POLIO GLOBAL ERADICATION INITIATIVE

2019 ANNUAL REPORT

SEMI-ANNUAL STATUS UPDATES
JANUARY - JUNE & JULY - DECEMBER 2019

World Health Organization · unicef · Rotary · CDC Centers for Disease Control and Prevention · Bill & Melinda Gates foundation · Gavi The Vaccine Alliance

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ACRONYMS

cVDPV	Circulating vaccine-derived poliovirus
cVDPV2	Circulating vaccine-derived poliovirus type 2
EUL	Emergency Use Listing
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
nOPV2	Novel oral polio vaccine type 2
tOPV	Trivalent oral polio vaccine
UAE	United Arab Emirates
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPV	Wild poliovirus
WPV1	Wild poliovirus type 1
WPV2	Wild poliovirus type 2
WPV3	Wild poliovirus type 3

EXECUTIVE SUMMARY

The year 2019 was marked by an upsurge in wild poliovirus (WPV) cases in Pakistan and Afghanistan, as well as by a large number of circulating vaccine-derived poliovirus (cVDPV) outbreaks. The emergence of COVID-19 in early 2020 significantly affected the planned response strategies and prompted the reorientation of thousands of polio personnel to serve the global pandemic response.

However, the year was also marked by renewed commitments and fresh approaches – placing the Global Polio Eradication Initiative (GPEI) in a strong position to respond effectively to the obstacles faced on the path to eradication.

In May 2019, the GPEI launched a new strategic plan that recognizes the challenges ahead and clearly articulates the road map to achieving a lasting success. In an extraordinary display of commitment to polio eradication, global public- and private-sector partners pledged US$ 2.6 billion towards the GPEI at the Reaching the Last Mile forum in Abu Dhabi, United Arab Emirates (UAE), in November.

October saw a major epidemiological milestone achieved, with the global certification of eradication of wild poliovirus type 3 (WPV3), following the global certification of eradication of wild poliovirus type 2 (WPV2) in 2015. With no WPV of any type detected on the African continent since 2016, the region is on the cusp of becoming the fifth of six WHO regions to be certified free of all WPV.

Committing to including a gender perspective across the initiative's work, the first GPEI Gender Equality Strategy was launched in 2019. Meanwhile, the GPEI made large strides towards introducing a new vaccine, the novel oral polio vaccine, and established a GPEI hub in Amman, Jordan for polio experts dedicated to defeating polio in Afghanistan and Pakistan.

These achievements, reached thanks to the innovations and commitment of thousands of personnel, show that despite setbacks, the goal remains in sight – to achieve a lasting world in which no child will ever again be paralysed by any type of poliovirus, be it wild or vaccine-derived.

WILD POLIOVIRUS

After years of significant progress in both Afghanistan and Pakistan, 2019 demonstrated just how quickly the virus can resurge when vaccination rates dip – and underlined why eradicating every last virus is paramount.

Determined to reverse setbacks, including the onset of a cVDPV outbreak in Pakistan, both countries embarked mid-year on a major relaunch of their respective efforts. By undertaking in-depth analyses of the major area-specific challenges that need to be addressed to reach that last unreached child, both Pakistan and Afghanistan completed road maps that lay out the strategy ahead.

To support swift, informed and effective action, the GPEI also established a new technical and programmatic hub in Amman to provide the most rapid, efficient and tailored support to both countries. The hub is already functional and is supporting country planning activities.

In the context of COVID-19 which emerged in 2020, the work carried out in 2019 to start reversing challenges in Afghanistan and Pakistan is continuing to be built on. Although the impact of the pandemic continues to be considerable and polio case numbers seem likely to rise, the programme continued its fight with a clearer understanding of where setbacks occurred and how to overcome them.

May

Launch of new

GPEI STRATEGIC PLAN 2019-2023

September

Launch of

GPEI GENDER STRATEGY 2019-2023

October

Certification of

Worldwide ERADICATION of WILD POLIO VIRUS type3

November

The Crown Prince of Abu Dhabi

REACHING EVERY LAST MILES Forum

in Abu Dhabi

CIRCULATING VACCINE-DERIVED POLIOVIRUSES

To tackle the evolving cVDPV emergency in 2019, efforts were intensified with emergency action based on sensitized tactics, focusing on lessons learned. A new strategy was developed in a matter of months, drawing upon global expertise to ensure the strongest possible response. These efforts began to show results at the end of the year, as several individual cVDPV outbreaks were successfully stopped, including in the Democratic Republic of the Congo, Kenya, Mozambique and the Niger.

Part of the new strategy involved accelerating the development of the novel oral polio vaccine type 2 (nOPV2) – a new tool to address outbreaks, which could be available for use under the Emergency Use Listing (EUL) procedure in the second half of 2020.

NEW PARTNERSHIPS

In 2019, Gavi, the Vaccine Alliance, formally joined the GPEI as a core partner. Gavi's contributions to strengthen routine immunization and expand inactivated polio vaccine (IPV) use will be critical. Gavi's partnership builds on the new outbreak gold standard set in Papua New Guinea in 2018, where the cVDPV outbreak was closed in a sustainable manner, ensuring that routine immunization strengthening continues for the long term.

Building on examples like this, the GPEI worked anew to strengthen broader integration, as the programme began to work more closely with WHO's Immunization, Vaccines and Biologicals, and Health Emergencies departments. Together, the programme and other departments worked to address outbreaks of different diseases, including COVID-19, and to improve access to life-saving vaccines for some of the most marginalized populations of the world.

ON THE FRONT LINES AGAINST COVID-19

At the dawn of the new decade, a new and global public health threat emerged – the global COVID-19 pandemic. The entire world began mobilizing in response and, at the country level, the GPEI infrastructure – with thousands of polio workers and an extensive laboratory and surveillance network – directly engaged in the effort. In a matter of weeks, the programme developed operational guidance for field staff supporting the response, and continued to help maintain critical routine immunization activities.

In March 2020, polio activities – particularly supplementary immunization activities – had to be paused as part of efforts to implement global social distancing strategies. Although some countries planned to resume urgent campaigns, this pause has impacted both polio programmatic efforts and epidemiology for the short and medium term.

The programme therefore mobilized into emergency readiness mode to ensure that, once the global COVID-19 situation allows it, supplementary immunization activities will be implemented in an appropriate and safe manner, given the new reality. Additionally, the programme increasingly worked in close coordination with broader immunization systems, as polio is but one of many vaccine-preventable diseases affected by the COVID-19 crisis.

PROTECTING THE FUTURE

During this time of uncertainty, the programme aimed to respond rapidly and flexibly, adapting appropriately based on the best available evidence in a changing environment. The goals included to respond using the new tools and commitments developed in 2019 and to relaunch the effort in its most effective manner.

Success can and will be achieved. Critical will be the ongoing support of international development partners in ensuring the necessary resources are rapidly put in place, not only to eventually eradicate polio, but in the immediate term to allow the GPEI infrastructure to continue to support the global pandemic response effort.

The core partners of the GPEI – WHO, Rotary International, the US Centers for Disease Control and Prevention, the United Nations Children's Fund (UNICEF), the Bill & Melinda Gates Foundation, and Gavi, the Vaccine Alliance – stand ready to support countries in their efforts.

ERADICATION

Nasrin Ahmadi, polio worker from Mazar-e-Sharif in Balkh province, Afghanistan

© WHO/Afghanistan/Roya Haidari

POLIOVIRUS TRANSMISSION

WPV3 was officially certified as eradicated in October 2019, following the certification of the eradication of WPV2 in September 2015. Nigeria reached a major milestone, with the last case of wild poliovirus type 1 (WPV1) detected in the country in 2016, and it is likely that the African continent will soon be certified wild polio-free. In 2019, WPV1 cases continued to be detected in just two countries: Afghanistan and Pakistan.

A completely fresh approach is required to defeat polio in these two nations. A significant increase in newly reported cases in 2019 compared to 2018, in particular in Pakistan, evidence of the continued geographic spread of the virus (including internationally to the Islamic Republic of Iran) and continued gaps in strategic implementation in key areas point to a high likelihood that transmission will continue for several years to come. This is compounded by the effects of the COVID-19 pandemic on polio immunization rates.

In Pakistan, the focus in the second half of 2019 was on conducting an in-depth analysis of all operational and communication aspects of the programme in all areas, restore community trust and engagement, and put in place new emergency measures to urgently improve operations with a view to seeing the effects of improvements on the actual virus epidemiology. In Afghanistan, a similar approach was implemented, including to ensure the implementation of culturally appropriate delivery mechanisms of vaccines. Partnerships with broader health initiatives were fostered, including through the COVID-19 response, and efforts were supported by a newly established partnership hub of experts based in Amman, Jordan.

With the regional certification of eradication of WPV in Africa, Pakistan and Afghanistan will represent the final global reservoir of WPV transmission. Given the global implications of continued WPV transmission in this area related to the risk of renewed international spread and the associated continued need to use the oral polio vaccine, it is imperative that all necessary efforts to finally address this last remaining reservoir must be made by partners, by the broader international development community and, most importantly, by the two concerned governments at all levels.

Afghanistan Vaccination Campaign, 20 - 24 July 2020 *© WHO/Afghanistan*

During the first polio campaign to resume in Afghanistan following a temporary pause in SIAs due to COVID-19, 7,858 vaccinators aimed to vaccinate 1,101,740 children in Laghman, Kunar and Nangarhar provinces. Vaccinators were trained on COVID-19 infection control and prevention measures and were equipped to answer parents' questions about the pandemic. Through the campaign, teams distributed 500,000 posters and 380,000 flyers featuring COVID-19 prevention messages.

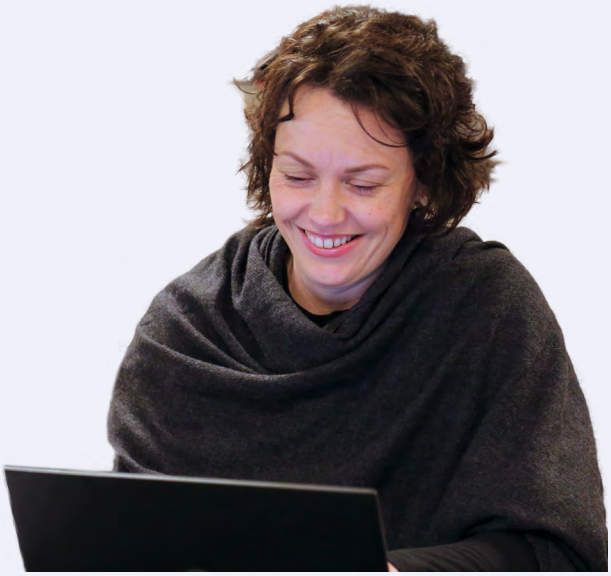
INSIGHT INTO THE AMMAN HUB

During a challenging year for polio eradication in the Eastern Mediterranean Region, with rising cases of WPV in Afghanistan and Pakistan, as well as outbreaks of vaccine-derived poliovirus in Pakistan and Somalia, the GPEI began the process of overhauling operations to address programme vulnerabilities and increase vaccine coverage.

To support efforts in the two remaining endemic countries, the GPEI established a hub in the third quarter of 2019. The GPEI hub, located in Amman, Jordan, is staffed by a dedicated team of experts from across the partnership with decades of experience fighting the poliovirus. GPEI staff in the hub have been brought together specifically to support the Pakistan and Afghanistan programmes as the countries focus on overhauling their management and operations. The hub will provide better coordination across the GPEI partnership, enable more rapid deployment of surge support and technical expertise to Pakistan and Afghanistan, and ensure quick, effective decision-making closer to the ground.

Support is organized into thematic areas, focusing on high-level advocacy, data analytics and risk assessment, country operational assistance and the strengthening of services beyond polio. It is anticipated that the Amman hub will offer critical support in 2020 as the programme resumes vaccination activities paused during the early stages of the COVID-19 pandemic and rapidly increases operations to protect vulnerable communities and fight outbreaks.

Dr Joanna Nikulin
Coordinator of the GPEI Hub
Amman, Jordan



Dr Nikulin was appointed Coordinator of the GPEI Hub in Amman in August 2020, after almost a year working as Interim Coordinator. Under her leadership, substantial progress has been made to ensure strong, timely and well-coordinated support to the polio eradication programmes in Afghanistan and Pakistan. In particular, Dr Nikulin has guided the constructive engagement of all partners to establish diverse workflows to achieve eradication in the endemic countries.

Dr Nikulin brings a wealth of experience in polio eradication, immunization and child health, having served in some of the most challenging settings worldwide. She joined the WHO polio eradication team in Amman in 2015 as Country Support Focal Point for Afghanistan and thereafter served as the Country Support Team Leader from September 2017 to September 2019. Between 2006 and 2015, Dr Nikulin served with UNICEF in Zambia, Uganda, Somalia and South Sudan as a Health Specialist. After completing studies in her home country, Finland, Dr Nikulin received her medical and post graduate degrees from Humboldt University and Julius Maximilian University in Germany.

CIRCULATING VACCINE-DERIVED POLIOVIRUS TRANSMISSION

In 2019, an increasing and unanticipated public health emergency appeared, with increasing circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks affecting parts of Africa primarily, but also areas of the Middle East and South-East Asia.

In Africa, a number of genetically distinct cVDPV2 outbreaks emerged and/or continued to spread, in particular affecting Nigeria and other areas of west Africa and the Lake Chad subregion; the Democratic Republic of the Congo, Angola and other parts of central Africa; and the Horn of Africa, with cases initially detected in Somalia spreading also to neighbouring Ethiopia (after having also been detected in Kenya in 2018).

cVDPV2s were also confirmed in Pakistan and were subsequently detected in Afghanistan, China, Malaysia and the Philippines.

In all instances, the continued spread of existing cVDPV2 outbreaks and the emergence of new cVDPV2s pointed to the insufficient quality of outbreak response with monovalent oral polio vaccine type 2 (mOPV2). The risk that these strains spread further or that new strains emerge was magnified by an ever-increasing mucosal immunity gap to type 2 poliovirus on the continent, following the switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine in 2016.

Africa stands on the cusp of a historic public health success: the potential certification of WPV eradication. This success would be a tribute to the tremendous efforts achieved by political leaders across the continent and by traditional, religious and community leaders, public health systems, front-line health workers and, most importantly, parents. They all dedicated themselves to a single and common goal: to find and vaccinate every child against WPV, no matter where they live. All heeded the call issued by Nelson Mandela in 1996 – at a time when WPV paralysed more than 75 000 children every year across every country on the continent – to "kick polio out of Africa".

Despite this, however, the certification of the eradication of WPV in Africa would mark an unfinished success story. To finish this success story, the increasing threat of cVDPV on the continent must also be addressed.

AFRICA'S RAPID RESPONSE TEAM

The Rapid Response Team gathers to discuss their next deployments. *© WHO/AFRO*

The multi-agency Rapid Response Team is central to responding to Africa's cVDPV outbreaks. The team is composed of 20 experts in operations and vaccination management, epidemiology, logistics and communications. Team members are drawn from the core partners of the GPEI: WHO, UNICEF, Rotary International, the US Centers for Disease Control and Prevention, the Bill & Melinda Gates Foundation, and Gavi, the Vaccine Alliance.

The team is mobilized whenever a new polio outbreak is confirmed in the African region.

Within the first 72 hours of the outbreak announcement, the Rapid Response Team deploys Team A. This team includes the GPEI Coordinator alongside an epidemiologist, an operations officer, a vaccine manager and a communicator for development. The team works closely with the health authorities in the affected country along with the relevant WHO and UNICEF country offices to prepare a risk assessment and outbreak response plan. Before the COVID-19 pandemic, the emergency response vaccination campaign, called "Round Zero", would begin within 14 days.

Team B takes over from Team A after the first eight weeks and continues the outbreak response activities, supporting the country office and government to end the outbreak as effectively as possible.

POLIO GLOBAL ERADICATION INITIATIVE

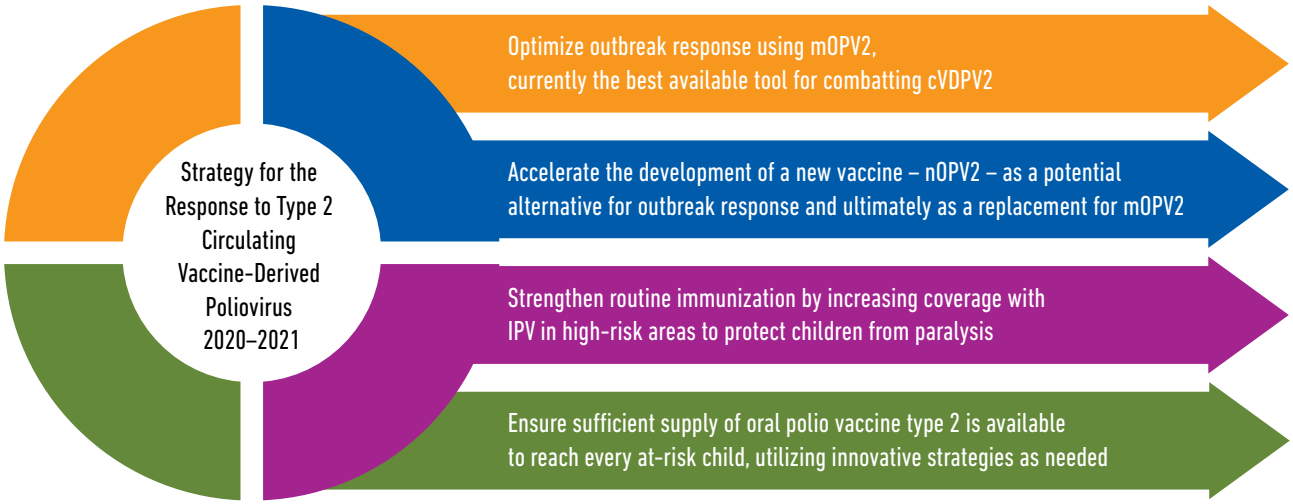
Strategy for the Response to Type 2 Circulating Vaccine-Derived Poliovirus 2020–2021

AN ADDENDUM TO THE POLIO ENDGAME STRATEGY 2019–2023

A NEW APPROACH TO CIRCULATING VACCINE-DERIVED POLIOVIRUS

Ongoing cVDPV outbreaks highlighted the urgent need to continue the work of polio eradication. It is important to remember that cVDPV outbreaks occur in areas with under-immunized populations and that cVDPVs are not related to, nor indicative of, a re-emergence of WPV.

In response to the growing cVDPV2 emergency in 2019, the GPEI developed a new approach to tackling such strains. The comprehensive *Strategy for the Response to Type 2 Circulating Vaccine-Derived Poliovirus 2020–2021* focuses on working with affected and at-risk countries to control the outbreaks of type 2 poliovirus.



A vaccine is administered to a child during a polio immunization campaign. *©WHO/AFRO*

The nOPV2, which will be made available under the WHO EUL procedure, is expected to be an important new tool to stop the vicious cycle of using mOPV2 to combat outbreaks, but in turn seeding new outbreaks of cVDPV2 among non-immunized population groups. In February 2020, Member States at the WHO Executive Board endorsed the main elements of the new response strategy, including the use of nOPV2 under the EUL.

Initial implementation of the new approaches began to show significant impact in late 2019, with several genetically distinct cVDPV2 strains successfully stopped, notably in the Democratic Republic of the Congo, Kenya and the Niger.

Amid the COVID-19 reality, the focus in the latter half of 2020 will be to intensify cVDPV2 response efforts using the most appropriate combination of vaccines, namely the effective use of mOPV2, IPV and tOPV in outbreak settings where more than one serotype circulate (as advised by the Strategic Advisory Group of Experts on immunization) and, where appropriate, nOPV2. Critical will be to ensure operations are adapted appropriately to assure the safety of both front-line health workers and the communities they serve.

146th session of the WHO Executive Board, Geneva, Switzerland, 3-8 February 2020 *© WHO/HQ*

GENDER

Women vaccinators during in Maiduguri city, Borno State in Nigeria *© WHO/Heehaw*

Gender equality and equity are core values for the GPEI, and the programme recognizes that gender-responsive approaches further strengthen polio eradication interventions. The GPEI launched its first-ever Gender Equality Strategy in May 2019 to provide a framework for and increase accountability in its work on gender-responsive programming, gender mainstreaming and to increase women's meaningful and equal participation at different levels of the Polio programme.

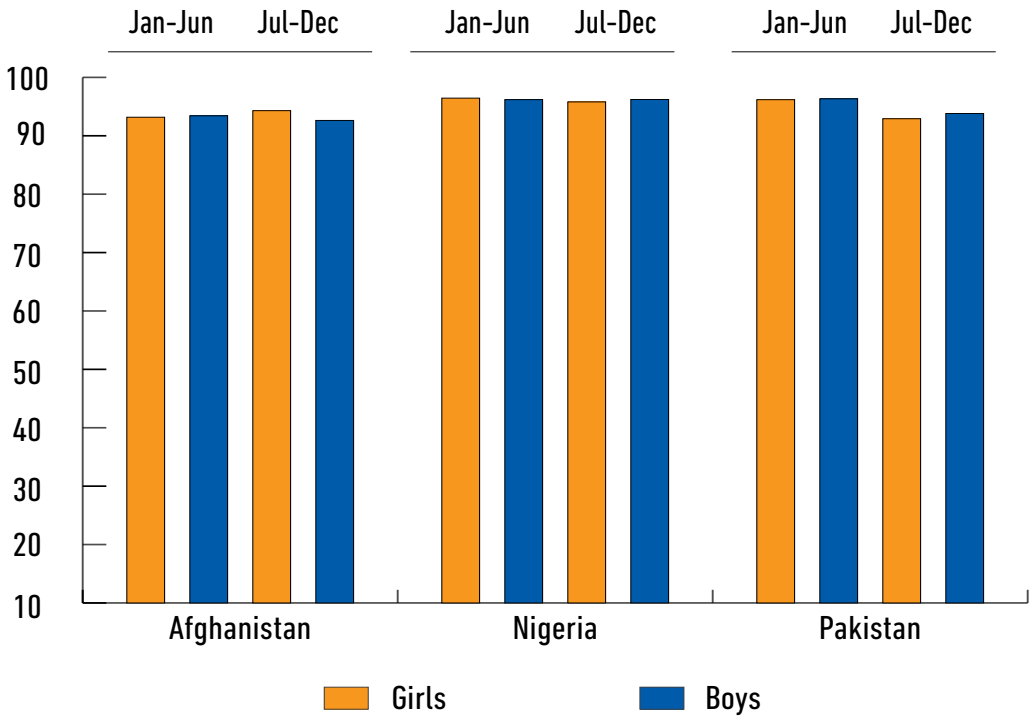
The Gender Equality Strategy covers the period of 2019-2023, is in all official WHO languages and can be accessed online at the GPEI global website. To fully implement the Gender Equality Strategy, specific and tailored Gender Action Plans, complete with measurable indicators and set timelines, are currently being developed jointly by WHO and UNICEF, to be rolled out during 2020.

To ensure equal access to vaccinations, surveillance and the engagement of women, the GPEI regularly monitors the four gender-sensitive indicators as laid out in the 2018 GPEI Technical Brief.

Annexes include data on these four indicators for the endemic countries and for indicators 2 and 3 for outbreak countries.

Analysis of the data for the reporting period does not show significant sex differences for the polio-endemic and outbreak countries, either for children reached in vaccination campaigns or for surveillance data. For example in Pakistan, post-campaign evaluation shows that 96.18% of all girls surveyed were vaccinated, compared with 96.33% of all boys in the January-June 2019 period while the period July-December 2019 shows a slight decrease with 92.92% of girls vaccinated and 93.82% of boys vaccinated[1] (see Figure 1).

Figure 1: Equal reach in immunization campaigns



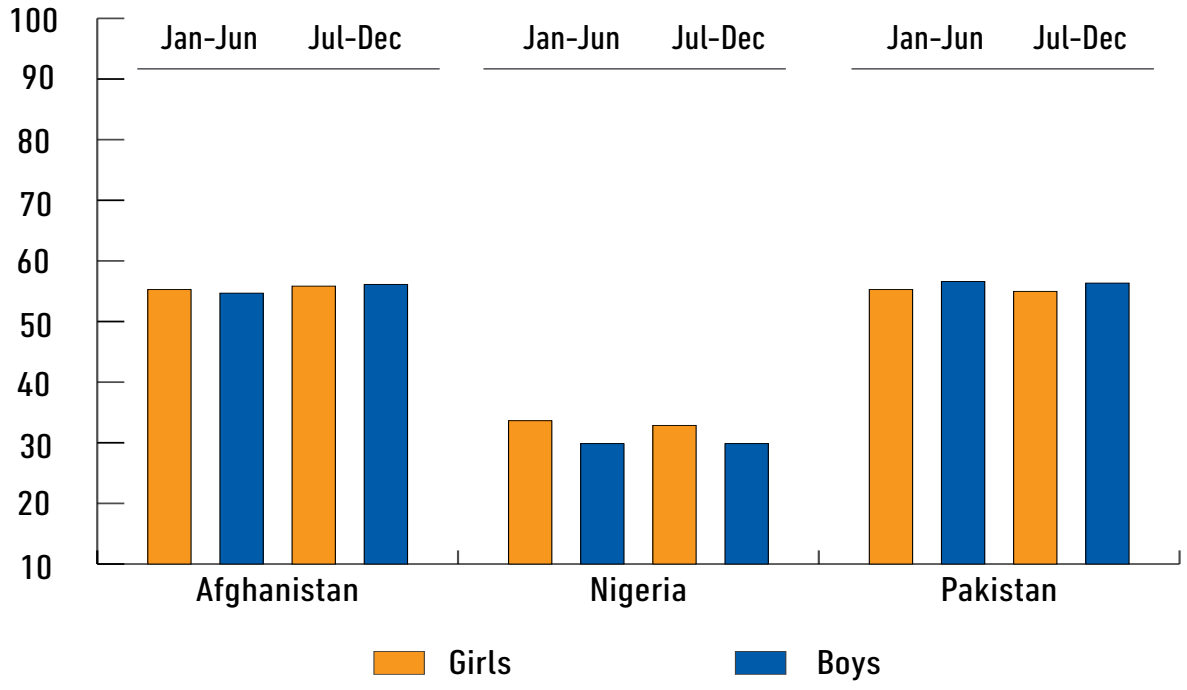
Source: Geneva: World Health Organization, analysis of sex-disaggregated data, conducted in 2019

1 The slight decrease is also due to the fact that during the Jan-Dec 2019 reporting period, the Pakistan Country Office implemented only 2 SIAs: 1) August 2019 - which was a SNID/Case response (targeting only one province with a smaller number of lots than other SNIDs since it was just one province- e.g. 100 UCs assessed versus the usual 600 assessed after SNIDs); 2) December 2019 NID (also smaller number of UCs assessed due to finger marker shortage- so 470 UCs assessed versus the usual 700 assessed after NIDs)

In Pakistan, the percentage of girls who received 0 doses is 0.58% while it is 0% for boys in the January-June 2019 period, while the July-December 2019 period showed a small increase in numbers with 0.85% of girls and 1.41% of boys who received 0 doses[2]. Of all girls surveyed, 99.06% had received three or more doses, compared with 99.09% of boys in the Januray-June 2019 period, while in the period July-December 2019 were registered 97.87% girls and 97.53% boys for the same indicator.

In Afghanistan 93.18% of all surveyed girls were vaccinated, compared with 93.42% of boys in the January-June reporting period, and 94.30% and 92.63% respectively in the July-December period. In Nigeria, the figure for girls was 96.45% and for boys 96.19% for the January-June period and 95.80% and 96.22% respectively for the July-December period (see Figure 1). Data also shows no major differences in doses received by girls and boys; for example, in Afghanistan 97.22% of girls had received three or more doses, compared with 96.20% of boys in January-June period, while the percentage is 94% for both girls and boys in the July-December period. Timeliness for disease notification was also similar for boys and girls. For instance, in Nigeria disease notification within three days was 33.64% for girls, compared with 32.11% for boys in the January-June period while in July-December was 32.86% for girls and 29.86% for boys. In Afghanistan 55.27% of girls and 54.68% of boys had disease notification within three days in the January-June period and similarly 55.84% and 56.12 % for girls and boys respectively for the July-December period. In Pakistan, the respective figures were 55.27% for girls and 56.59% for boys for January-June and 54.97%% and 56.34% for July-December for girls and boys respectively (see Figure 2).

Figure 2: Percentage of disease notification within 3 days per girls and boys



Source: Geneva: World Health Organization, analysis of sex-disaggregated data, conducted in 2019

2 See footnote 1 on page 14.

Voices from the field

Turning the tide: Vaccination and religious dialogue

In Union Council Kechi Baig, Quetta district, Balochistan province of Pakistan, Asma needs no introduction. When she talks, people listen. First, when she was one of the few female religious scholars at her local madrassa (school), and of late, as a champion for the polio programme.

© S.Gull/WHO Pakistan

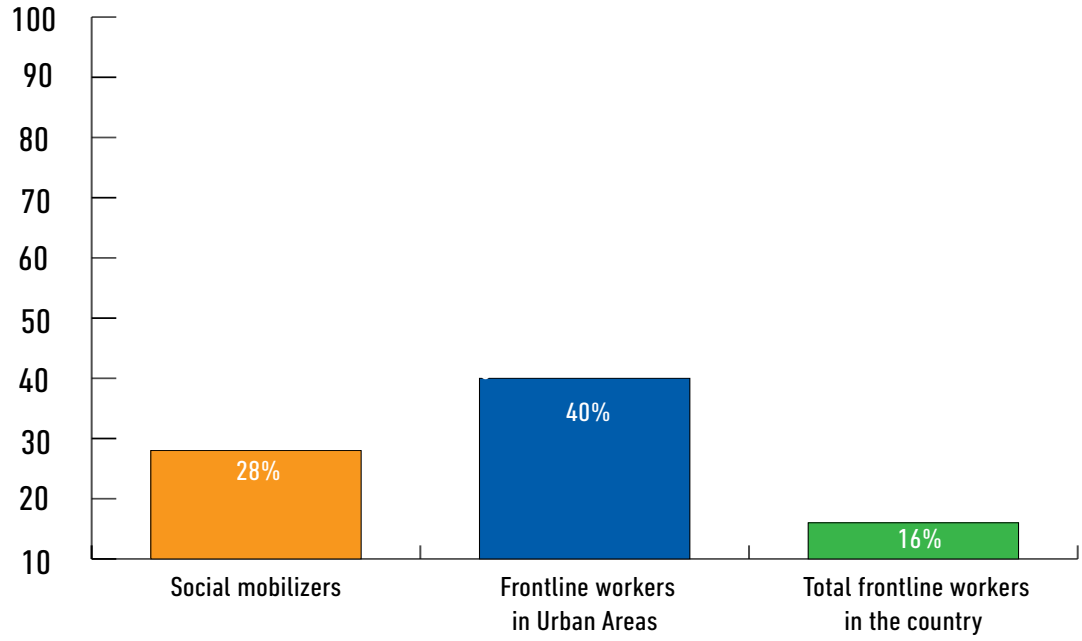
As one of three female religious support person (RSPs) out of a team of 118, she has given unique credence to the polio efforts in her community. Kechi Baig accounts for a significant number of refusals to vaccinate. Community health workers are sometimes unable to make headway with refusal families. In such cases, Asma plays an important role as a faith-based counsellor, drawing upon her knowledge and expertise on religious teachings with communication skills and personal friendships within the community. Asma convinces 15-20 'hard refusal' families in each vaccination campaign.

"I visit the households and leave with grandmothers convinced. As a madrassa teacher, I have seen that most females are unaware of religious teachings of Islam and the role of women to improve society. The polio fatwa (Islamic rulings) book proves to be very helpful because it contains authentic fatwas from venerated religious scholars."

Religious support persons, particularly women RSPs like Asma, play a very important role in mediating how people consider their choices for and against polio vaccination through the religious interface. By incorporating educative, spiritual, and medical knowledge, faith-based counselling goes a long way in neutralizing any refusal predispositions within the community.

Polio-endemic countries continue to engage female front-line workers in immunization activities. In Pakistan, women currently make up more than 63% of frontline health workers (compared to 60.5% in 2018), including vaccinators and social mobilizers, and account for 79% of vaccinators in the country's highest-risk areas. In Nigeria, over 82% of frontline health workers were women for the January-June period while the number increased for the second half of 2019 with women making up 86% of frontline health workers[3]; similarly, in 2019, 87.2% of volunteer community mobilizers were women in Nigeria. In Afghanistan, where insecurity and strict gender roles often restrict women's work and movement outside the home, women now make up 28% of social mobilizers and 40% of frontline health workers in urban areas. While 40% of frontline workers in urban areas are female, women comprise only 16% of all frontline workers in Afghanistan (see Figure 3).

Figure 3: Percentage of women working for Polio Eradication in Afghanistan



Source: Geneva: World Health Organization, analysis of sex-disaggregated data, conducted in 2019

The low number of women FLWs can to a large extent be attributed to an increasingly volatile security situation on the ground, hindering women's participation in the health workforce overall. Afghanistan is making efforts to ensure the safety of all front-line workers and increase women's participation to reach the target of having women comprise at least 50% of front-line workers in urban areas. As part of the 2019 Afghanistan NEAP, frontline worker selection committees were requested to make transparent and active efforts to engage more women as FLWs, including as vaccinators and supervisors. As a result, there is now one female member in the provincial FLW selection committee in Kabul, Kandahar, Kunar, Nangarhar and Farah provinces. In addition, out of 7 District Polio Officers (DPOs) 3 female DPOs have been recruited to work in Kandahar City.

3 The decrease compared to 2018 (93%) is partly due to the reduced number of supplemental immunization activities and an increase on geo-specific outbreaks response.

REACHING GENDER PARITY

In 2018, a baseline assessment on the gender-responsiveness of the program, highlighted the need for increased women's participation, particularly in oversight, management and decision-making[4].
With the approval of the GPEI Gender Equality Strategy and the GPEI Eradication Strategy in 2019, the GPEI has committed to extending women's engagement in the programme at all levels and areas, with an objective to reach gender parity (50%-50%) in TAGs, panels, governance and oversight bodies by 2020. As of 2019, parity was only achieved in the Strategy Committee, even if chaired by a man. Gender parity is an objective for TAGs in Afghanistan and Pakistan as outlined in the revised TORs. Gender parity monitoring and reporting will continue as part of the GPEI's regular reporting mechanisms on gender.

MOVING FORWARD

During 2020, GPEI will focus on the finalization of GPEI Gender Strategy Implementation Plans for endemic countries and training at all three levels of the program to create a conducive environment for effective implementation of the GPEI Gender Equality Strategy. These new areas of work will be complimented by improving overall communications and improved collection and analysis of sex-disaggregated data. GPEI will continue engagement with immunization partners as part of a broader approach to gender and immunization.

4 Gender Equality Strategy 2019-2023. Geneva: World Health Organization; 2019 (WHO/ POLIO/19.04). Licence: CC BY-NC-SA 3.0 IGO.

CERTIFICATION AND CONTAINMENT

Three-year-old Madsa is carried by her sister after receiving a polio vaccine during a door-to-door campaign in Maroua, Cameroon
© Gates Archives/ Dominique Catton

CERTIFICATION: THE INDEPENDENT STAMP OF APPROVAL FOR POLIO ERADICATION

In October 2019, the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC) reviewed all criteria related to global WPV3 transmission and concluded that this strain had been globally eradicated. This is the second WPV strain to be globally certified as eradicated, following WPV2 in 2015. Of wild strains, only WPV1 now remains, in areas of Pakistan and Afghanistan.

The announcement was made on World Polio Day – 24 October – in a ceremony attended by global partners in WHO's Executive Board room, the political and spiritual heart of WHO. Addressing the global community, the chair of the GCC, Professor David Salisbury, highlighted the appropriateness of marking this milestone in this particular room – the room where the global eradication of smallpox had been announced in 1980 and where, eight years later, the decision to eradicate polio from the world was taken.

Acknowledging that although challenges remained and that efforts to eradicate remaining WPV1 and to stop the emergence of cVDPV strains must continue to be intensified, Professor Salisbury underscored the achievements possible when the world works towards a global common goal. "For sure we are not there yet," he said. "But what an achievement it is that this particular strain – WPV3 – will never again paralyse any child anywhere in the world. It is an incredible feat, and one that shows us that the strategies – if fully implemented – work."

With no WPV of any type detected anywhere on the African continent since 2016, and the region now eligible to become the fifth WHO region to be certified free of all WPVs (along with the Region of the Americas, European Region, South-East Asia Region and the Western Pacific Region), WHO Regional Director for Africa Dr Matshidiso Rebecca Moeti addressed the gathering via videoconference and assured the group of ongoing efforts to rid Africa of all strains of poliovirus. "Wild poliovirus eradication in Africa – though a tremendous achievement – would be an unfinished success story.

Certificate of Worldwide Eradication of Wild Poliovirus Type 3

Professor David Salisbury, chair of the independent Global Commission for the Certification of Poliomyelitis Eradication, presenting the official certificate of WPV3 eradication to WHO Director-General Dr Tedros Adhanom Ghebreyesus. *©WHO*

We will not rest until the risk of cVDPVs in our region has also been addressed," she said.

Throughout 2019, the GCC continued to intensify its work and review the criteria that will need to be met to achieve global certification of WPV eradication. Within this context, the GCC recommended a process of sequential certification of WPV eradication, and subsequently a process for confirming the absence of vaccine-derived polioviruses, which would occur after the global certification of WPVs and subsequent oral polio vaccine withdrawal globally.

THE IMPORTANCE OF EFFECTIVE CONTAINMENT

Containment includes biosafety and biosecurity requirements for laboratories, vaccine production sites or any other facility that handles or stores poliovirus infectious materials, to minimize the risk of polioviruses being released into the environment.

Significant progress has been made since 2018, when WHO Member States adopted a World Health Assembly resolution committing to intensifying national efforts to contain type 2 poliovirus. Countries conducted national inventories of facilities holding WPV2 and cVDPV2 and destroyed unneeded materials. They designated facilities that will retain type 2 materials for key activities, such as vaccine production and research, and began certifying these facilities against WHO's *GAPIII Containment Certification Scheme*. As of 6 April 2020, 25 countries plan to retain type 2 materials in 76 designated poliovirus-essential facilities. National authorities of containment were established to oversee national certification processes, and 53 applications for certificates of participation in the *Containment Certification* Scheme were received from 18 countries. Seven countries have yet to submit applications.

While multiple countries incorporated poliovirus containment policy into national biorisk management legislation, some continued to struggle to ensure that their national authorities for containment do indeed have authority over their proposed facilities. Additional challenges included the continued use of mOPV2 as well as the proposed reintroduction of tOPV for cVDPV2 outbreak response, and a global shortage of GAPIII auditing capacity – an issue the programme continued to address through the provision of auditor training.

Optimism reigned regarding the transition to safer strain use (i.e. S19) and the potential benefits of the anticipated more genetically stable nOPV2.

INTEGRATION

During the first polio campaign to resume in Afghanistan following a temporary pause in SIAs due to COVID-19, 7858 vaccinators aimed to vaccinate 1'101'740 children in Laghman, Kunar and Nangahar provinces.
© WHO/Afghanistan

BLUEPRINTING FOR INTEGRATED ACTION

Integration is one of the three main pillars of the GPEI Polio Endgame Strategy 2019–2023. The GPEI committed to working more systematically with other members of the global health community as well as humanitarian and development actors for mutual gains and broader impact.

Integrated actions aim to help interrupt transmission, achieve and sustain polio eradication, strengthen immunization to contribute to universal health coverage, and prepare and respond to outbreaks and emergencies. The essence of this work is building a sustainable platform for the delivery of health services and the protection of populations from health threats through strengthening immunization programmes, vaccine-preventable disease surveillance, outbreak preparedness and response capacities, and engagement with communities to understand and respond to their needs.

The current COVID-19 pandemic exposed systemic weaknesses in health systems and vulnerabilities in the global community's ability to prevent and respond to pandemic threats. The effectiveness of global health systems needs to be improved, by sharing best practices, knowledge, human and logistics resources and closing the gap in response capabilities and readiness.

In 2019, a cross-regional, cross-departmental and cross-partnership working group mapped out priorities and actions for the integration of polio eradication and immunization activities, examining programme areas, including coordination and management, vaccine-preventable disease surveillance and laboratory networks, health information systems, community engagement, vaccine supply and delivery, outbreaks and emergencies. A Programme of Work for Integrated Action for Polio Eradication and Essential Immunization began being developed to provide a road map covering 2020 to 2023, with a longer-term vision for key global partners to enhance alignment and coordination among their interrelated activities so that integration is optimized. The work programme aims to provide a wide-ranging overview of integrated actions within common strategic priorities and critical programme areas. By outlining roles and responsibilities for each agency of the GPEI partnership and noting implementation milestones for key initiatives, the work programme will also provide a framework for monitoring the progress towards integration for both programmes. Immediate opportunities for tactical implementation focus on conducting integrated, multi-antigen vaccination campaigns; expanding the acute flaccid paralysis surveillance network for polio to broader vaccine-preventable disease and/or communicable disease surveillance; helping support responses to other outbreaks (not just COVID-19 but indeed other communicable disease outbreaks, such as Ebola in the Democratic Republic of the Congo) and emergencies; and promoting community trust and acceptance.

GAVI, THE VACCINE ALLIANCE, AS A CORE PARTNER

A long-standing partner in the global polio eradication effort, Gavi, the Vaccine Alliance, joined the GPEI as the sixth official core partner in 2019. Gavi is taking an active part in the GPEI at all levels of its governance, including the Polio Oversight Board and the Strategy Committee, and is an active participant of the GPEI hub and of the GPEI's governance review. On the request of the GPEI Strategy Committee, a framework for strengthened Gavi–GPEI collaboration was developed in September 2019. This framework describes the principles of collaboration, the already existing areas of joint work and the proposed additional points of collaboration. The framework is underpinned by the goal of strengthening transparency and accountability and having a greater impact of investment for both initiatives.

In 2019, Gavi completed the IPV roll out and finalized its governance approval for an IPV funding window for 2021–2025. Gavi's contributions will be critical to further accelerate routine immunization coverage with polio containing vaccines and other vaccines in priority countries and outbreak settings. At the same time, the collaboration with Gavi can more systematically help address the root causes of polio emergence in polio-free areas, namely inadequate routine immunization levels. A good example of this collaboration is the response to the cVDPV outbreak in Papua New Guinea. In 2018 and 2019, Gavi, the Vaccine Alliance, and GPEI partners worked in close coordination with the Government of Papua New Guinea to address the cVDPV outbreak, while laying the grounds for the recovery and reinvigoration of routine immunization in the country in a sustainable manner. This experience helped to inform similar approaches in other outbreak countries and settings.

While the GPEI will continue work to eradicate polio through virus detection and the vaccination of the unreached, including marginalized, mobile and vulnerable populations that are often missed in routine immunization, systematic collaboration with Gavi and other immunization partners will pave the way for a polio-free world. This collaboration will increase population immunity for polio using all polio containing vaccines and collaborative work to strengthen immunization systems to prevent the risk of future outbreaks.

FINANCING

Global leaders pledge US$ 2.6 Billion to eradicate polio a the Reaching the Last Mile Forum in Abu Dhabi, UAE on 19 Novermber 2019 *© Reaching The Last Mile Forum*

2019 DONOR UPDATE

The eradication effort faced significant challenges in 2019, including increasing vaccine-derived poliovirus outbreaks and rising WPV cases in the virus' last hiding places. While considering new strategies to overcome the virus, several key milestones were encouraging – from Nigeria marking three years without WPV, to the eradication of WPV3 and generous commitments (see Table 1) at the successful pledging event in Abu Dhabi – showing the world that the goal can be achieved.

Government partners and donors continued to bring the GPEI closer to eradicating polio and remained strong proponents of the initiative's mission. National leaders and ministers of health showed firm political support for polio eradication at the G7 and the G20 summits in 2019, building on the established recognition of GPEI efforts in these forums. The "G20 Osaka Leaders' Declaration" "reaffirmed commitment to eradicate polio," with a powerful global health agenda promoted by the Japanese

Table 1: Pledges announced for the GPEI at the Reaching The Last Mile Forum in Abu Dhabi in 2019

US$ 514'800'000	UK	SOVEREIGN DONORS US$ 1'272'596'000	GPEI US$ 2'605'336'000
US$ 215'920'000	USA		
US$ 160'000'000	CROWN PRINCE ABU DHABI		
US$ 160'000'000	PAKISTAN		
US$ 105'500'000	GERMANY		
US$ 84'170'000	NIGERIA		
US$ 10'830'000	NORWAY		
US$ 10'290'000	AUSTRALIA		
US$ 7'400'000	JAPAN		
US$ 2'220'000	LUXEMBOURG		
US$ 1'340'000	NEW ZEALAND		
US$ 116'000	SPAIN		
US$ 10'000	LIECHTENSTEIN		
US$ 1'080'000'000	BILL & MELINDA GATES FOUNDATION	CORE PARTNERS US$ 1'230'000'000	
US$ 150'000'000	ROTARY INTERNATIONAL		
US$ 50'000'000	BLOOMBERG PHILANTHROPIES	PHILANTHROPIES US$ 102'740'000	
US$ 25'000'000	DALIO PHILANTHROPIES		
US$ 15'000'000	TAHIR FOUNDATION		
US$ 6'400'000	UNITED NATIONS FOUNDATION		
US$ 2'000'000	ALWALEED PHILANTHROPIES		
US$ 1'000'000	CHARINA ENDOWMENT FUND		
US$ 1'000'000	NUNGHIA YANGBOA CHARITY FOUNDATION		
US$ 1'000'000	AHMED AL ABDULLA GROUP		
US$ 1'000'000	AL ANSARI EXCHANGE		
US$ 340'000	KASTA TECHNOLOGIES		

Source: GPEI Website

CELEBRATING UAE SUPPORT OF POLIO ERADICATION

The year 2019 was a critical year for mobilizing vital resources to implement the Polio Endgame Strategy 2019–2023 and to ensure continued progress against polio. His Highness Sheikh Mohamed bin Zayed Al Nahyan, Crown Prince of Abu Dhabi, and the UAE – a long-time supporter of the polio programme – further helped the GPEI's effort towards a polio-free world through dedicated leadership and commitment.

In November 2019, His Highness hosted the GPEI pledging event at the Reaching the Last Mile forum in Abu Dhabi. His Highness' commitment of US$ 160 million – contributing to a total of US$ 2.6 billion pledged from global leaders – builds upon the UAE's rich legacy over the past decade of protecting children against polio.

> We are proud to host the GPEI pledging moment in Abu Dhabi and thank all the attendees for their continued commitment to the eradication of polio.
>
> We remain firm in our mission to reach every last child and believe together we can consign polio to the pages of history.

Her Excellency Reem Al Hashimy, UAE Cabinet Member and Minister of State for International Cooperation

In total, the UAE has committed US$ 327.8 million since 2011 to helping end polio, with direct support to Pakistan as well as Afghanistan, Ethiopia, Kenya, Somalia and Sudan.

This support has, for example, provided for the delivery of more than 400 million drops of polio vaccine to protect the most vulnerable and hard-to-reach children in Pakistan, and has funded more than 5000 full-time vaccinators in high-risk areas in the country. Further, through the UAE Pakistan Assistance Program, the UAE has enabled 71 million Pakistani children to be vaccinated, and has supported nearly 100 000 community health workers.

Presidency, while the G7 ministers of health recognized their historic commitment to polio eradication.

At an extraordinary polio pledging event at the Reaching the Last Mile forum in November 2019 in Abu Dhabi, global leaders announced new commitments for the programme, bringing total pledges to US$ 2.6 billion against the US$ 3.27 billion needed to implement the Polio Endgame Strategy 2019–2023. In May, the UAE took a leading role in helping to launch the strategy, setting the stage for the pledging moment by bringing together influential stakeholders and high-level global leadership at an informal event in Geneva.

The funds pledged will enable the programme to reach millions of vulnerable children with vaccines. However, the future of polio eradication hinges on additional continuous support and engagement at all levels of the programme – from individuals to communities to local and national governments and donors.

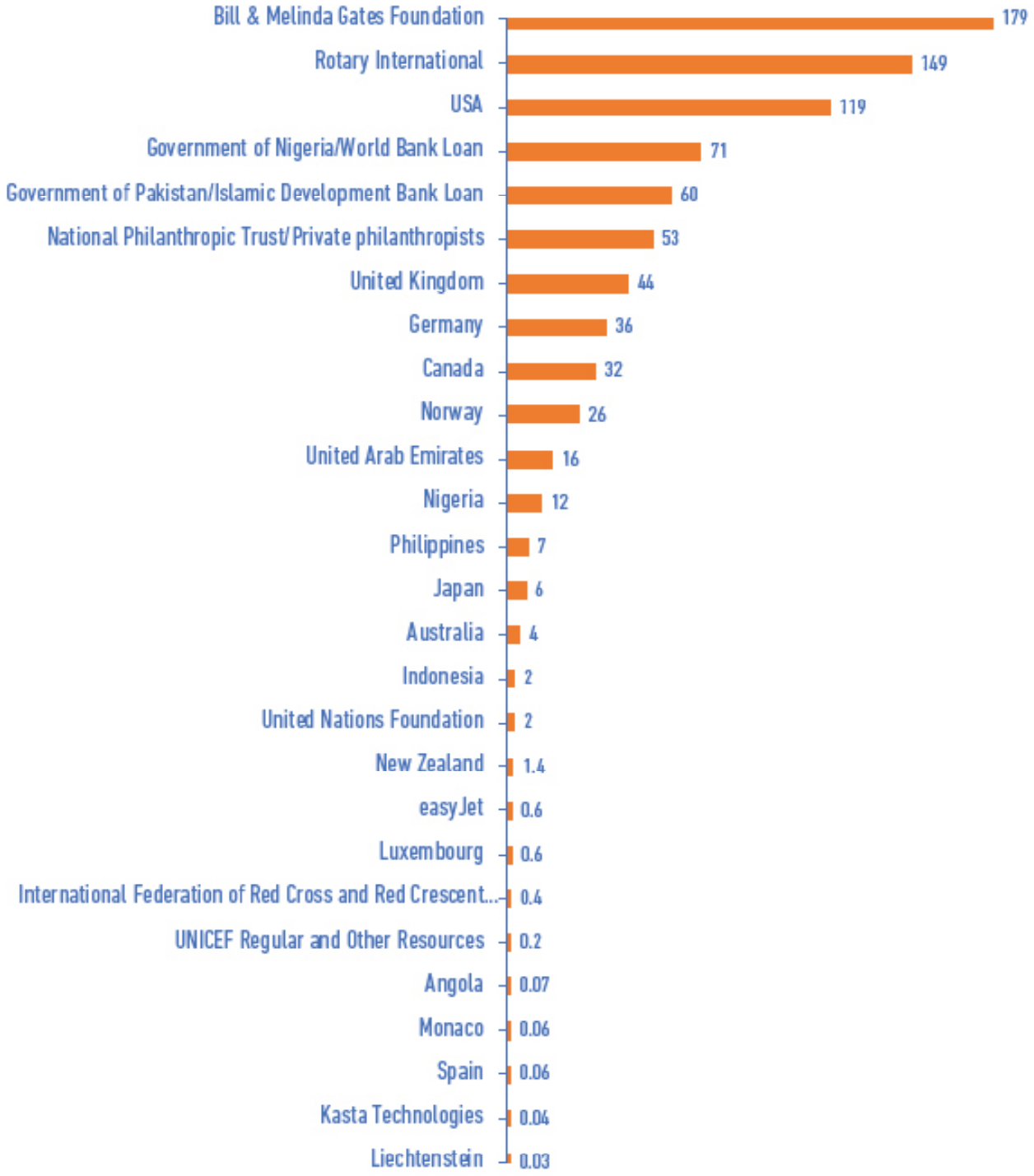
In 2020, the GPEI has had to adapt its approaches to the COVID-19 reality. It is expected that the financial resources required to eradicate polio may increase. As polio campaigns resume, additional investments are needed to protect health workers and communities during vaccination campaigns. The drop in essential immunization services and the pause in campaigns in 2020 may give rise to increased cases and costs to respond. The GPEI has begun a careful risk analysis of the evolving epidemiology to ensure responses are conducted in the safest and most efficient manner possible, including through multi-antigen activities when appropriate.

If the strategies needed to reach and vaccinate children are fully implemented and funded, **the GPEI is confident that it can deliver a world where no child lives in fear of polio**.

MONETIZED CONTRIBUTIONS TO THE GPEI IN 2019

The GPEI thanks the following donors for their generous contributions to the initiative's work in 2019, which helped ensure that the activities described in this Annual Report were implemented. The international development community's long-standing support is critical to delivering a polio-free future for everyone.

Table 2: Monetized contributions to the GPEI in 2019 (in US$ millions)



COUNTRY MONITORING

State / Area	Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Southern (Kandahar, Helmand)	Interrupt transmission	Number of cases	0 case	7	4
	High population immunity	% 0-dose	<10%	2.86%	2.65%
		LQAS (% lots with "High Pass")	>= 90%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NIDs; 2 SNIDs	3 NIDs; 2 SNIDs
		% children missed due to no visit/child absent (in 11 LPDs)		N/a	N/a
		% children missed due to refusal (in 11 LPDs)		N/a	N/a
	High virus detection	AFP rate	> 2 per 100 000	18.70%	16.20%
		Stool adequacy	> 80%	89.85%	89.09%
		Lab receipt to virus isolation result (median)	< 14 days	11	10
	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	6	12
	High population immunity	% 0-dose	<10%	0.32%	0.60%
		LQAS (% lots with "High Pass")	>= 90%		
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	1 NIDs; 2 SNIDs	3 NIDs; 2 SNIDs
	High virus detection	AFP rate	> 2 per 100 000	19.20%	18%
		Stool adequacy	> 80%	94.77%	94.81%
		Lab receipt to virus isolation result (median)	< 14 days	12	11
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal reach in immunization campaigns	% F/M vaccinated	ns*	93.18%	93.42%	94.30%	92.63%
Equal doses received	Median # doses F/M	ns	12	12	12	11
	% F/M 0-dose	ns	0.74%	0.73%	0.60%	1.45%
	% F/M 3+ doses	ns	97.22%	96.20%	94%	94%
Equal timeliness of disease notification	Median # days disease notification	ns	3	3	3	3
	% F/M <= 3 days	ns	55.27%	54.68%	55.84%	56.12%
Women's participation in immunization campaigns	% F/M frontline workers in urban areas	>50%	40%	60%	40%	60%

*Target of ns refers to achieving a non-significant result in terms of gender differences.

COUNTRY MONITORING

State / Area	Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
North Central (Kano, Katsina, Jigawa, Kaduna)	Interrupt transmission	Number of cases (cVDPV2)	0 case	0	0
	High population immunity	% 0-dose	<10%	0.90%	0.00%
		LQAS	>= 90%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	5 CR, 1 SNID	2 NIDs 1 SNIDs
		% children missed due to no visit/child absent		N/a	N/a
		% children missed due to refusal		N/a	N/a
	High virus detection	AFP rate	> 2 per 100 000	7.50	6.51
		Stool adequacy	> 80%	95.7	95.3
		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
Northeast (Borno, Yobe)	Interrupt transmission	Number of cases (cVDPV2)	0 case	2	2
	High population immunity	% 0-dose	<10%	4.12%	0.56%
		LQAS	>= 90%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	3 CR, 1 SNID	2 NIDs 1 SNIDs
		% children missed due to no visit/child absent		N/a	N/a
		% children missed due to refusal		N/a	N/a
	High virus detection	AFP rate	> 2 per 100 000	18.08	9.75
		Stool adequacy	> 80%	89.02	90.17
		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

COUNTRY MONITORING

State / Area	Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Rest of North (Sokoto, Kebbi, Zamfara)	Interrupt transmission	Number of cases (cVDPV2)	0 case	1	0
	High population immunity	% 0-dose	<10%	0.00%	0.00%
		LQAS	>= 90%	N/a	N/a
		% inaccessible	<5%	N/a	
		Number and type of activity	per plan	2 CR	2 NIDs, 3 CR, 1 sNID
		% children missed due to no visit/child absent		N/a	N/a
		% children missed due to refusal		N/a	N/a
	High virus detection	AFP rate	> 2 per 100 000	10.42	12.28
		Stool adequacy	> 80%	95.79	96,61
		Lab receipt to virus isolation result (median)	< 14 days	10	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)	0 case	12	12
	High population immunity	% 0-dose	<10%	0.55%	0.35%
		LQAS	>= 90%	N/a	N/a
		% inaccessible	<5%	N/a	N/a
		Number and type of activity	per plan	8 CR, 1 SNID	4 CR, 2 NID
	High virus detection	AFP rate	> 2 per 100 000	7.811	5.580
		Stool adequacy	> 80%	94.32	93.75
		Lab receipt to virus isolation result (median)	< 14 days	10	9
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal reach in immunization campaigns	% F/M vaccinated	ns	96.45%	96.19%	95.80%	96.22%
Equal doses received	Median # doses F/M	ns	10	10	11	10
	% F/M 0-dose	ns	1.10%	0.90%	0.29%	0.22%
	% F/M 3+ doses	ns	95.82%	96.29%	96.86%	95.04%
Equal timeliness of disease notification	Median # days disease notification	ns	5	5	5	5
	% F/M <= 3 days	ns	33.64%	32.11%	32.86%	29.86%
Women's participation in immunization campaigns	% F/M frontline workers	>80%	82%	18%	86%	14%

COUNTRY MONITORING

State / Area	Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
KP	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	26	63
	High population immunity	% 0-dose	<10%	0.70%	1.93%
		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, 2 SNIDs, 1 CR	1, NID, 1 SNIDs, 4 CR
		% children missed due to no visit/ child absent		N/a	N/a
		% children missed due to refusal		N/a	N/a
	High virus detection	AFP rate	> 2 per 100 000	18.79	21.23
		Stool adequacy	> 80%	82.86	82.61
		Lab receipt to virus isolation result (median)	< 14 days	11	10
	Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a
FATA (KPTD)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	8	11
	High population immunity	% 0-dose	<10%	0.50%	1.80%
		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, 2 SNIDs, 1 CR	1 NIDs, 2 CR
		% children missed due to no visit/ child absent		N/a	N/a
		% children missed due to refusal		N/a	N/a
	High virus detection	AFP rate	> 2 per 100 000	27.95	24.74
		Stool adequacy	> 80%	86.3	87.1
		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

COUNTRY MONITORING

State / Area	Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Karachi (SINDH)	Interrupt transmission	Number of cases (WPV1 and cVDPV2)	0 case	3	27
	High population immunity	% 0-dose	<10%	0.48%	0.48%
		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, 2 SNIDs, 1 CR	1 NIDs, 1 CR
		% children missed due to no visit/ child absent		N/a	N/a
		% children missed due to refusal		N/a	N/a
	High virus detection	AFP rate	> 2 per 100 000	15.36	17.14
		Stool adequacy	> 80%	89.27	89.31
		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 and cVDPV2)	0 case	7	23
	High population immunity	% 0-dose	<10%	0.13%	0.70%
		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, 2 SNIDs, 1 CR	1 NIDs, 1 SNIDs, 6 CR
	High virus detection	AFP rate	> 2 per 100 000	15.087	17.637
		Stool adequacy	> 80%	87.51	86.45
		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
All of country		Number of polio cases from families refusing OPV	0 case	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal reach in immunization campaigns	% F/M vaccinated	ns	96.18%	96.33%	92.92%	93.82%
Equal doses received	Median # doses F/M	ns	10	10	10	10
	% F/M 0-dose	ns	0.58%	0%	0.85 %	1.41 %
	% F/M 3+ doses	ns	99.06%	99.09%	97.87%	97.53%
Equal timeliness of disease notification	Median # days disease notification	ns	3	3	3	3
	% F/M <= 3 days	ns	55.27%	56.59%	54.97%	56.34%
Women's participation in immunization campaigns	% F/M frontline workers	>80%	63%	37%	63%	37%

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	7 cVDPV2	123 cVDPV2
High population immunity	% 0-dose	<10%	12.61%	25.50%
	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 CR	17 CR
High virus detection	AFP rate (national)	>2	2.79	3.42
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	64%	72%
	Stool adequacy (national)	>=80%	88.68	82.29
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	90%	100%
	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%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	4	3	2	2
	% F/M 0-dose	ns	13.64	13.64	27.06	29.17
	% F/M 3+ doses	ns	77.27	62.12	45.88	37.5
Equal timeliness of disease notification	Median # days disease notification	ns	5	5	5	5
	% F/M <= 3 days	ns	32.99	36.13	31.91	33.50

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	1 cVDPV2	8 cVDPV2
High population immunity	% 0-dose	<10%	1.39%	3.70%
	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	0	6 CR, 1 mop-up
High virus detection	AFP rate (national)	>2	5.59	6.53
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	92%
	Stool adequacy (national)	>=80%	94	89
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	100%	92%
	Lab receipt to virus isolation result (median)	< 14days	8	9
	Environmental surveillance	Yes or No	Yes	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	4	4	4	4
	% F/M 0-dose	ns	0	2.63	2.94	4
	% F/M 3+ doses	ns	91.43	84.21	91.18	76
Equal timeliness of disease notification	Median # days disease notification	ns	8	6	8	7
	% F/M <= 3 days	ns	19.12	30.99	18.03	25.93

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	0	1 cVDPV2
High population immunity	% 0-dose	<10%	0.64%	5.83%
	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	0	0
High virus detection	AFP rate (national)	>2 (national)	4.93	3.21
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	92%	62%
	Stool adequacy (national)	>=80% (national)	84%	82%
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	92%	67%
	Lab receipt to virus isolation result (median)	< 14 days	N/a	N/a
	Environmental surveillance	Yes or no	N/a	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	4	4	4	4
	% F/M 0-dose	ns	0	1.03	5.41	5.97
	% F/M 3+ doses	ns	93.33	96.91	83.78	89.55
Equal timeliness of disease notification	Median # days disease notification	ns	4	3	5	4
	% F/M <= 3 days	ns	49.37	51.37	43.64	47.87

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	0	0
High population immunity	% 0-dose	<10%	4.44%	5.96%
	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 CR, 1 SNID, 1 NID	4 CR, 1 mop-up
High virus detection	AFP rate (national)	>2	5.81	5.53
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	80%
	Stool adequacy (national)	>=80%	82.85	83.89
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	75%	60%
	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%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	5	6	4	5
	% F/M 0-dose	ns	4.82	4.12	1.30	9.46
	% F/M 3+ doses	ns	89.16	87.63	90.91	81.08
Equal timeliness of disease notification	Median # days disease notification	ns	4	5	5	5
	% F/M <= 3 days	ns	45.59	38.42	38.76	42.11

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	4 cVDPV2	17 cVDPV2
High population immunity	% 0-dose	<10%	4.88%	7.69%
	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 CR, 2 SNIDs	3 CR
High virus detection	AFP rate (national)	>2	7.48	9.1
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	86%	100%
	Stool adequacy (national)	>=80%	69.89	71.85
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	43%	43%
	Lab receipt to virus isolation result (median)	< 14 days	8	8
	Environmental surveillance	Yes or No	Yes	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	4	3	4	4
	% F/M 0-dose	ns	11.11	3.45	13.16	7.41
	% F/M 3+ doses	ns	61.11	68.97	63.16	72.22
Equal timeliness of disease notification	Median # days disease notification	ns	7	7	8	6
	% F/M <= 3 days	ns	20.51	30.91	31.25	28.41

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	0	9 cVDPV2
High population immunity	% 0-dose	<10%	9.68%	0.36%
	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 sNID	6 CR
High virus detection	AFP rate (national)	>2	11.23	10.86
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	96%	96%
	Stool adequacy (national)	>=80%	90	86.55
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	82%	68%
	Lab receipt to virus isolation result (median)	< 14 days	N/a	N/a
	Environmental surveillance	Yes or No	N/a	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	6	5	5	5
	% F/M 0-dose	ns	0.78	3.05	0	0
	% F/M 3+ doses	ns	95.35	92.07	92.37	91.5
Equal timeliness of disease notification	Median # days disease notification	ns	5	5	6	6
	% F/M <= 3 days	ns	34.81	34.06	30.32	30.04

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	0	0
High population immunity	% 0-dose	<10%	3.80%	2.00%
	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	0	0
High virus detection	AFP rate (national)	>2 (national)	4.41	3.37
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	90%	80%
	Stool adequacy (national)	>=80% (national)	79%	88%
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	50%	80%
	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%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	3	3	4	4
	% F/M 0-dose	ns	4.48	3.08	5.13	0
	% F/M 3+ doses	ns	89.55	86.15	92.31	88.33
Equal timeliness of disease notification	Median # days disease notification	ns	5	4	5	4
	% F/M <= 3 days	ns	39.34	44.35	40.79	45.79

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	21 cVDPV2	65 cVDPV2
High population immunity	% 0-dose	<10%	3.46%	4.94%
	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	6 CRs, 1 NID	18 CR, 1 sNID
High virus detection	AFP rate (national)	>2	9.03	8.99
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
	Stool adequacy (national)	>=80%	82.89	88.02
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	56%	77%
	Lab receipt to virus isolation result (median)	< 14 days	8	8
	Environmental surveillance	Yes or No	Yes	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	4	5	5	4
	% F/M 0-dose	ns	4.23	3.84	6.23	5.23
	% F/M 3+ doses	ns	81.73	80.06	79.49	80.32
Equal timeliness of disease notification	Median # days disease notification	ns	6	6	6	6
	% F/M <= 3 days	ns	30.05	27.22	28.64	27.84

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	1 cVDPV2	12 cVDPV2
High population immunity	% 0-dose	<10%	3.13%	4.20%
	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	3 CR	3 CR
High virus detection	AFP rate (national)	>2	2.55	2.98
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	86%	91%
	Stool adequacy (national)	>=80%	89.31	91.78
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	71%	91%
	Lab receipt to virus isolation result (median)	< 14 days	8	9
	Environmental surveillance	Yes or No	Yes	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	3	3	3	3
	% F/M 0-dose	ns	2.94	3.27	5.33	4.04
	% F/M 3+ doses	ns	86.03	88.24	76.67	85.35
Equal timeliness of disease notification	Median # days disease notification	ns	4	4	4	4
	% F/M <= 3 days	ns	45.73	41.77	40.52	45.09

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	0	18 cVDPV2
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	N/a	4 CR
High virus detection	AFP rate (national)	>2 (national)	5.46	5.58
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
	Stool adequacy (national)	>=80% (national)	90%	88%
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	90%	88%
	Lab receipt to virus isolation result (median)	< 14 days	N/a	N/a
	Environmental surveillance	Yes or no	N/a	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	3	3	3	3
	% F/M 0-dose	ns	0	0	0	0
	% F/M 3+ doses	ns	94.44	95.05	98.46	96.67
Equal timeliness of disease notification	Median # days disease notification	ns	4	4	4	4
	% F/M <= 3 days	ns	40.48	44.78	42.18	45.79

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	2 cVDPV1	3 cVDPV2
High population immunity	% 0-dose	<10%	19.40%	11.10%
	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	0	2 CR
High virus detection	AFP rate (national)	>2 (national)	1.70	3.20
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	50%	86%
	Stool adequacy (national)	>=80% (national)	81.5	86
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	69%	79%
	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%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	4	4	4	4
	% F/M 0-dose	ns	20	19.05	15.38	9.76
	% F/M 3+ doses	ns	80	76.19	84.62	85.37
Equal timeliness of disease notification	Median # days disease notification	ns	5	3	6	4
	% F/M <= 3 days	ns	46.43	56.76	35.14	45.05

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	1 cVDPV2	2 cVDPV1, 13 cVDPV2
High population immunity	% 0-dose	<10%	4.55%	13.04%
	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	0	2 CR
High virus detection	AFP rate (national)	>2	1.44	3.56
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	9%	18%
	Stool adequacy (national)	>=80%	32.92	51.03
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	80%	0%
	Lab receipt to virus isolation result (median)	< 14 days	N/a	N/a
	Environmental surveillance	Yes or No	N/a	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	3	3	3	3
	% F/M 0-dose	ns	9.52	4.17	10.59	20.88
	% F/M 3+ doses	ns	80.95	87.50	68.24	64.84
Equal timeliness of disease notification	Median # days disease notification	ns	13	18	6	5
	% F/M <= 3 days	ns	19.09	20.30	32.37	34.80

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case	3 cVDPV2	0
High population immunity	% 0-dose	<10%	9.79%	10.60%
	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 CR, 2 NIDs	1 CR, 1 sNID
High virus detection	AFP rate (national)	>2	5.30	4.61
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	100%	100%
	Stool adequacy (national)	>=80%	97.41	93.4
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	100%	95%
	Lab receipt to virus isolation result (median)	< 14 days	8	8
	Environmental surveillance	Yes or No	Yes	Yes
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	7	7	8	7
	% F/M 0-dose	ns	8.2	10.71	9.62	11.48
	% F/M 3+ doses	ns	85.25	85.71	88.46	83.61
Equal timeliness of disease notification	Median # days disease notification	ns	3	3	3	3
	% F/M <= 3 days	ns	59.26	57.14	59.49	63.64

COUNTRY MONITORING

Outcome	Indicator	Target	Jan-Jun 2019	Jul-Dec 2019
Interrupt transmission	Number of cases	0 case		8 cVDPV2
High population immunity	% 0-dose	<10%	9.70%	2.10%
	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	0	3 CR
High virus detection	AFP rate (national)	>2	3.43	5.55
	AFP rate (sub-national)	>2 (% of states/provinces meeting indicator)	83%	100%
	Stool adequacy (national)	>=80%	82.5	64.7
	Stool adequacy (sub-national)	>=80% (% of states/ provinces meeting indicator)	67%	50%
	Lab receipt to virus isolation result (median)	< 14 days	N/a	N/a
	Environmental surveillance	Yes or No	N/a	No
Low risk of reintroduction	RI improvement: % reduction in unimmunized children	>10%	N/a	N/a

COUNTRY MONITORING THROUGH GENDER-SENSITIVE INDICATORS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	3	3	3	3
	% F/M 0-dose	ns	18.18	5	5.88	0
	% F/M 3+ doses	ns	72.73	95	82.35	87.88
Equal timeliness of disease notification	Median # days disease notification	ns	3	5	7	8
	% F/M <= 3 days	ns	52.38	36.84	29.79	24.56

AFRICAN REGION

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	5	5	5	5
	% F/M 0-dose	ns	2.46	2.22	2.87	2.87
	% F/M 3+ doses	ns	90.37	90.35	88.38	88.40
Equal timeliness of disease notification	Median # days disease notification	ns	5	5	5	5
	% F/M <= 3 days	ns	38.82	37.01	38.67	38.40

REGION OF THE AMERICAS

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	4	4	4	4
	% F/M 0-dose	ns	0	0	0	0
	% F/M 3+ doses	ns	78.22	76.34	70.33	72.86
Equal timeliness of disease notification	Median # days disease notification	ns	5	5	5	4
	% F/M <= 3 days	ns	23.62	27	30.38	32.24

SOUTH-EAST ASIA REGION

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	13	13	14	14
	% F/M 0-dose	ns	0.76	0	1.32	0
	% F/M 3+ doses	ns	97.68	97.66	97.57	97.53
Equal timeliness of disease notification	Median # days disease notification	ns	3	3	3	2
	% F/M <= 3 days	ns	53.44	55.66	55.97	60.79

EUROPEAN REGION

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	5	5	5	5
	% F/M 0-dose	ns	2.22	3.05	2.92	2.06
	% F/M 3+ doses	ns	88.89	91.37	82.48	89.18
Equal timeliness of disease notification	Median # days disease notification	ns	4	3	4	3
	% F/M <= 3 days	ns	45.21	50.84	49.44	54.20

EASTERN MEDITERRANEAN REGION

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	10	10	10	10
	% F/M 0-dose	ns	0	0	1.14	0
	% F/M 3+ doses	ns	97.79	97.94	97.09	96.69
Equal timeliness of disease notification	Median # days disease notification	ns	3	3	3	3
	% F/M <= 3 days	ns	56.8	58	56.75	59.07

WESTERN PACIFIC REGION

Outcome	Indicator	Target	Jan-Jun 2019		Jul-Dec 2019	
			Female	Male	Female	Male
Equal doses received	Median # doses F/M	ns	3	4	3	4
	% F/M 0-dose	ns	2.15	1.04	2.70	2.99
	% F/M 3+ doses	ns	94.45	95.84	93.17	92.51
Equal timeliness of disease notification	Median # days disease notification	ns	3	2	3	2
	% F/M <= 3 days	ns	54.53	59.36	54.73	58.42

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