World Health Organization

SEVENTY-FIRST WORLD HEALTH ASSEMBLY **A71/9**
Provisional agenda item 11.3 **24 April 2018**

Polio transition and post-certification

Draft strategic action plan on polio transition

Report by the Director-General

1. The Seventieth World Health Assembly in May 2017 adopted decision WHA70(9) on poliomyelitis: polio transition planning, in which the Director-General was requested, inter alia, to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session. The request specified the clear identification of the capacities and assets, especially at country level, that are required to sustain progress in other programmatic areas and to maintain a polio-free world after eradication. The Health Assembly also requested a detailed costing of the capacities and polio-funded assets and a report on the efforts to mobilize the funding for transitioning capacities and assets that are currently financed by the Global Polio Eradication Initiative into the programme budget. The Executive Board, after considering a report on polio transition planning,[1] recalled this request in its decision EB142(2) (2018). This report responds to these requests.

2. The proposed draft strategic action plan has a five-year scope of work, is aligned with the draft thirteenth general programme of work, 2019−2023, and aims to strengthen country capacity around the core goals of that programme of work in order to achieve universal health coverage and enhance global health security.

3. The drafting of the action plan was informed by the findings of a review of the draft national polio transition plans of 12 of the 16 polio transition priority countries.[2] Comprehensive data were gathered from priority countries and all three levels of the Organization on the estimated costs for sustaining essential polio functions. Analysis was also conducted on the financing options for 2019, and the proposed programme budgets for 2020–2021 and 2022–2023; the five-year period was aligned with the time frame of the draft thirteenth general programme of work. A proposed set of activities with specific timelines and a process to monitor and evaluate progress have been developed to guide implementation. However, additional planning at the country level between key WHO programme areas will be required in 2018 and early 2019 to ensure that this strategic plan is implemented. Implementation will also be affected by uncertainties tied to the date of certification of the eradication of poliovirus, the governance structure of the polio Post-Certification Strategy, WHO's transformation

[1] See document EB142/11 and the summary records of the Executive Board at its 142nd session, fifth meeting.

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

agenda, and new initiatives related to immunization strengthening and vaccine-preventable disease surveillance being launched at regional and global levels. Additional detailed information on the draft plan is provided in the annexes, and a dedicated webpage has been established on which updated information on all aspects of the plan will be uploaded.[1]

OBJECTIVES OF THE DRAFT STRATEGIC ACTION PLAN FOR POLIO TRANSITION

4. The draft strategic action plan, which is aligned with the specifications set out in decision WHA70(9), has three key objectives:

(a) sustaining a polio-free world after eradication of polio virus;

(b) strengthening immunization systems, including surveillance for vaccine-preventable diseases, in order to achieve the goals of WHO's Global Vaccine Action Plan;

(c) strengthening emergency preparedness, detection and response capacity in countries in order to fully implement the International Health Regulations (2005).

5. These three objectives are tightly interlinked. After eradication, polio essential functions, such as surveillance, laboratory services and technical assistance for immunization, will need to be integrated into other programmatic areas, such as vaccine-preventable disease surveillance, so as to ensure efficiency and sustainability. Such integration will result in increased population immunity to vaccine-preventable diseases and reduce the number and frequency of outbreaks and public health emergencies, the vast majority of which are due to vaccine-preventable disease outbreaks. As polio will be a notifiable disease after eradication under the International Health Regulations (2005), the immunization and emergencies programmes at the three levels of the Organization will need to continue strengthening their collaboration in order to mount a timely and effectively response to a possible polio event or an outbreak.

(a) Sustaining a polio-free world after eradication of polio virus

6. Through the polio Post-Certification Strategy,[2] the Global Polio Eradication Initiative defines the technical standards and guidance for the essential functions required to sustain a polio-free world.

7. The Post-Certification Strategy's three goals focus on mitigating the current and future risks to sustaining a polio-free world:

- **containing polioviruses** in laboratories and vaccine manufacturers' and other facilities;
- **protecting populations** both in the immediate term from vaccine-derived polioviruses, by preparing and coordinating the global withdrawal of bivalent oral polio vaccine, and in the long term from any re-emergence of poliovirus, by providing access to safe and effective vaccines;

[1] http://who.int/polio-transition/en/ (accessed 3 April 2018).

[2] Polio post-certification strategy, available at http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transition-planning/polio-post-certification-strategy/ (accessed 3 April 2018).

- **detecting and responding to a polio event** by promptly identifying the presence of any poliovirus through a sensitive surveillance system and maintaining adequate capacity and resources to effectively contain or respond to a polio event.

8. The Strategy outlines the essential functions and capacities that will be needed in order to achieve these three goals and thereby complete the process of certification and sustain a polio-free world after eradication.

9. Many of the functions that are needed to sustain a polio-free world (for example, surveillance, laboratory networks and outbreak response) are best integrated into a broader system as this would facilitate staffing and financial planning. Other areas may greatly benefit from the expertise gained from existing synergies (for instance, vaccine stockpile management and immunization policy development). Within WHO, most of the essential functions are a natural fit to the area of work on immunization, for which good linkages and synergies exist between the two departments concerned (for instance, on the switch from trivalent to bivalent oral polio vaccine). However, some functions (such as outbreak response and preparedness, containment and possibly stockpile management) will need to be closely linked to similar functions in the WHO Health Emergencies Programme.

10. At the country level, governments will be responsible for integrating the essential functions into their short- and long-term national health sector plans, as recognized by the Executive Board in its decision EB142(2), and for allocating the financial resources needed to sustain these functions. However, if the polio transition process is not effectively managed and executed, sustaining the essential functions and ultimately maintaining a polio-free world will be at great risk. In many fragile States, WHO will continue to play a key role in providing support for implementing the Post-Certification Strategy. At the country level, immunization and health emergencies programmes will need to strengthen their capacities to consider fully the impact of polio transition and to absorb the essential functions, in line with the technical requirements of the Post-Certification Strategy.

(b) Strengthening immunization systems, including surveillance for vaccine-preventable disease, in order to achieve the goals of WHO's Global Vaccine Action Plan

11. At the country level, immunization programmes have relied heavily on polio-funded infrastructures over the past two decades to support the performance of key functions, such as immunization information systems, vaccine-preventable disease surveillance and laboratory networks, introduction of new vaccines, monitoring, cold chain and logistics. As a consequence, the gradual decrease and eventual phasing out of financial resources for polio presents a huge risk to immunization programmes.

12. Some 60% of the world's 19.5 million children who are either unvaccinated or incompletely vaccinated live in the 16 countries prioritized for polio transition, and almost 90% of estimated global deaths from measles occur in the same countries. Given those facts, achieving the goals of the Global Vaccine Action Plan and ultimately universal access to immunization and the health-related Sustainable Development Goals will be a huge challenge, unless the gaps opening up as polio funding declines are filled. The risks are particularly high on the African continent, with almost 90% of WHO immunization staff in Member States in the African Region being funded by polio financing, and with chronically underperforming or fragile States that depend heavily on the polio infrastructure for routine immunization services.

13. The potential risks to vaccine-preventable disease surveillance are particularly noteworthy. The Global Polio Eradication Initiative funds much of the global work on vaccine-preventable disease surveillance and has laid the groundwork for global and regional laboratory networks, links between laboratory and epidemiological surveillance, and indicator-based performance quality measures. In the polio priority countries, polio funding covers not only personnel costs but also transportation (including that of samples) and data collection/information systems for other vaccine-preventable disease surveillance. With polio funding resources rapidly decreasing and eventually being phased out, there is a high risk of losing the primary funding stream for vaccine-preventable disease surveillance, which will undermine work to sustain performance quality. The immunization community wants to avoid this risk by establishing a comprehensive approach, with efforts at the global and regional levels to elaborate a strategic vision for comprehensive vaccine-preventable disease surveillance, aligned with country and regional priorities, with direct linkages to immunization programmes.

14. The draft national transition plans of priority countries demonstrate that governments perceive polio transition as an opportunity to invest in strengthening immunization systems. In all the draft country plans, strengthening routine immunization and vaccine-preventable disease surveillance feature as the key national health priority for polio transition. In many polio-free countries, polio assets have already been well integrated into broader immunization-related activities.

15. The objective of strengthening immunization is fully aligned with the strategic direction of the draft thirteenth general programme of work on promoting health, keeping the world safe and serving the vulnerable. Achieving universal health coverage and the health-related Sustainable Development Goals is grounded in investing in prevention through building strong and resilient immunization systems, ensuring equity and filling coverage gaps so as to leave no one behind, and providing universal access to safe, quality, effective and affordable vaccines. As the discussion around the post-2020 immunization agenda starts to take shape, it is crucial to bring polio transition into these discussions and for WHO to take a leadership role.

16. Strengthening immunization is also closely linked to the objective of keeping the world polio-free. The risk of emergence of vaccine-derived polioviruses before the use of oral polio vaccine ceases and of possible outbreaks of polio from any poliovirus re-emergence after eradication will increase unless there is consistent improvement in routine immunization coverage rates.

(c) Strengthening emergency preparedness, detection and response capacity in countries in order to fully implement the International Health Regulations (2005)

17. At the country level, polio-funded staff members have often played a key role in the detection of large outbreaks through their surveillance role, and have also been the first to respond to public health emergencies: either disease outbreaks or disaster management in polio priority countries. The polio infrastructure, especially at the subnational level, can be essential to not only detection and response, but also prevention. In the Joint External Evaluations, part of the Monitoring and Evaluation Framework of the International Health Regulations (2005), polio surveillance and laboratory networks have been identified as an essential resource that a country can build upon to increase their core capacity to implement the Regulations.

18. Of the 16 priority countries for polio transition planning, there are 10 countries that are also priorities for the WHO Health Emergencies Programme for increased country capacitation (see Annex 4).

19. The WHO Health Emergencies Programme's proposed "country business model", a model of the core requirements needed in a country office to run its health emergency operations, will be centred on detailed country-by-country analysis of the current WHO country office's capacity and on calculations of the additional capacity needed for the WHO country office to carry out its core functions in public health emergencies. Existing polio-funded capacities will also be mapped out in these country office models.

20. Country reviews have identified the need for adjustments to the WHO Health Emergencies Programme's country business model, including the further strengthening of core laboratory, health systems, staff safety and security capacities, as well as the inclusion of field coordinator positions in key subnational hubs. In addition, they identified a programmatic need to continue the functions related to the Expanded Programme on Immunization, disease surveillance and operational support currently maintained through WHO's programmes on immunization, vaccines and biologicals and on polio.

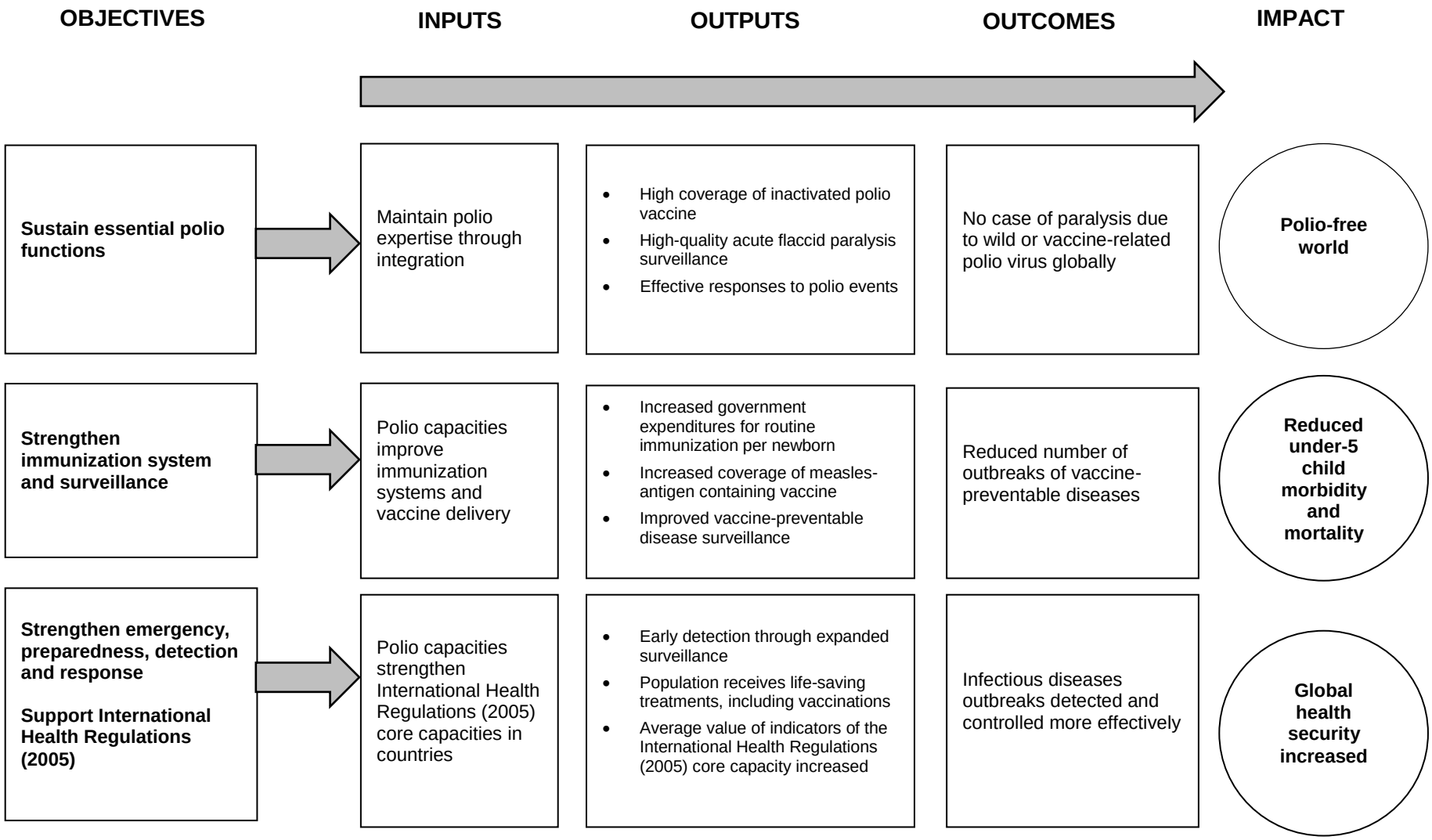
21. These capacities will enable WHO to be fit for purpose, particularly in fragile settings. Following the consolidation of core technical and operational positions in the priority countries, which will incorporate some polio functions and capacities, a business case will need to be developed to ensure sustained financing.

22. Opportunities for synergies between polio transition planning and the WHO Health Emergencies Programme's capacity-building plans will be actively pursued through joint planning visits to priority countries, and the development of a systematic approach to reassigning polio capacities and functions to core Programme positions in these priority countries. The long-term sustainability of this model depends on new multiyear contributions to the programme budgets for the bienniums 2020–2021 and 2022–2023 for WHO's work on emergencies.

23. This objective of the draft strategic action plan is closely interlinked with the previous two objectives of the plan. At the country level, when routine immunization fails, the emergencies programme steps in to respond to disease outbreaks. Vaccine-preventable disease outbreaks constitute a vast majority of health emergency events that the WHO Health Emergencies Programme responds to. In addition, any re-emergence of polio after eradication will trigger a response under the International Health Regulations (2005).

24. The figure illustrates the overall results chain of the polio transition plan.

Figure. Results chain of the polio transition plan



COUNTRY LEVEL ANALYSIS TO SUPPORT THE OBJECTIVES OF THE STRATEGIC PLAN

25. In close collaboration with the regional offices for Africa, South-East Asia and the Eastern Mediterranean, data were gathered from each polio priority country and nonpriority countries on the essential polio functions that need to be sustained for the period 2019–2023 according to the requirements of the polio Post-Certification Strategy – especially, polio surveillance and laboratories, and some core capacity to respond to possible outbreaks. These functions are crucial for meeting all the three objectives of the draft strategic action plan.

26. Analysis of the data was based on a standard costing template, which included specific categories from the Global Polio Eradication Initiative's Financial Resources Requirements that correspond to essential functions required to keep the world polio free. These categories included: surveillance and running costs (including technical assistance at 50%, given that large-scale polio vaccination campaigns will not be supported by the Global Polio Eradication Initiative after 2019); laboratory costs; and core functions and infrastructure needed for outbreak response. The countries used this template to estimate their costs for the time frame aligned with the draft thirteenth general programme of work.

27. Table 1 provides the overall summary of the estimated costs of sustaining essential polio functions through mainstreaming into national health systems or transitioning to other WHO programme areas. A detailed country-level breakdown in the African, South-East Asia and Eastern Mediterranean regions is given in Annex 1.

Table 1. Estimated costs for sustaining essential polio functions through mainstreaming or transitioning to other WHO programmes in 2019–2023 (US$)

		Draft thirteenth general programme of work		
	2018[a]	**2019[a]**	**Proposed programme budget 2020–2021[e]**	**Proposed programme budget 2022–2023[e]**
African Region				
Angola	8 125 623	7 979 824	14 149 666	13 844 145
Cameroon	1 340 467	2 116 532	3 395 047	1 335 890
Chad	4 372 000	4 125 000	5 450 000	4 800 000
Democratic Republic of the Congo	7 278 160	7 267 150	13 190 010	13 190 010
Ethiopia	4 929 700	4 869 700	5 812 000	5 812 000
Nigeria[b]	61 085 573	-	-	79 368 643
South Sudan	4 007 120	3 662 040	4 550 004	2 530 000
Non-priority countries (40)	19 727 222	18 062 040	30 068 440	25 318 960
Total	**110 865 865**	**48 082 286**	**76 615 167**	**146 199 648**

		Draft thirteenth general programme of work		
	2018[a]	**2019[a]**	**Proposed programme budget 2020–2021[e]**	**Proposed programme budget 2022–2023[e]**
South-East Asia Region				
Bangladesh	2 223 000	2 260 000	4 520 000	3 869 375
India	26 819 000	25 771 000	55 618 681	60 402 410
Indonesia	1 154 000	1 090 000	1 388 000	1 263 000
Myanmar	1 051 000	1 064 000	1 912 100	1 116 450
Nepal	1 307 000	1 327 000	2 654 000	2 654 000
Total	**32 554 000**	**31 512 000**	**66 092 781**	**69 305 235**
European Region				
Non-priority countries (12)	**267 000**	**267 000**	**267 000**	**267 000**
Eastern Mediterranean Region				
Afghanistan[b]	20 433 483			29 413 711
Pakistan[b]	51 466 882			61 393 768
Somalia	7 536 157	7 536 157	12 814 474	10 443 741
Sudan	2 208 028	2 208 028	3 842 116	3 497 751
Other countries (3)	5 247 448	5 148 613	9 062 006	8 037 853
Total	**86 891 998**	**14 892 798**	**25 718 595**	**112 786 824**
Country total	**230 578 863**	**94 754 084**	**168 693 543**	**328 558 707**
Regions and headquarters				
African and Intercountry Support Teams	13 377 778	13 377 778	13 725 556	13 725 556
South-east Asia	2 417 409	2 322 855	3 816 710	3 816 710
Eastern Mediterranean[c]	8 315 933			10 514 604
Western Pacific	2 083 000	2 083 000	2 083 000	2 083 000
Americas	938 000	938 000	938 000	938 000
European	2 202 000	2 202 000	2 202 000	2 202 000
Headquarters[d]	89 375 000	68 203 000	35 898 000	75 710 000
Total	118 709 120	89 126 633	58 663 266	108 989 870
Grand total	**349 287 983**	**183 880 717**	**227 356 809**	**437 548 577**

[a] Global Polio Eradication Initiative funding is available for 2018–2019.

[b] Endemic countries (Afghanistan, Pakistan and Nigeria) are not included in this analysis for 2019 and the biennium 2020–2021 as they will be funded by the Global Polio Eradication Initiative during this period, and their transition efforts will be implemented after certification (assumed date: 2021).

[c] Given ongoing endemic transmission in the Eastern Mediterranean Region, the Global Polio Eradication Initiative will cover the costs of regional essential functions until 2021.

[d] Headquarters costs for the Proposed programme budget 2022–2023 include US$ 33 million projected for the STOP programme of the United States Centers for Disease Control and Prevention.

[e] Domestic funds have been pledged to cover some of the estimated costs for the bienniums 2020–2021 and 2022–2023, as noted in Table 2.

FINANCING OPTIONS

28. Table 2 summarizes the estimated total financing need, financing to be covered through the Global Polio Eradication Initiative in 2018–2019, financing pledged or committed by national governments through domestic resources for 2020–2023 in their draft national transition plans, a proposed contingency fund allocation to mitigate risks associated with the release of domestic resources, and the financing gap that would have to be met by WHO for the period 2019–2023. The financing needs highlight the need for the costs of the polio essential functions in non-endemic countries, regional offices and headquarters for proposed programme budgets for the bienniums 2020–2021 and 2022–2023 to be budgeted and largely financed through other WHO programme areas; certain essential functions may be financed through the Global Polio Eradication Initiative until certification of polio eradication. To enable this shift of financing to the core WHO programme budget, the approximate costs for 2019, 2020–2021 and 2022–2023 have been included in the investment case for the draft thirteenth general programme of work.

Table 2. Options for financing essential polio functions to be transitioned: 2019-2023 (US$)

	2018[a]	**2019**[a]	**Proposed programme budget 2020–2021**	**Proposed programme budget 2022–2023**
Total estimated costs of sustaining essential functions	**349 287 983**	**183 880 717**	**227 356 809**	**437 548 577**
Financing commitments already made				
Polio/Global Polio Eradication Initiative[a] contribution	**(348 301 983)**	**(173 804 958)**	**–**	**(33 306 000)**[c]
Domestic funding/ governments[b]	**(986 000)**	**(8 926 759)**	**(51 650 758)**	**(134 409 816)**
Mitigating risks associated with the release of domestic funding				
Proposed contingency fund (10% of the domestic funds committed)		**1 000 000**	**5 000 000**	**14 000 000**
Total estimated financing gap				
WHO financing gap	**–**	**2 149 000**	**180 706 051**	**283 832 761**

[a] Global Polio Eradication Initiative funding available for 2018–2019. The figure for 2019 only includes the cost of transitioning essential functions in non-endemic countries and regions. Transitioning of functions is expected to begin in endemic countries after certification of eradication (assumed date: 2021). Figures in parentheses represent commitments and pledges.

[b] Actual and pledged: provisional figures have been extracted from countries' polio transition draft national plans. Figures in parentheses represent commitments and pledges.

[c] Projected Global Polio Eradication Initiative funding for the STOP Programme of the United States Centers for Disease Control and Prevention.

29. Polio transition countries with costed draft national transition plans have included some level of domestic funding to cover the costs of their polio transition plans. It is encouraging that their planned contributions increase over the five years of the strategic action plan and beyond. However there are many issues to bear in mind, including: (1) the exact funding allocations for the essential functions are hard to estimate, because many countries intend to contribute towards their broader transition plan priorities rather than just towards the costs of the essential polio functions; (2) many countries intend to start providing domestic funding towards the end of the five-year period (2019–2023) and expect WHO to continue supporting these functions until they are fully ready to take over; (3) many of the more fragile transition priority countries might not be able to allocate the funding they have committed to provide without external budget support; and (4) some countries would like WHO to continue to manage their polio infrastructures for a certain period of time as they are re-purposed to cover broader functions, and so will be financing these functions with contributions to the WHO budget.

30. To manage quickly any risks to the performance of the essential functions in countries with weak health systems when domestic funds are not released because of unforeseen circumstances, the Director-General is proposing to establish a nominal contingency fund (comprised of 10% of committed or pledged domestic funds for 2018, 2019 and the bienniums 2020–2021 and 2022–2023 – see Table 2). In principle, the Director-General could be authorized to approve any release of funds from this contingency fund based on clear identification of the urgent need.

31. Most of the polio transition countries will require additional bilateral and multilateral financing in the medium term, and some very fragile States will require long-term financing to be able to sustain polio essential functions. WHO has been called upon to provide country-level advocacy and resource mobilization support to national governments in securing additional financing to complement their domestic funding. In many transition countries, negotiations are ongoing to secure time-limited "bridge" funding from the GAVI Alliance through its health system strengthening grants to help to sustain some of the essential polio functions that also contribute to strengthening immunization systems and to help to achieve coverage and equity goals.

32. In line with the objectives of the draft strategic action plan, the polio transition countries want the essential polio functions to be primarily sustained through strengthening immunization and vaccine-preventable disease surveillance. Sustaining these functions can be done through resourcing under WHO's vaccine-preventable diseases budget category in the medium term. Additional support for certain functions could come from other WHO budget categories including the WHO Health Emergencies Programme, corporate services and enabling functions, neglected tropical diseases, and health systems. The preference expressed by polio transition countries for financing the essential polio functions through the WHO's vaccine-preventable diseases budget category supports the "merger" option of sustaining polio essential functions through integration of polio and immunization departments at all three levels of the Organization and to work in close collaboration with the WHO Health Emergencies Programme for dealing with large outbreaks of vaccine-preventable diseases and strengthening country capacity for full implementation of the International Health Regulations (2005).

33. As decided by the Polio Oversight Board at its meeting in October 2017,[1] the Global Polio Eradication Initiative has committed itself to mobilize funding for the activities to be implemented until cessation of the use of bivalent oral polio vaccine, which is planned for one year after certification. Even though there are uncertainties about the exact amount of this funding and the scope of activities that it will cover, it is an important component that needs to be factored in future costing estimates.

PROGRAMME BUDGET IMPLICATIONS

34. Although the Global Polio Eradication Initiative has informed most non-endemic countries about the scaling down of its funding support from 2016 to 2019 and expects to cease all funding after 2019 to these countries, it is encouraging all non-endemic countries to start transitioning their essential functions in 2019 to other WHO programme areas while funding is still available from the Initiative to cover the costs. Transitioning in 2019 will help those programme areas to make the case for continuing inclusion of these costs in WHO's proposed programme budgets for the biennium 2020–2021 and beyond. If countries propose the integration of the essential polio functions into other programme budget categories in 2019, then there may be a need to increase the budget ceiling for the latter in WHO's core budget, to shift resources from polio which is outside the core WHO budget.

35. For the development of the Proposed programme budget 2020–2021, joint planning at the country level between the polio and immunization departments and the WHO Health Emergencies Programme will be essential in order to review and delineate functions and their associated costs across the various budget categories. The additional financing needs for specific budget categories for the proposed programme budgets for 2020–2021 and 2022–2023 will be linked to the goals of the draft thirteenth general programme of work as polio transition benefits both the achievement of universal health coverage, including equitable access to vaccines and immunization, and the health security agenda, owing to strengthened country capacity to prevent, detect and respond to vaccine-preventable and other disease outbreaks. In addition, some of the operational or general services staffing costs associated with essential polio functions could be transitioned to the corporate services and enabling functions budget category to reflect the true costs of WHO country office operations.

UPDATE ON HUMAN RESOURCES PLANNING

36. The human resources teams in WHO headquarters and regional offices are working closely to manage positions throughout the polio programme and at all locations, in line with the reduced budgets from the Global Polio Eradication Initiative for the period 2017–2019. The Secretariat is continuing to track changes in polio programme staffing through a dedicated database of polio human resources developed for this purpose in 2017.

[1] See minutes of the meeting of the Polio Oversight Board, 2 October 2017 (available at http://polioeradication.org/wp-content/uploads/2016/07/pob-meeting-minutes-02102017.pdf, accessed 4 April 2018).

37. Priority is being given to maintaining the workforce required to provide support to Member States in ensuring the interruption of transmission, responding to outbreaks and conducting surveillance. In non-endemic and lower-risk countries, positions are being retained in order to ensure adequate capacity for ongoing surveillance, including in laboratories, while less essential functions are phased out. All vacancies are scrutinized and less critical positions are discontinued.

38. As shown in Table 3, the number of filled positions has declined by 12% since the downscaling of the Global Polio Eradication Initiative budgets began in 2016. Based on the declining budgets and the guidance provided, the number of staff positions has been decreased in lower-risk and non-endemic countries in all regions and at headquarters. Detailed information for WHO staff members in country offices aggregated per contract type is provided in Annex 2. It highlights the continued indemnity risks faced by the Organization owing to the large numbers of staff with continuing appointments and fixed-term positions. Annex 3 presents a breakdown by major office and region, aggregated by grade and contract type. It highlights the number of trained health workforce (international, national, and general services/operations) that would be lost in some of the countries with weak health systems with the closure of the polio programme and if effective polio transition efforts are not instituted to ensure essential functions are sustained beyond 2019. These experienced staff could be considered as assets to the local health systems, or to other WHO programme areas in the countries.

Table 3. Summary of polio positions by major office (2016–2018)

Major office	2016	March 2018	Change since 2016
Headquarters	77	70	-9%
Regional Office for Africa	826	713	-14%
Regional Office for South-East Asia[a]	39	39[a]	0%
Regional Offices for Europe	9	4	-55%
Regional Office for the Eastern Mediterranean	155	153	-1%
Regional Office for the Western Pacific	6	5	-17%
Total	**1112**	**984**	**-12%**

[a] The Regional Office for South-East Asia is in an advanced stage of transition with many functions and their costs shared with other programme areas. Therefore to calculate the polio positions a cut-off of >70% full-time equivalent was used.

39. Preliminary analysis of the shifts of staff members from the polio budget category to other budget categories in the African, South-East Asia, European and Eastern Mediterranean regions reveals that 47% were absorbed under Category 1 (Communicable diseases – primarily vaccine-preventable diseases); 29% moved to Category 6 (Corporate services/enabling functions); 8% to Category 3 (Promoting health through the life course); 7% to the WHO Health Emergencies Programme; 6% to Category 2 (Noncommunicable diseases); and 2% to Category 4 (Health systems).

40. On the basis of the reduced funding from the Global Polio Eradication Initiative, the Regional Office for Africa has instituted a systematic process of staff reductions in four waves. In wave 1, in 2017, 65 staff positions were abolished, with 8 staff members being moved to non-polio funding. In wave 2, for 2018, a total of 36 polio-funded staff positions will be abolished (excluding Nigeria and other at-risk countries around Lake Chad). In wave 3, for 2019, 11 polio-funded staff members will need to be served notification letters by March 2018. In wave 4, by March 2019, notification letters will need to be provided to the remaining 702 polio-funded staff in the African Region if additional non-polio funding to sustain their functions beyond 2019 is not identified. These revised staff position figures will be reflected in later reports, when the positions are vacated after leave and entitlements are exhausted.

41. The Regional Office for Africa has also established a system to better capture non-staff technical support. As at January 2018, the number of non-staff providing polio technical support was: 400 under special services agreements, 2556 under agreements for performance of work, 6 national consultants, 44 international consultants, and 78 personnel working through the STOP programme of the Centers for Disease Control and Prevention. Most of these non-staff, 81% of the total including nearly 2253 holders of agreements for performance of work, are working in Nigeria. These numbers fluctuate, based on polio campaigns, country priorities and contract end dates, and are captured on a monthly basis.

42. The Regional Office for Africa has initiated programmes to support affected staff members to prepare for work outside the polio programme and has conducted workshops in countries that faced the most reductions in positions: Angola, Democratic Republic of the Congo, and Ethiopia.

43. An indemnity fund has been established in WHO to cover the terminal indemnities and liabilities associated with the separation of staff members when polio eradication is certified and the Global Polio Eradication Initiative disbands. The cost of paying terminal liabilities to staff members who do not find employment with another WHO programme when the programme ends has been estimated at US$ 55 million. At the beginning of 2018, the sum of US$ 50 million will have been set aside in the indemnity fund. Moreover, in order to remove any disincentive for other programmes to recruit polio staff members, the Secretariat has agreed that, for polio staff members who are employed by other WHO programme areas, the indemnity fund will continue to cover any terminal liability at a pro-rated level between the polio fund and the new programme. This possibility will remain open for up to five years after the date of their transfer to another programme.

44. In order to keep staff members motivated and to ensure that the quality of surveillance and of supplementary and routine immunization activities is not compromised, the Secretariat, in managing the implementation of the strategic action plan, will support the development of a communication strategy involving headquarters, regional offices and concerned country office communication teams to ensure that senior officials are well equipped to communicate the meaning and implications of polio transition in an effective and transparent manner, and clear messages are sent to staff members to keep them informed about the polio transition process, while also noting the realities of financing. It is also expected that the messages will be harmonized with UNICEF at the three levels of the Organization.

PROPOSED MONITORING AND EVALUATION FRAMEWORK FOR POLIO TRANSITION

Monitoring and evaluation framework

45. The monitoring and evaluation framework, an essential and important component of the draft strategic action plan on polio transition, aims at ensuring proper monitoring of planned activities across the three levels of the Organization, over the course of the next five years, and supporting independent evaluation of the process and outcomes. The Health Assembly in decision WHA70(9) specifically called for regular reporting on the planning and implementation of the transition process to it through the Regional Committees and the Executive Board. Similarly, the Board in decision EB142(2) also called for reports to be submitted to all sessions of WHO's governing bodies during the period 2018–2020.

46. The monitoring and evaluation framework will have a well-defined process, based on agreed indicators, at all three levels of the Organization. The review process will use, at all levels, WHO's existing processes and mechanisms and existing information sources in order to lessen the burden of the monitoring and evaluation effort.

47. At the country level, it is proposed that the national government, national immunization technical advisory groups, the Inter-Agency Coordination Committees and the WHO Country Office could be engaged to monitor the implementation and performance of national polio transition plans through country-level indicators proposed in the monitoring and evaluation framework. At the regional level, the WHO regional offices could engage the Regional Immunization Technical Advisory Group to review progress across the transition countries in the Region and report to their respective Regional Committees. At the global level, the Strategic Advisory Group of Experts on immunization could be engaged to review the reports from the regional offices and provide recommendations that could be integrated into the annual report to be submitted to the governing bodies. Finally, the WHO Evaluation Office will conduct a mid-term evaluation of the implementation of the strategic action plan at the end of 2021, and a final evaluation at the end of 2023, and submit its reports and recommendations to the governing bodies.

Monitoring and evaluation indicators

48. To monitor progress towards achieving the three key objectives of the draft strategic action plan, the monitoring and evaluation framework aims to finalize and use a set of output and outcome indicators, to be measured with appropriate methodology and with reliable data sources. In addition, each indicator identified will be defined, and a baseline established for measurement. The proposed indicators are shown in Table 4.

49. The monitoring of the implementation of the strategic action plan will also require the tracking of specific commitments made by stakeholders, including national governments, multilateral agencies, private foundations, development partners, civil society organizations and vaccine manufacturers. Appropriate coordination mechanisms, building upon the existing polio transition steering committees, will need to be developed for coordinating the implementation of the strategic action plan at global, regional and national levels.

Table 4. Output indicators of the proposed monitoring and evaluation framework for the strategic action plan on polio transition

Objectives	Output indicators	Definition
Sustain essential polio functions	1. Inactivated polio vaccine coverage	>90% coverage with >3 doses of inactivated polio vaccine achieved in all countries with polio essential facilities that contain wild poliovirus
	2. High-quality acute flaccid paralysis surveillance	At least one case of non-polio acute flaccid paralysis should be detected annually/100 000 population aged less than 15 years In endemic regions, to ensure even higher sensitivity, this rate should be 2/100 000
	3. Polio event response	Any new polio virus outbreak stopped within 120 days
Strengthen immunization systems	1. Increased coverage with measles antigen-containing vaccine and rubella-containing vaccine	Number and proportion of countries providing two doses of measles antigen-containing vaccine through routine services with coverage levels of second dose of measles antigen-containing vaccine and rubella-containing vaccine >90% nationally and >80% in all districts
	2. Countries with regular reporting of vaccine-preventable disease surveillance data from districts	Percentage of countries with at least 80% of districts reporting vaccine-preventable disease surveillance data, even in the absence of suspected cases, in the past 12 months
	3. Government expenditure on routine immunization per newborn	Routine immunization expenditures funded by government sources as reported in the Joint Reporting Form divided by the number of live births as estimated by United Nations Population Division data
	4. Expansion of surveillance and laboratory system at country level	Number of countries where polio transition contributes to expanding and strengthening vaccine-preventable disease surveillance and laboratories
Strengthening emergency preparedness, detection and response capacity – support implementation of the International Health Regulations (2005)	1. Health events detected and risk assessed early in health emergencies	Percentage of detected events of public health importance for which health-related risks are assessed and communicated
	2. Populations affected by health emergencies have access to essential life-saving preventive and curative services and interventions	Percentage of emergencies affected populations that have received one or more essential life-saving preventive and curative services and interventions, including vaccinations
	3. Average value of the core capacity indicators of the International Health Regulations (2005)	The average proportion of core capacity indicators of the International Health Regulations (2005) in place in each polio transition country

RISKS AND UNCERTAINTIES

50. Given the dynamic nature of polio eradication efforts, the various transformation processes being introduced within WHO at all levels, the planned launching of the draft thirteenth general programme of work with a revised budgeting and planning process, and the development of new initiatives involving programme areas that will be affected by polio transition, the Organization will face several risks and uncertainties that may impinge on the finalization and implementation of the strategic action plan. Although these risks are being carefully monitored, mitigation measures are not available at the moment to address each of these risks effectively.

51. The uncertainties around the date of global certification of polio eradication will necessitate sustaining essential polio functions for a longer period than currently envisaged. Staff members working on these functions might have to continue to focus on ensuring that key polio indicators relating to surveillance, laboratories and outbreak response remain of the highest quality, even while their positions might have been integrated into other programme areas and they have additional responsibilities. Clear terms of reference for the staff members who have been transitioned to other programme areas in the "pre-certification" and "post-certification" periods will have to be defined that ensure the maintenance of the specific technical indicators. In addition, any shift in the date of global certification will also have a financial impact on the Organization as the essential functions associated with polio eradication might have to be sustained for longer and thus covered in the core budget. Any extension of the date of certification could also affect the Global Polio Eradication Initiative's ability to mobilize additional resources to support the endemic countries, and thereby curtail the allocations to support pre- and post-certification activities in non-endemic countries.

52. While financing through the Global Polio Eradication Initiative is being scaled down for non-endemic countries as planned between 2016 and 2019, it is assumed that some financing will be made available beyond this period to sustain critical functions like the Global Polio Laboratory Network until certification of eradication. Nevertheless, the risk remains that the quality of surveillance of acute flaccid paralysis might be affected if governments are not able to fully mainstream field surveillance functions and the Secretariat is unable to secure necessary resources to support essential polio functions that have been transitioned to other core budget categories.

53. Another serious risk is the potential loss of a large number of trained staff members in 2019, if critical decisions are delayed with regards to the transitioning of essential functions to other programme areas and budget categories. Given existing Staff Regulations and Staff Rules, sufficient time will need to be factored in for an orderly process of abolition of posts and any termination of appointments.

54. In many of the priority countries that have developed national polio transition plans, there remains the risk that funding commitments made by the government might not be allocated fully or on time, owing to socioeconomic challenges, instability, competing health and development priorities, or ongoing governance reforms impacting the health sector such as devolution. To mitigate this risk, the Secretariat proposes to establish a contingency fund with about 10% of the total domestic funding commitments for the period 2019 to 2023. This fund could be a flexible mechanism for WHO to step in to cover the most urgent needs and avoid a decline in the key technical indicators needed to ensure a polio-free world.

55. The polio Post-Certification Strategy clearly defines the technical norms and standards required to keep the world polio-free, but there is an urgent need to define the key elements of the future governance structure and financing modalities necessary to implement the Strategy after the closure of

the Global Polio Eradication Initiative. As many of the essential functions could have been transitioned to either the governments or other programme areas within WHO and/or other implementing partners, clear guidance will be required with regards to governance, oversight and accountability, and mobilization of additional financing that may be required for sustaining activities that ensure a polio-free world.

56. Several internal processes that have been recently launched, such as WHO's transformation agenda and the functional reviews of the WHO country offices, have the potential to reshape the way WHO is structured across its three levels. Others, such as the revised planning and budgeting process, may revamp the way WHO's programme budget is structured, including the current budget categories. The proposed approaches in the draft strategic action plan might have to be reviewed or revised based on the outcomes of these transformative processes, thereby possibly modifying both the timeline of implementation and the financing and monitoring aspects of the plan.

57. WHO country offices have indicated a clear preference for the essential polio functions to be largely transitioned to the immunization budget category, with additional elements to be considered under the corporate services, and health emergencies budget categories, but there is a risk that these programme areas are not currently structured to make decisions supporting this transition. Their current vision, strategies and associated planning guidelines have not taken into account the need for additional capacity at the country level (especially at the subnational level) and additional financing needs. In addition, though they may wish to transition certain essential functions, they may not want to retain staff members who are primarily trained in polio eradication. Training may be considered to re-purpose current polio staff members for broader responsibilities and functions.

THE WAY FORWARD

58. A road map with activities and milestones (Table 5) is being proposed in order to help to move the polio transition process forward, support implementation of the strategic action plan, track progress, and report to WHO's governing bodies. The four key areas for action are elaborated below.

59. First, it is evident that critical strategic decisions will have to be made with regards to the "merger" of most polio functions and capacities into the immunization programme area and support from the WHO Health Emergencies Programme to incorporate key capacities dealing with outbreak response and containment. Some of the general administrative services currently supporting the polio programme will also have to be considered for strengthening the corporate services and enabling functions at all three levels of the Organization. Another strategic decision that will be needed is to secure an agreement among all stakeholders on the ownership of essential polio functions in the post-certification era, the oversight and governance of the polio Post-Certification Strategy, and the financial implications.

60. Secondly, once these urgently-needed strategic decisions have been made, joint planning by the key programme areas in the priority transition countries will be needed to help to elaborate the Proposed programme budget 2020–2021.

61. Thirdly, it is vital that the joint planning at the country level, supported by regional offices and headquarters, leads to the essential polio functions transitioned into core WHO budget categories for the development of the Proposed programme budget 2020–2021. Polio transition priority countries are also strongly encouraged to consider the transition of the essential functions in 2019 while funding from the Global Polio Eradication Initiative remains available to finance these functions.

62. Fourthly, supportive services are needed at the country and regional levels to facilitate transition planning, for instance in the areas of planning, resource mobilization, advocacy, communications, and human resources management.

63. To address concerns of staff members affected by the uncertainties around the transition, a communications and human resources strategy will need to be in place in 2018. Its goals will include ensuring that: (1) all polio personnel have a timely and clear understanding of the process of transition planning; (2) all personnel understand the impact of transition planning on their career path and are aware of a process to seek clarification and feedback; (3) non-polio personnel are aware of the process and the impact on WHO programmes and finances. The communication element of the strategy will be driven by several core principles, namely: transparency of information and the planning process; credibility of the messenger and feedback mechanisms; relevance of communication tactics and products to the audience; fairness of information sharing and opportunities; and accuracy of human resources' and financial information in order to dispel any false reassurances.

64. In the context of planning for the closure of the polio programme and the need to sustain certain essential functions through other programme areas or mainstream them into the national health systems, the human resources strategy for the transition will have to support leadership at all three levels of the Organization to plan for the scaling down of personnel, track progress, and provide a package of support services to staff including counselling, re-training opportunities, career development skills building, and career transition through mobility. It would also be valuable to provide recognition to all polio personnel (staff and non-staff members) who have contributed to the success of this historic achievement through many years of dedicated service in the most challenging countries and environments.

65. Polio transition efforts, coupled with decline of resources from the Global Polio Eradication Initiative and the GAVI Alliance, could also be seen as a critical opportunity to support the development, financing and implementation of new initiatives to strengthen immunization systems, vaccine-preventable disease surveillance, and strengthen the capacity for implementation of the International Health Regulations (2005).

66. WHO's regional offices for Africa and the Eastern Mediterranean have prepared a business case to support all their Member States on the African continent in fully achieving their immunization goals. This business case is aligned with the vision of the draft thirteenth general programme of work to strengthen country capacities to achieve the health-related Sustainable Development Goals. In addition, WHO is embarking upon developing an investment case for vaccine-preventable disease surveillance that justifies the need for solid and sensitive surveillance systems as a measure of the impact of interventions against vaccine-preventable diseases. The investment case will primarily focus on the vaccine-preventable diseases currently targeted through a case-based and sentinel surveillance model, but is expected to incorporate other and new vaccine-preventable diseases that may be targeted for control in the next decade.

ACTION BY THE HEALTH ASSEMBLY

67. The Health Assembly is invited to note the report.

Table 5. Proposed road map for the draft strategic action plan on polio transition

Process/period	Activities	Milestones *Achieved*/to be delivered
Analysis – 2017	Comprehensive review of polio-funded human resources Comprehensive review of the programmatic, country capacity and financing risks of the scaling down of the polio programme	*Establishment of the indemnity fund to mitigate human resources risks* *Reports submitted to the Executive Board at its 140th session, and the Seventieth World Health Assembly in 2017*
Data collection, strategic review, costing 2018	Develop a framework for the development of the draft strategic action plan on polio transition Review of 12 draft national polio transition plans Review of polio Post-Certification Strategy; essential polio functions needed to keep the world polio-free – scale and scope Bottom-up estimation of the costing of essential polio functions: countries, regions and headquarters Collection and review of human resources data – impact of the downscaling of the Global Polio Eradication Initiative budget, and management of indemnity risks Review of preliminary financing options derived from national transition plans, and estimation of costs to be included in the investment case for the draft thirteenth general programme of work	*Report to the Executive Board at its 142nd session in January 2018 on the key components on the draft strategic action plan on polio transition* Finalization of the national transition plans by the end of June 2018 *Polio Post-Certification Strategy finalized and presented as a part of the report to the Executive Board at its 142nd session in January 2018.* *Draft strategic action plan includes detailed information on the costing of the essential polio functions; preliminary analysis of financing options and financing needed; and detailed human resources data* *Cost estimates and draft text provided for the investment case for the draft thirteenth general programme of work*
Joint planning and budgeting 2018–2019	Country-level review of polio-funded functions and capacities through joint planning visits by the polio eradication, immunization, emergencies, and other programme areas Input into the development of the Proposed programme budge 2020–2021 to highlight the transfer of the costs of essential functions and other assets from the polio budget to the WHO core budget Development of country-level resource mobilization plans and high-level advocacy strategies to support mainstreaming of polio essential functions into national systems or integration into other WHO programme areas Agreement among all stakeholders on the ownership of essential polio functions post-certification and the governance of the Post-Certification Strategy Development and introduction of a communication strategy about polio	At least three joint planning visits conducted in 2018 to highest priority polio transition countries in the African and Eastern Mediterranean regions, and three joint planning visits in 2019 Inclusion of polio essential functions and transition costs in the development of Proposed programme budget 2020-2021 Polio transition countries have resource mobilization plans in place to seek the funds needed for sustaining essential polio functions Convening a stakeholders' meeting to secure agreement on the implementation and governance of the Post-Certification Strategy A set of information and advocacy materials developed for distribution by the end of the second quarter of 2018, and quarterly updates to the web page

	transition for Member States, and staff members in both priority and non-priority countries Endemic countries (Afghanistan and Pakistan) are provided support to start the development of their transition plans in late 2018	
Implementation 2019–2023	Support for transition priority countries for the implementation of their transition plans and the integration of essential functions into other programme areas or national structures Support provided by the Secretariat to governments or WHO programme areas in implementing their resource mobilization plans Develop revised terms of reference for staff members performing essential polio functions in new programme areas	Key monitoring and evaluation output indicators are being met Financing available to support mainstreaming or integration of essential polio functions into WHO programme areas for the bienniums 2020–2021 and 2022–2023 Human resources services available to support staff members who will be transitioned or have their positions abolished
Monitoring and evaluation 2019–2023	A monitoring and evaluation framework developed with a clear results chain to monitor progress against the objectives of the strategic action plan and expected outcomes Progress monitored against a specific set of output indicators aligned with the three objectives of the strategic action plan A mid-term evaluation and an end-of-project evaluation to be conducted by the WHO Evaluation Office	Monitoring processes established at country, regional and headquarters levels with annual reporting to WHO's governing bodies Dashboard developed based on output indicators which is updated and shared with annual reports Mid-term evaluation at end-2021, and a final evaluation at the end of 2023 by the WHO Evaluation Office and reports submitted to the governing bodies

ANNEX 1

AFRICAN REGION

COSTS OF ESSENTIAL FUNCTIONS TO BE MAINSTREAMED AND/OR INTEGRATED INTO NATIONAL HEALTH STRUCTURES AND WHO PROGRAMMES BY YEAR AND BIENNIUM (US$)

Countries	Essential functions	2018	2019	2020–2021	2022–2023
Angola	Surveillance	6 109 604	6 009 868	14 149 666	13 844 145
	Laboratory	21 420	21 420		
	Core functions and infrastructures	1 994 599	1 948 536		
	Total	8 125 623	7 979 824		
Cameroon	Surveillance	1 011 342	1 011 342	3 395 047	1 335 890
	Laboratory	192 268	192 268		
	Core functions and infrastructures	136 856	912 922		
	Total	1 340 467	2 116 532		
Chad	Surveillance	1 400 000	1 400 000	5 450 000	4 800 000
	Core functions and infrastructures	2 972 000	2 725 000		
	Total	4 372 000	4 125 000		
Democratic Republic of the Congo	Surveillance	5 016 000	5 016 000	13 190 010	13 190 010
	Laboratory	111 160	100 150		
	Core functions and infrastructures	2 151 000	2 151 000		
	Total	7 278 160	7 267 150		
Ethiopia	Surveillance	1 051 932	991 932	5 812 000	5 812 000
	Laboratory	107 600	107 600		
	Core functions and infrastructures	3 770 168	3 770 168		
	Total	4 929 700	4 869 700		
Nigeria[a]	Surveillance and laboratory	52 892 614	–	–	79 368 643
	Core function and infrastructures	8 192 960	–		
	Total	61 085 573	–		
South Sudan	Surveillance	2 977 120	2 907 040	4 550 004	2 530 000
	Core functions and infrastructures	1 030 000	755 000		
	Total	4 007 120	3 662 040		
Other, non-priority countries	Surveillance and laboratory	9 789 000	9 472 000	30 068 440	25 318 960
	Core functions and infrastructures	9 938 222	8 590 040		
	Total	19 727 222	18 062 040		
African Region – Member States	Surveillance	80 247 612	26 808 182	76 615 167	146 199 648
	Laboratory	432 448	421 438		
	Core functions and infrastructures	30 185 805	20 852 666		
	Total	110 865 865	48 082 286		

Countries	Essential functions	2018	2019	2020–2021	2022–2023
Regional Office for Africa	Surveillance and laboratory	5 587 778	5 587 778	13 725 556	13 725 556
	Core functions and infrastructures	7 790 000	7 790 000		
	Total	13 377 778	13 377 778		
African Region – Member States and Regional Office	Surveillance	85 835 390	32 395 960	90 340 723	159 925 204
	Laboratory	432,448	421,438		
	Core functions and infrastructures	37 975 805	28 642 666		
	Total	124 243 643	61 460 064		

[a] The Global Polio Eradication Initiative will cover the costs of endemic countries until certification (assumed date: 2021).

SOUTH-EAST ASIA REGION

COSTS OF ESSENTIAL FUNCTIONS TO BE MAINSTREAMED AND/OR INTEGRATED INTO NATIONAL HEALTH STRUCTURES AND WHO PROGRAMMES BY YEAR AND BIENNIUM (US$)

Countries	Essential functions	2018	2019	2020–2021	2022–2023
Bangladesh	Surveillance	2 068 000	2 100 000	4 520 000	3 869 375
	Laboratory	155 000	160 000		
	Total	2 223 000	2 260 000		
India	Surveillance	14 435 000	14 051 000	55 618 681	60 402 410
	Laboratory	3 121 000	3 226 000		
	Core functions and infrastructures	9 263 000	8 494 000		
	Total	26 819 000	25 771 000		
Indonesia	Surveillance	890 000	890 000	1 388 000	1 263 000
	Laboratory	214 000	150 000		
	Containment	50 000	50 000		
	Total	1 154 000	1 090 000		
Myanmar	Surveillance	1 028 000	1 041 000	1 912 100	1 116 450
	Laboratory	23 000	23 000		
	Total	1 051 000	1 064 000		
Nepal	Surveillance	1 254 000	1 271 000	2 654 000	2 654 000
	Laboratory	53 000	56 000		
	Total	1 307 000	1 327 000		
South-East Asia Region – Member States	Surveillance	19 675 000	19 353 000	66 092 781	69 305 235
	Laboratory and containment	3 616 000	3 665 000		
	Core functions and infrastructures	9 263 000	8 494 000		
	Total	32 554 000	31 512 000		

Countries	Essential functions	2018	2019	2020–2021	2022–2023
Regional Office for South-East Asia	Surveillance and laboratory	2 417 409	2 322 855	3 816 710	3 816 710
	Total	2 417 409	2 322 855		
South-East Asia Region – Member States and Regional Office	Surveillance	22 092 409	21 675 855	69 909 491	73 121 945
	Laboratory and containment	3 616 000	3 665 000		
	Core functions and infrastructures	9 263 000	8 494 000		
	Total	34 971 409	33 834 855		

EASTERN MEDITERRANEAN REGION

COSTS OF ESSENTIAL POLIO FUNCTIONS TO BE MAINSTREAMED AND/OR INTEGRATED INTO NATIONAL HEALTH STRUCTURES AND WHO PROGRAMMES BY YEAR AND BIENNIUM (US$)

Countries	Essential functions	2018	2019	2020–2021	2022–2023
Afghanistan[a]	Surveillance	18,126,679	–	–	29 413 711
	Laboratory	–	–		
	Core functions and infrastructures	2 306 804	–		
	Total	20 433 483	–		
Pakistan[a]	Surveillance	35 767 070	–	–	61 393 768
	Laboratory	2 118 883	–		
	Core functions and infrastructures	13 580 929	–		
	Total	51 466 882	–		
Somalia	Surveillance	5 955 669	5 955 669	12 814 474	10 443 741
	Laboratory	–	–		
	Core functions and infrastructures	1 580 488	1 580 488		
	Total	7 536 157	7 536 157		
Sudan	Surveillance	2 208 028	2 208 028	3 842 116	3 497 751
	Laboratory	–	–		
	Core functions and infrastructures	–	–		
	Total	2 208 028	2 208 028		
Iraq[c]	Surveillance	1 972 374	1 873 539	3 327 029	3 015 698
	Laboratory	–	–		
	Core functions and infrastructures	–	–		
	Total	1 972 374	1 873 539		
Syrian Arab Republic[c]	Surveillance	1 271 980	1 271 980	2 807 817	2 285 806
	Laboratory	32 498	32 498		
	Core functions and infrastructures	348 007	348 007		
	Total	1 652 485	1 652 485		
Yemen[c]	Surveillance	1 506 524	1 506 524	2 927 160	2 736 349
	Laboratory	116 065	116 065		

Countries	Essential functions	2018	2019	2020–2021	2022–2023
	Core functions and infrastructures	–	–		
	Total	1 622 589	1 622 589		
Eastern Mediterranean Region – Member States	Surveillance	66 808 323	12 815 739	25 718 595	112 786 824
	Laboratory	2 267 446	148 563		
	Core functions and infrastructures	17 816 229	1 928 495		
	Total	86 891 998	14 892 798		
Regional Office for the Eastern Mediterranean[b]	Surveillance	8 315 933	–	–	10 514 604
	Total	8 315 933	–		
Eastern Mediterranean Region – Member States and Regional Office	Surveillance	75 124 256	12 815 739	25 718 595	123 301 428
	Laboratory	2 267 446	148 563		
	Core functions and infrastructures	17 816 229	1 928 495		
	TOTAL	95 207 931	14 892 798		

[a] Endemic countries will be supported by the Global Polio Eradication Initiative until certification of eradication (assumed date: 2021)

[b] Given ongoing endemic transmission in the Eastern Mediterranean Region, the Global Polio Eradication Initiative will cover the costs of regional essential functions until 2021.

[c] Iraq, Syrian Arab Republic and Yemen are also regional priority countries for polio transition in the Eastern Mediterranean Region.

ANNEX 2

POLIO-FUNDED STAFF MEMBERS BY CONTRACT TYPE, AS AT MARCH 2018

	Office (country/region)	Continuing	Fixed-term	Temporary	Total
Endemic countries	Afghanistan	5	10	20	35
	Nigeria	208	59	47	314
	Pakistan	3	6	41	50
Non-endemic priority countries	Angola	32	18	2	52
	Bangladesh[a]	5	–	3	8
	Cameroon	4	3	1	8
	Chad	22	2	6	30
	Democratic Republic of the Congo	45	5	2	52
	Ethiopia	35	6	–	41
	India[a]	1	4	15	20
	Indonesia[a]	–	–	3	3
	Myanmar[b]	–	–	–	–
	Nepal[a]	–	1	3	4
	Somalia	2	3	11	16
	South Sudan	1	3	12	16
	Sudan	–	–	6	6
WHO headquarters, regional and country offices	Headquarters	37	16	17	70
	African (regional and country offices)	112	41	47	200
	South-East Asia (regional and country offices) [a]	1	3	1	5
	European (regional and country offices)	4	–	–	4
	Eastern Mediterranean (regional and country offices)	10	11	25	46
	Western Pacific (regional and country offices)	2	2	1	5
Grand total		**528**	**193**	**263**	**984**

[a] The Regional Office for South-East Asia is in an advanced stage of transition with many essential functions and their costs shared with other programme areas. Therefore to calculate the polio positions a cut-off of >70% full-time equivalent was used.

[b] As the five positions in Myanmar are at 50% full-time equivalent, they have been excluded in this calculation.

ANNEX 3

POLIO-FUNDED STAFF MEMBERS IN MAJOR OFFICES/REGIONS BY GRADE AND CONTRACT TYPE, AS AT MARCH 2018

Office/Region	Grade	Continuing	Fixed-term	Temporary	Total
Headquarters	General Service	10	4	8	22
	International	27	12	9	48
	Total	37	16	17	70
African	General Service	307	55	58	420
	International	29	6	42	77
	National Officer	123	76	17	216
	Total	459	137	117	713
South-East Asia[a]	General Service	5	4	4	13
	International	–	1	1	2
	National Officer	1	3	20	24
	Total	6	8	25	39
Europe	General Service	2	–	–	2
	International	2	–	–	2
	Total	4	–	–	4
Eastern Mediterranean	General Service	9	14	36	59
	International	7	7	61	75
	National Officer	4	9	6	19
	Total	20	30	103	153
Western Pacific	International	2	1	1	4
	National Officer	–	1		1
	Total	2	2	1	5
Grand Total		**528**	**193**	**263**	**984**

[a] The Regional Office for South-East Asia is in an advanced stage of transition with many functions and their costs shared with other programme areas. Therefore to calculate the polio positions a cut-off of >70% full-time equivalent was used.

ANNEX 4

PRIORITY COUNTRIES FOR POLIO, IMMUNIZATION AND HEALTH EMERGENCIES[1]

Country	Polio[a]	Immunization	Health emergencies[b] (Tier 1+2)
Afghanistan	X	X	X
Angola	X		
Bangladesh	X		G3
Cameroon	X		
Central African Republic		X	X
Chad	X	X	X
Democratic Republic of the Congo	X	X	X
Ethiopia	X	X	X
Haiti		X	
India	X	X	
Indonesia	X	X	
Iraq			
Kenya		X	
Madagascar		X	G2
Mali			X
Mozambique		X	
Myanmar	X	X	X
Nepal	X		X
Niger		X	X
Nigeria	X	X	X
Pakistan	X	X	X
Papua New Guinea		X	
Somalia	X	X	X
South Sudan	X	X	X
Sudan	X		X
Syrian Arab Republic			X
Uganda		X	G2
Yemen		X	X

[a] Iraq, Syrian Arab Republic and Yemen are also regional priority countries for polio transition in the Eastern Mediterranean Region.

[b] G2/G3: Countries not on the current "priority list" of the WHO Health Emergencies Programme but dealing with graded emergencies.

= = =

[1] Shaded rows signify common priority countries for WHO's polio, immunization and health emergencies programme areas: nine countries plus Sudan.