

Center for Preparedness and Response (CPR)
Board of Scientific Counselors (BSC) Meeting
Thursday, March 24, 2022
Webinar

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**Center for Preparedness and Response (CPR)
Board of Scientific Counselors (BSC) Meeting
Thursday, March 24, 2022**

Webinar

Roll Call and Call to Order

Kimberly Lochner, ScD; Deputy Associate Director for Science, CPR and Designated Federal Official, CPR BSC

The BSC meeting began with roll call by Dr. Kimberly Lochner to ensure quorum was established. Dr. Lochner monitored attendance and quorum was maintained throughout the meeting.

Dr. Lochner also reviewed the BSC responsibilities, as per its charter, and the conflict-of-interest waivers. Members were requested to identify any conflicts and no conflicts were identified.

Dr. Lochner stated that the meeting would be led by the BSC Chair, Dr. Suzet McKinney. If voting was required only the Special Government Employee (SGE) Members and Ex Officio Members would vote.

BSC Members present:

Dr. Suzet McKinney
Dr. David Fleming
Dr. Jennifer Horney
Dr. David Lakey
Dr. Marissa Levine
Dr. Brent Pawlecki
Dr. Catherine Slempp
Dr. Vish Viswanath
Dr. Dawn Wooley
Dr. Paul Eder
Dr. Kristin DeBord
Mr. Michael Mair
Ms. Michele Askenazi
Dr. Benjamin Chan
Dr. Christina Egan
Dr. Jamie Ritchey
Mr. A.J. Schall

Suzet McKinney, DrPH, MPH; Chair, CPR BSC

Dr. McKinney called the CPR BSC Webinar to order at 1:07 PM EST and welcomed those in attendance.

Welcome Remarks

Ian Williams, PhD, MS, Deputy Director, CPR, CDC

CDC officially began response efforts to the Coronavirus 2019 (COVID-19) Pandemic on January 20, 2020. Today marked 794 days of activation of the Incident Management Systems (IMS). The agency remains committed to controlling and preventing COVID-19. The innovative solutions and lessons garnered thus far will be applied to future public health threats.

Dr. Williams highlighted several new initiatives that were launched since the BSC meeting in December 2021 to address the ongoing COVID-19 pandemic. One of the initiatives included the recent release of the COVID-19 Community Levels Modules, which examines case and hospitalization data from around the country. It helps users to understand the impact of the virus at the county and community levels, which can guide future public health actions.

Dr. Williams stated that CDC remains committed to putting data in the hands of users in a transparent way that will allow for swift action against COVID-19, and he invited members to subscribe to the COVID-19 Data Tracker Weekly Review. Every Friday, data tracker outcomes as well as other high-priority information and data results are examined. Subscription can be acquired from the [CDC COVID Data Tracker](#) website.

The risks of hospitalization and death from COVID-19 have reduced greatly for most people due to the current levels of vaccination and population immunity. However, this does not mean the county will not face other outbreaks or new variants that escape current immunity coverage. CDC will continue to address the needs of all communities and work closely with populations that remain disproportionately affected by the pandemic.

Dr. Williams acknowledged and thanked two BSC members, who are retiring from the board, for their service, Drs. Suzet McKinney and Dawn Wooley.

CPR BSC Polio Containment Workgroup (PCWG): Update

Catherine C. Slemp, MD, MPH, Co-Chair, PCWG

Dawn Wooley, PhD, Co-Chair, PCWG

Containment of polio-infectious material is critical to sustaining polio eradication progress. The policies developed by the Polio Containment Workgroup in conjunction with the U.S. National Authority for Containment of Poliovirus (NAC) assist laboratories in continuing their polio research in a manner that protects eradication efforts and successes garnered thus far. Their endeavors advance the work both domestic and global. The workgroup meets monthly to

review and deliberate on subjects such as biosafety; biosecurity; regulation and research; and organization and government lab practice experience.

After 30 years of polio eradication efforts, there are only two countries that have endemic poliovirus, Afghanistan and Pakistan. Wild type poliovirus 2 (PV2) and poliovirus type 3 (PV3) have been eradicated globally. Most polio cases globally are vaccine-derived strains of the virus. In the last twelve months, vaccine-derived poliovirus type 2 was seen primarily in Nigeria, Congo, the Coast of Africa, Afghanistan, and Pakistan. There was only one case of vaccine-derived poliovirus type 3, which occurred in Israel, and Madagascar saw cases of vaccine-derived poliovirus type 1. The eradication of polio on the African continent was declared in August 2020, but there was a case of poliovirus in Malawi in the fall of 2021. It has not, however, changed the eradication status of the continent because the strain was traced back to a Pakistan. This triggered outbreak activities. The World Health Organization (WHO) has categorized it as high-risk due to Malawi's vaccination rates and other factors.

One of the tasks in the polio eradication efforts is the containment of viral specimens in laboratories. Viral specimens are kept for research, vaccine manufacturing, and various other purposes. Containment protocols of those specimens are guided by WHO's Global Action Plan III (GAPIII). Each country has a national authority on containment. CDC is tasked with this role in the United States. The U.S. has the largest number of laboratories holding poliovirus in the world, but that number is decreasing. Facilities that maintain poliovirus are termed poliovirus essential facilities (PEF). The policies that guide the PEF work are issued by the U.S. NAC and compliance is voluntary.

In the last three years, more than 12,900 laboratories were surveyed by the U.S. NAC to identify which facilities were utilizing poliovirus infectious material. Over 200,000 vials and containers of poliovirus materials were destroyed through this search effort. In an effort to consolidate, more than 1,300 vials and containers were transferred to the PEFs. The U.S. NAC has conducted around 60 consultations, introduction and site visits, and gap assessments of the PEFs. They have also reduced the number of PEFs from 28 to 11. The policies developed by the U.S. NAC receive endorsement from the CPR BSC before moving to the PEFs. To date, twelve policies have been endorsed. All policies are based on the GAPIII recommendations.

Dr. Slep provided some recent updates. WHO predicts the global eradication of all wild type poliovirus by 2026. They are currently revising the GAPIII and expect the release of the revised guidance in late spring or early summer 2022. Short-term PEF facilities working with PV type 2 are scheduled to complete their work and transfer or destroy their material by December 2022. Lastly, the U.S. NAC is completing visits to all the long-term facilities to help prepare those laboratories for the revised GAPIII containment requirements.

The U.S. NAC is charged with policy development and review. The first draft is shared with the PCWG for review and recommendations. It is also reviewed by CDC subject matter experts and the PEFs for their recommendations. Once updates and changes have been made, the policy is finalized and reviewed by the BSC for deliberation and discussion. It is again disseminated to the PEFs for their comments. Updates are made if needed before moving to CDC for clearance

and publishing. The policies are also shared with WHO. Today, two new policies and one updated policy cleared by the PCWG were reviewed with the BSC for consideration: Occupational Health, Incident Response, and Personal Protective Equipment and Hand Hygiene. In the summer of 2022, the PCWG will focus on updates to the Storage Outside of Containment and Biorisk Management and Risk Assessment policies.

Dr. Wooley reviewed the policies being put forth for consideration by the BSC. The Policy for Poliovirus Occupational Health Programs at U.S. Poliovirus-Essential Facilities states that U.S. PEFs applying for a certificate of containment (including interim) must implement an occupational health plan (OHP). The comprehensive Occupational Health Programs will help PEFs to:

- develop biorisk management systems that address occupational health issues,
- engage occupational health professionals,
- ensure that individuals accessing PV containment area(s) have protective immunity to PV,
- establish surveillance systems to identify PV exposures and/or infections,
- ensure essential personnel have access to a health care provider, and
- provide medical services to personnel following a PV exposure or infection.

This policy pertains to long-term PEFs and is a companion to Emergency Response Policy. It includes a Health Surveillance Program, which require the establishment of baseline antibody levels and proof of vaccinations (i.e., childhood or adult) and protective immunity (i.e., serum neutralizing > 1:8 antibody titers to all three PV serotypes). A one-time inactivated polio vaccine booster will be required if antibody titers are below protective levels. Unvaccinated individuals will receive three doses.

The Policy for Personal Protective Equipment (PPE) and Hand Hygiene Practices was updated. It states U.S. PEFs applying for a certificate of containment (including interim) must implement PPE and hand hygiene practices in accordance with this policy. PEFs must conduct a site-specific risk assessment to determine additional hazard control measures required for their work and storage practices. The updated policy addresses recommendations resulting from a CDC/CPR sponsored risk model on exit shower and personal protective equipment. This policy is for long-term PEFs. Evidence from Gryphon Scientific risk modeling study was utilized for the policy development, which included wild type 3 infectious material. The updated policy now requires the following:

- Change out of street clothes
- Hood, face shield, double gloves, surgical mask
- Donning and doffing order
- PPE requirements in emergency response procedures

The Policy for Emergency Response and Exposure Management Plans at U.S. Poliovirus-Essential Facilities states U.S. PEFs applying for a certificate of containment (including interim)

must develop, implement, and maintain comprehensive emergency response plans and procedures applicable to incidents occurring in the PV containment area(s). The policy includes steps to:

- identify the potential for incidents and emergency scenarios involving poliovirus,
- prevent their occurrence,
- respond to emergency situations,
- limit the likelihood of illness or other damage that may be associated with them.

This policy pertains to long-term PEFs and is a system established to report incidents, exposures, infections, and “near-misses” to NAC within 24 hours, with an investigation of the incident to identify the root cause. The policy ensures emergency response procedures are reasonable and proportionate to the scale and nature of the emergency. Procedures for medical emergencies include first aid and hospitalizations. Isolation and testing procedures for individuals exposed to or infected with PV are also addressed.

After each of the policy highlights were shared, the floor was open for questions. A suggestion was made for the U.S. NAC to work closely with the PEFs to create an accompanying emergency response and exposure management communication plan for the community. Another suggestion was to add expectations of the engineering controls in the laboratories.

With no further questions, Dr. McKinney made a motion to accept the Policy for Poliovirus Occupational Health Programs at U.S. Poliovirus-Essential Facilities. The motion was seconded by Dr. David Fleming. The motion was unanimously approved. Dr. McKinney then asked for a motion for the approval of the update to the Policy for Personal Protective Equipment and Hand Hygiene Practices. Dr. Marissa Levine made the motion, and it was seconded by Dr. Jennifer Horney. The policy was unanimously approved by the BSC. Lastly, Dr. McKinney requested a motion to accept the Policy for Emergency Response and Exposure Management Plans at U.S. Poliovirus-Essential Facilities. Dr. David Lakey made the motion, and it was seconded by Dr. Marissa Levine. The policy was also unanimously approved by the BSC. Dr. McKinney concluded this session by thanking the U.S. NAC for their work to bring about the new policies and the update.

Strategic Capacity Building and Innovation Program (SCIP) Review Working Group (SRWG): Update

David L. Lakey, MD, Co-Chair, SRWG

David Fleming, MD, Co-Chair, SRWG

The Strategic Capacity Building and Innovation Program (SCIP) Review Working Group (SRWG) is co-chaired by Drs. David Fleming and David Lakey. SCIP is an end-to-end systematic process that suballocates CDC’s Preparedness and Response Capability funding provided by Congress. The process includes planning, priority setting, award and suballocation of funding, and performance monitoring. The goal is to have a meaningful public health impact. The SCIP portfolio is developed, monitored, and evaluated through a six-stage process:

- Stage 1: Pre-Planning and Priority Setting
- Stage 2: Funding Guidance and Call for Proposals
- Stage 3: Primary Review Process
- Stage 4: Secondary Review and Selection Process
- Stage 5: Communication of Results
- Stage 6: Performance Measurement and Evaluation

Planning and implementation occur in Stages 1-5, and performance measurement and evaluation in Stage 6.

SCIP is located in the Office of Science and Public Health Practice. It is an internal funding program that focuses on expanding CDC's capabilities and capacities to respond to public health emergencies. SCIP's resources develop the people, processes, and science needed for CDC to respond to public health emergencies whether chemical, biological, radiological, or nuclear. It also enhances epidemiology and surveillance, laboratory science, and medical countermeasures to advance preparedness, response timeliness, situational awareness, communication, and response evaluation.

SCIP has four portfolios. The Epidemiology and Surveillance Portfolio identifies trends and evidence to track and monitor public health events. In this portfolio, there are four key functions:

- Standardizing data collection and establishing a central repository
- Strengthening existing public health information and surveillance systems
- Promoting innovation and data collection and surveillance development
- Disseminating pertinent public health-related information regarding disease control and prevention

The Laboratory Science Portfolio advances laboratory science to improve diagnostics, data exchange, and surge capacity. It has three key functions: developing highly sensitive and accurate diagnostics; creating and supporting data reporting and analytical systems that convert data into information; and strengthening federal state and local laboratory response networks.

The Medical Countermeasures Portfolio improves clinical guidance and use of medicines and supplies. There are four components:

- Developing clinical practice guidelines to inform use of products within public health emergencies
- Developing informational tools and products to stockpile medical countermeasures and support state and local partners health systems and first responders and the public
- Ensuring that the appropriate regulatory mechanisms are in place to enable utilization of all the strategic national stockpile assets

- Supporting maintenance of subject matter expertise on the need for an appropriate strategies for the use of medical countermeasures.

The Cross-Cutting Portfolio has a multi-faceted focus that spans various portfolios with programs and activities that support health equity, preparedness and response exercises, and evaluations.

For fiscal year 2022, the total funding for SCIP is \$46.7 million. Eighty-seven percent of the funding is long-term meaning it is somewhat historic in nature and created in the post anthrax days almost 20 years ago. There has been little evolution in the allocation of long-term funding. Short term funding makes up the remaining 13%. This funding is typically one to three years. It is the proportion of SCIP that is dedicated to innovation.

Funding is allocated mostly on an assessment of individual project merit as projects are submitted each year. The majority of SCIP funding goes to the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), National Center for Environmental Health (NCEH), Center for Surveillance, Epidemiology, and Laboratory Services (CSELS), and Agency for Toxic Substances and Disease Registry (ATSDR). A very small percentage is utilized for CPR. The funding CPR receives from SCIP is used to enhance the preparedness activities in other parts of CDC.

The SCIP Review Working Group (SRWG) was established in December 2021 by the CPR Board of Scientific Counselors and was tasked with conducting an external review of the SCIP program. SRWG's charge is to do the following:

- Provide findings, observations and outcomes to the BSC/CPR that will help SCIP optimize use of limited resources
- Provide demonstrable value, and foster innovation to help the agency meet future public health emergencies. Specific activities include:
 - Providing an independent review and evaluation of SCIP goals, logic model, operational documents, and funding portfolio for BSC consideration,
 - Developing a draft implementation plan for any suggested changes to SCIP activities for BSC consideration,
 - Providing expert input to the BSC for consideration and discussion regarding the SCIP program and implementation plan.

The group had its first meeting in February 2022. The workgroup's timeline of work includes today's update to the BSC as well as another engagement with the BSC in June 2022 to present its findings and recommendations to the Board. Between June and December of 2022, SCIP will move forward on any recommendations that were approved.

SRWG Membership includes the following individuals:

- Dr. David Fleming

- Dr. David Lakey
- Mr. James Blumenstock
- Dr. Christina Egan
- Dr. Paul Halverson
- Dr. Jennifer Horney
- Dr. James Le Duc
- Dr. Jennifer Nuzzo
- Dr. Daniel Sosin
- Mr. Stephen Williams

SRWG has recognized three initial challenges and is seeking the board's discussion and advice to address these issues. The first challenge is the current funding constraints. Core capacity building requires dedicated, long-term, ongoing funding while work on innovation requires flexible, short-term, one-time funding.

The second challenge is capacity building and sustainment. The long-term capacity building element of SCIP is driven by historic allocations that potentially do not match the current preparedness and response realities or the lessons learned from COVID.

The third challenge is the need for innovation. The process for the short-term innovation project work does not have a centralized process for prioritizing work that falls within and across strategic areas, including work that should be prioritized from the lessons learned related to COVID.

CPR has also established the SCIP External Working Group (SEWG) to support SRWG. The SEWG's statement of work is contractual and includes three main tasks. The first is to interview stakeholders to gain feedback and perspectives related to SCIP. The group will also conduct a pilot characterization of the CSELS portfolio. The major task is to synthesize a report of their findings, which will be used to inform SRWG's recommendations to the BSC.

SRWG solicited the BSC's input on the key information or processes needed for the following:

- Determining the overall financial needs for the program between long and short-term funding
- Identifying CDC's current needs for long-term capacity building for preparedness and response that SCIP could/should address
- Developing CDC's approach for shorter-term innovation to improve overall preparedness and response capability

BSC comments:

- One of the things noted in the last two years is the importance of change management and communications, which should be key to the response. Changes need to be

communicated broadly to a number of different organizations and stakeholders in a way that is understandable.

- CDC budget, at least in the short term, has received substantial increases in parts of CDC that are not CPR, and some of that financing potentially overlaps with preparedness activities. Think about how, from an agency perspective, to integrate and assure that the funding is available in a way that is not duplicative or competitive.
- Public health people around the country are trying to figure out how to regain the trust of the public and key stakeholders. A key part of CDC's work, particularly in the short term, has to be exploring that area and determining the leadership role in achieving that goal.
- Determine what an agile CDC looks like. Part of this is a leadership mindset, but part of it is also having a short-term innovation capability, which includes funding, to be able to turn on or respond on the dime.
- What is often forgotten is that communication is a two-way street. Therefore, part of the capacity building should be determining how to get input. A number of practitioners in public health at the state and local levels did not always feel that CDC was receiving from them the input needed to make the best decisions. Also incorporate key stakeholders and even the public input for complex issues. The ultimate goal is to have bidirectional communication with effective feedback loops.
- The National Academies of Science will host a two-day workshop on building public trust in Public Health Emergency Preparedness and Response (PHEPR) science that may be helpful to attend. It will be held March 29-30, 2022.
- So much has gone awry in this current pandemic due mainly to social cohesion issues. Are there innovations that address or examine building social cohesion in disasters and responses? Thus far, social psychology and social cohesion work has not been widely integrated, but there is a need to.

Dr. Fleming said in some ways project-specific funding for long term sustainability creates a dynamic where what has been funded is what will continue to be advocated for because it was funded in the past. He felt a more flexible financing mechanism is needed so that a Center who is receiving some support for long term preparedness from CPR has some flexibility to move that money over time, as their priorities change rather than feeling that they are working under budget rules utilized in the past. It would need to be in context and probably require some clear definitions of what the core preparedness needs are for CDC outside of CPR. He asked the board for their thoughts.

Dr. McKinney said what rings loudest in her mind is the importance of the engagement with state and local health departments across all the work because they are partners to CDC and help the agency advance its work. The last two years have shown the importance of continuing to improve the quality of preparedness work.

Dr. Slep said it is important to regularly reexamine the plan to make sure the system is continuing to move in the desired direction. The idea is not to build to where you were but to build to where you want to be. Afterwards, flexible funding can be built into the system to

support that vision. Do the projects CDC funds regularly need to be tweaked to fit the direction that the agency is heading? So, the funding should change and shift to fit the direction of the plan, while still maintaining core capacities.

Dr. Lakey suggested an evaluation of the proposals that were not funded over the last several years due to lack of financial resources to categorize lost opportunities for innovative projects.

Dr. Ben Chan suggested a scan or assessment be conducted on the funding, both SCIP and the Data Modernization Initiative (DMI), for each of the preparedness programs' goals and work to ensure they align. New funding is being made available because of the pandemic, so it is important to assess the long-term, chronic funding and short-term funding to ensure they align. Dr. Levine piggybacked on Dr. Chan's comment suggesting an asset or capacity inventory. Does CDC know if it is utilizing its capacities as it should and are there hidden capacities that need to be discovered? Are assets being utilized efficiently and effectively?

Public Comment Period

No public comments were presented.

Meeting Recap and Action Items

Suzet McKinney, DrPH, MPH, Chair, CPR BSC

Kimberly Lochner, ScD; Deputy Associate Director for Science, CPR and Designated Federal Official, CPR BSC

Dr. McKinney, who is retiring from the BSC, thanked the BSC and CDC once again. She expressed it was an honor for her to serve the BSC for the past nine years.

The next BSC meeting will be June 1-2, 2022, from 1:00 PM to 5:00 PM EST. This will be a virtual webinar. Another meeting will also be held in the fall of 2022. Dr. Lochner also thanked Dr. McKinney and Dr. Wooley, for their service, leadership, and insight to the board and workgroups.

Meeting Adjourn

Suzet McKinney, DrPH, MPH; Chair, CPR BSC

With no further comments, the meeting was adjourned 1:55 PM EST.

CERTIFICATION

I hereby certify that to the best of my knowledge, the foregoing minutes of March 24, 2022, meeting of the Center for Preparedness and Response (CPR) BSC are accurate and complete.

6/14/2022

Date

_____/S/_____

Suzet McKinney, Dr. P.H., M.P.H.

Chair, Board of Scientific Counselors, CPR

APPENDIX A: CPR BSC Membership Roster

DESIGNATED FEDERAL OFFICIAL

Kimberly Lochner, ScD
Deputy Associate Director for Science, CPR
Centers for Disease Control and Prevention
Atlanta, Georgia

CHAIR

Suzet McKinney, D.Ph., M.P.H.
Principal, Director of Life Sciences
Sterling Bay
Chicago, Illinois
Term: 8/6/2018 – 9/30/2021

MEMBERS

David Fleming, MD
Distinguished Fellow, Trust for America's Health (TFAH)
Bainbridge, Washington
Term: 11/7/2019 - 9/30/2023

Jennifer A. Horney, MPH, PhD
Professor, College of Health Sciences
STAR Health Sciences Complex
Newark, Delaware
Term: 5/13/2021 – 9/30/2022

Brent Pawlecki, MD
Chief Health Officer
Wells Fargo
New York, New York
Term: 2/12/2019 - 9/30/2022

Catherine C. Slemp, MD, MPH
Public Health Policy and Practice, Consultant
Milton, West Virginia
Term: 2/08/2016 – 9/30/2022

Kasisomayajula Viswanath, PhD, MA, MCJ
Lee Kum Kee Professor, Health Communication
Department of Social and Behavioral Sciences
Harvard T.H. Chan School of Public Health
Boston, Massachusetts
Term: 2/15/2019 – 9/30/2022

Dawn Patricia Wooley, Ph.D.
Professor, Neuroscience, Cell Biology, and Physiology
Wright State University
Dayton, Ohio
Term: 8/1/2018 – 9/30/2021

David L. Lakey, MD
Chief Medical Officer
The University of Texas System
Austin, Texas
Term: 5/13/2021 – 9/30/2024

Marissa J. Levine, MD, MPH
Professor, College of Public Health
University of South Florida
Tampa, Florida
Term: 5/13/2021 – 9/30/2024

EX OFFICIO MEMBERS

Office of the Assistant Secretary for Preparedness and Response (ASPR)
U.S. Department of Health and Human Services
Kristin L DeBord, PhD
Director, Strategy Division
Washington, District of Columbia

Food and Drug Administration (FDA)
Michael J. Myers Ph. D
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U.S. Department of Health and Human Services
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National Institutes of Health (NIH)
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LIAISON REPRESENTATIVES

Christina Egan, PhD, CBSP
Association of Public Health Laboratories (APHL)
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Laura Magana, PhD
Association of Schools and Programs of Public Health (ASPPH)
President and CEO
Washington, District of Columbia

Parham Jaber, MD
Association of State and Territorial Health Officials (ASTHO)
Chief Deputy Commissioner for Public Health and Preparedness
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Benjamin P. Chan, MD, MPH
Council of State and Territorial Epidemiologists (CSTE)
State Epidemiologist
New Hampshire Department of Health and Human Services
Division of Public Health Services
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Michele Askenazi, MPH, CHES
National Association of County and City Health Officials (NACCHO)
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A. J. Schall, Jr., BS
National Emergency Management Association (NEMA)
Director, Delaware Emergency Management Agency
Department of Safety & Homeland Security
Smyrna, Delaware

Jamie Ritchey MPH, PhD
Tribal Epidemiology Center (TEC)
Director
Inter-Tribal Council of Arizona (ITCA)
Phoenix, Arizona

APPENDIX B: Acronyms

ATSDR	Agency for Toxic Substances and Disease Registry
BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
COVID	Coronavirus Disease
COVID-19	Coronavirus Disease 2019
CPR	Center for Preparedness and Response (CDC)
CSELS	Center for Surveillance, Epidemiology, and Laboratory Services
DMI	Data Modernization Initiative
GAPIII	Global Action Plan III (GAPIII)
IMS	Incident Management Systems
NAC	U.S. National Authority for Containment of Poliovirus
NCEH	National Center for Environmental Health
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
OHP	Occupational Health Plan
PCWG	Polio Containment Workgroup
PEF	Poliovirus Essential Facilities
PHEPR	Public Health Emergency Preparedness and Response
PPE	Personal Protective Equipment
PV	Poliovirus
PV2	Wild Type Poliovirus 2
PV3	Wild Type Poliovirus 3
SCIP	Strategic Capacity Building and Innovation Program
SEWG	SCIP External Working Group
SGE	Special Government Employee
SRWG	SCIP Review Working Group
WHO	World Health Organization