World Health Organization

SEVENTY-SECOND WORLD HEALTH ASSEMBLY **A72/10**
Provisional agenda item 11.3 **10 May 2019**

Polio

Transition

Report by the Director-General

1. An earlier version of this report was considered and noted by the Executive Board at its 144th session.[1] It has been updated and substantially expanded with information on costs and financing, human resources planning, and the monitoring and evaluation framework.

2. This report provides an update on the implementation of the strategic action plan on polio transition, which was requested by the Seventieth World Health Assembly in May 2018 in decision WHA70(9) and noted by the Seventy-first World Health Assembly.[2]

3. The strategic action plan has three key objectives:

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

(2) strengthening immunization systems, including surveillance for vaccine-preventable diseases, to achieve the goals of WHO's Global Vaccine Action Plan 2011–2020;

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

The results chain for the plan is illustrated in Annex 1.

4. The strategic action plan is a living document, and the management of polio transition is a country-focused process. Planning at the country level, across WHO's key programmatic areas, will be required throughout the action plan's five-year time span to ensure that it adapts to the evolving situation on the ground.

5. Implementation will be affected by uncertainties linked to the date of certification of the eradication of poliovirus, the evolution of discussions on the implementation of the polio Post-Certification Strategy, including its governance, oversight and financing, and ongoing initiatives related to vaccines, immunization and disease surveillance, such as WHO's post-2020 vaccine and immunization strategy and Gavi 5.0 – the Alliance's 2021–2025 strategy, among others. The Secretariat

[1] See document EB144/10 and the summary records of the Executive Board at its 144th session, fourth meeting.

[2] See document A71/9 and the summary records of the Seventy-first World Health Assembly, Committee A, sixth and eighth meetings.

has established a dedicated webpage, which is regularly updated about progress in implementation of the strategic action plan.[1]

6. Since the development of the strategic action plan in 2017, the Global Polio Eradication Initiative has been extended for the five-year period 2019–2023. The estimated budget for this extension of the Initiative is US$ 4200 million. The extension allows an additional period to prepare for sustaining a polio-free world after eradication and to strengthen routine immunization systems and emergency outbreak preparedness, detection and response capacities. That said, there is a risk that the additional time period and budget may engender a level of complacency among key stakeholders. Accordingly, WHO continues to advocate and support transition planning and to facilitate implementation of the strategic action plan in non-endemic priority countries.

7. As the world gets closer to the goal of polio eradication, the Director-General has made polio transition a key priority for the Organization at all three levels under the oversight of the Deputy Director-General. A high-level Polio Transition Steering Committee has been established, chaired by the Deputy Director-General, to consider issues such as the implications of the budget of the Global Polio Eradication Initiative for WHO's base budget, monitoring of the progress of country support visits, and the process launched by the first stakeholders' meeting to secure agreement on the implementation and governance of the Post-Certification Strategy (hereafter referred to as the "Montreux process" – see also paragraphs 11–12 below).

8. Since May 2017, the Secretariat has worked with the 16 countries[2] globally that were identified for polio transition and is planning to support four additional high-risk countries that are prioritized by the Regional Office for the Eastern Mediterranean.[3]

9. A polio transition team was established in the Secretariat in September 2018 to lead the programme of work laid out in the strategic action plan. The cornerstone of this work is country support visits to review polio-funded functions and capacities and to examine national transition plans to ensure that they meet the objectives of the strategic action plan.

10. Whereas previously polio transition planning focused primarily on decreasing the indemnity risks faced by the Organization owing to the large numbers of polio-funded staff with continuing appointments and fixed-term positions, the country planning process has revealed the need to sustain and/or selectively re-purpose experienced members of the health work force currently employed with polio funds, particularly in fragile and conflict-affected countries, in order to sustain eradication and to avoid backsliding on vaccine-preventable disease control efforts.

[1] Polio transition (https://www.who.int/polio-transition/en/, accessed 10 April 2019).

[2] The 16 global polio transition priority countries by region are: African Region (Angola, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, Nigeria and South Sudan), South-East Asia Region (Bangladesh, India, Indonesia, Myanmar and Nepal) and Eastern Mediterranean Region (Afghanistan, Pakistan, Somalia and Sudan).

[3] Iraq, Libya, Syrian Arab Republic and Yemen.

THE MONTREUX PROCESS: IMPLEMENTATION AND GOVERNANCE OF THE POST CERTIFICATION STRATEGY

11. The Secretariat convened a high-level meeting of key polio transition stakeholders (Montreux, Switzerland, 13 and 14 November 2018) in order inter alia to clarify the implications of the new five-year strategy of the Global Polio Eradication Initiative on polio transition; identify existing and potential financing options for polio transition; evaluate ways of achieving a smooth transition; and discuss options for governance of the polio transition and post-certification process.

12. At the meeting, the Secretariat committed itself, in order to lead the transition process forward, to undertake the following actions :

- to convene follow-up expert consultations[1] on the pragmatic implications of polio transition, across four thematic priorities:

    (a) integrated disease surveillance;

    (b) consultation on emergency preparedness, detection and response;

    (c) consultation on polio containment;

    (d) strengthening immunization systems

  and to proceed to the next stage in the Montreux process: the conclusions and recommendations of the four strategic consultations will be presented to a second high-level meeting of key polio transition stakeholders, to be organized by WHO in Geneva; this second high-level event will also consider future post-certification governance issues;

- to contribute to the development of the strategy of the Global Polio Eradication Initiative for 2019-2023;

- to work closely with the Global Polio Eradication Initiative on detailed analyses of country transition budgets to ensure that there is no duplication between transition budgets and funding of the Initiative and WHO;

- to continue to organize joint country visits to review national transition plans to ensure that they meet the objectives of WHO’s strategic action plan.

[1] At the time of writing (1 April 2019), feedback from these expert consultations is pending.

JOINT COUNTRY VISITS

13. The target of six joint country visits that was set for the 12-month period before the Seventy-second World Health Assembly has been exceeded. Between September 2018 and March 2019, the Secretariat has organized country support visits to Angola, Bangladesh, Cameroon, Chad, Ethiopia, India, Myanmar and South Sudan. The visits are ongoing, and a summary of outcomes (as at April 2019) is given in Table 1. Additional joint country support visits are planned to the remaining priority transition countries.

Table 1. Status update following country visits

Country	Outcomes
Myanmar – October 2018	The Ministry of Health and Sport plans to broaden the scope of the analysis provided in the document by elaborating further on the experience of the Regional Surveillance Officers, including key functions required at the regional, state and township levels and exploring options for the integration of surveillance within the organizational structure of the Ministry.
Bangladesh – November 2018	The national polio transition plan is well structured and laid out with clear action points and deliverables for each of the three planned phases of implementation. Planned activities under Phase 1 (2016–2019) are well on track.
India – November 2018	Implementation of national polio transition plan is on track. Government domestic funding is agreed for the National Polio Surveillance Project to maintain India polio-free and to support non-polio vaccination campaigns. Plans to transition management of the National Polio Surveillance Project from WHO to the Government are to be reviewed in 2020.
Ethiopia – December 2018	The national polio transition plan has been finalized and was endorsed by the national Inter-Agency Coordinating Committee in April 2018. The plan is comprehensive and provides detailed information on activities and costs. WHO and partners agreed to include an addendum to address the long-term vision and strategies for polio transition. The addendum will specify how essential functions will be transitioned to the Government, with timelines, and how WHO and partners can support this crucial phase. The document will be the basis for consultations with donors along with advocacy materials.
South Sudan – February 2019	The national polio transition plan was finalized in June 2018, following which the Government hosted a stakeholder consultation. The Government then endorsed the plan. Further support from WHO and partners is planned to integrate polio-funded human resources into the Expanded Progamme on Immunization, health emergencies and the Boma Health Initiative.
Cameroon – February 2019	Although requiring updating, the national polio transition plan is well developed with activities to be implemented and WHO and UNICEF budgets that show a decline over time as the country becomes less dependent on external funding.

Country	Outcomes
Angola – March 2019	The national polio transition plan is comprehensive with activities listed and costed for implementation. The Government is exploring options for the recruitment of public health officers to sustain integrated surveillance. Implementation of the plan will follow subject to approval of the plan by the Ministry of Health.
Chad – March 2019	A national committee for monitoring the implementation of the national polio transition plan was constituted in November 2018. This committee has been active in developing an addendum to the polio transition plan. This addendum extends the plan to 2023, adds details regarding the activities to pursue, and re-estimates the budget in line with these activities.

14. The main objectives of these country visits are:

(a) to review key elements of national polio transition plans;

(b) to discuss progress and timelines of the implementation of the plans;

(c) to review country-level financing opportunities and financing gaps;

(d) to discuss and align the national monitoring and evaluation framework with the global monitoring and evaluation framework of WHO's strategic action plan on polio transition, and to identify and engage key contributors to the inputs and outputs, as well as the proposed monitoring bodies to consult with stakeholders, including donors and development agencies, to raise awareness of transition funding requirements.

COSTS AND FINANCING TO SUPPORT THE OBJECTIVES OF THE STRATEGIC PLAN

15. In close collaboration with the regional offices for Africa, South-East Asia and the Eastern Mediterranean, staff at headquarters have gathered data from each polio priority country and from non-priority 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 strengthened immunization and some core capacity to respond to possible outbreaks. These functions are crucial for meeting all three objectives of the strategic action plan and were estimated to cost US$ 227 million for the biennium 2020–2021 and US$ 438 million for the biennium 2022–2023. The details of these costs, by country, region and headquarters, were included in the strategic action plan on polio transition noted by the Seventy-first World Health Assembly in 2018.[1]

The budget of the Global Polio Eradication Initiative 2019–2023 in relation to that of WHO's Thirteenth General Programme of Work, 2019–2023 and the Proposed programme budget 2020–2021

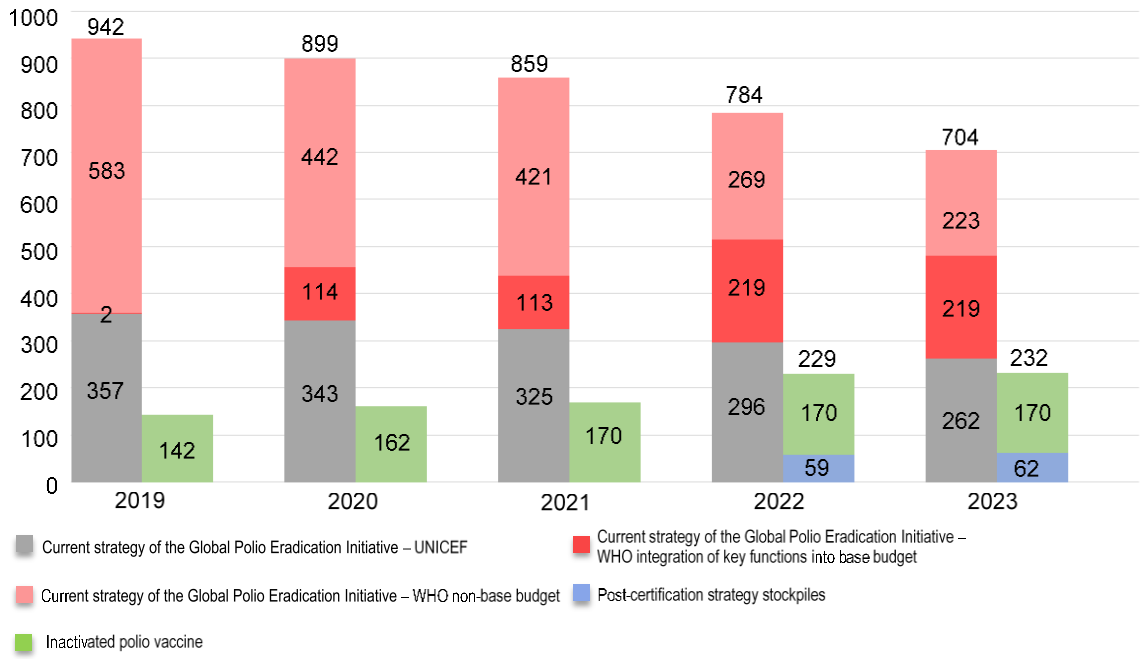
16. The WHO investment case to support the Thirteenth General Programme of Work, 2019–2023 includes a total of US$ 1867 million – US$ 1200 million for polio eradication and US$ 667 million for

[1] See document A71/9 and the summary records of the Seventy-first World Health Assembly, Committee A, sixth and eighth meetings.

polio transition, which is a process to sustain and mainstream critical polio functions post-eradication, not only to sustain a polio-free world but to continue strengthening immunization systems and emergency preparedness, detection and response capacities, especially in countries with vulnerable populations and weak health systems. These figures were based on the expectation that transmission of wild poliovirus would be interrupted in 2018 and the world would be certified polio-free in 2021. Because transmission of wild poliovirus was not interrupted, the Polio Oversight Board adopted a new Global Polio Eradication Initiative budget for a five year period that extended the polio eradication programme from 2019 to 2023, at a total cost of US$ 4200 million, predicated on the expected interruption of wild polio virus in 2020.

17. The WHO portion of the Initiative's budget for 2019–2023 is US$ 2600 million – an increase of US$ 738 million from the combined US$ 1867 million figure for Polio Eradication and Polio Transition in WHO's investment case, which was prepared before the extension of the Global Polio Eradication Initiative. The budget for polio-specific activities at WHO for the biennium 2020–2021 is US$ 1090 million, comprised of US$ 863 million budgeted by the initiative, and US$ 227 million as part of WHO's base budget (as shown in Fig., which illustrates the polio transition budget in the context of the overall cost of achieving and sustaining polio eradication). The WHO base budget amount is the cost of supporting essential public health core capacities – vaccine-preventable disease surveillance, immunization and emergency response – a cost that is currently funded by the Global Polio Eradication Initiative but will now become embedded in WHO's base programmes with links to the broader agenda on universal health coverage when alternative and sustainable sources of support are identified.

Fig. Costs (in US$ million) to achieve and sustain polio eradication for each of the five years 2019–2023



Funding of polio transition

18. For the years 2019–2023, the contribution from WHO's non-base programme budget (Fig., top bar, pink) is accompanied by an additional sum (second bar from the top, red) representing the cost of essential functions that are or will be supported by WHO's base programme budget. Over time there is a shift from support by the Global Polio Eradication Initiative for these essential functions to support from WHO's budget, namely US$ 227 million for the biennium 2020–2021 and a total of US$ 667 million for 2020–2023. The WHO base budget for polio essential functions increases in the biennium 2022–2023 when the costs of core functions and capacities from the polio-endemic countries move onto WHO's base budget (that is to say, this budget assumes that wild type poliovirus transmission will be interrupted by 2020). Of the US$ 227 million WHO base budget requirements in 2020–2021, domestic funding by priority countries of about US$ 52 million is foreseen, thus reducing the fundraising requirement to US$ 175 million. It is also expected that countries will gradually reduce their reliance on the Global Polio Eradication Initiative support over the next four years as transition plans are implemented and alternative, sustainable sources of support for essential functions are found.

Avoiding potential duplication between the budgets of the Global Polio Eradication Initiative and WHO

19. Member States have requested assurances that there is no duplication between the polio transition budgets of the Global Polio Eradication Initiative and WHO. At present, the polio budget subsumes both the base and non-base portion of WHO's programme budget, since activities within the WHO base are also part of the overall budget and strategy of the Global Polio Eradication Initiative for 2019–2023. These same costs do not appear anywhere else in WHO's programme budget. Over time, when core functions move into WHO's base programmes the budgets for the recipient programmes will increase and the polio budget will decline.

20. The results structure of the Proposed programme budget 2020–2021[1] includes a specific output (2.2.4 Polio eradication and transition plans implemented in partnership with the Global Polio Eradication Initiative) for which both budgets supporting WHO's polio activities (base and non-base) will be accounted for in order to avoid the duplication and allow clarity and transparency of the budget and funding.

21. Transition planning should continue uninterrupted regardless of the extended duration of the Global Polio Eradication Initiative. To ensure a smooth and timely transition, in non-endemic countries, health ministries can start to take on more essential functions, and within the Secretariat responsibilities for programme support will shift from polio departments to non-polio departments (and costs move onto WHO's base budget). Moreover, transitioning countries can use funding from the Global Polio Eradication Initiative to re-orient their polio-supported activities in accordance with their transition plans, provided that polio-essential functions necessary for certification are not weakened.

Domestic funding of transition plans

22. Polio transition countries with costed national transition plans have included a limited level of domestic funding. 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

[1] Document A72/4.

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 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 either will not be in a position to pledge co-financing or 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-built infrastructures for a certain period of time while they are re-purposed to cover broader functions, and so will be financing these functions with contributions to WHO's programme budget.

23. 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. The Secretariat 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 Gavi, the Vaccine Alliance through its grants for health system strengthening so as 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.

UPDATE ON HUMAN RESOURCES PLANNING

24. The Secretariat continues to track changes in polio programme staffing through a dedicated database of polio human resources that has been developed for this purpose.

25. Priority is being given to maintaining the workforce required to provide support to Member States in ensuring the interruption of poliovirus transmission, sustaining high levels of immunity, responding to outbreaks and conducting surveillance. In non-endemic and lower-risk countries, positions needed to support surveillance, including those in laboratories, and maintain high routine immunization coverage rates are retained, while remaining positions are phased out. All vacancies are scrutinized and less critical positions are discontinued or repurposed.

26. As shown in Table 2, the number of filled positions has declined by 15% since the downscaling of the budgets of the Global Polio Eradication Initiative began in 2016. Based on the declining budgets and the guidance provided, the number of polio funded 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 members with continuing appointments and fixed-term positions. An indemnity fund with more than US$ 50 million has been established in WHO to mitigate this risk. Annex 3 presents a breakdown by major office, 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 upon closure of the polio programme and if effective polio transition efforts are in place to sustain essential functions beyond 2019. These experienced staff members could be assets to the local health systems or to other WHO programme areas in these or other countries.

Table 2. Number of polio positions supported by the Global Polio Eradication Initiative, by major office (2016–2019)

Major office	2016	2018	2019	Variation (%) between 2016 and 2019
Headquarters	77	70	72	-6%
Regional Office for Africa	826	713	663	-20%
Regional Office for South-East Asia[a]	39	39	36	-8%
Regional Office for Europe	9	4	5	-44%
Regional Office for the Eastern Mediterranean	155	153	170	10%
Regional Office for the Western Pacific	6	5	3	-50%
Total	**1 112**	**984**	**949**	**-15%**

[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.

MONITORING AND EVALUATION FRAMEWORK FOR POLIO TRANSITION

Monitoring and evaluation framework

27. The monitoring and evaluation framework, developed in 2018, continues to be an essential and important component of the strategic action plan on polio transition and aims at ensuring effective monitoring of planned activities across the three levels of the Organization during the period 2019-2020 and to support a future independent evaluation of the process and outcomes.

28. The monitoring and evaluation framework follows a well-defined process that monitors progress, based on agreed indicators, at all three levels of the organization but particularly at country level. The approach taken is to use WHO's existing processes and mechanisms and existing information sources.

29. The Secretariat is in discussions to extend the mandate of the Polio Transition Independent Monitoring Board, with a streamlined membership and terms of reference adapted to include monitoring of the Montreux process.

Monitoring and evaluation indicators

30. To monitor progress towards achieving the three key objectives of the strategic action plan, the monitoring and evaluation framework aims at identifying and using a set of output and outcome indicators, to be measured with appropriate methods and using reliable data sources. For this year's report, Table 3 proposes a selection of key output indicators by country, with each defined and a baseline value established for measurement to the extent possible. In subsequent years, monitoring and evaluation will be reported against the 2018 baseline.

Table 3. Output indicators of the monitoring and evaluation framework for the strategic action plan on polio transition

Objective	Output indicators	Definition
Sustain a polio-free world after eradication	1. Coverage with inactivated polio vaccine	≥90% coverage with ≥2 doses of inactivated polio vaccine, achieved in all countries hosting poliovirus-essential facilities
	2. High-quality surveillance for acute flaccid paralysis	At least one case of non-polio acute flaccid paralysis should be detected annually per 100 000 population aged less than 15 years. In polio-endemic regions, to ensure even higher sensitivity, this rate should be two cases per 100 000 population aged less than 15 years
	3. Polio event response	Any new poliovirus outbreak stopped within 120 days
	4. Containment	Destruction or retention of materials infectious or potentially infectious with polioviruses verified and validated All poliovirus-essential facilities hold a valid certificate of containment
Strengthen immunization systems and surveillance	1. Measles-containing vaccine (MCV1 and MCV2) coverage[1]	Number of countries providing MCV1 and MCV2, through routine services with coverage levels of second dose measles-containing vaccine >90% nationally and >80% in all districts
	2. 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 the United Nations Population Division
	3. 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
Objective	**Output indicators**	**Definition**
Strengthening emergency preparedness, detection and response capacity – support implementation of the International Health Regulations (2005)	1. Health emergencies rapidly detected and responded to	Timeliness of emergencies detection, verification and response for reportable events under the International Health Regulations (2005)
	2. Epidemics and pandemics prevented	Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases (including yellow fever, cholera, meningitis and pandemic influenza)
	3. Countries prepared for health emergencies	States Parties to the International Health Regulations (2005) self-assessment annual reporting

[1] MCV1 and MCV2 refer to first and second dose of measles-containing vaccine.

31. Annex 5 sets out the 2018 baseline values for each indicator.

Current programmatic challenges identified by the monitoring and evaluation framework

32. As shown in Annex 5, and in relation to **achieving objective 1** of the strategic action plan (sustaining a polio free world after eradication), immunization coverage levels will need to improve considerably over the coming years.

33. The sensitivity of surveillance for acute flaccid paralysis will have to be maintained in each country at the level of at least one case of non-polio acute flaccid paralysis detected annually per 100 000 population aged less than 15 years. In endemic regions, to ensure even higher sensitivity, this rate should be two cases of non-polio acute flaccid paralysis per 100 000 population aged less than 15 years.

34. The response to polio events and outbreaks will need to continue to be as effective as it has been in the past several years.

35. **To achieve objective 2** (strengthening immunization systems) coverage levels with measles-containing vaccine (first and second doses) will need to improve substantially in many countries, and in line with measles elimination strategies. To ensure a successful polio transition process, expenditure on routine immunization per newborn will also need to be increased in most transition countries.

36. Disease surveillance laboratory support has expanded from polio-alone to include measles, rubella and yellow fever in many transition countries and this will need to be maintained and consolidated over the coming years.

37. **To achieve objective 3** (strengthening emergency preparedness, detection and response capacity in countries to fully implement the International Health Regulations (2005)) new indicators are under development relating to respectively: health emergencies rapidly detected and responded to, and emergence of high-threat infections hazards prevented (for which the measurement methods are under development).

THE WAY FORWARD

38. The road map with activities and milestones (Table 4) has been refined and is being implemented in order to move the polio transition process forward, support implementation of the strategic action plan, and track progress, thereby facilitating reporting to WHO’s governing bodies.

Table 4. Implementation of the polio transition road map

Process/period	Activities	Milestones	Implementation status
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	Achieved
		Reports submitted to the Executive Board and Health Assembly in 2017	Achieved
Data collection, strategic review, costing – 2018	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 Review of options for WHO's role in implementing the Post-Certification Strategy, including the strategic decision for "housing" the essential polio functions within WHO: "merged" vs "distributed" options 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 budget of the Global Polio Eradication Initiative, and to manage 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 Thirteenth General Programme of Work, 2019–2023	Report to the Executive Board at its 142nd session in January 2018 on the key components on the strategic action plan on polio transition	Achieved
		Finalization of the national transition plans by end June 2018	In progress
		Polio Post-Certification Strategy finalized and submitted as a part of the strategic action plan to the Health Assembly	Achieved
		Strategic 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	Achieved
		Cost estimates and draft text provided for the investment case for the Thirteenth General Programme of Work, 2019–2023	Achieved
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 budget 2020–2021 to highlight the transfer of the costs of essential functions and other assets from the polio budget to the WHO base budget Development of country-level resource mobilization plans and high-level advocacy strategies to support mainstreaming of polio essential	At least three joint planning visits conducted in 2018 to highest priority polio transition countries in the African Region and the Region of the Eastern Mediterranean; and three joint planning visits in 2019	Achieved
		Inclusion of polio essential functions and transition costs in the development of the Proposed programme budget 2020–2021	Achieved

Process/period	Activities	Milestones	Implementation status
	functions into national systems, or integration into other programme areas of WHO 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 communications strategy about polio transition for Member States, and WHO 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 12 months after their last detected case of poliomyelitis due to wild poliovirus	Polio transition countries have resource mobilization plans in place to seek the funds needed for sustaining essential polio functions	In progress
		Convening a first stakeholders' meeting to secure agreement on the implementation and governance of the Post-Certification Strategy; including follow up meetings on:	Achieved
		(1) immunization system strengthening	In progress
		(2) integrated disease surveillance	Achieved
		(3) emergency response management	In progress
		(4) poliovirus containment	In progress
		A set of information and advocacy materials developed for distribution by the end of the second quarter 2018, and webpage updated quarterly	In progress
Implementation – 2019–2023	Transition priority countries are supported for the implementation of their transition plans, and the integration of essential functions into other programme areas or national structures Support governments or WHO programme areas in implementing their resource mobilization plans Develop revised terms of reference for staff performing essential polio functions in new programme areas	Key monitoring and evaluation output indicators are being met	In progress
		Financing available to support mainstreaming or integration of essential polio functions into WHO programme areas for the bienniums 2020–2021 and 2022–2023	In progress
		Human resource services available to support staff members who will be transitioned, or their positions terminated	In progress
		Monitoring process established at country, regional and headquarters levels with annual reporting to WHO's governing bodies	In progress

Process/period	Activities	Milestones	Implementation status
Monitoring and evaluation – 2019–2023	A monitoring and evaluation framework developed with clear results chain to monitor progress against the objectives of the strategic action plan and expected outcomes Progress is monitored against 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 WHO's Evaluation Office	Dashboard developed based on output indicators which is updated and shared with annual reports	In progress
		Early evaluation of polio transition progress in 2020; and final evaluation at end-2023 by WHO's Evaluation Office and reports submitted to the governing bodies	To be delivered

39. The Secretariat will maintain the focus on countries, for instance by supporting the development, finalization, endorsement by national governments and implementation of national polio transition plans and by advocating the mainstreaming of public health functions currently funded by polio into national health programmes.

40. Progress has been made in the past six months in relation to the four thematic priorities of the Montreux process. WHO has committed itself to organizing a second high-level polio transition stakeholders' event to report back on progress made since November 2018, to facilitate strategic guidance of the process including the options on the future governance of functions outlined in the Post-Certification Strategy.

41. Joint operational planning by the key programmatic areas in the priority transition countries will occur to elaborate the implementation of the Proposed programme budget 2020–2021.

42. Additional supportive services are needed at WHO regional and country offices to facilitate transition planning, including in the areas of financing, resource mobilization, advocacy, communications, and human resources management.

43. In relation to engagement with civil society organizations, WHO will pursue an inclusive approach to polio transition. Some progress has been made since September 2018, for example, with the participation of the United Nations Foundation in many global events, and ad hoc contacts with other civil society organizations. These efforts will be enhanced and more targeted, to ensure that civil society organizations support advocacy efforts with countries to mainstream polio-funded essential functions into national health systems.

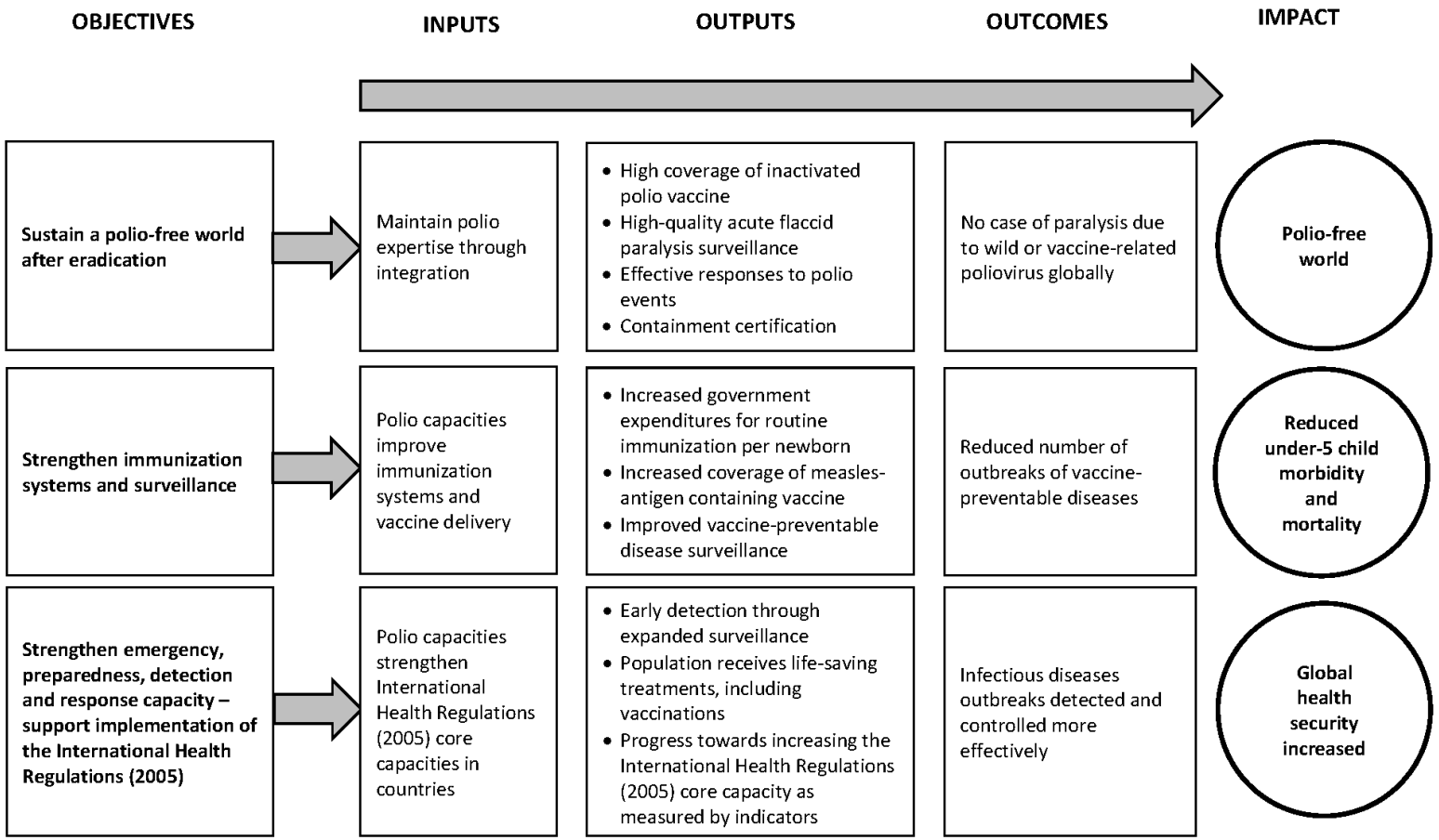
44. Polio transition efforts are a critical opportunity to support the strengthening of immunization systems, vaccine-preventable disease surveillance, and the capacity for implementation of the International Health Regulations (2005). In this context, and that of planning for the eventual closure of the polio programme, the human resources strategy for transition will have to support leadership at all three levels of the organization to plan for the sustainability, re-purposing and/or scaling down of personnel, as appropriate, and provide a package of support services to staff members, including capacity-building to take on expanded duties and career transition through mobility.

ACTION BY THE HEALTH ASSEMBLY

45. The Health Assembly is invited to note the report and to provide further guidance on the milestones for the implementation of the polio transition road map (as set out in Table 4).

ANNEX 1

RESULTS CHAIN OF POLIO TRANSITION



ANNEX 2

NUMBER OF STAFF MEMBERS FUNDED BY THE GLOBAL POLIO ERADICATION INITIATIVE, BY CONTRACT TYPE, AS AT APRIL 2019

	Office (country/region)	Continuing and fixed-term	Temporary	Total
Endemic countries	Afghanistan	15	21	36
	Nigeria	288	18	306
	Pakistan	12	46	58
Non-endemic priority countries	Angola	24	3	27
	Bangladesh[a]	6	3	9
	Cameroon	7	2	9
	Chad	29	4	33
	Democratic Republic of the Congo	47	1	48
	Ethiopia	39	0	39
	India[b]	6	6	12
	Indonesia[a]	0	3	3
	Iraq	0	5	5
	Libya	0	1	1
	Myanmar[a]	1	1	2
	Nepal[a]	1	3	4
	Somalia	5	14	19
	South Sudan	1	10	11
	Sudan	1	6	7
	Syrian Arab Republic	1	7	8
	Yemen	0	2	2
WHO headquarters, regional and country offices	Headquarters	53	19	72
	African (regional and country offices)	150	40	190
	South-East Asia (regional office) [a]	5	1	6
	European (regional and country offices)	4	1	5
	Eastern Mediterranean (regional and country offices)	21	13	34
	Western Pacific (regional and country offices)	3	0	3
Grand total		**719**	**230**	**949**

[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] India includes 15 staff members at 40% time which translates into six full-time equivalents.

ANNEX 3

STAFF MEMBERS FUNDED BY THE GLOBAL POLIO ERADICATION INITIATIVE IN MAJOR OFFICES BY GRADE AND CONTRACT TYPE, AS AT APRIL 2019

Major office	Grade	Continuing and fixed-term	Temporary	Total
Headquarters	General service	15	7	22
	International	38	12	50
	Total	**53**	**19**	**72**
Africa	General service	368	26	394
	International	37	40	77
	National officer	180	12	192
	Total	**585**	**78**	**663**
Eastern Mediterranean	General service	24	44	68
	International	18	59	77
	National officer	13	12	25
	Total	**55**	**115**	**170**
Europe	General service	2	0	2
	International	2	1	3
	Total	**4**	**1**	**5**
South-East Asia[a]	General service	12	5	17
	International	1	1	2
	National officer	6	11	17
	Total	**19**	**17**	**36**
Western Pacific	International	3	0	3
	National officer	0	0	0
	Total	**3**	**0**	**3**
Grand total		**719**	**230**	**949**

[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, Libya, 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.

ANNEX 5

COUNTRY-LEVEL MONITORING DASHBOARD: KEY INDICATORS FOR POLIO TRANSITION PLANS IMPLEMENTATION (JUNE 2018–DECEMBER 2023), REPORTED/MONITORED ON YEARLY BASIS

Objective 1: Sustaining a polio-free world after eradication					
Country	1.1: Administration of one dose of inactivated polio vaccine (Joint Reporting Form data and for 2017) (% coverage and timing per dose)	1.2: Bivalent oral poliovirus vaccine coverage as per Joint Reporting Form data and for 2017 (% coverage and timing per dose)	1.3: Acute flaccid paralysis surveillance sensitivity maintained (cases of non-polio Acute flaccid paralysis per 100 000 population aged less than 15 years)	1.4: Last poliovirus events and outbreaks responded to[1]	1.5: Environmental surveillance: number of sites (range or number of samples collected from each site in 2018)
Angola	47 (16 weeks)	52 (birth; 2, 4, 6 weeks)	Yes (3.25)	5 WPV cases in 2011	8 (12)
Bangladesh	7 (2016) (2, 6, 14 weeks)	97 (6, 10, 14 weeks)	Yes (2.5)	18 WPV cases in 2006	8 (4–26)
Cameroon	76 (14 weeks)	84 (birth; 6, 10, 14 weeks)	Yes (9.14)	5 WPV cases in 2014	30 (12–35)
Chad	46 (14 weeks)	44 (birth; 6, 19, 14 weeks)	Yes (10.55)	3 cVDPV cases in 2013	5 (25–35)
Democratic Republic of the Congo	69 (14 weeks)	79 (birth; 6, 10, 14 weeks)	Yes (6.57)	20 cVDPV cases in 2018	10 (12–30)
Ethiopia	NA (14 weeks)	76 (birth; 6, 10, 14 weeks)	Yes (2.5)	1 WPV case in 2014	4 (24)
India	45 (6, 14 weeks)	88 (birth; 6, 10, 14, 16–24 weeks)	Yes (9.67)	1 WPV case in 2011	51 (26-52)
Indonesia	47 (16 weeks)	80 (4, 8, 12, 16 weeks)	Yes (2.56)	2 WPV cases in 2006	12 (12–26)

[1] WPV : wild poliovirus ; cVDPV : circulating vaccine-derived poliovirus.

Objective 1: Sustaining a polio-free world after eradication					
Iraq	NA	77 (8, 16, 24 weeks; 18 months; 4–6 years)	Yes (7.98)	2 WPV cases in 2014	No site
Myanmar	72 (2016) (16 weeks)	89 (8 16 24 weeks)	Yes (2.74)	2 cVDPV cases in 2015	3 (26)
Nepal	16 (14 weeks)	90 (6, 10, 14 weeks)	Yes (2.99)	6 WPV cases in 2010	6 (26)
Nigeria	49 (2016) (14 weeks)	49 (2016) (birth; 6, 10, 14)	Yes (12.86)	34 cVDPV cases in 2018	103 (12–30)
Somalia	NA (2015) (14 weeks)	47 (birth; 6, 19, 14 weeks; 9–18 months))	Yes (7.3)	13 cVDPV cases in 2018	5 (52)
South Sudan	34 (14 weeks)	31 (6, 10, 14 weeks)	Yes (8.38)	2 cVDPV cases in 2014	5 (24–40)
Sudan	69 (2015) (14 weeks)	93 (2015) (6, 10, 14 weeks)	Yes (3.48)	45 WPV cases in 2009	No site
Syrian Arab Republic	65 (8, 16 weeks)	53 (12, 18 weeks)	Yes (4.63)	74 cVDPV cases in 2017	16 (1–12)
Yemen	61 (14 weeks)	62 (birth; 6, 10, 14 weeks)	Yes (6.08)	1 cVDPV case in 2013	No site
Data sources	**Joint Reporting Form**	**Joint Reporting Form**	**Global Polio Eradication Initiative surveillance**	**Global Polio Eradication Initiative surveillance**	**Global Polio Eradication Initiative surveillance**

Objective 2: Strengthen immunization systems and surveillance					Objective 3: Strengthen emergency preparedness, detection and response
Country	2.1: Coverage with one dose of measles-containing vaccine (%) (2017)	2.2: Coverage with two doses of measles-containing vaccine (%) (2017)	2.3: Government expenditure (in US$) on routine immunization per newborn in 2017	2.4: Vaccine-preventable disease surveillance: laboratory support expanded to measles	3.1: Average proportion (%) of 13 IHR core capacity indicators in place
Angola	49 (2016)	26 (2016)	NA	Yes	75
Bangladesh	94 (2016)	93 (2016)	7.89	Yes	78
Cameroon	77	NA (2016)	6.35	Yes	57
Chad	37	NA	2.61	Yes	44
Democratic Republic of the Congo	80	NA	0.19	Yes	65
Ethiopia	70 (2016)	NA (2016)	15.59	Yes	79
India	88	77	7.42	Yes	95
Indonesia	75	63	17.55	Yes	99
Iraq	66 (2016)	64 (2016)	161.11 (2016)	Yes	89
Myanmar	91 (2016)	86 (2016)	12.38 (2016)	Yes	62
Nepal	90	59	10.40	Yes	22
Nigeria	51 (2016)	NA (2016)	10.65	Yes	51
Somalia	46 (2016)	NA (2016)	NA	Yes	29
South Sudan	20 (2016)	NA	1.16	Yes	34
Sudan	87 (2015)	69 (2015)	4.78	Yes	67
Syrian Arab Republic	67	59	18.10	Yes	64
Yemen	65	46	0.74 (2016)	Yes	48
Data sources	**Joint Reporting Form**	**Joint Reporting Form**	**Joint Reporting Form and United Nations Population Division data**	**The Global Measles and Rubella Laboratory Network**	**WHO's Strategic Partnership for International Health Regulations (2005) and Health Security: Country profiles**