STATUS REPORT

JULY – DECEMBER 2014

PROGRESS AGAINST THE POLIO ERADICATION AND ENDGAME STRATEGIC PLAN 2013-2018

POLIO GLOBAL ERADICATION INITIATIVE

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HIGHLIGHTS

Objective 1: Poliovirus detection and interruption

- **Endemic countries:** Strong progress has been made in Nigeria towards eradicating the disease, but polio cases are on the rise in Pakistan, affecting Afghanistan.
- **Outbreaks:** In the Horn of Africa and central Africa, outbreaks appear close to being stopped. The response is strong in the Middle East, despite ongoing security challenges.
- **Wild poliovirus type 3 (WPV3):** November marked two years since the most recent case of WPV3 and onset of paralysis in Nigeria. With no reported cases of wild poliovirus type 2 (WPV2) since 1999, potentially just one of the three strains of wild poliovirus remains.
- **PHEIC:** In May 2014, WHO Director-General declared the international spread of wild poliovirus a "public health emergency of international concern" (PHEIC) and issued Temporary Recommendations under the International Health Regulations (2005) to minimize the risk of further global spread. Countries' implementation of the recommendations varied in the second half of 2014.

Objective 2: Immunization systems strengthening and OPV withdrawal

- The Strategic Advisory Group of Experts on immunization (SAGE) concludes global preparations are on track to switch from trivalent oral polio vaccine (OPV) to bivalent OPV in April 2016.
- The SAGE notes progress achieved with regard to inactivated polio vaccine (IPV) introduction worldwide.
- Efforts intensify in 10 priority countries (with the bulk of Global Polio Eradication Initiative infrastructure) to use the infrastructure in support of routine immunization systems strengthening.

Objective 3: Containment and certification

- **Certification**: The WHO South-East Asia Region was certified polio-free on 27 March 2014; certification of the conclusive global eradication of WPV2 is on track for 2015.
- **Containment**: In 2014, the Global Action Plan (GAP) to minimize post-eradication poliovirus facility-associated risks (GAPIII) was updated and aligned with Polio Eradication & Endgame Strategic Plan timelines, particularly with regard to the phased removal of OPVs.

Objective 4: Legacy planning

- A draft Global Legacy Framework is under development by a legacy planning working group, following outcomes from a Boston Consultancy Group evaluation. The draft plan was approved by the Polio Oversight Board. Legacy planning is to be guided by national priorities at the country level, with strong linkages to global priorities. Planning missions were conducted in the Democratic Republic of the Congo and Nepal. A practical example of legacy in action is support to the Ebola outbreak in west Africa.

INTRODUCTION

Following the request by Global Polio Eradication Initiative (GPEI) stakeholders to update the monitoring framework for the GPEI Polio Eradication & Endgame Strategic Plan 2013-2018 (the Endgame Plan), the framework has been revised to conform with the results-based approach to polio eradication outlined in the Endgame Plan, and to ensure that progress against the Endgame Plan is reflected through programme indicators across all four of its objectives.

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

The data published in the first semi-annual status report, covering January to June 2014 (available at http://www.polioeradication.org) are helping to drive the refinement of strategic approaches at the regional and country levels. The analysed data are helping to shine a spotlight on the critical operational gaps that need to be filled and are enabling the development and implementation of corrective measures as appropriate.

SUMMARY

By the end of 2014, significant progress had been made towards each of the Endgame Plan's four objectives; the world has never been in a better position to eradicate polio. As the GPEI enters 2015, efforts are being intensified to build on this progress and stop polio once and for all.

Capitalizing on progress in Nigeria, against outbreaks in central Africa and the Horn of Africa, and against two out of three strains of wild poliovirus

In Nigeria, no new cases due to wild poliovirus (WPV) occurred from July 2014 to the end of the year as a result of the improved quality of immunization campaigns. Subnational surveillance gaps in some areas remain, however, and the country continues to be affected by a persistent circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreak. The second half of 2014 also saw the two-year mark of the most recent case of WPV3, which was last detected globally in November 2012, in Nigeria. This allows cautious optimism that this strain may have been eradicated. It would be a historic milestone for the GPEI and would leave only one wild serotype – wild poliovirus type 1 (WPV1) – in circulation (WPV2 has not been detected anywhere since 1999).

In the second half of 2014, the outbreaks in the Horn of Africa, central Africa and the Middle East that spanned 2013 and the first half of 2014 were brought to the verge of being stopped. Thanks to regionally-coordinated outbreak responses in all three regions, one case was reported in this six-month period, in Somalia on 24 August. No case has been reported from any of the outbreaks since then. Risks remain across all three outbreak zones, however, such as residual surveillance gaps, which could hide undetected transmission, so none of the outbreaks has been considered closed. At the same time, the Middle East is considered at high risk of renewed reinfection, given the intense virus transmission in Pakistan and further deterioration of immunization systems in the Syrian Arab Republic and Iraq due to the conflict and security situation.

To minimize the risks of the renewed international spread of WPV, the International Health Regulations Emergency Committee reiterated its conclusion for the third time in November 2014 that the current situation regarding international spread remains a PHEIC and underlined its Temporary Recommendations for the vaccination of international travellers from polio-infected countries.

Preparing the world for the phased removal of oral polio vaccines

In October 2014, the SAGE reviewed global readiness for the planned phased removal of OPVs, beginning with a switch from trivalent OPV to bivalent OPV in April 2016. This readiness includes the introduction of IPV into all countries that currently use only OPV by end-2015, to continue to provide protection against all strains following the planned switch in 2016. Reviewing all evidence, the SAGE concluded that preparations for the switch are on track and urged countries to further intensify efforts.

A critical factor to assure a successful switch will be the containment of type 2 polioviruses in laboratories, as well as certification that WPV2, last detected in 1999, has indeed been globally eradicated. In late 2014, a new and updated global containment action plan was endorsed by the SAGE and progress towards WPV2 verification continued.The trigger for the global, phased withdrawal of OPVs will be to ensure that all persistent cVDPV2 outbreaks are fully stopped. At the end of 2014, persistent cVDPV2s endured in Nigeria and Pakistan.

Ensuring the legacy of polio eradication

In late 2014, work continued to ensure that the legacy of polio eradication can be secured, in other words that the investments made in the GPEI will continue to benefit other development goals in the long term through the documentation and transition of knowledge, lessons and assets. Ongoing consultations with Member States, major partners and stakeholders, as well as detailed pilot evaluations, reinforced the conclusions of the regional committees in 2013 that legacy planning should benefit existing health priorities and be driven by countries. Its success will require establishing a formal process in all countries where substantial assets for polio eradication were financed through external resources.

In 2015, finalization of the Global Legacy Framework will ensure that the essential functions of the GPEI's programme of work will be transitioned to other priorities. The Democratic Republic of the Congo India, Nepal and Nigeria have initially been selected for focused legacy transition planning support in 2015, with other countries with significant polio resources to be prioritized.

The final battleground: stopping transmission of poliovirus in Afghanistan and Pakistan

In 2014, Pakistan accounted for 85% of all WPV cases worldwide and, in the second half of 2014, it was the only country that continued to export the poliovirus internationally. This intense virus transmission across the country is now the greatest epidemiological risk to achieving a polio-free world, as too many children remain under-immunized (due to a number of factors, including operational challenges, insecurity, targeted attacks on health workers and hampered access). Mass population movements from previously inaccessible areas present both a risk and an opportunity. The risk is that the poliovirus continues to be exported from these areas, but the opportunity is that, for the first time in more than two years, populations can be reached at transit points as they move out of these areas.

Recognizing the risks Pakistan poses to the global effort, end-2014 saw a build-up in government commitments at all levels. Following initial strategic planning, an emergency meeting convened the political leadership from the high-risk provinces and districts to prepare a robust "low-season emergency plan" with consensus from all key levels. This low-season plan focuses on overcoming clearly identified, area-specific challenges in the early part of 2015 (the low season for polio transmission). The plan has all the necessary elements in place to rapidly eradicate polio; its success, however, hinges on its full implementation at all levels.

To facilitate implementation, a national task force reporting directly to the prime minister's office has been established, a cabinet committee on security for immunization has been formed, and close collaboration is being fostered to secure the assistance of the army and the Ministry of the Interior for polio eradication. Emergency operations centres established at the federal and provincial levels will oversee implementation, assure real-time monitoring and guide corrective actions as necessary.

In neighbouring Afghanistan, efforts focused on holding ground against the poliovirus in the face of importations from Pakistan. While the bulk of WPV cases is linked to cross-border transmission with neighbouring Pakistan, residual endemic poliovirus circulation persists and access challenges remain in some areas.

Looking to 2015

At the end of 2014, much epidemiological evidence justified cautious optimism, with Africa on the verge of polio-free status and the possible eradication of WPV3, although major challenges remain to be overcome. The GPEI will focus on five key areas of work in the first half of 2015, to maximize the opportunity that presents itself and to urgently overcome barriers preventing all children from being reached with life-saving polio vaccine:

1. further intensifying surveillance – to rapidly detect any residual transmission, in particular in parts of Nigeria, central Africa, the Horn of Africa and the Middle East;

2. securing a polio-free Africa and Middle East – by fully implementing emergency measures to urgently interrupt residual poliovirus transmission, reducing the risk of international spread and developing stronger outbreak response capacity;

3. providing surge support to Pakistan (and Afghanistan) – to help implement and evaluate the low-season plan in Pakistan, while further building on progress in neighbouring Afghanistan (which is epidemiologically linked to Pakistan);

4. preparing for phased removal of OPVs – by continuing to support countries in introducing IPV and preparing the world for the planned switch from trivalent OPV to bivalent OPV in early 2016;

5. engaging with routine immunization – with particular focus on 10 priority countries with the bulk of GPEI staff and infrastructure, to ensure that immunity levels to all vaccine-preventable diseases can be boosted.

Financing the Endgame Plan

By end-2014, the GPEI had received US$ 2.23 billion in contributions and was tracking an additional US$ 2.85 billion in pledges, against the overall 2013-2018 budget of US$ 5.5 billion. Full and rapid realization of all pledges would result in a remaining funding gap of US$ 451 million against the Endgame Plan.

OBJECTIVE 1: POLIOVIRUS DETECTION AND INTERRUPTION

Endemic countries

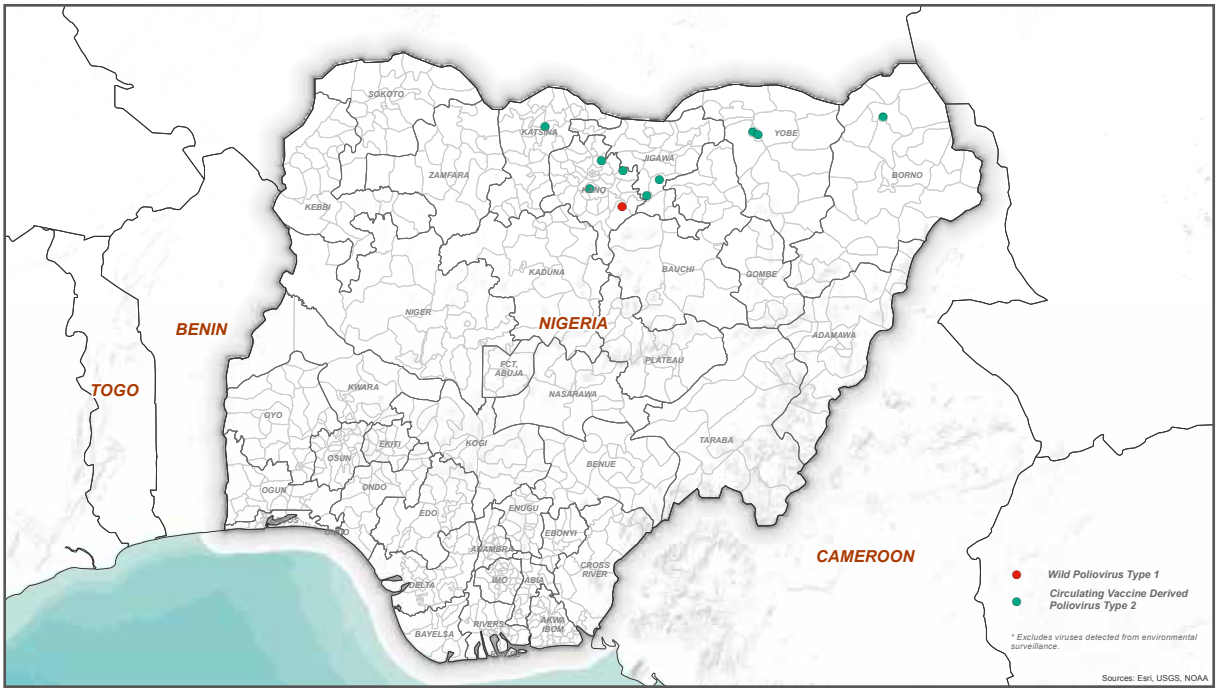
Strong progress in Nigeria

Nigeria has made major progress towards achieving polio-free status. The decrease in global cases is largely associated with progress achieved in Nigeria, which saw only one case of WPV1 in the second half of 2014, on 24 July. This led to a total of six cases in 2014, a significant decrease from 53 in 2013.

In September 2014, the Expert Review Committee on Polio Eradication and Routine Immunization identified Kano as the remaining place with persistent WPV transmission in the country. An analysis of strategic approaches began in high-risk states such as Borno and Yobe, including for areas with compromised access to populations, and based on its outcomes, strategies were targeted to inform ward-specific plans. Vaccine mix was optimized, to address both WPV and cVDPV transmission. Identification of any subsequent polioviruses (detected through acute flaccid paralysis (AFP) or environmental surveillance) will trigger an aggressive outbreak response consisting of a series of vaccination mop-up campaigns at 2-3 week intervals.

While access to children has improved substantially during the past year, access continues to be limited in many areas, and supplementary immunization activity (SIA) quality remains inadequate in areas that are accessible. The north of Nigeria continues to face substantial security challenges and gaps in surveillance that the region is attempting to address.

Nigeria wild poliovirus (N=1) and circulating vaccine-derived poliovirus (N=10) cases – July-December 2014

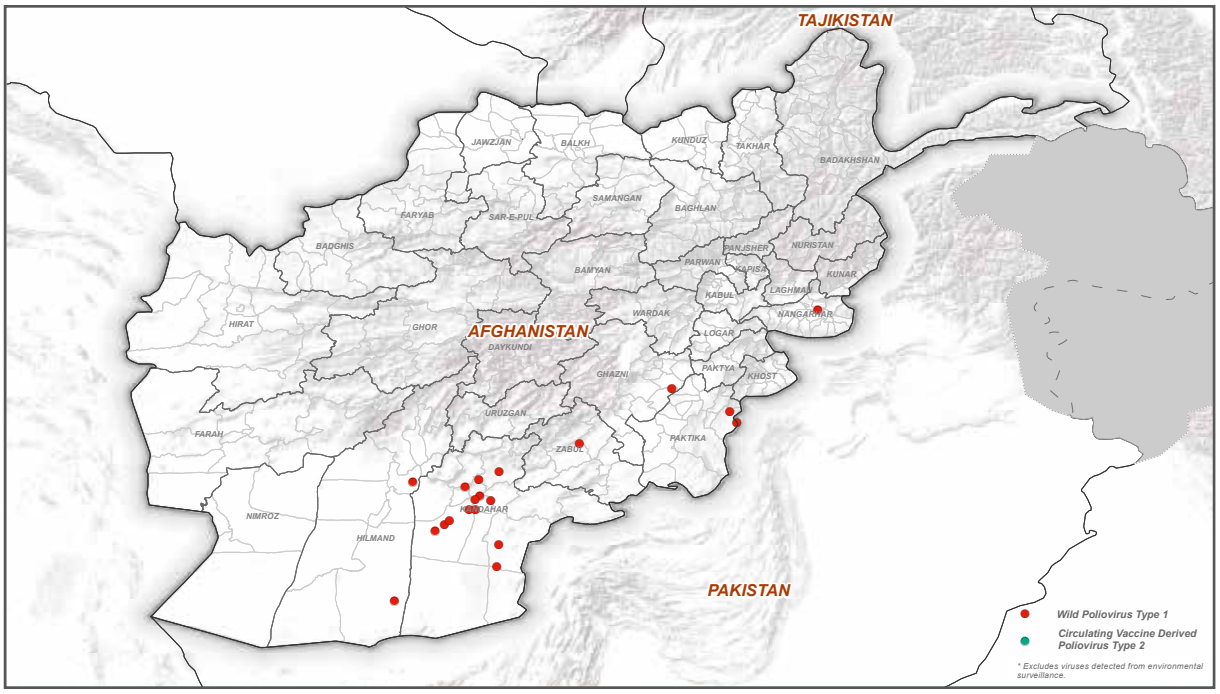


Progress but challenges in Afghanistan

Despite a low number of cases in the first half of 2014, July to December saw case numbers increase in Afghanistan. Twenty cases were reported between July and December, with the bulk linked to cross-border transmission with neighbouring Pakistan. No cVDPV2 cases

have been reported in the country since March 2013. This stresses the fact that Afghanistan's progress towards eradication is inextricably connected to progress made against the virus in Pakistan. The country succeeded in keeping numbers relatively low, considering the population movement across the porous border between the two. However, low-level endemic transmission and secondary spread of imported polioviruses demonstrate remaining vaccination coverage gaps that must be filled. Twice in 2014, local leaders suspended immunizations in the high-risk areas of Helmand province. Ongoing and local-level negotiations resolved both suspensions by highlighting the importance of maintaining the neutrality of public health efforts.

Afghanistan wild poliovirus (N=20) cases – July-December 2014



Polio cases on the rise in Pakistan, but new emergency plan aims to turn tide in early 2015

In Pakistan, the outbreak of WPV1 and cVDPV2 in the Federally Administered Tribal Areas continues, with poliovirus spreading to many areas of Pakistan and eastern Afghanistan. In the second half of 2014, Pakistan was the only country that continued to export the virus internationally. Polio cases peaked at the height of the high season in September, with monthly incidence steadily declining through the rest of the year.

Too many children in Pakistan continue to be under-immunized due to a number of factors, including operational challenges during immunization campaigns and, in some areas of insecurity, targeted attacks on health workers and hampered access.

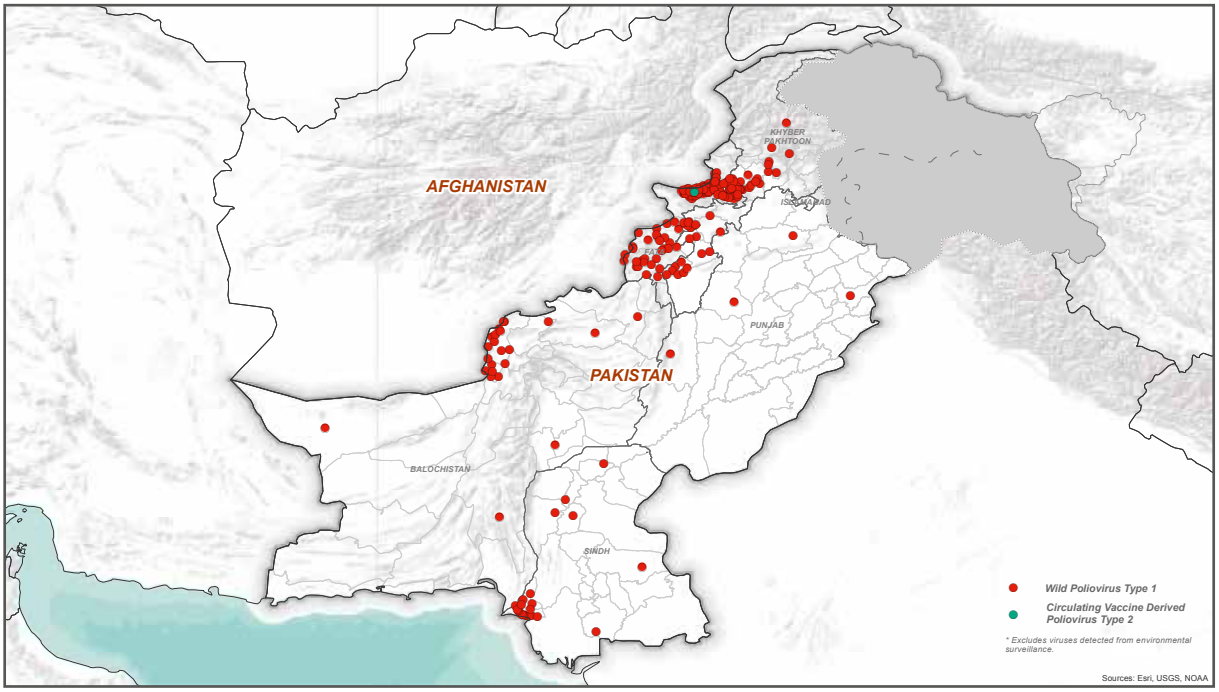
Despite the serious polio situation in Pakistan, the positive developments of last year bring hope for significant progress in 2015. According to polling data by Harvard in 2014, vaccine acceptance rates are at the highest levels ever recorded in Pakistan. Vaccine acceptance rates reach 99% in many areas in Pakistan, meaning that parents' desire to vaccinate their children is high, even in inaccessible and insecure areas. Further, the displacement of persons from North and South Waziristan meant that as populations from this area moved out, they

received the polio vaccine for the first time since 2012. Access to both areas also improved for the first time since 2012.

In 2015, Pakistan has the opportunity to reverse the current spike in cases and, in so doing, to take the world over the finish line of eradication. Recognizing both the risk and the opportunity present in 2015, end-2014 saw a build-up in government commitments at all levels. In November, an emergency meeting convened leaders from all high-risk provinces and districts to prepare a low-season emergency plan with consensus from all levels that focuses on overcoming operational and security challenges in the early half of 2015 (the low season for polio transmission). This plan has all the necessary elements in place to rapidly eradicate polio from Pakistan, but its success hinges on its full implementation.

To ensure this, implementation will be overseen directly by the office of the prime minister, which will monitor progress on a regular basis and redirect the plan as needed based on evolving epidemiology. It is the only social programme overseen in Pakistan by the prime minister. Emergency operations centres will be set up at the federal and provincial levels in Pakistan. These will be supported by Polio Eradication Committees at the district and union-council levels, which will ensure real-time monitoring of activities, enabling rapid response to changes and to the needs of local areas. In addition, the combination of vaccines given to children will be optimized to address both WPVs and cVDPVs. Close collaboration is being fostered to secure the assistance of the army and the Ministry of the Interior for polio eradication.

Pakistan wild poliovirus (N=206) and circulating vaccine-derived poliovirus (N=2) cases – July-December 2014



Outbreaks

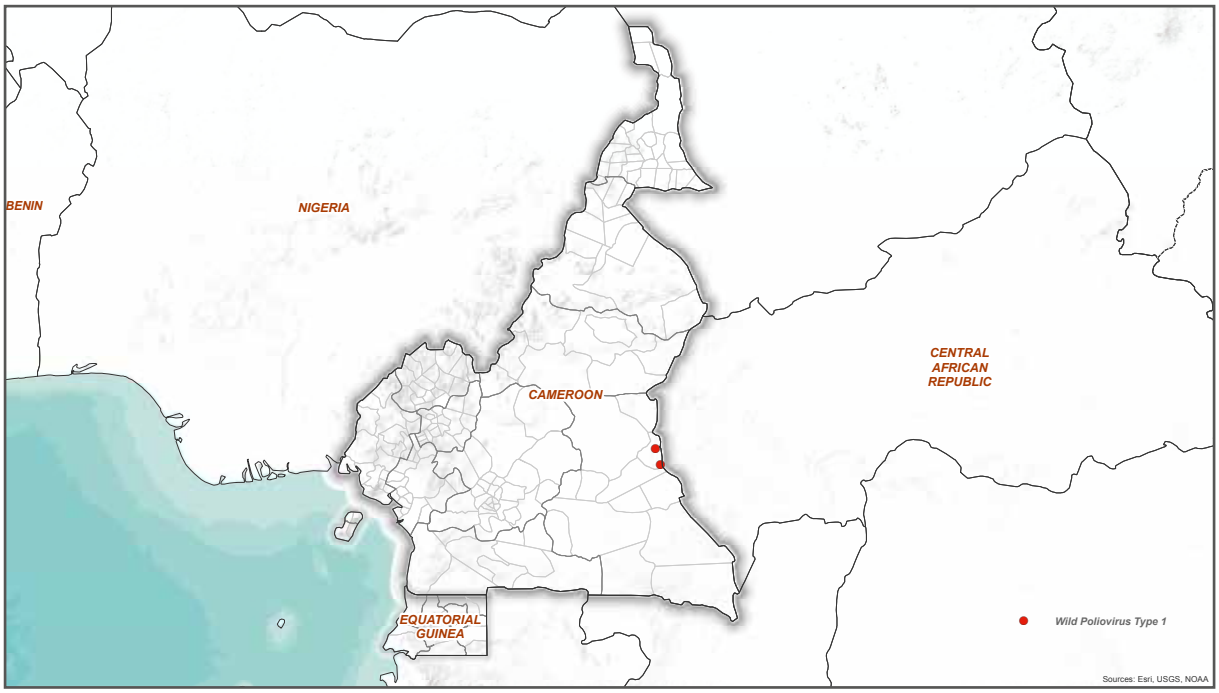
Central Africa

In central Africa, two WPV1 cases were reported in August 2014, the first in the region since February, from a refugee camp near the border with the Central African Republic. Detection of these cases alerted officials of the risk of residual, low-level transmission associated with this regional outbreak that was first detected in 2013 in Cameroon.

An international outbreak assessment conducted in September highlighted that the response was significantly strengthened throughout 2014, including by focusing on addressing major operational gaps and surveillance deficits. This progress was built on further throughout the last quarter of 2014, including through strengthened engagement with routine immunization systems, the Office of the United Nations High Commissioner for Refugees and nongovernmental organizations to ensure that both surveillance and campaigns are improved in formal and informal refugee camps, recognizing the ongoing risk of international spread. Particular focus is being given on areas with a high risk of undetected transmission, including Lake Chad, northern Cameroon and the Central African Republic. Activities are being coordinated regionally.

In 2015, it is critical to urgently and fully stop this outbreak, in particular given the progress achieved in Nigeria. Stopping this outbreak may hold the key to achieving a polio-free Africa. A total of 72 million doses of OPV have been administered to more than 8.6 million children across four countries.

Central Africa wild poliovirus (N=2) cases – July-December 2014

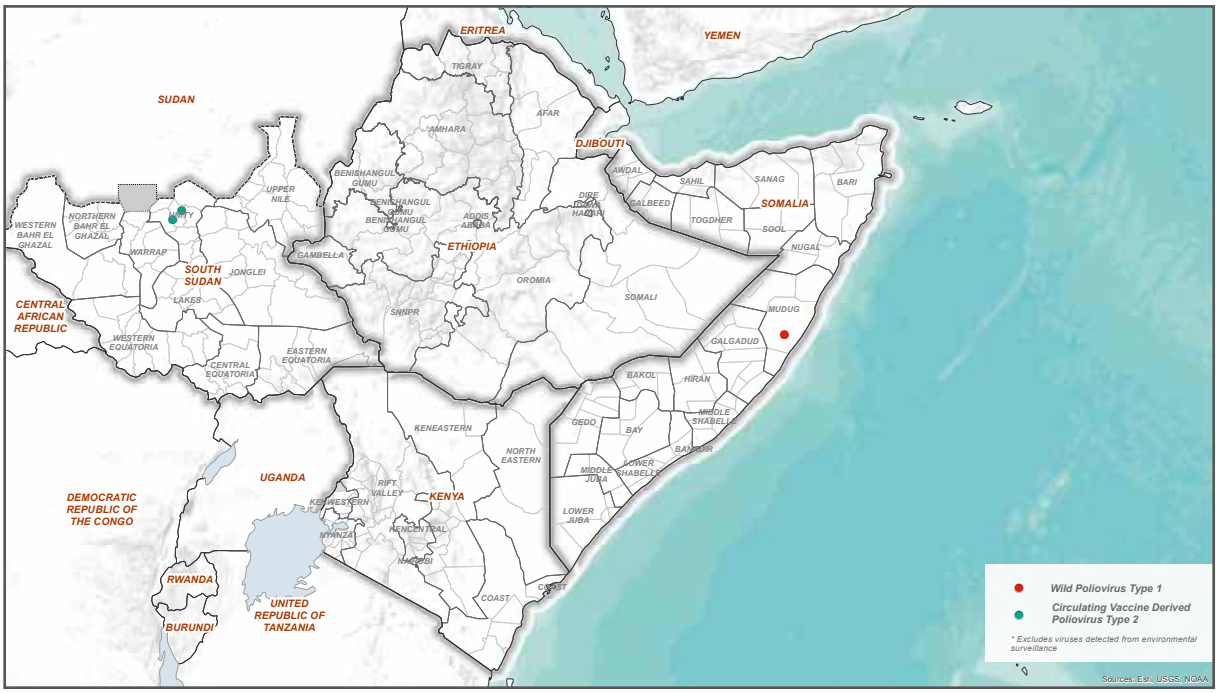


Horn of Africa

The WPV1 outbreak in the Horn of Africa has significantly declined, but confirmation of a case in Somalia in June 2014 underscores the dangers of ongoing, low-level residual transmission in the region. Regional outbreak response activities are continuing, and efforts are being made to strengthen and fill residual subnational surveillance gaps.

Two cases of cVDPV2 emerged in South Sudan in September, in a refugee camp area of Unity state. Immediate outbreak response was conducted, with the objective to rapidly stop the cVDPV2 in the infected area, while further boosting immunity to type 1 poliovirus to minimize the risk posed by any potential residual transmission of this strain in the region. A total of 130 million doses of OPV have been administered to more than 27 million children across four countries.

Horn of Africa wild poliovirus (N=1) and circulating vaccine-derived poliovirus (N=2) cases – July-December 2014



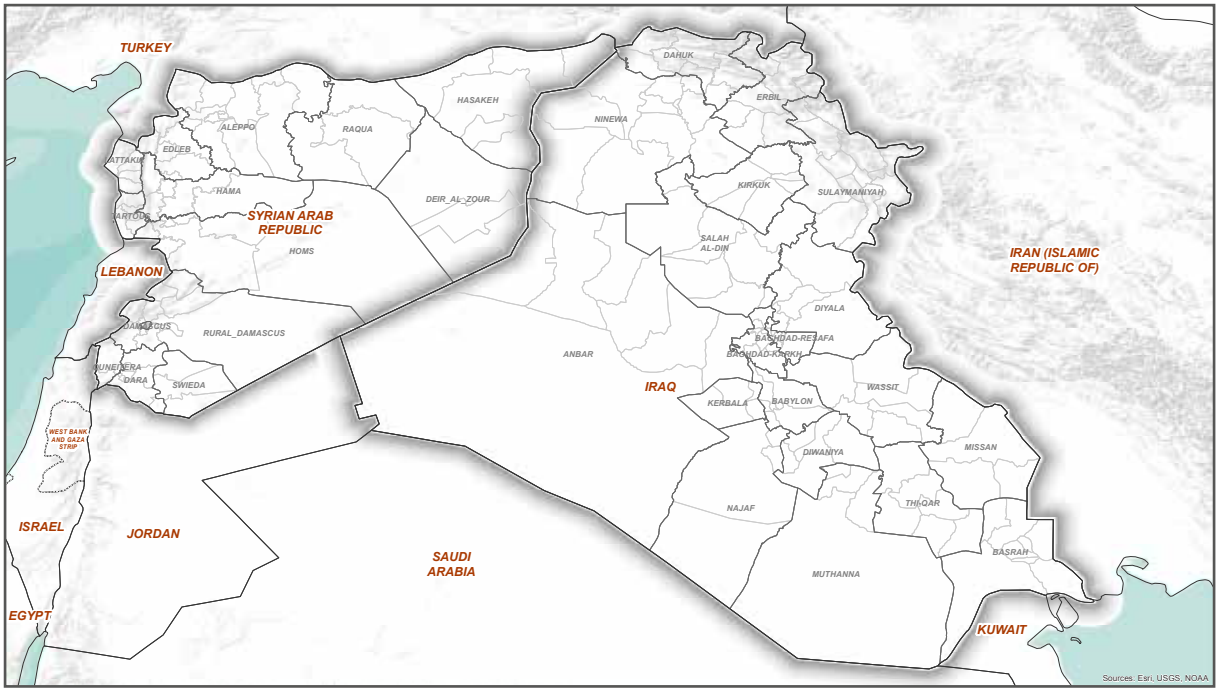
Middle East

The second half of 2014 saw the continuation of the Phase II Strategic Plan for Polio Outbreak Response in the Middle East across seven countries. Despite major disruptions to health and transport infrastructure, no new cases have been detected in Iraq since April, and in the Syrian Arab Republic since January. It is a remarkable achievement that has drawn on the commitment of the governments of the region, the health workers, and the desire of parents to access the vaccines for their children. A total of more than 140 million doses of OPV have been administered to nearly 30 million children across eight countries in the region.

In a complex political and security environment involving various governments and administrators, with the assistance and partnership of UN organizations and local and international nongovernmental organizations, the outbreak response is continuing across the lines of conflict to reach all children.

Phase III of the outbreak response, to be implemented in the first half of 2015, will build on progress achieved, identifying remaining under-vaccinated groups and filling residual surveillance gaps.

In the Middle East, no polio cases were detected during the July-December 2014 period



Public health emergency of international concern - PHEIC

On 5 May 2014, on the advice of the International Health Regulations (2005) Emergency Committee convened at the request of the WHO Executive Board, the Director-General declared the international spread of WPV to be a PHEIC and issued Temporary Recommendations for "states currently exporting WPVs" and "states infected with WPV but not currently exporting". The Temporary Recommendations contain advice on measures to reduce the risk of the international spread of WPV, such as declaring and managing the event as a national public health emergency and vaccinating travellers from affected countries against poliomyelitis.

On the advice of the Emergency Committee, the Director-General extended the original Temporary Recommendations on 3 August 2014 and again on 13 November 2014. On 13 November, the Temporary Recommendations were supplemented with specific measures for Pakistan, because of escalating WPV transmission in that country and the ongoing cross-border exportation of the virus into Afghanistan, including recommending Pakistan restrict at the point of departure the international travel of any resident lacking documentation of appropriate polio vaccination.

In the second half of 2014, all polio-affected countries continued to scale up and implement the Temporary Recommendations, although to variable success and extent. Additionally, polio-free countries such as Australia, China and India, are increasingly taking additional steps to minimize the risk and consequences of a potential poliovirus importation, including requiring travellers from polio-affected countries to show proof of vaccination as a visa requirement and/or administering an additional dose of polio vaccine upon arrival in the country.

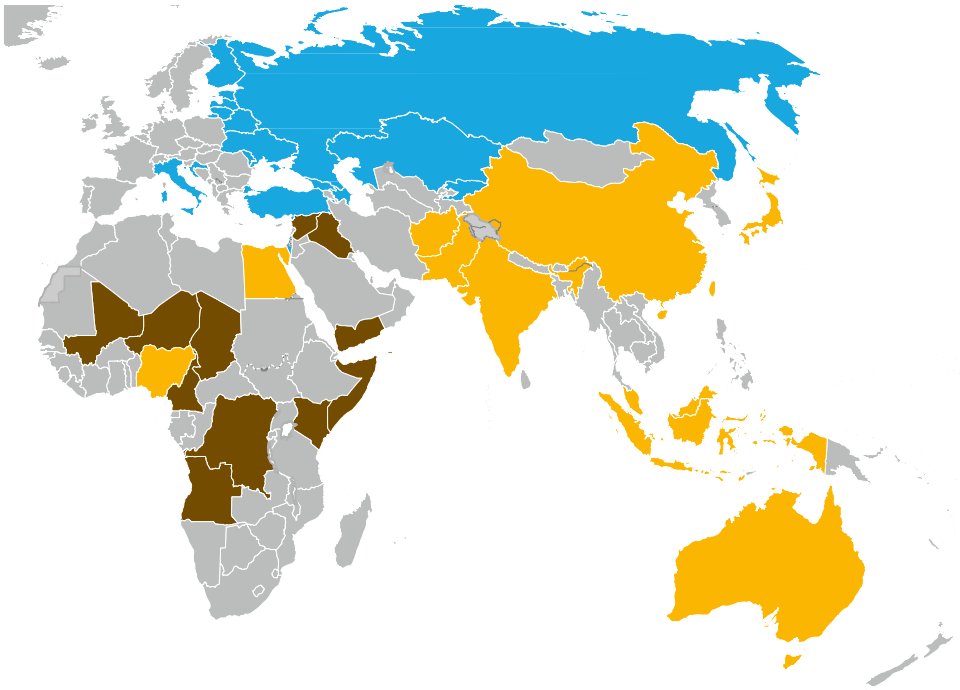
Strengthening surveillance

Across all infected countries and high-risk areas, efforts continued in the second half of 2014 to rapidly identify and fill residual subnational surveillance gaps. This is particularly true in all three outbreak zones, the Middle East, the Horn of Africa and central Africa (including in the Central African Republic).

Through guidance by regional technical advisory bodies, particular attention is being given to strengthen active surveillance for AFP cases in marginalized and at-risk population groups. Targeted and active AFP community searches are being conducted during vaccination campaigns whenever and wherever they are conducted to further complement existing AFP surveillance activities. Detailed analyses of surveillance indicators at the country, regional and global levels are aimed at highlighting critical gap areas, and field visits are organized in response to develop and implement corrective measures.

Rapidly identifying any polio transmission is critical, as it enables a full and comprehensive outbreak response. Filling surveillance gaps is a programmatic priority in 2015. Environmental surveillance is being further expanded, to supplement active surveillance for AFP cases (see map on page 13).

Plans for expanding environmental surveillance for polioviruses



EURO countries: Azerbaijan, Belarus, Georgia , Kyrgyzstan , Kazakhstan, Latvia ,Lithuania Republic of Moldova, Russian Federation, Turkey, Ukraine, Italy, Estonia, Finland and Croatia

ES established by end 2013: Afghanistan, Australia, China, Egypt, India, Indonesia, Israel, Malaysia, Nigeria, Japan and Pakistan

ES to be established by end 2015: Angola , Cameroon, Kenya, Niger, Chad, DR Congo, Iraq, Mali and Yemen, Syria, and Somalia

The risk of polio to west African countries – the impact of Ebola

West Africa has historically been one of the highest-risk areas for polio reinfection and outbreaks, given its geographic proximity to Nigeria and large-scale population movements across the region. The devastating Ebola outbreak affecting the region has further raised the spectre of the renewed spread of polio across the region.

The polio programme is monitoring the situation across the region closely. In the three Ebola-affected countries, Guinea, Liberia and Sierra Leone, population immunity has declined, as has surveillance for AFP, as the Ebola outbreak has limited the ability to conduct activities. However, poliovirus transmission levels are at a historic low in Nigeria (from where the virus would spread into west Africa) and population movements *into* the three Ebola-affected countries are limited. At the same time, the programme continues to conduct immunization campaigns across other west African countries, to build an immunity wall to minimize the risk of polio spreading again into the region. The programme is prepared to immediately implement large-scale supplementary immunization activities in the three Ebola-affected countries as soon as the situation allows.

Polio staff and infrastructure across the region continue to support Ebola outbreak response measures, by conducting surveillance, contact tracing, data management, logistics and supply distribution, and outbreak management. In Nigeria, the assets and experience of the dedicated polio eradication emergency operations centres and staff were instrumental in helping stop the Ebola outbreak in that country. Polio staff from India continue to be deployed to countries in the region to support the outbreak response.

OBJECTIVE 2: IMMUNIZATION SYSTEMS STRENGTHENING AND OPV WITHDRAWAL

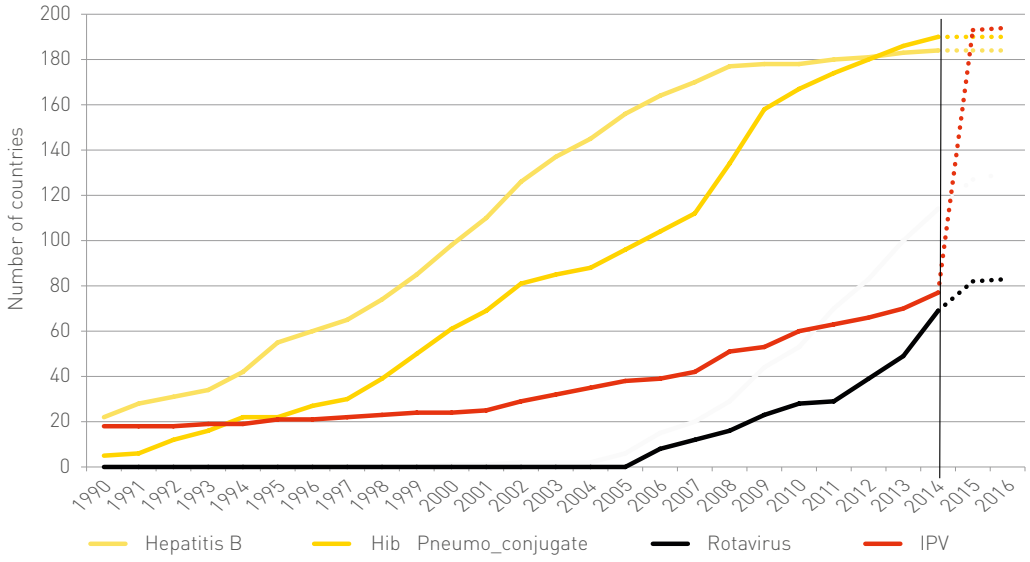
As part of the Endgame Plan, OPV use worldwide will eventually end, starting with the removal of oral poliovirus vaccine type 2 (OPV2) through the switch from trivalent OPV to bivalent OPV. A first step in this process is the introduction of at least one dose of IPV in all routine immunization programmes by the end of 2015. This will boost immunity against type 2 polioviruses and will also:

- reduce the risk of re-emergence of WPV2 or cVDPV2;
- facilitate the containment of outbreaks;
- accelerate WPV eradication by boosting immunity against poliovirus types 1 and 3 in children who have previously received OPV.

In October 2014, the SAGE reviewed progress towards global readiness for the coordinated, phased removal of OPVs and concluded that preparations are on track for a switch from trivalent OPV to bivalent OPV in April 2016. In particular, the group noted the progress achieved with regard to IPV introduction. All but three countries have committed to IPV introduction by the end of 2015. In total, the three remaining countries account for less than 0.05% of the global birth cohort and are not considered to be at high risk of emergence of a cVDPV2.

In conjunction with IPV introduction, Objective 2 of the Endgame Plan also includes efforts to strengthen routine immunization in 10 "focus" countries where there are significant polio resources and assets. A joint programme of work was initiated with GAVI, the Vaccine Alliance, to support this work. To date, six of these countries – Chad, Democratic Republic of the Congo, Ethiopia, India, Nigeria and Pakistan – have developed annual national immunization plans that leverage polio assets to improve broader immunization goals. In Pakistan, for example, a pilot project first evaluated in 16 districts is being expanded across all provinces, in close collaboration with the high-level provincial political leadership, to take steps to rapidly increase vaccination coverage among children. In addition, work is progressing to assess and quantify the contribution of polio-funded staff to routine immunization activities across the 10 focus countries.

Rolling out IPV globally



OBJECTIVE 3: CONTAINMENT AND CERTIFICATION

National laboratory survey and inventory activities for materials infected or potentially infected with WPVs were completed in all countries of the WHO Western Pacific Region, European Region and Region of the Americas by 2008. In 2009, the third version of the GAP assumed concomitant eradication of all three WPV types and required the containment of all WPV to be in place before the containment of all OPV/Sabin-derived polioviruses, expected at the time of OPV cessation. The renewed discussions on OPV cessation that were prompted by the confirmation of cVDPVs in turn led to the revision of the third edition of the GAP. The new GAP to minimize post-eradication poliovirus facility-associated risks after type-specific eradication of WPVs and sequential cessation of OPV use (GAPIII) outlines biorisk management requirements and other critical safeguards for handling wild, Sabin and Sabin-derived polioviruses following eradication and eventual OPV cessation.

In the second half of 2014, the strategic approach and plan to fully align GAPIII with the major milestones and timelines of the Endgame Plan were finalized and endorsed by the SAGE. Importantly, the revised GAPIII describes timely and specific requirements for poliovirus type 2 containment. Additionally, it sets the general parameters for the long-term containment of polioviruses following the cessation of all OPV use expected sometime after 2019.

The programme is currently working on the verification of eradication of WPV2 through the Global Commission for Certification of the Eradication of Poliomyelitis and on the implementation of appropriate containment of type 2 polioviruses in essential facilities, in preparation for the phased removal of OPV beginning with OPV2 withdrawal. The last reported case of WPV2 was in 1999.

OBJECTIVE 4: LEGACY PLANNING

The principal objective of the legacy planning work is to ensure that the investments made in the cause of polio eradication are built upon to benefit other development goals, through a comprehensive programme of work to document and transition the GPEI's knowledge, lessons learnt and assets. As an example, the infrastructure used in polio eradication is helping to support the response to the Ebola outbreak in west Africa, by providing staff for surge support and by conducting disease surveillance, contact tracing, data management, logistics and supply distribution, and outbreak management. In Nigeria, the assets and experience of the dedicated polio eradication emergency operations centre and staff were instrumental in helping to stop the Ebola outbreak in that country.

In 2013, the GPEI established a legacy planning working group to manage the development of legacy planning, including to ensure the consultations and evidence-based development necessary to inform the Global Legacy Framework, to be presented to the World Health Assembly in May 2015. A draft plan of the Framework was approved by the Polio Oversight Board in December 2014.

Throughout 2014, stakeholder input was sought into the overall direction of the legacy planning work, to better understand the capabilities of the programme and its knowledge and to steer the legacy planning working group in directions that could be of benefit to other health priorities.

An evidence database continues to be compiled, definitively outlining the capabilities, functions, assets and contributions of the GPEI to other priorities. Other programmes already benefiting from the GPEI infrastructure in particular are in the areas of disaster and crisis response, maternal and child health, sanitation and hygiene, child health days and new vaccine introductions. Critical activities polio staff are contributing to these areas include supporting routine immunization, disease surveillance, supply chain management and overall resource and capacity-building. Detailed pilot planning missions were conducted in the Democratic Republic of the Congo and Nepal, to initiate legacy planning and to learn how transition planning could function in different settings. To help guide countries in the development of legacy transition plans, guidelines are under development.

It is envisaged that legacy planning will be conducted in a phased manner, beginning with an initial small group of countries. Critical to success will be Member State and country-level donor engagement, including through discussions in upcoming relevant policy bodies, notably at the World Health Assembly and regional committees. A three-stage country-level planning and implementation process is envisaged, focusing on:

1. planning and decision-making
2. preparation
3. execution.

It is anticipated that legacy planning will be conducted on a national basis according to the Global Legacy Framework but that global priorities (e.g. emergency response capacity) will be open to discussion.

Strengthening the management of the Polio Eradication & Endgame Strategic Plan 2013-2018

Thanks to continued, generous support from the international development community, by end-2014 the GPEI had received US$ 2.23 billion in contributions and was tracking an additional US$ 2.85 billion in pledges, against the overall 2013-2018 budget of US$ 5.5 billion. Full and rapid realization of all pledges would result in a remaining funding gap of US$ 451 million against the Endgame Plan.

Globally, the GPEI underwent significant management and administrative changes in the second half of 2014, following a comprehensive management review conducted by PricewaterhouseCoopers. Based on the findings of the review, the Polio Oversight Board adopted a number of recommendations to more quickly and effectively achieve eradication. Of note is that a new finance and accountability committee is being established to ensure more rapid, comprehensive and transparent financial reporting for all stakeholders.In the first half of 2015, the GPEI will also carry out a midterm review of the Endgame Plan, which will assess progress to date and identity amendments as needed, including budgetary adjustments.

More information on the revised management structures can be found at http://www.polioeradication.org.

Annex 1 – Indicators definition and significance

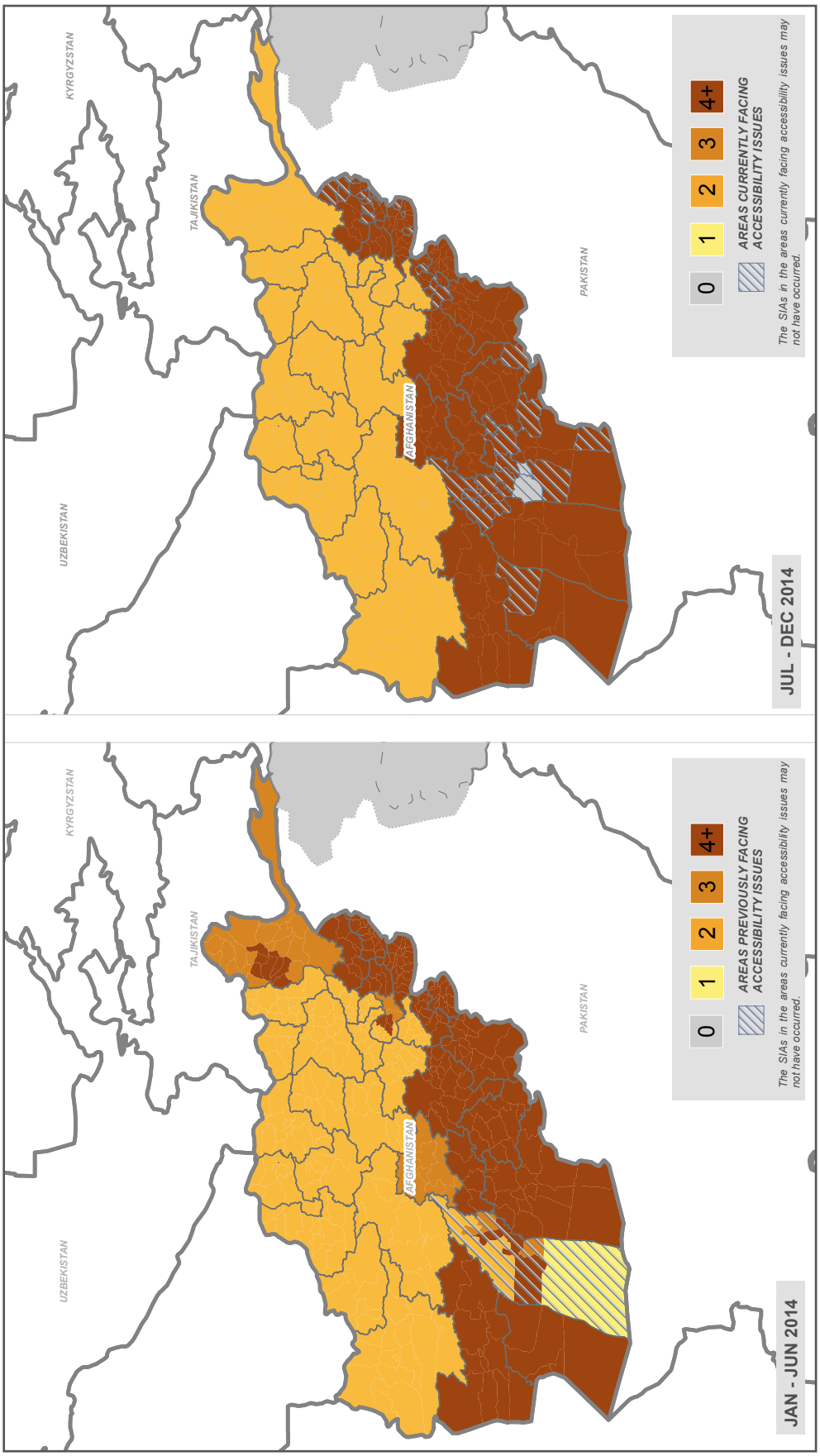
Indicator	Definition
0-dose	Percent of children between 6 and 59 months of age who have never received a dose of polio vaccine
LQAS	Lot Quality Assurance Sampling (LQAS) – a methodology, which classifies geographic areas (corresponding to 'lots') as having 'acceptable' or 'unacceptable' levels of vaccination coverage; based on sampling of individuals in a given geographic area against a pre-set decision value. Ideal methodology to detect areas with low vaccination coverage
Independent monitoring	Real-time independent monitoring of SIAs to assess levels of vaccination coverage achieved during a given SIA
% inaccessible	Percent of children missed during an SIA due to inaccessibility
% children missed due to child not being seen	Percent of children missed during an SIA due to house not visited or child not at home
% children missed due to refusal	Percent of children missed during an SIA due to caregiver refusal to allow vaccination
Number and type of activity	Number and type of SIAs conducted (ie National Immunization Days, Subnational Immunization Days)
Non-polio AFP rate	Non-polio AFP rate (npAFP) refers to surveillance sensitivity. Target is to achieve npAFP rate of 2/100.000 population aged <15 years
Stool adequacy	Further indicator to assess surveillance sensitivity. Target is to achieve 80% stool adequacy rate
IPV introduction	Indicator tracking progress in introducing IPV into routine immunization programmes of OPV-only using countries by end-2015
Primary isolation at the laboratory upon receipt of stool specimens	Virus isolation results available within 14 days of receipt of stool specimens at the laboratory
Routine immunization strengthening	Indicator to monitor progress against improving routine immunization in ten priority countries through use of GPEI infrastructure (Afghanistan, Angola, Chad, Democratic Republic of Congo, Ethiopia, India, Nigeria, Pakistan, Somalia and South Sudan), as measured through percent reduction in un-immunized children year-on-year, with DTP3-containing vaccine
Financial resources	Indicators to measure availability of funds to implement Polio Endgame Plan: -Proportion of 2014 required funds received -Proportion of 2013-2018 committed funds received
Human resources	Percent of positions vacant
OPV supply	Indicator tracking adequacy of available OPV supply for planned SIAs and type-specific buffer stock

Annex 2 – Endemic Country monitoring

AFGHANISTAN

Endemic Countries	State/Area	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Afghanistan	Southern (Kandahar, Helmand)	Interrupt transmission	Number of cases	0 case	0	15
		High population immunity	% 0-dose	<10%	0	0.71
			LQAS	>= 90%	90 start 85.7 end	N/a
			% inaccessible	<5%	56.4 start 58.3 end	N/a
			Number and type of activity	per plan	2 NIDs, 5 SNIDs	2 NIDs, 12 SNIDs
			% children missed due to no visit/ child absent (in 11 Low-performing districts)	<2%	5.5% start 6.9% end	5.5% start 7.2% end
			% children missed due to refusal (in 11 Low-performing districts)	<2%	0.7% start 1.8% end	1.3% start 2.4% end
		High virus detection	npAFP rate	> 2 per 100 000	12.2	17.9
			stool adequacy	> 80%	97.4	87.63
			lab receipt to virus isolation result (median)	< 14 days	11.9	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases	0 case	8	5
		High population immunity	% 0-dose	<10%	0.1	0.34
			LQAS	>= 90%	74.4 start 73.3 end	N/a
			% inaccessible	<5%	0.4 start 2 end	N/a
			Number and type of activity	per plan	2 NIDs, 8 SNIDs	2 NIDs, 8 SNIDs
		High virus detection	AFP rate	> 2 per 100 000	13.8	13.0
			stool adequacy	> 80%	90.4	95.86
			lab receipt to virus isolation result (median)	< 14 days	12.3	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	
			IPV introduction	intro by 2015	On track	
	All of country		Number of polio cases from families refusing OPV	0 case	6	

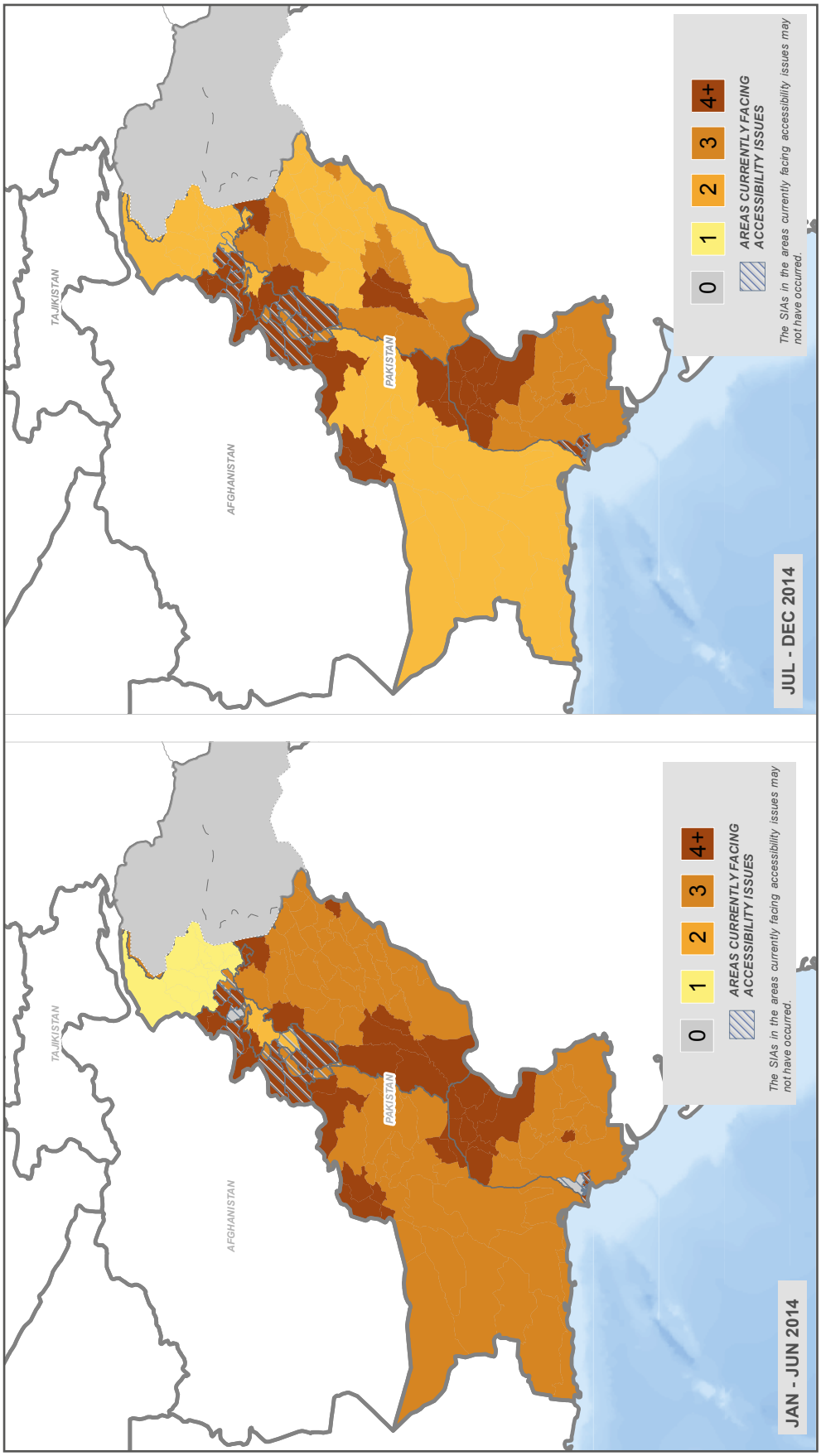
SIAs in Afghanistan



Endemic Countries	State/Area	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Pakistan	KP (Peshawar, Nowshera, Swabi, Charsaddah, Mardan, Bannu, Tank, Lakki Marwat)	Interrupt transmission	number of cases (WPV1 only)	0 case	17	51
		High population immunity	% 0-dose	<10%	1.6	3.22
			LQAS	>= 90%	71.4	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NID, 27 SNIDs	2 NIDs, 10 SNIDs
			% children missed due to no visit/ child absent	<2%	1.3% start 2.8% end	2.3% start 1.4% end
			% children missed due to refusal	<2%	1.7% start 2.6% end	1.3% start 0.7% end
		High virus detection	npAFP rate	> 2 per 100 000	8.2	9.53
			stool adequacy	> 80%	80.8	81.87
			lab receipt to virus isolation result (median)	< 14 days	9.6	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	FATA	Interrupt transmission	number of cases (WPV1 and cVDPV2)	0 case	90 (73+17)	208 (206+2)
		High population immunity	% 0-dose	<10%	52.5	37.96
			LQAS	>= 90%	80	N/a
			% inaccessible	<5%	28.2% start 28.1% end	N/a
			Number and type of activity	per plan	3 NID, 9 SNIDs	2 NIDs, 6 SNIDs
			% children missed due to no visit/ child absent	<2%	1.9% start 2.4% end	2.1% start 2.9% end
			% children missed due to refusal	<2%	0.1% start 0.1% end	0.1% start 0.1% end
		High virus detection	AFP rate	> 2 per 100 000	11.6	18.85
			stool adequacy	> 80%	82.8	85.98
			lab receipt to virus isolation result (median)	< 14 days	9	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

Endemic Countries	State/Area	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
	Karachi (SINDH)	Interrupt transmission	number of cases (WPV1 and cVDPV2)	0 case	WPV: 9 in Karachi (10 WPV in Sindh)	WPV: 14 in Karachi
		High population immunity	% 0-dose	<10%	15	(20 in Sindh)
			LQAS	>= 90%	70	0.57
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 15 SNIDs	2 NIDs, 10 SNIDs
			% children missed due to no visit/ child absent	<2%	1.60%	0.7% start 1.3% end
			% children missed due to refusal	<2%	0.80%	0.6% start 0.5% end
		High virus detection	AFP rate	> 2 per 100 000	5.6	5.6
			stool adequacy	> 80%	89.1	92.37
			lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015	On track	
	All of country		Number of polio cases from families refusing OPV	0 case	116	

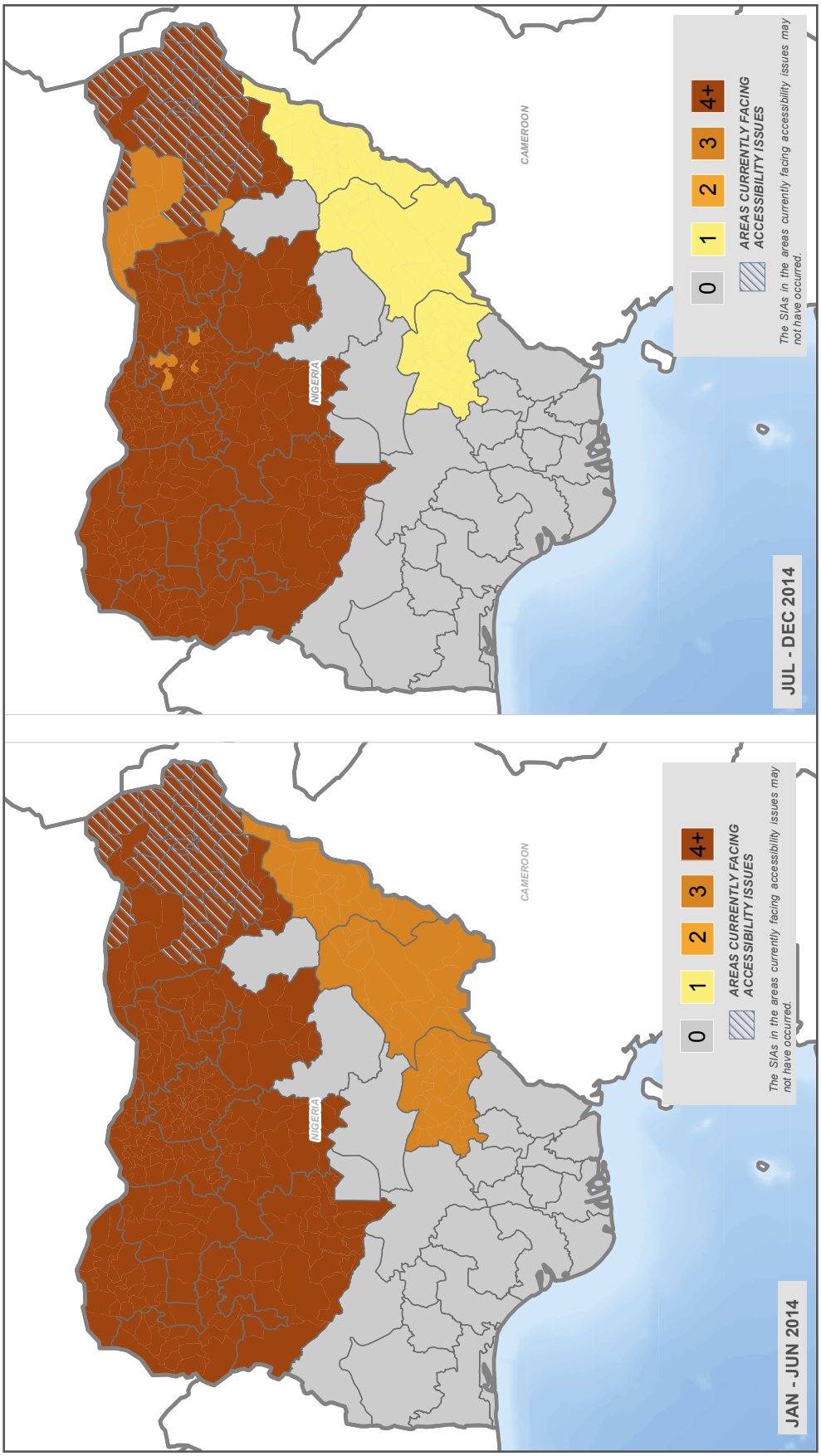
SIAs in Pakistan



Endemic Countries	State/Area	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Nigeria	North Central (Kano, Katsina, Jigawa, Kaduna)	Interrupt transmission	number of cases (WPV1 and cVDPV2)	0 case	11 (4+7)	7 (1+6)
		High population immunity	% 0-dose	<10%	0.80%	0.35
			LQAS	>= 90%	85 start 94.3 end	N/a
			% inaccessible	<5%	0	N/a
			Number and type of activity	per plan	2 NIDs,4 SNIDs	8 SNIDs
			% children missed due to no visit/ child absent	<2%	2.2% start 1.85% end	1.9% start 1.3% end
			% children missed due to refusal	<2%	0.4% start 0.5% end	1.9% start 1.3% end
		High virus detection	npAFP rate	> 2 per 100 000	13	15.21
			stool adequacy	> 80%	94.2	96.3
			lab receipt to virus isolation result (median)	< 14 days	11.9	14
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Northeast (Borno, Yobe)	Interrupt transmission	number of cases (WPV1 and cVDPV2)	0 case	14 (1+13)	2 (0+2)
		High population immunity	% 0-dose	<10%	4.6	1.23
			LQAS	>= 90%	46.7 start 70.6 end	N/a
			% inaccessible	<5%	9.8 start 11.1 end	N/a
			Number and type of activity	per plan	2 NIDs,4 SNIDs	6 SNIDs
			% children missed due to no visit/ child absent	<2%	3.7% start 3.1% end	3.2% start 3.2% end
			% children missed due to refusal	<2%	1.4% start 0.6% end	1.2% start 1.2% end
		High virus detection	AFP rate	> 2 per 100 000	15.2	10.58
			stool adequacy	> 80%	99	97.41
			lab receipt to virus isolation result (median)	< 14 days	11	12
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

Endemic Countries	State/Area	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Nigeria	Rest of North (Sokoto, Kebbi, Zamfara)	Interrupt transmission	number of cases	0 case	0	0
		High population immunity	% 0-dose	<10%	0	0
			LQAS	>= 90%	93.8 start 97.9 end	N/a
			% inaccessible	<5%	0	N/a
			Number and type of activity	per plan	2 NIDs,3 SNIDs	4 SNIDs
			% children missed due to no visit/ child absent	<2%	2.3% start 1.6% end	1.7% start 1.3% end
			% children missed due to refusal	<2%	0.4% start 0.1% end	0.2% start 0.2% end
		High virus detection	AFP rate	> 2 per 100 000	26.4	28.56
			stool adequacy	> 80%	96.4	99.48
			lab receipt to virus isolation result (median)	< 14 days	11.8	13
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	72% (national)	N/a
	Rest of country	Interrupt transmission	number of cases (cVDPV2 only)	0 case	0	0
		High population immunity	% 0-dose	<10%	0.5	0.3
			LQAS	>= 90%	82.8 start 94.5 end	N/a
			% inaccessible	<5%	0	N/a
			Number and type of activity	per plan	2 NIDs,3 SNIDs	6 SNIDs
		High virus detection	AFP rate	> 2 per 100 000	12.2	11.25
			stool adequacy	> 80%	97.4	99.28
			lab receipt to virus isolation result (median)	< 14 days	11.7	13
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015	On track	
	All of country		Number of polio cases from families refusing OPV	0 case	0	

SIAs in Nigeria



Outbreak	Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Central Africa	Cameroon (Most recent case: 9 July 2014)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days		
			Timing of 1st response	=<4 weeks		
		Follow-on Response	SIAs plan execution	=>3 campaigns within first 3 months		
			interim assessment	Conducted at 3 months	1st 3-m ass't	2nd 3-m ass't
			final assessment	Conducted at 6 months		n/a
		Interrupt transmission within 6 months of confirmation of outbreak	number of cases	0 case after 6 months	3	2
		High population immunity	% 0-dose	<10%	15.29	8.94
			LQAS	>= 90%		
			% inaccessible	<5%		
			Number and type of activity	per plan	6 NIDs	4 NIDs, 3 SNIDs
		High virus detection	AFP rate	>2 (national)	5.85	8.93
			AFP rate	>2 (% of states/provinces meeting indicator)		
			stool adequacy	>=80% (national)	79.09	77.08
			stool adequacy	>=80% (% of states/ provinces meeting indicator)		
			lab receipt to virus isolation result (median)	< 14 days	13	13
			Environmental surveillance	Yes or no	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015		On track

Outbreak	Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Central Africa	Equatorial Guinea (Most recent case: 3 May 2014)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days		
			Timing of 1st response	=<4 weeks		
		Follow-on Response	SIAs plan execution	=>3 campaigns within first 3 months		
			interim assessment	Conducted at 3 months	1st 3-m ass't	2nd 3-m ass't
			final assessment	Conducted at 6 months		
		Interrupt transmission within 6 months of confirmation of outbreak	number of cases	0 case after6 months	5	0
		High population immunity	% 0-dose	<10%	44.44	0
			LQAS	>= 90%		
			% inaccessible	<5%		
			Number and type of activity	per plan	3 NIDs, 1 SNID	4 NIDs
		High virus detection	AFP rate	>2 (national)	7.37	5.93
			AFP rate	>2 (% of states/provinces meeting indicator)		
			stool adequacy	>=80%	36.84	77.78
			stool adequacy	>=80% (% of states/ provinces meeting indicator)		
			lab receipt to virus isolation result (median)	< 14 days	18	18
			Environmental surveillance	Yes or no	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015		On track

Outbreak	Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Horn of Africa	Somalia (Most recent case: 11 August 2014)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days		
			Timing of 1st response	=< 4 weeks		
			SIAs plan execution	>= 3 campaigns within first 3 months		
		Follow-on Response	interim assessment	Conducted at 3 months		
			final assessment	Conducted at 12 months		
		Interrupt transmission within 12 months of confirmation of outbreak	number of cases	0 case after 12 months	4	1
		High population immunity	% 0-dose	<10%	24.47	19.08
			LQAS	>= 90%		
			% inaccessible	<5%		
			Number and type of activity	per plan	3 NIDs, 9 SNIDs	2 NIDs,7 SNIDs
		High virus detection	AFP rate	>2 (national)	9.54	6.77
			AFP rate	>2 (% of states/provinces meeting indicator)		
			stool adequacy	>=80% (national)	96.71	97.7
			stool adequacy	>=80% (% of states/ provinces meeting indicator)		
			lab receipt to virus isolation result (median)	< 14 days	11	11
			Environmental surveillance	Yes or no	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015		On track

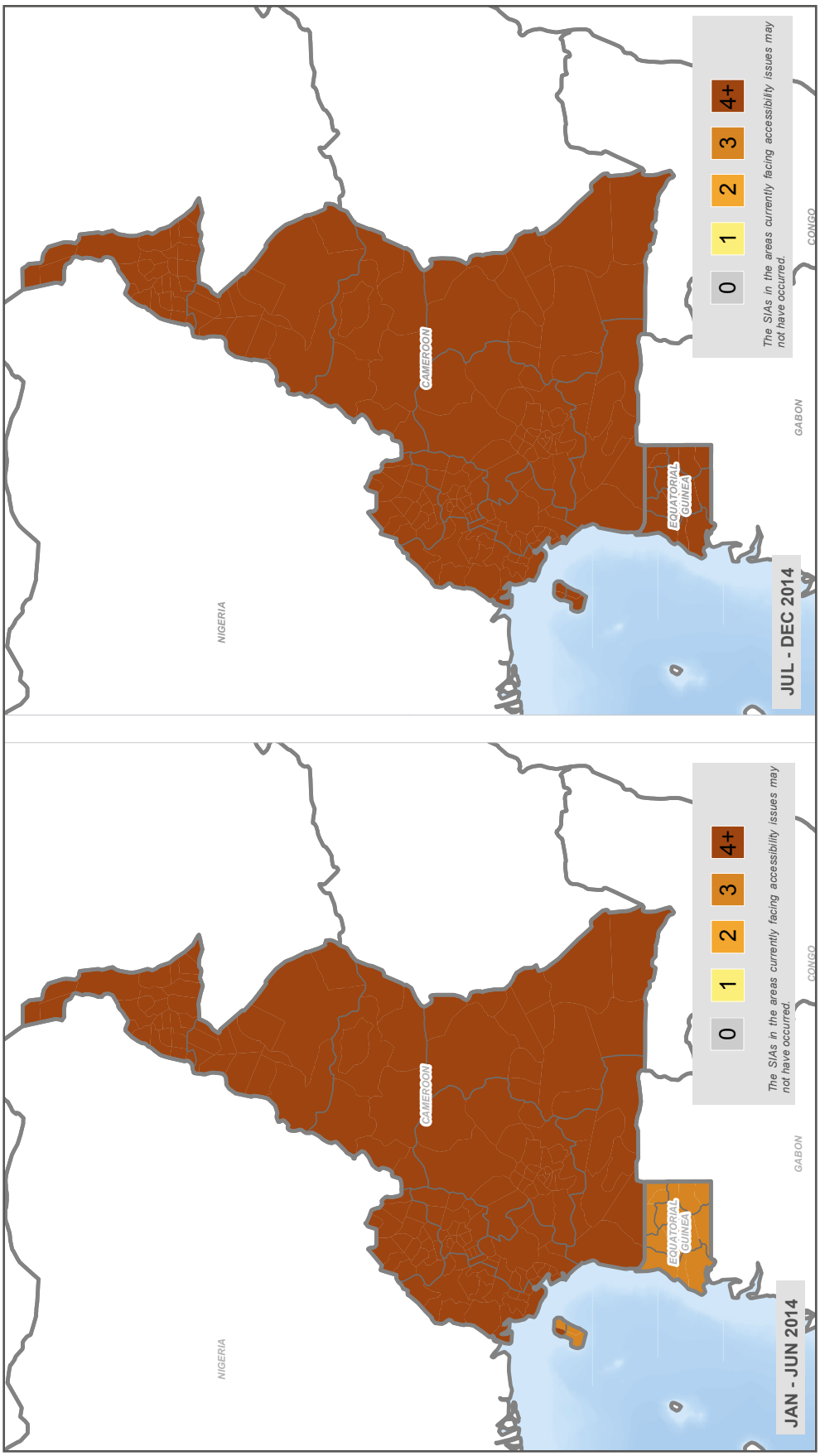
Outbreak	Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Horn of Africa	Ethiopia (Most recent case: 5 January 2014)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days		
			Timing of 1st response	=<4 weeks		
			SIAs plan execution	=>=3 campaigns wtihin first 3 months		
		Follow-on Response	interim assessment	Conducted at 3 months		
			final assessment	Conducted at 6 months		
		Interrupt transmission within 6 months of confirmation of outbreak	number of cases	0 case after 6 months	1	0
		High population immunity	% 0-dose	<10%	7.76	7.43
			LQAS	>= 90%		
			% inaccessible	<5%		
			Number and type of activity	per plan	4 SNIDs	1 NID, 2 SNIDs
		High virus detection	AFP rate	>2 (national)	2.97	2.8
			AFP rate	>2 (% of states/provinces meeting indicator)		
			stool adequacy	>=80% (national)	86.68	91.1
			stool adequacy	>=80% (% of states/ provinces meeting indicator)		
			lab receipt to virus isolation result (median)	< 14 days	13	12
			Environmental surveillance	Yes or no	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015		On track

Outbreak	Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Middle East	Syria (Most recent case: 21 January 2014)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days		
			Timing of 1st response	=< 4 weeks		
			SIAs plan execution	>= 3 campaigns within first 3 months		
		Follow-on Response	interim assessment	Conducted at 3 months		
			final assessment	Conducted at 12 months		
		Interrupt transmission within 12 months of confirmation of outbreak	number of cases	0 case after 12 months	1	
		High population immunity	% 0-dose	<10%	9.09	1.82
			LQAS	>= 90%		
			% inaccessible	<5%		
			Number and type of activity	per plan	6 NIDs, 6 SNIDs	2 NIDS, 1 SNID
		High virus detection	AFP rate	>2 (national)	4.32	2.83
			AFP rate	>2 (% of states/provinces meeting indicator)		
			stool adequacy	>=80% (national)	86.23	91.74
			stool adequacy	>=80% (% of states/ provinces meeting indicator)		
			lab receipt to virus isolation result (median)	< 7 days	12	12
			Environmental surveillance	Yes or no	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015	Already available	

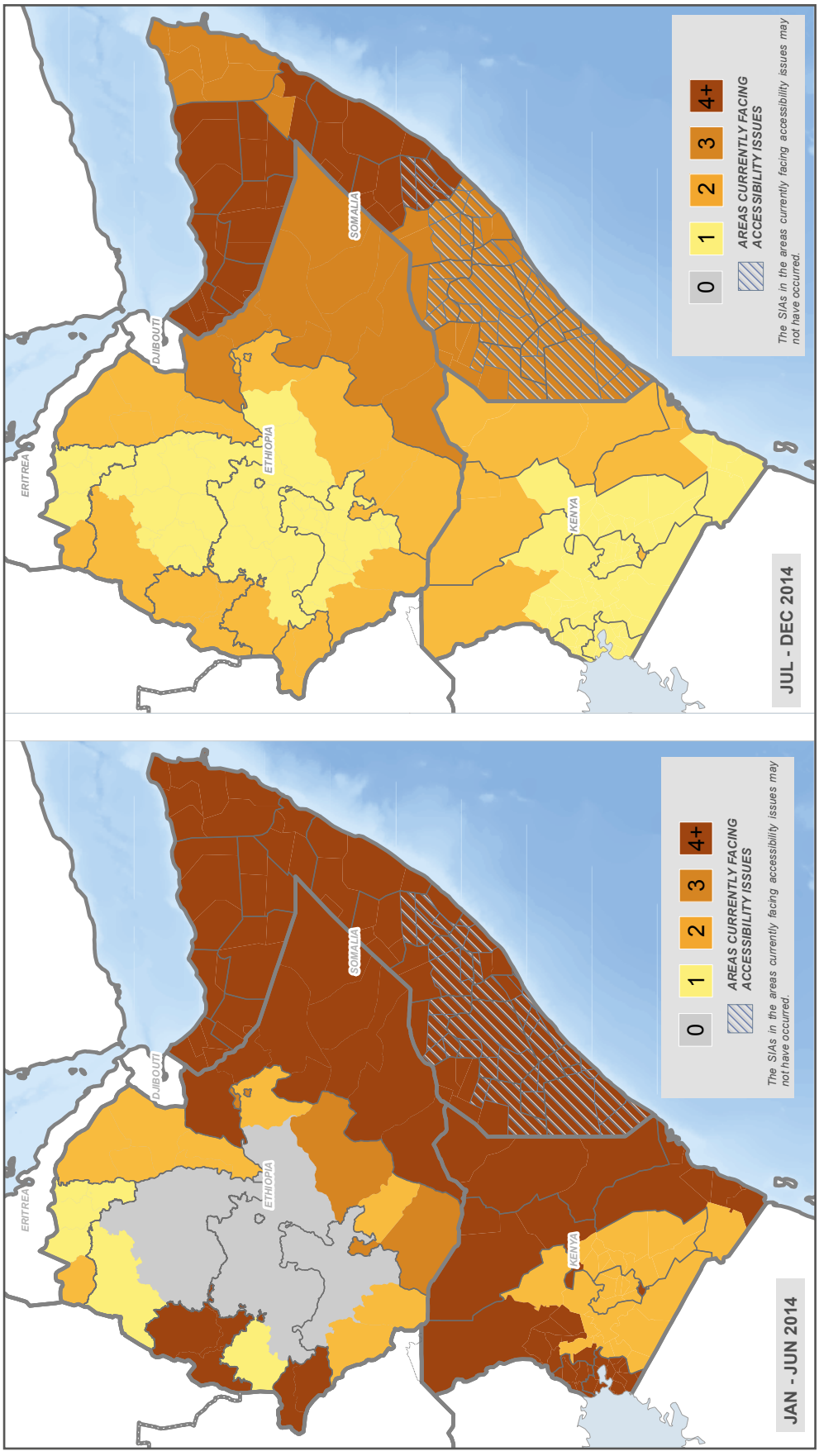
Outbreak	Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Middle East	Iraq (Most recent case: 7 April 2014)	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days		
			Timing of 1st response	=<4 weeks		
			SIAs plan execution	=>3 campaigns within first 3 months		
		Follow-on response	interim assessment	conducted at 3 months		
			final assessment	Conducted at 12 months		
		Interrupt transmission within 12 months of confirmation of outbreak	number of cases	0 case after 12 months	2	0
		High population immunity	% 0-dose	<10%	1.68	0
			LQAS	>= 90%		
			% inaccessible	<5%		
			Number and type of activity	per plan	3 NIDs, 2 SNIDs	2 NIDs, 4 SNIDs
		High virus detection	AFP rate	>2 (national)	5.18	3.35
			AFP rate	>2 (% of states/provinces meeting indicator)		
			stool adequacy	>=80% (national)	91.57	93.13
			stool adequacy	>=80% (% of states/ provinces meeting indicator)		
			lab receipt to virus isolation result (median)	< 14 days	11	11
			Environmental surveillance	Yes or no	No	No
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015		On track

Outbreak	Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Middle East	Israel	Initial Response	Initial responsiveness	Emergency declared + plan drafted within 10 days		
			Timing of 1st response	=<4 weeks		
			SIAs plan execution	=>3 campaigns within first 3 months		
		Follow-on response	interim assessment	Conducted at 3 months		
			final assessment	Conducted at 6 months		
		Interrupt transmission within 6 months of confirmation of outbreak	number of cases	0 case after 6 months		
		High population immunity	% 0-dose	<10%		
			LQAS	>= 90%		
			% inaccessible	<5%		
			Number and type of activity	per plan		
		High virus detection	AFP rate	>2 (national)		
			AFP rate	>2 (% of states/provinces meeting indicator)		
			stool adequacy	>=80% (national)		
			stool adequacy	>=80% (% of states/ provinces meeting indicator)		
			lab receipt to virus isolation result (median)	< 7 days		
			Environmental surveillance	Yes or no	Yes	Yes
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
			IPV introduction	intro by 2015	Already available	

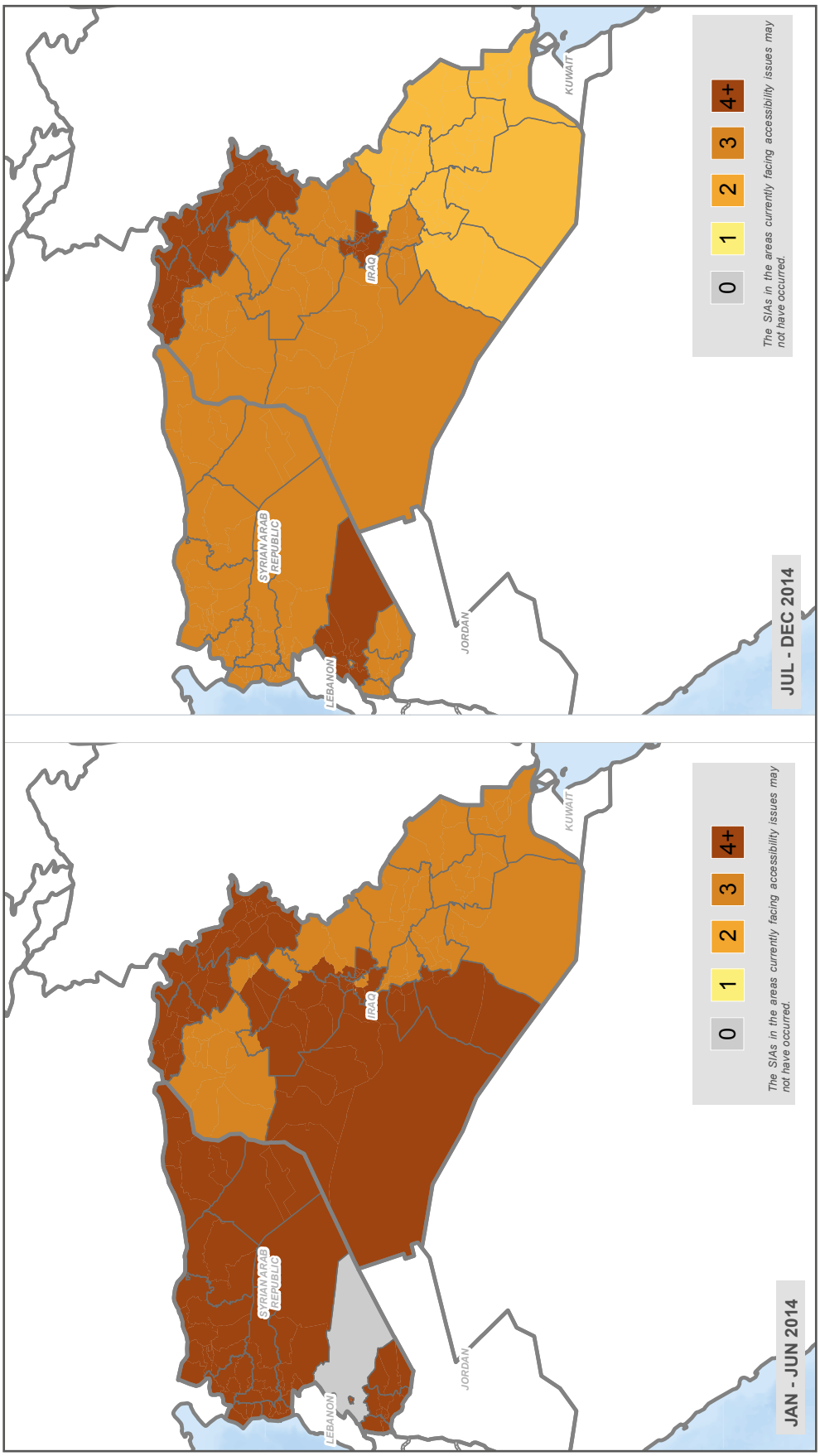
SIAs in Central Africa



SIAs in Horn of Africa



SIAs in Middle East



Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Angola	High population immunity	% 0-dose	<10%	3.45	2.61
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan		1 NIDs, 1 SNIDs
		AFP rate	>2 (national)	2.7	3.32
	High virus detection	AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	93.71	94.35
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	18 (median days)	18 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing
Benin	High population immunity	% 0-dose	<10%	1.72	0
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	2 NIDs	2 NIDs
	High virus detection	AFP rate	>2 (national)	4.52	2.78
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	86.14	80.95
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14days	18 (median days)	19 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing

Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Central African Republic (CAR)	High population immunity	% 0-dose	<10%	3 SNIDs	6 SNIDs
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	3 SNIDs	6 SNIDs
	High virus detection	AFP rate	>2 (national)	2.6	5.33
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	79.31	82.69
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	12 (median days)	12 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing
Chad	High population immunity	% 0-dose	<10%	6.06	5.45
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	2 NIDs, 1 SNID	1 NID, 1 NID
	High virus detection	AFP rate	>2 (national)	6.72	5.64
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	97.17	96.69
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	18 (median days)	18 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing

Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Congo	High population immunity	% 0-dose	<10%	38.46	30
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	1 NID	3 NIDs
	High virus detection	AFP rate	>2 (national)	4.58	5.73
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	95.45	83.93
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	14 (median days)	14 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing
Cote d'Ivoire	High population immunity	% 0-dose	<10%	1.59	0.89
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	1 NID	2 NIDs
	High virus detection	AFP rate	>2 (national)	5.04	4.05
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	93.02	85.14
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	12 (median days)	12 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing

Country	Outcome	% 0-dose	Target	Jan-Jun 2014	Jul-Dec 2014
Democratic Republic of the Congo	High population immunity	% 0-dose	<10%	3.62	2.4
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	2 NIDs	1 NID, 4 SNIDs
	High virus detection	AFP rate	>2 (national)		
		AFP rate	>2 (% of states/provinces meeting indicator)	5.04	5.59
		stool adequacy	>=80% (national)		
		stool adequacy	>=80% (% of states/ provinces meeting indicator)	90.72	86.89
		lab receipt to virus isolation result (median)	< 14 days	13 (median days)	14 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing
Gabon	High population immunity	% 0-dose	<10%	0	25
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	1 NID	2 NIDs
	High virus detection	AFP rate	>2 (national)	3.07	8.45
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	80	75
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	20 (median days)	18 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing

Country	Outcome	Indicator	Target	Jan-Jun 2014	Jul-Dec 2014
Mali	High population immunity	% 0-dose	<10%	4.92	1.39
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	2 NIDs	1 NID
	High virus detection	AFP rate	>2 (national)	3.04	3.23
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	88.5	95.08
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	19 (median days)	20 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing
Niger	High population immunity	% 0-dose	<10%	1.89	3.06
		LQAS	>= 90%		
		% inaccessible	<5%		
		Number and type of activity	per plan	2 NIDs, 1 SNID	1 NID, 3 SNIDs
	High virus detection	AFP rate	>2 (national)	2.63	2.43
		AFP rate	>2 (% of states/provinces meeting indicator)		
		stool adequacy	>=80% (national)	89.23	87.93
		stool adequacy	>=80% (% of states/ provinces meeting indicator)		
		lab receipt to virus isolation result (median)	< 14 days	36 (median days)	23 (median days)
		Environmental surveillance	Yes or no	No	No
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
		IPV introduction	intro by 2015		On track
		Containment	Complete Phase 1 containment (survey and inventory) by Oct 2014		Ongoing

Annex 5 – Analysis of OPV costs by region, Jan-Jun 2014 vs Jul-Dec 2014

Operational cost ($) per child (to reach and vaccine 1 child with 1 dose)	Jan-Jun 2014	Jul - Dec 2014
Global	0.30	0.32
AFRO	0.38	0.43
EMRO	0.17	0.16
SEARO	0.10	0.10
EURO	0.30	0.30

Increases due to:

- Intensified activities in Nigeria, including introduction of Direct Observation Polio Vaccination in key areas
- Reduction in estimated target population of northern Nigeria
- Higher level of activities in the second half of 2014 in key high-cost countries (DR Congo, Ethiopia, South Sudan).

Outcome	Indicator	Target	July-December 2014
All	**Financing:** 12-month cash gap		US$ 271 million
	Financing: Strategy funding gap		US$ 5.08 billion of US$ 5.5 billion committed (US$ 2.23 billion in contributions; US$ 2.28 billion in pledges. Realization of all pledges would result in remaining funding gap of US$ 442 million against Endgame Plan)
	Staffing: Percent of approved posts vacant	<10%	WHO HQ: 13.33% WHO Afghanistan: 14.39% WHO Nigeria: 8% WHO Pakistan: 13.29% WHO All: 12.48% CDC HQ: 18.03% CDC Afghanistan: 0% CDC Nigeria: 4.42% CDC All: 7.72%
High population immunity	**Vaccine supply:** % of weeks forecast below buffer in next 6 months	<10%	0 weeks
Low risk of virus re-introduction	Number of OPV-only using countries introducing IPV	**Per IMG**	All but three countries have committed to IPV introduction by the end of 2015. In total, the three remaining countries account for less than 0.05% of the global birth cohort and are not considered to be at high risk of emergence of a cVDPV2
	Plan in place to support routine immunization strengthening in 10 priority countries	**Per IMG**	Six countries – Chad, Democratic Republic of Congo, Ethiopia, India, Nigeria and Pakistan – have developed annual national immunization plans that leverage polio assets to improve broader immunization goals
	Reducing international spread of polio		PHEIC declared; countries implementing Temporary Recommendations
	Containment	**Per GAPIII**	GAPIII aligned with Polio Endgame timelines – SAGE endorsed
	Certification		Continued progress on WPV2 eradication verification
Legacy planning	Consultations inputs into plan	**By end 2014**	Continued progress on consultations to develop Global Legacy Framework by 2015; POB endorsed

objective 1	objective 2
objective 3	objective 4

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