GPEI Midterm Review (MTR)

PPG Engagement

April 17, 2015

Agenda

Item	Timing	Facilitator
Midterm Review 101 & Program Update	1:00 – 1:30 PM	Hamid
Objective 1*	1:30 – 2:30 PM	Brent
Break	2:30 – 2:45 PM	
Objective 2*	2:45 – 3:30 PM	Suchita
Objective 3*	3:30 – 3:45 PM	Brent
Objective 4*	3:45 – 4:15 PM	Carol
MTR Financial Framework	4:15 – 4:30 PM	Cindy
Summary/next steps	4:30 – 4:45 PM	Hamid

*** Sessions to be discussion focused to get input from the group after a brief programmatic update**

Workshop Objectives for Today

1. Understand purpose, context and methodology for the Mid-Term Review (MTR).

2. Provide input and feedback on progress, lessons learned/risks to date of the program.

3. Brainstorm implications of lessons learned/risks.

Midterm review objectives and scope

Objectives:

1. To provide **a comprehensive review of progress**
2. To recommend **appropriate changes** to the goals, strategies, activities, timeline and financial implications based on the review.
3. To **align stakeholders and donors around a shared set of lessons learned, risks and priorities** that will impact the remainder of the eradication effort.

In-Scope

1. Progress, gaps and recommendations tied to the four objectives of the plan
2. Understand lessons learned and drivers of performance
3. Cross-cutting advocacy
4. Financial scenario planning

Out-of-Scope

1. Management, governance and organization review
2. Evaluation of partner performance
3. Process evaluation
4. Revising the monitoring framework and the validity of the indicators
5. Refresh of cost savings (value for money) or impact analysis
6. Adjustments to country plans will be done after recommendations are reviewed and adopted

MTR Principles and Methodology

Principles:
- Transparency and collaboration
- Strategic review NOT examination of details
- Outside of endemics, level of review will be regional.
- Guided by original Strategic Plan and revised monitoring framework
- Will examine trend since 2013, as well as moment-in-time performance

We are here

Initial Assessment
- **Review existing sources and materials**
- **Develop initial assessment**
- **Capture lessons learned and risks**

Gather Input
- **Conduct workshops and additional interviews**
- **Gather input from key stakeholders including donors**
- **Develop initial draft report**

Draft report
- **Review report findings with Strategy Committee**
- **Revise report with input from key stakeholder groups**

Finalize report
- **Develop final report**
- **Gather final input**
- **Share report with the SC and POB members**
- **Publish final report**

Midterm Review Report Proposed Outline

Pages	Proposed Outline	
1	**I. Executive Summary**	
2	**II. Introduction**	
	III. Rationale and objectives	
	IV. Methodology	
	V. Context (polio & global environment)	
1-2	**VI. Cross-cutting Perspectives**	
10-14	**VII. Objective ______**	Sub-structure replicated by objective
	a. Assessment of progress	
	b. Lessons learned & risks	
	c. Strategic adjustments	
5	**VIII. Finance**	
1	**IX. Summary of findings**	
20-25		

We are here ↓ (week ending 17th April)

Month	March			April				May				June	
Week Ending	13th	20th	27th	3rd	10th	17th	24th	1st	8th	15th	22nd	5th	12th
Activities													
Desk review	■	■	■	■	■	■							
Interviews	■	■	■	■	■	■							
1st draft (structure)			■	■									
Partner consultations				■	■	■							
2nd draft (full)						■	■						
Final draft & document production								■	■	■	■		
Meeting cadence													
● Core Working Group		●		●		●		●		●			
○ SC	○ Approve workplan		○ Approve structure		○		○ Approve insights		○ Approve content		○ Check-in		
Key Milestones ▲	▲ Kickoff				▲ 4/10 PPG pre-read	▲ 4/15 WG 4/17 PPG		▲ 5/1 SC Check-In 4/30 IMB Check-in		▲ 5/11 FAC call	▲ 5/22 Report to POB	▲ 6/3 POB call	▲ 6/12 PPG meeting FAC meeting
Other dates				3/30 IMG	4/14 SAGE			4/29-4/30 IMB					

Stakeholder Feedback Timeline

Month	April		May					June	
Week Ending	17th	24th	1st	8th	15th	22nd	29th	5th	12th

Open comment

- 17th: PPG MTR Workshop
- 22nd: Notes disseminated
- **Open Feedback Period**
- 8th: Open feedback due

Narrative comments

- 15th: Full draft shared with SC, IMB, PPG
- 19th: Comments appreciated
- 29th: Final comments due

Final document production

- 22nd: POB Draft due
- 3rd: POB call
- 5th: Final publish
- 12th: FAC & PPG meeting

Situation 2013

Country	2013
Pakistan	93
Afghanistan	14
Nigeria	53
Somalia	194
Cameroon	4
Equatorial Guinea	0
Iraq	0
Syria	35
Ethiopia	9
Kenya	14
Total	**416**

WPV1 Cases, 2014

cVDPVs: Pakistan 21, Nigeria 30, S Sudan 2, Madagascar 1

Endemic countries
Infected countries

Country	2013	2014
Pakistan	93	306
Afghanistan	14	28
Nigeria	53	6
Somalia	194	5
Cameroon	4	5
Equatorial Guinea	0	5
Iraq	0	2
Syria	35	1
Ethiopia	9	1
Kenya	14	0
Total	**416**	**359**

Israel = Env. positive isolates (2013 – 136 ; 2014-14 , last 30 Mar 2014)
Gaza = Env. positve isolates (2013 – 7 ; 2014- 1, Jan)

LAST CHILD

Data as of 03 Feb 2015

Wild Poliovirus Cases, Last 6 months

Last Case Iraq, 7 April, 2014
Syria: 21 Jan
Israel (Env.): 30 March

Last Case Nigeria, 24 Jul

Last Case Cameroon, 9 Jul
Equatorial Guinea: 3 May

Last Case Somalia, 11 Aug
Ethiopia: 5 Jan

No WPV Reported in Africa or Middle East

Pakistan: WPV1 Cases, Last 6 months*

n=101

Improving Accessibility

- N & S Waziristan since June 2014
- Karachi Gadaap in recent weeks
- Quality gaps: Focus on missed children

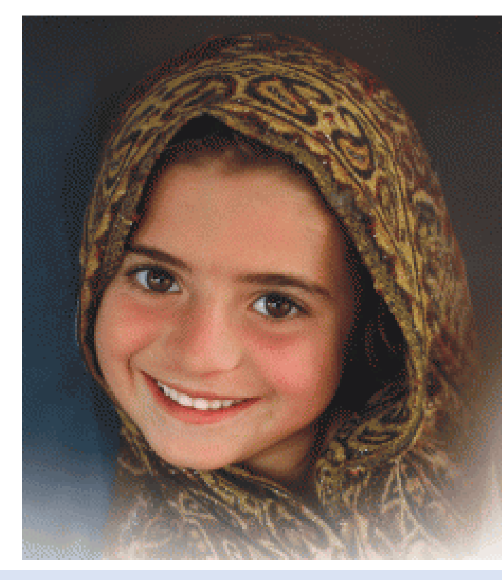
50
45
40
35
30
25
20
15
10
5
0

Oct Nov Dec Jan Feb Mar

EVERY LAST CHILD

*8 Oct 2014 to 7 April 2015

Getting Pakistan on Track in 2015



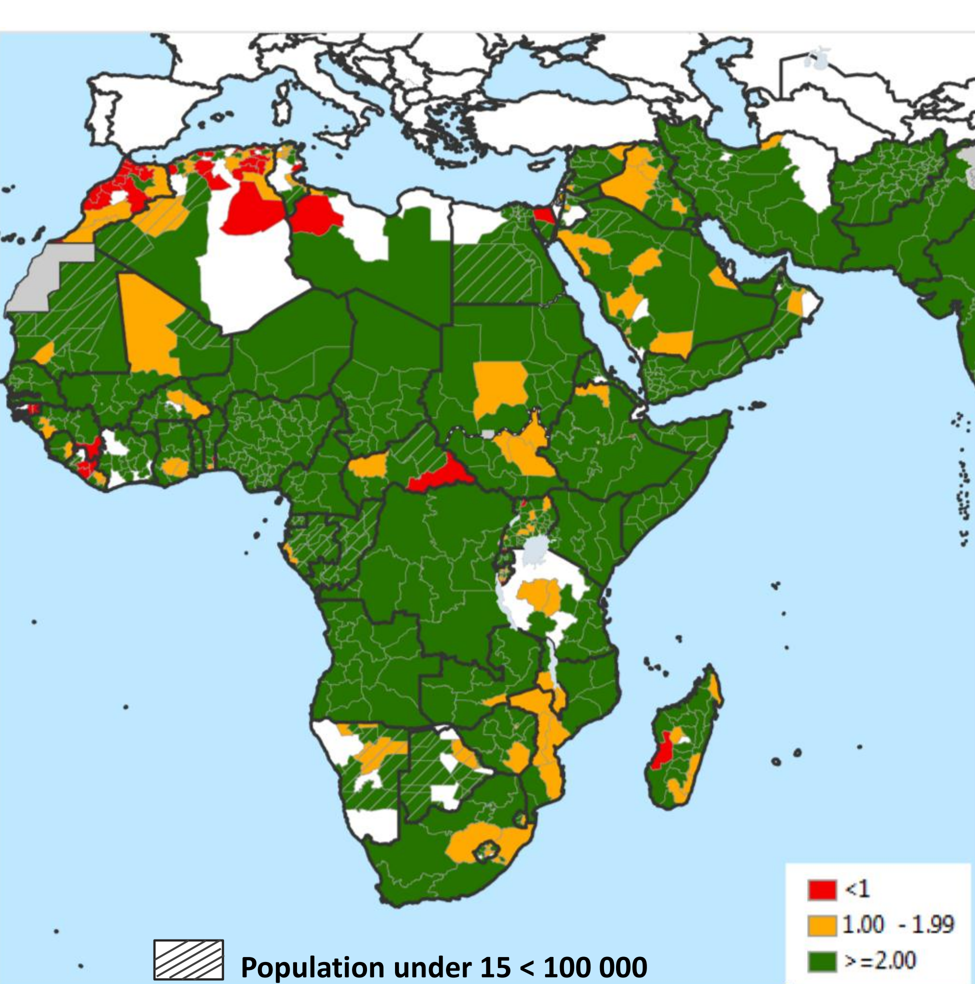
Can the Program

- **Vaccinate everywhere? - Improving access**
- **Monitor everywhere? - Restoring**
- **Enforce accountability? - EOCs starting to function**

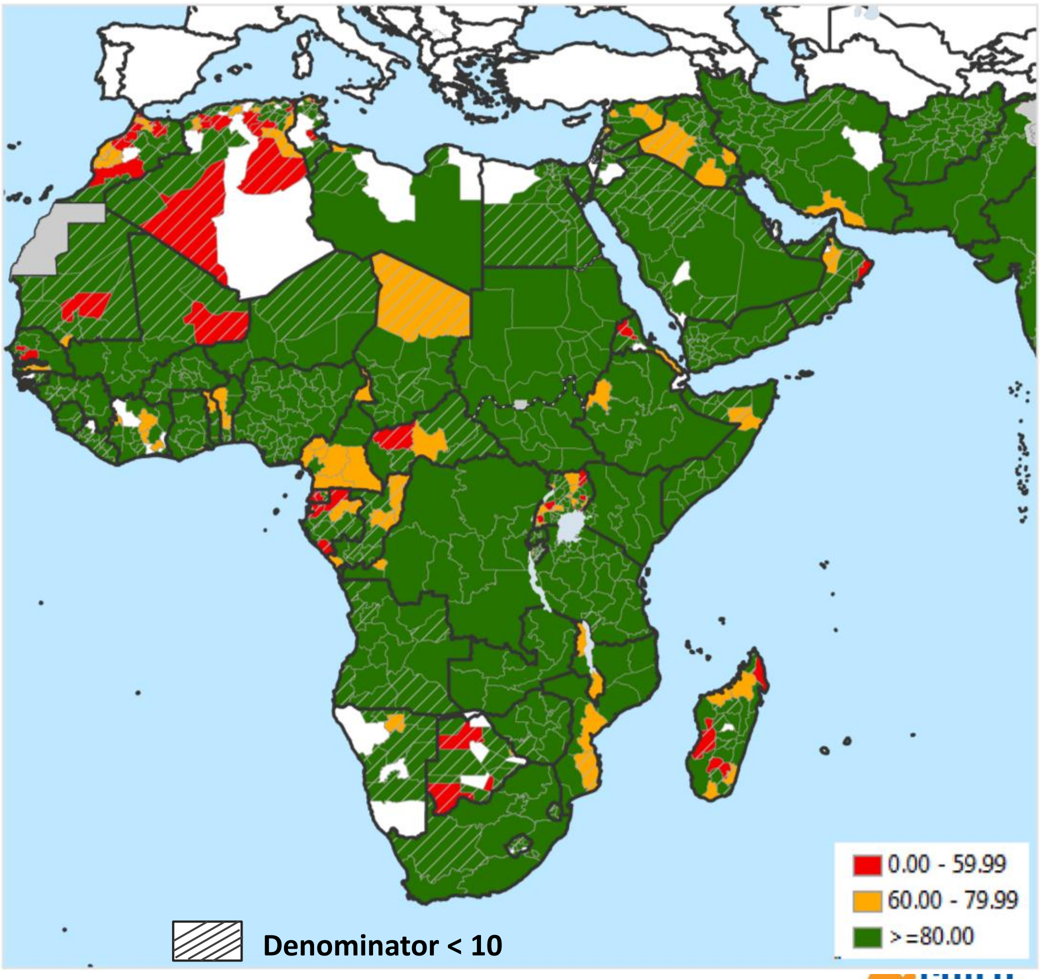
Surveillance Indicators, rolling 12 month

15-April-2014 to 14-April-2015

Non polio AFP rate



Adequate Stool Collection Rate



No AFP case

Data in WHO HQ as of 14 April 2015

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WORK IN PROCESS

POLIO GLOBAL ERADICATION INITIATIVE

Assessment of Progress: Objective 1: Polio virus detection and interruption

	Outcome	Geography	Achievement	Trend
Endemic Countries	Interrupt transmission	Afghanistan	● (red)	→
		Pakistan	● (red)	↘
		Nigeria	● (green)	↗
	High population immunity	Afghanistan	● (yellow)	→
		Pakistan	● (yellow)	→
		Nigeria	● (green)	→
	High virus detection	Afghanistan	● (green)	→
		Pakistan	● (yellow)	→
		Nigeria	● (green)	↗
High-risk countries	High population immunity		● (green)	→
	High virus detection		● (yellow)	→

	Outcome	Geography	Achievement	Trend
Outbreak countries	Initial response	Central Africa	● (yellow)	n/a
		Horn of Africa	● (green)	n/a
		Middle East	● (yellow)	n/a
	Follow-on response	Central Africa	● (yellow)	n/a
		Horn of Africa	● (green)	n/a
		Middle East	● (yellow)	n/a
	Interrupt transmission	Central Africa	● (yellow)	↗
		Horn of Africa	● (yellow)	↗
		Middle East	● (yellow)	→
	High population immunity	Central Africa	● (yellow)	→
		Horn of Africa	● (yellow)	↗
		Middle East	● (yellow)	↘
	High virus detection	Central Africa	● (yellow)	↗
		Horn of Africa	● (yellow)	↗
		Middle East	● (yellow)	↘

Key
- ● (green) Met or exceeded the target
- ● (yellow) Within 20% of achieving the target
- ● (red) Missed the target by >20%
- ● (black) No data

Summary of findings

- Stopping transmission in Afghanistan will be closely linked to progress in Pakistan which had a major increase in WPV cases in 2014. Nigeria has not had a WPV case since July 2014 or cVDPV case for over 4 months; however, progress is considered fragile due to population movements and insecurity in the North-East region. Outbreaks which began in non-endemic countries from 2013 have now been controlled yet many areas remain susceptible.
- SIA performance indicators remain mixed in all countries, but with innovative measures underway in many areas to reach vulnerable nomadic populations. Insecurity continues to hamper efforts to maintain high population immunity in both endemic and outbreak prone countries.
- Global surveillance indicators are consistently met in most countries at the national level; however, periodic presence of orphan viruses and persistent subnational gaps in stool adequacy indicate pockets of suboptimal surveillance, particularly in inaccessible areas.

WORK IN PROCESS

Lessons/Risks and Implications: Objective 1: Polio virus detection and interruption

Strategic activity	Lessons / Risks	Implications
• **Strengthening global surveillance**	• As WPV and cVDPV cases decrease, relative importance and reliance on surveillance increases---risk of delayed response and-or inefficient targeting of resources	• Critical to focus on surveillance in determining overall GPEI strategic priorities
	• Expanded surveillance efforts have been dependent on "surge" staff —risk of misallocation of staff and/or not being able to sustain capacity	• Need to map current surveillance staff patterns and allocate surge capacity to high risk areas; identify and train local staff
	• Level of surveillance analysis has been insufficient—risk of missing cases	• Need global strategic monitoring plan along with local accountability
	• Technologic innovations to support environmental surveillance as a valuable supplement to AFP surveillance—	• Need to fully implement global ES expansion plan as part of integrated national polio surveillance system

WORK IN PROCESS

Lessons/Risks and Implications: Objective 1: Polio virus detection and interruption

Strategic activity	Lessons / Risks	Implications
• **Maintaining appropriate immunization schedule**	• Persistent transmission and outbreaks and lack of monitoring inputs led to reliance on increased SIAs. Has not always led to desired impact—risk of staff and population fatigue	• Overall cost of SIAs higher than planned. Need to analyze quality and most efficient targeting of SIAs
	• Preferential use of bOPV can lead to persistence of cVDPV—risk to meeting switch criteria	• Need alignment on strategic program priorities to drive decision on what vaccine to use. No opportunity for sequencing strategies in Pakistan.
	• On a global scale, use of a data driven risk assessment approach to provide a range of SIA options can be a useful tool	• Need for continuous evaluation of assumptions used in modeling
	• IPV can be successfully used in co-administration with OPV for SIAs. IPV can be a useful too to increase immunity in endemic countries but risk of delaying IPV introduction into RI due to global supply issues	• Need for careful strategic analysis of when and where to use IPV with clear priorities and intensified efforts to expand global supply

WORK IN PROCESS

Lessons/Risks and Implications : Objective 1: Polio virus detection and interruption

Strategic activity	Lessons / Risks	Implications
• **Enhancing OPV campaign quality**	• Establish and enforce accountability frameworks for supervising and supporting front line workers	• Need to strategically introduce relevant accountability frameworks in other countries
	• Establish infrastructure at national and state level with sufficient staff , resources, and data to effectively manage and monitor polio operations. Need multiple monitoring tools	• Need political will and resources to establish well functioning EOCs in Pakistan; province EOCs need capacity to analyze data and regularly monitor SIAs through multiple approaches.
	• While inaccessibility has been a formidable challenge, "workarounds" for surveillance and SIAs have been introduced; additional challenges also affect quality of SIAs.	• Need to analyze effectiveness of innovative measures and regularly triangulate monitoring indicators.
	• Data in key areas show same children are consistently missed. Nomad, border, and internally displaced populations continue to be at high risk.	• Need further analysis of missed children. Focus on "chronically missed children" strategy for Pakistan and Afghanistan. Track mobile populations, IDPs, nomads; and target community outreach

Regularly monitored key performance indicators for priority PEI/RI activities

Category	Indicator	Threshold
Surveillance	Timeliness of Quarterly Polio Risk Assessment	>=80%
	% Active Case Search (ACS)	90% expected
	Timeliness of 60 day FUP	>=90% (61 - 70 days)
	# AFP Cases Reported	
	% AFP Cases verified	>=90% of reported
	% AFP Cases verified within 7 days	>=80% of verified
Routine Immunization	TC of Data Quality Self - assessment (DQS)	>=80% of LGA
	# LGAs Supervised	
	% wards with updated REW	80% of wards
	% Fixed Session Conducted	80% of planned
	% Outreach session conducted	80% of planned
	% Session monitored	80% of planned
	# HFs Visited	
	% HFs with vaccine stockout	<10% of HFs
	% HFs with updated monitoring chart	>=80% of HFs
IPDs including Demand Creation	Number of LGAs/Wards visited	
	% Micro plans validated	>=80% of MPs
	% of validated Teams for composition	>=80% of Teams
	% of personnel trained before implementation	100% of Teams
	% STF meeting with evidence	100%
	% LGAs with >=80% LQAS coverage (last IPDs)	>=80%
	Timely submission of Demand creation data	100%
Monitoring and evaluation	Number of Records of Integrated supportive supervision using Mobile Devise Data(MDD)	
	Timeliness and completeness of activity report	>=90%

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Monitoring and evaluation	Number of Records of Integrated supportive supervision using Mobile Devise Data(MDD)	
	Timeliness and completeness of activity report	>=90%

Accountability in Action – WHO Nigeria

Actions taken	North Center		North East		North West	
	Q1	Q2	Q1	Q2	Q1	Q2
Appreciation letter	55	53	83	14	28	407
Verbal commendation	30	78		179		417
Discussion to improve	27	11	11	124	19	65
Verbal warning		14	5	32	4	74
Written warning	15	19	17	43	128	108
Non- renewal of contract	35	32	10		29	170
Total	**162**	**207**	**126**	**392**	**208**	**1241**

WORK IN PROCESS

Lessons/Risks and Implications : Objective 1: Polio virus detection and interruption

Strategic activity	Lessons / Risks	Implications
• **Enhancing safety of OPV campaign operations in insecure areas**	• Insecurity has become even more constant and wider in scope over the last two years creating even more challenges to GPEI than anticipated • Further unanticipated interruptions (e.g. from outbreaks like Ebola) or destruction of functional health systems (e.g. Syria, Iraq) have led to increased risk for gaps in surveillance and/or transmission.	• Need for innovative tactics and flexible approaches to reach inaccessible populations and protect vaccinators. • Expect continued reliance on non-state actors (including private sector, NGOs) and adhoc facilities

WORK IN PROCESS

Lessons/Risks and Implications : Objective 1

Strategic activity	Lessons / Risks	Implications
• **Preventing and responding to polio outbreaks**	• National governments and local Ministries of Health need to be engaged from the start of the outbreak • Need for a more aggressive approach to outbreaks and a GPEI rapid response multi- disciplinary team which can deploy at the initial detection of an outbreak to augment local staff • Delayed case detection and slow response can prolong an outbreak. Outbreaks may be prevented or at least ameliorated through sensitive surveillance to identify gaps in immunity and detect cases early.	• Greater advocacy to raise awareness in high risk countries for potential outbreaks and to support action if necessary • Develop new SOPs for outbreak response, develop a rapid response roster of trained workers and who can be urgently deployed • Strengthening surveillance should be prioritized as cost effective and sustainable strategy to prevent outbreaks .

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WORK IN PROCESS

Assessment of Progress: Objective 2 – Immunization systems strengthening and OPV withdrawal

Key
- Green: Met or exceeded the target
- Yellow: Within 20% of achieving the target
- Red: Missed the target by >20%
- Black: No data

Routine immunization	Reduction in unimmunized children		Plan in-place to improve RI	
	Achievement	Trend	Achievement	Trend
Afghanistan	Red	TBD	Yellow	↓
Angola	Green *	TBD	Green **	→
Chad	Red *	TBD	Green	→
DRC	Red *	TBD	Green	→
Ethiopia	Yellow *	TBD	Green	→
India	Green	TBD	Green	→
Nigeria	Green *	TBD	Green	→
Pakistan	Red	TBD	Red **	↑
Somalia	Red *	TBD	Red	→
South Sudan	Red	TBD	Red	↑

* Assessment based on very limited data; ** Assessment varies based on sources

IPV introduction	Commitment to introduction		Introduction	
	Achievement	Trend	Achievement	Trend
Tier 1 countries	Green	TBD	Yellow	TBD
Tier 2 countries	Green	TBD	n/a	TBD
Tier 3 countries	Green	TBD	Green	TBD
Tier 4 countries	Yellow	TBD	Green	TBD

Summary of findings

- 20% of priority countries have met the target for reduction in unimmunized children. Trend data is unreliable due to long lag times for processing this indicator
- 6 out of 10 countries have a plan in-place to improve RI as of Dec 2014; however accounts of this varies across GAVI and WHO materials

- As of Mar-2015, all but 5 countries have either already introduced IPV or committed to so by end-2015
- 82 out of 194 countries have introduced IPV as of March 2015. This is an increase of 14 countries since January 2013.

EVERY LAST CHILD

Source: WHO Status Report (Jan – Jun 2014 and Jul-Dec 2014); WHO EB Jan 2015 Report; POB Scorecard (Dec 2014); GAVI Board December 9, 2014 Technical Update
Note: Awaiting March 2015 POB Scorecard Data for Trend

WORK IN PROCESS

Lessons/Risks and Implications: Objective 2

Strategic activity	Lessons / Risks	Implications

Increasing immunization coverage (10 focus countries)	• **Lessons from India**
	  • **Government engagement is critical**
	  • **Other partner and donor engagement also critical to transition polio support for RI**
		• Implement best practices from previous successes in other geographies
		• May have different set of expectations for endemic vs. non-endemic countries (priority for endemics is stopping WPV transmission)

	• National country plans needed as well as targeted interventions in high risk areas geographies (i.e. Nigeria)	
	• Nigeria staff accountability framework	
	• Challenges with lagging and quality indicator on coverage does not allow to adjust our strategies in real time	• Continue monitoring interim process indicators to measure success of strategies being implemented
	• Polio workers are doing significant amount of RI work, however, it is **difficult to directly attribute these specific activities to RI strengthening**	• Clarify what specific activities will have most impact on RI strengthening now and what activities are critical to ensure continue (legacy planning) beyond eradication • Clarify expectations for polio funded resources regarding accountability and measures on RI strengthening activities

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Strategic activity	Lessons / Risks	Implications
Ensuring appropriate IPV, bOPV, and mOPV products	• **IPV supply constraints greatest in Q1 2016 which will be before switch** • May not have realistic introduction plans for large countries which could put undue pressure on supply • Self- procuring countries who have not placed orders yet will not be accounted for during planning / forecasting for IPV and bOPV supply which will put program in reactive mode	• Continue to do more planning and consider trade-offs of IPV supply for campaigns and in RI • Continue to push for better demand forecasting at country level • Contingency planning underway – SAGE is reviewing • Good communication and advocacy with governments, agencies and manufacturers

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Lessons/Risks and Implications: Objective 2

Strategic activity	Lessons / Risks	Implications
Introducing IPV	• Adding a new vaccine to the immunization schedule • **Introduction delays due to supply, country readiness, etc.**	• Training for healthcare workers on why we need to have two vaccines • Technical assistance for countries (especially high risk geographies) • Active, high quality monitoring of implementation
Withdrawing OPV from routine and supplemental immunization activities	• Coordination and management for switch will test global and country processes (two week period) – tOPV removal verification • **Possible switch scenarios in Oct: (1) on track with no persistent cVDPV2; (2) move forward despite cVDPV2 and (3) SAGE decides to delay**	• Continue to do advance planning with countries, partners • Tracking mechanism for removal of tOPV • Engage private sector vaccination partners • Develop switch delay scenarios (plan)

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WORK IN PROCESS

Assessment of Progress: Objective 3—Containment and certification

Key
- 🟢 Met or exceeded the target
- 🟡 Within 20% of achieving the target
- 🔴 Missed the target by >20%
- ⚫ No data

Indicator	Original Due Date	Achievement	Trend	Comments
Align GAPIII with new endgame strategy and timelines	2013	Green	N/A	Achieved, but with delay from original timeline. WHA Resolution May 2015 urging Member States to implement and certify containment per GAP III. Additional clarity regarding national certification and enforcement required.
Certify WHO South-East Asia Region as poliofree	2014	Green	N/A	Certification March 2014.
Complete Phase 1 containment (survey and inventory) (except in polio-endemic countries)	2014	Red	→	Phase I (Gap II) still not completed in AFRO and EMRO.
Deliver WHO report to WHA on WPV2 eradication	2015	Yellow	↗	Global Certification Commission to meet in Sept 2015 to verify WPV2 eradication with expected report to WHA in 2016.
Gain international consensus on containment timing and safeguards	2015	Yellow	↗	WHA Resolution in May 2015 to address GAP III. Initial global and regional meetings held in early 2015 and others planned in 2015-6 to support training and advocacy for Phase I and II.

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Lessons/Risks and Implications: Objective 3—Containment and certification

Strategic activity	Lessons / Risks	Implications
Containing polio virus stocks	• National capacity to coordinate and monitor containment and to carry out required inventories needs to be strengthened in many countries, especially in AFR and EM—risk that switch could be delayed if countries not willing to take on ownership and accountability. • Standardized containment certification guidelines for vaccine manufacturers need to be developed. Verification of containment needs to be fully articulated	• Need identification of human resources and extensive global or regional level trainings. • WHO needs to develop containment standards and may be asked to verify the compliance of certified facilities against GAPIII. Need further follow-up with research and therapeutic uses of live polioviruses.
Certifying the eradication of WPVs	• Continues to be a challenge for AFRO and EMRO	• Dependent on Objective 1

EVERY LAST CHILD

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WORK IN PROCESS

Assessment of Progress: Objective 4 – Legacy Planning

Key
- 🟢 Met or exceeded the target
- 🟡 Within 20% of achieving the target
- 🔴 Missed the target by >20%
- ⚫ No data

Indicator	Original Due Date	Achievement	Trend	Comments
Initiate global legacy planning process, including stakeholder consultations, asset mapping and capturing lessons	2013	🟢	N/A	
Complete broad consultation process on polio legacy	2014	🟢	N/A	
Establish polio legacy plan	2015	🟡	➡	Some countries delayed in polio legacy planning due to eradication status and delays in undertaking the process.

Summary of findings

- Global legacy planning process initiated, including broad consultation process (ex. technical workshop for and high level briefing of the PPG; asset mapping and country level lessons learned included in Polio Legacy Transition Planning Toolkit; global lessons learned article published in November 2014.
- Legacy planning framework to be considered at the WHA 2015.
- Evidence base and current progress in polio eradication increases the urgency to undertake the legacy planning process.
- Some countries may be delayed in polio legacy planning due to eradication status, or slow to undertake the process.

WORK IN PROCESS

Lessons/Risks and Implications: Objective 4 – Legacy planning

Strategic activity	Lessons / Risks	Implications
Mainstreaming polio functions	• Failure to plan for mainstreaming jeopardizes sustaining a polio-free world	• Countries not able to identify and respond to outbreaks due to lack of adequate surveillance and outbreak response mechanisms
Leveraging the knowledge and lessons learnt	• India: • Legacy planning integrated into WHO country agreement • Polio-funded surveillance and social mobilization network repurposed to mainstream polio functions, and support RI and other health priorities • Funding support being gradually transferred to government or other funding sources	• Valuable lessons from India can be applied in other geographies

WORK IN PROCESS

Lessons/Risks and Implications: Objective 4 – Legacy planning

Strategic activity	Lessons / Risks	Implications
Transitioning the assets and infrastructure	• Lack of understanding of legacy planning across the partnership, at all levels (including at country level) • Additional stakeholders need to be involved in legacy planning (RI and HSS) • Polio funding is critical to immunization system infrastructure-"legacy in action" (Nepal and DRC)	• Accelerate the deployment of the legacy planning toolkit • Identify a cadre of experts to help countries with legacy planning process • Develop a comprehensive and coordinated engagement of stakeholders, including donor partners, across partnership • Develop more detailed country level monitoring/process indicators • Engage other organizations for funding sources (WB, Gavi, Development Banks, etc)

Agenda

Item	Timing	Facilitator
Midterm Review 101 & Program Update	1:00 – 1:30 PM	Hamid
Objective 1*	1:30 – 2:30 PM	Brent
Break	2:30 – 2:45 PM	
Objective 2*	2:45 – 3:30 PM	Suchita
Objective 3*	3:30 – 3:45 PM	Brent
Objective 4*	3:45 – 4:15 PM	Carol
MTR Financial Framework	4:15 – 4:30 PM	Cindy
Summary/next steps	4:30 – 4:45 PM	Hamid

Mid-Term Review: Finance and Budget Consideration

Budgetary assumptions being revisited during Mid-Term Review	
IMMUNIZATION ACTIVITIES	• Target population growth rate • Unit cost inflation (salaries, transportation) • Polio Campaign enhancements (LQAS, monitoring) • Security and access costs • Volume of campaigns post 2015 (esp. Pakistan and related risks) • Emerging risks (Libya, Ukraine,…) • t/bOPV switch costs • IPV introduction forecast assumptions (e.g. product mix, MDVP, price, population, catalytic support to India)
SURVEILLANCE AND RESPONSE CAPACITY	• Cost inflation of consumables and salaries • Lessons from India, Nepal , etc… on the needs for Surveillance post-eradication. • Integrate lessons learned from 2013-2014 outbreaks re: emergency response needs
CONTAINMENT & CERTIFICATION	• Overall costing assumptions, as work is now starting
CORE FUNCTIONS AND INFRASTRUCTURE	• Assess which innovations tested since 2013 could be “mainstreamed” • Duration of surge investments in outbreak or high-risk context • Salary/cost inflation • Fill/vacancy rate

Agenda

Item	Timing	Facilitator
Midterm Review 101 & Program Update	1:00 – 1:30 PM	Hamid
Objective 1*	1:30 – 2:30 PM	Brent
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Objective 2*	2:45 – 3:30 PM	Suchita
Objective 3*	3:30 – 3:45 PM	Brent
Objective 4*	3:45 – 4:15 PM	Carol
MTR Financial Framework	4:15 – 4:30 PM	Cindy
Summary/next steps	4:30 – 4:45 PM	Hamid

APPENDIX

Monitoring Framework and Strategic Plan Activities

GPEI Status Report laid out 16 main indicators for Objective 1

Interrupt Transmission
1. # of WPV1 cases

High Population Immunity
1. % 0 dose
2. LQAS
3. % inaccessible
4. # of doses administered
5. % children missed due to no visit/child absent
6. % children missed due to refusal
7. # and type of campaigns

High Virus Detection
1. NPAFP rate
2. Stool adequacy
3. Lab receipt to isolation time
4. RI: % reduction unimmunized children
5. IPV introduction
6. # of cases from families refusing OPV

Outbreak countries only
1. Initial response
2. Follow-on response

PEESP laid out 5 main activities for Objective 1

5.4 WHAT WILL BE DONE?

Major activities
1. Strengthening global surveillance to detect virus circulation
2. Maintaining an appropriate supplementary OPV immunization schedule
3. Enhancing OPV campaign quality to interrupt endemic transmission
4. Enhancing the safety of OPV campaign operations in insecure areas
5. Preventing and responding to polio outbreaks

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Emerging themes: Objective 1

PEESP Activity	Emerging themes
Strengthening global surveillance	• As WPV and cVDPV transmission decline, the importance of reliable surveillance dramatically increases in order to guide program decisions. Sustaining adequate number and quality of staff and laboratory resources will be critical for GPEI. • Despite meeting performance indicators at the national and subnational levels, the identification of orphan viruses in 2014 make it likely that surveillance is suboptimal in portions of both endemic and high risk countries. • While basic surveillance indicators are routinely reported, regular assessments and comprehensive, in-depth analysis are needed on a global, regional, national, and sub-national basis to regularly guide program efforts. • Expanded surveillance efforts have included active case searches during SIAs, contact sampling, and targeting of marginalized populations. However, in many circumstances, improved surveillance and innovations have been dependent surge capacity, which may be problematic to sustain. • Polio lab capacity throughout the Global Polio Laboratory Network has been expanded to increase timeliness of results. An environmental surveillance plan has been developed to expand the number of sites in both endemic and high risk countries in order to augment AFP surveillance. Additional human and equipment resources must be allocated to fully incorporate this approach into an integrated surveillance network. The future role of environmental surveillance as a real time assessment tool remains to be fully determined.
Maintaining appropriate immunization schedule	• The outbreaks in 2013-2014 plus the persistent transmission in endemic countries necessitated a global increase in the number of SIAs implemented compared to SIAs planned. • SIAs utilized either bOPV or tOPV based on strategic priorities in the target country. The preferential use of one vaccine or the other requires careful consideration of national and regional risks. • Experience in Kenya, Nigeria, Afghanistan, and Pakistan demonstrate that IPV-OPV co-administration during campaigns is feasible and can achieve high coverage. Given global supply limitations, future use of IPV in SIAs can directly impact the introduction of IPV in routine programs for non-polio countries. • The Risk Assessment Task Team of the GPEI now utilizes a data driven approach to produce a range of SIA options.

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Emerging themes: Objective 1 (continued)

PEESP Activity	Emerging themes
Enhancing OPV campaign quality	• Campaign quality remains mixed. While Nigeria has been able to substantially increase team quality and accountability at the local level, staffing models and support in Pakistan and Afghanistan require further refinement. • Except for pockets in Afghanistan, overall acceptance of polio vaccination is the highest the program has seen across the endemic countries. Accessibility has improved in most areas but some children remain chronically missed in many countries. • Nomad and border area populations remain at particular risk for being missed for surveillance and vaccination. Innovations such as involving community leaders in micro-planning to identify pastoral community settlements and use of transit point vaccinations, etc. needs to be expanded and sustained. • Innovative monitoring measures (e.g. GIS) have been implemented in some areas, but even basic Independent Monitoring is not yet routinely utilized in areas of Pakistan. Additional analysis of multiple, sometimes contradictory, data sources is required. • While national level commitment is essential to support both surveillance and vaccination efforts, provincial and district level leadership remains absolutely critical for achieving objectives and sustaining progress.
Enhancing safety of OPV campaign operations in insecure areas	• Insecurity, lack of access and attacks on humanitarian workers continues to negatively impact the delivery of vaccination efforts. • The withdrawal of State structures and personnel in the most violent parts of a few countries (e.g. Syria, Iraq, S Sudan, etc.) have necessitated program innovations, including remote planning, implementation and monitoring, third party engagement of Non State Armed Groups, and opportunistic approaches to reach children.
Preventing and responding to polio outbreaks	• Major outbreaks in 2013-14 in the Horn of Africa, Central Africa, and the Middle East demonstrated the fragility of both surveillance and response capacity in many countries. Outbreaks have now been controlled, however the time to stop transmission ranged from 8 weeks (Iraq) to over 54 weeks (Somalia). • Gains remain fragile due to fluctuating security and challenges to sustain interest and commitment in non-endemic countries. • Key lessons learned: national governments must be fully engaged in all phases of the outbreak response; a coordinated GPEI response team, deployed immediately, and with a clear designated Coordinator is essential. • New Standard Operating Procedures for Outbreak response have been finalized by the GPEI in early 2015. Trainings began in April 2015 for an interagency Rapid Response Team.

Objective 1 Sources Reviewed

Sources reviewed so far:

Jan-June 2014 Status Report

Jul-Dec 2014 Status Report

MMWR. Assessing and Mitigating the Risks for Polio Outbreaks in Polio-Free Countries — Africa, 2013–2014

GPEI Status Reports: Apr 2013, Sept 2013, Apr 2014, Sept 2014, April 2015 (draft)

IMB Reports: 7th (May 2013), 8th (Oct 2013), 9th (May 2014), 10th (Oct 2014)

GPEI response to IMB recommendations from 6th to 10th IMB Reports

Surveillance: current status and work in AFRO and EMRO, presentation at 11th IMB

Conclusions and Recommendations from Afghanistan Technical Advisory Group on Polio Eradication, December 2013 and June 2014

Conclusions and Recommendations from the Meeting of the Expert Review Committee on Polio Eradication in Nigeria (ERC), March 2013, Nov 2013, Apr 2014, Spet 2014, Jan 2015.

Summary Report from the Technical Advisory Group Meeting on Polio Eradication for Pakistan, Nov 2013, Jun 2014

Sources to be reviewed/upcoming input points:

GPEI Status Report: Apr 2015

IMB Report: 11th (May 2015)

Nigeria National Emergency Action Plan (NEAP), July 2013-June 2014

National Emergency Action Plan 2014 For Polio Eradication in Pakistan

Rationale for switching from tOPV to bOPV

Currently the risks associated with the type 2 component of tOPV outweigh the benefits

Since 1999, type 2 wild poliovirus has not been detected

The type 2 component of tOPV:

- Causes more than 90% of vaccine-derived polio viruses (VDPVs)
- Causes approx. 40% of vaccine-associated paralytic polio (VAPP) cases
- Interferes with the immune response to poliovirus types 1 and 3 in tOPV

The role of IPV:

- Reduce risks associated with the withdrawal of OPV type 2
- Facilitate interruption of transmission with the use of monovalent OPV type 2 in the case of outbreaks
- Hasten eradication by boosting immunity to poliovirus types 1 and 3

Objective 2 in three distinct steps

Before end 2015

Introduce

at least one dose of **IPV**

into **routine immunization**

2016

Switch

tOPV to bOPV

2019-2020

Withdrawal

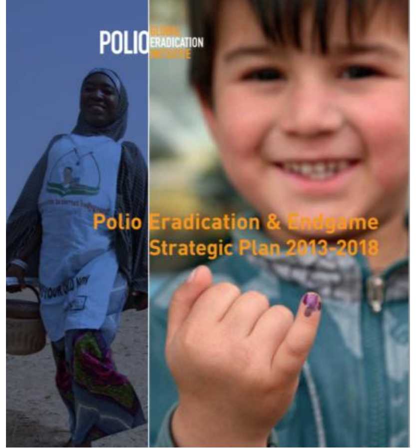
of bOPV and all OPV use in routine programmes

Ongoing STRENGTHENING of routine immunization services

Monitoring Framework and Strategic Plan Activities

GPEI Status Report laid out 4 main indicators for Objective 2

1. % reduction in unimmunized children (10 priority countries)
2. Plan to strengthen RI (10 priority countries)
3. # of OPV only using countries introducing IPV (commitment and introduction)



PEESP laid out 4 main activities for Objective 2

6.4 WHAT WILL BE DONE?

Major activities

1. Increasing immunization coverage
2. Ensuring appropriate IPV, bOPV and mOPV products
3. Introducing IPV
4. Withdrawing OPV from routine and supplementary immunization activities

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Emerging themes: Objective 2

PEESP Activity	Emerging themes
Increasing immunization coverage	• Where countries have done well, government **commitment to RI strengthening** and funding along with **national and agency level EPI-GPEI program integration** have made the difference • As of Dec 2014, only 4 out of 10 priority countries have met all 5 evaluation criteria for their RI strengthening plans. • Polio worker time spent on RI is not tracked regularly, but a BCG survey of 10 countries shows polio workers spent ~22% of their time on RI and ~46% of their time on all non-polio immunization activities.
Ensuring appropriate IPV, bOPV and mOPV products	• **IPV supply is expected to be tight**, even under best case scenarios, in Q1 of 2016. The program risks **delayed IPV introduction** if suppliers are unable to deliver volumes on the promised schedule and if there are unforeseen setbacks • bOPV supply is not expected to be a problem, but ensuring a **minimally burdensome registration process for manufacturers** given the short duration of use for this vaccine will be the biggest upcoming challenge. The program has a path forward on this via the WHA Resolution in May but may need to put in-place a back-up option if countries still choose to go their own way • **mOPV bulk supply has been secured** and protocol for its use has been developed. The program needs to **identify risks that may result in that supply being insufficient**, e.g. a large type-2 outbreak
Introducing IPV	• **Strong process is in-place** for assessing readiness and tracking IPV introduction, however a host of challenges related to funding availability, country capacity, and competing priorities with other vaccine introductions exist. • The program needs to stay vigilant and dedicated to tracking and managing to the process.
Withdrawing OPV from routine and supplemental immunization activities	• The biggest risks to tOPV withdrawal are **complex communication** and confusion in the field, **lack of visibility into global inventory** of tOPV (in cold chain, in pharma companies), and **waste management**. • The processes developed for tOPV wilthdrawal will set an important precedent for bOPV withdrawal in 2019-2020. The program needs to identify the markers of success for the withdrawal of tOPV so that **it can be clear about lessons learned and adjustments needed** for bOPV withdrawal.

Objective 2 Sources Reviewed

Sources reviewed so far:

- POB Readiness for Switch (Dec ‘14)
- POB RI Strengthening (Dec ‘14)
- GAVI Technical Update for POB (Dec ‘14)
- TFI Objective 2 (Dec ‘14)
- IMG Global Switch – Tracking Tool (Mar ‘15)
- WHO IPV Status Report (Mar ‘15)
- OPV Cessation Protocol (Oct ‘14)
- SAGE Recommendations (Oct ‘14)
- Polio legacy/transitioning to routine immunization, lessons learnt from India
- 2013 GPEI Annual Report
- 2014 GPEI Status Report (Jan – Jun)
- IMG Workshop Materials (3/30 – 4/2)
- IMG Chair Engagement (4/2)
- 2014 GPEI Status Report (Jul-Dec)

Sources to be reviewed/upcoming input points:

- Internal Interviews

GAPIII: WHO poliovirus containment policy

2009

Containment policy document (draft 2009):

WHO global action plan to minimize poliovirus facility-associated risk after eradication of wild polioviruses and cessation of routine OPV use (GAPIII)

- *GAPIII* (2009) addresses all 3 poliovirus strains together
  1. Eliminate all wild poliovirus,
  2. Stop vaccination with all 3 OPV strains simultaneously

- *Endgame Plan* introduces phased withdrawal of OPV strains
  1. Beginning with type 2 (tOPV-bOPV switch)

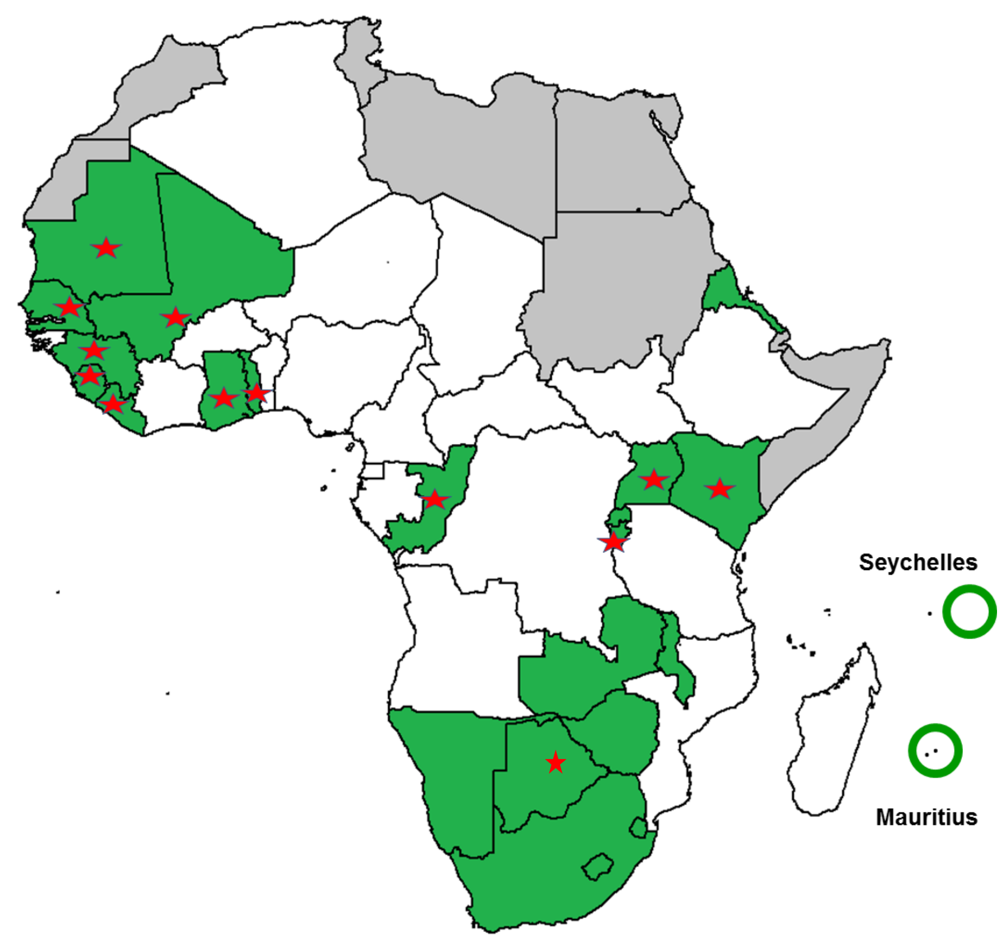
⇒ Need to revise *GAPIII* and align containment timelines with the *Endgame Plan*

- **Phase I:** Global Coordination for Readiness (until end-2015)
- **Phase II:** Global Poliovirus Type 2 Containment Period (2016 – 2018)
- **Phase III:** Long term Containment (2019 ➞)

2013

Progress-Certification in AFR, Dec 2014

- 29 countries have prepared and presented their complete country documentation
- 25 documentations accepted
  - 12 (48%) experienced later WPV importations



Documentation accepted

WPV following Documentation acceptance

Monitoring Framework and Strategic Plan Activities

PEESP laid out 5 main indicators for Objective 3 *(2013-2015)*

1. Align GAPIII with new endgame strategy and timelines
2. SEARO certification
3. Complete Phase 1 containment (survey and inventory) except in endemic countries
4. Delivery WHO report to WHA on WPV2 eradiction
5. Gain international consensus on containment timing and safeguards

GPEI Status Report laid out 2 main indicators for Objective 3

1. Containment—per GAP
2. SEARO certification

PEESP laid out 2 main activities for Objective 3

7.5 WHAT WILL BE DONE?

Major activities

1. Containing poliovirus stocks
2. Certifying the eradication of WPVs

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Emerging themes: Objective 3

PEESP Activity	Emerging themes
Containing poliovirus stocks	• Basic question as to the enforcement mechanism and authority of GAP III • National containment coordinators and national agency responsible for certification and enforcement not yet identified in most countries ; extensive training required in 2015. • Widely varying national capacities of national agencies. • Specific certification guidelines for IPV producers still need to be developed and promulgated • Phase I (Gap II) still not completed in AFRO and EMRO. Expanded inventory for Sabin 2 will be an additional task to be completed by July 2016. • Sensitivity regarding determination of “essential” facilities which are permitted to keep stocks of type 2 and how to implement containment for “non essential” labs, research facilities, and other testing facilities currently using type 2 poliovirus. • Major challenge to complete all identification, destruction, and transfer by July 2016.
Certifying the eradication of WPVs	• South-east Asia became the fourth WHO region to certify polio eradication in March 2014. • Efforts underway for the Global Certification Commission to consider status of global WPV2 eradication in September 2015. Continuing cVDPVs and containment issues remains a challenge. • Environmental surveillance recognized as a valuable augmentation to AFP surveillance, but specific role in certification is still evolving.

Objective 3 Sources Reviewed

Sources reviewed so far:

- Report of the Fourth Meeting of the core Global Certification Commission (GCC), November 2013
- Report of the Third Meeting of the core Global Certification Commission (GCC), August 2012
- Report from the Africa Regional Certification Commission (ARCC) to the Task Force on Immunization (TFI), Africa, December 2014
- Nineteenth Meeting of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific Region, November 2013
- Report of the South-east Asia Regional Certification Commission for Polio Eradication, March 2014

Sources to be reviewed/upcoming input points:

- Additional RCC reports from EURO and EMRO

Monitoring Framework and Strategic Plan Activities

PEESP laid out 3 main indicators for Objective 4 *(2013-2015)*

1. Initiate global legacy planning process, including stakeholder consultations, asset mapping and capturing lessons learnt
2. Complete broad consultation process on polio legacy
3. Establish polio legacy plan

GPEI Status Report laid out 1 main indicator for Objective 4

1. Consultations: inputs into plan

PEESP laid out 3 main activities for Objective 4

8.5 WHAT WILL BE DONE?

Major activities

1. Mainstreaming polio functions
2. Leveraging the knowledge and lessons learnt
3. Transitioning the assets and infrastructure

Projected effects on RI from discontinuation of the polio program

Effects on RI if polio teams were no longer contributing

Responses

Category	Total	AFRO	EMRO
Lower RI coverage	150	106	44
Higer drop out/default rates	51	47	4
Decreased community awareness	33	33	0
Reduced monitoring, training & supervision	29	22	7
Lower quality of service	26	19	7
Decreased comms & social mobilization	18	15	3
Insufficient data management	12	10	2
No impact	9	2	7
Reduced capacity building	8	5	3
Positive impact	4	2	2
Other	4	2	2
Reduced impact in remote districts	2	1	1
Lower commitment by healh care workers	2	2	0

Survey question: "What would be the impact on routine immunization if your team was no longer able to contribute?"
Source: RI IMG Polio Survey

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Emerging themes: Objective 4

PEESP Activity	Emerging themes
Mainstreaming polio functions	• Guidelines for mainstreaming polio functions are included in Transition Guidelines • Legacy planning will unfold differently in each country based on specific country context • **Relevant to all three activities is the creation of polio legacy transition planning toolkit consisting of the following:** Polio Legacy Transition Planning Frequently Asked Questions (FAQs); Polio legacy communications slides; Transition Guidelines; Lessons Learned (an example from the global perspective of a lessons learned paper); India Lessons Learned Legacy slide presentations (2); Lessons learned framework-guidelines for documenting lessons-learned at country-level.
Leveraging the knowledge and lessons learnt	• Guidelines for capturing and operationalizing lessons learned are included in the Transition Guidelines. • Valuable lessons being learned from those countries such as India that have begun to transition assets, and from examples of “legacy in action” are not necessarily being documented and shared.
Transitioning the assets and infrastructure	• Guidelines for transitioning assets and infrastructure are included in the Transition Guidelines. • Capturing “legacy in action” such as described in the “pilot planning studies” in DRC and Nepal provide useful examples of how polio assets can be used for other health priorities; more needs to be done to document other examples. • More people in other areas of the GPEI agencies (e.g., RI and HSS) need to be involved as the evidence base shows that these are areas where polio-funded staff spend a significant amount of time. • Nigeria example of EOC appointing a legacy committee and the Canadian Mission convening a meeting of donor partners is positive.

Objective 4 Sources Reviewed

Sources reviewed so far:

- Legacy communication presentation (March 2015)
- Legacy transition planning guidelines (March 2015)
- Polio Legacy Transition Planning FAQs (March 2015)
- POB legacy planning decision paper and presentation (Dec 2014)
- AFRO TFI presentation (Dec 2014)
- PPG legacy planning presentation and meeting report (Oct 2014)
- Global Polio Eradication Initiative : Lessons Learned and legacy (November 2014)
- UNICEF IEAG presentation Mar ‘15
- WHO/NPSP IEAG presentation Mar ’15
- Lessons learned framework-guidelines for documentation lessons learned at the country level

Sources to be reviewed/upcoming input points:

- Achieving GVAP goals-India presentation
- IEAG Conclusions and recommendations, Mar ‘15
- “Best Practices” reports from eight countries in AFRO (not yet available)

Analytical process for Section A: Assessment of Progress

POLIO GLOBAL ERADICATION INITIATIVE

Step 1: Collect raw data

- Primary reliance on WHO Status Report (2013, Jan-Jun 2014, Jul-Dec 2014)
- Supplement with additional data as available
- Color-coded every indicator in every time-period against the target: green = met or exceeded target, yellow = within 20% of meeting target, red = outside 20% of meeting target

Step 2: Assign a "counting-based" score

- Assign a score for each outcome based on the "counts" of red, yellow, and green for each of the indicators
- Green = >80% of all indicators were green, Yellow = mixed indicators, Red = >80% of all indicators were red

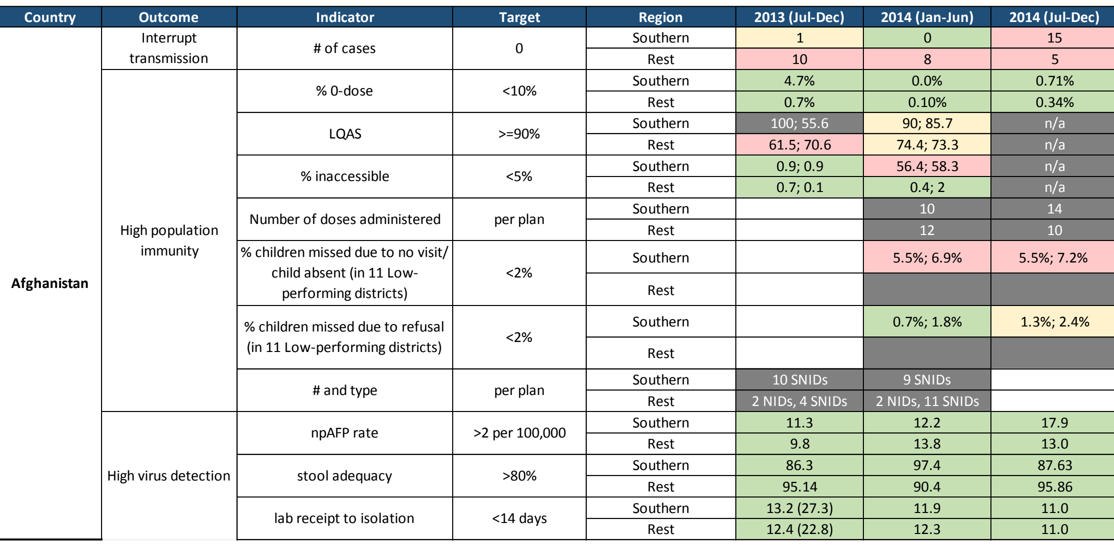
Step 3: Adjust with a subjective score

- Adjust counting-based score with contextual knowledge of indicators: e.g. downweighting indicators where there are holes or incomplete information, upweighting more reliable indicators, using a different source than the WHO Status Report if more recent information is available
- In general, subjective scoring only moves 1 category up or down from counting-based score and changes counting-based score in a minority of cases

Step 4: Validate score

- Compare subjective scores with POB scorecard
- Compare subjective scores with RATT underlying data. Note: this is different than the RATT score, project team compared the RATT data against the target set by monitoring framework
- Resolve any disagreements between counting-based and subjective score using validation score

Objective 1 example: Afghanistan (1 of 2)



Country	Outcome	Indicator	Target	Region	2013 (Jul-Dec)	2014 (Jan-Jun)	2014 (Jul-Dec)
Afghanistan	Interrupt transmission	# of cases	0	Southern	1	0	15
				Rest	10	8	5
	High population immunity	% 0-dose	<10%	Southern	4.7%	0.0%	0.71%
				Rest	0.7%	0.10%	0.34%
		LQAS	>=90%	Southern	100; 55.6	90; 85.7	n/a
				Rest	61.5; 70.6	74.4; 73.3	n/a
		% inaccessible	<5%	Southern	0.9; 0.9	56.4; 58.3	n/a
				Rest	0.7; 0.1	0.4; 2	n/a
		Number of doses administered	per plan	Southern		10	14
				Rest		12	10
		% children missed due to no visit/ child absent (in 11 Low-performing districts)	<2%	Southern		5.5%; 6.9%	5.5%; 7.2%
				Rest			
		% children missed due to refusal (in 11 Low-performing districts)	<2%	Southern		0.7%; 1.8%	1.3%; 2.4%
				Rest			
		# and type	per plan	Southern	10 SNIDs	9 SNIDs	
				Rest	2 NIDs, 4 SNIDs	2 NIDs, 11 SNIDs	
	High virus detection	npAFP rate	>2 per 100,000	Southern	11.3	12.2	17.9
				Rest	9.8	13.8	13.0
		stool adequacy	>80%	Southern	86.3	97.4	87.63
				Rest	95.14	90.4	95.86
		lab receipt to isolation	<14 days	Southern	13.2 (27.3)	11.9	11.0
				Rest	12.4 (22.8)	12.3	11.0

Step 2: Assign a "counting-based" score

	Outcome	Geography	Achievement	Trend
Endemic Countries	Interrupt transmission	**Afghanistan**		
	High population immunity	**Afghanistan**		
	High virus detection	**Afghanistan**		

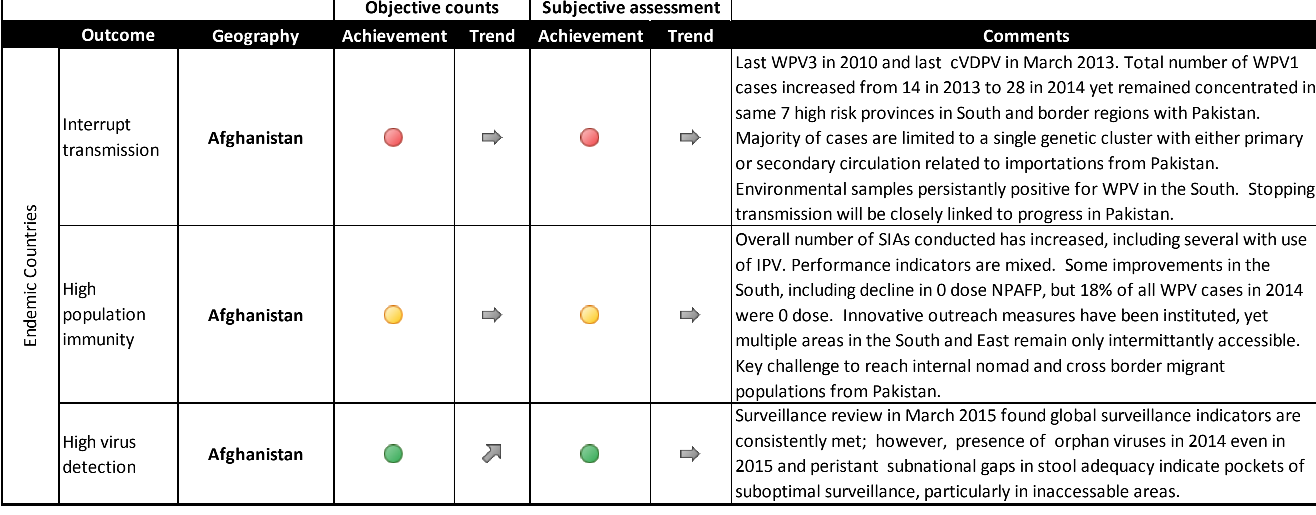
- Of the 2 possible indicators, 100% are red
- Mixed trend: worsening in the South, improving everywhere else

- Of the 8 possible indicators with data, 25% are red, 38% are yellow, 38% are green
- Of the 7 possible indicators with trend data, 4 have improved over time, 1 is level, and 2 are worse

- Of the 6 possible indicators, 100% are green
- Of the 6 possible indicators with trend data, 4 are better and 2 are level

Objective 1 example (2 of 2)

Step 3: Adjust with a subjective score



			Objective counts		Subjective assessment		
	Outcome	Geography	Achievement	Trend	Achievement	Trend	Comments
Endemic Countries	Interrupt transmission	**Afghanistan**	red	→	red	→	Last WPV3 in 2010 and last cVDPV in March 2013. Total number of WPV1 cases increased from 14 in 2013 to 28 in 2014 yet remained concentrated in same 7 high risk provinces in South and border regions with Pakistan. Majority of cases are limited to a single genetic cluster with either primary or secondary circulation related to importations from Pakistan. Environmental samples persistantly positive for WPV in the South. Stopping transmission will be closely linked to progress in Pakistan.
	High population immunity	**Afghanistan**	yellow	→	yellow	→	Overall number of SIAs conducted has increased, including several with use of IPV. Performance indicators are mixed. Some improvements in the South, including decline in 0 dose NPAFP, but 18% of all WPV cases in 2014 were 0 dose. Innovative outreach measures have been instituted, yet multiple areas in the South and East remain only intermittantly accessible. Key challenge to reach internal nomad and cross border migrant populations from Pakistan.
	High virus detection	**Afghanistan**	green	↗	green	→	Surveillance review in March 2015 found global surveillance indicators are consistently met; however, presence of orphan viruses in 2014 even in 2015 and peristant subnational gaps in stool adequacy indicate pockets of suboptimal surveillance, particularly in inaccessable areas.

Step 4: Validate score

	Outcome	Geography	Status Report	RATT Data	POB Scorecard
Endemic Countries	Interrupt transmission	**Afghanistan**	red		
	High population immunity	**Afghanistan**	yellow	green	yellow
	High virus detection	**Afghanistan**	green	green	

Workstream Assignments

Workstream	Lead	Key contributors
Introduction & Executive summary	Suchita Guntakatta	Andrew Freeman, Brent Burkholder
Objective 1	Omer Pasi	Brent Burkholder, Sahar Hegazi, Janet Zhou
Objective 2		
a) IPV Introduction	Suchita Guntakatta	Brent Burkholder, Terumi Yamazaki, Janet Zhou
b) tOPV/bOPV Switch	Same as above	Same as above
c) RI Support	Brent Burkholder	Sahar Hegazi, Terumi Yamazaki
Objective 3: Certification & Containment	Brent Burkholder	Rissa Durham
Objective 4: Legacy	Carol Pandak	Rissa Durham
Finance	Kelly Jarrett, Cindy Aiello	Michiyo Shima, Graham Thomas, Rissa Durham
Project management	Suchita Guntakatta	Rissa Durham, Janet Zhou

*Carol Pandak focal point for Advocacy