

PROVISIONAL SUMMARY RECORD OF THE FIFTH MEETING

**Palais des Nations, Geneva
Thursday, 25 May 2017, scheduled at 09:00**

**Chairman: Dr H. M. AL-KUWARI (Qatar)
later: Mr P. DAVIES (Fiji)
later: Dr H. M. AL-KUWARI (Qatar)**

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COMMITTEE A

FIFTH MEETING

Thursday, 25 May 2017, at 09:20

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1. SECOND REPORT OF COMMITTEE A (document A70/69)

The RAPPORTEUR read out the draft second report of Committee A.

The report was adopted.¹

2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 12 of the agenda (continued)

Poliomyelitis: Item 12.3 of the agenda

- **Poliomyelitis update** (document A70/14)

The representative of MALTA, speaking in his capacity as Chairman of the Executive Board, recalled that the Executive Board had noted, at its 140th session, the progress made in implementing the Polio Eradication Endgame Strategic Plan 2013–2018. It had commended the efforts of the remaining countries in which poliomyelitis was endemic – Afghanistan, Nigeria and Pakistan – to implement national emergency action plans, highlighting that the global epidemiology of poliomyelitis continued to constitute a public health emergency of international concern. The Executive Board had welcomed the commitment of Member States to implementing the globally synchronized switch from trivalent to bivalent oral polio vaccine in April 2016, urging continued surveillance of type 2 poliovirus from any source. The Executive Board had noted that it was important to continue to explore ways to mitigate the risks posed by the ongoing shortage of inactivated poliovirus vaccine and that a global post-certification strategy was being prepared under the Global Polio Eradication Initiative, to be finalized prior to the Seventy-first World Health Assembly.

The Executive Board had reviewed the information on the human resources funded by the Global Polio Eradication Initiative, and decision EB140(4) (2017) had been adopted. In that decision, the Director-General had been requested to present a report to the Seventieth World Health Assembly outlining the programmatic, financial and human-resource-related risks resulting from the winding-down and eventual discontinuation of the Global Polio Eradication Initiative and information on actions to mitigate those risks while ensuring that essential polio-related functions were maintained. The requested report was contained in document A70/14 Add.1.

Due to generous support from the international development community, the budget requirements for planned activities for 2016 had been fully met. The additional funds required for

¹ See page [...].

2017–2019 must be mobilized rapidly; the savings made in a poliomyelitis-free world could be used to address other public health and development needs. He urged Member States to ensure the full implementation of resolution WHA68.3 (2015) on poliomyelitis.

The representative of THAILAND expressed concern about the availability of inactivated poliovirus vaccine and recalled that in resolution WHA68.3 (2015) the Director-General had been requested to ensure a sufficient global supply of affordable inactivated poliovirus vaccine and to expedite and monitor the transfer of inactivated poliovirus vaccine technologies to manufacturers in developing countries. Countries without adequate facilities risked delayed containment of poliomyelitis outbreaks, as samples suspected to contain type 2 poliovirus must be shipped to other countries for processing. Prohibiting the retention of all materials specified in the WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII) could cause stagnation in virological research. She therefore urged WHO to develop more specific and practical containment guidelines, with a time frame adapted to resource-limited settings. Given the decrease in funding for the Global Polio Eradication Initiative, it was important that WHO should reassign polio-dedicated staff to other essential public health programmes. Increasing domestic resources was critical to ensuring a smooth transition from the Global Polio Eradication Initiative.

The representative of INDIA outlined actions taken by his Government to ensure that his country would remain polio-free, including the introduction of inactivated poliovirus vaccine and the switch from trivalent to bivalent oral polio vaccine. The National Polio Surveillance Project, created under the aegis of WHO in 1997, was supporting the Indian Government beyond its initial mandate. The rapid scaling down of the Project's structure and the elimination of some of its key functions by WHO therefore put not only India's polio programme at risk, but also other activities intended to strengthen the country's immunization programme. He called for continued support for the Project, in order to consolidate the achievements made to date. His Government would study the report on the risks of winding down the Global Polio Eradication Initiative to see how they might be mitigated without affecting essential polio-related functions.

The representative of GREECE said that routine polio surveillance and immunization programmes were ongoing in his country. Additional epidemiological surveillance had been set up for migrants, refugees and high-risk groups with low vaccination coverage, and environmental surveillance of sewage samples in possible polio-infected areas had been introduced. Those supplementary measures would be intensified in 2017. Inactivated poliovirus vaccine had been the only vaccine used in vaccination programmes since 2005. Finally, extra immunization measures were being used to treat migrants and refugees from countries in which poliomyelitis was endemic.

The representative of MALAYSIA congratulated the governments of Afghanistan, Nigeria and Pakistan for their commitment to eradicating poliomyelitis. Given the risk posed to national immunization programmes by the shortage of inactivated poliovirus vaccine, she urged WHO and the manufacturers of fractional intradermal dose inactivated poliovirus vaccine to make that vaccine available to low-risk countries in order to balance demand.

The representative of the RUSSIAN FEDERATION expressed concern regarding the continued endemic transmission of wild poliovirus in three countries, which could spread. Periodic reports on the circulation of vaccine-derived poliovirus in countries affected by humanitarian crises indicated that there were serious gaps in surveillance. Insufficient supplies of inactivated poliovirus vaccine, necessary for implementing national immunization programmes, continued to be a problem for many countries. The use of dose-sparing strategies had not been sufficiently studied and was not appropriate for a number of countries, including the Russian Federation. While the transition to bivalent oral polio

vaccine had been important, the risks associated with that transition had been underestimated. She commended WHO's efforts to develop guidelines on the sound storage and safe management of materials infected or potentially infected with type 2 poliovirus. She welcomed the development of the guidelines on containment certification and related training, but said that the proposed timeline should be extended. The reallocation of assets from the Global Polio Eradication Initiative, notably staff resources, should be conducted carefully.

The representative of the REPUBLIC OF KOREA said that the global shortage of inactivated poliovirus vaccine was a concern. WHO, partners and stakeholders should adopt a more realistic and practical approach to resolving that shortage. Her Government planned to establish a vaccine-production facility to help combat the shortage of inactivated poliovirus vaccine and called on WHO to facilitate the prequalification process for the vaccines produced. She asked WHO to provide detailed, country-specific recommendations for implementing GAPIII.

The representative of AUSTRALIA encouraged a continued focus on eliminating poliomyelitis in the three remaining countries in which it was endemic. The global switch from trivalent to bivalent oral polio vaccine was a significant achievement. The Secretariat and Member States should maintain efforts until poliomyelitis was permanently eradicated and should continue to plan for the post-certification period.

The representative of ANGOLA, speaking on behalf of the Member States of the African Region, said that challenges in human resources and funding posed a significant risk to eradicating poliomyelitis and to supporting other public health campaigns in the Region. Resources must be mobilized globally to consolidate the achievements made so far towards eradicating poliomyelitis. Efforts to interrupt the transmission of wild poliovirus should include: increasing surveillance at all levels; strengthening routine immunization; introducing inactivated poliovirus vaccine into routine immunization programmes; accelerating containment of poliovirus in laboratories; and finalizing polio transition plans to ensure that the existing poliomyelitis infrastructure can benefit other public health campaigns. He called on partners to prioritize the supply of inactivated poliovirus vaccine to the African Region and to provide continued financial support to the Region's Member States for planned poliomyelitis eradication activities.

The representative of the UNITED STATES OF AMERICA said that, although her Government remained optimistic that the transmission of wild poliovirus would be interrupted in the near future, vital resources must be maintained. Environmental surveillance remained a priority; the number of visible cases should not be relied upon, as evidenced by the persistence of poliovirus in Pakistan despite the decrease in the number of human cases. There was a need to increase access in the areas of Afghanistan and Nigeria not controlled by their national governments in order to vaccinate isolated children. Commending the efforts of frontline health care workers, she reiterated that sustaining quality in all aspects of the programme was essential.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND commended the commitment of the Governments of Afghanistan, Nigeria and Pakistan and called upon all Member States to boost efforts to eradicate poliomyelitis by 2020. The lessons learned thus far and the tools used to prevent and address public health emergencies of international concern must become integral to the way health systems operated worldwide. Phase I of GAPIII was being implemented in the United Kingdom, and updates would be provided on progress. Polio transition planning must be correctly and efficiently managed to minimize WHO's financial liabilities, without undermining vaccination programmes and surveillance. She asked how the programme budget for 2018–2019 would support countries in maintaining disease surveillance and routine immunization services as the budget of the Global Polio Eradication Initiative decreased.

The representative of COSTA RICA said that she fully supported the steps taken to eradicate poliomyelitis and urged WHO to redouble its efforts in order to eradicate the disease.

The representative of CÔTE D'IVOIRE said that the routine poliomyelitis vaccination programme had been strengthened in his country and acute flaccid paralysis surveillance increased. The switch from trivalent to bivalent oral polio vaccine had been made, the inactivated poliovirus vaccine had been introduced, and materials infected or potentially infected with wild poliovirus and Sabin type 2 strains of the disease had been destroyed.

The representative of SENEGAL said that, although the main performance indicators of polio eradication had been achieved at the national level, some regional disparities remained owing to supply shortages of the inactivated poliovirus vaccine and a lack of surveillance in certain areas of the country. He therefore called on WHO to reverse the decision to reduce the amount of funding allocated to poliomyelitis, strengthen acute flaccid paralysis surveillance and environmental surveillance in poor performing areas, and increase access to inactivated poliovirus vaccine.

The representative of LESOTHO said that the switch from trivalent to bivalent oral polio vaccine and the introduction of inactivated poliovirus vaccine had been successful in her country. Steps had also been taken to enhance acute flaccid paralysis surveillance, strengthen the capacity of health care workers and establish a polio outbreak preparedness and response plan in an effort to interrupt poliovirus transmission in the country. However, Lesotho was among the countries affected by the current supply shortage of inactivated poliovirus vaccine.

The representative of BAHRAIN said that her country had successfully introduced the inactivated poliovirus vaccine. She stressed the importance of research into fractional dose schedules and preparedness and response regarding outbreaks of wild poliovirus or circulating vaccine-derived poliomyelitis.

The representative of the UNITED ARAB EMIRATES outlined national efforts towards poliomyelitis eradication, including a national vaccination campaign in 2015 to maintain vaccination coverage.

The representative of JAPAN said that careful judgement on the timing of eradication efforts was required, particularly in areas experiencing instability or conflict and where surveillance was insufficient. Her country attached great importance to strengthening routine vaccination programmes using the inactivated poliovirus vaccine, building the capacity of health care workers and appropriate allocation of human resources. The current shortage of inactivated poliovirus vaccine was therefore extremely worrisome. With regard to essential containment facilities, she urged the Secretariat to share best practices with Member States in respect of the containment of poliovirus.

The representative of ARGENTINA, while recognizing the need for effective polio transition planning, said that current global efforts should focus on addressing the outbreak of poliovirus in areas affected by conflict or instability and on tackling the supply shortages of the inactivated poliovirus vaccine, particularly given that the use of fractional doses was not suitable in all countries.

The representative of the UNITED REPUBLIC OF TANZANIA said that steps continued to be taken in his country to strengthen immunization efforts against poliomyelitis and the switch from trivalent to bivalent oral polio vaccine had been made in 2016. It had not been possible to introduce the inactivated poliovirus vaccine before the switch, owing to the global supply shortages. His country remained at risk in respect of imported cases of poliovirus: routine immunization and surveillance

activities had therefore been undertaken in border areas to prevent the cross-border transmission of the disease.

The representative of MAURITANIA said that efforts were ongoing in his country after a resurgence in imported cases of poliomyelitis in 2009 and 2010 to strengthen the national routine vaccination programme and enhance acute flaccid paralysis surveillance. The switch from trivalent to bivalent oral polio vaccine in April 2016 had been a success, but response capacities would need to be strengthened to prepare for any potential re-importation of the virus. A sufficient supply of vaccines must be guaranteed.

The representative of the PHILIPPINES said that, in addition to surveillance and preparedness measures, the switch from trivalent to bivalent oral polio vaccine had been made in her country, and the inactivated poliovirus vaccine had been simultaneously introduced. Two phases of destruction of poliovirus isolates and an online laboratory containment survey of all facilities had been conducted. A polio endgame transition assessment would be conducted at the end of 2017 to verify the status of implementation and refine the national polio transition plan.

The representative of PANAMA said that the switch from trivalent to bivalent oral polio vaccine had been completed in Panama in 2014 and the inactivated poliovirus vaccine had been introduced into the national immunization programme. Her Government also intended to strengthen the capacities of the national network of poliovirus laboratories in accordance with the Polio Eradication and Endgame Strategic Plan 2013–2018. The Secretariat should continue to coordinate its actions to combat the poliovirus at a global level and provide the necessary technical support to Member States, particularly the most vulnerable countries, in order to accelerate the eradication process.

The representative of NIGERIA said that the switch from trivalent to bivalent oral polio vaccine had been completed in his country in 2016 and the routine immunization programme was being strengthened. Four cases of wild poliovirus type 1 had been detected in Borno State, Nigeria, in August 2016 after almost two years without any such cases. The outbreak was in a large part due to the limited access to that area as a result of the ongoing Boko Haram insurgency. In addition, three cases of circulating vaccine-derived poliovirus had been reported in 2016. Following the designation of the wild poliovirus outbreak as a public health emergency, the Government had launched an aggressive outbreak response plan alongside other affected States, and had made US\$ 30 million available to fund that response. Disease and environmental surveillance had been increased, efforts had been made to increase child vaccination in Borno State, travellers had been vaccinated at border crossings, and the switch from trivalent to bivalent oral polio vaccine had been completed. No further cases had been found since August 2016. In the light of such events, he urged WHO and other partners to redouble their efforts under the Global Polio Eradication Initiative and provide comprehensive support and sufficient vaccine supplies to the three polio-endemic countries.

The representative of MYANMAR said that acute flaccid paralysis surveillance and the national routine immunization programme had been strengthened following the detection of two cases of circulating vaccine-derived poliovirus type 2 in Myanmar in 2015. He therefore fully agreed that context-specific national plans should be devised to address any immunity gaps and reach every last child in polio-endemic and circulating vaccine-derived poliovirus-affected countries. A single dose of inactivated poliovirus vaccine had been introduced into the national routine immunization programme in 2015 and the switch had been made from trivalent to bivalent oral polio vaccine in 2016. Supply shortages of the inactivated poliovirus vaccine were therefore extremely worrying. He fully supported the Secretariat's approach to legacy planning, particularly given the long-term benefit of investment in poliomyelitis eradication for other health and development goals.

The representative of CANADA, speaking on behalf of the Member States of the Region of the Americas and the European Region, said that robust national health systems with strong surveillance and response capacities were critical in poliomyelitis eradication and even countries that had achieved eradication must remain vigilant, with high-quality surveillance and extensive vaccination coverage to prevent outbreaks of that disease. She expressed concern at the continued shortage of inactivated poliovirus vaccine, which had delayed the global introduction of the vaccine in some countries. The Global Polio Eradication Initiative should work with the GAVI Alliance to minimize the impact of the shortage, maximize the use of existing supplies and provide guidance on dose-sparing strategies. Commending the global reduction in the number of containment facilities maintaining poliovirus materials, she said that it was important to balance the need for robust containment measures while minimizing the impact to inactivated poliovirus vaccine production and supply. The transition of polio-related assets had to be strategic to ensure that country capacities remained fit for purpose until the Polio Eradication and Endgame Strategic Plan 2013–2018 had been completed.

The representative of INDONESIA said that a mass polio vaccination campaign focused on children under the age of five years had been carried out in her country. Given the shortage of inactivated poliovirus vaccine, she called on WHO to encourage manufacturers to increase their production capacity of that vaccine and share the relevant technology. She highlighted the importance of institutionalizing polio transition planning in every Member State, including with regard to containment. WHO should assist in building up the global stockpile of monovalent oral polio vaccine type 2 in case of an outbreak. Poliomyelitis could only be eradicated if activities were adequately funded.

The representative of SAUDI ARABIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the three countries in which poliovirus was still endemic should be fully supported by the international community, including financially, to ensure eradication of the virus. Quarterly analyses, risk reduction strategies, and systematic vaccination were key to ensuring that all children were vaccinated, and full surveillance was necessary post-immunization. The provisions of the International Health Regulations (2005) that covered travel to countries in which vaccination was required must also be implemented. Simulation exercises should be run in countries in which poliomyelitis had been eradicated in case of a re-emergence of that disease. Risks inherent in mass migrations of people across regions, such as for pilgrimages, should be taken into account when planning for such situations. He underscored the need to step up efforts to ensure the availability of sufficient stores of inactivated poliovirus vaccine to address the global shortage of that vaccine.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said that, in his country, the switch from trivalent to bivalent oral polio vaccine had been made and poliovirus containment activities had been carried out. Nevertheless, there had still been two recent cases of circulating vaccine-derived poliovirus. He expressed appreciation to partners, especially WHO, UNICEF, the GAVI Alliance and the United States Centers for Disease Control and Prevention, for their support in drawing up a response plan that was being implemented.

Mr Davies took the Chair.

The representative of IRAQ outlined the steps that had been taken in his country towards poliomyelitis eradication, namely the introduction of inactivated poliovirus vaccine, the completion of the switch from trivalent to bivalent oral polio vaccine, the enhancement of surveillance systems, and renewed focus on routine immunization through campaigns. Given the complex emergency situation in the region, priority had been given to immunizing internally displaced persons under the age of 15 and people entering the country from the neighbouring Syrian Arab Republic. Advocacy, communication and social mobilization in health promotion activities were also important.

Collaborative efforts were needed to develop more in-depth environmental surveillance, and interregional cooperation was crucial for regions, such as the Eastern Mediterranean Region, that needed additional support in polio transition planning.

The representative of GERMANY recalled that, although much progress had been made in reducing the number of poliomyelitis cases, successful and lasting eradication of poliomyelitis had not yet been achieved. At its May 2017 summit, the G20 had adopted a resolution emphasizing the importance of completely eradicating poliomyelitis.

The representative of KENYA outlined the steps taken in her country towards poliomyelitis eradication, such as increasing immunization coverage among the nomadic population, conducting supplementary immunization activities and introducing environmental surveillance to complement acute flaccid paralysis surveillance. With regard to transition planning, the national poliomyelitis eradication plan had been integrated so that resources initially used for poliomyelitis eradication would be used in routine immunization.

The representative of SPAIN encouraged Member States to continue their work to interrupt poliomyelitis transmission completely by the end of 2017. At that point, lessons on implementing health programmes in a challenging context could be learned from the experience of poliomyelitis eradication, and operational measures for other types of immunization would already be in place. Consideration should be given to the potential risks of establishing too many poliovirus containment facilities.

The representative of PARAGUAY highlighted that Member States would not be able to implement the global vaccine action plan, which required them to terminate use of the Sabin oral polio vaccine by 2020, if there continued to be a shortage of inactivated poliovirus vaccine. Likewise, Member States would not be able to adopt dose-saving strategies, such as using a fractional-dose inactivated poliovirus vaccine, until clear operational protocols on their use were established.

The representative of NIGER outlined the poliomyelitis eradication efforts in his country, including further vaccination campaigns and the introduction of strengthened surveillance and routine immunization systems. As a result, the transmission of wild poliovirus had been successfully interrupted in 2008, leading to the removal of Niger from the list of polio-endemic countries. His country had been certified as being free of wild poliovirus in April 2016. Nevertheless, major challenges remained in improving the provision of systematic immunization services and eradicating poliomyelitis, largely due to the circulation of wild poliovirus in countries bordering Niger. In collaboration with Chad and Nigeria, immunization response campaigns had been launched in 2016, resulting in over 95% immunization coverage in Niger. He said that the application of the International Health Regulations (2005) would undoubtedly help reinforce response and surveillance capacities along borders.

The representative of JAMAICA said that, while her country had been certified free of poliomyelitis since 1994, it remained at high risk for re-importation of the disease due to the high levels of tourist traffic and an immunization coverage rate of below 95%. The switch from trivalent to bivalent oral polio vaccine had been completed, all the Regional Certification Commission's recommended actions had been implemented and a polio outbreak and preparedness plan had been submitted to PAHO. Strengthening routine immunization systems to prevent vaccine-derived poliovirus emergencies, filling surveillance gaps to cover all children and enhancing outbreak prevention and response in high-risk areas were priorities.

The representative of ZIMBABWE congratulated Member States for making the switch from trivalent to bivalent oral polio vaccine, but said that the shortage of inactivated poliovirus vaccine must be resolved if his country was to continue meeting polio surveillance and coverage targets. Special attention should be given to areas where transmission of the disease was still occurring, and efforts to interrupt its transmission must be intensified.

The representative of MEXICO, while recognizing the progress made worldwide to stop poliomyelitis transmission, expressed concern at the ongoing challenges in producing inactivated poliovirus vaccine and the resulting shortage. In Mexico, an intersectoral group had been established to implement the Polio Eradication and Endgame Strategic Plan 2013–2018, and efforts would continue to be made to maintain high immunization coverage, increase epidemiological surveillance and take swift control measures in the event of an outbreak of wild poliovirus.

The representative of CUBA said that, in order to further poliomyelitis eradication efforts, high immunization coverage supported by a strong health system that ensured adequate access to public health resources was crucial. Acute flaccid paralysis surveillance should be supplemented by a strong environmental surveillance system. Funding and a sufficient supply of inactivated poliovirus vaccines were key to the successful implementation of the Organization's vaccination recommendations. She urged Member States to collaborate and exchange information to that end.

The representative of VIET NAM outlined the measures taken under his country's polio eradication plan, namely the organization of polio vaccination campaigns in high-risk areas, the switch from trivalent to bivalent oral polio vaccine for types 1 and 3, and the introduction of inactivated poliovirus vaccine. He expressed concern about the delay in delivery of inactivated poliovirus vaccine, which had resulted in a prolonged period without immunity to poliovirus type 2. He called for delivery to be made as soon as possible to ensure that children under the age of one year could be vaccinated. His country's Ministry of Health would require clear information in order to prepare the national strategy.

The representative of TOGO highlighted several achievements made by his Government in poliomyelitis eradication, including the attainment of 89% immunization coverage via the oral polio vaccine for poliovirus type 3, the containment of poliovirus type 2 and the switch to bivalent oral polio vaccine in the country's routine immunization programme. However, the shortage of inactivated poliovirus vaccine was posing a major risk to infants. He therefore requested the Global Polio Eradication Initiative partners to speed up the provision of the vaccine to countries that had already made the switch.

The representative of the ISLAMIC REPUBLIC OF IRAN said that a national transition plan had been prepared in his country, based on inactivated poliovirus vaccine use in addition to bivalent oral polio vaccine, environmental sampling and laboratory containment. Given the shortage of inactivated poliovirus vaccine, however, administration had to be limited to high-risk areas, specifically on the border with Afghanistan and Pakistan. A research study would be conducted to evaluate the immunogenicity and practical feasibility of fractional-dose inactivated poliovirus vaccine. Implementation of environmental surveillance was already under way, in cooperation with WHO, and poliovirus containment activities were being carried out.

The representative of BARBADOS said that inactivated poliovirus vaccine had been introduced into her country's routine immunization schedule, although the difficulties encountered by manufacturers in scaling up production meant that, as of May 2017, Member States of the Region of the Americas had been asked to give only one dose, rather than the two recommended by the Organization. Trivalent oral polio vaccine had been replaced by bivalent oral polio vaccine in her

country on 26 April 2016. By January 2016, a comprehensive survey had revealed that no wild poliovirus type 2 or vaccine-derived poliovirus type 2 was stored in the island's laboratories. Her Government would continue to work to implement the Polio Eradication and Endgame Strategic Plan 2013–2018.

Dr Al-Kuwari resumed the Chair.

The representative of the GAMBIA expressed concern at the global shortage of inactivated poliovirus vaccine, which his country had introduced in April 2015. The switch from trivalent to bivalent oral polio vaccine had been made in April 2016. Polio eradication activities in the African Region must continue to be adequately funded to ensure that the final goal could be reached.

The representative of MADAGASCAR said that his Government had undertaken its ninth poliomyelitis vaccination campaign in March 2017. In line with WHO recommendations, such campaigns were now being undertaken every six months. The interruption of vaccine-derived polio virus circulation had been officially declared in December 2016. In April that year, the country had switched from oral polio vaccine to inactivated poliovirus vaccine.

The representative of the BAHAMAS, emphasizing the need for Member States to maintain their eradication status, said that his country had switched from trivalent to bivalent oral polio vaccine and introduced injectable vaccines. Adequate stores of vaccine must be available, to which end it was to be hoped that the delivery system would change.

The representative of the DOMINICAN REPUBLIC said that his country's immunization schedule used inactivated poliovirus vaccine and bivalent oral polio vaccine. The switch from trivalent oral polio vaccine had been closely monitored. Acute flaccid paralysis had fallen to 0.46 cases per 100 000 children under the age of 15 in 2015 and in December 2016 the country had achieved the expected notification rate. Other indicators remained above minimum levels, with the exception of sample collection within the first 14 days. A review committee had been established to certify polio eradication. The import and use of poliovirus vaccines containing live Sabin type 2 virus strains had been banned as of 25 April 2016.

The representative of the PLURINATIONAL STATE OF BOLIVIA said that, following the switch from trivalent to bivalent oral polio vaccine in April 2016, her country still needed support from the Organization and sufficient supplies of vaccine to achieve satisfactory results and contribute to eradicating poliomyelitis worldwide.

The representative of BANGLADESH said that his country, which had been free of poliomyelitis since 2006, continued to work to maintain that status and eradicate the disease entirely. In order to overcome global vaccine shortages, the introduction of fractional doses of inactivated poliovirus vaccine into routine immunization from July 2017 was being considered. The switch from trivalent to bivalent oral polio vaccine had taken place on 23 April 2016. High-quality surveillance for acute flaccid paralysis was carried out and a plan was in place to respond to imported cases of any type of poliovirus. In order to ensure the success of the Polio Eradication and Endgame Strategic Plan 2013–2018, the Organization and global partners should continue to provide technical and financial support even after 2020.

The representative of NAMIBIA said that the significant progress made towards the eradication of poliomyelitis had already prevented millions of cases of paralysis and childhood deaths. The billions of dollars saved could be channelled into other activities such as the WHO Health

Emergencies Programme. With redoubled surveillance and identification efforts by those countries where cases were still occurring, and support from the global community, eradication might even be possible before 2020.

The representative of PAKISTAN reaffirmed the commitment of his Government and all political parties to the eradication of poliomyelitis. Access and security no longer presented barriers to progress. Work to date had resulted in the best epidemiological indicators yet seen in the country, but further efforts were needed to achieve complete success. The interruption of indigenous transmission in the two biggest reservoirs – Karachi and Khyber-Peshawar – was particularly significant. Pakistan had the largest environmental sampling system in the world, with progressive reductions in wild poliovirus isolates over the previous three years. The core reservoirs remained key areas for action, but the significant investments made in surveillance were proving their worth. Afghanistan and Pakistan represented a single epidemiological block, and the eradication task would not be complete until both countries achieved success simultaneously. More effort and investment would be needed to revitalize the Expanded Programme on Immunization and meet the targets set in his country's National Emergency Action Plan for Polio Eradication 2016–2017. His Government was investing its own resources in eradication activities, demonstrating its commitment to the cause and to achieving the ultimate objective of eradicating poliomyelitis.

The representative of MALDIVES, emphasizing that the risks of poliomyelitis would persist until the disease was eradicated globally, said that inactivated poliovirus vaccine had been introduced into her country's immunization schedule in March 2015 and bivalent oral polio vaccine had been used in all vaccination centres since April 2016. In addition to implementing the temporary recommendations issued by the Director-General under the International Health Regulations (2005), Member States must continue to work with all relevant partners, including vaccine manufacturers, to ensure the phased removal of oral polio vaccines from all immunization programmes, for which a sufficient supply of inactivated poliovirus vaccine was vital. Member States must also strengthen immunization and surveillance systems.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA, welcoming the progress made towards eradicating poliomyelitis but emphasizing the need to complete the task, said that his country had introduced inactivated poliovirus vaccine into its immunization schedule in February 2016 and successfully switched from trivalent to bivalent oral polio vaccine on 1 May 2016. Vaccination coverage had increased at all stages of the immunization schedule. With technical support from PAHO, a national preparedness and response plan for a potential poliomyelitis outbreak had been drawn up to deal with any imported cases that occurred or the identification of type 2 poliovirus from any source. The plan provided for the use of monovalent poliovirus type 2 vaccines from global stocks if necessary.

The representative of AFGHANISTAN said that, as a result of efforts to improve the quality of eradication measures, the number of cases of poliomyelitis reported in his country had fallen from 20 in 2015 to 13 in 2016 and only three in the first quarter of 2017. A strategy had been introduced to target the children of nomadic populations, and almost 123 000 returnee children had been vaccinated in 2016. Cross-border teams had been deployed to work with the large numbers of people who regularly moved between Afghanistan and Pakistan. A vaccination campaign using inactivated poliovirus vaccine had been conducted in 35 districts and environmental surveillance had been expanded to cover six provinces. As two of the three countries where the disease remained endemic, Pakistan and Afghanistan needed support from the international community to end the threat that poliomyelitis posed, not only to their own children but to the rest of the South-East Asia Region and the world as a whole.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES expressed concern at the challenges faced in eradicating poliomyelitis in the three countries where the disease remained endemic, particularly in view of the recent detection of wild poliovirus in north-eastern Nigeria and the humanitarian crisis in the Lake Chad region. Sustained investment was needed in Afghanistan, Pakistan and the Lake Chad basin using novel approaches to reach high-risk communities. In other countries, overall government financing strategies for immunization should be reviewed, given the important role that poliomyelitis funding, which was to be wound down, played in supporting broader immunization activities.

The representative of the GLOBAL HEALTH COUNCIL, INC., speaking at the invitation of the CHAIRMAN, said that work funded by the Global Polio Eradication Initiative contributed greatly to other health outcomes. With the imminent eradication of poliomyelitis, however, financial support from the Initiative was decreasing at the same time as many countries were having to increase the domestic resources they allocated to immunization. It was not yet clear how the transition period would be covered. All Member States and Global Polio Eradication Initiative partners should consider the implications of the transition and take steps to ensure that progress made in other areas was not undermined.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIRMAN, emphasized the beneficial role that pharmacists could play in immunization programmes, including in helping to overcome the lack of education and distrust of vaccines that led people to avoid vaccination. While transmission rates of wild poliovirus were at their lowest ever, the disease would continue to pose a threat to children until it was eradicated completely. Member States should use pharmacists as immunizers, both nationally and as part of global health relief forces combating poliomyelitis.

The representative of ROTARY INTERNATIONAL, speaking at the invitation of the CHAIRMAN, urged Afghanistan, Pakistan and Nigeria to sustain pressure on the virus by immunizing every child against poliomyelitis, especially in high-risk, mobile populations. High-quality surveillance was required. She welcomed the increased use of environmental sampling and sampling of healthy children to identify gaps and confirm the absence of the poliovirus. There was a need to leverage the full range of innovations, lessons learned, and physical and intellectual assets of poliomyelitis eradication to benefit broader public health priorities. Continued financial and political commitment and ownership were essential at the country level.

The representative of INTRAHEALTH INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that poliovirus was still prevalent in a handful of the world's poorest and most marginalized communities and its eradication depended on the success of health workers reaching those communities. Target countries must proactively manage their health care human resources and maintain the workforce needed to ensure interruption of transmission and effective response to outbreaks. Frontline health workers must be continuously supported and protected, particularly in dangerous settings. Sharing assets and lessons learned in the Global Polio Eradication Initiative with other global health initiatives would be useful.

The representative of UNICEF said that UNICEF remained committed to working with partners to identify innovative ways to mobilize communities and reach children with polio vaccines. The unprecedented partnership between Member States, communities, local and religious leaders, civil societies and the Global Polio Eradication Initiative partners had meant that poliovirus circulation was close to being interrupted. She commended frontline health workers, who often worked in trying circumstances. As the last few pockets of wild poliovirus were being tackled, UNICEF would redouble its commitment and determination until the world was certified polio free. UNICEF was

committed to working with Member States and the Initiative partners to implement a responsible transition plan.

The representative of the GAVI ALLIANCE, speaking at the invitation of the CHAIRMAN, said that the supply of inactivated poliovirus vaccines remained limited, which resulted in vaccine stock outs and programme suspensions, raising concerns about the risk of the possible re-emergence of polioviruses. At the same time, as the world was moving closer to poliovirus eradication, budgets and support had begun to decline. The GAVI Alliance was working together with countries, the Global Polio Eradication Initiative partners and stakeholders to develop plans to mitigate the effect of the poliovirus during the transition. Countries such as Somalia and South Sudan were particularly vulnerable, as their primary health care systems continued to rely on the support of polio staff. Under WHO's leadership, Member States and stakeholders should come together to determine appropriate action.

The DIRECTOR (Polio Eradication) said that achieving a polio-free world was within sight but progress was fragile. The current epidemiological situation continued to be a public health emergency of international concern. Efforts to support Afghanistan, Nigeria and Pakistan should be redoubled to help them implement their national emergency action plans and to ensure that resources were available to do so. There had been an impressive decrease in the number of poliomyelitis cases in Afghanistan and Pakistan. Both countries were working together closely to address the challenges of cross-border transmission and mobile populations.

It was time to intensify surveillance everywhere. The resurgence of the poliovirus in north-eastern Nigeria was a reminder of the danger of residual low-level transmission of the virus. Recent reports of acute flaccid paralysis cases caused by vaccine-derived polioviruses among populations where immunization coverage was too low demonstrated the importance of eradicating poliomyelitis so that all types of oral polio vaccines could be withdrawn.

The globally synchronized withdrawal of trivalent oral polio vaccines by Member States had been an extraordinary achievement. The commitment to introduce at least one dose of the inactivated poliovirus vaccine into routine immunization systems had been made by 126 Member States. A critical shortage of vaccines was very unfortunate; it was a priority under the Global Polio Eradication Initiative to manage the risk linked to such shortages. The available vaccines would continue to be allocated to the countries that faced the highest risk of outbreaks of type 2 vaccine-derived poliovirus. In the light of the better understanding of where the risks remained, a comprehensive review of risk classification was being conducted.

Support was extended to countries to adopt a fractional dose schedule, which would help stretch available supplies. While the supply situation would remain unstable until 2018, it was expected that by 2020 there would be more manufacturers on the market, which would reduce prices and ensure sufficient supply for two-dose schedules for the whole world.

Inactivated poliovirus vaccines played a limited role in preventing the emergence of new vaccine-derived polioviruses; its main role was to rapidly increase population immunity against type 2 poliovirus in combination with monovalent type 2 oral poliovirus. The global supply of monovalent type 2 oral poliovirus vaccine was available and the Director-General had authorized its release on many occasions for use in various campaigns. The removal of type 2 oral polio vaccine had permitted the world to substantially reduce the number of outbreaks of vaccine-derived polioviruses and vaccine-associated paralytic poliomyelitis.

It was important to minimize the risk of accidental release of polioviruses into the environment. The implementation of the WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII) had been slow for type 2 poliovirus, but it was time to accelerate efforts. The guidance and timelines with regard to the implementation of the global action plan would be revised. Once the poliovirus had been eradicated, some critical functions would need to be sustained, including

surveillance. The Global Polio Eradication Initiative would finalize the post-certification strategy by the end of 2017, which would be presented to the Health Assembly in 2018.

The Committee noted the report.

- **Polio transition planning** (document A70/14 Add.1)

The representative of MONACO introduced a draft decision proposed by the delegations of Andorra, Australia, Brazil, Canada, Ecuador, the Member States of the European Union, Georgia, Israel, Madagascar, Monaco, Montenegro, Mozambique, Nigeria, Norway, Pakistan, Panama, Thailand, the United States of America, Uruguay and Zambia. It would provide a road map to help WHO develop a strategic plan based on the needs and priorities of Member States, subsequently enabling Member States to take ownership and ensure that the transition constituted an opportunity and not a risk. It read:

The Seventieth World Health Assembly, having considered the updated report on Polio transition planning;¹

PP1 acknowledged that the active role taken by the Office of the Director General in directing and leading this process is of key importance;

PP2 emphasized the critical and urgent need to maintain and pursue eradication efforts in polio-endemic countries and sustain surveillance in countries through polio eradication certification, and the importance of ensuring that GPEI is fit for purpose, with adequate levels of qualified staff (from EB140(4));

PP3 acknowledged that GPEI ramp-down has started and highlighted the need for WHO to strategically manage the resulting impact on WHO Human Resources and other assets;

PP4 noted the ongoing process of developing a Post-Certification Strategy, that will define the essential polio functions needed to sustain eradication and maintain a polio free-world;

PP5 highlighted the need for WHO to work with all relevant stakeholders on options for ensuring effective accountability and oversight after eradication in the Post-Certification Strategy;

PP6 noted with great concern the reliance on Global Polio Eradication Initiative funding of WHO at global, regional and country levels, involving many WHO programme activities, and the financial, organizational and programmatic risks that this reliance entails for WHO, including risks for the sustainability of WHO's capacity to ensure effective delivery in key programmatic areas and to maintain essential continuing functions;

PP7 noted the list of proposed actions to be implemented by the end of 2017 as referred to in document A70/14 Add.1, in particular in relation to the development of a comprehensive WHO strategic polio transition action plan;

OP1 decided to urge the Director General:

- (a) to make polio transition a key priority for the Organization at its three levels;
- (b) to ensure that the development of the WHO strategic action plan on polio transition is guided by an overarching principle of responding to country needs and priorities, including by participating in and supporting Global Polio Eradication Initiative country transition planning;

¹ Document A70/14 Add.1.

- (c) to mainstream best practices from polio eradication into all relevant health interventions and build capacity and responsibility for polio eradication ongoing functions and assets in national programmes, while maintaining WHO's capacity to provide norms and standards for post eradication planning and oversight;
- (d) to explore innovative ways for mobilizing additional funding for the period 2017–2019 in order to mitigate the possible impact on Global Polio Eradication Initiative ramp-down and on the longer-term sustainability of key assets that are currently financed by Global Polio Eradication Initiative and to update Member States on this work, through a dedicated session at the forthcoming financing dialogue;

OP2 decided to request the Director General:

- (a) to develop a strategic polio transition action plan 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 that:
 - (i) clearly identifies the capacities and assets, especially at country and where appropriate community levels, that are required to:
 - sustain progress in other programmatic areas, such as disease surveillance; immunization and health systems strengthening; early warning, emergency and outbreak response, including the strengthening and maintenance of IHR core capacities;
 - maintain a polio free world after eradication;
 - (ii) provides a detailed costing of these capacities and assets;
- (b) to present to the Seventy-first World Health Assembly a report on the efforts to mobilize funding for transitioning capacities and assets that are currently financed by the Global Polio Eradication Initiative into the programme budget, to enable the Seventy-first World Health Assembly to provide guidance for the development of the programme budget for the biennium 2020–2021 and the Thirteenth General Programme of Work 2020–2025 on a realistic basis;
- (c) to report regularly on the planning and implementation of the transition process to the Health Assembly, through the Regional Committees and the Executive Board.

The financial and administrative implications for the Secretariat of the adoption of the draft decision were:

Decision:	Poliomyelitis: polio transition planning
A.	Link to the general programme of work and programme budget
1.	<p>Outcome(s) in the Twelfth General Programme of Work, 2014–2019 and output(s) in the Programme budget 2016–2017 to which this decision would contribute if adopted.</p> <p>Twelfth General Programme of Work, 2014–2019 outcome(s): No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally.</p> <p>Programme budget 2016–2017 output(s): Output 5.5.4. Polio legacy workplan finalized and under implementation globally.</p>
2.	<p>Brief justification for considering the draft decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.</p> <p>Not applicable.</p>

<p>3. Estimated time frame (in years or months) for implementation of any additional deliverables.</p> <p>The WHO strategic polio transition action plan and options is due to be developed by the end of 2017 and presented for consideration by the Executive Board at its 142nd session in January 2018. The strategic action plan will be further developed and refined for the Seventy-first World Health Assembly in May 2018. The timeline for implementation of the plan (and the cost) will be included in the strategic action plan.</p>
<p>B. Budgetary implications</p>
<p>1. Estimated total cost to implement the decision if adopted, in US\$ millions:</p> <p>Developing the strategic action plan and options, with costing, by the end of 2017 for submission the Seventy-first World Health Assembly through the 142nd session of the Executive Board will require dedicated staff resources at WHO estimated to be as follows: at headquarters, one P6, one P5 and one P4 staff member, and one G5 support staff member for 7 months (for the remainder of 2017), and a P5 staff member in the Regional Office for the Eastern Mediterranean and the Regional Office for Africa, and a half-time P4 staff member in the Regional Office for South-East Asia. The 2017 cost for staff is US\$ 1.06 million.</p> <p>The same staff complement will be required for the first 6 months of 2018, at a cost of US\$ 0.89 million.</p> <p>Operational costs for meetings and documentation in 2017 are estimated to be US\$ 0.03 million.</p> <p>The total estimated 13-month cost is therefore US\$ 1.98 million.</p> <p>In-kind support from staff in Polio Eradication and related programmes (for example, the WHO Health Emergencies Programme and Immunization, Vaccines and Biologicals) and country offices will also be required but is not costed. This estimate is based partly on the resources that have been required up to now to coordinate transition planning.</p>
<p>2.a. Estimated additional budgetary requirements in the current biennium, in US\$ millions:</p> <p>As stated in section B.1, the costs during 2017 will amount to US\$ 1.09 million; however, these will be accommodated within the Programme budget 2016–2017 envelope.</p>
<p>2.b. Resources available during the current biennium</p> <ul style="list-style-type: none"> – Resources available in the current biennium to fund the implementation of the decision if adopted, in US\$ millions: Funds to implement the decision are likely to be found within existing resources. – Extent of any financing gap, in US\$ millions: None. – Estimated resources, not yet available, which would help to close any financing gap, in US\$ millions: Not applicable.
<p>3. Estimated additional budgetary requirements in 2018–2019 (if relevant), in US\$ millions:</p> <p>The cost to deliver and continue to refine the strategic action plan and options in the first 6 months of 2018 is estimated to be US\$ 0.89 million for the headquarters and regional staff members outlined in section B.1.</p>

Has this been included in the Proposed programme budget 2018–2019?

The planning for achievement of the deliverables is an ongoing process but as far as possible, the costs will be included within the approved Programme budget 2018–2019. The cost of implementation of the strategic action plan and options will be included in the report that will be submitted to the Executive Board at its 142nd session and the Seventy-first World Health Assembly.

4. Estimated additional budgetary requirements in future bienniums (if relevant), in US\$ millions:

To be determined in the strategic action plan and options.

The representative of the RUSSIAN FEDERATION, supported by the representatives of ANGOLA on behalf of the Member States of the African Region, the UNITED ARAB EMIRATES, JAPAN, ARGENTINA, the PHILIPPINES and CUBA, expressed support for the draft decision.

The representative of GERMANY emphasized that the level of attention given by WHO to transition planning should be maintained. Polio transition was rightly considered to be a challenge for the Organization as a whole; a poorly managed transition process would undermine WHO's ability to carry out its functions and undermine global health overall. He welcomed the measures that were being developed to assess and mitigate risks. He asked how WHO would compensate for the decrease in voluntary funds and how it would adapt its structures. The transition of the polio programme had to be a fully transparent process and involve Member States.

The representative of AUSTRALIA said that the impact a decline in polio resources would have on WHO in its operations was a concern. If not managed appropriately, global health security and progress towards the health-related Sustainable Development Goals could be compromised. The actions taken by WHO to manage polio transition and minimize potential liabilities had been noted. WHO was urged to continue to place the highest priority on addressing programmatic, organizational and financial risks associated with the transition to ensure that the essential functions at the country level were maintained and financed sustainably.

The representative of SWITZERLAND said that a proper plan was necessary to maintain progress. The Global Polio Eradication Initiative coming to an end would have an impact on the Organization as a whole and country offices in particular. More details on possible solutions from the Secretariat would be welcome. It was important not to lose the knowledge and expertise acquired in the fight to eradicate poliomyelitis. The collaboration between WHO and the Global Polio Eradication Initiative partners must be strengthened. The challenges relating to human resources and maintaining the progress achieved were closely linked and must be addressed in a coordinated manner. Transition planning must be aligned with the transition strategies developed by countries in the context of the Initiative.

The representative of the UNITED STATES OF AMERICA said that the Global Polio Eradication Initiative had resulted in innovations that would benefit broader public health programmes. She urged WHO not to reduce the disease-surveillance workforce or its focus during the ramp-down; surveillance capabilities were essential and a key aspect of countries' compliance with the International Health Regulations (2005). The transition phase should be country-led and retain polio-essential functions. Polio assets, infrastructure, and best practices should be woven into core public health systems, mainstreamed, especially to support routine immunization efforts, and included in national budgets. A seamless surveillance system from community-based case detection to facility-based surveillance and response capacity was absolutely critical. Member States must reduce donor dependence and protect local funding. Fragile States, children in conflict areas and mobile populations would need ongoing external donor support and attention. Non-traditional approaches to

disease surveillance were needed. The future costs of protecting and sustaining a polio-free world should be designed to maintain and embed within the essential functions of global immunization systems.

(For continuation of the discussion and approval of the draft decision, see the summary record of the sixth meeting, section 1.)

The meeting rose at 12:20.

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