World Health Organization

Report on Polio Transition Planning

ADVANCE DRAFT

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I. INTRODUCTION

The Executive Board at its 140th session in January 2017 having considered the reports on poliomyelitis[1] and an update on World Health Organization's (WHO) Human Resources funded by the Global Polio Eradication Initiative (GPEI),[2] requested the Director – General to present to the Seventieth World Health Assembly a report that outlines the programmatic, financial and human – resource related risks resulting from the current winding-down and eventual discontinuation of the GPEI, as well as an update on actions taken and planned to mitigate those risks while ensuring that essential polio- related functions are maintained[3].

The current report is a response to the above decision and a draft was first presented to a meeting of Member States on 28th April 2017. Pre-ambular paragraph 5 of EB140 (4) emphasized the need to continue to provide the appropriate situation-specific and focused interventions in countries where transmission has not been interrupted. The emphasis in this report has therefore been on those polio priority countries where endemic poliovirus transmission has been interrupted, and to define key programmatic risks associated with the planned closure of the GPEI; and opportunities for mainstreaming of the polio infrastructure (staff, physical assets and knowledge) into the national health system, or integration into other WHO programme areas with critical needs. In addition, this report provides a general overview of the key organisational risks and challenges to be faced by WHO at all three levels of the organization associated with the closure of the GPEI and the transition planning and management process.

In EB140 (4) there is also a request for the Secretariat to continue reporting regularly to the Health Assembly through the Executive Board on the planning and implementation of the transition process.

The Secretariat considers the scaling down of the polio programme as a corporate WHO-wide exercise and is committed to inform and engage Member States in the process to ensure that polio assets and experience, and investments, help deliver wide ranging public health benefits. The final section, " Next Steps," describes actions taken since 1 January 2017, as well as a proposed list of actions to be completed between June and December 2017, with the aim of producing a comprehensive strategic polio transition roadmap to be presented at the EB142 January 2018.

II. PROGRESS IN POLIO TRANSITION PLANNING & MANAGEMENT

This report is based on the inputs received from WHO country offices, Offices of the African, Eastern-Mediterranean, and South East Asian Regions, and departments within Headquarters. Common templates and structured interviews were provided to solicit inputs for the report. This information can be challenged as not being independent, but the major programmatic risks identified are not new and can to some extent be cross validated against national polio transition plans that are being developed in polio priority countries, as well as findings in peer reviewed literature on the topic of polio transition.[4]

A small team has been established in the Office of the Director-General to coordinate the development and writing of this report, collect additional evidence, as well as to engage in extensive consultation with stakeholders.

With regards to polio transition planning, hitherto the debate in the WHO governing bodies has focused on the human resources aspect and in particular the 1,000 plus workforce holding staff contracts of varying types and for whom the Organization has a contractual liability. The larger

[1] Document EB 140/13
[2] Document EB 140/46
[3] Decision EB 140(4)
[4] Ref to the upcoming supplement or 2-3 of the previously publishes articles on surveillance and laboratories.

workforce, over 5,000, holding "non-staff" contracts has previously not been seriously considered as they represent a small financial liability. However, the programmatic functions at country level performed by this workforce is highly significant, and if withdrawn too rapidly, would leave some countries vulnerable or in worst case devoid of essential functions in vaccine preventable disease response and surveillance as will be illustrated later.

An update on staffing, as of 30 March 2017, including revised numbers on non-staff is presented in the updated paper on WHO's human resources funded by the GPEI[5]. Here it will be noted that there are a total of 1080 people funded by the GPEI holding WHO staff contracts, and this represents an overall 3% reduction when compared to data presented to the governing bodies in January 2017. The actual salary expenditure for the polio staff workforce was US 99.4 million for 2016, only marginally higher than the estimate of US 97.3 million reported at the EB January 2017. The assumptions employed in the terminal indemnity calculation presented in EB140/46 will be validated and the calculations updated using location specific post cost averages. In this context it is to be noted that while Headquarters in Geneva currently accounts for 7% (79) of polio-funded staff members, the cost is 17% of the total.

The updated paper on human resources describes that the Polio Indemnity Fund established in 2013 now stands at $40 million. It is envisaged that by the end of 2019, this Fund will have the $55 million needed to meet the expected separation costs.

As per the GPEI, there are sixteen polio priority countries for transition planning[6] and they represent more than 90% of all the GPEI supported polio infrastructure. These countries include: Afghanistan, Angola, Bangladesh, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Myanmar, Nepal, Nigeria, Pakistan, Somalia, South Sudan, and Sudan. It should be clearly noted that transition planning efforts are expected to be initiated in Pakistan and Afghanistan only once wild poliovirus transmission has been successfully interrupted, and transition planning efforts in Nigeria and in the adjoining Lake Chad region have been slowed down due to the urgent need to focus on stopping the current polio outbreak in the region.

Polio Transition Guidelines[7] developed by the GPEI, are being used to ensure government ownership of national polio transition, systematic mapping of all polio assets, identification of key public health priorities that could benefit from the polio infrastructure, engagement of stakeholders, development of a national polio transition plan with costing, and a financing strategy for implementing the transition plan. The WHO country offices, and WHO consultants and experts have been extensively involved in this process.

The decrease in the polio budgets for 2017-2019 provided in May 2016 to the polio transition countries by the GPEI has accelerated the transition planning efforts as countries will have to quickly adapt to much smaller funding from GPEI. For example, in Ethiopia, there will be a decrease in the polio budget from $39.8 million in 2016 to $4.6 million in 2019, which is 88.5% decrease in 3 years. In addition to accelerating transition planning, these budget decreases have also resulted in a substantial number of staff receiving termination notices, particularly in the African region.

Detailed polio asset mapping at the country level[8], one of the critical milestones of the transition planning process, has either been completed, or in process in 13 of the 16 priority countries. These documents reveal the extensive infrastructure (staff, non-staff, physical assets) that was needed, and established at the country level by the polio eradication initiative to stop poliovirus transmission, and sustain polio-free status.

[5] Document Annex to A70/XX (Poliomyelitis – Report by the Secretariat)

[6] http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transition-planning/country-transition-planning/

[7] Polio Transition Guidelines - http://polioeradication.org/wp-content/uploads/2016/07/TransitionGuidelinesForPolioLegacy.pdf

[8] Polio Transition Asset Mapping documents - web link

As per the country Transition Planning process tracking document[9] maintained by the GPEI, as of April 2017, 9 of the 16 polio priority countries (approximately 65%) have either completed or are in the process of completing 5 of the 7 milestones that are being tracked. Only one country (India) has completed drafting its national polio transition plan that is now being finalised for formal approval by the Government, and five other countries - Bangladesh, Cameroon, Chad, Indonesia and Nepal - are in the process of drafting their transition plans[10].

The Polio Oversight Board (POB) of the GPEI (that includes Director General, World Health Organization; Executive Director, UNICEF; Director, U.S. Centers for Disease Control and Prevention; President 2016-17, Rotary International; and, President, Global Development Program, Bill & Melinda Gates Foundation) has requested the establishment of the Polio Transition Independent Monitoring Board (TIMB) to independently monitor and guide the process of transition planning, assessing the quality, sufficiency, and impact of work being undertaken to achieve transition planning aims stated in the Polio Eradication and Endgame Strategic Plan 2013-18. The TIMB[11], which is made up of 11 members, will have had its first meeting on 4-5 May, 2017, and is expected to meet every 6 months until end 2019.

III. PROGRAMMATIC RISKS AND OPPORTUNITIES FROM POLIO TRANSITION

Upon review of inputs received from concerned Regional Offices, headquarter departments, and from draft national country transition plans, the following key programmatic risks and opportunities have been highlighted. The full text of contributions will be made available on the WHO polio transition website[12]. This report represents the first attempt to consolidate the programmatic risks and opportunities of polio transition.

A. Impact on Immunization:

RISKS: A 2016 human resource mapping by the Polio Department, WHO illustrates that up to 23% of polio-funded staff contracts are contributing to immunization and surveillance activities, 19% are working on broader Expanded Programme on Immunization (EPI) technical areas such as laboratory support or data management, and up to 55% are providing critical operational support to implement immunization services through WHO country offices. With the decrease of polio eradication funding, WHO offices at regional and country level face a real risk that their core EPI functions, and notably disease surveillance activities, will be disrupted. As a consequence, the overall performance of national immunization programmes will be negatively impacted.

There are clear inter-relationships and systemic synergies across the Expanded Programme on Immunization (EPI) and the Polio Eradication Initiative that also indicate that any down-scaling of polio resources will adversely affect the immunization programme. The interactions include, but are not limited to:

- Routine immunization strengthening (micro-planning, training, community mobilisation);
- Disease surveillance and laboratory capacity strengthening;
- Data quality, collection, analysis and management;
- Planning and execution of supplementary immunization activities (of polio and other Vaccine Preventable Diseases – VPDs); and
- Programme supervision and monitoring

[9] Tracking Document – web link
[10] Draft Transition Plans - web link
[11] TIMB: http://polioeradication.org/who-we-are/governance/transition-imb/
[12] Link to website

As illustrated in the 2016 Mid Term Review of the Global Vaccine Action Plan (GVAP)[13], Member States have an obligation to increase their engagement and commitment towards meeting the goals of the Global Vaccine Action Plan (2011-2020). The report was a sobering reminder that global aspirations such as the elimination of measles and rubella or the attainment of equitable immunization coverage still remain behind schedule.

The Measles & Rubella initiative (MRI) has identified 68 priority countries for support and all polio transition priority countries are included in this M&RI list. Of the 20.8 million infants who did not receive measles immunization in 2015 through routine immunization, more than half (53%) were in six of the polio transition priority countries (India, Nigeria, Pakistan, Indonesia, Ethiopia and the Democratic Republic of Congo). The measles and rubella elimination goal of GVAP is therefore already fragile and could suffer dramatically from withdrawing the polio support.

Furthermore, of the 19.4 million infants unimmunized with DTP3, nearly 60% reside in the 16 polio transition priority countries. This, despite the fact that polio resources have helped these countries map populations missed by routine immunization services and develop strategies to increase coverage and reduce inequity.

If the GVAP goals are to be reached by 2020, the integrity of the Expanded Programme of Immunization must not only remain intact but should be further strengthened and cannot suffer setbacks from polio transition.

The phasing out and closing of GPEI presents widespread risks for the WHO African Region given approximately 90% of its WHO-funded immunization staff and infrastructure are funded from GPEI resources. It is important to note that all WHO polio-funded staff based at the country level are termed Immunization Officers and work on a broad spectrum of vaccine preventable disease (VPD) activities – all linked to the 2014-2020 Regional Strategic Plan for Immunization (RSPI)[14], which was approved by the WHO Regional Committee for Africa in 2014. The RSPI builds on the GVAP and includes ambitious regional vaccine introduction and coverage targets dealing with pneumococcal conjugate vaccine, rotavirus vaccine, HPV vaccine, measles and rubella, MNTE, yellow fever, and meningitis. These targets were set considering the levels of WHO AFRO staffing in 2013-2014, and with a view for WHO to continue to be able to provide the technical assistance to countries to attain these objectives.

In addition to the phasing out of the GPEI and associated resources, the WHO African Region also faces the phasing out of GAVI support in years to come as countries undergo economic transition and will no longer be eligible to apply for GAVI support. At the December 2016 meeting, the Regional Immunization Technical Advisory Group (RITAG) recommended to the WHO Regional Director for Africa that a detailed programmatic risk analysis be conducted on the projected impact of the GPEI ramp-down/closure and GAVI transitioning on national immunization programmes and national disease surveillance systems in the African region, while also including the requirements that needed to be in place in the post-polio certification period. In the African region, the key areas within Immunization that were highlighted to be affected by the GPEI downsizing and closure include:

- **Disease surveillance activities** – All of AFRO's 47 WHO country offices receive GPEI seed surveillance funding on a quarterly basis to allow countries to conduct active surveillance activities for, not only Acute Flaccid Paralysis (AFP) but other VPD surveillance activities. Once GPEI closes, active disease surveillance may not be conducted optimally which would

[13] 2016 Midterm Review of the Global Vaccine Action Plan.
http://www.who.int/immunization/global_vaccine_action_plan/SAGE_GVAP_Assessment_Report_2016_EN.pdf

[14] Regional Strategic Plan for Immunization 2014–2020
https://www.aho.afro.who.int/en/ahm/issue/19/reports/regional-strategic-plan-immunization-2014%E2%80%9

lead to delayed detection and response of priority diseases and possible resurgence of some priority diseases.

- **Immunization information systems** – Given that all but one WHO immunization data management staff functions in the African region are currently funded by GPEI resources, there is a need to ensure that this data management capacity prevails to be able to monitor disease trends regularly with a view to detect and respond to disease outbreaks in a timely manner.
- **Laboratory support** – As GPEI-funding scales-down, polio-supported laboratories will require continued support for other VPD laboratory activities they conduct including for accreditation, purchasing reagents, equipment, training, materials and supplies. For example, in Nigeria, the two WHO accredited laboratories and other government laboratories that are supported by WHO GPEI resources, and that support measles/rubella and yellow fever, remain at risk.

The downsizing of the polio programme would contribute similar risks in the Eastern Mediterranean Region where the polio staff allocate a significant portion of their time to support other childhood immunization efforts, and vaccine preventable disease surveillance efforts in addition to Acute Flaccid Paralysis (AFP) surveillance. In polio transition priority countries like Sudan and Somalia, polio eradication efforts are fully integrated into either the EPI programme, or other childhood immunization efforts. In addition, surveillance for measles and rubella are integrated with AFP Surveillance for data management, oversight, technical bodies, communications and monitoring and supervision. The slow progress made in a fragile country like Somalia, where routine immunization coverage has improved from below 10% in 1980 to above 44% in 2015[15] is now at risk.

In the South East Asia Region, the biggest risk following the loss of polio networks will be for the achievement of the Regional goal of measles elimination and rubella control by 2020. The risk includes a potential stagnation or decline in the coverage of the first and second dose of measles and rubella containing vaccine under routine immunization, a strategy that is the backbone for measles elimination and rubella control, as well as a negative impact on the quality of surveillance for measles and rubella. Unless alternative mechanisms to sustain the technical functions and funding are identified urgently to replace the GPEI funds, up-scaling case-based laboratory supported surveillance for measles and rubella to achieve the goal of measles elimination/CRS control will remain a challenge.

Support for introduction of new vaccines in the South East Asia Region is likely to get compromised as well, in the event of polio networks not supporting activities such as training, post-introduction evaluations, and surveillance of adverse events following immunization.

OPPORTUNITIES: Key technical and operational polio-funded staff, and the extensive polio-funded infrastructure at the country-level, can be re-purposed to play a critical role in helping achieve the GVAP Goals, and related Regional immunization targets. Sustaining a, soon to be defined, core polio capacity will also be essential to ensure the effective implementation of the polio post-certification strategy.

Securing Universal Access to Immunization in the African Continent: WHO (AFRO & EMRO) is in the process of developing a business case for immunization for the African Continent whose ultimate goal is to assist Member States (AFRO & EMRO) in the African continent reduce the mortality and morbidity burden among women and children caused by VPDs. The business case will seek to ensure sufficient commitment of national leadership and resources to WHO to fully achieve the RSPI targets[16] and Addis Declaration on Immunization (ADI) Commitments.[17] This business case will be used primarily to identify and secure the necessary resources to improve surveillance

[15] WHO vaccine-preventable diseases: monitoring system, 2016 global summary. http://apps.who.int/immunization_monitoring/globalsummary

[16] Regional Strategic Plan for Immunization 2014–2020: https://www.aho.afro.who.int/en/ahm/issue/19/reports/regional-strategic-plan-immunization-2014%E2%80%9

[17] http://immunizationinafrica2016.org/ministerial-declaration-english/

capacity, data quality and use, as well as enhance the regional accountability mechanisms to monitor implementation of the RSPI and ADI commitments.

Strengthen Immunization in the South East Asia Region: Following the certification of polio eradication, polio assets and technical capacity have been used extensively to support broader immunization priorities during recent years. Key areas of involvement include surveillance for other vaccine preventable diseases (measles, rubella, diphtheria, pertussis, neonatal tetanus and acute encephalitis syndrome (AES), targeted technical support for supplementary immunization activities for measles elimination and rubella control, strengthening routine immunization systems, technical support for new vaccines introduction, operational research and clinical trials. This support by the polio infrastructure has been well recognised by the national Governments in the region, and they call for sustaining this technical support to secure larger public health dividends and achieve regional goals, as well as SDG health targets.

Achieving Measles & Rubella Elimination Goal: Measles elimination and rubella/CRS control is a priority for the member states of the African, Easter Mediterranean, and the South-East Asia regions. All three regions have adopted measles elimination goals.

Both Measles and rubella elimination programme, and the GPEI rely heavily on an extensive surveillance and laboratory network, a system of outbreak preparedness and response, periodic supplementary immunization activities and an active community mobilisation network to reach the 'last mile'. The Global Measles and Rubella Laboratory Network (GMRLN) were devised from the success of the Global Polio Laboratory Network (GPLN), and notable resources continue to be shared across the two networks in terms of staff, management and processes to conduct laboratory tests for case confirmation.

Currently, many measles and rubella surveillance activities depend upon and substantially benefit from the infrastructure and activities resourced by polio. At the present time, over 2500 polio-funded staff are supporting measles and rubella surveillance.

Additionally, of the 146 polio laboratories, 122 (84%) are accredited in the measles and rubella network and are at risk of being dismantled when polio resources decline. Based on the Financial Resource Requirements[18] outlined by the GPEI, it is provisionally estimated that it would cost approximately US$ 77 million annually to replace the GPEI resources currently used to bolster measles and rubella surveillance at country level. This represents approximately 70% of the global cost of conducting measles/rubella surveillance.

With decreases in polio funding, backsliding in immunization performance could be expected. Current measles and rubella surveillance activities, and ultimately, global disease elimination goals will be in jeopardy if this opportunity to build on gains to date is not firmly seized.

B. Impact on Global Health Security: Capacity to Detect and Respond to Epidemic and Pandemic prone diseases and other emergencies:

RISKS: With over 100 acute public health events reported on a yearly basis in the African region, there is need to ensure that a minimum human resource capacity with expertise in detecting and mounting response to acute public health events is maintained in critical countries in the region to alleviate the burden of epidemic prone diseases and attain the minimum International Health Regulations (IHR) 2005 core capacities. Without this field support, there will more likely be delays in detecting and mounting effective response to these threats in the African region.

[18] World Health Organization. Financial Resource Requirements 2013-2019. 2016. http://polioeradication.org/wp-content/uploads/2016/10/FRR2013-2019_April2016_EN_A4.pdf

There are many recent examples of how the polio infrastructure has been critical for detecting and responding to health emergencies, especially in fragile states or those with weak infrastructure. In many of the disease outbreaks that require large preventive and/or reactive vaccination campaigns, the expertise of the polio programme in preparing micro-plans and conducting vaccination campaigns have been extremely valuable. In Somalia, the Polio team has contributed in managing the current drought and Cholera emergencies through supporting the planning, implementation, and monitoring of the Oral Cholera Vaccination (OCV) campaigns targeting an estimated 500,000 people in high risk areas. In Sudan, polio staff were engaged in monitoring of large vaccination campaigns reaching tens of millions of children and adults against yellow fever, meningitis-A vaccination, and measles, besides supporting responses to Dengue Fever, and Acute Watery Diarrhoea outbreaks.

The recently controlled large urban yellow fever outbreaks in Democratic Republic of the Congo (DRC) and Angola further illustrate the critical role of the polio programme in assisting in the response to a given VPD. The north east of Nigeria also faces big risks from the GPEI downsizing. Mobile health teams (supported through GPEI) remain the only source of immunization and RMNCAH services in some areas suffering from the scourge of insurgency from Boko Haram and the associated destruction of health facilities. Polio staff and infrastructure were also central to the containment of Ebola in Nigeria.

In 2010, the WHO regional office for Africa revised the generic Integrated Disease Surveillance and Response (IDSR) technical guidelines developed in 2001 in response to several emerging and re-emerging infectious pathogens, the threats of non-communicable diseases, events and conditions, the adoption of the IHR 2005 and the One Health approach. Strengthening the IDSR and IHR implementation will be impacted without the resources and assets from the Polio programme such as surveillance, data management using GIS, laboratory, etc.

Polio-funded health workers, and physical assets such as vehicles, and cold chain equipment, have also been used to support logistics required for supervision and surveillance activities in other communicable diseases. This support was instrumental to control the recent Yellow Fever outbreaks in Angola, DRC and Uganda, support immunization activities during seasonal outbreaks for meningitis, and support the preparedness for the implementation of Pandemic Influenza Preparedness (PIP) framework.

OPPORTUNITIES: Strengthening the WHO Health Emergencies Programme (WHE): WHO is currently responding to an unprecedented number of crises; in the context of increasing urbanization, globalization and an intensification of civil conflicts, the negative impact on the health of vulnerable populations only seems likely to increase. Increased capacity is urgently needed in a number of WHO Country Offices, particularly those with ongoing emergencies and/or in fragile settings, in order for WHO to be fully equipped, in support of member states, to prepare for emergencies, mitigate risks, and when necessary lead the operational response.

Many of countries that the WHO Health Emergencies Programme (WHE) is targeting for increased capacitation are also polio transition priority countries. Of the 16 polio priority countries for transition planning, 6 countries fall under WHE's "Priority 1" for increase in capacitation, 5 countries fall under "Priority 2," and 5 countries fall under "Priority 3." Currently, in countries where the Polio programme has made a significant investment in infrastructure and capacity, polio staff are supporting technical areas such as surveillance, alert and response, emergency vaccination campaigns, emergency operating centres, as well as national and sub-national coordination. In some countries like Somalia, an integrated Polio and Emergency Coordinator position has been created to support childhood immunization and emergency responses in an integrated manner. The skills and systems that polio staff have built over the years may be directly relevant both to the core capacity requirements of WHE, but moreover to the increased resilience of the health system in high vulnerability countries. Recognizing that the WHE core capacity requirement does not include as many staff as currently employed for polio eradication, and does not include the structures at sub-national level as is currently maintained by polio, additional financing streams will need to identified to maintain such extensive networks.

Over the coming months, the WHO Health Emergencies Programme (WHE) is reviewing the core country capacity requirements for emergency preparedness and response, based on country context and needs, in priority WHO country offices. The core capacities required include: health emergency leadership and coordination; surveillance, early warning, risk assessment and health information management; infectious hazard management, partner engagement, communication and resource mobilisation; and administration, including financial and human resource management. During a health emergency, the team will provide emergency response support through deployments as needed within the country and beyond.

Over the next 6 to 12 months, WHE will work together with the Heads of WHO Offices to fully implement the WHE country business model appropriate to the country context, and to ensure this capacitation is institutionalised and sustained. Opportunities for synergies between the polio transition planning and the WHE capacitation plans will be actively pursued. A limited amount of funding is currently available for the initial investment required by WHE in 2017, but the long-term sustainability of this model is dependent upon new multi-year contributions for WHO's work in emergencies.

In polio transition priority countries, there is significant expertise and capacity to support national IHR core capacity strengthening efforts, and the development of National Action Plans. The report of the Joint External Evaluation (JEE) conducted in the Islamic Republic of Pakistan in 2016, noted that, "Systematic planning must determine how the assets and best practices of polio eradication are transitioned and mainstreamed over time to support other priorities, particularly immunization and vaccine-preventable disease surveillance. More generally, the integrated infectious disease surveillance and control system should be developed toward a more generic horizontal system capable of detecting and responding to any disease."[19]

In many of the polio transition priority countries, especially those that are fragile and in states of conflict, polio-funded staff and infrastructure are already integrated into the emergency operations, and remain the first responders to outbreaks of diseases or natural disasters.

Strengthening Integrated Disease Surveillance and Response (IDSR): Despite the progress made over the years, IDSR has not been fully implemented at district and community levels in most countries. The critical gaps in district level implementation of IDSR include inadequate capacity in managing data, limited capacity of district level epidemic management committees and rapid response teams, and lack of logistic and communication capacities. Experience from the recent major epidemics (EVD, Zika, Yellow fever etc.) has revealed that shortage of financial, human and logistic resources hampers preparedness and response to epidemic prone diseases.

The main core and supporting functions of IDSR and polio's AFP surveillance are quite similar and are applied at all levels of the health system from community, district and peripheral levels to national level. Polio-funded AFP surveillance network is an opportunity for enhancing IDSR: i) resources for improving surveillance including data management; ii) platform for networking national public health laboratories including safe and timely shipment of infectious substances; iii) adequate field operations for investigation and response to major outbreaks; and iv) capacity building for IDSR, IHR and One Health implementation. The polio infrastructure will be instrumental to support the implementation of the regional strategy for health security and emergencies.

The GPEI has also contributed in strengthening public health laboratories systems in the African region. It has established strong Polio Laboratory network that contributed to the strengthening of national capacities and its expansion to surveillance of other viral priority diseases such as measles, yellow fever, Influenza, MERS-CoV and Ebola.

[19] Joint External Evaluation of the Core Capacities of the Islamic Republic of Pakistan: Mission Report (27 April – 6 May, 2016). https://extranet.who.int/spp/sites/default/files/jeeta/WHO-WHE-CPI-2017.9-eng.pdf

C. Impact on Neglected Tropical Diseases and Nutrition supplementation:

RISKS: It is estimated that approximately 1.5 billion people are infected with Soil Transmitted Helminths (STH) worldwide.[20] Over 270 million preschool-age children and over 600 million school-age children live in areas where these parasites are intensively transmitted, and are in need of treatment and preventive interventions. The WHO department of Control of Neglected Tropical Diseases aims to reach 270 million pre-school children every year with deworming treatments. Deworming tablets are frequently co-administered with vitamin-A during polio vaccination campaigns organized as "Child Health Days" which are reliant polio funding. Globally over 150 million preschool children were treated in 2015 with this approach.

The South-East Asian Region has the highest number of STH infected children among all WHO regions, with India, Indonesia, and Bangladesh – all three being polio priority countries for transition, accounting for the majority of those. The Region has identified the elimination of Neglected Tropical Diseases as one of the priority programmes that should benefit from the skills of the polio team and its surveillance. The WHO African Region has the second highest number of infected children, with nearly 300 million children requiring Preventive chemotherapy (PC). Three of the four highest need countries in the African region, Nigeria, Ethiopia, and Democratic Republic of the Congo (DRC) are polio priority countries for transition.

In the 16 polio transition countries, in 2015, almost 55 million preschool children were dewormed through Child Health Days. In DRC, Pakistan and Myanmar the coverage with deworming of the children in need has been over 90%, and in Ethiopia over 60%.

However the expected progressive scaling down of the Global Polio Eradication Initiative (GPEI) can negatively impact STH PC coverage in the future. Because of the degree of integration between various NTD programmes, the process of winding down operations is not limited to STH programmes themselves. For example, either prior to 2020 or soon afterwards, the elimination or eradication programmes organized for Lymphatic Filariasis, Onchocerciasis and Poliomyelitis will have probably reached their eradication or elimination targets and the large campaigns conducted every year, that provide part of the infrastructure to reach children with albendazole and mebendazole will be phased out.

The mass polio vaccination campaigns and polio supported "Child Health Days" also offer an opportunity to conduct surveillance activities for Guinea worm, and thus support another global eradication effort. Cards with pictures of the worm emerging from the skin are provided to polio vaccination teams, and in many countries, a specific guinea worm awareness column is included in the polio vaccination tally sheets. House-to-house active case search and surveillance for guinea worm by the thousands of polio vaccinators in Nigeria helped certify the eradication of guinea worm in the country.[21]These Guinea worm surveillance activities are presently conducted in 8 countries, and 6 of them are among the Polio-transition Countries (Angola, Chad, DRC, Ethiopia, South Sudan, and Sudan).

OPPORTUNITIES: Ten of the 16 polio transition countries - Angola, Bangladesh, Cameroon, Ethiopia, India, Nepal, Nigeria, Somalia, South Sudan and Sudan - have indicated Neglected Tropical Diseases (NTDs) among their top 5 priorities for country budget allocation under Programme Budget 2018-19.

A key consideration is how to maintain the benefits achieved with STH control interventions at a cost sustainable for low income countries. The mass national and sub-national polio vaccination campaigns supported by GPEI provides an important and cost-effective delivery platform for the distribution of preventive chemotherapy for neglected tropical diseases.

[20] Soil-transmitted helminth infections. World Health Organization, Fact sheet No.366, updated March 2016
[21] http://www.who.int/features/2014/nigeria-stops-guinea-worm/en/

When the cost of the drug is covered by a donation, and using the polio supported "Child Health Days" infrastructure, the cost of deworming a child in need is less than 0.007 USD; this means that 1 USD is sufficient to treat more than 100 children.[22] The cost of deworming a child when such infrastructure is not present is approximately 30 times higher. It was the low marginal cost of deworming that convinced several polio endemic countries to adopt this approach.

A careful evaluation in countries where the financial support to Child Health Days or Immunization Days will be discontinued because of the eradication of Poliomyelitis should be conducted, and corrective measures taken, including identification of alternate delivery systems and financing, to maintain the present deworming activities and help achieve NTD goals.

Given that an estimated 1.5 million childhood deaths have been prevented, through the systematic administration of vitamin A during polio immunization activities,[23] a similar detailed analysis of the risks and identification of alternative platforms for the cost-effective delivery of nutritional supplements will be critical.

As is the case in India where the vast polio surveillance network is being utilised to also monitor neglected tropical disease like Kala Azar and lymphatic filariasis, similar approaches could be initiated in many other countries to ensure better surveillance of NTDs. In Nepal, the polio-funded Immunization Preventable Diseases (IPD) surveillance network is also being used to monitor acute encephalitis syndrome (AES).

Given that the lack of adequate sanitation, which is a key driver of STH transmission and poliovirus transmission, is expected to continue to be a problem in many STH endemic countries after 2020, the PC efforts could also be linked to the broader community awareness raising efforts targeting SDG goal for Clean Water and Sanitation, and in particular the target (6.2) by 2030, *to achieve access to adequate and equitable sanitation and hygiene for all and end open defecation*.

D. Impact on Maternal & Child Health interventions:

RISKS: Polio funded staff and physical assets have supported non-polio work, and especially interventions targeting maternal and child health in many countries. Most of these interventions are linked to broader immunization activities and the achievement of disease-specific goals like MNTE, measles, rubella, and introduction of new vaccines.

The support provided by the polio staff, assets and resources to organise "Child Health Days" in many countries with weak health infrastructure, has helped with reducing mortality and morbidity associated with VPDs, NTDs, poor nutrition, as well as assist in data collection and analysis. In many countries, these opportunities were also used to raise awareness about sanitation and hygiene, breast-feeding, and birth registration. For example, in DRC, during a nation-wide polio immunization campaign aiming to reach more than 16 million children under the age of five years, the campaign involving 19,000 social mobilizers to inform and involve communities, 90,000 vaccinators and more than 50,000 health workers, also provided de-worming tablets and Vitamin A supplements. In addition, large-scale birth registration was also carried out, targeting 117 'zones de santé' or health zones[24]. The withdrawal of polio funding will therefore have repercussions for Reproductive, Maternal, Child, and Adolescent Health (RMNCAH) programmes in many polio transition countries.

[22] Boselli *et al*. Integration of deworming into an existing immunization and vitamin A supplementation campaign is a highly cost-effective approach to maximize health benefits in Lao PDR (2011). *International Health* 3; 240-245.
[23] http://www.who.int/mediacentre/factsheets/fs114/en/
[24] http://polioeradication.org/news-post/a-common-package-for-childrens-health/

OPPORTUNITIES: As part of the WHO bottom-up 2018-19 Programme Budget planning process, of the 16 priority countries for polio transition, 15 have mentioned RMNCAH within their top 5 list of priorities for budget allocation.

Monitoring Child and Maternal Mortality to Achieve the SDGs: As per the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030),[25] and as indicated in SDG Goal 3 Health Targets 3.1 and 3.2[26] reduction of global maternal mortality ratio to less than 70 per 100,000 live births, and neonatal mortality to at least as low as 12 per 1000 live births, and under-five mortality to at least as low as 25 per 1000 live births, are top global health priorities. Conducting mortality audits and reviews is a key strategy for reducing preventable deaths among mothers and babies. It helps health system managers understand the causes of death, and the contributing factors, so they are able to take corrective actions to improve the quality of care.[27]

One of the options that should be considered in polio transition countries is to explore if the functions of current polio or disease surveillance network, and their data information system capacities could be expanded to monitor and track maternal and child mortality data.

Incorporating key elements of maternal death surveillance and response (MDSR) into existing broader surveillance networks can help countries collect better information for action by promoting routine identification and timely notification of maternal deaths, review of maternal deaths, and implementation and monitoring of steps to prevent similar deaths in the future.

One concrete proposal the Government of Nepal is exploring, is for the polio-funded Immunization Preventable Diseases (IPD) surveillance network to start monitoring paediatric mortality (1 to 59 months) from pneumonia and diarrhoea, the two major killers of under-five children in the country. The goal is to collect actionable public health data that will help improve the analysis of child mortality in the country, and help the government make more informed decisions to situate referral hospitals or primary health centres, reduce delays in treatment, and thereby reduce child mortality rates in the future.

Nepal is currently developing a five-year polio transition plan, including providing catalytic funding from the Ministry of Health starting from the next fiscal year to initiate a pilot of monitoring child mortality in selected districts. In the future, the Government is also considering extending the scope of child death monitoring nation-wide if there are sufficient resources.

E. Impact on Health Systems:

RISKS: The GPEI has invested heavily in country and international infrastructures in order to attain its eradication goal. Clear synergies exist with child health and routine immunization and the case has been made that the polio transition could strongly benefit local health systems. However, to date, this linkage with health systems strengthening has not been robustly examined and, in most countries, linkages to health systems goals have been limited to child health activities. That said, given the scale of GPEI, its reach to remote, rural, nomadic and migratory populations, and under-served communities, including the marginalised and urban poor, and the strength of its data collection and analysis programme, there have been major benefits for transition countries who have used the polio approach to strengthen primary care systems on their way to Universal Health Coverage (UHC).

Member states adopted in May 2016 the *WHO Framework on Integrated, People Centred Health Services*[28], providing a vision for how health systems could be reoriented to provide services across the care continuum in a more integrated way that created better health for whole populations

[25] http://www.who.int/pmnch/media/events/2015/gs_2016_30.pdf
[26] http://www.who.int/gho/publications/mdgs-sdgs/MDGs-SDGs2015_chapter1.pdf
[27] http://www.who.int/mediacentre/news/releases/2016/stillbirths-neonatal-deaths/en/
[28] http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1

rather than selected advances in particular diseases. The integration of "vertical" programmes like GPEI is essential to achieving this vision.

OPPORTUNITIES: Support for achieving Universal Health Coverage (UHC) – There are four main areas for examination for the future of the GPEI transition that could benefit the achievement of Universal Health Coverage (UHC):

Strengthening primary care services for health systems and security: the potential impact of GPEI-funded staff and assets for improving the quality and accessibility of front line services as part of country efforts at national UHC efforts is enormous. At the same time, the vertical focus of the GPEI programme to date means its influence has been very peripheral on primary care. In many countries, primary care will be the main entry point for national efforts to achieve UHC. Approaches such as those used in Nigeria to strengthen polio operations through Emergency Operations Centers (EOCs) and health camps can be considered for strengthening both outbreak preparedness and improving quality of care through stronger district primary care management in high priority districts. Shifting the attention in key polio districts to strengthening the primary care infrastructure and quality of basic services provision will be one of the top priorities for immediate impact of GPEI on health systems strengthening in transition countries.

Improving community engagement efforts for local health services strengthening – Engaged communities and families are the backbone of strong local health systems and of robust community tracking of reportable diseases for the International Health Regulations (IHR). The breadth of the GPEI programme and its strong outreach approach make the area of community engagement a natural priority for consideration in future benefits of polio transition to local health systems strengthening efforts. However, an integrated approach is needed given that routine immunization is often linked to more integrated community health services, such as consultations for diarrhoea, malnutrition, malaria, etc., and with efforts at improving sanitation. Stronger engagement of local community health structures and traditional systems will also be needed if this potential benefit to health systems is to be realized.

The work of the GPEI in Ethiopia, for example, highlights the possibilities of leveraging staff and NGO teams supported from polio funding for bolstering weak primary and preventive care systems in remote rural and border areas most at risk for poor health and outbreaks. Using networks, who have contacts and credibility within the hard to reach communities they are serving, would significantly advance country goals for UHC.

Build on GPEI data systems to create a culture of information in local health systems - The data systems needed and developed by the GPEI are among the most developed public health surveillance systems ever created. Important assets and approaches for geo-localization of cases and possible cases have been developed and deployed in almost all of the transition countries and most of these systems function in remote areas often untracked by local health information systems. Even more importantly, the culture of data use in the GPEI and its approaches for very rapid feedback of data (essential when tracking outbreaks or suspected cases) would have immediate application for improving the quality of health services and health worker performance.

Strengthening supply chains and access to safe medicines – One of the cornerstones of the GPEI initiative has been effective management of polio vaccine supply chains and cold chain maintenance. In many countries, the investment on central supply management and supply chain from GPEI has been a driving factor in overall improvements in access to safe medicines. However, in most cases, guidance notes, training and support has concentrated solely on management of oral polio vaccine, measles vaccines and inactivated polio vaccine management. Key investments will include a) analysing and improving supply chains and distribution, b) improving dispensing practices as the front line and c) investing in necessary upstream foundations such as strengthening medicines regulation at the national level.

IV. ORGANIZATIONAL RISKS & CHALLENGES

A. Organizational Risks - Impact on WHO's Capacity to support Member States:

1. Sub-National Offices: The polio eradication effort has needed significant financial resources, and technical and operational capacity at the sub-national level to be able to conduct large scale and consistently high quality immunization activities in order to reach and vaccinate all children, conduct active surveillance, and help stop poliovirus transmission. For example, GPEI resources have helped establish 18 provincial teams in Angola, 11 sub-offices in DRC, 37 field offices in Nigeria, 11 field offices in Nepal, and large number of district level staff in Somalia. To provide additional context, in Angola, there are 56 staff among the 18 provincial teams, and they are supported by a fleet of 26 vehicles, office space, and computing and communication equipment. These teams supplement the lack of skilled personnel in the local health systems, and were critical in responding to the recent yellow fever outbreak in the country.

This strong presence of WHO's polio-funded staff and infrastructure at the provincial and district level, including in some countries through the establishment of Emergency Operations Centres (EOCs) has been hugely beneficial for many member states that have not yet developed robust health systems at that level. These district and provincial offices and their technical and operational capacity, including data and information systems, have been widely utilised by the national and provincial governments to help implement other immunization campaigns, Child Health Days, and also help detect and respond to epidemic and pandemic prone diseases like Yellow fever, Ebola, Marburg, Meningitis, Cholera etc. The polio funded capacity at the sub-national level, in many critical countries, remains the sole capacity to respond to acute public health emergencies. The downscaling of this capacity, which has already been initiated in many countries, will leave member states highly vulnerable and impacts global health security.

2. Field Presence & Technical Support: Many member states rely heavily on the polio-funded staff and assets to support immunization and VPD control initiatives. For example, in DRC, it is estimated that 90% of all of WHO's infrastructure in the country is supported through GPEI funds. But with the already initiated and planned downscaling of the polio infrastructure, WHO will lose its field presence, coordinating role, and technical leadership in these countries. The loss of polio resources will also negatively impact crucial capacity building, technical support activities, and monitoring that is needed to strengthen immunisation systems at the national and sub-national levels, and also community engagement initiatives.

The downscaling of polio resources will also impact the optimal implementation of disease surveillance activities, and thereby result in gaps in the understanding of the epidemiological situations in many countries. In some countries, their only existing disease surveillance system rely significantly on polio-funded staff and resources to be operational. For example, in Nepal, WHO's Immunization Preventable Diseases (IPD) Network that is largely financed from polio resources has a staff of 61, situated in the central level and 11 district offices, and who support all 75 districts in the country. On a weekly basis this network actively monitors priority sites, and receives reports on various VPDs from 800 surveillance sites, and 1,100 informers. This is the only active surveillance network in the whole country.

In the 16 priority countries for polio transition, the loss of polio-funded technical, managerial and administrative capacity is expected to have a significant impact on the capacity of the WHO Country Office to respond to critical requests from member states for urgent support. In many public health emergencies, and during natural disasters, in districts and regions where there are no dedicated ERM teams, Country Offices have been able to quickly mobilize the polio technical teams and their physical assets to support the Government. In addition, in districts with weak local capacity, polio teams have provided significant administrative, coordination, data collection and analysis, and communication support.

3. Support National Priorities: Many member states also rely on the polio-funded staff and infrastructure to support other urgent national, regional or global priorities, including Measles and Rubella elimination goals, and GVAP goals. The same polio-funded infrastructure is also used to help plan for, implement, and monitor the successful introduction of new vaccines. For example, the Government of India has noted the need to rely on the National Polio Surveillance Project (NPSP) to provide primary responsibility for polio, measles, rubella and congenital rubella syndrome (CRS), and other vaccine-preventable disease (VPD) surveillance for at least the next three to five years due to current gaps in the Integrated Disease Surveillance Programme (IDSP). The large number of new vaccines being introduced rapidly over the next two to three years in India will also require continued technical assistance and enhanced surveillance support from NPSP to protect this major investment in public health. In addition, the performance of the VPD laboratory networks and associated data management systems will also not be of the highest standards with the planned reduction of polio resources. All these negative ramifications will directly result in VPD outbreaks not been detected, investigated or responded to in time, and lead to loss of lives.

4. Service Delivery Systems: The vast technical and operational infrastructure, including logistics and cold chain systems have also served as a delivery platform for other health interventions. This coupling of multiple interventions during the annual or semi-annual mass polio immunization campaigns in many countries have helped reduce the cost of the delivery of these additional health interventions in resource poor settings, and have made full use of the planning, coordination and monitoring expertise of WHO's polio-funded staff. Some of these additional interventions have included the regular distribution of de-worming tablets to pre-school age children, vitamin-A supplementation, administration of measles vaccinations, and maternal and neonatal tetanus (MNT) vaccinations, insecticide treated bed nets for malaria control, oral rehydration salts (ORS), protein biscuits, etc.

In addition, health camps organised by the polio staff to reach and vaccinate remote populations have also provided basic primary care services, and referrals to the nearest primary healthcare facilities. These camps have also helped provide referrals for prosthetics, rehabilitation services or corrective surgery for polio-affected children. The house-to-house polio vaccination campaigns have also been used as platforms to conduct surveillance of specific NTDs like guinea worm, or communicable diseases, and distribute communication materials to parents dealing with WASH, routine immunization, delivery in hospitals, and registration of new births. There have also been many instances where polio vaccination efforts in remote nomadic populations have been integrated with vaccination of cattle or camels.

5. Serving hard-to-reach communities & insecure areas: Polio resources have also contributed significantly to WHO's ability to be present and serve communities in areas that are unstable, are highly insecure, or in a state of active conflict. Given that the polio-funded workforce are the largest in number in most of the polio transition priority countries, funds from the polio programme shoulder a large burden of the cost of ensuring that personnel, property and assets of the WHO Country offices at the national and sub-national level are compliant with the "Minimum Operating Security Standards," (MOSS) of the United Nations Department of Safety and Security (UNDSS), and thereby help manage and mitigate security risks. The security measures supported by polio programme funds include specific measures for protection of office premises, specific equipment for all WHO vehicles, purchase of armoured vehicles, purchase of telecommunication equipment, satellite phones, emergency radios, purchase of Personal Protective Equipment, recruitment of additional Security personnel, and ensuring that staff working in high-risk areas undergo SSAFE training (Safe and Secure Approaches in Field Environment). All of these risk mitigation measures also contribute to the successful implementation of all other WHO programmes in these high-risk areas.

6. Polio Investments: Lastly, the withdrawal of the significant flow of financial resources for polio eradication to WHO as a whole, the Africa, Eastern Mediterranean, and South-East Asia Regions, and the 16 polio priority countries will underpin the impact on the level of support that can be provided to Member States. It must be noted that for the biennium 2016-17, as of 31 December,

2016: WHO globally spent US$ 587 million on polio eradication, which is 27% of its total expenditure in 2016; African Region spent US$ 297 million on polio eradication that constitutes 44.2% of their total expenditure in 2016; the Eastern-Mediterranean Region spent US$ 172 million on polio eradication that constitutes 43.5% of their total expenditure in 2016; and the South-East Asia Region spent US$ 37 million, that constitutes 24% of their total expenditure in 2016[29]. Similar analysis of the percentage of the expenditure on polio eradication in the 16 priority countries in 2016 reveals a range from a low of 10.4% in Myanmar to a high of 92.4% in Pakistan.

The polio eradication initiative has been established within WHO as a special initiative with a clear and specific goal, however, its staff and infrastructure have provided cross-support to other programmes and created a *de facto* health system that has been critical for the outcomes of these other programme areas, as well as for achieving the priorities of Member States. As highlighted in the many of the above sections, the loss of approximately 20% of WHO's biennium budget would have grave consequences for WHO's capacity at the country level in member states that have weak health systems or in fragile states, especially at the provincial and district levels.

B. Organizational Challenges

Complexity: Given that the Polio Eradication Initiative has been in existence for close to 30 years, polio transition planning has now become one of the most complex endeavours attempted, and poses a reputational risk to WHO if not well managed. It involves coordination of a multiplicity of actors, stakeholders, programme areas; management of various risks – human resources, financing, programmatic, reputation; development of unique transition plans and solutions in the 16 countries; and development of a coherent governance and oversight structure.

WHO faces the greatest risks from polio transition, in terms of downscaling of human resources, financing, and impact on other programmatic areas. So, for the transition processes initiated within WHO to be successful, they need to be well-coordinated and aligned with the structure and timing of the processes that are already underway through the GPEI, specific polio transition planning efforts in the 16 affected Member States, polio transition dialogues with donor Governments and their aid agencies, engagement of Non-state Actors, academic and research institutions, and collaboration with relevant organizations such as the Global Alliance of Vaccines (GAVI).

The GPEI process is managed through the Transition Management Group (TMG) and its three separate work streams. The GPEI, through it specific Management Groups, has also provided Country Transition Guidelines, developed and shared budget decrease figures for 2017-2019 with the polio transition countries, helped establish a Transition Independent Monitoring Board (TIMB) to review the country planning process, launched the development of the Post-Certification Strategy (2021-2030), and supported stakeholder engagement through many fora, including the Polio Partners' Group.

Within WHO, efforts are underway at all three levels of the organisation. A global Post-Polio Transition Steering Committee has been established with the participation of AFR, EMR and SEAR Offices, and relevant HQ Departments; a Global HR Working Group has been established to manage and guide the HR planning process at all levels and also reduce terminal liabilities; and a small dedicated team has been established in the Office of the Director-General to coordinate the response to the Governing bodies decision EB 140 (4). At the regional level, similar Committees have been established under the leadership of the Directors of Programme Management (DPM), and relevant Directors, and Regional focal points for Polio transition appointed. At the country level, the Head of the WHO Offices (HWO) are deeply engaged in the development of the National Polio Transition Plan in close collaboration with the Government and relevant stakeholders in the country.

At all levels of the organization, given that polio-funded staff and assets have been engaged in providing substantial support for other WHO and Government initiatives at the country level, effective polio transition planning efforts will involve deep engagement with key programme areas

[29] http://extranet.who.int/programmebudget/Biennium2016/Flow

including, Immunization, Maternal and Child Health, Emergencies, Neglected Tropical Diseases, and Health Systems in order to minimise the risks from the downscaling of the polio infrastructure on other programmatic areas, and seize opportunities to integrate or mainstream this infrastructure to achieve broader health goals.

Budget & Financing: While the GPEI has shared in May 2016 declining budget figures to the 16 polio transition countries for the period 2017-2019, and accordingly many countries have started the process to reduce the number of WHO staff, other programme areas that have also been benefitting from the use of this polio infrastructure now face significant financing challenges in trying to potentially integrate some of the critical polio assets just to maintain status quo, or exploit additional opportunities.

Given the difficult external financing environment, these programme areas, especially Immunization and Emergencies, are already facing funding gaps for their existing level of work. In addition, the Programme Budget 2018-19 has already been developed, and has limited flexibility to increase the budget space to accommodate additional costs of integrating any polio functions. For example, for the VPD programme area, it has been estimated that a 15% increase in Programme Budget 18-19 would be needed to allow scale up of surveillance and technical assistance, potentially absorbing some of the capacity currently financed with polio funds, to at least keep status quo in terms of Programme outcomes. More significant scale up of 30% is expected to be needed up to 2021 to achieve GVAP goals. Potentially, accommodating some of the polio funded resources into the Programme Budget will be a zero-sum game, and result in the need to remove the budget space for another area of work.

While some element of budget flexibility can be integrated as part of the Operational Planning process for PB 2018-19, one can clearly expect gaps in programme outcomes in the short term (2018-2019) if polio funding is withdrawn too rapidly, and there is no additional financing. Options for additional financing should be explored through dialogue with external financing partners to address the critical short-term gaps. A more robust and coordinated budget development process must be initiated for Programme Budget 2020-2021 where the post-certification polio requirements are to be included.

Lastly, in most of the 16 polio priority countries for transition, the feasibility for absorption of the financing needs through domestic resources in the short term (3-5 years) seems unlikely. The vast majority of these countries fall in the Least Developed Countries list, and will rely on external financing to sustain the essential polio functions, as well as non-essential infrastructure that can support other national and global health priorities.

Sustaining a Polio-Free World Post Certification of Polio Eradication: As GPEI develops the Post-Certification Strategy (PCS) for the Polio Eradication Initiative, there are many critical questions will have to be dealt with by WHO at all three levels of the organization.

As a matter of priority, clear technical definition of the "essential polio functions," and the scale, and scope/timing of these functions will have to be articulated to ensure that these functions are identified and protected during the downsizing and eventual closure of the GPEI. Options will have to be developed at all three levels, including financing, for integrating some of these functions into other programme areas, and for potentially, mainstreaming some functions into the government infrastructure.

Given that poliomyelitis is a disease targeted for eradication, clear delineation of the roles, responsibilities and limitations will have to be articulated of WHO programme areas that are mandated as per IHR (2005)[30] to help manage the risks and public health response associated with events due to a IHR notifiable disease in the long run. This would include the development of the core capacities needed for future surveillance and response in order to live up to the IHR requirements.

[30] http://www.who.int/ihr/9789241596664/en/

As noted earlier, the financing needed for sustaining the essential polio functions, which in global health security terms will mean for perpetuity, will have to be carefully planned for. This is especially true given the inability of many of the Member States in the high-risk countries and polio transition countries to absorb the costs of mainstreaming the polio infrastructure or specific functions in the short to the medium term. Careful budget planning and resource mobilization is also critical to ensure that there is sufficient budget capacity, and eventually financing, for programme areas that would be mandated to integrate some of the essential polio functions post-certification of eradication.

V. NEXT STEPS

A. Key Actions since in January 2017

Active High-level Oversight at all three levels:

- Acknowledgement of the serious programmatic, financial and human resource implications of the polio ramp down and understanding that mitigation is a corporate secretariat priority.
- WHO senior executives and their networks fully engaged. The Global Policy Group (GPG) consisting of DG, DDG and RDs) fully involved as well as networks of Directors of Programme Management (DPM; Directors of Administration and Finance (DAFS) as well as relevant Assistant Director Generals (ADGs)
- Active engagement of the WHO representatives (WRs) in 16 polio countries
- Briefing to all new Heads of WHO Country Offices during induction
- Engagement of the WHO post –polio transition Steering Committee co-chaired by EXD/DGO and ADG/GMG, and regional colleagues
- A small team established within the office of the Director General to coordinate the polio transition on behalf of the WHO Secretariat
- Regular tracking of progress through coordination calls with regions and countries.
- Regions, Countries and HQ departments asked to provide overview of major programmatic risks from polio ramp down.
- Review of WHO corporate risk register to ascertain overall magnitude of polio transition risks.
- Commitments for inclusion of Polio Transition as an Agenda in Regional Committee meetings

Coordinated Human Resources Planning & Budget Management

- Updating of HR staff numbers and in particular focus on getting volume of non- staff.
- Stabilization of HR baseline for polio staff and reconciliation with previous independent studies.
- Inventory of tools and instruments being employed across WHO for tracking polio transition
- Review of programme Budget 2018-19 priorities and budget allocations for 16 priority countries.

Support for Country-level Transition Planning & Implementation

- Technical support for planning in Indonesia, Nepal, Ethiopia, India, Myanmar, Sudan

Stakeholder Engagement

- Informal meeting of the EB decision co- sponsors 20 March
- Polio Partners Group Meeting on 31 March
- Discussion during GVAP Meeting in Washington DC in April
- Presentation to SAGE Meeting in April
- Preparation for meeting of Members States 28 April
- Meetings with NGOs and Health Institutions March, April
- Meetings with GPEI Partners; RITAG - Africa

B. Proposed actions between WHA and end 2017

Active High-level Oversight at all three levels:

- Detailed briefing on polio transition to Director General- elect immediately after WHA with explanation of the corporate risk polio transition presents for WHO and agreement on regular communication to external stakeholders
- Sustained DGO oversight of organisation-wide Transition Planning & management
- Meeting in Geneva of 16 WRs, regional and headquarters staff to discuss progress of the country transition plans combined with a mission briefing, quarter 3-4 2017
- Discussion of polio transition during the Regional Committees 2017 in AFRO, EMRO and SEARO
- Development of a dedicated "Polio Transition" site on the WHO website where tracking of country planning and staff reduction will be regularly updated.
- Active support for a designated team within DGO tasked with the Development of Strategic Road Map & Options – by end 2017

Coordinated Human Resources Planning & Budget Management

- Monthly transition HR dashboards to be developed and shared in "Polio Transition" website
- HR Plans for staff retention, re-training, managed terminations
- Communication Plans and products – Internal and External
- Operational Planning - Programme Budget 2018-19 and revisions
- Advance planning for 2020-2021 programme Budget development

Development of Strategic Action Plan & Options – by end 2017

- Collect more granular details on a prioritised set of "Programmatic Risks" that would have the biggest public health impact.
- Identify the critical gaps that would be left by the decrease in polio budgets, and eventual closure of GPEI, and prioritise the gaps the need to be addressed urgently.
- Develop a timeline and specific options for addressing the gaps – HR, Financing, Coordination, and Policy.
- Develop an implementation and monitoring framework that can be tracked.