



Every
Missed
Child

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

June 2012

An extract from the polio dictionary

missed /misd/ **1.** Failed to reach, or come into contact with **2.** Failed to notice, see or hear **3.** Passed by without touching **4.** Failed to accomplish, achieve, or attain **5.** A child unprotected, a life put at risk **6.** Success sacrificed

INDEPENDENT MONITORING BOARD OF THE GLOBAL POLIO ERADICATION INITIATIVE

June 2012

The Independent Monitoring Board was convened at the request of the World Health Assembly to monitor and guide the progress of the Global Polio Eradication Initiative's 2010-12 Strategic Plan. This plan aims to interrupt polio transmission globally by the end of this year.

This fifth report follows our sixth meeting, held in London from 15 to 17 May 2012. We will next meet from 29 to 31 October 2012, in London, and will issue our next report thereafter.

Our absolute independence remains critical. We have benefited from many engaged discussions with representatives of the Programme and other interested parties. As ever, we are grateful to them. The views presented in this report are entirely our own.

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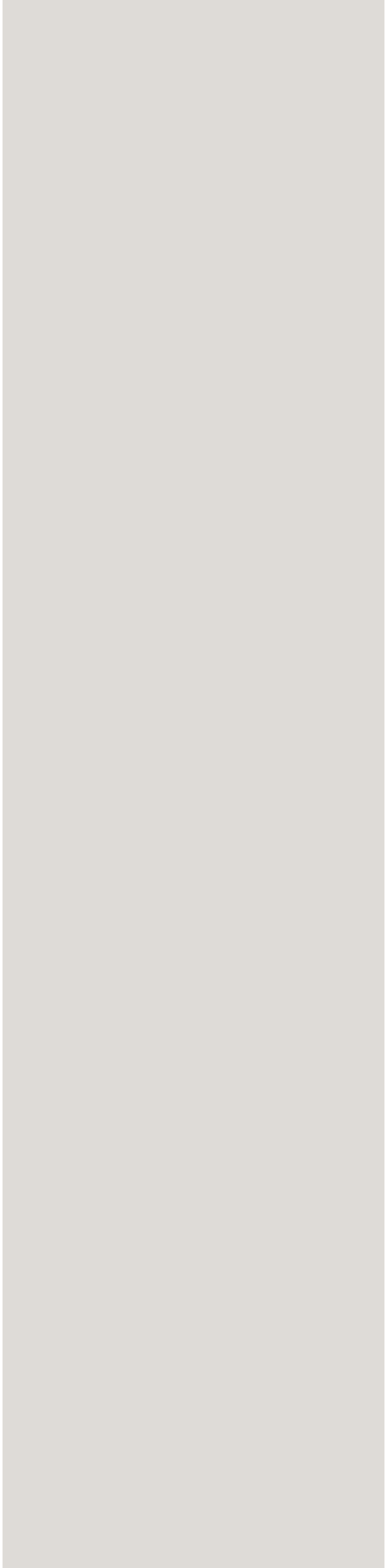
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CONTENTS

Executive summary	5
Cases & milestones	9
Global view	13
Sanctuary by sanctuary	23
Conclusions & recommendations	41



EXECUTIVE SUMMARY

1. Polio is at its lowest level since records began. In the first four months of 2012, there have been fewer cases in fewer districts of fewer countries than at any previous time and, importantly, many fewer than in the same period last year.
2. Polio is gone from India – a magnificent achievement and proof of the capability of a country to succeed when it truly takes to heart the mission of protecting its people from this vicious disease.
3. No cases of polio have been reported in Angola and the Democratic Republic of Congo since the beginning of 2012. Chad has reported just three. In the first four months of 2011 there had already been 73 cases in these same three countries.
4. Despite this very positive news, a towering and malevolent statistic looms over the Polio Eradication Programme: 2.7 million children in the six persistently affected countries have never received even a single dose of polio vaccine.
5. The Global Polio Eradication Initiative's compelling slogan 'Every Last Child' captures the vision for success and sums up its ultimate aim. If the eradication effort cannot track down and vaccinate 'Every Missed Child', this will be its downfall.
6. 2.7 million is too big a number. It should be sending shock waves through the leadership of the Global Programme and through the political and public health leadership in each affected country. No-one should avert their gaze from the challenge that this number poses. At the global level, at the national level and in cities, towns and villages, the precise reasons for all missed children – not just those who have never received even one dose – should be laid bare and rapid corrective action taken.
7. Nor should another home truth be ignored. India and the other successful countries are continuing to expend huge commitment, massive vaccination activity, vast amounts of senior leadership time and a great deal of money to protect themselves from re-infection by their neighbours.
8. A few weeks ago and in advance of this report, the IMB wrote to the Director-General of the World Health Organisation because the 65th World Health Assembly was meeting in Geneva and on its agenda was a draft resolution declaring polio a programmatic emergency for global public health. In its letter, the IMB spoke of a crisis. A crisis because recent successes have created a unique window of opportunity, which must not be lost. A crisis because a funding shortfall threatens to undermine the increasing containment of the virus. And a crisis because an explosive resurgence now would see country after country under attack from a disease that they thought their children were protected from.

9. In this report the IMB highlights key and urgent challenges on which the Global Polio Eradication Initiative must focus:
- The primary risk to the Programme is its precarious financial position. Under-financing is simply not compatible with the ambitious goal of stopping polio transmission globally. Currently vaccination campaigns are being cut, escalating the risk of an explosive return of polio just as it is at its lowest level in history.
 - The underpinning assumption of the polio eradication effort is that all countries in the world recognise that their collective will is necessary to gift to the world freedom from the scourge of polio. We do not see this 'global public good' philosophy driving the Programme. The participation in eradication as well as the donation of resources is uneven. We hope that the 65th World Health Assembly resolution on polio will bring countries together once more in a common cause.
 - Consistently high quality vaccination and surveillance must be achieved everywhere. Islands of excellence are not enough. Considerable improvements to the Programme's management approach have been set in motion, but the required degree of change has not yet been achieved. We set out our view of what remains to be done, and how momentum can be maintained.
 - The world needs to know what is planned for the months and years after 2012. This is a far-reaching and complex matter, which embraces technical aspects of vaccine deployment, the setting of targets and goals, funding decisions and resource mobilisation, further solutions for weak commitment and poor performance (where it is still occurring), reassuring the polio workforce about their future, and ensuring that the successes of the Polio Programme leave a footprint for future generations. Planning for the 'polio endgame' is in hand, but we are not convinced that the fundamental nature of what is required is fully understood by the Programme.
 - Further outbreaks risk substantially harming the Programme, bolstering transmission and diverting finances and focus. More innovative methods need to be used to extinguish the possibility of outbreaks in a more comprehensive way.
10. The Programme thinks and acts too much in isolation. Children missed by polio teams may be reached by other services. Stronger, more effective alliances can bring eradication closer.

11. It is clear to everyone associated with the Global Polio Eradication Initiative that remaining polio virus infection is confined not just to a few countries but to a small number of discrete locations within these countries. The IMB has called these 'sanctuaries' for the polio virus – places with large numbers of missed children where the virus can take safe refuge, multiply and prepare itself for a fresh attack on the vulnerable.
12. In this report, we examine ten such sanctuaries spread across the six remaining polio-affected countries. We examine the key challenges identified by national programmes and the corrective actions they have instigated. In these sanctuaries, reaching missed children is the one operational objective that trumps all others. Every child that the Programme fails to reach is a child left vulnerable. It is here that the fight against polio will be won or lost. The extraordinary challenges faced require extraordinary actions, determination and resolve.
13. The good progress in Angola, the Democratic Republic of Congo and Chad sits alongside the improvements in Pakistan's Programme where considerable challenges remain, but momentum is building. Elsewhere, the picture is less bright. Nigeria and Afghanistan are missing far too many children:
- Nigeria is now the only country in the world to have three types of polio virus. The country's Programme understands its major problems, but is yet to show that it is overcoming them. Nigeria poses a substantial risk to the global goal, in part because it has many neighbouring countries that are vulnerable to the spread of infection. The risk of an explosive return of polio in Nigeria and West Africa is ever-present and raises the chilling spectre of many deaths and a huge financial outlay to regain control. The country's impressive political and public health leaders are to be strongly encouraged: they have made strong progress in the past, and need to do so again.
 - Afghanistan is on the 'critical list'. Insecurity has been an explanation for poor performance in the past, but it is causing considerable consternation that security has recently begun to show signs of improvement yet polio case numbers are rising. This should take the Afghanistan Programme back to basics, to show, through its leadership and commitment, that it can deliver high quality programmes reliably and consistently, through methods that are working well elsewhere (and indeed in some parts of Afghanistan).
14. The Programme has missed all but one of its 2010-12 Strategic Plan milestones. But in the last six months, its operation has strengthened considerably. In the past, the Programme has been unable to sustain progress as it comes close to its goal. Now is the time to make sure that history does not repeat itself: to take the bold actions needed to build on this once-in-a-generation opportunity.

15. The IMB recommends that:

- I. An emergency meeting of the Global Polio Partners Group is held to mobilise urgent funding to re-instate cancelled campaigns.
- II. The Polio Oversight Board should continuously review the effectiveness of the Programme to achieve improvement; ten transformative activities are set out for this purpose.
- III. A polio 'end-game and legacy' strategy should be urgently published for public and professional consultation.
- IV. A plan to integrate polio vaccination into the humanitarian response to the food crisis and conflict in West Africa should be rapidly formulated and implemented. Alliances with all possible programmes must be urgently explored, to make every contact count.
- V. The presence of polio virus in environmental samples should trigger action equivalent to that of an outbreak response (this recommendation subject to rapid feasibility review).
- VI. 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.
- VII. The number of missed children (those with zero doses of vaccine, those with fewer than three 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 three numbers should be placed on the desk of each of the Heads of the Spearheading Agencies at the beginning of each week. This action should commence immediately.



Cases & milestones

Figure 1: Global situation (1st January to 2nd May - 2011/2012 comparison). In the first four months of 2012, there have been substantially fewer cases in fewer districts of fewer countries than in the same period last year.

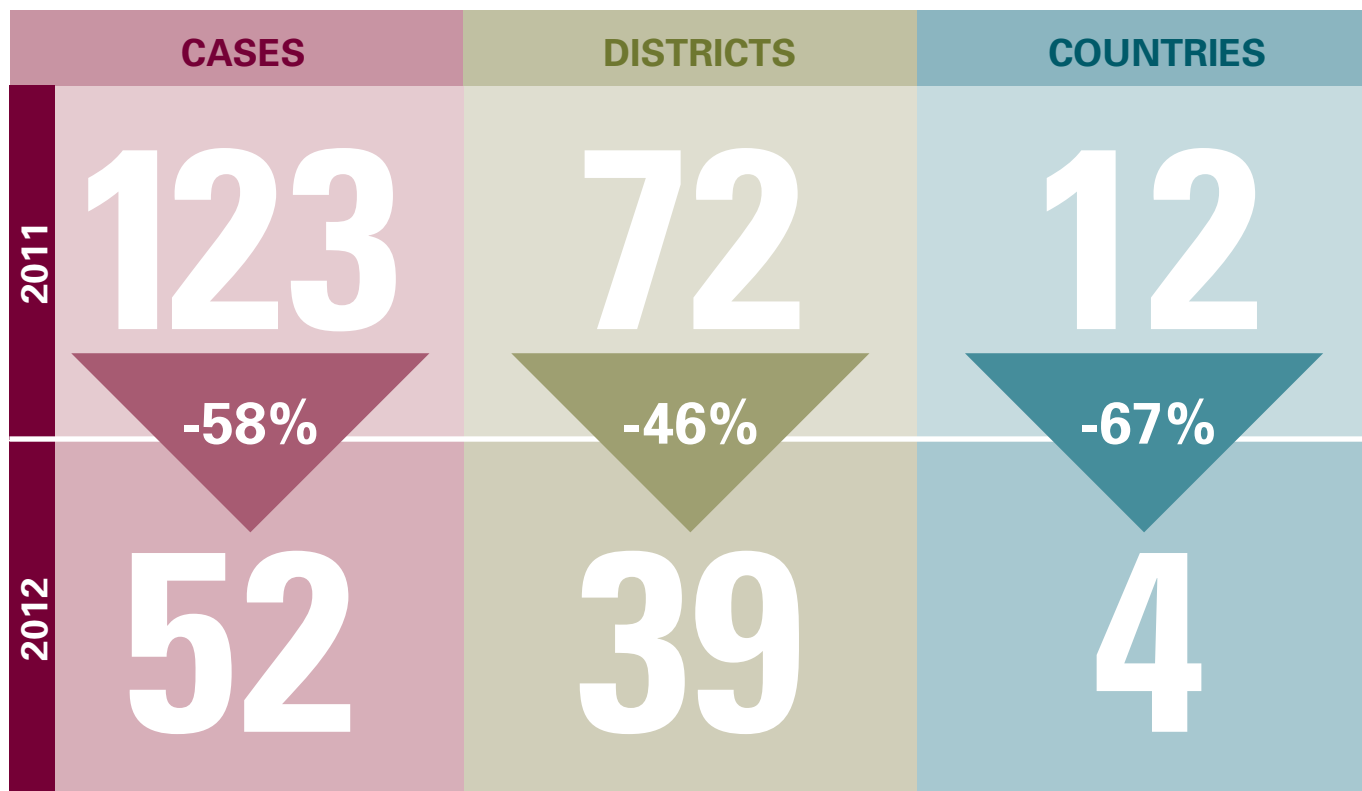
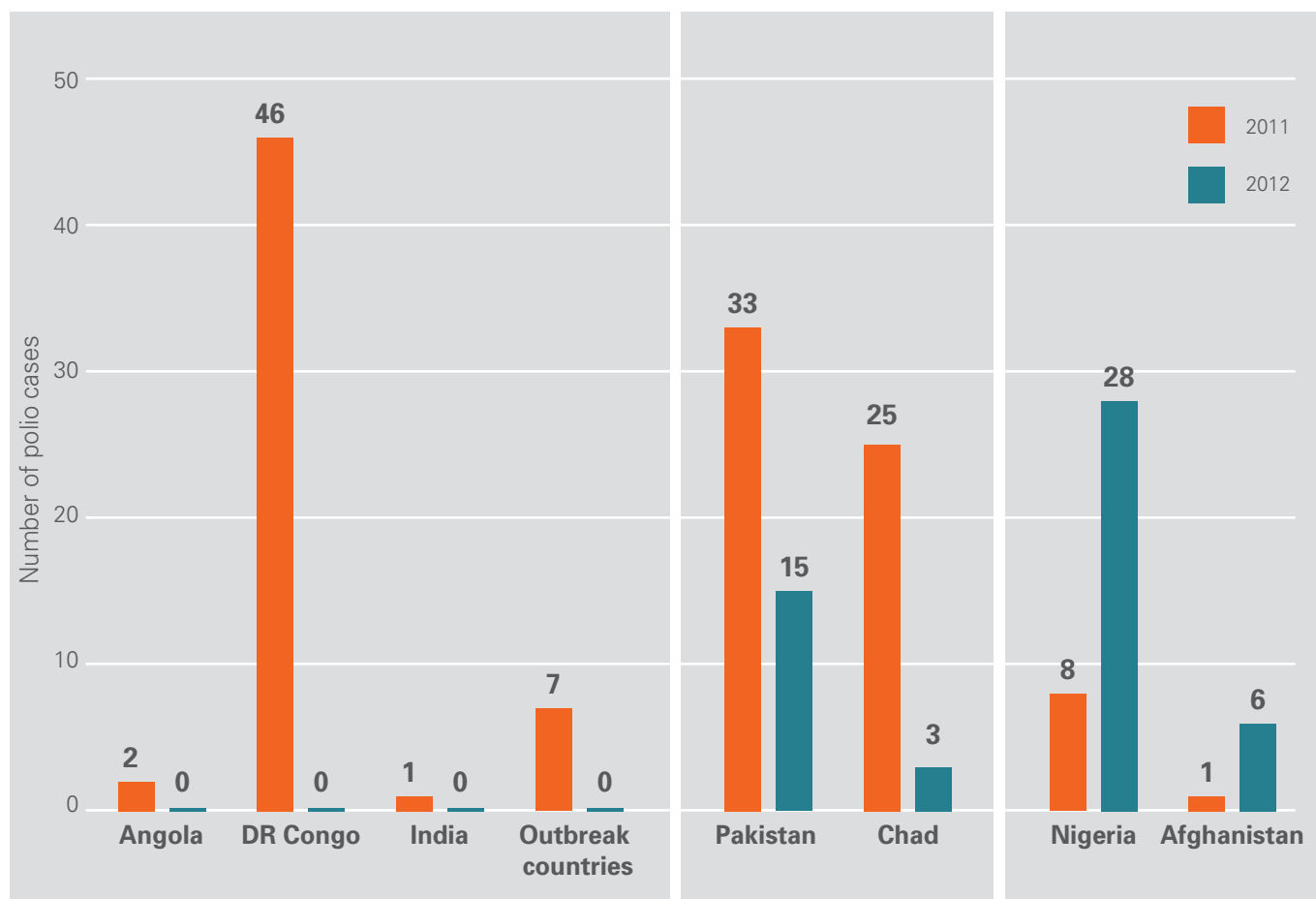


Figure 2: Global situation (1st January to 2nd May - 2011/2012 comparison). So far this year, no cases in Angola, DR Congo, or India; no outbreaks; a reduction in Pakistan and Chad; but substantial increases in Nigeria and Afghanistan in comparison with the same period last year.



CASES

In the first four months of 2012 there have been fewer cases of polio, in fewer districts, of fewer countries than at any time in history. Transmission is always lower at this time of year, but the Programme's current position is substantially stronger than it was in the same low-transmission period last year (figure 1).

Analyzing this by country reveals a mixed picture across the Programme (figure 2). There has been some very strong performance indeed, but areas of deep concern persist.

The very best news comes from India. For years, many believed that the challenge of stopping polio transmission in India would be the downfall of the Programme; that, quite simply, it could not be done. They have been proven wrong. In January 2012, India achieved the major milestone of a year passing without a single case of polio. The country is no longer polio-endemic. What many thought unachievable has been achieved. Confidence in the Programme should receive a major boost as a result of this.

Developments elsewhere offer some promising news. Angola and DR Congo, two countries with re-established polio transmission, have not reported a case of polio yet this year. The last case reported in Angola was in July 2011; in DR Congo, December 2011. In the first four months of 2012, Chad, the third country with re-established transmission, has seen 88% fewer cases than during the same period last year. Pakistan has had less than half as many cases as in the same period last year. There have been no outbreaks of polio outside of the endemic and re-established transmission countries.

But there is also some very concerning news. Both Nigeria and Afghanistan have had many more cases so far this year than they had at the same time last year.

Case numbers are only one measure of progress, but they matter. They correlate well with the other measures by which we assess programme performance, both quantitative and qualitative.

AT A GLANCE

So far this year, polio transmission is better confined than ever before

India's impressive success shows the way forward

Some countries have achieved reductions in case numbers in recent months

Nigeria and Afghanistan are the exceptions – their case numbers continue to climb; they are outliers in a growing success story



MILESTONES

The 2010-12 Strategic Plan set out a series of milestones:

Mid-2010: Cessation of all polio outbreaks with onset in 2009: On track

This milestone was achieved, with no evidence to suggest that any 2009 outbreak was or is ongoing.

End-2010: Cessation of all 're-established' polio transmission: Missed

This milestone was missed. Transmission was stopped in Sudan by the deadline, but not in Angola, Chad or DR Congo. Chad continues to have transmission. Angola and DR Congo have had no cases for some months, but need to improve surveillance and immunisation performance to sustain this apparent success.

Ongoing: Cessation of new outbreaks within 6 months of confirmation of index case: Missed

Twenty countries have had outbreaks since the start of 2010. The Programme has succeeded in stopping each of them within six months. Only one, in Mali, lasted slightly beyond this. Despite the milestone being missed because of this, this has been an area of strong performance.

End-2011: Cessation of all poliovirus transmission in at least 2 of 4 endemic countries: Missed

India achieved this milestone, but no other country did so. The challenges of stopping transmission in Afghanistan, Nigeria and Pakistan are substantial and discussed in depth in this report.

The Strategic Plan's final milestone is the cessation of all wild poliovirus transmission by the end of 2012. We discuss the status of this milestone at the conclusion of this report.

AT A GLANCE

When they occur, outbreaks are being swiftly dealt with

The endemic countries – Afghanistan, Nigeria and Pakistan – present the greatest ongoing concern

The Programme has achieved just one of its four Strategic Plan milestones

The background is a solid teal color. On the left side, there are four stylized water droplets of varying sizes, arranged in a descending staircase pattern from top to bottom. The droplets are a lighter shade of teal than the background. The text 'Global view' is positioned on the right side of the page.

Global. view

GLOBAL VIEW

Figure 3: The Global scale of cancelled campaigns in 2012

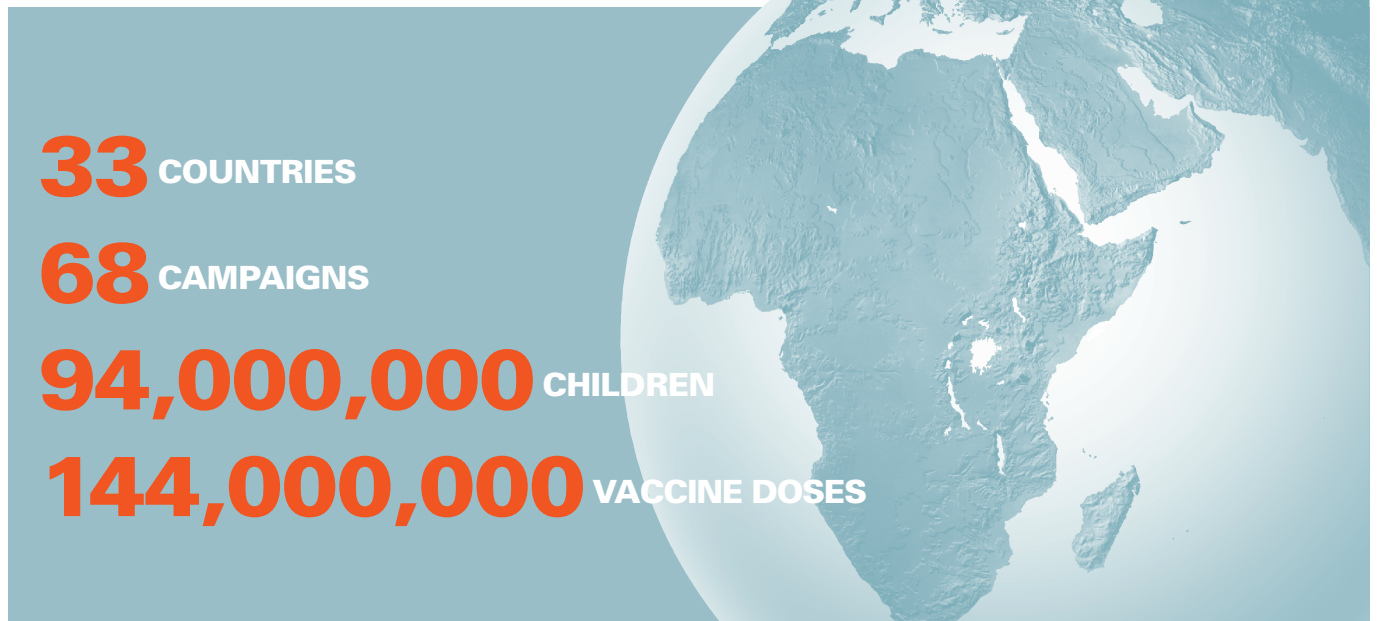

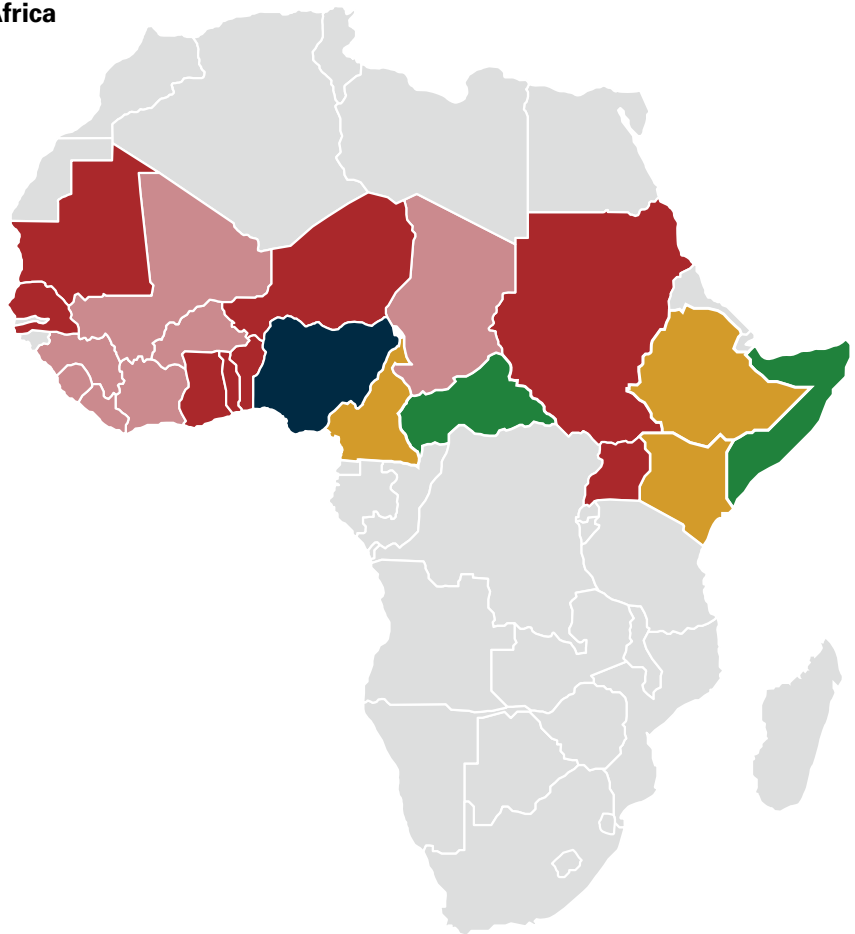


Figure 4: Endangered campaigns in Africa

Each of the 20 countries on the map was infected by polio from Nigeria between 2006 and 2010. So far in 2012, eight of these have gone without planned vaccination campaigns because of the funding shortfall. By the end of 2012, only two will not have been affected.

-  Campaign already missed in 2012
-  Future 2012 campaign cancelled
-  Future 2012 campaign scaled back
-  No 2012 campaign cancelled
-  Nigeria



GLOBAL VIEW

At the highest strategic level, four issues demand priority focus:

1. Under-financing is simply not compatible with the ambitious goal of stopping polio transmission globally. Currently vaccination campaigns are being cut, escalating the risk of an explosive return of polio just as it is at its lowest level in history.

The archives of the Global Polio Eradication Programme hold one report after another that show a funding gap. Each call for donations to fill this gap has been entirely genuine, but people tire of hearing the message.

This makes it difficult to highlight the missing funds yet again.

The current context though, is different and special. At just the time that the global drive to stop polio is making strong progress – stronger than has been seen for many years – the financial situation is leading to active cut-backs in the number of polio vaccination campaigns. Swathes of Africa are being hit, endangering polio and non-polio affected countries.

In recent months, the Programme has broken free of its decade-long stagnation, the millstone of the ‘final one per-cent’.

India’s success is deeply impressive, and should convince even the most hardened of skeptics that global polio transmission is an achievable goal. The Programme’s epidemiological position has never been so strong, with only four countries affected by polio cases in the first four months of 2012.

It is the bitter-sweet juxtaposition of strong progress and severe cuts that makes this crisis so cruel.

The Programme is at a high-water mark in other ways too. There have been significant improvements to the management approach and accountability over the last year, led from the most senior levels of the spearheading partners and of the governments of the countries affected by polio. The World Health Assembly has just declared polio eradication a programmatic emergency for global public health. This brings an unprecedented level of focus.

In short, this is a position of strength that the Programme must capitalize on. A funding cut now jeopardises its ability to do so. A valuable window of opportunity risks being lost.

The Programme’s budget for 2012-13 is \$2.2 billion. The current funding gap is \$945 million. The most visible impact of this funding shortfall is the cancellation of important vaccination campaigns. The scale of these is large: 94 million children will be affected before the end of the year (figure 3).

AT A GLANCE

The funding shortfall has reached crisis point and is leading to action that makes no sense

The Programme’s epidemiological position has never been so strong

Led from the top, greater managerial grip on the performance of the Programme is working

The World Health Assembly has declared polio an emergency

Cuts will lead to cancelled vaccination doses for 94 million children this year



Many of the cancelled campaigns were due to take place in West and Central Africa. While polio continues to circulate in northern Nigeria (and recently circulation has not just continued, but increased), these countries are at significant risk of infection. History demonstrates this. Between 2006 and 2010, 20 African countries were infected by polio virus derived from Nigeria. Yet campaigns have been cancelled in the majority of these vulnerable countries (figure 4).

Planning was done knowing that funding would be tight. No extraneous campaigns were planned. If the GPEI now cannot conduct the required campaigns that are needed, this puts the entire goal at terrible risk. An outbreak becomes much more likely. Besides their immediate impact, outbreaks create further expense, divert the attention of programme staff, and are demotivating. And so the Programme slips back.

Cancelled campaigns are the most visible concern, but the repercussions of a funding shortfall run deeper than this. It creates strain across the Programme. Recruitment of much-needed staff is delayed. Considerable time is diverted to chasing cash flow. Financial shortfall has multiple minor effects that add up to a significant impact on performance.

There are complex longstanding issues with the funding of polio eradication, which have not been openly discussed: who should be paying for the Eradication Programme? The Programme receives financial support from only a minority of the governments that signed up to it, and whose citizens will ultimately share the benefit of this global good. Amongst the richest countries of the world, contributions are not commensurate with what is required to complete the task.

The immediate problem needs to be rapidly resolved: allowing the African campaigns to be cancelled is foolhardy. But the Programme also needs a more permanent solution to its state of chronic under-funding. It cannot hope to stop transmission and reach eradication by limping forward from one funding crisis to the next.

We recommend an emergency meeting of the Global Polio Partners Group with one item on the agenda: how to resolve the financial shortfall that is jeopardizing the Programme, such that i) the cancelled campaigns can be reinstated, and ii) the Programme has the required funding to capitalize on the golden opportunity that it now has, rather than this being squandered.

2. The Programme has embarked upon a transformation of its management approach; this transformation needs to be vigorously continued.

Our previous reports have criticised several aspects of the Global Programme’s management. Clearly, a programme that can reduce the global incidence of polio by 99% is an impressive operation. Stopping transmission in over 100 countries is no small feat. We deeply respect this. But this is not the aim. The aim is to reach 100%, and on that count the Programme has not been fit for purpose.

AT A GLANCE

Campaign cuts will expose an entire band of West and Central Africa to great risk

These campaigns were not arranged as optional extras; they are essential

The finance gap strikes beyond cancelled campaigns; it impairs the Programme extensively

Allowing the campaigns to remain cancelled is not just risky, it is foolhardy

The leap from 99% to 100% eradication has long proved elusive



The Programme had got stuck in a certain way of operating which, though capable of reaching the 99% mark, made it unable to reach 100%. Indeed, we judged that the success in reaching 99% was partly to blame for the subsequent stagnation. Success breeds inertia. Habits and approaches that had previously yielded success stopped doing so, and the Programme was slow to fully appreciate this.

Across a number of different strategic areas, we have highlighted the need for the Programme to raise its game. At first this was met with some resistance. But soon the Programme's leaders responded well to our critique.

Our observations about what change is required have spanned several reports, and the Programme's actions have been similarly dispersed. Drawing these together, we summarise overleaf the ten ways in which the Programme was falling short of the mark; ten ways in which transformation was required. Together, these transformations can turn a 99% Initiative into a 100% Initiative.

In some of these areas, there has been considerable progress. The Programme is in substantially better shape than it was a year ago. But in other areas the required transformation has barely started. The Programme can – and must – push on with this process.

We recommend that the Polio Oversight Board pays particular attention to continuing the process of programmatic change that has been started. We have set out ten transformations needed by the Programme (figure 5), and have made an assessment of the progress achieved towards each. We recommend that the Polio Oversight Board uses these as a guide in reviewing progress and planning further action.

AT A GLANCE

Our critique of the Programme's management has not been easy to hear, but has stimulated a good response

We now summarise the ten major transformations that we have said are needed

There has been excellent progress on some; far less on others

Figure 5: TEN TRANSFORMATIONS NEEDED BY THE GLOBAL POLIO ERADICATION INITIATIVE

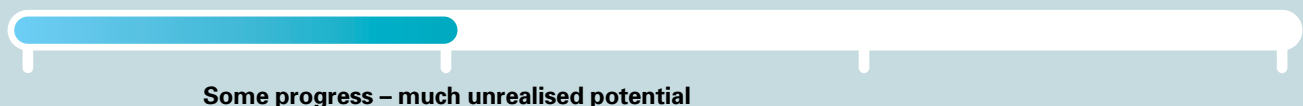
Transformation 1: Senior leaders give the Programme true operational priority

Emergency protocols have been activated by WHO, CDC and UNICEF. Heads of spearheading agencies meet quarterly to coordinate. WHO Regional Directors and UN Secretary-General are providing personal leadership. A Head-of-Government led task force has been established in every endemic country.



Transformation 2: Close collaboration and coordination amongst partners

Considerably closer working between spearheading partners at global and regional levels, **but** some non-spearheading partners still feel under-involved; coordination is variable at national level; there is no systematic approach to identify and build practical alliances with non-polio initiatives at local level; spearheading partners too often work separately, including vaccinators and social mobilisers; and inter-country meetings across vulnerable borders (e.g. Nigeria, Chad, Niger and Cameroon) could be more frequent.



Transformation 3: Staff all well-managed and accountable

160 staff have been trained explicitly in managing people, a first for WHO. Increasingly, underperforming staff are not allowed to linger in post. There is more engagement of individuals with the power to hold staff to account, such as District Commissioners in Pakistan, **but** engagement of State Governors in Nigeria is variable; NGOs in Southern Afghanistan are poorly accountable.



Transformation 4: Sufficient technical support staff in-country

Many additional international and national staff are in-post or under recruitment through a number of different mechanisms including STOP teams, **but** structures to manage these major personnel surges are not yet sufficiently developed to make best use of these staff; and there is greater potential to use the resources available to other public health initiatives present on the ground.



Transformation 5: Front-line vaccinators well-trained and well-motivated

Pay has been increased in some countries. Emergency action plans pay attention to selection, training and monitoring of vaccinators, **but** the fundamental issue of timely pay remains unresolved in many places; there is much potential to improve the way in which the programme staff think of and treat front-line workers; far more could be done to engage and motivate these crucial individuals.

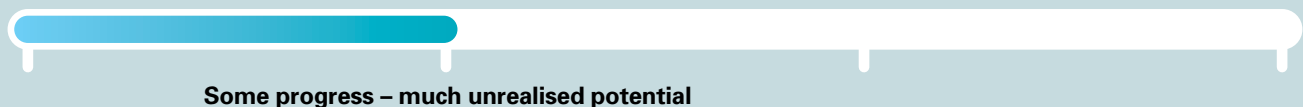
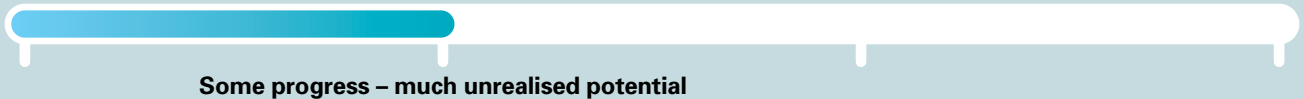


Figure 5: TEN TRANSFORMATIONS NEEDED BY THE GLOBAL POLIO ERADICATION INITIATIVE

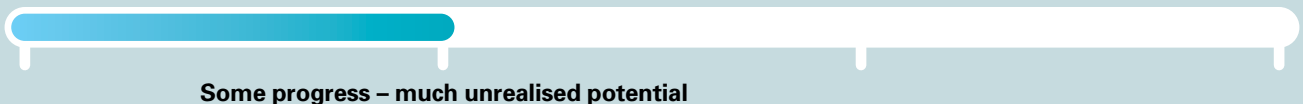
Transformation 6: Insight-rich actionable data used throughout the Programme

Global-level data are becoming better integrated, with a single data platform under development, **but** data are still reported upwards more than used for critical analysis and insight; we are yet to see a surge in insight-rich analyses available to national and local teams; the collection of 'missed children' data still needs more attention; and a clear, unified data monitoring system still remains elusive.



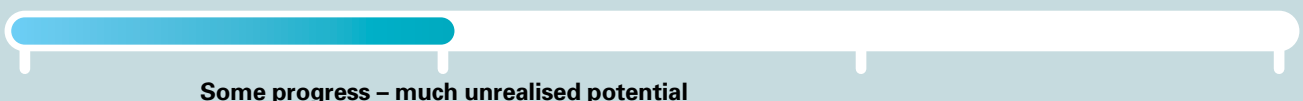
Transformation 7: Highly engaged global movement in support of polio eradication

The Programme is becoming more comfortable with communicating risk and adverse news, **but** it remains very striking that, apart from Rotarians and the work of the Global Poverty Project in Australia, there is little public-led movement in support of completing eradication; nor is there sufficient support from other global health initiatives that have much to gain from the GPEI's success – and much to lose from its failure.



Transformation 8: Thriving culture of innovation

A global-level process has been established to identify and develop innovations, **but** the first cycle hangs uncompleted, pending formation of the Polio Eradication Steering Committee; despite some good examples of local innovation, there is still no systematic approach to empower or to spread local innovation.



Transformation 9: Systemic problems tackled through development and application of best practice solutions

The latest action plans apply substantial lessons from India across the Programme. A think-tank has been established to develop capability in dealing with insecurity. Social mobilization has received more focus, **but** there has been slow progress in tackling the systemic problems of poor quality social data and poor quality microplans.



Transformation 10: Parents' pull for vaccine dominates over 'push'

There is an increased focus on social mobilization, and a major surge in communications personnel, **but** there is as yet no step-change from 'push' to 'pull'.





3. The Programme needs to set out a compelling vision of how its completion will benefit global health more broadly than the eradication of polio, and far beyond the technical ‘endgame’ issues that are currently monopolizing its focus.

The Programme assumes that achieving a polio-free world would be so impressive that it already has the most compelling vision that it could wish for. This sounds reasonable, until one realises how much more than that it can accomplish, how much more it can stand for. However impressive the eradication of polio may be, the Programme is falling far short of its potential if it confines its vision just to this. Polio is invisible to much of the world and has been for a decade or more. It is least visible in countries that could most afford to bolster support for the Programme.

This is a programme that reaches into households bereft of any other healthcare; whose micropans map whole communities; whose communication and surveillance networks penetrate the most deprived populations on earth. It has trained thousands, built laboratory capacity, strengthened the international cold chain. Its completion will prove the enormity of what the global community can accomplish. So what is to happen when polio has been eradicated? How will all of this potential be used? Or will its legacy be scattered to the four winds?

The Programme operates on a psychological time-line that starts in 1988 and finishes with the eradication of polio. Many of the partner agencies have separate exciting visions for the future of global health (other elimination initiatives, strengthened routine immunisation programmes, universal healthcare) but fail to meaningfully set out the many ways in which the Polio Programme can contribute. To the generation that follows, the eradication of polio will not be the end of the timeline. It will be the beginning. What is the polio footprint? What is the legacy that will arm future programmes? This is what the Polio Programme needs to set out.

We ask people in the Programme, ‘What will happen after transmission has been stopped?’ They talk to us about the tOPV-bOPV switch, about cVDPV, about fractional dose IPV. The Emergency Action Plan does the same. As usual, technical vaccine issues dominate the focus. In that well-worn phrase they are ‘necessary but not sufficient’.

There are several reasons why planning for what happens next must be done now and cannot simply wait for eradication to be achieved. After eradication, infrastructure and momentum will be lost fast without a plan in place. To many, finishing the eradication of polio is currently feeling like a grim slog to the end. Setting out a broader vision can also help reignite enthusiasm.

Reassurance needs to be given to the millions of polio eradication staff around the world that they will not be jobless when polio is gone. Their skills and experience will be of great value to other health services. If no-one communicates this, then their concern for themselves and their families is a distraction from the vital work with which they are entrusted.

AT A GLANCE

The Programme is short-sighted about its legacy, which can extend far beyond the eradication of polio

The eradication initiative has built valuable infrastructure – will this simply be left to atrophy?

Polio eradication is not being linked in with other major global health goals, despite clear potential to do so

When we ask ‘what happens next?’ we often get just a technical response about polio vaccines

Setting out what follows eradication will make eradication more likely

Staff will assume they are heading for redundancy unless they are told otherwise, sapping their will to stop polio

AT A GLANCE

Communicating the full potential of the Programme lays bare what is at stake

Financial support will be bolstered if the Programme properly articulates how it meets donors' wider objectives

The programme must be bold in its prevention of further damaging outbreaks

The humanitarian crisis in West Africa could too easily be compounded by polio

All who have a stake in this programme need to understand the full extent of what it can achieve, and therefore also what is at risk. Its failure would severely limit enthusiasm for other major global health programmes, particularly those involving vaccination, disease elimination or major partnerships. If the Programme communicated this it would not be scaremongering, but presenting a genuine comprehensive view of what stands to be gained or lost.

In most of the funding partner agencies, those who sign the cheques have portfolios far broader than polio eradication. Yet the Programme is currently asking them only what they can give to support polio eradication. It should be telling them the full story about what their investment can accomplish, about how the Programme can meet several of their broader objectives.

The Programme plans to publish its endgame strategy later this year. So far its vision has been too narrow.

We recommend that instead of developing an 'endgame strategy', the Programme develops an 'endgame and legacy strategy' that sets out the beginning of what comes next, as well as the end of polio. This should be urgently published for public and professional consultation.

4. Further outbreaks risk substantially harming the Programme, bolstering transmission and diverting finances and focus. More innovative methods need to be used to extinguish the possibility of outbreaks in a more comprehensive way.

The Programme, and indeed the world, must take bold action if it can help to bring closer the prize of stopping polio transmission. Opportunities must be seized as they arise. Preventing outbreaks is a vital part of this. As the number of countries where polio circulates falls, it becomes increasingly important to confine the virus within those borders. Outbreaks elsewhere have a great human cost, and also create significant distraction and expense for the Programme.

We welcome the Programme's intention to coordinate closely with the humanitarian response to the food crisis in West Africa and the armed conflict in Mali. These populations will be vulnerable to polio infection and vulnerable to being missed by traditional campaigns. Using every opportunity to reach them with polio drops will protect the individuals, and will reduce the risk of outbreaks amongst at-risk and displaced populations.

We recommend that the Programme's plan to integrate polio vaccination into the humanitarian response to the food crisis and conflict in West Africa be rigorously developed and urgently implemented. Alliances with all possible programmes must be urgently explored to make every contact count.

The International Health Regulations provide a mechanism through which the risk of international polio spread could be lessened. The time is drawing near when people travelling from countries in which polio circulates should be required to show a certificate proving they have received a course of vaccination before they travel.

We recommend that contingency plans are drawn up to make use of the International Health Regulations to require that people travelling from a polio-affected country have a complete and documented course of vaccination before they are allowed to travel. These plans should be developed with an intention that they be implemented when just two countries with endemic or re-established transmission remain.

There is also the question of what defines an outbreak. Currently, an outbreak response is triggered when a case is detected. But drawing samples from sewage offers a more sensitive way to detect low-level transmission. The wider use of environmental surveillance, coupled with an appropriate response, could detect and close down outbreaks more rapidly.

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 that the feasibility and logistics of this need to be looked into but this should be done rapidly.

AT A GLANCE

The Programme must boldly use the tools that it has available – the time to employ the International Health Regulations is drawing close

Environmental surveillance offers a means to bolster outbreak detection, and should be far more widely used



Sanctuary by
sanctuary

SANCTUARY BY SANCTUARY

The challenge of stopping polio transmission globally is concentrated not only in a small number of countries, but in specific parts of these countries. Our previous report termed these 'sanctuaries' for the polio virus, places in which it has taken safe refuge.

There is no mystery about why the virus is safe in these sanctuaries. In one vaccination campaign after another, too many children are being missed. Stopping transmission therefore requires a razor-sharp focus on reaching these missed children; on vaccinating more children with the next round than were vaccinated with the last. Without this focus, the Programme is simply an expensive way to vaccinate some children many times, whilst missing other children over and over again.

Programme data from the six countries with persistent transmission suggest that there are 2.7 million children aged under five years who have never received even a single dose of polio vaccine (figure 6). The much larger number who receive a dangerously low number of doses is not easy to discern from programme statistics. Even within small areas, the missed children may belong disproportionately to minority population groups. Not all of these are in the sanctuaries. But if a data-driven, missed-children-focused approach can be honed in the sanctuaries, it can be applied elsewhere also.

Our previous reports have examined the Programme country by country. In this report, we look sanctuary by sanctuary. Many of the challenges in the polio sanctuaries fall into the same general categories (poor programme management, low community demand). But if we drill down and examine the situation in detail, we find that in no two sanctuaries are the challenges the same. As we examine each sanctuary, we take a particular interest in the precision with which the reasons for missed children are understood, solutions described, and impact tracked. Imprecise descriptions of 'poor quality', 'management issues' and 'refusals' say little about what the problem is, and therefore about what solution is required. A sharp focus on missed children, insight-rich data, and precise plans represent the strongest possible force to expel the virus that is sheltering in each of these sanctuaries, and therefore to secure global polio eradication.

We focus on the sanctuaries for two reasons. First, they are the areas that demand greatest focus. Second, we consider the Programme's actions in them to be a window onto the country programme as a whole. If a country can get to grips with its areas of most intense challenge, it is in a strong position to stop transmission elsewhere as well.

AT A GLANCE

Sanctuaries for the polio virus - places in which it has taken safe refuge

Sanctuaries only exist because too many children are missed on vaccination day

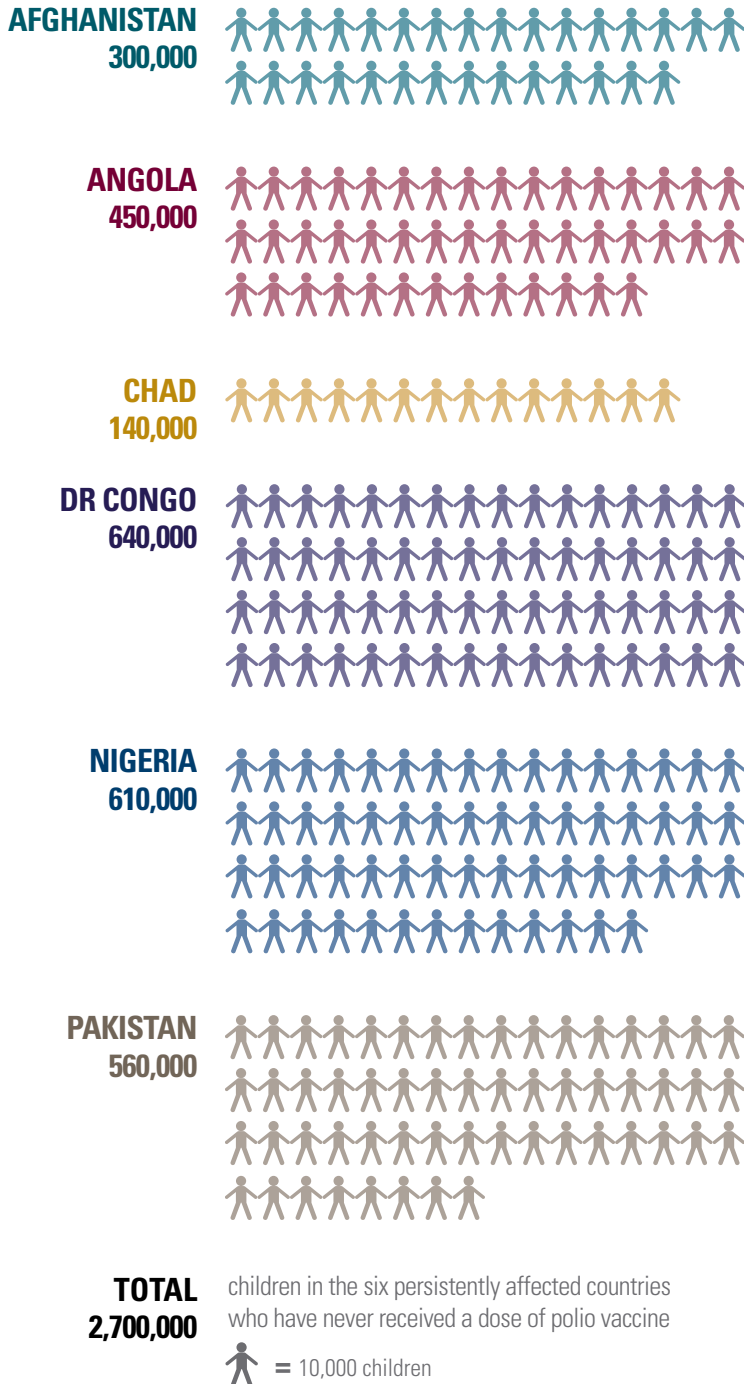
Some children are missed entirely – 2.7 million children have never received even a single dose of vaccine; even more receive a dangerously low number of doses

The challenges in each sanctuary are unique, but the approach needs to be the same - pinpointing and pursuing the reasons why children are missed

If a country can get a strong grip on its toughest sanctuaries, it can do so anywhere

THE NEVER CHILDREN

Figure 6: 2.7 million children have never received even a single dose of polio vaccine, in the six countries with persistent polio transmission.



These numbers are estimated using 'percentage of 0-dose children' (CDC Assessment of Risks to the Global Polio Eradication Initiative Strategic Plan 2010-2012) and estimates of the population aged under five years (United Nations World Population Prospects: The 2010 Revision)



Afghanistan

AT A GLANCE

Insecurity is not the only problem in Helmand and Kandahar- security has recently improved, yet more children are being missed

Unaware of vaccination campaigns, parents are out when the vaccinators call

The basics of running a vaccination day are repeatedly going wrong

Helmand and Kandahar

Two-thirds of Afghanistan's polio cases in 2011 were in two southern provinces: Helmand and Kandahar. Last year a dramatic rise in polio cases occurred here and there was confusion within the Programme's leadership as to why.

In the minds of the world, Helmand and Kandahar are associated with insecurity. This insecurity has been a major challenge for the Programme. But it is absolutely not the only, or even the major, reason why children are now being missed. Despite recent positive signs of improving security in a few places, vaccination coverage has actually been declining.

Parental awareness of forthcoming campaigns remains very poor indeed in Helmand and Kandahar. In Kandahar district, the main reason why children are missed is that nobody is home when the vaccinator visits. Campaign awareness is considerably higher where Immunisation Communication Networks have been established. These are present in only a quarter of the 13 highest risk districts, and need to be expanded. Poor campaign awareness is not the only problem. In Shawalikot, where less than 10% of caregivers were aware of an upcoming campaign, the main reason for missed children is simply that houses are not visited – a shortcoming in microplanning, vaccinator training and/or supervision.

There is starting to be more insight into the specific reasons why children are being missed in each district. The Programme has instigated some sensible corrective actions. Provincial Governors are being charged with direct oversight of performance. District EPI Management Teams are also being given a greater role in ensuring campaign quality. To enhance communications, increased use of radio broadcasting is planned.



There is still very significant room for improvement. For example, the delivery of vaccination campaigns is reliant on NGOs contracted by the Ministry of Public Health to implement the Basic Package of Health Services. The accountability of these NGOs needs to be strengthened. This is not easy because the sub-contracting chain is often long and complex. This problem demands a credible solution, which is simply not yet clear.

The Programme has been slow in realising the extent to which its problems extend beyond insecurity. It needs urgently to catch up in its analysis of the area-specific reasons why children are being missed, and in instigating more effective solutions.

National Analysis

Despite the extensive shortcomings of the Programme in Afghanistan's main polio sanctuary, there remain reasons for hope. The President is personally involved. Permanent Vaccination Teams have been proved a success, and their use must now be maximised. The IMB was impressed with the formation of an inter-ministerial forum, to lead a 'whole-Government' approach to polio eradication. This is exactly the joined-up working and wide ownership required to realise a polio-free Afghanistan. Polio is not just the responsibility of the Ministry of Public Health but of the entire Afghan Government – all have their part to play.

An independent review of the Programme, as we recommended in our February 2012 report, will take place in July. The prime objective of this review must be to identify the area-specific, detailed actions required to drastically reduce the number of children being missed, so that these can be set in motion immediately.

The IMB was pleased to hear some examples of joint Afghan-Pakistan co-operation. We also heard of the need for this to become weekly – if not daily – liaison and for joint real-time tracking of cases and campaigns. We urge both Governments to work together to further this promising relationship.

Afghanistan is firmly on the 'critical list'. For too long, the veil of security has concealed the wide range of shortcomings that exist throughout the Programme. The country's emergency action plan lifts this veil, but sustained improvements in the analysis and rectification of problems are needed if polio is going to be stopped any time soon.

AT A GLANCE

NGO accountability needs to be tougher

Presidential leadership and cross-government working are welcome

Afghanistan is on the 'critical list' - the extent of its problems now clearer. Razor-sharp solutions must emerge

Angola



AT A GLANCE

Luanda is the natural home for polio in Angola

Children sleep in the heart of the nation's capital, unprotected by vaccine

Luanda's problems and solutions have been set out with clarity

Poor surveillance and unacceptable levels of missed children are putting Luanda at high risk

Luanda

Home to a third of the country's population, with many people lacking access to clean water and adequate sanitation, it is no surprise that Luanda has been the driver of polio transmission in Angola.

Independent monitoring data have their limitations, but the trend that they show in Luanda is concerning. The percentage of children missed by vaccination days has increased steadily over the last year. In March 2012, eight of the nine municipalities missed more than 10% of children. This is not a war-zone. Nor is it a far flung inaccessible part of the country. These children sleep at night in the heart of the nation's capital. This is not a situation that should be tolerated.

The Programme was able to clearly set out some of the reasons why children are still being missed: vaccinator 'no-show', poor recruitment, poor outreach to communities. It was able to describe credible solutions: inclusion of polio in health worker appraisals, criteria for timely recruitment, co-working with religious leaders.

We repeat previously expressed concerns about the quality of surveillance in Luanda. The Programme accepts these concerns and has taken some important steps forward, such as procuring additional vehicles and building awareness amongst local communities. However, Luanda's average AFP rate remains barely higher than the threshold regarded as acceptable and lower than the average over the last two years. The country does need to show greater ambition to strengthen surveillance further. If a case occurs in Luanda and is not rapidly detected, transmission could readily take hold amongst this densely packed population.

National analysis

Angola has not had a case of polio for 10 months – a promising position for the country to be in. Angola is to be congratulated for the improvements that it has made to its programme over recent years. It has come a long way in building its fortress against polio. But as we dig below the surface, in Luanda in particular, we continue to find that the foundations of this fortress are not yet strong enough to guarantee Angola ongoing protection. Congratulations now would be premature.

The financial investment of the Angolan Government in the Eradication Programme is to be warmly praised. Other polio-affected countries would do well to learn from this most tangible demonstration of ownership and true accountability. We are aware that a Presidential election is planned for August 2012. Planning must be sufficiently rigorous to ensure that this heightened political activity has no detrimental effect on the Polio Programme.

Surveillance gaps and large numbers of missed children are significant problems throughout the country. The IMB heard that environmental surveillance is planned for June 2012. It is vital that this is instigated as rapidly and widely as possible. Such intelligence will help the Angolan Programme focus its efforts during the vital months ahead.

AT A GLANCE

With no case for 10 months, Angola has come far but improvements in the organization and quality control of its programme are still needed

Forthcoming elections must not derail progress, and strengthening surveillance is key



Chad

AT A GLANCE

Transmission in Chad tends to be country-wide though in 2011, Logone Orientale had more cases than any other province

The country has been systematic in finding missed children in Logone Orientale

Noting that they are often missed, Chad is strengthening its focus on nomadic children

Smallpox would not have been eradicated without helicopters

The situation in Chad is somewhat different from that in the other persistently affected countries. The challenge is not concentrated in any one geographic area. It is mainly a national, dispersed challenge.

One area on which it does make sense to focus is the province of Logone Orientale in the south of the country, bordering the Central African Republic and Cameroon. In 2011, this province had 58 cases of polio; nearly half of the country's total. Most of these were in the district of Bebedjia. In 2012, the province's two cases have both been in Bessao. This district sits on a well-established migration route, so its population fluctuates considerably over time.

The Programme has been successful in improving vaccination campaigns in Logone Orientale. They are missing fewer children than they were six months ago. Reasons for refusal have been systematically identified and tackled.

The Programme has also identified the importance of nomads. Two of the country's three polio cases in 2012 have been amongst this small minority group. Data show that children in nomadic families are twice as likely as others to have had absolutely no doses of polio vaccine. The vaccination campaigns of March and April 2012 have involved focused effort to reach nomadic children. We commend the Programme's collaboration with the Ministry of Livestock, to identify and reach nomadic settlements.

Our February 2012 report highlighted the vulnerability of scattered island communities in Lake Chad, bordering on Nigeria, Niger and Cameroon. We were heartened to hear that the President of Chad has made available helicopters to help reach these communities during vaccination campaigns.



Nationally, data continue to show slow but steady improvement in Chad. We are still not seeing the kind of major increase in immunity levels that would convince us that step-change has been achieved, and that the country will imminently rid itself of polio. Low routine immunization coverage means that there is very little protective buffer against further outbreaks taking hold. But the situation is much improved from when we labeled it an emergency a year ago; problems have been systematically identified and tackled.

Some fundamental problems remain – with the cold chain and vaccine stocks, with staff training, with the quality of microplans. And while polio is rampant in Nigeria, Chad remains at substantial risk. The Programme is to be congratulated for what it has achieved so far, and needs to doggedly persist in its pursuit of missed children.

AT A GLANCE

Chad has come far in the last year

But Chad's low routine immunization coverage and proximity to Nigeria mean that it still has further to go



DR Congo

AT A GLANCE

Northern Katanga has made promising progress over recent months

Strong engagement work with communities and religious groups is paying dividends

Northern Katanga

Northern Katanga is a remote part of the Democratic Republic of Congo, with a dispersed population. It has received particular focus for some time, partly because overt resistance to the polio vaccine was thought to be causing many children to be missed.

Promising progress has been made. In the district of Tanganyika during the first quarter of 2012, the proportion of children missed by vaccination campaigns was reduced from 17% to 8%. This was due, in part at least, to a particular focus on engaging the religious groups that had long been opposing vaccination. This intensive effort saw a number of children being vaccinated against polio for the first time in their life.

Overt refusal remains a substantial problem. Of all children missed, 40% are missed because of this. But this leaves 60% who are missed for other reasons. Detailed use of social data in Katanga has been impressive, unearthing problems and generating solutions.

The IMB concluded that the Programme has acted with rigour in Northern Katanga to identify and deal with the reasons why children are being missed. It has further to go, but is making promising progress.

National analysis

DR Congo has not reported a case of polio since December 2011. But it is far too early for anybody to say with confidence that this truly represents the interruption of transmission. It is absolutely appropriate that the country's Programme remains in a high state of alert.

'Religious refusals' are still a significant problem. The IMB was pleased to hear the distinction made between 'hesitant refusals' and 'entrenched refusals'. The latter are the hardest nut to crack but the smallest in number. The former represent potentially rapid wins for a proactive, passionate communications programme. Parents who 'hesitantly refuse' could, if successfully converted set off a domino effect in their communities, adding their own voices to the partners' communications drive.

The difficulties in DR Congo are not all to do with refusals. Very low routine immunisation coverage means that there is no safety net. Strengthening this and working to further improve the coverage of vaccination campaigns is crucial.

Objective assessment from CDC indicates that surveillance performance has improved. The IMB welcomes this. DR Congo is fortunate that the inaccessibility of parts of the country provides some natural protection against the spread of the polio virus. But it is widely accepted that polio can survive in small seemingly isolated communities. We urge greater use of environmental surveillance to identify once and for all whether there are secret sanctuaries for the polio virus in DR Congo.

We congratulate the country for the undoubted progress that it has made. We sincerely hope to be able to offer our full congratulations in due course. Whether or not we are able to will depend on the country's resolve to continue improving its programme, even in the apparent absence of cases. Doing so is more crucial than ever.

AT A GLANCE

No cases in DR Congo in 2012 but the Programme must be alive to the dangers that still exist

Most refusals are 'hesitant', not 'entrenched' and represent potential quick wins

Routine immunization is poor – there is no safety net

Surveillance must continue to improve. Are there any secret sanctuaries?

DR Congo remains vulnerable. Encouraging improvements in the Programme must continue



Nigeria

AT A GLANCE

Insecurity is a significant problem in Borno – but not the only one

Data must be better used to provide detailed, useful insights and focused corrective actions

The Programme has a loose grip in Borno – it must be tightened

In Nigeria, the polio virus has four particular sanctuaries – the northern states of Borno, Kano, Sokoto and Zamfara. Together, they are home to two-thirds of the polio cases detected so far in 2012.

Borno

Borno state, in the north-east corner of Nigeria, is home to over 5 million people. Some live on islands of Lake Chad. Some live in the north of the state, where sandy desert makes access difficult. Borno borders Niger, Chad and Cameroon.

There are many reasons why children are being missed in Borno. Shootings and explosions are sadly a feature of daily life in some parts of the state and some Local Government Areas are under curfew as a result, which makes movement difficult. A recent bomb blast destroyed a store of solar refrigerators, so the cold chain now has problems. The Programme also described 'non-compliance' as a block to vaccinating children, with the main reason for refusal being on religious grounds.

The IMB felt that the problems in Borno have not been adequately analysed or described. We saw very little data that provided insight into the all-important detail. We know, for example, that 22% of missed children in Borno are missed due to refusals. We did not hear about the remaining 78%. Has there been a proper analysis of the missed children data? If so, has it been used?

Some actions have been listed in response to the problems identified. While these seem reasonable, we have only heard them expressed in very general terms. Once the challenges have been analysed with greater precision, so specific focused actions need to be planned to overcome them. We appreciate the many challenges,



and that progress is being made. But currently the IMB does not have confidence that these challenges are being gripped to a sufficient degree.

Kano

In the centre of northern Nigeria lies Kano, with a predominantly urban population of some 11 million people. Of all Nigerian states, Kano has the smallest proportion of children who have had at least three doses of oral polio vaccine. This figure currently stands at 74%, well below the 90% target. Independent Monitoring data from March showed that more than half of Local Government Areas in Kano missed more than 10% of children. This too is the worst performance in the country. Kano had all three types of polio virus in 2011, and both type 1 and type 3 cases so far in 2012.

The Programme listed a large number of reasons why children are being missed: refusals due to lack of felt need, or because of parental concerns about the vaccine's safety; lack of accountability at Local Government Area level; poor microplans; insecurity; under-engagement of traditional leaders; an inadequate number of vaccination teams, and vaccine stock-outs.

The Programme provided a long list of actions that are being taken. It was unclear what the main problems are, or how the Programme is prioritising action. We have not seen much data that provide sharp insights into the problems that have been listed.

The state has piloted some strategies that are now being rolled out elsewhere: a specific effort to vaccinate nomadic populations, and the use of GPS mapping to improve the quality of microplans. The latter is a good example of how the process of innovation can work well. GPS mapping was originally intended to track the performance of teams on vaccination days. Its use has now evolved, and it is employed primarily in advance of the vaccination days, to create better microplans for the teams to use.

The state has a Polio Task Force in situ, chaired by the Deputy Governor. We are told that all 44 Local Government Area Chairmen participated in the March vaccination campaign. We welcome the fact that the May campaign was deferred when it became clear that inadequate preparation had been made.

The IMB concluded that while there are good examples of innovation in Kano, many of the reasons why children are being missed are not yet being adequately addressed.

AT A GLANCE

Kano scores worst for missed children

Data must be used to help prioritize actions

Commendable innovation

State Polio Task Force functioning well

AT A GLANCE

In Zamfara, strong alignment of actions instigated with challenges faced

Politicians in Sokoto must be stronger in their support of and leadership for the Programme if they are to turn back anti-vaccine influences

What new and extraordinary measures can now be taken?

Nigeria's impressive leaders must regain mastery of the art of polio eradication

The National Emergency Action Plan is solid. Paper must be translated to performance

Nigeria is a great source of concern. But there is hope. The Programme must reproduce the much praised performance of 2010

Zamfara & Sokoto

The neighbouring states of Zamfara and Sokoto have predominately agricultural economies. They have had nine cases of polio so far in 2012. By this time last year they had had only one.

For Zamfara, the IMB was shown a detailed table to describe the challenges, and actions taken to address each. This was the only Nigerian sanctuary for which links between challenges and actions were clearly set out. Each challenge had a credible set of actions associated with it.

In Sokoto, the Programme lists a number of major challenges. Inadequate political commitment was highlighted, particularly evidenced by the fact that only eight of the 23 Local Government Area chairmen participated in the most recent vaccination campaign. Refusals are a concern, particularly in the more metropolitan Local Government Areas, and this is driven in part by anti-OPV rhetoric from religious and academic leaders.

Unfortunately it is not clear how the proposed solutions in Sokoto will be different from anything that has been done before, although each sounds sensible. The Programme plans further advocacy and sensitization. We were just told that 'efforts are being made' to enhance accountability.

National analysis

Like the leaders of the Global and National Programme, the IMB was shocked at the events of 2011, where a seemingly promising programme fell into disarray. Since then, a great deal of time has been spent trying to recapture the momentum of 2010. But the impressive leaders of the Nigerian Programme have not reached full mastery of the strategies required to put the Programme back on course. Nigeria is now the only country in the world to have all three types of polio virus – type 1, type 3, and circulating vaccine-derived type 2 virus. The continued transmission of polio here poses a real threat to its neighbours. This mastery is needed fast.

We very much welcome the National Emergency Action Plan. We welcome the surge of partner staff that will support its implementation, although managing this large number of staff is a challenge that needs further attention. We particularly welcome the fact that the President has inaugurated a national task force, and that each state has a task force led by a Deputy Governor. The new National Emergency Action Plan will need to be built on, but is a real opportunity for Nigeria. Through its thorough implementation, the IMB urges Nigeria to demonstrate that skepticism about its programme is ill-founded.

It would be wrong for the IMB to conceal its continuing concern about the poor programmatic performance in Nigeria. But we draw confidence from the experience of 2010, when the Programme made exhaustive efforts to uncover the reasons why children were being missed and to implement solutions. The Programme must recover its ability to do the basics thoroughly. At the heart of the eradication drive is a focus on finding missed children – something it was doing well in 2010.



Pakistan

AT A GLANCE

There are three places in Pakistan where the polio virus has sanctuaries most firmly established: Gaddap in Karachi (particularly Union Council 4); Khyber Agency in FATA; and Pishin, in Balochistan.

Union Council Four, Gaddap, Karachi

A densely-populated Pushto area with a severe lack of basic services and low literacy rates, Union Council Four is a stronghold for the polio virus within the larger sanctuary of Gaddap. Since 2006, more than 80% of Gaddap's polio cases have been in UC-4. In the March 2012 vaccination campaign, independent monitoring data showed that 6% of children in Gaddap were missed – the highest figure in Sindh and Punjab.

The Programme has clearly identified the major blocks to reaching more missed children. Non-local, non-Pushto-speaking vaccinators have been unable to engage mothers and gain access to children. Temporarily employed vaccinators have in the past been changed minutes before a campaign is due to start and as a result are unprepared and unfamiliar with the terrain. Migrant workers have not been fully identified nor included in microplans, leaving their children most vulnerable.

The Programme is to be praised for its sound analysis of the reasons why children were being missed and for the tightly-matched actions instigated in response. Local, Pushto-speaking vaccinators are being targeted for recruitment on permanent, better paid contracts. Campaigns have been postponed if preparation is deemed inadequate. Additional transit vaccination points are helping better serve the migrant community.

Union Council Four, Gaddap: a sanctuary within a sanctuary

Problems clearly identified. Tightly-matched actions instigated

Led by an enthusiastic District Commissioner and supported by a strong Programme team, it seems that UC-4 and Gaddap may be turning the corner. Recent environmental surveillance samples have tested negative for the polio virus. Recent community engagement drives are impressive. If the Programme can now also strengthen its migrant population strategy, it can capitalise on this new positive direction.

Pishin, Quetta Block

Pishin District is one of the three most problematic areas in the polio-afflicted Quetta Block (the others being Quetta City and Killah Abdullah). The population is 99% Pushto. In the most recent March 2012 immunisation campaign, 16% of children were missed.

We were presented with a long list of reasons why children are being missed. There are pockets of refusals. Teams are often poorly constituted (too many child vaccinators, not enough females or government workers). Limited movement of GPEI partner staff because of security concerns means a lack of support and supervision. And though the Programme has worked hard to remove the paramedics who were undermining its progress, many of the medical officers who have replaced them are so far disinterested.

A long list of challenges is in some respects reassuring. The Programme has identified well the reasons why children are being missed. The analysis has helped formulate sound corrective actions. Polio control rooms have been established and poor performing staff have been suspended. Polio campaigns have been staggered to spread supervision, and outsourcing has been implemented. The clear assignment of responsibilities to each partner is to be commended.

The IMB was concerned to hear the Programme state that ‘certain things seem unmanageable with the current stance’. If this is true, the stance must be changed – and changed quickly. Further analysis and action will be needed but now is no time for defeatism. A solid foundation exists on which the Programme can build.

Khyber Agency, FATA

Khyber Agency is home to the only type 3 polio virus circulation in Asia. Since 2010, it has recorded 64 cases of polio – an astonishingly high figure.

Insecurity has been a problem in Khyber, but the Programme has acted opportunistically to vaccinate displaced children in refugee camps: en masse, up to the age of 15, and with a Short-Interval Additional Dose strategy. Some of those vaccinated had not received polio drops since September 2009. The impressive determination to vaccinate these vulnerable children must be sustained.

The Programme has been innovative in using local children as an adjunct to its social mobilisation teams, enabling the teams to reach into compounds that would otherwise be off-limits to them.

The Programme in UC4 is performing well – it should aim for perfection

Medical officers in Pishin must raise their game

The Programme has performed a strong analysis of the problems and instigated sound actions

If a programme is to be successful, nothing should be regarded as ‘unmanageable’

Khyber Agency – home to the only WPV3 in Asia

In the face of insecurity the determination to reach children is impressive

Rapid intelligence on the fluid security situation is imperative

The security situation remains volatile, so the Programme needs to be poised to respond to the changing situation. The better it can keep itself informed and prepared, the better able it will be to send vaccination teams into newly accessible areas at a moment's notice.

FATA is not one single, unchanging block of insecurity and inaccessibility. In the last six months, the number of accessible areas has increased. The major problem here is that children are still missed even when they are accessible. Actions proposed include disciplinary action against poor performing staff, more Government-accountable staff and greater engagement with religious and political leaders. The IMB was not yet convinced that these appear sufficient to rectify the current problems. More must be done, or the impressive efforts in refugee camps and conflict-affected areas will be in vain.

The IMB noted a difference of emphasis between the country representatives and the Programme on the use of 'firewalling'; the latter having less confidence in its effectiveness. A shared understanding of the merits and demerits of this should rapidly be established.

National analysis

The last six months have seen impressive developments in the Pakistan Programme, since the IMB's October 2011 report memorably described it as 'deeply dysfunctional'. Revitalized energy and the highest political leadership resulted in an augmented National Emergency Plan (NEAP) fit for the purpose of stopping polio transmission. The Programme lifted its game considerably, and needs to continue to do so.

With the power to co-ordinate basic local services (including education, sanitation and health), District Commissioners represent a critical element of the enhanced eradication effort. They are uniquely placed to increase the attractiveness of the 'polio package'. The IMB heard of rubbish clearance instigated by the Polio Eradication Programme, and of nutritional supplements distributed at the same time as polio drops. Such things are vital in building community goodwill and increasing the "pull" for polio vaccination. The IMB urges continued empowerment of the District Commissioners, and that they seek to maximise the attractiveness of the polio package in their areas.

The IMB has been informed that District Commissioners are having to spend a disproportionate amount of time liaising separately with the different GPEI Partners. This risks preventing them from focusing their energy where it will have greatest impact – overseeing the implementation of vaccination campaigns locally. We urge the GPEI Partners to identify a more streamlined mechanism through which the District Commissioners can seek their combined support. Greater integration of GPEI Partners from the national to the local level can realize the concept of "one polio team", with UNICEF and WHO at its heart.

More must be done to improve performance in accessible areas

The effectiveness of 'firewalling' must be established

The Programme in Pakistan has raised its game

District Commissioners have a vital role to play and are having to spend too much time in separate conversations with partners

Motivation is vital to maintaining momentum. The IMB has heard increasing mention of the real polio heroes of Pakistan: the vaccinators and social mobilisers that go from house to house, street to street, campaign after campaign. This is encouraging and must continue. A country can be measured by how it treats its heroes. Progress is being made, but further efforts are required to make the job of vaccinator and social mobiliser more attractive. Payment is one important aspect of this. The country has been talking about direct payment mechanisms for some time now; these must be widely and rapidly implemented.

We welcome the Programme's focus on its polio sanctuaries. There is always an inherent tension in this. The Programme must not become blinkered to vulnerabilities elsewhere in the country. The IMB heard of worrying results from environmental surveillance across Pakistan including in Lahore, Punjab. It is clear the virus is circulating widely. The Programme must not allow new sanctuaries to sprout.

The Pakistan Programme has re-joined the road to stopping polio transmission. There are still many challenging kilometres ahead. If it can sustain its current intensity of will and rigour of approach, this programme appears increasingly well placed to reach the end.

Polio heroes must be better rewarded

The Programme must not drop its guard elsewhere in the country

Pakistan has much improved its performance – the improvement must continue



Conclusions & recommendations

CONCLUSIONS

The 2010-12 Strategic Plan aims to stop polio transmission by the end of 2012. This goal has long been off track. It remains so, although recent months have seen the Programme's progress accelerate. Each infected country has – now, or at some time in recent years – demonstrated its capability and will. The challenge is for each to achieve peak performance quickly and simultaneously. Once every country is reaching enough missed children, transmission will quickly be stopped. It would be premature to entirely rule-out achieving the end-2012 milestone.

The current position of the Programme is strong in many ways, creating an opportunity to build momentum that really must be seized. It must be seized by addressing the substantial risks to the eradication goal – the financial shortfall chief amongst them. It must be seized by being ambitious about the further programmatic improvements that are possible.

Our recommendations address the major concerns at global level. We ask that country programmes reflect on our findings, nationally and in every sanctuary. The most urgent improvements are needed in Nigeria and in Afghanistan.

The challenge of stopping transmission is a challenge of reaching missed children. The Programme's focus on this has sharpened a little in the last year, but still has far to go.

We will next review progress at the end of October 2012. We urge that each country and each partner grip the challenges that remain. The prize of a polio-free world is drawing closer, but is far from secure.

RECOMMENDATIONS

1. We recommend an emergency meeting of the Global Polio Partners Group with one item on the agenda: how to resolve the financial shortfall that is jeopardizing the Programme, such that i) the cancelled campaigns can be reinstated, and ii) the Programme has the required funding to capitalize on the golden opportunity that it now has, rather than this being squandered.
2. We recommend that the Polio Oversight Board pays particular attention to continuing the process of programmatic change that has been started. We have set out ten transformations needed by the Programme, and have made an assessment of the progress achieved towards each. We recommend that the Polio Oversight Board uses these ten transformations as a guide in reviewing progress and planning further actions.
3. We recommend that instead of developing an 'endgame strategy', the Programme develops an 'endgame and legacy strategy' that is about the beginning of what comes next, as well as the end of polio. This should be urgently published for public and professional consultation.
4. We recommend that the Programme's plan to integrate polio vaccination into the humanitarian response to the food crisis and conflict in West Africa be rigorously developed and urgently implemented. Alliances with all possible programmes must be urgently explored to make every contact count.
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.
6. We recommend that contingency plans are drawn up to make use of the International Health Regulations to require that people travelling from a polio-affected country have a complete and documented course of vaccination before they are allowed to travel. These plans should be developed, with an intention that they be implemented when just two countries with endemic or re-established transmission remain.
7. The number of missed children (those with zero doses of vaccine, those with fewer than 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 three numbers should be placed on the desk of each of the Heads of the Spearheading Agencies at the beginning of each week. This action should commence immediately.

The IMB will also examine two areas further. The first is to seek reassurance about the way in which the Programme is balancing the use of Independent Monitoring and Lot Quality Assurance Sampling, and how the quality of data will be improved. The second is to scrutinise the plans in place to prevent a global shortage of oral polio vaccine in 2013, which has been identified as a risk.

