World Health Organization

SEVENTY-FIRST WORLD HEALTH ASSEMBLY **A71/9**
Provisional agenda item 11.3 **24 April 2018**

Polio transition and post-certification

Draft strategic action plan on polio transition

Report by the Director-General

1. The Seventieth World Health Assembly in May 2017 adopted decision WHA70(9) on poliomyelitis: polio transition planning, in which the Director-General was requested, inter alia, to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session. The request specified the clear identification of the capacities and assets, especially at country level, that are required to sustain progress in other programmatic areas and to maintain a polio-free world after eradication. The Health Assembly also requested a detailed costing of the capacities and polio-funded assets and a report on the efforts to mobilize the funding for transitioning capacities and assets that are currently financed by the Global Polio Eradication Initiative into the programme budget. The Executive Board, after considering a report on polio transition planning,[1] recalled this request in its decision EB142(2) (2018). This report responds to these requests.

2. The proposed draft strategic action plan has a five-year scope of work, is aligned with the draft thirteenth general programme of work, 2019−2023, and aims to strengthen country capacity around the core goals of that programme of work in order to achieve universal health coverage and enhance global health security.

3. The drafting of the action plan was informed by the findings of a review of the draft national polio transition plans of 12 of the 16 polio transition priority countries.[2] Comprehensive data were gathered from priority countries and all three levels of the Organization on the estimated costs for sustaining essential polio functions. Analysis was also conducted on the financing options for 2019, and the proposed programme budgets for 2020–2021 and 2022–2023; the five-year period was aligned with the time frame of the draft thirteenth general programme of work. A proposed set of activities with specific timelines and a process to monitor and evaluate progress have been developed to guide implementation. However, additional planning at the country level between key WHO programme areas will be required in 2018 and early 2019 to ensure that this strategic plan is implemented. Implementation will also be affected by uncertainties tied to the date of certification of the eradication of poliovirus, the governance structure of the polio Post-Certification Strategy, WHO's transformation

[1] See document EB142/11 and the summary records of the Executive Board at its 142nd session, fifth meeting.

[2] Seven countries in the African Region (Angola, Cameroon, Chad, the Democratic Republic of the Congo, Ethiopia, Nigeria and South Sudan), five in the South-East Asia Region (Bangladesh, India, Indonesia, Myanmar and Nepal) and four in the Eastern Mediterranean Region (Afghanistan, Pakistan, Somalia and Sudan).

agenda, and new initiatives related to immunization strengthening and vaccine-preventable disease surveillance being launched at regional and global levels. Additional detailed information on the draft plan is provided in the annexes, and a dedicated webpage has been established on which updated information on all aspects of the plan will be uploaded.[1]

OBJECTIVES OF THE DRAFT STRATEGIC ACTION PLAN FOR POLIO TRANSITION

4. The draft strategic action plan, which is aligned with the specifications set out in decision WHA70(9), has three key objectives:

(a) sustaining a polio-free world after eradication of polio virus;

(b) strengthening immunization systems, including surveillance for vaccine-preventable diseases, in order to achieve the goals of WHO's Global Vaccine Action Plan;

(c) strengthening emergency preparedness, detection and response capacity in countries in order to fully implement the International Health Regulations (2005).

5. These three objectives are tightly interlinked. After eradication, polio essential functions, such as surveillance, laboratory services and technical assistance for immunization, will need to be integrated into other programmatic areas, such as vaccine-preventable disease surveillance, so as to ensure efficiency and sustainability. Such integration will result in increased population immunity to vaccine-preventable diseases and reduce the number and frequency of outbreaks and public health emergencies, the vast majority of which are due to vaccine-preventable disease outbreaks. As polio will be a notifiable disease after eradication under the International Health Regulations (2005), the immunization and emergencies programmes at the three levels of the Organization will need to continue strengthening their collaboration in order to mount a timely and effectively response to a possible polio event or an outbreak.

(a) Sustaining a polio-free world after eradication of polio virus

6. Through the polio Post-Certification Strategy,[2] the Global Polio Eradication Initiative defines the technical standards and guidance for the essential functions required to sustain a polio-free world.

7. The Post-Certification Strategy's three goals focus on mitigating the current and future risks to sustaining a polio-free world:

- **containing polioviruses** in laboratories and vaccine manufacturers' and other facilities;
- **protecting populations** both in the immediate term from vaccine-derived polioviruses, by preparing and coordinating the global withdrawal of bivalent oral polio vaccine, and in the long term from any re-emergence of poliovirus, by providing access to safe and effective vaccines;

[1] http://who.int/polio-transition/en/ (accessed 3 April 2018).

[2] Polio post-certification strategy, available at http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transition-planning/polio-post-certification-strategy/ (accessed 3 April 2018).

- **detecting and responding to a polio event** by promptly identifying the presence of any poliovirus through a sensitive surveillance system and maintaining adequate capacity and resources to effectively contain or respond to a polio event.

8. The Strategy outlines the essential functions and capacities that will be needed in order to achieve these three goals and thereby complete the process of certification and sustain a polio-free world after eradication.

9. Many of the functions that are needed to sustain a polio-free world (for example, surveillance, laboratory networks and outbreak response) are best integrated into a broader system as this would facilitate staffing and financial planning. Other areas may greatly benefit from the expertise gained from existing synergies (for instance, vaccine stockpile management and immunization policy development). Within WHO, most of the essential functions are a natural fit to the area of work on immunization, for which good linkages and synergies exist between the two departments concerned (for instance, on the switch from trivalent to bivalent oral polio vaccine). However, some functions (such as outbreak response and preparedness, containment and possibly stockpile management) will need to be closely linked to similar functions in the WHO Health Emergencies Programme.

10. At the country level, governments will be responsible for integrating the essential functions into their short- and long-term national health sector plans, as recognized by the Executive Board in its decision EB142(2), and for allocating the financial resources needed to sustain these functions. However, if the polio transition process is not effectively managed and executed, sustaining the essential functions and ultimately maintaining a polio-free world will be at great risk. In many fragile States, WHO will continue to play a key role in providing support for implementing the Post-Certification Strategy. At the country level, immunization and health emergencies programmes will need to strengthen their capacities to consider fully the impact of polio transition and to absorb the essential functions, in line with the technical requirements of the Post-Certification Strategy.

(b) Strengthening immunization systems, including surveillance for vaccine-preventable disease, in order to achieve the goals of WHO's Global Vaccine Action Plan

11. At the country level, immunization programmes have relied heavily on polio-funded infrastructures over the past two decades to support the performance of key functions, such as immunization information systems, vaccine-preventable disease surveillance and laboratory networks, introduction of new vaccines, monitoring, cold chain and logistics. As a consequence, the gradual decrease and eventual phasing out of financial resources for polio presents a huge risk to immunization programmes.

12. Some 60% of the world's 19.5 million children who are either unvaccinated or incompletely vaccinated live in the 16 countries prioritized for polio transition, and almost 90% of estimated global deaths from measles occur in the same countries. Given those facts, achieving the goals of the Global Vaccine Action Plan and ultimately universal access to immunization and the health-related Sustainable Development Goals will be a huge challenge, unless the gaps opening up as polio funding declines are filled. The risks are particularly high on the African continent, with almost 90% of WHO immunization staff in Member States in the African Region being funded by polio financing, and with chronically underperforming or fragile States that depend heavily on the polio infrastructure for routine immunization services.

13. The potential risks to vaccine-preventable disease surveillance are particularly noteworthy. The Global Polio Eradication Initiative funds much of the global work on vaccine-preventable disease surveillance and has laid the groundwork for global and regional laboratory networks, links between laboratory and epidemiological surveillance, and indicator-based performance quality measures. In the polio priority countries, polio funding covers not only personnel costs but also transportation (including that of samples) and data collection/information systems for other vaccine-preventable disease surveillance. With polio funding resources rapidly decreasing and eventually being phased out, there is a high risk of losing the primary funding stream for vaccine-preventable disease surveillance, which will undermine work to sustain performance quality. The immunization community wants to avoid this risk by establishing a comprehensive approach, with efforts at the global and regional levels to elaborate a strategic vision for comprehensive vaccine-preventable disease surveillance, aligned with country and regional priorities, with direct linkages to immunization programmes.

14. The draft national transition plans of priority countries demonstrate that governments perceive polio transition as an opportunity to invest in strengthening immunization systems. In all the draft country plans, strengthening routine immunization and vaccine-preventable disease surveillance feature as the key national health priority for polio transition. In many polio-free countries, polio assets have already been well integrated into broader immunization-related activities.

15. The objective of strengthening immunization is fully aligned with the strategic direction of the draft thirteenth general programme of work on promoting health, keeping the world safe and serving the vulnerable. Achieving universal health coverage and the health-related Sustainable Development Goals is grounded in investing in prevention through building strong and resilient immunization systems, ensuring equity and filling coverage gaps so as to leave no one behind, and providing universal access to safe, quality, effective and affordable vaccines. As the discussion around the post-2020 immunization agenda starts to take shape, it is crucial to bring polio transition into these discussions and for WHO to take a leadership role.

16. Strengthening immunization is also closely linked to the objective of keeping the world polio-free. The risk of emergence of vaccine-derived polioviruses before the use of oral polio vaccine ceases and of possible outbreaks of polio from any poliovirus re-emergence after eradication will increase unless there is consistent improvement in routine immunization coverage rates.

(c) Strengthening emergency preparedness, detection and response capacity in countries in order to fully implement the International Health Regulations (2005)

17. At the country level, polio-funded staff members have often played a key role in the detection of large outbreaks through their surveillance role, and have also been the first to respond to public health emergencies: either disease outbreaks or disaster management in polio priority countries. The polio infrastructure, especially at the subnational level, can be essential to not only detection and response, but also prevention. In the Joint External Evaluations, part of the Monitoring and Evaluation Framework of the International Health Regulations (2005), polio surveillance and laboratory networks have been identified as an essential resource that a country can build upon to increase their core capacity to implement the Regulations.

18. Of the 16 priority countries for polio transition planning, there are 10 countries that are also priorities for the WHO Health Emergencies Programme for increased country capacitation (see Annex 4).

19. The WHO Health Emergencies Programme's proposed "country business model", a model of the core requirements needed in a country office to run its health emergency operations, will be centred on detailed country-by-country analysis of the current WHO country office's capacity and on calculations of the additional capacity needed for the WHO country office to carry out its core functions in public health emergencies. Existing polio-funded capacities will also be mapped out in these country office models.

20. Country reviews have identified the need for adjustments to the WHO Health Emergencies Programme's country business model, including the further strengthening of core laboratory, health systems, staff safety and security capacities, as well as the inclusion of field coordinator positions in key subnational hubs. In addition, they identified a programmatic need to continue the functions related to the Expanded Programme on Immunization, disease surveillance and operational support currently maintained through WHO's programmes on immunization, vaccines and biologicals and on polio.

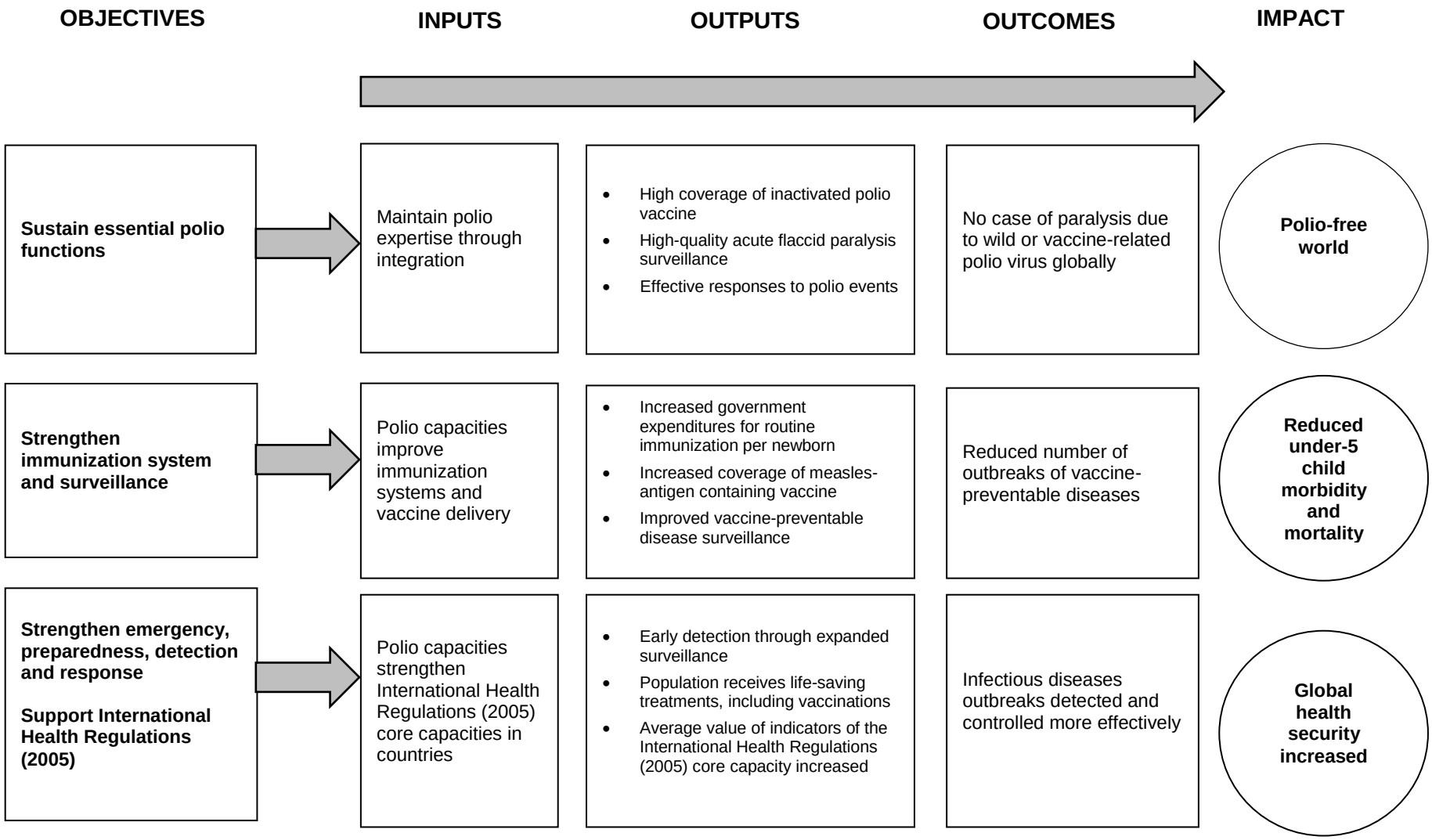
21. These capacities will enable WHO to be fit for purpose, particularly in fragile settings. Following the consolidation of core technical and operational positions in the priority countries, which will incorporate some polio functions and capacities, a business case will need to be developed to ensure sustained financing.

22. Opportunities for synergies between polio transition planning and the WHO Health Emergencies Programme's capacity-building plans will be actively pursued through joint planning visits to priority countries, and the development of a systematic approach to reassigning polio capacities and functions to core Programme positions in these priority countries. The long-term sustainability of this model depends on new multiyear contributions to the programme budgets for the bienniums 2020–2021 and 2022–2023 for WHO's work on emergencies.

23. This objective of the draft strategic action plan is closely interlinked with the previous two objectives of the plan. At the country level, when routine immunization fails, the emergencies programme steps in to respond to disease outbreaks. Vaccine-preventable disease outbreaks constitute a vast majority of health emergency events that the WHO Health Emergencies Programme responds to. In addition, any re-emergence of polio after eradication will trigger a response under the International Health Regulations (2005).

24. The figure illustrates the overall results chain of the polio transition plan.

Figure. Results chain of the polio transition plan



COUNTRY LEVEL ANALYSIS TO SUPPORT THE OBJECTIVES OF THE STRATEGIC PLAN

25. In close collaboration with the regional offices for Africa, South-East Asia and the Eastern Mediterranean, data were gathered from each polio priority country and nonpriority countries on the essential polio functions that need to be sustained for the period 2019–2023 according to the requirements of the polio Post-Certification Strategy – especially, polio surveillance and laboratories, and some core capacity to respond to possible outbreaks. These functions are crucial for meeting all the three objectives of the draft strategic action plan.

26. Analysis of the data was based on a standard costing template, which included specific categories from the Global Polio Eradication Initiative's Financial Resources Requirements that correspond to essential functions required to keep the world polio free. These categories included: surveillance and running costs (including technical assistance at 50%, given that large-scale polio vaccination campaigns will not be supported by the Global Polio Eradication Initiative after 2019); laboratory costs; and core functions and infrastructure needed for outbreak response. The countries used this template to estimate their costs for the time frame aligned with the draft thirteenth general programme of work.

27. Table 1 provides the overall summary of the estimated costs of sustaining essential polio functions through mainstreaming into national health systems or transitioning to other WHO programme areas. A detailed country-level breakdown in the African, South-East Asia and Eastern Mediterranean regions is given in Annex 1.

Table 1. Estimated costs for sustaining essential polio functions through mainstreaming or transitioning to other WHO programmes in 2019–2023 (US$)

		Draft thirteenth general programme of work		
	2018[a]	**2019[a]**	**Proposed programme budget 2020–2021[e]**	**Proposed programme budget 2022–2023[e]**
African Region				
Angola	8 125 623	7 979 824	14 149 666	13 844 145
Cameroon	1 340 467	2 116 532	3 395 047	1 335 890
Chad	4 372 000	4 125 000	5 450 000	4 800 000
Democratic Republic of the Congo	7 278 160	7 267 150	13 190 010	13 190 010
Ethiopia	4 929 700	4 869 700	5 812 000	5 812 000
Nigeria[b]	61 085 573	-	-	79 368 643
South Sudan	4 007 120	3 662 040	4 550 004	2 530 000
Non-priority countries (40)	19 727 222	18 062 040	30 068 440	25 318 960
Total	**110 865 865**	**48 082 286**	**76 615 167**	**146 199 648**

		Draft thirteenth general programme of work		
	2018[a]	**2019**[a]	**Proposed programme budget 2020–2021**[e]	**Proposed programme budget 2022–2023**[e]
South-East Asia Region				
Bangladesh	2 223 000	2 260 000	4 520 000	3 869 375
India	26 819 000	25 771 000	55 618 681	60 402 410
Indonesia	1 154 000	1 090 000	1 388 000	1 263 000
Myanmar	1 051 000	1 064 000	1 912 100	1 116 450
Nepal	1 307 000	1 327 000	2 654 000	2 654 000
Total	**32 554 000**	**31 512 000**	**66 092 781**	**69 305 235**
European Region				
Non-priority countries (12)	**267 000**	**267 000**	**267 000**	**267 000**
Eastern Mediterranean Region				
Afghanistan[b]	20 433 483			29 413 711
Pakistan[b]	51 466 882			61 393 768
Somalia	7 536 157	7 536 157	12 814 474	10 443 741
Sudan	2 208 028	2 208 028	3 842 116	3 497 751
Other countries (3)	5 247 448	5 148 613	9 062 006	8 037 853
Total	**86 891 998**	**14 892 798**	**25 718 595**	**112 786 824**
Country total	**230 578 863**	**94 754 084**	**168 693 543**	**328 558 707**
Regions and headquarters				
African and Intercountry Support Teams	13 377 778	13 377 778	13 725 556	13 725 556
South-east Asia	2 417 409	2 322 855	3 816 710	3 816 710
Eastern Mediterranean[c]	8 315 933			10 514 604
Western Pacific	2 083 000	2 083 000	2 083 000	2 083 000
Americas	938 000	938 000	938 000	938 000
European	2 202 000	2 202 000	2 202 000	2 202 000
Headquarters[d]	89 375 000	68 203 000	35 898 000	75 710 000
Total	118 709 120	89 126 633	58 663 266	108 989 870