Global Polio Eradication Initiative

Monitoring of key recommendations from November 2012 report of Independent Monitoring Board

April 2013

World Health Organization

Rotary International

CDC

unicef

Global Polio Eradication Initiative (GPEI)

Independent Monitoring Board (IMB) November 2012 report - *Polio's Last Stand?*: monitoring of key recommendations

April 2013

Background

On 21 November 2012, the Independent Monitoring Board (IMB) shared its final report - *Polio's Last Stand?* - following its seventh meeting on 29-31 October with the heads of the Global Polio Eradication Initiative (GPEI) spearheading partner agencies and the Global Health Program of the Bill & Melinda Gates Foundation. In its report, the IMB put forward ten key recommendations - this document provides an overview of progress against these recommendations.

IMB recommendations

Recommendation	**Response**	**Status** (as at April 2013)
1. We recommend that the International Health Regulations Expert Review Committee urgently issue a standing recommendation by May 2013 that will introduce pre-travel vaccination or vaccination checks in Afghanistan, Nigeria and Pakistan until national transmission is stopped. No country should allow a citizen from any endemic polio state to	Recommendation follow-up continuing	The Polio Oversight Board (PoB) discussed this recommendation at length, and WHO's Director-General committed to interacting with Member States on the recommendation at the Executive Board (EB) in January 2013. At the ensuing EB, there was substantial discussion around this topic, with broad consensus among Member States on the need to revisit strong enforcement and a potential IHR standing recommendation for countries where wild poliovirus transmission persists beyond 2014. Several Member States also continued to call for the full implementation of WHO's existing recommendations for vaccination of travellers (http://www.who.int/ith/en/).

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cross their border without a valid vaccination certificate.		In early 2013, Pakistan and Nigeria undertook additional measures to reduce likelihood of international spread of polio. Pakistan has placed vaccination booths in international airports to vaccinate outgoing children; Nigeria has strengthened cross-border vaccination. The Strategic Advisory Group of Experts on immunisation (SAGE), at its April 2013 meeting, noted the complexity involved in establishing vaccination requirements for travellers from endemic areas under the IHR, and encouraged a technical review of the potential epidemiologic impact of establishing such requirements. Member States will continue to deliberate on this important issue at the upcoming World Health Assembly (WHA) in May and at Regional Committees (RCs) later in the year. The programme will continue to collaborate with WHO's Department of Global Capacities Alert and Response (which coordinates the secretariat's implementation of IHR).
2. We recommend that within the next fortnight, programme leaders in Afghanistan, Nigeria, Pakistan and Chad discuss their country's plan and best practice elsewhere to write, with their partners, a list of no more than five priority goals that they will achieve by the end of April 2013, circulate these goals to all programme staff, and	Recommendation adopted	Following the last IMB meeting, the three remaining endemic countries set country-specific top low-season priorities goals (summarized below), which have been incorporated into their respective national emergency action plans. In Pakistan, the goals were developed at a special reservoir consultation attended by federal, provincial and district officials and GPEI partner teams, in mid-November 2012. This was followed by review and endorsement by an independent expert consultation in mid-December 2012.

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maintain the focus and pace necessary to achieve them.		Afghanistan's goals were finalized by its national Technical Advisory Group (TAG) at end-November 2012. In Nigeria, the Government and partners revised the National Emergency Action Plan in December 2012 and as part of that the low season priorities were identified. Globally, the country-specific priority goals were reviewed and endorsed at a global GPEI partners meeting in Atlanta, USA, in January 2013. Nigeria: -Refining microplans -Strengthening team selection, training and performance -Accessing children in security-compromised areas -Reducing non-compliance -Intensifying programme management, especially deployment of strong government and partner staff to worst-performing LGAs Pakistan: -Implementing aggressive and area-specific SIA strategy -Implementing underserved Pashtun population strategy -Restoring LQAS and SIA monitoring in high-risk areas -Implementing security operations and political advocacy -Integrating social mobilization and operations in microplans Afghanistan: -Updating list of high-risk districts and track performance

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		-Expanding and improving performance of permanent polio teams (PPTs) -Implementing aggressive and area-specific SIA strategy in the low season -Ensuring appropriate vaccinator selection -Improving collection, analysis and use of missed children data and reasons for inaccessibility, and implementation of corrective measures -Strengthening capacity of District EPI Management Team, focused on Kandahar and Hilmand.
3. We recommend that an analysis be urgently commissioned to examine the relationship between the frequency and quality of vaccination campaigns, to guide programmatic decisions about the optimum interval between campaigns.	Recommendation adopted	The debate that quantity of SIAs is at the cost of quality has been carried out over the last two decades. One large argument against lengthening inter-campaign interval has been continuous quality improvement in India despite nearly monthly rounds in high-risk areas during 2004-2011; a more recent argument has been the improvement in assessed quality in Pakistan during 2012 despite no change in frequency of rounds, and particularly despite Short Interval Additional Dose (SIAD) SIAs having been conducted in the highest risk areas during that period. However, gaps between rounds of up to 2 months generally occur when there are seasonal events that can confound analysis: Eid or Ramadan, or end of year holidays. Arguments in favour of lengthening inter-campaign interval have mostly centred on Nigeria, where the usual 4-week time period between rounds leaves little time for assessment, innovation and training. Using the current "dashboard" scheme, there are several tasks that need to be completed 3 weeks before the start of a campaign, during a time when the team is still very involved in evaluating and closing out the previous campaign.

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		For Nigeria, Global Good recently conducted a regression analysis using LQAS-assessed SIA quality during 2012–2013 and found no statistically significant relationship between time between rounds and LQAS assessment. Similarly, CDC conducted an analysis, using "dashboard" data from the October 2012 through March 2013 SIAs, of the correlation of time between SIAs and the state of pre-campaign preparation at the state and LGA level. This analysis showed no relationship between state of preparation and interval between rounds. However, the lack of variability in the length of time between rounds limited the ability to detect an effect. Therefore, at this point, the programme is aware of no strong evidence to support the hypothesis that lengthening interval between campaigns would improve quality. Additionally, in 2005, mathematical modeling underscored that a rapid and large-scale response to poliovirus detection is preferable to a delayed response of increased quality (in terms of impact on number of subsequent cases and duration of outbreak). Based on this modeling, the WHA issued international outbreak response guidelines to countries (resolution WHA 59.1, May 2006).
4. We recommend that every endemic country district-level taskforce (or equivalent) should be constituted to include a parent,	Recommendation adopted with some variance	District-level views of the community are already an important component of district-level planning and oversight. Identified community representatives provide reflective community insights and represent parents and the wider community as a whole, at district-

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representing parents of the district.		level taskforce meetings. In Nigeria, community and traditional leaders are members of LGA-level and State immunization taskforces, and attend regular meetings. Plans are being put in place to include 'Ardo' representation (traditional leaders of nomadic communities). In Pakistan, religious leaders have been nominated as mandatory representatives at each District Polio Eradication Committee since December 2012. Community representatives (teachers, elders, religious leaders) are engaged at the Union-Council level. In Afghanistan, as District EPI Management Teams begin to solidify, UNICEF will continue to promote the formal participation of community leaders. In addition, UNICEF is conducting periodic KAP surveys among families in high-risk communities to better understand their perspectives and needs.
5. We recommend that every opportunity be taken to 'pair' other health and neighbourhood benefits with the polio vaccine.	Recommendation adopted	The full engagement and support of communities is a key factor for success in the remaining three endemic countries. These countries are already adding additional health interventions using the polio infrastructure. <u>Nigeria:</u> Fixed posts deliver additional antigens and at health centers/outreach

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		sessions in all wards of the country for routine immunization. Governance structures set up to support polio eradication, including at state and LGA level, focus on aligning polio activities with routine immunization activities. Polio-funded staff support routine immunization through a) updating Reaching Every Ward (REW) microplanning, b) monitoring routine immunization sessions, c) conducting trainings of frontline health workers, d) support data collection and analysis for routine immunization, and e) by integrating routine immunization information with polio communication. During every round of Immunization Plus Days (IPDs), the following additional 'pluses' are offered to communities (depending on the area/availability): hepatitis vaccine (incl monitoring of 3 doses), DPT (incl monitoring of 3 doses), measles vaccine (incl monitoring of 2 doses), yellow fever vaccine (incl monitoring of 2 doses), tetanus vaccine (incl monitoring of 2 doses) and Vitamin A (incl monitoring of 2 doses), all offered in one fixed site per ward. Additional 'pluses' offered by the teams as they move house to house can include soap, deworming tables, candies and paracetamol. The quantity and variation in 'pluses' however is variable, and subject to local availability and funding. From March 2012 to March 2013, the following additional antigens were provided to children aged <1 year during IPDs: DPT (2.497 million doses); hepatitis (1.45 million doses); measles (949,000 doses); and, yellow fever (527,100 doses). Within the context of the 'Saving One Million Lives Initiative', launched by HE President Jonathan in October 2012, synergies between the polio programme and broader public health systems are

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		now sought, in particular with routine immunization. The Plan aims to save one million lives by 2015, by focusing on improving linkeages between maternal and child health services, malaria control, child nutrition, prevention of mother-to-child transmission of HIV, routine immunization and polio eradication. <u>Pakistan:</u> In Pakistan, 'pairing' of health interventions is conducted directly through SIAs, and using the polio infrastructure outside of SIAs. Through SIAs: Vitamin A is added twice per year nationwide. Additional regular add-ons are deworming tablets and OPV is added to measles campaigns. In high-risk areas of Federally Administered Tribal Areas (FATA), hygiene kits are co-distributed in medical campaigns. Outside of SIAs, Rotary's Pakistan PolioPlus Committee is carrying out intensified interventions in select high-risk Union-Councils to help create community demand for polio immunizations. For example, in Pakistan, Rotarians are organizing 'clean neighbourhood initiatives' alongside polio activities, to facilitate the removal of garbage from neighbourhoods. Rotary Clubs have organized Health Camps in Polio High Risk Districts, which include Charsadda, Mardan, Battagram and Peshawar in KP; Dadu, Sanghar and Karachi in Sindh, Lahore and Gujranwala in Punjab; Killa Abdullah and Quetta in Balochistan. These health camps serve underprivileged communities with broader health care services. On an average, 1000 – 1500 people benefit from the Free Health Camps. Rotary has also

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		inaugurated six "Polio Resource Centers" in areas including Balochistan, KP, and Karachi, Sindh. The aim of the Resource Centers is to strengthen routine immunization in newborn and infants, create awareness of polio and build confidence in the surrounding community. Throughout Karachi, 10 permanent immunization centers have also been established that provide a wide range of immunization activities. Since November 2012, 22,071 children were provided health services other than polio vaccine and 10,634 adults were provided health care services. Moving forward, Pakistan plans to expand the delivery of additional health interventions in specific high-risk areas and is already coordinating with other UN agencies maximize to convergence of services. Under the leadership of the UN resident coordinator, all UN agencies are focusing and fast-tracking social, civic and health programmes in polio high-risk districts – special funding in the amount of US$1.76 million has been allocated for this initiative. <u>Afghanistan:</u> Vitamin A is added twice per year to nationwide immunization campaigns, as are deworming tablets, and OPV is regularly added to measles campaigns. Engagement of the Afghanistan Red Crescent and other line ministries staff in support of polio eradication through the Inter-Ministerial Task Force are supporting an initiative to improve routine immunization in 28 high-risk districts.

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		West Africa: In the context of the Mali and broader Sahel crises, the polio effort is being aligned with the broader humanitarian response activities, in particular in refugee camps. OPV is offered alongside DPT, measles and Vitamin A in Burkina Faso, Niger, Mauritania, Mali, Guinea, Guinea Bissau Liberia, Côte d'Ivoire, Sierra Leone and Senegal. The AFP surveillance network is searching for cases of cholera, measles and other vaccine-preventable disease outbreaks.
6. The IMB requests a report on vaccine supply at each of its future meetings.	Recommendation adopted	A summary of the current supply situation is being provided in a separate document to the IMB. Starting in 2013, a specific slide summarising the latest vaccine supply information was added to the weekly Interagency Country Support Group (IACSG) conference calls. To further strengthen vaccine supply management globally, a Vaccine Management Working Group of the GPEI now convenes quarterly to review changes in demand.
7. We recommend that the Programme accelerate planning to set out how the learning from polio eradication can be captured rigorously and comprehensively,	Recommendation adopted	'Legacy Planning' is the fourth objective of the new Polio Eradication and Endgame Strategic Plan 2013-2018. The legacy planning process will officially begin in April 2013, following the presentation of the new Plan at the Global Vaccine

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overseen and funded with minimal distraction to current work.		Summit in Abu Dhabi. Legacy planning for the GPEI will have three main goals: (1) to mainstream into existing public health programmes the polio-related work on broad immunization activities, disease surveillance and response; (2) to ensure that the knowledge and lessons learnt by the programme in identifying and reaching marginalized children and populations with basic health interventions will inform other public health programmes; and (3) to transfer the relevant capacities, processes and assets that the programme has created, for the benefit of other health priorities, as the Global Polio Eradication Initiative comes to completion, and eventually closure. Immediate next steps: a consultation process on legacy planning will begin with stakeholders, donors, other health initiatives and implementing partners in order to provide input for a discussion paper for Member States to review at Regional Committees (RCs) in 2013. The outcomes of this consultative process will be brought to the World Health Assembly (WHA) for consideration in 2014, through the RCs.
8. We recommend that an intensive 'Polio Watch' be established in the countries at	Recommendation adopted	Regional assessments of risk of outbreaks in polio-free countries and areas have been regularly undertaken since 2010 (earlier for the European Region). In 2011, a Risk Assessment Working Group

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highest risk of a polio outbreak. We further recommend that the responsible WHO Regional Offices should issue within the next month an action plan for strengthening vaccination coverage and surveillance in these areas.		composed of WHO Regional Office teams and CDC was established, which has since then been used to coordinate and standardize risk assessment methodologies between Regions. Each regional office team has regularly informed GPEI partners about the results of risk assessments and shared prioritized work plans of activities to respond to and mitigate the identified risks. The regional offices of the Regions of the Americas, Europe and Western Pacific (certified polio-free), the Region of South-East Asia (recently polio-free), and the two remaining endemic regions of Africa and the Eastern Mediterranean have produced mitigation plans and facilitated fund mobilization to strengthen routine immunization, conduct supplementary immunization activities and strengthen surveillance. Regional offices advocate with country governments to address gaps in surveillance and immunity, and provide technical assistance in filling programme gaps. In order to prioritize global resources and assure the optimal use of available funds and vaccine supplies, WHO and UNICEF conduct a quarterly detailed consultation with GPEI partners on SIA prioritization. In Africa, countries with close geographic proximity to Nigeria, particularly in West Africa, retain the highest focus of partners in resource allocation and prioritization of activities.
9. We recommend that India plans for a simulation exercise to test the readiness of its emergency response plans. We recommend that the exercise should begin, on	Recommendation already implemented	In March 2012, the India Expert Advisory Group (IEAG) for Polio Eradication recommended that "simulations of the emergency response plans at national and state levels should be conducted by the Union government on an urgent basis."

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an unannounced date in mid-2013, by selecting a sample of districts at random and carrying out real-time simulation-based scrutiny of their emergency response capability.		In October 2012, detection of a wild poliovirus (WPV) was reported. The WPV was subsequently confirmed to be a laboratory contaminant. This reporting prompted a widespread and comprehensive simulation of outbreak response. The simulation underscored the efficacy of national- and state-level preparedness plans.
10. We recommend that a continual live audiovisual feed should be broadcast online from the Nigerian Emergency Operations Centre, with a facility for the world's polio experts and the IMB to observe and provide input at any time.	Recommendation follow-up modified	Information on operational management, challenges and progress in endemic countries should be readily available, to ensure that endemic countries have access to the best expertise available to support their efforts in interrupting wild poliovirus transmission. In Nigeria, while a live feed has not been established, a number of new communication and monitoring innovations have been recently established which significantly increase the real time flow of information from Nigeria to global partners. An online dashboard accessible to all partners now tracks a set of pre and intra campaign indicators that measure LGA and State readiness for implementation and progress through-out campaigns. The dashboard has been integral to informing the decisions of the EOC to postpone implementation for states and/or LGAs that cannot demonstrate adequate preparation for planned rounds. A Daily Summary Update is now shared by the EOC with partners, which summarizes preparations and progress through each polio SIA campaign. The updates highlight specific challenges at both the state and LGA level and what is being done to address any bottleneck.

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		The EOC receives ongoing input of experts from each of the technical partners in the GPEI through locally-deployed staff, as well as experts from regional and head offices. Every six months, the Expert Review Committee (ERC) provides guidance. Performance of vaccination teams in some of the highest risk areas of the country are now tracked to ensure that daily work plans are completed and that missed settlements are identified. During the recently completed April IPD, performance of vaccination teams in 309 Wards in 28 very high-risk LGAs in 5 states was tracked in real time with the data downloaded at the LGA and analyzed at the end of each day. This data is also uploaded to the Vaccination Tracking System where global partners and stakeholders are able to follow the performance of these teams in real time. There is early evidence that this new innovation is improving team performance and the quality IPDS in the areas it is being used.