

# **Mid-term evaluation of the implementation of the Strategic Action Plan on Polio Transition (2018–2023)**

## **Executive summary**

1. The Seventieth World Health Assembly, in decision WHA70(9) (2017), requested the Director-General 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. In response to this request, a draft strategic action plan was presented to, and noted by, the Health Assembly in May 2018.<sup>1</sup> A provision for a mid-term evaluation was included in the polio transition road map<sup>2</sup> that was prepared to support implementation of the strategic action plan.<sup>3</sup>
2. This mid-term evaluation was included in the Organization-wide evaluation workplan for 2020–2021, approved by the Executive Board at its 146th session in February 2020.<sup>4</sup> The evaluation was conducted by an external independent evaluation team that was selected by the Evaluation Office through an open tender. The evaluation team undertook its main work during the fourth quarter of 2021 and first quarter of 2022 and delivered the final evaluation report in early April 2022.
3. In accordance with the modalities of this evaluation, the Evaluation Office is submitting the executive summary of the evaluation to the Seventy-fifth World Health Assembly (see Annex).<sup>5</sup>

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<sup>1</sup> Document A71/9; see also document WHA71/2018/REC/2, summary records of the Seventy-first World Health Assembly, Committee A, sixth and eighth meetings.

<sup>2</sup> Document A71/9, Table 5.

<sup>3</sup> A separate report on the Secretariat's activities in respect of polio transition planning and polio post-certification is contained in document A75/24.

<sup>4</sup> Document EB146/38, Annex, approved by the Executive Board at its 146th session; see also document EB146/2020/REC/2, summary records of the third meeting, section 3.

<sup>5</sup> The full report of the mid-term evaluation of the implementation of the Strategic Action Plan on Polio Transition is available on the website of the Evaluation Office (<https://www.who.int/about/what-we-do/evaluation/corporate-evaluations/programmatic-evaluations>, accessed 27 April 2022).

## ANNEX

### **MID-TERM EVALUATION OF THE IMPLEMENTATION OF THE STRATEGIC ACTION PLAN ON POLIO TRANSITION (2018–2023)**

#### **EXECUTIVE SUMMARY**

#### **INTRODUCTION**

1. The progress towards eradication of poliovirus globally is one of the greatest success stories of the global health community. When the Global Polio Eradication Initiative started in 1988, polio paralysed more than 1000 children worldwide every day. Since then the global incidence of wild poliovirus cases has decreased by 99.9%, with only five cases of wild poliovirus reported in 2021. At present, only two countries in the world are categorized as polio endemic – Pakistan and Afghanistan. A total of around US\$ 20 billion have been spent to support polio eradication activities globally since the launch of the Global Polio Eradication Initiative in 1988. Beyond achievements related to eradication of poliovirus, significant global funding for polio eradication programmes over the last three decades has supported wider health system strengthening efforts, including immunization, vaccine-preventable disease surveillance and outbreak responses.

2. 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. The Strategic Action Plan on Polio Transition (2018–2023) (hereafter referred to as the Action Plan) was developed and presented to the World Health Assembly in May 2018. It has three key objectives, namely to:

- (a) sustain a polio-free world after the eradication of poliovirus;
- (b) strengthen immunization systems, including surveillance for vaccine-preventable diseases;
- (c) strengthen emergency preparedness, detection and response capacity in countries to fully implement the International Health Regulations (2005).

3. Initially, 16 countries across three WHO regions were selected as polio transition priority countries with their selection based on their reliance on Global Polio Eradication Initiative resources. Later, four additional countries were added mainly because the fragility of their health systems and insecurity posed potential threats to polio gains in those countries.

#### **OBJECTIVE, SCOPE AND EVALUATION QUESTIONS**

4. The focus of the mid-term evaluation had two dimensions: an outcome-based dimension (assessing the status and implementation of the Action Plan) and a formative and forward-looking dimension.

5. The evaluation focused on progress across the 20 polio transition priority countries and further investigated progress at the regional and global levels. The evaluation aimed to:

- document key achievements, best practices, challenges, gaps and areas for improvement in the design and implementation of the Action Plan;
- identify the key contextual factors and changes in the global public health realm that have affected the development and implementation of the Action Plan and the road map developed in 2018; and
- make recommendations, as appropriate, on the way forward to enable the successful implementation of the Action Plan.

6. The overarching evaluation questions are as follows:

- (1) What have been the key achievements, best practices, challenges, gaps and areas for improvement in the **design** of the Action Plan? (relevance)
- (2) What have been the key achievements, best practices, challenges, gaps and areas for improvement in the **implementation** of the Action Plan? (effectiveness and efficiency)
- (3) Does the implementation of the Action Plan have the potential to create and/or contribute to **sustainable changes**? (sustainability)
- (4) What **recommendations** are appropriate on the way forward to enable successful implementation of the Action Plan?

7. Cross-cutting aspects of gender, equity and human rights were assessed to the extent possible throughout the evaluation by adopting WHO's cross-cutting evaluation strategies on gender, equity, vulnerable populations and human rights.

## METHODOLOGY

8. The overall process and methodological approach followed the principles set forth in the WHO Evaluation Practice Handbook, the United Nations Evaluation Group Norms and Standards for Evaluation and Ethical Guidelines for Evaluation. The mid-term evaluation employed a mixed methods approach. The inception phase focused on refining the evaluation design and was concluded in November 2021.

9. The evaluation began with a comprehensive secondary review of more than 243 documents and a review and analysis of existing databases and dashboards. The document review was complemented and triangulated by collecting qualitative primary data, including through key informant interviews (75 informants) and country case studies in Bangladesh, Nigeria and Somalia (consisting of a document review, key informant interviews (30) and group discussions (45 informants)). In addition, an online survey was sent to key polio stakeholders in 18 Member States<sup>1</sup> (178 respondents (41 women and 131 men)<sup>2</sup> out of 312 sampled, corresponding to a 57% response rate). Secondary quantitative data

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<sup>1</sup> Excluding polio endemic countries that were not yet in transition mode: Afghanistan and Pakistan, where key informant interviews were conducted instead.

<sup>2</sup> Four respondents did not reply to this question and two did not disclose their gender.

analysis focused on indicators reported in the polio transition dashboard and other official WHO, Global Polio Eradication Initiative and UNICEF data sources.

10. The evidence collected contributed to exploring key achievements and identification of best practices, challenges, gaps, areas for improvement and changes in public health that have affected the implementation of the Action Plan and road map. Information from both primary and secondary data guided the development of findings and recommendations on the way forward and proposed modifications to the Action Plan.

## LIMITATIONS

11. The evaluation faced some limitations related particularly to the COVID-19 pandemic, which restricted face-to-face meetings and the availability of key informants, while also causing delays. However, despite this, the participation rate for planned interviews was high at 93%, suggesting a high level of interest in the topic.

12. Additionally, it is important to note that none of the data collection methods involved randomized sampling. Instead, the evaluation followed a strategy of purposive sampling, with informants selected based on their ability to provide rich and diverse opinions and information. Potential selection bias was minimized by ensuring a diverse range of informants, a large number of informants and respondents and a high response rate to the online survey (57%), as well as by ensuring that saturation levels were met in terms of addressing the evaluation questions, with very little new information emerging in the last interviews.

13. It is, however, important to note that, while the country case studies provided an opportunity to illustrate programme progress and challenges in a wide range of contexts, the countries used for the case studies were purposely selected. The case studies are thus not intended to present a statistically valid sample and are not representative of the entire population of polio transition countries, but were used to explore in more detail contextual factors affecting progress, thus bringing to light lessons learned and best practices.

14. The evaluation methods used are, generally speaking, prone to social desirability bias, by which respondents may distort information to present what they perceive as a more favourable impression. To mitigate the impact of this bias and to stimulate honesty and truthful answers, all informants, including survey respondents, were guaranteed anonymity. Furthermore, triangulation was applied during the analysis, comparing information across different categories of key informants, the document and data review and the survey results.

## KEY FINDINGS

### Relevance, appropriateness, coherence and alignment – design of the Action Plan

15. The Action Plan developed in 2017/2018 was based on assumptions at that time regarding the timelines for polio eradication; however, it inadequately recognized the differences in financial and health system capacities, in the scale and scope of polio vaccination coverage and surveillance and in the level and degree of vulnerabilities across the countries prioritized for polio transition. The process employed for the Action Plan was largely consultative and inclusive of key stakeholders, yet some key country-level stakeholders and donors felt less involved. This resulted in an overall design that was relevant to some, but not all, countries prioritized for polio transition. Overall, the Action Plan did not

address barriers to access and other vulnerabilities affecting women and girls (and other vulnerable groups).

16. The context for polio transition has altered drastically since 2018, including fractures in fragile States, the worsening security situation in many countries, the evolution of polio outbreaks, challenges to health systems, and disruptions and delays due to the COVID-19 pandemic. The Action Plan has not been sufficiently flexible to respond effectively to the evolving polio epidemiology, with large increases in circulating vaccine-derived poliovirus outbreaks and financial constraints experienced by governments over the period of implementation, which ideally should have resulted in documented amendments to overall Action Plan timelines, targets and the pace of polio transition efforts across many countries.

17. The monitoring and evaluation framework is reasonably detailed, but suffers from inadequate target setting, a lack of concrete milestones for output indicators and a limited number of process indicators against which to assess progress. Furthermore, the evaluation team noted inadequate disaggregation of indicators by gender/equity; no differential target setting based on context and baseline indicators for the 20 polio transition priority countries; a lack of polio containment indicators; and only self-assessment indicators for tracking progress on objective C of the Action Plan (strengthening emergency preparedness, detection, and response capacity in countries in order to fully implement the International Health Regulations (2005)).

18. Overall, the Action Plan is well aligned with, and complements, related international policies, strategies and guidelines. However, alignment of planning for polio transition with the transition efforts of UNICEF and Gavi, the Vaccine Alliance was less clear and the role of the Global Polio Eradication Initiative in transition activities is not clearly laid out.

### **Progress against Action Plan monitoring and evaluation framework and road map – implementation of the Action Plan**

19. Overall, the mid-term results show that:

- objective A of the Action Plan (sustaining a polio-free world) is threatened by a sharp increase in the number of circulating vaccine-derived poliovirus outbreaks over the time period 2018–2021 and continued vastly insufficient inactivated polio vaccine and oral polio vaccine coverage rates across many polio transition priority countries. Acute flaccid paralysis indicators, on the other hand, have been stable, with decreases noted in 2020, but with high performance across most polio transition priority countries, except those in the African Region;
- in relation to objective B (strengthening immunization systems and vaccine-preventable disease surveillance), there has been limited change in the indicators since 2018; however, a slight decreasing trend was observed across most polio transition priority countries in 2020. Indicators are still below the performance targets in most polio transition priority countries, except those in the South-East Asia Region;
- improvements in objective C indicators (strengthening emergency preparedness, detection and response capacity) have on the whole been visible across countries since 2018.

20. Despite disruption due to the COVID-19 pandemic, the poliovirus epidemiology and political unrest in many countries, polio transition efforts have moved forward in most countries, albeit at a

slower pace than expected. Most Action Plan road map indicators have been met, although with some key milestones facing delays.

21. Polio transition progress was especially noted in countries in the South-East Asia Region where integration was already in place before Action Plan implementation started, across the Eastern Mediterranean Region through the introduction of the concept of integrated public health teams and in the African Region by accelerating integration at country level.

22. National polio transition plans are well aligned with the context, but their finalization, endorsement and implementation have proven challenging in many countries, mainly due to financial limitations, political instability, frequent changes of government staff being diverted from polio transition activities in order to respond to outbreaks due to circulating vaccine-derived poliovirus and to the COVID-19 pandemic. Overall, implementation of national polio transition plans (whether endorsed or not) has faced significant challenges, leading to the revision of plans in many countries, especially across the African Region.

23. Transitioning of WHO human resources has seen Global Polio Eradication Initiative-funded positions decrease by 27% in polio transition priority countries between 2018 and 2021 – in line with the vision of the Action Plan. Most polio-funded staff members at the country level were integrated into other WHO country office programmes or were shifted to short-term contracts or consultancies but, in some countries, polio expertise was reported to have been lost. It is too early to elaborate on the extent to which the scaling down of human resources and the integration of polio staff has affected polio work and/or strengthened immunization and surveillance or health emergency responses, but experiences of the human resources scale down in Nigeria imply an overall weakening of polio efforts. Reductions in Global Polio Eradication Initiative-funded staff at headquarters and in regional offices were less pronounced. It was noted that the WHO “non-staff” polio workforce (consultants and other contracts) is not reported to the WHO governing bodies in annual polio transition reports, yet in many countries this type of workforce is substantial and much higher in number than WHO “staff” categories.

### **Key contextual factors affecting implementation of the Action Plan**

24. Since the Action Plan was developed in 2018, an increasing number of circulating vaccine-derived poliovirus outbreaks and slower than expected progress on eradication of wild poliovirus have affected the timelines for polio eradication and prospects for sustaining a polio-free world. Several countries experiencing outbreaks of circulating vaccine-derived poliovirus have not implemented a timely vaccination response because of delays in preparing for the use of novel type 2 oral poliovirus vaccine. Supply shortages of inactivated polio vaccine, pandemic-related disruptions and inaccessibility due to heightened insecurity constituted additional barriers to sustaining a polio-free world.

25. The COVID-19 pandemic, coupled with increasing insecurity and political unrest in the polio transition priority countries, has challenged polio and routine vaccine-preventable disease surveillance and vaccination coverage, deflecting attention away from polio transition efforts to respond to these challenges. Vaccine coverage inequity is prevalent in many countries, with pockets of zero-dose children laying the ground for future outbreaks. Global health experts have cautioned that the consequence of COVID-19 on vaccine-preventable diseases may last long after the pandemic recedes, and its full detrimental effect has yet to be seen.

26. Yet the COVID-19 pandemic also clearly demonstrated how leveraging polio assets can contribute to improved health emergency responses, which has been well documented by WHO. It is

now critical that WHO strategically utilize this documentation for advocacy and resource mobilization efforts.

### **Effective and efficient management of the implementation of the Action Plan**

27. The foundation and preparations for polio transition have been established by WHO, with governance structures and support systems largely in place. However, there is room for improvement and some restructuring is warranted to enhance regional and country ownership of the transition.

28. Essential polio functions for polio low-risk countries were transitioned into the WHO base budget when developing WHO's Programme budget 2022–2023. This is considered a major achievement and a key enabler for integration within WHO and for transitioning to governments in the longer term.

29. Support for implementation of the Action Plan and programme management have largely been effective, but challenges were encountered as a result of the COVID-19 pandemic and larger organizational weaknesses in terms of continued vertical and siloed operations and mindsets.

30. High-level attention at WHO has been important for progressing and advocating for polio transition and joint corporate workplans that foster accountability across departments. This has to some extent mitigated the lack of integration and the siloed approaches within WHO – observed especially at the regional and global levels. However, more efforts are needed to fully integrate polio functions as a key step towards effective polio transition.

31. Effective communication on polio transition with Member States, donors and key stakeholders and across programmes has suffered from the delayed development of a communications framework and inadequate engagement and coordination of all actors on polio transition.

32. Although various suitable monitoring mechanisms, including the polio transition dashboard, have been set up, there has been inadequate strategic application and interpretation of progress and a deterioration in indicators, with limited reflection and corrective actions in terms of poliovirus epidemiological trends, changing security situations and countries' economic situations. Except for transition activities not being started in the two countries where polio is endemic, the integrated public health teams approach being applied in some countries in the Eastern Mediterranean Region and a regional workplan being developed for the Eastern Mediterranean, the evaluation team did not find evidence of differential tracking, differential timelines or differential target setting for polio transition. The sharp increase in circulating vaccine-derived poliovirus outbreaks did not change the transition timelines for these countries until the Global Polio Eradication Initiative decided to continue funding 11 "high polio risk" countries until mid-2021. Furthermore, countries such as Nigeria and Somalia, with persistently low polio vaccination coverage rates, circulating vaccine-derived poliovirus outbreaks, insecurity and equity concerns, are still aiming to transition polio assets and functions to national governments within the next two to three years, which seems unrealistic and linked with high risks.

33. Declining financial resources is a critical challenge, along with limited commitment to sustaining essential functions, which was further compounded by the COVID-19 pandemic. Resource mobilization plans have been developed in the majority of polio transition priority countries. However, funding falls short of the needs and prevailing funding gaps in some regions and countries remain a concern. Unpredictable and short-term funding for polio transition at the global level has affected timely planning, including human resource planning at the regional and country levels.

34. Ownership for polio transition at the country level and leadership at the regional office level were observed, with regional and national plans for polio transition being prioritized in demanding contexts. Conducting functional reviews of WHO country offices and alignment with polio transition efforts is a good practice, yet challenges as a result of the limited flexible funding of the WHO base budget prevented full implementation of functional review recommendations.

35. The Polio Transition Independent Monitoring Board was praised for its accountability role, having brought forth actionable recommendations for improving the effectiveness and efficiency of polio transition efforts, although they could be presented more clearly with end-points and timelines.

### **Sustainable change and sustainable integration of polio resources and staff**

36. The vaccine-preventable disease surveillance infrastructure and the ability to interpret and use the gathered data for programming and detecting outbreaks and integration into wider immunization and outbreak responses are impressive and in the longer term have the potential to be the biggest legacy of polio eradication efforts. However, sustaining these gains is challenged particularly in countries where funding from the Global Polio Eradication Initiative has dwindled or is expected to dwindle without a guarantee of sustainable funding.

37. The massive infrastructure established under polio eradication efforts also greatly improved the ability to respond to health emergencies. The infrastructure, including competent laboratories, has been critical in responding to the COVID-19 pandemic in a rapid and wide-reaching way.

38. At the country level, integration efforts are ongoing, resulting in an established cadre of responders who are qualified as routine immunization and public health specialists in some regions. The South-East Asia Region is furthest along in the transition journey, boasting an integrated public health network and strong political will on the part of governments, with domestic financing being raised for the response in some countries. The Eastern Mediterranean Region has the potential to showcase positive results through the integrated public health teams concept, while the African Region has shown integration on the ground, with frontline polio workers responding to outbreaks of measles, cholera, yellow fever and meningitis, among others. Sustainable long-term financing poses one of the most critical challenges to sustainability – including the uncertainty of obtaining funding from donors and other key stakeholders, including Member States. The lack of a coordinated resource mobilization strategy, along with the lack of a clear fundraising roadmap based on an integrated approach to resource mobilization at headquarters and in regional offices, will continue to negatively affect the prospects of sustainability and maintaining a polio-free world. The role and influence of the intergovernmental Working Group on Sustainable Financing provides an opportunity to secure more flexible financing for continued transition efforts if advocated for at the highest level.

39. Best practices identified by the mid-term evaluation include “re-tooling staff” – creating a cadre with technical capacity beyond polio at the country, regional and global levels (for example, the India network responding to Ebola virus disease in West Africa; and the network of surveillance and immunization medical officers in Bangladesh). Other best practices include working with the WHO Health Emergencies Programme to establish a roster of people who can be deployed in response to outbreaks and other public health crises and securing domestic financing for polio transition (mainly countries in South-East Asia, as well as Angola).

40. However, some polio transition priority countries may not be able to maintain polio assets after transition due to various contextual factors that affect their ability to mobilize resources and increase domestic financing and capacity. The need for diversified planning and support is critical, since some



countries will not be able to “foot the bill” and will not have the required capacity of health systems in place to sustain essential polio functions by the end of 2023. Such countries will require continued long-term support from international partners, and long-term planning is warranted.

41. Although some regions are further along the path towards sustainability, the aim of fully transitioning any of the 20 priority countries by 2023 is considered unachievable. Key to successful transition is continued support from WHO regional and country offices that are empowered and have the capacity to help countries plan and advocate for integration and sustainable financing for polio transition at the highest levels.

## CONCLUSIONS

42. The Strategic Action Plan on Polio Transition (2018–2023), developed under the direction of WHO, was a good response to the dire need in 2016–2017 to develop clear guidance on the strategic direction to secure the legacy of polio activities and to document the extent to which WHO human resource capacities relied on funding from the Global Polio Eradication Initiative. In 2018, after a largely consultative and inclusive development process, the Action Plan was broadly appropriate and relevant based on assumptions made at the time and was aligned with global guidance. However, the Action Plan did not appear to adequately accommodate differing country contexts at baseline and countries’ corresponding ability or readiness to transition, for example in fragile States. The plan also lacked the required focus on gender, human rights and equity. Furthermore, the plan did not specify the role of UNICEF as a key implementing organization for polio transition.

43. The initial three-year implementation period of the Action Plan has been confronted with challenges and the Action Plan, by design, has not been contextualized and flexible enough to adapt to these challenges. The polio epidemiology has altered dramatically since 2019. Impacts of the COVID-19 pandemic and continuous political unrest during the period from 2018 to 2021 in several polio transition priority countries have presented significant barriers for its implementation. The Action Plan was not designed as a living document able to respond adequately to contextual and epidemiological changes. This has impeded progress and means that adjustments are required. Several countries with persistently low polio vaccination coverage rates, circulating vaccine-derived poliovirus outbreaks, insecurity and severe equity concerns are still aiming to transition polio assets to governments within the next two to three years, which seems unrealistic and linked with great risks for polio gains.

44. Despite the significant challenges, progress towards the goals of the Action Plan has been noted and some key indicators and milestones have been reached or maintained despite the COVID-19 pandemic and political instability, which is considered a major achievement. Polio and immunization coverage rates, as well as acute flaccid paralysis surveillance indicators, have largely remained unchanged or with minor decreases since 2018 across polio transition priority countries, but outbreaks of circulating vaccine-derived poliovirus have significantly increased in several countries, threatening polio gains. The development, endorsement and implementation of national polio transition plans has proven very challenging, with limited domestic funding commitments.

45. Indicators on health emergency preparedness and response have improved overall and polio infrastructure has greatly benefited the COVID-19 response, and this has been well documented by WHO. It would be important now to leverage these reports as advocacy and fundraising tools for sustaining essential polio structures to advance global health security. Donor interest in funding post-COVID-19 recovery and resilience efforts is an opportunity that polio transition efforts, not to mention broader immunization efforts, can tap into, building on the successful initial response and building holistic health systems in countries.

46. The monitoring and evaluation framework design and oversight system are characterized by gaps that limit accountability and impede corrective actions. Transition efforts have struggled as a result of inadequate reflection on the rapidly changing context over time and insufficiencies in oversight and strategic direction, with gaps in the information and guidance required to support sound decisions and necessary course corrections.

47. In terms of responsibility and accountability, the Action Plan was overly centred at the headquarters level of WHO, which made it difficult to revise and amend the plan promptly in the light of rapidly and drastically shifting contexts. Appreciation of regional and national contexts in a revitalized and more flexible plan going forward would be enhanced by shifting the balance of responsibility and accountability from headquarters to regional and country offices.

48. Regional directors and WHO representatives have been identified through the evaluation as key entry points and decision-makers for promoting polio integration and transition. Country-level voices need to be heard in polio transition discussions, including on when to redirect strategies and timelines. Regional and country ownership of polio integration and transition has generally promoted implementation of polio transition, and there is an opportunity to build on lessons learned from the South-East Asia Region, from the integrated public health teams concept being rolled out in the Eastern Mediterranean Region and from the integration of polio, immunization, health emergencies and primary health care in the African Region.

49. The designation of the Deputy Director-General as accountable for the Action Plan demonstrated the high priority accorded to polio transition at WHO. The Action Plan's governance and oversight structures are multi-layered and extensive, but sometimes not fully active. Programme management has been reasonably effective given the circumstances. However, it has been affected by inefficiencies related to a lack of proper integration of polio functions at WHO headquarters, changes in funding prospects and a possible duplication of efforts.

50. The polio programme remains a highly vertical structure within WHO, especially at headquarters, and in some regional offices. This vertical structure inhibits effective coordination, synergies and polio transition efforts. Integration of polio functions and staff within immunization, health emergencies and/or primary health care programmes at WHO is considered a prerequisite and a key driver for transitioning polio functions and assets to national governments. Regions and countries that have managed to start transitioning responsibilities for sustaining polio functions to governments have ensured integration at WHO before transitioning to the government.

51. WHO has been working on polio transition, without substantial ownership on the part of the Global Polio Eradication Initiative for transition, since 2018 and in a somewhat siloed approach. WHO should focus on strengthening and developing management and coordination structures to enhance the synergy and contribution of WHO, the Global Polio Eradication Initiative and other relevant programmes within WHO to the planning and review process at both headquarters and the regional level. The Global Polio Eradication Initiative has a critical role to play in helping to shape transition, as eradication and transition go hand in hand, and needs to increase ownership and responsibility for polio transition and improve collaboration with WHO and UNICEF on polio transition. Reorganized and revitalized decision-making structures within WHO should enable frank discussions and concrete decisions with the Global Polio Eradication Initiative, partners, donors and Member States on polio transition timelines given the changing context, and generate predictable long-term plans for funding polio transition. This requires strong leadership to guide the discussions and ensure accountability in decision-making.

52. There is a need for more high-level political commitment, coordination, clear communication and advocacy on the important opportunity that polio assets offer in helping achieve broader global health initiatives, including the Sustainable Development Goals, global health security and universal health coverage. The lack of clarity regarding messaging on transition and integration and the apparent lack of a common understanding of their meaning were fuelled in part by communication gaps between stakeholders at all levels, including within WHO and with partners and donors. Senior management advocacy is needed at all three levels, yet with a strong push to move accountability and decision-making on transition closer to regions and countries for more country-specific approaches and oversight.

53. Sustainability, to a large degree, hinges on securing flexible and predictable financing for a continued polio transition response – to that effect, the integration of transition funding for essential polio functions in the WHO base budget is seen as a major achievement in the short term. Fragmented and unpredictable funding are major issues affecting planning for integration and transition. Although supporting polio functions in the Programme budget 2022–2023 under WHO’s base budget will help to advance integration efforts, strong emphasis and intensified efforts on joint resource mobilization are needed. There is a need to take advantage of opportunities to pursue integrated funding for sustaining polio functions and the response to other vaccine-preventable diseases and health emergencies.

54. The Polio Transition Independent Monitoring Board (TIMB) has provided useful monitoring of polio transition efforts, as well as recommendations and ways forward for transition activities, with a strong focus on integration. The role of the TIMB is important in ensuring a frank and honest review of progress and will be even more critical in the future, since key elements of Action Plan implementation are de facto only now materializing, with essential functions being integrated into the WHO base budget for 2022–2023. The role of the TIMB will be essential to help guide implementation and to maintain donor confidence, as well as to maximize links with the separate Polio Independent Monitoring Board<sup>1</sup>. This is particularly important given the sensitivities surrounding polio transition and thus the need for an independent oversight body.

55. Now is the time to revisit and revise, as appropriate, the Action Plan to make it more responsive to the diverse range of contexts, by addressing the challenges observed and building on the best practices and enablers for polio transition that have been identified.

## RECOMMENDATIONS

56. The mid-term evaluation proposes 10 overall recommendations, along with related sub-recommendations, which are presented below.

**Recommendation 1: By the end of 2023, develop a global polio integration and transition vision** clarifying the role and positioning of polio transition in relation to other WHO investments in primary health care, vaccine-preventable diseases and emergency response, as well as broader, global polio and polio transition efforts.

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<sup>1</sup> It should be noted that there are two independent entities: the GPEI Polio Independent Monitoring Board (broader polio programme); and the Transition Independent Monitoring Board.

Sub-recommendations – ensure that the vision:

- (a) is developed based on consultation with and buy-in from all appropriate stakeholders, including partners involved in polio eradication, and is flexible enough to allow regions and countries to develop regional and country-specific plans;
- (b) includes a theory of change aligning with the larger landscape in which transition efforts are undertaken and the specific contribution that these efforts make to strengthening immunization systems and emergency preparedness; and that it ensures linkages with regional offices' theories of change (see recommendation 2);
- (c) incorporates gender equality aspects and access for vulnerable populations, which should also be included in the theory of change;
- (d) ensures longer-term strategic planning around agreed timelines and modes of operation forming the basis for financial and human resource planning.

**Recommendation 2: By the end of 2023, develop regional polio integration and transition action plans (in the African, Eastern Mediterranean and South-East Asia Regions)** as the key vehicles for regional- and country-tailored approaches for sustaining polio assets, identifying appropriate levels and positioning of human and financial resources, and ensuring they are “living documents” with periodic updates that take into consideration capacities, epidemiological context and resources.

Sub-recommendations – ensure that the plans:

- (a) are formulated, led and owned by the WHO regional offices and guided by a polio integration and transition vision formulated, led and owned by WHO headquarters (recommendation 1);
- (b) include clear objectives, strategies, investments, timelines and outcomes for the region and countries working in collaboration with the Global Polio Eradication Initiative, WHO headquarters, country offices, governments, civil society organizations, United Nations agencies and other development partners to strengthen buy-in, fundraising and stakeholder engagement in transition efforts;
- (c) include theories of change and results frameworks, including clear milestones and realistic indicators that are tailored to the context;
- (d) allow for flexibility and differentiated country approaches and differentiated timelines for transition based on context, taking into account the fragility of health systems, political insecurity, circulating vaccine-derived poliovirus outbreaks and domestic funding potential in individual countries;
- (e) fully incorporate gender equality and access for vulnerable populations (also reflected in country transition plans, when they are due for revision);
- (f) are preceded, in the interim, by polio transition workplans in all three regions, with milestones and indicators linked to the Strategic Action Plan on Polio Transition (2018–2023).

**Recommendation 3: Empower WHO regional and country offices to lead polio transition by ensuring sufficient resources, capacity and guidance on polio transition.**

Sub-recommendations:

- (a) allocate adequate resources to WHO regional and country levels to effectively lead and implement polio transition efforts;
- (b) strengthen regional and country offices' capacity and authority for resource mobilization and high-level advocacy;
- (c) provide tailored guidance and support as requested by the regional or country office, as identified through oversight mechanisms;
- (d) develop capacity-building plans for regional and country offices to manage and oversee polio transition implementation at the country level;
- (e) develop plans for supporting countries and their national health systems and authorities in building their capacity to plan for and deliver on polio transition;
- (f) finalize, disseminate and implement, as a matter of urgency, the draft communications framework for polio transition at all three levels (see also recommendation 4).

**Recommendation 4: Enhance coordination among all polio (transition) partners to ensure adequate and coordinated stewardship and more inclusive and informed decision-making processes.**

Sub-recommendations:

- (a) engage with the Global Polio Eradication Initiative and UNICEF to formalize collaboration arrangements on polio integration and transition, while defining clear roles and responsibilities at the global, regional and country levels;
- (b) convene a forum for transition that includes the Global Polio Eradication Initiative, WHO, UNICEF, Gavi, the Vaccine Alliance and donors, to discuss plans, gauge end-points for eradication and promote transparent and predictable financing for sustaining polio assets; make adjustments and modifications and assess and share learning on emerging issues, milestones, and related to the vision and respective regional action plans – both globally and at regional levels;
- (c) discuss, as a matter of urgency, the draft communications framework for polio transition with all relevant polio partners and donors (see also recommendation 3);
- (d) engage more actively with non-State actors (civil society, nongovernmental organizations and the private sector), in accordance with the Framework of Engagement with Non-State Actors, on transition planning and identifying solutions tailored to the context.

**Recommendation 5: Accelerate integration and management of polio assets with other key WHO programmes, strengthening synergies, collaboration, coordination and coherence around integration.**

Sub-recommendations:

- (a) initiate a Deputy Director-General-led inclusive process to assess obstacles and successes for integration of the polio programme and strengthen related planning and implementation (mirrored at regional offices under the Regional Directors' leadership);
- (b) strengthen headquarters and regional offices' proactive coordination for planning, monitoring and managing integration, including alignment of human resources, budget, resource mobilization and operational planning management;
- (c) clarify how integration supports maintaining a polio-free world and benefits other health programmes, including health emergency preparedness and response, immunization, universal health coverage and primary health care, as a prerequisite to regional and country transition planning, and develop and implement strategies for achieving said integration (see sub-recommendation 7a for the investment case);
- (d) explore the use of polio staff as surge capacity for health emergencies;
- (e) develop a clear long-term plan for staff integration, starting with transitioning polio back-office functions followed by migrating technical functions as needed, both at headquarters and in regional offices;
- (f) continue joint planning (between the polio programme, the Immunization, Vaccines and Biologicals Department, the WHO Health Emergencies Programme, etc.), including by developing specific annual workplans on polio transition (headquarters, regions) with oversight by the Deputy Director-General.

**Recommendation 6: Enhance governance and independent monitoring of polio transition.**

Sub-recommendations:

- (a) ensure regular regional-led steering committee and regional-led technical working group meetings (or separate polio transition committee/working group meetings), with the participation of headquarters and country representatives as appropriate;
- (b) ensure the steering committees set up for polio transition meet frequently, adhere to an agreed standard agenda and, as appropriate, periodically invite external partners to participate (for example, Global Polio Eradication Initiative members, UNICEF);
- (c) implementation of the regional action plans should ensure: periodic gauging and revisiting of end-points for eradication, and adjustments to transition timelines and for contextual changes;
- (d) clarify the role and functioning of the Polio Transition Independent Monitoring Board, including any required revision of the terms of reference, mandate and end-date, method of work, governance relationships with the Polio Independent Monitoring Board, Global Polio Eradication

Initiative and WHO governing bodies, and reporting (including actionable recommendations and WHO management responses).

**Recommendation 7: Develop and operationalize a comprehensive resource mobilization strategy to stimulate predictable and flexible funding for sustaining polio assets in line with required resources, and build WHO's capacity to advocate for sustainable resource mobilization.**

Sub-recommendations:

- (a) create linked headquarters and regional office investment cases for sustaining polio assets for countries, the Global Polio Eradication Initiative and donors, articulating required resources, with these investment cases to be developed in collaboration with the Global Polio Eradication Initiative, relevant WHO programmes and other donors to ensure resources mobilization and sustainable financing;
- (b) incorporate the results of functional reviews to inform investment case planning;
- (c) ensure that predictable forecasting and long-term financing are available to fragile polio transition priority countries;
- (d) initiate resource mobilization efforts for integrated responses to COVID-19, polio, vaccine-preventable diseases, health emergencies, etc.;
- (e) continue high-level advocacy with partners and Member States at the global level, focusing on flexible funding for the WHO base budget;
- (f) ensure coordinated corporate resource mobilization (polio resource mobilization and overall communication and fundraising efforts), moving away from a "polio eradication only" focus to further foster a coordinated integration agenda;
- (g) provide technical support to regional and country offices for sustainable resource mobilization, planning and outreach to governmental entities beyond ministries of health, recognizing differing country contexts.

**Recommendation 8: Strengthen integrated surveillance systems for polio, other vaccine- preventable diseases and health emergencies, including ensuring core funding from the WHO base budget to serve as a key source of interim financing and a tool for catalysing and leveraging future sustainable financing of vaccine-preventable disease surveillance.**

Sub-recommendations:

- (a) guarantee funding through the WHO base budget for sustaining polio surveillance in the interim;
- (b) advocate for Member States to define integrated vaccine-preventable disease (including polio) surveillance activities as a central core funded activity supported by Member States' contributions;

- (c) plan, together with the Global Polio Eradication Initiative, the polio programme, the Immunization, Vaccines and Biologicals Department, the WHO Health Emergencies Programme and donors, for polio surveillance activities to be integrated with other vaccine-preventable diseases to sustain surveillance (through the platforms discussed under recommendation 4);
- (d) develop a strategic approach to strengthening surveillance and response in a select number of fragile countries, including the possible transfer of polio resources to a multidisciplinary early warning surveillance and response mechanism (through the platforms discussed under recommendation 4);
- (e) support capacity-building activities for improved integrated vaccine-preventable disease surveillance within the government health system – including supporting and collaborating with local non-State actors (e.g., civil society and nongovernmental organizations) working on polio surveillance.

**Recommendation 9: Develop, as a matter of urgency, a final monitoring and evaluation framework,** with key performance indicators and end-points for 2023 and milestones for all output indicators that are realistic and aligned with the draft monitoring and evaluation framework of the Action Plan (following the theories of change in recommendations 1 and 2), to strengthen the relevance and strategic use of the monitoring and evaluation framework and to steer implementation of the Action Plan.

Sub-recommendations:

- (a) revise Action Plan output indicators and targets to increase their relevance; add indicators on polio containment and health emergency preparedness and response that are not self-assessed;
- (b) add gender and equity disaggregated data (including zero-dose children) when available or already collected by partners;
- (c) process indicators: closely monitor implementation status of national transition plans, trends in all WHO contract types of Global Polio Eradication Initiative-funded staff and functional integration within WHO to deliver on the Action Plan;
- (d) agree on differentiated targets for polio transition in regional workplans for all indicators with milestones up to 2023;
- (e) identify more specific and defined activities, with clearer milestones in joint corporate workplans, with active monitoring and reporting.

**Recommendation 10: Enhance dissemination of monitoring and evaluation reporting and learning.**

Sub-recommendations:

- (a) develop an operational research agenda and specific analyses, including to document lessons from past integration efforts, readiness for transitioning polio assets to governments), specific approaches that into account fragility of health systems, political insecurity, circulating vaccine-derived poliovirus outbreaks and domestic funding potential, and different transition/integration pathways for different contexts;



- (b) regularly update (at least twice a year) the Action Plan dashboard monitoring and evaluation framework indicators, linking directly to data sources if possible;
- (c) provide annual updates on the most strategic output indicators and discuss these for decision-making at polio transition steering committee meetings. Monitor and discuss to a greater extent polio outbreaks in technical polio transition meetings (new data are continuously available for this critical indicator in relation to objective A (sustaining a polio-free world));
- (d) provide a more detailed analysis in reports to governing bodies of the trends in Action Plan output indicators. This should be integrated and analysed in the main reports and include indicator trends by country and region. Include a polio “non-staff” overview and trends in reports to WHO governing bodies;
- (e) regularly provide updates on progress to all donors and polio partners.

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