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FRAMEWORK FOR CERTIFICATION OF POLIO ERADICATION IN THE AFRICAN REGION

Report of the Secretariat

EXECUTIVE SUMMARY

1. Certification of polio eradication is conducted on a World Health Organization (WHO) regional basis. A Region is considered for certification only when all Member States demonstrate the absence of wild poliovirus (WPV) transmission for at least three consecutive years on the basis of certification-standard surveillance for polio. By 2014, poliomyelitis had been certified to have been eradicated in four of the six WHO regions, except for the African and East Mediterranean Regions.

2. The Sixty-eighth World Health Assembly in 2015 adopted a resolution to ensure interruption of WPV transmission; achieve and maintain certification standard surveillance; introduce inactivated polio vaccine (IPV) before the global withdrawal of the type-2 component of the trivalent oral polio vaccine (tOPV); and ensure that polio assets, lessons learnt and knowledge acquired are used to support other national health priorities.

3. The African Region has made marked progress towards poliomyelitis eradication. By June 2018, no WPV case had been confirmed in the African Region for 22 months since the last case in Nigeria with onset on 21 August 2016, and the last wild poliovirus isolated from the environment on 27 September 2016. All Member States in the Region withdrew the type 2 component of the oral polio vaccine (OPV) by May 2016. Phase 1a documentation of laboratory containment of polio viruses has been conducted by all Member States. IPV has been introduced in routine immunization programmes in Member States that received the vaccine from global stocks. As of June 2018, progressively, almost all Member States (39 out of 47) have been supplied with IPV. A total of 40 countries out of 47 have had their national documentation for claiming polio-free status accepted by the African Regional Certification Commission (ARCC) for Poliomyelitis Eradication. The ARCC plan for accepting documentation of polio-free status from the remaining Member States by 2019 is in place.

4. With this progress, the African Region could be certified to have eradicated polio by end 2019 or early 2020. However, despite the progress made, the current polio surveillance gaps in Member States pose the threat of the Region fulfilling the criteria for certification of poliomyelitis eradication by end 2019. There have also been outbreaks of circulating vaccine-derived polioviruses (cVDPVs) which indicate low population immunity and risk of poliovirus re-introduction in countries that have claimed polio-free status.

5. This framework proposes to Member States priority interventions towards certification of polio eradication in the Region and to remain polio-free post certification. These include conducting risk assessments; strengthening surveillance with expanded use of technological innovations; improving preparedness and the quality of polio outbreak responses; reaching children in insecure areas; laboratory containment of polioviruses; strengthening national certification committees and processes; implementing the International Health Regulations (IHR, 2005); strengthening routine immunization; institutionalizing accountability of polio-funded personnel; finalizing the polio transition plans and implementing the post-polio certification strategy.

6. The Regional Committee is invited to examine and adopt the actions proposed in this framework.

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ANNEXES

ABBREVIATIONS

AFP	Acute flaccid paralysis
AFRO	WHO Regional Office for Africa
ARCC	African Regional Certification Commission for Polio Eradication
bOPV	bivalent oral polio vaccine
cVDPV2	circulating vaccine-derived poliovirus type 2
GIS	Geographic Information Systems
GPEI	Global Polio Eradication Initiative
IDSR	Integrated disease surveillance and response
IHR	International Health Regulations (2005)
ICC	National Interagency Coordination Committee
IPV	Inactivated polio vaccine
mOPV2	monovalent oral polio vaccine type 2
NCCPE	National Certification Committee for Polio Eradication
NTF	National task force for containment
NPEC	National polio expert committee
OPV	Oral polio vaccine
PEF	Polio essential facility
PHEIC	Public health emergency of international concern
POSE	Polio outbreak simulation exercise
tOPV	trivalent oral polio vaccine
WHO	World Health Organization
WPV	Wild poliovirus

INTRODUCTION

1. Poliomyelitis, an irreversible paralyzing viral disease, is caused by three serotypes of wild poliovirus (WPV).[1] In 1988, the Forty-first World Health Assembly adopted a resolution[2] to eradicate all types of poliomyelitis globally by the year 2000. Since then, there has been a 99% reduction of cases, globally. Unfortunately, three countries are still polio-endemic, one of which is in Africa.

2. On 26 May 2012, the World Health Assembly declared ending polio a "programmatic emergency for global public health". Resultantly, the Global Polio Eradication and Endgame Strategic Plan 2013–2018 (Annex 1) was developed to guide Member States.

3. A region is considered for certification only when all countries in the geographical area demonstrate the absence of wild poliovirus transmission for at least three consecutive years with certification-standard surveillance.[3] By 2014, the three poliovirus strains had been certified as eradicated in four of the six WHO regions, except the African and East Mediterranean Regions.[4]

4. In May 2015, the Sixty-eighth World Health Assembly adopted a resolution[5] to ensure interruption of WPV transmission; achieve and maintain certification standard surveillance; introduce inactivated polio vaccine (IPV) before the global withdrawal of the type-2 component of the trivalent oral polio vaccine (tOPV) by May 2016.

5. With the presence of wild poliovirus in the three endemic countries, there is a risk that poliomyelitis may spread to other countries. The persistent surveillance gaps and low population immunity pose a threat of poliovirus importation and the certification of the Region as having eradicated poliomyelitis.

6. This implementation framework has been formulated to guide Member States in ensuring regional certification of poliomyelitis eradication.

CURRENT SITUATION

7. The African Region has made marked progress towards poliomyelitis eradication. In the last five years, there was a reduction from 128 WPV cases in 2012, seventy-six cases in 2013, seventeen cases in 2014,[6] and no reported case in 2015. Unfortunately, in July 2016, after almost two years, four cases were confirmed from the insecure areas of Borno State in northern Nigeria.

8. The insecurity in Borno State resulted in some areas not being reached by vaccination and surveillance teams for a considerable period of time. As such, circulation of polioviruses was not detected until when those areas became accessible. The Government of Nigeria together with Global Polio Eradication Initiative (GPEI) partners quickly mounted an outbreak response to halt further circulation of polioviruses.

9. During the Sixty-sixth Regional Committee in Addis Ababa, Ethiopia, in 2016, the Ministers of Health of the Lake Chad Basin countries[7] declared the polio outbreak in Nigeria a subregional public health emergency and intensified efforts to quickly stop the outbreak.

1 http://www.who.int/biologicals/areas/vaccines/poliomyelitis/en/.
2 World Health Assembly resolution WHA41.28, global eradication of poliomyelitis by 2000.
3 http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/certification/.
4 Global Polio Eradication Initiative Independent Monitoring Board Report, November 2017.
5 World Health Assembly, Document A68/21/ Add1 – 15 May 2015.
6 WHO polio weekly global update, January 2018.
7 Cameroon, Central African Republic, Chad, Niger and Nigeria.

Additionally, a Lake Chad Basin polio task team coordination comprising Member States and GPEI partners was formed to strengthen collaboration in responding to the outbreak. By June 2018, no WPV had been confirmed in the African Region for 22 months since the last case in Nigeria with onset on 21 August 2016, and the last WPV isolated from the environment on 27 September 2016. This is mostly due to the improved quality of the vaccination campaigns in countries.

10. All Member States in the African Region withdrew oral type 2 polio vaccine by switching from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) by May 2016.[8] As of June 2018, thirty-nine Member States had introduced IPV in their routine immunization programmes, with the remaining 10 Member States[9] failing to do so due to global shortage. The routine immunization coverage in the Region has stagnated at around 74% for a number of years. All Member States submitted national documentation of phase 1a laboratory containment of polioviruses according to the GPEI Global Action Plan (GAP) III in 2016.[10]

11. By June 2018, a total of 40 countries out of 47 had their national documentation for claiming polio-free status accepted by the African Regional Certification Commission (ARCC) for Poliomyelitis Eradication.[11] The remaining countries have planned to present their complete documentation to the ARCC by November 2019 (Annex 2). With this progress, the African Region could be certified to have eradicated polio by end 2019 or early 2020. In readiness for the polio programme winding down and its eventual closure, Member States have developed costed polio transition plans to ensure that polio assets benefit other public health interventions.[12]

ISSUES AND CHALLENGES

12. **Insecurity and inaccessibility:** Implementation of planned activities to strengthen surveillance, routine immunization and outbreak responses has been hampered by inaccessibility to localized insecure areas. It is, therefore, difficult to rule out any lingering poliovirus transmission in these areas.

13**. Continued poliovirus transmission and suboptimal outbreak responses:** The confirmation of WPV[13] in 2016 and the circulating vaccine-derived polio virus type 2 (cVDPV2) outbreaks[14] in the eastern part of the Democratic Republic of the Congo, Kenya and Nigeria in 2017 and 2018, coupled with low routine immunization coverage, pose a threat of spread of polioviruses to other countries. The quality of some outbreak responses have been suboptimal, resulting in continued transmission.

14. **Persistent surveillance gaps:** The African Region has persistent poliomyelitis surveillance gaps due to insecurity, weak health systems, competing priorities and in some situations, apathy, as some Member States have not confirmed any polio outbreak for many years. In some instances, surveillance for polio is not prioritized due to perceived competing priorities such as other disease outbreaks and health emergencies.

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8 Seventieth WHA report by the Secretariat -A70/14 document on poliomyelitis.

9 Burkina Faso, Eritrea, Ghana, Malawi, Rwanda, Sierra Leone, Tanzania, Togo, Zambia and Zimbabwe.

10 WHO, Progress report on Polio Eradication Status and Endgame Strategy in the African Region (Document AFR/RC67/INF.DOC/5). *In: Sixty-seventh session of the WHO Regional Committee for Africa, Victoria Falls, Republic of Zimbabwe, 28 August–1 September 2017.* Brazzaville, Congo, World Health Organization, Regional Office for Africa, 2017.

11 ARCC report on progress towards certification, Yaounde-Cameroun meeting, 11–15 December 2017.

12 Executive Board EB/142 report by the Secretariat on Polio Transition Planning, January 2018.

13 Insecure areas of Borno State in Nigeria

14 Several provinces in the Democratic Republic of the Congo, Nairobi-Kenya and several States in Nigeria

15. **Constraints on polio laboratories' performance:** To confirm polioviruses, the WHO Regional Office for Africa has worked with Member States to establish 16 national polio laboratories in the Region which serve the country where the laboratory is situated as well as some neighbouring countries. In some countries where the national laboratories are situated, there are severe restrictions that affect importation and clearance of laboratory reagents, which results in stock-outs and delays in processing specimens.

16. **Low population immunity:** The stagnation and decline in routine immunization performance in some countries implies that there are areas at risk of importation and emergence of poliovirus outbreaks. Furthermore, the suboptimal quality of some polio vaccination campaigns, as well as global shortage of IPV has resulted in low population immunity, with accumulation of populations susceptible to poliovirus infections.

17. **Inadequate containment of polioviruses:** Some research laboratories in the African Region have not fully complied with the containment measures for destruction of potential poliovirus infectious materials to avoid re-introduction/leakage into the environment and populations which could cause massive polio outbreaks. Additionally, despite the switch to bOPV by May 2016, some vials of tOPV have recently been found in health facilities,[15] and their continued use could result in cVDPV2 outbreaks. Furthermore, the use of mOPV2 in response to cVDPV2 outbreaks[16] poses the risk of emergence of "de-novo" cVDPV2.

18. **Weak national polio committees:** National polio committees in some countries have not been fully functional for some years, and this has affected the quality of annual updates and reports. This performance poses a risk of the ARCC not having credible evidence and documentation to certify the Region polio-free.

19. **Reduction of polio-funded personnel and sustaining a post-certification polio-free Region:** As per the WHO Executive Board decision in 2016[17] to reduce indemnity and liability costs to the Organization, the African Region commenced abolition of some polio staff positions according to projected GPEI country budget ceilings. Furthermore, with the closure of the GPEI after certification of polio eradication, there could be some risk of not sustaining poliovirus containment in laboratories and of not guaranteeing polio outbreak detection and response quality as the polio infrastructure will have been dismantled. The reduction of polio-funded personnel could also negatively impact surveillance and implementation of other health interventions in the region.

THE REGIONAL FRAMEWORK FOR ACTION

Vision, goal, objectives, targets and milestones

20. **Vision:** A Region free of polioviruses

21. **Goal:** To achieve certification of the Region as polio-free by end 2019

22. **Objectives:**

(a) To strengthen acute flaccid paralysis (AFP) poliomyelitis surveillance in all countries, including functional environmental surveillance in selected countries.

[15] Chad, Democratic Republic of the Congo, Nigeria.
[16] Cameroon, Chad, Democratic Republic of the Congo, Mozambique, Niger and Nigeria.
[17] Executive Board EB/140/46 report by the Secretariat on Human Resource update, Nov. 2016.

(b) To strengthen national polio certification committees and documentation processes in all countries for declaration of poliomyelitis eradication.

(c) To sustain a polio-free Region after certification of polio eradication.

23. **Targets and Milestones**

(a) Targets

By December 2019

(i) All Member States have their polio-free status documentation accepted by the ARCC.
(ii) The Region has been certified polio free.

By January 2020

(i) All Member States commence implementation of the post-polio certification strategy to sustain a polio-free Region.

(b) Milestones

By December 2018

(i) All Member States in the Region achieve and sustain certification-level[18] surveillance at national and subnational levels.
(ii) All selected Member States have fully functional environmental surveillance that meets the set performance indicators.

By March 2019

(i) All Member States have trained and fully functional national polio committees in readiness for submitting annual update reports and documentation of their polio-free status.

Guiding principles

24. **Country ownership and leadership:** The functionality of the national polio surveillance network is the responsibility of the government at all levels and Member States should enhance their leadership role in ensuring sensitive surveillance systems for certification.

25. **Partnership:** Achieving polio eradication will require continued availability of resources (financial, material and human) from GPEI partners, governments and nongovernmental organizations.

26. **Intersectoral collaboration:** Particularly in insecure areas, intersectoral collaboration with the government, military forces and other sectors will be key in reaching underserved populations.

27. **Integrated approach:** The polio surveillance system is part of the integrated disease surveillance and response (IDSR) system in the Region and this approach should be strengthened at all levels.

[18] At least a non-polio acute flaccid paralysis rate of 2 per 100 000 under five children years and a stool adequacy of at least 80%.

28. **Result-oriented approach:** The improvement in the quality of polio activities should be measured by close monitoring of set performance indicators, and management actions should be swiftly taken where the indicators are deteriorating.

29. **Accountability and evidence-based**: Implementation of the accountability framework for the polio programme at all levels should be "centre stage" for improving programme performance.

30. **Innovations**: National polio programmes have a vast range of innovations and technologies that are proving useful in improving programme performance and data quality.

PRIORITY INTERVENTIONS AND ACTIONS

31. **Conducting risk assessments:** Member States should periodically conduct risk assessments and determine risk for polio transmission and importation. In addition, emerging risks such as insecurity and conflict, population movements and vaccination refusal should be incorporated in the analysis. The risk assessments should be done on a quarterly basis at the national and subnational levels and shared with partners for implementing mitigation measures.

32. **Strengthening surveillance and laboratory capacity**: Member States should urgently strengthen AFP surveillance at all levels (national and subnational) to detect any poliovirus transmission in time for rapid response. In addition to AFP surveillance, in priority areas that fit the criteria for establishing environmental surveillance, Members States should ensure that governmental departments/ministries, such as those dealing with environmental issues, are brought on board to select the collection sites for conducting environmental surveillance. Member States should facilitate clearance waivers or ease clearance procedures for critical laboratory reagents to avoid stock-outs and ensure continued functionality of the polio laboratories.

33. **Improving quality of outbreak response and preparedness plans:** Member States should interrupt poliovirus outbreaks within the shortest period of time by mounting high quality responses. To achieve this, Member States should urgently develop polio outbreak preparedness plans that should be regularly updated. It is also critical that Member States put in place mechanisms to mitigate factors that are contributing to low outbreak response quality, particularly by avoiding unnecessary delays and expediting the transfer of available funding at national level to the implementation levels, improving selection and training of local vaccination teams, enhancing field supervision, monitoring and evaluation of implemented activities.

34. **Increasing accessibility in conflict areas:** Member States should ensure the safety and increase the accessibility of vaccination teams. In some instances, days of tranquillity should be negotiated between factions in conflict to allow vaccination activities to take place. In dangerous and insecure areas where vaccination teams' safety cannot be guaranteed, Member States as a last option, could explore the use of government military forces to conduct actual vaccination.

35. **Ensuring containment and destruction of polioviruses:** To avoid leakage of polioviruses from laboratories and re-introduction into populations and the environment, all Member States should destroy potential poliovirus infectious materials in national laboratories, including in bio-medical research laboratories, once the specimens have been used for the intended research purposes. Furthermore, Member States should quickly conduct validation exercises and destroy tOPV vials found in public and private health facilities. For countries that use mOPV2 for outbreak response to cVDPV2s, the global guidelines for ensuring that all mOPV2 vials are retrieved and destroyed after the response should be strictly adhered to. South Africa, the only Member State in the African Region that has applied to retain wild polioviruses as a Polio

Essential Facility (PEF), should adhere to the global guidelines of being a PEF. In a situation where there is suspicion that containment of polioviruses may have been broken/leaked, the Member State should instantly report to WHO for further investigations and immediate implementation of corrective measures.

36. **Implementing IHR (2005):** Any Member State with an outbreak of WPV or cVDPV should, under the current International Health Regulations (IHR, 2005), immediately declare the outbreak a national public health emergency. This declaration should facilitate mobilization of additional resources from the GPEI partners and the Member State to quickly stop the outbreak. In a situation, where the outbreak poses a risk of spread to nearby countries, the Member States in that geographical area should quickly and jointly declare the outbreak a subregional public health emergency of international concern (PHEIC), and ensure implementation of high-quality cross-border surveillance and synchronized vaccination activities to avoid spread.

37. **Strengthening routine immunization delivery:** Member States should quickly work on re-vitalizing routine immunization to improve population immunity and data quality. Emphasis should be placed on reaching underserved and vulnerable populations in hard-to-reach areas that are at risk of polioviruses. Also, with the recently improved availability of IPV stocks in all countries in the Region, Member States should ensure rapid increase in IPV coverage for boosting population immunity to mitigate cVDPV2 outbreaks.

38. **Reaching hard-to-reach, border area and migrant populations:** Member States should map out hard-to-reach, border areas and seasonal migrant routes with estimation of populations. All efforts should be made to increase access to vaccinations and surveillance using local innovations, such as geo-mapping and micro-planning, which should be coupled with other health interventions to increase acceptability and uptake of polio vaccines. Cross-border vaccination, including permanent transit point vaccination and market day vaccination, and surveillance of migrant/nomadic populations should also be strengthened.

39. **Expanding use of technologies and innovations:** The GIS-based technological innovations, available in the Regional Office provide "real-time" geographical information on implementation of planned surveillance, immunization and supportive supervision. They are proving useful in improving programme performance and should be urgently adopted and scaled up by all Member States with the help of the Regional Office for Africa, including the Intercountry Support Teams (ISTs) and WHO country offices. Member States should use the generated data from these innovations to further strengthen surveillance and routine immunization.

40. **Strengthening certification processes:** Member States should urgently review the membership and activities of the national committees in preparation for robust documentation and updates for the ARCC to confidently declare certification of poliomyelitis eradication of the African Region. In some instances, Member States should consider replacing persistently inactive national committee members. The appointed national committee members should be trained and re-oriented to ensure capacity is built for certification processes. Member States should ensure that annual updates and reports on national certification activities are submitted in time to the ARCC according to the stipulated deadlines.

41. **Improving accountability based on evidence**: To further improve programme performance and ensure certification of polio eradication in the Region in the shortest possible time, Member States should develop key programme performance indicators that should contribute to the key regional indicators for measuring progress of implementation of the Framework (annex 3). Member States should conduct periodic monitoring and evaluation activities to measure progress.

Where there is evidence of chronic staff apathy, with persistent programme deterioration that puts the Region at risk of not being certified polio-free, accountability management actions should be taken on government and agencies' staff working on the programme.

42. **Implementing polio transition planning and post-polio certification strategy:** Member States should mobilize domestic and in-country development partner support through interagency coordinating committees to fill the gap that may be caused by the current polio transition planning to ensure sustenance of the progress being made towards certification. To maintain polio–free status after certification, Member States should put in place mechanisms for sustaining polio essential functions (containing the polioviruses in laboratories, promptly detecting any poliovirus outbreak that may occur, and conducting adequate outbreak responses).

43. The Regional Committee is invited to examine and adopt the proposed framework. Progress in implementing the framework should be presented to the Seventieth session of the Regional Committee in 2020.

ANNEX 1: Monitoring Framework for the Global Polio Eradication and Endgame Strategic Plan 2013–2018

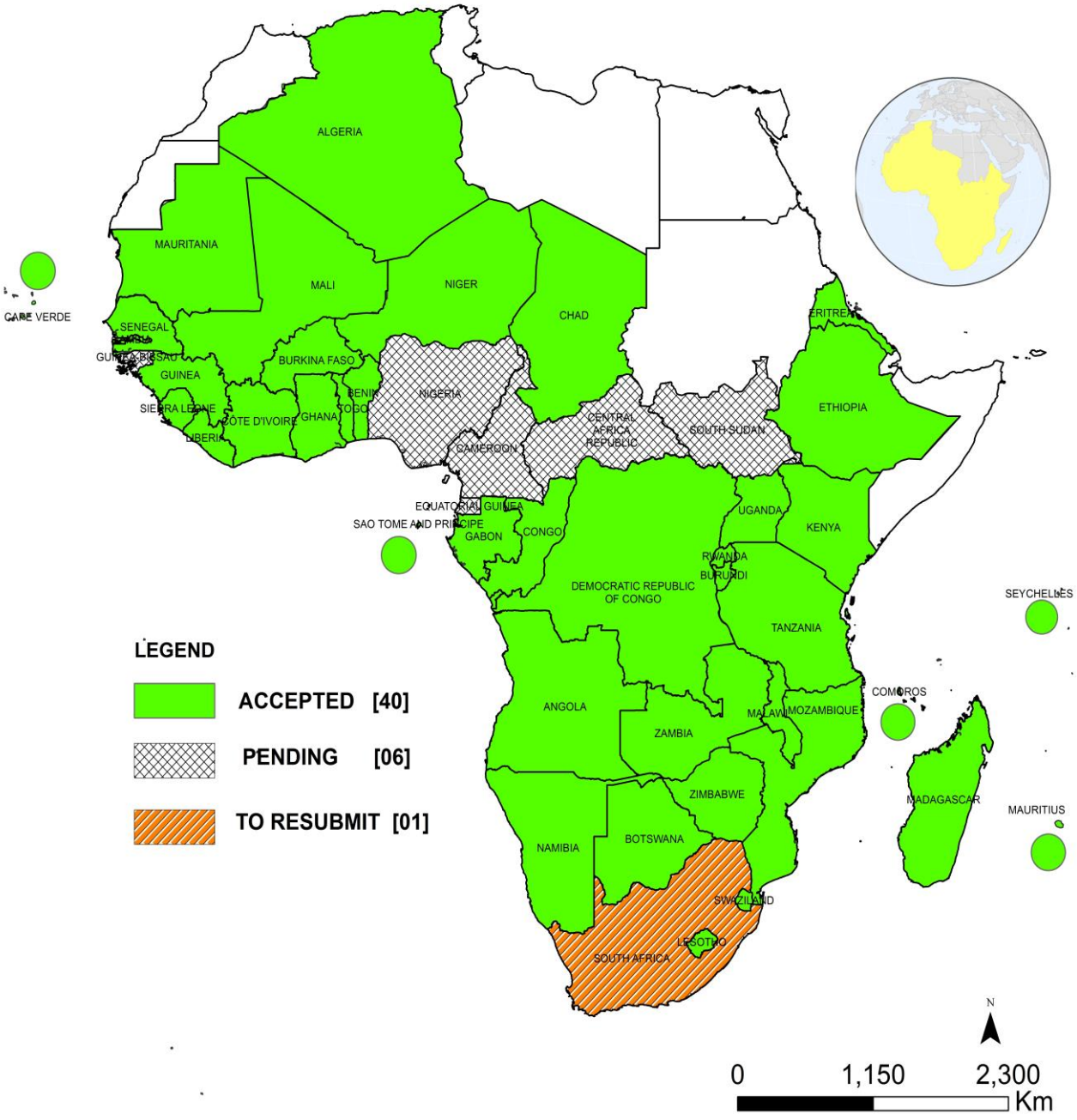
STRATEGIC PLAN OBJECTIVES	OUTCOME INDICATORS	OUTPUT INDICATORS					
		2013	2014	2015	2016	2017	2018
Poliovirus Detection and Interruption: Complete the interruption of wild poliovirus transmission globally and more rapidly detect and interrupt any new outbreaks due to vaccine-derived polioviruses **Monitored by the IMB**	*All wild poliovirus transmission stopped by end-2014* *All new cVDPV outbreaks stopped within 120 days*	Achieve and maintain an AFP rate of › 2/100,000 in all states/provinces of high-risk countries Achieve and maintain adequate stool sample collection in 80% of cases in all states/ provinces of high-risk countries Establish › 80% LQAS-confirmed coverage in all high-risk areas of Nigeria and Afghanistan; ›90% in high-risk areas of Pakistan Establish full safety and security framework in the 3 endemic countries All current cVDPV outbreaks stopped by end-2013	Establish 10 new environmental sampling sites in countries at risk of cVDPV and WPV outbreaks Maintain › 80% LQAS-confirmed coverage in high-risk areas of Nigeria and Afghanistan; ›90% in high-risk areas of Pakistan Convene IHR review committee; establish recommendations for post-2014 Develop full contingency plans to limit international spread and interrupt transmission	Establish 10 additional environmental sampling sites in countries with national OPV facilities If transmission persists, implement full contingency plans to limit international spread and interrupt transmission	Maintain certification-standard surveillance down to the first subnational level in all countries in certified and non-certified regions	Implement type 2 virus response protocol for post-OPV era	Establish type 1&3 response protocols for post-OPV era

STRATEGIC PLAN OBJECTIVES	OUTCOME INDICATORS	OUTPUT INDICATORS					
		2013	2014	2015	2016	2017	2018
Immunization Systems Strengthening and OPV Withdrawal: Strengthen immunization services in "focus countries", introduce IPV and withdraw OPV2 globally **Monitored by the SAGE**	*OPV type 2 withdrawn globally by end-2016* *At least 10% annual increase in DTP3 coverage achieved in 80% of high-risk districts of all focus countries from 2014 to 2018*[37]	Develop annual national immunization coverage improvement plans in at least 5 of the focus countries Put IPV supply and financing strategy for IPV introduction in place	Dedicate > 50% of polio-funded field personnel's time to immunization systems strengthening tasks Develop annual national immunization coverage improvement plans in all focus countries Ensure all countries with national producers or self-procuring have access to a licensed bOPV product Achieve 10% year-on-year improvement in DTP3 coverage rates in high-risk districts in at least the 5 focus countries with plans established in 2013[38]	Establish mOPV2 stockpile of bulk and finished product Finalize target date for last OPV2 use Facilitate and support introduction of at least 1 dose of IPV into RI schedules in all OPV-using countries Achieve 10% year-on-year improvement in DTP3 coverage rates in high-risk Districts in all focus countries	Finalize Global IPV policy for post-OPV era Achieve 10% year-on-year improvement in DTP3 coverage rates in high-risk districts in all focus countries	Achieve 10% year-on-year improvement in DTP3 coverage rates in high-risk districts in all focus countries	Establish mOPV1 and mOPV3 stockpiles of bulk and finished product

STRATEGIC PLAN OBJECTIVES	OUTCOME INDICATORS	OUTPUT INDICATORS					
		2013	2014	2015	2016	2017	2018

Containment and Certification: Certify the eradication and containment of all wild polioviruses by end-2018 and enhance long-term global security from poliomyelitis Monitored by the Global Certification Commission	*Global polio eradication certified by end-2018*	Align GAPIII with new endgame strategy and timelines	Certify WHO South-East Asia Region as polio-free Complete Phase 1 containment (survey and inventory) (except in polio-endemic countries)	Deliver WHO report to WHA on WPV2 eradication Gain international consensus on containment timing and safeguards	Implement biocontainment safeguards for all WPVs	Implement safe handling of all Sabin type 2 polioviruses	Complete certification process for all 6 WHO regions, leading to global certification of polio eradication Prepare for eventual containment of all Sabin poliovirus at the time of bOPV withdrawal
Legacy Planning: Develop a plan to ensure that polio investments contribute to future health goals, through documentation and transition of lessons learnt, Processes and assets of the Global Polio Eradication Initiative **Monitored by the WHA** The objectives and indicators shown here are indicative	*Polio legacy plan developed by end-2015*	Initiate global legacy planning process, including stakeholder consultations, asset mapping and capturing of lessons learnt	Complete broad consultation process on polio legacy	Establish polio legacy plan	Initiate implementation of the polio legacy plan		

ANNEX 2: Status of accepted documentation of polio-free countries in the African Region by the ARCC, as of June 2018



ANNEX 3: Key Regional indicators for measuring progress of implementation of the Framework

	Task	Indicators
1.	Conducting risk assessments	• Number of countries that submit quarterly polio risk assessment in time. • Geographical mapping of priority areas based on the risk assessment. • Availability of quarterly risk assessment with maps at the regional level.
2.	Enhanced surveillance and laboratory confirmation	• Number of countries that meet the major AFP certification-level surveillance indicators. • Number of priority countries with functional environmental surveillance based on the set indicators. • Number of national polio laboratories that are annually accredited in the Region.
3.	Improving outbreak response preparedness quality	• Number of countries with updated polio outbreak response preparedness plans. • Number of outbreak responses that are accepted at 90% using lot quality assurance sampling (LQAS). • Number of outbreaks stopped within 120 days.
4.	Achieving containment of polioviruses	• Number of countries with documented phase 1b containment reports, according to GAP III, submitted in time to AFRO.
5.	Implementing IHR (2005) during poliovirus outbreaks	• Number of countries that promptly declare WPV or cVDPV outbreaks as national public health emergencies. • Number of countries that vaccinate travellers once as recommended by the IHR Emergency Committee on Polio.
6.	Strengthening routine immunization and introducing IPV	• Number of countries with annual increase in routine immunization coverage. • Number of countries that have introduced IPV. • Number of countries with cVDPV outbreaks.
7.	Strengthening certification committees and processes	• Number of countries with trained and functioning national polio committees. • Number of countries submitting quality annual progress reports in time. • Number of countries whose polio-free documentation is accepted by the ARCC.
8.	Expanding the use of technological innovations and establishing accountability framework	• Number of countries that are conducting active surveillance and supportive supervision using real-time GIS-based platforms. • Number of countries using key performance indicators for their accountability framework.
9.	Polio transition planning and post-polio certification strategy	• Number of countries with finalized polio transition plans endorsed by the national interagency coordination committees (ICC). • Number of countries with post-polio certification strategy endorsed by the ICC.