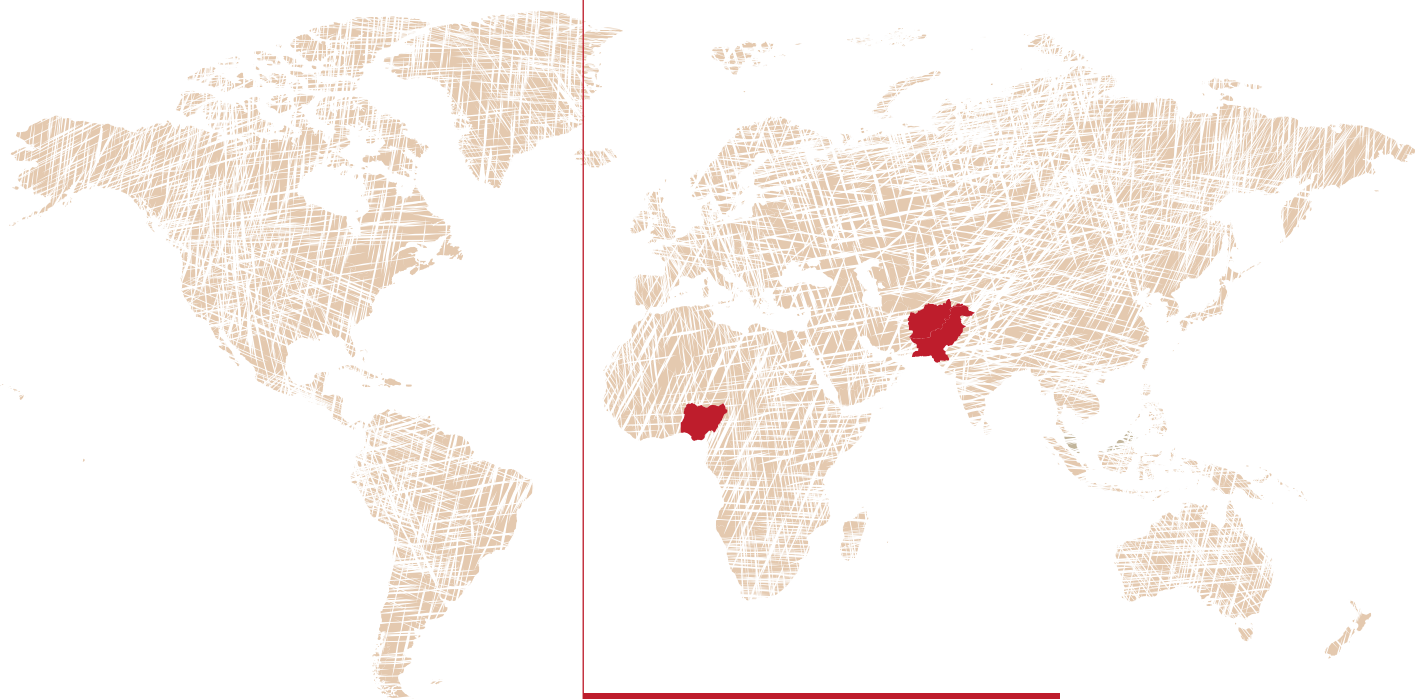


Independent Monitoring Board of the  
**Global Polio Eradication Initiative**



Seventh Report – May 2013

# THIS CLOSE...



... if communities embrace the polio eradication programme as their own

## **INDEPENDENT MONITORING BOARD OF THE GLOBAL POLIO ERADICATION INITIATIVE**

### **May 2013**

The Independent Monitoring Board provides an independent assessment of the progress being made by the Global Polio Eradication Initiative in the detection and interruption of polio transmission globally.

This seventh report follows our eighth meeting, held in London from 7 to 9 May 2013.

At our meetings, we benefit from the time and energy of many partners of the Global Polio Eradication Initiative. We value our open discussions with these many people, but the views presented here are our own. Independence remains at the heart of our role. Each of us sits on the board in a personal capacity. As always, this report presents our findings frankly, objectively, and without fear or favour.

**Sir Liam Donaldson (Chair)**  
Former Chief Medical Officer, England

**Dr Nasr El Sayed**  
Assistant Minister of Health, Egypt

**Dr Jeffrey Koplan**  
Vice President for Global Health,  
Director, Emory Global Health Institute

**Professor Ruth Nduati**  
Chairperson, Department of  
Paediatrics and Child Health,  
University of Nairobi

**Professor Michael Toole, AM**  
Deputy Director (International Health),  
Burnet Institute

**Dr Ciro de Quadros**  
Executive Vice President,  
Sabin Vaccine Institute

**Dr Sigrun Mogedal**  
Special Advisor,  
Norwegian Knowledge Centre  
for the Health Services

**Dr Arvind Singhal**  
Marston Endowed Professor  
of Communication,  
University of Texas at El Paso

**Secretariat:**  
**Dr Paul Rutter**  
**Mr Niall Fry**



## Executive Summary

1. This is the first report of the Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative (GPEI) since the end-2012 target for interrupting polio transmission was missed.
2. It is also the IMB's first report since the tragic killings of polio workers in Pakistan and northern Nigeria. Their loss is deeply felt by the whole public health world. Their lives and service to public health will be honoured if the goal of eradication is achieved quickly and decisively.
3. The missed target for interruption of transmission is not a reason for pessimism. The Programme's achievements of the last three years have been formidable. After 'flat-lining' for a decade (there was no significant reduction in the number of wild polio virus cases between 2001 and 2010), case numbers have dropped substantially since 2010. In 2012 there were three endemic countries (down from four in 2010). In 2012, there were cases in just two other countries (down from 16 in 2010). In 2012, there were 223 cases of people (mainly children) being paralysed by wild polio virus (down from 1352 in 2010).
4. The latest data at the time of writing this report (8 May 2013) show 26 cases of wild polio virus in 2013, compared to 53 by the same time last year.
5. This is good news – but whilst the polio virus has been knocked down, it is certainly not knocked out.
6. In each of its previous reports, the IMB has set out a consistent analysis of the reasons why the Programme is performing sub-optimally. Failure to focus intensively enough on why children were not being vaccinated. Failure to ensure accountability. An inability to rapidly and reliably transfer methods of Programme excellence to areas where performance is mediocre or poor. Failure to put continuous quality improvement at the heart of the Programme. These are some of the big areas of dysfunction that allow the polio virus to remain within its comfort zone.
7. The Programme has made major progress in dealing with these problems. A global emergency has been declared, and a staff surge put in place. Accountability has been strengthened in many areas, and vaccinator pay and selection improved. There has been a sharper focus on finding missed children, and on the key endemic areas ('sanctuaries'). These changes, and many others, have enabled the Programme to turn the tide in its favour, and to achieve substantial gains.
8. In this report, we have created a 'system map' for polio eradication. Some parts of this system have been designed and built over many years by the Programme. Others represent the complex natural environment in which the Programme operates – with political, financial and security factors affecting its work in myriad ways.

9. In its previous two reports, the IMB has strongly recommended the introduction of mandatory polio vaccination certification for people travelling out of endemic countries. The IMB continues to believe that this would be a powerful underpinning measure to the eradication effort. It is one of a number of new actions that could help tip the balance against the polio virus's continuing survival.
10. The complexity of the system map is a stark reminder that each domain of activity (political, technical operations, security, financial, strategic) has an important bearing on local communities where vaccination programmes succeed or fail. More than this, the factors within these domains of the system map can interact with others in ways that are not always possible to predict or control.
11. It is also clear from the system map that the Programme is only as strong as its weakest point and that the complex forces affecting communities cannot be completely controlled.
12. Regrettable though it is, the Polio Programme – and its vaccine in particular – are subject to great negativity in many of the places where the virus still circulates. Many communities regard the vaccine as being imposed from the outside and do not understand the benefit that it brings. Parents ask "why so many doses?" and often get unsatisfactory answers. When anti-Programme campaigners recently produced a series of CDs to spread their message in Nigeria, these found a receptive audience, their messages spreading rapidly across the north.
13. The IMB is deeply concerned by the Global Programme's weak grip on the communications and social mobilization that could not just neutralise communities' negativity, but generate more genuine demand. Within the Programme, communications is the poor cousin of vaccine delivery, undeservedly receiving far less focus. Communications expertise is sparse throughout. UNICEF, the lead agency for communications, is underpowered. But communications is everybody's business and should be more prominently at the heart of the Programme's concerns. We have warned of this weakness for some time. It has not been addressed, and is now a real and present danger to eradication.
14. In areas where communication capability is strong the IMB sees:
  - Rapid rebuttal of unfounded and unscientific claims about the vaccine
  - Engagement in dialogue with communities and local groups to achieve widespread community support, particularly with women's groups and religious leaders
  - Education of and explanation to parents and communities, as well as to vaccinators themselves (so that there is no question that they cannot answer in an informative and reassuring way)

- The incorporation of polio vaccine delivery with other health and social benefits that communities value
- Consistent and effective advocacy of the benefits of the vaccine.

The problem is that this is not happening on the scale and with the energy and focus needed to make a difference where it matters the most.

- 15.** The GPEI's strategic plan articulates that "experience throughout the GPEI has shown that polio virus circulation stands little chance of surviving in fully mobilized communities, even in the most difficult contexts". The IMB could not have put it better. The leaders of the Programme need to make this rhetoric a reality, which it currently is not. If not dealt with, the current communications shortfall is a deep threat to the Programme. But if gripped, and managed with ambition, stronger communications has the potential to transform the Programme's progress.
- 16.** If a billion-dollar-a-year emergency global health programme were established from scratch today, its management structure would look nothing like that of the Global Polio Eradication Initiative. It would probably have a central secretariat authorized to provide a single source of clear and rapid leadership on behalf of the partners. Now is probably not the time for a radical structural overhaul, but the complex multi-partner structure is creating serious problems that need to be addressed. When the partners disagree on important issues (such as data sharing or the role of IPV), the result is too often protracted and circular debate that can literally last for years. This stagnation, maintenance of the status quo, allows the virus to live on. Relatedly, the core partners expend too much energy focused inwards, rather than being sharply responsive to what the polio-affected countries need from them as a group. If major restructuring is deemed too disruptive at this stage of the Programme, the global partners instead need to far better mitigate these problems, which are a major drag on progress, within the current structures.
- 17.** Moving at snail's pace because of intra-partnership disagreement, the idea of using injectable polio vaccine (IPV) in endemic countries has been discussed for more than two years now. According to the endgame plan, IPV will be introduced in the three endemic countries (and 137 others) in 2015. Some favour introducing it sooner into the endemic countries, believing it would help to stop transmission. Discussion of this idea has been circular, because there are no operational trial data to test the hypotheses advanced in support of, and against, the concept. A trial in Pakistan, planned for later this year, needs to answer all of the immunological, operational and communications questions once and for all. Circular debate cannot continue. The Programme needs to have a clear and evidence-based plan on this by the end of 2013.

- 18.** Afghanistan is on the brink of stopping polio transmission, but has been at this point for some time. It needs a final major push to resolve the basic errors still plaguing its vaccination campaigns. Its ability to access 'inaccessible' areas is a real strength, but sizeable communities still remain for it to reach. From the top of government downwards, the need to stop transmission by the end of 2014 must be more clearly expressed, and acted on, by all.
- 19.** Nigeria's Programme has surged forward over the last year, in most areas and in many different ways. Still though, progress in a number of Local Government Areas is stagnant – a thorn in the Programme's side. Insecurity is a more significant issue than ever, and the Programme's approach to reflect this has not yet been optimised. Despite its recent progress, Nigeria remains the country most in need of greater strategic focus on communications.
- 20.** Pakistan transformed its Programme in 2012. Heightened political commitment drove through a raft of programmatic improvements. These had real impact, significantly reducing circulation of the virus. The country held elections in the days following the IMB meeting. Strong leadership of the Programme from those coming into power will now be crucial. Interrupting transmission in Pakistan never looked easy, and recent events make it harder still. Pakistan's Programme is strong, but there must be little doubt of the considerable challenge ahead.
- 21.** In all three endemic countries, there has been clear evidence of absolute commitment to eradicating polio from the highest political levels. For each country to sustain this will be crucial to stopping transmission.
- 22.** Cases of polio in Somalia and Kenya, reported in the days since the IMB's meeting, are deeply worrying, and a reminder that no country is safe from polio until it is eradicated from the world entirely.
- 23.** The Independent Monitoring Board judges that stopping polio transmission by the end of 2014 is a realistic prospect. It is important to understand what this will take. Over the last two years, this Programme has been vastly improved throughout. Transmission can be stopped if the Programme recognises the absolute need to continually improve, and does so with urgency and nimbleness. The Programme that finally stops transmission will not be the Programme as it exists today, but one that has rapidly and purposefully evolved from it. It will be a Programme that truly puts communities at its centre, and that sees communications as being key to its success, rather than as a mitigating measure in a Programme driven by supply. It will be a Programme that grips every weakness as it arises; continually scanning the polio eradication system to turn every element in its favour.



## CONTENTS

INTRODUCTION	10
POLIO CASES	12
THE POLIO ERADICATION SYSTEM	18
AFGHANISTAN	23
NIGERIA	26
PAKISTAN	30
ENGAGED COMMUNITIES ERADICATE POLIO	33
RESPONSIVE AND COORDINATED GLOBAL MANAGEMENT	40
BREAKING THE POLICY DEADLOCK: IPV IN ENDEMIC COUNTRIES	45
TEN TRANSFORMATIONS	48
CONCLUSIONS AND RECOMMENDATIONS	52



## Introduction

Many different factors collude to sustain the transmission of polio. Transmission will only be stopped for good when the Programme achieves top-notch performance in regard to each of them.

This report introduces the concept of the Polio Eradication System, with a map of these multiple different factors and how they interact. This makes it clear that the system to eradicate polio is only as strong as its weakest point.

Many parts of the Programme are now very strong, and the IMB congratulates all those who have worked tirelessly to achieve this. But in some aspects, and in some parts of the endemic countries, the Programme has very weak points.

We highlight these weaknesses country by country. We then examine two programmatic weaknesses at global level – the need for a major boost in emphasis on communications (to address the problem that in key communities the vaccine is viewed negatively and parents do not see the need for their children to have it), and the need for better-coordinated, more responsive management of the global partnership. Finally, we make clear the need to resolve the deadlock on a key policy issue – when best to deploy IPV in the remaining endemic countries.

In the midst of so many strengths, why focus on the weaknesses? Because the polio virus will seize on them. Impressive as recent progress has been, the IMB is firmly of the view that the task of stopping transmission in the remaining endemic areas is enormous and should not be under-estimated. It is certainly the greatest challenge that the Programme has ever faced so, to succeed, the Programme needs to be the greatest it has ever been.

**POLIO CASES**



## At a glance

### Polio Cases

The Global Polio Eradication Initiative has made strong progress over the last two years. This is reflected in the number of cases and countries affected by polio.

At the time of the IMB's meeting, on 8 May 2013, there had been 26 cases so far in the year, in just three countries – Afghanistan, Nigeria and Pakistan.

In the same period a year ago (1 January – 8 May 2012), there were 53 cases in four countries. Transmission has since been interrupted in Chad, and the number of cases in the three endemic countries in 2013 to date is half of what it was in 2012.

Two years ago (1 January – 8 May 2011), there were 145 cases in 12 countries. In other words, five times as many cases in four times as many countries as there have been this year. In that period, each of Pakistan, Chad and DR Congo had suffered more than 30 cases of polio – more, in other words, than the entire global total two years on.

### Vulnerable countries

No country in the world is completely safe until polio is extinguished entirely. But some countries are significantly more vulnerable than others. The IMB was presented with a strong scientific analysis of the most risky areas, region by region. We had two concerns.

First, that when the analysis highlights areas of risk, sufficient action is not always being taken to mitigate this risk. Second, that the analysis should not replace a 'common sense' assessment of where the greatest risks may be. Combining the analysis presented to us with our common sense assessment, the countries in Africa about which we are most concerned are shown in the figure on page 15.

**Strong progress over two years**

**Just 26 cases so far in 2013**

**Half as many as last year**

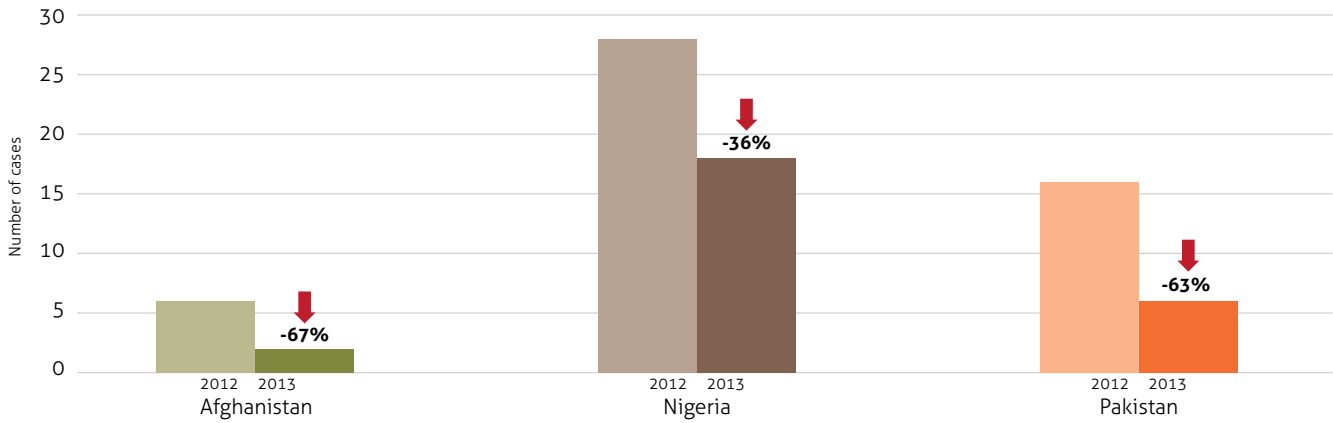
**One-fifth of the total two years ago**

**The threat of polio still hangs over a host of vulnerable countries**

**Across the world, countries lie prone to polio importation**

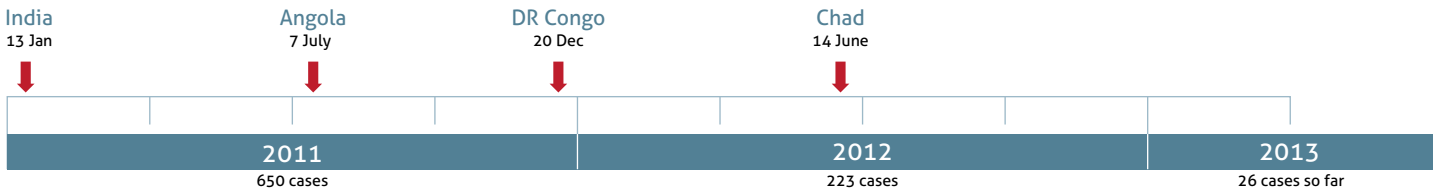
KNOCKED DOWN BUT NOT OUT: WILD POLIO IN THE THREE ENDEMIC COUNTRIES

Cases in each of the endemic countries; 2012/13. 1 January to 7 May period

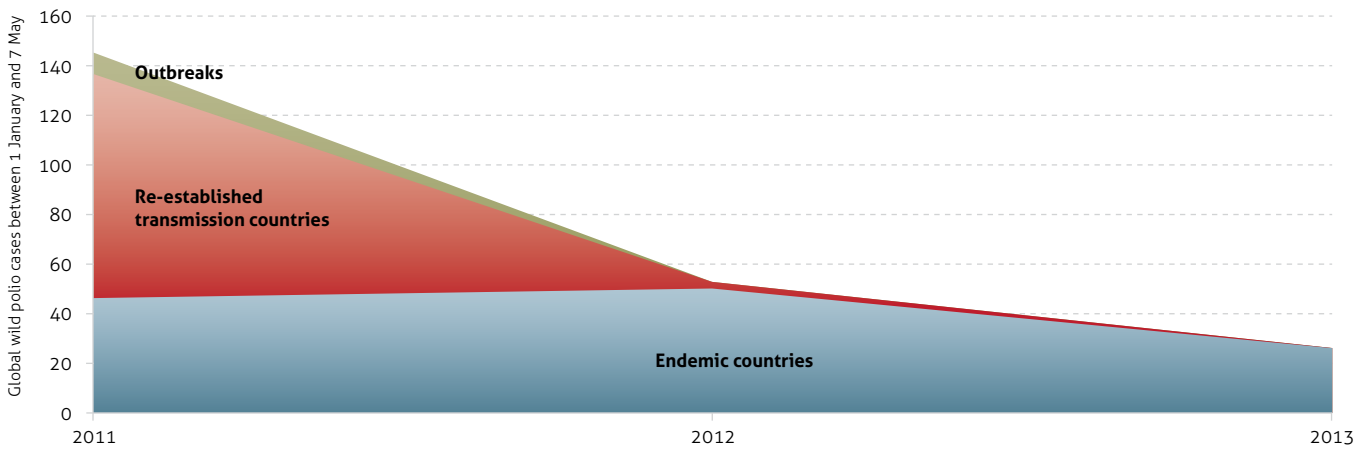


MAKING POLIO HISTORY: STRONG PROGRESS...

Most recent case in:



...BUT THE ENDEMIC HARD CORE REMAINS



## COUNTRIES ACROSS AFRICA SIT VULNERABLE TO POLIO IMPORTATION

### Mali

- Population: 15 million
- Vaccination campaigns disrupted by recent conflict

### Niger

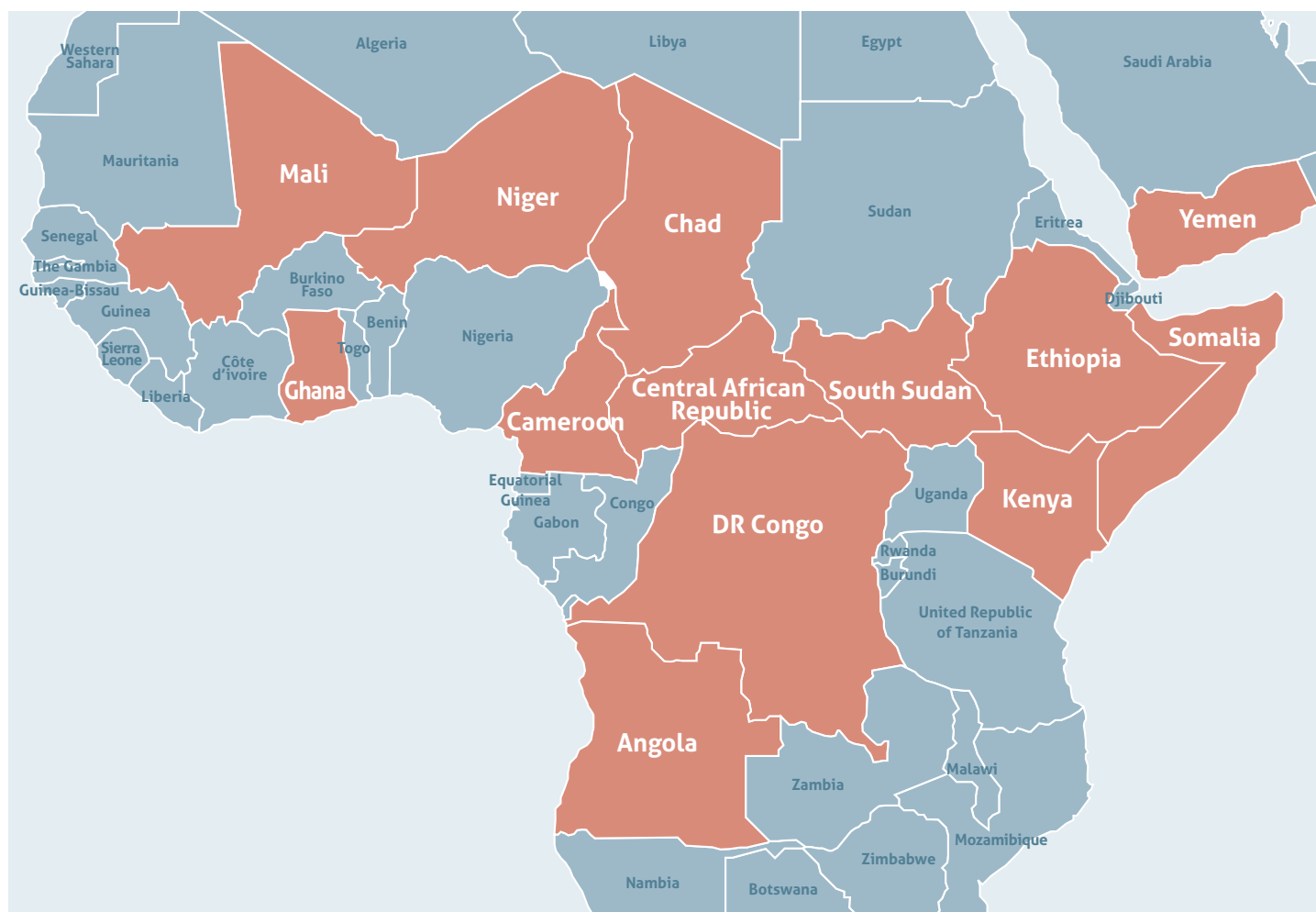
- Population: 17 million
- Imported wild polio case from Nigeria: 15 November 2012

### Chad

- Population: 11 million
- Across Lake Chad: polio endemic in Nigeria

### South Sudan

- Population: 9 million
- Threadbare health system in world's youngest country



### Yemen

- Population: 24 million
- cVDPV type 3 recorded as recently as August 2012

### Ghana

- Population: 24 million
- A sea of red on the GPEI's risk assessment

### Central African Republic

- Population: 5 million
- SIAs postponed since December 2012 due to insecurity

### Ethiopia

- Population: 91 million
- SIAs postponed to Q4 2013 despite long border with Somalia

### Somalia

- Population: 10 million
- Over 500,000 children unvaccinated for three years due to conflict
- Wild polio case: 18 April 2013: outbreak response ongoing

### Cameroon

- Population: 20 million
- Sub-optimal performance along border with Nigeria

### DR Congo

- Population: 76 million
- Long history of anti-vaccine sentiment

### Kenya

- Population: 44 million
- OPV3 coverage along border with Somalia less than 50% in places
- Wild polio case: 30 April 2013: outbreak response ongoing

### Angola

- Population: 19 million
- Only recently polio-free, large areas still vulnerable

## At a glance

The risks are not confined to the African continent. In Asia, the Philippines and Indonesia are high on the at-risk list, especially given their vast and mobile populations. In Europe, the IMB heard worrying reports of decreasing coverage in Ukraine. In the Eastern Mediterranean Region, on-going conflict in Syria and resulting refugee movement creates the kind of opportunity that the polio virus yearns for.

Experts view circulating vaccine-derived poliovirus (cVDPV) in different ways. In one sense, it is a polio virus like any other – it paralyses children and circulates in the wild, even though it originates from the vaccine. In another sense, it is quite different from wild poliovirus and its transmission is easier to stop. Some therefore view its presence as a marker of low vaccine coverage – and therefore as a beacon within the population, warning that wild polio would easily circulate if imported.

Whichever view one takes, cVDPV is of great concern. Cases caused by this virus type are not included in the headline counts, but their impact should not be overlooked. Four countries have had cVDPV cases in 2013. These are Pakistan (3 so far in 2013), Afghanistan (3), Chad (1) and Somalia (1).

### **New outbreak: Horn of Africa**

In Somalia, the warning beacon of cVDPV has burned brightly. The country has seen continuous cVDPV transmission for over three years. After the IMB had met, we heard the long-dreaded news: a case of wild polio had been detected. The result of a new importation, this is the first wild polio case since March 2007.

Somalia has long been a concern due to the large numbers of unvaccinated children. This year it is estimated that half a million children were not accessed by vaccinators. In previous years, this number has reached 800,000. As a result, Somalia has possibly the largest pool of polio susceptible children in the world.

This challenge is confounded further by the population movements within the country and beyond. Predictably enough, and in a worrying sign of the potential escalation of this crisis, within the last two weeks a case of wild polio in a four-month old girl was confirmed in Dadaab, Kenya – the first case in that country since July 2011. Dadaab hosts a major centre for over 500,000 refugees from across the Horn of Africa. It is not yet clear by what route the virus entered Somalia. This demonstrates the need for surveillance to be heightened across the region, including in Kenya.

The seriousness of this situation cannot be over estimated. Population movements and the existence of large immunity gaps across the Horn of Africa provide a perfect environment for the polio virus to spread unhindered.

Somalia and Kenya have launched an emergency response. Without prompt and effective action, wild polio could become re-established in the Horn of Africa. Every community needs to have the tools to prevent, and detect, the spread of polio.

**Asia, Europe, Eastern Mediterranean: all with susceptible areas**

**cVDPV: a warning beacon of low immunisation coverage**

**Eight cases of cVDPV this year, in four countries**

**The feared news: wild polio in susceptible Somalia**

**And now a case in Kenya**

**With population movement and weak immunity, the Horn of Africa as a whole is at risk**



## At a glance

### Compatible cases

There are a significant number of 'compatible' polio cases. Such cases arise when a person has clinical symptoms and signs suggestive of polio infection, but there was no laboratory confirmation of this diagnosis. These cases represent a partial failure of the surveillance system, since a well-performing surveillance system should detect possible cases early and provide definitive stool sample testing. In 2012, there were just 223 confirmed cases of wild polio – but there were an additional 273 'polio compatible' cases. The IMB believes that the issue of compatible cases needs to receive more attention – surveillance systems should be improved to reduce their number, and the Programme needs to ensure that the expert review committees reviewing compatible cases have the resources that they need (such as videos of patients who cannot be examined by the committee in person) to enable accurate clinical diagnosis.

WE RECOMMEND THAT COMPATIBLE CASES BE ROUTINELY REPORTED IN THE PROGRAMME'S BULLETINS, REPORTS AND PRESENTATIONS ALONGSIDE THE NUMBER OF CONFIRMED CASES. WE RECOMMEND THAT FURTHER ATTENTION BE GIVEN TO REDUCING THE NUMBER OF COMPATIBLE CASES THROUGH BETTER SURVEILLANCE, AND THAT EXPERT REVIEW COMMITTEES RECEIVE THE RESOURCES THEY NEED TO SUPPORT ACCURATE DIAGNOSIS WHEN SUCH CASES ARISE.

**More 'compatible cases' in 2012 than confirmed cases of polio**

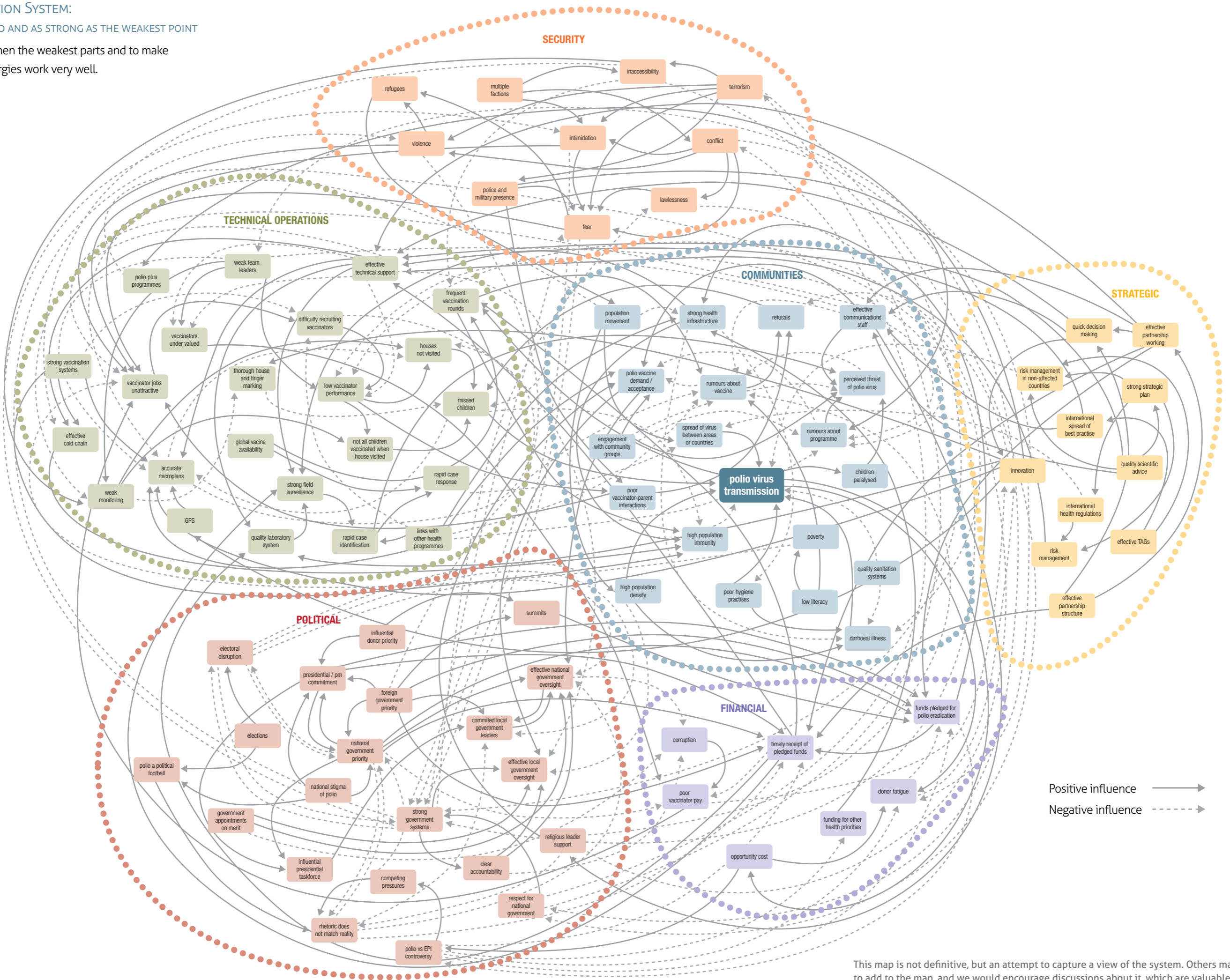
**'Compatible cases' do not exist if surveillance is done well**



# THE POLIO ERADICATION SYSTEM:

COMPLEX, INTER-RELATED AND AS STRONG AS THE WEAKEST POINT

It is essential to strengthen the weakest parts and to make the interfaces and synergies work very well.



This map is not definitive, but an attempt to capture a view of the system. Others may well be able to add to the map, and we would encourage discussions about it, which are valuable in themselves.

## The Polio Eradication System

The Global Polio Eradication Initiative is a complicated system of many parts. The IMB has created a map of this vast system (see previous page) that shows just how complex it really is. Polio survives thanks to the interplay of many different factors. At the centre of the Polio Eradication System are communities. It is here that polio circulates, and that vaccine is demanded, accepted, or refused. What happens within those communities is determined by the interaction of many factors within major domains of influence: financial, political, strategic, technical operations, and security.

The lesson from the system map is that the system is as strong as its weakest point. Despite the depth of experience and expertise in the Programme, and its wealth of data, nobody is able to say exactly where and when the next case of polio will occur. By their very nature, complex systems have some unpredictable outcomes. The system cannot be perfectly controlled. All domains must be addressed, and the inter-relationship between the different components taken account of.

The Programme's **security** situation has changed since the IMB last issued a report. Unprecedented attacks on polio vaccinators have shocked people around the world. In Pakistan, 16 polio workers have been killed since July 2012 – most in seemingly coordinated and barbaric attacks in December 2012. In Nigeria in February, nine vaccinators were shot dead in a single day. These events usher in a new, grim reality for the Programme. The governments and people of Nigeria and Pakistan have responded superbly. They have shown their absolute determination to eradicate polio. The immediate aftermath of these attacks has passed, but we must now ask whether plans are well-designed for operating in this new reality, where security risks to polio workers and citizens are ever-present. Compromises may have to be made. For example, risks may be taken to enter an insecure area to give the polio vaccine, but the level of risk of a return visit to vaccinate missed children may be considered too high; so coverage as a result is reduced. Such risks must be mitigated by running high quality campaigns, and by considering other measures such as vaccination at transit points. We return to the vital question of security in the country sections of this report.

The **political** domain of the polio eradication system is vital to its success. High-level political commitment to eradication is stronger than ever before, both in the endemic countries and globally. Strong and consistent alignment between high-level political will and local level action is a deciding factor in whether the polio virus is extinguished in a particular area. In most of the affected areas, the main local or district official is responsible to the President, Prime Minister or Health Minister and accepts accountability for the Programme in his jurisdiction. However, this is not the case everywhere. Failing to take action to address a situation where local or district officials are not fully committed or have other priorities ultimately leads to more missed children. This is an example of where a factor in one domain of the

**Security –  
horrendous attacks on polio  
workers: a grim new reality**

**Political –  
still too much variation in local  
leaders' commitment**

## At a glance

system map feeds through to compromise the effectiveness of the Programme in the heart of communities. As the system map illustrates, political commitment can have negative as well as positive effects. In particular, where parts of the population do not respect the authority or ability of government leaders, programmes that are strongly supported by such leaders can be tarnished by association. This highlights the need for political ownership to be balanced by community ownership. It also highlights the need for cross-partisan political commitment – in other words, for polio eradication to enjoy broad support from all political parties, not just from those in government.

The Programme's **financial situation** has benefited enormously from the Global Vaccine Summit in April 2013. Of the Programme's \$5.5 billion budget for 2013-18, \$4 billion has now been pledged. The system map illustrates how important it is that pledged funds are now received in a timely manner, and that they are received at the front-line with an assurance of continuity. There is no room for complacency on these crucial financial matters. The Programme has worked hard to secure the funds that have been pledged so far. This means that the remaining funds will be even harder to find.

**Technical operations** have been the foundation of the Programme since its outset. How successfully missed children are found and vaccinated. Whether there is a secure vaccine cold chain. The extent to which clear, comprehensive micro plans are in use. How efficiently cases of acute flaccid paralysis are identified and laboratory-investigated. How well vaccine rounds are led and managed. Whether houses and children's fingers are marked. The identification and genetic finger-printing of polio virus in sewage systems. If one or two of these factors are weak then the virus lives to kill another day. These and many other factors in the technical operations domain of the polio eradication system are vital. The Programme has had 25 years to refine them and this part of its work is generally strong. However, again as the system map shows, even one weak link can release the polio virus to cause further cases of illness or death.

The polio vaccine is the technical tool at the heart of the Programme. Previous additions to the Programme's vaccine armoury have revolutionised its progress – most recently, the development of bOPV, which many consider to have been a prerequisite for India's success. There is a vaccine already developed, but not yet being used in the polio endemic countries. This vaccine is IPV. We return to this issue later in this report.

In its previous two reports, the IMB has strongly recommended the introduction of mandatory polio vaccination certification for people travelling out of endemic countries. The IMB continues to believe that this would be a powerful underpinning measure to the eradication effort. It is one of a number of new actions that could help tip the balance against the polio virus's continuing survival.

**The system is not simple – political commitment can have ill effects as well as good**

**Financial – on a strong footing after the Global Vaccine Summit, but money must reach the front-line**

**Technical operations – considerably strengthened, but one weak link is all the virus needs**

**Using every tool: when best to deploy IPV?**

**Using every tool: the value of International Health Regulations**

## At a glance

**Communities** sit at the centre of the system map. The Programme forgets this at its peril. However strong the Programme's other elements may be, it cannot get to the polio virus without working through the influences on the individuals, families, leadership, and social networks that make up the community. The Programme refers to its work in this domain as 'communications' and 'social mobilisation'. These are receiving pitifully little strategic focus, given their vital importance to the Programme. This major area of weakness is currently a grave risk to the Programme. Later in the report, we address this issue in detail.

The communities domain refers mostly to local areas, but religious communities in particular extend beyond the local. The Programme is stronger in its engagement with religious leaders. When the Programme's new Islamic Advisory Council met in March, it discussed the ways in which Islamic leadership can help communities to ensure protection for all Muslim children. Similarly, a group of Islamic scholars travelled to Pakistan in support of the Programme, and the International Fiqh Academy has recently called for parents to ensure that their children are vaccinated against polio.

The effort to eradicate polio from the world should benefit greatly from being a **strategic**, coordinated, and global one. If instead of one global programme there were separate programmes in each country, none of them coordinating with one another, we would expect progress to be far slower. But is the benefit of this global approach being seen in practice? Are the global headquarters providing what the countries really need? Does the Global Programme rapidly spread best practice across the system? Is the partnership nimble and decisive? There are currently some major shortfalls in these areas. We set out the issues later in this report. Returning again to the complex inter-relationships of domains in the polio eradication system map, a metaphorical butterfly beating its wings because of headquarters dysfunction in Geneva, New York City or Atlanta can disrupt the delivery of life-saving vaccine to children in poor communities thousands of miles away.

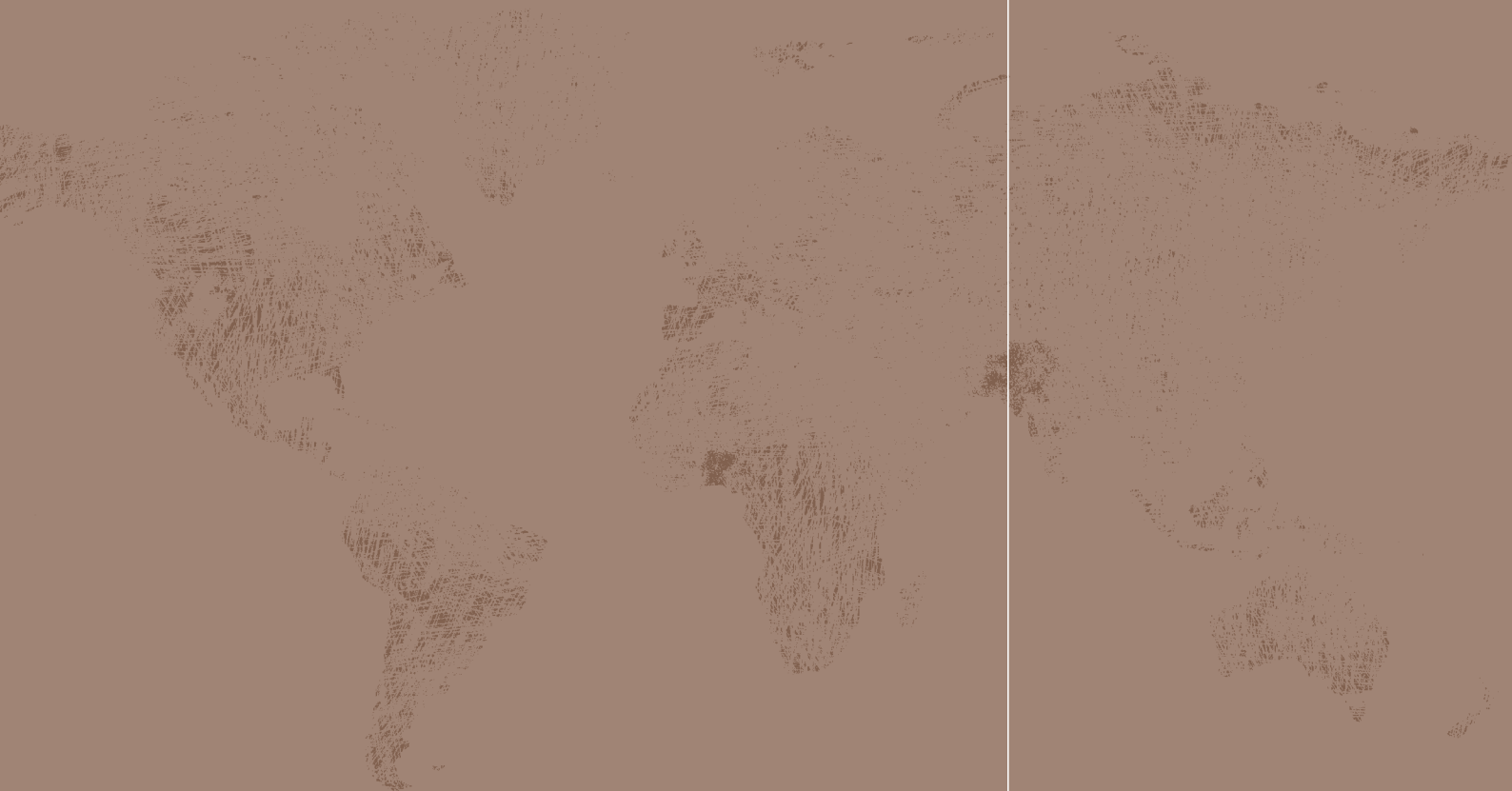
**Communities – at the heart of the system, but this is not truly reflected in the Programme's approach.**

**Weak strategic focus on communications and social mobilisation**

**Strategic – the benefits of being 'One Global Programme' are not fully materialising**

**Dysfunctions in Global Programme management remain**

## AFGHANISTAN



## At a glance

### Afghanistan

Afghanistan is on the brink of eradicating polio, but it will not do so unless it achieves excellence in implementation. It has been this way for some time. With only 37 cases in 2012, and just two so far in 2013, a polio-free future should be within close reach but it does not seem to be. Looking back two years, the Polio Programme in Afghanistan was ahead of those in Pakistan and Nigeria. It remains ahead, with Afghanistan still closer to interrupting indigenous transmission than either of the other two endemic countries. But while the Programmes in Pakistan and Nigeria have both undergone transformative change over the past 18 months, the Programme in Afghanistan, from its better starting position, should now be free of polio. It is not.

The Programme often develops new ideas, and sets itself new goals. The irony is that while its ideas are leading-edge, the quality of action to meet them often lags behind.

At field level, much of the problem is simply this: vaccinators continue to miss children through making basic errors, and their supervisors let such errors slip through the net.

Children are most commonly missed because they are not available when the vaccinators first call, and the vaccinators fail to return as they should. Children are also missed because they are new-born, sick or sleeping, and vaccinators do not appreciate, or cannot communicate, the need for such children to be vaccinated. Most basic of all, 20% fewer children would be missed if the vaccinators simply visited every house in their area. These vaccinators need to be motivated, yet cash does not always flow to them as smoothly as it should.

These are basic problems that a programme serious about polio eradication simply has to master. The Programme has developed some good ideas – a more direct way of getting payment to vaccinators, and a surge of cluster supervisors and mobilisers in key areas. If they are to help transform the Programme, these important measures should be implemented quickly and effectively.

There are also specific areas of dysfunction that must be addressed urgently:

- The inter-ministerial task force should be drawing government departments together in support of eradication – yet the first meeting of the task force was delayed for many months, and then attended by few departments and even fewer ministers
- However difficult, the barrier to eradication being created by an individual in a key province who is not working in the interests of the Programme should be decisively dealt with
- The leaders of a number of NGOs (particularly BRAC and Afghan Health and Development Services (AHDS), operating in Hilmand and Kandahar) must actively hold each local team accountable for delivering the high level of performance needed to stop polio transmission. This does not appear to be happening at the moment.

**On the brink of eradicating polio – but what will now tip Afghanistan from 'close' to 'success'?**

**Leading-edge ideas, but implementation often lags**

**Basic errors by vaccinators continue to sabotage the Programme's efforts**

**The latest ideas to address these problems must be fast-tracked into implementation**

**Inter-ministerial task force: much promised, little delivered**

**NGO leaders must hold local teams accountable**



## At a glance

The Programme has clearly identified 31 low-performing districts. These districts will determine whether or not the polio virus has a future in Afghanistan. Focused attention from the highest levels needs to be brought to bear on these districts, and those who have the power – and responsibility – to affect the required improvements within them. It is an open question as to whether the standard of accountability of these district and provincial governors is high enough to ensure effective action.

So far in 2013, two Afghan children have been paralysed by polio. Both have been in the eastern region, in areas to which the Programme has not yet gained access. Although just 20% of missed children are missed due to inaccessibility, these are an important group. They represent pools of children sitting susceptible to the spread of polio.

The Programme in Afghanistan has two substantial strengths – its ability to make inaccessible areas accessible, and a higher level of parental demand, or at least readiness, for the vaccine than in any other endemic country. To an extent, these are related – parental demand aids access. The Programme is rightfully proud of this position, but these strengths cannot be assumed either self-sustaining or sufficient. ‘Soft refusals’ (parents erroneously reporting their children to be absent, for example, rather than directly refusing the vaccine) are of great concern. 25% of missed children in the polio sanctuaries are due to refusals – the majority ‘soft’. There are also significant areas still not accessed by the Programme. In tackling these issues, the Programme is building from a position of strength – but it is not there yet.

In each of our reports, we have praised the progress being made in Afghanistan, by talented and dedicated people in difficult circumstances. But it is in nobody’s interests – least of all those of Afghan children – for us still to be here in two years’ time, praising iterative change. Our challenge is simply this: finally completing eradication needs this Programme to find ways to accelerate its pace – to bring more people in to help if it needs them; to focus sharply on fixing the basic problems that remain; to aspire to even greater levels of community demand; and for the patches of strong commitment within government to be transmitted throughout. The Programme requires a step-change in mind-set – that the country’s goal of stopping transmission is not just a target on paper, but a genuine deadline to be respected.

**Sharp focused accountability needed in the 31 low-performing districts**

**Accessing many children, but not all**

**A strong communications programme, but the population is showing signs of uncertainty**

**Pace + commitment + quality implementation = a polio-free Afghanistan, soon**

**NIGERIA**



## At a glance

### Nigeria

The pace of improvement in Nigeria's Polio Programme over the last six months has been greater than at any other point in its history. Its efforts are starting to show a real impact. Nigeria has reported 18 wild cases in 2013 compared to 28 for the same period in 2012.

Positivity and confidence in the Programme is growing. Highlights of the last six months include: greater investment in local health services (building community goodwill for the Programme); further emphasis on reaching under-served communities; 'green shoots' of better partnership working (including with Muslim women's associations); and greater professionalism and 'grip' stemming from the Emergency Operations Centres.

Vital to success in Nigeria is the strength of commitment at Local Government Area (LGA) level and the personal qualities of LGA Chairmen. It is quite clear to all observers that in the majority of Nigeria's 774 LGAs, major improvements are being achieved. However, the contrast with the relatively small number of LGAs where performance has stagnated could not be starker. In those areas, it is vitally important for the leadership of the Nigerian Programme to hold to account those key local officials whose priorities clearly lie elsewhere than with the Polio Programme.

The fully committed LGA Chairman who oversees a local programme that is "eradication standard" is easy to recognise. He attends every polio task force meeting. He works hand-in-hand with traditional leaders and Programme partners. He addresses community concerns and needs. He releases Programme funds well in advance of vaccination campaigns. He does not tolerate poor performing staff. He seizes control and he drives the Programme forward.

Equally, the LGA Chairmen who are not reaching this standard are clearly visible. A list of poor performing LGAs is on display in the Abuja Emergency Operations Centre. We commend the Programme for focusing their efforts on these disappointing LGAs. The LGA Chairmen responsible should continue to receive weekly, if not daily, telephone calls from the State and Federal level during which they should present key performance data and the corrective actions being implemented. Ahead of our next meeting, the IMB will ask for a list of all LGAs who have failed to improve their performance.

Vaccination programmes throughout the world and over time have been forced to deal with anti-vaccine rumours. Based on junk science, outright lies and propaganda, these rumours are often propagated by high profile individuals who put self-promotion and self-interest above the lives of children. All parents want the best for their children. But how do they know what is best? How do they distinguish

**Unprecedented improvements in Nigeria's Programme**

**All eyes on a minority of LGA Chairmen standing in the way of eradication**

**"Eradication standard" LGA Chairmen demonstrate how to get the job done**

**LGA Chairmen in poor performing areas should receive close attention**

**Nigeria has struggled to deal with anti-vaccine lies**

## At a glance

between misinformation and the truth? As we describe later in this report, there has recently been a surge of anti-polio-vaccine propaganda in Nigeria, which makes this task even harder for parents.

In speaking recently to parents who had refused the polio vaccine in Nigeria, IMB sources heard mothers and fathers ask very intelligent and pointed questions that any parent would like to know the answer to.

*"I have children over five years old and they were vaccinated. Why?"*

*"What is an excess dose? How much is too much?"*

*"For other ailments I have to buy drugs. But polio vaccine is free. Why?"*

*"How can I be sure of the safety of the vaccine?"*

*"There has been no polio here for years. But it is difficult getting three meals a day. Why not address that instead?"*

*"I saw vaccinators and asked them what polio was. The answers were not clear. Who can I trust?"*

*"Why do vaccinators keep coming back again and again and again?"*

To those who work in the Polio Programme, the answers may seem obvious. But for parents, these questions are vital and the answers too often absent. This divide, where it happens, must be bridged or it will remain yet another reason why the polio virus survives to kill and maim. Parents must have access to information and the facts about polio and the polio vaccine.

Vaccinators and social mobilisers play an important role in providing this information. The former group need to receive adequate training in how to handle and respond to parents' queries on the door step. Refusal situations can be role-played during campaign preparation. Vaccinators need to be selected on the basis of their ability to communicate with parents in a professional, courteous and persuasive manner. The latter group, social mobilisers, are doing fine work in Nigeria but their numbers remain limited. They need to be supported to do the maximum outreach possible in between campaigns and their numbers need to be expanded further so that every low performing LGA is served.

Vital though their work is, vaccinators and social mobilisers are not the sole source of information for parents. Every single individual in the Programme from every single partner has a role to play in communicating the facts to the people. We urge all officials to take personal responsibility for ensuring that the information they themselves have is available also to those on the front line and in particular to parents. A river of knowledge can wash away the trepidation with which many regard the polio vaccine.

**Parents simply wish to know the truth**

**Parents are crying out for information they can trust**

**Highest quality front-line staff are needed to build parents' confidence**

**Communication: the responsibility of every single polio worker**

## At a glance

Later in this report (“Engaged Communities Eradicate Polio”), we focus specifically on the communications challenges that the Programme now faces – in all of the endemic countries, but particularly in Nigeria. If the Nigerian Programme can take these messages to heart, it can further transform its Polio Programme.

Since the IMB last met in October 2012, Nigeria has suffered a spate of attacks on its brave polio workers. These men and women died serving their country. There is only one way to honour their memory – to push on in the quest for a polio-free country. We commend the Nigeria Programme for doing exactly this.

Insecurity in Nigeria is most challenging in the North East States of Borno and Yobe. These two states currently account for 69% of wild polio cases in Nigeria (and hence at the time of our meeting in the entire continent of Africa) in 2013. Population immunity has steadily declined. In Yobe, a quarter of non-polio AFP cases in quarter four of 2012 had received zero doses of polio vaccine. In Borno, over 335,000 children (32% of the target population) were missed during the April 2013 campaign. Polio will not be eradicated in Nigeria unless these trends are reversed.

Tackling insecurity is a complex issue. Picking the correct mix of strategies will vary not just state to state but from district to district and ward to ward. The IMB is deeply conscious of the sensitivities involved and the need to allow negotiations to take place away from the full glare of publicity where necessary. We urge the leadership of the Nigerian Programme to assure itself that every possible step is being taken ensure that children are protected against the polio virus despite the on-going insecurity.

The Nigerian Programme knows better than anyone that eradication will be achieved only if the improvements seen over the last six months continue. If this occurs (with the communications and security problems in particular being more firmly gripped), then the IMB believes that Nigeria can be polio-free by the end of 2014.

**WE RECOMMEND THAT NIGERIA URGENTLY FINALISE A MORE DETAILED OPERATIONAL PLAN TO DEAL WITH THE SECURITY ISSUES THAT IT FACES, DRAWING ON THE EXPERIENCES OF AFGHANISTAN AND PAKISTAN.**

**Nigeria honours its fallen polio heroes with continued commitment**

**Insecurity in Borno and Yobe: a priority for the Programme**

**Security threat needs to be met with a more robust and detailed plan**

**If the current pace of improvement can be sustained, Nigeria will stop transmission soon**



## At a glance

### Pakistan

Pakistan transformed its Polio Eradication Programme in 2012. Its Augmented National Emergency Action Plan was strongly formulated and skillfully implemented in many parts of the country. District Commissioners led the charge, many of them developing expertise in polio eradication as they took on direct responsibility for the work in their district. The composition of vaccinator teams was improved. A mechanism was introduced to get payment direct to vaccinators, cutting out the middleman. There was a substantially heightened sense of accountability, and a tangible and energetic will to expel polio from Pakistan. As 2012 drew to a close, the impact of this work was clear to see. The country had 198 cases of polio in 2011. In 2012, this was reduced by 71% to 58.

December 18 and 19 2012 are dates that scar the history of polio eradication. In a seemingly coordinated fashion, nine vaccinators were shot and killed in multiple separate incidents in both Karachi and Khyber Pakhtunkhwa. The nation of Pakistan was aghast, as was the world. These were acts of unthinkable cruelty, directed against health workers who were doing nothing less, or more, than protecting the children of their communities against polio.

The country was not cowed, and the Polio Eradication Programme has continued. Indeed the Programme has not just continued, but has made considerable gains in the months since December. It has prioritised well, focusing more resources on the districts of highest epidemiological risk. The Programme was not able to carry out as many vaccination rounds as originally planned, but has still made very good use of the low transmission season. The deep dedication of so many – from the country's 250,000 vaccinators to the President – is to be applauded. From the federal and provincial governments, to the districts, to the Programme's partners – all have played their part. Given the circumstances in which they have operated, nothing more could have been asked of them.

We must now set the emotion aside, to look objectively at the work that remains. Because although we recognise the constraints under which the Programme must now operate, the polio virus does not. Eradicating polio from Pakistan was already difficult, and has now become more so.

Karachi is of great concern. UC-4 Gadap, from which polio has previously been exported both nationally and internationally, remains particularly important. Security is a great challenge here, which the Programme has dealt with well so far. But it still has a considerable way to go. In the most recent campaign for which data are available (phase two of the March SIAD), 23% of children in the highest priority areas of Karachi could not be reached. All who work to rid Karachi of polio deserve great praise, but their work is far from complete. The remaining access issues need urgent resolution.

**2012: a year of transformation for the Pakistan Programme**

**Unthinkable acts of violence threatened to undermine improvements**

**But the Programme marched on: priorities were set and dedication was unflinching**

**Eradicating polio from Pakistan was never going to be easy, and is now harder than ever**

**Ever-present concern for Karachi**

## At a glance

Over the last six months, circulation of the polio virus in Pakistan has been reduced to a small number of areas – in Karachi, Quetta, Faisalabad, Hyderabad, and Peshawar. This is not to say that it cannot spread again. In each of these areas, the Programme's leaders need to be determined to avoid this possibility. This means resolving access problems and continuing to ensure the highest possible level of vaccinator performance. Particularly if some children remain inaccessible in their own homes, the IMB believes that there would be merit in a more ambitious transit vaccination strategy – to vaccinate children at times when they can be reached, and when they might be unknowingly carrying virus around the country.

The most concerned parents in Pakistan should be those in the northwest – in Khyber Pakhtunkhwa and in FATA – particularly in Peshawar and Waziristan.

Peshawar is a transport hub, through which people and therefore the virus pass on their way to and from Afghanistan, to and from FATA, and to and from Karachi. This high level of population movement is a gift to the polio virus, so there needs to be a very strong programme here in response. But in Peshawar the Programme is at a level of dysfunction that is now seen nowhere else in the country. It is not operating anywhere near the level required to stop transmission.

In Waziristan, tens of thousands of children sit vulnerable to polio, because they have been denied vaccination for many months now. As the IMB convened its meeting in early May, we heard emerging news of polio cases here. If vaccination does not restart soon, there is sadly the potential for a sizeable outbreak here and for many children to be paralysed or killed as a result.

Since the IMB's meeting, Pakistan has elected a new government. It comes into power at a crucial time for polio eradication. It must be clear that a very difficult task lies ahead. Success is very far from assured. If the remaining issues that we have described can be solved, stopping polio transmission in Pakistan will not take long. But those issues are very difficult to solve, and the more time that passes before they are solved, the more the virus will spread and so the longer it will take.

Key to success will be the absolute and total engagement of district leaders, and a refusal to settle for the levels of access that the Programme is currently achieving. The previous government hands a strong Programme onto the next but, because of events in December 2012 and since, not one that can yet stop polio for good. Those coming into power would do well to retain the organisational structure that has proved so successful. The next six months are absolutely vital. No time can be lost in re-establishing momentum after the electoral period.

**WE RECOMMEND THAT THE INCOMING PAKISTAN GOVERNMENT SEEK TO RETAIN THE PRIME MINISTER'S MONITORING CELL AND OTHER STRUCTURES THAT HAVE LED POLIO ERADICATION EFFORTS SO SUCCESSFULLY DURING THE PREVIOUS GOVERNMENT'S TERM**

**A real fear of polio spreading from the remaining endemic areas: transit vaccination strategy vital**

**Peshawar the low point of programme performance**

**Waziristan: polio outbreak flashpoint**

**New Government must rapidly and firmly grasp the Polio Programme**



**ENGAGED COMMUNITIES  
ERADICATE POLIO**



## At a glance

### Engaged Communities Eradicate Polio

How do parents in the endemic areas view the polio vaccine? Do they see it as cherished protection; as a scientific miracle that shields their children from a life-destroying disease? Or a ruse, a sinister threat, a disguised chemical that harms the very children it claims to protect? Or do they simply see it as a political pawn, a bargaining chip for the disenfranchised, having realised that the vaccine seems important to those in power?

For too many parents, the vaccine is more seen as a threat or a pawn than as cherished protection. The Programme could never hope to charge for this life-protecting substance – in too many places, it is a struggle to give it away for free.

How do parents see the Polio Programme, its million vaccinators passing through their streets, marking houses with chalk and taking detailed notes? Do they see it as we do – a uniquely impressive global endeavour, reaching into areas where few other services do? Or do they see an unwelcome intrusion, a poorly justified presence, a cover for prying eyes where such eyes are not welcome?

For too many people, the offer of polio vaccine to their children is unwelcome. They regard it as being imposed from the outside and do not understand the benefit it is bringing. They may not be able to get answers to basic questions such as “why so many doses?” They may fear it will harm their child or influence them in a malign way. Their view of the polio vaccine often contrasts unfavourably with how they see the benefits that other health measures (e.g. deworming tablets) or other vaccines (e.g. measles) will bring. A winter of repeated vaccination rounds can leave even the least suspicious parents with serious doubts about the Programme’s aims and purpose.

The Polio Programme and its vaccine are subjects seen with increasing negativity.

The IMB is deeply concerned by the Programme’s weak grip on the communications and social mobilization that could not just neutralise this negativity, but generate more genuine demand. We have warned for some time that this is the Programme’s least steady ground (see ‘Warnings not heeded’ overleaf). With insufficient action having been taken, deep cracks are now starting to show. The negativity with which both the vaccine and the Programme are viewed in key endemic areas now poses a real and present danger to eradication.

**Polio vaccine through the eyes of parents: too often more grievance than gift**

**Polio Programme through the eyes of parents: welcome protector or unwelcome intruder?**

**“Why so many doses?” – repeated campaigns build suspicion**

**Both Programme and vaccine are seen with increasing negativity**

**Communications and social mobilisation are the Programme’s least steady ground**

**Severe lack of grip is allowing deep cracks to grow**

**Warnings not heeded:  
The IMB has repeatedly highlighted  
a major imbalance in the programme,  
which has now reached crisis point**



### **April 2011 IMB Report**

**We urge greater focus on demand**

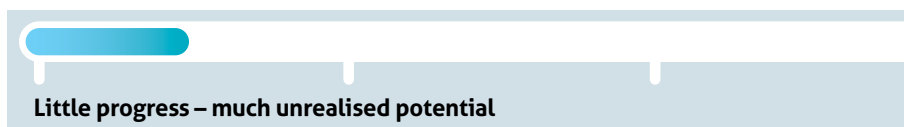
The GPEI's focus on the supply of vaccines remains greater than the focus on demand from parents ... The most memorable setbacks have arisen from demand-side, not supply-side, problems."

### **June 2011 IMB Report**

**The GPEI is based on 'push' with very little 'pull'; where is the mobilization of demand from parents?**

### **July 2012 IMB Report**

**Required transformation: Parents' pull for vaccine dominates over 'push'**



Recent events in Nigeria are an example. Academics – known to harbour views against the polio vaccine but not previously engaged by the Programme – set about spreading messages of the harm that the vaccine can do. They described it as a deliberate plot to control the population, as a cause of AIDS, of cancer, and of polio. They produced a series of CDs, which circulated widely. They took to the airwaves to expand on their message. The Programme seemed caught unawares by this. After some weeks, it produced a CD of its own, though with more limited circulation. The anti-vaccine campaigners remained a step ahead – they produced a counter-attack almost before the Programme's CD was released. The Programme now believes that it has brought this under control, but damage has been done, seeds of doubt sown deeper amongst the population. How did this happen? Why did the population so readily embrace the lies? Why did it take many weeks to turn the situation around?

**Anti-vaccine messages in Nigeria:  
more prominent than the  
Programme, more popular than  
the Programme**

## At a glance

In short, why were those who sought to damage the Programme more effective communicators and social mobilisers than the Programme itself?

At the time of these events, the UNICEF team in Nigeria had no Chief of Vaccination and no Chief of Health. When the Expert Review Committee (ERC) met in March 2013 to advise the country's Programme, not one of its members had any communications expertise. The Programme has major communications challenges in Nigeria and elsewhere, and it seemingly lacks the capacity to mount a full response.

How extensive, and how deeply ingrained, are anti-Programme sentiments in northern Nigeria? The Programme does not appear to know; it is flying blind. Perhaps there is just low-level resistance to the idea of polio vaccination. But perhaps there is much more serious anti-Programme sentiment bubbling away under the surface, ready to explode. Several well-informed IMB sources fear the latter to be closer to the truth, but there are few data available to really tell us. The Programme needs to know which of these situations it is in.

UNICEF is the agency charged with leading the Programme's communications and social mobilization work. At the IMB's meeting, external observers described UNICEF's polio teams in the endemic countries – but its headquarters team in particular – as “decimated”. We heard of several instances in which one person is trying to do the job of two or three; of organograms that currently resemble Swiss cheese – full of holes.

The blame does not lie solely with UNICEF. To view communications as the responsibility of a single agency is unsophisticated and bureaucratic. If communities are refusing vaccine, if parents are not demanding it to protect their children, and if vaccinators cannot satisfactorily address a mother or father's questions about the vaccine, then these are not problems for one agency to solve, but fundamental barriers to eradication that must be addressed by the Programme (countries and their partners) corporately. Communication is everybody's business.

On an area as important as communications, the Programme cannot afford to put all of its eggs in one basket. There needs to be a level of redundancy built into the system, so that if one part starts to weaken the system as a whole can still stand. This is another reason why seeing communications as the responsibility of one agency alone is a shortsighted one.

The Programme accepts that recent months have not been its happiest in communications terms. As it rebuilds its position, the Programme needs not just to regain the lost ground. It needs to raise its ambitions; to correct once and for all the under-emphasis that communication and social mobilization has received for many years.

**As major challenges arise, key posts sit empty**

**Establishing the true extent of anti-vaccine sentiment must be a priority**

**UNICEF's polio team described as “decimated”**

**Communications must be a priority for all partners**

**The whole GPEI must work together to rebuild and enhance its communication efforts**

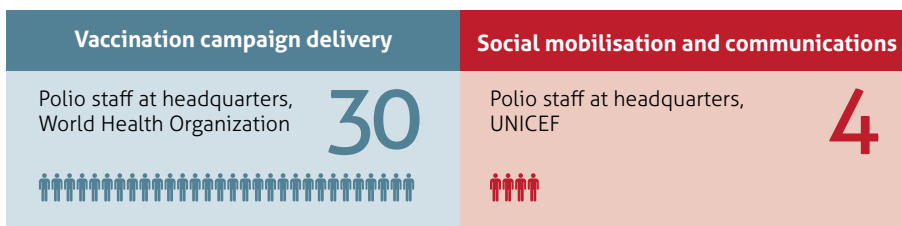
**Aspirations must be raised: strong communications can provide a major boost**

## At a glance

### Communications input to the Programme is threadbare

Almost universally, when any part of the Global Programme holds a meeting of any size, those whose mind focuses on supply of the vaccine far outnumber those who focus on demand. There is poignant symmetry in this: missing communicators and social mobilisers means missed children. This is true in the Technical Advisory Group meetings; in the headquarters meetings; and in the Emergency Operations Centers. It is this that allows the under-emphasis on demand to continue. It is clearly not just up to UNICEF to fix this.

#### BALANCED STRATEGIC FOCUS? STAFFING OF HEADQUARTERS



#### BALANCED ADVICE? TAGs\* IN THE ENDEMIC COUNTRIES



\*Technical Advisory Groups; known as Expert Review Committee (ERC) in Nigeria

#### SHIFTING THE NEEDLE: REACTIVE TO PROACTIVE

- React to refusals VS Proactively generate demand
- Offer 'polio-plus' when refusals become intractable VS Offer 'polio-plus' commonly
- When refusals arise, study the reasons why VS Pick up population sentiment early; prevent doubts becoming refusals
- React to prominent programme opponents VS Engage potential programme opponents as they begin to emerge



## At a glance

Some may read these comments and think them harsh. We would refer them to two prominent chapters of the polio history book. First, recall the resurgence of polio in Nigeria and its neighbours a decade ago, when widespread rumours forced vaccination to stop. Second, talk to anybody who saw India's victory against polio close up – they describe the success being underpinned by immensely strong social mobilisation.

In its social mobilisation, the Programme is operating far below excellence. In too many ways, its approach to communications is reactive where it should be proactive. It is struggling to break through deep-seated problems, and falls far short of harnessing parents as a true asset in support of the Programme's goal. Crucially, it has failed to turn around the negative reputation of the polio vaccine in communities where it is regarded as a threat rather than as life-saving.

The major change over the last year has been a personnel surge, establishing large social mobilisation networks in each of the endemic countries. This is welcome, and will play an important role. But the structure of these networks is currently very bottom-heavy. There is neither the strategic capacity within UNICEF, nor the passion within the wider Programme, to best direct their efforts as they engage parents in support of polio eradication. There is not the human resource or the focus to make best use of the deep and granular insights that these networks – as people enmeshed in local communities – can provide about the needs and beliefs of parents. Achieving these aims requires significant and skilled oversight, and an understanding across the Programme that this work is vitally important.

The Programme has too much of a 'one-way' attitude to communications, wanting to bring people round to its view rather than concentrate on listening and on dialogue. True dialogue exists in pockets, and is very effective – but it is not systematised. In many places, there is clearly a disconnect between the services that people really want (such as measles vaccination, maternal and child healthcare, and basic primary healthcare) and what the Programme is offering them. This is a complex issue, which the Programme cannot address alone. But the issue demands that the Programme be sophisticated in response, and that more emphasis be placed on listening. It demands nimble and sophisticated work, in which local communications teams are able to amend their approach in response to their particular community. It demands that the partners look more deeply within their own agencies, to strengthen the links between the Polio Programme and their many other endeavours, a number of which are far higher on parents' wish lists. It also demands that the Polio Programme reach out as widely as possible, to work through community groups that enjoy a level of trust not afforded to the Programme.

**History shows the pivotal importance of communications**

**The Programme's communications must get on the front foot – from reactive to proactive**

**Many social mobilisers now in place – but how well are they being directed?**

**Building community trust involves dialogue, not diktat; trust, not persuasion; links, not isolation**

## At a glance

Although more communications expertise is required within the Programme, there is also a need to seek out the expertise that already lies within communities. If the Programme's experts can subjugate their own expertise to that of the community, this is a powerful route to building trust. It is communities themselves who understand best what they want, what they need and what they think. We are surprised not to hear the voice of the child more prominently within the Programme. It is difficult to imagine a more powerful unifier than communities hearing children ask "Who will protect me against polio?"

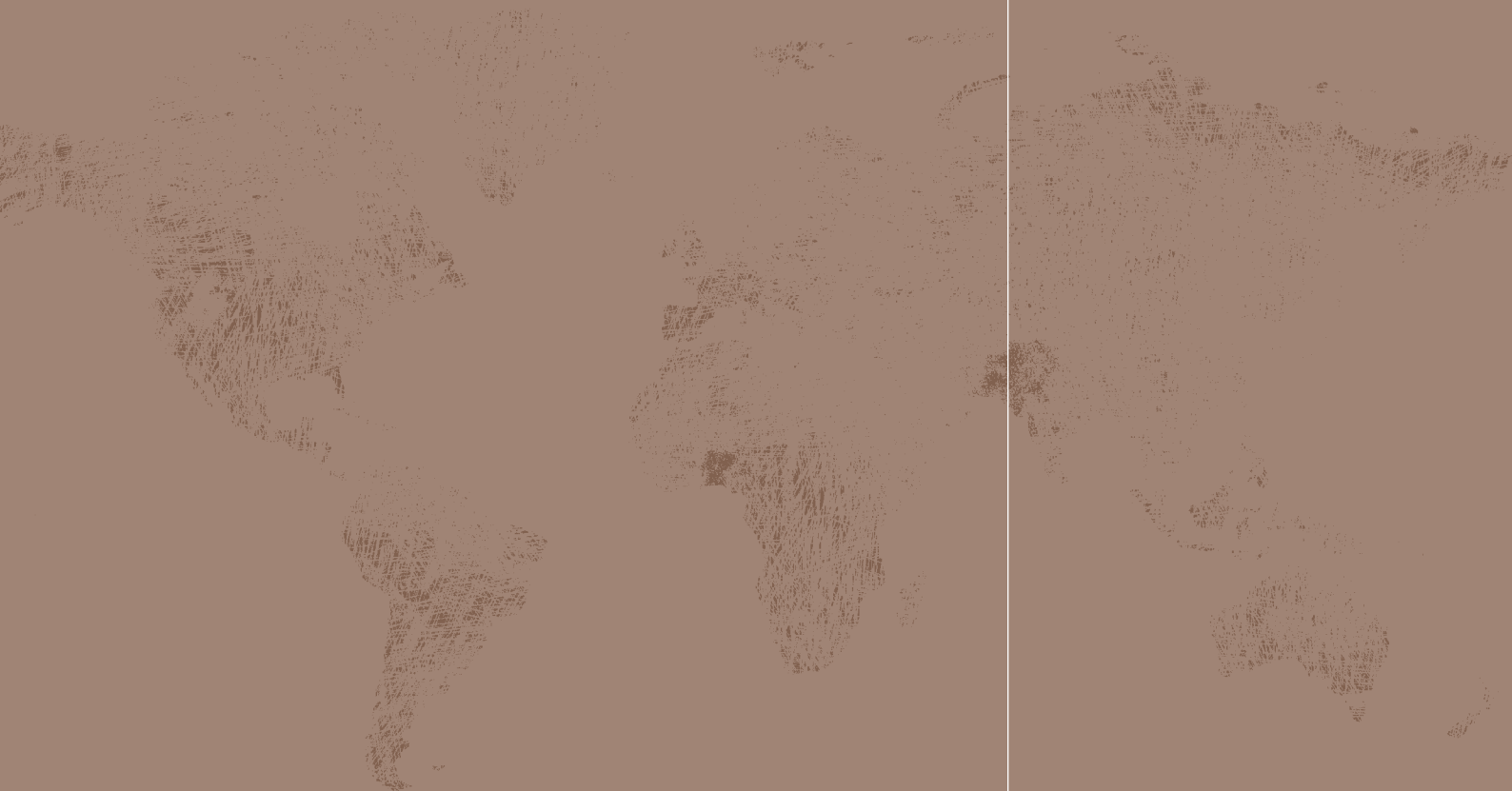
The GPEI's own strategic plan articulates that "experience throughout the GPEI has shown that poliovirus circulation stands little chance of surviving in fully mobilized communities, even in the most difficult contexts". The IMB could not have put it better. The leaders of the Programme need to make the rhetoric a reality. When parents are engaged, this overcomes not just refusals, but children missed for every reason. Even access to insecure areas becomes far easier if the population is calling out for the vaccine. If it is not dealt with, the current communications shortfall is a deep threat to the Programme. But if it is gripped, and managed with ambition, there is transformative potential here.

WE RECOMMEND THAT THE PROGRAMME URGENTLY CONSTRUCT AND IMPLEMENT A PLAN TO CORRECT ITS CRIPPLING UNDER-EMPHASIS ON SOCIAL MOBILIZATION AND COMMUNICATIONS. THIS SHOULD ADDRESS THE NEED TO REHABILITATE THE REPUTATION OF THE VACCINE IN PLACES WHERE IT HAS FALLEN INTO DISREPUTE; TO ELEVATE THE SOCIAL MOBILIZATION NETWORKS TO EXCELLENT PERFORMANCE; AND TO BRING SUBSTANTIALLY MORE COMMUNICATIONS EXPERTISE TO THE TABLE IN THE PROGRAMME'S KEY STRATEGIC FORUMS, INCLUDING PARTNERSHIP HEADQUARTERS AND TAGs/ERCs.

**Communities are experts in themselves**

**Rhetoric says "communications is key" but reality says "our focus is elsewhere"**

**RESPONSIVE AND COORDINATED  
GLOBAL MANAGEMENT**





## Responsive and Coordinated Global Management

If a billion-dollar-a-year multi-partner emergency global health programme were established from scratch today, its management structure would look nothing like that of the Global Polio Eradication Initiative.

The Programme's structure is characterised by a plethora of committees and working groups. Coordination mechanisms are cumbersome; decision-making processes are unclear. Strategic questions too easily get lost. No one entity has the power to hold the entire system to account for delivery.

Some IMB sources would like to see a complete overhaul of the Programme's global management structures, to create, perhaps, a single central Secretariat that can drive issues forward. There is a strong argument for this. However, the IMB believes that the value of making such a major change at this late stage is a matter of judgement for the Polio Oversight Board itself.

At the very least, the Programme needs to recognise the challenges inherent in its structure, and determinedly find ways to mitigate them. It is important to be specific about what is wrong with the current situation, and therefore what needs to change. We have two particular concerns:

### 1. Complex coordination and suboptimal support mechanisms impede decision-making, particularly on controversial issues

The Programme has achieved much. But on some key strategic issues, progress has been made at snail's pace. Almost two years ago, the IMB's July 2011 report said:

**SELECTIVE USE OF COMBINED IPV/OPV IS BEING TALKED ABOUT;  
WHY NOT TAKE A SERIOUS LOOK AT IT?**

*"Proponents highlight the particular value of this idea in areas where access to children is severely limited by conflict... Others are opposed to the idea, believing that it adds unnecessary complexity and cost, and could be dangerous. This question is floating in the ether rather than being grasped."*

July 2011 IMB Report

Throughout 2012, we heard on-going grumbles about this issue and vague indications that a trial was intended. Views were polarized. Finally, at our May 2013 meeting, we were informed that a trial will take place in Pakistan later this year. In short, we have seen two years of circular discussion before the obvious next step was taken.

**GPEI management structure:  
cumbersome and convoluted**

**Some would like to see a central  
secretariat, to pick up the pace  
of improvement**

**If changing the structure is felt  
too disruptive, the downsides  
of the current structure must be  
better mitigated**

## At a glance

Similarly, in mid-2011 we were aware of discussions between partners about data sharing. To us, this seemed essential. How can a partnership hope to operate without its core data being available to all? Yet despite on-going discussions, data continued to be poorly shared between the partners. Every time the partnership needed to prepare its quarterly status report for the IMB, a member of CDC staff would have to get on a plane, to fly from Atlanta to Geneva simply to access data that are absolutely core to the Programme. One observer described this as “incredible but true”.

Two years later, there is finally tangible progress. A data-sharing agreement has been signed. A shared data platform will – we are now told – be up and running by July.

With both of these issues – IPV and data sharing – the discussion has been characterised by disagreement within the partnership. Innovative ideas will often create disagreement, and so for disagreement to create paralysis is a dangerous state of affairs. A programme that cannot deal with disagreement is a programme that stagnates in the status quo. Something needs to change in the way the Programme operates, so that no key issue is allowed to fester for month after month.

## **2. The global-level partners are not optimally providing the endemic countries with the support that they need**

The global headquarters of the partner agencies are not always focused on the daily need to ensure they are connected with the issues of most importance in the endemic countries. It is as if the partners are focusing too much attention inwards on one another, rather than outwards to the countries. Are they really asking the countries, with one voice, “What do you need from us? How can we best support what you are doing?” How can they work with the countries to focus even more locally, to ensure bottom-up planning that reflects the problems in the locations that are still under-performing?

A key role for headquarters should be to catalyse the spread of best practice from one place to another. The Programme’s speed in doing so leaves much to be desired. Does everybody in the Nigerian Programme understand the comprehensive approach to insecurity that has been taken in Afghanistan, from which they can learn? No. The partners at headquarters level should ask themselves why this is the case, and what they can do to quickly and effectively overcome this.

We continue to see too many examples of unfilled posts in endemic countries. When we ask, we are told that recruitment is on-going; that the posts are difficult to fill. Even worse, we are told that “the IMB should keep away from operational matters”. But sometimes operational matters are global impediments to eradication and need to be highlighted. This is a crucial issue. Is it reaching the top? Does the Polio Oversight Board monitor a list of unfilled positions? Is there not more that headquarters could do to get the much-needed people into the field?

**Snail-like progress in decision-making on IPV and data sharing highlight the inadequacies of the GPEI’s global management structure**

**Global headquarters failing to focus on country support**

**Headquarters slow to spread best practice**

**Unfilled posts in endemic countries: a barrier to eradication that must be lifted**

### Overcoming the issues

The Programme's 2013-18 Eradication and Endgame Strategic Plan is complex. It requires the Programme to do five things at once: to stop polio transmission; to improve routine immunisation systems; to introduce IPV into 140 countries; to coordinate global containment; and to plan its legacy. It is right to have a single plan with all of these aims, but the Programme needs to very carefully manage the risk of losing focus on the most difficult objective of all – stopping polio transmission. This makes it yet more crucial to address the two key issues that we have described.

The IMB recognises that these issues are not straightforward, and that there is no straightforward solution. We also recognise that thought has already been given to these issues, but see a real need for more. Middle management in any organisational structure is a good place to understand concerns that are not always visible to top leadership. IMB sources at this level speak of their unease with the current situation.

#### VOICES FROM THE PROGRAMME'S MIDDLE MANAGEMENT

- *"My day is taken up attending multiple cross-agency working group meetings, often with the same people"*
- *"Who do I go to for immediate direction and support on this issue? Why is it so difficult to understand who is in charge of this particular issue?"*
- *"What real value is global headquarters adding to the front-line?"*
- *"If this is a global emergency, why does it take so long to get decisions made?"*

At the heart of the matter is a yearning for short decision chains, for clarity in who leads on what, for rapid action in response to urgent challenges, for each and every group to add real value, and for a greater feeling of "one team".

The role of the Polio Oversight Board is crucial in resolving the issues described here, which go to the heart of inter-agency working. The members of the Polio Oversight Board are providing strong leadership, but this leadership is not as visible as it might be within the Programme as a whole. It would be powerful if the Board could find ways to more openly demonstrate its high level of engagement and leadership. It has an important role to play in setting the tone for a more collaborative, action-orientated, outward-looking partnership.

We do not recommend a full governance review, which could too easily take on a life of its own. But we do make three recommendations to help address these issues:

**Complexity of the new Strategic Plan risks worsening these issues**

**Middle management concerns must be heard**

**Polio Oversight Board has a vital leadership role to play**

WE RECOMMEND THAT THE POLIO OVERSIGHT BOARD STUDY CAREFULLY THE IMB'S ANALYSIS OF THE CURRENT MANAGEMENT ISSUES OF THE PROGRAMME AND DECIDE ON A WAY FORWARD, BEARING IN MIND THE NEED TO MAINTAIN CURRENT PRIORITIES. TO INFORM THE BOARD'S DISCUSSION, WE RECOMMEND THAT THE PARTNERS' HEADQUARTERS CONSIDER THESE TWO QUESTIONS, THROUGH A SHORT SERIES OF FOCUSED MEETINGS:

- HOW CAN WE WORK TOGETHER IN A MORE ORDERED AND EFFICIENT WAY, ENABLING ACTION TO PROCEED AT THE SPEED REQUIRED IN A PROGRAMMATIC EMERGENCY?
- HOW CAN WE BE MORE SHARPLY FOCUSED ON WHAT THE POLIO-ENDEMIC COUNTRIES NEED FROM US AS A GROUP, AND HOW CAN WE BETTER COORDINATE EFFORTS TO PROVIDE THIS, INCLUDING ON CONTROVERSIAL ISSUES?

WE RECOMMEND THAT THE POLIO OVERSIGHT BOARD HEAR CANDID VIEWS DIRECTLY FROM IN-COUNTRY REPRESENTATIVES OF BOTH GOVERNMENT AND PARTNER AGENCIES, ABOUT WHAT THEY NEED FROM THE PARTNERS AT HEADQUARTERS LEVEL.

WE RECOMMEND THAT THE POLIO OVERSIGHT BOARD ESTABLISH A MECHANISM TO MORE FREQUENTLY MONITOR KEY MANAGEMENT INFORMATION, INCLUDING DETAILS OF ANY UNFILLED POST AND ITS RECRUITMENT PROCESS, AND THAT IT PUBLISH RECORDS OF ITS MEETINGS.

**BREAKING THE POLICY DEADLOCK:  
IPV IN ENDEMIC COUNTRIES**



## At a glance

### Breaking the Policy Deadlock: IPV in Endemic Countries

The idea of stopping polio transmission by using IPV in addition to OPV has been discussed for many years now. Vaccine is the Programme's main technical tool. Previous vaccine alterations have transformed progress – most recently, the introduction of a bivalent oral vaccine (bOPV) in India played a critical role in the country's subsequent success.

The Programme's endgame plan requires IPV to be introduced to 140 countries' immunisation systems (these countries currently rely on oral vaccine). Amongst these 140 countries are Afghanistan, Pakistan and Nigeria – the countries of central importance to polio eradication. The plan is for all 140 countries to make this switch in 2015 - a highly ambitious aim.

All being well, the endemic countries will have stopped polio transmission before this time. The primary aim of introducing IPV is to mitigate the risk of vaccine-derived type 2 virus outbreaks when tOPV is withdrawn from use, as the Endgame Plan requires. But in the endemic countries, IPV could have an additional major benefit. In the event that an endemic country has not interrupted wild virus transmission by the time of its introduction, IPV could well help them to do so.

This begs the question: given that IPV will need to be introduced within the next few years, and that doing so could help stop virus transmission, why should the three endemic countries not introduce IPV now?

This is a very attractive idea indeed, although the issue is not straightforward.

Some argue that introducing IPV would have little effect in the remaining endemic areas. The introduction of IPV would best happen within the existing national vaccination system, not in parallel to it. The delivery of IPV therefore requires a functioning immunisation system, and such systems tend to be weak in these places. Some also argue that introducing IPV would dilute countries' focus on OPV campaigns.

However, both of these arguments are diminished by the Programme's existing plans to support the strengthening of immunisation systems and to particularly concentrate this support on the endemic areas.

It is not clear how the population would react to IPV. This is important. Some fear that its introduction would lead to greater refusal of OPV, as people question the effectiveness of OPV and ask why it is still needed. Some believe that IPV would have to be introduced across a whole country or not at all, because confining it to particular areas would create an enormous communications challenge. Others counter that the challenge is not so great – that surely people can be helped to understand that IPV is most needed in areas where polio is still actively circulating?

**New vaccines have transformed the Programme**

**IPV to be introduced in 140 countries in 2015**

**Could endemic countries benefit from earlier IPV introduction?**

**Many in favour but many against: the argument must be settled once and for all**

## At a glance

Some argue that IPV would require vaccinators to be retrained en masse. Using IPV in house-to-house campaigns is indeed an option, but it need not be the approach. The plan is to introduce IPV into existing immunisation systems that are already using injectable vaccines; IPV proponents simply ask: in the endemic countries, why not do this sooner rather than later?

Some are really very positive about the value of IPV. In the remaining endemic countries, injectable medication is often valued far more highly than oral preparations. The population may welcome an injectable vaccine, leading to higher levels of coverage.

There is absolutely no way to untangle these questions through discussion alone. Who can really know, in the abstract, whether the advantages outweigh the disadvantages? The Programme has fallen into the trap of discussing the issue for far too long now, without having enough information to ever reach a conclusion. Clearly, therefore, the next step must be to gather that information.

It is deeply dismayed that the Programme has now been discussing this round in circles for two years now. Finally though, there is now a trial of IPV use planned in Pakistan later this year. It is absolutely crucial that this trial provide all of the information required to make the key decisions – should the endemic countries introduce IPV as soon as possible, or should they wait until 2015? If they introduce it soon, should they do so nationally or should they focus on the areas with on-going transmission? How is it best explained to the population?

This requires well-designed multi-faceted trials, examining not just the immunological questions, but the important operational and communications aspects. The Programme cannot afford to end the year concluding that “more research is needed”. If it does, the uncertainty will persist until 2015 and a potential opportunity will have been missed. The Programme must learn the lessons of bOPV. This idea was debated for many years before being actually put into practice. When it was put into practice, it catalysed progress.

In IPV, the endemic countries may (or may not) have a transformative tool sitting right under their noses. For the Programme to not properly and quickly investigate this possibility would be regrettable since it might turn out that lives were lost needlessly. There are questions to be answered – and they must be answered quickly.

**WE RECOMMEND THAT, THROUGH THE NECESSARY TRIALS, THE PROGRAMME SHOULD BY THE END OF 2013 BE ABLE TO CONCLUSIVELY ANSWER THE QUESTIONS: “SHOULD THE ENDEMIC COUNTRIES INTRODUCE IPV AS SOON AS POSSIBLE, OR SHOULD THEY WAIT UNTIL 2015? IF THEY INTRODUCE IT NOW, SHOULD THEY DO SO NATIONALLY OR SHOULD THEY FOCUS ON THE AREAS WITH ON-GOING TRANSMISSION? HOW IS IT BEST EXPLAINED TO THE POPULATION?”**

**Circular discussions have prevented progress**

**Technical, operational, and communications aspects must be understood**

**No time for further prevarication: upcoming IPV trial in Pakistan must answer all the questions**





## Ten Transformations

Looking back over the IMB's previous six reports is a revealing exercise.

It is pleasing to see how far the Programme has come in the last two and a half years and the responsive manner in which some of the IMB's recommendations have been embraced.

But perhaps even more striking are the vast majority of past IMB observations that still remain highly relevant today.

To provide a snapshot:

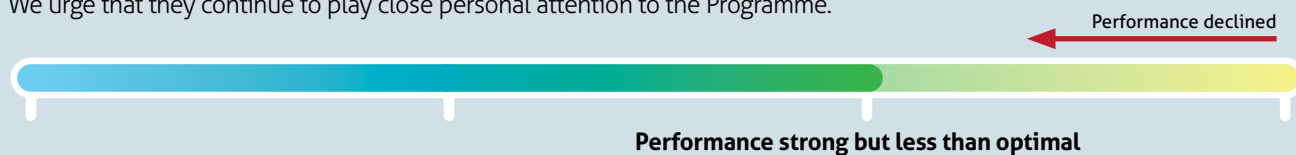
- In our April 2011 report, the IMB noted that "efficiencies can be gained and demand generated through optimising synergies with the delivery of other basic services to the same population groups". Although such "pairing" of services has occurred sporadically throughout the Programme since, such efforts are far from uniform or widespread.
- In July 2011, the IMB observed that "there are clear synergies between the goals of GAVI and the goal of the GPEI". Over the last few months, the GPEI and GAVI have finally embarked on a close working relationship, but this relationship will need to be actively nurtured over the coming months and years if it is to realise its full potential.
- And in October 2011, the IMB reflected that "there is no shortage of high-level advocacy and commitment. The challenge is in aligning the actions of state and local leaders with this.....traditional leaders need to be involved". Commitment from local leaders is still lacking in many of the remaining polio affected districts.

The IMB's previous reports still hold important messages for today's Programme. Each new report does not supersede previous publications – rather it is an addition to our growing compendium of observations and advice.

In our fifth report (June 2012) we examined the Programme's progress in the light of all previous recommendations and set out "ten transformations" that the GPEI needed to achieve if eradication was to be realised. On the next two pages we examine to what extent these transformations have taken place and in doing so reveal where further attention is required.

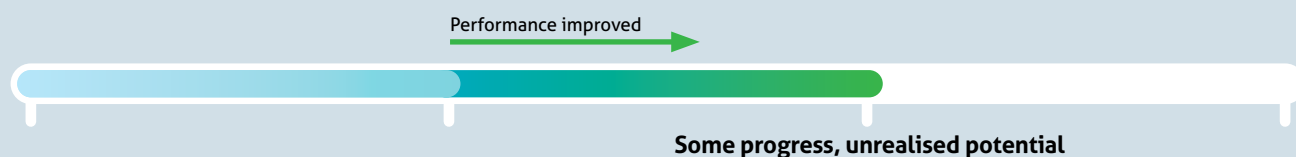
### Transformation One: Senior leaders give the Programme true operational priority

Participation in the Polio Oversight Board is on occasion delegated to deputies. Within the UN agencies there is still weak collaboration between polio and other teams. Vital staff positions are often left unfilled for long periods of time. The IMB was greatly impressed by the attendance of all three Heads of State at the UN General Assembly polio event. We urge that they continue to play close personal attention to the Programme.



### Transformation Two: Close collaboration and coordination amongst partners

Collaboration amongst core partners has improved although there remains work to be done if all partners are to feel their voice is heard. The involvement of GAVI in the partnership bodes well but does not negate the need to work directly with other immunisation partners. In country, polio control rooms and emergency operations centres are having a positive effect. We urge the engagement and involvement of the widest possible range of partners, including religious and traditional leaders.



### Transformation Three: Staff all well-managed and accountable

With 504 graduates, the WHO-led management training programme has been one of the success stories of the last twelve months. Across the endemic countries there is much evidence of local leaders holding their teams to account for performance. But, in each country, a small but significant number of local leaders pay little personal attention to the success of the Programme. State and national leaders must continue to press this minority to improve else the country will suffer.



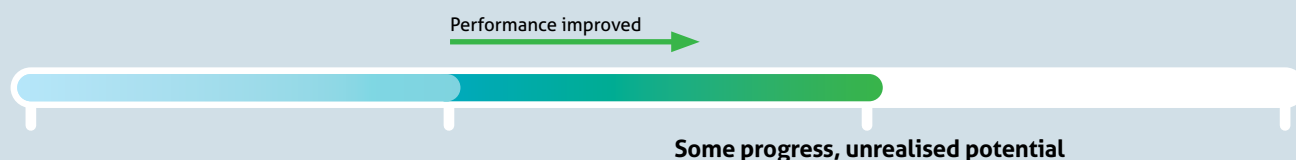
### Transformation Four: Sufficient technical support in-country

The surge of partners' technical assistance to the endemic countries has been impressive. WHO alone has 3220 surge staff. UNICEF has scaled up its social mobilisation presence in high risk areas at impressive speed from a very low base. However, in Nigeria and Afghanistan over a quarter of high risk areas do not have this essential support. Most worrying though are the major gaps in national level Programme posts, especially UNICEF, which will continue to have a negative effect on the coordination of scarce resources.



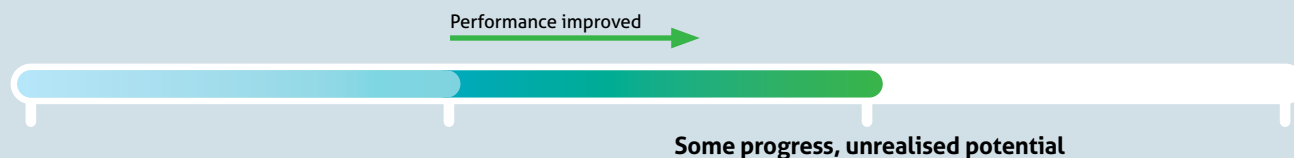
### Transformation Five: Front-line vaccinators well trained and motivated

Vaccinators' salaries have increased in all three endemic countries. Direct payments to bank accounts have improved the timeliness with which funds are received. Public praise of "polio heroes" is more apparent. However, the IMB continues to hear reports of unmotivated vaccinators, unable to answer basic questions from parents. Continued efforts are needed to ensure vaccinators feel safe in areas of insecurity and conflict.



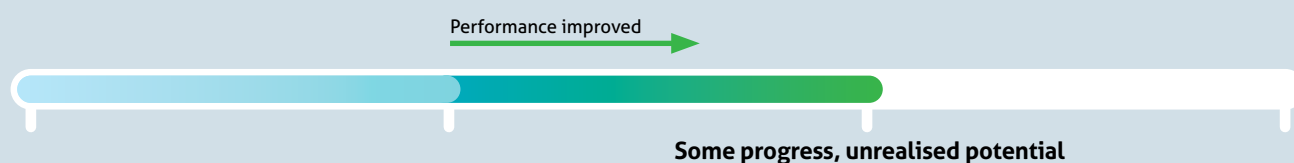
### Transformation Six: Insight-rich actionable data used throughout the Programme

District-level “dashboards” are informing decisions on campaign preparation quality. However, communications data still remains largely separate from the regular epidemiological updates. Awareness as to the unique mix of views in different communities is far from complete. The much-heralded standard global data platform “POLIS” will be more an archive of historical data than a tool for hastening eradication if it is not launched soon.



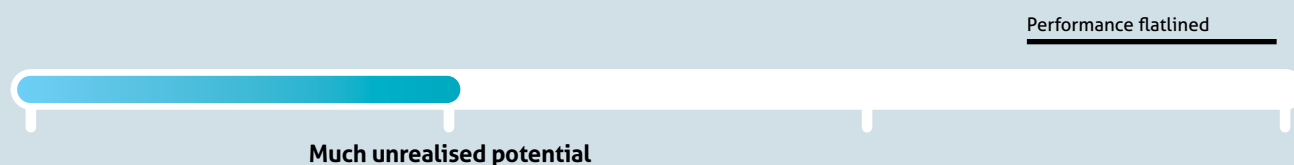
### Transformation Seven: Highly engaged global movement in support of polio eradication

The Vaccine Summit in Abu Dhabi was a great success. The impressive engagement with Islamic Leaders, energetically facilitated by the WHO Regional Director for the Eastern Mediterranean Region is to be applauded. There remains a feeling however, that this global movement has still not reached a tipping point. Its visibility amongst the global public still lags far behind other global health initiatives such as AIDS or malaria.



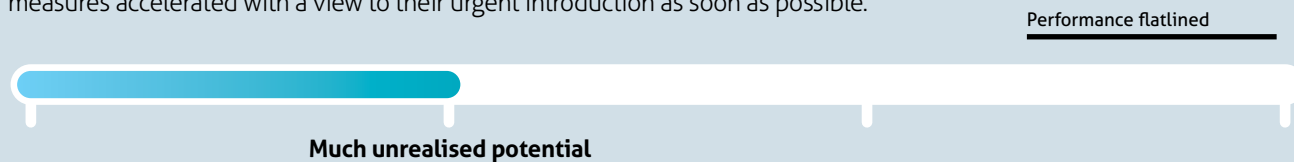
### Transformation Eight: Thriving culture of innovation

Innovation is far from thriving. The speed with which innovative approaches are assessed and rolled out on a wide scale is slow. Permanent Polio Teams are still referred to as an “innovation” in Afghanistan when they should be established best practice. Only now is a time-line for their potential introduction in Nigeria being drawn up. Approaches such as expanded age groups take an age to be considered, their application delayed by the stifling GPEI bureaucracy. GIS technology has shown its worth but is too often used as a fig leaf for shortcomings on other potential innovations.



### Transformation Nine: Systemic problems tackled through development and application of best practice solutions

Each endemic country still has different strengths that the others could learn from, and the mechanisms for achieving this are suboptimal. The GPEI has developed a framework for operating in insecure areas that includes a selection of “extraordinary contingency measures” should transmission continue beyond 2014. The IMB will like to see work on these measures accelerated with a view to their urgent introduction as soon as possible.



### Transformation Ten: Parents’ pull for vaccine dominates over programme’s push

Very disappointing. Acceptance rather than demand is the Programme’s limited ambition – an ambition it is failing to fulfil. Vast numbers of parents fail to understand the need for multiple doses and struggle to get answers to basic questions. A few good examples of pairing polio drops with other services can be found but their presence is the exception not the norm.



## CONCLUSIONS AND RECOMMENDATIONS



## Conclusions and Recommendations

All of those who work towards polio eradication should be proud of what they have achieved over the last two years. The prospects of interrupting polio transmission globally have been transformed by their work. Their determination to improve the Programme in so many different ways has been deeply impressive.

But as this report makes clear, the virus is unforgiving and so much more work is needed. The polio eradication system is complex, and only as strong as its weakest point. We have paid particular attention to the major points of weakness within the system as it stands, which must now be addressed. Our critique should not cause people to lose heart, but to recognize the need to continue the trajectory of programmatic improvement that has been achieved over the last two years.

If this is done, and full funding secured, the IMB judges that polio transmission can be interrupted globally by the end of 2014.

As detailed in the body of the report, we make eight recommendations:

1. We recommend that the Programme urgently construct and implement a plan to correct its crippling under-emphasis on social mobilization and communications. This should address the need to rehabilitate the reputation of the vaccine in places where it has fallen into disrepute; to elevate the social mobilization networks to excellent performance; and to bring substantially more communications expertise to the table in the Programme's key strategic forums, including partnership headquarters and TAGs/ERCs.
2. We recommend that, through the necessary trials, the Programme should by the end of 2013 be able to conclusively answer the questions: "Should the endemic countries introduce IPV as soon as possible, or should they wait until 2015? If they introduce it now, should they do so nationally or should they focus on the areas with on-going transmission? How is it best explained to the population?"
3. We recommend that the Polio Oversight Board study carefully the IMB's analysis of the current management issues of the Programme and decide on a way forward, bearing in mind the need to maintain current priorities. To inform the board's discussion, we recommend that the partners' headquarters consider these two questions, through a short series of focused meetings:
  - How can we work together in a more ordered and efficient way, enabling action to proceed at the speed required in a programmatic emergency?
  - How can we be more sharply focused on what the polio-endemic countries need from us as a group, and how can we better coordinate efforts to provide this, including on controversial issues?

4. We recommend that the Polio Oversight Board hear candid views directly from in-country representatives of both government and partner agencies, about what they need from the partners at headquarters level.
5. We recommend that the Polio Oversight Board establish a mechanism to more frequently monitor key management information, including details of any unfilled post and its recruitment process, and that it publish records of its meetings.
6. We recommend that the incoming Pakistan government seek to retain the Prime Minister's Monitoring Cell and other structures that have led polio eradication efforts so successfully during the previous government's term.
7. We recommend that Nigeria urgently finalise a more detailed operational plan to deal with the security issues that it faces, drawing on the experiences of Afghanistan and Pakistan
8. We recommend that compatible cases be routinely reported in the Programme's bulletins, reports and presentations alongside the number of confirmed cases. We recommend that further attention be given to reducing the number of compatible cases through better surveillance, and that expert review committees receive the resources they need to support accurate diagnosis when such cases arise.

