

Poliomyelitis

Report by the Secretariat

1. The Executive Board at its 140th session noted an earlier version of this report.¹ The text has been updated and revised in light of the Board's deliberations and also now contains an updated version of the report on WHO's human resources funded by the Global Polio Eradication Initiative, which appeared in document EB140/46, Annex, which was also noted by the Board. The Board adopted decision EB140(4) on poliomyelitis, requesting 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 Global Polio Eradication Initiative, as well as an update on actions taken and planned to mitigate those risks while ensuring that essential polio-related functions are maintained ...". This requested report is contained in the accompanying document A70/14 Add.1.
2. Strong progress continues to be made since the Health Assembly called for the worldwide eradication of poliomyelitis in 1988.² At the time, poliomyelitis was endemic in more than 125 countries around the world and more than 350 000 children a year were paralysed for life by poliovirus. Today, transmission of wild poliovirus is at its lowest levels ever, with endemic transmission occurring in parts of only three countries – (in order of burden of disease) Pakistan, Afghanistan and Nigeria. In 2016, 37 cases of poliomyelitis had been reported worldwide. In 2017,³ one case of poliomyelitis has been reported, with global certification therefore planned by 2020 (instead of 2019). Only one wild serotype (poliovirus type 1) continues to be detected; wild poliovirus type 2 was officially declared eradicated in 2015 and no case of paralytic poliomyelitis due to wild poliovirus type 3 has been detected anywhere since November 2012. More than 16 million people are walking today who otherwise would have been paralysed. An estimated 1.5 million childhood deaths have been prevented through the systematic administration of vitamin A during polio immunization activities. The world stands on the brink of an historic global public health success.
3. The progress has been made possible by the global network of support and engagement of stakeholders, first and foremost by Member States. More than 20 million volunteers administer polio vaccines and other life-saving medicines to more than 400 million children worldwide every year. To date, the global effort to eradicate polio has saved more than US\$ 27 000 million, and the global eradication of poliovirus will result in savings of an additional US\$ 20 000–25 000 million, funds which can be applied to the delivery of other life-saving health interventions.

¹ See document EB140/13 and the summary records of the Executive Board at its 140th session, tenth meeting, section 1.

² Resolution WHA41.28, Global eradication of poliomyelitis by the year 2000 (<http://www.who.int/ihr/polioresolution4128en.pdf>, accessed 13 October 2016).

³ All data in this report are as at 8 February 2017.

4. The risks and consequences of failure, by contrast, are significant: an epidemic-prone disease, polio will spread again beyond its current borders, and, within 10 years, upwards of 200 000 new cases will again be reported around the world, every year. Progress is, moreover, fragile; this was underscored in August 2016 with the confirmation of four new cases of paralytic poliomyelitis due to wild poliovirus type 1 in Borno State, north-eastern Nigeria, the first reported in the country and the African Region since July 2014. These risks underscore the urgent need for the rapid and sustainable achievement of a polio-free world, recalling resolution WHA68.3 (2015), in which the Health Assembly urged Member States to make available urgently the financial resources required for the full and continued implementation of the Polio Eradication and Endgame Strategic Plan. To help more effectively to guide and oversee progress towards interrupting poliovirus transmission, the remit of the Independent Monitoring Board is currently being adjusted to focus even more strongly on achieving attainment of this critical objective of the Strategic Plan.

5. The declaration in 2014 of international spread of wild poliovirus as a Public Health Emergency of International Concern and the Temporary Recommendations promulgated under the International Health Regulations (2005) remain in effect. National polio emergency action plans continue to be implemented in all countries affected by circulation of either wild poliovirus or vaccine-derived polioviruses, and all countries currently affected by circulation of either type of virus have declared such events to be national public health emergencies.

6. Between 17 April and 1 May 2016, all 155 countries and territories that were still using trivalent oral polio vaccine successfully switched its use to the bivalent oral polio vaccine through a globally-synchronized replacement. It was the first step in the phased removal of oral polio vaccines, which will culminate with the cessation of use of all oral polio vaccines following global certification of eradication of all wild poliovirus types. Since the declaration of eradication of wild poliovirus type 2 in September 2015, Member States are completing efforts to identify facilities holding type 2 polioviruses (wild, vaccine-derived or Sabin), destroy unneeded materials or appropriately contain needed materials in poliovirus-essential facilities.

7. In 2016, acceleration of transition planning continued (see paragraphs 20–25) in order: to ensure effective advance human resource planning at all levels of the Secretariat to reduce the number of polio-funded staff and associated financial liabilities; to understand the consequences of the loss of polio-funded staff and infrastructure on other WHO programme areas, and WHO country offices; and to help to identify opportunities to mainstream or integrate polio functions into other programmes areas or national health system, where feasible.

8. The partners of the Global Polio Eradication Initiative continue to engage closely with all Member States and the broader international development community in efforts to secure rapidly the additional US\$ 1300 million¹ required to achieve a lasting polio-free world.

INTERRUPTION OF POLIOVIRUS TRANSMISSION

9. In 2016, 37 cases of paralytic poliomyelitis due to wild poliovirus had been reported globally, compared to 74 in 2015. All the cases were reported from Pakistan, Afghanistan and Nigeria and were caused by wild poliovirus type 1. Also in 2016, three cases due to circulating vaccine-derived poliovirus of type 1 had been reported from the Lao People's Democratic Republic (all from

¹ For most up-to-date budget and financial information, see <http://polioeradication.org/financing/> (accessed 6 March 2017).

January 2016), compared to 32 cases due to circulating vaccine-derived polioviruses from seven countries in 2015. Two separate circulating vaccine-derived polioviruses type 2 have been detected in Borno and Sokoto States, Nigeria (see paragraph 14).

Countries with continued endemic transmission of wild poliovirus: Pakistan, Afghanistan and Nigeria

10. Afghanistan and Pakistan continue to be treated as a single epidemiological block. In 2016, 20 cases of paralytic poliomyelitis had been reported in Pakistan, compared to 54 in 2015. In Afghanistan, 13 cases were reported, compared to 20 in 2015. In 2017, one case has been reported, from Afghanistan. The two countries demonstrated strong progress over the past nine months, and technical advisory groups, reviewing latest epidemiological data in 2016 following the “low season” of poliovirus transmission, concluded that rapid interruption of transmission of wild poliovirus was feasible in both countries. Realization of that goal will, however, depend on reaching all missed children, filling chronic gaps in strategy implementation and being able to vaccinate children in infected areas that have been difficult to access owing to insecurity. The remaining reservoirs of wild poliovirus transmission are the three corridors linking the two countries: eastern Afghanistan/Khyber-Peshawar, Greater Kandahar/Hilmand-Quetta, and Paktika/Patkya/Khost-Khyber Pakhtunkhwa/Federally Administered Tribal Areas. The two country programmes are enhancing their joint focus on improving programme operations (supplementary immunization activities and surveillance) in these three corridors. Programme coordination has significantly improved in 2016 at the national and provincial/regional levels as well as among the bordering districts in the three common corridors of transmission.

11. In Pakistan, the number of reported cases of poliomyelitis continues to decline. The year 2016 saw the lowest-ever annual number of polio cases in the country but environmental surveillance continues to detect poliovirus over a wide geographical range, indicating ongoing transmission. Two of the three core reservoirs of poliovirus (Karachi and Peshawar) have demonstrated encouraging progress in 2016. Of particular note, Karachi has not reported a case of poliomyelitis for almost one year and only three environmental positive samples since March 2016. The situation in the reservoir of the Quetta block is concerning as there is continued local transmission of wild poliovirus together with the emergence of circulating vaccine-derived poliovirus type 2 since June 2016. Moreover, there is an outbreak of poliomyelitis in interior Sindh, with four cases reported during the second half of 2016. A national emergency action plan for the disease is being overseen directly by the office of the Prime Minister. Emergency operations centres at federal and provincial/regional levels ensure almost real time monitoring of activities, implementation of corrective action and increased accountability and ownership at all levels. Most importantly, the national plan focuses on identifying chronically missed children and the reasons why they are missed and on implementing area-specific approaches to overcome these challenges. As a result, innovative community-based strategies are being implemented, operational weaknesses of the programme are increasingly being corrected, and access in previously inaccessible areas is continuously being improved. Increasing vaccination coverage rates are observed in the Peshawar-Khyber corridor and Karachi. Concerted efforts are being applied to improve programme operations and to strengthen supervision and monitoring mechanisms in the Quetta block and interior Sindh. Pakistan has positioned itself to achieve polio eradication, thanks to commitment at all levels across the political parties. Continued leadership and sustained operations throughout the period of the forthcoming national elections will be critical to success.

12. In Afghanistan, polio eradication is at the top of the Government’s health agenda. In 2015 and 2016, the Government scaled up its efforts to accelerate polio eradication nationally amid multiple complex challenges, including increasing conflict and insecurity in many parts of the country. The

National Emergency Action Plan continues to serve as the guiding document for its polio eradication activities. Emergency operation centres are operating at the national and regional levels with the aim of intensifying, guiding and coordinating efforts of all partners for implementing the National Emergency Action Plan under one roof. Most areas of Afghanistan are polio-free, but wild poliovirus continues to circulate in localized geographical areas in the Eastern and Southern Regions of the country. In 2016, the country reported a total of 13 cases in just four districts. Two geographical areas are of particular importance: Bermel district in Paktika province and Sheegal district in Kunar province, whence 11 of the 13 polio cases in 2016 have been reported.

13. In Nigeria, four new cases of poliomyelitis due to wild poliovirus type 1 were confirmed in July and August 2016 from Borno State, the first reported from the country since July 2014. Genetic sequencing of the isolated viruses indicate they are most closely linked to a wild poliovirus type 1 last detected in Borno State in 2011. With the lack of access and the inability to conduct high-quality vaccination and surveillance in many areas of the State, this strain has likely circulated undetected in this inaccessible population since that time. The Government of Nigeria immediately launched an aggressive outbreak response according to revised international outbreak response protocols, with five rounds of large-scale supplementary immunization activities to deliver additional doses of bivalent oral polio vaccine at short intervals. The Government declared the outbreak to be a national public health emergency. At the same time, additional measures are being implemented to increase the sensitivity of subnational surveillance. The response is part of a broader regional outbreak response, coordinated with neighbouring countries, in particular the Lake Chad subregion, including northern Cameroon, parts of Central African Republic, Chad and southern Niger. At the sixty-sixth session of the Regional Committee for Africa (Addis Ababa, 19–23 August 2016), health ministers declared the polio outbreak to be a regional public health emergency for countries in the Lake Chad subregion. Detection of these cases underscores the risk posed by low-level undetected transmission and the urgent need to strengthen subnational surveillance everywhere. The Global Polio Eradication Initiative has reviewed and revised supplementary immunization activity plans to meet the supply requirements of bivalent oral polio vaccine associated with this outbreak response, while ensuring that other high-risk countries are able to maintain high levels of population immunity.

Circulating vaccine-derived poliovirus

14. In late 2015 and early 2016, Member States affected by outbreaks of circulating vaccine-derived polioviruses type 2 intensified their responses to ensure that circulation of these viruses was stopped before the globally-synchronized switch from trivalent oral polio vaccine to bivalent oral polio vaccine in early 2016 (see paragraph 6). In 2016, one case of poliomyelitis due to circulating vaccine-derived poliovirus type 2 was reported in Sokoto State, Nigeria. A separate circulating vaccine-derived poliovirus type 2 was confirmed in Borno State; it was isolated from an environmental sample (collected in March 2016) and stool specimens (collected in August 2016) from a healthy contact of one of the cases of polio due to wild poliovirus type 1 (see paragraph 13), during strengthened surveillance activities in the area. Genetic sequencing of this strain indicates that it has been circulating for almost four years in the area and was last detected in northern Nigeria in November 2014. With the lack of access in many areas and the inability to conduct high-quality vaccination and surveillance in key areas of Borno State, the strain has likely circulated undetected in this inaccessible population. Multicountry response plans, including improvement of surveillance quality at the subnational level across the Lake Chad subregion, continue to be implemented. The Government of Nigeria responded fully and immediately, in line with new protocols established for the detection of vaccine-derived poliovirus type 2 in the period following the switch from use of trivalent oral polio vaccine. The Director-General authorized the release of monovalent oral polio vaccine type 2 from the global stockpile at the request of the Government of Nigeria for use in the response. The Lao People's Democratic Republic was affected by a circulating vaccine-derived poliovirus outbreak (type 1) and

no case has been reported from that country since 11 January 2016. In several countries, however, gaps in the quality of subnational surveillance persist in key areas where previously circulation of vaccine-derived polioviruses had been confirmed, including parts of Guinea.

15. The Global Polio Eradication Initiative is actively monitoring the presence of vaccine-derived poliovirus type 2, from any source. Detection of such strains in the first 6 to 12 months after the switch from trivalent oral polio vaccine to bivalent oral polio vaccine is expected, given that children who had previously received trivalent oral polio vaccine will continue to excrete the type 2 strain originally contained in the trivalent vaccine for a limited period of time. Each detection of type 2 vaccine-derived virus from any source results in the immediate activation at global, regional and country levels of a newly-established incident management system, with the aim of conducting a thorough risk assessment associated with the isolated strain and implementing, if appropriate and necessary, an outbreak response, including the accessing of the global stockpile of monovalent oral polio vaccine type 2. Monovalent oral polio vaccine type 2 was released from the global stockpile for implementation of response activities in the countries of the Lake Chad subregion (Cameroon, Central African Republic, Chad, Niger and Nigeria), as well as Mozambique and Pakistan. In India and Pakistan, fractional-dose inactivated polio vaccine was used in response to the detections of vaccine-derived poliovirus type 2 in the environment. New evidence indicates that monovalent oral polio vaccine type 2 is more efficacious than previously understood. This new evidence, reviewed by the Strategic Advisory Group of Experts on immunization during recent meetings (Geneva, 18–20 October 2016¹ and 9–10 February 2017²), will underpin revision of global outbreak response protocols, necessitating fewer rounds of supplementary immunization activities.

Public Health Emergency of International Concern – minimizing the risk of international spread of poliovirus

16. Episodes of international spread of poliovirus continued in 2016 with the poliovirus circulating across the shared border of Afghanistan and Pakistan. Minimizing the risk and consequences of new international spread of polioviruses requires: full implementation of the eradication strategies in the remaining infected areas; comprehensive application of the Temporary Recommendations issued by the Director-General under the International Health Regulations (2005); and heightened surveillance and outbreak response preparedness plans by all Member States in order to facilitate a rapid response to new cases of detection of poliovirus. During its teleconference (7 February 2017), the Emergency Committee under the International Health Regulations (2005) regarding the international spread of poliovirus recommended extending the Temporary Recommendations for a further three months.

PHASED REMOVAL OF ORAL POLIO VACCINES

17. The successful switch from trivalent to bivalent oral polio vaccine (see paragraph 6) was a milestone; it was the largest-ever withdrawal of one vaccine and associated introduction of another. By end-September 2016, all Member States had confirmed completion of the switch. This achievement is a tribute to the extraordinary commitment, leadership and engagement of all Member States. Cessation of the use of oral polio vaccine is necessary to eliminate the very rare long-term risks of vaccine-

¹ Meeting of the Strategic Advisory Group of Experts on immunization, October 2016 – conclusions and recommendations. Weekly epidemiological record, 2 December 2016 (<http://apps.who.int/iris/bitstream/10665/251810/1/WER9148.pdf?ua=1>, accessed 7 March 2017).

² The report of the meeting will be made available on the WHO website at <http://www.who.int/immunization/policy/sage/en/>.

derived polioviruses associated with its use, and is a key strategy of the Polio Endgame Plan, which had been endorsed by the Strategic Advisory Group of Experts on immunization and the Health Assembly.

18. To prepare for the switch to bivalent oral polio vaccine, all countries had committed themselves to introduce at least one dose of inactivated polio vaccine into their routine immunization programmes. The level of commitment to meet this goal has been exceptional. At its meeting in October 2016, the Strategic Advisory Group of Experts on immunization noted both the reduction in supplies of inactivated polio vaccine, due to technical difficulties that manufacturers have encountered in scaling up production, and the expectation that the global vaccine supply will remain fragile through 2018.¹ Available supply of this vaccine is being prioritized to routine immunization in areas at highest risk of circulation of vaccine-derived poliovirus type 2 (Tier 1 and 2 countries). Every effort is being made to ensure that remaining low-risk countries receive inactivated polio vaccine supplies in 2018. The Global Polio Eradication Initiative is exploring with Member States and WHO's regional offices the feasibility of instituting dose-sparing strategies, such as using intradermal administration of fractional-dose inactivated poliovirus vaccine. The Strategic Advisory Group of Experts on immunization also strongly recommended that countries should start preparing for use of a fractional intradermal dose inactivated poliovirus vaccine in a two-dose schedule, in lieu of a single intramuscular full dose, a recommendation further stressed by the body's Polio Working Group at its recent meeting (Geneva, 9 and 10 February 2017). Some Member States, notably Bangladesh, India, and Sri Lanka, have already adopted fractional-dose schedules in their immunization programmes in order to ensure that sufficient quantities of inactivated polio vaccine are available for continued vaccination of the full birth cohort.

CONTAINMENT

19. Efforts to contain poliovirus type 2 have progressed in 2016, following the publication 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).² As at 17 January 2017, 175 countries and territories reported that they no longer had wild or vaccine-derived poliovirus type 2, 18 reported that they did, and 12 were completing reports. So far, 30 countries have designated 75 poliovirus-essential facilities to retain type 2 polioviruses, but some of them still have to nominate the national authority for containment that will be responsible to certify that these facilities meet the containment requirements described in GAPIII. In support of Member States' efforts to complete Phase I of GAPIII, the Secretariat is developing guidance to help facilities to identify samples that are likely to harbour type 2 polioviruses, recommending their destruction or safe and secure handling. In support of the implementation of Phase II, the Secretariat has raised awareness about containment and strengthened national capacity by training staff of national authorities for containment and poliovirus-essential facilities about GAPIII implementation and certification. WHO has published the Containment Certification Scheme to support the WHO Global Action Plan for Poliovirus Containment,³ which is aimed at guiding national authorities for containment in their efforts

¹ Meeting of the Strategic Advisory Group of Experts on immunization, October 2016 – conclusions and recommendations. Weekly epidemiological record, 2 December 2016 (<http://apps.who.int/iris/bitstream/10665/251810/1/WER9148.pdf?ua=1>, accessed 7 March 2017).

² Document WHO/POLIO/15.05 (http://polioeradication.org/wp-content/uploads/2016/09/GAPIII_2014.pdf, accessed 7 March October 2017).

³ The Containment certification scheme to support the WHO global action plan for poliovirus containment (GAPIII-CCS) (available at http://polioeradication.org/wp-content/uploads/2017/02/CCS_2016EN.pdf, accessed

to certify facilities' compliance with the requirements of GAPIII, in consultation with the Global Commission for the Certification of the Eradication of Poliomyelitis. Furthermore, training is currently offered to auditors expected to participate in containment audits of poliovirus-essential facilities. With this support, concerned Member States are expected to complete Phase I and progress with Phase II of GAPIII, formally engaging concerned facilities in the certification process.

TRANSITION PLANNING

20. Polio transition planning (previously referred to as legacy planning) has intensified in 2016 and in 2017. The transition planning efforts within the Global Polio Eradication Initiative have three goals: (1) to ensure that those functions essential to maintaining a polio-free world after eradication are mainstreamed into continuing public health programmes; (2) to ensure that the lessons learned from polio eradication activities are captured and then shared with other health initiatives and all Member States; and (3) where feasible and appropriate, to plan the transfer of capabilities, assets and processes in order to support other health priorities. In addition to the three programme-specific goals, Organization-wide efforts are underway to assess the significant financial, human resources, programmatic and country-capacity risks associated with the decline in polio funding and eventual closure of the Global Polio Eradication Initiative that eradication of polio creates.

21. In April 2016, the Global Polio Eradication Initiative published detailed budgets for 2016–2019,¹ showing the decreased expenditure from 2017 for each country, region and activity. These budgets provided an impetus to the transition planning process at the country level, which is intended to be driven by countries, in line with their national health goals and priorities. These budgets also help to drive human resource planning, leading to reduction in staffing levels and thereby reduced terminal liabilities for the organization. As noted by the Health Assembly in 2014,² WHO is liable for significant indemnity costs for the contracts that are terminated because of programme closure, owing to the high number of staff and non-staff contracts financed from polio-specific funds, in particular in the African Region. Details from an independent study conducted in September 2016, and updated information since the study, are provided in the Annex to this document.

22. WHO and other partners in the Global Polio Eradication Initiative are providing technical support to Member States in their polio transition planning efforts. The 16 countries that have the greatest polio-funded infrastructure are in the process of drawing up their transition plans. As a result of the detection of wild poliovirus type 1 in Nigeria, transition planning efforts have been slowed down in Nigeria and other countries of the Lake Chad subregion; however, the momentum should not be lost and planning should continue in the other countries, in close cooperation with other relevant stakeholders, including donors.

23. WHO and other partners in the Global Polio Eradication Initiative have launched a process to develop their agency-specific transition plans. At WHO headquarters, the WHO Global Steering Committee on Transition Planning was established in 2016 with representation from relevant regions and Secretariat departments. An Organization-wide Global Polio Transition Human Resources

8 March 2017) replaces and supersedes the WHO verification that certified poliovirus-essential facilities comply with GAPIII (Annex 4).

¹ Document WHO/POLIO/2016.03 (available at http://polioeradication.org/wp-content/uploads/2016/10/FRR2013-2019_April2016_EN_A4.pdf, accessed 8 March 2017).

² See document A67/47 and the summary records of the Sixty-seventh World Health Assembly, Committee B, second meeting, section 4 (document WHA67/2014/REC/3).

Working Group has also been established to fully identify and manage the human resource risks and associated liabilities (see Annex); an independent study was commissioned, and conducted in September 2016, to assess country-capacity and WHO's programmatic risks, and develop appropriate recommendations for the consideration of the Secretariat's Global Policy Group and WHO's governing bodies. Further to the Executive Board's decision EB140(4) (2016), the Secretariat is preparing a report on polio transition planning for submission to the Seventieth World Health Assembly. A meeting of Member States will be held at the end of April 2017 to discuss the first draft of this report.

24. In 2016, a Polio Transition Independent Monitoring Board was established to monitor and guide independently both the country and global aspects of transition planning, reporting on progress and engagement.

25. As part of the transition planning efforts at country, regional and global levels, the Secretariat is also working with its Global Polio Eradication Initiative partners to develop a post-certification strategy that will define and cost the essential functions needed, after certification, to maintain a polio-free world. The development of this strategy will go through extensive consultations with all Member States, including discussions by the regional committees, before it is finalized ahead of the Seventy-first World Health Assembly in 2018.

FINANCE AND MANAGEMENT OF THE GLOBAL POLIO ERADICATION INITIATIVE

26. Thanks to the generous continuing support of the international development community, including Member States (especially the countries where poliomyelitis is endemic), multilateral and bilateral organizations, development banks, foundations and Rotary International, the budget for planned activities for 2016 was fully financed. Efforts are under way to mobilize, by mid-2017, the additional US\$ 1300 million¹ required to fully fund the implementation of the Polio Eradication and Endgame Strategic Plan and to secure a lasting polio-free world and global certification in 2020. In addition to the significant humanitarian benefits associated with polio eradication, the drive is also associated with substantial economic benefits. A polio-free world will reap savings of a total of more than US\$ 50 000 million (with US\$ 27 000 million already saved), funds that can be used to address other pressing public health and development needs. Critical to achieving a lasting polio-free world is the rapid mobilization of the additional funds needed. The Global Polio Eradication Initiative published an investment case² for polio eradication, clearly summarizing the economic and humanitarian rationale for continued investment in the Initiative.

ACTION BY THE HEALTH ASSEMBLY

27. The Health Assembly is invited to note the report, including the information presented in the Annex, and to encourage Member States to ensure full implementation of resolution WHA68.3 (2015).

¹ The most up-to-date budget and financial information is available at <http://polioeradication.org/financing/> (accessed 7 March 2017).

² Available at <http://polioeradication.org/wp-content/uploads/2017/03/InvestmentCase.pdf> (accessed 10 April 2017).

ANNEX

**WHO'S HUMAN RESOURCES FUNDED BY THE GLOBAL POLIO
ERADICATION INITIATIVE – AN UPDATE**

1. This document provides an update on the human resources funded by the Global Polio Eradication Initiative,¹ as requested by the Programme, Budget and Administration Committee of the Executive Board.² The report, which was considered and noted³ by the Board in January 2017, has also been revised in the light of comments during the Board's discussions.
2. In response to the sixth annual report of the Independent Expert Oversight Advisory Committee,⁴ an independent study was undertaken in September 2016 to provide specifically: an updated overview of the human resources at WHO funded by the Global Polio Eradication Initiative; an updated projection of the financial liabilities under different scenarios; and recommended priorities to reduce liabilities and enhance polio-related human resource planning.
3. Recent developments in transition planning for the Global Polio Eradication Initiative and updated data since the independent study in September 2016 are set out in the following paragraphs.

PROGRESS IN TRANSITION MANAGEMENT

4. Several actions have been taken and initiatives implemented with the twin objectives of shaping the post-eradication transition plan and limiting the scale of potential liabilities resulting from staff separations.

(1) A WHO-wide Post-Polio Transition Planning Steering Committee has been established in order to ensure common understanding, at all levels of the Secretariat, of the significant programmatic, organizational and financial risks associated with the decreasing budgets and eventual closure of the Global Polio Eradication Initiative; to identify mitigating factors; and to consider the potential integration of essential functions and resources of polio eradication work into other programmes (for example, surveillance, outbreak response, immunization and health systems). Similar committees have been established in the African Region, the South-East Asia Region and the Eastern Mediterranean Region in order to develop region- and country-specific transition plans.

(2) An ad hoc human resources working group, reporting to the Steering Committee, has been established to plan for, and proactively manage, the eradication programme's staff and non-staff personnel in order to reduce indemnity exposure and support where feasible their re-assignment to other programme areas, without jeopardizing the timely achievement of eradication.

¹ Document EB140/46, Annex.

² See document EB140/5.

³ See the summary records of the Executive Board at its 140th session, tenth meeting, section 1.

⁴ See document EBPBAC24/2 (http://apps.who.int/gb/pbac/pdf_files/pbac24/PBAC24_2-en.pdf, accessed 8 March 2017).

- (3) The ad hoc human resources working group has developed a dedicated database of polio human resources that is updated continually. The database allows ongoing monitoring, including the monthly production of a dashboard for review by Director, Polio Eradication and Director, Human Resources and tracks upcoming contract expirations and retirements, new and discontinued positions, and staff costs. The database is the source of the human resources information provided in this report (which has been reconciled to the figures from independent studies reported previously).
- (4) Budget reduction targets for the period 2016–2019 have been provided to all regional offices, which have accordingly started to plan for fewer staff.
- (5) The Regional Office for Africa has hired a planning officer dedicated solely to the polio transition and involved all heads of WHO country offices in the process. Plans to reduce staffing by more than 100 staff members in country offices (excluding Nigeria and at-risk countries around Lake Chad) are already under way in 2017, and further reductions will be made in 2018 and 2019. Some of the reductions are reflected in this report, while others that are in progress will be seen in future reports when they get recorded in the Global Management System. The Regional Office for Africa is putting programmes in place to help affected staff members to prepare for work outside of the polio programme. For example, workshops that cover competency-based interviewing, writing curriculum vitae and other professional development activities have been held in Angola, the Democratic Republic of the Congo and Ethiopia.
- (6) Within the South-East Asia Region, the WHO Country Office in India has begun to implement the ramp-down of the polio programme. In the context of this transition, national and state governments will be assuming up to 50% of the cost of the programme and its infrastructure, including staff, by 2020. In addition, the entire fleet of the Indian polio programme's vehicles will be sold or retired and the function will be outsourced. As a result, close to 300 special services agreements with drivers will not be renewed by the end of 2017.
- (7) The Director-General established a fund in 2013 to help to cover the indemnity costs associated with the closure of the polio programme. At the end of 2016, the fund had a balance of US\$ 20 million, primarily arising from unspent funds from post occupancy charges. A further US\$ 20 million was identified at the beginning of 2017 arising from exceptional investment and foreign exchange income realized in 2016, for which the Director-General has authorized the allocation to the Polio Staff Indemnity Fund. Total available financing for these indemnity costs therefore now stands at US\$ 40 million. By the end of 2019, this Polio Staff Indemnity Fund is expected to have the US\$ 55 million needed to meet the separation costs resulting from the end of the polio programme. The state of the Indemnity Fund is reported each year in WHO's audited financial statements (note 6.2.b in WHO's financial report for 2016), and the latest update will be given to the Seventieth World Health Assembly.
- (8) Technical support is being provided to the 16 priority countries that account for more than 90% of Initiative-funded assets for development of national transition plans. Their progress in developing and implementing transition plans is being monitored by the Secretariat at headquarters and regional levels.
- (9) Member States will have ongoing access to polio programme data through a dedicated site on the WHO web portal that is being developed.

MAPPING OF HUMAN RESOURCES FINANCED FROM GLOBAL POLIO ERADICATION INITIATIVE FUNDS

5. Building upon the data collected from the Global Management System by the independent study and reported to the Executive Board in January 2017,¹ the Secretariat developed a human resources database that will be the source for ongoing monitoring and reporting to the governing bodies, and will be used to inform the systematic reduction of staffing levels as the WHO polio programme winds down and to minimize liabilities for the Organization in the process.

Overall composition of the WHO polio-funded workforce (as at 20 March, 2017)

6. There are 1346 WHO staff positions supported by the Global Polio Eradication Initiative, of which 1080 are currently filled.²

7. Most filled positions (74%) are in the African Region, followed by the Eastern Mediterranean Region (14%), headquarters (7%) and the South-East Asia Region (4%) (Appendix 1).

8. More than half the WHO staff members funded by the Global Polio Eradication Initiative (55%) work in operations support and 29% work on immunization and surveillance; technical support accounts for 13% of the workforce and coordination of activities for 3% (Appendix 2).

9. Staff contracts are divided between temporary (22%) and longer-term (78%). The longer-term staff are further segmented into continuing and fixed-term appointments. Liabilities are highest for staff members with continuing appointments (56% of total staff).

10. The staffing mix varies by region and office, with the Eastern Mediterranean Region accounting for more temporary staff than others, while the African Region has a larger share of staff on longer-term contracts (Appendix 3).

11. The 2016 year-end cost of the polio staff workforce was US\$ 99.4 million, in line with the amount that had been projected from August 2016. This figure excludes non-staff costs which are categorized under operations or activities in the Global Management System.

12. Many personnel working on polio eradication have non-staff contracts particularly in the African, South-East Asia and Eastern Mediterranean regions:

- the number of non-staff contracts in the Eastern Mediterranean Region was 2606 in March 2017, compared with 152 filled staff positions; this figure includes more than 1500 holders of agreements for performance of work in Afghanistan and Pakistan combined and 701 personnel in Iraq, Pakistan and Somalia contracted through the United Nations Office for Project Services;

¹ See document EB140/46, Annex.

² Source for all staffing data: Global Management System database, 20 March 2017.

- in the African Region 2752 non-staff contracts were identified (as at August 2016), including 551 special services agreements, compared with 799 filled staff positions in March 2017;
- the South-East Asia Region has 1103 non-staff contractors employed under special services agreements, 90% of whom are working in India.

13. The polio programme continues to increase its use of non-staff personnel in lieu of staff members, in order to maximize flexibility in the management of human resources and minimize additional liabilities. From 2013 through 2016, the ratio of the cost of staff members to that for non-staff members has declined from 45% to 32%, and the proportion of non-staff members has grown to nearly 70% of the total personnel costs.

14. Data on non-staff contracts are collected from focal points in regional offices' human resources teams and compiled manually as they cannot be extracted directly from the Global Management System. The Secretariat is seeking better ways to collect and analyse data associated with non-staff contracts, which include: agreements for performance of work, special services agreements and local contractor agreements with individuals and personnel agencies.

15. The current analysis has, however, focused on members of the workforce who hold staff contracts as they represent the most significant driver for liabilities and human resources planning.

Evolution of polio-funded staffing

16. As reported to the Executive Board in January 2017, the number of WHO staff members funded by the Global Polio Eradication Initiative had grown by 10% (98 positions) from 2013 to 2016. The increase was necessary in order to: build capacity in country offices in the countries endemic for poliomyelitis (Pakistan, Afghanistan and Nigeria); respond to the multicountry outbreak of poliomyelitis in the Middle East in 2014 and Nigeria in 2016; establish a regional centre for health emergencies and polio eradication in Amman; plan and implement the global withdrawal of type 2 component in oral polio vaccine; strengthen immunization systems and surveillance in high-risk countries; and develop guidelines to contain the poliovirus (in laboratories for example) after the interruption of transmission.

17. However, since the beginning of 2017 when the winding down of the Global Polio Eradication Initiative in non-endemic countries began, the overall number of polio-funded staff members has declined by 3%. Three regions and headquarters have fewer filled positions now compared with August 2016, with the African Region accounting for the reduction of 27 polio-funded staff. (Appendix 4)

Reliance on the Global Polio Eradication Initiative's funds for staffing in regions and countries

18. The degree of reliance on the Global Polio Eradication Initiative's funds for staffing varies by region: the African Region has the highest share of such-funded staff as a percentage of their total staff (31%), followed by the Eastern Mediterranean Region (16%) and the South-East Asia Region (7%).

19. Countries that rely most heavily on the Global Polio Eradication Initiative's funding for more than 50% of their staffing include Angola, Chad, the Democratic Republic of the Congo, and Nigeria, while the Initiative supports 48% of the staffing in Pakistan. There are countries that have been polio-free for more than 10 years and still have between 20% and 50% of all staff positions supported by the Initiative's funds; they will have to rapidly reduce their dependence on that source of funding in the next one to three years, in line with projected declines in polio funding.

20. The Secretariat is working at all levels to address the strategic challenges of the decrease in the staffing levels that will occur in line with the Global Polio Eradication Initiative's declining budgets for 2017–2019.

FINANCIAL LIABILITIES ASSOCIATED WITH WHO'S STAFF MEMBERS FINANCED WITH FUNDS OF THE GLOBAL POLIO ERADICATION INITIATIVE

21. The analyses of the terminal indemnity costs are based on likely scenarios included in the independent study first presented to WHO's governing bodies in 2013 and updated in the report to the Executive Board in January 2017.

Maximum indemnity forecast

22. Based on the worst-case scenario, the maximum indemnity costs upon programme closure in 2019 associated with filled staff positions as at August 2016 were estimated to be US\$ 109 million. This estimate does not represent a significant change from that made in 2013 (US\$ 105 million) despite the increase in the number of staff, mainly because of:

- the increased flexibility of contracts, which reduces potential liability in the worst-case scenario by US\$ 4 million compared to a scenario where the share of temporary contracts would have stayed the same as in 2013;
- the strengthening of the United States dollar against local currencies; at a constant exchange rate indemnities would have been US\$ 9 million higher in the worst-case scenario;
- a more detailed indemnity forecast that allows for manageable mitigating measures and a progressive decrease of resources in the period 2017–2019 (information that was not available in 2013); the new forecast gives an estimate of US\$ 55 million in indemnity payments over three years.

23. Key elements of this scenario include: (1) the assumption that the polio programme will close at the end of 2019 and resources will fall in line with the Global Polio Eradication Initiative's financial resources requirements for 2016–2019,¹ which make it necessary for regional offices to adapt their budget for 2017 and include the budget reductions in the Proposed programme budget and operational plans for 2018–2019; and (2) partial synchronization of contract end dates with programme closure and the possibility of reassigning some international Professional-grade staff onto longer-term contracts.

¹ See <http://polioeradication.org/financing/financial-needs/financial-resource-requirements-frr/gpei-requirements-2016-2019/> (accessed 8 March 2017).

24. These scenarios and indemnity projections, shown in Appendix 5, will be updated in the regular reports on polio to the governing bodies. For now the only change from the report to the Executive Board in January 2017 (document EB140/46, Annex), is the amount set aside for the terminal indemnity, from \$20 million to \$40 million.

WHO'S PRIORITIES TO REDUCE LIABILITIES AND ENHANCE POLIO-RELATED HUMAN RESOURCE PLANNING

25. Based on requests from Member States and the ongoing work of the WHO-wide Post-Polio Transition Planning Steering Committee, the following next steps have been identified for urgent implementation and continuous monitoring.

Human resource management

26. New measures to oversee closely and review decisions about staff funded by the Global Polio Eradication Initiative include the following:

- development of a dedicated database of polio human resources (see paragraph 4);
- proactive management of vacancies, in order to discontinue unnecessary positions and limit increases in staffing while maintaining the workforce required to ensure interruption of transmission and to respond to outbreaks;
- finding means to enhance oversight and tracking of non-staff contracts given their importance for polio transition planning – currently, non-staff data rely on manual collection from the procurement systems at country or regional levels;
- engagement with the programme area network in the Secretariat to identify crucial polio-funded functions that could be integrated into other programmes, and to assess and maximize opportunities for internal reassignments for international Professional-grade staff impacted by the polio transition;
- skills mapping and job re-profiling to assist staff members to transition from the polio programme;
- introduction of a new process for the review and approval by Director, Polio Eradication (with regular submission of updates to the ad hoc human resources working group) for all new longer-term contracts and positions using Global Polio Eradication Initiative funds.

Budget management

27. The Polio Eradication Department in headquarters, working closely with regional offices and the Department of Planning, Resource Coordination and Performance Monitoring, has ensured that the lowered polio budget targets for 2017–2019 are reflected in regional and headquarters submissions for the Proposed programme budget 2018–2019.

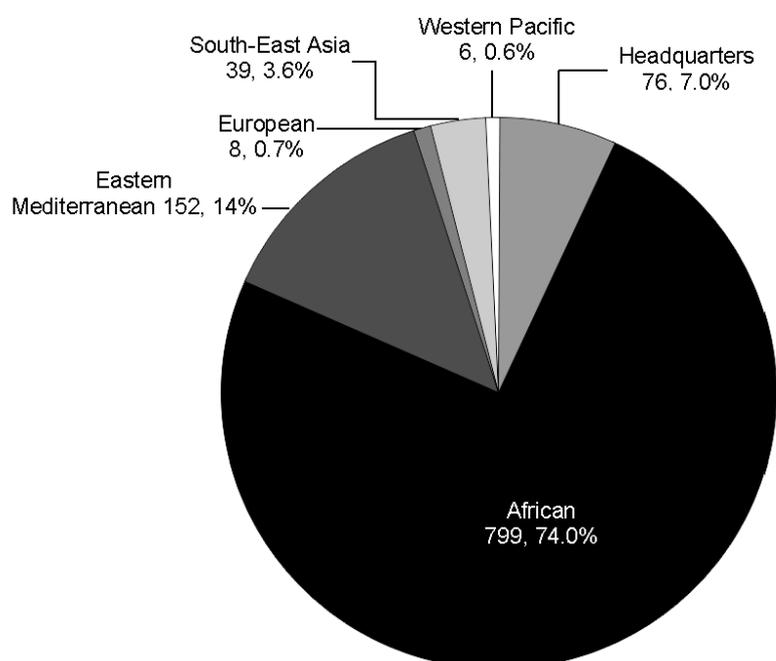
28. Given that many country offices and other health programmes rely heavily on staff funded by the Global Polio Eradication Initiative and its resources, the WHO-wide Post-Polio Transition Planning Steering Committee is working closely with technical programmes in headquarters, regions and countries to ascertain the programmatic risks arising from the loss of staff members funded by the Global Polio Eradication Initiative.

Reporting

29. The Secretariat will continue to provide reports to Member States every six months and as requested on the progress of transitioning staff members out of the polio programme as it nears and achieves certification of eradication in the coming years and limiting organizational liabilities.

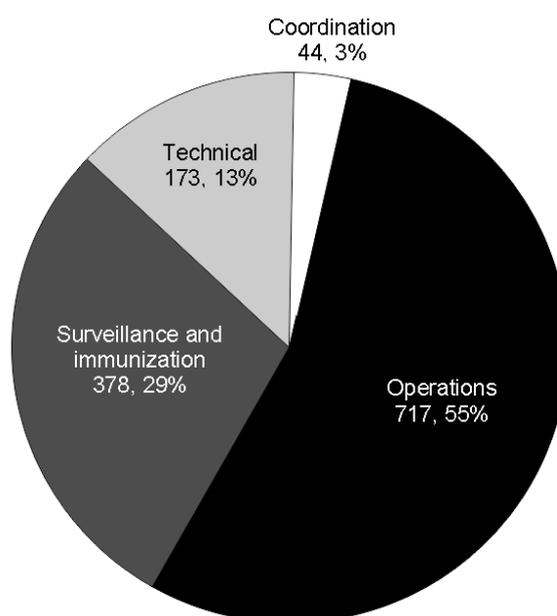
Appendix 1

Staff per region



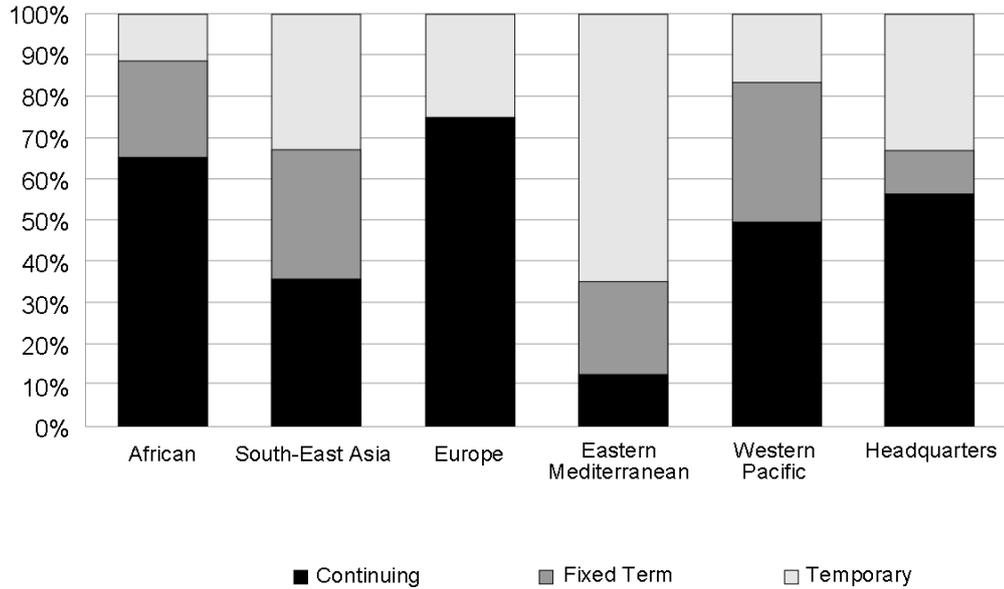
Appendix 2

Staff per function



Appendix 3

Staff contract by region (scaled 100%)



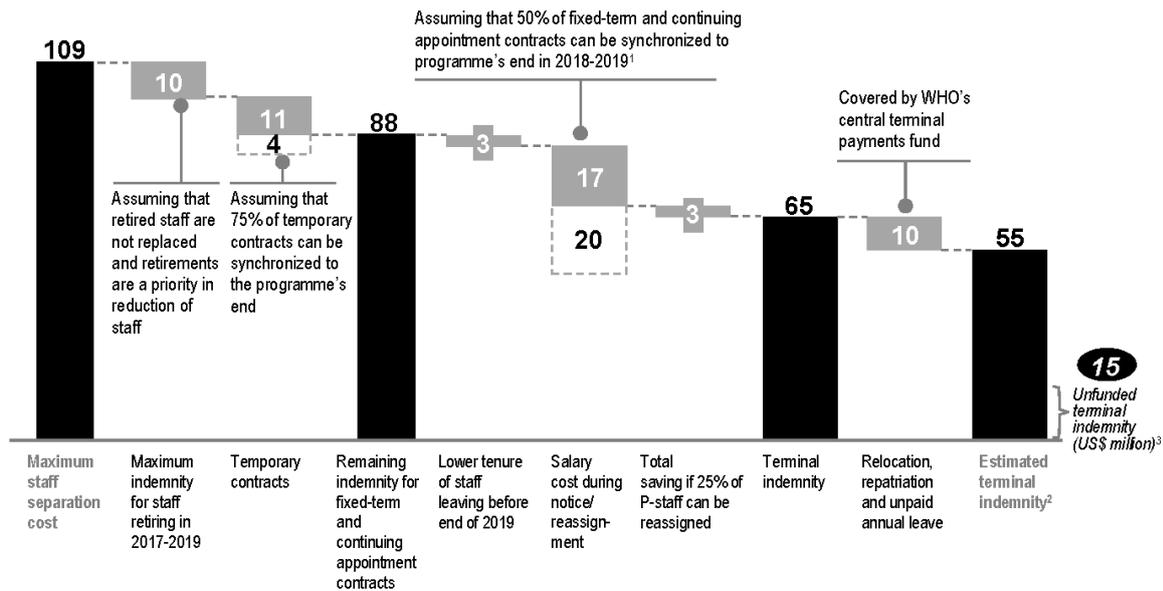
Appendix 4

Headcount by office and region

Office/Region	Headcount			
	2013	2016	2017 March	2016–2017 Increase/decrease
Africa	837	826	799	-3%
South-East Asia	41	39	39	
Europe	12	9	8	-11%
Eastern Mediterranean	76	155	152	-2%
Western Pacific	3	6	6	
Headquarters	50	77	76	-1%
Total	1 019	1 112	1 080	-3%

Appendix 5

Maximum and “planned” scenarios for indemnity exposure estimate: evolution from maximum estimated terminal indemnity to scenario with proactive planning and progressive decreases (US\$ million, 2016 estimate for separation costs by end of 2019)



¹ No synchronization assumed in 2017.

² Of which, US\$ 6 million in 2017, US\$ 7 million in 2018, US\$ 42 million in 2019. Based on current human resources rules; if a change in policy is approved that postpones the retirement age to 65 years, the indemnity cost would be US\$ 3-4 million higher.

³ US\$ 40 million have already been set aside for terminal indemnity.

= = =