# Report on implementation of June 2012 IMB recommendations

October 2012

## *1. An emergency meeting of the Global Polio Partners Group is held to mobilise urgent funding to reinstate cancelled campaigns.*

- July conference call held to discuss resource mobilization plans
- As of October
  - 2012 gap is effectively closed
  - 2013 gap reduced to US$340.76 m (including 75% likely prospects)
  - Impact: high priority campaigns rescheduled for end 2012
- Two major contributors to filling the gap:
  - WHA declaration of eradication as a programmatic emergency
  - UNGA polio event characterizing eradication as a “once-in-a-generation” opportunity
- A robust long-term strategy, more strategic collaboration of partners (task force for resource mobilization), concrete progress, and UNGA momentum, planning for the Vaccine Summit in April 2013 should result by mid-2013 in a majority of the long-term funding needed

## *2. The Polio Oversight Board should continuously review the effectiveness of the Programme to achieve improvement; ten transformative activities are set out for this purpose.*

- Polio Oversight Board has met twice (June and Sept) since last IMB report
- Visits by Heads of Agencies &/or senior staff:

| Country | Number of visits |
|---|---|
| CDC | 2 visits to Nigeria |
| Rotary | 1 visit to Nigeria by Rotary President (July 2012)* |
| UNICEF | 1 visit to Chad by Executive Director (April 2012) |
| WHO | 2 visits to Pakistan and 1 visit to Afghanistan by Regional Director, WHO EMRO<br><br>2 visits to Nigeria, 2 visits to Pakistan, and 1 visit to Afghanistan by WHO Assistant Director General |

*Afghanistan, Nigeria and Pakistan have all been visited by Rotary Senior Leaders, with visits to Heads of State in the last 7 months.

## *3. A polio 'end-game and legacy' strategy should be urgently published for public and professional consultation.*

- Consultant hired in July 2012
- Input from WHO Regional and Country Offices, the polio donor and stakeholder community, the Polio Partnership Group, the SAGE polio working group, and spearheading partners
- Draft transmitted to the IMB on 18 October; input expected on final version (due end-2012)

- Key strategy milestones identified:
  - end-2014: interruption of WPV transmission
  - 2015-16: tOPV-bOPV switch
  - end-2018: global certification
- 2013-2018 budget developed: US$5.5 b
- Broad 2013 consultations on program legacy planned to ensure polio investments/assets are secured for broader global health benefits

## *4. A plan to integrate polio vaccination into the humanitarian response to the food crisis & conflict in W Africa should be rapidly formulated & implemented. Alliances with all possible programmes must be urgently explored, to make every contact count.*

- Challenges: nutrition/food crises, insecurity, flooding, and cholera
- Actions:
  - Country plans developed to integrate nutrition, health (including OPV), and WASH
  - Cross-border meetings held to strengthen collaboration (Niger and Nigeria; Mali, Burkina Faso, and Cote d'Ivoire; Lake Chad - Cameroon, Chad, Niger, and Nigeria; and Cameroon and Chad) and focus on nomadic and other mobile populations (Burkina Faso, Mali, Niger, Chad, and Mauritania)
  - Refugees and IDPs targeted in all SIAs (e.g., IDPs in Mali and Malian refugees in Burkina Faso, Niger and Mauritania)
  - Additional synchronized SIA conducted in Niger (all regions except Agadez), Mali (the 6 regions accessible in South), Burkina Faso (all regions neighboring Niger and Mali), and Guinea (Conakry and Kankan) due to increased mobility in these areas
  - Synchronized SIAs Oct & Nov in Benin, Burkina Faso, Cameroon, CAR, Chad, Cote d'Ivoire, DRC, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria and Sierra Leone

## *5. We recommend that environmental surveillance should be much expanded in its use, and that, if feasible, a positive environmental sample should trigger a full outbreak response. We recognize the feasibility and the logistics of this need to be looked into but this should be done rapidly.*

- Environmental surveillance workshop held May 2012
  - By end-2012: Strategy/guidance developed (e.g., risk areas for undetected WPV importation/circulation, cVPDV emergence)
- Funds sought to support optimization of sample collection/concentration. RFP to use funds expected in 2012-Q4; work to commence in early 2013
- While new technologies are developed, expansion priorities are:
  - 2012-Q4: Add/change collection sites in the Kano metro area
  - 2013-Q1: Start collection in Luanda for local concentration and remote testing
  - 2013-Q2 or later: Initiate collection at sites in Maiduguri (lab capacity must be increased to accommodate this)
  - 2013-Q4: Consider new sites in major transport hubs of sub-Saharan Africa
- By end-2015: 15-20 new sites globally to help monitor OPV2 cessation, elimination of Sabin 2, facility containment (vaccine manufacturing sites) (Endgame 2013-18)

## *6. Contingency plans should be drawn up now to activate the International Health Regulations to require travellers from polio-affected countries to carry a valid vaccination certificate; this measure should be implemented when just two affected countries remain.*

3 options considered (with Department of Global Capacities Alert and Response):

1. Amendment to the IHR
    - only way to "require" vaccination prior to travel
    - NOT favored as : 1) process is long (>2 years); 2) rejected in 2008 by WHA; and 3) countries can opt out
2. DG/WHO to issue a 'Temporary Recommendation' under the IHR
    - NOT favored as "considerable administrative effort and related processes", including declaration of a "public health emergency of international concern", the establishment of an "IHR Emergency Committee," review every 3 months, and duration < 24 months
3. DG/WHO to issue a 'Standing Recommendation' under the IHR
    - Favored by WHO as could potentially include vaccination or review of proof of vaccination and exit screening
    - Process could begin late 2012 or early 2013

## *7. The number of missed children (those with 0 doses of vaccine, those with <3 doses, and those missed in each country's most recent vaccination campaign) should henceforth be the predominant metric for the Programme; a sheet of paper with these 3 numbers should be placed on the desk of each of the Heads of the Spearheading Agencies at the beginning of each week. This should commence immediately.*

- Consensus on best metric – triangulation of independent data on missed children over time
  - LQAS conducted in high-risk/worst-performing areas immediately after SIA rounds
  - OPV immunization status of non-polio AFP cases
  - post-campaign market surveys and 'independent monitoring'
- Other data improvements
  - house-based monitoring of missed children during the SIAs to enable immediate correction
  - 'results monitoring frameworks' showing outcome (SIA quality, OPV status of non-polio AFP cases) and impact data (polio cases, environmental isolates) for highest-risk areas
  - partner calls to optimize quarterly SIA planning based on best data and modeling
  - re-designed computerized data platform at WHO/HQ to receive, process, and share data
  - data sharing agreements (with appropriate safeguards) between WHO/HQ and partners