# Global Polio Eradication Initiative (GPEI) Status Report

11 July 2016
Surveillance data as of 28 June 2016

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Seattle, Washington USA

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  - Afghanistan
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    - Coverage estimates and missed children
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*The boundaries and names shown and the designations used on these maps do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.*

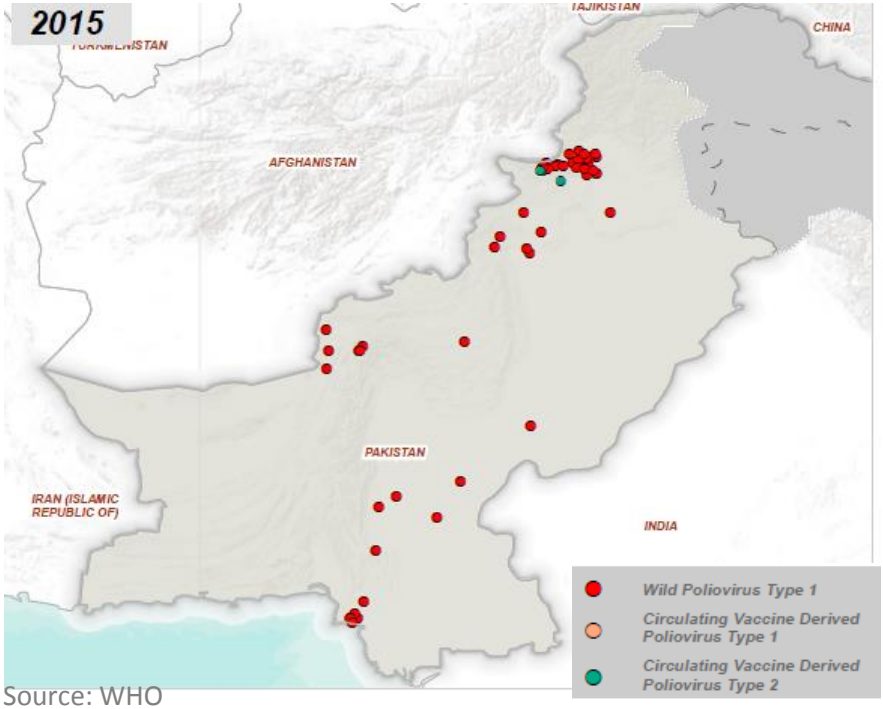
# Topline Messages

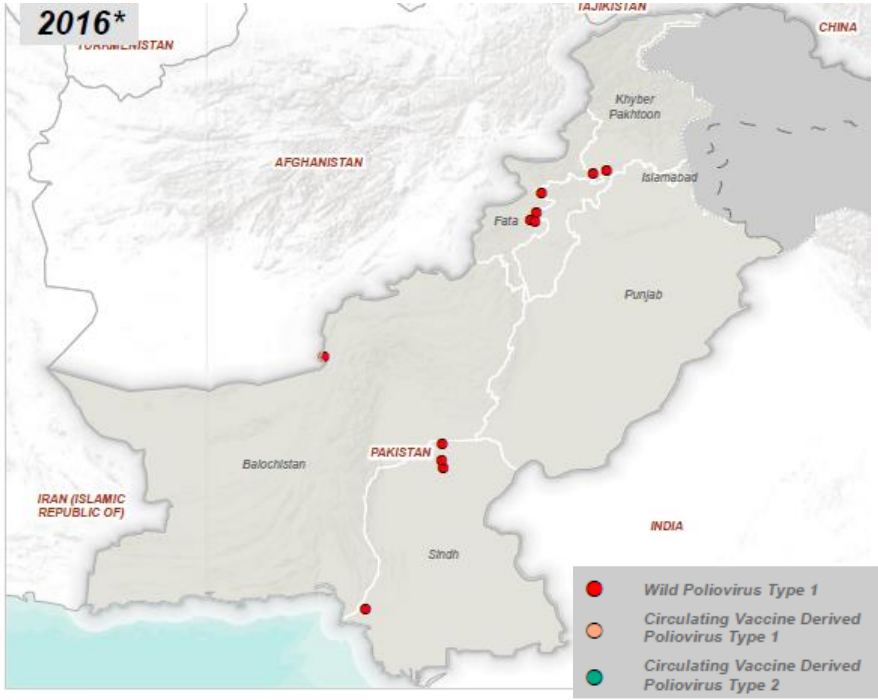
- The programme continues to strive to interrupt WPV transmission in 2016 and enable the world to be polio-free by 2019.
- Pakistan and Afghanistan are on track to stop polio in 2016—but critical gaps need to be addressed to increase the likelihood of eradication in 2016, particularly: access in Eastern Afghanistan, improving SIA quality in Southern Afghanistan, and parts of Pakistan including Karachi and Northern Sindh.
- Africa is on track to be certified as polio-free in 2017—but more needs to be done to close surveillance gaps in key countries, while improving the immunization coverage including quality of SIAs especially as the number of SIAs decrease.
- While the program's response to VDPV outbreaks is good in most counties, it was substantially delayed in Madagascar and Ukraine, and had poor performance in Guinea.
- Post-switch, the program has new guidelines to direct outbreak response; to date mOPV2 has only been released for use twice, both times in Nigeria.
- GPEI is now better coordinated, although a few management challenges remain in the final eradication push, particularly in the following areas:
    - Identifying dedicated staff for GPEI specific roles and tasks
    - Tight global IPV supply through 2017
    - Balancing the remaining risks while adhering to approved global budget
    - Systematic application of successful strategies to the areas where poliovirus continues to thrive
    - Using a holistic analysis of data to drive programme change in the most critical areas
    - Ensuring timely resolution of gaps in cash and funding
- The program must also address non-endemic areas with risk due to inaccessibility and ongoing active conflict, including:
    - Middle East (Syria, Yemen, Iraq, Libya)
    - Africa (Nigeria, CAR, South Sudan)

# ENDEMIC COUNTRIES


PAKISTAN

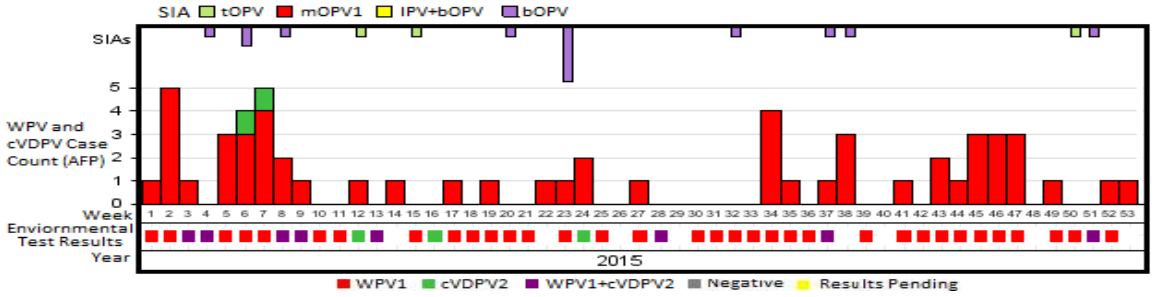
# **Pakistan:** WPV and cVDPV cases, 2015 and Jan 2016 – Jun 2016

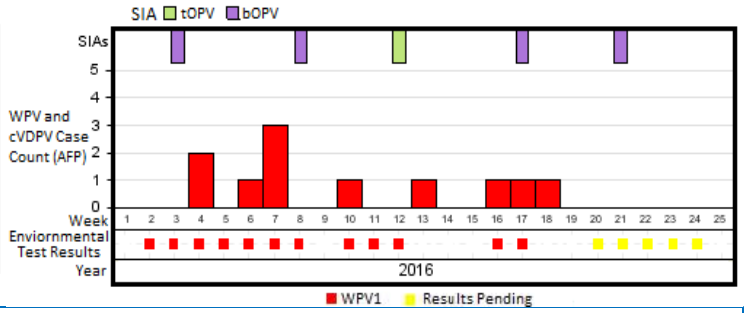



Source: WHO

WPV and cVDPV cases, environmental results by onset week,and SIAs*, 2015 and Jan to Jun 2016



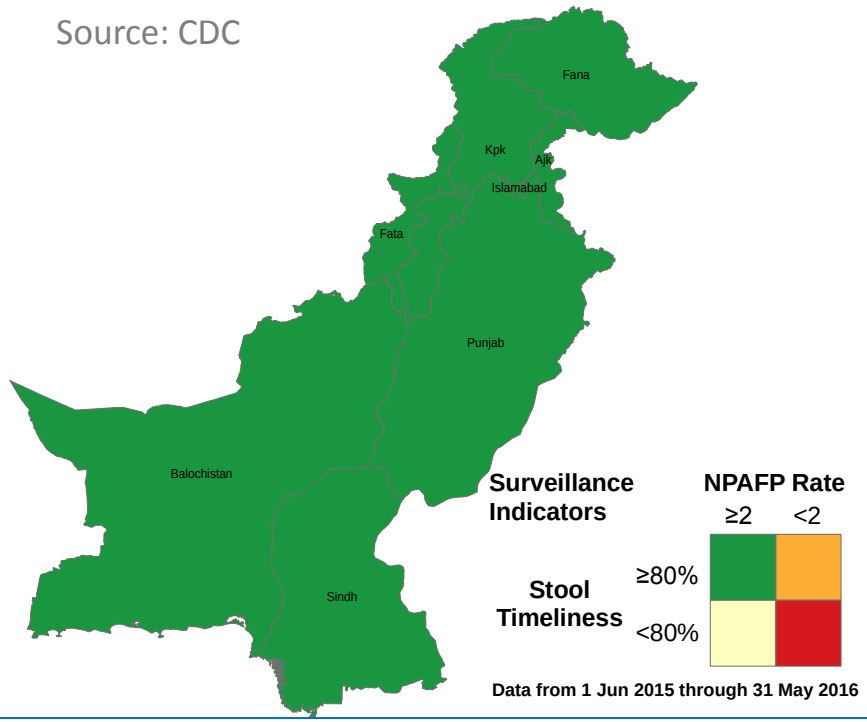




In 2015, Pakistan had 54 WPV1 cases; YTD in 2016 there are 12 cases, compared to 25 cases in the same period in 2015 (NOTE: 13th case reported wk 27, 2016, onset 18-June-2016, 24 month child, 1 dose OPV, FATA: Waziristan). *Pakistan IPV SIA data were unavailable in POLIS

# **Pakistan:** Surveillance meets standards at the province level*, and accessibility has continued to improve
Jun 2015 – May 2016

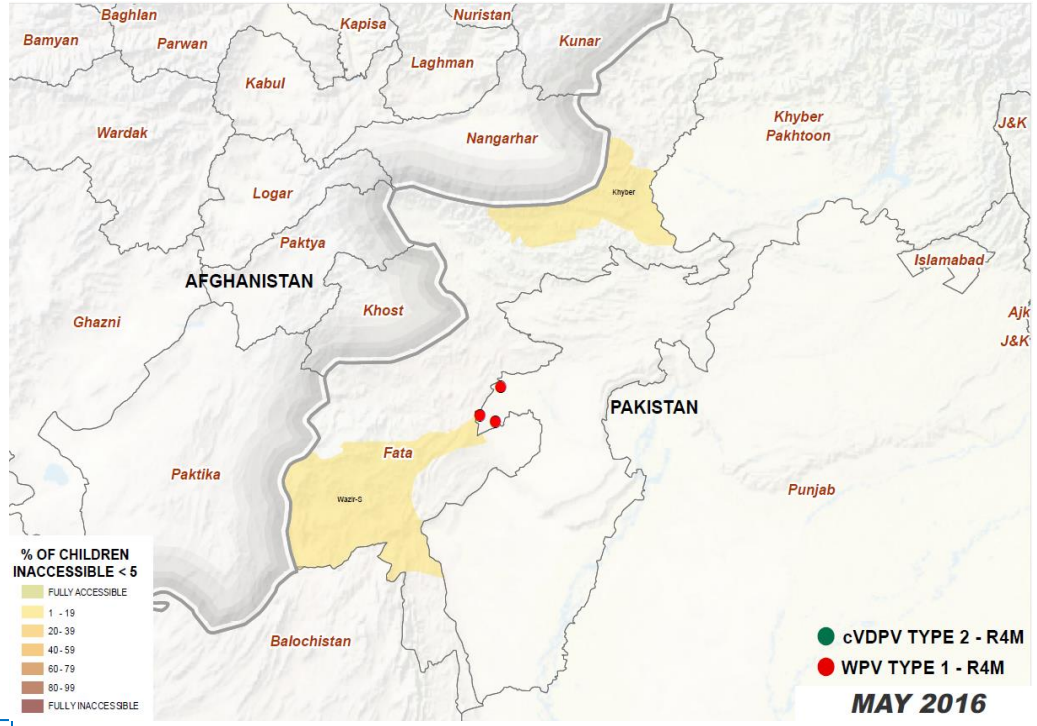
## Surveillance

Source: CDC




Stool timeliness: 2 stool specimens, collected ≥ 24 hours apart, among AFP cases < 15 yrs old w/in 14 days of paralysis onset

## Accessibility

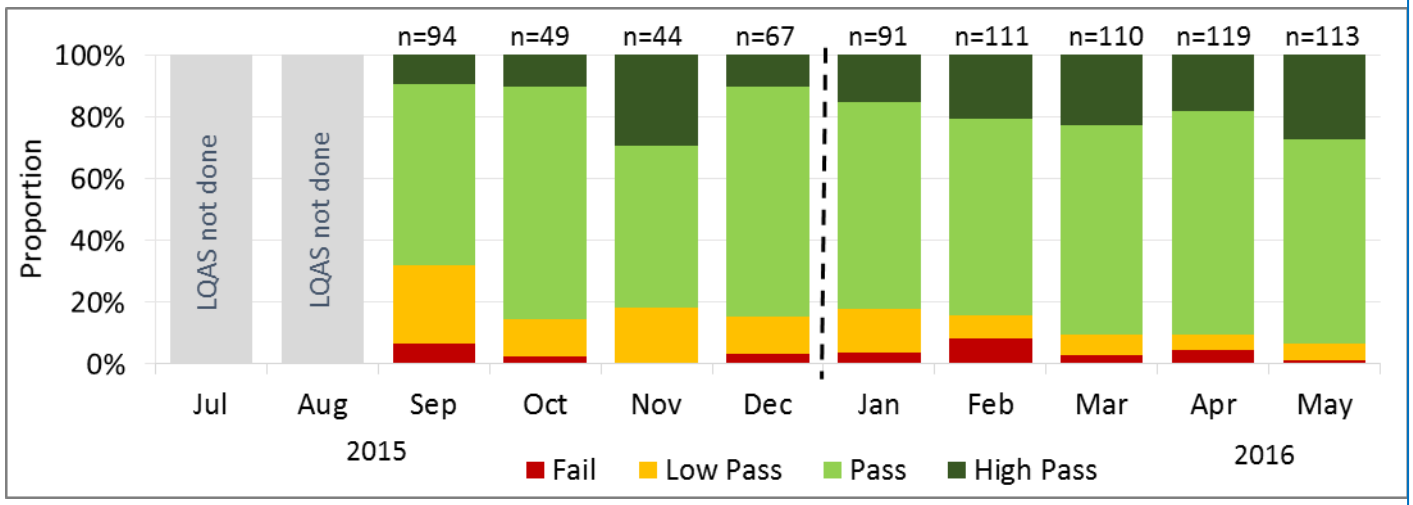



Source: WHO; *data reported as of May, 2016

*Note: surveillance gaps do exist within provinces, for example Karachi/Sindh.

# **FATA:** Improvement in SIA quality and high immunity based on NPAFP Jul 2015 – May 2016

## LQAS Survey Results by SIA

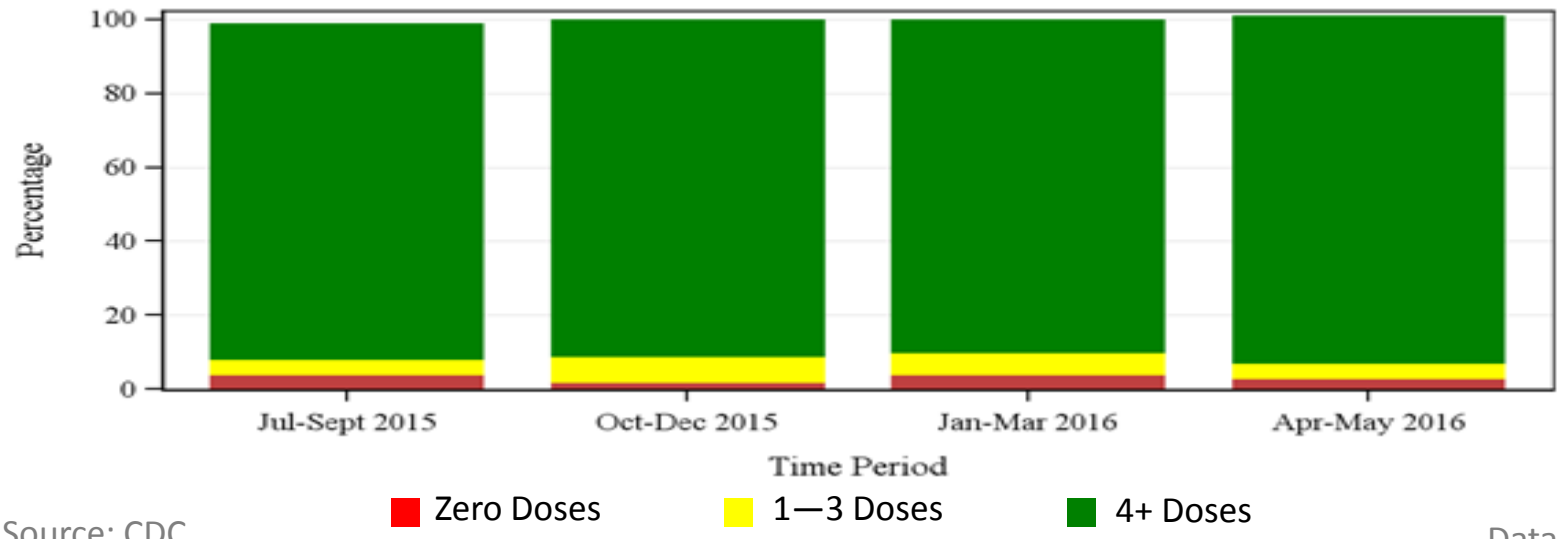



Note: Pakistan and Afghanistan results use different LQAS categories of unvaccinated children to estimate coverage.

Pakistan # of unvaccinated children categories:

0 = High Pass (95%+)
1-3 = Pass (90%-94%)
4-8 = Low Pass (80%-89%)
≥ 9 = Fail (< 80%)

## Percentage of NPAFP cases 6-35 months, by OPV status

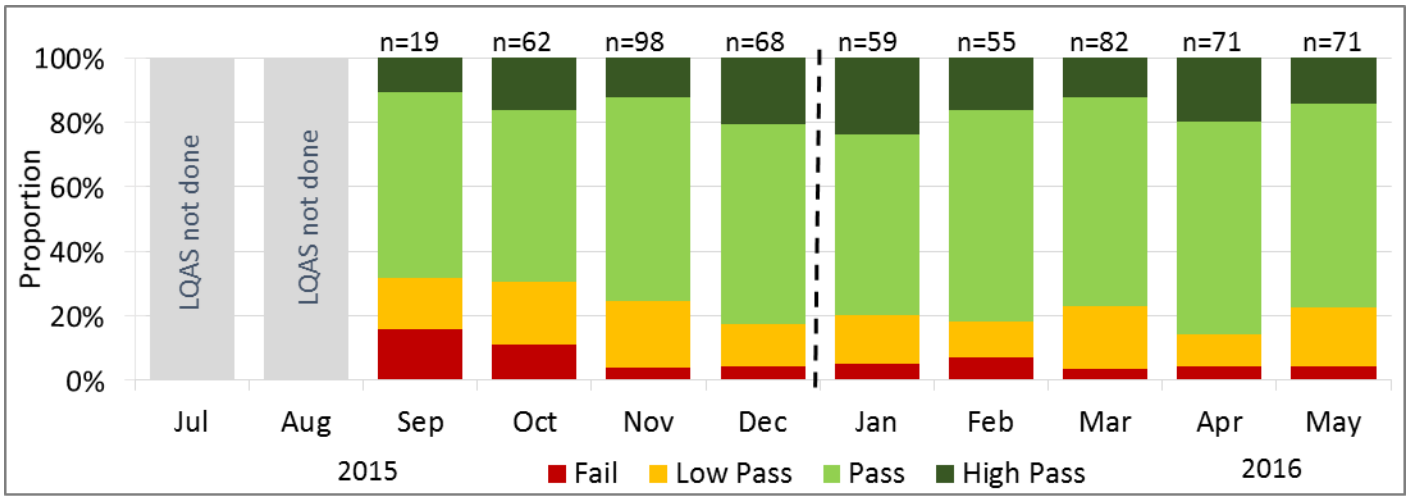



Source: CDC

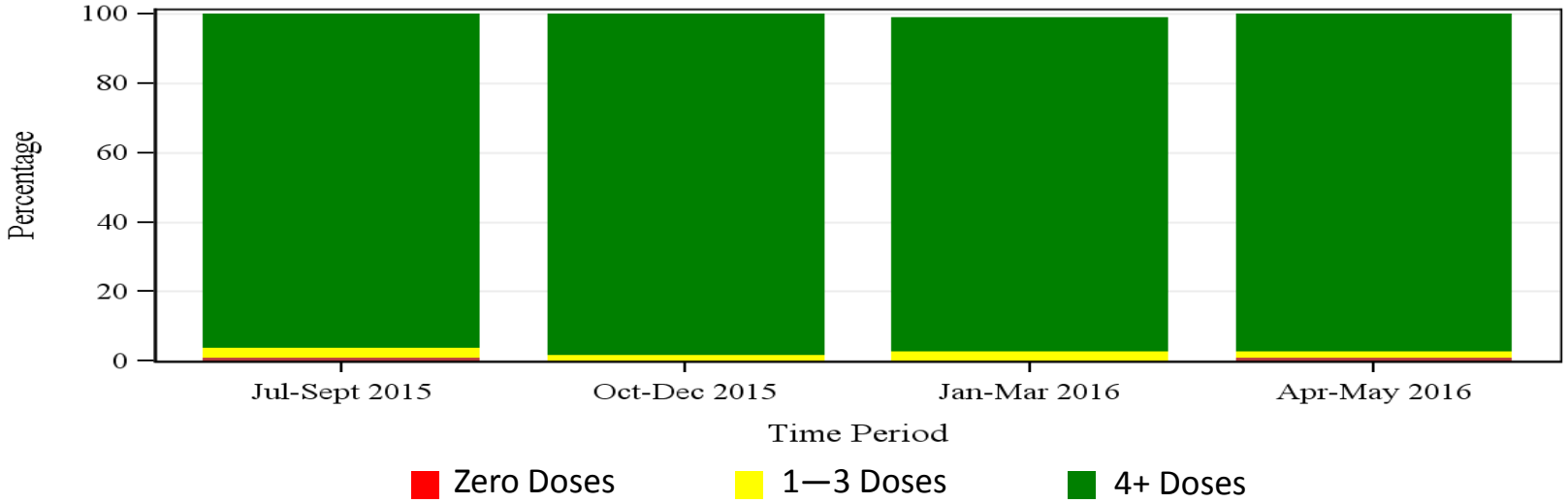
Data as of June 14, 2016

# **KP:** Improving SIAs and high immunity based on NPAFP Jul 2015 – May 2016

## LQAS Survey Results by SIA




## Percentage of NPAFP cases 6-35 months, by OPV status

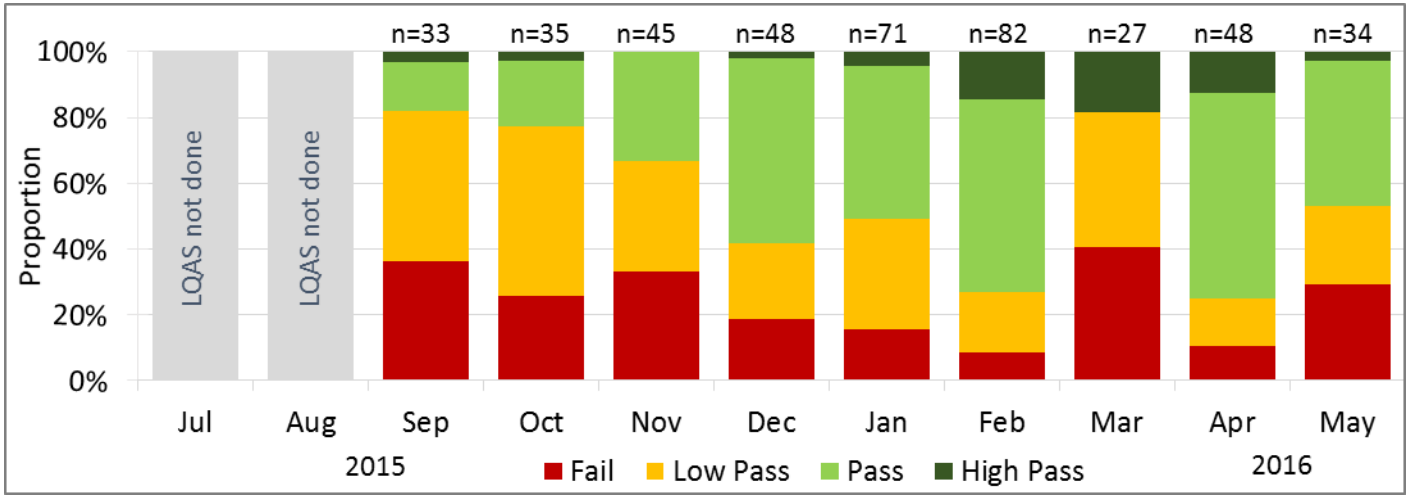



Source: CDC

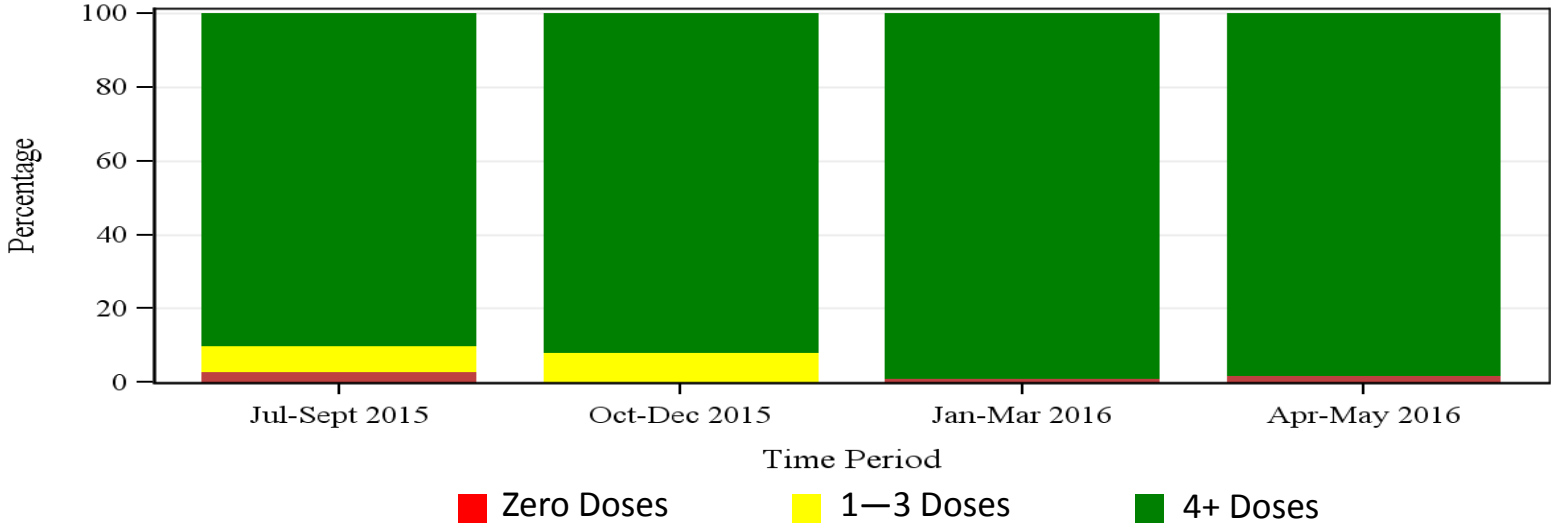
Data as of June 14, 2016

# **Karachi:** Variable SIA quality, improving immunity found by NPAFP Jul 2015 – May 2016

LQAS Survey Results by SIA




Percentage of NPAFP cases 6-35 months, by OPV status

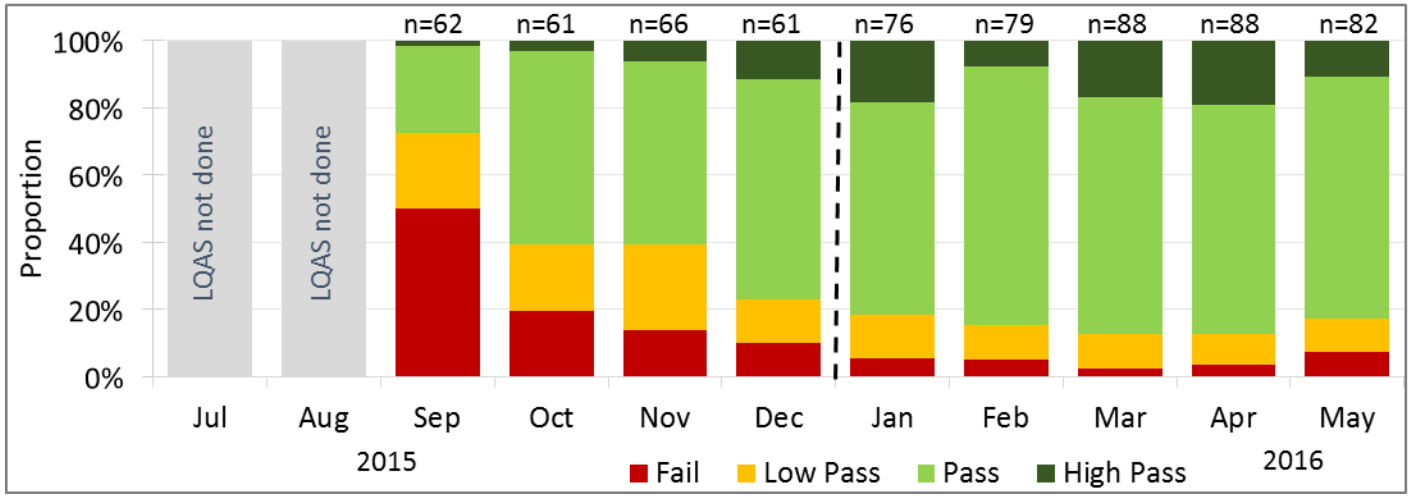



Source: CDC

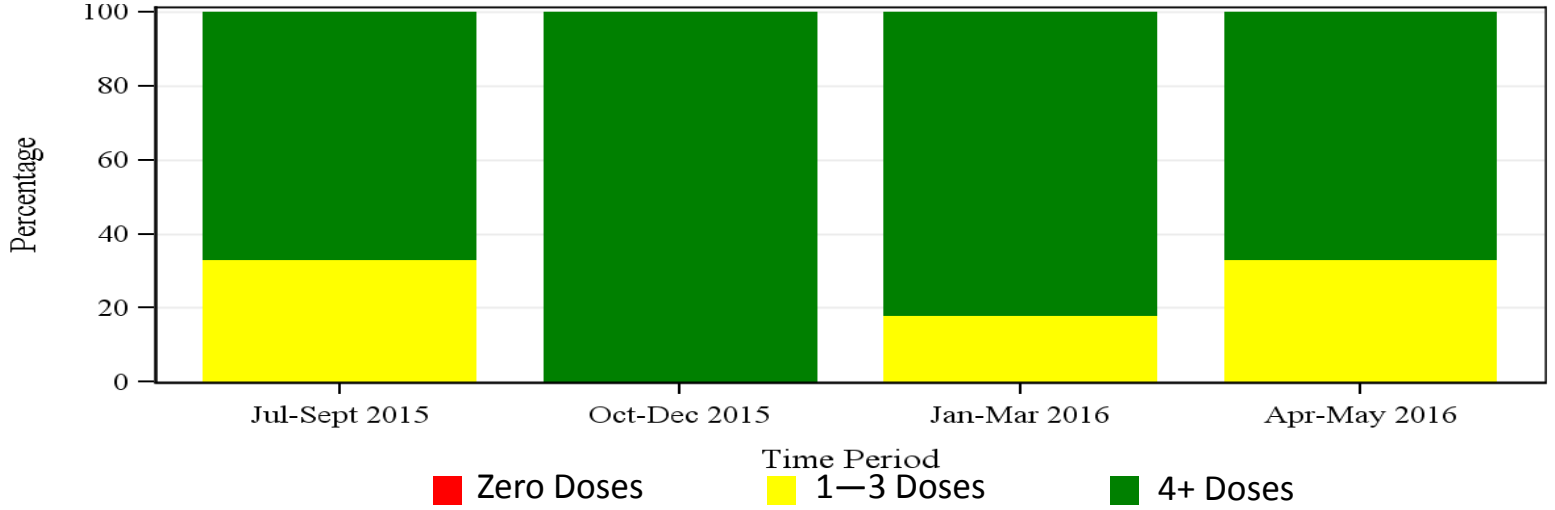
Data as of June 14, 2016

# **Quetta:** Improving SIA quality but immunity still lags based on NPAFP Jul 2015 – May 2016

LQAS Survey Results by SIA




Percentage of NPAFP cases 6-35 months, by OPV status



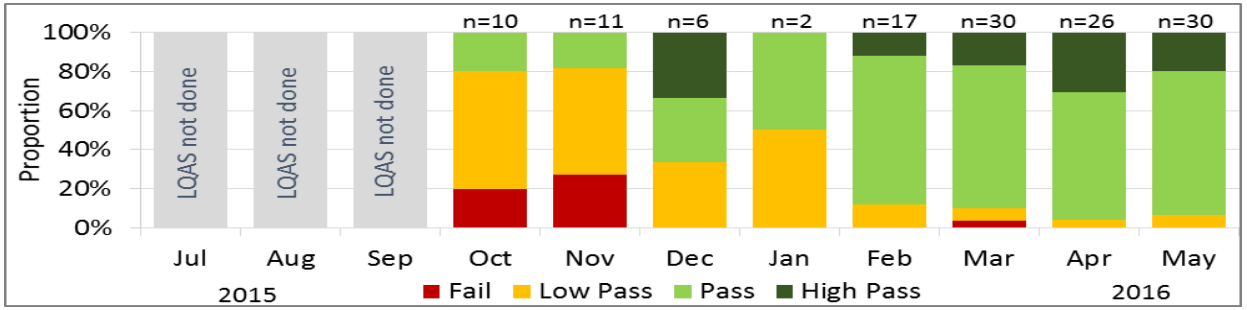

Source: CDC

Data as of June 14, 2016

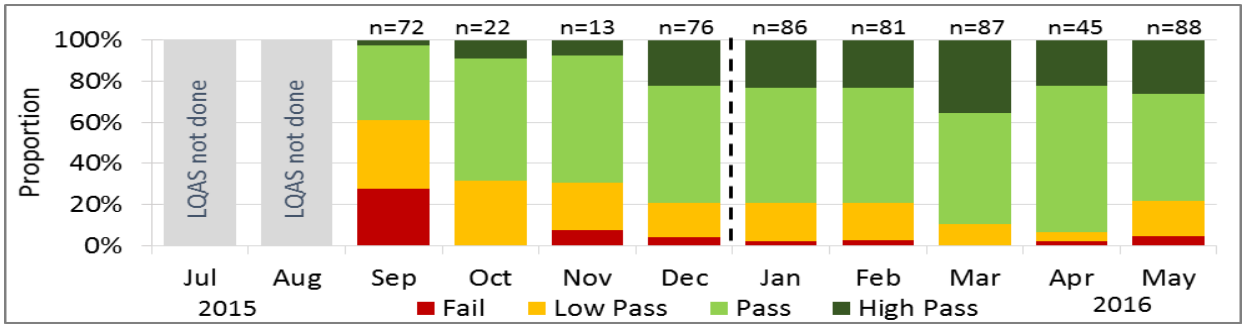
# **Pakistan:** SIA quality varies among high risk transmission areas

Jul 2015 – May 2016

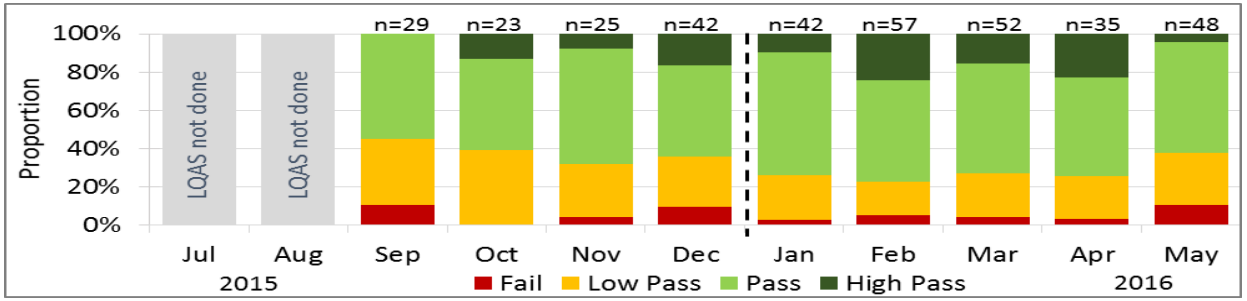
**Khyber**



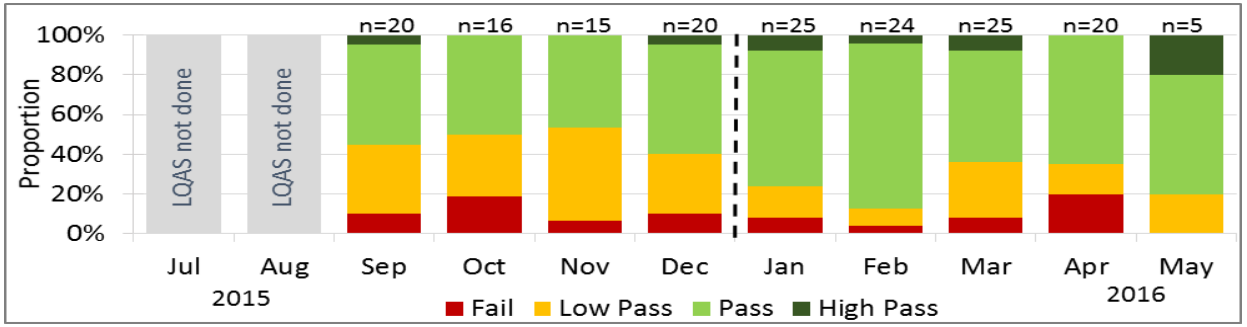

**Peshawar**



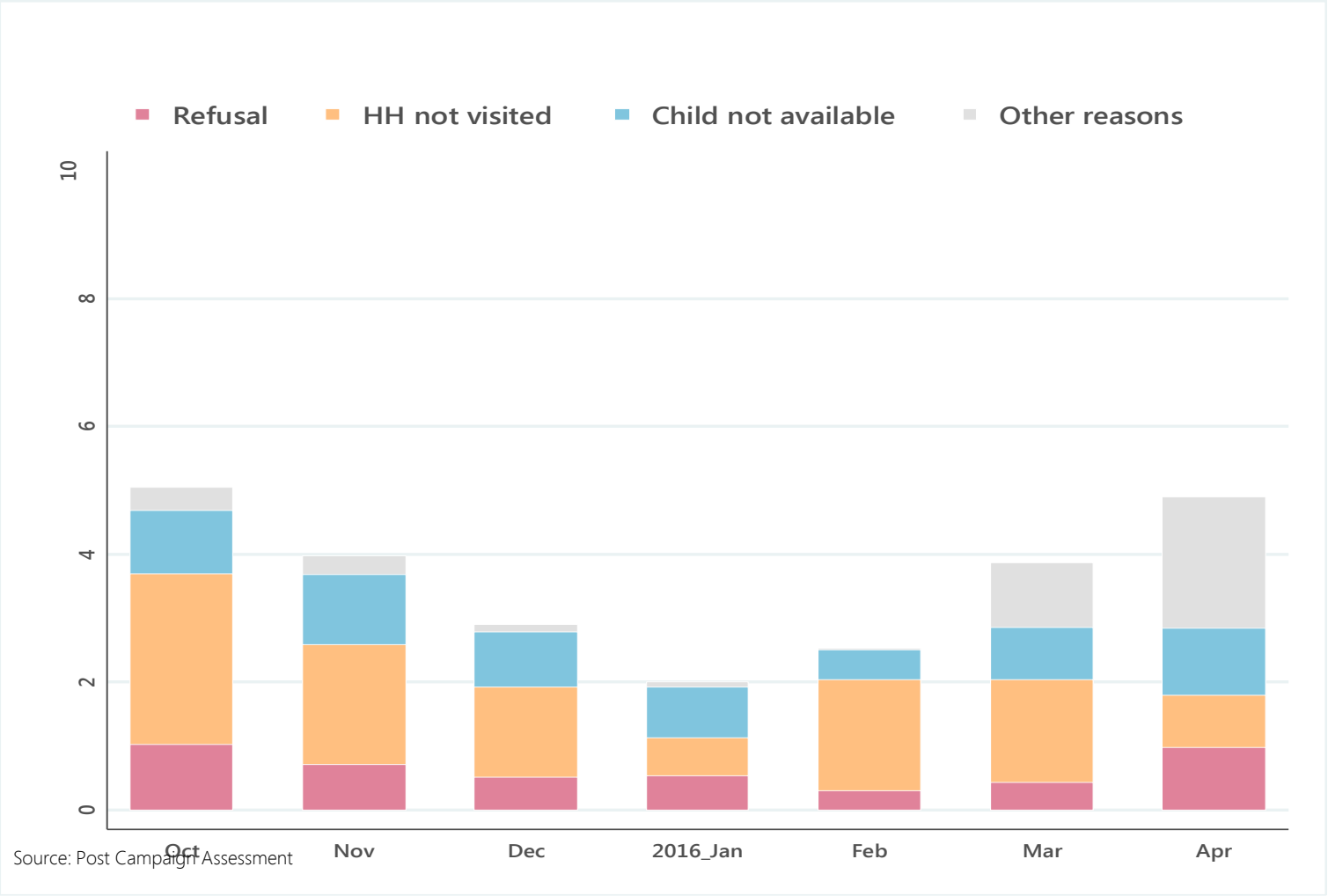

**Northern Sindh**
(Kambar, Larkana, Jacobabad, Shikarpur, Kashmore, Ghotki, Sukkur, Khairpur)




**High Risk Karachi Towns**
(Baldia, Gadap, Giqbal)

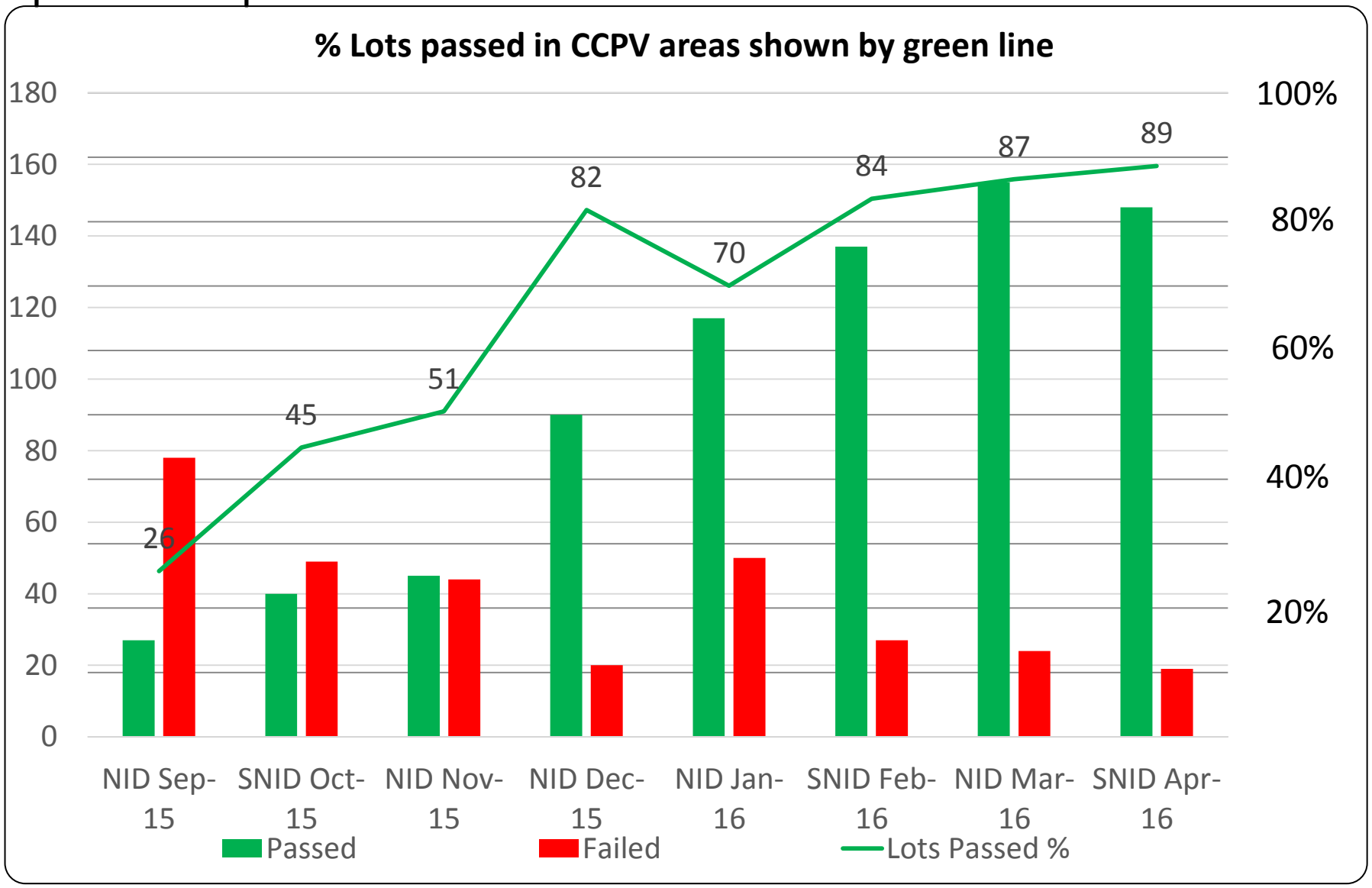


# **Pakistan:** Trends in missed children in high risk (tier 1) districts Oct 2015 – Apr 2016




Missed children remained at 5% in April 2016. While fewer children were missed due to lack of visiting households, the % missed for “refusals” is rising in select areas; investigation of the % missed for “other reasons” found vaccinated children had not been finger marked.

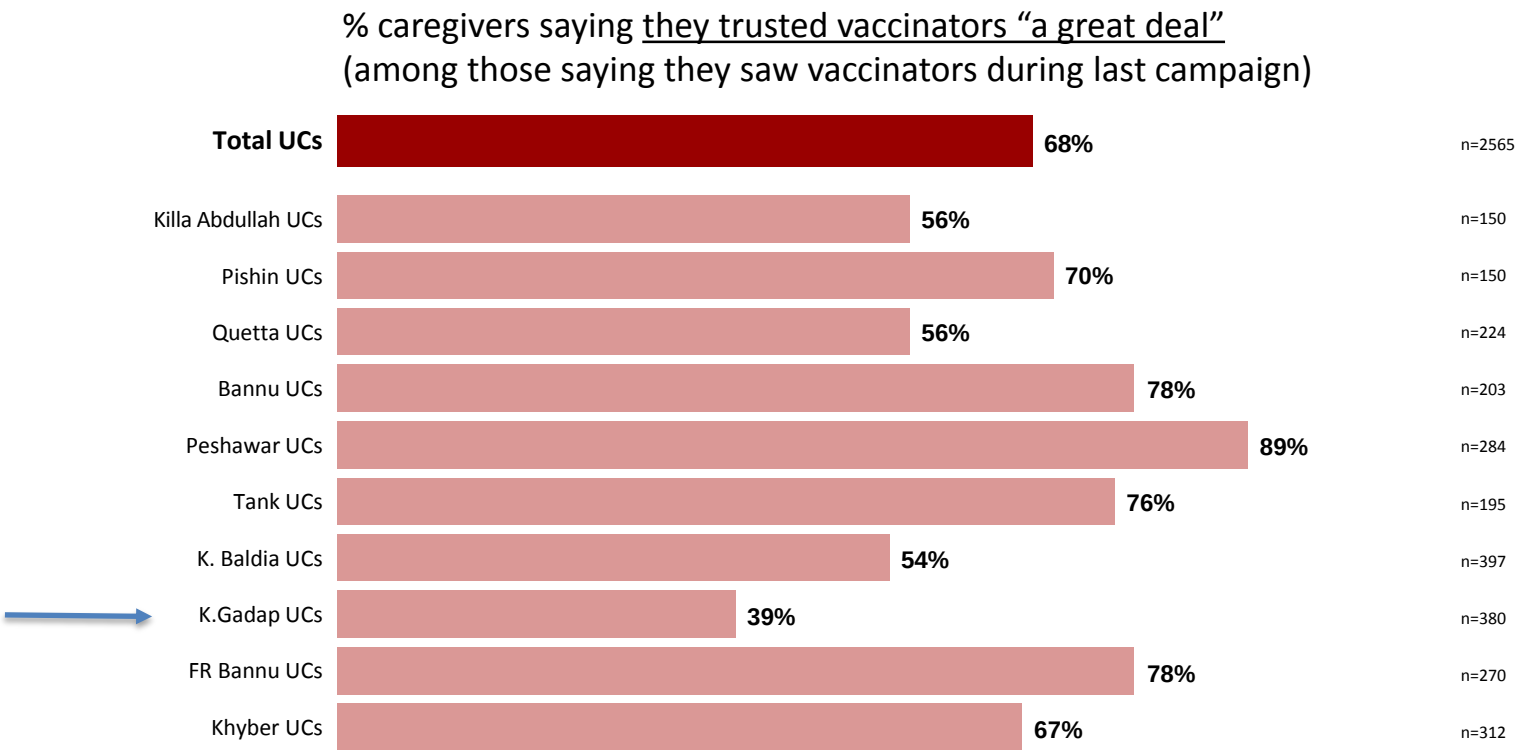
# **Pakistan:** Evidence of increasing performance in CCPV* areas Sep 2015 – Apr 2016




*EOC managed Continuous Community Protected Vaccination areas only

# **Pakistan:** Caregiver trust in polio vaccinators varies by Union Council, Mar 2016

Overall, caregivers say they trust vaccinators "a great deal". Karachi Gadap is a substantial outlier.



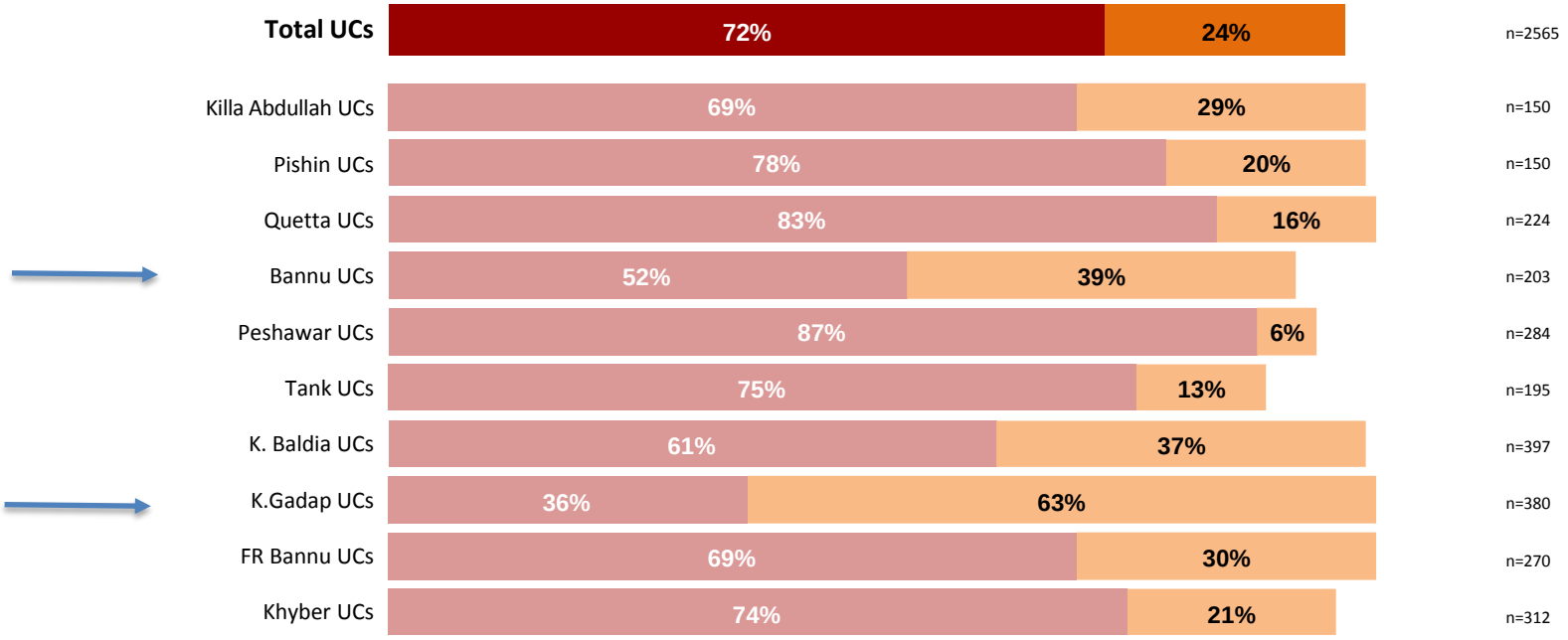

*Overall, how much did you trust the polio vaccinator(s)? Would you say…?*

*Harvard KAP study, March 2016*
*Data is representative of 10 tier 1 districts*

# **Pakistan**: Caregiver assessment of current vaccinators compared to previous vaccinators, by Union Council, March 2016

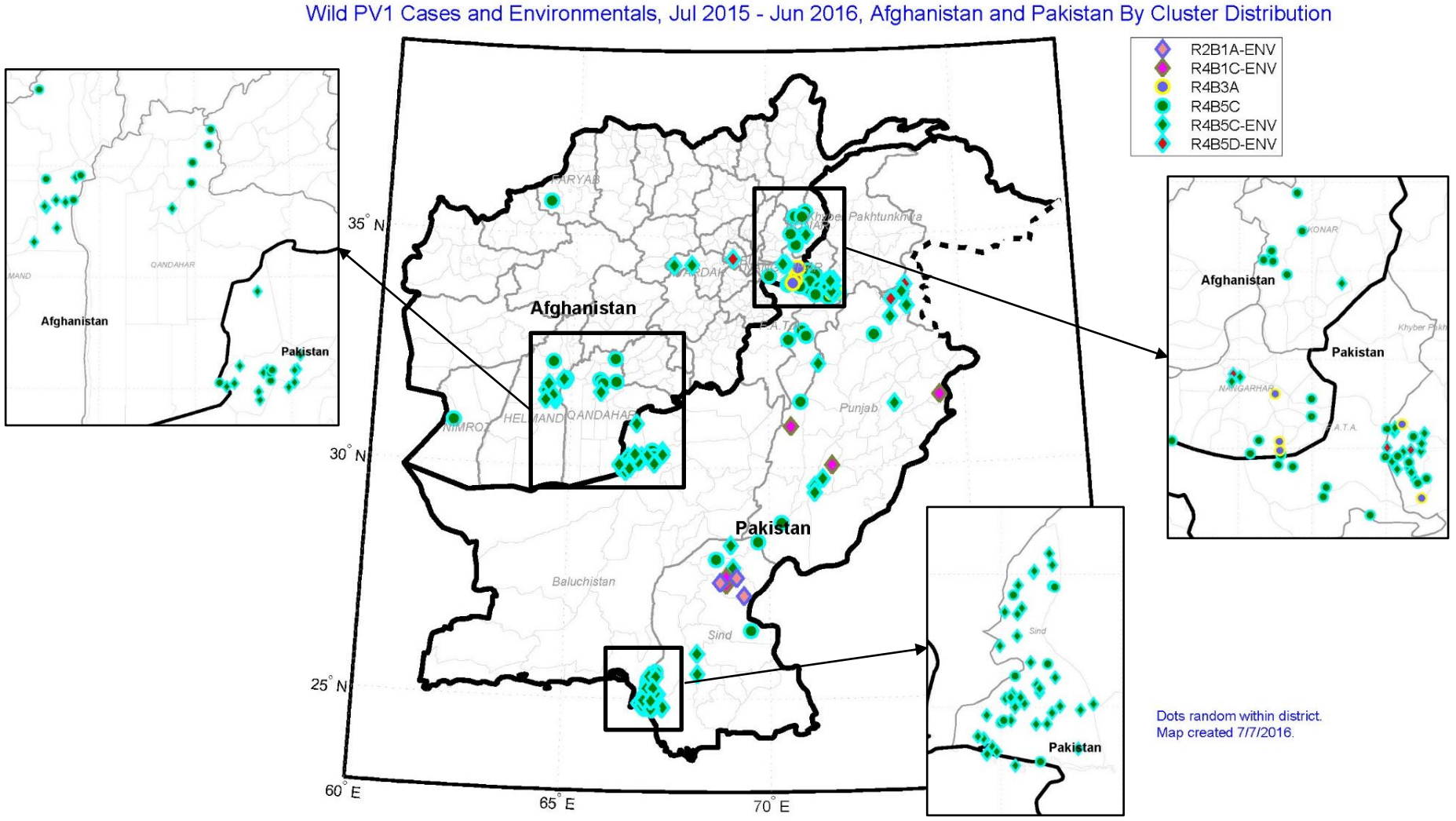
Overall, caregivers say "current" vaccinators are better than "previous" vaccinators, although challenges remain in Bannu and Karachi Gadap.

% of caregivers saying—compared to other vaccinators who have visited home in past—these vaccinators were better or same (among those saying they saw vaccinators during last campaign)




*Harvard KAP study, March 2016*
*Data is representative of 10 tier 1 districts*

# **Endemic Countries:** WPV1 cases and environmental, Jul 2015 – Jun 2016

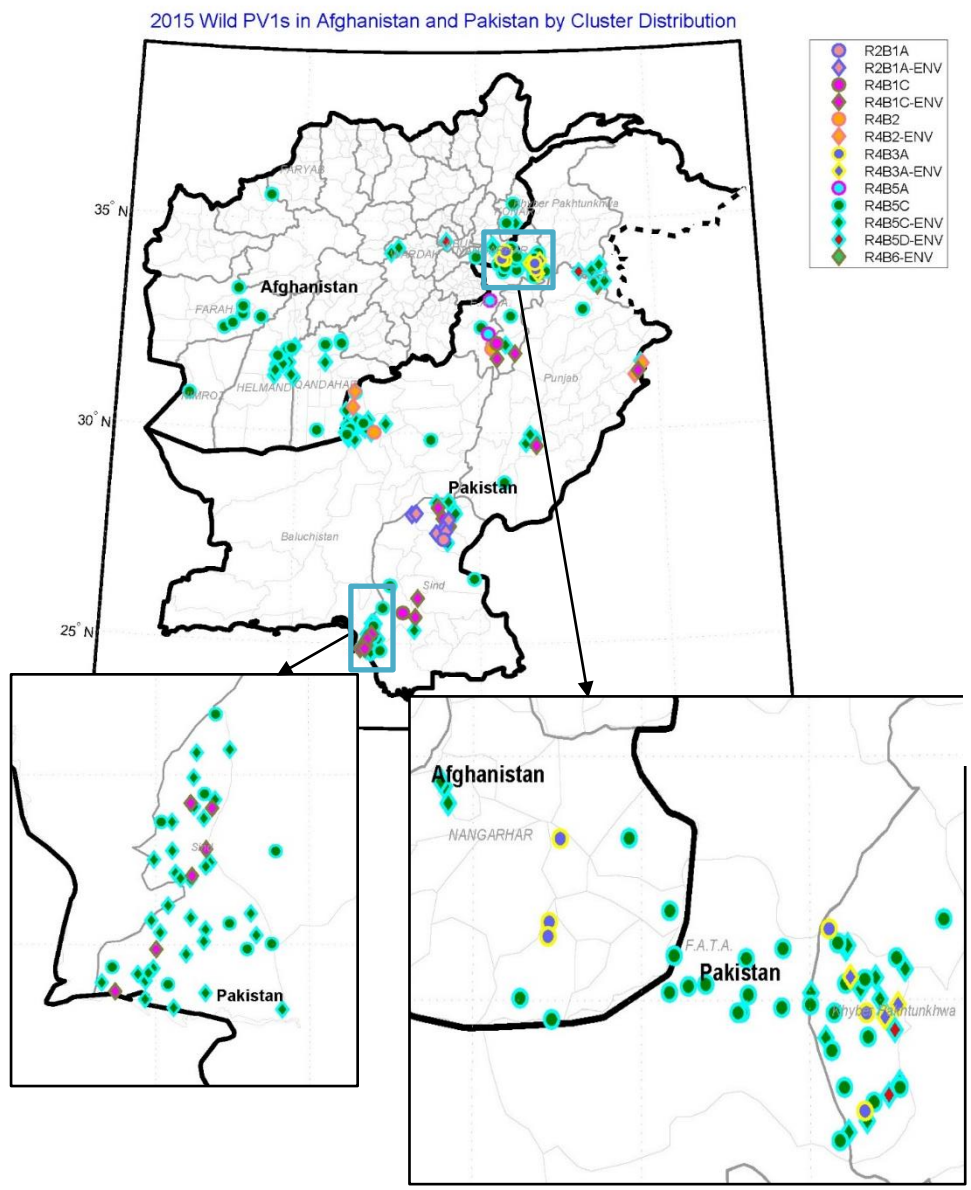



Environmental surveillance reveals transmission in areas without AFP cases.

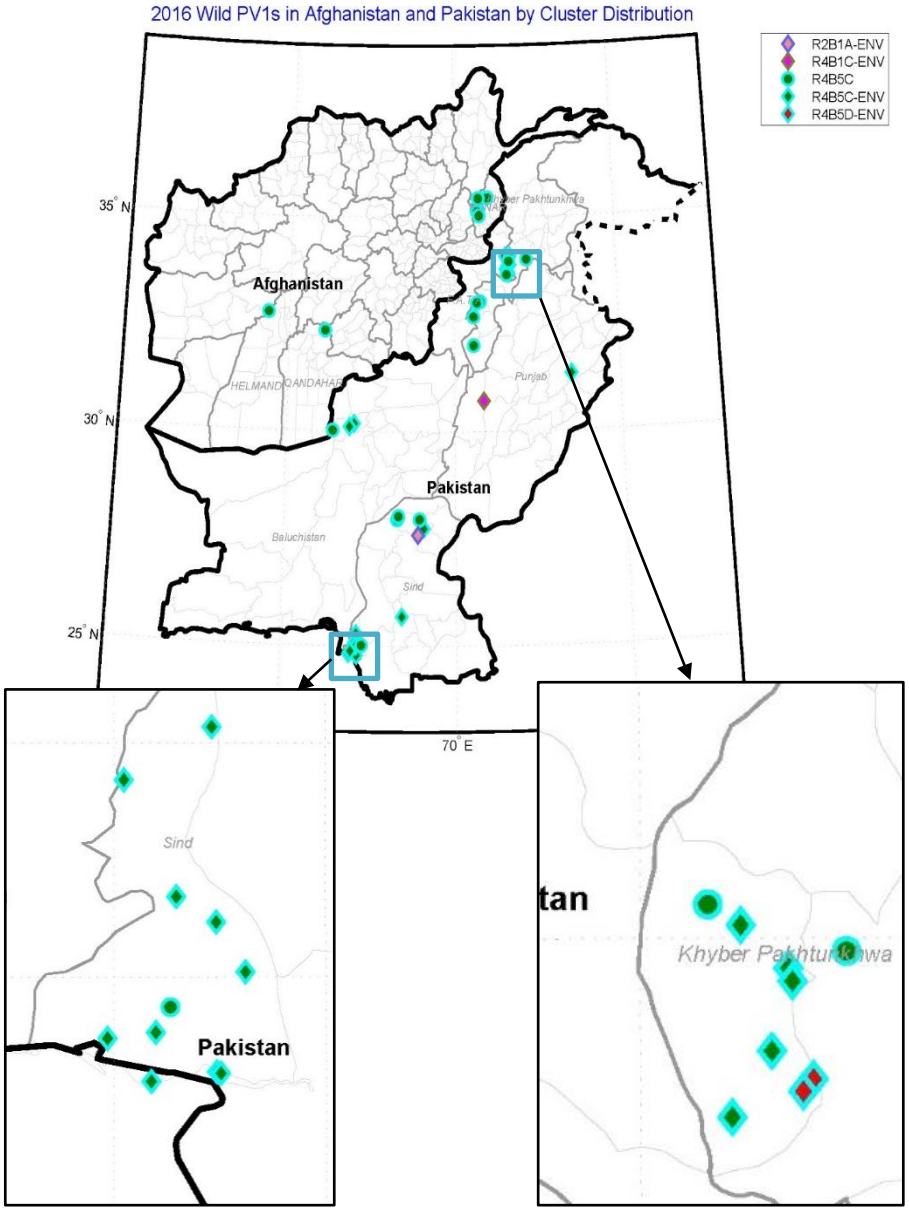
Source: CDC

# **Endemic Countries:** Decreased viral diversity from 2015 to 2016*

2015

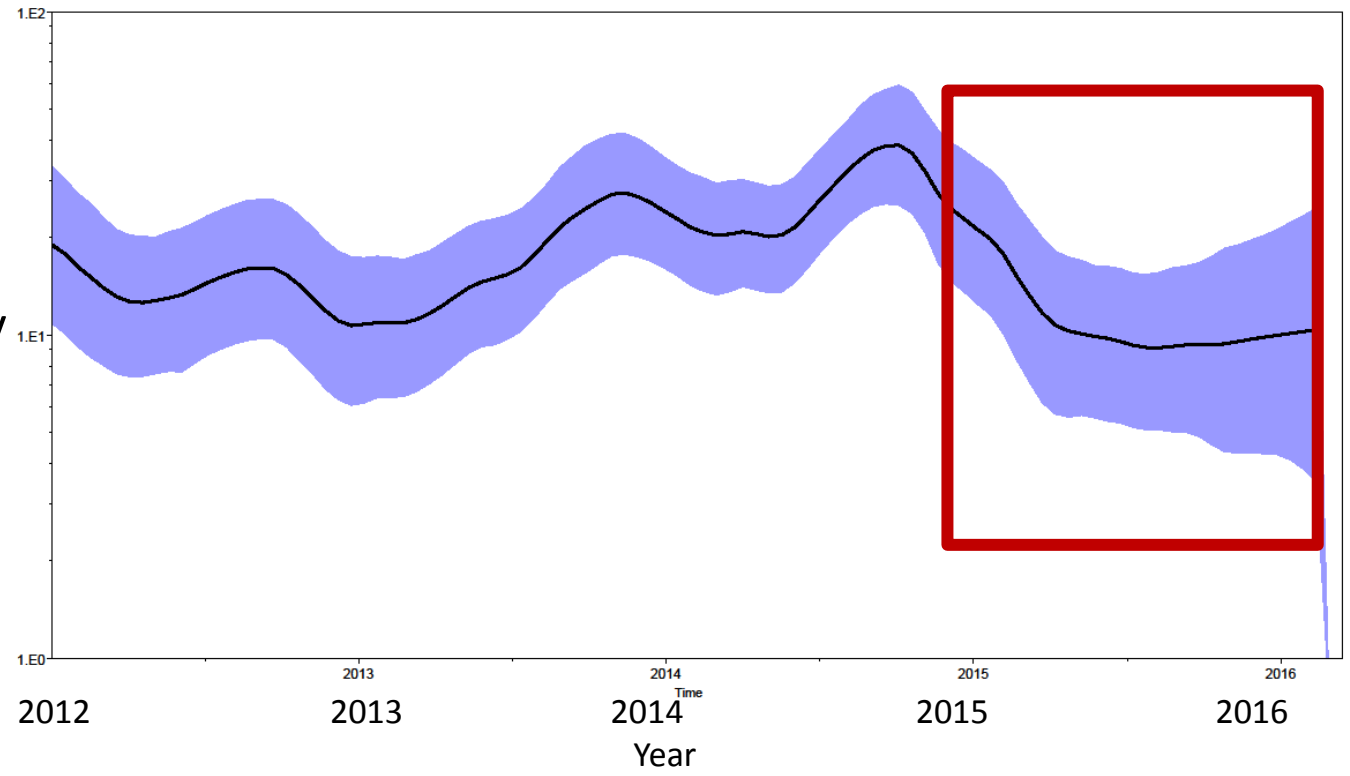



2016




*2016 data from Jan-Jun (Source: CDC)

# **Endemic Countries:** Genetic diversity of WPV1 shows evidence of decreasing in 2015-2016 compared to previous few years



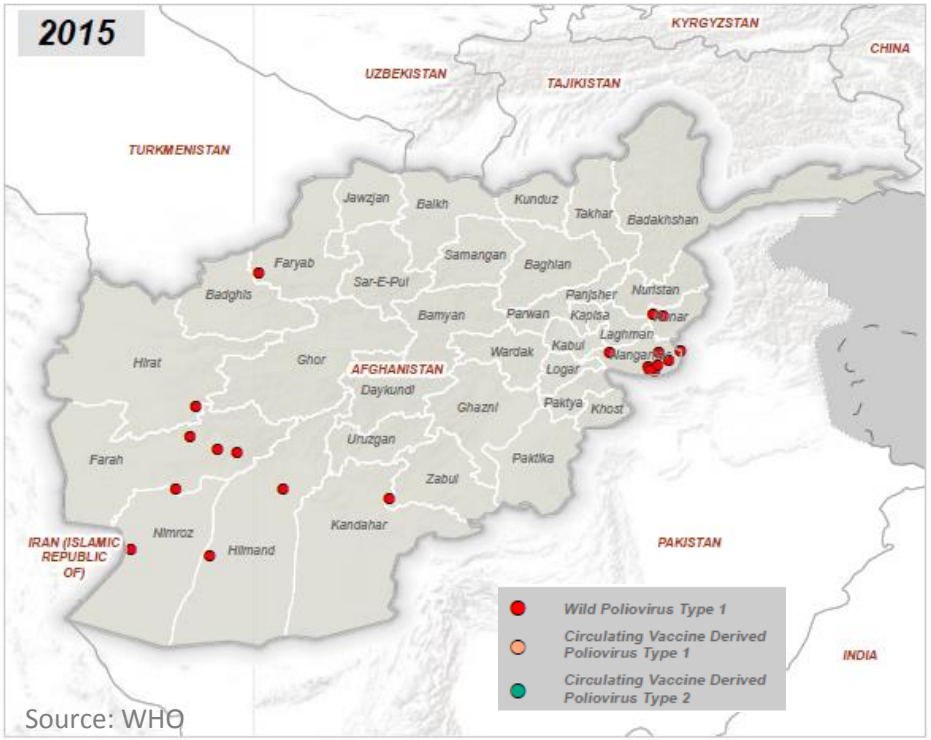

Note: blue-shaded area shows 95% confidence interval

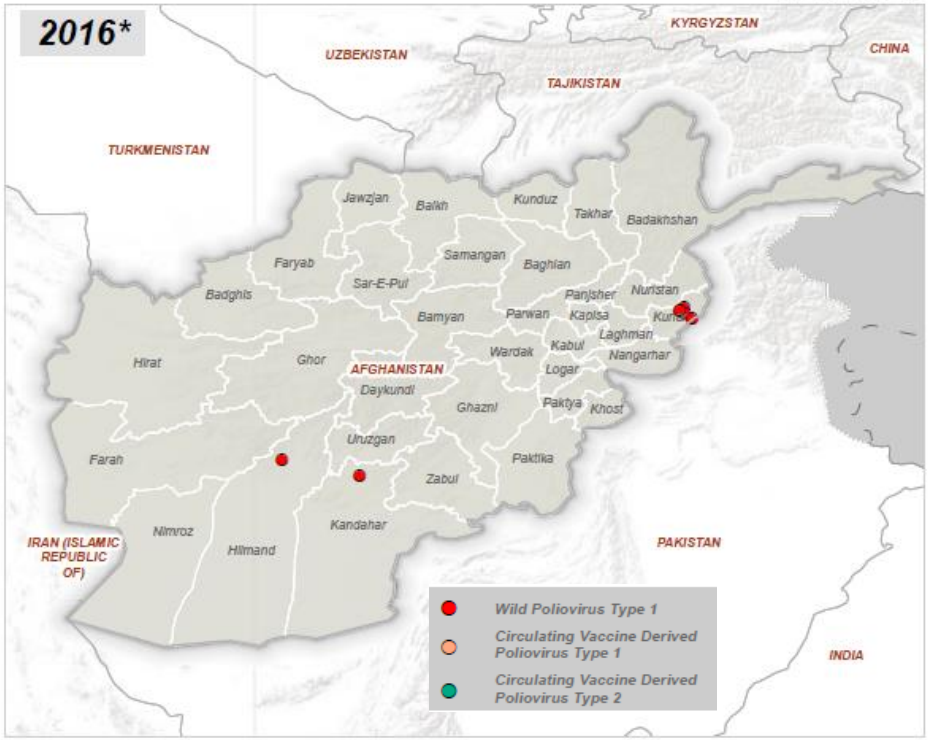
Source: CDC

Note: Twelve new sequences were added to the update (4 AFG [latest:4Feb] and 8 PAK [latest:25 Feb]).


AFGHANISTAN

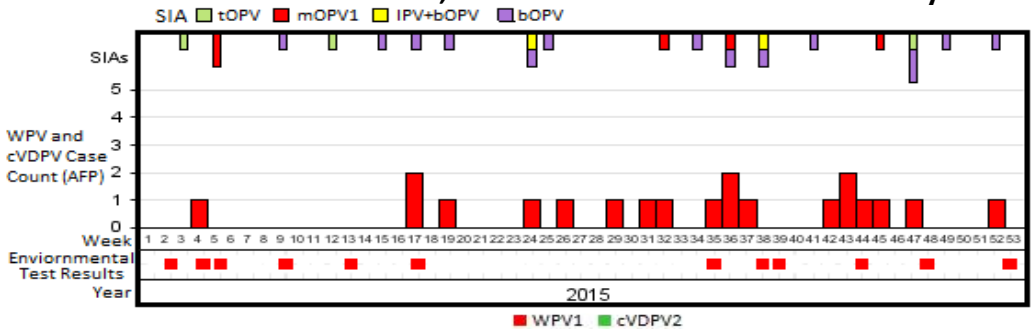
# **Afghanistan:** WPV and cVDPV cases, 2015 and Jan 2016 – Jun 2016

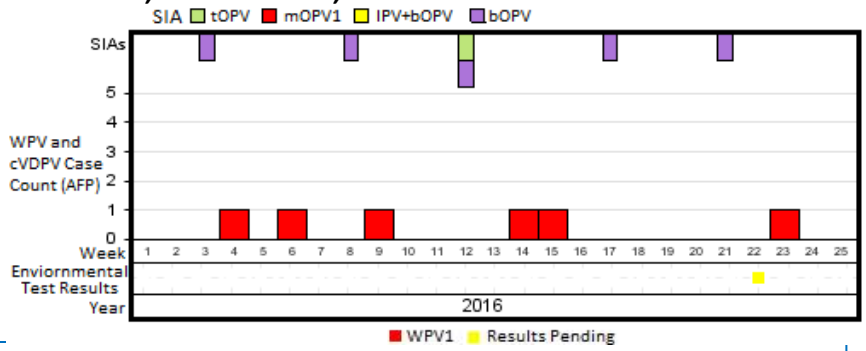



Source: WHO

WPV and cVDPV cases, environmental results by onset week, and SIAs, 2015 and Jan to Jun 2016

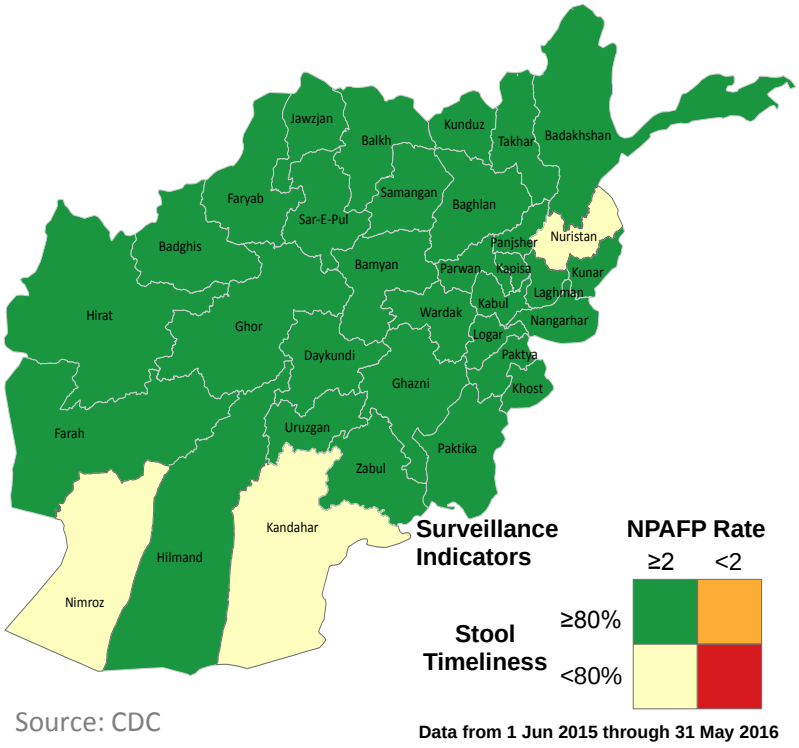



In 2015, Afghanistan had 20 WPV1 cases; YTD in 2016 there are 6 cases, compared to 4 cases for the same period in 2015.

# **Eastern and Southern Regions:** Access problems are increasing in parts of east and south, and are also of concern in parts of north (Kunduz, inaccessible since late 2015)

## Surveillance



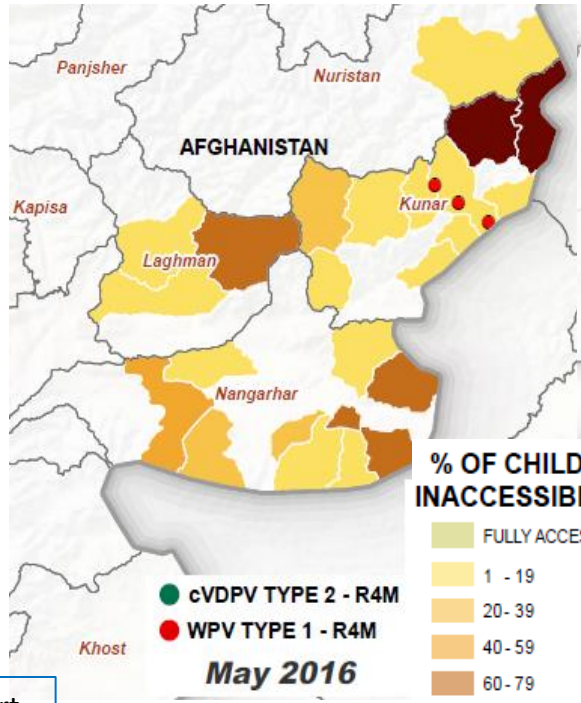

Source: CDC

Data from 1 Jun 2015 through 31 May 2016

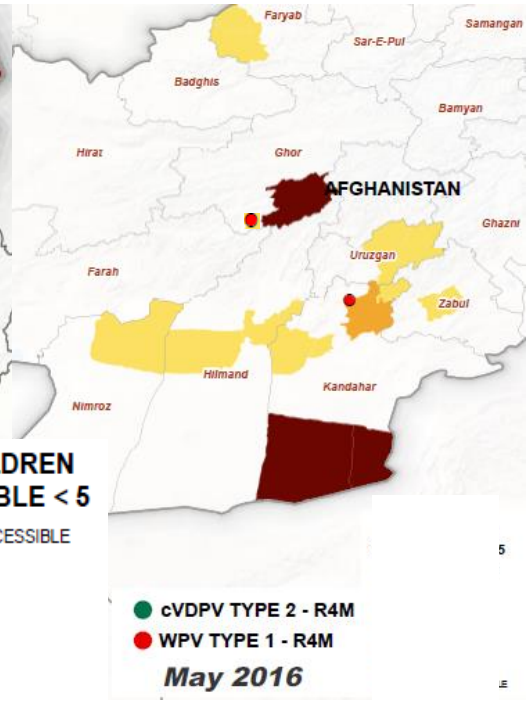
Stool timeliness: 2 stool specimens, collected ≥ 24 hours apart, among AFP cases < 15 yrs old w/in 14 days of paralysis onset

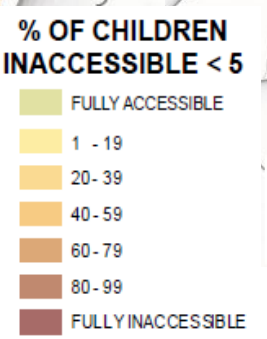
## Accessibility

### East




### South



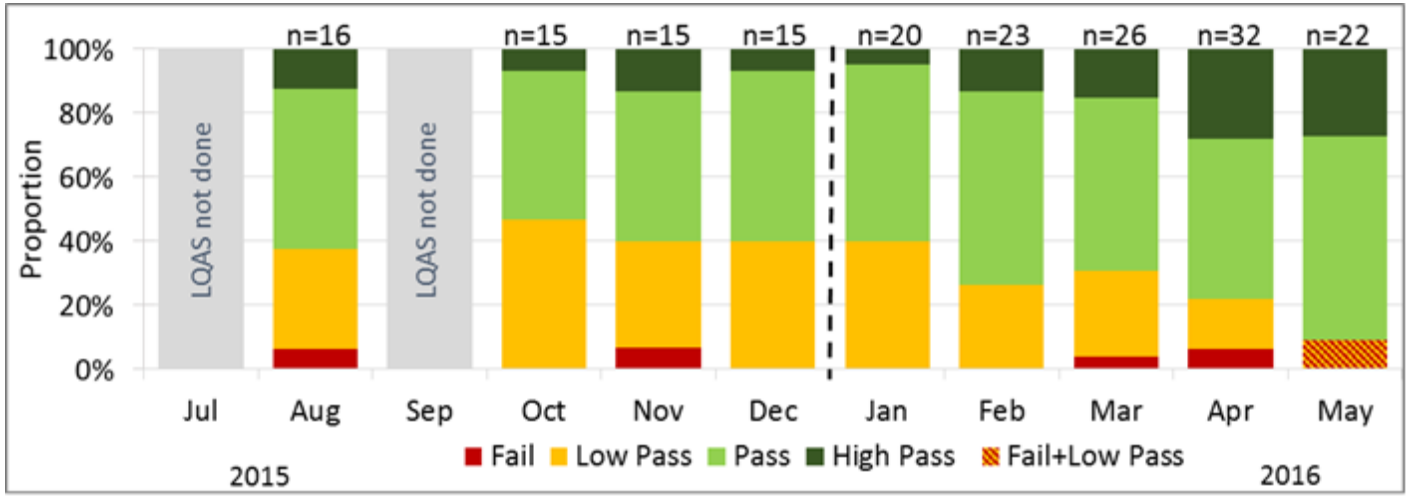




Source: WHO

A June 2016 review found that core AFP surveillance indicators have been maintained sufficiently above the standards in the access compromised areas, despite the challenges on the ground.

# **Eastern Afghanistan:** Improving SIA quality and immunity in accessible areas, Jul 2015 – May 2016

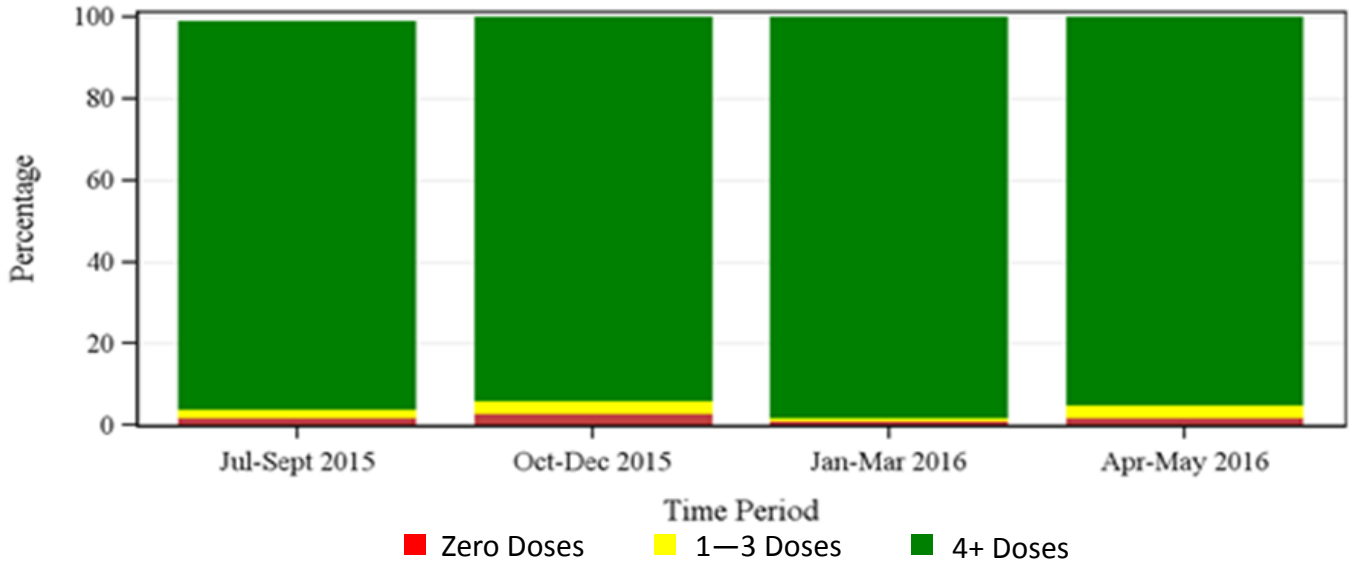
LQAS Survey Results by SIA




Note: Afghanistan LQAS categories for unvaccinated children:
0-3 = High Pass (90%+)
4-8 = Pass (80%-89%)
9-19 = Low Pass (60%-79%)
≥ 20 = Fail (< 60%)

In May reports LQAS low pass (60%-79%) and fail (<60%) categories are combined

Percentage of NPAFP cases 6-35 months, by OPV status

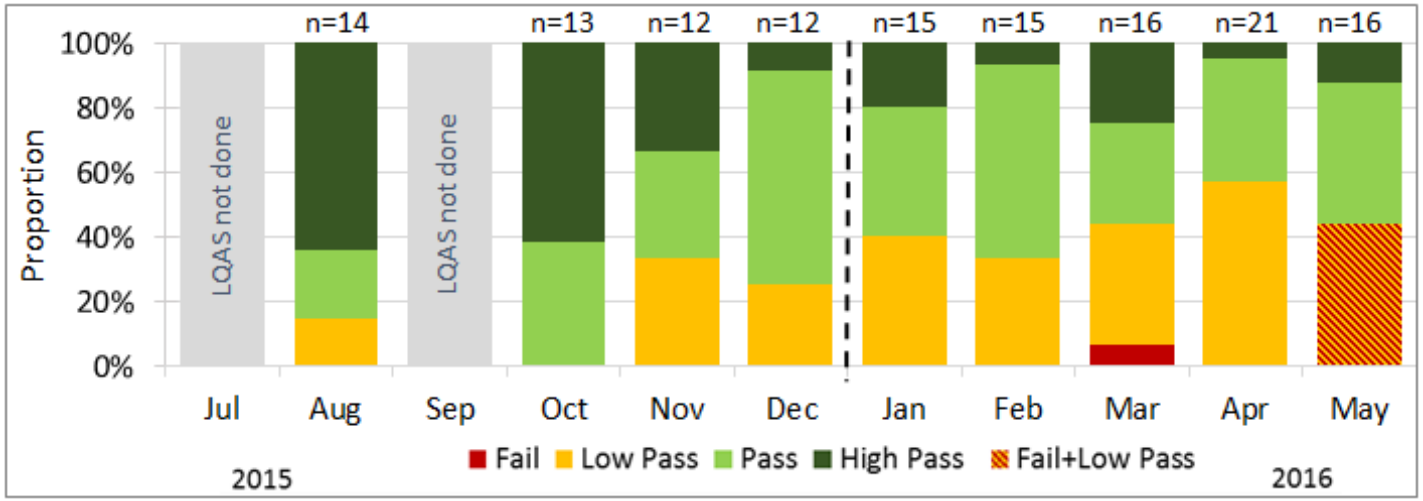



Source: CDC

Data as of June 14, 2016

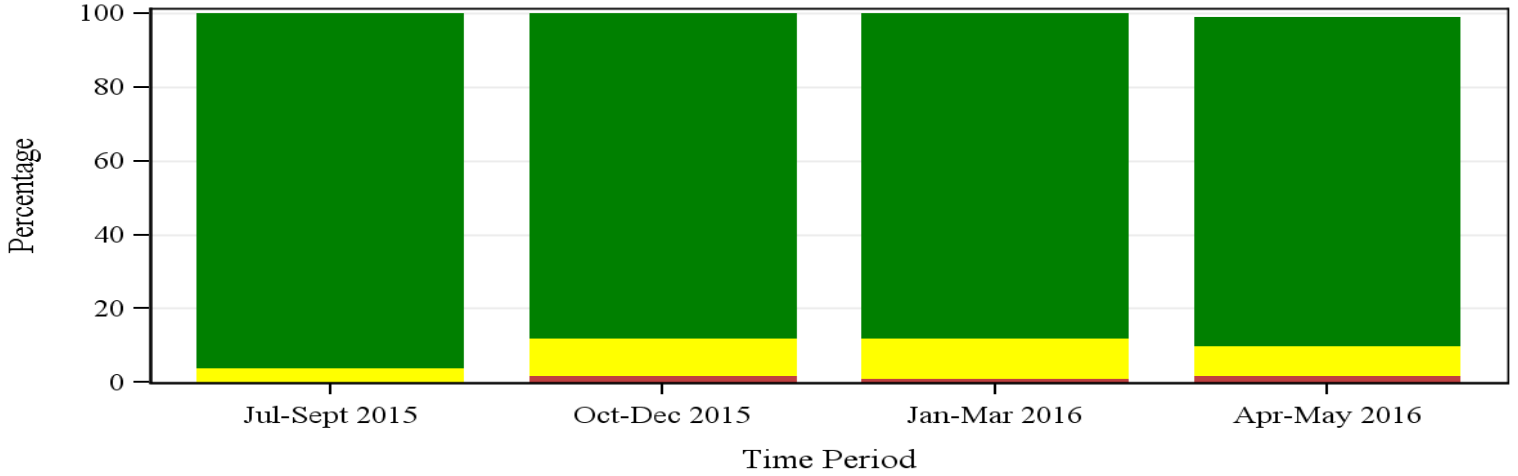
# **Southern Afghanistan:** SIA quality does not yet show improvement despite increased efforts during 2016, Aug 2015 – May 2016

LQAS Survey Results by SIA




Note: LQAS low pass (60%-79%) and fail (<60%) categories are combined in May reports.

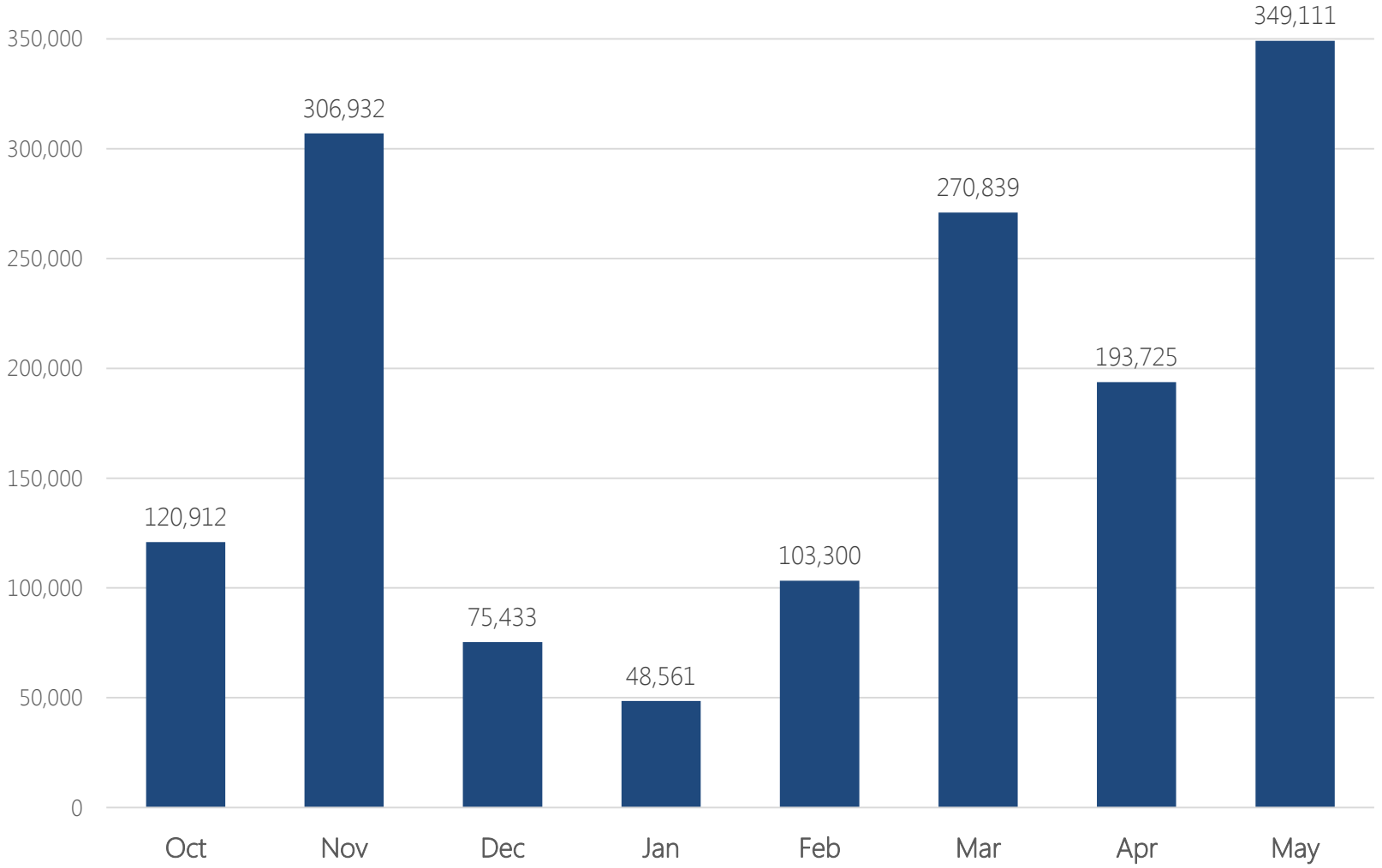
Percentage of NPAFP cases 6-35 months, by OPV status




Source: CDC

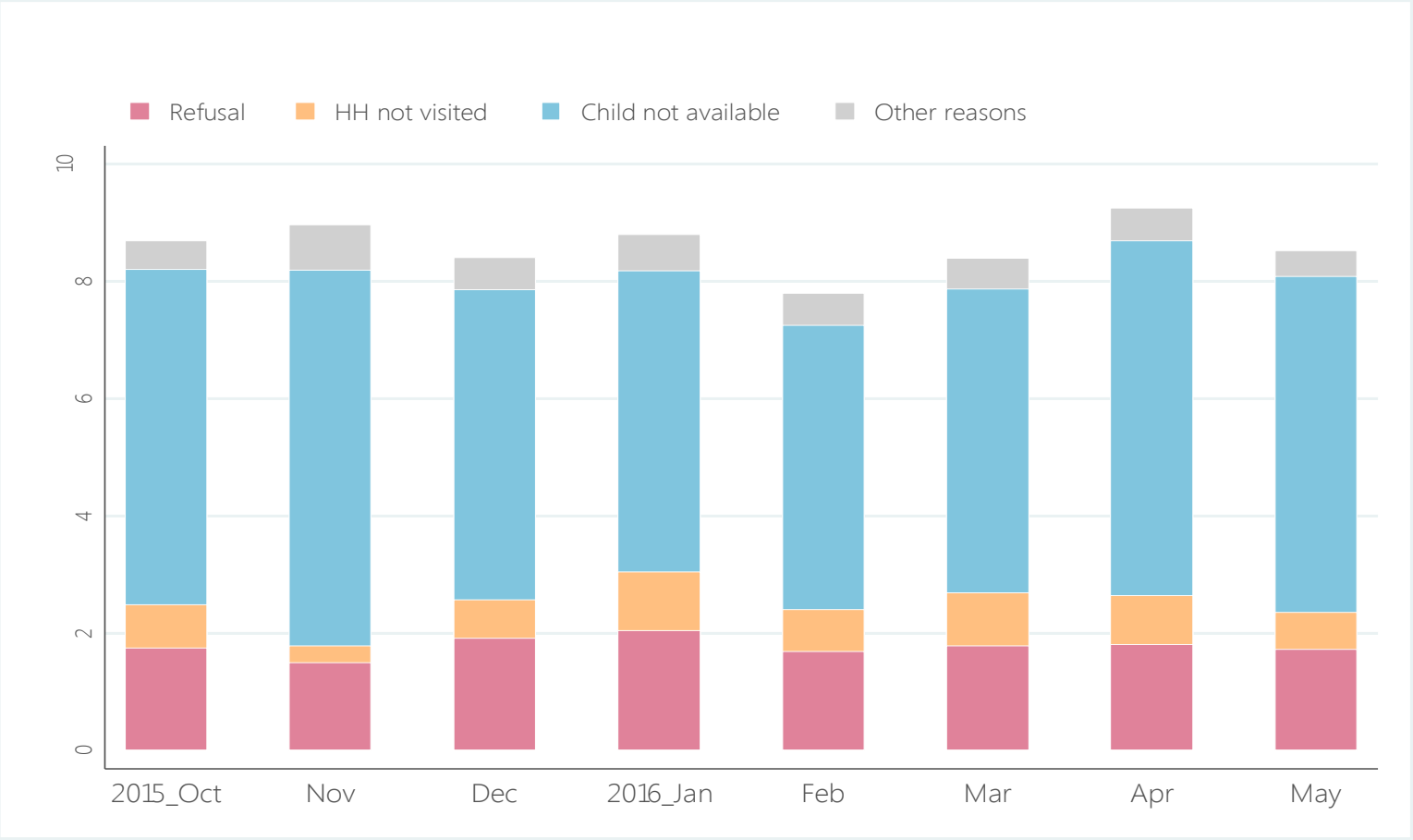
Data as of June 14, 2016

# **Afghanistan:** Number of children missed due to inaccessibility
## Oct 2015 – May 2016




Source: Joint UNICEF/WHO Access Analysis

# **Afghanistan:** Overall, about 8% to 9% of children in high risk areas (low performing districts*) are missed by SIAs, Oct 2015 – May 2016

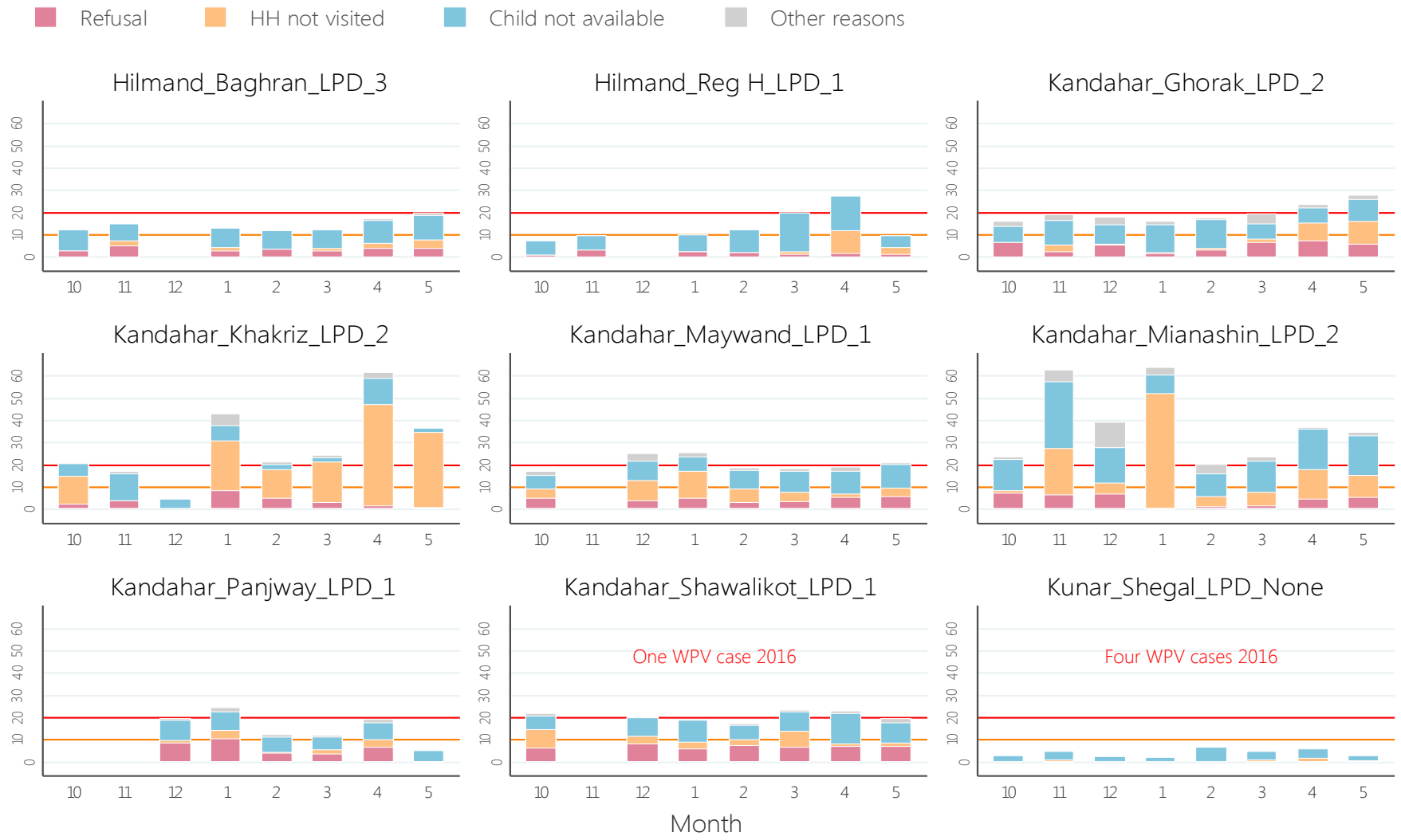



Source: Post Campaign Assessment.

*LPD status is 2016 designation

The % of children missed due to refusals in Afghanistan remains the highest of any polio priority country. 2015 KAP data has also demonstrated potential relationships between children missed due to 'unavailable' and missed due to passive refusals.

# **Afghanistan:** Trends in missed children among chronically low performing districts*, Oct 2015 – Apr 2016




Source: Post Campaign Assessment
Note: *LPD status is 2016 designation.

While the % of children missed by SIAs varied from 8% to 9% nationally, low performing districts had much more variation and demonstrated chronically larger estimates of missing children.

# Endemic Countries Summary

- **Pakistan** is on a trajectory to stop polio—but some critical gaps still need to be addressed to increase the likelihood of this happening in 2016, especially the increase in SIA quality in **Karachi and northern Sindh**, and the identification and targeting of unvaccinated high risk mobile and underserved populations

- A further scale up of local level frontline workers in high risk UCs and improvements of SIA quality in **Karachi** will require time to show an impact on results. It will be critical that all remaining campaigns are implemented with well-selected, well-trained frontline workers in the most critical areas, with strong oversight and full implementation of an accountability systems in place so that impact can be seen before the end of 2016.

- Substantial progress has been made in the highest risk areas of **Peshawar, FATA and Quetta**, resulting in a reduction in both the intensity of virus transmission and the genetic diversity of circulating virus. Sustaining high coverage in these areas is critical for the remainder of 2016.

- While **Afghanistan** shows indications of progress, the programme urgently needs to increase access in AGE controlled areas especially in Eastern region and improve SIA quality in accessible areas. Two WPV cases in the Southern region indicate continued local circulation here. Critical districts remain under-immunized with no or sub-optimal monitoring and supervision. Access gaps in the east create blind-spots and immunity gaps.

- The EOCs that are now operational in **Kabul** and the three high risk regions will need to provide oversight and management to ensure success in 2016 and beyond. Access negotiations will need to be coupled with interventions to meet other community health needs. Efforts to bolster SIA quality and the performance of frontline workers will need to be in place before September, and accompanied by a system that can motivate and remedy performance where required.


AFRICA

# Africa Topline Messages

- Africa is on track to be certified polio-free in 2017. Surveillance currently has limitations and needs strengthening in Liberia, Sierra Leone, Guinea and Madagascar. There are significant surveillance gaps at the sub-national level in key countries in Africa (South Sudan, Mali, Niger, and DRC).

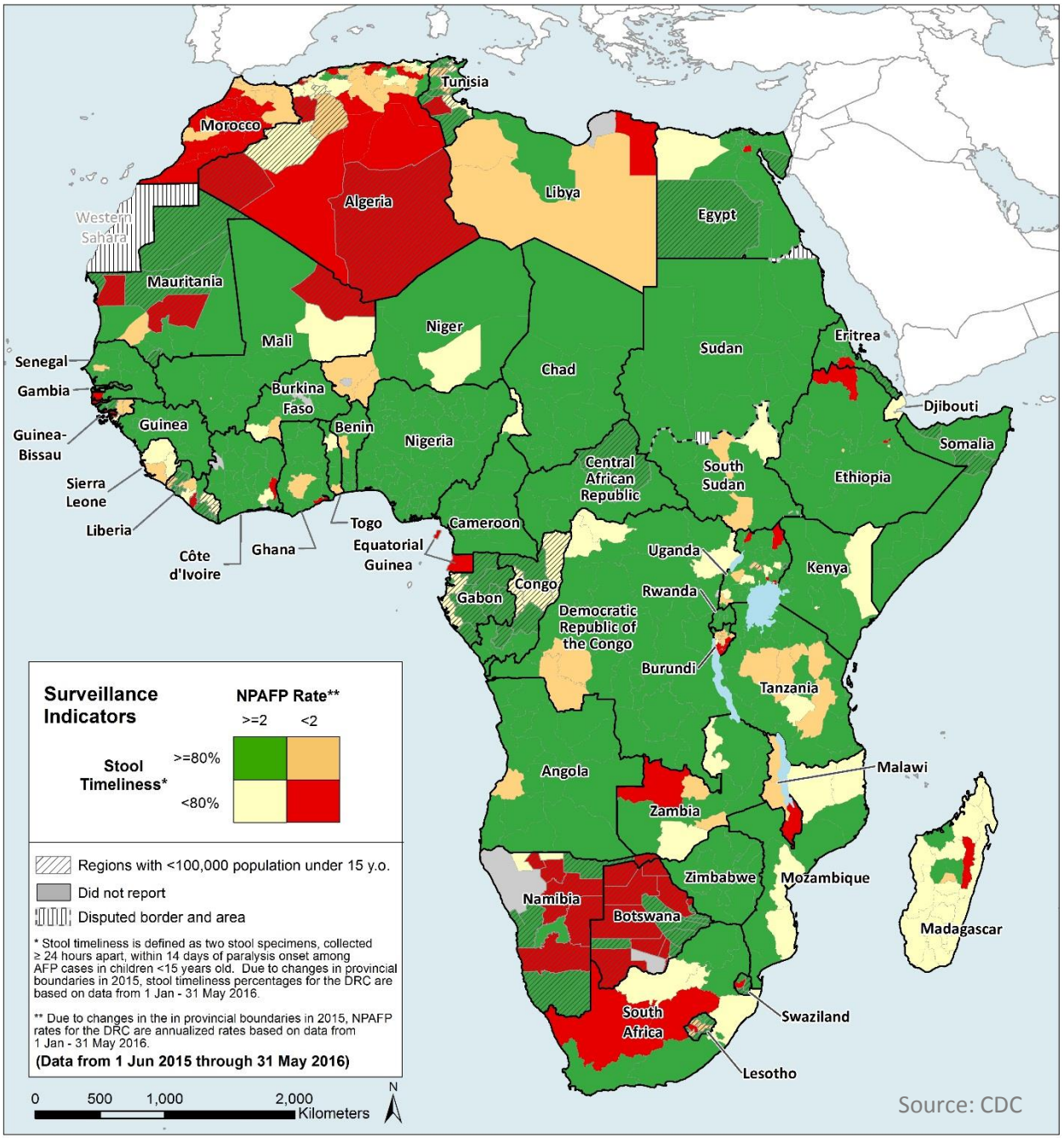
- Nigeria has sustained high quality polio campaigns, but political and social commitment, especially in key states, is proving difficult to sustain and government domestic financing, especially at the State level, is declining in the face of a national funding crunch.

- Recent discovery of an orphan cVDPV2 in an environmental sample from Borno indicates the limitations in reaching the full child population and conducting AFP surveillance in security-compromised areas in Northeast Nigeria/Lake Chad area.

# **Africa:** Surveillance at the province level has improved since Feb 2015, however, many vulnerabilities remain Jun 2015 – May 2016

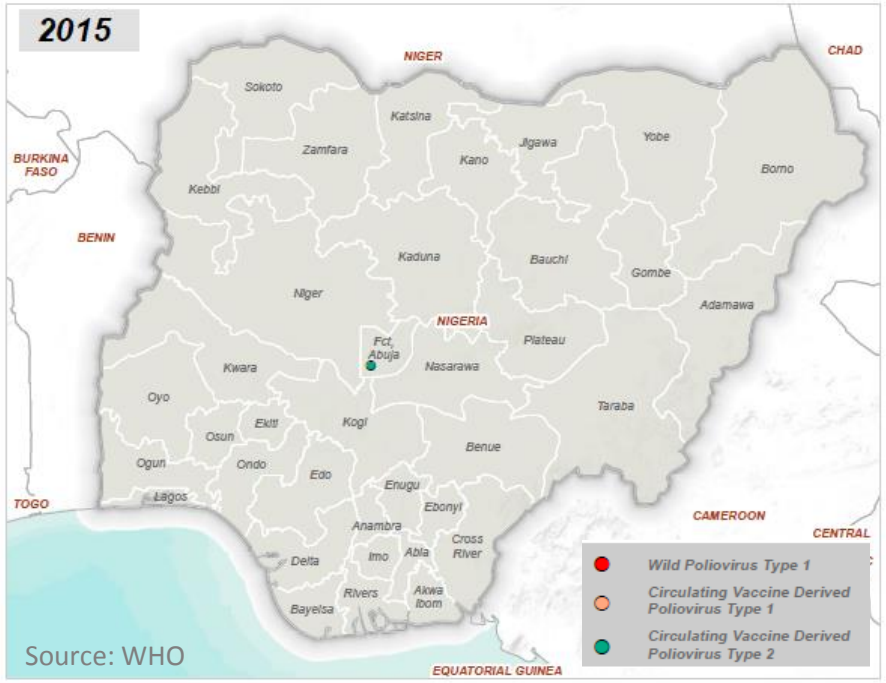
West Africa has improved following the Ebola outbreak, however, Sierra Leon and Liberia are still below standard.

Areas in several sub-Saharan countries, large parts of Northern, Southern and South East Africa have weak surveillance.



# **Nigeria:** No WPV but VDPV2 events persist into 2016

cVDPV2 case, 2015



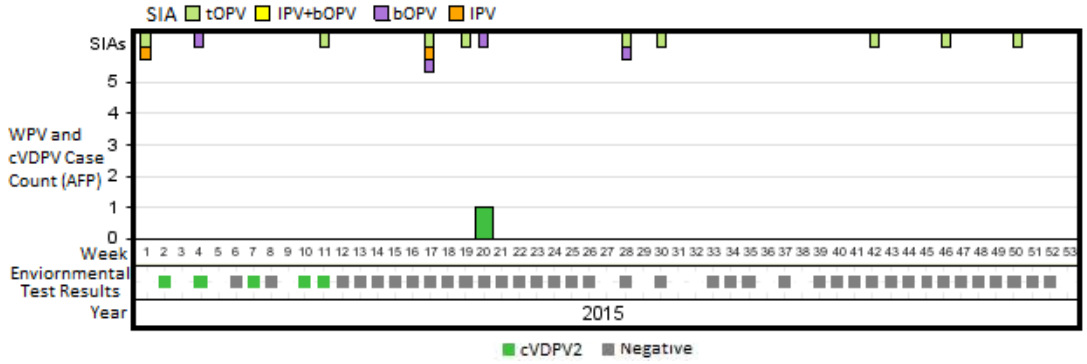

2015 cVDPV2 case

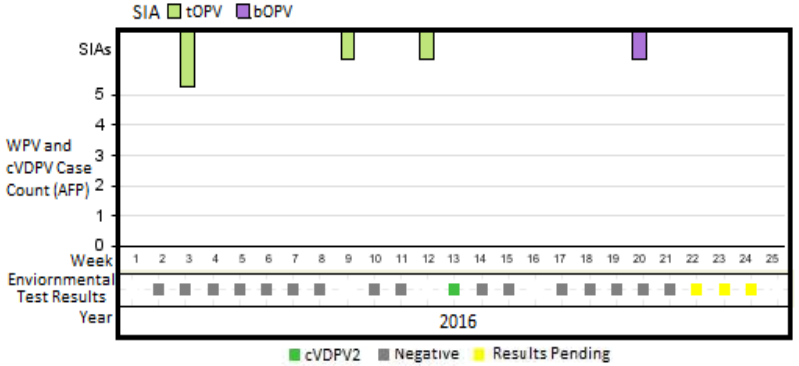
- single case was linked to several positive environmental samples

2016 VDPV2 events

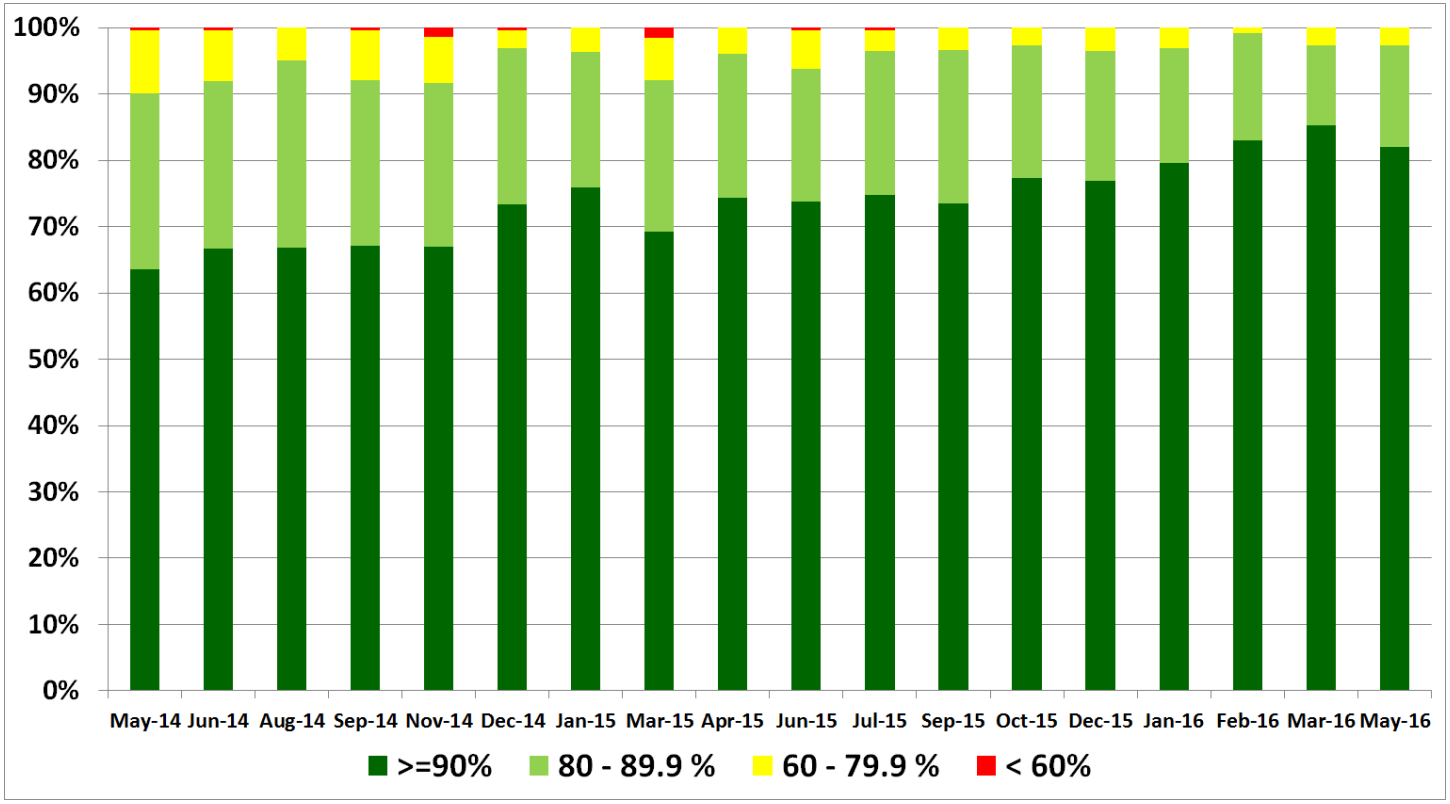
- positive environmental VDPV2 in Borno State
- aVDPV2 in Jigawa State
- mOPV2 was used in two responses in 2016

cVDPV2 cases, environmental results by onset week, and SIAs, 2015 and Jan to Jun 2016

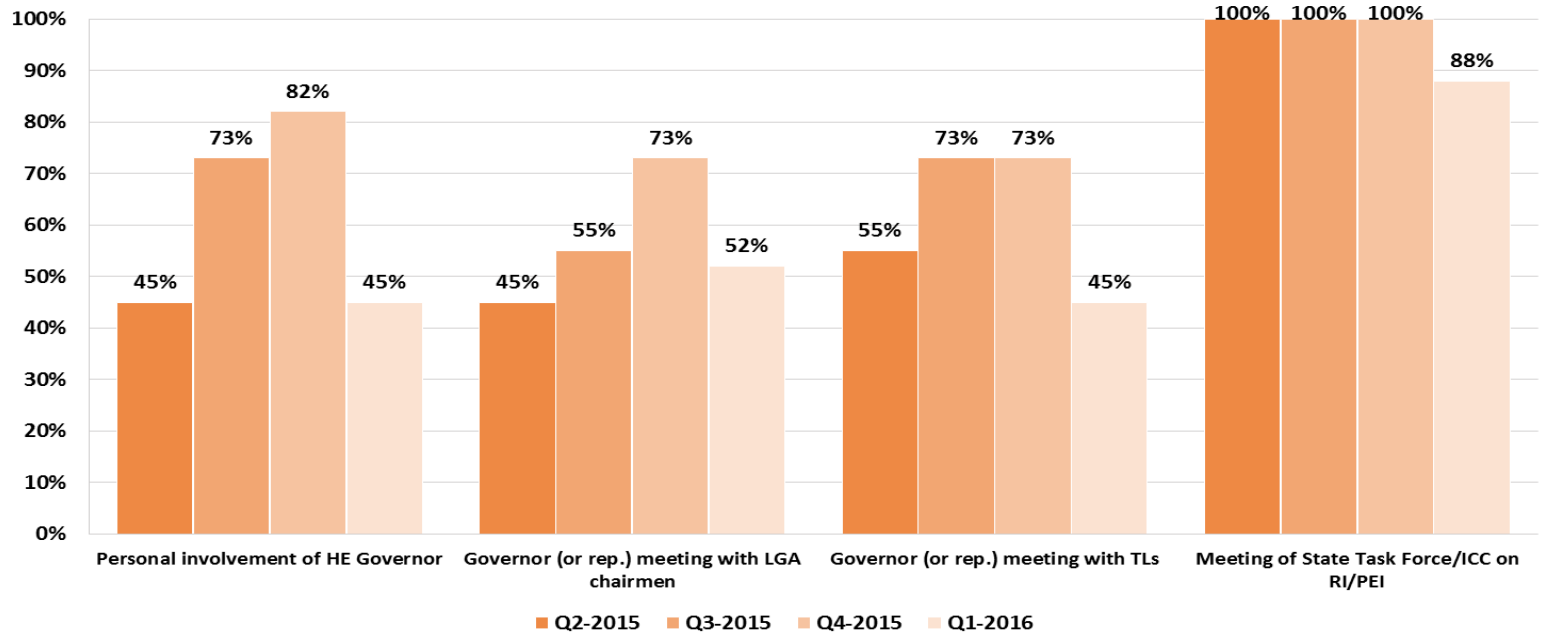


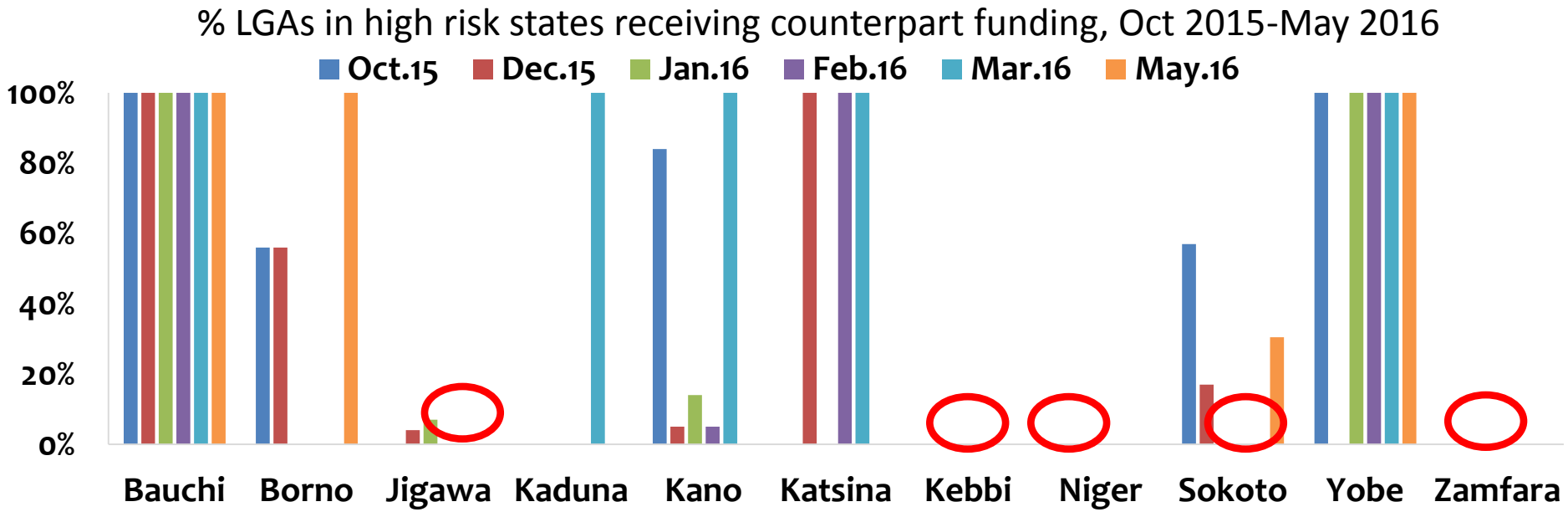



**Nigeria:** Improving quality of immunization activities in 11 high risk states—trends in LQAS results
May 2014 – May 2016



# **Nigeria:** Abuja Commitment Indicators in 11 high risk states, Q2-2015 – Q1-2016

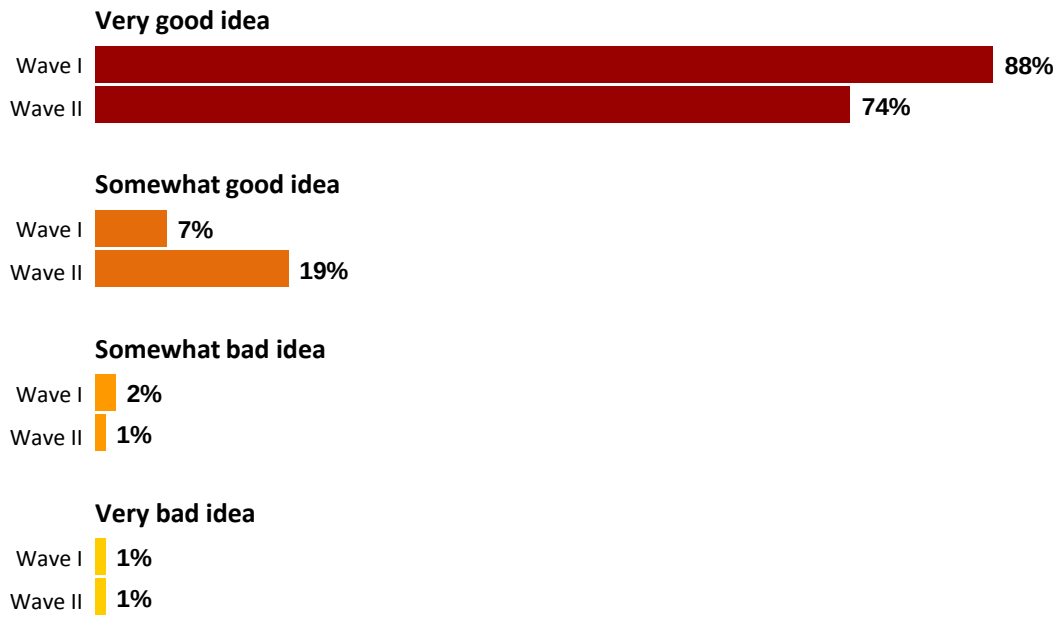


# **Nigeria:** Caregiver views of giving OPV to children in neighborhood, 2014 - 2016

Overall, social support for giving polio drops to children is declining in the 10 highest risk states.

- % caregivers saying giving polio drops to children in neighborhood is a…




- *Questionnaire evolution between years suggests the need for caution in interpreting comparisons over time.*

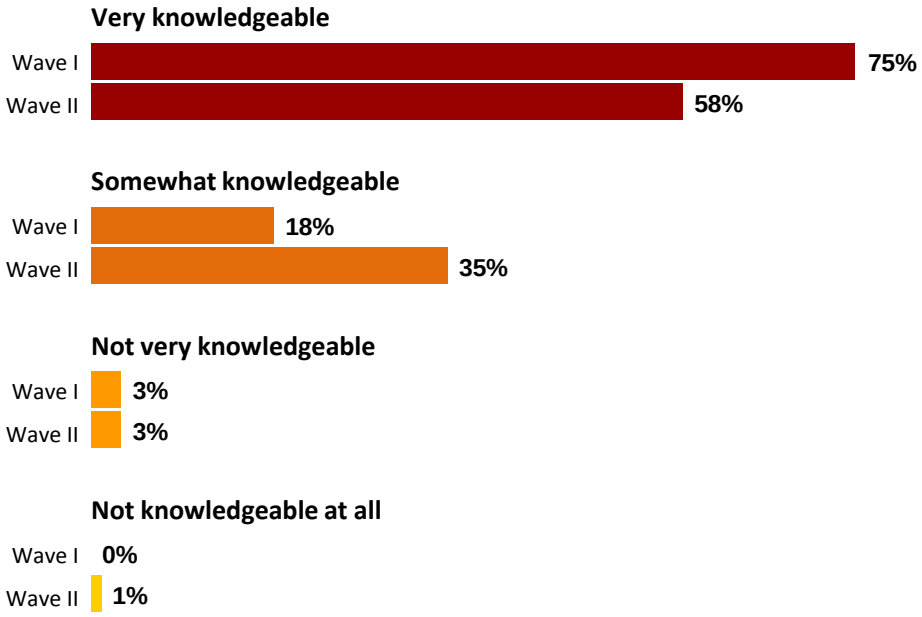
Wave 1 = data from April, 2014
Wave 2 = data from March, 2016

- Wave I n=2629
- Wave II n=3649

# **Nigeria:** Caregiver perceptions of vaccinator knowledge/competence 2014 - 2016

Caregiver perceptions of vaccinator competence in the 10 highest risk states has declined by nearly 20% over the last 2 years.

% caregivers saying vaccinators were…
(among those saying they saw vaccinators during last campaign)

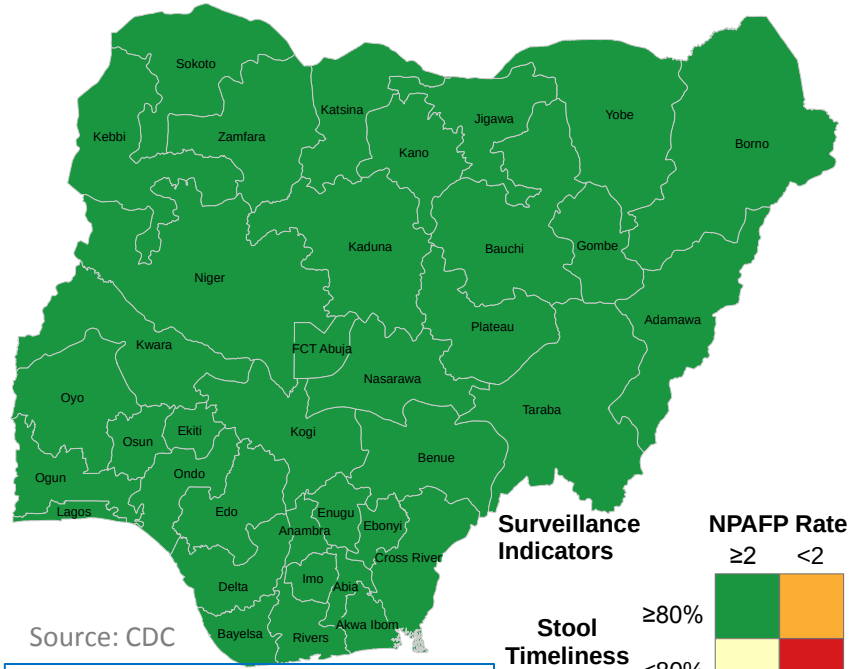



- *Questionnaire evolution between years suggests the need for caution in interpreting comparisons over time.*

- Wave I n=2058
- Wave II n=3051

# **Nigeria:** Jun 2015 – May 2016

## Surveillance




Source: CDC

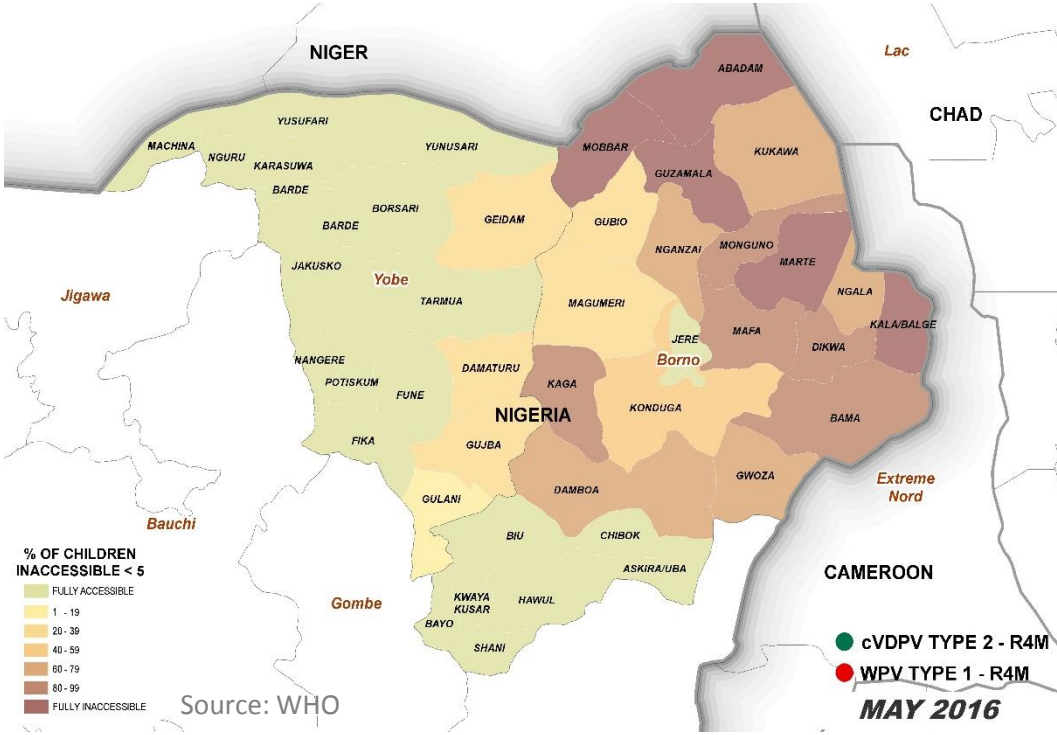
Stool timeliness: 2 stool specimens, collected ≥ 24 hours apart, among AFP cases < 15 yrs old w/in 14 days of paralysis onset

**Surveillance Indicators**

| Stool Timeliness | NPAFP Rate ≥2 | NPAFP Rate <2 |
|---|---|---|
| ≥80% | | |
| <80% | | |

**Data from 1 Jun 2015 through 31 May 2016**

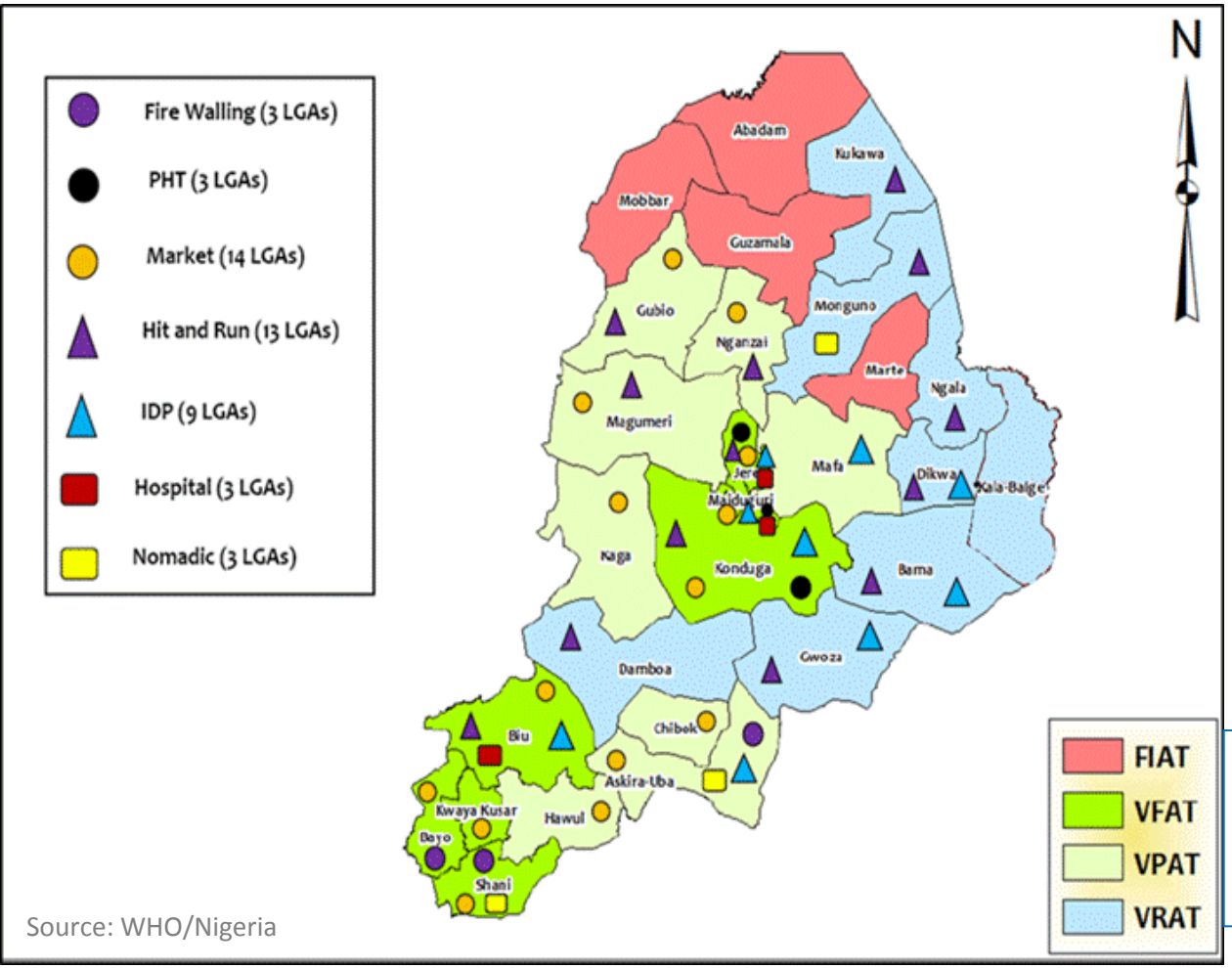
## Accessibility




Source: WHO

- Primary surveillance indicators continue to be met at the state level but gaps exist at the LGA level.
- Possibly more than 550,000 children in Borno State are being missed due to insecurity; there are ongoing efforts to reach those children through 'hit and run' campaigns, at IDP camps, at border areas and transit points.
- Following the VDPV2 environmental isolate, 23 out of 27 LGAs in Borno will receive a third round of mOPV2 in July, 2016, followed by a round of intradermal IPV in August.

# **Nigeria:** Programme continues to use special intervention strategies to reach children in inaccessible areas of Borno State, May 2016



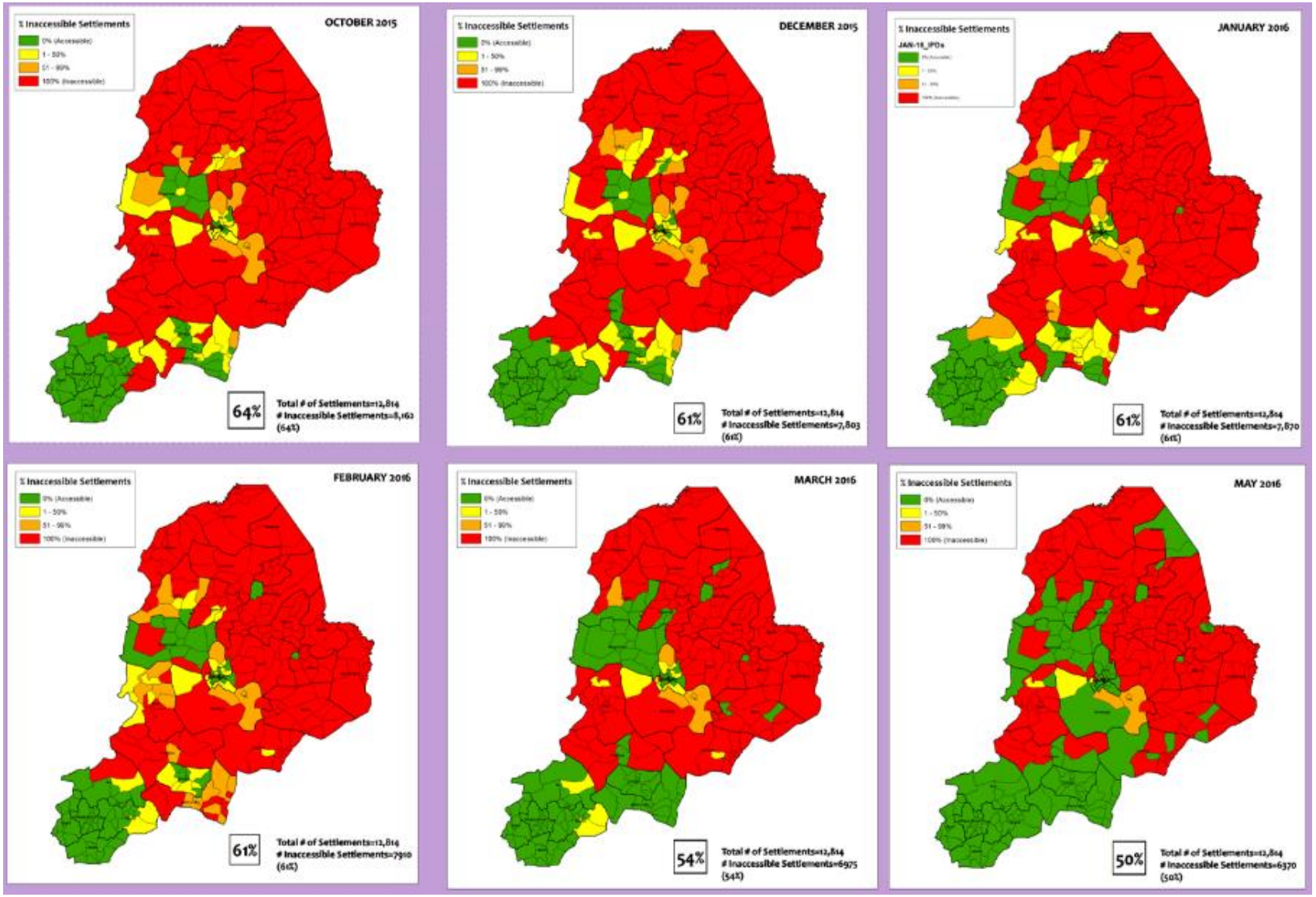

Source: WHO/Nigeria

The map is based on Special Intervention Data for 2016

**FIAT**: Fully Inaccessible Territories
**VFAT**: Fully Accessible Territories
**VPAT**: Partially Accessible Territories
**VRAT**: Recently Accessible Territories

# **Nigeria:** % Settlements inaccessible has decreased in Borno

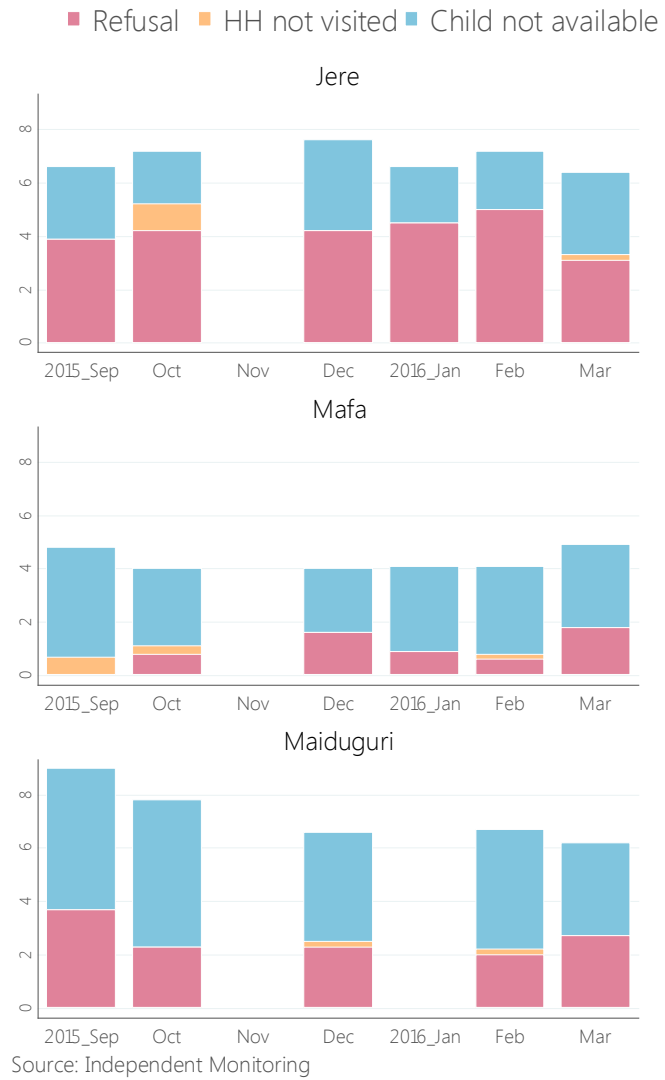
## Oct 15 – May 16




SOURCE: Accessible population and settlement for H2H SIAs data : Borno State Team

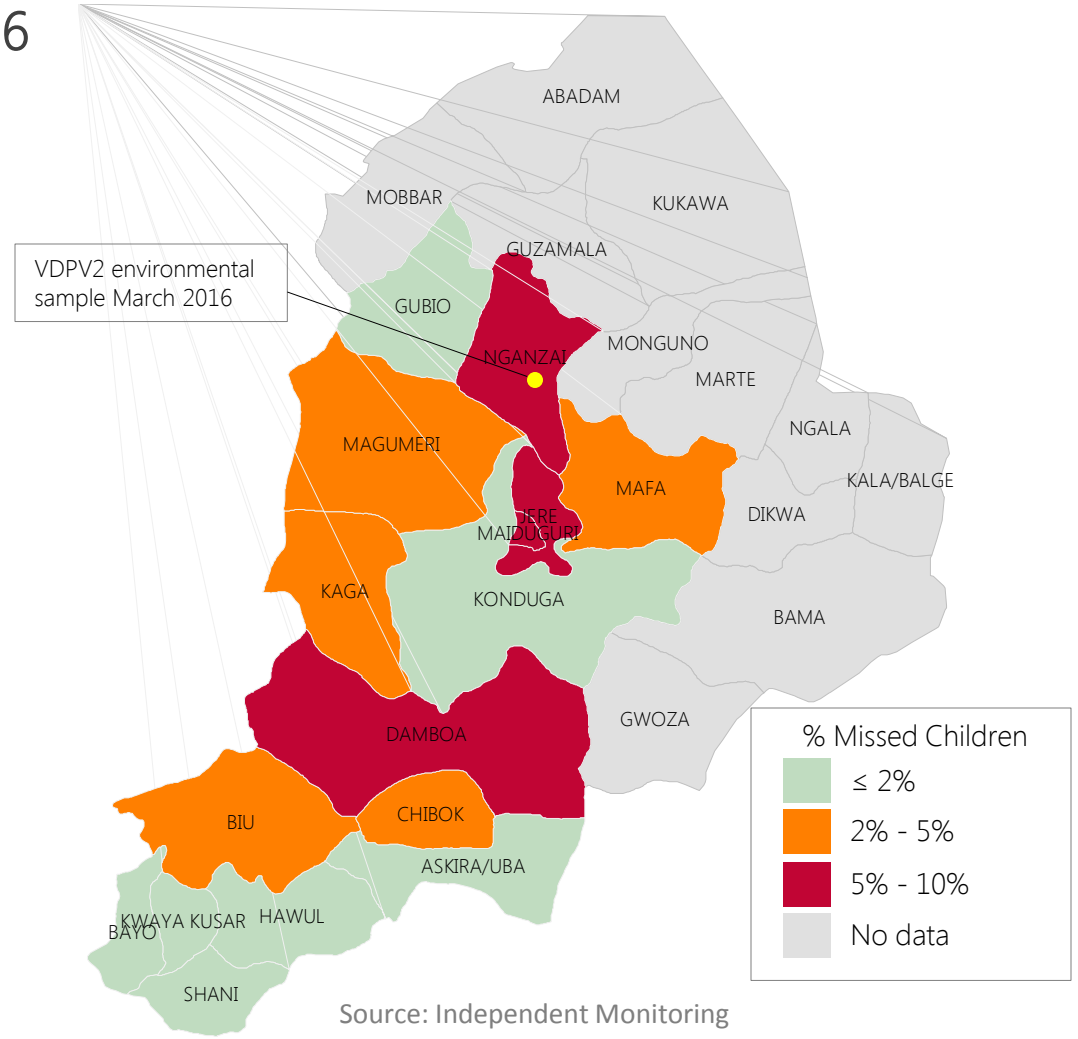
# Nigeria: Borno State

## Trends in missed children, selected LGAs, Borno, Sep 2015 – Mar 2016




Source: Independent Monitoring

## Proportion of missed children Borno, March 2016

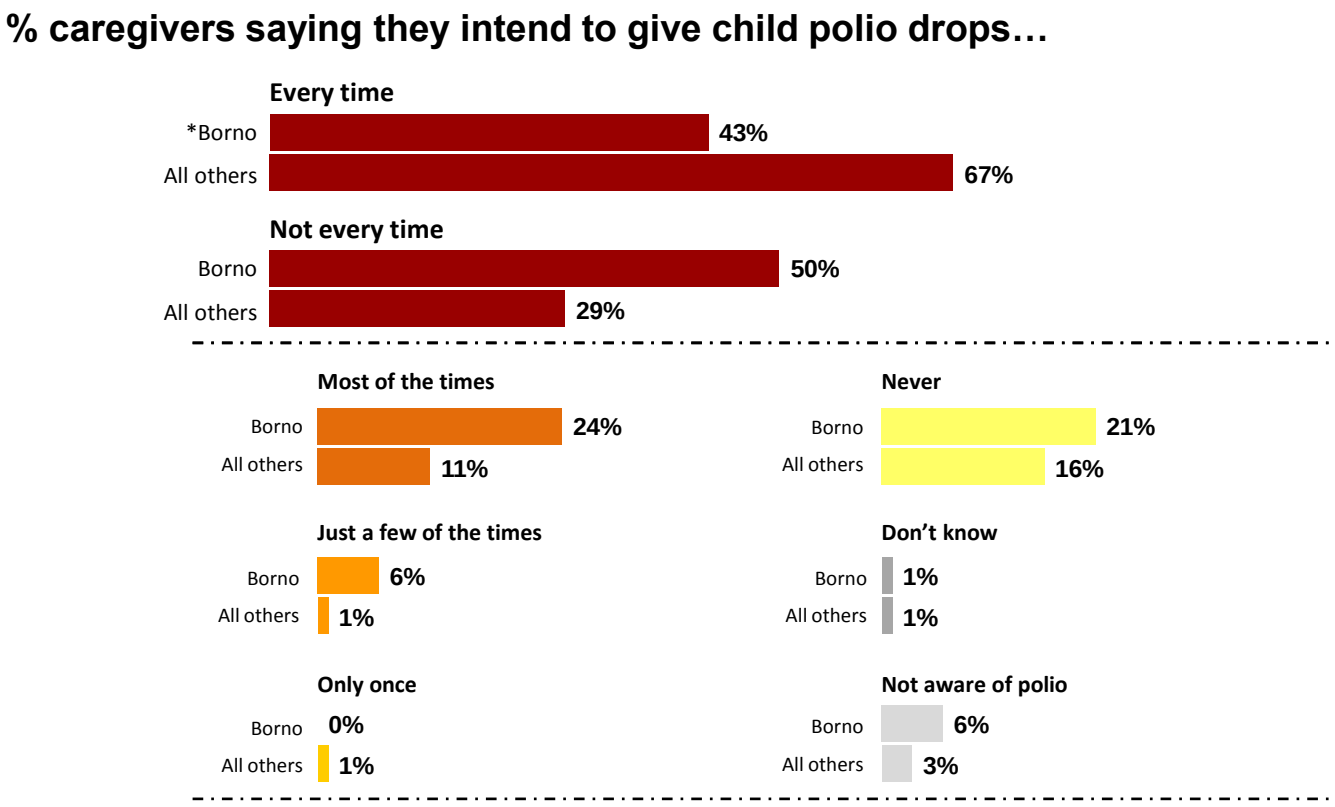



Source: Independent Monitoring

From Sep 2015 to May 2016 the % of children in Borno who were inaccessible was estimated to have decreased from 51% (866,234) to 34% (588,043).

# **Nigeria:** Caregiver intent to give OPV - Borno vs. All other high risk states, March 2016

Borno caregivers are less inclined to accept polio vaccination 'every time' it's offered compared to the other 10 high risk states in Nigeria.




*Borno n=502
All others n=3147

*By the time [index child] reaches [his/her] 5th birthday, how often do you intend to have polio vaccinators give [index child] polio drops? Would you say…?*

*Harvard KAP Study, Wave 2: March 2016*

# DRC is at risk of cVDPVs

- DRC had cVDPV outbreaks in 2010-2012 and 8 aVDPVs during 2010-2015.

- aVDPV2 case confirmed on 1 March 2016 in Tshopo province (former Orientale), onset on 15 January 2016. Two preplanned National Immunization Days (NIDs) and 1 sub-national Immunization Day (SNID) (in Tshopo and Bas Uele), all with tOPV, were conducted after the onset of the case.

- An OBRA (Outbreak Response Assessment) related to the Tshopo aVDPV2 case concluded [on 10-Jun-2016] that AFP surveillance was not sensitive enough to detect all transmission.

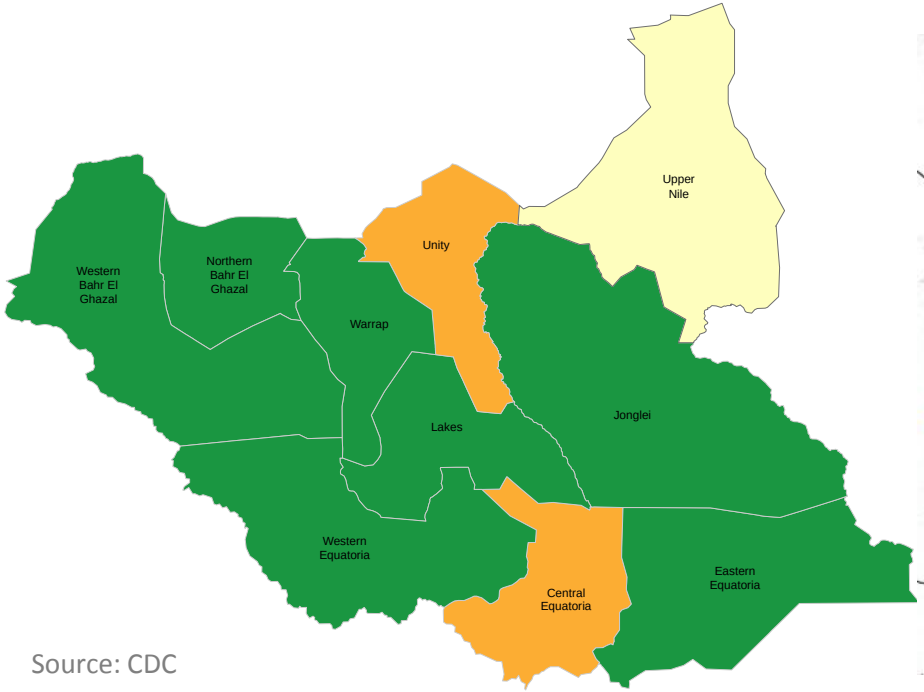
- aVDPV2 case was confirmed on 26 May 2016 in Mongala province (former Equateur) with onset 15 March 2016. Two NIDs with tOPV (24-26 March and 14-16 April 2016) were conducted after case onset.

# South Sudan is also at risk of cVDPVs

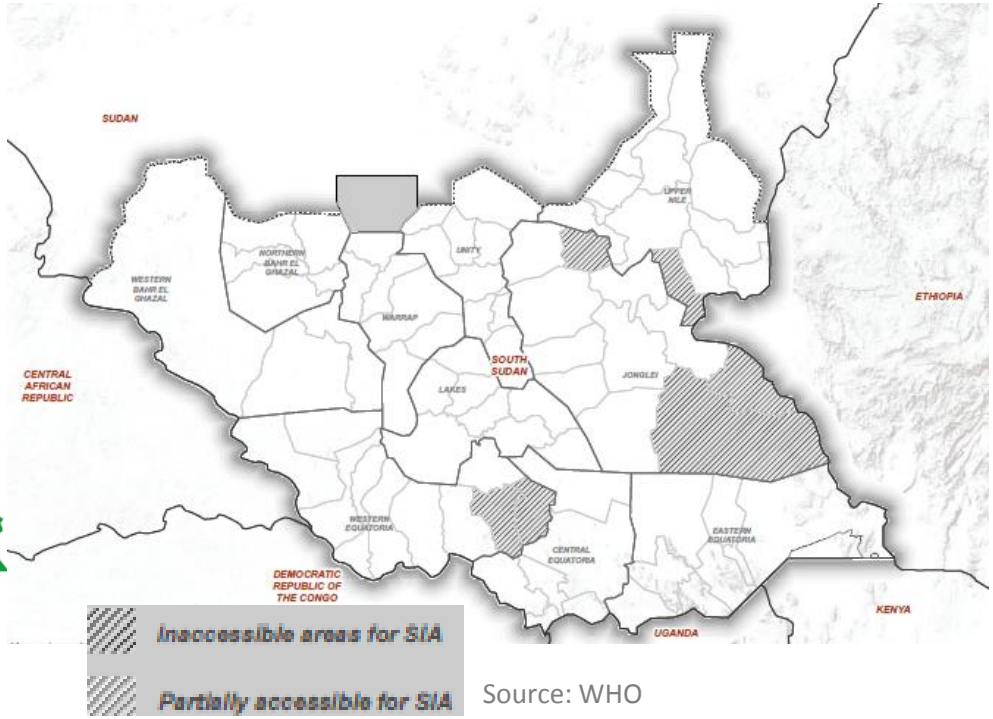
- VDPV2 outbreak that started in 2014 was just closed (OBRA, June 2016).
- 2015 aVDPV2 (not related to 2014 outbreak) was detected.
- Considering low routine immunization and slow roll out of IPV particularly in conflict affected states the risk of VDPV2 outbreak remains a possibility in the post-switch scenario.
- While there is a significant improvement in surveillance indicators , there is still sub-optimal specimen adequacy and silent counties.
- There are unreached children in conflict affected areas, and pockets of unimmunized children in other areas.

# **South Sudan:** Surveillance quality Jun 2015 – May 2016

## Surveillance and Accessibility




Source: CDC




Source: WHO

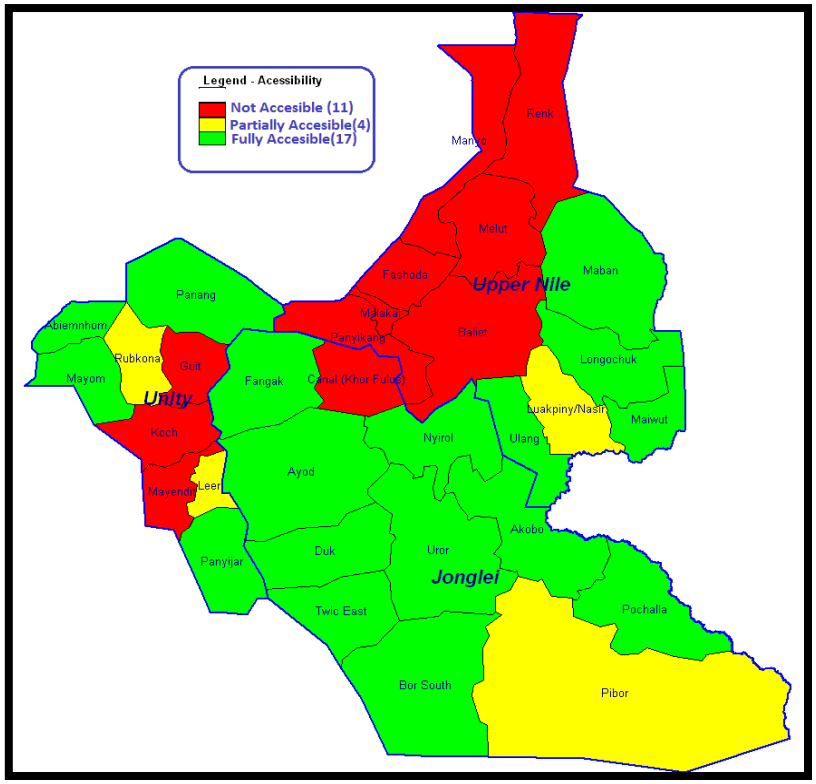
Stool timeliness: 2 stool specimens, collected ≥ 24 hours apart, among AFP cases < 15 yrs old w/in 14 days of paralysis onset

| Surveillance Indicators | NPAFP Rate ≥2 | NPAFP Rate <2 |
|---|---|---|
| Stool Timeliness ≥80% | | |
| Stool Timeliness <80% | | |

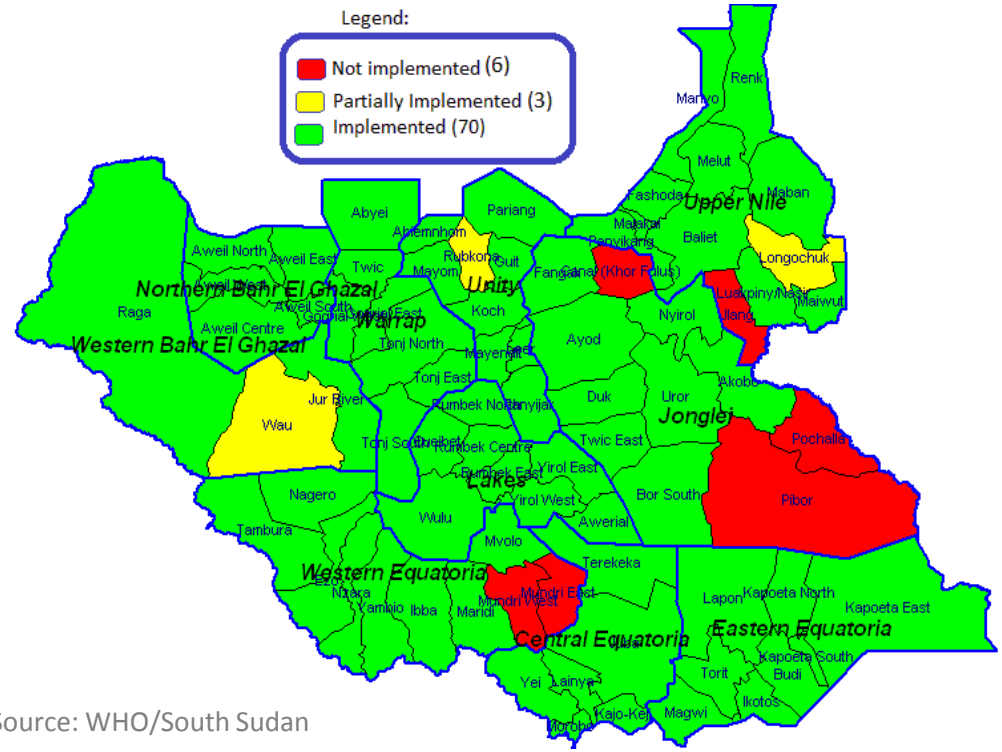
**Data from 1 Jun 2015 through 31 May 2016**

# **South Sudan:** Access for SIAs

**As of 14 March 2016**




**As at end of May 2016**

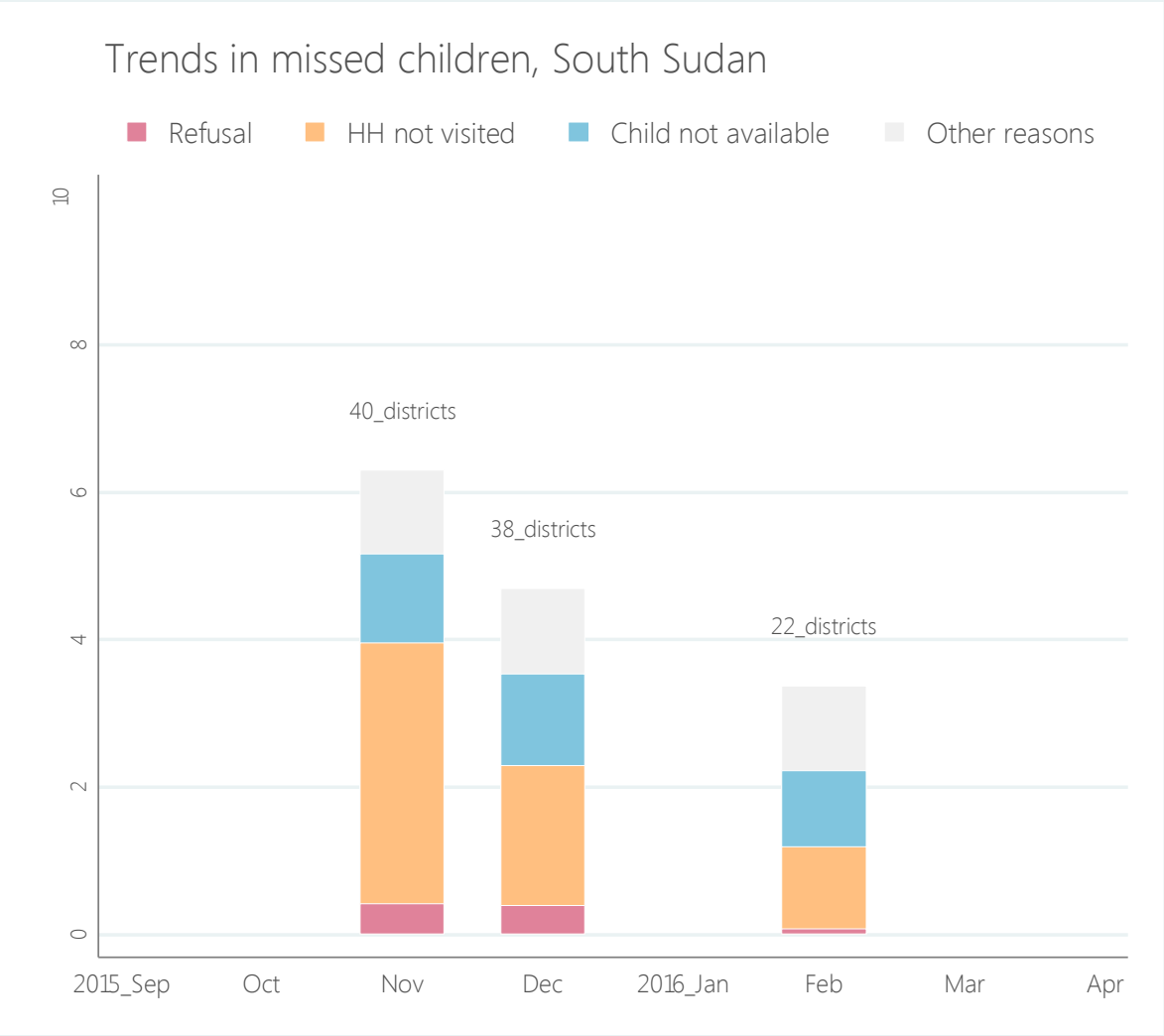



Source: WHO/South Sudan

- Access has greatly improved since start of outbreak
- Some health facilities still non-functional
- Staff are restricted from traveling to some areas
- Movement of funds through banking system remains a challenge
- Difficulty in logistics including cold chain, accommodation and transportation

# **South Sudan:** Reductions in percent of missed children

## Sep 2015 – Feb 2016




Source: Independent Monitoring

# Africa Summary

- Africa has maintained its WPV polio-free status since the last case in August, 2014.
- Many areas in Africa have improved AFP surveillance—but substantial variation at sub-State reveals gaps and requires more attention. Countries bordering Lake Chad have large pockets of unreached and inaccessible children due to the Boko Haram insurgency.
- cVDPV transmission persisted in Borno, Nigeria after the detection in 2014. The EOC estimates that less than 150,000 children remain chronically missed in Borno.
- Nigeria responded aggressively to recently detected cVDPV2 in Borno. SIA with mOPV2 was implemented within two weeks of notification. The round was unable to reach many chronically inaccessible areas, highlighting the challenges to interrupt transmission.
- Eradication efforts in Nigeria need to regain the political oversight and social commitment in place prior to interrupting WPV transmission, especially in key northern states and LGAs where domestic funding, government oversight and caregivers perception of the programme is steadily declining. National government should be encouraged to fulfill its funding commitment and re-activate the Presidential Task Force in wake of the challenges in the NE.
- WHO and UNICEF have facilitated establishment of a Lake Chad Task Team to help coordinate surveillance and immunization activities in this high risk area.


OUTBREAKS

# Outbreaks / VDPV2 events: Sep 2015 – May 2016

- Three VDPV outbreaks were ongoing in Sep 2015 (Madagascar, South Sudan, Ukraine). Since that time, 3 additional cVDPV outbreaks (Lao PDR, Myanmar, Guinea) and 17 VDPV2 events (AFR, EMR, SEAR, WPR) were identified.
- SIAs were conducted in response to all 6 VDPV outbreaks; immunization responses have been recommended or already implemented in 11 of the 17 VDPV events. mOPV2 was used in two separate responses in Nigeria: 1) Jigawa following VDPV2 event, 2) Borno in response to ongoing VDPV2 transmission.
- **cVDPV outbreaks** – GPEI's track record in quick and effective responses to VDPV outbreaks has been mixed in Guinea and Ukraine, both of which were experiencing complex emergency situations. The Ukraine outbreak was closed 9 months after the last case, although the quality of 3 SIAs and surveillance were suboptimal. After more than 22 months since the last case, the South Sudan outbreak, where substantial security concerns and surveillance gaps continue, was closed.
- **VDPV2 events** – swift response to a confirmed VDPV2 case in Tshopo, DRC with two NIDs and an SIA round covering the province prior to the Switch. Events in other countries preceded the Switch but were discovered during or after the Switch, these include: Egypt (limited response with tOPV), DRC (Mongala province: two SIAs were implemented since the onset of paralysis), Kenya (one SIA implemented after a positive ES result), Niger (three SIAs), and Syria (no response deemed feasible nor necessary). Nigeria and India had the only events that occurred post Switch (Jigawa: 3 mOPV2 SIAs; Hyderabad: one round fIPV; Kolkata: no response); all other events occurred pre- or during the switch, but were discovered afterwards.

# VDPV2 Events since Sep 2015

| Year | Country | Location | Onset/ Collection | AFP/ ES | # NT changes | Classifi-cation |
|---|---|---|---|---|---|---|
| 2015 | Pakistan | Quetta | 12-Sep | ES | 8 | a |
| | India | Mumbai | 29-Sep | ES | 6 | a |
| | China | Guangdong | 13-Oct | ES | 7 | a |
| | Niger | Niamey | 15-Nov | ES | 8 | a |
| | Senegal | Dakar | 15-Nov | ES | 6 | a |
| | Syria | Deir al Zour | 6-Dec | AFP | 6 | a |
| | Pakistan | Quetta | 14-Dec | ES | 6 | a |
| | India | Mumbai | 29-Dec | ES | 7 | a |
| | Kenya | Nairobi | 30-Dec | ES | 7 | a |
| 2016 | DRC | Tshopo | 13-Jan | AFP | 16 | a |
| | India | Delhi East | 1-Feb | ES | 6 | a |
| | India | Delhi North | 18-Feb | ES | 7 | a |
| | Egypt | Al-Taur | 15-Mar | ES | 6 | a |
| | DRC | Mongala | 15-Mar | AFP | 6 | pending |
| | India | Kolkata | 25-Apr | ES | 6 | pending |
| | Nigeria | Jigawa | 14-May | AFP | 8 | pending |
| | India | Hyderabad | 16-May | ES | 10 | pending |

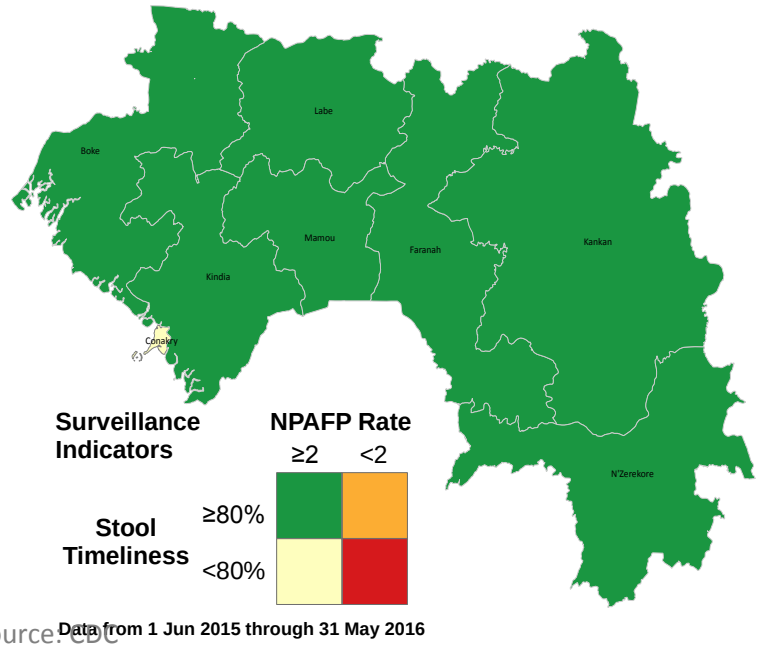
The number of VDPV2 events are expected to decline post Switch

# Performance indicators in recent outbreaks

| Number of days from… to… | Standard (days) | Guinea | Mada-gascar | Myanmar | Lao PDR | Ukraine |
|---|---|---|---|---|---|---|
| from confirmation to OBRA 1 | 90 | 177 | 261 | 104 | 109 | 98 |
| from confirmation to Team A arrival | 3 | 42 | 264 | n/a | 24 | 8 |
| from confirmation to response plan | 14 | 62 | 294 | 3 | 21 | 21 |
| from confirmation to 1st round | 14 | 11 | 54 | -2 | 7 | 50 |
| from first to last case | - | 471 | 327 | 194 | 126 | 7 |
| from confirmation to grading | 3 | 4 | 252 | 2 | 8 | 17 |
| Number of SIA conducted (to date) | > 3 | 7 | 8 | 5 | 7 | 3 |
| from confirmation to release of funds | 14 | 3 | 297 | n/a | 14 | n/a |

# **Guinea:** cVDPV2 outbreak, Jul 2015 – Dec 2015

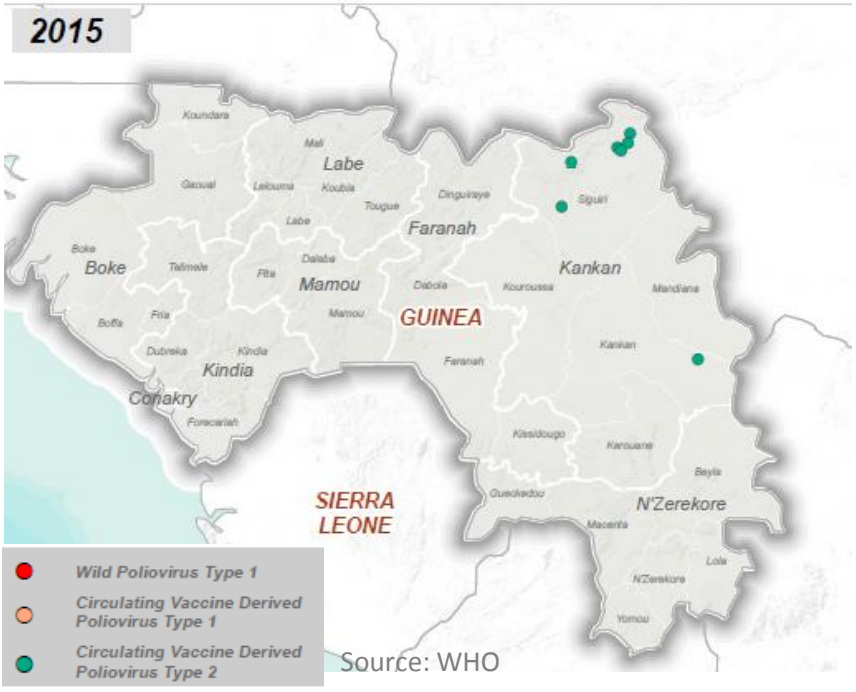
## Surveillance




Source: CDC

Stool timeliness: 2 stool specimens, collected ≥ 24 hours apart, among AFP cases < 15 yrs old w/in 14 days of paralysis onset

## cVDPV2 cases detected in 2015 only

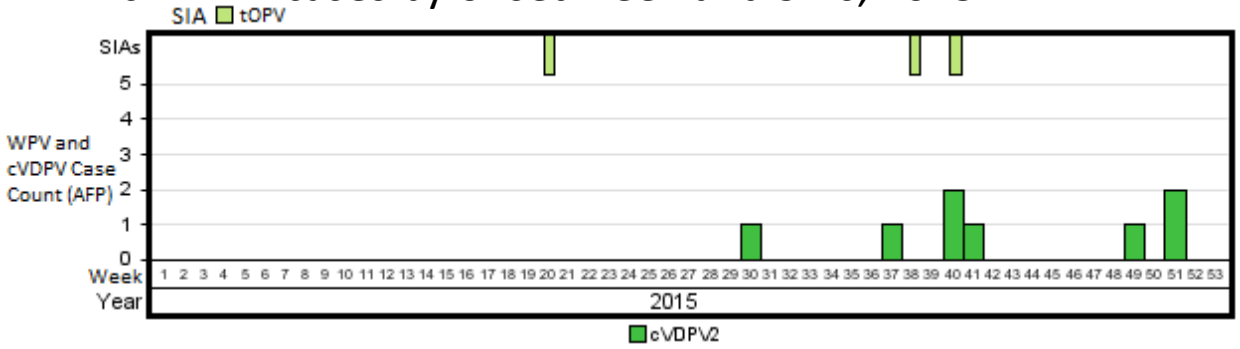



Source: WHO

- Surveillance improved at province level, but Conakry failed to meet both indicators (too small to see on slide).

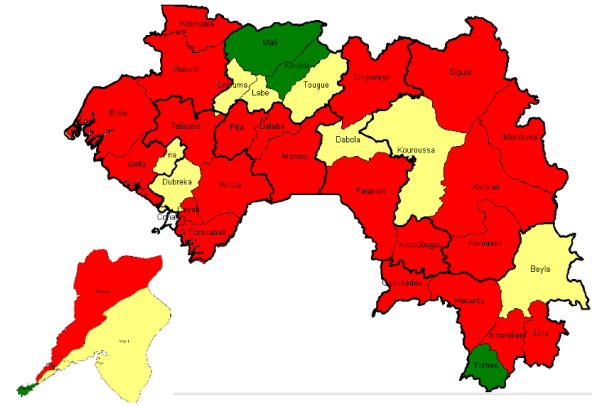
- The outbreak remains open.

## cVDPV2 cases by onset week and SIAs, 2015



# **Guinea:** LQAS indicates few prefectures* have the desired SIA quality in contrast to Independent Monitoring, Mar – Apr 2016

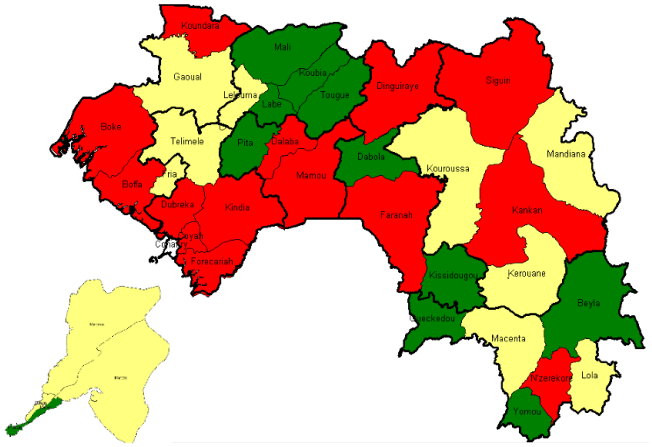
**March**



**LQAS**

| Performance LQAS |
|---|
| Rejeté |
| Moyenne |
| Bonne |

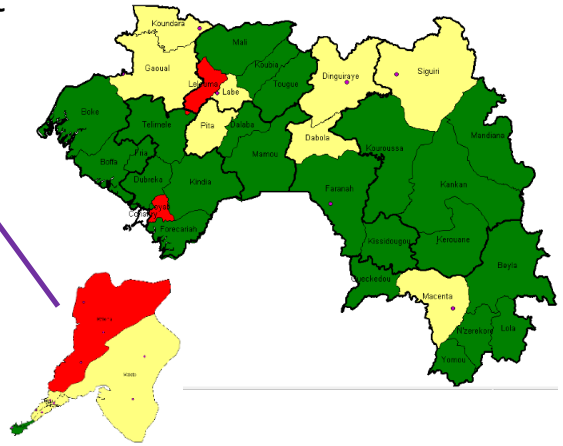
**April**

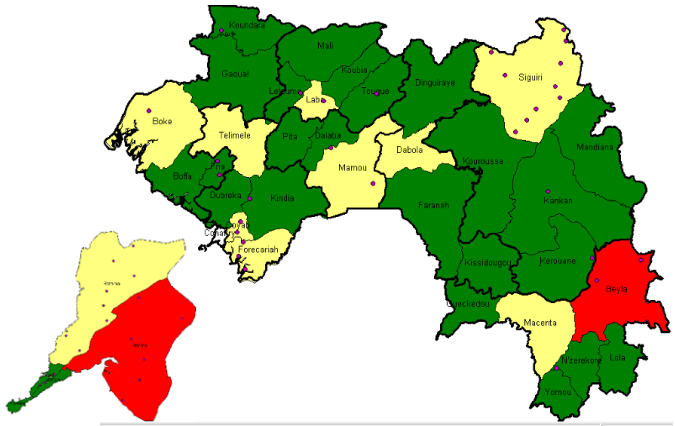


Conakry shown as separate enlargement

**IM**

| % enfants manqués Ménage+Hors Ménage |
|---|
| >10% |
| ]5%-10%[ |
| <=5% |
| 1 zone ins couv |





*prefecture is analogous to district

Source: WHO/Guinea

# **Madagascar:** cVDPV1 outbreak, Sep 2015 – Jun 2016

## Surveillance

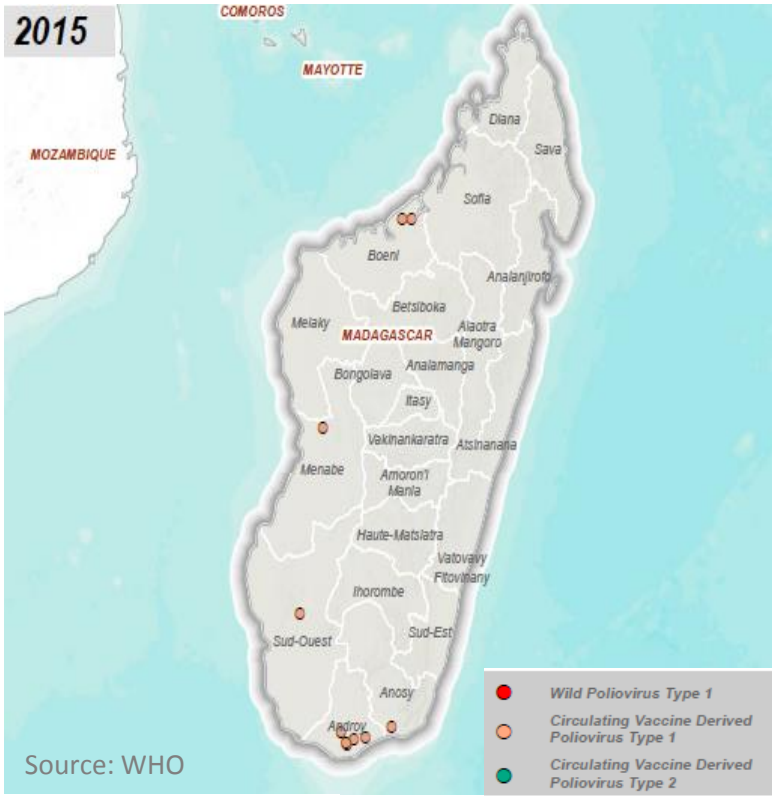

| Surveillance Indicators | NPAFP Rate ≥2 | NPAFP Rate <2 |
|---|---|---|
| Stool Timeliness ≥80% | | |
| Stool Timeliness <80% | | |

**Data from 1 Jun 2015 through 31 May 2016**

Stool timeliness: 2 stool specimens, collected ≥ 24 hours apart, among AFP cases < 15 yrs old w/in 14 days of paralysis onset

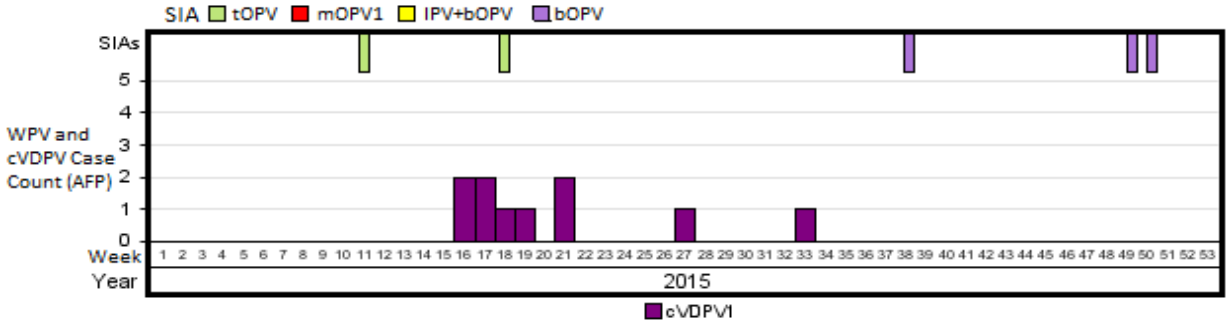
Source: CDC

## cVDPV1 cases detected in 2015 only




Source: WHO

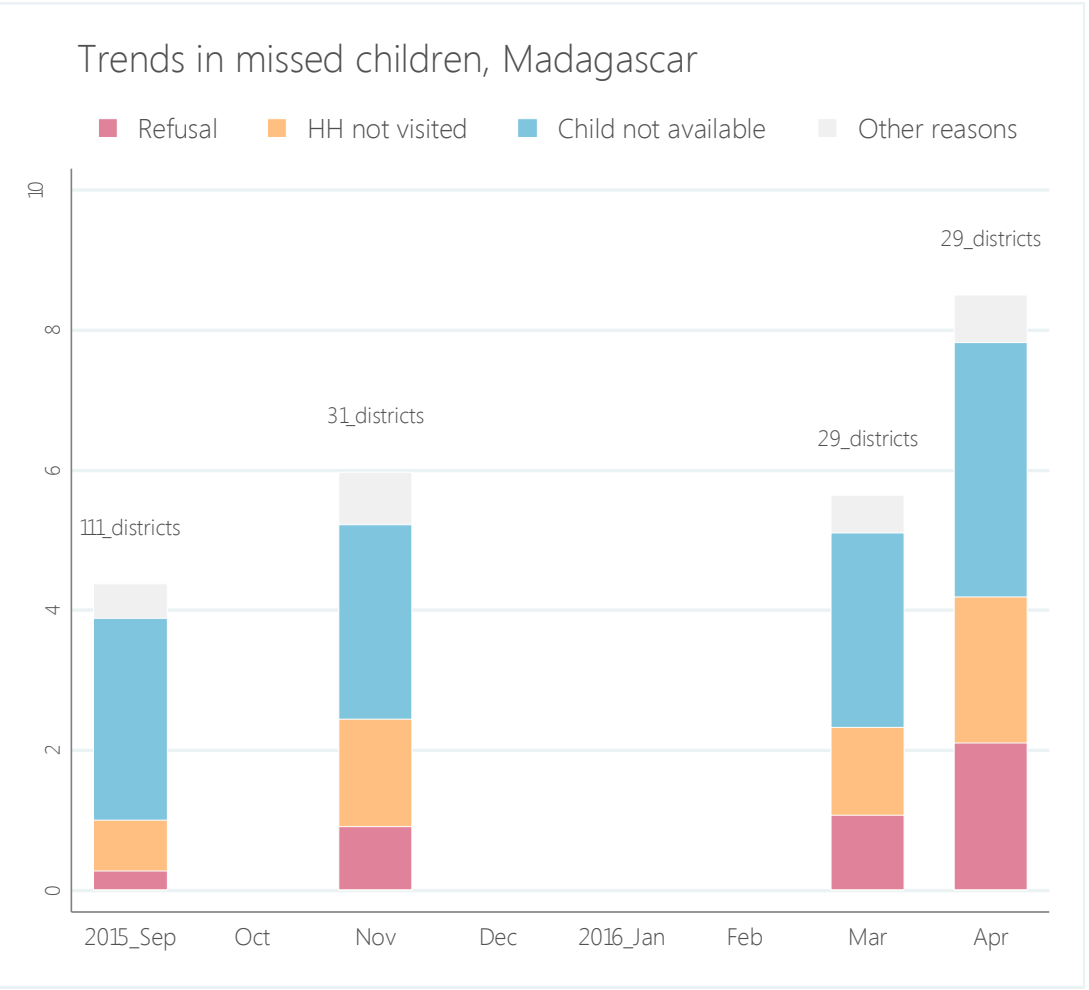
## cVDPV1 cases by onset week and SIAs, 2015




Madagascar had two VDPV2 outbreaks in the last 10 years.

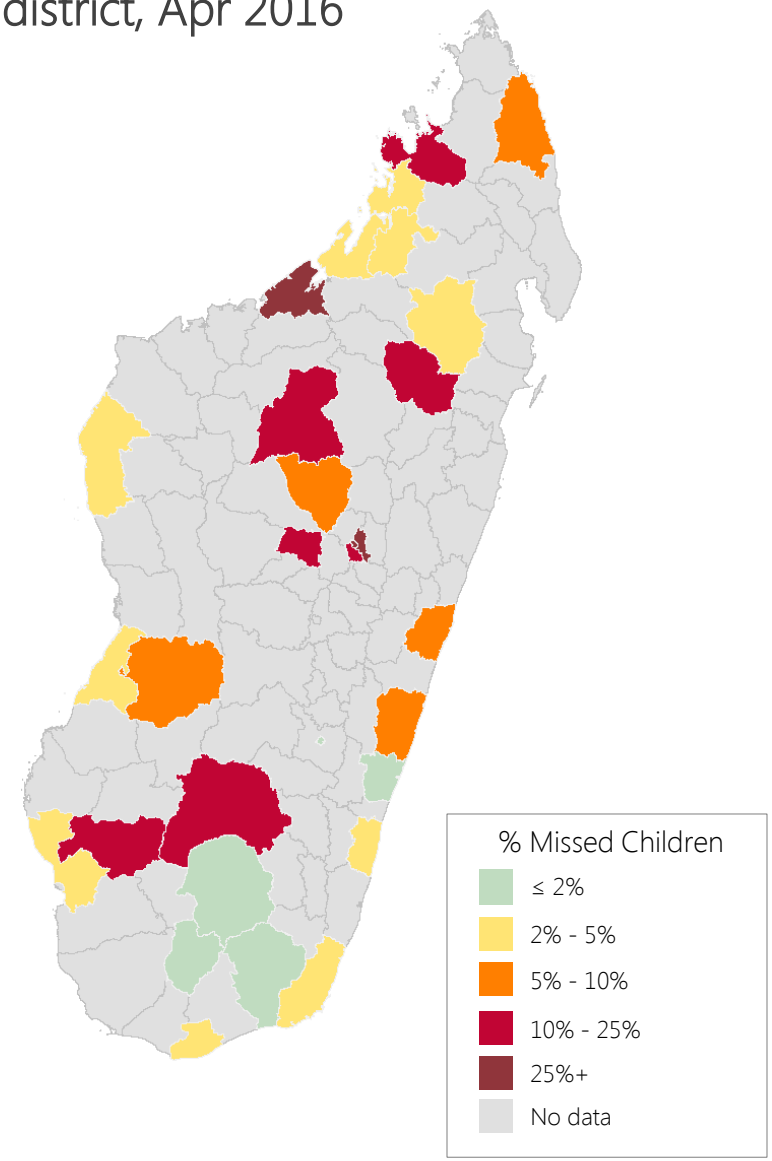
The VDPV1 outbreak remains open.

# **Madagascar:** Percent of missed children, Sep 2015 – Apr 2016

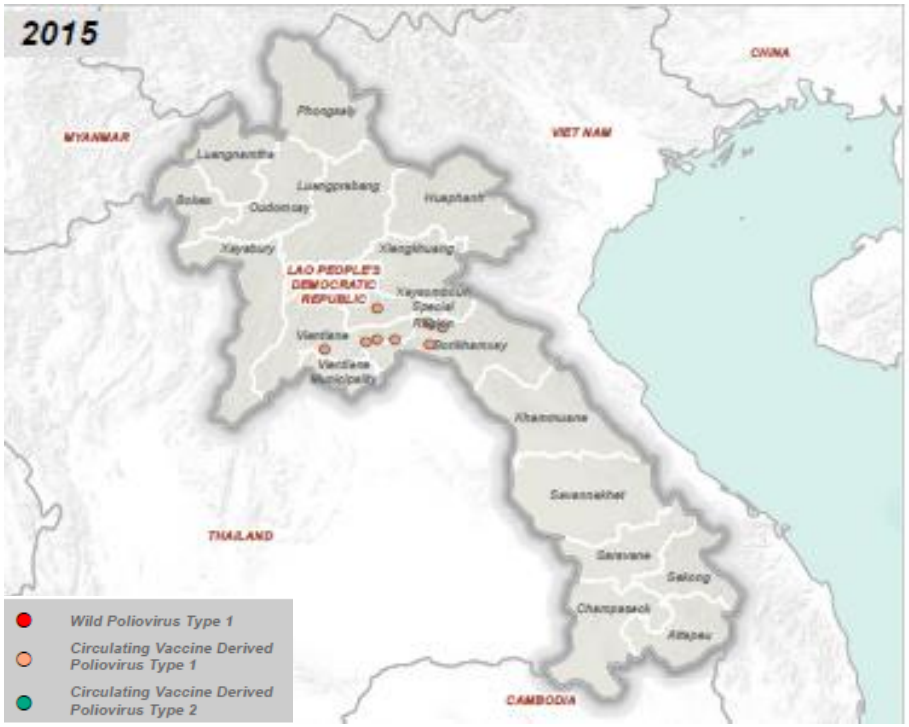


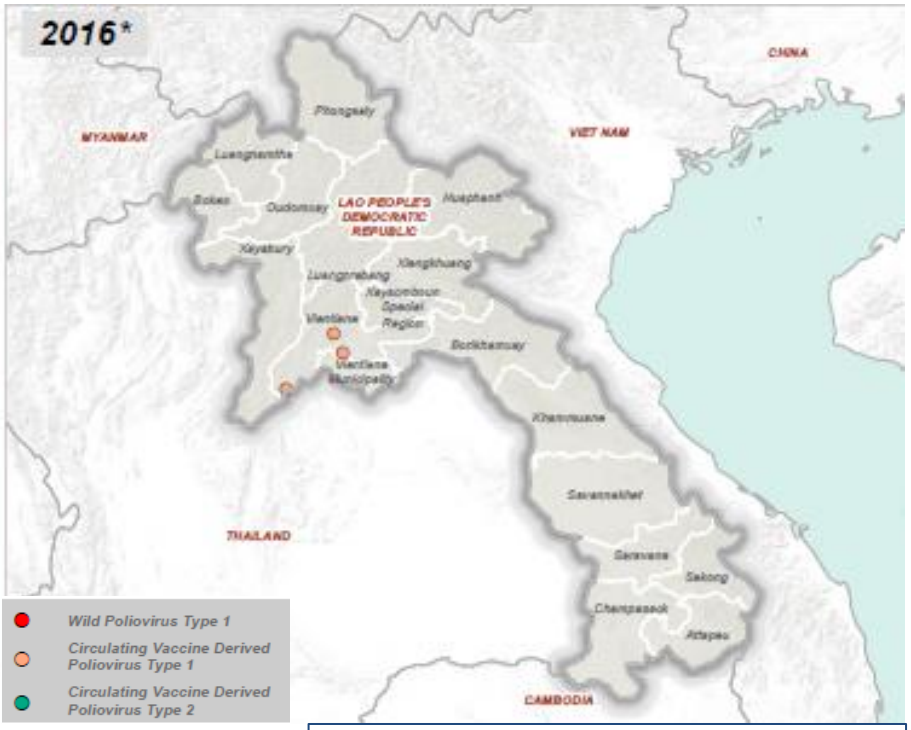

Source: Independent Monitoring

Proportion of missed children by district, Apr 2016



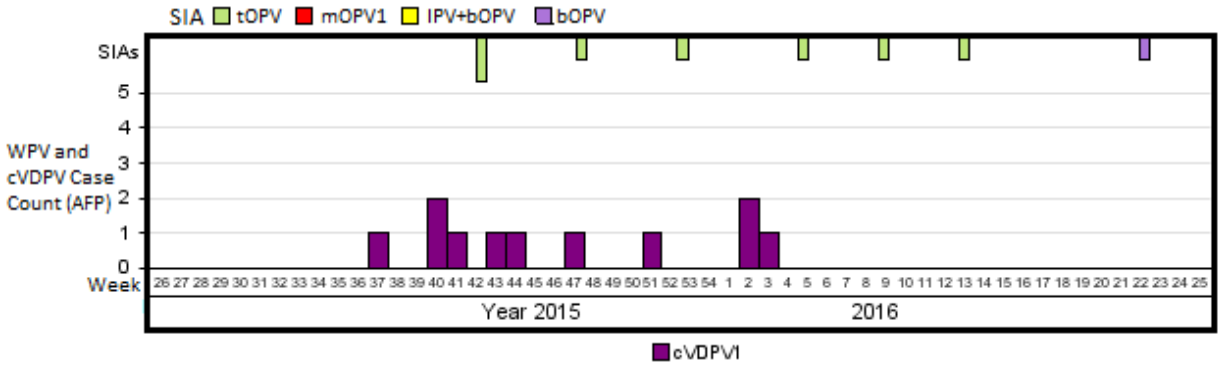
# **Lao PDR:** cVDPV1 outbreak, Sep 2015 – Jun 2016



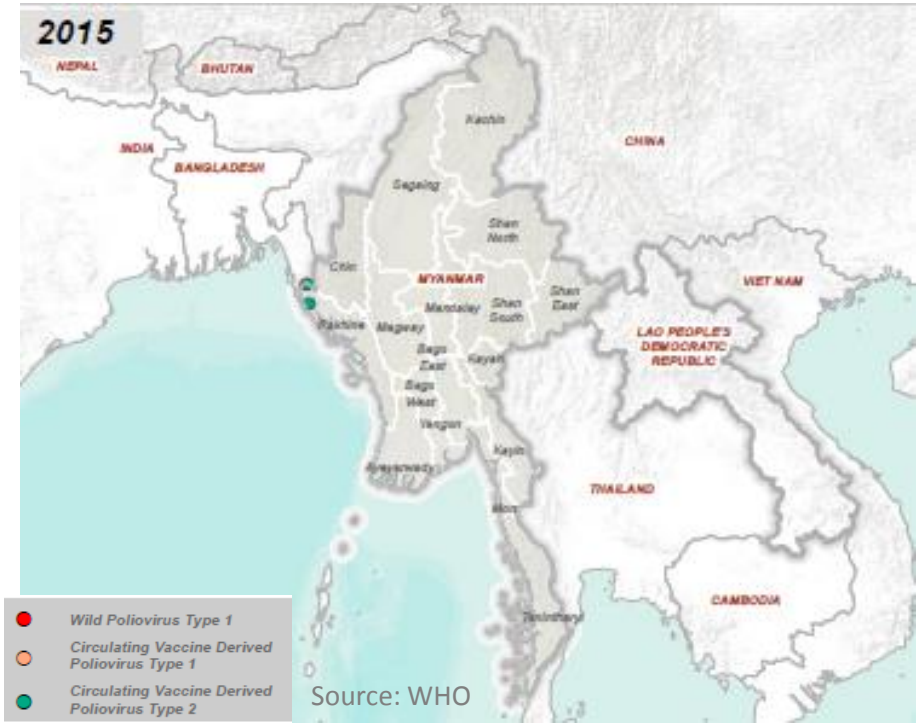

Source: WHO

cVDPV1 cases by onset week and SIAs, 2015



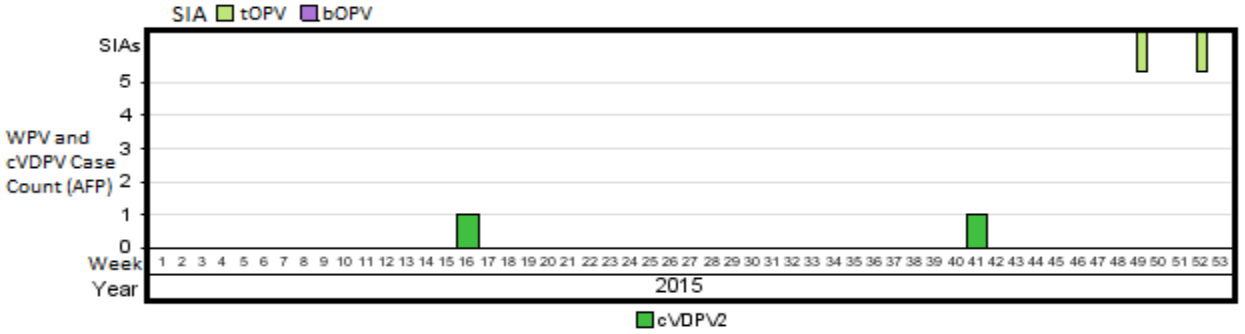

- All cases and positive contacts were members of the same ethnic minority.
- 4 of 11 cases were 15-44 years of age.
- 7 SIAs, some targeted all ages (Oct 2015 – May 2016).
- The outbreak remains open.

# **Myanmar:** cVDPV2 outbreak, Sep 2015 – Jun 2016




- Both cases were members of the same ethnic minority.
- Only 3-month OBRA conducted thus far, second OBRA scheduled for late Sep early Oct, 2016.
- The outbreak remains open.

cVDPV2 cases by onset week and SIAs, 2015



# Outbreak Summary

**What's going well**

- Normative guidance and tools in place to support planning and management of polio outbreaks and VDPV2 events
- Strong technical expertise for polio outbreak control and management of VDPV emergence
- Global coordination mechanism is in place (OPRTT) along with strong advocacy capacity across GPEI, but performance is suboptimal

**What's not going well**

- GPEI operational capacity improved but weaknesses continue -- limited pool of qualified personnel for immediate response, delays in deployment and decision making, delay in fund disbursement, suboptimal coordination (e.g., Guinea)
- Limited national preparedness, slow responses and weak oversight and political commitment by national authorities leading to limited SIA quality, delays or no declaration of public health emergency
- Lack of reference to quality measures in current guidance documents are a vulnerability for effective outbreak response

**Key priorities moving ahead**

- Build capacity for polio outbreak preparedness and response at country, IST and region levels
- AFP surveillance still needs improvement in many areas within Africa
- Establishing a multi-agency, multi-country comprehensive approach in Lake Chad region to attempt to address risks there
- Continued high-level advocacy efforts as soon as virus isolation occurs
- Further strengthen coordination across all parts of the partnerships

**Countries at risk**

- Risk of outbreak continuing: Guinea
- Risk of new events/outbreaks: DRC, South Sudan, Syria, Yemen, Ukraine

# GPEI GLOBALLY

# Global Overview

- **GPEI is working effectively at global level,** with clear roles among task teams and an efficient mechanism for identifying and addressing risks. A few critical challenges remain in the final leg of eradication
- **The on-going cash gap and overall funding gap that exist for the period 2016-2019 urgently need to be filled.**
- GPEI has made remarkable progress towards reaching the 4 strategic objectives, however **the management of the Global Partnership with its current infrastructure** (with its numerous groups and task teams) has a huge transactional cost.
- **For the first time, countries have been provided with budget ceilings to ensure the global GPEI budget can be maintained**. Countries will be expected to conduct effective, quality campaigns within the planned SIA calendar, and to begin transitioning responsibly in 2016 to ensure gains are maintained and utilized in support of routine immunization.
- The programme has updated and further developed outbreak response SOPs, guidelines for outbreak preparedness and technical guidelines for SIA quality. **The programme needs to continue to ensure, however, that in all contexts, the basic gold standards for outbreak investigation, SIAs, and surveillance continue to be systematically applied; adherence to these strategies continues to be critically monitored at country, regional and global levels.**
- The programme has  a wealth of data and has made strides in more effectively using data for action in specific contexts. **Yet the programme needs to offer greater opportunities to make faster, more strategic use of the data available**, particularly in the areas where the programme is most vulnerable in the final year before interruption.
- The existing **tight supply of IPV** will continue to be a challenge for the interruption of poliovirus transmission and routine immunization until 2018.
- **OPV cessation:** as we approach the endgame, the programme will need to start planning for total OPV cessation and ensuring all resources are secured to do this in a timely manner.