



## ***Update of Partners' Report on Ten Transformations***

**IMB Meeting, London**

**April 2013**

*Addendum to the October 2012 report*



## *April 2013 update*

### 1. Senior leaders give the Programme true operational priority

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

The Polio Oversight Board has met four times by teleconference: June 2012, September 2012, November 2012 and February 2013

The Polio Emergency Steering Committee convened for the first time on 19 June 2012 and has met regularly via teleconference or face-to-face: July 2012, September 2012, October 2012, November 2012, January 2013, February 2013 and March 2013.

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

Agency	Number of visits
CDC	2 visits to Nigeria
Rotary	1 visit to Nigeria by Rotary President (July 2012); 1 visit to Pakistan by past Rotary President (December 2012); 1 visit to Pakistan by Rotary International PolioPlus Committee Chair (March 2013); and, 2 visits to India and Nigeria by Rotary Foundation Chair (in February and March 2013, respectively).
UNICEF	1 visit to Chad by Executive Director (April 2012) 1 visit by Director of Programmes to Joint RMT with representation from WCARO and ESARO including Nigeria, DR Congo, Chad, Angola and South Sudan as well as Horn Of Africa countries (Dakar in October 2012) 1 visit by all 3 endemic Country Representatives with RD in ROSA (Kathmandu in November 2012)
WHO	2 visits to Pakistan, 1 visit to Afghanistan by Regional Director, WHO EMRO; leadership role in the Cairo Islamic Scholars Conference in March 1 visit to Nigeria, 1 visit to DR Congo and 2 visits to Angola by Regional Director, WHO AFRO 3 visits to Nigeria (incl to ERC in March 2013), 3 visits to Pakistan, and 2 visits to Afghanistan by WHO Assistant Director General; and 2 visits to Egypt, to meet with polio team leaders from Afghanistan and Pakistan to discuss operations, and to participate in the Cairo Islamic Scholars Conference in March.
BMGF	1 visit to Nigeria by CEO Jeff Raikes and President, Global Development Dr Chris Elias to Nigeria (November 2012)

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

Country	Number of meetings
Afghanistan	<p>Zero meetings of the President’s Task Force to date</p> <p>An inter-ministerial task force held its first meeting in December 2012 to engage all the line departments.</p> <p>First meeting with the District Governors of high risk districts in Kandahar was held in March 2013 and was co-chaired by Governor of Kandahar, Minister of Public Health, and President’s Focal Person on Polio Eradication.</p>
Nigeria	<p>Four meetings of Nigeria’s Presidential Task Force were held between October 2012 and April 2013.</p> <p>October meeting: Chaired by His Excellency the President, attended by Governors/Deputy Governors from 11 high-risk states and LGA Chairmen from 45 LGAs with declining population immunity.</p> <p>January meeting: Chaired by His Excellency the President, attended by Governors/Deputy Governors from 11 high-risk states.</p>
Pakistan	<p>Meeting of the Prime Minister’s Task Force held on 18 December 2012. The Task Force reviewed and endorsed the National Emergency Action Plan for 2013.</p>

## 2. Close collaboration and coordination amongst Partners

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

OPV continues to be administered alongside emergency humanitarian response activities across West Africa. To supplement regular synchronized campaigns held in the region, a synchronized campaign was conducted in February/March in selected areas in 3 countries: Mali, Burkina Faso and Mauritania. These sites were chosen based on risk analysis which pointed to an increased risk for poliovirus transmission in the region due to the ongoing cases of wild polio virus (WPV) in Nigeria and the ongoing humanitarian crisis with subsequent increased population mobility across the region. Synchronized polio SIAs are planned in April and May in West Africa.

#### Mali:

- Since March 2012, Mali has been experiencing a humanitarian crisis in the three northern provinces of Gao, Kidal and Timbouctou, resulting in more than 241,448 internally displaced persons (IDPs) and 166,425 refugees in neighbouring countries.

- Five rounds of polio NIDs were conducted from March to November 2012. For security reasons, all three northern provinces (except three districts in Kidal and one district in Gao in March 2012) could not be reached during this period. Additionally, three districts in Mopti could not be covered.
- The Medical Board, Ordre des Médecins du Mali, succeeded in dispatching three missions of approximately 30 health professionals to the north, to work with local NGOs.
- In November 2012, SIAs reached 7.4 million children with bivalent OPV. In March 2013, SIAs reached 1.5 million children.
- Further SIAs in 2013 are planned, including in the three northern conflict affected regions, to be combined with Vitamin A and deworming. Three provinces and three districts in Mopti will again not be covered during the upcoming April SIAs.
- In addition to this, 3 rounds of routine immunization catch up activities with all antigens are also planned. The end of May round for the entire north is still scheduled, although the successful conduct of all of these planned activities are subject to an improved access and security in the north. In response to the ongoing measles outbreak in Kidal region, the decision was made to use the measles response vaccination undertaken by MDM Belgique with UNICEF financial support to add on OPV and Vitamin A for this region. The campaign is currently ongoing, and half way (Day 5 out of 10 scheduled), 16,720 children under five have been reached with OPV (83%).

**Burkina Faso, Niger, Mauritania:**

- SIAs continue to be conducted to reach refugee populations. Refugee children aged 0-11 months (1,395) are enrolled in the routine EPI programme delivered with the local health center structures. All these activities are conducted by the Ministry of Health in conjunction with UNHCR, WHO, UNICEF, Médecins Sans Frontière (MSF) and Médecins du Monde (MDM).
- In Mauritania, OPV administration to children less than 5 years was provided upon their arrival in the refugee camps. AFP surveillance is also strengthened, with 1 AFP case in the camp (investigated and diagnosed as non-polio). In the coming months Mauritania is planning to conduct a Maternal and Child week nationally starting on 24 April, which will include routine immunization (children 0 - 11 months), OPV (0 - 59 months) in the refugee camps (target 0 - 59 months = 19,930 children). The NIDs planned for 22-25 May and in June will also include refugee camps and hosting communities. In order to ensure reinforcement of immunity through routine immunization, Mauritania is finalizing a collaborative agreement with national NGOs to support vaccination in refugee camps and in hosting communities (20 days per month through mobile teams).
- Vaccination activities in Niger are also being coordinated with adjoining areas of Nigeria.

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

The second annual GPEI partners' meeting was held in January 2013. Among the issues discussed during the 2-day meeting were coordination of support for low-season priorities in the polio-endemic countries, updating and refining the organization of the partnership, and getting started on Objective 2 of the new GPEI Polio Eradication and Endgame Strategic Plan 2013-2018 (immunization systems strengthening and OPV withdrawal). To assist with the latter, the meeting was also attended by high-level representatives from GAVI and from the respective routine immunization sections of the partner agencies.

The efficiency and effectiveness of different coordination groups (Polio Emergency Steering Committee, Inter-agency Coordination Group, Polio Advocacy Group, Inter-agency Innovation Working Group, Finance Working Group) were assessed and recommendations made for further optimization of coordination. The Polio Steering Committee, “PSC”), consisting of the 2 highest technical-level staff from partners) has continued to meet every 2–4 weeks to oversee coordination and progress of the programme. The groups under the PSC were reorganized to better serve the priorities of the 2013–2018 Endgame Strategic Plan. To oversee Objective 1 (“Poliovirus Detection and Interruption”), an “Eradication Management Group” (EMG) was formed (2 high-level technical staff from each agency) and has been meeting every 2–4 weeks to coordinate partner operations focussing on eradication of WPV and control of cVDPV. To oversee “Objective 2”, an “Immunization Systems Management Group” (IMG) has been formed with strong involvement of the routine immunization groups from around the partnership. The other working groups are either subsumed in the two management groups or will report to the PSC (Finance Working Group and Polio Advocacy Group).

To coordinate support to endemic countries, weekly calls to support Nigeria are being held, led by the WHO African Regional Office. Separate monthly calls are also held to coordinate support for Afghanistan and for Pakistan.

Within those countries, core group meetings that represent partner agencies are occurring on a regular basis. Pakistan is continuing to support “polio control rooms” during SIAs to manage and coordinate activities. Since the last IMB meeting, Nigeria, with support of the BMGF, has established an “Emergency Operations Centre” in Abuja, where meetings are held daily during SIAs and several times per week between campaigns to coordinate operations. In addition, EOCs have been or are being established at the state level. Polio Control Rooms in Afghanistan were established recently at national level, in four provinces of Southern Region and 11 low performing districts, to be functional from early May 2013.

### **3. Staff well-managed and accountable**

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

In total, 504 staff in supervisory and managerial positions have been trained through the WHO-led management training programme (142 in Afghanistan, 156 in Nigeria, 180 in Pakistan, 26 in Chad, and 33 in DR Congo). The purpose of these trainings is to ensure effective managers capable of motivating staff and organising work towards successful achievement of individual results. The content and related exercises of the trainings build on and reinforce the Accountability Framework. Following these trainings, accountability and management will be rolled into induction type trainings for all newly recruited staff and included in periodic refresher trainings for existing staff.

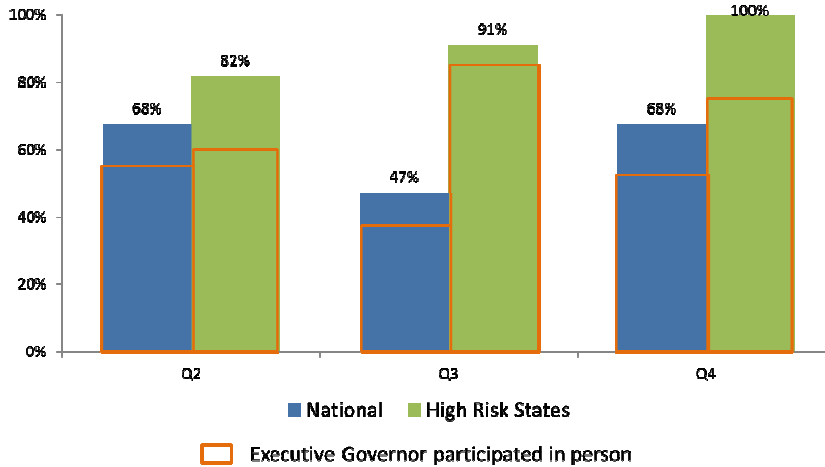
#### **b) How often have the State Governors in Nigeria chaired polio meetings since May 2012?**

Throughout 2012, the Nigeria programme tracked state leadership for polio eradication using the Abuja Commitments as well as the Nigeria Immunization Leadership Challenge. Data and verifying evidence generated from these sources shows that State Governors’ involvement with polio

increased only slightly at the national level between Q2 and Q4. The State Governors of the 11 High Risk states, however, demonstrated a steady increase in leadership support for the polio programme during 2012.

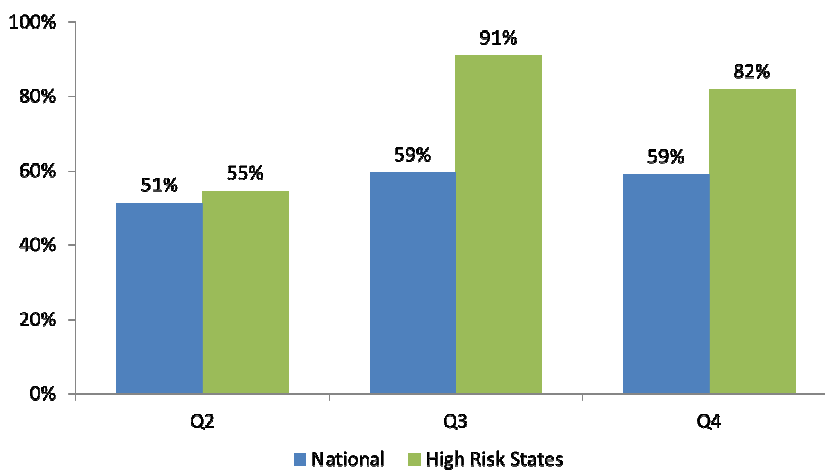
Nationally, 68% of states reported personal involvement of either the Executive or Deputy Governor in a public event in support of polio in Q4 2012. In contrast, all of the 11 High Risk States reported such events in Q4, up from 82% in Q2. Executive Governors themselves (rather than the Deputy Governor) participated in the majority of these events, particularly in the High Risk States.

**States Reporting Involvement of the Executive or Deputy Governor in at Least One Public Event in Support of Polio, National and High Risk States, Q2-Q4 2012**



In Q4 2012, 82% of High Risk States reported at least one meeting between the Executive or Deputy Governor and LGA Chairman to discuss polio, up from just 55% in Q2. Nationally, just 59% of states reported such a meeting in Q4.

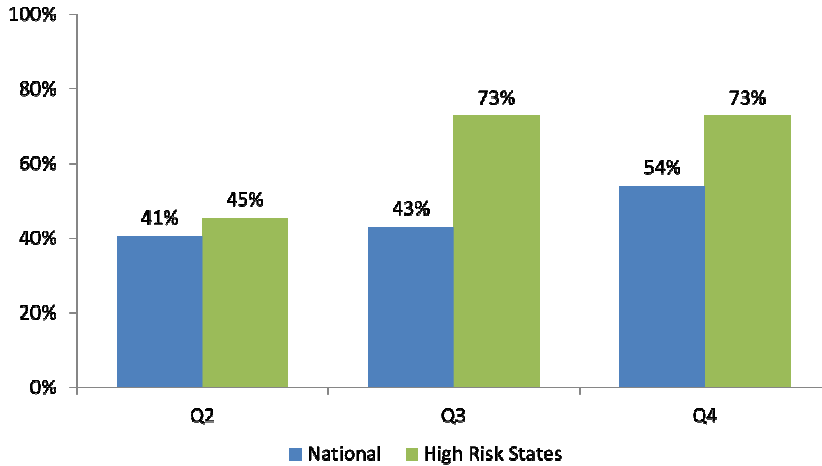
**Proportion of States Reporting at Least One Quarterly Meeting between the Executive or Deputy Governor and LGA Chairmen, National and High Risk States, Q2-Q4 2012**



The majority of State Governors in High Risk States (73%) reported meeting quarterly with traditional leaders to discuss polio in Q3 and Q4. Fewer Governors reported such meetings

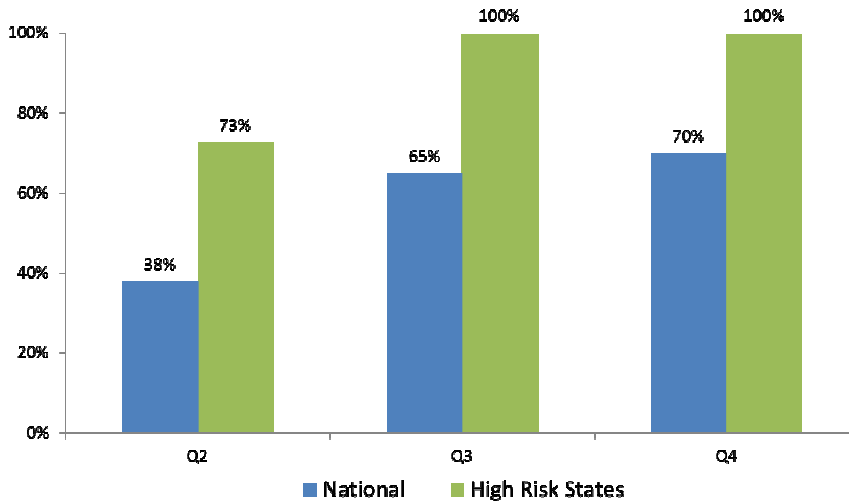
nationally, with just 54% in Q4.

**Proportion of States Reporting at Least One Quarterly Meeting between the Executive or Deputy Governor and Traditional Leaders, National and High Risk States, Q2-Q4 2012**



The increase in states convening quarterly meetings of a State Task Force on polio and RI, which grew from 38% in Q2 to 70% in Q4, is a notable area of improvement in state leadership for polio. All High Risk states reported convening a State Task Force meeting in both Q3 and Q4. As recommended by the Presidential Task Force, these meetings are chaired by State Deputy Governors.

**Proportion of States Convening a State Task Force on Polio & RI, Q2-Q4 2012**



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

NGOs remain important partners, though are no longer playing the role as direct implementer of SIAs in the high risk districts of Southern Region. All PEI country teams of WHO, UNICEF, MoPH and staff from the Grant Commission Management Unit (GCMU) conducted field exercises in August 2012 in 22 provinces of Afghanistan to assess the performance of BPHS NGOs in routine EPI. The report was submitted to MoPH in September 2012. The polio team leader and other national team members regularly travel to evaluate SIA performance.

Two of the Deputy Ministers, General Director Preventive Medicine and one director from each department of the MoPH monitored the campaign in various parts of Kabul in October 2012 and the March 2013 NIDs.

#### 4. Sufficient technical support staff in-country

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

##### **WHO**

As part of the global emergency efforts, WHO has deployed significant new technical assistance to highest-risk areas to more effectively support the endemic countries' eradication efforts. In total, nearly 3,220 additional staff (as at April 2013) have been deployed in the three remaining endemic countries (2207 in Nigeria, 680 in Pakistan and 333 in Afghanistan). The bulk of the new staff had been already in place by mid-2012, and the agencies' surge in capacity went hand-in-hand with the Governments, which are undertaking similar activities to scale up technical capacity. Recruitment is also underway to ensure that senior positions at the national, state/province level are filled to enhance management capacity.

WHO – Staff Surge	AFGHANISTAN	NIGERIA	PAKISTAN
As of April 2013	333	2207	680

The overriding priority remains to integrate the new surge workforce into a well-functioning operational outfit. Activities are continuing to focus on ensuring the necessary management and training is in place, with relevant administrative support, to ensure the scaled-up workforce can operate in the most efficient – and accountable – manner possible.

##### **CDC**

CDC now has 18 staff members posted to positions in the field, and is supporting 11 contractors posted to the field, not counting National STOP (“NSTOP”) staff. The international STOP programme has 165 volunteers deployed currently. In addition to continuing the focus on surveillance and vaccination activities, the programme has been recruiting members with skills in informatics. The programme also now includes a special training module on management for staff being deployed to Nigeria, Pakistan and the Democratic Republic of Congo. At CDC’s Atlanta headquarters, scale-up of staff was completed by October. To support the programmes in Nigeria and Pakistan, CDC has established NSTOP programmes. In Nigeria, CDC supports with Abuja-based members, 10-state-based members (in 10 Northern states), and 38 recently hired, locally recruited, LGA-based staff (“Expanded NSTOP”). The programme is looking to increase the Expanded NSTOP effort with another 62 staff recruited from the highest risk LGAs. In addition, the programme makes use of ancillary staff who have undergone a 2-week polio training. These ancillary staff include residents in the country’s Field Epidemiology and Laboratory Training Programme as well other public health professionals and academics. The Pakistan NSTOP programme is continuing with 32 individuals.

##### **UNICEF**



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

<b>Scale-up of social mobilization networks in high-risk areas HRAs</b> October 2011-April 2013		
	<b>Number of HRAs covered</b>	<b>% of target HRAs covered</b>
<b>PAKISTAN</b>		
Oct-11	82	10
Jan-12	521	58
May-12	521	58
Oct-12	789	88
Apr-13	789	88
<b>NIGERIA</b>		
Oct-11	0	0
Jan-12	0	0
May-12	957	38
Oct-12	1827	73
Apr-13	21	
<b>AFGHANISTAN</b>		
Oct-11	50	25
Jan-12	50	25
May-12	52	27
Oct-12	142	73

<b>Scale-up of technical support</b>			
<b>Country</b>	<b>Number of social mobilizers in 2011</b>	<b>Number of social mobilizers in 2012</b>	<b>Number of social mobilizers in 2013</b>
India	9,125	9,125	8,117
Afghanistan	2,100	2,056	3,436
Pakistan	800	1,056	1,059
DR Congo	N/a	18,688	18,688
Nigeria	N/a	2,100	2,127

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

In Pakistan, the programme has engaged with:

- The UN Resident Coordinator’s Office and the United Nations Country Team (UNCT) resulting in an agreement that all UN activities in the country will include a focus on polio high risk districts/areas. 1.7 million USD have been earmarked by UNCT for these joint activities.
- The Pakistan Motorway and Highway Police Department to obtain their support of transit immunization on all major inter-provincial / inter-district roadways

- The Pakistan Military in FATA resulting in an opportunity to conduct SIADs in Bajour and delivery of OPV in parts of Bara tehsil, Khyber Agency for the first time in 3 years.
- National experts in Pakistan on access issues in FATA (for example senior ex-government, ex-military, and political analysts with expertise on FATA).
- Major nursing and Social Work schools of the University of Karachi for supporting SIAs as vaccinators or monitors.
- In critical tribal agencies of FATA (Bara and Tirrah areas of Khyber Agency), OPV is offered as part of an immunization package along with hygiene kits, in particular during windows of opportunity to access populations that are not consistently reached.
- There is a plan for a nationwide measles campaign during 2013. The first phase is planned for June in Sindh and southern Punjab; OPV will be added.
- Pashtun university students in Punjab (Government College Lahore and others) were retained to strengthen SIA supervision and monitoring in high-risk Pashtun settlements.
- In addition, police and other security agencies under the control of deputy commissioners support SIAs in Gadap, including in UC4.

#### In Nigeria

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

#### **CDC**

CDC has taken advantage of its Field Epidemiology Training Programmes (FETPs) in Nigeria and Pakistan to engage experienced and talented public health officials from those countries to bolster the polio eradication effort. These staff are typically mid-career public health staff with a solid understanding of the country's public health system. They are chosen through a competitive process to enter into the 2-year practicum. In Pakistan, they've increased the programme's reach into previously inaccessible areas, and have played a big role in improving management and accountability in these areas. In Nigeria, experienced staff have been recruited to work at the state level to support polio eradication (NSTOP). Those staff work closely both with Nigerian government staff as well as GPEI partners in the field. More recently, a second group of staff have been recruited locally to work at the LGA level (Expanded NSTOP); a major component of the programme is improvement of routine immunization systems at this level.

#### **UNICEF**

UNICEF has just entered into a partnership agreement with Harvard University's Opinion Research Programme, which will conduct social research which can rapidly poll community perceptions in high risk areas. The programme will benefit from Harvard's network of local research agencies in the field, which will provide reliable social data on community perceptions that undergoes rigorous quality assurance from Harvard's School of Public Health.

UNICEF is also working with BBC World Service Trust to engage in a similar partnership agreement that will leverage BBC's capacity globally and in countries to reach caregivers and communities more strategically and systematically by media programmes.

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

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

Country	Average daily salary 2012	Average daily salary 2011	Hours of training
Nigeria	600 Naira (700 Naira in 2013)	500 Naira	5-6 hours
Pakistan	500 Rupees	300 Rupees	4-5 hours
Afghanistan	200 Afghani	150 Afghani	6 hours
Chad	2500 CAF	2500 CAF	4 hours

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

*“The heart of the polio eradication programme globally is the frontline worker who ensures that polio vaccine reaches every child in their microplan.” GPEI Polio Eradication and Endgame Strategic Plan 2013-2018.*

New strategic approaches are outlined in the new GPEI Polio Eradication and Endgame Strategic Plan 2013-2018, to more effectively support the work of frontline health workers. The strategic plan emphasis is on ensuring vaccinators and supervisors with the right profiles are recruited, trained, compensated and supported through effective supervision, even in the most difficult areas.

Special vaccinator selection committees are now established in each of the remaining endemic countries, with local membership, to find workers who are both acceptable to the local community and are as accountable as possible to local authorities.

Programmes are focusing on overhauling training procedures with a focus on interactive skill-based training, and providing other supportive measures to maintain a trained and motivated on-the-ground workforce who understand the community dynamics, speak the local language and are socially acceptable to deliver OPV. A new interpersonal communication skills kit is being produced and special training conducted in several high-risk areas of Nigeria and Pakistan, and a similar module was rolled out in select districts of Kandahar in the last quarter of 2012.

In recognition of the importance of frontline workers, many of whom put themselves at personal risk all in efforts to protect children from lifelong polio-paralysis, all three endemic countries raised daily wage rates for vaccinators in 2012. Frontline workers who are victims of attacks, and their families, receive awards (certificate and cash), both through the CDC Foundation’s ‘Polio Heroes Fund’ and by the governments of the endemic countries.

Following the tragic attacks on health workers in Pakistan and Nigeria, there has been widespread and universal condemnation from all sectors of public and civil society across both countries, and indeed the world, that such attacks on health workers are completely unacceptable. All political parties have condemned these attacks and expressed their support for frontline health workers, as

have traditional and religious leaders across both countries. Similar statements were also issued at the global level, including by the core partners of the GPEI, the OIC, the UN Secretary-General and other political institutions, foundations, and leaders, including by Islamic scholars at the recently-held high-level Cairo Consultation of Islamic Scholars.

The Governments of Pakistan and Nigeria have established coordination between security and law enforcement agencies and the polio programme to enhance safety and security of health workers. Three police personnel have died in recent months while protecting vaccination teams during targeted attacks.

## 6. Insight-rich actionable data used throughout the Programme

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

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

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

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

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

The programme has developed 'results monitoring frameworks' showing the most important programme inputs, outcome indicators (SIA quality, OPV status of non-polio AFP cases) and impact data (polio cases, environmental isolates) for the highest-risk areas (see examples in joint CDC/WHO report for the October IMB meeting). The programme has also developed a Special Investigation Toolkit which provides a framework of investigation to understand underlying reasons for chronically missed children. To date, this revised and standardized tool has been rolled out in Afghanistan, though the GPEI awaits the investigation report.

Using the best available data and modeling outputs, partners have initiated a series of regular joint consultations, beginning in mid-2012, to optimize quarterly SIA planning. The POLIS project (Polio Information System), a BMGF-supported project to re-design the computerized data system at

WHO/HQ, will greatly strengthen WHO's capacity to receive, process and share epidemiological and SIA data provided by countries and Regions.

This project to develop a standard global polio data platform has been underway at WHO headquarters since mid-2012. The main objectives of this 'POLIS' project are to facilitate the access to - and use of - polio eradication data, including data on surveillance quality and SIAs. POLIS converts previous polio databases, which consist of databases with different formats and analysis requirements, into one unified web-based system. The new system will then bring all polio data together into a central data store ('data mart'), with common dimensions (geography, time, virus, vaccine type, etc), utilizing state-of-the-art, standardized data storage based on SEQUEL server technology. Multiple web-based outputs and options will enable the visual analysis of results and generate pre-defined online reports, as well as interactive online reports linked directly to the central database (reflecting the most up-to-date data). This new platform will greatly facilitate data analysis requirements for both routine reporting and special reports, such as research studies. As a web-based system, the platform will be accessible by users outside of WHO headquarters (ie WHO polio teams at regional and country levels), and is expected to be operational in July 2013.

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

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

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

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

Additionally, a local-level assessment of the security situation is now being conducted with district-level officials and local law enforcement agencies, ahead of any activity being implemented.

## **7. Highly engaged global movement in support of polio eradication**

**How successful was activity at the UN General Assembly and associated concert in Central Park?**

**How is the Programme now capitalising on this activity to further the momentum of a global movement? What more is planned? Was there an increase in “hits” on the GPEI's website following the UNGA activity?**

The side event on polio eradication convened by the UN Secretary-General on 27 September 2012 and the subsequent Global Citizen festival marked the beginning of increased activities to generate a global movement in support of the worldwide effort to eradicate polio.

**World's Biggest Commercial**

Rotary has continued to attract celebrities and the general public to participate in the 'World's Biggest Commercial'. To date, approximately 15,000 participants from 144 countries have participated in this social media effort and all have been encouraged to share it through their networks. A 'best of' section of the commercial was aired in New York in Times Square in February and March 2013.

In addition, at the Sundance Film Festival in January 2013, Rotary set up a booth and engaged more than 70 new celebrities in the 'World's Biggest Commercial', and all were reminded to share it through their respective social media networks.

**World Polio Day**

World Polio Day afforded a further opportunity to raise public awareness about polio eradication efforts. Rotary celebrity ambassadors (including Jackie Chan, Angelique Kidjo, Ziggy Marley, Jack Nicklaus) shared 'This Close' messages and the 'This Close' public service announcement with 34 million followers on Facebook and Twitter. In addition, Rotary-led 'Thunderclap' on World Polio Day resulted in #endpolio 'trending' in multiple countries with a reach of 24.2 million and 82 million impressions. There were also 14 million media impressions globally. Rotary's End Polio Now website had 14,968 page visits and 584,519 page views.

**Japan events**

In February 2013, UNICEF led events that included WHO and Rotary that engaged the government, public and private sector. Activities included a breakfast with high-level Japanese officials and media, a public reception, a luncheon co-hosted by the American Chamber of Commerce Japan and a media roundtable.

**Media tour for new Strategic Plan**

A media tour was organized by the Gates Foundation that included speakers from the GPEI partnership in Washington DC, New York and London that was designed to educate journalists and editorial boards at top-tier outlets in donor countries about the new Strategic Plan. Since the aim was to generate accurate, positive coverage of eradication efforts over the long-term, turnout was just as important as spot coverage of the plan. Media outlets that attended the briefings included *The New York Times*, *Washington Post*, *Economist*, BBC, AFP, Associated Press, Reuters, NPR, *Forbes*, *Scientific American*, *Science*, *Independent (UK)*, *BMJ* and others, including journalists from Germany, France and Canada who joined the briefings remotely.

**Scientific Declaration**

On 11 April 2013, 450 scientists and technical experts from 80 countries launched the Scientific Declaration on Polio Eradication, which emphasized the achievability of eradication and offered a strong endorsement of the Global Polio Eradication Initiative's (GPEI) new Strategic Plan.

The declaration received coverage in numerous top-tier donor country outlets, including the UK, US and Germany. Coverage included seven original newspaper/magazine articles, one radio segment and eight stories in online outlets. Notably, *The Lancet* published a story on the Strategic Plan, emphasizing external expert confidence in eradication, and *The Independent* (UK) published an article highlighting the experts' endorsement of the plan and the importance of upfront funding. Reinhard Burger, one of the declaration's key signatories, was interviewed in three major German newspapers: *Süddeutsche Zeitung*, *Berliner Zeitung* and *Der Spiegel*.

In addition, the declaration was covered in major outlets in India (*The Hindu*), Nigeria (*The Guardian, Vanguard*), Pakistan (*Daily Times, Observer*) and Africa (*AllAfrica*).

Five signatories authored opinion pieces about the declaration, including Jacob John in the *Wall Street Journal India Real Time Blog*, Peter Piot in the *Guardian Global Development Blog*, Ciro de Quadros in the *Huffington Post* and Reinhard Burger and Sabine Diedrich in *Ärztezeitung*.

Numerous signatories and their organizations tweeted about the declaration. 151 handles tweeted a total of 188 tweets using #poliodeclaration, reaching 1.8 million unique users. Between 9-14 April, 495 handles tweeted a total of 640 tweets using #endpolio, reaching 1.7 million unique users. Many high-visibility individuals and organizations, including schools of public health and prominent global health and development institutions, helped amplify the declaration on Twitter. Groups also posted about the declaration on Facebook.

## Influentials

Since the polio influencers strategy was launched in September 2012, 34 influential individuals have used their voices in support of polio eradication through communications activities:

- Opinion pieces: 20 influencers from the US (7), Canada (3), UK (3), Germany (2) and globally (5) have authored 38 opinion pieces on polio eradication, published in a mix of top-tier traditional and social media outlets. Notable authors and outlets include:
  - Seth Berkley authored a piece in *Wall Street Journal's India Real Time*
  - Siddharth Chatterjee of the IFRC authored five pieces, including in *Forbes* and *The Guardian Global Development Blog*
  - Reinhard Burger, President of Germany's Robert Koch Institute, authored pieces in *Die Welt*, *scienceblogs.de*, *Ärztezeitung* and *Ärzteblatt*
  - Peter Piot authored a piece in *The Guardian Global Development Blog*
  - Larry Brilliant is authoring a piece with Bill Foege for the *Scientific American Guest Blog*
- Media engagement: 14 influencers served as media spokespeople, either as part of planned story pitches or in response to negative news. Notable examples include:
  - Naveen Thacker, former President of the Indian Academy of Pediatrics, was featured in five news pieces, including a Q&A in *New York Times' India Ink* focusing on India's efforts
  - Zulfiqar Bhutta of Aga Khan University was interviewed by several outlets, including

- *Al Jazeera*, following the shootings of Pakistan health workers
  - Ramesh Ferris was interviewed on 13 *CBC Radio* interviews in Canada and featured in *TIME*, *Huffington Post* and *CNN/IBN* highlighting his trip to India around the second polio-free anniversary
  - Zulfiqar Bhutta, Walt Orenstein, Helen Rees, Sir Gus Nossal, Sania Nishtar and Oyewale Tomori were featured in articles about the Scientific Declaration
- Social media: The tweets of several influentials on polio eradication have reached more than 24.7 million users, according to a TweetReach analysis. An additional 10 influentials whom are updated with polio eradication news tweet regularly about polio. In addition to partner social media accounts, several high-visibility individuals, including Aseefa Bhutto Zardari and Shashi Tharoor, have tweeted and re-tweeted influentials.
  - Inform updates: Informational updates have been set on a monthly basis to as many as 212 influentials from the US (74), Canada (32), UK (35), Germany (49) and globally (22). To date, 88 influentials have sent positive responses.

### **Engagement with Islamic leaders**

In March 2013, The Grand Imam of Al-Azhar, Doctor Ahmad Al Tayyeb, called for the protection of Muslim children against poliovirus transmission by ensuring they receive the required polio vaccine. He stressed the importance of increasing the awareness of the correct Islamic teachings on the subject to combat all deformed and false beliefs, and confirmed that Al-Azhar is ready to continue to exert all efforts to enlighten individuals and communities about the rights of children to be protected against polio and all other diseases and the obligation of all parents to ensure that their children are protected.

This was announced at a meeting held at Al-Azhar during which the Grand Imam met with Islamic scholars from several countries. The scholars expressed their solidarity with the children of the Islamic world and reaffirmed their resolve to support the people, health workers and governments of the three countries where polio is not yet eradicated, namely Afghanistan, Nigeria and Pakistan.

Recognizing with grave concern the ongoing transmission of wild poliovirus in parts of Afghanistan, Nigeria and Pakistan, and the remaining political, cultural, societal, operational and security challenges preventing all children in these areas from being vaccinated against polio, and in particular the tragic and deadly attacks against frontline health workers in parts of Pakistan and Nigeria, Islamic scholars from several countries met for two days in Cairo from 6–7 March to discuss the major obstacles preventing these countries from stopping polio transmission and trying to reach a consensus on how Islamic leadership can help communities to overcome these barriers and ensure protection for all children.

### **Global Vaccine Summit**

His Highness General Sheikh Mohammed bin Zayed bin Sultan Al Nahyan, Crown Prince of Abu Dhabi, and Bill Gates, co-chair of the Bill & Melinda Gates Foundation, and UN Secretary-General Ban Ki-moon are co-hosting a vaccine summit in Abu Dhabi in April to continue momentum in the Decade of Vaccines, a vision and commitment to reach all children with the vaccines they need.

This summit highlighted the role that vaccines and immunization systems play in achieving global



child health and development goals. Individuals and institutions with innovative approaches demonstrated commitment across a broad spectrum of the vaccine enterprise gathered to renew their commitment to children and immunizations.

The Summit included a special session on the progress towards polio eradication and emphasize the importance of the world uniting to fully fund the new GPEI Polio Eradication and Endgame Strategic Plan 2013-2018. The GPEI will report on commitments made at the Summit during the IMB meeting.

## 8. Thriving culture of innovation

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

### Status of 'innovations'

1. House-based microplanning in Nigeria
  - The new house based microplans are reviewed after every second round and now takes into account results from GIS mapping process as these are available in the northern high risk states. As a result of this, the number of settlements in the house-based micro-plans in the 11 high risk states increased from 106,729 in Q4 2012 to 128,507 in Q1 2013. This is contributing to improving SIA quality in highest risk states that have had this process ongoing for several months (all NWZ states and NEZ states not affected by insecurity).
2. Dashboards
  - Dashboards are now in use in all 3 endemic countries
3. Permanent Polio Teams (PPTs) in Afghanistan
  - In Afghanistan, there are 68 Permanent Polio Teams (PPTs) who supplement vaccine delivery outside of the normal campaign schedule, and are functional in 10 of the 11 Low Performing Districts (LPDs). The Quarterly target for PPT is approximately 300,000 children which is 45% of the total target of LPDs. The average monthly coverage achieved varies from district to district ranging from 45%-90%. A total of 265,969 (>75% of the PPT target) children, with at least one additional dose of OPV, while 164,401 (53%) received at least two doses of OPV during the period of April-December 2012. Over 17,000 (6%) received OPV for the first time through PPTs.
  - In Nigeria, the Emergency Operations Center in Abuja is negotiating the feasibility of establishing PPTs in insecure areas of northern Nigeria, in up to 12 Local Government Areas in three states. A protocol for the deployment of permanent teams has been developed and a budget developed. A timeline for moving ahead is being finalized.
4. Security Practices:
  - Refer to section 9A of this report
5. Expanded age group of SIAs
  - Expanded Age Group SIAs are now a standard approach in outbreak response scenarios, even where there is no evidence of cases above the age of 5 years
  - Expanded Age Group SIAs are being carefully considered in all 3 endemic countries balancing the expected benefits with potential risks due to the complex political/social environment and efforts to improve the fundamentals of SIA implementation (microplanning, training, etc)

6. SMS for community-based surveillance in Nigeria
  - This project continues to be implemented and evaluated.
7. GIS/GPS for improved microplans and SIA implementation
  - GIS mapping has been completed in all 8 states except for a number of Wards in Borno, where access has been limited due to security issues. Alternatives are being considered which would allow completion of the Borno GIS mapping by May 15, 2013.
  - Ward maps have been printed & distributed for the 7 GIS-mapped states. A final verification step is underway in which the LGA and Ward teams sign-off on the maps as being accurate and complete with respect to settlement numbers and names. When verified, final maps for LGAs and Wards will be printed and laminated for extended use. Due to the logistics and personnel challenges involved with vaccination team tracking, the maximum number of LGAs tracked in any SIA will be 50. In January, a decision was made to change the vendor providing tracking support. The new vendor is rapidly scaling up tracking capacity and 28 LGAs were tracked in April 2013.
  - Vaccinator team tracks are uploaded each evening at the LGA level, and feedback is provided by a support team by the following morning. This feedback consists of geographical coverage (5 area visited by team) for large urban areas, and a visited/not visited statistic for small settlements and hamlets. A consolidated “missed settlement” list is provided to the LGA team and the national and state EOCs on day 5 to direct mop-up activities, and again on Day 6 to evaluate the mop-up coverage. A Web-based dashboard provides detailed coverage statistics, maps, and the actual team tracks at the LGA, Ward, and settlement level, and is updated daily during the campaign.
8. Characterizing nomadic populations in Nigeria
  - The GIS mapping project provided GIS base maps and GIS-enabled android phones to the CDC/N-STOP project for use in collecting geospatial reference data for migrant groups. The result was over 6000 additional settlement names identified as migrant/Fulani communities in the 7 GIS-mapped states. GIS maps showing these newly identified settlements were printed and used in the January IPD, which focused on poorly-served populations and areas.
9. Mobile technology (including SMS) for monitoring and social mobilization in Afghanistan:
  - System developed and hardware/software procured and set up
  - Schedule to be launched for May campaign 2013

## **10. Systemic problems tackled through development and application of best practise solutions**

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

Since the last meeting in September 2012, UNICEF HQ (Think Tank Chairs) sent an email in March 2013 to the Think Tank members to provide an update on overall progress in polio eradication and on the developments especially in Pakistan and Nigeria. Additionally, some bilateral communication also took place between the polio team in NY and OCHA and UNDSS in NY. However, the expectation now is for the joint WHO and UNICEF teams in country to drive this forward and work directly with the country representatives of the various Think Tank members to ensure collaboration and coordinate for operationalizing the matrix developed from the global level meeting. UNICEF will continue to provide Think Tank members with quarterly updates on overall progress and challenges and will propose to convene a follow-up meeting of the Think Tank members in NY once the new Security Officer-Polio joins by Q2 2013.

Additionally, an informal GPEI working group on security has also been having teleconferences to discuss any arising security related issues and help coordinate and align work in this area. The working group has members from the five core partners.

The security environment and its political and social determinants have evolved substantially in the three remaining endemic countries and Somalia. Recognizing this reality, the GPEI has developed and is working under a framework for operating in insecure areas. Underpinning this framework is a thorough analysis of both the cross-cutting and unique security issues in the four countries. The overarching framework is complemented by country-level plans, outlining area-specific operational approaches.

The main strategic approaches of the framework are:

1. Clearly defining the area-specific security threats (scope, nature and determinants):
  1. Assessing context, ie: armed conflict warring between warring parties; militant insurgency; concerns about safety of vaccine and/or other mistrust; local disputes; and, criminal violence.
  2. Defining impact on operations, ie: SIA planning and implementation; and, ability to monitor quality of SIAs and surveillance.
2. Developing strategies to mitigate risks:
  1. Further engaging host government, including through constitution of security coordination committees for polio eradication comprised of senior officers from law enforcement agencies and security forces, at national, provincial and district levels.
  2. Continuously monitoring local threat assessment, and ensure analyses guide microplanning including: modifications to operational tactics (eg speed of operations, phased implementation, fixed site vs house-to-house, level of public visibility), intensified engagement of local community leaders, expanded recruitment of local staff with greater freedom to operate in insecure areas and better understanding of local complexities, and expanded use of permanent polio teams (PPTs).
  3. Intensifying support of WHO and UNICEF to the programme, including by: increased use of security hardware, communications and specialised training of staff in security management and negotiations; strategic deployment of staff with negotiated access; stronger coordination with UNDSS and local law enforcement agencies, and other agencies (ICRC, IFRC, local NGOs, Islamic relief organizations); increased capacity for political and conflict analysis; and, strengthening security coordination and communications across all levels of the GPEI partnership.
  4. Exploring options for continued delivery of polio vaccines, including increased use of Short Interval Additional Dose (SIAD) approach, adding OPV systematically to other mass vaccination campaigns, vaccinating children older than 5 years in poorly vaccinated areas whenever a window of opportunity allows, and enhancing linkages to routine immunization, including conducting RI catch up campaigns.
  5. Implementing containment strategies in areas that remain inaccessible for prolonged periods (eg >6 months), including: increased use of PPTs (see above), vaccination of populations at transit points, increased intensity of SIAs in surrounding areas and distant settlements linked to the high-risk inaccessible community, use of polio infrastructure to support negotiated rapid scale-up of routine immunization, intensified civil-military cooperation, enhanced public advocacy and support to create strong

demand for vaccination in excluded communities.

3. Implementing strategies to increase public support, access and demand for polio vaccination, at all levels:
  1. Fully integrating community mobilization activities in the unified operational and security microplans, with inclusion of local mosques and sensitization of religious and community leaders.
  2. In partnership with religious leaders and institutions, assessing and promptly responding to misinformation and rumours against vaccination.
  3. Strategic use of mass media to shape public perceptions through third party voices and credible experts.
  4. Formation of a high-level and credible Islamic Advisory Group (IAG), through consultative process with leading Islamic scholars and leaders from Pakistan, Afghanistan, Egypt, Saudi Arabia and institutions such as the Organisation of Islamic Cooperation (OIC), Health Ministers Council of the Gulf Cooperation Council (GCC), International Islamic Fiqh Academy and the Federation of Islamic Medical Associations.
  5. Increased use of 'PolioPlus' to increase local support for polio vaccination. Further to the IMB's recommendation to 'pair' polio vaccination with other health interventions, as a priority is the establishment of health and civic services by government in long neglected communities, to include routine immunization and other basic services in high-risk areas (similar to the '107 High-Risk Block Plan' in northern India and the 'Saving One Million Lives' plan in Nigeria); establishing closer linkages to other UN programmes (ranging from access to WASH, health education and rural poverty reduction); organization of strategically timed and well-organized health camps, and well-developed community health resource centers by Rotary; and identification of specific communities and assessment of which interventions are highly valued by local populations to determine feasibility of delivering these.
  
4. Planning extraordinary contingency measures if WPV transmission continues beyond 2014:
  1. Following recommendations by the IMB and deliberations at WHO's Executive Board (EB) in January 2013, an International Health Regulations (IHR) committee would be convened to advise on additional measures that could be implemented to reduce the risk of international spread.
  2. Significantly raising the prevalence by permanent transit teams to immunize children moving in and out of inaccessible areas.
  3. Intensifying civil-military cooperation mechanisms.
  4. Increasing incentives for periods of calm, and invest in advocacy and mediation for corridors of peace for vaccinations.
  5. Using the polio infrastructure to support scale-up of routine immunization with addition of IPV.
  6. When access is available, maximizing immunity response through mass delivery of IPV via hand-held jet injectors.

Following the tragic attacks on health workers in Pakistan and Nigeria, there has been widespread and universal condemnation from all sectors of public and civil society across both countries, and indeed the world, that such attacks on health workers are completely unacceptable. Governments of affected countries and GPEI partners have strongly reaffirmed their commitment to continue and intensify their support. There is widespread, perhaps unprecedented support, for the work of frontline health workers and a clear commitment at all levels that the safety and security of

frontline health workers must be paramount.

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

- Direct technical support visits to remaining polio-affected countries have included:
  1. WHO-India (National Polio Surveillance Project personnel): 2 missions to Nigeria (each comprising 16 medical officers for a duration of 3 months), 2 to Kenya , 1 to Uganda, 1 to Pakistan and 1 to Afghanistan (7 missions total = 42 people)
  2. UNICEF India: 11 missions to Pakistan, Afghanistan and Nigeria; additional support missions are planned to Pakistan in Q2 2013

Selected Outcomes

UNICEF is currently supporting an evaluation of the India Polio Learning Exchange (IPLE) to quantify how support from the Indian programme has impacted polio-affected countries from national to community levels.

**10. Parents' "pull" for vaccine dominates over "push"**

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

The proportion of refusals among all children <5 in the three endemic countries is approximately 1.23%. This may seem like an insignificant percentage, but it only takes small pockets of non-compliance to spark an outbreak in areas of unvaccinated children. In Pakistan, for example, 33% of all 2011 cases came from refusal families. In 2012, this had been reduced to 12%. This year, the proportion is 40%, though cases are few, and the proportion represents only 2 cases among 5. Khyber Pakhtunkhwa (KP) in Pakistan presents the largest risk, together with Sokoto, Kaduna and Kano in Nigeria, where over 50% of 2012 cases come from refusal families. Community resistance against the programme that is demonstrated in some areas represents a minority of areas, but it does have an effect on broader public sentiment. COMNet staff has been conducting focused community meetings in an effort to better understand a package of services that might help open doors for OPV and provide essential services.

In Pakistan, 83% of parents in high risk districts across the country are willing to vaccinate their children if the vaccine is provided, with even higher rates - at 91% - in the most at-risk areas of KP. When asked how likely they would be to take their children to a vaccination centre if teams did not arrive with OPV, 71% said 'likely' or 'very likely.' These indicators suggest a high level of community demand and commitment to vaccinating children with OPV, particularly if the programme shifts to revised strategies of broader service delivery and local ownership in areas that are security compromised.

In the past months, attacks against polio workers in Pakistan and Nigeria have shaken the GPEI, but not diminished resolve to finish the job. The programme has revised some of its operational approaches including communication to foster demand for immunization services such as polio vaccination. Communication is shifting from risk communication about the dire effects of polio to a

more gain framed approach that emphasizes the benefits of immunization in protecting children—a key concern of parents in areas with high levels of insecurity. In Pakistan and Afghanistan, where Knowledge, Attitudes and Practice studies have recently been conducted, parental concern about polio infection is low: 15% among caregivers in high risk districts of Afghanistan, and 18% in Pakistan. However, there is near universal concern over the safety of children as violence and uncertainty about the future increases.

The public face of the campaign is also evolving to better place locally trusted leaders to drive the campaigns, with mobilizers and campaign planners working behind the scenes to support these initiatives.

House to house communication in the remaining polio sanctuaries will focus on ensuring these local faces are the ones who engage in personal interaction on the doorstep, work to select vaccinators, monitor the campaigns and ensure the safety of all health workers. Media campaigns will continue to emphasize the need for collective action, social and individual responsibility to protect children against disease, but in light of the new security dynamic, these approaches will adopt more subtle approaches, focusing on comprehensive advocacy for broad immunization, and integrated content within news and media programmes, as opposed to overt public service announcements.