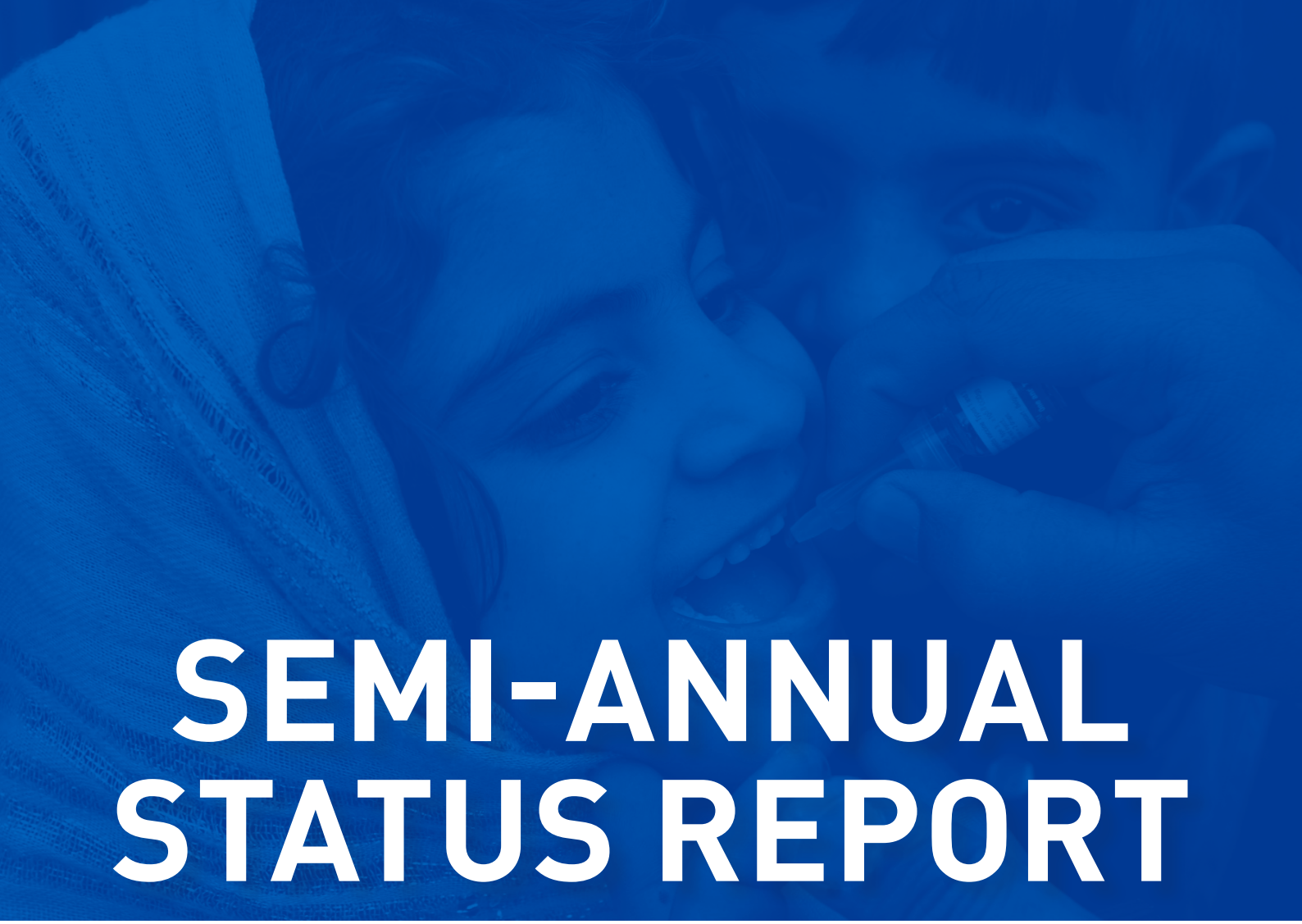


SEMI-ANNUAL STATUS REPORT

JULY TO DECEMBER 2017

PROGRESS AGAINST THE POLIO ERADICATION & ENDGAME STRATEGIC PLAN

POLIO GLOBAL ERADICATION INITIATIVE

SEMI-ANNUAL STATUS REPORT

JULY TO DECEMBER 2017

PROGRESS AGAINST THE POLIO ERADICATION & ENDGAME STRATEGIC PLAN

POLIO GLOBAL ERADICATION INITIATIVE

Published by the World Health Organization (WHO) on behalf of the Global Polio Eradication Initiative.

Suggested citation. Global Polio Eradication Initiative: Semi-annual Status Report July – December 2017, Progress against the polio Eradication & Endgame Strategic Plan. Geneva, Switzerland: World Health Organization; 2018 (WHO/Polio/18.02). Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/about/licensing.

Printed by the WHO Document Production Services, Geneva, Switzerland.

Layout by L'IV Com Sàrl, Switzerland.

Contents

Acronyms

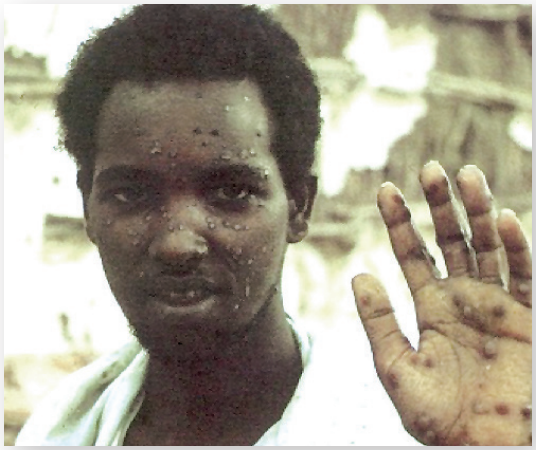
AFP	Acute flaccid paralysis
bOPV	Bivalent oral polio vaccine
CCS	Containment Certification Scheme
cVDPV	Circulating vaccine-derived poliovirus
cVDPV2	Circulating vaccine-derived poliovirus type 2
GAPIII	Third edition of the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use
GCC	Global Commission for the Certification of the Eradication of Poliomyelitis
GPEI	Global Polio Eradication Initiative
IPV	Inactivated polio vaccine
mOPV2	Monovalent oral polio vaccine type 2
OPV	Oral polio vaccine
PCS	Post-Certification Strategy
PEF	Polio Essential Facility
SAGE	Strategic Advisory Group of Experts on immunization
SIA	Supplementary immunization activity
tOPV	Trivalent oral polio vaccine
UNICEF	United Nations Children's Fund
VDPV	Vaccine-derived poliovirus
VDPV2	Vaccine-derived poliovirus type 2
WHO	World Health Organization
WPV	Wild poliovirus
WPV1	Wild poliovirus type 1
WPV2	Wild poliovirus type 2

Introduction

The Global Polio Eradication Initiative (GPEI) Polio Eradication & Endgame Strategic Plan (Endgame Plan) aims to make polio the second-ever human disease to be eradicated from the world. This document includes a detailed narrative for each of the Endgame Plan strategic objectives, broken down by geography where appropriate. The narrative is followed by a series of annexes that contain the monitoring framework indicators for endemic countries, outbreak countries and high-risk countries, and global indicators.

At the time of the GPEI's founding in 1988, polio was endemic in more than 125 countries and paralysed 350 000 children every year. Since then, the GPEI has overseen a 99% reduction in annual cases of polio. Today, only three countries remain endemic to wild poliovirus (WPV) transmission, and the world is closer than ever to being polio-free.

The strategies outlined in the Endgame Plan have brought the world to the brink of being polio-free and have set the groundwork for sustaining a polio-free world in perpetuity. The strategies remain appropriate for achieving success and will be pursued until global certification. After eradication of WPV has been certified, the Post-Certification Strategy (PCS) will guide the activities that need to be implemented and the functions that must be sustained to maintain a world free of polio. The GPEI secretariat will continue to report semi-annually and annually to all partners, stakeholders and Member States on progress towards the objectives of the Endgame Plan, until the eradication of WPV globally has been certified.



Ali Maalin, last smallpox case, Somalia, 1977

Eradicating a disease is not easy but when it is successfully achieved, something remarkable occurs. Consider that in the 20th century alone, smallpox killed more than 500 million people, all over the world. That is more than the casualties of all the wars combined (including the First and Second World Wars). But thanks to the global smallpox eradication effort, since 1977 not a single human being has been infected – or has died – due to smallpox. It is an incredible achievement and a perfect example of a sustainable and equitable global public good.

The world is attempting to achieve precisely the same feat with polio: ensuring that no child anywhere will ever again be paralysed by any poliovirus – be it wild or vaccine-derived. Humanity is closer to achieving this goal than ever before, but the unwavering commitment of every partner, every stakeholder, every donor, every political leader, and every mother and father is needed to achieve success.

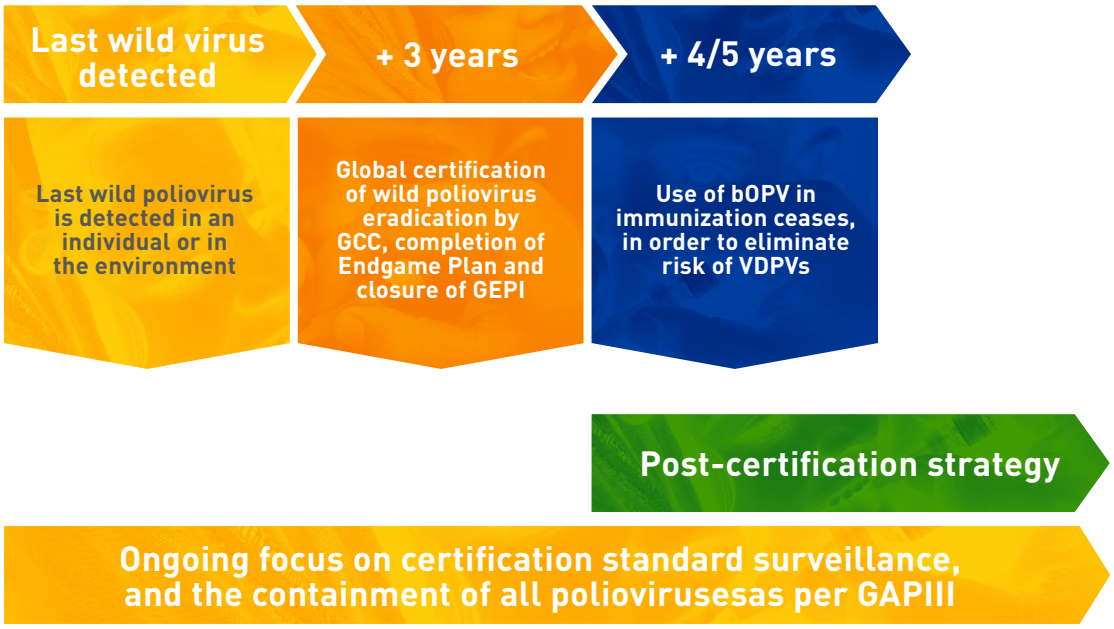
Together, let us achieve something historic: let us achieve that no person will ever again know the pain of lifelong polio paralysis.

Securing a lasting polio-free world for all generations to come – *beyond 2018...*

The strategies outlines in the Polio Eradication & Endgame Strategic Plan 2013–2018 (Endgame Plan) have brought the world to the brink of being polio-free and are appropriate to achieve a world permanently free of both wild and vaccine-derived polioviruses. The Polio Oversight Board in 2017 endorsed extending the Endgame Plan beyond 2018, to ensure ultimate and lasting success for all generations to come. Strategies of the Endgame Plan must be fully financed and implemented.

The exact date when polio will be eradicated, or indeed when it will be certified as such, is difficult to assign. However, the timeline below summarized from the Endgame Plan illustrates the major milestones that need to be met to achieve a lasting polio-free world, free of transmission of any strain of poliovirus (whether wild or vaccine-derived).

Timeline following detection of last poliovirus



Objective 1
Poliovirus detection and interruption

At a glance…

Pakistan and Afghanistan continued to intensify eradication efforts and implement their respective national emergency action plans, overseen by each country's head of state. They continued to treat the virus transmission as a single epidemiological block and focused on coordinating activities in both countries.

In Nigeria, and across the Lake Chad subregion, outbreak response persisted in response to the detection of wild poliovirus type 1 (WPV1) in Borno in August 2016, the first WPV detected in the country since 2014. It was a sobering reminder of the fragility of progress and of the dangers of subnational surveillance gaps and low-level residual transmission. Although no new cases have been reported from Nigeria since 2016, undetected ongoing transmission in the parts of Borno that remain inaccessible cannot be ruled out.

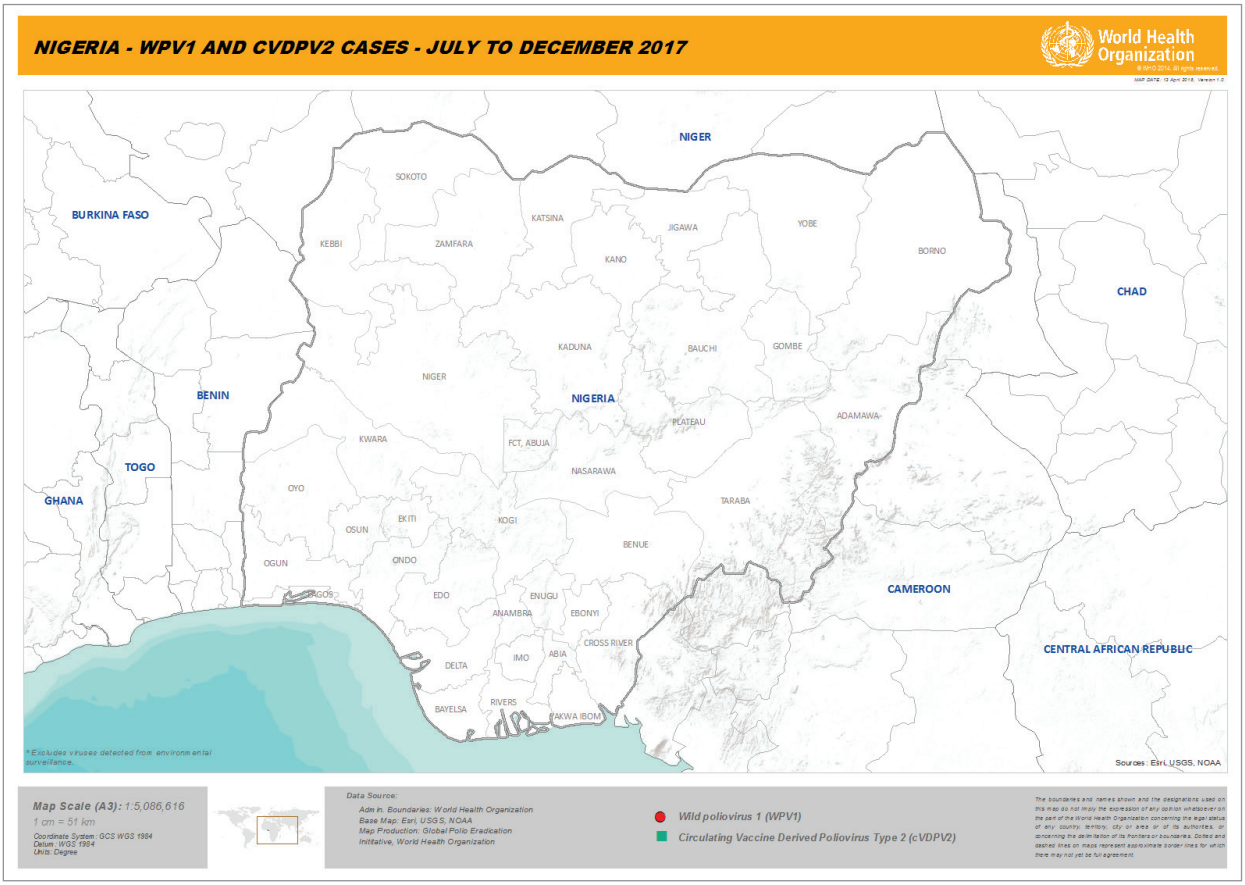
With wild polio now in fewer countries, responding to outbreaks of circulating vaccine-derived polioviruses (cVDPVs) is increasingly important to stop all types of poliovirus transmission. Circulating VDPV type 2 (cVDPV2) outbreaks were detected in 2017 in the Syrian Arab Republic and the Democratic Republic of the Congo, highlighting the dangers of this strain. Authorities in both countries immediately launched urgent action to address these outbreaks.

Recognizing that gender roles and norms, and their underpinning power relations, are powerful determinants of health outcomes, the GPEI is committed to identifying and addressing gender-related barriers to immunization and disease surveillance. The GPEI recently conducted a thorough gender analysis to identify and measure gender-related elements in its immunization, communication and disease surveillance activities. For the first time, this report provides a summary of this analysis.

Nigeria and Lake Chad subregion

In Nigeria, no new case due to WPV1 was confirmed in 2017 after the detection of cases in August 2016 from Borno state (related to a strain last detected in Borno in 2011). However, owing to ongoing surveillance gaps in high-risk and inaccessible areas, this strain's undetected and continued circulation cannot be ruled out. The Government of Nigeria continued an aggressive outbreak response, conducted in close coordination with neighbouring countries across the Lake Chad subregion, and within the context of the broader humanitarian emergency affecting the region. The lack of access and inability to conduct high-quality vaccination and surveillance in many areas of the state remained the primary challenge. A key objective was to prevent the outbreak from spreading to other areas of the region, and additional measures were implemented to both increase surveillance sensitivity and boost immunity levels. They included scaling up environmental surveillance; testing healthy individuals (including adults) as they exited inaccessible areas; establishing permanent vaccination posts to vaccinate children and older age groups at key crossing points to inaccessible areas; and rapidly conducting mop-up immunization campaigns as and when windows of opportunity arose or areas became accessible.

The regional response was coordinated through a joint partnership with the Lake Chad Coordination mechanism, based in N'Djamena, Chad. Bringing together all partners, notably the ministries of health and the implementing partners (WHO and UNICEF), this coordination



aimed to support the planning, implementation and monitoring of plans across the region, strengthen surveillance and improve the quality of supplementary immunization activities (SIAs). It facilitated cross-border collaboration and actions, and helped to address specific challenges facing the programme, including reaching populations in difficult-to-access areas, displaced populations and populations on the move.

The focus was to maintain the multinational, regional outbreak response across the Lake Chad subregion, identify and fill remaining gaps, including on surveillance and SIA operations, and provide substantial epidemiological evidence of the current status of polio transmission (or its cessation).

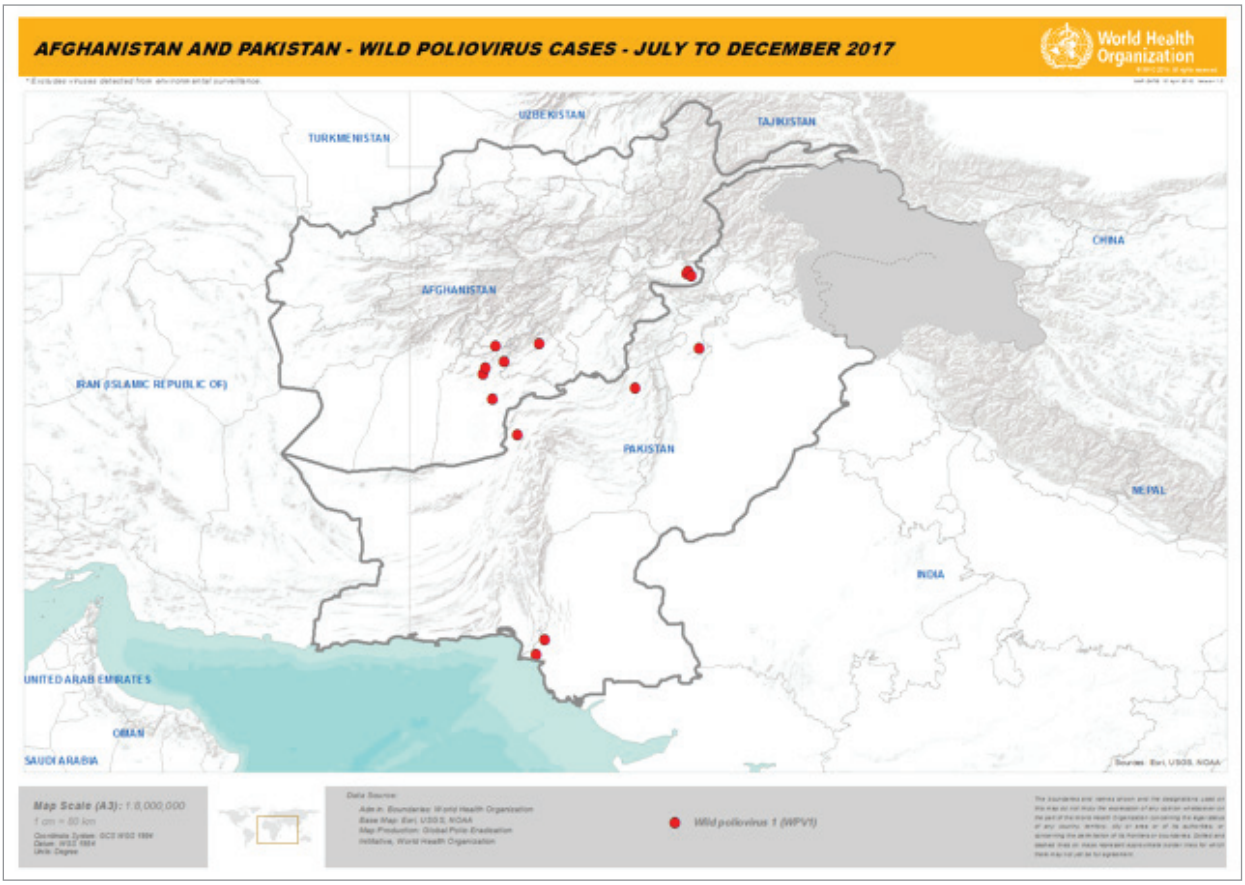
Afghanistan and Pakistan

Afghanistan and Pakistan continued to be treated as a single epidemiological block. In 2017, eight cases of paralytic poliomyelitis due to WPV1 were reported in Pakistan, compared to 20 in 2016. In Afghanistan, 14 cases were reported, compared to 13 in 2016. The two countries continued to demonstrate strong commitment, and independent technical advisory groups underscored the feasibility of rapidly interrupting remaining strains of transmission. Realizing that goal, however, will depend on reaching all missed children. Both countries continued to coordinate activities closely, focusing their efforts on clearly identifying missed children, determining why they were missed, and putting in place operational plans to

overcome these challenges. In particular, emphasis was placed on reaching highly mobile population groups, travelling both internally within both countries and across the border. Virus transmission was shown to be primarily restricted to cross-border corridors linking eastern Afghanistan with Khyber Pakhtunkhwa and Federally Administered Tribal Areas in Pakistan, and southern Afghanistan (Kandahar and Helmand) with Quetta, Balochistan and Karachi, Sindh. Programme coordination continued to improve in 2017 at the national and provincial/regional levels, as well as among the bordering districts in the common corridors of transmission, with focus on the vaccination of high-risk mobile populations and those living along the border. At the same time, polio-free areas of both countries needed to maintain strong levels of immunity and surveillance.

Environmental surveillance in both countries confirmed the risk of ongoing virus transmission to polio-free areas, imported from remaining reservoir areas. Of particular concern was Karachi (Pakistan), given the ongoing detection of positive environmental samples and confirmation of a case of paralytic poliomyelitis due to WPV in August 2017, the first in greater Karachi since January 2016.

Both Afghanistan and Pakistan adjusted and fine-tuned their national emergency action plans for polio eradication, building on the lessons learned and concentrating on improving programme operations during the low-transmission season (October to May). The updated plans placed particular emphasis on the Quetta block, Karachi and Rawalpindi/ Islamabad in Pakistan, and southern and

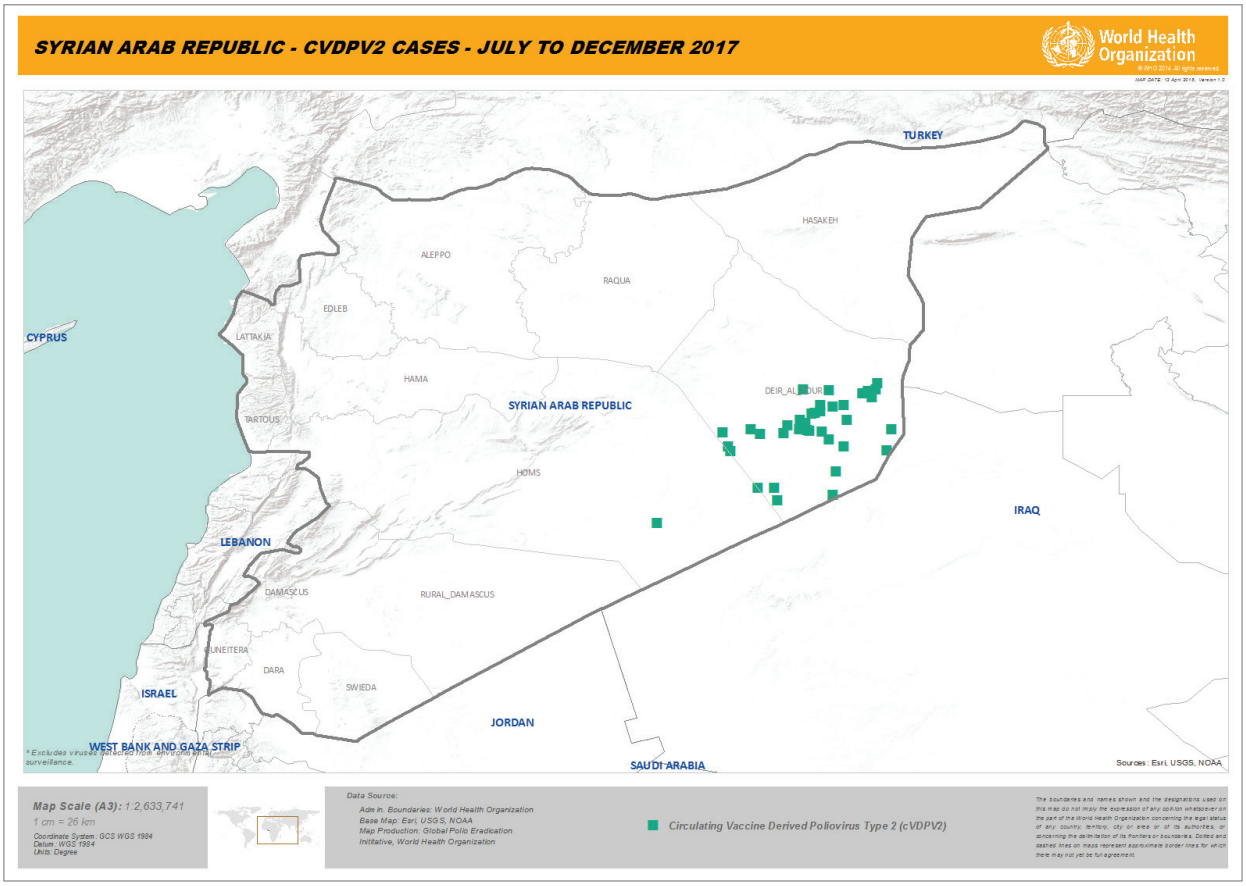


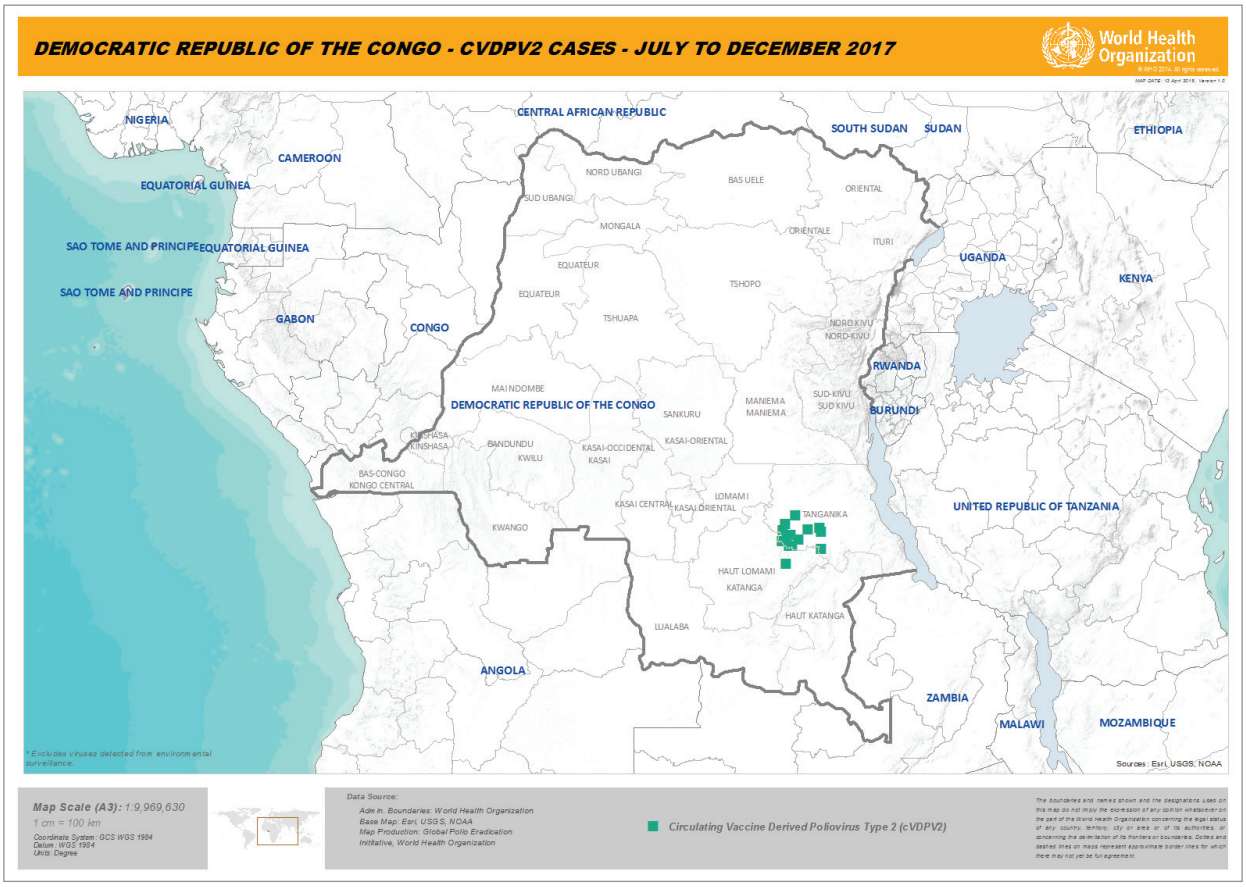
eastern Afghanistan. Consistently reaching and vaccinating high-risk mobile population groups remained essential for Afghanistan and Pakistan, in order to interrupt transmission over the coming months. Another factor critical to achieving success was sustaining continued effective leadership at all levels in both countries..

Circulating vaccine-derived poliovirus transmission

In 2017, two countries were affected by cVDPV2: the Syrian Arab Republic and the Democratic Republic of the Congo, with 74 and 22 cases reported from these countries, respectively.

In the Syrian Arab Republic, the bulk of cases were from Mayadin district, Deir-Ez-Zor governorate, the epicentre of the outbreak, with Raqqa and Homs also affected. Two vaccination campaigns were conducted in mid-2017, using both monovalent oral polio vaccine type 2 (mOPV2) and inactivated polio vaccine (IPV). To mitigate the risk of further spread from the outbreak zone to neighbouring areas and countries, the north-west of the Syrian Arab Republic, Turkey and Lebanon received additional IPV doses for targeted use in high-risk populations, and Iraq conducted immunization activities with IPV in vulnerable populations. Outbreak response was conducted in the context of the broader humanitarian emergency. During one of the campaigns, for example, water purification tablets were distributed to more than 400 000 people. No new cases were detected in the country after September 2017.





In the Democratic Republic of the Congo, cVDPV2 cases totalled 22 in 2017, in two separate outbreaks: in Haut-Lomami province (with spread to Tanganyika province), and in Maniema province. An outbreak response was launched that included the use of mOPV2 in line with internationally-agreed outbreak response protocols. However, operational gaps in quality hampered implementation, as high-risk populations remained under-immunized. The most recent case was reported in December 2017, strongly suggesting that outbreak response intensification in 2018 is urgently needed. In early 2018, the government declared cVDPV2s to be a national public health emergency, a clear statement of commitment to address and fill residual operational gaps in quality.

International Public Health Emergency of International Concern

Countries remained on full alert, as per the Temporary Recommendations of the Emergency Committee under the International Health Regulations, which concluded in November 2017 that the current epidemiological situation continued to constitute a Public Health Emergency of International Concern.

Gender

Gender roles and norms, and their underpinning power relations, are powerful determinants of health outcomes. To reach every last child and achieve a polio-free world, the GPEI remained committed to identifying and addressing

gender-related barriers to immunization and disease surveillance.

The GPEI recently conducted a thorough gender analysis that identified and measured gender-related elements in its immunization, communication and disease surveillance activities. The Gender Technical Brief analysed the ways in which the gender of the child, caregiver and front-line worker influenced the likelihood that a child is immunized against polio. Its specific focus was on the gendered determinants of immunization in the GPEI's 16 priority countries.

To ensure equal access to vaccinations and the engagement of women, four gender-sensitive indicators were developed to monitor progress:

1. Girls and boys reached in vaccination campaigns

The indicator compared the percentage of girls and boys vaccinated after an immunization campaign, recorded from lot quality assurance sampling and post-campaign monitoring data.

2. Total doses received

The total number of doses received was recorded for children aged 6–59 months in acute flaccid paralysis (AFP) case data. The dosage count is an additional measure to assess children's overall participation in vaccination campaigns or routine immunization. Gender comparisons were made for the median number of doses, the percentage of zero doses, and the percentage of three or more doses.

3. Disease surveillance timeliness

The AFP case data included information on the date of onset of paralysis and the date of notification by the caregiver(s). The notification delay was calculated from the difference in days between onset and notification. This measure showed whether the child's gender biased how quickly his or her disease was notified within the surveillance system. Timeliness was assessed by comparing median values and by the percentage of male and female cases notified within three days.

4. Women's participation in immunization activities

The indicator measured the percentage of women and men front-line workers, including all vaccinators and social mobilizers.

Annex 1 includes data on these four indicators for the endemic countries while Annex 2 contains data for outbreak and high-risk countries for indicators 2 and 3. Statistical testing and analysis of the data from the reporting period does not show significant differences in terms of gender for most countries, either for children reached in vaccination campaigns or for surveillance data. However, data in Syria shows that the percentage of 0 doses was 27% for girls while it was 15% for boys, and similarly, 72% of boys surveyed had received three or more doses, compared to only 32% of girls. For Central African Republic (CAR), 96% of boys surveyed had received three or more doses, compared to only 74% of girls during the second half of 2017. In CAR, disease notification within 3 days was 24% for girls, compared to 38% of boys. Gender differences in the timeliness of surveillance were also noted in Cote d'Ivoire, Ukraine, Sierra Leone and Mali. The programme continues to closely monitor the data for these countries and investigate significant findings to guide its work.

Endemic countries continue to engage female frontline workers in immunization activities, and women currently constitute 56% of frontline workers, including vaccinators and social mobilizers, in Pakistan and over 90% in Nigeria. In Afghanistan, currently 13% of frontline workers are women, while the figure is 42% in the country's urban areas.

Objective 2
Phased removal of oral polio vaccines

At a glance…

A major achievement in the last two years was the largest globally-synchronized vaccine roll-out in history, which took place over a two-week period at the end of April 2016, when the type 2 component of oral polio vaccine (OPV) was removed in 155 countries and territories around the world through the switch from trivalent OPV (tOPV) to bivalent OPV (bOPV). Active surveillance continued for type 2 virus from any source, while data indicated this strain had almost completely disappeared worldwide. Two outbreaks of cVDPV2 were detected in the Syrian Arab Republic and the Democratic Republic of the Congo, but these outbreaks were seeded prior to the switch.

Globally, the GPEI continued to face a shortage of IPV, but the supply situation markedly improved; all 35 countries that experienced delayed delivery or for which supply was interrupted should be supplied during the first half of 2018. The global IPV supply situation was also partly mitigated by Member States, which increasingly adopted and implemented a fractional dose schedule, as recommended and endorsed by the Strategic Advisory Group of Experts on immunization (SAGE).

Following the declaration of global eradication of wild poliovirus type 2 (WPV2) in September 2015, all countries switched from the trivalent formulation of OPV (containing all three serotypes of poliovirus), to the bivalent formulation (containing type 1 and 3 serotypes, but not type 2) during the second half of April 2016. The switch involved 155 countries and territories in total and was expected to lead to significant public health benefits; almost 40% of all vaccine-associated paralytic poliomyelitis cases (approximately 200 cases per year) and 90% of cVDPV outbreaks over the past 10 years were associated with the type 2 component of tOPV. These cases should no longer occur. Efforts endured to conduct surveillance for any new emergence of cVDPV2 (as evidenced by the new outbreaks in the Syrian Arab Republic and the Democratic Republic of the Congo), maintain strong outbreak response capacity with mOPV2, and ensure that no residual tOPV use remained anywhere.

To prepare for the switch to bOPV, all countries had committed to introducing at least one dose of IPV into their routine immunization programmes. A global supply constraint, which had emerged due to technical difficulties manufacturers had encountered to scale up production, resulted in some countries experiencing delays in supply. Based on the manufacturers' current projections, all countries that previously experienced delays should receive supply by the first half of 2018. During the period of shortage, this vaccine's available supply was prioritized to routine immunization in areas at highest risk of VDPV2 outbreaks (Tier 1 and 2 countries). The GPEI continued to explore with Member States and WHO regional offices the feasibility of instituting dose-sparing strategies, such as using intradermal fractional dose IPV, as recommended by the SAGE. Member States were increasingly adopting this approach, notably Bangladesh, India, Sri Lanka and countries across the Region of the Americas. This approach helped to ensure that sufficient quantities of the vaccine were available for continued vaccination of the respective birth cohorts.

Following global certification of WPV eradication, bOPV will be withdrawn from routine immunization programmes, thereby eliminating the long-term risks of any VDPV.

Objective 3
Containment and certification

At a glance…

To minimize the facility-associated risk of poliovirus release into the environment that could lead to outbreaks, Member States intensified their efforts to ensure the identification of unneeded materials and prioritize their destruction. Countries that need to retain poliovirus to sustain critical national or international functions must officially establish national authorities for containment and initiate the containment certification process of their designated poliovirus-essential facilities (PEFs).

With fewer cases of WPV reported from fewer countries than ever before, the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC) accelerated its work to prepare for the eventual certification of WPV eradication worldwide. As part of this process, the GCC faced two important and challenging tasks: obtaining and evaluating convincing evidence of the interruption of poliovirus transmission and evidence of poliovirus containment to a high level where they are being held.

Containment

Implementation efforts to contain WPV2 in laboratories progressed in 2017, guided by the *WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use* (GAPIII). The *Guidance for non-poliovirus facilities to minimize risk of sample collections potentially infectious for polioviruses* was being finalized to support last steps in the identification and destruction of remaining type 2 polioviruses or their transfer to certified PEFs and retention there. The GCC accepted responsibility for global containment oversight following the *Containment Certification Scheme to support the WHO Global Action Plan for Poliovirus Containment* (GAPIII-CCS). A Containment Advisory Group was established to address technical issues related to GAPIII and amendments were recommended. The secretariat supported strengthening the technical capacity of the national authorities for containment by training auditors in GAPIII and CCS.

The current priority remained to contain type 2 viruses in such facilities. WHO provided support to Member States in their efforts to ensure the appropriate containment of polioviruses and thus to maintain eradication status. Numerous countries (29) declared hosting an excessive number of facilities (91) and the desire to continue to retain poliovirus. These 29 countries represent 52% of the global birth cohort (2017).

The continued focus in 2017 was to:

- complete inventories of all poliovirus type 2 materials;
- prioritize the destruction of unneeded poliovirus type 2 materials;
- officially establish national authorities for containment, and initiate the containment certification process of designated PEFs; and
- begin the inventories of poliovirus types 1 and 3 as soon as possible.

To further intensify global containment efforts, the GPEI secretariat made plans to present a resolution for consideration to the World Health Assembly in May 2018, seeking international consensus on an intensification of this area of work.

Certification

With fewer cases of WPV reported from fewer countries than ever before, the GCC accelerated its work to prepare for the eventual certification of WPV eradication worldwide.

As part of this process, the GCC faced two important and challenging tasks:

- obtaining and evaluating convincing evidence of the interruption of poliovirus transmission; and
- obtaining and evaluating evidence of polioviruses containment to a high level where they are being held.

Discussions focused on reviewing regional progress in the remaining endemic regions of Africa and the Eastern Mediterranean; defining the parameters that will be used for certification; discussing surveillance requirements, including in settings requiring additional data such as conflict settings; and evaluating the requirements for safely containing polioviruses in laboratory settings.

While global certification continued to apply mainly to WPV eradication, it was agreed that a process to verify the elimination of VDPVs was also needed. Discussions of what that process will look like continued. VDPV elimination will occur after the global withdrawal of all OPV, which should be completed one to two years after global certification of WPV eradication.

The GCC stayed independent of WHO and of involvement in national polio vaccination implementation or polio surveillance programmes. WHO regions are eligible for certification following the absence of WPV from any country and any population source in each region in the presence of certification-standard surveillance. Regional certification is conducted by Regional Certification Commissions. Global certification will follow the successful certification of all six WHO regions, and will be conducted by the GCC.

To date, four regions have been certified as free of WPVs: the Region of the Americas (1994), the Western Pacific Region (2000), the European Region (2002) and the South-East Asia Region (2014).

Objective 4

Transition planning and post-certification strategy

At a glance…

With WPV transmission at its lowest levels ever, WHO Member States and partners continued to discuss measures needed not only to achieve eradication but to sustain it in the long term. The strategic functions that must be sustained to ensure that once polio is eradicated it will *remain* eradicated are outlined in the draft Post-Certification Strategy. At the same time, Member States continued to review progress towards transition planning, aimed at ensuring that the infrastructure established to eradicate polio will continue to benefit broader public health and development goals, even after the disease is gone. A strategic action plan, including estimated costs of what is needed to keep the world polio-free and sustain progress in other areas, such as immunization, emergency preparedness and response capacity, was being developed based on guidance from the Executive Board for presentation to the World Health Assembly in May 2018.

Post-Certification Strategy

Based on guidance and requests from Member States, the GPEI partnership developed the PCS to define the technical standards and guidance for the essential functions required to sustain a polio-free world. The three goals of the PCS are to:

- contain polioviruses
- protect populations
- detect and respond to polioviruses.

To achieve these objectives, essential functions must be upheld, including the ongoing ability to maintain population immunity, conduct disease surveillance, enable outbreak response should it be needed, and contain polioviruses in facilities retaining stock.

The PCS was developed in broad consultation for presentation to the World Health Assembly in May 2018.

Transition planning

The polio eradication infrastructure has always contributed to broader public health and humanitarian goals, including routine immunization strengthening, the surveillance of other vaccine-preventable diseases, outbreak response support, as well as humanitarian emergency response support. It is critical to sustain these gains and ensure that the infrastructure established to eradicate polio contribute to broader health goals.

Most resources, staff and infrastructure remained concentrated in the 16 priority countries in sub-Saharan Africa, the Middle East and South-East Asia, which were the main focus of country-level planning. Of 19.5 million infants worldwide not immunized through routine services, 60% live in these 16 countries and almost 90% of deaths from measles globally occur in them. Ten of these 16 countries continue to be prone to regular outbreaks or complex health emergencies. The risks therefore are significant, unless the world maintains investment in strengthening these countries' immunization systems.

Of the 16 countries, 12 developed draft national transition plans. These plans clearly indicate in which national health priorities governments want to integrate their polio assets. They also lay out the governments' capacity to take

over. In almost all countries, strengthening immunization systems and vaccine preventable disease surveillance was a top priority.

Polio transition remained a key priority for WHO at its three levels. WHO's vision for polio transition consists of three closely interlinked pillars:

1. to ensure a polio-free world will be sustained
2. to invest in strengthening immunization systems
3. to strengthen emergency preparedness and response capacity.

It remained critical that specific funding requirements to sustain these three pillars be aligned with WHO's Global Programme of Work as of 2020/2021. The World Health Assembly in May 2018 will present a unique opportunity for all countries, partner organizations and stakeholders to endorse WHO's vision on polio transition and ensure that all partners, stakeholders and countries move forward together in a concerted manner.

Financing the global polio eradication initiative

At a glance…

Thanks to generous commitments by partners around the world, including new commitments made at the Rotary International convention in June 2017, the GPEI received contributions, pledges and other commitments that fully fund the US$ 7 billion budget estimated to be needed for the period through 2019. However, it is critical that donors monetize their pledges and commitments in a timely manner to ensure smooth, uninterrupted programme operations.

Efforts continued to make sure that the current US$ 7 billion budget stretch as much as possible into 2020, by ensuring the programme is managed and operates in the most cost-effective manner possible while responsibly managing risks. Budget reviews, risk assessments and prioritizations remained part of this process. Based on evolving epidemiology, the GPEI will further refine/update the budget for 2019/2020 in mid-2018.

Thanks to the generous continuing support of the international development community, including Member States (especially the countries where poliomyelitis is endemic and the generous donors to the GPEI) as well as multilateral and bilateral organizations, development banks, foundations and Rotary International, the budget for 2017 for planned activities was fully financed. At an extraordinary pledging moment at the Rotary International convention in June 2017 in Atlanta, USA, numerous public- and private-sector partners from around the world joined Rotary in announcing new commitments, bringing total pledges against the additional US$ 1.5 billion budget validated by the Polio Oversight Board to US$ 1.2 billion. Major new pledges announced in Atlanta included US$ 450 million from the Bill & Melinda Gates Foundation, US$ 150 million from Rotary International, Can$ 100 million from the Government of Canada, €55 million from the European Commission, US$ 30 million from the United Arab Emirates and Aus$ 18 million from Australia. Since the pledging moment in June 2017, the global community made significant additional pledges, commitments and contributions, including by the United Kingdom, New Zealand, Germany, Japan, the United States and Liechtenstein. To ensure achieving and maintaining a polio-free world, the GPEI will continue to mobilize additional commitments. In the second half of 2018, the GPEI will evaluate various budget scenarios to ascertain the impact of ongoing poliovirus transmission on the financial requirements to achieve global certification.

WHO, Rotary International, the US Centers for Disease Control and Prevention, UNICEF, the Bill & Melinda Gates Foundation and Gavi, the Vaccine Alliance, stand ready to continue to support Member States in their efforts to fully implement the Endgame Plan, thereby securing a lasting polio-free world for all generations to come.

AFGHANISTAN

Endemic Country	State/Area	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Afghanistan	Southern (Kandahar, Helmand)	Interrupt transmission	Number of cases	0 case	4	5	
		High population immunity	% 0-dose	<10%	0.74%	0.69%	
			LQAS (% lots with "High Pass")	>= 90%	N/a	N/a	
			% inaccessible	<5%	N/a	N/a	
			Number and type of activity	per plan	2 NIDs, 5 SNIDs	2 NIDs, 6 SNIDs	
			% children missed due to no visit/child absent (in 11 LPDs)		TBC	TBC	
			% children missed due to refusal (in 11 LPDs)		TBC	TBC	
		High virus detection	AFP rate	> 2 per 100 000	18.9	21.4	
			Stool adequacy	> 80%	86.01	88.13	
			Lab receipt to virus isolation result (median)	< 14 days	11	11	
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a	
	Rest of country	Interrupt transmission	Number of cases	0 case	1	3	
		High population immunity	% 0-dose	<10%	0.41%	0.13%	
			LQAS (% lots with "High Pass")	>= 90%	N/a		
			% inaccessible	<5%	N/a	N/a	
			Number and type of activity	per plan	2 NIDs,4 SNIDs	2 NIDs,4 SNIDs	
		High virus detection	AFP rate	> 2 per 100 000	17.2	17.5	
			Stool adequacy	> 80%	93.71	95.94	
			Lab receipt to virus isolation result (median)	< 14 days	12	12	
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC		
	All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a	
			IPV introduction	intro by 2015	Yes (Sep-15)	Yes (Sep-15)	
		Monitoring of gender equality and women's engagement				**F**	**M**
		Equal reach in immunization campaigns	% F/M vaccinated	ns		91.9%	92.5%
		Equal doses received	Median # doses F/M	ns		13	13
			% F/M 0-dose	ns		0.22%	0.7%
			% F/M 3+ doses	ns		98.89%	97.55%
		Equal timeliness of disease notification	Median # days disease notification	ns		3	3
			% F/M <= 3 days	ns		56.02%	58.49%
		Women's participation in immunization campaigns	% F/M frontline workers in urban areas	Women > 50%		42.7%	57.3%

ns: Refers to achieving a non-significant result in terms of gender differences.

PAKISTAN

Endemic Country	State/Area	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017
Pakistan	KP (Peshawar, Nowshera, Swabi, Charsaddah, Mardan, Bannu, Tank, Lakki Marwat)	Interrupt transmission	Number of cases (WPV1 only)	0 case	0	1
		High population immunity	% 0-dose	<10%	0.31%	0.73%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 4 SNIDs	2 NIDs, 5 SNIDs
			% children missed due to no visit/child absent		TBC	TBC
			% children missed due to refusal		TBC	TBC
		High virus detection	AFP rate	> 2 per 100 000	17.47	22.54
			Stool adequacy	> 80%	82.27	83.76
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	FATA	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	0	0
		High population immunity	% 0-dose	<10%	0.00%	0.43%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 3 SNIDs	2 NIDs, 4 SNIDs
			% children missed due to no visit/child absent		TBC	TBC
			% children missed due to refusal		TBC	TBC
		High virus detection	AFP rate	> 2 per 100 000	35.61	41.65
			Stool adequacy	> 80%	86.89	89.33
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

PAKISTAN, continued

Endemic Country	State/Area	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017
Pakistan	Karachi (SINDH)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	0	0
		High population immunity	% 0-dose	<10%	0.28%	64.00%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	3 NIDs, 3 SNIDs	2 NIDs, 5 SNIDs
			% children missed due to no visit/child absent		TBC	TBC
			% children missed due to refusal		TBC	TBC
		High virus detection	AFP rate	> 2 per 100 000	12.17	12.8
			Stool adequacy	> 80%	90.16	84.3
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases (WPV1 only)	0 case	3	2
		High population immunity	% 0-dose	<10%	0.41%	1.46%
			LQAS (% UCs w/ 0-3 missed children; i.e. "Pass")	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs, 6 SNIDs	2 NIDs, 6 SNIDs
		high virus detection	AFP rate	> 2 per 100 000	11.1	11.6
			Stool adequacy	> 80%	88.38	86.2
			Lab receipt to virus isolation result (median)	< 14 days	11	11
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	0% reduction (2015 vs 2014)	0% reduction (2015 vs 2014)
	All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a
			IPV introduction	intro by 2015	Yes (Jul-15)	Yes (Jul-15)

PAKISTAN, continued

Endemic Country	State/Area	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
		Monitoring of gender equality and women's engagement				F	M
Pakistan		Equal reach in immunization campaigns	% F/M vaccinated	ns		85.5%	85.7%
		Equal doses received	Median # doses F/M	ns		10	10
			% F/M 0-dose	ns		1.15%	1.16%
			% F/M 3+ doses	ns		98.35%	98.42%
		Equal timeliness of disease notification	Median # days disease notification	ns		3	3
			% F/M <= 3 days	ns		51.46%	53.73%
		Women's participation in immunization campaigns	% F/M frontline workers	Women > 80%		55.8%	44.2%

ns: Refers to achieving a non-significant result in terms of gender differences.

NIGERIA

Endemic Country	State/Area	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017
Nigeria	North Central (Kano, Katsina, Jigawa, Kaduna)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	0	0
		High population immunity	% 0-dose	<10%	0.06%	0.46%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs 2 SNIDs	2 SNIDs
			% children missed due to no visit/child absent		TBC	TBC
			% children missed due to refusal		TBC	TBC
		High virus detection	AFP rate	> 2 per 100 000	29.14	23.55
			Stool adequacy	> 80%	98.98	97.15
			Lab receipt to virus isolation result (median)	< 14 days	10	10
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Northeast (Borno, Yobe)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	0	0
		High population immunity	% 0-dose	<10%	1.30%	0.66%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs 2 SNIDs	3 SNIDs
			% children missed due to no visit/child absent		TBC	TBC
			% children missed due to refusal		TBC	TBC
		High virus detection	AFP rate	> 2 per 100 000	36.27	31.75
			Stool adequacy	> 80%	93.27	93.72
			Lab receipt to virus isolation result (median)	< 14 days	9	9
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

NIGERIA, continued

Endemic Country	State/Area	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017
Nigeria	Rest of North (Sokoto, Kebbi, Zamfara)	Interrupt transmission	Number of cases	0 case	0	0
		High population immunity	% 0-dose	<10%	0%	0.48%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs 3 SNIDs	3 SNIDs
			% children missed due to no visit/child absent		TBC	TBC
			% children missed due to refusal		TBC	TBC
		High virus detection	AFP rate	> 2 per 100 000	39	20.66
			Stool adequacy	> 80%	99.9	99.46
			Lab receipt to virus isolation result (median)	< 14 days	9	9
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
	Rest of country	Interrupt transmission	Number of cases (cVDPV2 only)	0 case	0	0
		High population immunity	% 0-dose	<10%	0.20%	0.17%
			LQAS	>= 90%	N/a	N/a
			% inaccessible	<5%	N/a	N/a
			Number and type of activity	per plan	2 NIDs 2 SNIDs	3 SNIDs
		High virus detection	AFP rate	> 2 per 100 000	22.7	16.59
			Stool adequacy	> 80%	99.09	98.53
			Lab receipt to virus isolation result (median)	< 14 days	9	9
		Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	14% reduction (2015 vs 2014)	14% reduction (2015 vs 2014)
	All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a
			IPV introduction	intro by 2015	Yes (Feb-15)	Yes (Feb-15)

NIGERIA, continued

Endemic Country	State/Area	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
		Monitoring of gender equality and women's engagement				F	M
Nigeria		Equal reach in immunization campaigns	% F/M vaccinated	ns		96.7%	96.4%
		Equal doses received	Median # doses F/M	ns		12	12
			% F/M 0-dose	ns		0.09%	0.2%
			% F/M 3+ doses	ns		99.44%	99%
		Equal timeliness of disease notification	Median # days disease notification	ns		5	5
			% F/M <= 3 days	ns		38.23%	37.44%
		Women's participation in immunization campaigns	% F/M frontline workers	Women > 80%		NA	NA

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Angola	High population immunity	% 0-dose	<10%	9.86%	4.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID	N/a	
	High virus detection	AFP rate (national)	>2	4.22	3.06	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	94%	89%	
		Stool adequacy (national)	>=80%	97.89	97.7	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	94%	
		Lab receipt to virus isolation result (median)	< 14 days	10	10	
		Environmental surveillance	Yes or No	Yes	Yes	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	2% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	N/a	N/a	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		3	3
		% F/M 0-dose	ns		4.88	3.51
		% F/M 3+ doses	ns		73.17	82.46
	Equal timeliness of disease notification	Median # days disease notification	ns		3	5
		% F/M <= 3 days	ns		47.44	32.63

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Benin	High population immunity	% 0-dose	<10%	0.00%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID	1 NID, 1 SNID	
	High virus detection	AFP rate (national)	>2	4.36	4.54	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	83%	
		Stool adequacy (national)	>=80%	90.29	97.25	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	83%	92%	
		Lab receipt to virus isolation result (median)	< 14days	8	8	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	17% (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Aug-15)	Yes (Aug-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		4	4
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		96	92.59
	Equal timeliness of disease notification	Median # days disease notification	ns		6	7
		% F/M <= 3 days	ns		25.49	25.42

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Burkina Faso	High population immunity	% 0-dose	<10%	1.12%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	N/a	N/a	
	High virus detection	AFP rate (national)	>2	3.39	3.88	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	85%	92%	
		Stool adequacy (national)	>=80%	89.51	91.52	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	92%	100%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a	
		IPV introduction	intro by 2015	N/a	N/a	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		6	6
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		98.11	94.92
	Equal timeliness of disease notification	Median # days disease notification	ns		3	3
		% F/M <= 3 days	ns		50.7	59.57

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Cameroon (Most recent case 9 July 2014)	High population immunity	% 0-dose	<10%	1.42%	0.34%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID, 2 SNIDs	2 SNIDs	
	High virus detection	AFP rate (national)	>2	8.59	9.26	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%	
		Stool adequacy (national)	>=80%	86.62	90.08	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	80%	90%	
		Lab receipt to virus isolation result (median)	< 14 days	10	10	
		Environmental surveillance	Yes or No	Yes	Yes	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC		
		IPV introduction	intro by 2015			
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		6	6
		% F/M 0-dose	ns		3.08	1.21
		% F/M 3+ doses	ns		95.38	90.3
	Equal timeliness of disease notification	Median # days disease notification	ns		4	4
		% F/M <= 3 days	ns		41.67	40.41

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Central African Republic	High population immunity	% 0-dose	<10%	4.00%	2.38%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs	1 NID, 1 SNID	
	High virus detection	AFP rate (national)	>2	9.5	7.08	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	86%	
		Stool adequacy (national)	>=80%	89.36	89.86	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	86%	86%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	1% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Sep-15)	Yes (Sep-15)	
	Gender-sensitive Indicators				F	M
	Equal doses received	Median # doses F/M	ns		4	5
		% F/M 0-dose	ns		5.26	0
		% F/M 3+ doses	ns		73.68	95.65
	Equal timeliness of disease notification	Median # days disease notification	ns		6	5
		% F/M <= 3 days	ns		23.53	38.46

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Chad	High population immunity	% 0-dose	<10%	3.45%	2.16%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs, 2 SNIDs	1 NID, 1 SNID	
	High virus detection	AFP rate (national)	>2	8.74	11.7	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	67%	
		Stool adequacy (national)	>=80%	90.6	90.59	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	89%	92%	
		Lab receipt to virus isolation result (median)	< 14 days			
		Environmental surveillance	Yes or No	Yes	Yes	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	17% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Aug-15)	Yes (Aug-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		5	5
		% F/M 0-dose	ns		2.72	1.54
		% F/M 3+ doses	ns		89.12	94.62
	Equal timeliness of disease notification	Median # days disease notification	ns		5	5
		% F/M <= 3 days	ns		32.18	30.69

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Congo	High population immunity	% 0-dose	<10%	12.12%	20.69%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NIDs	n/a	
	High virus detection	AFP rate (national)	>2	5.34	5.63	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	91%	91%	
		Stool adequacy (national)	>=80%	92.73	94.92	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	100%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	50% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	N/a	N/a	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		4	3
		% F/M 0-dose	ns		33.33	11.76
		% F/M 3+ doses	ns		66.67	64.71
	Equal timeliness of disease notification	Median # days disease notification	ns		4	2
		% F/M <= 3 days	ns		46.67	71.88

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Côte d'Ivoire	High population immunity	% 0-dose	<10%	1.56%	2.94%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID	1 sNID	
	High virus detection	AFP rate (national)	>2	4.1	3.21	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	35%	
		Stool adequacy (national)	>=80%	95.14	91.16	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	94%	55%	
		Lab receipt to virus isolation result (median)	< 14 days		8	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	38% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Jun-15)	Yes (Jun-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		3	3
		% F/M 0-dose	ns		4.76	1.67
		% F/M 3+ doses	ns		76.19	76.67
	Equal timeliness of disease notification	Median # days disease notification	ns		6	3
		% F/M <= 3 days	ns		32.79	54.02

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Democratic Republic of the Congo	High population immunity	% 0-dose	<10%	2.52%	3.60%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID, 3 SNIDs	7 SNIDs	
	High virus detection	AFP rate (national)	>2	5.39	6.60	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	92%	100%	
		Stool adequacy (national)	>=80%	87.14	84.77	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	81%	77%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	3% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Apr-15)	Yes (Apr-15)	
	Gender-sensitive Indicators				F	M
	Equal doses received	Median # doses F/M	ns		4	4
		% F/M 0-dose	ns		4.23	3.2
		% F/M 3+ doses	ns		79.8	81.6
	Equal timeliness of disease notification	Median # days disease notification	ns		5	5
		% F/M <= 3 days	ns		34.5	34.16

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Equatorial Guinea (Most recent case 3 May 2014)	High population immunity	% 0-dose	<10%	60%	0%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	N/a	1 NID	
	High virus detection	AFP rate (national)	>2	3.75	3.69	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	57%	57%	
		Stool adequacy (national)	>=80%	66.67	50	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	75%	25%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC		
		IPV introduction	intro by 2015			
	Gender-sensitive Indicators*				**F**	**M**
	Equal doses received	Median # doses F/M	ns		4	3
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		66.67	66.67
	Equal timeliness of disease notification	Median # days disease notification	ns		41	7
		% F/M <= 3 days	ns		33.33	0

*Where there were less than 10 observations, data has not been tested for statistical significance.
ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Ethiopia (Most recent case 5 January 2014	High population immunity	% 0-dose	<10%	0.43%	1.33%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	NA	2 SNIDs	
	High virus detection	AFP rate (national)	>2	2.7	2.52	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	73%	72%	
		Stool adequacy (national)	>=80%	92.69	91.98	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	100%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	62% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Dec-15)	Yes (Dec-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		4	4
		% F/M 0-dose	ns		1.83	1.71
		% F/M 3+ doses	ns		82.57	87.18
	Equal timeliness of disease notification	Median # days disease notification	ns		4	4
		% F/M <= 3 days	ns		38.17	45.64

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Gabon	High population immunity	% 0-dose	<10%	0.00%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID	1 NID	
	High virus detection	AFP rate (national)	>2	6.49	6.83	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	80%	
		Stool adequacy (national)	>=80%	91.67	95.83	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	88%	90%	
		Lab receipt to virus isolation result (median)	< 14 days	10	10	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	48% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Dec-15)	Yes (Dec-15)	
	Gender-sensitive Indicators**				**F**	**M**
	Equal doses received	Median # doses F/M	ns		4	2
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		83.33	60
	Equal timeliness of disease notification	Median # days disease notification	ns		4	5
		% F/M <= 3 days	ns		46.15	41.67

*Where there were less than 10 observations, data has not been tested for statistical significance.
ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Guinea	High population immunity	% 0-dose	<10%	1.82%	1.49%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs	2 NIDs	
	High virus detection	AFP rate	>2 (national)	9.66	7.17	
		AFP rate	>2 (% of states/provinces meeting indicator)	100%	100%	
		stool adequacy	>=80% (national)	93	95.36	
		stool adequacy	>=80% (% of states/provinces meeting indicator)	100%	100%	
		lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or no	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	1.6% (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Nov-15)	Yes (Nov-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		4	4
		% F/M 0-dose	ns		4.35	0
		% F/M 3+ doses	ns		78.26	77.27
	Equal timeliness of disease notification	Median # days disease notification	ns		5	4
		% F/M <= 3 days	ns		37.14	44.35

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Iraq (Most recent case 7 April 2014)	High population immunity	% 0-dose	<10%	1.44%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs	3 SNIDs	
	High virus detection	AFP rate (national)	>2	4.66	4.94	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	95%	95%	
		Stool adequacy (national)	>=80%	88.39	85.36	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	80%	68%	
		Lab receipt to virus isolation result (median)	< 14 days	11	11	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	16% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Jan-16)	Yes (Jan-16)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		7	7
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		98.8	94.12
	Equal timeliness of disease notification	Median # days disease notification	ns		2	3
		% F/M <= 3 days	ns		60.28	55.41

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Lao People's Democratic Republic	High population immunity	% 0-dose	<10%	9.1	28.6	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	N/a	N/a	
	High virus detection	AFP rate	>2 (national)	3.9	4.4	
		AFP rate	>2 (% of states/provinces meeting indicator)	N/a	N/a	
		stool adequacy	>=80% (national)	N/a	N/a	
		stool adequacy	>=80% (% of states/provinces meeting indicator)	83%	63.6	
		lab receipt to virus isolation result (median)	< 14 days	N/a	N/a	
		Environmental surveillance	Yes or no	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	8% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Oct-15)	Yes (Oct-15)	
	Gender-sensitive Indicators**				**F**	**M**
	Equal doses received	Median # doses F/M	ns		3	3
		% F/M 0-dose	ns		0	50
		% F/M 3+ doses	ns		33.33	50
	Equal timeliness of disease notification	Median # days disease notification	ns		5	6
		% F/M <= 3 days	ns		30.77	30.77

*Where there were less than 10 observations, data has not been tested for statistical significance.
ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Liberia	High population immunity	% 0-dose	<10%	2.17%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs	1 NIDs	
	High virus detection	AFP rate (national)	>2	6.96	1.21	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	91%	27%	
		Stool adequacy (national)	>=80%	79.41	91.67	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	58%	47%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	N/a	
		IPV introduction	intro by 2015	N/a	N/a	
	Gender-sensitive Indicators**				F	M
	Equal doses received	Median # doses F/M	ns		3	2
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		83.33	0
	Equal timeliness of disease notification	Median # days disease notification	ns		7	10
		% F/M <= 3 days	ns		20	33.33

*Where there were less than 10 observations, data has not been tested for statistical significance.
ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Madagascar (Most recent case 29 May 2015)	High population immunity	% 0-dose	<10%	0.00%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID	1 NID	
	High virus detection	AFP rate (national)	>2	7.17	6.00	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%	
		Stool adequacy (national)	>=80%	91.2	96.55	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	86%	100%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	Yes	Yes	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	15% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (May-15)	Yes (May-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		5	5
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		94.85	96.81
	Equal timeliness of disease notification	Median # days disease notification	ns		3	3
		% F/M <= 3 days	ns		58.02	56.69

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Mali	High population immunity	% 0-dose	<10%	3.23%	6.56%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID	1 NID	
	High virus detection	AFP rate (national)	>2	3.32	2.93	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	89%	78%	
		Stool adequacy (national)	>=80%	83.09	91.8	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	67%	89%	
		Lab receipt to virus isolation result (median)	< 14 days	8	8	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	29% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	N/a	N/a	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		4	3
		% F/M 0-dose	ns		10.71	3.03
		% F/M 3+ doses	ns		89.29	75.76
	Equal timeliness of disease notification	Median # days disease notification	ns		7	5
		% F/M <= 3 days	ns		21.57	34.78

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Myanmar	High population immunity	% 0-dose	<10%	7.14%	9.46%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	1 NID	2 SNIDs	
	High virus detection	AFP rate	>2 (national)	1.96	4.11	
		AFP rate	>2 (% of states/provinces meeting indicator)	41%	94%	
		stool adequacy	>=80% (national)	96%	95%	
		stool adequacy	>=80% (% of states/provinces meeting indicator)	100%	94%	
		lab receipt to virus isolation result (median)	< 14 days	N/a	N/a	
		Environmental surveillance	Yes or no	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	0.6% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Dec-15)	Yes (Dec-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		3	3
		% F/M 0-dose	ns		12.12	5.13
		% F/M 3+ doses	ns		78.79	92.31
	Equal timeliness of disease notification	Median # days disease notification	ns		4	3
		% F/M <= 3 days	ns		48.48	56.44

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Niger	High population immunity	% 0-dose	<10%	1.60%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs, 1 SNID	2 SNIDs	
	High virus detection	AFP rate (national)	>2	4.76	8.01	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	86%	
		Stool adequacy (national)	>=80%	83.46	78.84	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	72%	28%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	Yes	Yes	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	11% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Jul-15)	Yes (Jul-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		9	9
		% F/M 0-dose	ns		0.6	0
		% F/M 3+ doses	ns		97.62	96.43
	Equal timeliness of disease notification	Median # days disease notification	ns		8	8
		% F/M <= 3 days	ns		18.82	20.25

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Sierra Leone	High population immunity	% 0-dose	<10%	4.17%	0.00%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs	1 NIDs	
	High virus detection	AFP rate (national)	>2	2.53	3.46	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	75%	
		Stool adequacy (national)	>=80%	87.88	80.43	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	75%	50%	
		Lab receipt to virus isolation result (median)	< 14 days	9	9	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	N/a	
		IPV introduction	intro by 2015	N/a	N/a	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		3	3
		% F/M 0-dose	ns		0	0
		% F/M 3+ doses	ns		85.71	88.89
	Equal timeliness of disease notification	Median # days disease notification	ns		7	3
		% F/M <= 3 days	ns		26.09	63.16

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Somalia (Most recent case 11 August 2014)	High population immunity	% 0-dose	<10%	13.48%	14.68%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs	1 NID, 5 NIDs	
	High virus detection	AFP rate (national)	>2	7.16	5.48	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%	
		Stool adequacy (national)	>=80%	98.45	100	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	100%	100%	
		Lab receipt to virus isolation result (median)	< 14 days	7	7	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	2% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (Nov-15)	Yes (Nov-15)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		7	7
		% F/M 0-dose	ns		12.24	16.67
		% F/M 3+ doses	ns		79.59	71.67
	Equal timeliness of disease notification	Median # days disease notification	ns		3	2
		% F/M <= 3 days	ns		59.72	62.03

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Syria (Most recent case 21 January 2014)	High population immunity	% 0-dose	<10%	6.33%	16.49%	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	2 NIDs	1 NID, 3 SNIDs	
	High virus detection	AFP rate (national)	>2	3.84	4.6	
		AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	79%	71%	
		Stool adequacy (national)	>=80%	77.72	70.23	
		Stool adequacy (sub-national)	>=80% (% of states/provinces meeting indicator)	79%	64%	
		Lab receipt to virus isolation result (median)	< 7 days	12	12	
		Environmental surveillance	Yes or No	No	No	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	1% increase (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes (<2015)	Yes (<2015)	
	Gender-sensitive Indicators				**F**	**M**
	Equal doses received	Median # doses F/M	ns		2	6
		% F/M 0-dose	ns		26.98	14.93
		% F/M 3+ doses	ns		31.75	71.64
	Equal timeliness of disease notification	Median # days disease notification	ns		3	2
		% F/M <= 3 days	ns		43.62	52.5

ns: Refers to achieving a non-significant result in terms of gender differences.

Country	Outcome	Indicator	Target	Jan–Jun 2017	Jul–Dec 2017	
Ukraine	High population immunity	% 0-dose	<10%	13.5	29.0	
		LQAS or IM out-of-house result	>= 90% or <5%	N/a	N/a	
		% inaccessible	<5%	N/a	N/a	
		Number and type of activity	per plan	N/a	N/a	
	High virus detection	AFP rate	>2 (national)	2.6	1.9	
		AFP rate	>2 (% of states/provinces meeting indicator)	N/a	N/a	
		stool adequacy	>=80% (national)	97.8	92.4	
		stool adequacy	>=80% (% of states/provinces meeting indicator)	N/a	N/a	
		lab receipt to virus isolation result (median)	< 14 days	N/a	N/a	
		Environmental surveillance	Yes or no	Yes	Yes	
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	TBC	0.6% decrease (2015 vs 2014)	
		IPV introduction	intro by 2015	Yes	Yes	
	Gender-sensitive Indicators				F	M
	Equal doses received	Median # doses F/M	ns		4	5
		% F/M 0-dose	ns		29.41	28.57
		% F/M 3+ doses	ns		52.94	64.29
	Equal timeliness of disease notification	Median # days disease notification	ns		2	4
		% F/M <= 3 days	ns		77.78	50

ns: Refers to achieving a non-significant result in terms of gender differences.

Annex 2 – Outbreak, high-risk countries and 6 WHO Regions

WO region	Outcome	Indicator	Target	Jul–Dec 2017	
Gender-sensitive Indicators				F	M
AFR	Equal doses received	Median # doses F/M	ns	7	7
		% F/M 0-dose	ns	1.3	0.94
		% F/M 3+ doses	ns	93.75	93.75
	Equal timeliness of disease notification	Median # days disease notification	ns	4	4
		% F/M <= 3 days	ns	40.03	41
AMR	Equal doses received	Median # doses F/M	ns	4	4
		% F/M 0-dose	ns	0	3.51
		% F/M 3+ doses	ns	77.65	78.95
	Equal timeliness of disease notification	Median # days disease notification	ns	5	5
		% F/M <= 3 days	ns	24.53	25
EMR	Equal doses received	Median # doses F/M	ns	10	10
		% F/M 0-dose	ns	2	1.48
		% F/M 3+ doses	ns	95.93	96.97
	Equal timeliness of disease notification	Median # days disease notification	ns	3	3
		% F/M <= 3 days	ns	55.6	57.68
EUR	Equal doses received	Median # doses F/M	ns	5	5
		% F/M 0-dose	ns	6.38	2.86
		% F/M 3+ doses	ns	82.98	88.1
	Equal timeliness of disease notification	Median # days disease notification	ns	4	3
		% F/M <= 3 days	ns	45.87	51.8
SEAR	Equal doses received	Median # doses F/M	ns	14	14
		% F/M 0-dose	ns	1.01	1.01
		% F/M 3+ doses	ns	97.92	97.81
	Equal timeliness of disease notification	Median # days disease notification	ns	3	3
		% F/M <= 3 days	ns	51.31	55.01
WPR	Equal doses received	Median # doses F/M	ns	3	3
		% F/M 0-dose	ns	2.2	1.8
		% F/M 3+ doses	ns	93.86	93.26
	Equal timeliness of disease notification	Median # days disease notification	ns	2	2
		% F/M <= 3 days	ns	63.68	64.1

ns: Refers to achieving a non-significant result in terms of gender differences.

Annex 3 – Analysis of cost per child by region, January–June 2017 vs July–December 2017

Operational cost (US$) per child (excl OPV costs) to reach and vaccinate 1 child with 1 dose	Jan–Jun 2017	Jul–Dec 2017
Global	0.36	0.36
Regional Office for Africa	0.37	0.38
Regional Office for the Eastern Mediterranean	0.33	0.33
Regional Office for South-East Asia	0.10	0.10
Regional Office for Europe	0.30	0.30
Regional Office for the Western Pacific	0.27	0.27

Annex 4 – Global monitoring

Outcome	Indicator	Target	Jul–Dec 2017
All	**Financing:** 12-month cash gap		July-December 2018: $122m, 13% of GPEI budget
	Financing: Strategy funding gap		Target to reduce gap to zero, i.e. fully finance the budget, by Q4 (October). Strategy is to target core GPEI donors and partners (CDC, Rotary, Gates, National Philanthropic Trust) to target contributions to fill GPEI 2018 budget gaps, while continuing outreach to attract new donors.
	Staffing: Vacant approved posts	<10%	WHO HQ – 13% WHO Nigeria – 4% WHO Afghanistan – 3% WHO Pakistan – 0% WHO Total HQ plus endemics – 5% WHO Total Overall – 11%
High population immunity	**Vaccine supply:** Planned SIAs cancelled due to vaccine shortage		No planned SIAs cancelled due to vaccine shortage
Low risk of virus reintroduction	Number of OPV-only using countries		All countries committed to IPV introduction ahead of the switch from trivalent OPV to bivalent OPV in April 2016. However due to a global IPV supply constraint, some low risk countries have experience delays in receiving IPV supply or have not been resupplied, if they had introduced earlier. By end-2017, 107/126 countries had introduced IPV. Currently, as the supply situation has slightly improved, all countries have been offered a time slot for shipment of supply. The aim is to complete all introductions in 2018, and so far in the current year an additional country has introduced and 6 countries have resumed IPV programmes. All 155 trivalent OPV-using countries successfully switched to bivalent OPV by May 2016
	Plan in place to support routine immunization strengthening in 10 priority countries		Strengthening routine immunization through PEI network is one of the important components of the National Emergency Action Plans (NEAPs) of the three endemic countries. PEI-EPI synergy teams established at EOCs of each endemic country. Main aim is to support supervision and monitoring of EPI fixed sites and outreach sessions in close collaboration with EPI programmes. Analysis of quarterly monitoring data for 2017 submitted by PEI staff shows that on average, 500 EPI fixed sites and outreach sessions are being monitored per month by Afghanistan PEI team. Similarly, 3000 outreach sessions and 5000 EPI facilities are monitored per month by Pakistan and Nigeria PEI teams. According to NEAPs for 2018, these countries will maintain this current level of PEI support to strengthen routine immunization. Additionally, India, Chad, Ethiopia and tje Democratic Republic of Congo also have developed annual immunization plans that leverage polio assets to improve broader immunization goals.
	Reduction in the international spread of polio		Declared PHEIC remains in place
	Containment and certification	Per GAPIII	• *Guidance for non-poliovirus facilities to minimize risk of sample collections potentially infectious for polioviruses* being finalized • Global Commission for the Certification of Eradication of Poliomyelitis (GCC) has accepted responsibility for global containment oversight following *Containment Certification Scheme to support the WHO Global Action Plan for Poliovirus Containment* (GAPIII-CCS) and issued recommendations on containment in October 2017 that are published on the website • Containment Advisory Group established to address technical issues related to GAPIII met twice and issued recommendations that are published on the website.

Outcome	Indicator	Target	Jul–Dec 2017
Transition and post-certification strategy	Consultations inputs into plans		• 16 priority countries in process of developing transition plans (draft national plans now in place in 12 of 16 countries) • Progress monitored by Transition Independent Monitoring Board • Post-certification strategy being developed in extensive stakeholder consultations • Report on development of strategic action plan on transition and post-certification strategy being prepared, as per WHA Decision WHA70(9)

www.polioeradication.org

POLIO GLOBAL ERADICATION INITIATIVE

WHO/POLIO/18.02