

## **Polio transition planning**

### **Report by the Secretariat**

#### **INTRODUCTION**

1. The Executive Board at its 140th session in January 2017 adopted decision EB140(4) on poliomyelitis, in which the Director-General was requested, inter alia, 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.

2. The present document was prepared in response to decision EB140(4) and is based on inputs received from WHO country offices, the regional offices for Africa, the Eastern Mediterranean and South-East Asia, together with relevant departments at headquarters. Common templates and structured interviews were provided to solicit inputs for the report, an initial draft of which was presented to a meeting of Member States on 28 April 2017.

3. This report limits itself to a short summary section in respect of human resource risks and associated mitigation efforts, since these issues are already included in the Annex to document A70/14. That Annex should be read in conjunction with this report to obtain a holistic understanding of the human resources, programmatic and financial risks arising from polio transition, and in order to inform the debate under the agenda subitem on polio transition planning, for which this report has been prepared.

4. The Secretariat considers that the scaling-down of the polio programme is one of the principal key risks faced by the Organization. WHO's Global Policy Group is fully engaged in tackling this issue, and polio transition planning is treated as a corporate, WHO-wide exercise. The Secretariat, further to decision EB140(4), is committed to informing Member States and engaging them in the process to ensure that essential polio functions, assets, experience, and significant investments by donor partners, help to sustain a polio-free world after the global certification of polio eradication; and, where feasible, help to achieve other critical global public health goals in affected Member States that have been supported through the polio efforts.

#### **POLIO TRANSITION: PROGRAMMATIC RISKS AND OPPORTUNITIES**

5. The following key programmatic risks and opportunities have been highlighted in the inputs received from the regional offices concerned and headquarters departments, and from draft national country transition plans. This report represents the first attempt to consolidate details of the programmatic risks and opportunities of polio transition in a single document.

## A. Impact on immunization

### Risks

6. The Annex to the Secretariat's update on human resources, submitted to the Executive Board at its 140th session,<sup>1</sup> illustrated that 23% of WHO's polio-funded staff contribute to immunization and surveillance activities, 19% contribute to broader technical areas within the Expanded Programme on Immunization, including laboratory support and data management, and 56% provide critical operational support to implement surveillance and immunization activities through WHO country offices. Following the decrease in polio eradication funding, WHO offices at regional and country level risk experiencing the disruption of their core functions for the Expanded Programme of Immunization, particularly disease surveillance activities.

7. There are clear inter-relationships and synergies across the Expanded Programme on Immunization and the Global Polio Eradication Initiative. These include:

- Routine immunization strengthening (micro-planning, training and community mobilization);
- Disease surveillance and laboratory capacity strengthening;
- Data quality, collection, analysis and management;
- Planning and execution of supplementary immunization activities (against polio and other vaccine-preventable diseases);
- Programme supervision and monitoring.

8. The 2016 mid-term review of the global vaccine action plan<sup>2</sup> provided a sobering reminder that global aspirations such as the elimination of measles and rubella or the attainment of equitable immunization coverage still remain behind schedule.

9. The Measles & Rubella initiative has identified a list of 68 priority countries for support, which includes all polio transition priority countries. Of the 20.8 million infants who did not receive measles immunization in 2015, more than half (53%) were in six of the polio transition priority countries (Democratic Republic of the Congo, Ethiopia, India, Indonesia, Nigeria and Pakistan). The measles and rubella elimination goal of the global vaccine action plan is therefore fragile and could suffer dramatically from the withdrawal of polio support.

10. Furthermore, of the 19.4 million infants unimmunized with diphtheria, tetanus and pertussis (DTP3), nearly 60% reside in the 16 polio transition priority countries. This situation persists, despite the fact that polio resources have helped these countries to map populations missed by routine immunization services and to develop strategies to increase coverage and reduce inequity. If the goals of the global vaccine action plan are to be reached by 2020, the integrity of the Expanded Programme

---

<sup>1</sup> Document EB140/46, Annex.

<sup>2</sup> See 2016 midterm review of the global vaccine action plan. Available at [http://www.who.int/immunization/global\\_vaccine\\_action\\_plan/SAGE\\_GVAP\\_Assessment\\_Report\\_2016\\_EN.pdf](http://www.who.int/immunization/global_vaccine_action_plan/SAGE_GVAP_Assessment_Report_2016_EN.pdf), accessed 7 May 2017).

of Immunization must not only be preserved; it should also be further strengthened and protected from setbacks following polio transition.

11. The phasing-out and closing of the Global Polio Eradication Initiative presents widespread risks for the WHO African Region given that approximately 90% of its WHO-funded immunization staff and infrastructure are funded from resources of the Initiative. It is important to note that all WHO polio-funded staff based at the country level have the title “Immunization Officer”; they work on a broad spectrum of vaccine-preventable disease activities – all linked to the Regional Strategic Plan for Immunization 2014–2020,<sup>1</sup> which was endorsed by the WHO Regional Committee for Africa in 2014.<sup>2</sup> The Regional Strategic Plan builds on the global vaccine action plan and includes ambitious targets for regional vaccine introduction and coverage, in respect of pneumococcal conjugate vaccine, rotavirus vaccine, vaccines against human papilloma virus, measles and rubella, maternal and neonatal tetanus elimination, yellow fever, and meningitis. These targets were set considering the levels of staffing in the African Region in the period 2013–2014, and to support WHO’s continued ability to provide the technical assistance to countries necessary in order to attain these objectives.

12. In addition to the phasing-out of the Global Polio Eradication Initiative and associated resources, the African Region also faces the phasing out of support from the GAVI Alliance in years to come as countries undergo economic transition and cease to be eligible to apply for support from the GAVI Alliance. At the December 2016 meeting, the Regional Immunization Technical Advisory Group recommended to the Regional Director for Africa that a detailed programmatic risk analysis be conducted on the projected impact of the phasing-out/closure of the Initiative and transitioning of funding from the GAVI Alliance on national immunization programmes and national disease surveillance systems in the African Region, while also including the requirements that need to be in place in the post-polio certification period. The analysis identified a number of key areas in the African Region that will be affected by the downsizing and closure. Several of these are set out below.

- **Disease surveillance activities** – All of the African Region’s 47 WHO country offices receive seed surveillance funding for the Global Polio Eradication Initiative on a quarterly basis to allow countries to conduct active surveillance activities for acute flaccid paralysis, but also for surveillance activities in respect of other vaccine-preventable diseases. Once the Global Polio Eradication Initiative closes, active disease surveillance may not be conducted optimally, which could lead to delayed detection and response for priority diseases and the possible resurgence of some priority diseases.
- **Immunization information systems** – Staff functions in the African Region in respect of the management WHO immunization data are largely funded by resources for the Global Polio Eradication Initiative, and there is a need to ensure that this data management capacity prevails so that disease trends can be monitored regularly, thus allowing disease outbreaks to be detected and responded to in a timely manner.
- **Laboratory support** – As funding for the Global Polio Eradication Initiative is scaled down, polio-funded laboratories will require additional resources to sustain laboratory activities that they conduct against other vaccine-preventable diseases, to purchase reagents, equipment and other supplies, as well as to ensure ongoing training and to maintain their accreditation. For

---

<sup>1</sup> Regional Strategic Plan for Immunization 2014–2020 <https://www.who.int/en/ahm/issue/19/reports/regional-strategic-plan-immunization-2014%E2%80%99>.

<sup>2</sup> See resolution AFR/RC64/R4.

example, in Nigeria, the two WHO-accredited laboratories and other government laboratories that are supported by the Global Polio Eradication Initiative, and that also support efforts against measles, rubella and yellow fever, remain at risk.

13. The downsizing of the polio programme would involve similar risks in the Eastern Mediterranean Region, where the polio staff allocate a significant portion of their time to support other childhood immunization efforts, and surveillance efforts for other vaccine-preventable disease in addition to acute flaccid paralysis surveillance. In polio transition priority countries like Somalia and Sudan, polio eradication efforts are fully integrated into either the Expanded Programme on Immunization, or other childhood immunization efforts. In addition, surveillance for measles and rubella is integrated with acute flaccid paralysis surveillance for data management, oversight, technical bodies, communications and monitoring and supervision. The slow progress made in a fragile country like Somalia, where routine immunization coverage has improved from below 10% in 1980 to above 44% in 2015<sup>1</sup> is now at risk.

14. In the South-East Asia Region, the biggest risk following the loss of polio networks will be for the achievement of the goal of measles elimination and rubella/congenital rubella syndrome control in the South-East Asia Region by 2020.<sup>2</sup> The risk includes the potential stagnation of or decline in the coverage of the first and second dose of measles- and rubella-containing vaccine under routine immunization, a strategy that is the backbone for measles elimination and rubella control, as well as a possible negative impact on the quality of surveillance for measles and rubella. Unless alternative mechanisms to sustain the technical functions and funding are identified urgently to replace the funds for the Global Polio Eradication Initiative, scaling up case-based laboratory-supported surveillance for measles and rubella to achieve the goal of measles elimination and rubella/congenital rubella syndrome control will remain a challenge. Support for the introduction of new vaccines in the South-East Asia Region is likely to be compromised as well, if polio networks cease to support activities such as training, post-introduction evaluations, and surveillance of adverse events following immunization.

## Opportunities

15. Key technical and operational polio-funded staff, and the extensive polio-funded infrastructure at the country level, can be re-purposed in order to play a critical role in helping achieve the goals of the global vaccine action plan, and related regional immunization targets.

16. **Securing universal access to immunization in the African continent.** The African and Eastern Mediterranean regions are in the process of developing a business case for immunization for the African continent, the ultimate goal of which is to support the Member States of those regions in the African continent to reduce the mortality and morbidity burden among women and children caused by vaccine-preventable diseases. The business case is intended to ensure sufficient commitment on the part of national leadership and resources in order to enable WHO to fully achieve the targets of the

---

<sup>1</sup> WHO vaccine-preventable diseases: monitoring system, 2016 global summary. Available at [http://apps.who.int/immunization\\_monitoring/globalsummary/countries?countrycriteria%5Bcountry%5D%5B%5D=SOM](http://apps.who.int/immunization_monitoring/globalsummary/countries?countrycriteria%5Bcountry%5D%5B%5D=SOM), accessed 15 May 2017.

<sup>2</sup> See resolution SEA/RC66/R5 (2013).

Regional Strategic Plan for Immunization 2014–2020<sup>1</sup> and the commitments of the Addis Declaration on Immunization (2016).<sup>2</sup>

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

18. **Achieving the measles and rubella elimination goal.** Measles elimination and rubella/congenital rubella syndrome control is a priority for the Member States of the African, Eastern Mediterranean and the South-East Asia regions. All three regions have adopted measles elimination goals.

19. Both the measles and rubella elimination programme, and the Global Polio Eradication Initiative rely heavily on an extensive surveillance and laboratory network, a system of outbreak preparedness and response, periodic supplementary immunization activities and an active community mobilization network to “go the last mile”. The Global Measles and Rubella Laboratory Network was inspired by the success of the Global Polio Laboratory Network, and notable resources continue to be shared across the two networks in terms of staff, management and processes to conduct laboratory tests for case confirmation.

20. Additionally, of the 146 polio laboratories, 122 (84%) are accredited in the measles and rubella network and are at risk of being dismantled when polio resources decline. Based on the financial resource requirements outlined by the Global Polio Eradication Initiative,<sup>3</sup> it is provisionally estimated that it would cost approximately US\$ 77 million annually to replace the Global Polio Eradication Initiative resources currently used to bolster measles and rubella surveillance at country level. This represents approximately 70% of the global cost of conducting measles/rubella surveillance. At the present time, a workforce of over 2500 polio-funded individuals is supporting measles and rubella surveillance.

---

<sup>1</sup> Regional Strategic Plan for Immunization 2014–2020: <https://www.aho.afro.who.int/en/ahm/issue/19/reports/regional-strategic-plan-immunization-2014%E2%80%259>, accessed 15 May 2017.

<sup>2</sup> See <http://immunizationinafrica2016.org/ministerial-declaration-english/>, accessed 8 May 2017.

<sup>3</sup> World Health Organization. Financial Resource Requirements 2013–2019. 2016. Available at [http://polioeradication.org/wp-content/uploads/2016/10/FRR2013-2019\\_April2016\\_EN\\_A4.pdf](http://polioeradication.org/wp-content/uploads/2016/10/FRR2013-2019_April2016_EN_A4.pdf), accessed 8 May 2017.

## **B. Impact on global health security: capacity to detect and respond to epidemic- and pandemic-prone diseases and other emergencies**

### **Risks**

21. With over 100 acute public health events reported every year in the African Region, there is a need to guarantee a minimum human resource capacity with expertise in detecting acute public health events and mounting a response to them. In this way, the burden of epidemic-prone diseases can be alleviated and the minimum International Health Regulations (2005) core capacities attained. Without this field support, it is likely that there will be delays in detecting these threats in the African Region and in mounting an effective response to them.

22. In many disease outbreaks that require large preventive and/or reactive vaccination campaigns, the expertise of the polio programme in preparing micro-plans and in conducting vaccination campaigns has been valuable. In Somalia, the polio team has contributed to managing the current drought and cholera emergencies by supporting the planning, implementation, and monitoring of the oral cholera vaccination campaigns targeting an estimated 500 000 people in high-risk areas. In Sudan, polio staff were engaged in the monitoring of large campaigns reaching tens of millions of children and adults to vaccinate them against yellow fever, meningitis, and measles, in addition to supporting responses to outbreaks of dengue fever and acute watery diarrhoea.

23. The recently controlled large urban yellow fever outbreaks in the Democratic Republic of the Congo and Angola further illustrate the critical role of the polio programme in assisting in the response to a given vaccine-preventable disease. The north east of Nigeria also faces big risks from downsizing of the Global Polio Eradication Initiative. Mobile health teams (supported through the Initiative) remain the only source of immunization and services for reproductive, maternal, newborn, child and adolescent health in certain areas suffering from the scourge of insurgency from Boko Haram and the associated destruction of health facilities. Polio staff and infrastructure were central to the containment of Ebola in Nigeria.

24. In 2010, the WHO Regional Office for Africa revised the generic Integrated Disease Surveillance and Response technical guidelines,<sup>1</sup> which had been developed in 2001 in response to several emerging and re-emerging infectious pathogens, the threats of noncommunicable diseases, events and conditions, the adoption of the International Health Regulations (2005) and the “One Health” approach. Strengthening the revised technical guidelines will be negatively impacted by Polio downsizing.

25. Polio-funded health workers, and physical assets such as vehicles, and cold chain equipment, have also been used to support logistics required for supervision and surveillance activities for other communicable diseases. This support was instrumental in controlling the recent yellow fever outbreaks in Angola, Democratic Republic of the Congo and Uganda; in supporting immunization activities during seasonal outbreaks for meningitis; and in supporting preparedness for the implementation of the Pandemic Influenza Preparedness Framework.

---

<sup>1</sup> World Health Organization and Centers for Disease Control and Prevention (2010). Technical Guidelines for Integrated Disease Surveillance and Response in the African Region, Brazzaville, Republic of Congo and Atlanta, USA: 1–398 (available at [https://www.cdc.gov/globalhealth/dphswd/idsr/pdf/Technical%20Guidelines/IDSR%20Technical%20Guidelines%202nd%20Edition\\_2010\\_English.pdf](https://www.cdc.gov/globalhealth/dphswd/idsr/pdf/Technical%20Guidelines/IDSR%20Technical%20Guidelines%202nd%20Edition_2010_English.pdf), accessed 9 May 2017).

## Opportunities

26. **Strengthening the WHO Health Emergencies Programme.** WHO is currently responding to an unprecedented number of crises, and increased capacity is urgently needed in a number of country offices, particularly those with ongoing emergencies and those in fragile settings.

27. Many of the countries that the WHO Health Emergencies Programme is targeting for increased capacitation are also polio transition priority countries. Of the 16 polio priority countries for transition planning, six fall under the Programme's "Priority 1" for increase in capacitation, five fall under "Priority 2". In some countries like Somalia, an integrated Polio and Emergency Coordinator position has been created to support childhood immunization and emergency responses in an integrated manner. The skills and systems that polio staff have built over the years may be directly relevant not only to the core capacity requirements of the Programme, but also to the increased resilience of the health system in high vulnerability countries. In view of the fact that the Programme's core capacity requirement does not include as many staff as are currently employed for polio eradication, and does not include the extensive networks at subnational level that are currently maintained by polio, additional financing streams will need to be identified.

28. The WHO Health Emergencies Programme is reviewing the core country capacity requirements for emergency preparedness and response, based on country context and needs, in priority WHO country offices.

29. Over the next six to 12 months, the Programme will work together with the heads of WHO country offices to fully implement the Programme's country business model in line with the country context, and to ensure that this capacitation is institutionalized and sustained. Opportunities for synergies between polio transition planning and the Programme's capacitation plans will be actively pursued. A limited amount of funding is currently available for the initial investment required by the Programme in 2017, but the long-term sustainability of this model is dependent upon new multiyear contributions for WHO's work in emergencies.

30. In polio transition priority countries, there is significant expertise and capacity to support efforts to strengthen national core capacities required under the International Health Regulations (2005), and the development of national action plans. The report of the Joint External Evaluation conducted in Pakistan in 2016, noted that, "Systematic planning must determine how the assets and best practices of polio eradication are transitioned and mainstreamed over time to support other priorities, particularly immunization and vaccine-preventable disease surveillance. More generally, the integrated infectious disease surveillance and control system should be developed towards a more generic horizontal system capable of detecting and responding to any disease."<sup>1</sup>

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

32. **Strengthening Integrated Disease Surveillance and Response.** Despite the progress made over the years, Integrated Disease Surveillance and Response has not been fully implemented at

---

<sup>1</sup> Joint External Evaluation of the IHR Core Capacities of the Islamic Republic of Pakistan: Mission Report (27 April–6 May 2016). Geneva: World Health Organization; 2017. Available at <https://extranet.who.int/spp/sites/default/files/jeeta/WHO-WHE-CPI-2017.9-eng.pdf>, accessed 9 May 2017.

district and community levels in most countries. The critical gaps in district level implementation include inadequate capacity in managing data, limited capacity of district level epidemic management committees and rapid response teams, and lack of logistic and communication capacities.

33. The main core and supporting functions of Integrated Disease Surveillance and Response and polio's acute flaccid paralysis surveillance are quite similar and are applied at all levels of the health system from community, district and peripheral levels to national level. The Polio-funded acute flaccid paralysis surveillance network constitutes an opportunity to enhance Integrated Disease Surveillance and Response by: (i) using polio-funded data management capacities; (ii) creating a network of national public health laboratories that support the safe and timely shipment of infectious substances; and (iii) using polio-funded field operations for investigating and responding to major outbreaks. The integration of polio-funded workforce can build capacity for implementing Integrated Disease Surveillance and Response, the International Health Regulations (2005) and the "One Health" approach.

### **C. Impact on neglected tropical diseases and nutrition supplementation**

#### **Risks**

34. It is estimated that approximately 1.5 billion people are infected with soil-transmitted helminths worldwide.<sup>1</sup> Over 270 million preschool-age children and over 600 million school-age children live in areas where these parasites are intensively transmitted, and are in need of treatment and preventive interventions. The WHO programme for the control of neglected tropical diseases aims to reach 270 million preschool children every year with deworming treatments. Deworming tablets are frequently co-administered with vitamin A during polio vaccination campaigns, organized as "Child Health Days", which are reliant on polio funding. Globally, over 150 million preschool children were treated in 2015 with this approach.

35. The South-East Asian Region is the WHO region with the highest number of children infected with soil-transmitted helminths, with India, Indonesia and Bangladesh accounting for the majority of cases. The region has identified the elimination of neglected tropical diseases as one of the priority programmes. The African Region has the second-highest number of infected children, with nearly 300 million children requiring preventive chemotherapy. Three of the four countries with the greatest need in the African Region – Nigeria, Ethiopia, and the Democratic Republic of the Congo – are polio priority countries for transition.

36. In the 16 polio transition countries, in 2015, almost 55 million preschool-age children were dewormed through Child Health Days. In the Democratic Republic of the Congo, Pakistan and Myanmar the coverage with deworming of the children in need of treatment has been over 90%; and in Ethiopia it has been over 60%.

37. However, the expected scaling-down of the Global Polio Eradication Initiative will have a negative impact on coverage with preventive chemotherapy against soil-transmitted helminths in the future. The degree of integration that exists between various neglected tropical disease programmes means that the process of winding down operations is not limited to soil-transmitted helminths programmes. For example, either prior to 2020 or soon afterwards, the elimination or eradication

---

<sup>1</sup> Soil-transmitted helminth infections. World Health Organization, Fact sheet No. 366, updated January 2017. Available at <http://www.who.int/mediacentre/factsheets/fs366/en/>, accessed 15 May 2017.



programmes organized for lymphatic filariasis, onchocerciasis and polio will have probably reached their eradication or elimination targets and the large campaigns conducted every year, which provide part of the infrastructure for reaching children with albendazole and mebendazole, will be phased out.

38. The mass polio vaccination campaigns and polio-supported Child Health Days also offer an opportunity to conduct surveillance activities for guinea-worm disease, and thus support another global eradication effort. House-to-house active case search and surveillance for guinea-worm disease conducted by the thousands of polio vaccinators in Nigeria helped to certify the eradication of guinea-worm disease in the country.<sup>1</sup> These surveillance activities are presently conducted in eight countries, and six of them are among the polio-transition countries: Angola, Chad, Democratic Republic of the Congo, Ethiopia, South Sudan and Sudan.

39. An estimated 250 million preschool children are at risk from vitamin A deficiency.<sup>2</sup> In vitamin-A deficient areas, a substantial proportion of pregnant women are also vitamin-A deficient. In addition, an estimated 250 000 to 500 000 vitamin A-deficient children become blind every year, half of them dying within 12 months of losing their sight. Vitamin A supplementation is therefore critical for maternal and child survival, and deficiency can lead to increased child morbidity and mortality in the long term.

## Opportunities

40. Ten of the 16 polio transition countries – Angola, Bangladesh, Cameroon, Ethiopia, India, Nepal, Nigeria, Somalia, South Sudan and Sudan – have indicated neglected tropical diseases among their top five priorities for country budget allocation under the Programme budget 2018–2019.

41. The mass national and subnational polio vaccination campaigns supported by the Global Polio Eradication Initiative provide an important and cost-effective delivery platform for the distribution of preventive chemotherapy for neglected tropical diseases. When the cost of the drug is covered by a donation, and using the polio supported infrastructure of Child Health Day, the cost of deworming a child is less than US\$ 0.007.<sup>3</sup> The cost of deworming a child when such infrastructure is not present is approximately 30 times higher. It was the low marginal cost of deworming that convinced several polio-endemic countries to adopt this approach.

42. A careful evaluation should be conducted in countries where the financial support to Child Health Days or Immunization Days will be discontinued because of the eradication of polio, and its impact on maintaining the present deworming activities and achieving 2020 goals for neglected tropical diseases.

43. Given that an estimated 1.5 million childhood deaths have been prevented, through the systematic administration of vitamin A during polio immunization activities,<sup>4</sup> a similar detailed analysis of the risks involved and identification of alternative platforms for the cost-effective delivery of nutritional supplements will be critical to reducing child morbidity and mortality rates.

---

<sup>1</sup> See <http://www.who.int/features/2014/nigeria-stops-guinea-worm/en/>, accessed 10 May 2017.

<sup>2</sup> See <http://www.who.int/nutrition/topics/vad/en/>, accessed 10 May 2017.

<sup>3</sup> Boselli G. Integration of deworming into an existing immunisation and vitamin A supplementation campaign is a highly cost-effective approach to maximise health benefits in Lao PDR (2011). *Int Health* 3; 240–245.

<sup>4</sup> See <http://www.who.int/mediacentre/factsheets/fs114/en/>, accessed 10 May 2017.

44. As is the case in India, the vast polio surveillance network can also be utilized to monitor neglected tropical diseases like visceral leishmaniasis and lymphatic filariasis. In Nepal, the polio-funded Immunization Preventable Diseases surveillance network is also being used to monitor acute encephalitis syndrome.

## **D. Impact on maternal and child health interventions**

### **Risks**

45. Polio-funded staff and physical assets have supported interventions targeting maternal and child health in many countries.

46. The support provided by the polio staff, assets and resources to organize Child Health Days in many countries with weak health infrastructure, has helped to reduce mortality and morbidity associated with vaccine-preventable diseases, neglected tropical diseases, vitamin A deficiency and poor nutrition, as well as assisting in data collection and analysis. In many countries, the opportunities provided by Child Health Days were also used to raise awareness about sanitation and hygiene, breastfeeding, and birth registration. For example, in the Democratic Republic of the Congo, during a nationwide polio immunization campaign aiming to reach more than 16 million children aged under 5 years, the 50 000 health workers also provided deworming tablets and Vitamin A supplements. In addition, large-scale birth registration was also carried out, targeting 117 ‘zones de santé’ or health zones.<sup>1</sup> The withdrawal of polio funding will have repercussions for reproductive, maternal, newborn, child and adolescent health programmes in many polio transition countries and will have an impact on the achievement of critical global targets, including those of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)<sup>2</sup> and associated health targets 3.1 and 3.2 of Sustainable Health Goal 3 (Ensure healthy lives and promote well-being for all at all ages).<sup>3</sup>

### **Opportunities**

47. As part of WHO’s bottom-up planning process for the Proposed programme budget 2018–2019, 15 of the 16 priority countries for polio transition have mentioned reproductive, maternal, newborn, child and adolescent health in their top five list of priorities for budget allocation.

48. **Monitoring child and maternal mortality to achieve the Sustainable Development Goals.** In line with the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030),<sup>4</sup> and as indicated in Sustainable development Goal 3, targets 3.1 and 3.2 are top global health priorities.<sup>5</sup> Conducting mortality audits and reviews is a key strategy for reducing preventable deaths among

---

<sup>1</sup> See <http://polioeradication.org/news-post/a-common-package-for-childrens-health/>, accessed 10 May 2017.

<sup>2</sup> <http://www.who.int/life-course/partners/global-strategy/global-strategy-2016-2030/en/>, accessed 10 May 2017.

<sup>3</sup> <http://www.who.int/sdg/targets/en/>

<sup>4</sup> [http://www.who.int/pmnch/media/events/2015/ga\\_2016\\_30.pdf](http://www.who.int/pmnch/media/events/2015/ga_2016_30.pdf)

<sup>5</sup> Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births; target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births. See [http://www.who.int/gho/publications/mdgs-sdgs/MDGs-SDGs2015\\_chapter1.pdf](http://www.who.int/gho/publications/mdgs-sdgs/MDGs-SDGs2015_chapter1.pdf), accessed 10 May 2017.

mothers and babies. It helps health system managers to understand the causes of death, and the contributing factors, so they are able to take corrective actions to improve the quality of care.<sup>1</sup>

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

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

51. One concrete proposal that the Government of Nepal is exploring, is for the polio-funded Immunization Preventable Diseases surveillance network to start monitoring paediatric mortality (covering children aged 1–59 months) from pneumonia and diarrhoea, the two major killers in the country of children aged under 5. The goal is to collect actionable public health data that will help to improve the analysis of child mortality in the country, and help the Government to make more informed decisions to situate referral hospitals or primary health centres, reduce delays in treatment, and thereby reduce child mortality rates in the future. Initial discussions with the Government of Nepal on a multiyear transition plan have indicated a willingness by the Ministry of Health to work with WHO towards the transition of the Immunization Preventable Diseases surveillance network.

52. **Global Financing Facility in support of Every Woman, Every Child.** Member States could consider the engagement of the Global Financing Facility in support of Every Woman, Every Child while developing their national polio transition plans to help catalyse the innovative financing needed to contribute to efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children. It is estimated that compared with current trends, an accelerated investment scenario would help to prevent a total of 4 million maternal deaths, 107 million child deaths, and 21 million stillbirths between 2015 and 2030 in 74 high-burden countries.<sup>2</sup>

## **E. Impact on health systems**

### **Risks**

53. The Global Polio Eradication Initiative has invested heavily in country and international infrastructures in order to attain its eradication goal. Clear synergies exist with child health and routine immunization and the case has been made that the polio transition could strongly benefit local health systems. However, to date, this linkage with health systems strengthening has not been robustly examined and, in most countries, linkages to health systems goals have been limited to child health activities. That said, given the scale of the Global Polio Eradication Initiative, its reach to remote, rural, nomadic and migratory populations, and to under-served communities, including the marginalized and urban poor, together with the strength of its data collection and analysis programme, there could be major benefits for transition countries that use the polio approach to strengthen primary care systems on their way to achieving universal health coverage.

---

<sup>1</sup> See <http://www.who.int/mediacentre/news/releases/2016/stillbirths-neonatal-deaths/en/>, accessed 10 May 2017.

<sup>2</sup> See <http://www.who.int/life-course/partners/global-strategy/global-financing-facility/en/>, accessed 10 May 2017.

54. In May 2016 the Health Assembly adopted the framework on integrated, people-centred health services,<sup>1</sup> which offers a vision of how health systems could be reoriented to provide services across the continuum of care in a more integrated way that creates better health for whole populations, rather than seeking selected advances in particular diseases. The integration of “vertical” programmes like the Global Polio Eradication Initiative is essential to achieving this vision.

55. The downsizing of the polio infrastructure will also have an impact on the attainment of the Sustainable Development Goal 3, target 3.8,<sup>2</sup> on achieving universal health coverage, access to health services, and access to essential medicines and vaccines.

## **Opportunities**

56. In considering the future transition of the Global Polio Eradication Initiative, there are four main areas for examination that could benefit the achievement of universal health coverage.

57. **Strengthening primary care services for health systems and security.** Global Polio Eradication Initiative-funded staff and assets have the potential to make an enormous impact in improving the quality and accessibility of front-line services as part of national efforts to achieve universal health coverage. At the same time, the vertical focus of the Global Polio Eradication Initiative programme to date means that its influence on primary care has been very peripheral. In many countries, primary care will be the main entry point for national efforts to achieve universal health coverage. Approaches such as those used in Nigeria to strengthen polio operations through emergency operations centres and health camps can be considered both for strengthening outbreak preparedness and for improving quality of care through stronger district primary care management in high priority districts. Shifting the attention in key polio districts to strengthening the primary care infrastructure and quality of basic services provision will be one of the top priorities for ensuring that the Global Polio Eradication Initiative has an immediate impact on health systems strengthening in transition countries.

58. **Improving community engagement efforts for the strengthening of local health services.** Engaged communities and families are the backbone of strong local health systems and of robust community tracking of reportable diseases for the International Health Regulations (2005). The breadth of the Global Polio Eradication Initiative programme and its strong outreach approach make community engagement a natural priority in considering the future benefits of polio transition to efforts to strengthen local health systems. Stronger engagement of local community health structures and traditional systems will also be needed if this potential benefit to health systems is to be realized.

59. The work of the Global Polio Eradication Initiative in Ethiopia, for example, highlights the possibilities of leveraging staff and teams from nongovernmental organizations, supported by polio funding, for bolstering weak primary and preventive health care systems in remote rural and border areas most at risk for poor health and outbreaks. Using networks that have contacts and credibility within the hard-to-reach communities they are serving would significantly advance country goals for universal health coverage.

---

<sup>1</sup> See resolution WHA69.24.

<sup>2</sup> See <http://www.who.int/sdg/targets/en/>, accessed 10 May 2017.

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

61. **Strengthening supply chains and access to safe medicines.** One of the cornerstones of the Global Polio Eradication Initiative has been effective management of polio vaccine supply chains and cold chain maintenance. In many countries, the investment in central supply management and supply chains from the Global Polio Eradication Initiative has been a driving factor in overall improvements in access to safe medicines. However, in most cases, guidance notes, training and support have concentrated solely on management of oral polio vaccine, measles vaccines and inactivated poliovirus vaccine. Key investments will support the following, among other things: analysing and improving supply chains and distribution; improving dispensing practices at the front line; and investing in necessary upstream foundations, such as strengthening medicines regulation at the national level.

## HUMAN RESOURCE RISKS AND MITIGATION

### Human resources update

62. An update on staffing as at 20 March 2017, including revised numbers on non-staff, is presented in the Annex to the report by the Secretariat on poliomyelitis.<sup>1</sup> The paper notes that there are a total of 1080 currently filled WHO staff positions funded by the Global Polio Eradication Initiative, and this represents an overall reduction of 3% when compared with data presented to the governing bodies in January 2017.<sup>2</sup> 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%). More than half the WHO staff members funded by the Global Polio Eradication Initiative (55%) work in operations support, while 29% work on immunization and surveillance; technical support accounts for 13% of the workforce, with coordination of activities accounting for 3%.

63. The actual salary expenditure for the polio staff was US\$ 99.4 million for 2016, only marginally higher than the estimate of US\$ 97.3 million reported to the Executive Board in January 2017.

64. As the Global Polio Eradication Initiative develops the post-certification strategy for the Polio Eradication Initiative, as a matter of priority, a clear identification of the “essential polio functions,” and the scale, and timing of these functions will have to be articulated to ensure that the functions concerned may be protected during the downsizing and eventual closure of the Global Polio Eradication Initiative. Options will have to be developed at all three levels, including financing, for integrating some of these functions into other programme areas, or mainstreaming some of them into the government infrastructure. Managing the decreases in the polio budget and associated workforce

---

<sup>1</sup> Document A70/14.

<sup>2</sup> See document EB140/46, Annex.

reductions, while also ensuring that the staff that fulfil essential polio functions are identified and maintained, is a significant challenge that needs to be addressed urgently.

65. Given that polio is a disease targeted for eradication, a clear delineation of the roles, responsibilities and limitations will have to be articulated for WHO programme areas that are mandated as per the International Health Regulations (2005)<sup>1</sup> in order to help to manage the long-term risks and public health response associated with events due to a notifiable disease under the Regulations. This would include the development of the core human resources capacities needed for future surveillance and response in order to live up to the requirements of the Regulations.

## **Mitigation**

66. 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 to 2016, the cost of staff members has declined from 45% to 32% of the total personnel costs, and the cost of non-staff members has grown to nearly 70% of total personnel costs. Currently, data on non-staff cannot be extracted directly from the Global Management System. The Secretariat is exploring 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.

67. Some additional and 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;
- 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 respond to outbreaks;
- enhancement of oversight and tracking of non-staff contracts, given their importance for polio transition planning;
- 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 for all new longer-term contracts and positions using funds of the Global Polio Eradication Initiative;
- strengthening of the Global Polio Transition Human Resources Working Group;
- development of a uniform human resources strategy for managing the reduction of the polio-funded staff and workforce from 2017–2019;

---

<sup>1</sup> See <http://www.who.int/ihr/9789241596664/en/>, accessed 11 May 2017.

- development and online sharing of quarterly human resources dashboard for the polio transition.

## **FINANCIAL RISKS AND MITIGATION**

68. The decrease in the polio budgets for 2017–2019 was communicated to the 16 polio transition countries in May 2016 by the Global Polio Eradication Initiative, and this has accelerated the transition planning efforts as countries will need to adapt quickly to much smaller funding from the Initiative. For example, in Ethiopia, there will be a decrease in the polio budget from US\$ 39.8 million in 2016 to US\$ 4.6 million in 2019, an 88.5% decrease in 3 years.

69. The declining polio budget figures for the period 2017–2019 will also have an impact on other programme areas that have also been benefitting from the use of the polio infrastructure, and now face significant financing challenges in trying to integrate some of the critical polio assets simply in order to maintain the status quo, or to exploit additional opportunities. Given the difficult external financing environment, these programme areas, especially the areas of immunization and emergencies, are already facing funding gaps for their existing level of work.

70. The withdrawal of significant financing provided for polio eradication to WHO as a whole, to the African, Eastern Mediterranean, and South-East Asia Regions, and to the 16 polio priority countries will also have an impact on the general operations of the Organization at all three levels, and on the level of support that can be provided to the Member States affected.

71. For the biennium 2016–2017, as at 31 December 2016, WHO's spending on polio eradication was as follows: at the global level, US\$ 587 million, which represents 27% of the total expenditure of the Organization in 2016; the African Region, US\$ 297 million, which constitutes 44.2% of the Region's total expenditure in 2016; Eastern Mediterranean Region, US\$ 172 million, which constitutes 43.5% of the Region's total expenditure in 2016; and the South-East Asia Region, US\$ 37 million, which constitutes 24% of the Region's total expenditure in 2016.<sup>1</sup> Similar analysis of the percentage of polio expenditure in the 16 priority countries in 2016 reveals a range from a low of 10.4% in Myanmar to a high of 92.4% in Pakistan.

72. A detailed expenditure analysis will be conducted urgently for country offices in order to proceed with an itemized reduction in different expenditure categories, as well as work to plan for retention or dispersal of fixed assets.

73. Given that the proposed programme budget 2018–2019 has already been developed without full consideration of the risks associated with the polio transition, programme budget categories will have to make use, as part of the operational planning process for the programme budget, of the flexibility available to the Director-General to increase the budget space in order to accommodate the additional costs of integrating any polio functions. For example, for programme area 1.5, vaccine-preventable diseases, it has been estimated that a 15% increase in the Programme budget 2018–2019 would be needed to allow scale-up of surveillance and technical assistance, potentially absorbing some of the capacity currently financed with polio funds, simply to maintain the status quo in terms of programme outcomes. It is expected that a more significant scale-up will be needed up to 2021 in order to achieve the goals of the global vaccine action plan. Potentially, accommodating some of the polio-funded

---

<sup>1</sup> See <http://extranet.who.int/programmebudget/Biennium2016/Flow>, accessed 11 May 2017.

resources into the programme budget would be a “zero-sum game”, with budget space needing to be removed for other areas of work.

74. Clearly, in the short term (between 2018 and 2019) gaps in programme outcomes are to be expected if polio funding is withdrawn too rapidly, and should no additional financing be made available. Options for additional financing should be explored through dialogue with external financing partners in order to address the critical short-term gaps, including the forthcoming financing dialogue. The use of domestic resources and innovative financing mechanisms will also have to be explored as part of a financing strategy to address the risks faced by other programme areas and Member States as a result of the Global Polio Eradication Initiative budget decrease.

75. However, in most of the 16 priority countries for polio transition, absorbing their financing needs through domestic resources in the short term (3–5 years) will be a challenge. The vast majority are least developed countries and will rely on external financing to sustain both essential polio functions and non-essential infrastructure that can support other national and global health priorities.

76. There is also a risk in terms of securing the financing needed for sustaining the essential polio functions for the post-certification period of polio eradication. In global health security terms, these functions will have to be sustained for perpetuity, and so any financing solution will have to be sustainable and included as part of the core budget financing. A more robust and coordinated budget development process must be initiated in early 2018 for the Programme budget 2020–2021, where the post-certification polio requirements are to be included.

77. In order to address the financial liabilities associated with downscaling polio-funded staffing, a Polio Indemnity Fund was established in 2013, and the Fund now stands at US\$ 40 million. It is envisaged that by the end of 2019, the Fund will have the US\$ 55 million needed to meet the expected separation costs, based on the “most likely” scenario that was modelled.<sup>1</sup> Key elements of this scenario that will help to reduce the financial liabilities include the following: (1) the assumption that the polio programme will close at the end of 2019 and that resources will fall in line with the Global Polio Eradication Initiative’s financial resources requirements for 2016–2019,<sup>2</sup> 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) for staff with fixed-term or continuing appointments, partial synchronization of contract end-dates with programme closure, and the possibility of reassigning some international staff in the professional category to other areas.

78. The financial liability calculations will be validated using new post cost averages adjusted for geographic location and other changes, including changes in the mandatory age of separation.

79. In order to manage a phased reduction in polio expenditure there is a need for very detailed planning and this effort is contingent upon collection of robust data and collaboration across the three levels of the Organization. The network of Directors of Administration and Finance, and the Heads of WHO Country Offices will play a key role in this process.

---

<sup>1</sup> See document A70/14, Annex.

<sup>2</sup> See <http://polioeradication.org/financing/financial-needs/financial-resource-requirements-frr/gpei-requirements-2016-2019/>, accessed 11 May 2017.



## ORGANIZATIONAL RISKS AND MITIGATION

80. In addition to the programmatic, human resource and financial risks, appraisal of the situation has pinpointed some complex interrelationships that warrant bringing an overall organizational strategic perspective to bear on the matter. First and foremost, polio transition must be reviewed against its broader impact on the Secretariat's capacity to support Member States and on WHO's vision in the medium term. The list of topics to be reviewed from a holistic perspective includes the following.

81. **Subnational offices.** The polio eradication effort has needed significant financial resources, and technical and operational capacity at the subnational level for conducting large-scale and consistently high-quality immunization activities in order to reach and vaccinate all children, conduct active surveillance, and help to stop poliovirus transmission. For example, Global Polio Eradication Initiative resources have helped to establish 18 provincial teams in Angola, 11 sub-offices in the Democratic Republic of the Congo, 37 field offices in Nigeria and 11 field offices in Nepal, and to deploy a large number of district level staff in Somalia. In Angola, for example, there are 56 staff among the 18 provincial teams, and they are supported by a fleet of 26 vehicles and benefit from office space and computing and communication equipment. These teams supplement the lack of skilled personnel in the local health systems, and were critical in responding to the recent yellow fever outbreak in the country.

82. The strong presence of WHO's polio-funded staff and infrastructure at the provincial and district levels, including in some countries through the establishment of emergency operations centres has been hugely beneficial for many Member States that have not yet developed robust health systems at that level. These district and provincial offices and their technical and operational capacity, including data and information systems, have been widely utilized by the national and provincial governments to help to implement other immunization campaigns and Child Health Days, and also to detect and respond to epidemic and pandemic prone diseases like yellow fever, Ebola, Marburg, meningitis and cholera. The polio-funded capacity at the subnational level, in many critical countries, remains the sole capacity to respond to acute public health emergencies. The downscaling of this capacity, which has already been initiated in many countries, will leave Member States highly vulnerable and will have an impact on global health security.

83. **Field presence and technical support.** Many Member States rely heavily on the polio-funded staff and assets to support immunization and initiatives for controlling vaccine-preventable diseases. The current downscaling of the polio infrastructure, together with that planned for the future, will cause WHO to lose its field presence, coordinating role, and technical leadership in some countries in greatest need. The loss of polio resources will also have a negative impact on crucial capacity building, technical support activities, and monitoring that are needed to strengthen immunization systems at the national and subnational levels, and on community engagement initiatives.

84. The downscaling of polio resources will also have an impact on the optimal implementation of disease surveillance activities, and will thereby result in gaps in understanding of the epidemiological situations in many countries. In some countries, the only existing disease surveillance system relies significantly on polio-funded staff and resources to be operational. For example, in Nepal, the only active surveillance network in the whole country, WHO's Immunization Preventable Diseases surveillance network, which is largely financed from polio resources, has a staff of 61, situated in the central level and in 11 district offices, and who support all 75 districts in the country. On a weekly basis, this network actively monitors priority sites, and receives reports on various vaccine-preventable diseases from 800 surveillance sites and 1100 informers.

85. In the 16 priority countries for polio transition, the loss of polio-funded technical, managerial and administrative capacity is expected to have a significant impact on the capacity of the WHO country offices concerned to respond to urgent requests from Member States for critical support. In many public health emergencies, and during natural disasters, in districts and regions where there are no dedicated emergency risk management teams, country offices have been able to mobilize the polio technical teams and their physical assets rapidly in order to support the government. In addition, in districts with weak local capacity, polio teams have provided significant support in terms of administration, coordination, data collection and analysis, and communication.

86. Polio resources have also contributed significantly to WHO's ability to be present and serve communities in areas that are unstable, highly insecure, or in a state of active conflict. Given that the polio-funded workforce is the largest in number in most of the polio transition priority countries, funds from the polio programme shoulder a large burden of the cost of ensuring that personnel, property and assets of the WHO country offices at the national and subnational levels are compliant with the United Nations Minimum Operating Security Standards and thereby help to manage and mitigate security risks. The security measures supported by polio programme funds include specific measures for protecting office premises, specific equipment for all WHO vehicles, purchase of armoured vehicles, purchase of telecommunication equipment, satellite phones and emergency radios, purchase of personal protective equipment, recruitment of additional security personnel, and ensuring that staff working in high-risk areas undergo United Nations training in safe and secure approaches in the field environment. All these risk mitigation measures also contribute to the successful implementation of all other WHO programmes in these high-risk areas, including emergency response, and help to support the delivery of national health initiatives in high-risk and insecure areas.

87. **Support to national priorities.** Many Member States also rely on the polio-funded staff and infrastructure to support other urgent national, regional or global priorities, including measles and rubella elimination goals, and the goals of the global vaccine action plan. The same polio-funded infrastructure is also used to help to plan for, implement, and monitor the successful introduction of new vaccines. For example, the Government of India has noted the need to rely on the National Polio Surveillance Project to provide primary responsibility for surveillance of polio, measles, rubella and congenital rubella syndrome, and other vaccine-preventable diseases for at least the next 3–5 years due to current gaps in the Integrated Disease Surveillance Programme. The large number of new vaccines being introduced rapidly over the next 2–3 years in India will also require continued technical assistance and enhanced surveillance support from the National Polio Surveillance Project in order to protect this major investment in public health. In addition, the performance of the vaccine-preventable disease laboratory networks and associated data management systems will also not be of the highest standard following the planned reduction of polio resources. All these negative implications will lead directly to outbreaks of vaccine-preventable disease not being detected, investigated or responded to in time, with a consequent loss of lives.

88. **Service delivery systems.** The vast technical and operational infrastructure, including logistics and cold chain systems has also served as a delivery platform for other health interventions. This coupling of multiple interventions during the annual or six-monthly mass polio immunization campaigns in many countries has helped to reduce the cost of delivering these additional health interventions in resource-poor settings, and has made full use of the planning, coordination and monitoring expertise of WHO's polio-funded staff. These additional interventions have included the regular distribution of deworming tablets to preschool-age children, vitamin A supplementation, administration of measles vaccinations, and maternal and neonatal tetanus vaccinations, insecticide-treated bednets for malaria control, oral rehydration salts and protein biscuits.

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

90. **Partnership and process complexity.** WHO has housed a large number of small-to-medium sized partnerships. Over the past 5–8 years, many of these have been dissolved or have moved to independent status outside WHO. In many ways, the polio partnership is unusual among hosted partnerships – in terms of its longevity, its construction and its operations. Given that the Global Polio Eradication Initiative has been in existence for nearly 30 years, polio transition planning has now become an extremely complex undertaking that poses a reputational risk to WHO if poorly managed.

91. Transition planning involves several parallel processes, some of which are outside WHO’s direct control: a multiplicity of actors, stakeholders and programme areas need to be coordinated; various risks need to be managed – in the areas of human resources, financing, technical programmes and reputation; unique transition plans and solutions need to be developed in each of the 16 priority countries; and a coherent governance and oversight structure needs to be conceived and established.

92. At the country level, within the 16 polio priority transition countries (Afghanistan, Angola, Bangladesh, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Myanmar, Nepal, Nigeria, Pakistan, Somalia, South Sudan and Sudan), significant efforts are under way to ensure government ownership of the national polio transition process, systematic mapping of all polio assets, identification of key public health priorities that could benefit from the polio infrastructure, engagement of stakeholders, development of a costed national polio transition plan, and the development of a financing strategy for implementing the transition plan. WHO, at all three organizational levels, and partners in the Global Polio Eradication Initiative have been extensively involved in this process.

93. The Global Polio Eradication Initiative partnership polio transition process is managed through the Transition Management Group and its three separate work streams. The Global Polio Eradication Initiative, through its specific management groups, has also: provided Country Transition Guidelines; developed and shared figures on the budget decrease for 2017–2019 with the polio transition countries; helped to establish an independent board to monitor country planning process for transition; launched the development of a post-certification strategy for the period 2021–2030; and supported stakeholder engagement through many forums, including the Global Polio Partners’ Group.

94. Among the Global Polio Eradication Initiative partners, it is WHO that faces the greatest risks from polio transition – namely, those associated with downscaling of human resources, financing, and the impact on other programmatic areas and for Member States. If the transition processes initiated within WHO are to be successful, they need to be well coordinated and aligned with the structure and timing of the processes that are already under way. The processes concerned involve the following: those undertaken through the Global Polio Eradication Initiative; specific country-level polio transition planning efforts in the 16 priority countries; polio transition dialogues with donor governments and their aid agencies; engagement with non-State actors, academic and research institutions; and collaboration with relevant organizations such as the GAVI Alliance.

95. **WHO polio transition strategy.** It is evident that the risks associated with a downsizing of the polio infrastructure may materialize in the form of severe problems if downsizing is not well planned and executed. There is acknowledgement of these risks across WHO, and all senior executives and their networks will be actively involved in managing these risks as a corporate priority.

96. Within WHO, transition planning efforts are under way at all three levels of the Organization. A global post-polio transition steering committee has been established with the participation of the regional offices for Africa, the Eastern Mediterranean and South-East Asia, together with relevant departments at headquarters; a global human resources working group has been established to manage and guide the human resources planning process at all levels and to reduce terminal liabilities; and a small dedicated team has been established in the Office of the Director-General to coordinate the response to decision EB140(4).

97. At the regional level, polio transition committees have been established under the leadership of the Directors of Programme Management, and relevant Directors and regional focal points for polio transition have been appointed. Polio transition will also be addressed at the forthcoming regional committees in the three affected regions. At the country level, the Heads of WHO Country Offices are deeply engaged in the development of the National Polio Transition Plan in close collaboration with the Government and relevant stakeholders in the country.

98. Member States will be kept informed throughout this process, by various means, including briefings and the establishment of a dedicated “polio transition planning,” website. Detailed polio asset mapping at the country level, draft national plans, a country transition planning dashboard, and updated human resource data and processes will be uploaded and updated regularly in this website. Formal communication updates will also be provided to both internal and external partners and stakeholders.

99. Many activities have been under way in the period since the Executive Board held its 140th session, and this effort will be sustained. The Annex below provides a tentative list of actions planned for the period June–December 2017. This list is made on the basis of a timeline that would allow a comprehensive WHO strategic polio transition action plan and options to be developed and presented for consideration by the Executive Board at its 142nd session in January 2018.

100. Following the debate on this subject at the Seventieth World Health Assembly, and in light of any recommendations made, the immediate emphasis of the Secretariat will be to collect all inputs and to provide a comprehensive briefing to the Director-General-elect.

#### **ACTION BY THE HEALTH ASSEMBLY**

101. The Health Assembly is invited to take note of the report.

ANNEX

**PROPOSED LIST OF SECRETARIAT ACTIONS BETWEEN  
1 JUNE AND 31 DECEMBER 2017**

**Active high-level oversight at all three levels of the Organization**

- Detailed briefing on polio transition to the Director-General-elect immediately after the Seventieth World Health Assembly, highlighting the corporate risks that polio transition presents, as well as the need for regular communication to external stakeholders.
- Sustained oversight by the Office of the Director-General of the Organization-wide polio transition planning and management of risks.
- Meeting in Geneva of the 16 WHO Representatives concerned, and of regional and headquarters staff in order to discuss progress of the country transition plans, combined with a mission briefing, third or fourth quarter, 2017.
- Discussion of polio transition during the regional committees 2017 in the African, Eastern Mediterranean and South-East Asia regions.
- Development of a dedicated polio transition planning webpage on the WHO website where detailed data on the following: WHO polio transition risks and process; the country-level polio transition planning process; and Global Polio Eradication Initiative partnership polio transition process will be made available, and regularly updated.
- Active support for a designated team within the Office of the Director-General tasked with the development of the strategic action plan and options – by end 2017.

**Coordinated human resources planning and budget management**

- Quarterly planning dashboards on transition human resources and national transition to be developed and shared on polio transition planning webpage.
- Human resource plans for staff retention, re-training and career transition to be developed and shared and coordinated between headquarters and the three regions concerned.
- Communication plans and products to be developed and shared, for both internal and external audiences.
- Programme areas to explore the use of operational planning for the Programme budget 2018–2019 to revise budget needs, and develop financing strategies to cover increased budgets.
- Discussions initiated across the Organization to ensure advance planning for development of the Programme budget 2020–2021, ensuring that polio transition needs are taken into consideration.

**Development of a strategic action plan and options – by end 2017**

- Collect more precise details on a prioritized set of “programmatic risks” that would have the biggest public health impact; coordinate with all relevant departments and programme areas.
- Identify the critical gaps that would be left by the decrease in polio budgets, and eventual closure of Global Polio Eradication Initiative, and prioritize the gaps that need to be closed urgently.
- Develop a timeline and specific options for dealing with the gaps – covering the areas of human resources, financing, coordination, and policy.
- Develop an implementation and monitoring framework that can be tracked.

= = =