

2 Outbreak Risk Assessment is a critical step to plan for an effective response

- Risk assessment reviews biological and contextual characteristics, and risk of spread

Table 8: Risk elements to assess the potential for further poliovirus transmission

Risk element	Example of risk factors (not exhaustive)
Virologic risk	• High degree of genetic deviation from parent OPV; number and nature of nucleotide changes; linkage to other virus(es); and expert interpretation by virologists.
Contextual risk	• Recent poliovirus detection or other sentinel events; sensitivity of AFP surveillance system; population density; immunization coverage and population immunity; geographic access; conflict; inaccessible or hard-to-reach populations; and population movement. • Previously experienced chronic polio outbreak or classified as consequential geography (see Persistent outbreaks: beyond Day 180).
Risk of international transmission	• Border area with high population mobility, nomadic or refugee populations, cross-border conflict, and international travel routes.



- Discussions with global- and regional-level partners will inform decisions including
  - If a vaccination response is necessary
  - Vaccine(s)
  - Number of major campaigns (i.e. supplementary immunization activities)
  - Geographic scope and targeted age group, especially for type 2 outbreaks

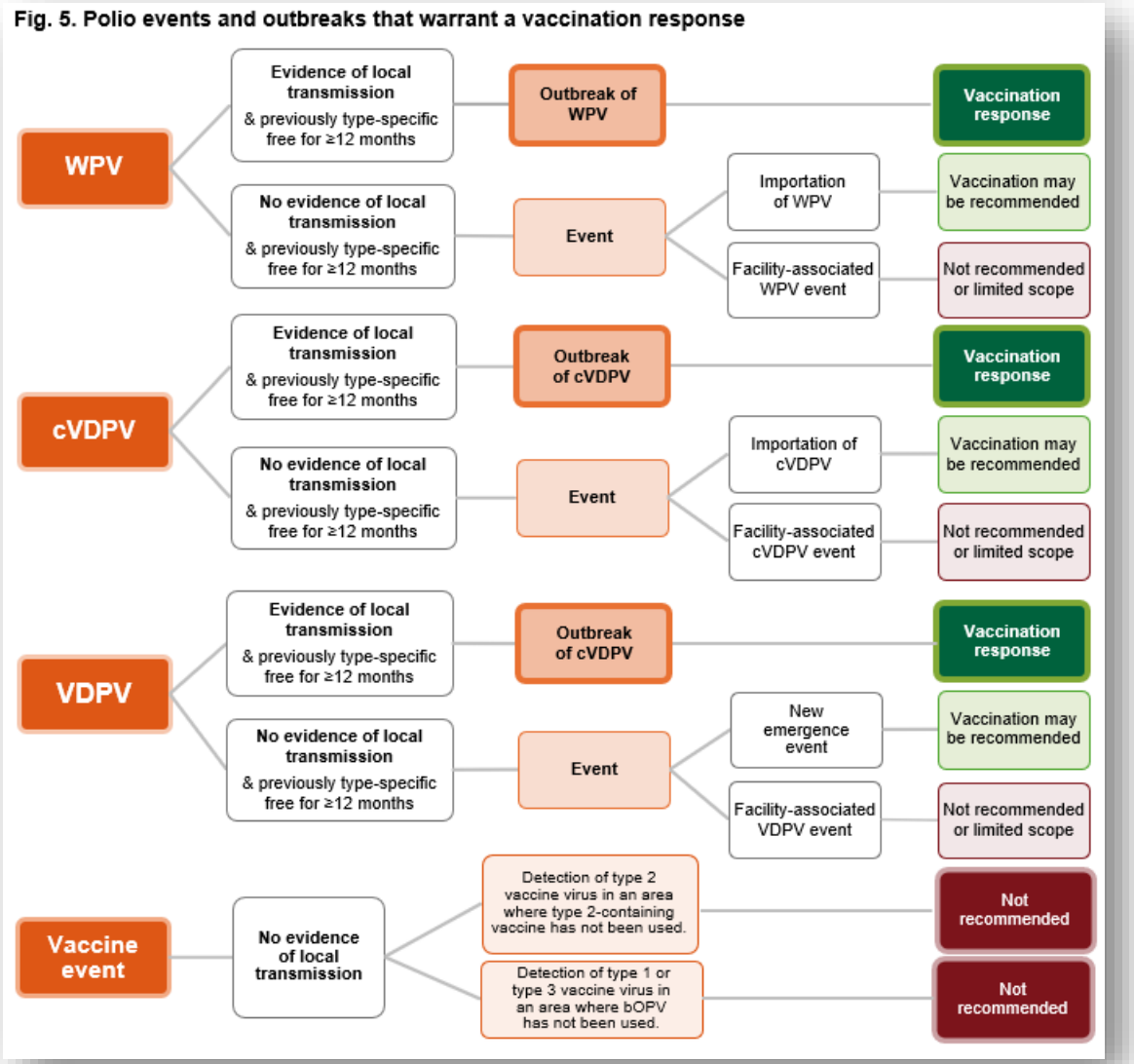
2 When a vaccination response is warranted

- Risk assessment will help inform decision
- Consideration of factors that elevate the risk of transmission and potential for spread
  - type of poliovirus; history of OPV use; evidence of local transmission; travel history; and facility-associated exposure

Table 11. Situations that may warrant a vaccination response.

Vaccination response	Situation
Required	Outbreak: detection with evidence of local transmission.
Recommended	• Event with high likelihood to evolve into an outbreak. • Event in an area that historically experienced difficult-to-stop poliovirus transmission. • Event in an area with major surveillance gaps.
Not recommended or of limited scope (with continued monitoring)	• Isolated ES detection with low likelihood to evolve into an outbreak. • Facility-associated events. • iVDPV detection with no evidence of local transmission. • aVDPV with none of the above criteria.

Fig. 5. Polio events and outbreaks that warrant a vaccination response



2 Vaccine choice for outbreak response

POLIO GLOBAL ERADICATION INITIATIVE

Countries that use OPV in routine immunization

- OPV based on type-specific outbreak
- IPV use (full or fractional) may be co-administered with OPV
  - Recommended for outbreak response but speed and quality is of utmost importance and must be assured. IPV use may be better in later campaigns.
- ***IPV not recommended as a standalone vaccine for vaccination response except as an additional round in areas where repeated OPV campaigns have not successfully interrupt virus transmission.***
  - IPV will be a more effective booster than an additional OPV dose in these situations.

Countries that use IPV only in routine immunization

- May use IPV under specific conditions, otherwise use type-specific OPV

Table 12. Vaccines recommended in response to a new polio outbreak

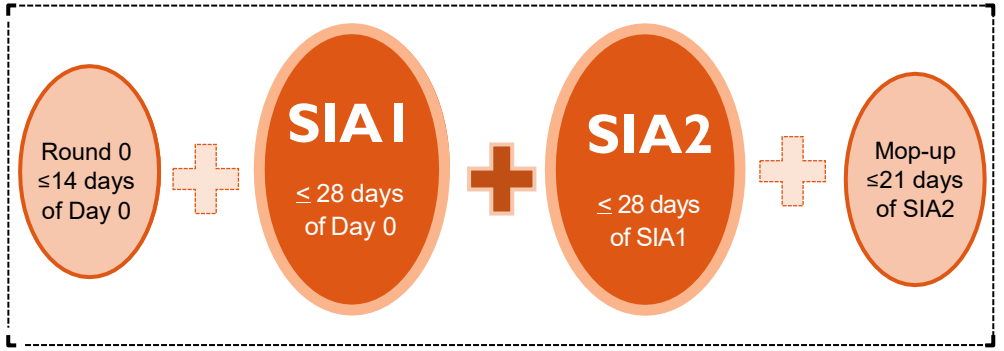
	Type of outbreak	Countries using OPV in routine immunization	Countries using only IPV in routine immunization
Single type	WPV1 or cVDPV1	bOPV[a] (+IPV)[b]	IPV if the country has: • high level of sanitation and hygiene; and • transmission is confined to a well-defined population or geography. Type-specific OPV(s): country does not meet above criteria for IPV use
	cVDPV2	nOPV2 (+IPV)[b]	
	cVDPV3	bOPV (+IPV)[b]	
Multiple types	WPV1/cVDPV1 and cVDPV2	bOPV + nOPV2[c] (+IPV)[b]	
	WPV1/cVDPV1 and cVDPV3	bOPV (+IPV)[b]	
	cVDPV2 and cVDPV3	bOPV + nOPV2[c] (+IPV)[b]	

2 Initial outbreak vaccination response includes

- Round 0 (optional): conducted within 14 days of virus detection and targeted geographic scope where the virus was detected
    - If cannot complete within 14 days, skip Round 0 and plan for the first major response campaign
- Major response campaigns (i.e., SIAs): three SIAs but may be two SIAs in specific situations
- Mop-up campaign (if necessary): evidence of gaps in vaccination coverage

Fig. 6a. Example of an initial outbreak vaccination response with three major response campaigns (SIAs)

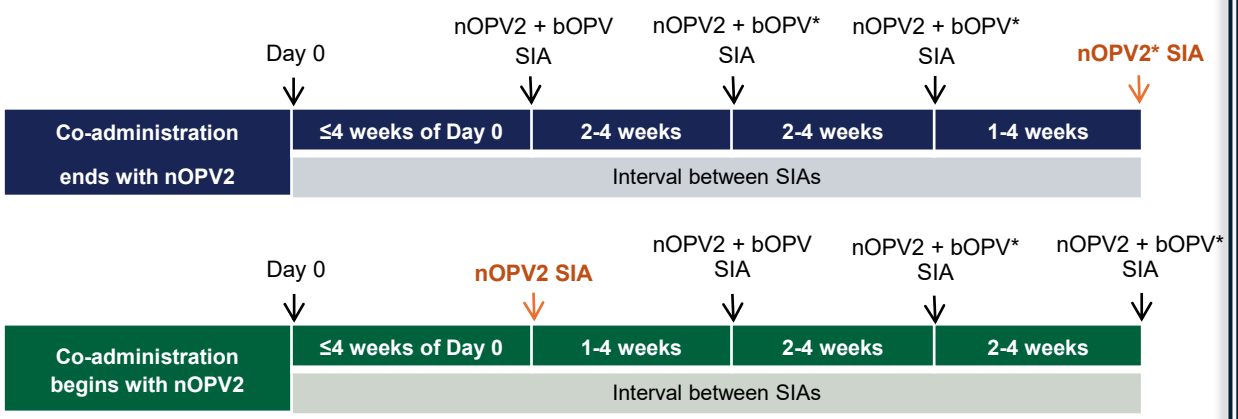
Fig. 6b. Example of an initial outbreak vaccination response with two major response campaigns (SIAs)



2 Major response campaigns for concurrent outbreaks

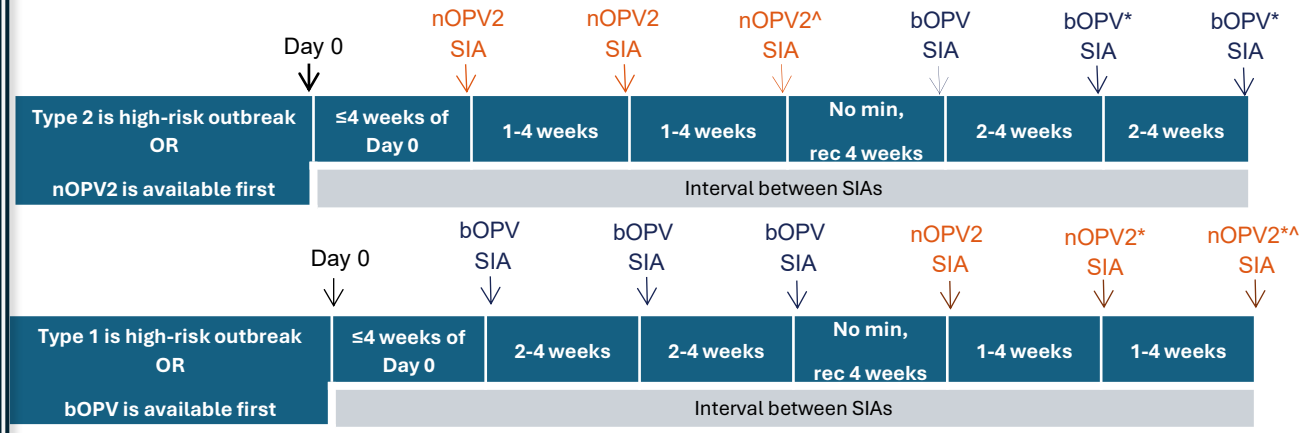
- Options are for co-administration or sequential administration of nOPV2 and bOPV.
- Best option based on several considerations described in the SOPs as well as Risk Assessment discussions

Fig. 7. Example of co-administration of nOPV2 and bOPV based on initial vaccine use



*Consider adding fractional or full IPV dose to the SIA to boost humoral and intestinal immunity.

Fig. 8. Example of sequential administration of nOPV2-bOPV based on initial vaccine use

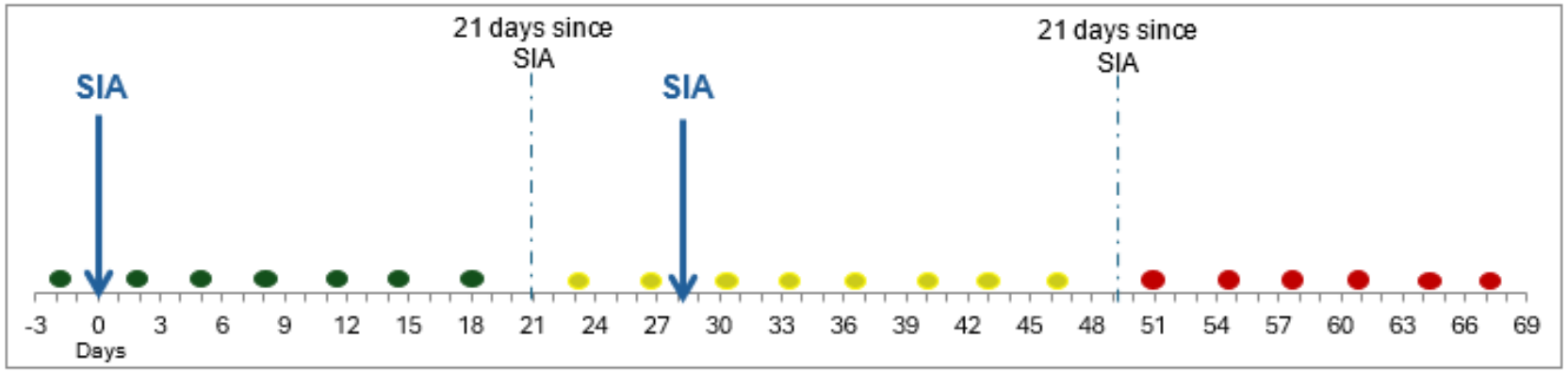


* Consider adding (f)IPV to the SIA to boost immunity.
^ If more than four weeks between nOPV2 SIAs, add another nOPV2 SIA and/or (f)IPV to boost type 2 immunity.

2 Breakthrough Transmission

- Guiding principle: **all viruses must be responded with two SIAs in a timely manner** (“covered”)
- Slight language revision to make this point clearer.

Fig. 11. Examples of breakthrough transmission



- Detections shown in **green dots** are **not** breakthrough transmission. These detections have been covered by two SIAs.
- Detections shown in **yellow dots** are breakthrough transmission. They “breakthrough” the first SIA. They are covered by the second SIA but also require an additional SIA so they are covered by a total of two SIAs.
- Detections shown in **red dots** are breakthrough transmission. They “breakthrough” both SIAs and require two additional SIAs to be covered.

2 Additional topics described as part of Vaccination Response

MONITORING SIA

VACCINE MANAGEMENT

INTEGRATED CAMPAIGNS

STRENGTHENING ROUTINE IMMUNIZATION

2 Surveillance enhancements

- AFP surveillance remains the primary means for detecting poliovirus in most countries
- May be supplemented with environmental surveillance (ES), where feasible.
- "Strengthening Polio Surveillance during a Poliovirus Outbreak" summarizes the activities needed to improve AFP surveillance and ES.
    - Also include recommendations for addressing challenges, such as inaccessible areas and special populations (Box 9).

Box 9. Topics in surveillance in outbreak settings

1. Checklist of surveillance strengthening activities.
2. Place polio surveillance system on high alert.
3. Enhance AFP surveillance:
    - active surveillance, review of repor
    - training, sensitization on AFP case notification;
    - supervision and validation of AFP
    - logistics and prioritization of sampl
4. Enhance environmental surveillance:
    - review ES network, sampling freq performance; and
    - expand network within and beyon zone, where necessary and feasi
5. Laboratory surveillance coordination:
    - Establish close coordination, prio contingency planning for shipping samples.
6. Other strategies:
    - AFP contact sampling, ad hoc AF community-based searches.
7. Special populations, insecure or inacc
8. Monitor surveillance enhancements
9. Possible signs of diminished surveillar need of corrective actions:
    - orphan viruses, cluster of compat detection with no AFP case.

As available in *Strengthening Polio Surveillance du Outbreak*.[46]

POLIO GLOBAL ERADICATION INITIATIVE

Strengthening Polio Surveillance during a Poliovirus Outbreak

Revised February 2026

According to GPEI's Standard Operating Procedures for responding to poliovirus events or outbreaks, maintaining a robust and sensitive polio surveillance system that can promptly detect virus transmission is critical for interrupting poliovirus transmission and effectively closing outbreaks. Surveillance data are used to 1) **inform and guide further response** activities, including supplementary immunization activities (SIAs) beyond the original outbreak-affected area and 2) **provide evidence of the successful interruption** of virus transmission. Generally, the geographic scope for response activities (i.e., outbreak-affected and high-risk areas) is identified through a detailed country risk assessment with input from technical experts and may target subnational areas. However, the aim for surveillance strengthening should remain nationwide and could even span multiple countries; poliovirus can move anywhere in a country or across its borders.

Purpose: This document serves as a quick reference guide summarizing globally recommended surveillance activities to achieve a sensitive polio surveillance system. It covers surveillance for acute flaccid paralysis (AFP), environmental surveillance (ES) and laboratory surveillance. Most countries should already have these measures in place. The key priorities are: 1) **to ensure polio surveillance activities are functioning** as intended, and 2) **to adapt or enhance activities to address the challenges** presented by the outbreak.

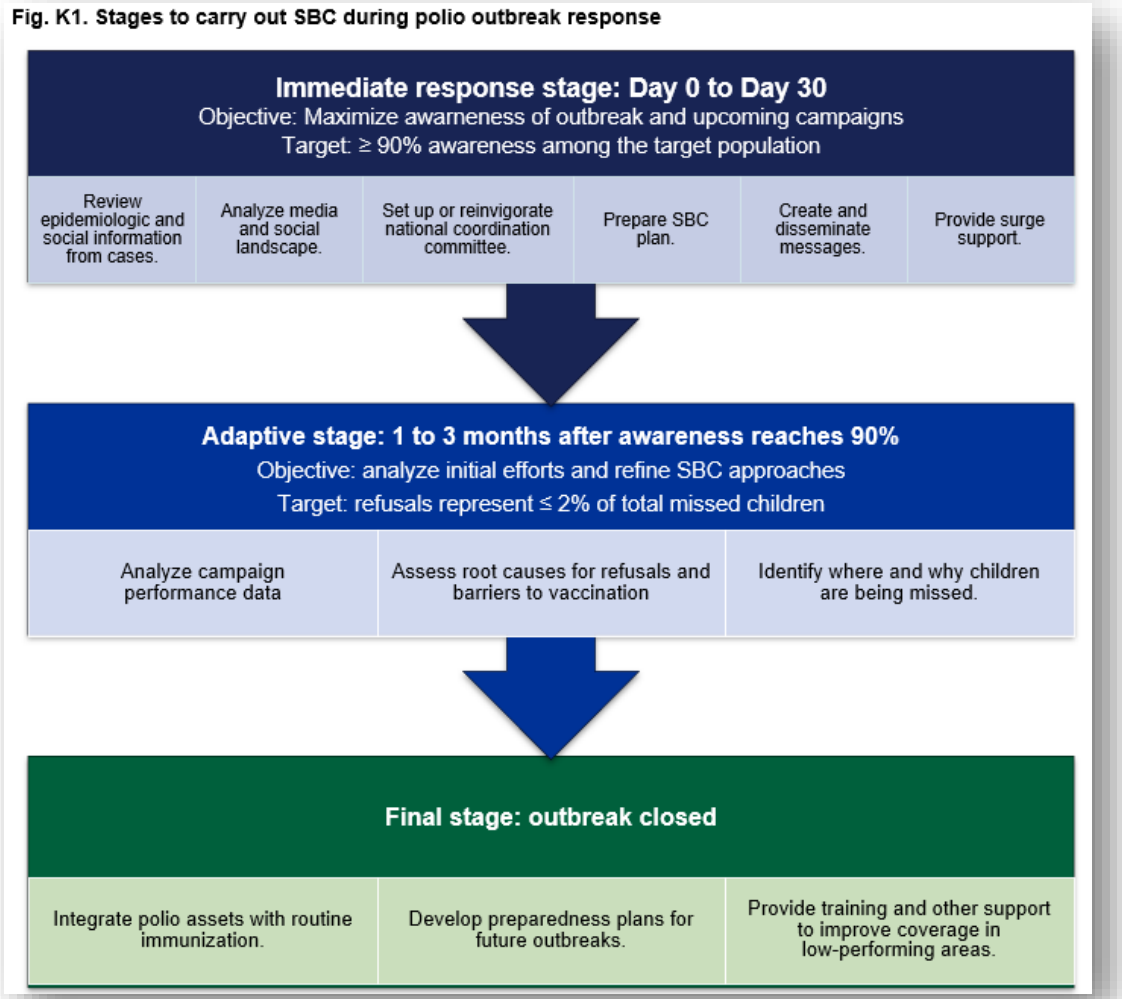
This document outlines essential surveillance activities for outbreak response, presented as a checklist with brief explanations (see next page). National and subnational **polio outbreak response plans should use this guidance.** For further technical details, see the global polio surveillance references in Annex 1.

This document is current as of February 2026 and supersedes any previous publications.

Target audience: This guide is intended for professionals involved in poliovirus surveillance activities during outbreaks, at all levels within a country.

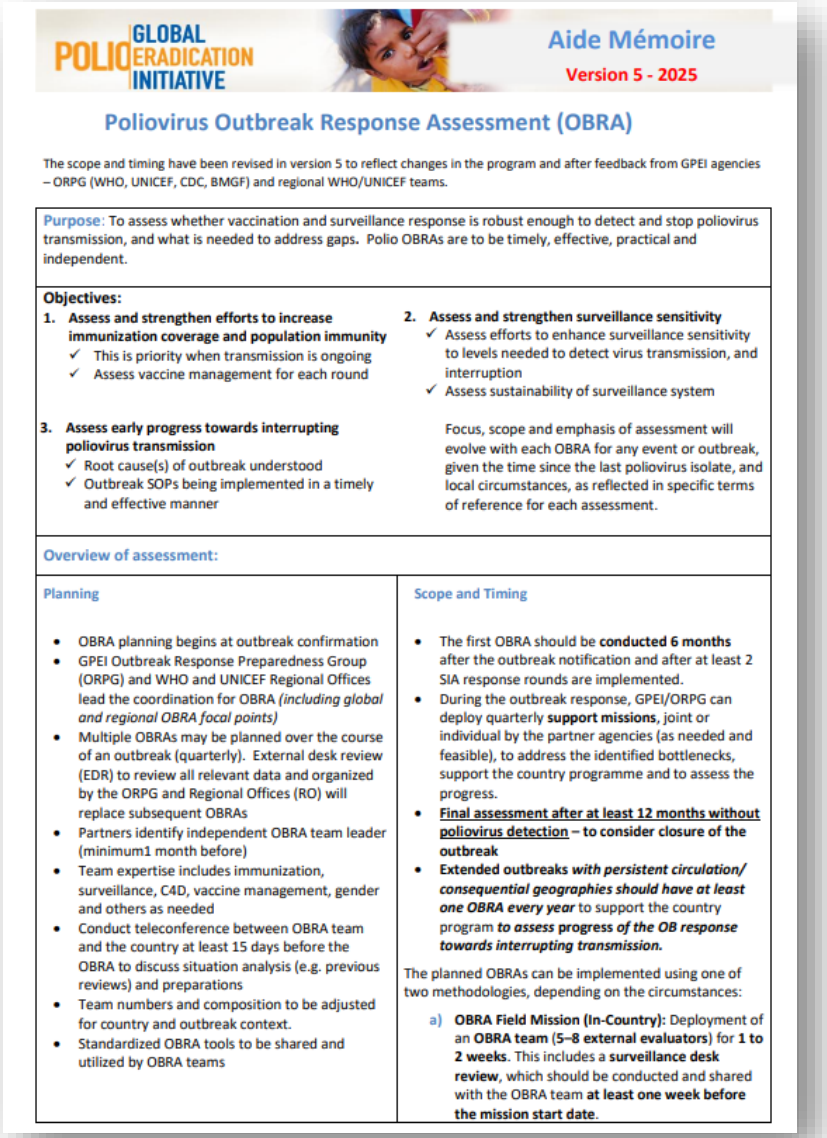
2 Social and behavioural change (SBC) communication

- SBC aims to produce measurable, positive shifts in individual behaviours and social norms through
  - community engagement, advocacy, social mobilization, risk communication and misinformation management
- SBC is integral to every step in the outbreak response process
- Further details on SBC communication, such as the framework are included in Annex K



2 On the path to interruption

- Independent outbreak response assessment (OBRA) should be conducted during an outbreak
- Purpose of an OBRA is to assess whether surveillance efforts and the vaccination response are robust enough to detect and interrupt poliovirus transmission
- The SOPs includes key details from the GPEI's Aide Memoire: Poliovirus Outbreak Response Assessment (OBRA), version 5



POLIO GLOBAL ERADICATION INITIATIVE

Aide Mémoire

Version 5 - 2025

Poliovirus Outbreak Response Assessment (OBRA)

The scope and timing have been revised in version 5 to reflect changes in the program and after feedback from GPEI agencies – ORPG (WHO, UNICEF, CDC, BMGF) and regional WHO/UNICEF teams.

Purpose: To assess whether vaccination and surveillance response is robust enough to detect and stop poliovirus transmission, and what is needed to address gaps. Polio OBRAs are to be timely, effective, practical and independent.

Objectives:

1. **Assess and strengthen efforts to increase immunization coverage and population immunity**
   - ✓ This is priority when transmission is ongoing
   - ✓ Assess vaccine management for each round
2. **Assess and strengthen surveillance sensitivity**
   - ✓ Assess efforts to enhance surveillance sensitivity to levels needed to detect virus transmission, and interruption
   - ✓ Assess sustainability of surveillance system
3. **Assess early progress towards interrupting poliovirus transmission**
   - ✓ Root cause(s) of outbreak understood
   - ✓ Outbreak SOPs being implemented in a timely and effective manner

Focus, scope and emphasis of assessment will evolve with each OBRA for any event or outbreak, given the time since the last poliovirus isolate, and local circumstances, as reflected in specific terms of reference for each assessment.

Overview of assessment:

Planning

- OBRA planning begins at outbreak confirmation
- GPEI Outbreak Response Preparedness Group (ORPG) and WHO and UNICEF Regional Offices lead the coordination for OBRA *(including global and regional OBRA focal points)*
- Multiple OBRAs may be planned over the course of an outbreak (quarterly). External desk review (EDR) to review all relevant data and organized by the ORPG and Regional Offices (RO) will replace subsequent OBRAs
- Partners identify independent OBRA team leader (minimum1 month before)
- Team expertise includes immunization, surveillance, C4D, vaccine management, gender and others as needed
- Conduct teleconference between OBRA team and the country at least 15 days before the OBRA to discuss situation analysis (e.g. previous reviews) and preparations
- Team numbers and composition to be adjusted for country and outbreak context.
- Standardized OBRA tools to be shared and utilized by OBRA teams

Scope and Timing

- The first OBRA should be **conducted 6 months** after the outbreak notification and after at least 2 SIA response rounds are implemented.
- During the outbreak response, GPEI/ORPG can deploy quarterly **support missions**, joint or individual by the partner agencies (as needed and feasible), to address the identified bottlenecks, support the country programme and to assess the progress.
- **Final assessment after at least 12 months without poliovirus detection – to consider closure of the outbreak**
- **Extended outbreaks *with persistent circulation/ consequential geographies should have at least one OBRA every year*** to support the country program ***to assess progress of the OB response towards interrupting transmission.***

The planned OBRAs can be implemented using one of two methodologies, depending on the circumstances:

a) **OBRA Field Mission (In-Country):** Deployment of an **OBRA team (5–8 external evaluators)** for **1 to 2 weeks**. This includes a **surveillance desk review**, which should be conducted and shared with the OBRA team **at least one week before the mission start date**.

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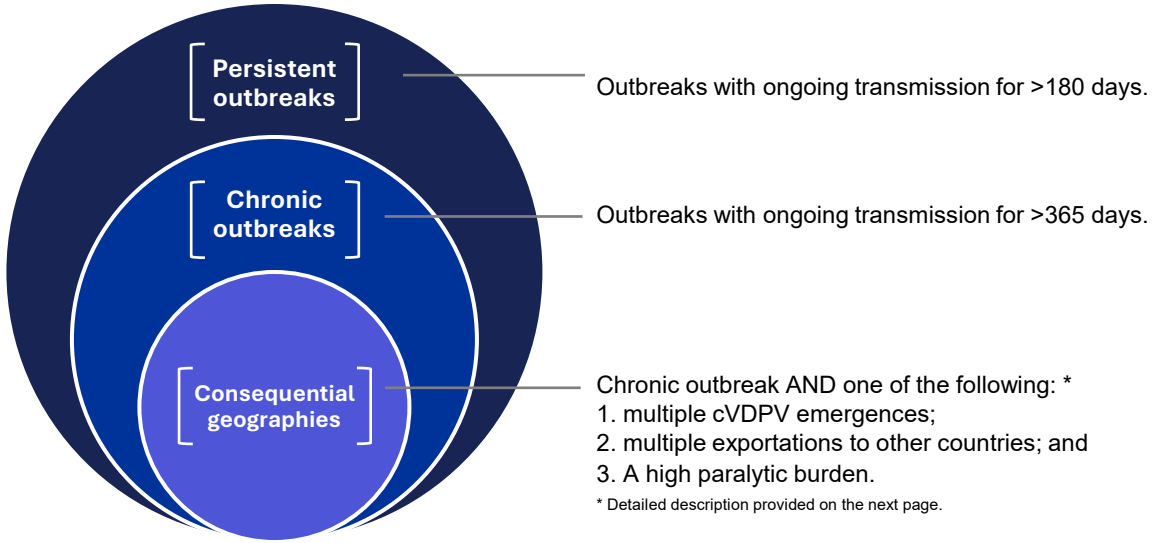
3 Section 3. Persistent outbreaks: beyond Day 180

Step-by-step guidance for countries facing challenges that have extended an outbreak beyond six months – and in some cases for more than a year

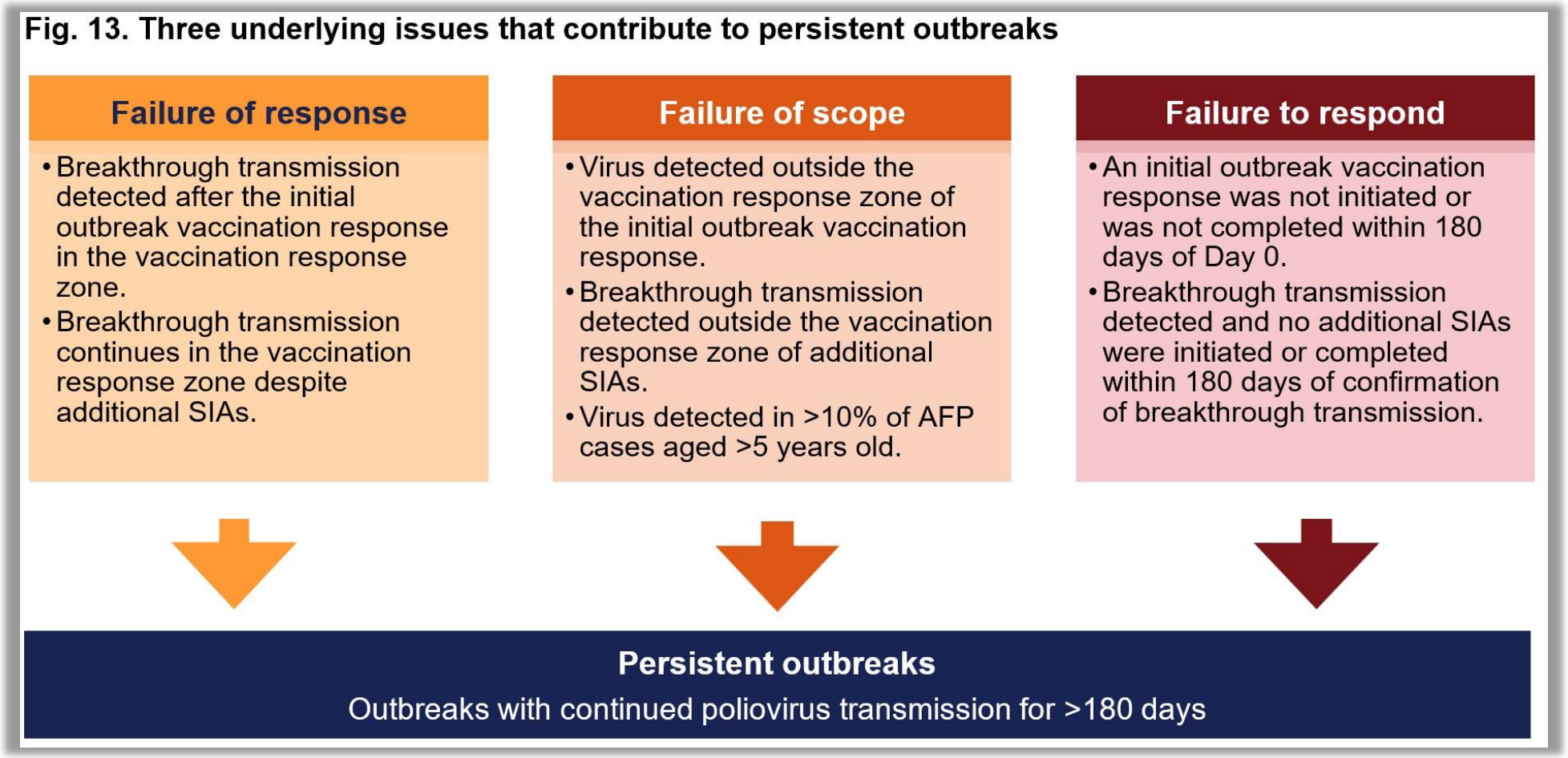
3 Persistent Outbreak Categories

- Since 2016, 54% of outbreaks were not stopped within 180 days
  - Need to identify the underlying causes to effectively address them.
- Differences in categorization results in different levels of support and oversight
- Note: Classification of countries into each of these categories will be made in consultation with regional offices; GPEI's Outbreak Response and Preparedness Group (ORPG) will also be involved in classifying outbreaks.

Fig. 12. Relationship of persistent outbreaks, chronic outbreaks and consequential geographies



3 Why do outbreaks persist? Three categories



3 Identify drivers for a persistent outbreak

Start from the big picture

- What are the main “failures”

In-depth review of response performance

- Situation analyses guided by the “failures”

Low routine immunization coverage

Regular reassessments

3 What needs to be done: change response tactics

- Shift from general response activities to more resolute approach that aligns with four pillars
    1. greater government ownership, oversight and coordination
    2. the development and implementation of a more aggressive response plan;
    3. aggressive and tailored outbreak response activities; and
    4. assured global technical and financial support

Table 17. Operational framework for national response coordination by outbreak classification

Category	New outbreak	Persistent outbreak	Chronic outbreak & consequential geography
Definition	≤ 180 days	181–365 days	> 365 days (+ specific criteria for CG)
Plan	National polio outbreak response plan (NPORP) *Timeline: within 14 days of notification of the outbreak*	Revised and updated national polio outbreak response plan (NPORP) *Timeline: within two (2) months of new classification*	National emergency action plan (NEAP) *Timeline: within two (2) months of new classification*
Governance	• National EOC	• National Polio Oversight Committee	• National Polio Oversight Committee • External TAG (consequential geographies only)
Diagnostics steps	• Review campaign data and epidemiology	• Examine the causes for failure (of response, of scope, to respond) • Identify corrective measures • Update the NPORP with more tailored approaches to country context	• Examine the causes for failure (of response, of scope, to respond) • Identify corrective measures • Update NEAP with SIAs and non-SIAs interventions
Assessment tools	• OBRAs	• OBRAs • Field and desk reviews	• OBRAs • Field and desk reviews
Monitoring frequency	• Weekly SitReps	• Weekly SitReps • Monthly updates to the Polio Oversight Committee	• Weekly SitReps • Monthly updates to the Polio Oversight Committee • Quarterly TAG meeting (consequential geographies only)

3 Path to interruption

- Countries, regional- and the global level must assess performance indicators monthly to ensure response activities are optimally implemented.
- Each indicator has an optimal target followed by a caution period before reaching failure. In addition, standard indicators for surveillance, SBC, RI and gender should be monitored.

Table 20. Process and performance indicators for measuring progress for persistent outbreaks

Indicator	Definition	Optimal	Caution	Failed to meet	Critically failed to meet
Update of the NPORP	Time from classification as a persistent outbreak (Day 180) to the publication of revised NPORP.	≤60 days	>60-180 days	>180 days	Not applicable; tiering only to failed to meet
Development of the NEAP	Time from classification as a chronic outbreak (Day 365) to the publication of the NEAP.				
Percent of plan activities implemented	Percent of plan activities that are implemented during the plan period.	>90%	75-90%	50-74%	<50%
Percent of plan activities implemented on time	Percent of activities implemented by target date outlined in the plan.	>90%	75-90%	50-74%	<50%
Percent change in number of infected administrative level 1 geographies (e.g. district, province, state, region)	Percent change in the number of infected administrative level 1 geographies, comparing current 6 months to previous 6 months with a 90-day lag for surveillance.	≥50% decline	0% to <50% decline	0% to 25% increase	>25% increase
Percent change in number of polio cases	Percent change in number of polio cases comparing current 6 months to previous 6 months with a 90-day lag for surveillance	≥50% decline	0% to <50% decline	0% to 25% increase	>25% increase

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4 Section 4. Closing an Outbreak

Guidance for countries on the process to close and document a polio outbreak

4 Closing an outbreak and next steps

CLOSING AN OUTBREAK: ALIGNS WITH OBRA AIDE MEMOIRE VERSION 5.0 (2025)

POST OBRA PLAN

AFTER-ACTION REVIEW

TRANSITION TO THE ESSENTIAL PROGRAMME ON IMMUNIZATION

GAVI SUPPORT

- Provides an overview of the
  - process to officially close a polio outbreak
  - review and documentation of polio outbreak response activities
  - continued improvements to polio immunity
    - transition immunization strengthening efforts to Essential Programme on Immunization
    - GAVI support

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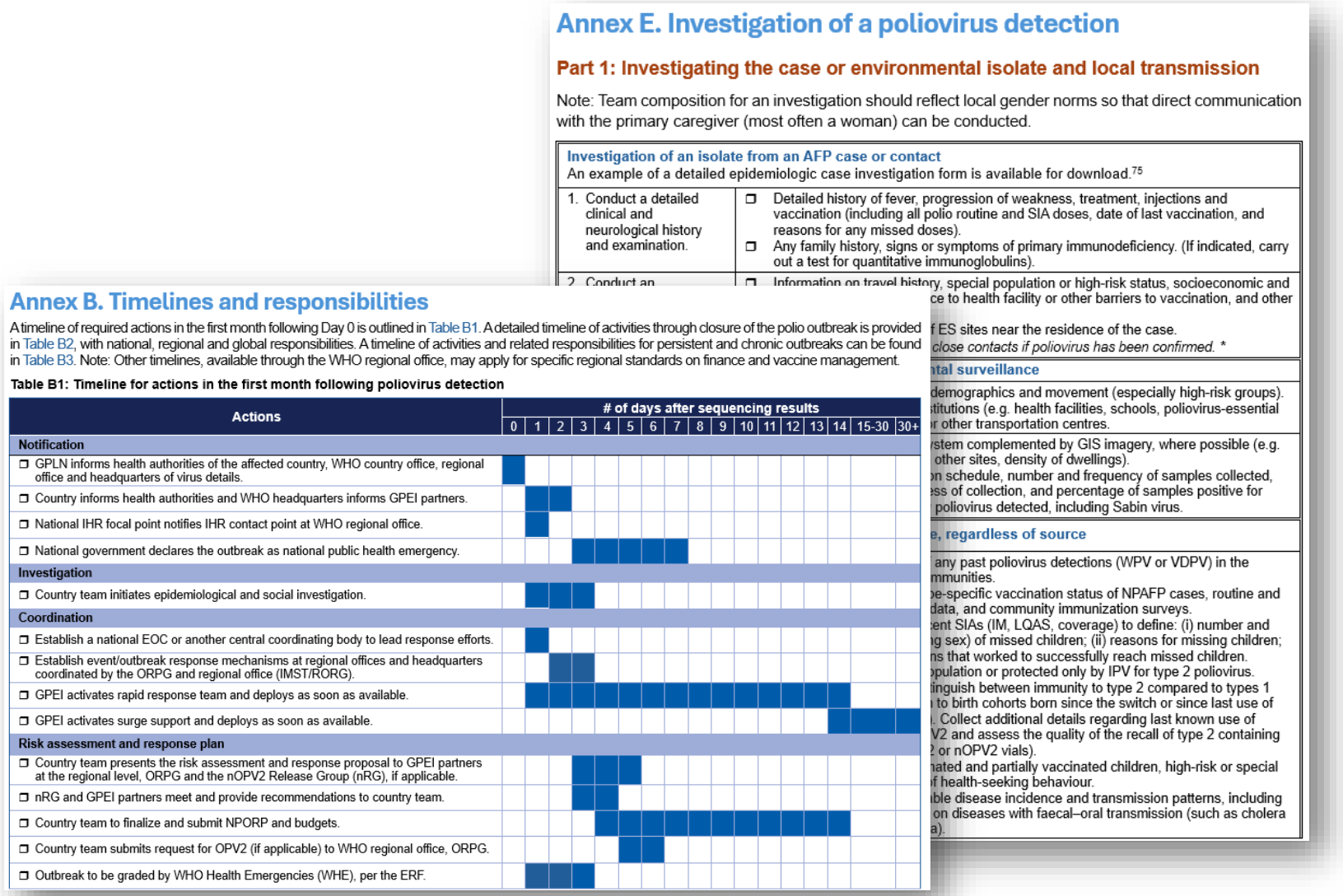
POLIO GLOBAL ERADICATION INITIATIVE

Annexes

Two types of annexes included in the SOP

First type: Operational guidance

- Formatted to print off for use as a job aid
- List of activities to complete



Annex E. Investigation of a poliovirus detection

Part 1: Investigating the case or environmental isolate and local transmission

Note: Team composition for an investigation should reflect local gender norms so that direct communication with the primary caregiver (most often a woman) can be conducted.

Investigation of an isolate from an AFP case or contact An example of a detailed epidemiologic case investigation form is available for download.[75]	
1. Conduct a detailed clinical and neurological history and examination.	❒ Detailed history of fever, progression of weakness, treatment, injections and vaccination (including all polio routine and SIA doses, date of last vaccination, and reasons for any missed doses). ❒ Any family history, signs or symptoms of primary immunodeficiency. (If indicated, carry out a test for quantitative immunoglobulins).
2. Conduct an	❒ Information on travel history, special population or high-risk status, socioeconomic and ce to health facility or other barriers to vaccination, and other

f ES sites near the residence of the case.
*close contacts if poliovirus has been confirmed. **

tal surveillance

demographics and movement (especially high-risk groups).
titutions (e.g. health facilities, schools, poliovirus-essential
r other transportation centres.

stem complemented by GIS imagery, where possible (e.g.
other sites, density of dwellings).
n schedule, number and frequency of samples collected,
ss of collection, and percentage of samples positive for
poliovirus detected, including Sabin virus.

e, regardless of source

any past poliovirus detections (WPV or VDPV) in the
mmunities.
e-specific vaccination status of NPAFP cases, routine and
data, and community immunization surveys.
ent SIAs (IM, LQAS, coverage) to define: (i) number and
g sex) of missed children; (ii) reasons for missing children;
s that worked to successfully reach missed children.
pulation or protected only by IPV for type 2 poliovirus.
inguish between immunity to type 2 compared to types 1
to birth cohorts born since the switch or since last use of
. Collect additional details regarding last known use of
V2 and assess the quality of the recall of type 2 containing
or nOPV2 vials).
nated and partially vaccinated children, high-risk or special
f health-seeking behaviour.
ble disease incidence and transmission patterns, including
on diseases with faecal–oral transmission (such as cholera
a).

Annex B. Timelines and responsibilities

A timeline of required actions in the first month following Day 0 is outlined in Table B1. A detailed timeline of activities through closure of the polio outbreak is provided in Table B2, with national, regional and global responsibilities. A timeline of activities and related responsibilities for persistent and chronic outbreaks can be found in Table B3. Note: Other timelines, available through the WHO regional office, may apply for specific regional standards on finance and vaccine management.

Table B1: Timeline for actions in the first month following poliovirus detection

Actions	# of days after sequencing results																
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15-30	30+
Notification																	
❒ GPLN informs health authorities of the affected country, WHO country office, regional office and headquarters of virus details.	■																
❒ Country informs health authorities and WHO headquarters informs GPEI partners.		■	■														
❒ National IHR focal point notifies IHR contact point at WHO regional office.		■															
❒ National government declares the outbreak as national public health emergency.				■	■	■	■	■									
Investigation																	
❒ Country team initiates epidemiological and social investigation.		■	■	■													
Coordination																	
❒ Establish a national EOC or another central coordinating body to lead response efforts.		■															
❒ Establish event/outbreak response mechanisms at regional offices and headquarters coordinated by the ORPG and regional office (IMST/RORG).			■	■													
❒ GPEI activates rapid response team and deploys as soon as available.		■	■	■	■	■	■	■	■	■	■	■	■	■	■		
❒ GPEI activates surge support and deploys as soon as available.															■	■	■
Risk assessment and response plan																	
❒ Country team presents the risk assessment and response proposal to GPEI partners at the regional level, ORPG and the nOPV2 Release Group (nRG), if applicable.				■	■	■											
❒ nRG and GPEI partners meet and provide recommendations to country team.				■	■												
❒ Country team to finalize and submit NPORP and budgets.					■	■	■	■	■	■	■	■	■	■	■		
❒ Country team submits request for OPV2 (if applicable) to WHO regional office, ORPG.						■	■										
❒ Outbreak to be graded by WHO Health Emergencies (WHE), per the ERF.		■	■	■													

Second type: Elaboration of Details

- Provides further information on topics raised in the main body

Annex D. Prioritization of outbreak response activities in a resource-constrained environment

The Global Polio Eradication Initiative (GPEI) has recently faced constrained resourc
for all proposed and planned activities in polio-outbreak countries. As outlined in the GI
programme has responded by strategically leveraging resources to maintain processe
or sequential approach to regionally defined epidemiological blocks.[73] This approach m
to support outbreak responses across the globe are diminished.

Operating within this fiscal environment requires difficult prioritizations, which are mad
as each country context and each outbreak will be unique. However, general considera
limited resources are outlined in Fig. D1. Modifications to the prioritization scheme shou
specific outbreak serotype and situation, such as the co-circulation of multiple poliovirus
response efforts should include active collaboration with routine immunization progr
coverage of the inactivated polio vaccine (IPV) and bivalent oral polio vaccine (bO
opportunities for adding polio vaccines and sharing costs with other immunization
strengthening initiatives, such as periodic intensifications of routine immunization (PIRIs
vaccination campaigns.

Activities to potentially de-prioritize

Lowest risk

1. IPV campaigns: When added to existing supplementary immunization activity
polio vaccine (OPV), IPV increases overall campaign budget needs due to bot
the lowest price for a 5-dose vial is $1.25 per dose) and logistical and implemen
IPV to an existing OPV SIA may also negatively affect coverage. Countries shou
OPV-only, house-to-house SIAs to achieve high coverage.[74] An alternative ap
IPV coverage is to integrate it with other planned nationwide vaccination activitie
SIAs and neglected tropical disease interventions.
2. Expanded age group campaigns: Unless there is clear evidence of transm
groups and a sizeable immunity gap in older aged children, SIAs should focus
years of age. This allows the programme to conduct house-to-house SIAs w
schools and other sites where older children congregate. It also save
implementation costs while focusing efforts on the age group that often drives
3. Limited Round 0: Round 0 has deviated from its original purpose to rapidly
located within a small radius of poliovirus detection and often mirrors large-scal
can be found by limiting the Round 0 to its original purpose, conducting only on
polio-outbreak country, or skipping Round 0 if one cannot be conducted within
if there were significant delays from sample collection until the confirmation of
4. Reduce scope of campaigns from a national to subnational immunization da
large SNID to a smaller SNID: Especially for large countries, vaccination ca
focused only on geographies with active transmission or at high risk for spr
savings in vaccine and implementation costs while still delivering a timely, hig
There is a risk, however, that due to a surveillance delay or gap, the smaller sc
result in a "failure of scope" with virus transmission outside the targeted vaccin
5. Reduce the number of SIAs from three to two: Some outbreaks have su
transmission with two SIAs. If only two SIAs will be conducted due to cons
countries should focus on timely, high-quality SIAs with a maximum of four-wee
remains for "failure of response" due to campaign delays or poor-quality SIAs.

Annex I. Current polio vaccine options

The oral polio vaccine (OPV) induces effective humoral and intestinal mucosal immunity and remains the vaccine of choice in OPV-using countries to interrupt transmission rapidly.

Bivalent oral polio vaccine (bOPV)

bOPV is a live-attenuated vaccine containing Sabin poliovirus types 1 and 3. The vaccine induces humoral immunity to protect against paralysis and mucosal immunity to prevent transmission of poliovirus type 1 and 3. bOPV is widely used in routine immunization. It is the vaccine of choice in responding to outbreaks of wild poliovirus type 1 (WPV1) or circulating vaccine-derived poliovirus types 1 and 3 (cVDPV1, cVDPV3).

Inactivated poliovirus vaccine (IPV)

IPV is an inactivated vaccine that contains poliovirus types 1, 2 and 3. The vaccine induces strong humoral immunity, protecting against paralysis to all three poliovirus types. In OPV-vaccinated or poliovirus-exposed individuals, IPV provides a strong boost in mucosal immunity which protects against transmission of the virus within the community. IPV administered to OPV-naïve children has been shown to modestly reduce the duration and frequency of virus excretion.

Novel oral polio vaccine type 2 (nOPV2)

nOPV2 is a modification of the type 2 Sabin monovalent OPV (mOPV2). Clinical studies have demonstrated that nOPV2 provides effective immunogenicity against type 2 poliovirus while being more genetically stable and less likely to revert to a form that can cause paralysis in children who have not been sufficiently immunized. nOPV2 is the vaccine of choice in responding to cVDPV2 outbreaks. The vaccine is available through a global stockpile maintained by the Global Polio Eradication Initiative (GPEI) and can be released only under the authorization of the Director-General of World Health Organization (WHO).

Sabin monovalent oral polio vaccine type 1 (mOPV1)

mOPV1 is a live-attenuated vaccine containing Sabin poliovirus type 1 only. It induces humoral immunity to prevent paralysis and mucosal immunity to prevent transmission of poliovirus type 1. mOPV1 is not part of routine immunization programmes and is not currently available in the global stockpile. mOPV1 is only available upon consultation with WHO and the United Nations Children's Fund (UNICEF) and requires an estimated lead time of 9–12 months before it is planned for use.

Sabin monovalent oral polio vaccine type 2 (mOPV2) and trivalent oral polio vaccine (tOPV)

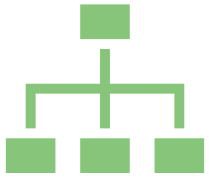
Since the withdrawal of type 2-containing OPV from routine immunization in 2016 and until the rollout of nOPV2 in 2021, vaccination response to outbreaks of type 2 circulating vaccine-derived poliovirus (cVDPV2) had been implemented only using Sabin-based monovalent OPV type 2 (mOPV2) or trivalent OPV (tOPV). These vaccines, while effective in inducing individual immunity and halting transmission, have a higher risk of reversion to neurovirulence than nOPV2 and hence seeded new outbreaks in the areas with low vaccination coverage. mOPV2 (but not tOPV) is still available in a global stockpile maintained by the GPEI and can be released only under the authorization of the WHO Director-General; however, nOPV2 remains the vaccine of choice in responding to type 2 poliovirus outbreaks.

WAY FORWARD

Shift from a static to a “living document”

The SOPs will be reviewed every six months to determine if an update is required

If no update required, will mark with a “reviewed in …” to signify it remains the current version



Structure of the SOPs provides flexibility to update

The main body of the text is focused on contextual and strategic considerations, unlikely to change frequently

Annexes include operational components of response efforts that may require more frequent updates

A Technical Companion Document is also available that describes the analytical findings that informed changes in outbreak response strategies.

Polio Outbreak Response Resources

- OBR SOPs Version 5: https://polioeradication.org/wp-content/uploads/2026/04/Standard-Operating-Procedures-for-responding-to-a-poliovirus-event-or-outbreak-V.5-Pre-publication.pdf
- OBR SOPs Version 5 Technical Companion Document https://polioeradication.org/wp-content/uploads/2026/04/Technical-Companion-Document.pdf
- OBR SOPs Version webinar slides and recording will be available on the Outbreak Preparedness & Response – GPEI webpage
- For polio outbreak resources
  - Resource Hub – GPEI (Outbreak preparedness and response)

OBR SOP Version 5 is your global resource to adapt for your region or country needs

OBR SOP Version 5 does not reflect specific practices within WHO regions or national programmes

Encouraged to adapt the guidance to their context and needs.

Examples include:

Shortened version specific to “new outbreaks” or “outbreaks that persist”

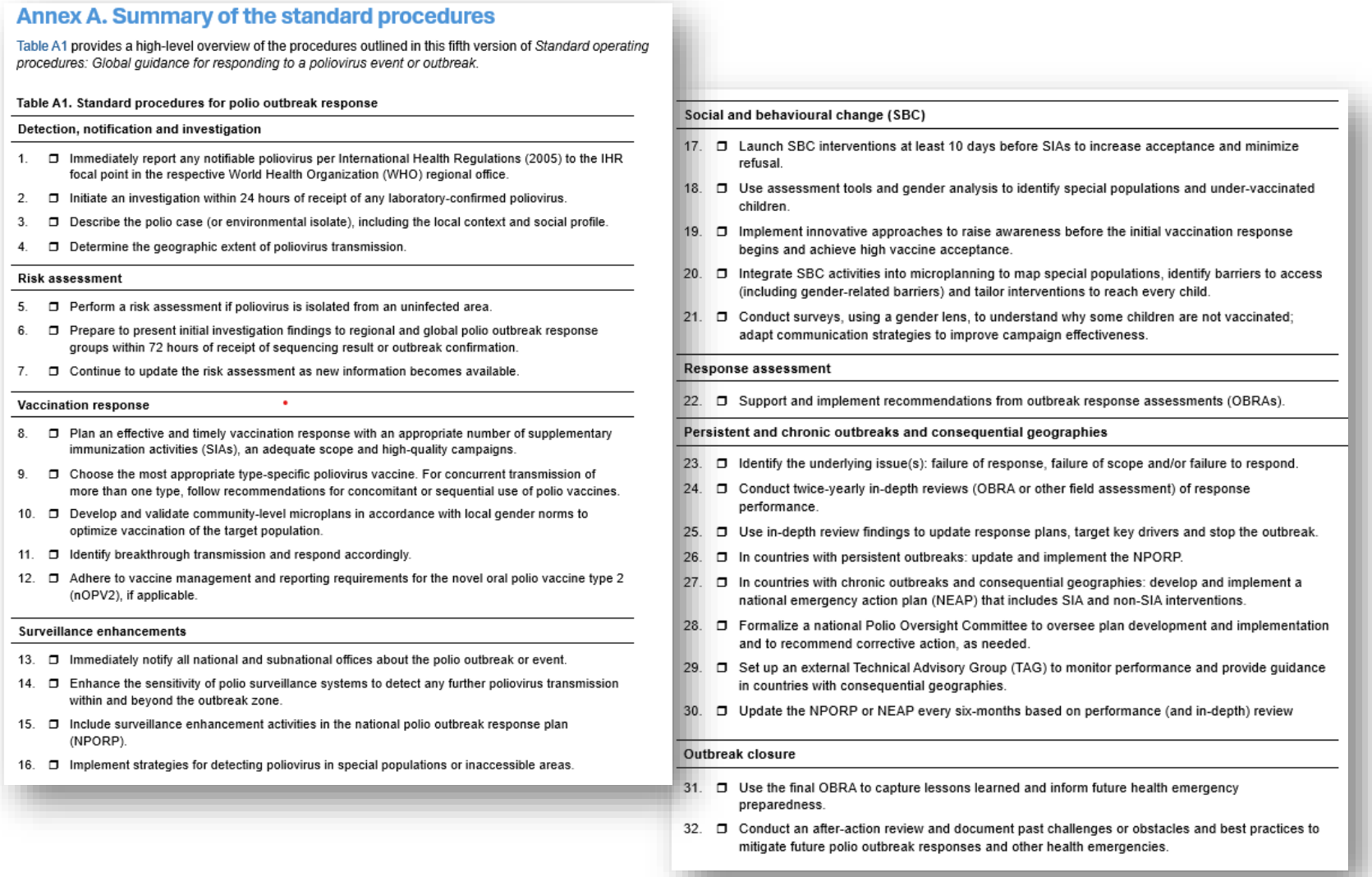
Checklist of activities to conduct by topic areas (e.g. initial vaccination response, surveillance, social and behavior change communication, etc.)

QUESTIONS & ANSWERS SESSION

ADDITIONAL SLIDES

Annex A: Summary of the standard procedures

- Checklist of all the procedures listed in each of the chapters



Annex A. Summary of the standard procedures

Table A1 provides a high-level overview of the procedures outlined in this fifth version of *Standard operating procedures: Global guidance for responding to a poliovirus event or outbreak.*

Table A1. Standard procedures for polio outbreak response

Detection, notification and investigation

1. ❒ Immediately report any notifiable poliovirus per International Health Regulations (2005) to the IHR focal point in the respective World Health Organization (WHO) regional office.
2. ❒ Initiate an investigation within 24 hours of receipt of any laboratory-confirmed poliovirus.
3. ❒ Describe the polio case (or environmental isolate), including the local context and social profile.
4. ❒ Determine the geographic extent of poliovirus transmission.

Risk assessment

5. ❒ Perform a risk assessment if poliovirus is isolated from an uninfected area.
6. ❒ Prepare to present initial investigation findings to regional and global polio outbreak response groups within 72 hours of receipt of sequencing result or outbreak confirmation.
7. ❒ Continue to update the risk assessment as new information becomes available.

Vaccination response

8. ❒ Plan an effective and timely vaccination response with an appropriate number of supplementary immunization activities (SIAs), an adequate scope and high-quality campaigns.
9. ❒ Choose the most appropriate type-specific poliovirus vaccine. For concurrent transmission of more than one type, follow recommendations for concomitant or sequential use of polio vaccines.
10. ❒ Develop and validate community-level microplans in accordance with local gender norms to optimize vaccination of the target population.
11. ❒ Identify breakthrough transmission and respond accordingly.
12. ❒ Adhere to vaccine management and reporting requirements for the novel oral polio vaccine type 2 (nOPV2), if applicable.

Surveillance enhancements

13. ❒ Immediately notify all national and subnational offices about the polio outbreak or event.
14. ❒ Enhance the sensitivity of polio surveillance systems to detect any further poliovirus transmission within and beyond the outbreak zone.
15. ❒ Include surveillance enhancement activities in the national polio outbreak response plan (NPORP).
16. ❒ Implement strategies for detecting poliovirus in special populations or inaccessible areas.

Social and behavioural change (SBC)

17. ❒ Launch SBC interventions at least 10 days before SIAs to increase acceptance and minimize refusal.
18. ❒ Use assessment tools and gender analysis to identify special populations and under-vaccinated children.
19. ❒ Implement innovative approaches to raise awareness before the initial vaccination response begins and achieve high vaccine acceptance.
20. ❒ Integrate SBC activities into microplanning to map special populations, identify barriers to access (including gender-related barriers) and tailor interventions to reach every child.
21. ❒ Conduct surveys, using a gender lens, to understand why some children are not vaccinated; adapt communication strategies to improve campaign effectiveness.

Response assessment

22. ❒ Support and implement recommendations from outbreak response assessments (OBRAs).

Persistent and chronic outbreaks and consequential geographies

23. ❒ Identify the underlying issue(s): failure of response, failure of scope and/or failure to respond.
24. ❒ Conduct twice-yearly in-depth reviews (OBRA or other field assessment) of response performance.
25. ❒ Use in-depth review findings to update response plans, target key drivers and stop the outbreak.
26. ❒ In countries with persistent outbreaks: update and implement the NPORP.
27. ❒ In countries with chronic outbreaks and consequential geographies: develop and implement a national emergency action plan (NEAP) that includes SIA and non-SIA interventions.
28. ❒ Formalize a national Polio Oversight Committee to oversee plan development and implementation and to recommend corrective action, as needed.
29. ❒ Set up an external Technical Advisory Group (TAG) to monitor performance and provide guidance in countries with consequential geographies.
30. ❒ Update the NPORP or NEAP every six-months based on performance (and in-depth) review

Outbreak closure

31. ❒ Use the final OBRA to capture lessons learned and inform future health emergency preparedness.
32. ❒ Conduct an after-action review and document past challenges or obstacles and best practices to mitigate future polio outbreak responses and other health emergencies.

Annex B: Timelines and Responsibilities

Required actions in the first month following Day 0

Table B1: Timeline for actions in the first month following poliovirus detection

Actions	# of days after sequencing results																
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15-30	30+
Notification																	
❒ GPLN informs health authorities of the affected country, WHO country office, regional office and headquarters of virus details.	■																
❒ Country informs health authorities and WHO headquarters informs GPEI partners.		■	■														
❒ National IHR focal point notifies IHR contact point at WHO regional office.		■															
❒ National government declares the outbreak as national public health emergency.				■	■	■	■	■									
Investigation																	
❒ Country team initiates epidemiological and social investigation.		■	■	■													
Coordination																	
❒ Establish a national EOC or another central coordinating body to lead response efforts.		■															
❒ Establish event/outbreak response mechanisms at regional offices and headquarters coordinated by the ORPG and regional office (IMST/RORG).			■	■													
❒ GPEI activates rapid response team and deploys as soon as available.		■	■	■	■	■	■	■	■	■	■	■	■	■	■		
❒ GPEI activates surge support and deploys as soon as available.															■	■	■
Risk assessment and response plan																	
❒ Country team presents the risk assessment and response proposal to GPEI partners at the regional level, ORPG and the nOPV2 Release Group (nRG), if applicable.				■	■	■											
❒ nRG and GPEI partners meet and provide recommendations to country team.				■	■												
❒ Country team to finalize and submit NPORP and budgets.					■	■	■	■	■	■	■	■	■	■	■		
❒ Country team submits request for OPV2 (if applicable) to WHO regional office, ORPG.						■	■										
❒ Outbreak to be graded by WHO Health Emergencies (WHE), per the ERF.		■	■	■													

Timeline and responsibility for outbreak response activities from Day 0 to closure

Table B2 (continued)

Timeline	Function	Activities	Responsibility	
			National	Regional and global
Within 24 hours of notification	Communication	Inform national authorities and other relevant partners of polio outbreak.	National government/health authorities	
		Inform GPEI partners of polio outbreak.		WHO headquarters to inform GPEI partners
		Alert UNICEF supply division if type 2 poliovirus detected.		WHO, UNICEF headquarters
	Coordination and advocacy	Brief Minister of Health, Head of Government/State and other relevant officials on the specific steps required for an urgent response to stop transmission: 1. Establish a national EOC if an existing emergency coordination structure is not already in place, led by a senior government official as the designated outbreak focal point and supported by staff for administration, strategic communication, operations, logistics, supply management and finance. 2. Implement the required response operations to stop poliovirus transmission as per the outbreak response SOPs, virus type and classification. 3. Ensure systematic monitoring mechanism at all levels (national, regional and district) on progress of planning, implementation and follow-up actions throughout response activities. 4. Report timely and regularly on the progress of outbreak response activities to the head of government/state and GPEI partners.	National health authorities, with support from WHO and UNICEF country offices	With support from GPEI partners to ensure the national health authorities have the necessary information to communicate effectively with country stakeholders
	Coordination	• Establish coordination mechanism among national, regional and global partners.	National health authorities, with support from WHO	GPEI partners

Table B2: Timeline and responsibility for outbreak response activities from Day 0 to closure of outbreak

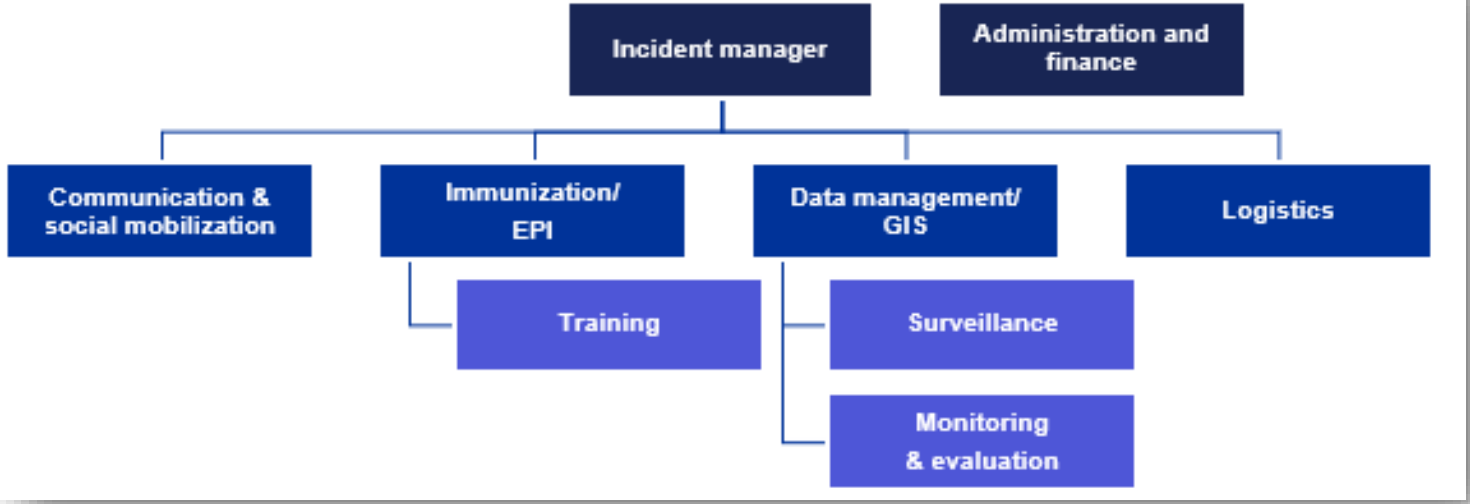
Timeline	Function	Activities	Responsibility	
			National	Regional and global
Notification of virus from laboratory – Day 0	Coordination	Establish an outbreak management team with representation from all relevant agencies.	National government/health authorities, with support from WHO/UNICEF country offices	Regional offices to coordinate with countries and ORPG
	Resources	• Review national polio outbreak preparedness and response plan, if available. • Read reports or documents of previous outbreak response activities.	National government/health authorities with support from WHO/UNICEF country offices	
		Identify trained or experienced polio outbreak response persons in country/region.	National government/health authorities, with support from WHO/UNICEF country offices	WHO and UNICEF regional offices/headquarters to rapidly provide required documents

Annex C: National Emergency Management

- **Preparedness:** General information on the importance of conducting polio outbreak simulation exercises to test national polio outbreak response plan

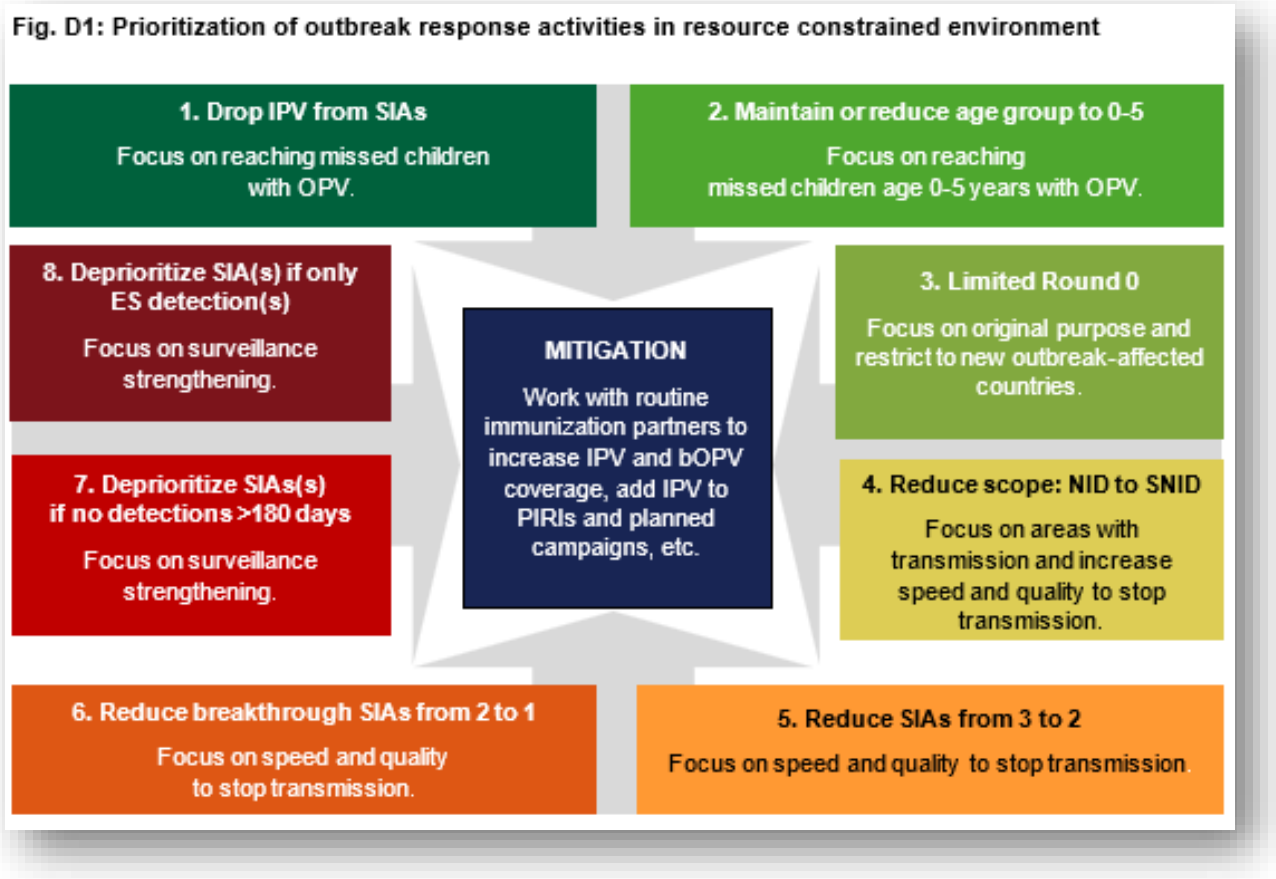
- **Response:** Example of national Emergency Operations Centre structure for responding to a polio outbreak

Fig. C1. Sample national EOC structure for a polio outbreak response



Annex D. Prioritization of outbreak response activities in a resource constrained environment

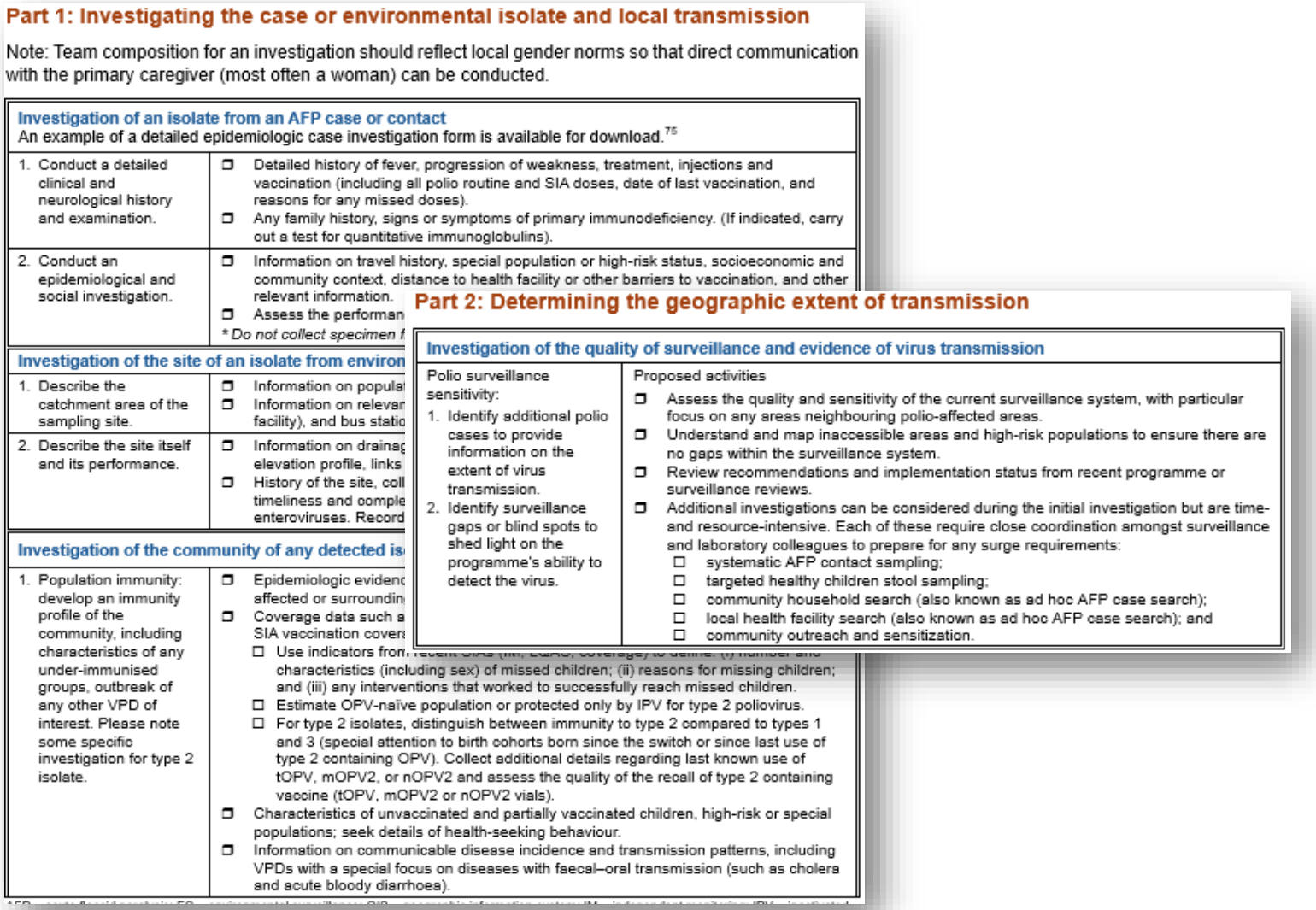
- General considerations for prioritizing limited resources
- The prioritization scheme is ordered from 1 to 8 based on lowest to highest anticipated impact on interruption



Annex E: Investigation of a poliovirus detection

Part 1: Details on investigating the case or environmental isolate and local transmission

Part 2: Determining the geographic extent of transmission



Part 1: Investigating the case or environmental isolate and local transmission

Note: Team composition for an investigation should reflect local gender norms so that direct communication with the primary caregiver (most often a woman) can be conducted.

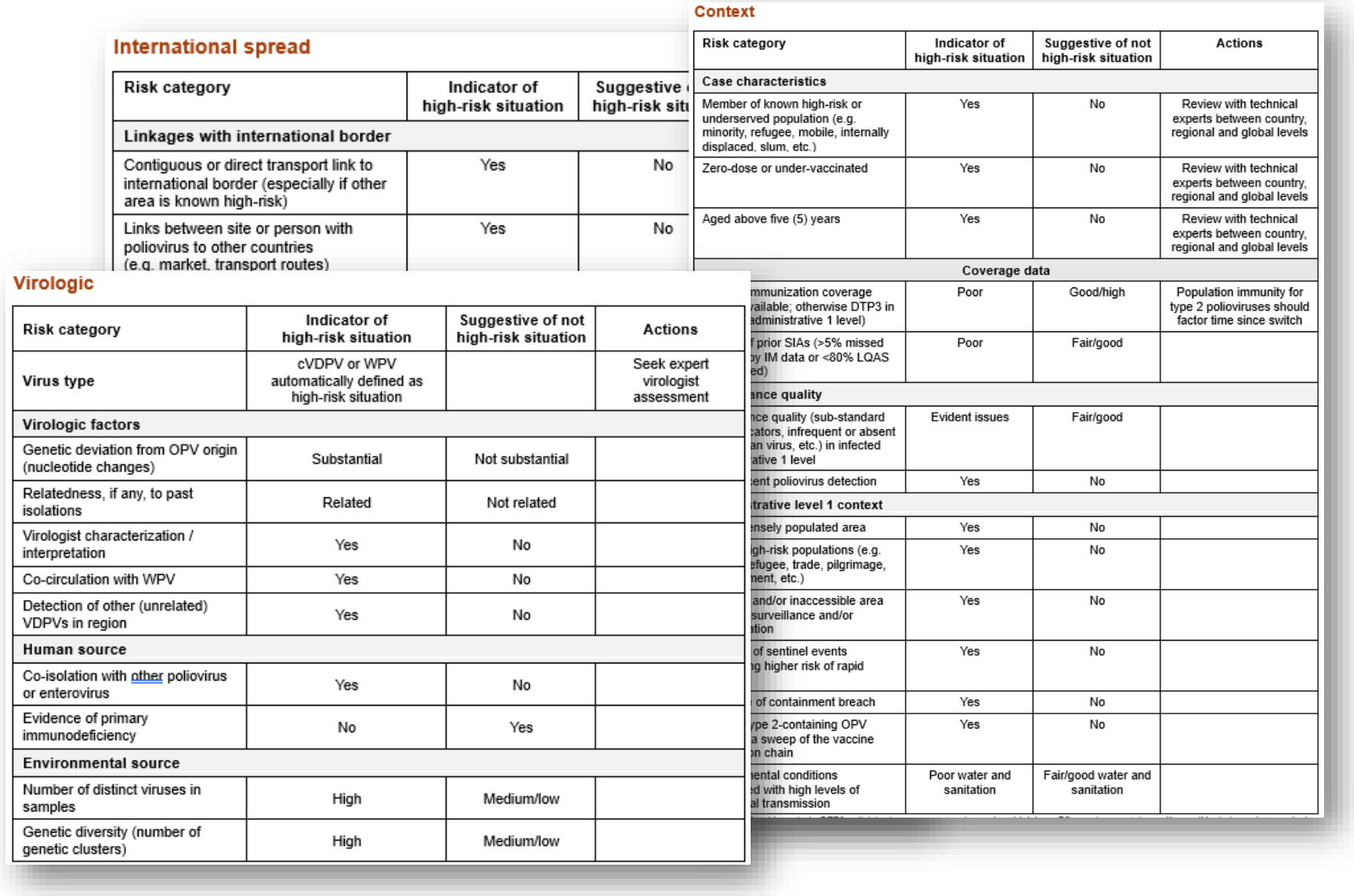
Investigation of an isolate from an AFP case or contact An example of a detailed epidemiologic case investigation form is available for download.[75]	
1. Conduct a detailed clinical and neurological history and examination.	❒ Detailed history of fever, progression of weakness, treatment, injections and vaccination (including all polio routine and SIA doses, date of last vaccination, and reasons for any missed doses). ❒ Any family history, signs or symptoms of primary immunodeficiency. (If indicated, carry out a test for quantitative immunoglobulins).
2. Conduct an epidemiological and social investigation.	❒ Information on travel history, special population or high-risk status, socioeconomic and community context, distance to health facility or other barriers to vaccination, and other relevant information. ❒ Assess the performan ** Do not collect specimen f*
Investigation of the site of an isolate from environ	
1. Describe the catchment area of the sampling site.	❒ Information on popula ❒ Information on relevar facility), and bus statio
2. Describe the site itself and its performance.	❒ Information on drainag elevation profile, links ❒ History of the site, coll timeliness and comple enteroviruses. Record
Investigation of the community of any detected is	
1. Population immunity: develop an immunity profile of the community, including characteristics of any under-immunised groups, outbreak of any other VPD of interest. Please note some specific investigation for type 2 isolate.	❒ Epidemiologic evidenc affected or surroundin ❒ Coverage data such a SIA vaccination cover ☐ Use indicators fron characteristics (including sex) of missed children; (ii) reasons for missing children; and (iii) any interventions that worked to successfully reach missed children. ☐ Estimate OPV-naïve population or protected only by IPV for type 2 poliovirus. ☐ For type 2 isolates, distinguish between immunity to type 2 compared to types 1 and 3 (special attention to birth cohorts born since the switch or since last use of type 2 containing OPV). Collect additional details regarding last known use of tOPV, mOPV2, or nOPV2 and assess the quality of the recall of type 2 containing vaccine (tOPV, mOPV2 or nOPV2 vials). ❒ Characteristics of unvaccinated and partially vaccinated children, high-risk or special populations; seek details of health-seeking behaviour. ❒ Information on communicable disease incidence and transmission patterns, including VPDs with a special focus on diseases with faecal–oral transmission (such as cholera and acute bloody diarrhoea).

Part 2: Determining the geographic extent of transmission

Investigation of the quality of surveillance and evidence of virus transmission	
Polio surveillance sensitivity: 1. Identify additional polio cases to provide information on the extent of virus transmission. 2. Identify surveillance gaps or blind spots to shed light on the programme's ability to detect the virus.	Proposed activities ❒ Assess the quality and sensitivity of the current surveillance system, with particular focus on any areas neighbouring polio-affected areas. ❒ Understand and map inaccessible areas and high-risk populations to ensure there are no gaps within the surveillance system. ❒ Review recommendations and implementation status from recent programme or surveillance reviews. ❒ Additional investigations can be considered during the initial investigation but are time- and resource-intensive. Each of these require close coordination amongst surveillance and laboratory colleagues to prepare for any surge requirements: ☐ systematic AFP contact sampling; ☐ targeted healthy children stool sampling; ☐ community household search (also known as ad hoc AFP case search); ☐ local health facility search (also known as ad hoc AFP case search); and ☐ community outreach and sensitization.

Annex F: Risk Assessment Overview

- Summary of elements for a systematic risk assessment of a new VDPV, WPV, or vaccine-like 2 isolates



International spread

Risk category	Indicator of high-risk situation	Suggestive high-risk sit
Linkages with international border		
Contiguous or direct transport link to international border (especially if other area is known high-risk)	Yes	No
Links between site or person with poliovirus to other countries (e.g. market, transport routes)	Yes	No

Virologic

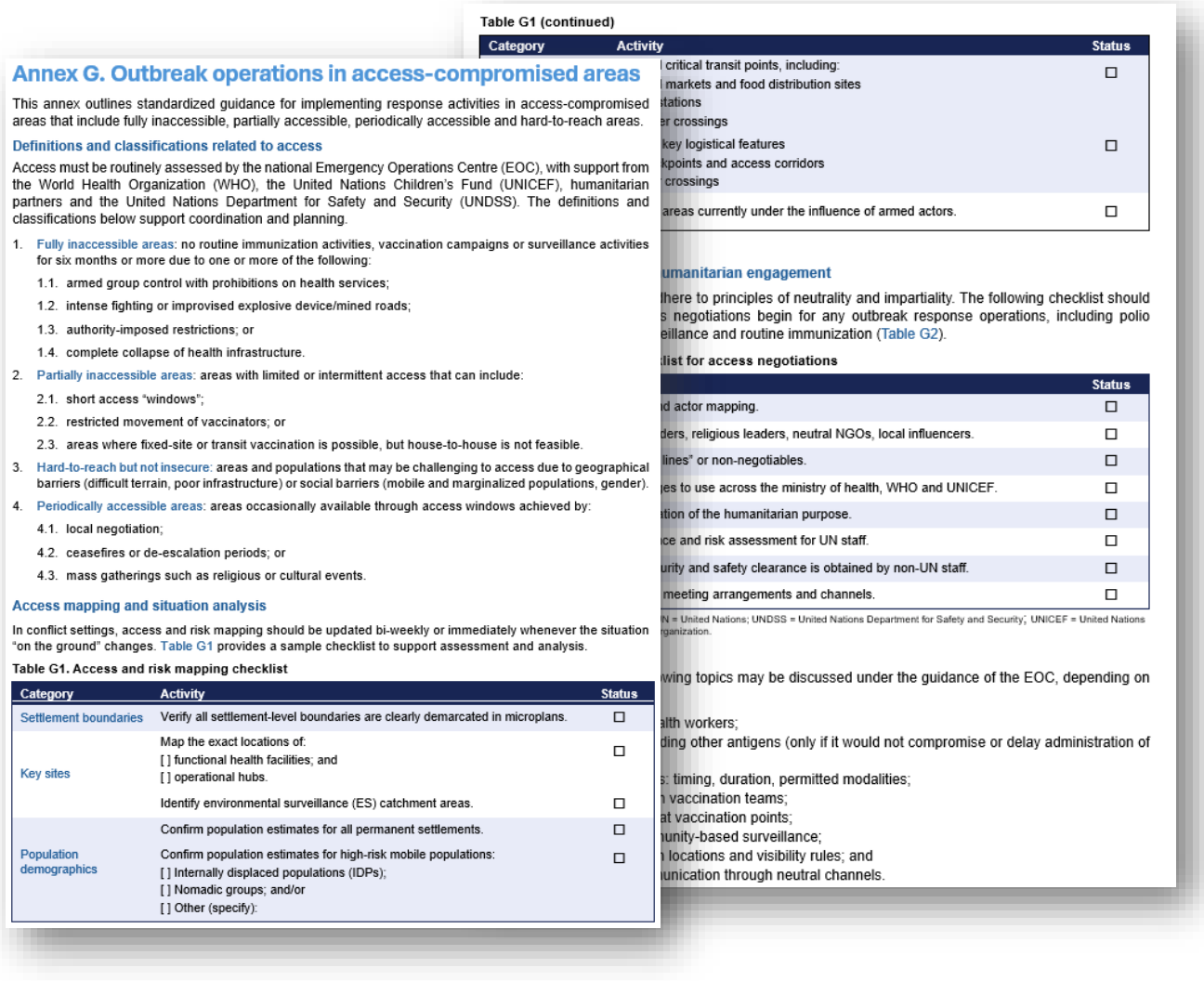
Risk category	Indicator of high-risk situation	Suggestive of not high-risk situation	Actions
Virus type	cVDPV or WPV automatically defined as high-risk situation		Seek expert virologist assessment
Virologic factors			
Genetic deviation from OPV origin (nucleotide changes)	Substantial	Not substantial	
Relatedness, if any, to past isolations	Related	Not related	
Virologist characterization / interpretation	Yes	No	
Co-circulation with WPV	Yes	No	
Detection of other (unrelated) VDPVs in region	Yes	No	
Human source			
Co-isolation with other poliovirus or enterovirus	Yes	No	
Evidence of primary immunodeficiency	No	Yes	
Environmental source			
Number of distinct viruses in samples	High	Medium/low	
Genetic diversity (number of genetic clusters)	High	Medium/low	

Context

Risk category	Indicator of high-risk situation	Suggestive of not high-risk situation	Actions
Case characteristics			
Member of known high-risk or underserved population (e.g. minority, refugee, mobile, internally displaced, slum, etc.)	Yes	No	Review with technical experts between country, regional and global levels
Zero-dose or under-vaccinated	Yes	No	Review with technical experts between country, regional and global levels
Aged above five (5) years	Yes	No	Review with technical experts between country, regional and global levels
Coverage data			
mmunization coverage vailable; otherwise DTP3 in dministrative 1 level)	Poor	Good/high	Population immunity for type 2 polioviruses should factor time since switch
f prior SIAs (>5% missed y IM data or <80% LQAS ed)	Poor	Fair/good	
ance quality			
nce quality (sub-standard cators, infrequent or absent an virus, etc.) in infected ative 1 level	Evident issues	Fair/good	
ent poliovirus detection	Yes	No	
trative level 1 context			
nsely populated area	Yes	No	
gh-risk populations (e.g. efugee, trade, pilgrimage, ment, etc.)	Yes	No	
and/or inaccessible area surveillance and/or tion	Yes	No	
of sentinel events g higher risk of rapid	Yes	No	
of containment breach	Yes	No	
ype 2-containing OPV a sweep of the vaccine n chain	Yes	No	
ental conditions d with high levels of l transmission	Poor water and sanitation	Fair/good water and sanitation	

Annex G: Outbreak operations in access-compromised areas

- Outlines standardized guidance for implementing response activities in access-compromised areas that include fully inaccessible, partially accessible and hard-to-reach areas



Annex G. Outbreak operations in access-compromised areas

This annex outlines standardized guidance for implementing response activities in access-compromised areas that include fully inaccessible, partially accessible, periodically accessible and hard-to-reach areas.

Definitions and classifications related to access

Access must be routinely assessed by the national Emergency Operations Centre (EOC), with support from the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), humanitarian partners and the United Nations Department for Safety and Security (UNDSS). The definitions and classifications below support coordination and planning.

1. Fully inaccessible areas: no routine immunization activities, vaccination campaigns or surveillance activities for six months or more due to one or more of the following:
   - 1.1. armed group control with prohibitions on health services;
   - 1.2. intense fighting or improvised explosive device/mined roads;
   - 1.3. authority-imposed restrictions; or
   - 1.4. complete collapse of health infrastructure.
2. Partially inaccessible areas: areas with limited or intermittent access that can include:
   - 2.1. short access "windows";
   - 2.2. restricted movement of vaccinators; or
   - 2.3. areas where fixed-site or transit vaccination is possible, but house-to-house is not feasible.
3. Hard-to-reach but not insecure: areas and populations that may be challenging to access due to geographical barriers (difficult terrain, poor infrastructure) or social barriers (mobile and marginalized populations, gender).
4. Periodically accessible areas: areas occasionally available through access windows achieved by:
   - 4.1. local negotiation;
   - 4.2. ceasefires or de-escalation periods; or
   - 4.3. mass gatherings such as religious or cultural events.

Access mapping and situation analysis

In conflict settings, access and risk mapping should be updated bi-weekly or immediately whenever the situation "on the ground" changes. Table G1 provides a sample checklist to support assessment and analysis.

Table G1. Access and risk mapping checklist

Category	Activity	Status
Settlement boundaries	Verify all settlement-level boundaries are clearly demarcated in microplans.	☐
Key sites	Map the exact locations of: [ ] functional health facilities; and [ ] operational hubs.	☐
	Identify environmental surveillance (ES) catchment areas.	☐
Population demographics	Confirm population estimates for all permanent settlements.	☐
	Confirm population estimates for high-risk mobile populations: [ ] Internally displaced populations (IDPs); [ ] Nomadic groups; and/or [ ] Other (specify):	☐

Table G1 (continued)

Category	Activity	Status
	critical transit points, including:	☐
	markets and food distribution sites	
	tations	
	er crossings	
	key logistical features	☐
	kpoints and access corridors	
	crossings	
	areas currently under the influence of armed actors.	☐

umanitarian engagement

here to principles of neutrality and impartiality. The following checklist should s negotiations begin for any outbreak response operations, including polio eillance and routine immunization (Table G2).

list for access negotiations

	Status
d actor mapping.	☐
ders, religious leaders, neutral NGOs, local influencers.	☐
lines" or non-negotiables.	☐
es to use across the ministry of health, WHO and UNICEF.	☐
tion of the humanitarian purpose.	☐
ce and risk assessment for UN staff.	☐
urity and safety clearance is obtained by non-UN staff.	☐
meeting arrangements and channels.	☐

N = United Nations; UNDSS = United Nations Department for Safety and Security; UNICEF = United Nations rganization.

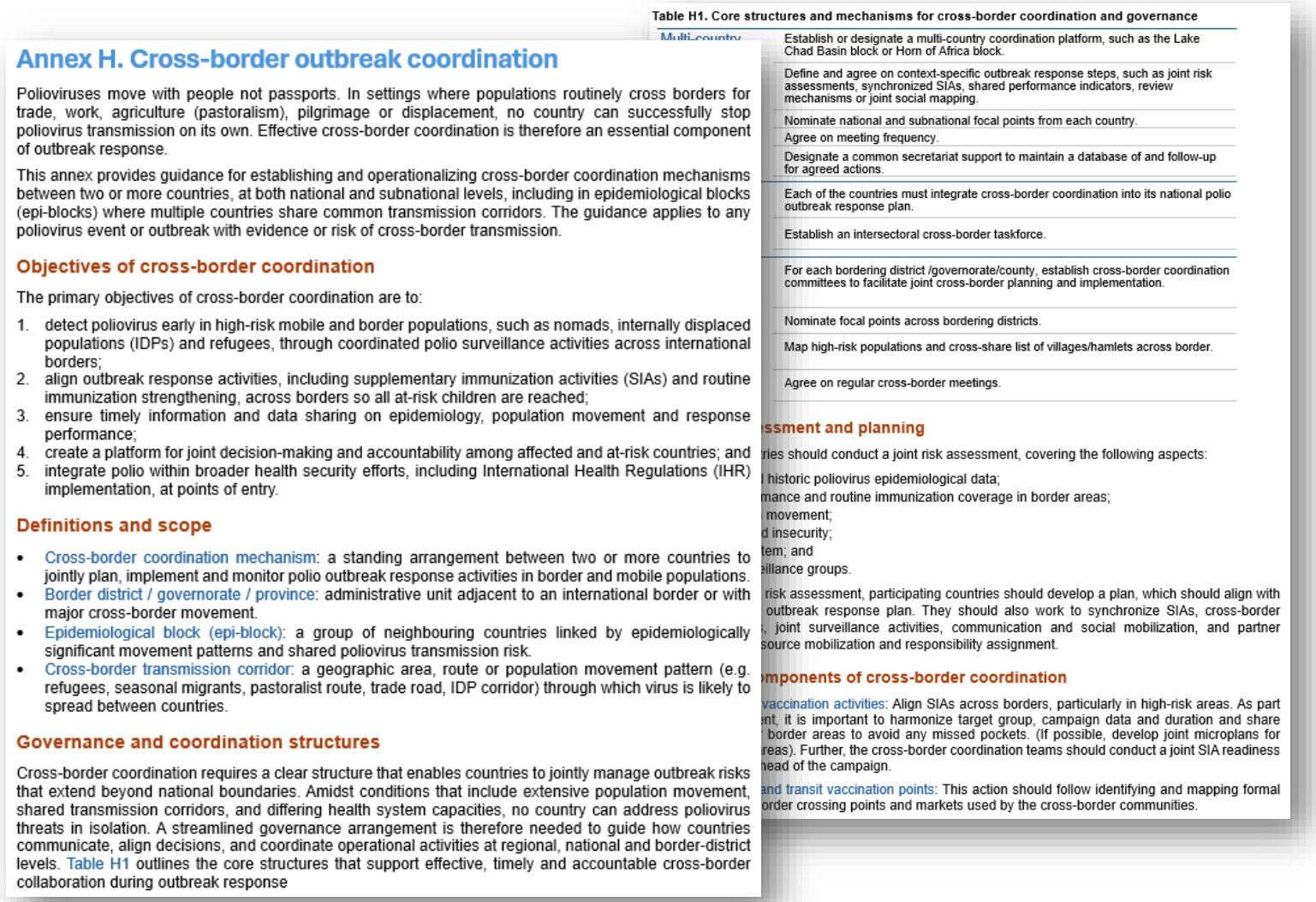
wing topics may be discussed under the guidance of the EOC, depending on

lth workers;
ding other antigens (only if it would not compromise or delay administration of

: timing, duration, permitted modalities;
vaccination teams;
at vaccination points;
unity-based surveillance;
locations and visibility rules; and
unication through neutral channels.

Annex H: Cross-border outbreak coordination

- Guidance for establishing and operationalizing cross-border coordination mechanisms between two or more countries
  - at national and subnational levels
  - epidemiological blocks (epi-blocks) where multiple countries share common transmission corridors



Annex H. Cross-border outbreak coordination

Polioviruses move with people not passports. In settings where populations routinely cross borders for trade, work, agriculture (pastoralism), pilgrimage or displacement, no country can successfully stop poliovirus transmission on its own. Effective cross-border coordination is therefore an essential component of outbreak response.

This annex provides guidance for establishing and operationalizing cross-border coordination mechanisms between two or more countries, at both national and subnational levels, including in epidemiological blocks (epi-blocks) where multiple countries share common transmission corridors. The guidance applies to any poliovirus event or outbreak with evidence or risk of cross-border transmission.

Objectives of cross-border coordination

The primary objectives of cross-border coordination are to:

1. detect poliovirus early in high-risk mobile and border populations, such as nomads, internally displaced populations (IDPs) and refugees, through coordinated polio surveillance activities across international borders;
2. align outbreak response activities, including supplementary immunization activities (SIAs) and routine immunization strengthening, across borders so all at-risk children are reached;
3. ensure timely information and data sharing on epidemiology, population movement and response performance;
4. create a platform for joint decision-making and accountability among affected and at-risk countries; and
5. integrate polio within broader health security efforts, including International Health Regulations (IHR) implementation, at points of entry.

Definitions and scope

- Cross-border coordination mechanism: a standing arrangement between two or more countries to jointly plan, implement and monitor polio outbreak response activities in border and mobile populations.
- Border district / governorate / province: administrative unit adjacent to an international border or with major cross-border movement.
- Epidemiological block (epi-block): a group of neighbouring countries linked by epidemiologically significant movement patterns and shared poliovirus transmission risk.
- Cross-border transmission corridor: a geographic area, route or population movement pattern (e.g. refugees, seasonal migrants, pastoralist route, trade road, IDP corridor) through which virus is likely to spread between countries.

Governance and coordination structures

Cross-border coordination requires a clear structure that enables countries to jointly manage outbreak risks that extend beyond national boundaries. Amidst conditions that include extensive population movement, shared transmission corridors, and differing health system capacities, no country can address poliovirus threats in isolation. A streamlined governance arrangement is therefore needed to guide how countries communicate, align decisions, and coordinate operational activities at regional, national and border-district levels. Table H1 outlines the core structures that support effective, timely and accountable cross-border collaboration during outbreak response

Table H1. Core structures and mechanisms for cross-border coordination and governance

Multi-country	Establish or designate a multi-country coordination platform, such as the Lake Chad Basin block or Horn of Africa block.
	Define and agree on context-specific outbreak response steps, such as joint risk assessments, synchronized SIAs, shared performance indicators, review mechanisms or joint social mapping.
	Nominate national and subnational focal points from each country.
	Agree on meeting frequency.
	Designate a common secretariat support to maintain a database of and follow-up for agreed actions.
	Each of the countries must integrate cross-border coordination into its national polio outbreak response plan.
	Establish an intersectoral cross-border taskforce.
	For each bordering district /governorate/county, establish cross-border coordination committees to facilitate joint cross-border planning and implementation.
	Nominate focal points across bordering districts.
	Map high-risk populations and cross-share list of villages/hamlets across border.
	Agree on regular cross-border meetings.

ssment and planning

ries should conduct a joint risk assessment, covering the following aspects:

historic poliovirus epidemiological data;
mance and routine immunization coverage in border areas;
movement;
d insecurity;
tem; and
illance groups.

risk assessment, participating countries should develop a plan, which should align with outbreak response plan. They should also work to synchronize SIAs, cross-border joint surveillance activities, communication and social mobilization, and partner source mobilization and responsibility assignment.

mponents of cross-border coordination

vaccination activities: Align SIAs across borders, particularly in high-risk areas. As part nt, it is important to harmonize target group, campaign data and duration and share border areas to avoid any missed pockets. (If possible, develop joint microplans for reas). Further, the cross-border coordination teams should conduct a joint SIA readiness head of the campaign.

nd transit vaccination points: This action should follow identifying and mapping formal order crossing points and markets used by the cross-border communities.

Annex I: Current polio vaccine options

- Brief description of current polio vaccine options for responding to outbreaks

Annex I. Current polio vaccine options

The oral polio vaccine (OPV) induces effective humoral and intestinal mucosal immunity and remains the vaccine of choice in OPV-using countries to interrupt transmission rapidly.

Bivalent oral polio vaccine (bOPV)

bOPV is a live-attenuated vaccine containing Sabin poliovirus types 1 and 3. The vaccine induces humoral immunity to protect against paralysis and mucosal immunity to prevent transmission of poliovirus type 1 and 3. bOPV is widely used in routine immunization. It is the vaccine of choice in responding to outbreaks of wild poliovirus type 1 (WPV1) or circulating vaccine-derived poliovirus types 1 and 3 (cVDPV1, cVDPV3).

Inactivated poliovirus vaccine (IPV)

IPV is an inactivated vaccine that contains poliovirus types 1, 2 and 3. The vaccine induces strong humoral immunity, protecting against paralysis to all three poliovirus types. In OPV-vaccinated or poliovirus-exposed individuals, IPV provides a strong boost in mucosal immunity which protects against transmission of the virus within the community. IPV administered to OPV-naïve children has been shown to modestly reduce the duration and frequency of virus excretion.

Novel oral polio vaccine type 2 (nOPV2)

nOPV2 is a modification of the type 2 Sabin monovalent OPV (mOPV2). Clinical studies have demonstrated that nOPV2 provides effective immunogenicity against type 2 poliovirus while being more genetically stable and less likely to revert to a form that can cause paralysis in children who have not been sufficiently immunized. nOPV2 is the vaccine of choice in responding to cVDPV2 outbreaks. The vaccine is available through a global stockpile maintained by the Global Polio Eradication Initiative (GPEI) and can be released only under the authorization of the Director-General of World Health Organization (WHO).

Sabin monovalent oral polio vaccine type 1 (mOPV1)

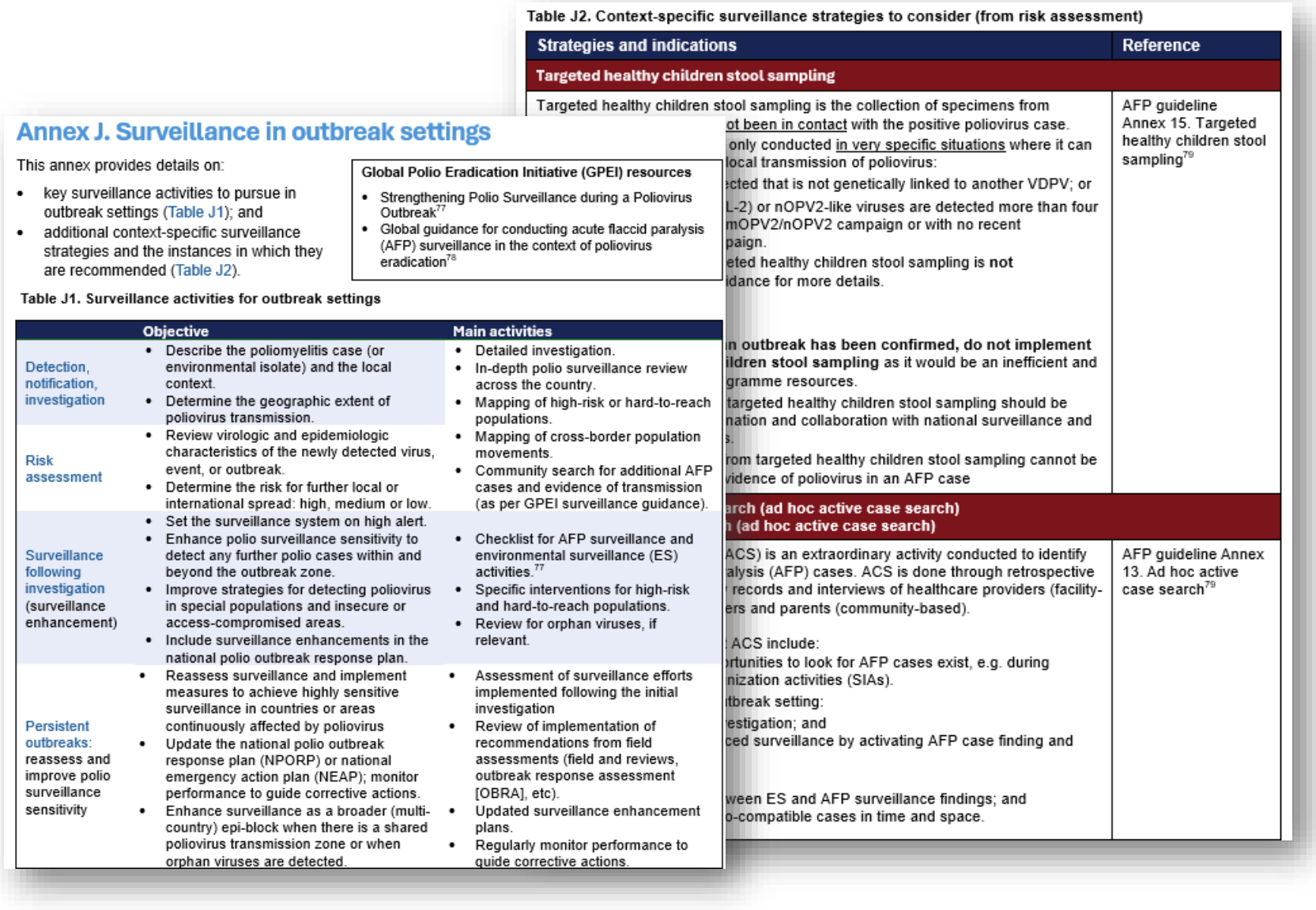
mOPV1 is a live-attenuated vaccine containing Sabin poliovirus type 1 only. It induces humoral immunity to prevent paralysis and mucosal immunity to prevent transmission of poliovirus type 1. mOPV1 is not part of routine immunization programmes and is not currently available in the global stockpile. mOPV1 is only available upon consultation with WHO and the United Nations Children's Fund (UNICEF) and requires an estimated lead time of 9–12 months before it is planned for use.

Sabin monovalent oral polio vaccine type 2 (mOPV2) and trivalent oral polio vaccine (tOPV)

Since the withdrawal of type 2-containing OPV from routine immunization in 2016 and until the rollout of nOPV2 in 2021, vaccination response to outbreaks of type 2 circulating vaccine-derived poliovirus (cVDPV2) had been implemented only using Sabin-based monovalent OPV type 2 (mOPV2) or trivalent OPV (tOPV). These vaccines, while effective in inducing individual immunity and halting transmission, have a higher risk of reversion to neurovirulence than nOPV2 and hence seeded new outbreaks in the areas with low vaccination coverage. mOPV2 (but not tOPV) is still available in a global stockpile maintained by the GPEI and can be released only under the authorization of the WHO Director-General; however, nOPV2 remains the vaccine of choice in responding to type 2 poliovirus outbreaks.

Annex J: Surveillance in outbreak settings

- Summary of key surveillance activities in outbreak settings
- Context-specific surveillance strategies



Annex J. Surveillance in outbreak settings

This annex provides details on:

- key surveillance activities to pursue in outbreak settings (Table J1); and
- additional context-specific surveillance strategies and the instances in which they are recommended (Table J2).

Global Polio Eradication Initiative (GPEI) resources

- Strengthening Polio Surveillance during a Poliovirus Outbreak[77]
- Global guidance for conducting acute flaccid paralysis (AFP) surveillance in the context of poliovirus eradication[78]

Table J1. Surveillance activities for outbreak settings

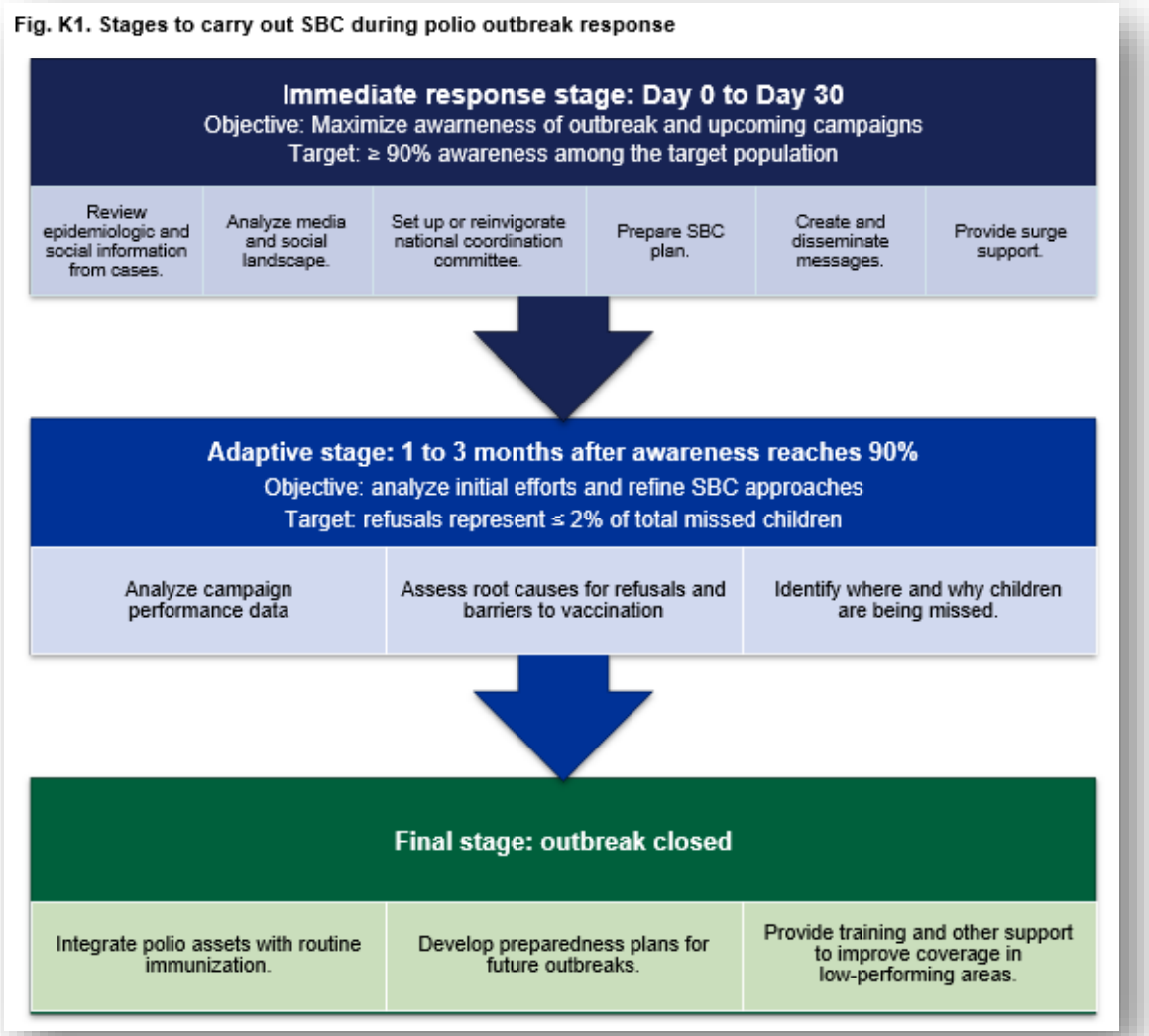
	Objective	Main activities
Detection, notification, investigation	• Describe the poliomyelitis case (or environmental isolate) and the local context. • Determine the geographic extent of poliovirus transmission.	• Detailed investigation. • In-depth polio surveillance review across the country. • Mapping of high-risk or hard-to-reach populations. • Mapping of cross-border population movements.
Risk assessment	• Review virologic and epidemiologic characteristics of the newly detected virus, event, or outbreak. • Determine the risk for further local or international spread: high, medium or low.	• Community search for additional AFP cases and evidence of transmission (as per GPEI surveillance guidance).
Surveillance following investigation (surveillance enhancement)	• Set the surveillance system on high alert. • Enhance polio surveillance sensitivity to detect any further polio cases within and beyond the outbreak zone. • Improve strategies for detecting poliovirus in special populations and insecure or access-compromised areas. • Include surveillance enhancements in the national polio outbreak response plan.	• Checklist for AFP surveillance and environmental surveillance (ES) activities.[77] • Specific interventions for high-risk and hard-to-reach populations. • Review for orphan viruses, if relevant.
Persistent outbreaks: reassess and improve polio surveillance sensitivity	• Reassess surveillance and implement measures to achieve highly sensitive surveillance in countries or areas continuously affected by poliovirus • Update the national polio outbreak response plan (NPORP) or national emergency action plan (NEAP); monitor performance to guide corrective actions. • Enhance surveillance as a broader (multi-country) epi-block when there is a shared poliovirus transmission zone or when orphan viruses are detected.	• Assessment of surveillance efforts implemented following the initial investigation • Review of implementation of recommendations from field assessments (field and reviews, outbreak response assessment [OBRA], etc). • Updated surveillance enhancement plans. • Regularly monitor performance to guide corrective actions.

Table J2. Context-specific surveillance strategies to consider (from risk assessment)

Strategies and indications	Reference
Targeted healthy children stool sampling	
Targeted healthy children stool sampling is the collection of specimens from ot been in contact with the positive poliovirus case. only conducted in very specific situations where it can local transmission of poliovirus: ected that is not genetically linked to another VDPV; or L-2) or nOPV2-like viruses are detected more than four mOPV2/nOPV2 campaign or with no recent paign. eted healthy children stool sampling is **not** idance for more details. **n outbreak has been confirmed, do not implement** **ildren stool sampling** as it would be an inefficient and gramme resources. targeted healthy children stool sampling should be nation and collaboration with national surveillance and s. rom targeted healthy children stool sampling cannot be vidence of poliovirus in an AFP case	AFP guideline Annex 15. Targeted healthy children stool sampling[79]
rch (ad hoc active case search) **(ad hoc active case search)**	
ACS) is an extraordinary activity conducted to identify alysis (AFP) cases. ACS is done through retrospective records and interviews of healthcare providers (facility- ers and parents (community-based). ACS include: rtunities to look for AFP cases exist, e.g. during nization activities (SIAs). tbreak setting: estigation; and ced surveillance by activating AFP case finding and ween ES and AFP surveillance findings; and o-compatible cases in time and space.	AFP guideline Annex 13. Ad hoc active case search[79]

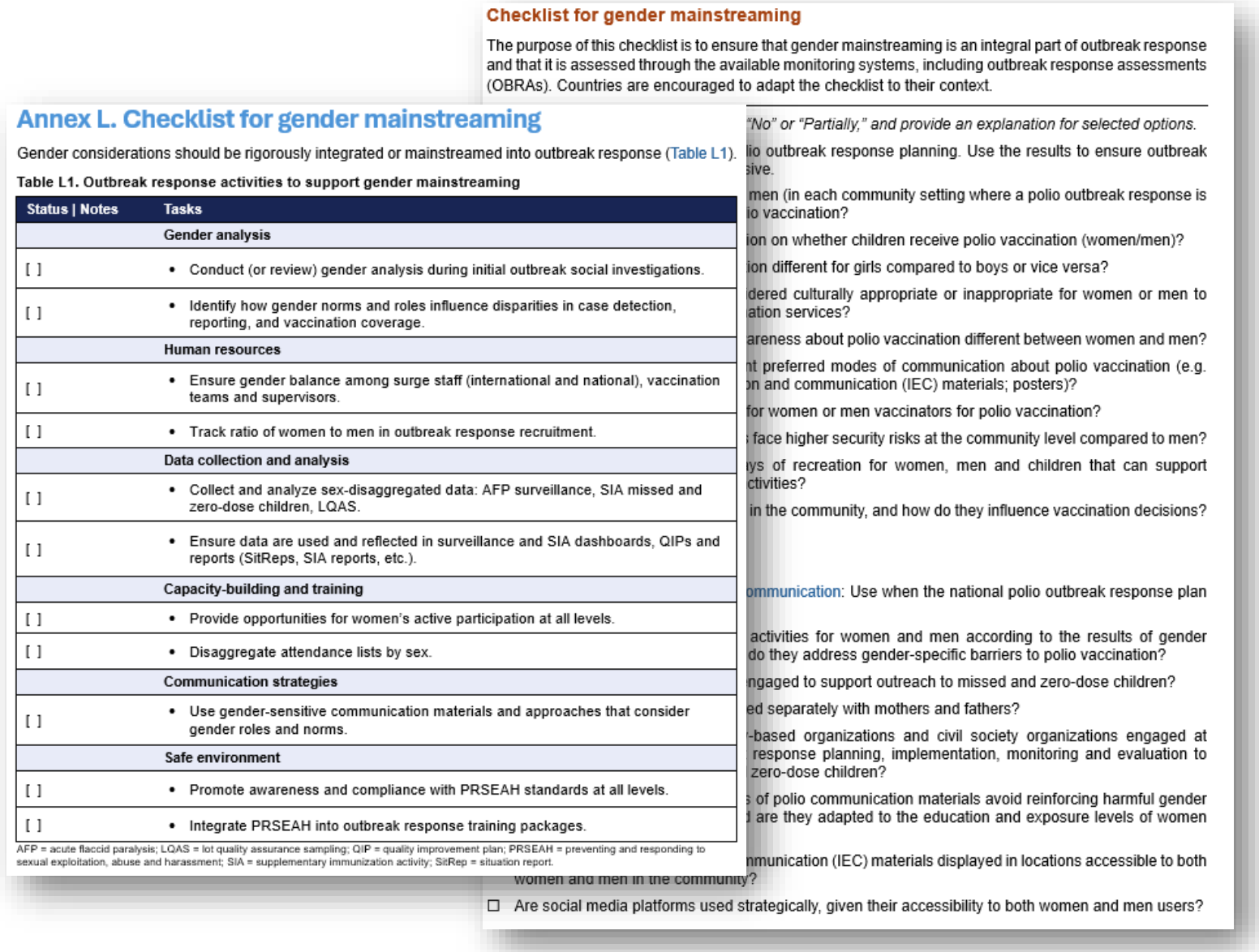
Annex K: Additional SBC guidance

- Includes details on the
  - Framework to support outbreak response
  - Five innovative approaches for effective communication
  - Implementation strategies
  - Monitoring for effective implementation



Annex L: Checklist for gender mainstreaming

- Includes checklists to
  - Support gender considerations during polio outbreak response activities
  - Ensure gender mainstreaming is an integral part of outbreak response and assessed through available monitoring systems



Annex L. Checklist for gender mainstreaming

Gender considerations should be rigorously integrated or mainstreamed into outbreak response (Table L1).

Table L1. Outbreak response activities to support gender mainstreaming

Status | Notes	Tasks
	Gender analysis
[ ]	• Conduct (or review) gender analysis during initial outbreak social investigations.
[ ]	• Identify how gender norms and roles influence disparities in case detection, reporting, and vaccination coverage.
	Human resources
[ ]	• Ensure gender balance among surge staff (international and national), vaccination teams and supervisors.
[ ]	• Track ratio of women to men in outbreak response recruitment.
	Data collection and analysis
[ ]	• Collect and analyze sex-disaggregated data: AFP surveillance, SIA missed and zero-dose children, LQAS.
[ ]	• Ensure data are used and reflected in surveillance and SIA dashboards, QIPs and reports (SitReps, SIA reports, etc.).
	Capacity-building and training
[ ]	• Provide opportunities for women's active participation at all levels.
[ ]	• Disaggregate attendance lists by sex.
	Communication strategies
[ ]	• Use gender-sensitive communication materials and approaches that consider gender roles and norms.
	Safe environment
[ ]	• Promote awareness and compliance with PRSEAH standards at all levels.
[ ]	• Integrate PRSEAH into outbreak response training packages.

AFP = acute flaccid paralysis; LQAS = lot quality assurance sampling; QIP = quality improvement plan; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment; SIA = supplementary immunization activity; SitRep = situation report.

Checklist for gender mainstreaming

The purpose of this checklist is to ensure that gender mainstreaming is an integral part of outbreak response and that it is assessed through the available monitoring systems, including outbreak response assessments (OBRAs). Countries are encouraged to adapt the checklist to their context.

"No" or "Partially," and provide an explanation for selected options.

io outbreak response planning. Use the results to ensure outbreak sive.

men (in each community setting where a polio outbreak response is io vaccination?

ion on whether children receive polio vaccination (women/men)?

ion different for girls compared to boys or vice versa?

dered culturally appropriate or inappropriate for women or men to ation services?

areness about polio vaccination different between women and men?

nt preferred modes of communication about polio vaccination (e.g. n and communication (IEC) materials; posters)?

for women or men vaccinators for polio vaccination?

face higher security risks at the community level compared to men?

ys of recreation for women, men and children that can support ctivities?

in the community, and how do they influence vaccination decisions?

ommunication: Use when the national polio outbreak response plan

activities for women and men according to the results of gender do they address gender-specific barriers to polio vaccination?

ngaged to support outreach to missed and zero-dose children?

ed separately with mothers and fathers?

-based organizations and civil society organizations engaged at response planning, implementation, monitoring and evaluation to zero-dose children?

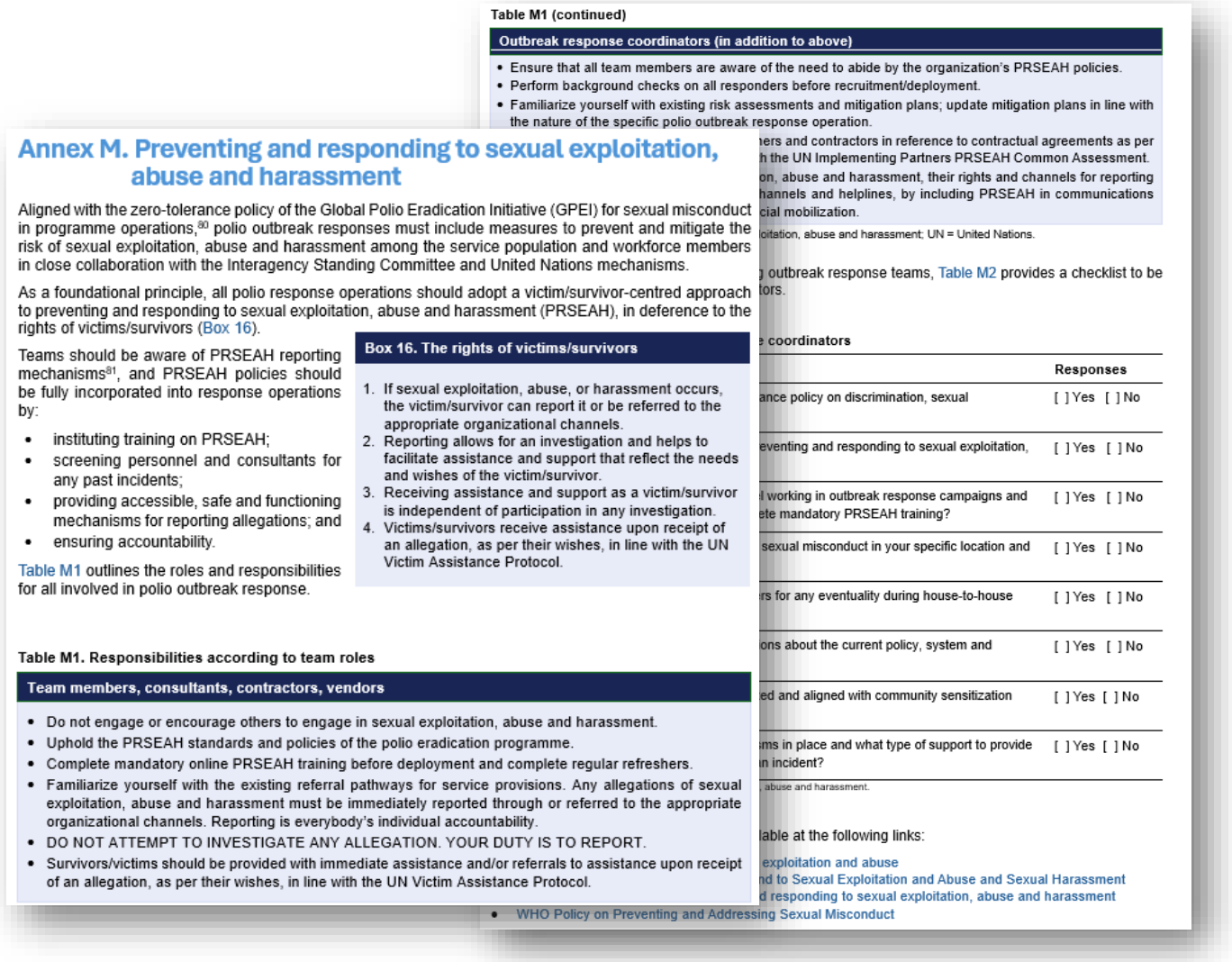
s of polio communication materials avoid reinforcing harmful gender l are they adapted to the education and exposure levels of women

nmunication (IEC) materials displayed in locations accessible to both women and men in the community?

☐ Are social media platforms used strategically, given their accessibility to both women and men users?

Annex M: Preventing and responding to sexual exploitation, abuse and harassment

- Aligned with GPEI's zero-tolerance policy for sexual misconduct in programme operations
- Provides further guidance on measures to prevent and mitigate the risk of sexual exploitation, abuse and harassment among the service population and workforce members
  - Team members, consultants, contractors and vendors
  - Outbreak response coordinators
- Includes a checklist for outbreak response coordinators



Annex M. Preventing and responding to sexual exploitation, abuse and harassment

Aligned with the zero-tolerance policy of the Global Polio Eradication Initiative (GPEI) for sexual misconduct in programme operations,[80] polio outbreak responses must include measures to prevent and mitigate the risk of sexual exploitation, abuse and harassment among the service population and workforce members in close collaboration with the Interagency Standing Committee and United Nations mechanisms.

As a foundational principle, all polio response operations should adopt a victim/survivor-centred approach to preventing and responding to sexual exploitation, abuse and harassment (PRSEAH), in deference to the rights of victims/survivors (Box 16).

Teams should be aware of PRSEAH reporting mechanisms[81], and PRSEAH policies should be fully incorporated into response operations by:

- instituting training on PRSEAH;
- screening personnel and consultants for any past incidents;
- providing accessible, safe and functioning mechanisms for reporting allegations; and
- ensuring accountability.

Table M1 outlines the roles and responsibilities for all involved in polio outbreak response.

Box 16. The rights of victims/survivors

1. If sexual exploitation, abuse, or harassment occurs, the victim/survivor can report it or be referred to the appropriate organizational channels.
2. Reporting allows for an investigation and helps to facilitate assistance and support that reflect the needs and wishes of the victim/survivor.
3. Receiving assistance and support as a victim/survivor is independent of participation in any investigation.
4. Victims/survivors receive assistance upon receipt of an allegation, as per their wishes, in line with the UN Victim Assistance Protocol.

Table M1. Responsibilities according to team roles

Team members, consultants, contractors, vendors

- Do not engage or encourage others to engage in sexual exploitation, abuse and harassment.
- Uphold the PRSEAH standards and policies of the polio eradication programme.
- Complete mandatory online PRSEAH training before deployment and complete regular refreshers.
- Familiarize yourself with the existing referral pathways for service provisions. Any allegations of sexual exploitation, abuse and harassment must be immediately reported through or referred to the appropriate organizational channels. Reporting is everybody's individual accountability.
- DO NOT ATTEMPT TO INVESTIGATE ANY ALLEGATION. YOUR DUTY IS TO REPORT.
- Survivors/victims should be provided with immediate assistance and/or referrals to assistance upon receipt of an allegation, as per their wishes, in line with the UN Victim Assistance Protocol.

Table M1 (continued)

Outbreak response coordinators (in addition to above)

- Ensure that all team members are aware of the need to abide by the organization's PRSEAH policies.
- Perform background checks on all responders before recruitment/deployment.
- Familiarize yourself with existing risk assessments and mitigation plans; update mitigation plans in line with the nature of the specific polio outbreak response operation.

ers and contractors in reference to contractual agreements as per h the UN Implementing Partners PRSEAH Common Assessment.
on, abuse and harassment, their rights and channels for reporting hannels and helplines, by including PRSEAH in communications cial mobilization.

oitation, abuse and harassment; UN = United Nations.

outbreak response teams, Table M2 provides a checklist to be tors.

e coordinators

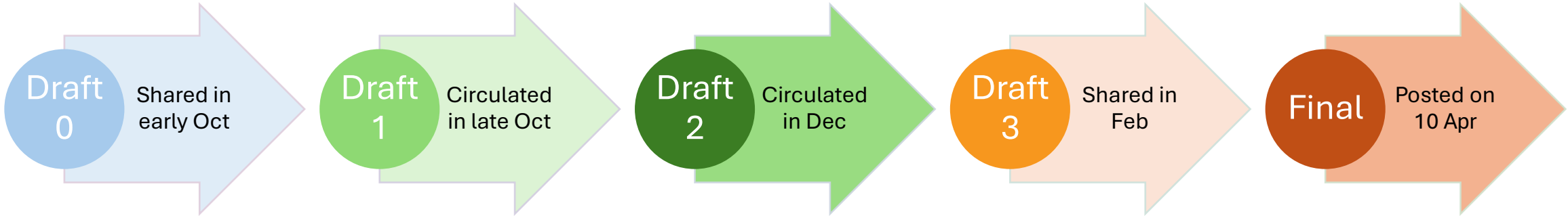
	Responses
ance policy on discrimination, sexual	[ ] Yes [ ] No
eventing and responding to sexual exploitation,	[ ] Yes [ ] No
l working in outbreak response campaigns and ete mandatory PRSEAH training?	[ ] Yes [ ] No
sexual misconduct in your specific location and	[ ] Yes [ ] No
rs for any eventuality during house-to-house	[ ] Yes [ ] No
ons about the current policy, system and	[ ] Yes [ ] No
ed and aligned with community sensitization	[ ] Yes [ ] No
ms in place and what type of support to provide n incident?	[ ] Yes [ ] No

abuse and harassment.

lable at the following links:

- exploitation and abuse
- nd to Sexual Exploitation and Abuse and Sexual Harassment
- d responding to sexual exploitation, abuse and harassment
- WHO Policy on Preventing and Addressing Sexual Misconduct

Engagement process: Balance of speed with broader partnership input



Prior to Draft 0: Stakeholder Survey re: changes needed and topics to keep in SOP

Draft 0: Shared within Task Team to prepare for broader partnership review

Presentation and feedback in Oct at AFRO Regional Meeting and GPEI Partner's Meeting in AFRO

Draft 1: Circulated to ORPG, IMST, RORG, SG (inc. regional OB focal points), VSG, Gender, SAM, PRAG, EMU, and GCG for written feedback. Regional offices requested to share with GPEI coordinators and selected country offices.

Conducted verbal feedback meetings in English & French.

Draft 2: Circulated to ORPG, IMST, RORG, SG (inc. regional OB focal points), VSG, Gender, SAM, PRAG, EMU, GCG, and SC for written feedback.

Draft 3: Written and verbal feedback from TT members and selected partners for editorial review

Advance Launch of the SOP in Jan-Feb with regional teams and Outbreak GPEI Coordinators and surge staff supporting OBR

Final: Posted on the GPEI website in April.

Also posted: Technical Companion Document providing the analyses behind updated recommendations.