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**GPEI Responses to**

**IMB's 19th Report Recommendations (Dec 2020)**

 April 2021

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Sustain the momentum of resumed polio activities

1. **The polio-endemic, polio-outbreak and polio vulnerable countries should sustain delivery of all resumed polio activities by ensuring that rigorous COVID-19 protective measures for health workers and communities are in place.**

Following the pandemic related pause in polio operations, house-to-house SIAs resumed in Q2 2020. To protect communities and front-line workers during polio SIAs, GPEI provided frontline workers new and/or updated operationalization guidelines and training materials on infection prevention and control (IPC) and conducted SIAs under a set of principles of safety to do no harm to communities. Additionally, SIA budgets were increased to account for personal protection equipment (PPE) and IPC costs, which are essential to safely conduct preventive and outbreak response SIAs during the pandemic.

Field reports from countries show that most safety measures were strictly observed by frontline workers during house-to-house campaigns held since July 2020. These safety measures will continue during 2021 for all the planned and outbreak SIAs.

1. **The WHO and UNICEF should organize for polio and essential immunisation field staff to be vaccinated against COVID-19 to protect them and the communities that they are serving.**

GPEI is working with national authorities in the endemic countries to ensure that frontline workers are included in the group of health care providers that are being prioritized for vaccination. National and Provincial EOCs in Pakistan and Afghanistan prepared lists of PEI frontline workers to prioritize for vaccination through close coordination with Provincial EPI programs. Around half a million health workers are now vaccinated in Pakistan—while most of them are doctors and paramedics, a proportion of PEI workers were vaccinated. As per policy of both countries, older age group and high-risk groups are prioritized for COVID 19 vaccination, so the overall progress on vaccination of frontline polio workers remains slow. However, as the COVAX supply is improving, it is expected that house to house workers will soon be included for vaccination.

Establish a public health emergency modus operandi for polio eradication

1. **The polio-endemic, polio-outbreak and polio vulnerable countries should remodel their polio programmes as a public health emergency, building upon, and learning the lessons from, the response to the COVID-19 emergency.**

GPEI's End-game Strategy is being revised and a main focus of the new strategy is to incorporate lessons learned from the COVID 19 response to re-establish polio eradication as a public health emergency and priority of the highest order. The revised strategy also ensures that the GPEI agencies, endemic countries and global partners are accountable for rapid progress, as a means of cementing the emergency nature of the programme. In response to the recommendations of the GPEI management review, the new GPEI structure focuses on empowering field staff to make context driven decisions. Also, Rapid Response and incident management teams are established or are being established at regional levels to enhance capacity for urgent and effective support to outbreak responses in their respective countries.

The Pakistan Polio Programme and Integrated Models of service

1. **Following its emergence from the first wave of COVID-19, and the appointment of a new Special Assistant to the Prime Minister on Health (a post with the status of Federal Minister), the Pakistan government should “reset” its Polio Programme to strengthen its performance. The approach should drive action through technical, political, and social measures. The “reset” should also incorporate implementation of recommendations 1 and 2, as well as ensuring there is a strong staffing structure to support the national leadership team.**

During the recent TAG meeting, the SAPM re-iterated his commitment to implementation of the components of this recommendation including a 'reset' and the need for a strong staffing structure at national leadership-level. The Ministry of Health has appointed a new national EOC coordinator and Deputy EOC coordinator.

To further advocate this issue, a call between the POB Chair, IMB Chair and Special Assistant to the Prime Minister (SAPM) was held. Below are the main outcomes of the call:

1. The SAPM agreed that eradication will not be achieved with current approaches. Replicating the COVID response approach won’t be easy, but the polio programme and its partners must work towards a common goal, understand the main challenges, have the ability to utilize data independently, critically and in real-time. Data and micro plans are important to identify ‘red flags’ e.g. continuously missed children in the same place as well as use of technology like GPS to track missed children;
2. It was also agreed that SAPM and the National EOC coordinator will develop deep connection to the field and provinces backed up by regular visits. This is to help understand the realities, listen, hear concerns, and get the real picture in the field first-hand. However, workload of SAPM and DG Health due to ongoing pressure from COVID is bit of a concern;
3. A boost to the 40 Super High-Risk Union Council (SHRUCs) initiative is important to ensure deprived and resentful communities get the help they need that will encourage greater trust in the polio programme. Although the overall progress is slow, the Health Minister in KP is focusing on expanding health care and an integrated service delivery package for the SHRUCs;
4. SAPM needs time to think on how to leverage the Prime Minister’s influence towards inclusion of Polio Tier 1 districts as part of the support package for underserved population, financed through the Global Finance Facility Initiative started by the World Bank;
5. New NEOC coordinator and deputy NEOC coordinator are appointed following Dr. Rana’s promotion as DG Health Pakistan.

Upcoming high-level advocacy missions include the DG WHO visit to Afghanistan and the POB Chair and Strategy committee chair visit to Pakistan in May 2021.

1. **From the federal level, the Special Health Adviser to the Prime Minister and the national Emergency Operations Centre Coordinator should forge a “real-time” relationship with the chief secretaries and health ministers of the provinces. Without strong national provincial teamwork, barriers to eradication will endure. This effective leadership role can only work if there are actual visits to the provinces as well as regular discussions through videoconferencing.**

Currently, regular videoconferencing is held between national and provincial EOCs following each SIA and the Special Health Adviser to the Prime Minister recently visited Karachi and KP. Provincial visits by SAPM are expected to be more regular once the COVID situation becomes more stable. The issue was also discussed during the advocacy call between SAPM and chair of the POB. Future advocacy mission of GPEI principals to Pakistan will also provide opportunity to further emphasize importance of provincial visits by SAPM.

1. **The Special Assistant to the Prime Minister of Pakistan on Health should take charge of the implementation of the “polio sub-package” initiative in 40 super-high-risk union councils, which has been moving far too slowly and failing to reach its transformational potential; specific focus should be given to WASH interventions and their progress tracked.**

See details given under recommendations 4.

Also, the SAPM reiterated support for this initiative following the TAG meeting.

Coordination discussions between the polio programme and key stakeholders of the NHSP have commenced and there is broad consensus that the polio programme should be a formal partner in the NHSP with clear roles and responsibilities and engagement in the coordination mechanisms put in place. There is also consensus among partners that polio affected Tier 1 districts or parts thereof be included in the project as negotiations with provinces are ongoing.

Director Polio EMRO, UNICEF Regional Chief of Health and some members of the Hub have taken the following actions

1. Engaged with the WB focal points for health in the region and the country office and sought their advice on how to best involve the polio programme in the NHSP and develop an ongoing coordination mechanism.
2. Engaged with the GAVI focal points for Pakistan to ensure Gavi and the polio programme are harmonized in their areas of convergence and work together to ensure NHSP includes communities with the most unimmunized children that are also affected by polio in the Polio Tier 1 districts and work closely to jointly advocate with the rest of the NHSP stakeholders.
3. Discussed with WHO and UNICEF country leadership and technical teams on how to harmonize polio, EPI and the NHSP and ensure the polio programme is included in the NHSP partnership.
4. Discussed with NEOC leadership and Federal DG Health about developing the clear terms of engagement for the partnership between Pakistan’s polio eradication programme and the NHSP.
5. Advocated with the Provincial Minister of Health, Chief Secretary and Health Secretary Sind to include polio Tier 1 districts, or at least, Super High-Risk Union Councils of Karachi in the provincial selection of areas for the first phase of the NHSP.
6. Discussed and developed consensus on inclusion of polio eradication programme as a partner in the NSHP with the key external policy advisors, especially Dr. Ala Alwan, Dr. Zafar Mirza (former Minister of Health Pakistan and current advisor from WHO to the government on NHSP) and Dr. Awad Mataria, Director Universal Health Coverage, WHO EMRO. Dr. Awad led a delegation of partners and donors that was reviewing the elements of UHC and PHC in the NHSP.  The delegation recommended engagement of polio programme in the NHSP.

The timelines of the NHSP and the Polio Sub-package for Integrated Service Delivery (ISD) for the SHRUCs have now become synchronized given the delays in the implementation of the polio sub-package. The interventions and financing of the two should now be aligned further.  The NHSP is still being negotiated across donors and federal and provincial governments and will take several months to a year before implementation commences.  Meanwhile, some targeted interventions in SHRUCs are being implemented, including a push to organize well-planned and managed health camps.

1. **The Special Assistant to the Prime Minister of Pakistan on Health should seek the Prime Minister’s authority to direct the investment being planned with the World Bank and the Global Financing Facility for Women and Children (GFF) into polio high-risk districts.**

Advocacy with the Minister, Government of Pakistan and partners is ongoing to address this issue, as mentioned above.

As noted above, advocacy has been conducted with Dr. Rana Safdar, who is now the Federal Director General of Health and with the Provincial Health Minister, Chief Secretary and Health Secretary of Sind.   The visit of POB members that is being planned is an excellent opportunity to directly advocate with the Prime Minister and Chief and Health Ministers of provinces.

1. **The Integrated Programme of Work should produce guidance quickly to counteract that widespread belief that oral polio vaccine campaigns can never be effective in an integrated model of delivery.**

OPV delivery strategies vary depending on whether the objective is rapid outbreak response or delivery of additional, preventive doses, such as occurs when co-delivering bOPV with measles or other SIAs. Typically, the programme has preferred door-to-door OPV vaccination given the ease of delivering an oral vaccine and the belief that by going door-to-door higher coverage rates are achieved. However, this has also led to a preponderance of single intervention activities – i.e., OPV only – and growing community hesitancy/resistance to accepting polio drops when other health and social service needs exist.

The polio programme recognizes that stand-alone OPV vaccination activities are no longer sufficient in all contexts to address community concerns and needs as well as attain high coverage levels. The polio programme is therefore placing greater emphasis on integrated activities from the perspective of delivering multiple interventions in targeted geographies and improving coordination, planning and management with essential immunization services, as described in the iPOW.

The Afghanistan Polio Programme and integrated models of service

1. **The senior headquarters and regional office leadership of the GPEI should work closely with their counterparts in the World Bank and Global Financing Facility for Women and Children (GFF) to ensure that the recently initiated Kabul-based discussions on increasing performance management and accountability of the Sehatmandi scheme conclude successfully; they should seek to incorporate a Polio Programme delivery strand.**

The POB chair has reached out to the World Bank to advocate for incorporating the polio program as part of the Sehatmandi scheme. The Director Polio EMRO will also reach out to the WB Afghanistan Team. In the context of Sehatmandi, the new BPHS contracts are being reviewed and the recent TAG, held in Kabul, also recommended that integrated service delivery for underserved and high-risk areas for poliovirus transmission be part of new contracts through the Sehatmandi initiative.

1. **The WHO and UNICEF headquarters management teams should take immediate action to resolve the dysfunctional working and conflict between their Afghanistan polio teams.**

The WHO and UNICEF teams have resolved their differences following interventions at the regional level and facilitated by the Hub and HQs. Specific commitments on coordination and communication were confirmed in the meeting convened by the WHO and UNICEF RDs. A follow up joint agency mission in March 2021 that included the WHO polio director, the EMRO polio director, the UNICEF ROSA health chief and the UNICEF HQ deputy polio director, confirmed that both country teams have agreed to basic principles of working as one team.

It is also important to mention that new country representatives and deputy representatives were recently appointed by WHO and UNICEF. In addition, a new UNICEF polio team lead and deputy lead appointments are being finalized. Both the agencies and Hub are facilitating coordination between teams in the period of transition.

1. **The Afghanistan government and the Hub should take immediate steps to strengthen the role of the national Emergency Operations Centre; as part of this process they should write new role specifications for the Health Minister’s Senior Adviser and national Polio Focal Person and for the Head of the national Emergency Operations Centre so that staff know who is directing their work on different occasions.**

The Hub has started the process of a program review by an independent third party supported by the CDC. The review will look at the structure, functions, roles and responsibility and accountability within the programme and make recommendations. This review has started and is expected to be completed during Q2 of 2021.

1. **The Afghanistan government’s polio team should build on and extend the success of the pilot scheme that gained access through locally based negotiations.**

Using lessons learnt, the Afghanistan team has developed a 'South Region Plan' that focuses on a multipronged approach for inaccessible areas that includes improving the reach of integrated services. Local level access negotiations are a regular feature of the Afghanistan program and for the March SIAs, 4 additional districts of South East and Wardak province of Central region will be allowed to conduct house-to-house vaccination. However, the local negotiations in southern region have yet to make any breakthrough.

EMRO--wider ownership of the Polio Emergency

1. **The RD EMRO should work with health ministers of all members states to establish a high-level commission to use influence to rid the region of polio, the last in the world to do so.**

The Regional Subcommittee for Polio eradication and outbreak response has been constituted. The main objectives of this subcommittee are to have greater and collective regional actions on polio eradication, a more integrated approach for service delivery alongside other health programs for underserved and polio high risk areas in endemic and outbreak countries of the region and support efforts to gain access in conflict affected areas.

A first meeting of the subcommittee was held on 16 March and attended by Health Ministers or their representatives from 11 member states of the EMRO region (Afghanistan, Pakistan, Egypt, Iran, Iraq, Lebanon, Oman, Sudan, Tunis, Saudi Arabia and UAE). The meeting was hosted by the Regional Director EMRO and UNICEF Director ROSA. Health Ministers of UAE and Egypt are serving as co-chairs of this subcommittee.

Member states of the subcommittee agreed on the following areas of collaborative efforts:

* Evaluate the evolving programmatic and epidemiologic situation and determine what concrete support can be offered to Afghanistan, Pakistan and any other Member State imminently threatened or affected by a polio outbreak.
* Involve all relevant cultural, political, religious, and civil society partners as needed and requested by the affected country, and promote the political and social neutrality, as well as acceptance, of the polio eradication programme.
* Facilitate access to vaccination of all children in the Region, particularly those living in areas of conflict and insecurity.
* Promote the establishment of essential health and civic services in the multiple deprived communities where polio is entrenched.
* Encourage and support polio transition through the integration of essential polio functions and capacities into national health systems, strengthening essential immunization programmes, enhancing disease surveillance and outbreak preparedness and response capacities.
* Regularly report on outcomes and progress through the official processes of WHO governing bodies (Regional Committee, Executive Board, World Health Assembly).

Polio outbreaks

1. **Closure of all polio outbreaks should be paired with immediate action to plan and resource strengthened essential immunisation and surveillance activities.**

Leveraging the experience from Papua New Guinea and the additional resources to strengthen regional Rapid Response Teams (RRTs), the polio programme will ensure that outbreak response activities coordinate with EPI and immunization partners such as Gavi to boost essential immunization performance in outbreak and neighboring geographies between OPV rounds and following the closure of the polio outbreak.

Using the outbreak event as an opportunity to flag systemic EPI weaknesses and mobilize support from broader immunization partners, i.e., Gavi, to boost essential immunization performance and outreach vaccination including IPV, will help to ensure ‘collateral benefits’ of GPEI outbreak response expenditures.

Additionally, sufficient surveillance funding has been included in the 2021 GPEI FRR, and early versions of the new 5-year (2022-26) GPEI budget, including funding to begin a Direct Detection initiative, which should speed virus detection.

1. **A specific protocol and decision-making group should be established to advise on compliance with – or reconsider the necessity of the 12-week rule (i.e. only deploying the novel type 2 oral polio vaccine if no prior use of type 2-containing oral polio vaccines in this time period); such high-level guidance will avoid doubt and confusion in interpreting this rule; it will require important judgements on national and subnational geographies and may need scientific modelling data on the distance of monovalent oral polio vaccine- induced contiguous spread.**

For bOPV SIAs, the interval of 6 weeks is driven only by assessment of risk of recombination. So, it is primarily the understanding of how long Sabin 1,3 can be shed by vaccine recipients that has driven this interval choice. Typically, less than 10% of vaccine recipients would shed type 1 and 3 vaccine virus at 6-week post vaccination. Most of cessation of shedding takes place by 3-4 weeks.

For mOPV2 SIAs, the interval of 12 weeks is driven primarily by two factors: 1) ability to assess nOPV2 performance: given they are both type 2 vaccines, using them close to each other will confound the assessment of impact on interruption of transmission and classification of on-going isolation of type-2 viruses in cases/ES isolates – this is not relevant for bOPV SIAs and thus in that case the interval between SIAs could be shorter; and 2) assessment of recombination: Given type 2 shedding tends to be slightly longer than type 1 and 3 shedding in most circumstances – with evidence of shedding into 8-12 weeks in rare instances, the interval was chosen to be longer than what we recommended for bOPV SIAs.

Ensuring compliance with the initial use criteria that requires countries do not use nOPV2 in the same area when mOPV2 has been used within 12 weeks or a bOPV campaign has been conducted within 6 weeks is part of the nOPV2 dose release process, which is led by the OPRTT. Compliance with these criteria is a pre-requisite for releasing the nOPV2 doses to a country. Note that these specific 'waiting periods' only apply for the initial use period, after which point, they will no longer be required. An nOPV Release Group was established to make recommendations to the DG WHO on the release of nOPV. Guidance has been developed outlining the process for the release of nOPV and the TORs of the nOPV Release Group. Part of the mandate of the release group is to review a country risk assessment to determine the need to respond. The risk assessment has been modified to ensure the proposed vaccination response satisfies the initial use framework criteria (12 weeks since last mOPV2/ 6 weeks since last bOPV campaign in the same area; functioning ES site in the response area; non-Polio AFP rate in 80% of districts).

1. **The communications strategy for the rollout of the novel oral polio vaccine is crucially important; it must be fully transparent, regularly assessed against actual experience of vaccine deployment and adjusted accordingly.**

The recently formed Global Communication Group, in consultation with the nOPV2 WG, OPRTT, regional offices and field staff, has developed a comprehensive communications plan to support the rollout of nOPV2. The plan encompasses external communications and C4D and aims to create an environment that fosters vaccine uptake and instils confidence in the feasibility of eradication. The plan is being implemented and utilizes communications expertise from outside and across the partnership to achieve the following outcomes:

* + Establish common understanding of communication risks and challenges associated with the implementation of the new cVDPV2 strategy, advising GPEI on significant social barriers, risk and implications of technical decisions;
	+ Collectively identify strategic communications interventions and solutions to help ensure the successful implementation of the new cVDPV2 strategy and maintain confidence in the programme;
	+ Maintain high levels of community trust in, and acceptance of polio vaccines (including mOPV2, tOPV and nOPV2) by safeguarding against misinformation and/or backlash regarding vaccine safety and efficacy;
	+ Shape an effective and consistent global narrative that positively impacts public discourse and supports Strategy roll-out in the field.

A detailed description of the communication plan has been included in GPEI's report to the IMB.

1. **The GPEI should guide polio programmes in outbreak countries in how to deploy inactivated polio vaccine to achieve maximum population protection from paralytic polio (with a zero-tolerance philosophy towards its occurrence).**

The use of IPV in outbreak response is part of the *Strategy for the Response to Type 2 Circulating Vaccine-Derived Poliovirus, 2020–2021* and will be included in the revised version of Outbreak Response SOPs and the new GPEI 2022-2026 end-game strategy, influenced by the recent recommendations of SAGE and the Cessation Risk Task Team (CRTT). Revised versions of the SOPs and GPEI endgame strategy are expected to be completed by June 2021.