



Partners' Report on Ten Transformations

IMB Meeting, London

October 2012



1. Senior leaders give the Programme true operational priority

A) How often have the Heads of Spearheading Agencies met since June 2012?

The Polio Oversight Board has met twice by teleconference: in June 2012 and in September 2012.

The Polio Emergency Steering Committee convened for the first time on 19 June 2012 and has met periodically via teleconference. The first face-to-face meeting was on 6 September 2012.

B) How many visits have they and senior GPEI staff made to polio-affected countries?

Agency*	Number of visits
CDC	2 visits to Nigeria
Rotary**	1 visit to Nigeria by Rotary President (July 2012)
UNICEF	1 visit to Chad by Executive Director (April 2012)
WHO	2 visits to Pakistan, 1 visit to Afghanistan by Regional Director, WHO EMRO (during these visits the RD met the President, Prime Minister, Chief Ministers, and Governors) 2 visits to Nigeria, 2 visits to Pakistan, and 1 visit to Afghanistan by WHO Assistant Director General

*In addition to the top level management visits indicated here, senior polio managers at director, coordinator, regional advisor level have also made visits to polio affected countries. These are reflected in a table at the end of this report that addresses IMB query "d".

**Afghanistan, Nigeria and Pakistan have all been visited by Rotary Senior Leaders, with visits to Heads of State in the last seven months.

C) How often has the Head of Government Task Force met in each polio-affected country?

Country	Number of meetings
Afghanistan	There is a monthly "Polio Policy Group Meeting" which is chaired by the Minister of Public Health and is attended by WHO and UNICEF Country Representatives, Director General Preventive Medicine, Bill and Melinda Gates Foundation and PEI team leaders of WHO and UNICEF. USAID is honorary member. With the appointment of a Special Advisor on polio by the President recently, periodic review meetings with the Governors and the Head of State are being planned.
Nigeria	Monthly meetings of Presidential Task Force
Pakistan	Quarterly meetings of the Prime Minister's Task Force and weekly meetings held under the Prime Minister-appointed Polio Focal Point, Ms Shahnaz Wazir Ali.

2. Close collaboration and coordination amongst Partners

A) Please describe how the Programme has integrated with the humanitarian response in West Africa. How successful has this been? What are you doing to help the local Programme build practical alliances with non-polio initiatives?

West and Central Africa was faced with several crises in 2012 including a nutritional crisis, insecurity and the Mali complex emergency, flooding and cholera outbreaks. In response to these crises, several countries in the region developed plans to integrate and implement curative and preventive activities in nutrition, health (including vaccination) and WASH. The interventions aimed to ensure an integrated and multi-sectoral response to the nutritional and humanitarian response.

Integrating polio vaccination to nutritional and emergency interventions offered an opportunity to access children that may be otherwise inaccessible or un-immunized. Also, a great number of children (and their mothers) are seen in centers that provide nutrition interventions and there is high demand for nutritional interventions which lead to less missed opportunities to vaccinate children.

Overall, refugees and IDPs are prioritized and included in all planned SIAs in countries and are targeted with specific messages and communication activities. The programme succeeded in integrating OPV into the nutritional and emergency responses in the region as follows:

- Nigeria: integrating polio and routine immunization in the Children Moderate and Acute Malnutrition (CMAM) centers established in response to the nutritional crisis (collaboration with WFP). Focus is to have an integrated approach that aims at having a *Strategy for Intensified Polio Ward Communication* activities, reaching the unimmunized child and the expansion of cold chain facilities in the response in the polio high risk States in the North).
- Chad: polio was integrated in the response to the nutritional crisis. In the context of revitalization of the health facilities, 100 paramedics were trained in July 2012, including on polio vaccination. There are plans to recruit additional paramedics, starting with 130 extra staff in November 2012.
- Burkina Faso: the total number of Malian refugees is estimated at 34,877 (UNHCR), concentrated in the northern provinces of Soum and Oudalan within the Sahel Region. SIAs continue to be conducted to reach refugee populations. Refugee children aged 0-11 months (1,395) are enrolled in the routine EPI programme delivered with the local health centers structures. All these activities are conducted by the Ministry of Health in conjunction with UNHCR, WHO, UNICEF, Médecins Sans Frontière (MSF) and Médecins du Monde (MDM).
- Mali: cooperative agreements have been signed with international NGOs (MSF, MDM Belgique, ALIMA) and national ones (Groupe Pivot Santé et Population (GPSP) and FENASCOM), as well as the Ordre des Médecins (national medical organization) for support to the health system and rehabilitation of the health centers. Through these partnerships, routine vaccination (including OPV), and integrated campaigns (polio, measles, vitamin A, deworming and at times nutritional screening) were held in the north of Mali (in Timbouctou, Kidal and Gao).
- Senegal: vaccination of all children admitted in the nutritional therapeutic centers (currently in Diourbel and Matam regions, to be scaled up in the remaining 8 regions) as a package of prevention and care (Health, HIV, Wash, Nutrition and Communication). In flood areas, mobile teams conduct monthly visits to vaccinate children up to 5 years of age in shelters that host flood victims.

- In DR Congo, a plan has been developed to integrate OPV into emergency response (2013 convergence plan in the District of Tanganyika with OPV, nutrition, Wash. and C4D).
- In Chad, the Minister of health organized a cross-border meeting in early October in N’Djamena with key officials and provincial Governors from Chad, Nigeria, Cameroon and Niger. This was a key recommendation from TAG and the national emergency action plan, and more than 60 people attended this meeting.
- Vaccination activities in Niger are also being coordinated with adjoining areas of Nigeria.

Additionally, OPV continues to be administered alongside emergency humanitarian response activities. Other mechanisms of reaching communities and areas affected by the emergency and conflict with OPV, and multi-country immunization campaigns continue to be conducted across West Africa.

To supplement regular synchronized campaigns held in the region, a synchronized campaign was conducted in June/early July in 4 countries: Niger (all regions except Agadez); Mali (the 6 regions accessible in the South); Burkina Faso (all regions neighboring Niger and Mali); and Guinea (Conakry and Kankan). These sites were chosen based on risk analysis which pointed to an increased risk for poliovirus transmission in the region due to the ongoing cases of wild polio virus (WPV) in Nigeria and the ongoing nutritional and humanitarian crisis with subsequent increased population mobility across the region. A campaign was also held in Nigeria. Synchronized polio SIAs are planned in October and November involving 14 countries in West and Central Africa (Benin, Burkina Faso, Cameroon, CAR, Chad, Cote d’Ivoire, DRC, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria, Sierra Leone).

B) Please describe also how the Spearheading Partners are co-ordinating and streamlining their interaction in order to speak with one voice to local partners on the ground.

At the international level, country-specific conference calls have been held either weekly or every other week since January in order to coordinate activities in the priority countries. Both field and headquarters staff from the partner agencies are invited to participate in these calls. In addition, the Inter-Agency Country Support meeting is held weekly with all partners to review the global polio situation and weekly issues arising in each of the polio priority countries. To further coordinate cross-cutting priorities, an “Interagency Coordination Group” was formed in August and has met three times by conference call. This group consists of 2 high-level technical staff members from each of the 5 partners. A cross-agency Polio Emergency Steering Committee was established to review progress, risks and coordinate actions across the partnership on a regular basis (with the intention to meet on a monthly basis), and also support the quarterly meetings of the Head of Agency-level Polio Oversight Board.

In the polio priority countries, weekly core group meetings are held between partners and with national government officials. The Operations Center established in Pakistan has further helped create a hub for coordination and a similar center is now being established in Nigeria at both national and priority state levels.

Further streamlining is ongoing to ensure that governments do not receive different advice and different risk assessments from partner agencies.

3. Staff well-managed and accountable

A) How many staff in each polio-affected country have now been through the WHO-led management training programme? How many more staff are being targeted for this training programme?

The WHO-led management training programme has been delivered in all four polio priority countries, with further plans underway for DR Congo and the African Regional Office. The target staff for these workshops are state/provincial level staff, area and zonal coordinators, as well as national WHO, UNICEF and Ministry of Health polio managers. A key priority of optimizing the surge is through the conduct of training for management and accountability.

In total, 429 staff have been trained through the WHO-led management training programme (142 in Afghanistan, 81 in Nigeria, 180 in Pakistan and 26 in Chad, with plans in place to train a further 27 staff in DR Congo). The purpose of these trainings is to ensure effective managers capable of motivating staff and organising work towards successful achievement of individual results. The content and related exercises of the trainings build on and reinforce the Accountability Framework. Following these trainings, accountability and management will be rolled into induction type trainings for all newly recruited staff and included in periodic refresher trainings for existing staff.

Workshops conducted				
Country	Date	Location	# of participants WHO	# of participants UNICEF
Pakistan	Apr-12	Islamabad	20	2
Pakistan	Apr-12	Karachi	30	1
Pakistan	May-12	High risk provinces	116	11
Afghanistan	May-12	Kabul	16 (+ 8 MOH)	12
Afghanistan	Aug-12	Kandahar	92 (+10 MOH)	4
Nigeria	Mar-12	Abuja	25 (+ 2 MOH)	4
Nigeria	Aug-12	Abuja	42	8
Chad	8/5-10/5	N'Djamena	21 (+ 4 MOH)	1

B) How often have the State Governors in Nigeria chaired polio meetings since May 2012?

The Presidential Task Force has recommended that the Deputy Governors Chair the State Task Force on polio eradication.

In Q2 2012, 51% of governors convened meetings with LGA Chairmen to discuss priority actions to improve routine immunization and polio eradication activities. In the 11 high-risk states, 55% of governors convened such meetings.

The programme in Nigeria is actively tracking the engagement of state governors and state administration vis-a-vis the Abuja Commitments, including by tracking the personal involvement of governors in public events for polio (68% of governors in Q2 2012, and in the 11 high-risk states,

82% of governors were personally involved in public events); meetings between governors and traditional leaders to review their engagement in routine immunization and polio eradication (41% of governors held such meetings in Q2 2012, and in the 11 high-risk states, 45% of governors held such meetings); and, convening of state task force meetings (38% of states convened such meetings in Q2 2012, and in the 11 high-risk states, 73% of states convened such meetings).

However, it was noted during the recent ERC in Nigeria that state-level engagement has been inconsistent between Q4 of 2011 and Q2 of 2012. The percentage of high-risk states that convened State Task Force meetings went up from 64% in Q4 2011 to 91% in Q1 2012, and slid back to 73% in Q2 2012. Similarly, there was inconsistency in the percentage of high-risk states that convened meetings between the Governors and LGA Chairmen from 36% in Q4 2011 to 82% in Q1 2012, and to 55% in Q2 2012.

C) How many visits have senior GPEI staff in Afghanistan made to the field to evaluate the performance of NGOs on the ground since June 2012?

In Afghanistan, field review visits were conducted to key provinces in the country in August and September 2012, including by:

- 6 senior staff members of WHO’s polio eradication unit, including national campaign coordinators, national surveillance coordinators and regional polio officers;
- 6 senior staff members of UNICEF’s polio eradication/EPI team;
- 1 senior polio consultant from the Bill and Melinda Gates Foundation; and, from the Ministry of Public Health, the National EPI Manager, the Advisor to the DG Preventive Medicine and 3 other senior members of the national EPI team.

These visits reviewed overall field operations, rather than NGO-specific activities. NGOs remain important partners, primarily responsible for implementation of routine immunization services, though are no longer playing the role as direct implementer of SIAs in the high risk districts of Southern Region.

4. Sufficient technical support staff in-country

A) Please update us with the figures for surge staff now deployed in country and staff still waiting to be deployed. What resources have you managed to elicit from other programme's on the ground to bolster GPEI capacity?

WHO

As part of the global emergency efforts, WHO has deployed significant new technical assistance to highest-risk areas to more effectively support the endemic countries’ eradication efforts. In total, nearly 2,200 additional staff (as of end September) have been deployed in the three remaining endemic countries (1,880 in Nigeria, 301 in Pakistan and 51 in Afghanistan). The bulk of the new staff were already in place by mid-year, and the agencies’ surge in capacity is going hand-in-hand with the Governments, which are undertaking similar activities to scale up technical capacity. Recruitment is also underway to ensure that senior positions at the national, state/province level are filled to enhance management capacity.

WHO – Staff Surge	AFGHANISTAN	NIGERIA	PAKISTAN
As of September 2012	51	1800	301
End of 2012 (projected)	55	2207	680

The overriding priority is now to rapidly integrate the new surge workforce into a well-functioning operational outfit. Activities are therefore focusing on ensuring the necessary management and training is in place, with relevant administrative support, to ensure the scaled-up workforce can operate in the most efficient – and accountable – manner possible, and to begin making an impact on operations and epidemiology as quickly as possible.

CDC

CDC now has 20 staff members posted to positions in the field, and is supporting 13 contractors posted to the field. The STOP program has doubled the number of STOP assignees over the past 18 months from 79 to 162, and has increased the time most STOP assignees spend in the field from 3 months to 5 ½ months. CDC has hired an additional 20 Atlanta-based staff members to support the global partnership and provide technical assistance in-country. In addition, CDC has established a “national STOP” (“NSTOP”) programme in Nigeria to employ 28 Nigerian staff members to support polio activities in the country, and has expanded the Pakistan NSTOP program from 16 to 32 individuals.

ROTARY

Rotarians in Nigeria held a meeting on 22-23 June in Abuja under the leadership of The Past Rotary International President from Nigeria to discuss plans for enhanced Rotarian engagement. It was agreed that Past District Governors would lead Rotary teams for the remaining 4 rounds of Subnational Immunization Plus Days in high risks states. Also, the National PolioPlus Committee Chair is targeting Rotary ambassadors for each of the worst performing districts.

In Pakistan, the National PolioPlus Committee Chair has an office manager and a newly hired Project Manager who will help coordinate Rotary efforts in the worst performing districts.

Plans are underway to further expand Rotary infrastructure in Pakistan, Nigeria, Chad and DRC with professional staff to support Rotarian activities.

UNICEF

UNICEF has significantly scaled up the social mobilization networks in priority countries in the past year, as outlined in the tables below.

Scale-up of social mobilization networks in high-risk areas (HRAs)		
October 2011-October 2012		
	Number of HRAs covered	% of target HRAs covered
PAKISTAN		
Oct-11	82	10
Jan-12	521	58
May-12	521	58
Oct-12	789	88
NIGERIA		
Oct-11	0	0
Jan-12	0	0
May-12	957	38
Oct-12	1827	73
AFGHANISTAN		

Oct-11	50	25
Jan-12	50	25
May-12	52	27
Oct-12	142	73

Scale-up of technical support		
Country	Number of social mobilizers in 2011	Number of social mobilizers in 2012
India	9,125	9,125
Afghanistan	2,100	2,056
Pakistan	800	1,056
DR Congo	N/a	18,688
Nigeria	N/a	2,100

B) What resources have you managed to elicit from other programmes on the ground to bolster GPEI capacity?

WHO

In Pakistan, the program has engaged with:

- The UN Resident Coordinator’s Office and the United Nations Country Team (UNCT) resulting in an agreement that all UN activities in the country will include a focus on polio high risk districts/areas. 1.5 million USD have been earmarked by UNCT for these joint activities.
- The Pakistan Motorway and Highway Police Department to obtain their support of transit immunization on all major inter-provincial / inter-district roadways
- The Pakistan Military in FATA resulting in an opportunity to conduct SIADs in Bajour and delivery of OPV in parts of Bara tehsil, Khyber Agency for the first time in 3 years.
- National experts in Pakistan on access issues in FATA (for example senior ex-government, ex-military, and political analysts with expertise on FATA)
- Major nursing and Social Work schools of the University of Karachi for supporting SIAs as vaccinators or monitors

In Nigeria

- A Memorandum of Understanding has been signed between the Government of Nigeria and the Federation of Muslim Woman’s Association of Nigeria (FOMWAN) outlining their role in supporting polio SIAs.
- A pact has been signed between the Government of Nigeria and Traditional Leaders of the northern States outlining their role in improving SIA quality in poor performing wards of high risk LGAs
- Agreements with Ministry of Religious Affairs and Ministry of Women’s Affairs for their support of polio IPDs

CDC

CDC has taken advantage of its Field Epidemiology Training Programs (FETPs) in Nigeria and Pakistan to engage experienced and talented public health officials from those countries to bolster the polio eradication effort. These staff are typically mid-career public health staff with a solid understanding of the country’s public health system. They are chosen through a competitive process to enter into the 2-year practicum. In Pakistan, they’ve increased the program’s reach

into previously inaccessible areas, and have played a big role in improving management and accountability in these areas. In Nigeria, the biggest impact of the program so far has been in expanding outreach to nomadic populations and scattered settlements in the highest-priority LGAs. They also provided a mechanism for conducting rapid assessments when needed, as in early October when refusals appeared to be increasing across the North and when an increase in cases in Katsina prompted concerns about the large number of children missed by vaccination campaigns there.

ROTARY

The National PolioPlus Committee Chair, Aziz Memon, in Pakistan is collaborating closely with Coca Cola Pakistan to gain access to advertising and for water and other resources during immunization activities.

Rotary is establishing a Rotary Polio Resource Center (RPRC) with the collaboration of Bright Education society-Qasba Town, Karachi which will provide coverage to Site Town and the adjoining districts of Gadap and Orangi towns. The planned activities are focused on social mobilization and outreach through a team of religious, community and social workers with the networking of local CBOs and NGOs. This will be replicated in other high risk areas of the country. Rotarians are also establishing polio transit check posts in border areas of the country.

UNICEF

UNICEF has used NGO workers as surge support on the ground in high-risk areas including FATA and Balochistan.

5. Front-line vaccinators well-trained and well-motivated

A) How many countries have fully instigated direct payments to vaccinators?

Two countries have instigated direct payment mechanisms for vaccinators: Nigeria and Pakistan.

B) What is the average salary of a vaccinator in each of the polio-affected countries? How does this compare to a year ago? How many hours of training does the average vaccinator get in each polio-affected country before they begin work in the field?

Country	Average daily salary 2012	Average daily salary 2011	Hours of training
Nigeria	600 Naira	500 Naira	5-6 hours
Pakistan	500 Rupees	300 Rupees	4-5 hours
Afghanistan	200 Afghani	150 Afghani	6 hours
Chad	2500 CAF	2500 CAF	4 hours

C) What activities has the Programme undertaken in each country to publicly praise front-line workers?

In Afghanistan, to publicly commend the work of vaccinators and the risks they face in high-risk areas, an award (certificate and cash) will be given to the family of a vaccinator who tragically died in a mine blast during polio vaccination activities in Hilmand province.

UNICEF and WHO in Pakistan have developed a modified IPC training module for all vaccinators. The module awaits clearance from the National Steering Committee, expected shortly, before roll-

out to the field. In Afghanistan, a revised IPC module for frontline workers has been developed; 500 vaccinators and social mobilizers in Kandahar were trained on 7-8 October. The training package is expected to be rolled-out to the rest of the province and Helmand before the end of the year. In Nigeria, UNICEF is amidst developing revised one-day training on IPC skills which should be implemented ahead of the November campaigns.

Pakistan's mass-media polio campaign "How Far Would You Go" aims to position real people at the heart of eradication efforts, showcasing polio heroes who demonstrate going to great lengths for vaccination. After the tragic attacks on polio teams in Karachi, a new advertisement was developed to increase the risk perception of polio, and highlight the heroism of frontline workers. The ad featured Abrar Khan, a polio-affected Pashtun from Baldia town, Karachi. Abrar Khan works as a COMNet's social mobilizers in his community, and is the very example of someone who overcomes challenges to ensure every child is vaccinated. His personal call to action was widely publicized, and he has been well-received across the country as a true champion for eradication.

6. Insight-rich actionable data used throughout the Programme

How many missed children are there in (a) each polio sanctuary, (b) each remaining polio-affected country? Please include a copy of the weekly update sheet on missed children circulated to Heads of Agencies (recommendation seven from the IMB's June 2012 report). What information do vaccination teams have today to guide their work that they didn't have six months ago? When will the "shared data platform" be launched?

GPEI partners and affiliated modeling experts have carefully considered various options to best analyze and display data to track 'missed children' and quality of immunization activities in Polio Sanctuaries and polio-affected countries. There is consensus that the most insightful display of data in tracking missed children involves triangulation of different sources of data that independently indicate proportion of missed children over time. These methods allow assessment of trends and preempt controversies when the accuracy of population figures is challenged by local and national authorities.

The following data are triangulated to assess missed children over time:

- Lot Quality Assurance Sampling (LQAS) conducted in high-risk/worst-performing areas immediately after SIA rounds;
- OPV immunization status of non-polio AFP cases;
- Demographic and social data on polio cases to develop a risk profile (Nigeria and Pakistan);
- Post-campaign market surveys and 'independent monitoring'.

Most importantly, the programmes in Pakistan and Nigeria are focusing increasingly on house-based monitoring of missed children during the SIAs to enable review of data in evening meetings and enabling immediate corrective actions during the campaign.

The programme has developed 'results monitoring frameworks' showing the most important programme inputs, outcome indicators (SIA quality, OPV status of non-polio AFP cases) and impact data (polio cases, environmental isolates) for the highest-risk areas (see examples in joint CDC/WHO report for the October IMB meeting).

Using the best available data and modeling outputs, partners have initiated a series of regular joint consultations, beginning in mid-2012, to optimize quarterly SIA planning. The POLIS project (Polio

Information System), a BMGF-supported project to re-design the computerized data system at WHO/HQ, will greatly strengthen WHO's capacity to receive, process and share epidemiological and SIA data provided by countries and Regions; it is envisioned that WHO regional office and priority country teams will eventually be able to use and directly benefit from the central POLIS platform.

To further enhance the quality and depth of polio data analysis, mathematical modeling and risk assessments, WHO intends to share AFP surveillance and SIA data with core GPEI partners on a monthly basis under terms and conditions that have been agreed on by each partner agency. The Director-General of WHO is currently informing the Member States that provide the data about the rationale for sharing these data during the polio eradication emergency and the safeguards provided by the terms and conditions under which data will be shared.

Improvements of the information base to guide polio vaccination teams and other polio field staff in priority countries (especially in Afghanistan, Pakistan, Nigeria and Chad) over the last 6 months resulted from the large human resource 'surge', including associated training and capacity building efforts, as well as from the systematic establishment and monitoring of accountability frameworks.

Following are some of the major changes in the information and tools that are now being provided to field workers:

- much improved and more detailed house-based microplans with maps and directions that clearly identify points for starting and ending the day, and clear boundaries for each day of work;
- more precise demarcation of areas of responsibility and rationalization of the workload per day for each vaccination team;
- improved vaccinator training that is interactive and includes role-play with increasing emphasis on inter-personal communication skills;
- more systematic supervision of vaccination team; and,
- better guidance to work in insecure and high-threat environments.

7. Highly engaged global movement in support of polio eradication

How successful was activity at the UN General Assembly and associated concert in Central Park? How is the Programme now capitalising on this activity to further the momentum of a global movement? What more is planned? Was there an increase in “hits” on the GPEI's website following the UNGA activity?

On 27 September, the UN Secretary General convened a side event at the UNGA titled “Our Commitment to the Next Generation: The Legacy of Polio-Free World” with support from all of the polio partners. Most notable was the participation of all of the heads of state of the remaining polio-endemic countries and the clear commitments of support from the highest level of government. Also notable was a new multi-year loan from the Islamic Development Bank of US\$227 million to Pakistan for polio eradication activities which should be operationalized by the end of this calendar year. Other participants included the Prime Minister of Australia, ministerial-level representatives from the governments of the United States, United Kingdom, Canada, Japan and Finland, BMGF and the Heads of Agency of the Spearheading Partners.

The event was followed by a Global Citizens festival, an awareness-raising concert in Central Park on 29 September, which attracted a global audience of 15 million. This concert was organized by

the Global Poverty Project (GPP) and all participants were directed to “theendofpolio.com” website set up by the GPP. This unique concert/event highlighted polio eradication and Rotary International prominently among a few other key global initiatives and challenges, and helped draw 60,000 citizen activists to Central Park who participated in social media activism.

Some of the key results of the launch of this global movement by GPP through this concert includes: A) Call to action and on-line petitions to polio-endemic and donor governments that were signed by 34,295 people in the lead up to and during the Festival and an additional 30,021 people who signed up via theendofpolio.com website; B) 25,815 people tweeted about polio from Global Citizen website and helped spread the word; C) 22,638 people shared information about polio on Facebook from Global Citizen website and raised awareness; D) there were more than 2 billion media impressions on the concert and social issues that were raised; E) and more than 1 million people worldwide watched the concert/event through live web streaming, and it was re-broadcast a few more times;

An analysis on the impact of these activities on visitors to the GPEI website will be conducted after the calendar month of October (data analysis available on monthly basis).

To sustain this momentum, a significant number of events are being planned to mark World Polio Day on October 24 by Rotarians around the world and other GPEI partners and supporters.

The successful UNGA side event was the culmination of a range of actions in targeted countries, some of which are highlighted below and which speak to the point of developing a highly engaged, global movement.

In Canada, all Canadian Rotarians (approximately 22,000) were asked to reach out to their member of parliament to encourage both a multi-year commitment and a public/private sector matching arrangement in support of polio eradication. One tangible result of this was the announcement by Canada’s Minister of International Cooperation of a matching arrangement through which funds up to C\$ 1 million raised by Canadian Rotarians will be matched dollar-for-dollar by the Government of Canada, and further matched by BMGF for a funding potential of up to C\$3 million. This was elucidated in a session of parliament which highlighted polio eradication and the role of Rotary International: <http://peterbraid.ca/mp-peter-braid-question-period-global-eradication-of-polio-initiative-gpei/>. Canadian Rotarians will continue to work to encourage the Canadian government to make a multi-year commitment to support the 2013-2018 needs of the GPEI.

In the UK, Rotarians wrote to the members of Parliament and the members of European Parliament to encourage the UK’s continued support and a new multi-year commitment for the GPEI. Rotarians, together with UNICEF, the British Pakistan Foundation and the Global Poverty Project, held a garden party during the Paralympics. The event featured the participation of Paralympians, including some who were polio survivors, and also a photo exhibit of Paralympians. The Global Poverty Project, joined by Rotary, Results, and other partners in the UK, presented petitions urging the UK’s continued support for polio eradication to the new Secretary of State for International Development, Justine Greening. GPP has also organized a meeting of the All Party Parliamentarians Group on 22 October to highlight polio eradication efforts in Nigeria, Pakistan and Afghanistan.

In October, 2012 during the WHO EMRO regional Committee meeting in Cairo, the regional Director hosted a luncheon meeting along with the Director General and Ministers of Health to help mobilize solidarity amongst the Islamic world, and secure commitments from key nations to assist polio eradication efforts in Pakistan, Afghanistan, Somalia and Northern Nigeria. A resolution

adopted by the EMRO Regional Committee includes language on Member States expressing their solidarity with Afghanistan and Pakistan in their efforts to eradicate poliomyelitis, through political, financial and technical support.

Next steps

On World Polio Day (24 October), Rotary International will invite one and all to get online and participate in the World's Biggest Commercial, promoting the global effort to eradicate this crippling childhood disease. The innovative, interactive campaign gives everyone a chance to join Archbishop Desmond Tutu, Bill Gates, Jackie Chan, Amanda Peet and other world figures and celebrities already participating in Rotary's "This Close" campaign (as in, "this close" to ending polio) in raising awareness and support for polio eradication. Participants can upload photos of themselves to Rotary's polio eradication website, endpolionow.org, to be edited into the constantly expanding promotional spot. Participants will receive an email with a direct link to their image and comment within the commercial.

Also on World Polio Day, Rotary will make available for purchase "End Polio Now," an eclectic album of songs performed by its celebrity polio eradication ambassadors from the music industry, including polio survivors Itzhak Perlman (classical violin); Donovan (folk rock); and Staff Benda Bilili (Congolesse soukous). The album will be available via iTunes and at shop.rotary.org.

Rotaractors, Rotarians, the Global Poverty Project and members of the Australian public have been invited to participate in an event on 20 October at Australia's Parliament House to raise awareness of polio eradication efforts.

On 22 October, Rotary Finland will participate in a World Polio Day seminar that has been organized by the National Institute for Health and Welfare, Rotary Finland, the Ministry for Foreign Affairs of Finland, Ministry of Social Affairs and Health of Finland, and the Finnish Association of Polio Survivors.

Further to the recent WHO EMRO Regional Committee meeting, the Kingdom of Saudi Arabia is making efforts to secure the public support of the Imam of Kabbah (Mecca) to assist in mobilizing greater support from other Islamic leaders, all other Islamic nations, and all sectors of the community to ensure that every child is reached and vaccinated against polio and other diseases.

The programme is aware of the unique and time-limited opportunity to build on the momentum generated by the polio side event by leveraging the wide range of strong statements of commitment by the UN Secretary General, the leaders of polio-endemic countries, by GPEI partners, and organizations such as the Islamic Development Bank and FC Barcelona. These declarations of support dovetail with epidemiologic progress and the forthcoming Polio Eradication and Endgame Strategy, providing a timely opportunity to engage (or re-engage) the support of the global donor community – both in the public and private sector. A Polio Endgame Resource Mobilization Task Force has been created for the purpose of capitalizing on the momentum following the UN General Assembly event and driving support for the funds needed to implement the Polio Eradication and Endgame Strategy. This Task Force is intended to replicate the intense focus and successful collaboration among an expanded group of GPEI stakeholders that led to the success of the UN General Assembly Polio Side Event.

The partnership will also work to maintain and "reactivate" members of the general public who took action in support of polio eradication in the lead up to the global festival and will seek new

opportunities to engage and expand this new group of supporters at key moments over the next several months, including on World Polio Day, Rotary’s anniversary (23 February) and in the lead up to a potential donor conference in March/April 2013.

8. Thriving culture of innovation

Since the Innovations Working Group was established, how many innovations have been approved for large scale implementation in the field? How are these progressing? Are Permanent Polio Teams being established outside of Afghanistan?

Status of ‘innovations’

1. House-based microplanning in Nigeria
 - In August 2012, the Nigeria program revised the procedures for microplanning and shifted from a child-based to a field-verified house-based microplan. This involved physical enumeration of all houses and nomadic settlements and division of vaccinator team areas according to rational workload
2. “Dashboards” with a number of key indicators have been developed and are being used to track campaign preparations in Pakistan, Afghanistan and Nigeria
3. Permanent Polio Teams (PPTs) in Afghanistan
 - The PPT strategy has been launched in a phase-wise manner in Afghanistan with the aim to eventually cover all 13 high risk districts in Southern Region and 3 priority districts in Farah province. Currently there are 39 PPTs in 5 districts of Southern Region and 2 districts of Farah province of Western Region (see table below).
 - Permanent polio teams have not been established outside these areas.

Region	Province	District	Teams	Supervisors
South	Kandahar	Kandahar city (Loya Viala, Manzil Bagh)	6	1
		Spin Boldak	5	1
	Helmand	Lashkargah	7	1
		NadaAli	6	1
		Marja	7	1
SUB- TOTAL			31	5
West	Farah	Bala Baluk	3	1
		Khak-i-Safaid	5	1
	SUB_ TOTAL			8
TOTAL			39	7

- WHO Nigeria is exploring the feasibility of establishing PPTs in insecure areas of northern Nigeria
4. Security Practices:
 - The Polio Research Committee (PRC) funded a study on the best practices related to conduct of development activities in security compromised areas. In addition, a “Think Tank” has been established to provide guidance on working in areas of insecurity.
 5. Expanded age group of SIAs

- There is some evidence that including children above the usual target group of <5 years of age is effective in quickly ending outbreaks; in addition, there is some evidence that in endemic situations, a large proportion (possibly the majority) of persons shedding WPV are older than age 5 years.
 - Expanded Age Group SIAs are now a standard approach in outbreak response scenarios, even where there is no evidence of cases above the age of 5 years
 - Expanded Age Group SIAs are being carefully considered in all 3 endemic countries balancing the expected benefits with potential risks due to the complex political/social environment and efforts to improve the fundamentals of SIA implementation (microplanning, training, etc)
6. SMS for community-based surveillance in Nigeria
- MedicMobile has been contacted as a software contractor and intermediary with carriers.
 - Commencement of the project is anticipated in early 2013.
7. GIS/GPS for improved microplans and SIA implementation
- ESRI has been contracted to provide detailed satellite maps for 8 northern Nigeria states (including complete listing of settlements and comprehensive maps)
 - The complete listing of settlements is finalized for 4 of 8 states, the others to be completed by December. Maps are being used as an additional tool in refining microplans with more geospatially accurate distribution of settlements to inform team assignments, agree on settlement responsibilities between teams in ward boundary areas, and identify smaller missed settlements/hamlets.
 - The tracking of vaccination teams has been complex; original plans are not feasible and alternatives are still under evaluation. Various approaches to GPS tracking of teams have been tried, and the project is settling on an approach where GPS tracking data are reviewed first at the LGA level before being uploaded to a web server for wider use. The goal is to incorporate GIS/GPS data into the newly-established Dashboard being used by the program before and during SIAs.
8. Characterizing nomadic populations in Nigeria
- Pilot work originally conducted during 2011 has been further expanded to examine issues of settled groups vs. mobile groups in ethnic minorities (Fulani), and temporary settlements along stock movement routes
 - History of high proportion of non-vaccination among this ethnic group and other migrants documented by FELTP studies
 - Recommendations made to involve local Fulani leaders in microplanning process
9. Vaccine tracking at district level during polio SIAs
- Piloted in Chad in 2011
 - Current priority countries are Angola, Chad, DRC, Nigeria
10. Expansion of LQAS sampling
- LQAs protocol was finalized based on consensus reached among all partners and this methodology will become the current standard
 - In addition, further research is being conducted to explore the workload vs. benefit of increasing the sample size. This could result in greater precision of the results but needs to be weighed against the additional operational effort that would be required. A protocol has been developed to conduct this operational research in Nigeria before the end of 2012.
11. Rotary proposals for increased advocacy and fund-raising

- Rotary has funded two initiatives to train more personnel in both activities, which are underway
12. Polio Research Committee (PRC):
- The PRC provides another source of innovations complimentary to the Innovation Working Group.
 - The PRC has supported pilots to assess telecommunication technology that could, potentially, be used more widely in the program.
 - Types of uses of telecommunication technology include using SMS to evaluate SIA coverage, sending SMS to informants to stimulate AFP reporting and using mobile phones for data transmission.
 - The PRC has recommended a move towards rapid, small scale social research to better understand barriers to and opportunities for immunization in area with chronically missed children—Nigeria and Pakistan have initiated activities to develop methodologies and utilize findings for programme decisions.

9. Systemic problems tackled through development and application of best practise solutions

A) What conclusions has the insecurity think tank so far reached? How are these being addressed?

During their first Polio Oversight Board in 2012, the Heads of Agencies of the GPEI partners suggested that UNICEF Executive Director lead in identifying how GPEI can operate more effectively in insecure areas to ensure more children are being vaccinated. UNICEF HQ generated a concept note paper to propose ideas on how to improve access to children in high threat environments. The paper included several suggestions, one of which was establishment of an Inter-Agency Think Tank at global level.

Despite good coordination and collaboration efforts at country level, some opportunities remain for the polio programme and partners to learn and benefit from the experience, resources, networks and programmes available by other agencies and partners in the field. UNICEF HQ/Polio Team held initial internal discussions with WHO and other partners and country offices, Program Division (PD) and Office of Emergency Operations (EMPOS) about establishing an inter-Agency Think Tank. The objectives of the Think Tank were as follows:

- 1) exchange lessons learnt and best practices about operating in insecure areas and ensure all strategies are being considered to maximize polio immunization and coverage in these areas;
- 2) build upon the maximum accessibility achieved by any agency to reach children and deliver polio vaccine in the priority areas;
- 3) increase visibility of the polio programme, facilitate and enhance further collaboration between agencies at all levels;
- 4) assist in reaching consensus on global level policy guidance and address issues related to inter-agency coordination.

Two meetings of the Inter-Agency Think Tank were convened on 10 August and 10 September in UNICEF, NY. The meetings were chaired by UNICEF Directors (PD) and EMPOS.

- Nine UN agencies have been engaged: in addition to UNICEF, the Think Tank included membership from WHO, UNDSS, OCHA, UNHCR, FAO, UNDP, DPA, and DPKO. More than 20 bilateral meetings and communications were established with each of those agencies.
- Think Tank members received an update on GPEI, progress so far and challenges. Additionally, the meetings helped highlight polio eradication as a joint UN priority based on the 5 year plan and statements of UN SG.
- Think Tank members declared their support for the programme and interest and commitment to collaborate with polio eradication activities in key countries to reach more children through their own programmes at country level.
- Based on priority issues identified, the Think Tank members provided initial input into a Matrix identifying lessons learnt by the member agencies for each area of work and proposed potential collaborations with the polio programme to improve access to children in high threat environment. Some of the examples of such areas of collaboration include: UNHCR's proposal of integrating polio vaccination into their IDP and refugee programs; FAO's proposal of integrating polio advocacy and messaging into their current training programme through their available networks in these areas; and, OCHA's proposal of tailoring humanitarian access monitoring framework for polio eradication.

The next steps are to ensure operationalization at country-level in a coordinated manner across the agencies, and in a sustainable manner.

B) How confident are you that all best practise from India and across the world has been captured and implemented in the remaining polio-affected countries?

When India was officially removed from the list of polio-endemic countries in February 2012, India's rich experience in stopping transmission in one of the world's most tenacious and complex reservoirs of wild poliovirus was shared with the remaining endemic, re-established transmission and outbreak countries.

In the IMB's January 2012 report, it called upon the India polio eradication programme to support polio-infected countries through the application of lessons learned: "If India knew 10 years ago what it knows now, it would have been able to stop transmission more quickly," the report said. "We hope that the programme can now find some energy to assist other countries' programmes."

Key lessons from the India programme have been incorporated into the emergency action plans of the endemic countries. They included: 1) surge of staff at the district level; 2) strengthening local accountability; 3) enhanced monitoring; 4) focus on missed children; 5) accurate microplanning; 6) close tracking of performance indicators.

The India Polio Programme has responded by establishing a Learning Exchange Programme to support remaining polio-affected countries through a process that offers materials and technical expertise to other programmes. The India Learning Exchange (ILE) offers three forms of assistance: telephonic consultations and materials sharing; in-country learning opportunities for external teams; and the deployment of staff from the India programme to other countries to develop their in-house capacity. Learning exchange activities include sharing programmatic best practices in areas such as: programme management, methods to maximize coverage during rounds, monitoring and evaluation formats, communication and training materials, and ground-level tools

to increase the effectiveness of front-line vaccinators and social mobilizers. The exchange activities are linked to an accountability framework that includes a description of outcomes of each mission to help ensure these investments are productive and relevant to the polio eradication effort. A thorough documentation of the India polio programme by UNICEF is also underway, including an online tool in development to allow remaining polio-affected countries to easily access India programme materials.

The ILE has resulted in the following activities and outcomes:

Activities

- Remote assistance and sharing of tools: Afghanistan, Angola, CAR, Chad, Nigeria, and Pakistan.
- Partner and government officials from polio-affected countries visits to India in 2012:
 1. Two visits from Pakistan have been received so far (Government of Pakistan delegation visited in May, facilitated by BMGF and partners, and a UNICEF team visited in September, including Communication for Development, Media and M&E Specialists, and the ComNet Coordinator).
 2. An 11-member delegation from Afghanistan visited in June (GOA and UNICEF) facilitated by UNICEF.
- Direct technical support visits to remaining polio-affected countries have included:
 1. WHO-India (National Polio Surveillance Project personnel): 2 missions to Nigeria (each comprising 16 medical officers for a duration of 3 months), 2 to Kenya , 1 to Uganda, 1 to Pakistan and 1 to Afghanistan (7 missions total = 42 people)
 2. UNICEF India: 9 missions to Pakistan, Afghanistan and Nigeria.

Selected Outcomes

The documents and direct support sent from the Indian program have impacted the polio-affected countries from national to community levels. WHO-India (NPSP) surveillance medical officers and UNICEF India staff have made important local-level interventions while working at sub-national level and resulted in major improvements to program strategies, some of which are highlighted below:

Nigeria

- Implementation of the high risk approach to focus resources and efforts on the highest risk areas
- Re-structuring of the microplanning process – move from child-based microplans to field-verified house-based microplans.
- Re-structuring of the vaccination teams and rationalized workload.
- Redesigning the methodology and tools for training of the frontline workers.
- Implementation of in-process “concurrent monitoring” based on house-based microplans including same-day feedback of results at ward level meetings.
- Support to the Communication Review.
- Overall support to the VCM network in June and September.

Pakistan

- Review of monitoring and evaluation tools and renewed focus on in-process monitoring.
- Applying lessons learned from the India “underserved strategy” to approaches for the underserved Pashtun populations in Pakistan.
- Support to the Communication Review and regular assistance to new Media Specialist.
- Support of a Management Training for senior WHO district staff to enhance management at the field level.
- Direct Disbursement Mechanism (DDM) – not from India, but a good practice

Uganda/Kenya

- Detailed review of surveillance system and identification of key steps for improvement.
- Support towards improved SIA activities (review of microplanning and monitoring) with focus on high risk areas.

Afghanistan:

- M&E support.
- Facilitator to design and conduct media and advocacy workshop for radio jockeys.
- Capacity development support, including development of IPC training module for frontline workers.
- Participation in cross-border meeting in July.
- Programmatic support to Integrated Communications Network (ICN) in October.
- Took part in a surveillance review along with WHO Afghanistan team.

10. Parents' “pull” for vaccine dominates over “push”

What is being done to increase the appetite for polio vaccine amongst parents? Are there any parts of the world where you feel there is a significant movement from Programme push to parents' pull? What is the Programme's guidance to local teams in terms of increasing the package provided to parents together with polio drops?

The building of dedicated social mobilization networks that are able to engage members of the highest risk communities is a key operational strategy in the most at risk areas. The programme now has more social mobilizers on the frontlines than ever before, reaching out to some 800,000 caregivers in 78% of the highest risk households. In order to build on a platform of existing trust, these community workers are largely recruited from the highest risk populations themselves.

Refusals continue to reduce, and now account for less than 1% of all children under five in the 3 endemic countries. However, this proportion is higher in the most challenging areas of northern Nigeria; Katanga, DR Congo, and Quetta Block, Pakistan. Here, refusals account for up to 3% of all children under 5 years in targeted areas.

Although the gold standard must always be to motivate parents to actively demand polio vaccine, in reality, hoping for parents' active ‘pull’ for OPV in the most marginalized, volatile and insecure environments may be setting an unrealistic target unless there are much wider development investments or efforts to partner with the kind of programmes and organizations who are able to provide them. This problem is exacerbated when parents have not personally seen a case of polio in their community for some years. A healthy amount of risk perception is a key motivating driver to vaccinate against any disease, and the programme has intensified communication of risk in

some areas to help stimulate greater demand.

For this reason it has been absolutely vital to amplify house to house communications with a strategic approach to community and mass media that replicates as far as possible the power of the personal interaction on the doorstep. New mass media campaigns have been launched in Afghanistan and Pakistan that not only build on the power of inter-personal communication, but help ignite a broader social movement against polio. Campaigns emphasize the need for collective action, social and individual responsibility to protect children against disease.

Gains can already be seen. The proportion of refusals among all children <5 in the three endemic countries has reduced from 1% to 7% since last year. This may seem insignificant, but it only takes small pockets of non-compliance to spark an outbreak in areas of unvaccinated children. In Pakistan, for example, 36% of all 2011 cases came from refusal families. This year, the proportion has been reduced to 10%. Quetta Block remains at risk, together with Sokoto and Kano, Nigeria, where 60% of 2012 cases come from refusal families.

In Pakistan, the proportion of parents who will now take more proactive measures to vaccinate their children if teams don't arrive has increased over the last 9 months. When asked what they would do if their children did not receive OPV during the campaigns, the proportion who said 'Do nothing' has reduced from 27% to 22% from January to September. 62% said they would take their child to the health centre, up from 59% in January. An increased sense of accountability for polio can also be seen by the slight increase in those who said they would complain about teams not arriving, either to the polio hotline (2% up from 1% in January), or that they would complain to the health facility (8% up from 6%). Those who said they did not know what they should do, have reduced from 7% to 5%.

Further questions:

a. Can you please provide us with the definitive position of the Programme regarding LQAS and Independent Monitoring? Please tell us how the Programme is balancing the use of these two techniques to achieve maximum benefit.

During the last Global Polio Management Team meeting (24-26 September in Geneva), the partners agreed and accepted the conclusions from 2 expert consultations on campaign monitoring that were held in Nairobi, Kenya that included participation from partners, endemic countries, and WHO Regional Offices (AFRO, EMRO). In summary, both LQAS and Independent Monitoring have a role to play in campaign monitoring. They are tools with different goals that should be utilized recognizing their methodological differences.

Lot Quality Assessment Sampling (LQAS)

Goal: to provide a statistically valid estimate of campaign quality

Areas for use: targeted high risk areas in countries with persistent poliovirus transmission (primarily endemic and re-established countries)

Limitations: greater operational burden (need for more in-depth training compared to IM, surveyors with higher level of education, more time to conduct the sampling compared to IM, significantly more expensive than IM).

Independent Monitoring (IM)

Goal: to measure general trends in campaign performance and gather social data about why children are missed across a broad area or country. While the quality of IM can be variable, it does provide useful information. It identifies underperforming trends at sub-district levels over multiple rounds.

Areas for use: all countries conducting SIAs with broad sampling across districts

Limitations: should not be used or communicated to statistically estimate "coverage" – sampling is by convenience.

b. What is the current situation with regards to the constrained vaccine supply previously expressed? What is being done to address this problem and is this achieving success?

Update for trivalent OPV in 2012

- Supply of trivalent OPV is increasingly tight (cumulative availability is forecasted to be +2 million doses at year end), while demand is expected to increase due to recent cVDPV2 outbreaks in Somalia, Kenya, Chad and Pakistan; and, Nigeria requirements for December to be confirmed by the country (17.8 million doses reserved).
- Confirmation remains outstanding for routine demand for remainder of the year for several pending orders. There is uncertainty about some routine requests to be funded by government (procurement services) for the remainder of the year (eg Niger and Uganda).
- Registration and licensing of additional products in Nigeria and Pakistan to facilitate resolution of supply challenges in these two countries:
 - Currently only two suppliers (with significant capacity) with the same products are registered in both countries.
 - Bio Farma is now registered in Nigeria (however, their annual production volume is not sufficient for large scale campaigns).

Update for bivalent OPV in 2012

- Cumulative availability is forecasted to be +20 million doses at year end. This is critical for global outbreak response capacity.
- Registration and licensing of additional products in Nigeria and Pakistan to facilitate resolution of supply challenges will continue to be a priority.
 - Bio Farma is now registered in Nigeria and registration in Pakistan is ongoing (however, their annual production volume is not sufficient for large scale campaigns).
 - Sanofi license is expected by the end of the year and temporary import permit granted for 2012 for Nigeria.
 - Haffkine has initiated the necessary letter of request to the NRA of Nigeria.
- Vaccine requirement for the planned campaigns until end January 2013 in Pakistan have been ordered and there is a possibility for advancing of the campaigns.

Update for 2013

- A gap of more than 300 million doses of OPV was identified in June 2012 affecting mostly 1Q 2013 but UNICEF Supply Division conducted a series of mitigation efforts resulting in identifying 300 million doses which should be able to fill this gap. This was mainly done through strong advocacy by Supply Division resulting in two manufacturers changing production plans. In addition the following were done to help address the anticipated gap:
 - WHO is working to fast-track WHO pre-qualification of a new OPV manufacturer
 - There are plans to improve monitoring of in-country residual quantities to take into account for 2013 shipments.
- WHO, in consultation with GPEI partners, revised the demand scenario by shifting low-risk

campaigns to 2Q and later in 2013.

- UNICEF and WHO are putting in place extra monitoring of risk mitigation strategies to help ensure success and give early-alert in case of delay.
- There is more need for facilitation of registration for other suppliers (Haffkine and Sanofi) in Nigeria.

The following uncertainties could significantly alter 2013 supply needs:

- Potential changes in epidemiology of the virus, outbreaks of WPV, and continued circulation of VDPV.
- Potential impact of India demand.
- Funding availability for continued SIAs.
- Expanded age group recommendations and implementation.
- Changes in supplier availability (including regulatory delays).

Other issues regarding polio vaccine in 2013-2017

- Current tender is covering supply for the period of 2013-2017.
- This is a critical period as it crosses the threshold of eradication, switch of tOPV to bOPV in routine and SIAs and eventual cessation of OPV
- Summary of offers:
 - Insufficient supply offered for first half of 2013, but subsequently remedied (per above summary).
 - Sufficient supply offered for 2014-2017 (based on current projected plans).
 - Some manufacturers require minimum quantities in order to 'stay in the business'. However, the total minimums required are more than the total demand.
 - Prices appear to remain stable.
- It will be critical to address vaccine management challenges in countries to ensure the most efficient use of available resources (vaccines and funds).

c. Please provide us with a list of key decisions that the GPEI will ask SAGE to make at their upcoming meeting.

The polio session at the 6-8 November meeting of SAGE will include presentations on 'Major developments since the April 2012 SAGE meeting', on the draft Polio Endgame Strategy, Legacy and Budget 2014-2018, and presentations by the SAGE Polio Working Group on the role of IPV in OPV cessation, and by the secretariat on 'Accelerating polio emergency eradication efforts: expanding the target age groups for bOPV campaigns and/or including IPV in campaigns'.

The introductory presentation will set the context for the whole afternoon session and will provide an overview on the current status polio eradication, progress, challenges and risks. GPEI expects that SAGE might bring up additional issues that should be addressed or considered in stopping WPV transmission, the polio endgame strategy, and towards optimizing the legacy of the GPEI.

The presentation by the SAGE Working Group will inform SAGE on their review and deliberations on OPV2 cessation as the first step towards phased removal of SABIN/OPV viruses. SAGE has already recommended that all countries should consider introducing 1 IPV dose into the routine vaccination programme to mitigate the risks associated with OPV2 cessation. The WG will present additional information that was requested by SAGE in its last meeting on affordable IPV options, supply, delivery routes and impact on mucosal immunity.

A decision will be requested from SAGE on whether the current SAGE recommendation on OPV2 cessation should be revised. Suggested revised recommendations include: a) a universal recommendation that all countries should introduce at least 1 IPV dose into the routine immunization programme; additional measures such as a 2 dose IPV schedule and/or catch-up campaigns should be considered in areas at high risk of VDPV emergence before the switch; b) both IPV dose-sparing options (intramuscular adjuvanted IPV and intradermal fractional dose IPV) should be pursued to achieve 'affordable IPV' options, c) countries should plan to continue at least 1IPV dose through at least 5 years after cessation of all OPV use (bOPV cessation), d) synchronized OPV2 cessation should be planned during 2015-2016.

SAGE's view will be sought on two strategies that potentially could accelerate cessation of wild poliovirus transmission; 1) the role for expanding the target age group for OPV campaigns and 2) the role of IPV campaigns in endemic countries.

d. Please provide us with the number of staff (working exclusively on polio) based at global headquarters level for each Spearheading Partner. Also for WHO AFRO and EMRO. Of these staff, how many individual visits were made to polio-affected countries and on average for how long did they stay?

Agency	Number of staff at Global HQ	Number of visits to polio-affected countries in 2012
CDC	70 technical staff	137 trips (average length: 14 days)
Rotary	10 technical staff*	2 trips (average length: 14 days)
UNICEF	10 technical staff	12 trips (average length 9 days)
WHO (HQ, EMRO, AFRO**)	40 technical staff	103 trips (average length: 9 days)

* Rotary has also appointed a group of 41 Rotary volunteers, the End Polio Now Zone Coordinators, appointed for each Rotary district worldwide to work on advocacy, fundraising and awareness in their respective areas.

**Additional trips to polio affected countries are also made by AFRO's IST staff, though these are not reflected here