

4. Strategic Objective IV

Mainstreaming of the Global Polio Eradication Initiative

Milestone 2008 ²⁵	Status
Milestone 1: All joint GAVI/Polio priority countries will implement integrated plans.	Not achieved
Milestone 2: All countries will have integrated or expanded AFP reporting, as appropriate (especially for measles and neonatal tetanus).	Not achieved
Milestone 3: All countries will have a GAVI-supported Interagency Coordination Committee (ICC) and if appropriate, a Technical Advisory Group (TAG).	Achieved
Milestone 4: All polio-funded “human resources” will formally contribute to multi-disease programmes.	Achieved
Milestone 5: All countries will have polio operations which are fully integrated with those for measles.	Not achieved

As the world’s single-largest internationally coordinated public health effort, the GPEI has developed a comprehensive public health infrastructure throughout some of the world’s most under-served countries. Comprising human resources, communication networks, operational guidelines and standards, independent strategic guidance bodies and streamlined partner coordination mechanisms, together with the ‘nuts and bolts’ of the operation – the offices, vehicles and medical and non-medical equipment – this infrastructure is not only a living asset to the countries in which it operates, but is superbly placed to assist in disease surveillance, large-scale immunization operations, and public health or national emergencies as they occur.

In 2008 alone, GPEI staff and infrastructure responded to catastrophic floods in Bihar, India, were deployed to tackle the Ebola outbreak in the Democratic Republic of the Congo as well as outbreaks of cholera and avian influenza in Africa and Asia, and provided support for measles immunization in several countries, as well as immunization with DTP, yellow fever and tetanus toxoid (TT) vaccines in Nigeria.

In many areas of the world, polio staff constitute the single largest resource of technical assistance for immunization and surveillance in low-income countries. Of 999 WHO immunization staff in the AFR, for example, 914 (91%) are funded by the polio programme, with the vast majority spending a considerable proportion of their time on work related to immunization, surveillance and outbreak

response for diseases other than polio. Polio employs more than 3000 technical and support staff globally. Their day-to-day work includes health staff training, district-level microplanning, refurbishment of vaccine cold chain systems, and scaling up the technical capacity of networks for surveillance and monitoring of vaccine-preventable diseases (VPDs). As human resources in the polio effort are scaled down with progress towards eradication, it will be essential that this does not create a vacuum for other health programmes.

Key decisions on post-eradication planning in 2008 – notably the WHA resolution in May – paved the way for more concrete planning for the mainstreaming of the GPEI in the long term. A key element of a new strategic plan for GPEI is a timeline to help countries in their long-term planning and preparation for integration and downscaling processes, once polio is eradicated. The timeline is of course dependent on interrupting WPV transmission in the remaining infected areas. The downscaling processes will eventually encompass all functions currently performed by polio-funded staff – such as immunization planning and monitoring, policy development, training and surveillance for other VPDs – with a view to transitioning these functions to other internationally- or nationally-funded immunization staff.

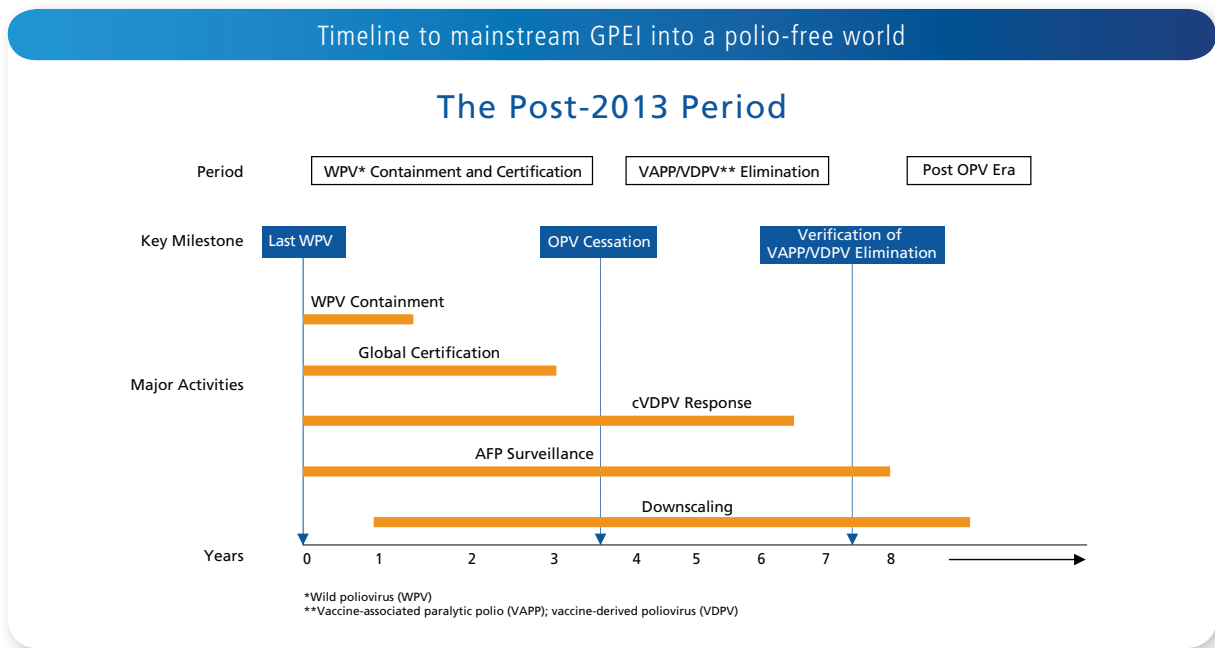
To minimize the risks associated with OPV cessation, international agencies and national governments will need to, inter alia: ensure sustained AFP surveillance for at least five years following OPV cessation; maintain long-term polio surveillance and outbreak response capacity;

²⁵ Details in Appendix A.

implement full containment of Sabin polioviruses; and verify VAPP/VDPV elimination.

To this effect, work continued in 2008 to ensure that the long-term functions, including containment, surveillance and outbreak response capacity, would be managed in the long-term in other, non-GPEI institutions and oversight bodies (e. g. WHO’s Global Alert and Response Network

and the SAGE). In the near-term, a risk analysis will be conducted to ascertain how downscaling will affect other public health programmes, and a risk management plan developed in coordination and consultation with country-level programmes and appropriate stakeholders in other public health programmes, especially immunization.



Counting every child – Because every child counts

In the teeming streets of India's Uttar Pradesh state, ensuring each of the estimated 38 million children in India's most populous state receives the optimum doses of polio vaccine remains one of the GPEI's greatest challenges.

For here, some 500 000 children are born every month and until recently, the names of up to half of those children were not making it onto the official medical registry.

Each month, mobile polio vaccination teams, which walk from house to house to ensure blanket immunization coverage, continued to find unregistered, unimmunized newborns. Not only are these infants susceptible to contracting and carrying polio, but their unregistered status skews immunization coverage figures, making planning for the immunization effort an unwanted guessing game.

Seeking a solution, the National Polio Surveillance Project established the Tracking Every Newborn initiative, where individual immunization teams recorded the details of each newborn infant on their house-to-house visits, moments before giving them their first dose of OPV.

In a 12-month pilot project undertaken across one block in each of eight districts of western Uttar Pradesh, the names of all newborns were added to the immunization registers held by the local Auxiliary Nurse Midwives (ANMs). After six months, the number of registered children had nearly doubled. While the ANM registers showed 16 569 newborn children, polio workers confirmed an *additional* 15 742 newborn children.

It was then possible to determine more accurate immunization coverage, which showed, for example, that of the 32 311 infants who now appeared on the official register, only 60% were fully immunized against diphtheria, tetanus and pertussis (DTP3).²⁶

The Tracking Every Newborn project has also motivated the community – from ANMs and vaccinators to the parents themselves – to ensure that all newborn children are placed on the official register for routine immunization purposes.

The Uttar Pradesh Government subsequently requested that the successful initiative be expanded to other blocks, to ensure every child in Uttar Pradesh gets counted – because every child counts.



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Polio's determination to reach every newborn child in India has proved a boon for Uttar Pradesh's official immunization register.

26 DTP3 coverage is used as a measure of immunization coverage.