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Polio transition planning

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 decision called for the identification of the capacities and assets, especially at the country level, that are required to maintain a polio-free world after eradication and to sustain progress in other programmatic areas that might be negatively impacted by the scaling-down of the polio eradication infrastructure. A detailed costing of the capacities and assets and the financing that might be required to integrate some of the polio-funded assets into other programmatic areas was also requested.

2. This report should be considered as work in progress, which provides the key components of a strategic action plan that will be finalized by the Seventy-first World Health Assembly. It is aligned with the draft thirteenth general programme of work 2019−2023 and aims to respond partially to the requests made by in decision WHA70(9). In addition, it provides updated information on the human resources and budget planning associated with polio transition planning. The annexes provide detailed information and web links on ongoing country-level processes that have an impact on polio transition.

POLIO TRANSITION: A NEW VISION

3. Management of polio transition planning was initially based around mitigating the human resource-related, financial, programmatic and country capacity risks faced by the Organization owing to the scaling-down and eventual closure of the Global Polio Eradication Initiative. This approach focused on reduction of the liabilities, but the drafting of the thirteenth general programme of work provides an opportunity, and a new vision, for polio transition planning efforts to support the three strategic priorities that can maximize WHO's contribution to achieving the Sustainable Development Goals.

4. To support the first strategic priority of ensuring healthy lives and promoting well-being for all, existing polio assets at the country level can support countries to achieve the goal of leaving no one behind in priority areas such as women's, children's and adolescents' health, communicable diseases and immunization activities, and especially to reduce inequalities in countries with relatively weak health infrastructure. In many polio transition countries, polio staff members are already contributing to other programmatic areas, including reproductive, maternal, newborn and child health, and other communicable diseases.

5. To contribute to the second strategic priority of supporting countries to strengthen health systems and to progress towards universal health coverage, polio assets and functions at the country

level will be critical to ensuring access to high-quality essential health care services and medicines, including vaccines, especially in fragile settings.

6. To support WHO's third strategic priority of keeping the world safe from epidemics and other health emergencies, and of ensuring that populations affected by emergencies have rapid access to essential life-saving health services, the crucial functions of the polio programme in many fragile and conflict-affected countries, including coordination, immunization, surveillance, laboratory services, response, and risk communication, will be essential. The country-level capacities of the polio programme will also help to enhance the progress made by all countries towards strengthening core capacities under the International Health Regulations (2005). The knowledge and experience of polio staff members in addressing the health-related challenges associated with population movements, including flows of refugees, migrants and internally displaced populations, as well as cross-border surveillance and immunization activities will also be critical to achieve this strategic goal.

7. The draft thirteenth general programme of work is built on placing countries at the centre of WHO's work. Successful implementation of the general programme of work therefore depends on matching closely tailored efforts to different country contexts. The presence of significant polio assets in the most highly vulnerable, fragile and conflict-affected countries should therefore be leveraged to help WHO to provide operational support in these Member States, with the full assistance of the international development community. In the second tier of less vulnerable polio transition countries, WHO will provide high-quality technical assistance to ensure that polio capacities fully support country priorities, while also meeting the need to sustain polio-free status after eradication. In these countries, there will be a graduated process of scaling down financing and technical support, with strong expectations that national governments will absorb the capacities and the costs of these critical assets over the medium term, as specified in their transition plans. In third tier polio transition countries, those with much stronger health systems, a sufficiently large trained workforce and stronger economic capabilities, WHO will focus on strategic advisory services, while expecting these governments to fully absorb and fund the polio assets and capacities needed to meet their health priorities in the short term. WHO will provide technical assistance to enhance the mobilization of domestic and external financing, in order to support all three tiers of polio transition countries and to ensure sustainability.

DEVELOPMENT OF A STRATEGIC ACTION PLAN ON POLIO TRANSITION

8. This broader vision for polio transition will help to allay Member States' concerns about the need to sustain progress in other key programmatic areas, such as: disease surveillance; immunization; health systems strengthening; and early warning, emergency and outbreak response, including the strengthening and maintenance of core capacities under the International Health Regulations (2005). It will also help to sustain the crucial polio functions that will be needed to ensure a polio-free world after eradication. Lastly, it will enable more coordinated planning for longer-term financing and budgeting in the context of programme budgets for 2020–2021 and beyond.

9. Detailed discussions across the Secretariat, including regional and country offices, have identified an initial set of programmatic priorities and streams of work that need to be aligned for polio transition. The focus of the strategic action plan will be on how these priorities and streams of work will be linked to the vision of the draft thirteenth general programme of work and WHO's role in covering the gaps. This report aims to present the key elements of the strategic action plan, for submission to the Seventy-first World Health Assembly together with an implementation and monitoring framework.

ELEMENTS OF THE STRATEGIC ACTION PLAN

National polio transition plans aligned with the scaling-down of Global Polio Eradication Initiative resources[1]

10. Polio programme resources at the country level include both "assets" and "functions". Assets include all the human resources and physical infrastructure funded and established by the polio programme in that country, at both national and subnational levels. Polio programme functions are the systems, processes and activities that these assets carry out. Collecting detailed information on polio assets and functions at national and subnational levels has been an essential step in country transition planning. The data generated from this mapping exercise provide a baseline of the size, structure, location and activities of the polio programme in a specific country, along with an estimated cost of sustaining these assets.

11. The detailed asset mapping exercise demonstrates that 60–90% of polio-funded personnel contribute to broader immunization, service delivery, surveillance, management and operations. Surveillance units are essential components of these assets. Consisting of a surveillance medical officer, an administrative assistant and a driver, these units conduct active cased-based surveillance for both acute flaccid paralysis and other vaccine-preventable diseases (such as measles, rubella, Japanese encephalitis and neonatal tetanus). They are often the main resource that the country draws upon to respond to major disease outbreaks, natural disasters and other emergencies (cholera, malaria and yellow fever outbreaks in Angola and earthquake in Nepal, for example).

12. Even though human resources are vital polio-funded assets on the ground, documentation has revealed that polio-funded physical infrastructure and systems/processes are equally important. In the absence of adequate government infrastructure (including transportation and communications equipment, and adequate data-processing capacity), immunization, broader disease surveillance and outbreak response activities in countries are largely dependent on polio-funded WHO physical assets and equipment. In many countries (such as Chad, the Democratic Republic of the Congo, Ethiopia and South Sudan), access to most hard-to-reach areas is only possible thanks to WHO's fleet of polio-funded 4 x 4 vehicles. In some cases (Chad and Ethiopia, for example), WHO office space at the national or subnational level is partially or fully funded by polio resources. A snapshot of the detailed asset mapping exercise conducted in 14 priority countries, with a functional and geographical breakdown, is available for review on the website of the Global Polio Eradication Initiative.[2]

13. Most of the resources provided by the Global Polio Eradication Initiative go to the country level, and they support functions that go far beyond polio eradication. The Initiative has been supporting polio transition planning efforts in 16 priority countries that account for more than 90% of the assets funded by it.[3] In order to mitigate the negative impact of the planned decrease of Global Polio Eradication Initiative resources, a process has been set in motion to develop national transition

[1] See Annex 1, Summary Global Polio Eradication Initiative budget scale-down figures for WHO country offices in non-endemic countries.

[2] Country transition planning (http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transition-planning/country-transition-planning/, accessed 21 December 2017).

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

plans in these countries,[1] under the leadership of national governments, with support from WHO and UNICEF regional and country offices. The Global Polio Eradication Initiative, through its Transition Management Group, has been supporting the planning process with guidelines,[2] technical assistance, communications and advocacy support, and tracking progress through a series of milestones.[3]

14. As of December 2017, eight countries[4] have costed draft transition plans. Most of these plans are early drafts, with initial costings. The target date for all 14 countries (except Afghanistan and Pakistan, which will officially start planning when polio transmission has been interrupted) to finalize their costed draft plans by the end of 2017 will not be met.

15. The countries will further develop these plans over the next six months with broader stakeholder input. However, the early drafts and the planning process already clearly highlight the challenges in mainstreaming polio-funded assets and functions into existing country health structures. Almost all the draft plans have a longer-term country capacity-building and financing strategy that includes provision for domestic funding, but in the short or medium term (2–5 years) the plans rely heavily on external technical and financial support.

16. All countries in the South-East Asia Region are making progress and have developed transition plans in close coordination with their national governments, adopting a country-tailored approach. Progress has been slow in highly fragile countries (Somalia, for example), which face multiple challenges, including limited planning and absorption capacity, lack of sustainable funding options and competing priorities. Draft plans from other fragile countries (such as Chad, the Democratic Republic of the Congo, and South Sudan) reveal the risks related to implementation and sustainability. In the absence of much stronger national ownership and significant external support, it is highly likely that some of these costed national plans will remain unexecuted.

17. Given the countries' immediate lack of capacity to mainstream polio-funded assets and functions, country plans reflect an expectation that WHO will continue its operational support in key areas such as immunization, integrated disease surveillance, primary health care delivery and emergency response. In fragile countries, this support is expected to be more comprehensive (including systems strengthening elements) and for a much longer duration. The details of draft country plans, with a specific focus on how they match polio assets with national priorities and funding options under consideration, are presented in Annex 2.

[1] At the global level, the Global Polio Eradication Initiative tracks progress and provides support to only 16 countries, on which most of its resources are concentrated. However, it is important to note that the guidelines issued by the Initiative in the context of polio legacy planning encourage all countries receiving funding from the Global Polio Eradication Initiative to develop transition plans. In fact, the Regional Office for Africa, through its regional initiatives and structures, has prioritized all polio-funded countries in the Region. Similarly, the Regional Office for the Eastern Mediterranean is developing a more holistic regional approach, looking also at other fragile countries in the Region (such as Iraq, the Syrian Arab Republic and Yemen).

[2] Global Polio Eradication Initiative. Polio legacy planning: guidelines for preparing a transition plan. Geneva; 2015 (http://polioeradication.org/wp-content/uploads/2016/07/TransitionGuidelinesForPolioLegacy.pdf, accessed 21 December 2017).

[3] Milestones: (1) raising awareness, (2) establishing in-country coordination, (3) mapping assets, (4) mapping country priorities, (5) establishing strategies to match polio assets with national priorities, (6) developing a draft costed transition plan, and (7) finalizing the transition plan, including funding commitments and an execution plan.

[4] Bangladesh, Cameroon, Chad, the Democratic Republic of the Congo, India, Indonesia, Myanmar, and Nepal.

Sustaining a polio-free world after eradication

The draft post-certification strategy

18. As the world moves towards certification of the eradication of wild poliovirus, the Global Polio Eradication Initiative has started a process to define the technical standards and guidance for the essential functions required to sustain a polio-free world. This guidance can be found in the draft post-certification strategy.[1]

19. Implementation of the post-certification strategy will require: (a) planning by health and finance ministries, which will need to absorb or continue to support the three goals set out below (paragraph 23); (b) internal planning by organizations (current partners of the Global Polio Eradication Initiative, including WHO and UNICEF, and other organizations not currently engaged in polio eradication efforts) that will support these functions and activities; and (c) planning by new partners and health initiatives beyond the polio partnership for how they will begin to support activities in the post-certification world.

20. The main criteria set by the Global Commission on the Certification of Eradication as prerequisites for the global certification of polio eradication are to show the absence of wild poliovirus, isolated from cases of acute flaccid paralysis (suspect polio), healthy individuals or environmental samples, in all WHO regions for a period of at least three years in the presence of high-quality, certification-standard surveillance.[2] A process will also be undertaken, with the Global Commission on the Certification of Eradication and the Strategic Advisory Group of Experts on immunization, to determine the criteria and methodology for validating the absence of vaccine-derived poliovirus after global withdrawal of oral polio vaccine (OPV). Some polio-essential functions and capacities therefore need to be maintained in order to complete the process of certification of polio eradication, and also to ensure that a polio-free world is sustained after certification.

21. Especially at the country level, a set of capacities and assets will need to be maintained to sustain a polio-free world (Annex 3). The risks are higher in some of the world's poorest countries if the transition is not well planned and effectively implemented. Managing these risks will require leadership from stakeholders outside the Global Polio Eradication Initiative.

22. The post-certification strategy therefore has a strong focus on risk mitigation, and threats of re-emergence of the virus after global certification are considered in three categories: (a) continued use of OPV; (b) unsafe handling of any poliovirus; and (c) undetected transmission. The strategy outlines how to address, reduce, mitigate and, where possible, eliminate these risks.

23. The following three goals have been identified to mitigate the current and future risks to maintaining a polio-free world:

> **Goal 1. Contain polioviruses.** The objective of the first goal is to achieve and sustain containment of polioviruses in laboratories and vaccine manufacturers' and other facilities. The

[1] Polio post-certification strategy (http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transition-planning/polio-post-certification-strategy, accessed 21 December 2017).

[2] For the definition of eradication as the interruption of wild poliovirus transmission, see Smith J, Leke R, Adams A, Tangermann RH. Certification of polio eradication: process and lessons learned. Bull World Health Organ. 2004; 82:24-30 (http://www.who.int/bulletin/volumes/82/1/24-30.pdf, accessed 21 December 2017).

focus will initially be on reducing the number of facilities storing poliovirus and on implementing and monitoring compliance with containment requirements, with appropriate safeguards.

Goal 2. Protect populations. The second goal aims to protect populations both in the immediate term from vaccine-associated paralytic poliomyelitis and vaccine-derived poliovirus, by preparing and coordinating the global withdrawal of bivalent OPV, and in the long term from any poliovirus re-emergence, by providing access to safe, effective vaccines.

Goal 3. Detect and respond to a polio event. The focus of the third goal is to detect promptly any poliovirus in a human being or in the environment through a sensitive surveillance system and to maintain adequate capacity and resources to effectively contain or respond to a polio event.

24. As decided by the Polio Oversight Board at its meeting in October 2017,[1] the Global Polio Eradication Initiative partnership will focus on defining the technical functions required after certification and will mobilize funding for the activities to be implemented until cessation of the use of bivalent OPV, which is planned for one year after certification.

25. The financial resources required for these critical polio functions will depend on how the future "owners" will determine the organization and management of the goals set out in the post-certification strategy. The Global Polio Eradication Initiative will provide cost estimates for the activities from certification to withdrawal of bivalent OPV. In addition, a separate financial model with high-level cost estimates for the longer-term period after withdrawal of bivalent OPV – which will need to make assumptions concerning additional information and key decisions that are not known today – will be developed.

26. The draft post-certification strategy proposes that implementation of the strategy and operationalization of pledged funding through cessation of bivalent OPV and beyond will be the responsibility of the future owners of the functions laid out in this document. The transition or "hand-off" of the essential functions described in the three post-certification strategy goals, as well as governance, management and reporting activities, must begin well before the dissolution of the partnership.[2] It is therefore critical to identify the future owners of these functions and activities as soon as possible, so that an assessment can be made regarding the capacity, capability and change effort required for them to be successful.

27. Ownership and financial resources from national governments will be key factors for achieving the three goals of the post-certification strategy to sustain a polio-free world. In many fragile countries, WHO will have a key role to play in implementing the strategy. Within WHO, programmatic areas that would most likely be the owners of these essential polio functions would include Immunization and Health Emergencies. The business models initiated by these two programmatic areas to strengthen country capacity will have to fully consider the implications of polio transition planning and incorporate the guidance given in the post-certification strategy.

[1] See minutes of the meeting of the Polio Oversight Board, 2 October 2017 (available at http://polioeradication.org/wp-content/uploads/2016/07/pob-meeting-minutes-02102017.pdf, accessed 21 December 2017).

[2] See minutes of the meeting of the Polio Oversight Board, 22 April 2017 (available at http://polioeradication.org/wp-content/uploads/2017/06/POB_Minutes_Mtg20170422.pdf, accessed 21 December 2017).

Strengthening immunization

28. The Global Vaccine Action Plan has set ambitious targets to improve access to immunization and tackle vaccine-preventable diseases. With the Action Plan's 2020 target date approaching, accelerated efforts are required to improve access to lifesaving vaccines. Development partners' capacity to support these efforts will become even more critical.

29. Given that nine of the 16 priority countries for polio transition are in Africa,[1] the phasing-out of polio resources presents serious risks to the immunization systems of these countries and WHO's capacity to support them.

30. In order to mitigate this risk, the WHO regional offices for Africa and the Eastern Mediterranean are developing a business case to mobilize political commitment and financial resources to continue supporting all 54 Member States on the African continent in fully achieving their immunization goals. This business case will be aligned with the need to transform the scope and timing of the Secretariat' support to Member States, based on the maturity of their health systems and the vision of the draft thirteenth general programme of work, in order to help them to achieve the health-related Sustainable Development Goals.

31. The business case proposes that, in order to strengthen access to immunization, countries will have to progress across six key components of immunization systems: programme management and financing; immunization service delivery and introduction of new vaccines; disease surveillance and management of outbreaks of vaccine-preventable diseases; data management and analytics; vaccine quality, safety and regulation; and community engagement.

32. A four-tier WHO immunization "maturity grid" has been established across the six key components, to help to identify the main gaps and determine the type of support that African countries will need from the Secretariat to address those gaps. To support African countries in achieving the desired level of maturity in the six key immunization components, seven key functions have been identified, in order to provide tailored support based on the country's maturity model.[2]

33. In the past two decades, surveillance of vaccine-preventable diseases in the African Region has been heavily supported by funding from the Global Polio Eradication Initiative. The closing of the Initiative presents important risks for the vaccine-preventable disease surveillance network in the African Region, especially as alternative funding streams to support such surveillance have not been identified. With some countries in the Region simultaneously transitioning out of support from The GAVI Alliance and the Global Polio Eradication Initiative or soon to be no longer eligible for support from The GAVI Alliance, funding becomes an even bigger challenge.

34. It is therefore imperative that a costed comprehensive vaccine-preventable disease surveillance model is developed that highlights the investment needed to maintain a sensitive and effective

[1] Angola, Cameroon, Chad, the Democratic Republic of the Congo, Ethiopia, Nigeria, Somalia, South Sudan and Sudan.

[2] The seven key functions identified include: (1) establish norms and standards; (2) develop evidence-based policies and guidance; (3) monitor and address the situation of vaccine-preventable diseases and assess progress towards targets; (4) engage and advocate with governments and key partners; (5) provide technical support and build capacities; (6) provide material and equipment; and (7) implement field operations. The business model focuses on normative and technical support, with field operations being implemented by governments or non-State actors.

surveillance system and to ensure a rapid response to new and existing threats to public health posed by vaccine-preventable diseases in the post-polio eradication era.

35. In the South-East Asia Region, collaboration with national governments and partners to articulate and realign programmatic priorities using polio resources is aimed at supporting immunization activities, with measles elimination and rubella control, improvements in routine immunization coverage and the introduction of new vaccines as the key priorities.

Strengthening emergency preparedness and response

36. Of the 16 priority countries for polio transition planning, six are classified by the WHO Health Emergencies Programme as "Priority 1" for increased country capacitation, and five are categorized as "Priority 2" (see Annex 6).

37. The WHO Health Emergencies Programme's proposed country business model will be centred on: detailed country-by-country analysis of the current WHO country office capacity; and calculating the additional capacity needed for WHO's core functions as an operational agency in emergencies. Existing polio-funded capacities will also be mapped out in these country business models.

38. Country reviews have identified the need for adjustments to the WHO Health Emergencies Programme's country business model, including the need to further strengthen core laboratory, health systems, staff safety and security capacities, as well as to include field coordinator positions in key subnational hubs. In addition, there is a 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.

39. 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.

40. Opportunities for synergies between polio transition planning and the WHO Health Emergencies Programme's capacity-building plans need to be actively pursued, with the development of a systematic approach to reassigning polio capacities and functions to core Programme positions in priority countries. The long-term sustainability of this model depends on new multiyear contributions to WHO's work in emergencies.