

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

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Core evaluation team: Maiken Mansfeld Jacobsen (Team Leader), Michele Gross (Deputy Team Leader), Ann Levin, Ida Marie Pierrel-Boas

Rosenkæret 13, st.tv
2860 Søborg
Denmark
<https://www.ehg.dk>

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Any enquiries about this evaluation should be addressed to:

Evaluation Office, World Health Organization

Email: evaluation@who.int

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Abbreviations and acronyms

| | |
|-------------|---|
| Action Plan | Strategic Action Plan on Polio Transition (2018-2023) |
| AFP | Acute flaccid paralysis |
| AFR | WHO African Region |
| AFRO | WHO Regional Office for Africa |
| CDC | U.S. Centers for Disease Control and Prevention |
| COVID-19 | Coronavirus disease 2019 |
| CRM | Coordinated Resource Mobilization Department in WHO |
| CSO | Civil society organization |
| DDG | Deputy Director-General (of WHO) |
| cVDPV | circulating vaccine-derived poliovirus |
| EMR | WHO Eastern Mediterranean Region |
| EMRO | WHO Regional Office for Eastern Mediterranean |
| EPI | Expanded Programme on Immunization |
| EQ | Evaluation Question |
| Gavi | The Global Alliance for Vaccines and Immunization |
| GPEI | Global Polio Eradication Initiative |
| GPW13 | WHO Thirteenth General Programme of Work 2019-2023 |
| IA | Immunization Agenda |
| IHR | International Health Regulations (2005) |
| IMB | Independent Monitoring Board |
| IPHT | Integrated Public Health Teams |
| IPV | Inactivated polio vaccine |
| IVB | Immunization, Vaccines, and Biologicals Department in WHO |
| IVD | Immunization and vaccine development |
| KI | Key informant |
| KII | Key informant interview |
| KPI | Key performance indicator |
| M&E | Monitoring and evaluation |
| MCV1 | One-dose measles containing vaccine |
| MCV2 | Two-dose measles containing vaccine |
| MoH | Ministry of Health |
| NGO | Non-governmental organization |
| OPV | Oral polio vaccine |
| PEESP | Polio Eradication & Engagement Strategic Action Plan |
| PHC | Primary Health Care |
| POB | Polio Oversight Board |
| POL | Polio Eradication Programme (In WHO) |

| | |
|--------|--|
| iPOW | Interim Programme of Work for Polio/Essential Immunization |
| PTP | Polio Transition Programme in WHO |
| RI | Routine immunization |
| SDG | Sustainable Development Goal |
| SEAR | WHO South-East Asia Region |
| SEARO | WHO Regional Office for South-East Asia |
| SIA | Supplementary immunization activities |
| SPRP | COVID-19 Strategic Preparedness and Response Plan |
| TIMB | Transition Independent Monitoring Board |
| TOR | Terms of Reference |
| UHC | Universal Health Coverage |
| UN | United Nations |
| UNEG | United Nations Evaluation Group |
| USAID | United States Agency for International Development |
| VPD | Vaccine-preventable disease |
| WHA | World Health Assembly |
| WHE | WHO Health Emergencies Programme |
| WHO | World Health Organization |
| WPV | Wild poliovirus |
| WUENIC | WHO/UNICEF estimates of national immunization coverage |

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Glossary of terms

| Term | Definition | Source |
|--------------|--|--|
| Integration | “Integration under the GPW13 umbrella aims at achieving greater efficiencies and better impact by creating programmatic synergies.” | WHO Thirteenth General Programme of Work 2019-2023 (GPW13) |
| | “Integration can help lay a path towards successful transition by building synergies between polio and other health programmes and emphasizing the value of the polio infrastructure for broader health goals, with a view of encouraging country ownership, political commitment, and sustainable financing.” | WHO, Draft Framework for Polio Transition Strategic Communications, 3rd draft, August 2021 |
| Transition | “Polio transition is the process of repurposing and transferring the network and infrastructure developed by the polio programme to strengthen broader health priorities, especially essential immunization and emergency preparedness and response, under the leadership of national authorities. The goal of transition is to transfer the responsibility to national governments to ensure long-term sustainability of essential functions.” | WHO, Draft Framework for Polio Transition Strategic Communications, 3rd draft, August 2021 |
| Polio Assets | Include both physical assets (infrastructure, cars, computers, systems, etc.) and human resources, knowledge and management. | Evaluation team definition |

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 States¹ (178 respondents (41 women and 131 men)² out of 312 sampled, corresponding to a 57% response rate). Secondary quantitative data 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.

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

² Four respondents did not reply to this question and two did not disclose their gender.

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 roadmap – 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 Board³. 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.

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;

³ 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](#).

- (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.

1 Introduction

Evolution of the Strategic Action Plan on Polio Transition (Action Plan)

1. The progress towards eradication of poliovirus globally is one of the greater success stories of the global health community. When the Global Polio Eradication Initiative (GPEI) started in 1988, polio paralysed more than 1000 children worldwide every day. Since then, polio has been eliminated in more than 123 countries, and the global incidence of wild poliovirus (WPV) cases has decreased by 99,9% with only 5 WPV cases reported in 2021⁴. The WHO South-East Asia Region (SEAR) was declared free of poliovirus in 2014⁵; and most recently, the WHO African Region (AFR) was certified free of wild WPV in August 2020⁶. At present, only two countries in the world are categorized as polio endemic - Pakistan and Afghanistan, situated in the WHO Eastern Mediterranean Region (EMR)⁷. If polio is eradicated, it would only be the second time in history that a disease affecting humans has been eradicated, the first being smallpox with the last case isolated in 1977.
2. A global push for polio eradication by 2026 is underway after several delays in reaching eradication timelines⁸. In 1988 the World Health Assembly (WHA) declared the commitment of the World Health Organization (WHO) to the global eradication of poliomyelitis by 2000⁹. By the year 2000, the global incidence of polio had been reduced by over 99%, but the eradication target was missed¹⁰. Four countries experienced significant challenges to WPV eradication efforts (Afghanistan, India, Nigeria and Pakistan) over the next 10 years. India was officially certified as polio-free in 2014¹¹, and Nigeria in 2020¹². Re-importation of WPV to countries that were previously polio-free had also complicated eradication efforts, especially in AFR^{13,14,15}. Reaching the last mile in polio eradication efforts has thus proven very challenging.
3. Since the launch of the GPEI in 1988, a total of around US\$ 20 billion have been spent to support polio eradication activities globally, with around one billion spent each year in the period 2013-2019 and US\$ 652 million spent in 2020¹⁶. Beyond achievements related to eradication of poliovirus, the significant global funding for polio eradication programmes over the last three decades has supported wider health system strengthening efforts, including immunization, disease surveillance and outbreak responses.

⁴ Global Polio eradication initiative website: <https://polioeradication.org/>, accessed 18 February 2022

⁵ <https://polioeradication.org/news-post/who-south-east-asia-region-declared-polio-free/>

⁶ <https://www.who.int/news/item/25-08-2020-global-polio-eradication-initiative-applauds-who-african-region-for-wild-polio-free-certification>

⁷ <https://polioeradication.org/where-we-work/polio-endemic-countries/>

⁸ GPEI Polio Eradication Strategy 2022–2026, <https://polioeradication.org/gpei-strategy-2022-2026/>

⁹ Resolution WHA41.28: Global eradication of poliomyelitis by the year 2000. Forty-first World Health Assembly. World Health Organization 1988. <http://www.who.int/ihr/polioresolution4128en.pdf>

¹⁰ Report of the Independent Monitoring Board of the Global Polio Eradication Initiative, April 2011.

http://www.polioeradication.org/Portals/0/Document/Data&Monitoring/IMB_Reports/IMB_Report_April2011.pdf.

¹¹ Website: <https://www.mea.gov.in/bilateral-documents.htm?dtl/23154/WHO+Certifies+India+As+Polio+Free>, accessed 4 April 2022

¹² Website: <https://www.who.int/news/item/25-08-2020-global-polio-eradication-initiative-applauds-who-african-region-for-wild-polio-free-certification>, accessed 4 April 2022

¹³ World Health Organization. Resurgence of wild poliovirus types 1 and 3 in 15 African countries, January 2008–March 2009. *Wkly Epidemiol Rec.* 2009;84:133–40

¹⁴ World Health Organization. Progress towards global polio eradication—status of wild poliovirus circulation in Africa, 2011. *Wkly Epidemiol Rec.* 2012;87:109–15

¹⁵ World Health Organization. Polio global eradication initiative. Annual report 2009. Geneva: The Organization; 2010

¹⁶ GPEI website: <https://polioeradication.org/financing/expenditure-information/annual-expenditure-reports/>, accessed 20 March 2022

4. With significant achievements toward the eradication of poliovirus globally by 2017, WHO Member States and the Independent Expert Oversight Advisory Committee (IEOAC) emphasized the need for the development and implementation of a polio transition plan. The Seventieth World Health Assembly in May 2017 adopted decision WHA70(9) on poliomyelitis: polio transition planning, in which the Director-General was requested, inter alia, to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session. The Strategic Action Plan on Polio Transition (2018 -2023) which was developed and presented to the World Health Assembly in May 2018¹⁷ and 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 (IHR) (2005).

5. Yet, polio transition planning initially evolved under the GPEI leadership from “legacy planning” at a strategic level under the Polio Eradication Endgame Strategy (2013-2018), which was the fourth objective of the GPEI Strategy to ensure that the world remains polio-free and that the investments made to eradicate polio contribute to future health goals. The main elements of transition were threefold – to mainstream essential polio functions; to capture and share lessons learned from eradicating polio; and to transition polio assets, as appropriate, to benefit other health priorities¹⁸. To that extent, transition planning as a concept has been ongoing since 2013 at the national level with activities starting in 2015/2016. Support from WHO and GPEI partners (i.e., through provision of tools, guidance and technical assistance, and advocacy support) to polio transition priority countries have helped develop costed national transition plans for some countries. Notwithstanding delegating responsibility of supporting polio transition implementation to WHO and UNICEF in 2018, GPEI under its Endgame Strategy 2019-23¹⁹ remained committed to continued engagement in transition planning. This included advocating for mainstreaming of functions, coordinating with WHO on transitioning costs for functions needed after certification to WHO’s base budget, engaging in governance discussions, etc.

Polio transition planning

6. As the world comes closer to the certification of global polio eradication, GPEI resources have gradually decreased. These changes in financing have necessitated countries to proactively plan for a transition away from GPEI resources. Many countries have relied (and some still rely) heavily on polio-funded infrastructure to support key health system functions such as vaccine-preventable disease surveillance, immunization information systems, laboratory networks, cold chain, logistics, etc. Sixteen polio transition priority countries²⁰ together received over 90% of the GPEI resources and were selected as polio transition priority countries in light of the expected GPEI funding dwindle and need to sustain essential polio functions when GPEI sunsets. Later another four countries were added as polio transition priority countries mainly because of their fragility (Libya, Iraq, Syria and Yemen)²¹.

7. To manage transition successfully, governments have been encouraged to lead the development of national transition plans that determine what polio functions will be integrated into other

¹⁷ [WHO A71/9, The Strategic Action Plan on Polio Transition \(2018-2023\)](#)

¹⁸ GPEI. Polio Eradication & Endgame Strategic Plan 2013-2018. [PEESP EN A4.pdf \(polioeradication.org\)](#)

¹⁹ GPEI. The Polio Endgame Strategy 2019-2023: Eradication, Integration, Containment and Certification, <https://polioeradication.org/who-we-are/polio-endgame-strategy-2019-2023/>

²⁰ Afghanistan, Angola, Bangladesh, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Myanmar, Nepal, Nigeria, Pakistan, Somalia, South Sudan and Sudan

²¹ GPEI website: <https://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transition-planning/country-transition-planning/> accessed 4 April 2022

existing initiatives, and what functions may be prioritized or phased out. Each national plan should address local needs and priorities and may draw on lessons learned from the various pathways to achieving eradication²².

Objectives of the evaluation

8. The mid-term evaluation of the Strategic Action Plan on Polio Transition (2018-2023) is one of the milestones referenced in the Action Plan Road map and was included in the WHO Evaluation Office's proposed biennial workplan 2020–2021 submitted to and approved by the Executive Board at its 146th session in February 2022²³.
9. As a mid-term evaluation, its focus is on two dimensions: outcome-based (assessing the status and implementation of the Action Plan) and formative. Regarding the latter, and recognizing significant changes in the context surrounding polio, emphasis is placed on the forward-looking element of the evaluation mandate to generate learning and proposing any modifications needed to adapt to the changing context, as well as informing relevant discussions and decisions both within WHO and its governing bodies, and by Member States.
10. In line with the terms of reference (TOR) (see annex 1), the evaluation aims 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 roadmap developed in 2018; and
 - make recommendations as appropriate on the way forward to enable the successful implementation of the plan.

Overarching evaluation questions

11. The overarching evaluation questions (EQ), developed during the inception phase, 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?
12. Each of the main EQs is addressed through its respective sub-questions. Table 1 provides a listing of the relevant sub-questions for each major EQs.
13. 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 rights²⁴. The evaluation included an assessment under each of the EQs on the extent to which the Action Plan had considered gender mainstreaming

²² GPEI, Polio Legacy Planning: Guidelines for Preparing a Transition Plan, 2015 <https://polioeradication.org/wp-content/uploads/2016/07/TransitionGuidelinesForPolioLegacy.pdf>

²³ <https://www.who.int/about/what-we-do/evaluation/resources/evaluation-workplan-2020-2021>

²⁴ WHO evaluation practice handbook, 2013:

https://apps.who.int/iris/bitstream/handle/10665/96311/9789241548687_eng.pdf;jsessionid=9B180AA9A01A375CAB32D1CC80916FEF?sequence=1

and equity in health issues in the design, implementation and outcomes of the Action Plan and related recommendations for the future.

Table 1: Evaluation questions and relevant sub-questions

| Evaluation questions (EQ) |
|---|
| EQ1: What have been the key achievements, best practices, challenges, gaps, and areas for improvement in the design of the Action Plan? |
| <p>1.1: To what extent was the design of the Action Plan relevant and appropriate to achieve its intended purpose and objectives and did it respond to the needs and priorities of targeted countries?</p> <p>1.2: To what extent does the Action Plan align, complement, and link with other related policies, plans, strategies, and programmatic guidance in a coherent manner?</p> |
| EQ2: What have been the key achievements, best practices, challenges/ gaps, and areas for improvement in the implementation of the Action Plan? |
| <p>2.1 To what extent is the Action Plan on course to achieving its results across the three objectives of the Action Plan and related process indicators and roadmap?</p> <p>2.2 What have been the key contextual factors and changes in the global public health realm that have affected the implementation of the Action Plan and the roadmap developed in 2018?</p> <p>2.3 To what extent has implementation of the Action Plan and roadmap been managed effectively by WHO in a way that leads to successful polio transition in targeted countries based on optimal use of resources?</p> |
| EQ3: Does the implementation of the Action Plan have the potential to create and/or contribute to sustainable changes? |
| <p>3.1 To what extent is the implementation of the Action Plan likely to contribute to sustainable change in relation to the three key objectives of the Action Plan and on broader outcomes and anticipated impact indicators?</p> <p>3.2 To what extent have polio resources and staff been integrated in a sustainable manner into other health programmes in line with the Action Plan and what are the indications towards future financing models?</p> |
| EQ4: What recommendations are appropriate on the way forward to enable the successful implementation of the Action Plan? |

2 Methodology

14. The overall process and methodological approach followed the principles set forth in the WHO evaluation practice handbook²⁵ and the United Nations Evaluation Group Norms and Standards for Evaluation and Ethical Guidelines for Evaluation²⁶.
15. The mid-term evaluation is considered both a summative (outcome-based) and a formative (process) evaluation employing a mixed methods approach. The inception phase focused on refining the evaluation design and was concluded in November 2021.
16. The evaluation was initiated with a **comprehensive secondary document review** (more than 243 documents) and a review and **analysis of existing databases and dashboards**. The implementation status of the Action Plan, generated from the existing data review, was validated, and complemented, by: qualitative primary data including **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 administered to key polio stakeholders in 18 Member States²⁷ (178 respondents (41 women and 131 men of those who chose to disclose this) out of 312 sampled, corresponding to a 57% response rate). Secondary quantitative data analysis focused on indicators reported in the polio transition dashboard²⁸ and other official WHO, GPEI, and UNICEF data sources.
17. The evidence collected assisted exploring key achievements, and identification of best practices, challenges, gaps, areas for improvement and changes in the public health realm that have affected the implementation of the Action Plan and roadmap. Information from both primary and secondary data guided the development of findings and recommendations on the way forward and proposed modifications. Please refer to Annex 4 for a detailed methodological description.
18. Gender and equity indicators and disaggregated data were reported whenever possible. The selection of county case studies and key informants sought to strike a gender and equity balance and during country case studies inclusion of subnational respondents was endeavoured.

²⁵ WHO evaluation practice handbook. WHO 2013

http://apps.who.int/iris/bitstream/handle/10665/96311/9789241548687_eng.pdf;jsessionid=987A50207698DDBF0E42AE67BF886EF5?sequence=1

²⁶ United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation 2016.

<http://www.unevaluation.org/document/detail/1914>

²⁷ Excluding polio endemic countries that were not yet in transition mode: Afghanistan and Pakistan, where KII were instead conducted

²⁸ <https://www.who.int/teams/polio-transition-programme/monitoring-and-evaluation-dashboard>

3 Findings

3.1 EQ1: Design of the Action Plan

3.1.1 Sub-question 1.1 – Relevance, coherence and appropriateness of the design

Summary of findings – Relevance, coherence and appropriateness of the design

The Strategic Action Plan on Polio Transition (Action Plan) developed in 2017/2018 was based on assumptions at that time regarding the timelines for polio eradication; but inadequately recognized the different financial and health system capacities, scale and scope of polio vaccination coverage and surveillance, and level and degree of vulnerabilities across the countries selected for polio transition. The process employed for the Action Plan development was largely consultative and inclusive of key stakeholders, however some key country-level stakeholders and donors have felt less involved. This resulted in an overall design which was relevant to some, but not all, countries prioritised for polio transition. Attention to addressing barriers and vulnerabilities to access for women and girls (and other vulnerable groups) is generally not evident in the Action Plan.

The context for polio transition has altered drastically since 2018 including fractures in fragile states, declining security in many countries, the evolution of polio and Vaccine-preventable disease (VPD) outbreaks, challenges to health systems, and disruption and delays due to the COVID-19 pandemic. The Action Plan has not been sufficiently flexible from a design perspective to adjust effectively for the evolving polio epidemiology with large increases in circulating vaccine-derived poliovirus (cVDPV) outbreaks and financial constraints experienced by governments over the period of implementation which ideally should have resulted in documented amendments of overall Action Plan timelines, targets and the pace of polio transition efforts across many countries.

The monitoring and evaluation (M&E) framework is reasonably detailed but suffers from inadequate target setting and concrete milestones against which to assess progress. Furthermore, the evaluation team noted inadequate disaggregation 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 tracking progress on objective C of the Action Plan.

3.1.1.1 Relevance of Action Plan, partner engagement and coherence with needs and priorities

19. To ensure the continuation of past polio eradication investments under the GPEI (an unprecedented level of commitment for a single disease) - and to galvanize the opportunity to strengthen routine immunization and emergency response after eradication, the global community recognized that **polio transition planning needs to be prioritized and implemented congruently with polio eradication efforts**. Planning for transition was undertaken with the premise of planning for a future with less polio funding, and identifying essential assets and functions needed to sustain efforts in addition to alternative funding mechanisms.
20. The “passing of the baton” from GPEI leadership to WHO governance and leadership further promoted development of the Action Plan which was by and large considered a **participatory and inclusive process** that was requested by Member States. According to informants and documentary evidence, the Action Plan arose from a request by WHO Member States based on a perceived lack of urgency to plan and a consensus view of “processes falling short of expectations”, despite active discussions around the legacy of polio with GPEI and WHO. Most

key informants (KIs) interviewed believed that the Action Plan was warranted at the time of its inception and reflected the reality of where they were at that point in time on polio eradication efforts and with control of vaccine-derived polio virus outbreaks. Momentum was further driven at the time given the anticipation that polio would be eradicated soon, and thus a pressing need to support and protect core polio resources.

21. Concrete planning for transition of assets²⁹ was deemed critical because polio eradication is managed outside of the WHO's budgetary, planning and management structures. Member States were concerned about the impact of the polio funding ramp down on WHO's operational and programmatic capacity because of polio funding cross-subsidizing WHO's other technical programmes. It was seen as important to scrutinize which assets were being supported by the polio programme (e.g., how many staff would be affected by the approaching eradication and related costs to sustain the functions and infrastructure). This call for transparency raised by Member States laid the pathway for the Action Plan and a more transparent and thoughtful planning by WHO, taking into consideration corporate risks to implementation. Initial planning, culminating in development of the Action Plan was reported by most informants **as engaging, inclusive and transparent with active input and participation from the regional level** providing critical data and related analysis of the state of affairs in the priority countries.

Yet, a few informants had a critical voice on how the formulation of the Action Plan was drafted, developed and managed, mentioning that external partners and stakeholders were informed and invited, but the decisions were mainly kept at WHO level. At country level some informants felt that the Action Plan development was a "Geneva-led" process with limited engagement of key stakeholders from polio transition priority countries.

22. Polio transition planning was set in motion for 16 priority countries with the ultimate objective of national governments taking over the functions so far supported through the GPEI network, by shifting the responsibility from WHO to the Ministries of Health³⁰. **The Action Plan however did not fully appreciate that respective regions and countries were at different stages on the polio transition trajectory at its inception.** Countries had very diverging indicators on polio vaccination coverage ranging from below 50% coverage to above 90%, with several countries facing compromised security situations thus reflecting considerably different risk profiles. In the WHO South-East Asia region (SEAR) for instance, the polio programme was never separated from immunization and functioned in a highly integrated manner with immunization and health emergency teams within WHO and in national governments/systems. Many SEAR countries (e.g., India and Bangladesh) had also started much earlier with polio transition discussions, and transition was already underway before the Action Plan was developed.
23. On the other hand, some informants expressed that some polio transition priority countries had not been ready for transition. This was especially the case in fragile countries where health systems are weak, governments were unlikely to be able to take over financial or operational responsibilities for sustaining essential polio functions within a reasonable time period.
24. Partly in response, during the planning phase, WHO established a maturity grid to identify main gaps and determine support countries would need. Although risks to implementation were clearly identified in 2018 (e.g., funding commitments by governments not allocated on time); there was **limited reference to concrete mitigation plans for some of the risks identified**, and actual

²⁹ See definition in glossary of terms

³⁰ WHO, *Polio transition planning*, Report by the Director General, EB 142/11, January 2018, page 4, <https://www.who.int/publications/i/item/EB142-11>

application of the “maturity grid” assessment did not seem to be followed up in the process of implementing the Action Plan.

25. **The needs and priorities of polio transition priority countries have also changed over the years since the Action Plan was developed.** Polio resurgence including circulating vaccine-derived poliovirus (cVDPV), budget variations and lack of secure funding, and the COVID-19 pandemic changed the needs and priorities of the countries. However, **Action Plan timelines, strategies and targets did not adequately respond to these changes – multiple key informants did not view the Action Plan as a “living document”.** This will be explored in more detail in the next sections of the report.
26. **Gender, equity issues and human rights aspects**, all of which influence health-seeking behaviours and health outcomes, **are not sufficiently addressed in the Action Plan.** Gender-related barriers operate at multiple levels, from the individual and the household to the community, and hindered access to immunization services and equity issues are evident in the polio response when considering zero-dose communities and zero-dose children³¹.
27. Despite the fact that the Action Plan professes its alignment with the objective of strengthening immunization and related activities under the draft WHO Thirteenth General Programme of Work (GPW13) on promoting health, keeping the world safe and serving the vulnerable, it does not mention gender and human rights specifically, only equity is partially considered³². This despite the mentioning (in the GPW13) of gender, equity and human rights as strategic priorities that must be included in all programmes to the extent that “Policies and programmes need to address gender as a determinant of health (among others) when tackling issues of access and risk³³”.
28. Health interventions cannot effectively meet the needs of all unless informed by sex-disaggregated data and gender-sensitive analysis and action. From an equity perspective, informants cited that involvement of both male and female vaccinators is a prerequisite to successful vaccination campaigns “reaching zero-dose children”. Key informants stated that gender specifically was overlooked when developing the Action Plan. Informants however noted that disease surveillance action plans already have a gender component, which naturally had a spill over effect to polio transition. Yet, the evaluation team did not find evidence on this in M&E frameworks for transition nor in the implementation of transition plans at country level.
29. Under GPEI, a strategy on gender equality, endorsed by the GPEI Oversight Board in 2019, was developed to promote the integration of a gender perspective into programming and to support countries in addressing gender-related barriers to polio vaccination. The aim is to increase coverage and women’s meaningful participation in the polio programme³⁴. Furthermore, the GPEI strategy 2022-2026³⁵ as well as the GPEI 2018 technical gender brief and its 2022 Gender brief³⁶ confirm commitment to gender equality and gender responsive programming. The Global Alliance for Vaccines and Immunization’s (Gavi) Gender Policy from 2008 with a recent 3rd

³¹ “Zero-dose children” definition: children who have not received any routine immunization, <https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities>

³² WHO, World Health Assembly, A71/9, Polio transition and post certification, *Draft strategic action plan on polio transition*, Report by the Director-General, April 2018, https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_9-en.pdf

³³ WHO, *13th General Programme of Work 2019-2023*, 2018 *13th GPW*

³⁴ GPEI, *Gender Equality Strategy 2019-23*, <https://polioeradication.org/gender-and-polio/gender-and-polio-eradication/>

³⁵ GPEI polio eradication strategy 2022-2026, *Delivering on a promise*; 2020. <https://polioeradication.org/gpei-strategy-2022-2026/>

³⁶ GPEI, *Technical Brief: Gender 2018*, <https://polioeradication.org/wp-content/uploads/2018/03/GPEI-Gender-Technical-Brief-2018-ver-3.0.pdf> ; GPEI, *Gender equality as a path to polio eradication*, Jan 2022 https://polioeradication.org/wp-content/uploads/2022/02/FINAL_Gender_brief_Jan2022.pdf

edition³⁷ also recognises promoting gender transformative programming as a key vehicle to reaching zero-dose children and communities. The lack of focus on gender in the Action Plan seems to be a missed opportunity and a significant gap in the Action Plan design, given the importance recognised under GPEI and Gavi.

3.1.1.2 *Timelines, costing of the Action Plan and human resources planning*

30. At the time of drafting the Action Plan, polio eradication appeared closer to realisation and timelines for the proposed budget cuts and human resources planning might have been realistic at that point in time. However, the overall timelines for transition of some countries, especially fragile states, seems unrealistic.
31. The observed polio epidemiology in 2018 and onwards both in terms of WPV and cVDPV outbreaks, coupled with the COVID-19 pandemic and increasing political unrest in many of the polio transition priority countries have changed the prospects for polio transition. The Action Plan roadmap, milestones, targets and overall timelines for transition were generally not amended during implementation of the plan, except for postponing transition plans for Afghanistan and Pakistan until eradication was achieved.
32. The Action Plan was informed by a review of the draft national polio transition plans of 12 of the 16 polio transition priority countries. In addition, comprehensive data were gathered from priority countries and costs for sustaining essential polio functions were estimated³⁸. The evaluation team has reviewed seven national transition plans, developed before 2018, which are assumed to have provided background for the Action Plan costing and human resource sections. The costing of the Action Plan for these countries overall matches the costing in the national transition plans. Nonetheless, some of these national polio transition plans were never implemented and are currently being revised. This was mainly the case for transition plans in the African Region (AFR). According to correspondence with country offices, one of the main reasons for not implementing these plans was financial constraints. This aspect is elaborated on later in the report.

3.1.1.3 *Appropriateness of the Action Plan M&E framework and roadmap*

33. **The Action Plan provided a commonly shared vision on polio transition** and the vast majority of informants find that the objectives were appropriate and aligned to global health discourses on integration and system strengthening. However, some informants expressed the opinion that the objectives of the Action Plan should have focused on strengthening of primary health care (PHC) on the road to universal health coverage and not be limited to strengthening of immunization, surveillance, and health emergency programmes.
34. Donors and Member States were also pleased that transparency was provided on the actual number of WHO staff as part of the polio workforce and the size of budgets needed to sustain essential polio functions. Also, that these numbers would be tracked during implementation. Previously, the quantity of assets and staff was not known, thus a great need for transparency and data to drive thoughtful planning.
35. The Action Plan noted that a final M&E framework would be developed based on the proposed framework in the original plan. **An online dashboard with indicators has been launched and constitutes the M&E framework for the Action Plan** together with a roadmap. To avoid duplication and ease the burden of data collection by countries, the indicators for polio transition

³⁷ Gavi Alliance Policy version 3.0, <https://www.gavi.org/sites/default/files/programmes-impact/Gavi-Gender-Policy.pdf>

³⁸ WHO, World Health Assembly, A71/9, Polio transition and post certification, *Draft strategic action plan on polio transition*, Report by the Director-General, April 2018, https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_9-en.pdf

were based on indicators collected through existing processes (e.g. International Health Regulations, GPEI, WHO/UNICEF joint reporting forms etc.)

36. From the discussion with key informants, it seems that the dashboard is considered user friendly, but has mainly been used for reporting to governing bodies. This will be elaborated on further in the report section 3.2.3.
37. The evaluation team noted the following limitations and gaps in relation to the dashboard/ M&E framework:
 - Outcome indicators are not shown or referred to in the dashboard and have unclear targets;
 - Performance indicators are missing for some output level indicators and 2023 targets for output indicators are not clear;
 - There are no milestones related to output indicators between 2018 and 2023;
 - For indicators that have targets, most seem unrealistic to reach by 2023 for many of the priority countries. However, it is not clear if these are targets for 2023 or an earlier year;
 - Output indicators have no disaggregation of data by gender and only to a limited extent on equity (only one out of 13 output indicators consider equity and fragility aspects);
 - The indicator “Any new poliovirus outbreak stopped within 120 days” was replaced with: “year-end active outbreak”, the former seems more appropriate to monitor outbreak response effectiveness;
 - There is no process indicator related to containment of polio virus which seems relevant to sustaining a polio free world and is further a key performance indicator in the GPEI strategy 2022-2026;
 - International Health Regulations' (IHR) self-assessment indicators seem not fully appropriate as the only output indicators for health emergency preparedness and response;
 - The dashboard contains only two process indicators despite the fact that polio transition is a protracted intervention which lends itself to measuring, in part, processes to show success. Furthermore, the process indicator: “Development and endorsement of national transition plans” is not monitoring implementation status of the national transition plans, which is a critical indicator for polio transition to track in order to set milestones and targets; and
 - Data sources are not clear throughout the dashboard, and some links are not working.

3.1.2 Sub-question 1.2 – Alignment of the Action Plan

Summary of findings – Alignment of the Action Plan

The Action Plan is overall 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 was less clear and the role of GPEI in transition activities is not clearly laid out in the Action Plan. The COVID-19 pandemic presented an opportunity to rethink and develop an interim plan of work

38. **The Action Plan overall aligns with, and complements related international policies, strategies, and guidelines at the global level.**
39. **The groundwork for the Action Plan began under GPEI** and is linked to the Polio Endgame Strategy 2019-2023 (particularly under goal two)³⁹. Despite the delegation of polio transition from GPEI to WHO and UNICEF, GPEI under the Endgame strategy 2019-2023 remained committed to continued engagement in transition planning. This included advocating for mainstreaming of

³⁹ Goal 2 - health systems strengthening, integration of surveillance systems into wider VPD surveillance and preparedness for outbreaks/emergencies.

functions, coordinating with WHO on shifting costs for functions needed after certification, and engaging in governance discussions. The GPEI Strategy 2022-2026 links to the Action Plan across all objectives⁴⁰. Yet in the Action Plan itself, the role of GPEI on transition activities is unclear. Several key informants noted an insufficient collaboration between WHO and GPEI on polio transition efforts.

40. The Action Plan, **overall aligns, complements, and links with other related policies, plans, and strategies** which together have an underlying focus on equity and delivering routine immunization services (inclusive of comprehensive vaccine-preventable disease surveillance systems) and responding to emergencies and outbreaks that are integrated with primary health care ultimately contributing to Universal Health Coverage (UHC). Of critical importance is embedding continued polio responses after eradication into the Immunization Agenda (IA) 2030 in addition to the alignment of VPD surveillance. Alignment to the policies, strategies and guidelines mentioned below is critical to achieving WHO’s triple billion targets which focus on increasing UHC and improving primary health care, strengthening emergency preparedness and response, and reaching underserved communities.

Figure 1: Polio alignment with various strategic and programmatic plans⁴¹



41. Figure 2 and further detailed in Annex 7. Those that align with all three objectives of the Action Plan can be seen in the centre of the figure. Details on where they overlap is elaborated below:

- *WHO Thirteenth General Programme of Work 2019-2023 (GPW13)*. This overall programme of work for WHO states that eradication of polio will remain a key priority, including making sure that the world is kept polio-free and that gains made with the implementation of polio eradication activities are not lost in the post-polio transition process. It further states that essential functions currently supported by polio funds should be integrated into a broader health effort (for example, integrated disease surveillance, outbreak preparedness and

⁴⁰ The GPEI Strategy 2022-2026 has five strategic objectives: 1) greater political will; 2) community engagement; 3. Expand integration through more partners; 4. Changes to campaigns and outbreak response; and 5. Enhance surveillance efforts

⁴¹ WHO, Polio transition team presentation to the evaluation team, 15 October 2021

response systems and poliovirus containment will need to be absorbed into other biosafety and bio security efforts).

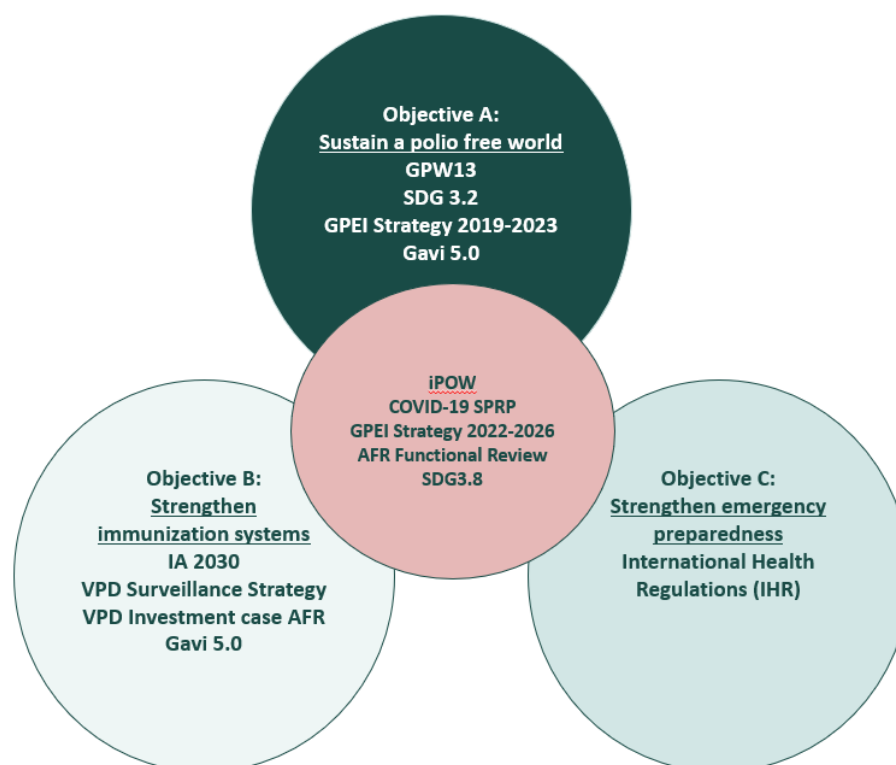
- *The Interim Programme of Work (iPOW) for Polio/Essential Immunization*: “Integration” and “transition” are interrelated processes. The activities identified in the iPOW can help deliver support to transition in a more efficient, coherent, and integrated manner, and help move more smoothly towards a successful transition. Twenty-two integrated high priority actions (to be completed by end of Q1/2021) were identified, focusing on the global and regional level within three thematic/programmatic areas of work. Examples of activities include engaging in routine analysis of COVID-19 impact on polio and VPD surveillance, conducting thorough analysis of the impact of COVID-19 on prospects for further integration of polio and other VPD laboratories, assessing the global impact of COVID-19 on community attitudes towards immunization, and including Expanded Programme on Immunization (EPI) staff as part of any regional polio rapid response team now with gradual expansion. Oversight and monitoring of the iPOW falls under the remit of the Programme Directors’ Forum with support from regional directors of WHO and UNICEF. Unfortunately, the implementation status of the iPOW was not registered in the minutes of the Polio Oversight Board (POB) and the results and status were not available to the evaluation team⁴².
- *COVID-19 Strategic Preparedness and Response Plan (SPRP)*: There is no specific mention of tapping into the extensive polio assets (a missed opportunity to praise the efforts of polio networks in responding to the pandemic) but the SPRP recognizes that it will be critical that the COVID-19 vaccine response “is anchored in and strengthens existing immunization programme capacities”, which rely heavily on polio networks and assets.
- *IA 2030*: represents the vision and strategy for vaccines and immunization for the next decade and has a strong focus on equity and delivering immunization services integrated with primary health care and aims to advance sustainable progress against multiple vaccine-preventable diseases. The Action Plan calls for country-specific responses to transition, in line with IA 2030, which presents a strategic framework that is meant to be flexible, allowing countries to adapt the global framework to their context to provide customized support. The long-standing and far-reaching coordination, oversight, surveillance efforts and use of data fostered under eradication efforts can be focused to address wider immunization efforts identified as part of the IA 2030.
- *The GPEI Polio Endgame Strategy 2019-23*, correlates and aligns across two objectives of the Action Plan, including stopping all circulating vaccine-derived poliovirus outbreaks, contributing to strengthening immunization and health systems to sustain polio eradication and ensuring sensitive poliovirus surveillance and preparing and responding to polio outbreaks.
- *The GPEI Strategy 2022-26* aligns well with the Action Plan and its objectives. Transition is specifically mentioned under strategic objective 4: “Improve frontline success and the commitment to supporting an expedited risk-based transition of UNICEF and WHO staff and infrastructure to Member States and essential immunization or health emergency programmes”.
- *Functional reviews*: Functional reviews of WHO country offices were planned and conducted in most polio transition priority countries immediately before the Action Plan or concurrently with its initial implementation to identify means of better aligning the workforce and operations of WHO to host countries’ health situation, needs and priorities. The Nigeria case study revealed that the functional review showed the “relevance and timeliness of WHO’s Transformation agenda, to realign its resources ... embracing an integrated service delivery model and responding to Nigeria’s quest to achieve universal health coverage”⁴³.

⁴² [Polio Oversight Board](#)

⁴³ Functional review of the WHO country office Nigeria, findings, and recommendation slide deck.

- *Sustainable Development Goals*: The Action Plan is aligned with the SDG goal 3 of ensuring healthy lives and promote well-being for all at all ages and specifically indicator 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.
- *Gavi 5.0. (2021-2025)*⁴⁴ aligns with the Action Plan with a vision of “Leaving no one behind with immunisation” and a mission to save lives and protect people’s health by increasing equitable and sustainable use of vaccines. The Gavi strategy 5.0 focuses on reaching zero-dose children strengthening health systems to increase equity in immunization and ensuring programmatic sustainability.
- *International Health Regulations*: objective C of the Action Plan contributes directly to implementing the IHR 2005.
- *The Global Strategy on Comprehensive VPD Surveillance* promotes the development of high-functioning surveillance systems that will generate high-quality, usable data to strengthen national immunization programmes, inform vaccine introduction decision-making, and fortify timely and effective detection and response to VPD and other infectious disease outbreaks, safeguarding national and global health security. The global comprehensive VPD surveillance strategy is coordinated with other regional and global strategies and plans. The Action Plan is listed under disease-specific activities together with GPEI.
- *The investment case for VPD surveillance in AFR* aligns with the Action Plan by aiming to reinforce Member States ownership, strengthen coordination, and articulate VPD surveillance within a broader disease surveillance system. It also highlights a holistic approach to better consider community-based surveillance.

Figure 2. Alignment with related international policies, strategies, and guidelines



⁴⁴ Gavi Strategy, phase 5, 2021-2025 <https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025>

42. **The alignment of polio transition planning with UNICEF is less clear.** From 2016-2018 under GPEI both countries and agencies (WHO and UNICEF) began developing transition plans (or at least engaging in discussion around transition) together with the Centers for Disease Control and Prevention, USA (CDC). However, UNICEF and WHO, despite sharing ideas on transition planning and implementation, opted for separate transition plans with UNICEF not seeking endorsement of their plan from GPEI. This has contributed to a lack of clear division of roles between the agencies in relation to polio transition at the global, regional, and country level. Given the context of COVID-19, and UNICEF revising its polio transition plan a “UNICEF representative at the Transition Independent Monitoring Board (TIMB) meeting pointed to a programmatic window of opportunity to align common immunization goals”⁴⁵.
43. **The Action Plan did not take into consideration how Gavi in the same period embarked on transition of vaccine programmes**⁴⁶ and funding for such to national governments in some of the same countries prioritised for polio transition (e.g. Angola, India, Indonesia and Nigeria)⁴⁷. The Gavi transitioning countries will need to absorb the full costs of new vaccines and health systems improvements previously financed by Gavi, while sustaining the programmatic systems that have facilitated the introduction of vaccines. Embarking on GPEI transition and well as Gavi transition creates further economic challenges for some of these countries. Furthermore, the Action Plan does not appear to have sufficiently applied learnings from experiences of Gavi’s work on transitioning since 2008 with a needed focus on long-term planning for transition countries (10+ years), using a risk based differentiated approach and country-tailored strategies.

3.2 EQ2: Implementation of the Action Plan

3.2.1 Sub-question 2.1 – Progress against the Action Plan M&E framework and roadmap

Summary of findings

Results at mid-term generally show:

- Objective A of the Action Plan, Sustain 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 a 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 somehow stable but with declines noted since 2020, and with continued high performance across most polio transition countries except in the African Region.
- In relation to objective B, Strengthening immunization systems and vaccine-preventable disease surveillance, limited change on indicators was noted since 2018, however a slight decreasing trend was observed across most polio transition countries in 2020. Indicators are still below the performance targets in a majority of polio transition priority countries, except those in the South-East Asia Region.
- Improvements on objective C indicators, Strengthening emergency preparedness, detection and response capacity, were generally visible across countries since 2018.

⁴⁵ TIMB, *Building stronger resilience, the essential path to a polio-free world*, TIMB 5th Report, December 2021

⁴⁶ Gavi Alliance Eligibility and Transition Policy v 3 effective 2018., <https://www.gavi.org/sites/default/files/document/gavi-eligibility-and-transition-policy.pdf>

⁴⁷ Managing the Gavi transition, Learning network for transition Countries, PPT, Dec 2017, accessed 22 March 2022 https://www.linkedimmunisation.org/wp-content/uploads/2017/12/Managing-the-Gavi-transition_eng.pdf

Summary of findings

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 roadmap indicators have been met, though with some key milestones facing delays.

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

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

Transitioning of WHO human resources has seen GPEI-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 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 be lost. It is too early to elaborate on the extent to which the human resource scale-down/integration of polio staff has affected polio work and/or strengthened immunization and surveillance or health emergency responses, but experiences in Nigeria on the human resource scale-down imply an overall weakening of polio efforts. Reductions of GPEI-funded staff in headquarters and 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 numbers than WHO “staff” categories.

Background for the M&E framework

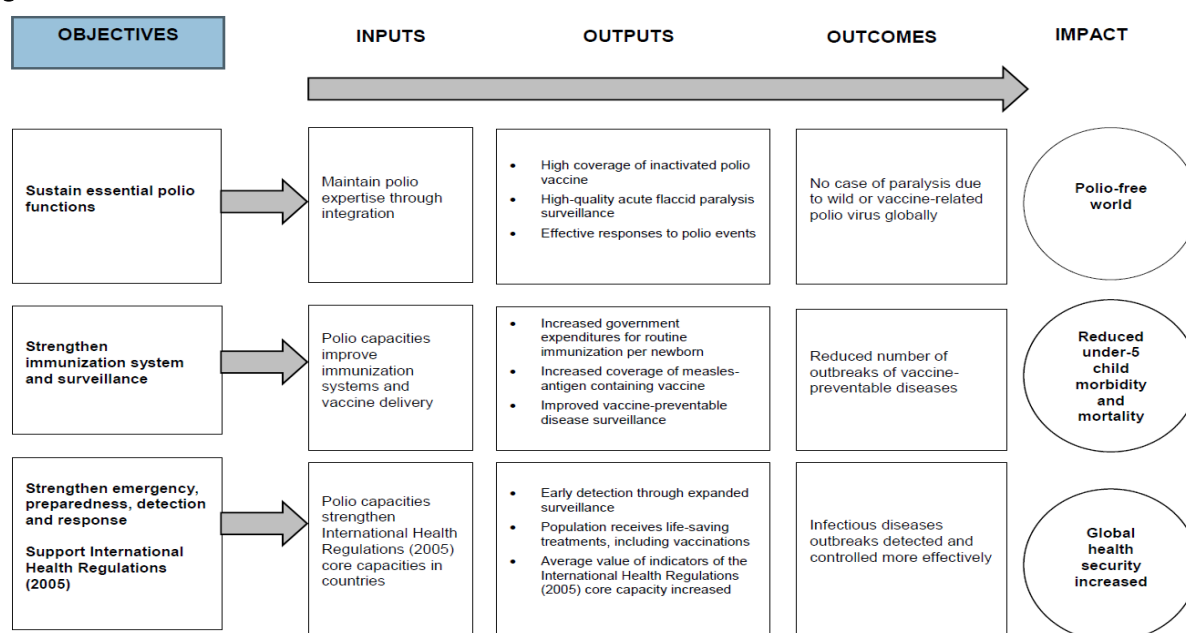
44. The draft M&E framework for the Action Plan was integrated in the Action Plan⁴⁸ and contained the results chain (see Figure 3), indicators and their definitions along with a proposed roadmap for implementation. In 2018, the World Health Assembly acknowledged these output indicators while providing for development of a country level dashboard to monitor implementation of the plan⁴⁹. A baseline was established in 2018, yet most baseline data were from 2016⁵⁰.

⁴⁸ WHO, World Health Assembly, A71/9, Polio transition and post certification, *Draft strategic action plan on polio transition*, Report by the Director-General, April 2018, https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_9-en.pdf

⁴⁹ WHO, World Health Assembly, A72/10, *Polio Transition, Report by the Director-General*, May 2019, https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_10-en.pdf

⁵⁰ WHO, World Health Assembly, A72/10, *Polio Transition, Report by the Director-General*, Annex 5, May 2019, https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_10-en.pdf

Figure 3: Action Plan results chain⁵¹



45. The dashboard to monitor progress on polio transition, published on the WHO website⁵², was developed in 2020. It provides a set of output and process indicators for the priority countries. The dashboard tracks indicators from 2018 and beyond - a baseline this mid-term evaluation has applied accordingly.
46. Since endorsement of the Action Plan in 2018, the results chain has been modified slightly in terms of the language of objectives and some output indicators have been amended or left out (including the output indicator on polio containment). Output indicators in the Action Plan and country-level key indicators do not fully match. Informants expressed that this was a result of a revision and refinements of indicators made in consultation with other technical units in WHO during the first year of implementation. A final overall M&E framework for the polio transition Action Plan was not developed beyond the polio transition dashboard.
47. This section presents an overview of the progress against the M&E framework of the Action Plan, which includes: Progress on outcome level indicators, progress on output level indicators, progress on process indicators and finally a progress on the roadmap milestones. (see Annex 2 for detailed progress by region and country).

3.2.1.1 Overall progress on **outcome level indicators of the Action Plan**

48. Progress at outcome level shows **declining performance on objective A of the Action Plan which focused on sustaining a polio free world**. The number of cVDPV cases in polio transition priority countries was low in 2018 (67 cases), but increased sharply through 2020 (reaching 833 cVDPV cases reported in 2020) after which it decreased to 516 cases reported in 2021 (see Table 2 below). Outbreaks are reportedly due to persistent polio immunity and surveillance gaps.
49. **Objective B of the Action Plan** focuses on strengthening immunization systems and surveillance and a decreasing trend of outbreaks for measles, rubella, diphtheria, tetanus and pertussis

⁵¹ WHO, World Health Assembly, A71/9, Polio transition and post certification, *Draft strategic action plan on polio transition*, Report by the Director-General, April 2018, https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_9-en.pdf

⁵² [Polio transition dashboard](#)

reported between 2018 and 2020 was noted, however with a spike in 2019 for some VPDs. Considering vaccination coverage for measles did not improve during the period, the explanation for this decreasing trend of outbreaks should probably be found elsewhere.⁵³ Proposed explanations for the decreasing trend of VPD outbreaks include that large measles outbreaks in 2019 resulted in higher natural immunity levels than in subsequent years. This, coupled with COVID-19 restrictions and precautions and possible underreporting in 2020 due to COVID-19, is expected to have influenced the reduction in measles outbreaks according to a recent report by WHO⁵⁴. “While reported measles cases dropped in 2020, evidence suggests we are likely seeing the calm before the storm as the risk of outbreaks continues to grow around the world”⁵⁵.

50. **The Action Plan does not stipulate a quantitative outcome performance indicator for objective C** which focuses on strengthening emergency, preparedness, detection and response. However, there is **evidence based on the COVID-19 response across all three WHO regions that infectious disease outbreaks (specifically COVID-19) have been detected and controlled more effectively due to use of polio assets**^{56,57}. This aspect is elaborated further in section 3.2.2.

⁵³ WHO, Global progress against measles threatened amidst COVID-19 pandemic, 10 November 2021 [Measles press release](#)

⁵⁴ Dixon MG, Ferrari M, Antoni S, et al. *Progress Toward Regional Measles Elimination — Worldwide, 2000–2020*, 2021 <http://dx.doi.org/10.15585/mmwr.mm7045a1>

⁵⁵ WHO, Global progress against measles threatened amidst COVID-19 pandemic, 10 November 2021 [Measles press release](#)

⁵⁶ WHO, *Contributions of the polio network to the COVID-19 response: turning the challenge into an opportunity for polio transition* <https://www.who.int/publications/i/item/contributions-of-the-polio-network-to-the-covid-19-response-turning-the-challenge-into-an-opportunity-for-polio-transition>

⁵⁷ WHO, NeXtwork - *The role and contribution of the integrated surveillance and immunization network to the COVID-19 response in the WHO South-East Asia Region (Bangladesh, India, Indonesia, Myanmar and Nepal)*, 2021 <https://www.who.int/publications/i/item/9789290228899>

Table 2: Action Plan outcome indicators for 20 polio transition priority countries, 2018-2021

| Objective | Outcome indicator | 2018 | 2019 | 2020 | 2021 |
|--|---|--|--|--|--|
| Objective A: Sustain a polio free world | No case of paralysis due to wild or vaccine-related polio virus globally ¹ | 100 reported polio virus cases (AFP) of which 67 cVDPV cases 33 WPV cases | 477 reported polio virus cases (AFP) of which 301 cVDPV cases and 176 WPV cases | 973 reported polio virus cases (AFP) of which 833 cVDPV cases 140 WPV cases | 521 reported polio virus cases (AFP) of which 516 cVDPV cases 5 WPV cases |
| Objective B: Strengthen immunization systems and surveillance | Reduced number of outbreaks of vaccine-preventable diseases ² | | | | |
| | • Measles cases reported ³ | 171 459 | 411 524 | 114 535 | N/A |
| | • Rubella cases reported ⁴ | 14 407 | 9 197 | 4 183 | N/A |
| | • Diphtheria cases reported ⁵ | 15 520 | 20 331 | 9 484 | N/A |
| | • Tetanus cases reported ⁶ | 9 388 | 10 210 | 4 307 | N/A |
| | • Pertussis cases reported ⁷ | 31 669 | 14 351 | 14 049 | N/A |
| Objective C: Strengthen emergency, preparedness, detection and response | Infectious diseases outbreaks detected and controlled more effectively ⁸ | N/A | N/A | YES | YES |

¹ The number of polio cases (cVDPV or WPV) in the 20 polio transition priority countries is reflected here, Ref: GPEI data: <https://extranet.who.int/polio/public/CaseCount.aspx> accessed 2 April 2022

² The evaluation team has selected these key VPDs to ascertain any trends as the polio transition dashboard does not track or define this indicator. Ref for these data: <https://immunizationdata.who.int/> accessed 5 March 2022

³ 2020: Data missing from Afghanistan, Iraq and Libya

⁴ 2018: Data missing from Somalia. 2020: Data missing from Afghanistan, Libya, Somalia, Bangladesh

⁵ 2018: Data missing from Angola, Cameroon, Chad, DRC, Ethiopia, South Sudan, Sudan. 2019: Data missing from Angola, Cameroon, Chad, DRC, South Sudan, Afghanistan, Libya. 2020: Data missing from Angola, Cameroon, Chad, DRC, Nigeria, South Sudan, Afghanistan, Libya.

⁶ 2018: Data missing Somalia, Sudan, Indonesia, Myanmar. 2019: Data missing from Angola, Afghanistan, Libya, Somalia, Sudan. 2020: Data missing from Afghanistan, Libya, Somalia.

⁷ 2018: Data missing from Cameroon, Chad, South Sudan, Sudan, Yemen. 2019: Data missing from Cameroon, Chad, Ethiopia, Nigeria, South Sudan, Afghanistan. 2020: Data missing from Cameroon, Chad, Ethiopia, Nigeria, South Sudan, Afghanistan, Libya.

⁸ This indicator is very broad and not easily tracked and the polio transition dashboard does not track or define this indicator or performance targets

AFP: Acute flaccid paralysis

3.2.1.2 Overall progress on **output level** indicators of the Action Plan

51. Summary of progress against output indicators

Large country and regional variations between the 20 polio transition priority countries were noted on most output indicators for the Action Plan. **Coverage levels for polio and measles containing vaccines were generally far behind performance targets in AFR and WHO Eastern Mediterranean Region (EMR) polio transition priority countries, with some country exemptions in EMR (Iraq, Pakistan and Sudan). Coverage levels in SEAR countries were generally high and**

above 80% in all five countries except in Indonesia. Coverage levels since 2018 have been either relatively flat or in some cases with declining trends, particularly observed in 2020. Data available on district level vaccination coverage suggest geographical inequalities. Polio surveillance indicators were relatively stable across the period, except in AFR and across some countries in SEAR where notable declines were noted in 2020/2021. Marked increases in the cases of cVDPV and WPV were reported between 2018 and 2021. Cases were almost exclusively noted in EMR and AFR. The number of reported cVDPV cases increased by 670% from 67 cases in 2018 to 516 cases in 2021. In 2021, 83% of the cVDPV cases were reported in Nigeria. The number of WPV outbreaks, on the other hand, decreased to only 5 reported cases in 2021. Government expenditures on routine immunization decreased overall, whereas country self-assessment on health emergency core capacity indicators generally increased over the period under investigation.

52. Table 3 below provides a consolidated overview of progress against output indicators for 20 polio transition priority countries and are elaborated below with regional disaggregation per indicator as appropriate. Country-level indicators are provided in Annex 2.

Table 3: Action Plan output indicators for the period 2018-2021 for 20 polio transition priority countries⁵⁸

| Output Indicator | 2018 | 2019 | 2020 | 2021 | Performance indicator ⁵⁹ |
|---|------|------|------|------|---|
| Objective A: Sustain a polio free world after eradication | | | | | |
| 1.1 IPV1 ⁶⁰ | 61% | 71% | 67% | N/A | >90%* in all countries |
| 1.2 POL3 ⁶¹ | 73% | 74% | 72% | N/A | >90%* in all countries |
| 1.3 Non-Polio AFP rate (n/100 000). ⁶² | 7,2 | 7,7 | 6,2 | 7,2 | At least 1/100 000 aged < 15 years (2/100 000 in endemic countries) |
| 1.4 % Adequate stool specimen collection. ⁶³ | 87% | 91% | 83% | 79% | > or = 80% |
| 1.5 Polio cases (cVDPV). ⁶⁴ | 67 | 301 | 833 | 516 | No performance indicator except: Any new poliovirus outbreak stopped within 120 days which is not tracked |
| 1.5 Polio cases (WPV). ⁶⁵ | 33 | 176 | 140 | 5 | No performance indicator except: Any new poliovirus outbreak stopped within 120 days which is not tracked |
| 1.6 Environmental surveillance: # of sampling sites ⁶⁶ | 366 | 418 | 440 | N/A | No performance indicator |

⁵⁸ The table includes Afghanistan and Pakistan which are not yet in transition mode but are still monitored in the polio transition dashboard. Note that percentages in the table are not weighted averages.

⁵⁹ [Polio transition dashboard](#)

⁶⁰ IPV: inactivated polio vaccine; Definition of IPV1: percentage of surviving infants who received at least one dose of inactivated polio vaccine. Ref for figures: [WHO/UNICEF Joint Estimates of National Immunization Coverage \(WUENIC\)](#) accessed 5 March 2022

⁶¹ Definition of POL3: The percentage of one-year-olds who have received three doses of polio vaccine in a given year (<https://www.who.int/data/gho/data/indicators>). Which as per communication with the WHO polio transition team is referred to as “coverage of bivalent oral polio vaccine” in the polio transition dashboard. Ref for figures: [WHO/UNICEF Joint Estimates of National Immunization Coverage \(WUENIC\)](#) accessed 5 March 2022

⁶² Definition: Non-Polio AFP rate= Rate of non-polio AFP/100.000 children <15 years, ref: GPEI. Ref: <https://extranet.who.int/polis/public/CaseCount.aspx>

⁶³ 'Adequate' stool specimens defined as: two stool specimens collected between 24-48 hours apart, within 14 days after the onset of paralysis, [polio transition dashboard](#) Ref for numbers: [GPEI polio data](#) 3 April 2022

⁶⁴ [GPEI polio data](#) accessed 3 April 2022

⁶⁵ [GPEI polio data](#) accessed 3 April 2022

⁶⁶ [Polio transition dashboard](#)

| Output Indicator | 2018 | 2019 | 2020 | 2021 | Performance indicator ⁵⁹ |
|--|------|------|------|------|--|
| 1.6 Environmental surveillance: average # of samples at sites ⁶⁷ | 21 | 19 | 13 | N/A | All environmental polio surveillance sites provide one adequate sample per month |
| Objective B: Strengthening immunization systems and surveillance | | | | | |
| 2.1 MCV1 % ⁶⁸ | 72% | 71% | 70% | N/A | Country coverage > 90% with one dose of measles containing vaccine through routine services* |
| 2.2 MCV2 country ⁶⁹ | 59% | 59% | 58% | N/A | Country coverage > 90% with two doses of measles containing vaccine through routine services* |
| 2.3 MCV2 districts ⁷⁰ | 33% | 40% | 37% | N/A | District coverage > 80% with two doses of measles containing vaccine through routine services* |
| 2.4 Government expenditures on routine immunization (US\$ million). ⁷¹ | 19,0 | 11,3 | 9,9 | N/A | No performance indicator |
| Objective C: Strengthening emergency preparedness, detection and response capacity – support implementation of the International Health Regulations | | | | | |
| 3.1 Average % of IHR self-assessment annual reporting of laboratory core capacity. ⁷² | 54% | 59% | 67% | N/A | No performance indicator |
| 3.2 Average % of IHR self-assessment annual reporting of surveillance core capacity. ⁷³ | 73% | 71% | 77% | N/A | No performance indicator |
| 3.3 Average % of IHR self-assessment annual reporting of emergency framework core capacity. ⁷⁴ | 50% | 51% | 61% | N/A | No performance indicator |

* The timeframe for reaching this target is not specified in the polio transition M&E framework

N/A: data not available

53. **Output indicators 1.1 and 1.2: Polio vaccination coverage** - vaccination coverage indicators include monitoring coverage of inactivated polio containing vaccine first dose (1.1: inactivated polio vaccine (IPV1)⁷⁵ and coverage of polio third dose (1.2: POL3)⁷⁶. The average estimated IPV1 coverage for all 20 countries increased between 2018 and 2019 but saw a decline in 2020 (61% in 2018, 71% in 2019 and 67% in 2020). Therefore, the target of >90% coverage was not achieved and was 13% lower than the global average at 80% in 2020⁷⁷. Figure 4 illustrates the regional averages and a visible trend of lowest coverage in AFR (55% in 2020) with some minor increase

⁶⁷ Ibid

⁶⁸ Definition: Vaccine coverage with one dose of measles containing vaccine [polio transition dashboard](#) Ref for figures: [WHO/UNICEF Joint Estimates of National Immunization Coverage \(WUENIC\)](#). accessed 5 March 2022

⁶⁹ Definition: Vaccine coverage with two doses of measles containing vaccine [polio transition dashboard](#) Ref for figures: [WHO/UNICEF Joint Estimates of National Immunization Coverage \(WUENIC\)](#) accessed 5 March 2022

⁷⁰ [Polio transition dashboard](#)

⁷¹ Ibid

⁷² Ibid

⁷³ Ibid

⁷⁴ Ibid

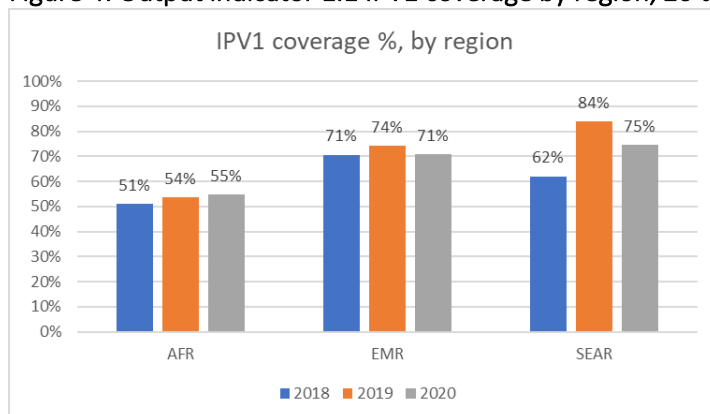
⁷⁵ Definition of IPV1: percentage of surviving infants who received at least one dose of inactivated polio vaccine

⁷⁶ Definition of POL3: The percentage of one-year-olds who have received three doses of polio vaccine each year (<https://www.who.int/data/gho/data/indicators>). Which as per communication with the WHO polio transition team is referred to as “coverage of bivalent oral polio vaccine” in the polio transition dashboard.

⁷⁷ [WHO/UNICEF Joint Estimates of National Immunization Coverage \(WUENIC\)](#) accessed 5 March 2022

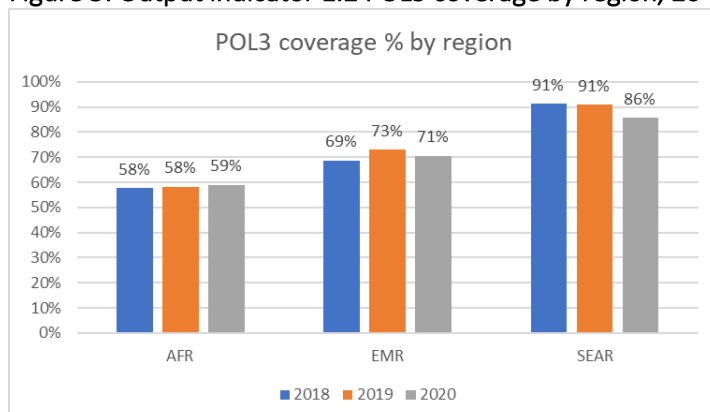
since 2018, higher coverage rates across EMR countries (71% in 2020) with a decline noted in 2020, and highest coverage levels in SEAR countries with significant improvement between 2018 and 2019, after which the trend declined to 75% on average across the SEAR countries⁷⁸. Note that averages are not weighted averages. Country specific coverage of IPV1 is presented in Annex 2.

Figure 4: Output indicator 1.1 IPV1 coverage by region, 20 transition priority countries, 2018-2020



54. The average estimated coverage of the third dose polio (POL3) for all 20 countries combined saw a plateauing trend between 2018 and 2020 (73% in 2018, 74% in 2019 and 72% in 2020) with the 2020 estimate 11% lower than the global average (83%)⁷⁹. Disaggregating by region, SEAR countries on average reported reductions from 91% to 86% coverage, whereas AFR and EMR saw slight increases in coverage estimates of the third dose of polio vaccination between 2018 and 2020. SEAR countries however being on significantly higher coverage level estimates, than EMR and AFR countries (Figure 5). Country specific coverage of POL3 is presented in Annex 2.

Figure 5: Output indicator 1.2 POL3 coverage by region, 20 transition priority countries, 2018-2020



55. Analysis of GPEI polio vaccination coverage data for 2020⁸⁰ **show overall limited signs of gender bias, yet a few countries presents with gender biases** (Table 4) across some periods, examples include Angola and South Sudan where more females than males had received at least 3 polio vaccines doses (Angola: 76% vs 47% Jan-Jun 2020; South Sudan 83.3% vs 69.8% in Jul-Dec 2020) and less females than males were polio “zero-dose” (Angola: 15.6% vs 31.9% in Jan-Jun 2020; South Sudan: 3.0% vs 10.5% in Jul-Dec 2020). In DRC and Sudan however, more females than

⁷⁸ [WUENIC data](#) accessed 5 March 2022

⁷⁹ [WUENIC data](#) accessed 5 March 2022

⁸⁰ GPEI, 2020 Annual report, Semi-annual status updates

males were likely to be polio zero-dose children (DRC: 10.3% vs 6.1% in Jan-Jun 2020; Sudan: 6% vs 3.3 in Jan-Jun 2020).

56. **High proportions of polio zero-dose children were found in Angola, Somalia and Yemen suggesting geographical equity concerns**, with the proportion of polio zero-dose children above 10% in 2020 (see Table 4). Such high proportions of zero-dose children allude to potential future epicentres of polio outbreaks, and indicates equity concerns since these children tend to be clustered in communities without any basic health services⁸¹. Furthermore, a recent study found that once children receive one dose of a vaccine, most children go on to receive other vaccines⁸².

Table 4. Equity and Gender aspects on polio vaccination coverage in 2020 across polio transition priority countries⁸³

| | | % Female/Male 0-dose and 3+ dose | | | |
|--------------------|---------|-------------------------------------|-------|--------------|-------|
| | | Jan-Jun 2020 | | Jul-Dec 2020 | |
| | | Female | Male | Female | Male |
| AFR | | | | | |
| Angola | 0-dose | 15.56 | 31.91 | 7.89 | 4.88 |
| | 3+ dose | 75.56 | 46.81 | 71.05 | 68.29 |
| Cameroon | 0-dose | 0 | 0.89 | 1.47 | 4.49 |
| | 3+ dose | 91.3 | 92.86 | 89.71 | 87.64 |
| Chad | 0-dose | 7.14 | 7.88 | 4.32 | 4.57 |
| | 3+ dose | 77.14 | 79.39 | 82.7 | 73.6 |
| DR Congo | 0-dose | 10.34 | 6.17 | 8.6 | 6.68 |
| | 3+ dose | 76.94 | 80.67 | 72.09 | 76.07 |
| Ethiopia | 0-dose | 5.71 | 8.78 | 8.04 | 8.74 |
| | 3+ dose | 77.14 | 71.62 | 69.64 | 72.03 |
| Nigeria | 0-dose | 0.22 | 0.3 | 0.19 | 0.14 |
| | 3+ dose | 97.73 | 97.76 | 98.65 | 98.29 |
| South Sudan | 0-dose | 4.17 | 7.04 | 3.03 | 10.47 |
| | 3+ dose | 88.89 | 84.51 | 83.33 | 69.77 |
| EMR | | | | | |
| Afghanistan | 0-dose | 2.69 | 3.28 | 6.65 | 9.64 |
| | 3+ dose | 92.55 | 93.43 | 84.54 | 80.83 |
| Iraq | 0-dose | - | - | - | - |
| | 3+ dose | - | - | - | - |
| Libya | 0-dose | - | - | - | - |
| | 3+ dose | - | - | - | - |
| Pakistan | 0-dose | 1.23 | 0.75 | 0.97 | 0.7 |
| | 3+ dose | 97.84 | 98.16 | 97.04 | 98.11 |
| Somalia | 0-dose | 16.88 | 9.52 | 15 | 27.12 |
| | 3+ dose | 76.62 | 79.76 | 76.67 | 64.41 |
| Sudan | 0-dose | 6 | 3.33 | 7.53 | 5.38 |
| | 3+ dose | 92 | 86.67 | 84.93 | 87.63 |
| Syria | 0-dose | - | - | - | - |
| | 3+ dose | - | - | - | - |
| Yemen | 0-dose | 15.85 | 14.81 | 19.13 | 21.14 |
| | 3+ dose | 74.39 | 71.3 | 70.43 | 68 |

57. **Output indicator 1.3: Polio surveillance – rate of non-polio AFP/100 000 children <15 years.** The performance indicator is defined as “at least one case of non-polio acute flaccid paralysis (AFP) should be detected annually/ 100 000 ages less than 15 years. In endemic areas this rate should

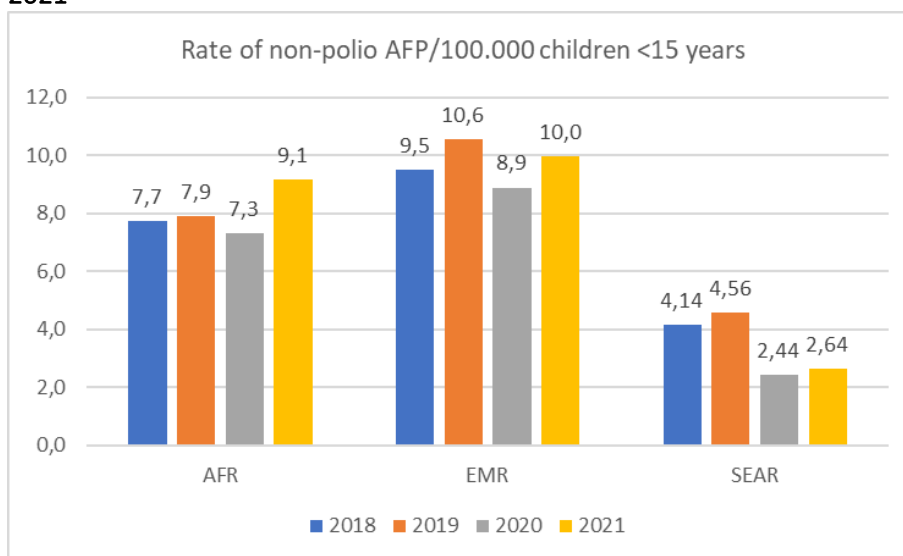
⁸¹ <https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal>

⁸² O. Cata-Preta et al 2021, Zero-dose children and the immunisation cascade: Understanding immunisation pathways in low and middle-income countries, Vaccine, Volume 39, Issue 32, 22 July 2021, Pages 4564-4570

⁸³ GPEI, 2020 Annual report, Semi-annual status updates

be 2/100 000⁸⁴. Performance on this indicator is well above the targets in all polio transition countries except in Myanmar. The average rate of non-polio AFP cases for the 20 polio transition priority countries reached 7.2 in 2021, which is similar to the rate reported in 2018. The rate had a drop in 2020 to 6.2. Figure 6 below depicts the trend across the three regions, with notable drops across all three regions in 2020, which is assumed to be caused by COVID-19 disruptions. At global level, AFP cases reported from January to July 2020 declined by 34% compared with the same period in 2019, which was assessed to be caused by the pandemic⁸⁵.

Figure 6: Output indicator 1.3 Rate of non-polio AFP/100.000 children < 15 years, by region, 2018-2021⁸⁶



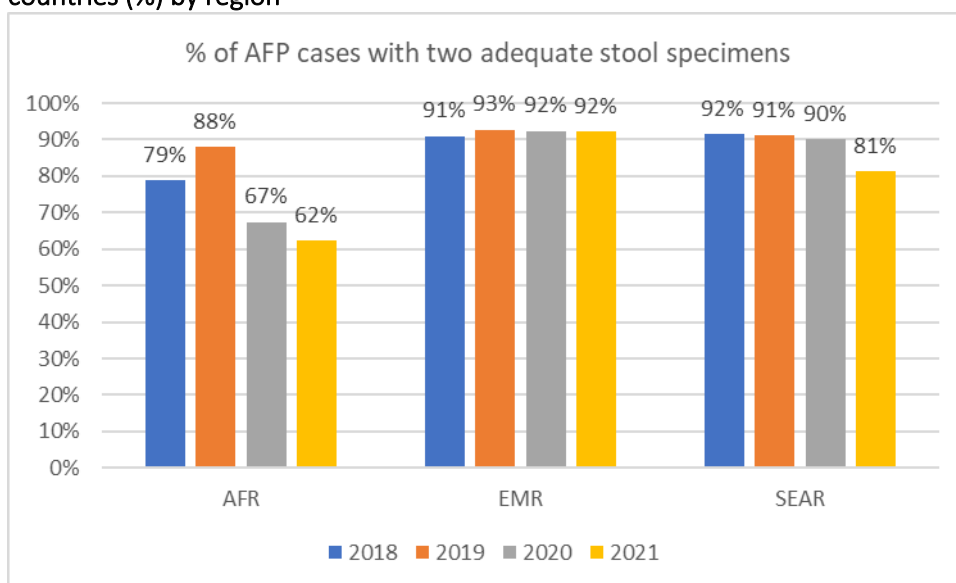
58. **Output indicator 1.4: Polio surveillance – percentage of AFP cases with adequate stool specimens** defined as “at least 80% of AFP cases having adequate stool specimens collected”. The average proportion of AFP cases with adequate stool collection in the 20 polio transition priority countries has increased between 2018 and 2019, but then decreased in 2020 and 2021, and remained below 2018 levels in 2021 (2018: 87%; 2019: 91%, 2020: 83% and 2021: 79%); It should be noted that these averages are not weighted averages and thus should only be used to assess change over time and not the actual coverage levels per region. This indicator remained above the performance target of 80% in 2021 for all eight polio transition countries in EMR and in Bangladesh, Myanmar and Nepal. When disaggregating data by region, performance below the target of 80% is observed across all polio transition countries in the AFR since 2020 and with signs of recovery in 2021 in only two AFR polio transition priority countries (Cameroon and Ethiopia), while the remaining AFR countries saw further declines in 2021 (Angola, Chad, DRC, Nigeria and South Sudan). EMR polio transition countries all remained with high performance above the target across all four years in all countries. A decreasing trend was observable across SEAR polio transition countries in 2021 with India and Indonesia below the 80% target in 2021. Country specific data on AFP surveillance trends are presented in Annex 2.

⁸⁴ WHO, World Health Assembly, A72/10, *Polio Transition, Report by the Director-General*, May 2019, https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_10-en.pdf

⁸⁵ Burkholder B, Wadood Z, Kassem AM, Ehrhardt D, Zomahoun D. *The immediate impact of the COVID-19 pandemic on polio immunization and surveillance activities*. 2021

⁸⁶ [GPEI polio data](#) accessed 2 April 2022

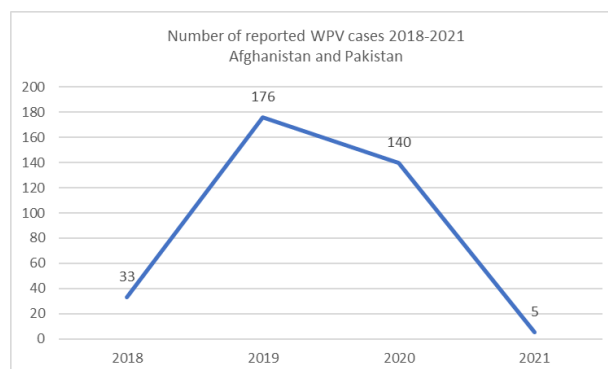
Figure 7: Output indicator 1.4 AFP cases with adequate stool collection, in 20 transition priority countries (%) by region⁸⁷



59. **Output indicator 1.6: Polio surveillance - the number of environmental surveillance sites with at least one adequate sample per month.** The results increased from 366 in 2018 to 440 in 2020, however, the number of samples per site demonstrated a slight decreasing trend (see Table 3).

60. **Output indicator 1.5: Polio outbreaks⁸⁸** – the M&E framework of the Action Plan monitors the number of polio cases reported, the type of virus and the number of active outbreaks at the end of the year. The Action Plan mentioned monitoring of polio event responses with any new polio virus outbreak stopped within 120 days. However, this indicator is not being tracked in the dashboard as it was replaced by “the number of active outbreaks at the end of the year.”

Figure 8: Output indicator 1.5 Number of wild poliovirus cases reported, 2018-2021



61. The number of WPV outbreaks in polio transition priority countries increased in the period 2018 to 2020; with 33 cases reported in 2018, 176 cases in 2019 and 140 reported WPV cases in 2020. In 2021, only 5 WPV cases were reported. All WPV cases during the period 2018-2021 were reported in Afghanistan and Pakistan (see Figure 8). While significant progress has been made on WPV interruption in 2021, the number of cVDPV cases in polio transition countries have witnessed a sharp increase since 2018, most notably in 2020 but remaining at high levels in 2021⁸⁹ (see Figure 9). Between 2018 and 2021, the number of reported cVDPV cases increased by 670% from 67 cases in 2018 to 516 cases in 2021. 83% of the cVDPV cases reported in 2021 were reported in Nigeria. Only 6 of the 20 polio priority countries have not recorded any cVDPV outbreaks in the time-period 2018-2021 (Bangladesh, India, Iraq, Libya, Syria and Nepal). In 2020, the highest number of cases was recorded in EMR (most cases reported in Afghanistan, Pakistan,

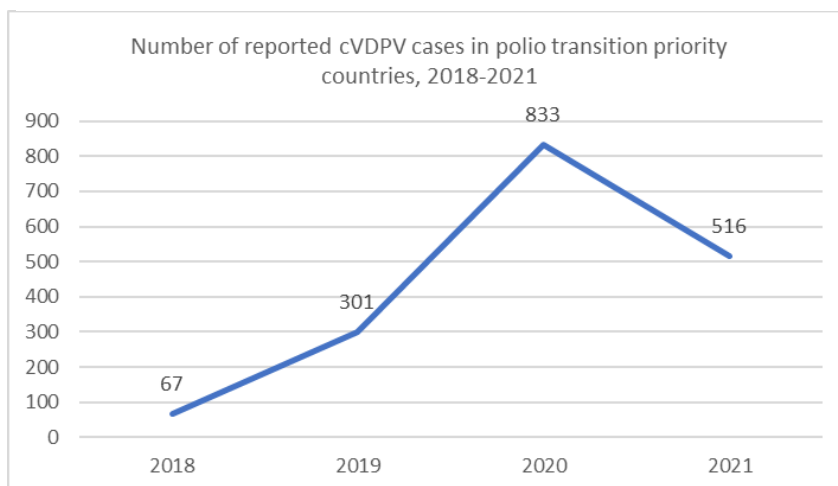
⁸⁷ [GPEI polio data](#) accessed 2 April 2022

⁸⁸ [GPEI polio data](#) accessed 2 April 2022

⁸⁹ [GPEI polio data](#) accessed 2 April 2022

Sudan and Yemen) whereas in 2021, the highest number of cases were reported in AFR⁹⁰. Country specific data have been explored further in Annex 2.

Figure 9. Output indicator 1.5 cVDPV cases reported in 14 polio transition priority countries 2018-2021



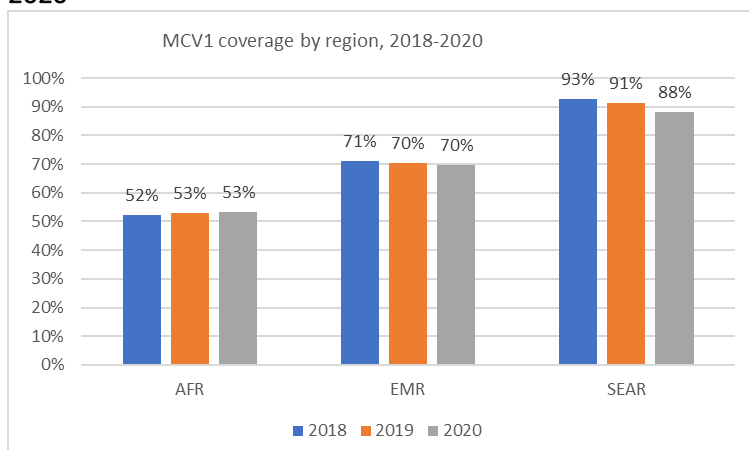
62. **Output indicators 2.1, 2.2 and 2.3: Vaccine coverage of measles containing vaccines⁹¹** – the average estimated MCV1 (indicator 2.1) coverage for all 20 countries decreased slightly between 2018 and 2020 (72%, 71% and 70% respectively – see Table 3), below the target of >90% coverage and 13% lower than the global average at 80% in 2020⁹². Figure 10 depicts the trend across the three polio transition priority regions for all 20 countries. It should be noted that these are not weighted averages and thus should only be used to assess change over time and not the actual coverage levels per region. Whereas polio transition countries in AFR show a slightly increased trend but still low country coverage levels ranging from 44% (Angola) to 62% (Cameroon) in 2020, transition countries in SEAR show a slightly decreasing trend but continued high coverage ranging from 76% (Indonesia) to 97% (Bangladesh) in 2020. EMR polio transition countries present with a more or less stable trend over the period 2018-2020 but with large diversity between countries ranging from 46% (Somalia) to 86% (Sudan) in 2020. Country specific coverage has been explored in Annex 2.

⁹⁰ [GPEI polio data](#) accessed 2 April 2022

⁹¹ [WUENIC data](#) accessed 5 March 2022

⁹² [WUENIC data](#) accessed 5 March 2022

Figure 10: Output indicator 2.1. MCV1 coverage trend by region, 20 transition priority countries, 2018-2020⁹³

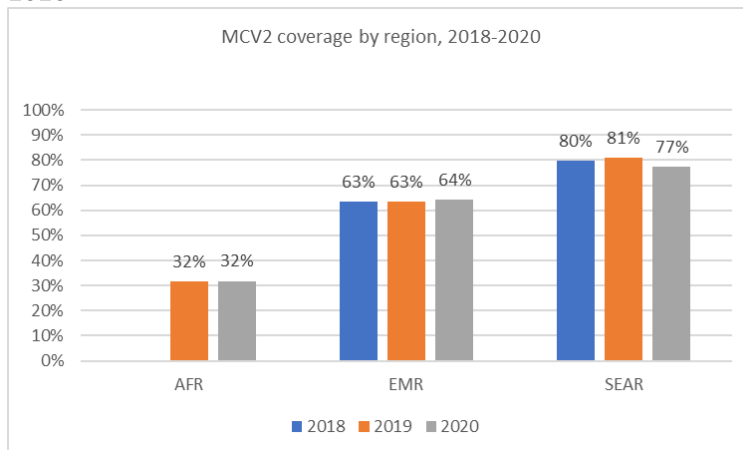


63. The average coverage of two-dose measles vaccine (MCV2) (indicator 2.2) for polio transition priority countries witnessed limited fluctuations between 2018 and 2020 (59%, 59% and 58% respectively – see Table 3). Figure 11 illustrates the trend across the three polio transition priority regions (among 15 countries providing multi-year data), again these averages are not weighted averages. Only SEAR shows a declining trend, with other regions (AFR and EMR) having stable estimates across the period, though far from the performance target of 90%. Large variations are noted for MCV2 coverage among polio transition priority countries which had estimates for this indicator. The variations ranged from 12% (Nigeria) to 93% (Bangladesh and Iraq) in 2020. MCV2 coverage is also monitored in terms of coverage at subnational levels, using the performance indicator % of districts in the country with an MCV2 coverage level above 80%. Yet only half of the 20 polio transition priority countries consistently have such estimates. Large variations are noted between countries, ranging from 1% in Nigeria to 100% in Bangladesh in 2020. In most countries with these estimates, less than 60% of districts have an MCV2 coverage >80%⁹⁴ which points to sustained inequity issues and immunization gaps in many countries (including Afghanistan, Angola, Ethiopia, Nigeria, India, Indonesia, Nepal, Pakistan, Sudan, and Yemen). Country specific coverage data are presented in Annex 2.

⁹³ [WUENIC data](#) accessed 5 March 2022;

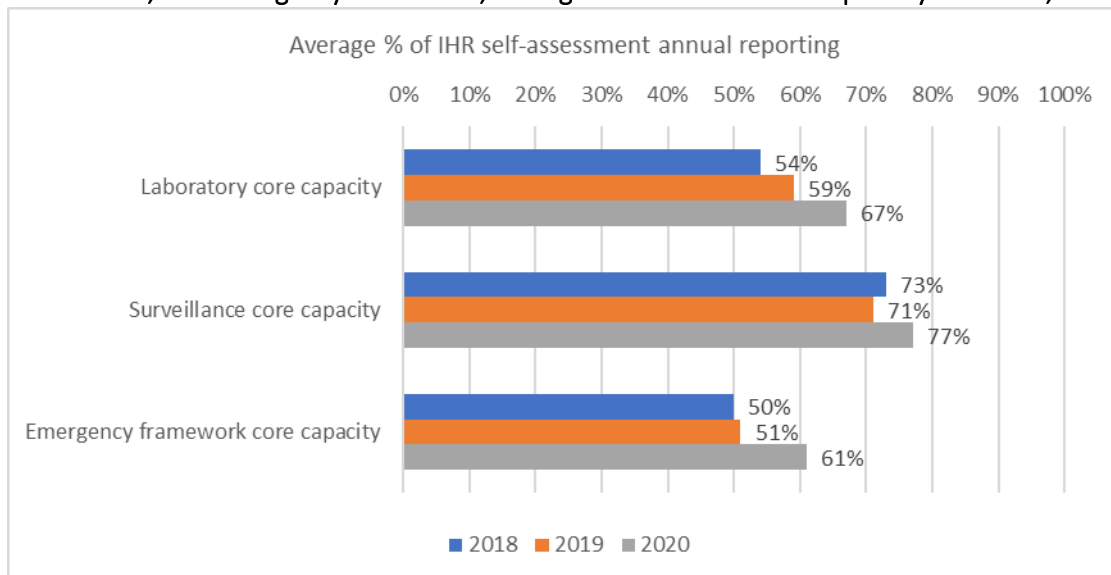
⁹⁴ WHO Polio transition dashboard: <https://www.who.int/teams/polio-transition-programme/monitoring-and-evaluation-dashboard>

Figure 11: Output indicator 2.2 MCV2 coverage trend by region, 15 transition priority countries, 2018-2020⁹⁵



64. **Output indicators 3.1, 3.2, 3.3 IHR self-assessment annual reporting of laboratory, surveillance and emergency framework core capacities.** Between 2018 and 2020, countries' self-assessment rates on core capacity levels in regard to laboratory, surveillance and emergency frameworks increased. The largest collective increases for the 20 polio transition countries were noted on laboratory core capacity, followed by emergency framework core capacity and surveillance core capacity. The increase was generally greatest between 2019 and 2020 (see Figure 12). Note that averages are not weighted averages and should mainly be used to assess trend over time.

Figure 12: Output Indicators 3.1, 3.2.& 3.3 IHR self-assessment reporting on core capacity - laboratory, surveillance, and emergency framework, averages across 20 transition priority countries, 2018-2020⁹⁶



⁹⁵ [WUENIC data](#) accessed 5 March 2022; Note missing data from AFR in particular with only Angola, Ethiopia and Nigeria providing data and for 2019 and 2020

⁹⁶ WHO Polio transition dashboard: <https://www.who.int/teams/polio-transition-programme/monitoring-and-evaluation-dashboard>

3.2.1.3 Progress on **process indicators** of the Action Plan

65. The Action Plan monitors and reports on two process indicators through the dashboard and in reports to governing bodies. These include 1. Development and endorsement status of national polio transition plans and 2. The number of positions funded by GPEI.

| Process Indicators | 2018 | 2019 | 2020 | 2021 | Performance target |
|--|------|------|------|------------------------------------|---|
| Development and status of national polio transition plans | | | | 9 final, 9 in draft/under revision | Approved transition plan = transition plan drafted/uploaded/endorsed by Government or ICC |
| Number of polio positions supported by GPEI in 20 polio priority countries | 671 | 639 | 526 | 490 | No performance indicator |

Process indicator: Status of national polio transition plans

66. The management of polio transition is a country-focused process, and transition planning at country level is essential to its success. Transition planning is a process of analysing the infrastructure, knowledge, and functions of the polio programme, and managing their scale down or transfer to other health programmes, including immunization and health emergency programmes. The process involves mapping these assets at country, regional and global levels, and conducting an analysis against national and global health and development needs. Where there is overlap, and where it is possible, assets will be incorporated into alternative health programmes and systems. Integration opportunities between polio eradication and essential immunization activities or primary health care services both in terms of integrated service delivery, and at management and coordination levels, needs to be explored during transition planning, and the risks and benefits needs to be analysed.

67. Development and endorsement of national polio transition plans is considered a key milestone for polio transition and has also been mentioned by Member States, partners and the TIMB⁹⁷ as a critical indicator for monitoring polio transition efforts. TIMB further recommended in their 4th report from November 2020 that all national plans be revisited in light of COVID-19⁹⁸.

68. As of January 2022, a total of **9 out of 20 polio transition priority countries have a final national polio transition plan in place**, 9 are still in a draft version or under revision⁹⁹. **4 national plans have been endorsed by the national government**. Of the four endorsed plans, **two (India and Bangladesh) are currently being fully implemented** and **two countries started implementation in Jan 2022 (Nigeria and Somalia)**. Additionally, five of the eight final national plans are not polio transition plans but rather WHO plans for Integrated Public Health Teams (IPHT) roll-out and are as such not endorsed by the government; of these, **three are currently being implemented**. (see box below explaining IPHT piloting in WHO Regional Office for Eastern Mediterranean (EMRO))

⁹⁷ TIMB, *Navigating Complexity, Adapting to new challenges on the journey to a polio-free world*, Fourth report, 2021 <https://polioeradication.org/wp-content/uploads/2021/02/4th-TIMB-Report-Navigating-Complexity-20210131.pdf>

⁹⁸ Ibid

⁹⁹ And two countries are not yet in transition mode (Afghanistan and Pakistan) – see later

EMRO – piloting Integrated Public Health Teams

The concept of Integrated Public Health Teams (IPHT) was endorsed by the Polio Transition Steering Committee and was taken up faster in EMRO than other regions including in Libya, Iraq, Sudan (initially piloted in that country), Syria, and Yemen, guided by a regional working group. The IPHT concept is based on an interim bridging strategy until functions are transferred to national governments in the longer-term. The COVID-19 pandemic has provided an opportunity and the momentum to test the concept in practice both for immediate funding and for “recovery and resilience post-COVID-19”, working under the guidance of the WHO Regional office (with a focus on Somalia and Sudan to start). EMRO, moving forward with implementation, sees the IPHTs serving the purpose of:

- Tackling inefficiencies and “misses” by ensuring an integrated response to surveillance, VPD and emergency response
- Planning, through detailed mapping exercises (e.g. for surveillance), the resources needed to meet overall surveillance goals on a country-by-country basis – recognizing that this is not a one size fits all exercise and is dependent upon country infrastructure
- Advocating for a two step-process of WHO integration/ transition and then government transition

Groundwork is being laid through the IPHT for sustainability, through integration, of polio efforts, while more time is needed to realize the eventual outcomes.

69. **Yemen, Nepal, and Indonesia confirm that they are partially implementing a national polio transition plan, although these have not yet been endorsed by government.** In addition, **10 countries report that the plan is currently under revision or available in a draft version only.** Of note is that six out of seven polio transition priority countries in AFR (Angola, Cameroon, Chad, DRC, Ethiopia, South Sudan) had national polio transition plans endorsed by government in 2017 or 2018, but they were never implemented for various reasons, mainly lack of domestic funding commitments, COVID-19, polio virus outbreaks, and political unrest. These aspects will be explored further under section 3.2.2.
70. **Two countries (Afghanistan and Pakistan)** report that a transition plan is not a priority now because the countries are still classified as polio endemic and efforts are being focused on eradication.
71. Table 5 presents an overview of the national polio transition plans, their endorsement and implementation status as of January 2022 and reasons for delays in implementation for countries where this information was available. Information for this table was provided by informants through interviews and written responses to queries and survey data which was validated and triangulated by reaching out to all evaluation country focal points.

Table 5: Status of national polio transition plans as of January 2022 for 20 polio transition priority countries

| Country | Status of transition plan | Previous transition plan ever implemented | Transition plan currently being implemented | Comment | Polio transition dashboard status# as of Jan 2022 |
|--------------------------|---------------------------|--|---|--|---|
| AFR | | | | | |
| Angola ¹ | Under revision | Yes, but only in 2020. Implementation stalled. | No | Polio transition plan for 2019-2024 was endorsed in 2018 by government, implementation started in 2020 but stalled . Has had many obstacles to proceed with implementation and the plan is no longer relevant, and thus need for a new plan according to key informants. Revised version not yet available. | Developed and endorsed (2019) |
| Cameroon | Under revision | No | No | 2017-2021 Transition Plan - endorsed by government in May 2017, but never implemented . Currently a new plan under revision, revised version not yet endorsed and no draft version available. | Developed and endorsed (2018) |
| Chad | Under revision | No | No | 2018-2022 National polio transition plan endorsed by government in Dec 2017 – but never implemented . Plan currently under revision, not yet available. Revised version not yet endorsed. | Developed and endorsed (2018) |
| DR Congo ¹ | Under revision | No | No | 2018-2022 transition plan endorsed in September 2017 by government, but never implemented . New plan under revision, no draft version available. | Developed and endorsed (2018) |
| Ethiopia | Under revision | No | No | Transition Plan 2018-2022 endorsed by Government in April 2018, but never implemented . Whereas the transition plan was developed in 2016-2017, a number of health emergencies (cVDPV2 outbreak COVID-19 pandemic) and political crises (civil war) overtook attention to implement the plan. Plan under revision, not yet available. | Developed and endorsed (2018) |
| Nigeria ² | Final | No | Yes, partially | The polio transition process started in 2016 but was deprioritized due to the WPV outbreak in August 2016. Polio transition plan was recently revised and endorsed by government in July 2021 . Seed copies of the plan are currently being printed and distributed to the States. Sensitization of the Stakeholders at the State level is currently ongoing but lack of funds is particularly affecting the full implementation of the Plan. | Developed and endorsed (2020) |
| South Sudan | Under revision | No | No | National polio transition plan for 2018-2022 was endorsed in May 2018 by government, but never implemented . New plan under revision. Draft version of revised plan not available. | Developed and endorsed (2018) |
| EMR | | | | | |
| Afghanistan ¹ | No plan | N/A | No | Not a priority at the moment to develop a transition plan due to polio endemic status. | Not developed |
| Iraq ¹ | Final | N/A | No | Integrated Public Health Team Plan is finalised and endorsed by WHO WR . Despite not yet being implemented some strategic steps have already been implemented. | Not developed |

| Country | Status of transition plan | Previous transition plan ever implemented | Transition plan currently being implemented | Comment | Polio transition dashboard status# as of Jan 2022 |
|-------------------------|---------------------------|---|---|---|---|
| | | | | <ul style="list-style-type: none"> - Ministry of Health established the National Steering and Technical Committees. - With WHO support, Integrated Polio and VPDs Budget Planning workshops was conducted in Dec. 2021 and an official request was sent to the National Polio Transition committee chairman to conduct the national review of the plan - Ministry of Health sent an official letter to Ministry of Finance in April 2021 regarding the budgetary allocation. | |
| Libya ¹ | Final | N/A | No | Integrated Public Health Team plan was developed and endorsed by the WHO WR in February 2022. The polio programme has very little footprint in the country. | Not developed |
| Pakistan ¹ | No plan | N/A | No | Not a priority at the moment to develop a transition plan due to polio endemic status. | Not developed |
| Somalia ² | Final | N/A | Yes, Implementation to start 1/1/22 | Endorsed by government on 25/08/2021, Time period of plan: 2021-2024 The next phase of implementation, beginning Jan 2022, will provide opportunity to concretize planning and strategies to achieve transition objectives. | Draft not endorsed |
| Sudan ¹ | Final | N/A | Yes | Integrated Public Health Team plan 2018-2030 of 18 March 2021. Finalised and endorsed by the WHO WR. Implementation of the IPHT plan faced some delay due to the political situation. IPHT training is planned for Q1 of 2022 | Draft not endorsed |
| Syria ¹ | Final | N/A | Yes | Integrated Public Health Team plan finalised in October 2021. Integration in place, government is fully onboard, but plan not endorsed by government as it is a WHO strategy. Ministry of Health Syria is managing the Polio programme through their surveillance cell within the PHC department. Environmental Sampling is done through the partnership between the Ministry of Health and the municipalities. Field officers and APW contracts are paid by WHO. | Not developed |
| Yemen ¹ | Draft | N/A | Yes, Partially | Draft version dated 19 Sep 2021. Sent for endorsement in Sep 2021, but still not endorsed by government, yet agreed in principle. The plan has been shared with the Ministry and integration of functions is in process of implementation gradually. Funds will be required to continue with the critical functions of polio and other VPD surveillance. The country will try to secure funds though this is a challenge due to shrinking financial support from donors. | Not developed |
| SEAR | | | | | |
| Bangladesh ² | Final | N/A | Yes | National polio transition plan from 2016 endorsed by government, implementation in three phases: phase 1 (2016-2018); phase 2 (2019-2022); phase 3 (2022-2026). | Developed and endorsed (2018) |

| Country | Status of transition plan | Previous transition plan ever implemented | Transition plan currently being implemented | Comment | Polio transition dashboard status# as of Jan 2022 |
|------------------------|--------------------------------|---|---|---|---|
| India ¹ | Final | N/A | Yes | Finalized and endorsed before 2018 through a multi-phased process , Time period: 2018-2021, 2022-2026 | Developed and endorsed (2018) |
| Indonesia ¹ | Final, but needs to be updated | N/A | Yes, (but not yet endorsed by govt.) | The national polio transition plan is a ‘Sustainability Plan’. The current draft plan from 2017 is being implemented . The plan needs to be updated due to 2-year gap caused by COVID-19 pandemic. The Government of Indonesia has allocated budgets to support a large proportion of the surveillance, laboratory, and immunization costs, previously funded by GPEI. | Draft not endorsed |
| Myanmar ¹ | Draft | N/A | No | The national plan is in the draft format, not endorsed by government. The plan is currently suspended due to political situation in the country. | Draft not endorsed |
| Nepal ¹ | Under revision | A plan was discussed and developed in 2017, partially implement-ted | Partially | The national polio transition plan is in draft and still being discussed in government, not yet endorsed . Time period: 2017-2021, now under revision. Catalytic funding by government in 2019 to express commitment, pooling of immunization resources to support other health goals (other VPDs and emergencies), Delays due to frequent change in government, federalization and then due to COVID-19 pandemic. | Draft not endorsed |

<https://www.who.int/teams/polio-transition-programme/polio-transition-dashboard>

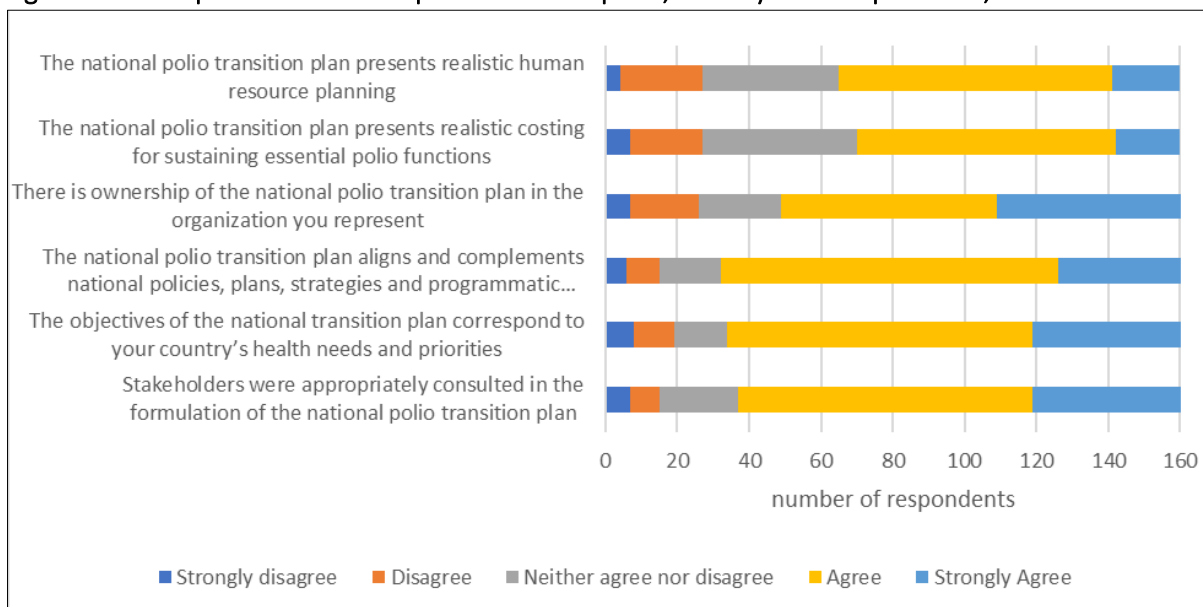
¹ Validated by national evaluation focal point

² Ref: country case study report

Assessment of the national polio transition plans and their development

72. Figure 13 shows the results of the online survey administered to country level stakeholders regarding development of national transition plans. The majority of respondents to this question were staff from WHO country offices (86%).

Figure 13: Perceptions on national polio transition plans, country level respondents, n=160



73. Respondents **generally replied that national polio transition plans have objectives that correspond to the country's health needs and priorities** (strongly agree or agree: 78%) and align to national policies (strongly agree or agree: 80%). This was generally confirmed by a review of national polio transition plans conducted by the evaluation team. Yet the **timelines for transition of all polio functions were assessed to be unrealistic for some countries**. An example includes the national transition plan for Somalia, where the goal of the plan, which has recently been developed, is a complete handover of programme to the government by 2024¹⁰⁰. Given the sustained major challenges with security and health service delivery, low coverage of polio vaccinations, and Somalia having one of the most fragile and weak health systems in the world, this fast transition pace is considered attached with high risks for polio gains. (see Annex Somalia country case report).
74. When triangulating data, there **were mixed opinions on the extent to which stakeholders were appropriately consulted in the formulation of national polio transition plans** – keeping in mind the majority of respondents were from WHO. Responses from the online survey showed 26% strongly agreed and 51% agreed that there was appropriate consultation, however with country variations. Lack of involvement of other agencies, stakeholders, partners, outside of WHO in the development of country transition plans was noted by some key informants with consequences for alignment and integration of transition efforts. Key informants and survey respondents reported that the process of developing national polio transition plans was highly WHO-led in some countries. A few respondents noted that, in an extreme case, WHO led the plan with insufficient engagement and expected the government to implement using donor funds. Other countries reported high level of engagement of stakeholders (see box from Bangladesh country case study).

¹⁰⁰ WHO, *Polio Transition Plan for Somalia, 2021-2024*, 2021

Bangladesh' experience with engagement of stakeholders during the national polio transition plan development

The initial polio transition planning preparatory process was a WHO and Government- led process. Support was extended from WHO headquarters to regional to country office at a high level. In addition, from global level, both Gavi and GPEI supported the process. The Bangladesh Government was the key stewardship including the joint secretary, programme manager (Expanded Programme on Immunization) the line Director and relevant health system stakeholders including the Directorate General of Drug Administration, the National EPI, the Polio Lab, and the planning wing of the Ministry. International partners were engaged (UNICEF, USAID, World Bank, FCDO, JICA) as well as NGOs and civil society organizations.

(Bangladesh country case study report – See Annex)

75. The vast majority of respondents agreed or strongly **agreed that there was ownership of the plan in the organisation** they represented (WHO or UN Agency or Civil society organization (CSO) or Government entity) (70%). This aspect also varied among countries; it seemed there was strong ownership in Bangladesh (80% agreed and 20% strongly agreed while none disagreed). In Nigeria 61% agreed/strongly agreed and in Somalia 57% agreed/strongly agreed.
76. About half of the respondents felt that that polio transition plans include realistic costing (56%) and human resources planning (59%). However, large variations between countries were noted. For example, in Bangladesh 80% agreed that the national plan had realistic costing plans, in Somalia 72% agreed, and in Nigeria only 54% agreed.

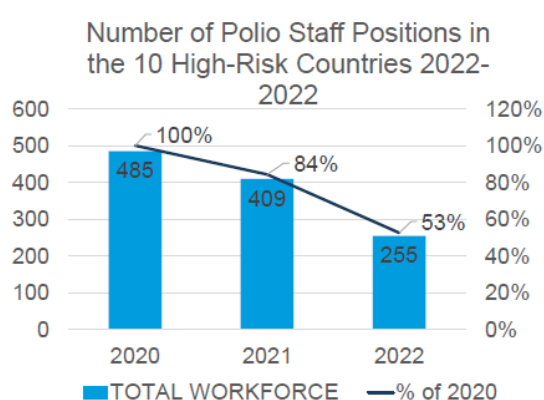
Process indicator: Number of polio positions supported by GPEI over time.

77. WHO has set up a dedicated database to monitor the polio programme staffing trends. The total number of WHO polio staff funded by GPEI has decreased by 31% from 2016 to 2021 (from 1 112 to 772) since the GPEI started downscaling support in 2016. The largest decrease was found in AFR (302/37%). Both EMR and SEAR had decreases of approximately 10%¹⁰¹. **The reduction of positions funded by GPEI in the period 2018 through 2021, for the 20 polio transition countries only was 27% overall (30% in AFR, 16% in EMR and 14% in SEAR) – (see Table 6).**
78. The planned scale down of GPEI funded positions by the end of 2023 was not clearly laid out in the Action Plan and had no target indicators. It is thus difficult to assess whether this process indicator is on track.
79. Significant variances were noted between countries in the regions. In AFR, the largest reductions were observed in **Angola and Nigeria between 2018 and 2021**. In EMR, the number of GPEI funded staff has mainly been concentrated in the two polio endemic countries (Afghanistan and Pakistan) and in Somalia. The remaining countries in the EMR rely only to a limited extent on GPEI funding. In SEAR, India and Bangladesh are the main countries relying on GPEI funded staff, of which Bangladesh saw an increase of 50% (4 positions) between 2018-2021 and India noted a decrease of 35% (7 staff positions) during the same period (see Table 6).

¹⁰¹ WHO, Executive Board, Poliomyelitis, EB150/22 *Polio transition planning and polio post-certification*, Report by the Director-General, January 2022, https://apps.who.int/gb/ebwha/pdf_files/EB150/B150_22-en.pdf

80. The **decline in the number of GPEI positions over the same time-period in WHO headquarters was 6% (from 70 in 2018 to 66 in 2021)**. The change in WHO regional offices was not clearly differentiated from the data available. However, the total reduction of all GPEI funded positions (WHO headquarters, regional offices, and country offices) was 22% between 2018 and 2021, thus lower than for the polio priority transition countries at 27%.
81. An explicit remit of WHO in the Action Plan is to address liabilities and contingency funding. The large number of polio staff with long-term contracts in WHO represents a risk in terms of liability. **Progress has been noted recently in AFR** where the largest number of staff funded by GPEI are present. Since 2020 AFR has reduced liabilities by reducing the proportion of the workforce on long-term contracts by 47% as depicted in the Figure 14.

Figure 14: Trend of polio staff position in AFR 2020-2022.¹⁰²



82. Despite reductions in staff and reduced liabilities in AFR, WHO faces continued indemnity risks owing to the large number of staff with continuing appointments and fixed-term positions. The proportion of staff with a temporary contract (versus a continued or fixed-term contract) decreased between 2018 and 2020 from 26% to 23% (Table 6).
83. **It is further important to note that polio workforce special contracts, consultants etc. do not appear in these GPEI position overviews which are reported annually to the Executive Board and the World Health Assembly.** In Somalia, for instance, 14 positions were considered “WHO staff” (Table 6), yet an additional 235 people were working on the polio programme on other WHO contract types (Local Individual Contractor agreements and agreements for performance of work) financed by GPEI in addition to the 668 polio community workers active in the country. (see Annex with Somalia country case study).

Table 6. Trend of the number of GPEI funded positions 2018-2021 (as of Sep 2021) and % temporary staff.¹⁰³

| Country | 2018 | 2019 | 2020 | 2021 | Change between 2018-2021 n (%) | 2018 temporary staff (%) | 2021 temporary staff (%) |
|---------|------|------|------|------|--------------------------------|--------------------------|--------------------------|
| Angola | 52 | 27 | 22 | 21 | -31 (-60%) | 4% | 5% |

¹⁰² WHO, Member states information session on polio transition, January 2022

¹⁰³ WHO, World Health Assembly, A74/20, Poliomyelitis, Polio transition planning and polio post-certification, Report by the Director-General, April 2021 https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_20-en.pdf and polio transition dashboard (2018-2020)

| Country | 2018 | 2019 | 2020 | 2021 | Change between 2018-2021 n (%) | 2018 temporary staff (%) | 2021 temporary staff (%) |
|-------------------|------------|------------|------------|------------|--------------------------------|--------------------------|--------------------------|
| Cameroon | 8 | 9 | 6 | 6 | -2 (-25%) | 13% | 0% |
| Chad | 30 | 33 | 19 | 22 | -8 (-27%) | 20% | 14% |
| DRC | 52 | 48 | 48 | 47 | -5 (-10%) | 4% | 2% |
| Ethiopia | 41 | 39 | 41 | 41 | 0 (0%) | 0% | 0% |
| Nigeria | 314 | 306 | 232 | 207 | -107 (-34%) | 15% | 5% |
| South Sudan | 16 | 11 | 14 | 13 | -3 (-19%) | 75% | 92% |
| Total AFR | 513 | 473 | 382 | 357 | -156 (-30%) | 14% | 8% |
| Afghanistan | 35 | 36 | 38 | 37 | +2 (+6%) | 57% | 57% |
| Iraq | 5 | 5 | 4 | 4 | -1 (-20%) | N/A | N/A |
| Libya | 1 | 1 | N/A | N/A | N/A | N/A | N/A |
| Pakistan | 50 | 58 | 47 | 37 | -13 (-26%) | 82% | 62% |
| Somalia | 16 | 19 | 15 | 14 | -2 (-13%) | 69% | 57% |
| Sudan | 6 | 7 | 2 | 7 | +1 (17%) | 100% | 86% |
| Syria | 8 | 8 | 5 | 4 | -4 (-50%) | 63% | 64% |
| Yemen | 2 | 2 | N/A | N/A | N/A | N/A | N/A |
| Total EMR | 123 | 136 | 111 | 103 | -20 (-16%) | 63% | 64% |
| Bangladesh | 8 | 9 | 13 | 12 | +4 (50%) | 38% | 33% |
| India | 20 | 20 | 15 | 13 | -7 (-35%) | 75% | 92% |
| Indonesia | 3 | 3 | 3 | 1 | -2 (-67%) | 100% | 100% |
| Myanmar | N/A | 2 | 2 | 2 | 0 (0%) | N/A | 50% |
| Nepal | 4 | 4 | N/A | 2 | -2 (-50%) | 75% | 100% |
| Total SEAR | 35 | 30 | 33 | 30 | -5 (-14%) | 69% | 67% |
| TOTAL | 671 | 639 | 526 | 490 | -181 (-27%) | 26% | 23% |

84. The funding cuts from GPEI have especially impacted staff in Angola and Nigeria as illustrated in Table 6. The GPEI-funded staffing levels in other polio transition African countries had little change between 2018 and 2021. Pakistan in EMR and India in SEAR further saw significant declines in staffing funded by GPEI.
85. Several informants highlighted that the **recent human resources cut had affected programme delivery** in terms of both responding to cVDPV outbreaks and moving on with implementation of polio transition. The TIMB also flagged this concern¹⁰⁴. Some respondents felt that the human resources **scaling down process had moved too fast in countries where cVDPV outbreaks continued to occur**. Some informants were concerned that the 500+ termination notice letters sent to staff in AFR in early 2021, will result in the exit of talented personnel and poses a risk in countries facing polio outbreaks. Staff motivation was also reported to have been affected due in part to the paradoxical situation that, with the ramp down of GPEI, if they did an efficient job of responding to cVDPV outbreaks they would lose their jobs.

¹⁰⁴ TIMB, Polio Transition Independent Monitoring Board, Building stronger resilience, Fifth report, December 2021 <https://polioeradication.org/wp-content/uploads/2022/01/5th-TIMB-report-Building-stronger-resilience-20211231.pdf>

86. WHO Regional Office for Africa (AFRO) has established a system to better capture polio “non-staff” support. Table 7 shows the 2022 polio workforce in the ten polio high-risk countries in AFR illustrating that most of the polio workforce are actually “non-staff” (953) which includes: contracts under special services agreements, contracts under agreements for performance of work, national and international consultants (and in Nigeria short term contracts). Thus, a significant number of non-staff polio workers are still forming the largest part of the polio workforce.

Table 7: Polio workforce by staff/non-staff in 10 polio high-risk countries in AFR by January 2022¹⁰⁵

| Country | Non-staff | | Staff | | Non-staff and Staff Combined | |
|--------------|------------|-----|------------|-----|------------------------------|-------------|
| | Number | % | Number | % | Total | % |
| Angola | 35 | 58% | 25 | 42% | 60 | 5% |
| Chad | 41 | 75% | 14 | 25% | 55 | 4% |
| Cameroon | 55 | 87% | 8 | 13% | 63 | 5% |
| DRC | 70 | 64% | 40 | 36% | 110 | 8% |
| Ethiopia | 80 | 65% | 43 | 35% | 123 | 9% |
| Guinea | 18 | 69% | 8 | 31% | 26 | 2% |
| Kenya | 8 | 42% | 11 | 58% | 19 | 1% |
| Niger | 23 | 59% | 16 | 41% | 39 | 3% |
| Nigeria | 370* | 83% | 76 | 17% | 446 | 34% |
| South Sudan | 350 | 96% | 14 | 4% | 364 | 28% |
| Total | 953 | | 229 | | 1,305 | 100% |

* Includes both existing non-staff + previous staff whose posts were converted into short term contracts in 2021

87. Few countries have to date experienced a massive GPEI ramp down, one being Nigeria, which reportedly had caused the lay-off of experienced staff. According to the country case study conducted in Nigeria, this disengagement of staff had led to inefficiency in the implementation of the polio programme. The staff that were let go were valuable assets to the health system. Due to shortages in human resources, key informants expressed that the country is now prone to persistent delays in the confirmation of AFP laboratory samples (on average it takes a cVDPV AFP case 43 days to be confirmed, against the 2022-2026 GPEI target of 35 days), and slower in responding to cVDPV outbreaks.

88. The evaluation team was not able to ascertain overall how many staff had been lost to the WHO and how many had shifted to other positions within WHO or government as this is not tracked overall. It was recently reported that only 6 WHO staff in AFR have been lost to the Organisation and that all polio staff in 37 low risk countries have been integrated into other departments (particularly immunization and health emergency programme)¹⁰⁶, yet in the Nigeria country case study, key informants gave another perception of high rates of disengagement of experienced polio staff, and AFRO recently communicated that additional support is being brought on board to surge back human resource capacity to 2019 levels in Nigeria¹⁰⁷.

89. There was no information available on the extent WHO staff have been absorbed by government across the countries as this is not tracked. However, informants revealed that the strategy of WHO staff being absorbed by government as envisioned in the Action Plan had not yet been

¹⁰⁵ WHO Member State Information Session, Update on Polio transition, January 2022

¹⁰⁶ WHO, Member State Information Session, Update on Polio transition, January 2022

¹⁰⁷ WHO, Member State Information Session, Update on Polio transition, January 2022

effective in most countries, mainly due to salary levels in government not being competitive. It was common knowledge that the labour market has been distorted by WHO salaries that are higher than national programme salaries which makes the shift to government seem unrealistic.

3.2.1.4 Progress on the roadmap for the Action Plan

90. The overall implementation status of the polio transition roadmap as of January 2022 is presented in Table 8 below. **Milestones achieved on time** were mainly activities related to initial data collection, strategic review, planning, budgeting and monitoring and evaluation activities, of which some were completed even before the Action Plan was developed.
91. **Milestones that have faced delays but are in progress** as of January 2022 are mainly related to the implementation phase. This includes finalization of national polio transition plans (initially planned to be completed by June 2018), national resource mobilization plans (milestone 2019), finalisation of information and advocacy materials (milestone 2019), meetings on polio virus containment (milestone 2019), and finally early evaluation of polio transition progress (milestone in 2020).
92. **Ongoing activities with milestones on track include** financing of WHO programme areas for the biennium 2022–2023 (partially achieved, budget approved, but financing of the budget is ongoing), human resource services available to support staff members who will be transitioned (on-going and in progress),
93. **The only milestone which is considered off-track** by the evaluation team is “Key monitoring and evaluation output indicators are being met”. This is nonetheless considered a very important milestone. (refer to section 3.2.1 for detailed trends description)
94. In the following sections of this report, roadmap milestones will be explored in more detail under their relevant sections.

Table 8. Implementation status of the polio transition road map (as of January 2022)

| Process/period | Milestones | Implementation/status as of January 2022 |
|--|---|--|
| Analysis – 2017 | • Establishment of the indemnity fund to mitigate human resources risks | Achieved in 2017 |
| | • Reports submitted to the Executive Board (EB) and World Health Assembly (WHA) in 2017 | Achieved in 2017 |
| Data collection, strategic review, costing – 2018 | • Report to the EB at its 142nd session in January 2018 on the key components on the strategic action plan on polio transition | Achieved in 2018 |
| | • Finalization of the national transition plans by end June 2018 | Delayed – in progress |
| | • Polio Post-Certification Strategy finalized and submitted as a part of the Action Plan to the WHA | Achieved in 2017 |
| | • 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 in 2017/18 |
| | • Cost estimates and draft text provided for the investment case for the GPW13, 2019–2023 | Achieved in 2018 |
| Planning and budgeting – 2018–2019 | • 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 | Achieved in 2018 and 2019 |

| Process/period | Milestones | Implementation/status as of January 2022 |
|--|--|---|
| | Mediterranean: and three joint planning visits in 2019 | Achieved, but only partially for 2020-2021 programme budget |
| | <ul style="list-style-type: none"> Inclusion of polio essential functions and transition costs in the development of the Proposed programme budget 2020–2021 | Delayed, in progress |
| | <ul style="list-style-type: none"> Polio transition countries have resource mobilization plans in place to seek the funds needed for sustaining essential polio functions | Achieved |
| | <ul style="list-style-type: none"> Convening a first stakeholders’ meeting to secure agreement on the implementation and governance of the Post-Certification Strategy; including follow up meetings on: <ol style="list-style-type: none"> immunization system strengthening integrated disease surveillance emergency response management poliovirus containment | Achieved |
| | | Achieved |
| | | Achieved |
| | <ul style="list-style-type: none"> A set of information and advocacy materials developed for distribution by the end of the second quarter 2018, and webpage updated quarterly | Delayed, in progress |
| | | Delayed, in progress |
| Implementation – 2019–2023 | <ul style="list-style-type: none"> Key M&E output indicators are being met | Off track |
| | <ul style="list-style-type: none"> Financing available to support mainstreaming or integration of essential polio functions into WHO programme areas for the biennium 2020–2021 and 2022–2023 | Ongoing – in progress |
| | <ul style="list-style-type: none"> HR services available to support staff members who will be transitioned, or their positions terminated | Ongoing – in progress |
| Monitoring and evaluation – 2019–2023 | <ul style="list-style-type: none"> Monitoring process established at all 3 levels with annual reporting to WHO’s governing bodies | Achieved in 2020 |
| | <ul style="list-style-type: none"> Dashboard developed based on output indicators which is updated and shared with annual reports | Achieved in 2020 |
| | <ul style="list-style-type: none"> 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 | Delayed – in progress |

3.2.2 Sub-question 2.2 – Contextual factors affecting implementation

Summary of findings – Contextual factors affecting implementation

Since the Action Plan was developed in 2018, an **increasing number of cVDPV outbreaks and slower progress on eradication of WPV than expected** have changed the timelines for polio eradication and prospects for sustaining a polio-free world. Several countries that experienced outbreaks of cVDPV have not implemented a timely vaccination response because of delays in preparing for the use of novel type 2 oral poliovirus vaccine (nOPV2). Supply shortages of IPV, pandemic disruptions and inaccessibility due to heightened insecurity constituted additional barriers to sustaining a polio free world.

Vaccine coverage inequity is prevalent in many countries, with pockets of zero-dose children laying the ground for future outbreaks.

Summary of findings – Contextual factors affecting implementation

The **COVID-19 pandemic, coupled with increasing insecurity and political unrest** in the polio transition priority countries, have challenged polio and routine VPD surveillance and vaccination coverage, **deflecting attention away from polio transition efforts to respond to these challenges**. Global health experts have cautioned that the consequence of COVID-19 on VPDs may last long after the pandemic recedes, and its full detrimental effect has yet to be seen. Yet, the pandemic also clearly demonstrated how **leveraging polio assets can contribute to improved health emergency responses and this has been well documented by WHO**. It is now critical that WHO strategically utilize this documentation for advocacy and resource mobilization efforts

95. In 2017, when the Action Plan was drafted, the vision was that WPV would be eradicated globally by 2023 and the world would be ready to implement the Polio Post Certification Strategy. cVDPV outbreaks were perceived by most as being under control and the assumption was that all countries, including Afghanistan and Pakistan, would implement national polio transition plans¹⁰⁸.
96. Yet the landscape has changed significantly since development of the Action Plan, with delays in WPV eradication, an increasing number of cVDPV outbreaks, escalating conflicts, fragility and political unrest in polio transition countries and not least the COVID-19 pandemic. These factors are reported to have negatively affected surveillance, vaccination coverage, and proper outbreak responses and caused delays in implementation of national polio transition plans and timelines for polio transition in general. However, the COVID-19 pandemic also accelerated integration of functions and leveraged the polio infrastructure for an improved emergency response. This demonstrated a good example of “polio transition in action”, with polio resources greatly contributing to global health security (see section below for more detail).
97. Key informants expressed that the Action Plan needs to be extended or that a new Action Plan for polio transition is necessary after 2023 due to these significant challenges and delays. Several informants also recommended that due to these significant changes it would be critical to revisit the vision of polio transition and carefully judge which countries should be planning for transition now and which should be planning for integration now and with a vision for transition in the longer term.
98. Below the key contextual factors in the global public health realm affecting polio transition efforts are explored in more detail.

3.2.2.1 COVID-19 pandemic

99. Immediately after COVID-19 was declared a pandemic in March 2020, the Polio Oversight Board (POB) of GPEI recommended “that all polio outbreak response, supplementary immunization activities (SIAs) be suspended until June 2020 and all preventive SIAs be postponed until the second half of the year”. The POB further recommended that critical functions of polio surveillance (AFP and environmental surveillance) should continue and whenever feasible be integrated into COVID-19 surveillance. The POB also called on national polio eradication programmes to prioritize support for the response to COVID-19¹⁰⁹.
100. From March to May 2020, 28 countries across the world suspended a total of 62 polio vaccine SIAs to prevent the spread of COVID-19. Polio outbreak response vaccination campaigns were,

¹⁰⁸ WHO presentation, Moving forward in a changing Environment: Global overview. TIMB meeting Nov 2021

¹⁰⁹ GPEI. *Polio Eradication in the Context of the COVID-19 Pandemic*: Summary of urgent country and regional recommendations from the Polio Oversight Board meeting of March 24, 2020

however, resumed from August 2020 in Afghanistan and Pakistan and in countries experiencing cVDPV outbreaks. Preventive polio vaccination campaigns and routine immunization service delivery also suffered from pandemic restriction and diversion of resources¹¹⁰.

101. **Almost all key informants stressed that COVID-19 has caused large scale disruption of polio vaccination and routine immunization and surveillance activities in 2020 and 2021.** Planned polio transition activities, **including implementation of national polio transition plans**, also slowed down or even stalled during the pandemic. The COVID-19 pandemic caused specific strain on countries' fiscal space to commit domestic resources to polio transition funding¹¹¹. WHO country missions to review and support transition implementation were also suspended in 2020 and into 2021¹¹².
102. **Furthermore, attention of governments, ministry and WHO staff across all polio transition countries was largely diverted to tackle the pandemic.** Across AFR it is estimated that 61% of the polio workforce spent at least 50% of their time on the COVID-19 response, in SEAR almost 2600 personnel spent between one quarter and three quarters of their time on the COVID-19 response and in EMR 1243 polio staff contributed to the pandemic response^{113,114}. COVID-19 response activities performed by the polio workforce across the 20 polio transition priority country included mainly COVID-19 surveillance, contact tracing, vaccination roll-out, laboratory support, coordination, community engagement, data management, and logistics¹¹⁵.
103. **Despite the circumstances of suspended vaccination campaigns and disruptions of health systems and routine immunization services, the estimated coverage of polio vaccinations (IPV1 and POL3) and measles containing vaccine (MCV1) remained more or less stable in the seven polio transition priority countries in AFR in 2020¹¹⁶, whereas AFP surveillance took a noticeable decline** across all seven countries in 2020 and 2021 compared to previous years¹¹⁷. Polio transition priority countries of **SEAR appear to have been more affected by the pandemic in terms of coverage of polio and measles containing vaccinations with backsliding estimates** of IPV1, POL3, MCV1 and MCV2 in all countries except Bangladesh in 2020 and a declining performance on AFP surveillance in 2021¹¹⁸. Around half of the eight polio transition priority countries in EMR also saw declining estimated coverage of polio and measles vaccinations in 2020 compared to previous years¹¹⁹, and signs of deteriorating polio surveillance in 2020 across three countries (Afghanistan, Pakistan and Iraq), though with some level of recovery in 2021¹²⁰.
104. **COVID-19 nevertheless also provided an important opportunity to demonstrate how the polio infrastructure can support broader health security outcomes.** COVID-19 underlined the critical role that polio teams perform in the public health workforce, especially in countries with disrupted or fragile health systems. The polio programme with its massive "boots on the ground" and highly experienced workforce in disease surveillance and outbreak response was able to

¹¹⁰ Burkholder B, Wadood Z, Kassem AM, Ehrhardt D, Zomahoun D. *The immediate impact of the COVID-19 pandemic on polio immunization and surveillance activities*. 2021

¹¹¹ WHO Polio transition through COVID-19 response: Establishing "integrated public health teams" in priority countries
Concept note

¹¹² WHO, Executive Board, Poliomyelitis, EB148/23 Polio transition planning and polio post-certification, Report by the Director-General, December 2020 https://apps.who.int/gb/ebwha/pdf_files/EB148/B148_23-en.pdf

¹¹³ Ibid

¹¹⁴ WHO. Member State Information Session, Update on Polio transition, 13 Jan 2022

¹¹⁵ Ibid

¹¹⁶ [WUENIC estimates](#)

¹¹⁷ [GPEI polio data](#)

¹¹⁸ [WUENIC estimates](#)

¹¹⁹ Ibid

¹²⁰ [GPEI polio data](#)

reach some of the most remote and insecure areas of the world and was called upon by national governments and international communities to support the pandemic response¹²¹.

105. **Collaboration and coordination** between the polio programme and other departments of WHO, particularly the health emergency division, **has also been strengthened** due to the pandemic response according to key informants across all regions, countries and headquarters. The WHO's Integrated Public Health Team approach was augmented by COVID-19¹²² as an interim integration strategy before transitioning to national governments. In Somalia, Sudan, Syria and Yemen, the approach is currently being set up bringing together polio, emergencies and immunization expertise and building on the strong polio footprint. The pandemic response was further seen as accelerating implementation of integration between WHO Health Emergencies Programme (WHE) and the Polio programme, reinforcing implementation of the Action Plan.
106. **The importance of the polio infrastructure to the COVID-19 response has been well documented by WHO.** In 2020, WHO issued a report clearly illustrating the contribution of the polio network to the pandemic response¹²³, and recently SEAR published a report on the polio network's broader contributions to public health in the region including COVID 19, highlighting its value as a public health good¹²⁴. In AFRO, a dashboard has recently been launched with real-time data depicting the contribution of polio resources to COVID-19 vaccine roll out¹²⁵.
107. It is now **critical that WHO strategically utilizes this documentation for advocacy and resource mobilization efforts** to sustain essential polio functions. Increasing donor interest in providing funding for recovery and resilience post-COVID-19 is an opportunity that polio and broader immunization and surveillance programmes can tap into. Some key informants felt that WHO had not yet taken advantage of this.
108. Global health experts have cautioned that the consequence of COVID-19 on VPDs may last long after the pandemic recedes¹²⁶. Since cVDPV outbreaks may take between 12-18 months to develop in seriously under-immunized population pockets¹²⁷, the complete aftermath of COVID-19 disruptions on the polio epidemiology is yet to be seen. A recent WHO and CDC report also warns that a potential major measles outbreak could follow in settings with large numbers of unvaccinated children due to severe COVID-19 disruptions of routine immunization programmes¹²⁸.

¹²¹ WHO, *Contributions of the polio network to the COVID-19 response: turning the challenge into an opportunity for polio transition*, 2020

¹²² WHO, [EB 150th session, December 2021](#)

¹²³ WHO, *Contributions of the polio network to the COVID-19 response: turning the challenge into an opportunity for polio transition*, 2020

¹²⁴ WHO, *NeXtwork - The role and contribution of the integrated surveillance and immunization network to the COVID-19 response in the WHO South-East Asia Region (Bangladesh, India, Indonesia, Myanmar and Nepal)*, 2021

¹²⁵ [Contribution of polio resources to COVID-19 vaccine roll out dashboard](#)

¹²⁶ Leslie Roberts, *Polio, measles, other diseases set to surge as COVID-19 forces suspension of vaccination campaigns, disease surge due to vaccination campaign suspension, 2020*

¹²⁷ [GPEI website, Circulating vaccine-derived poliovirus](#)

¹²⁸ WHO, *Global progress against measles threatened amidst COVID-19 pandemic*, 10 November 2021 [Measles press release](#)

109. Country case study – Nigeria’s experience with

COVID-19. The COVID-19 pandemic severely strained the health system in Nigeria, which caused marked disruptions to polio vaccination and routine immunization service delivery especially in 2020¹²⁹. As a result, access to immunization services such as measles, polio and pertussis were substantially affected and hard-fought gains in vaccination coverage were negatively impacted, due to a combination of the following factors: (i) restrictions (lockdown measures) placed on movement and travel to contain the spread of the virus, (ii) human resource capacity of PHC facilities strained due to the high volume of hospitalizations caused by the COVID-19 virus and health workers being redeployed to respond to the pandemic, (iii) postponement of scheduled supplemental immunization campaigns, (iv) diversion of finances from the government and development partners to deal with COVID-19 response, and (v) demand-side challenges e.g. the reluctance of parents to bring children to be vaccinated due to fear of infection and non-urgent medical care being postponed.

To mitigate these disruptions, the government of Nigeria through the National Primary Healthcare Development Agency, in collaboration with development partners, implemented various integrated strategies. (see box)

Nigeria’s experience with integration of COVID-19 and other health priorities

The government of Nigeria through the National Primary Healthcare Development Agency, in collaboration with development partners, implemented the “Optimized Integrated Routine Immunization Sessions” and the “whole family” approach which combines COVID-19 vaccination with healthcare services such as childhood vaccination, malnutrition and screening for non-communicable diseases. Nigeria also took advantage of the cVDPV outbreak response to support COVID-19 vaccine rollout.¹

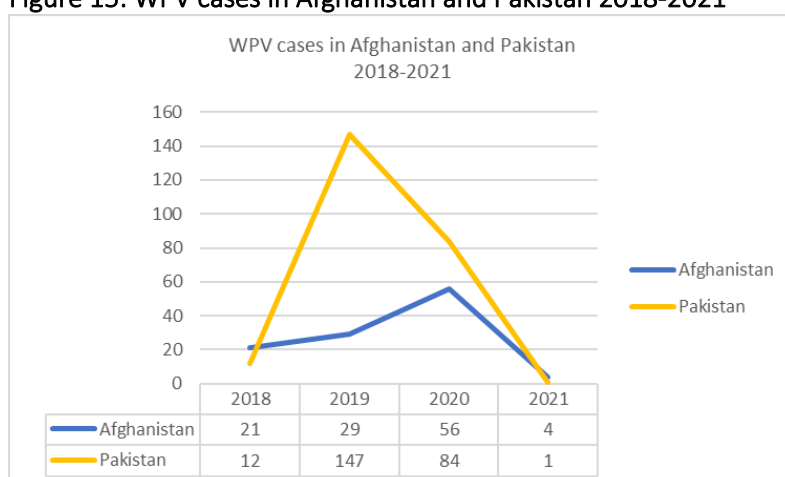
(Nigeria country case study report – See Annex)

3.2.2.2 Polio epidemiology developments and persistent equity concerns

110. Two countries in the world are still considered polio endemic - Pakistan and Afghanistan. At the time of drafting the Action Plan, the world was close to eradicating WPV. In 2018, the total number of WPV outbreaks was recorded at 33, which however took a sharp increase to 176 cases in 2019, declined to 140 cases in 2020 and then decreased substantially to only five cases reported in 2021 (see Figure 15) with four in Afghanistan and one in Pakistan.

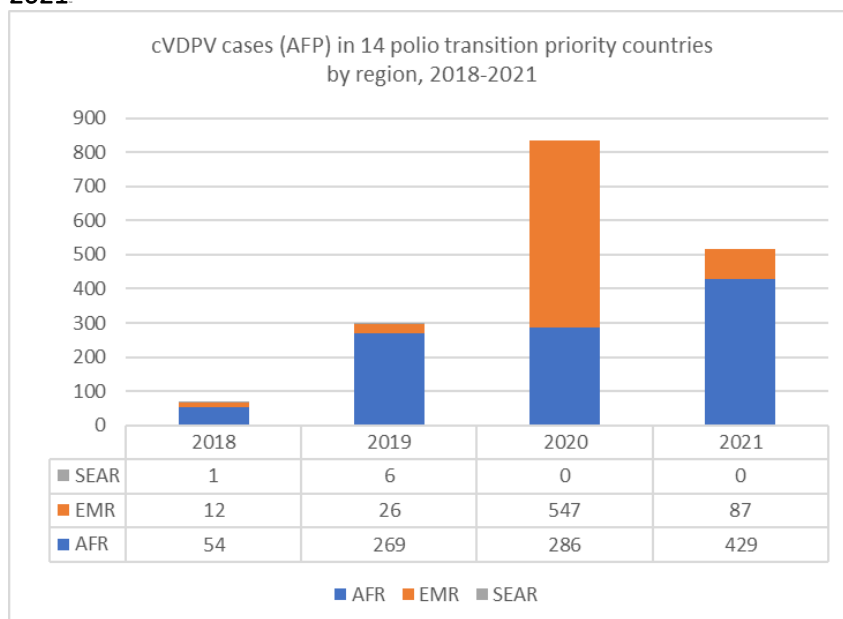
¹²⁹ UNICEF, Tracking the situation of children during COVID-19, May 2021 [UNICEF COVID-19 tracker](#)

Figure 15: WPV cases in Afghanistan and Pakistan 2018-2021¹³⁰



111. Whereas significant progress has been made on WPV interruption, cVDPV outbreaks increased sharply in 2019 and 2020 and continue in 2021 to affect countries mainly in AFR and EMR. The number of cVDPV cases has increased by 670% between 2018 and 2021 (see Figure 16) among 14 polio transition priority countries. **Only 6 of the 20 polio priority countries have not recorded any cVDPV outbreaks in the period 2018-2021** (Bangladesh, India, Iraq, Libya, Syria and Nepal).

Figure 16: cVDPV cases (AFP), 14 polio transition priority countries, regional disaggregation, 2018-2021¹³¹



112. In 2020, the highest number of cVDPV cases was recorded in EMR (mainly in Afghanistan and Pakistan) whereas in 2021, the highest number of cases was reported in AFR, and mainly in Nigeria (see Figure 15 and 18) Nigeria has been the epicentre of cVDPV2 outbreaks since mid-2021¹³².

¹³⁰ [GPEI polio data](#)

¹³¹ UNICEF, Tracking the situation of children during COVID-19, May 2021 [UNICEF COVID-19 tracker](#)

¹³² WHO, [Weekly epidemiological record](#), 17 September 2021

Figure 17: cVDPV cases (AFP) in 7 polio transition priority countries of AFR, 2018-2021¹³³

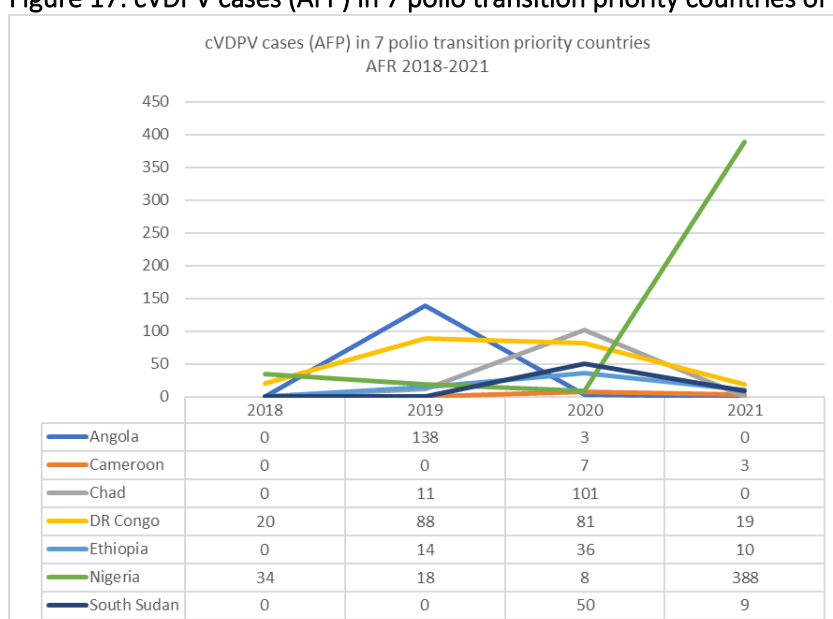
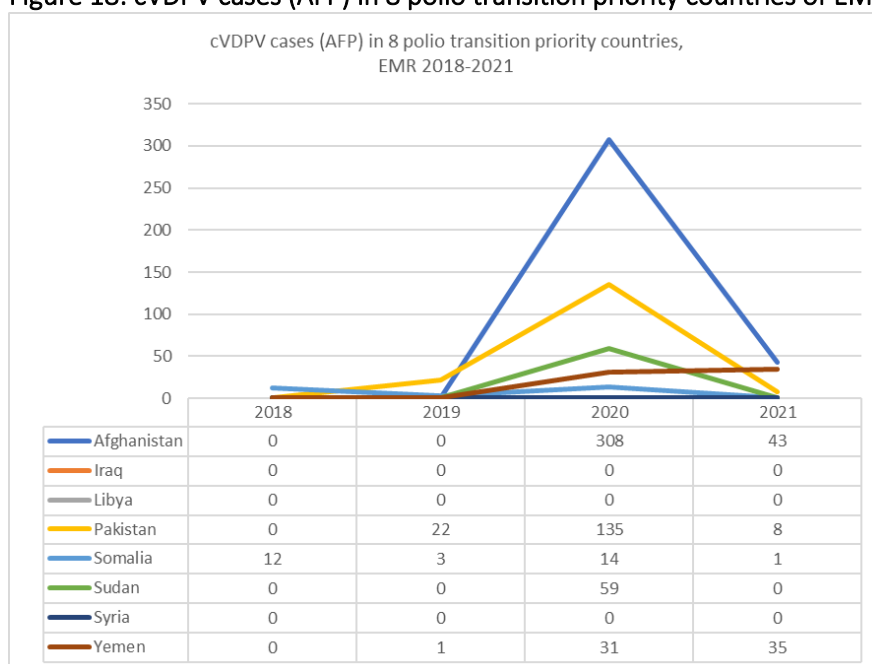


Figure 18: cVDPV cases (AFP) in 8 polio transition priority countries of EMR, 2018-2021¹³⁴



113. The reasons for the recent increases in cVDPV outbreaks have been analysed by GPEI¹³⁵ and several factors appear to have affected prevention of and response to cVDPV outbreaks. cVDPV outbreaks are possible when persistent immunity gaps and inadequate surveillance persists¹³⁶ and the recent switch from oral polio vaccines (OPV) to IPV or from trivalent to bivalent OPV might have increased vulnerabilities¹³⁷. In addition, several countries that experienced outbreaks of cVDPV2 have not implemented a timely vaccination response because of delays in preparing for the use of novel type 2 oral poliovirus vaccine (nOPV2). Supply shortages of IPV were also

¹³³ [GPEI polio data](#)

¹³⁴ [Ibid](#)

¹³⁵ [GPEI website, Circulating vaccine-derived poliovirus](#)

¹³⁶ [GPEI website, Circulating vaccine-derived poliovirus](#)

¹³⁷ [GPEI website, Circulating vaccine-derived poliovirus](#)

reported¹³⁸. Furthermore, reaching communities with vaccination and surveillance has further been challenged by insecurity and COVID-19 disruptions to vaccination campaigns and surveillance. Inequity is abundant in many countries, with pockets of zero-dose children laying the ground for future outbreaks. Some countries also reported shortages of resources to respond to outbreaks due to the ramp down in GPEI funds (see example from the Nigeria case study below).

Nigeria Country case study analysis on the increased number of cVDPV cases reported in 2021

In 2021 there was a major resurgence of cVDPV2 cases throughout the year, which has been fuelled mainly by poor operational and surveillance activities such as delayed detection of the virus, poor outbreak responses due to delayed laboratory sequence reports and late distribution of nOPV2 vaccines.

Other contextual factors include the damaging effects of the COVID-19 pandemic on polio surveillance, poor implementation of surveillance and vaccination activities and the rising insecurity in most parts of the country, thereby resulting in falling coverage of essential childhood immunization rates. In 2021, a total of 29 states and 201 local government areas had outbreaks of cVDPV2, with more outbreaks occurring in the northern states when compared to the southern states. In addition, the number of staff supporting the polio programme in Nigeria has decreased by 54% between 2020 and 2021 and resource challenges have been reported in Nigeria to respond to the outbreaks.

(Nigeria country case study report – see Annex)

114. Major equity concerns persist in some polio transition priority countries with the proportion of polio zero-dose children (proportion of children who have not received any polio vaccination) above 10% in Angola, Somalia and Yemen signalling deprived communities and possible reservoirs for outbreaks (Table 9). “Reaching zero-dose children means reaching the missed communities they are a part of”¹³⁹.

Table 9. Zero-dose children (%) across polio transition priority countries

| | % 0-dose | |
|--------------|--------------|--------------|
| | Jan-Jun 2020 | Jul-Dec 2020 |
| AFR | | |
| Angola | 21.18 | 6.25 |
| Cameroon | 0.00 | 3.27 |
| Chad | 7.06 | 2.65 |
| DR Congo | 7.41 | 7.22 |
| Ethiopia | 7.56 | 8.20 |
| Nigeria | < 2 | < 2 |
| South Sudan | 4.58 | 7.38 |
| EMR | | |
| Afghanistan* | 9.17/1.02 | 18.37/3.30 |
| Iraq | N/A | N/A |
| Libya | N/A | N/A |
| Pakistan | < 2 | < 1 |
| Somalia | 13.29 | 20.35 |
| Sudan | 3.00 | 5.76 |
| Syria | N/A | N/A |
| Yemen | 9.36 | 19.37 |

*Southern (Kandahar/Helmand)/Rest of country

¹³⁸ WHO, [Weekly epidemiological record](#), 17 September 2021

¹³⁹ <https://www.gavi.org/vaccineswork/zero-dose-child-explained>

115. **In Somalia, zero-dose children and under-immunized children prevail** particularly in inaccessible areas and in hard-to-reach communities. In 2020, it was estimated that 250.000 children under 5 years were residing in inaccessible areas, representing **8.1%** of the target population. In the period July-December 2020, the proportion of zero-dose children was 20% (vastly above the threshold of 10%)^{140, 141}. The Somalia Health and Demographic survey from 2020¹⁴² showed widespread inequity in vaccination coverage among children, reporting that whereas 19% of children in urban areas had received all basic vaccinations¹⁴³, less than 1% of children in nomadic areas had received all basic vaccinations.

3.2.2.3 *Conflicts, fragility and political unrest*

116. A large number of polio transition priority countries are severely challenged by political instability, fragility, ongoing and escalating conflicts and security issues. This is leading to disrupted health systems or health systems on the brink of collapse, and considerable challenges in reaching underserved and displaced communities.

117. EMR is particularly affected by conflicts and security challenges. In EMR, 43% of the region's population (101.6 million people), currently rely on humanitarian assistance, and the region currently has 10 major humanitarian emergencies¹⁴⁴. Over 32.2 million people are internally displaced and the region hosts 64% of the world's refugees. Fragility, ongoing and protracted conflicts and compromised security situations are reported in Afghanistan, Iraq, Libya, Somalia, Sudan, Syria and Yemen¹⁴⁵. In these countries, health systems have faced enormous challenges over a protracted period, causing severe shortages in providing health services, weakened infrastructure, and limited supplies.

118. After four decades of instability in **Afghanistan**, the conflict in 2021 resulted in a collapse of the Afghan government and take-over by the Taliban in August 2021. The transition of the government is an enormous challenge for access to health care. The country's already fragile health system is completely overwhelmed, and resurgence of polio is a major concern. Key informants expressed that WHO has remained on the ground and continues to support despite not really knowing who to collaborate with under the present regime.

¹⁴⁰ [GPEI-2020-Annual-Report-ISBN-9789240030763.pdf \(polioeradication.org\)](#)

¹⁴¹ WHO PPT, Special populations, Access and Security Issues, 2020

¹⁴² The Somali Health & Demographic Survey 2020 <https://www.nbs.gov.so/somali-health-demographic-survey-2020/>

¹⁴³ DTP, Polio 3 doses, Measles 1st dose and BCG

¹⁴⁴ WHO, Member states information session on polio transition, January 2022

¹⁴⁵ WHO EMRO, Update on polio transition in the Eastern Mediterranean Region, ppt. TIMB meeting Nov 2021

119. Conflicts and insecurity in **Somalia** have hampered development in recent years and have weakened an already overstretched health system. The polio programme in Somalia has suffered from extreme security challenges and related inaccessibility of communities with recent reports of a growing political crisis in the country¹⁴⁶(see box).

Country case study Somalia - Insecurity and inaccessible areas

Since 2017, Somalia's polio programme has been engaging with local elders to negotiate access to inaccessible districts as one of the strategies to ensuring all children are reached with polio vaccines. However, 14 districts of the country remain inaccessible and obstruction of vaccination campaign by anti-government elements have been reported in conflict-affected areas. Transit Vaccination Points vaccinators have been employed as a strategy to vaccinate inaccessible populations in border areas. Surveillance activities are continued through VPs in the inaccessible areas and, by 2018, 40% of the total number of AFP cases have been reported in inaccessible areas. Yet, WHO is not able to conduct supporting supervision or to verify the work that has been done by community workers and this reportedly creates gaps that are very difficult to deal with.

(Somalia country case study, Annex)

120. Conflicts and political unrest are also evident in the AFR. Of the seven polio transition priority countries, conflicts and fragility are especially prone in DRC, Nigeria, South Sudan and Ethiopia. Due to the conflict that erupted at the end of 2020 in **Ethiopia**, more than 5.2 million people in Tigray are in need of humanitarian support and health care services. More than 2.1 million people have been displaced and over half of the health facilities in Tigray are not operational¹⁴⁷.

121. The poor security situation in many parts of **Nigeria** was identified as a major hindrance to the polio transition efforts in the country. Persistent armed conflict with Boko Haram in North-Eastern Nigeria is resulting in widespread displacements, food insecurity, and many victims of violence. The number of people in need of urgent assistance in north-east Nigeria rose to 10.6 million since the onset of the COVID-19 pandemic (Nigeria Country case report -Annex).

Country case study Nigeria- Impact of insecurity

The ongoing insecurity situation caused by Boko Haram insurgency, banditry, kidnapping in parts of the country especially in the North-East and the North-Western States, remains a problem for both eradication and transition efforts because most of the health care workers in these regions are currently unable to access some security compromised communities to conduct disease surveillance and routine vaccination activities in a safe and effective manner which poses a potential threat to polio eradication efforts (Nigeria country case study – Annex)

122. In SEAR, political instability and conflicts are less of a challenge, except in Myanmar. Myanmar has been under a Military government since February 2021. Informants stated that most of the previous Ministry of Health officials have been replaced by new staff and there is currently limited interaction between the Ministry of Health and WHO. The national polio transition plan in Myanmar has been temporarily suspended because of these challenges.

¹⁴⁶ Somtribune, [Political Unrest Deepens in Somalia](#), January 2022

¹⁴⁷ WHO, [Crisis in northern Ethiopia](#)

3.2.3 Sub-question 2.3 – Managed effectively and efficiently

Summary of findings

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

Essential polio functions for polio low-risk countries were **transitioned into the WHO base budget** during the development of the WHO programme budget 2022–2023. This is considered a major achievement and a key enabler for integration within WHO and for transition to government in the longer perspective.

Support for implementation of the Action Plan and programme management **have largely been effective**, but challenges were encountered related to the COVID-19 pandemic and larger organizational weaknesses in terms of continued verticalized and siloed operations and mindsets.

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

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

As much as the various suitable monitoring mechanisms have been set up, **inadequate strategic application and interpretation of progress/deterioration of indicators** with limited reflection and corrective actions vis-a-vis the poliovirus epidemiological trends, changing security situations and countries' economic situations is noted.

Declining financial resources is a critical challenge along with limited government commitment to sustaining essential polio functions and was further compounded by the COVID-19 pandemic. Resource mobilization plans have been developed in the majority of polio transition 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 have affected timely planning, including human resources planning at regional and country level.

Ownership at WHO country level for polio transition and leadership at WHO regional office level were observed, with regional and national plans for polio transition being prioritised amidst demanding contexts. The conduct of **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 funds of the WHO base budget prevented full implementation of the functional review recommendations.

The **TIMB was praised for its accountability role having brought forth actionable recommendations** for improving the effectiveness and efficiency of polio transition efforts though they could be presented more clearly with endpoints and timelines.

3.2.3.1 *The WHO Transition programme*

123. **A dedicated WHO headquarters polio transition team was set up in 2017** with a specific role including: facilitating and coordinating transition activities across the three levels of WHO; providing management, technical and operational support to the Deputy Director-General (DDG) in the role of secretariat for the polio transition steering committee, tracking implementation of polio transition joint corporate workplans, monitoring and reporting progress towards the objectives of the Action Plan and providing support, as needed, to regional and country offices. The polio transition team appears very dedicated, but to some extent also represents a silo within a highly fragmented environment. While they have succeeded in starting discussions, improving collaboration and progressing on key milestones, the ownership for polio transition among other related departments (particularly the Immunization, Vaccines, and Biologicals Department (IVB), WHE and Polio) is weaker. This aspect will be elaborated further in this section under WHO coordination and communication.

124. **Whereas the roles within WHO are clearly defined**, and evidence collected through the evaluation support that the division of responsibility is being implemented, **it remains unclear what the role of GPEI on polio transition entails**. According to multiple informants, GPEI has handed over polio transition completely to WHO to manage. However, the strong interlinkages of polio eradication and polio transition makes such a “clear cut” division of labour very difficult to implement. Multiple informants further mentioned that GPEI should take responsibility as well for polio transition and that the two processes of eradication and transition should go hand in hand. Other informants noted the value of the lesson from development more generally of ensuring an exit strategy and sustainability plan for a given country programme.

3.2.3.2 *WHO polio transition monitoring mechanisms*

125. Several platforms have been set up in WHO to monitor progress on polio transition, these include dashboards and databases at headquarters and regional office level, joint corporate workplans at headquarters level, and polio transition workplans at regional office level (EMRO).

Polio transition dashboard

126. A polio transition dashboard was developed in 2020, tracking output indicators on the Action Plan M&E framework. The dashboard was intended to be updated twice yearly, under the oversight of the Polio Transition Steering Committee¹⁴⁸. However, the evaluation team found multiple discrepancies with official data sources WHO/UNICEF estimates of national immunization coverage (WUENIC)¹⁴⁹ and GPEI polio data¹⁵⁰ for the years 2018, 2019 and 2020 when cross checking reported results and thus limited evidence at the time of the evaluation that the dashboard is being updated regularly to align with official data sources. The evaluation further noted large discrepancies between vaccination coverage data reported by national administrative structures and WUENIC for instance.

127. Furthermore, **progress on Action Plan output level indicators is generally not being presented or discussed strategically** in relevant platforms such as the polio transition steering committee meetings and polio transition technical working group meetings. Discussions in steering committee meetings tend to focus more on operational issues, especially budgetary issues, roadmaps and joint workplan activities rather than progress on the Action Plan output

¹⁴⁸ WHO, World Health Assembly, A71/9, Polio transition and post certification, Draft strategic action plan on polio transition, Report by the Director-General, April 2018, https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_9-en.pdf

¹⁴⁹ [WHO/UNICEF estimates of national immunization coverage](#) (WUENIC)

¹⁵⁰ [WHO AFP data](#)

indicators¹⁵¹. Trend analysis of core output indicators of the M&E framework were not covered sufficiently and were not critically scrutinised to appropriately inform governing bodies. Below is an example of the level of analysis provided in the latest WHA report from April 2021.

“Data from the first year of monitoring (before COVID-19) show an increase in both coverage with inactivated polio vaccine as well as the second dose of measles vaccines in priority countries and surveillance for acute flaccid paralysis. In two of the three WHO regions concerned with polio transition, the core capacities for emergency preparedness, detection and response under the IHR (2005) have increased”¹⁵².

128. The above analysis does not refer to changes in key output indicators of the Action Plan, including the marked increase in the cases of cVDPV and WPV and does not mention that coverage levels for IPV1, OPV, MCV1 and MCV2 were generally far behind performance targets. It also does not discuss the large variations on most output indicators across the countries and regions and refers those interested to the online dashboard for more information. These gaps in monitoring and proper reporting of the transition indicators points to a shortage of strategic application and interpretation of progress and regress.

Workplans on polio transition

129. **Progress on polio transition is mainly monitored by WHO through its joint corporate workplan on polio transition**¹⁵³. Joint corporate workplans constitute an important accountability tool to guide and monitor efforts and the reporting back to Member States and are linked to the three objectives of the Action Plan. Activities are aligned to reflect priorities in the various regions and implementation of actions in the regions fall under the oversight of the regional steering committees on polio transition.
130. The first joint polio transition corporate workplan was developed in 2020, with the objective of defining roles and responsibilities, and ensuring accountability. The workplan covered the period June 2020 – May 2021¹⁵⁴ and included 33 actions¹⁵⁵. The implementation rate was 91% by July 2021.
131. The second joint corporate workplan on polio transition July 2021 – June 2022¹⁵⁶ focuses on: country implementation, resource mobilization, strategic communication and advocacy. The workplan stipulates 35 actions/activities for AFRO, EMRO and SEARO, and for various headquarters units and WHO departments. As of January 2022, 26% of the activities/deliverables in the joint corporate workplan on polio transition had been completed and 51% were on track. The remaining 23% have a revised timeline. Delays have been noted, particularly on resource mobilization and high-level advocacy. The detailed workplan for 2021/22 and its status can be found in Annex 3.

¹⁵¹ WHO Polio Transition Steering Committee meeting minutes 4 March 2021, 15 May 2020, 20 July 2020 and 25 Nov 2020

¹⁵² WHO, World Health Assembly, A74/20, Poliomyelitis, Polio transition planning and polio post-certification, Report by the Director-General, April 2021

<https://polioeradication.org/wp-content/uploads/2021/06/Polio-DG-Report-74-WHA-2021.pdf>

¹⁵³ Joint refers to being joint between WHO programmes and joint between HQ and regional levels.

¹⁵⁴ WHO, Joint Corporate Workplan on Polio Transition, June 2020 - May 2021, excel sheet

¹⁵⁵ Actions include focusing on: Country implementation, budget planning for 2022/2023 and resource mobilization, integration of polio transition in strategic frameworks (IA2030, GAVI 5.0, comprehensive VPD surveillance), leveraging on opportunities of COVID-19 and mitigating risks, and accountability aspects (dashboard, reporting, updates). Activities were designated to WHO headquarters units (IVB, PRP, PTP, DDG, DG, POL, CRM, WHE), and regions (EMRO/AFRO/SEARO).

¹⁵⁶ WHO, Joint Corporate Workplan on Polio Transition, July 2021 - June 2022, excel sheet

132. The evaluation team found that activities in the **joint corporate workplans are appropriate and relevant and reflect the challenges and opportunities** as discussed in polio transition steering committee meetings and technical coordination meetings. However, some activities are very broadly defined, making it difficult to track (e.g. 'assist resource mobilization initiatives at the global and regional levels' and 'enhance capacity at regional and country levels').
133. **As a good example of regional leadership on polio transition and regional specific approaches**, EMRO developed a regional workplan on polio transition for 2021¹⁵⁷, endorsed by the regional steering committee in February 2021 (see box). Other regional offices (AFRO and SEARO) did not share regional workplans on polio transition with the evaluation team.

Best practice - EMRO regional workplan on polio transition

EMRO took leadership on polio transition, by developing a regional workplan for polio transition in 2021. Workstreams of the regional transition plan include development of national polio transition plans, operationalisation of IPHTs, resource mobilization plans, integrated VPD surveillance, coordination and monitoring.

EMRO is tracking and reporting on progress of the regional workplan; by the end of December 2021, 6 out of 16 activities had been completed, 3 of 16 were ongoing, and 7 of 16 were postponed to 2022. However, the workplan does not mention milestones and targets of Action Plan M&E indicators such as IPV, MCV coverage, polio outbreaks etc, which would have been a useful outcome monitoring indicator at regional or country level as deemed relevant.

Other polio transition databases and scorecards

134. **Polio human resources databases:** A dedicated polio human resources database was set up by WHO in 2017 to track changes in polio programme staffing¹⁵⁸. The database has been analysed and explored under section 3.2.1.
135. **The African Region launched a scorecard** at the Regional Committee meeting in August 2021 to monitor country progress with specific programmatic indicators¹⁵⁹. The scorecard tracks indicators for implementation of timely, high-quality polio outbreak response, readiness to introduce nOPV2 as the new vaccine becomes eligible for broader use, strengthening routine immunization to close immunity gaps, and transitioning polio assets into national health systems. Ministers committed to regularly reviewing progress together on each of these indicators to ensure collective success in urgently finishing the job on polio and securing a polio-free future. This scorecard was, however, not accessible online to the evaluation team at the time of writing this report.
136. The evaluation teams finds, supported by multiple informants' concerns, that as much as the various monitoring mechanisms focus on appropriate activities for polio transition efforts, and despite the various platforms for monitoring, **there is limited reflection for how the poliovirus epidemiological trends, changing security situations and countries' economic situations vis-à-vis COVID-19 pandemic and other health priorities at global level impact on polio transition**. This included how best to consider the impact of cVDPV outbreaks on polio transition planning and implementation, revising said plans as necessary as well as budgets and personnel to avoid polio endemic situations again.

¹⁵⁷ WHO EMRO regional working plan on polio transition tracking sheet, Dec 2021

¹⁵⁸ WHO, *Polio transition planning, Report by the Director General*, EB 142/11, January 2018, page 12

¹⁵⁹ WHO. Member State Information Session, Update on Polio transition, 13 Jan 2022

137. In November 2018, WHO convened a high-level meeting of key stakeholders in Montreux to secure agreement on the implementation of polio transition and discuss options for governance of the Polio Post-Certification Strategy. Recommendations of the high-level meeting included that a differentiated approach to polio transition is required that recognizes the circumstances of individual countries¹⁶⁰.

- Highly vulnerable, fragile/conflict-affected countries, where some progress with transition planning may be possible, but continued technical and financial support will be required in the medium to long term;
- Lower risk countries, where a faster pace is possible for transitioning capacity-building support, to enhance routine immunization and emergency response capability; and
- Countries with stronger health systems, with a sufficiently large, trained workforce and stronger economic capabilities; these governments will gradually be able to fully integrate and fund the polio assets and capacities needed to meet their health priorities.

138. In line with these observations, the TIMB in their 5th report from December 2021 recommended that the polio transition team should add two other dimensions to their assessment of progress. These included countries' current level of polio capability and resilience and the feasibility of delivering the plan in the light of political, economic, population, conflict, and other situation factors.

139. Beyond not starting transition activities in the two endemic countries, applying the IPHT approach in some countries of the EMR and a regional workplan for EMRO, the evaluation team did not find evidence or documentation of **differential tracking, differential timelines or differential target setting for polio transition**. The sharp increase in cVDPV outbreaks did not change the transition timelines for these countries until GPEI decided to continue funding 11 “high polio risk” countries by mid-2021 which seemed not to be coordinated with WHO. Furthermore, countries such as Chad, DRC, Nigeria, Somalia, and South Sudan, with persistent low polio vaccination coverage rates, cVDPV outbreaks, insecurity and severe equity concerns are still aiming to transition polio assets to government within the next 2-3 years which seems to be unrealistic and attached with great risks for polio gains.

3.2.3.3 WHO support to implementation of the Action Plan, including risk management

Support to national transition planning

140. The WHO polio transition programme and the three WHO regional offices have supported polio transition priority countries develop national transition plans. At present 9 countries out of 18 have final national polio transition plans. The development of these plans has been an extensive process and recently almost all previously endorsed final transition plans from the AFR were revisited due to COVID-19 and are still in a draft format. In most cases the process was led by WHO country and regional offices, with varying levels of engagement of government (see also elaborated section 3.2.1).

141. National polio transition planning is generally aligned with the **criteria set by GPEI for legacy planning but to varying degrees**¹⁶¹. Documentary and informant evidence point to overall general alignment with the criteria laid out under “legacy planning” guidelines while leaving room for

¹⁶⁰ WHO, Supporting polio transition in countries and globally: A shared responsibility, Stakeholders’ meeting summary, Montreux, Switzerland, November 2018

¹⁶¹ GPEI, Polio Legacy Planning: Guidelines for Preparing a Transition Plan, 2015 <https://polioeradication.org/wp-content/uploads/2016/07/TransitionGuidelinesForPolioLegacy.pdf>

country-specific information. The plans to a large extent describe how countries are planning to integrate essential polio functions into national health systems and include a section addressing HR aspects, some even with revised terms of references. However, detailed implementation plans were not available for several national transition plans. Furthermore, the costing and assessment of budgets for polio transition in the national plans varied in detail. These ranged from highly detailed costings or budget estimation with assessments of financial gaps (e.g., Ethiopia and Nigeria) to plans without estimates of their costs or budgets (e.g., Indonesia, Iraq). In the GPEI polio legacy planning guidelines¹⁶², countries are encouraged to consider equity issues, yet gender is not mentioned specifically.

142. Whereas WHO has really pushed for national transition plans to be developed, support for their implementation is now urgently warranted as very few countries are actually implementing their plans (see section 3.2.1).

VPD Surveillance

143. Over 70% of respondents to the survey agree that there has been integration of AFP surveillance with other disease surveillance; however, over half agree that the integration of AFP surveillance into larger VPD surveillance still presents a challenge. These actions and vision are guided by the plan to develop “country-owned plans” for integrated and comprehensive VPD surveillance built on and including the existing polio workforce as part of the polio transition process¹⁶³. This emphasis and recognition of the need to align and integrate surveillance efforts across the key strategies, policies and guidance is a core component of the work to tackle VPDs, ensure epidemic and emergency preparedness and maintain a polio free world.

144. As an example of a good practice, **WHO has developed and piloted the VPD surveillance planning and budgeting tool**, funded under the UHC Partnership, to assist countries to develop budgets on surveillance of vaccine-preventable diseases¹⁶⁴. The pilot in Karnataka State, India, entailed a two-day online workshop and seven weeks of data collection and validation, culminating in development of a VPD surveillance budget for Karnataka State. The pilot implementation found the methodology feasible and the tool to be user-friendly.

Somalia’s plan for integrated disease surveillance and response system

Somalia is planning for a robust integrated disease surveillance and response (IDSR) system bringing polio surveillance, VPD and emergency health surveillance under one umbrella in the existing public health IDSR system. Somalia’s only functioning emergency health surveillance system is reportedly weak and fragmented with very low population coverage and a key priority mentioned in the polio transition plan is to transition AFP and the Early Warning, Alert and Response Network surveillance systems to the government integrated disease surveillance and response system. This synergistic approach carries great potential for improving in a sustainable way effectiveness and efficiencies of disease surveillance. (Somalia country case study - Annex)

¹⁶² GPEI, Polio Legacy Planning: Guidelines for Preparing a Transition Plan, 2015 <https://polioeradication.org/wp-content/uploads/2016/07/TransitionGuidelinesForPolioLegacy.pdf>

¹⁶³ GPEI, Polio Eradication and Essential Programme on Immunization, Interim Programme of Work (iPOW) for Integrated Actions in the context of the COVID-19 pandemic, September 2020 <https://polioeradication.org/wp-content/uploads/2020/09/Integration-POW-under-Covid-v2.0.pdf>

¹⁶⁴ This tool will allow countries to develop budgets to advocate for domestic and external funding for surveillance. Funding requirements are estimated for: admin and finance, capacity building, case detection, environmental surveillance, investigation and confirmation, public health response, reporting, and lab investigation and confirmation.

Risk management and decision making based on new information

145. WHO monitors risks as a corporate priority through the global risk management committee¹⁶⁵ (revitalised in 2021). Risks are analysed and compiled into a centralised risk register; however, management and tracking of progress against risks lack rigour with more polio risks “open” than “closed”, particularly in AFR. In 2021, polio was specifically pointed out as one of the 16 key risks to the Organization as well as incomplete implementation of polio eradication strategies. WHA reports recorded the most cited risks as the huge infrastructure and reliance on GPEI resources to sustain WHO field presence in many countries, including their coordination role and technical leadership – not least at subnational levels with provision teams, sub-offices, field offices, etc.¹⁶⁶.
146. Table 10 presents a summary of the 60 risks extracted from the WHO risk register related to polio between 2016-2021 by type of risk and whether it is ongoing or ‘open’, resolved or ‘closed’ or still in draft. **Almost half the risks were technical in nature (45%) while 20% were related to financial issues. The majority of the risks in the register were reported from AFRO (45%), followed by EMRO (20%), HQ (15%), and South-East Asia Regional Office (SEARO (12%)).** Major risks reported include the risk of not being able to sustain decentralised offices and logistics when GPEI sunsets. GPEI resources helped to establish 18 provincial teams in Angola, 11 sub-offices in the Democratic Republic of the Congo, 37 field offices in Nigeria and 11 field offices in Nepal, and to deploy a large number of district level staff in Somalia. In Angola, for example, there are 56 staff among the 18 provincial teams, and they are supported by a fleet of 26 vehicles and benefit from office space and computing and communication equipment.

Table 10: Polio related risks as per the WHO risk register, 2016-2021

| Type of Risk | # (%) | Status |
|--------------------------------|-----------|---------------------------------------|
| Technical/public health | 27 (45%) | Open (59%), Closed (30%), Draft (11%) |
| Financial | 12 (20%) | Open (33%), Closed (42%), Draft (25%) |
| Political/governance | 7 (12%) | Open (29%), Closed (71%) |
| Strategic | 6(10%) | Open (83%), Closed (17%) |
| Staff, systems, and structures | 5 (8%) | Closed (80%), Draft (20%) |
| Reputational | 3 (5%) | Open (33%), Draft (67%) |
| Total | 60 | |
| Region | # (%) | Status |
| AFR | 27 (45%) | Open (56%), Closed (26%), Draft (19%) |
| EMR | 12 (20%) | Open (25%), Closed (58%), Draft (17%) |
| SEAR | 7 (12%) | Open (29%), Closed (71%) |
| EUR | 2 (3%) | Closed (50%), Draft (50%) |
| WPR | 3 (5%) | Open (33%), Closed (33%), Draft (33%) |
| HQ | 9 (15%) | Open (67%), Closed (22%), Draft (11%) |
| Total | 60 | |

147. **Among the risks, 27 (45%) have remained open, 23 (38%) are closed, and 10 (17%) are in draft form.** When the status is stratified as per type of risk, most technical and strategic risks are still open. Other types of risks are more likely to be closed – i.e., financial, political/governance, and staff, systems and structures. When the risks are stratified by region, the AFR and HQ risks are more likely to be open, while risks in the EMR and the SEAR are more likely to be closed.
148. Informants expressed the view that as much as risks are collected and analysed in the risk register, follow-up actions are not always properly monitored. Informants also conveyed that the risk

¹⁶⁵ WHO Principal risks, as of May 2021 Principal risks

¹⁶⁶ WHO, World Health Assembly, A70/14 Add.1. Polio transition planning, Report by the Secretariat, May 2017 https://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_14Add1-en.pdf

management system is still evolving and that its success requires recognition of the registers' value at all levels and in all departments, including among the technical platforms of polio, polio transition, IVB and WHE, and to ensure monitoring of follow-up actions.

149. WHO set up a contingency fund of US\$ 50 million to cover the terminal indemnities and liabilities associated with the separation of staff. WHO is also covering terminal liability at a pro-rated level to remove disincentives for other programmes to recruit polio staff members.
150. Recommendations from the Montreux meeting (November 2018), also highlighted in the Report by the Director-General to the Executive Board (December 2018)¹⁶⁷ stated that polio transition should take a differentiated approach based on country context and risks. As previously mentioned, the evaluation team finds, based on the reviewed documents and informants, that this approach has only been partially implemented. Several key informants reported a lack of coherence with the situation on ground and the continued strive towards polio transition in countries where this was not feasible or not the correct risk management strategy. Some informants specified that when large emerging cVDPV outbreaks occur, including in fragile countries, confusion and frustration occur as, on the one hand WHO stresses efforts and resources to prioritize polio outbreaks, whilst at the same time reducing funding and requesting development of a national polio transition plan.

Country support missions

151. **Missions to countries and high-level meetings have proven effective in garnering interest in transition planning.** The objective of country missions is to review, and where appropriate, update and facilitate finalization and implementation of national transition plans and provide support for resource mobilization plans and high-level advocacy strategies¹⁶⁸. Several informants mentioned that joint country missions have constituted an important component of the support by WHO to implement polio transition across priority countries. They have proven effective for engaging in high level advocacy meetings with national government and partners and proved helpful in progressing on polio transition planning and implementation. Some key informants and the document review revealed that better planning of some country missions is necessary for more effective outcomes¹⁶⁹.

¹⁶⁷ WHO, Executive Board, EB144/10, Polio Transition, Report by the Director-General, December 2018 https://apps.who.int/gb/ebwha/pdf_files/EB144/B144_10-en.pdf

¹⁶⁸ WHO, EB 144th Session, Polio Transition report by the Director General, page 2, December 2018

¹⁶⁹ WHO AFRO, Overview of progress AFRO Polio Transition Activities – TIMB/GPEI Meeting, Nov 2020

152. Table 11 provides an overview of country missions and high-level meetings (note that missions were temporarily suspended in 2020 due to COVID-19). Country mission reports have been drafted after each mission with clear recommendations on the way forward. Key informants mentioned that resuming in-country missions was a key priority in 2022 to stimulate polio transition work at country level.

Table 11: Country mission schedule

| Country | Period |
|---|---------------------|
| Myanmar – IVB mission | 13 - 20 Oct 2018 |
| Bangladesh | 2 - 10 Nov 2018 |
| DRC – RITAG | 14 - 16 Nov 2019 |
| India | 26 Nov – 5 Dec 2018 |
| Ethiopia | 11 - 14 Dec 2018 |
| South Sudan | 18 - 23 Feb 2019 |
| Cameroon | 26 Feb – 1 Mar 2019 |
| Angola | 10 - 15 Mar 2019 |
| Chad | 25 - 29 Mar 2019 |
| Angola – JEE mission | 16 - 24 Nov 2019 |
| Sudan | 1 - 5 Dec 2019 |
| DRC by RO (HQ remotely) | 26 - 29 April 2021 |
| Ethiopia by RO (HQ remotely) | 3 – 9 May 2021 |
| Nigeria by RO (HQ remotely) | 4 - 8 Oct 2021 |
| EMRO countries by RO | Various dates |
| Global and regional meetings | |
| Montreux - Global stakeholders' meeting | 13 - 14 Nov 2018 |
| Rwanda - AFRO Surveillance Business Case | 19 - 23 Nov 2018 |
| Geneva - High Level HQ/AFRO meeting | 27 Jan 2020 |
| Cairo - High Level HQ/EMRO meeting | 2 - 6 Sep 2019 |
| Atlanta - CDC/WHO Surveillance meeting | 27 - 28 Mar 2019 |
| Brazzaville - HQ Joint mission to AFRO RO | 18 - 23 May 2021 |

In addition to the county missions, several high-level meetings have been convened at global and regional levels during the period 2018-2021 (see

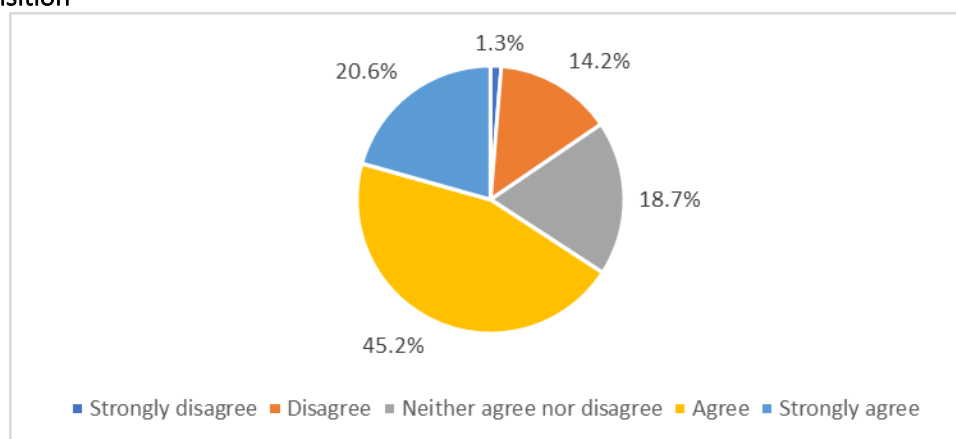
153. Table 11 above). High-level regional consultations have included WHO headquarters, members of TIMB and WHO regional offices, and in some cases staff from WHO country offices (EMRO). These meetings have generally contributed to clear actions on the way forward for the region. However, there was no evidence of involvement of Member States in these high-level consultations, which seems a missed opportunity to create country ownership of polio transition¹⁷⁰.

3.2.3.4 WHO coordination and communication with Member States, donors, and key stakeholders and across internal programmes

154. There were generally mixed perceptions among key informants and respondents on the extent to which WHO effectively coordinates and communicate on polio transition with Member States, donors, key stakeholders and across internal programmes.

155. At country level, survey respondents generally felt that WHO coordinates well with countries on polio transition. **The online survey results found that two-thirds (66%) of survey respondents at country levels felt that WHO effectively coordinates** with countries around polio transition while only 15% disagreed, as shown in Figure 19 below. Of note however is that 80% of the respondents were from WHO Country Offices, and that 19% neither agreed nor disagreed. The proportion who reported that WHO effectively coordinates with counties (agreed or strongly agreed) were more or less equal across the three regions.

Figure 19: Respondents on whether WHO effectively coordinates with countries around polio transition



156. The evaluation team found that communication and understanding of the remit of polio transition and its integration agenda has been strained due to **delays of an approved communications strategy on polio transition**. A draft exists which is now under final review¹⁷¹. Part of the problem has included an overall lack of clarity about what polio transition and integration entail, how they are defined and how to smartly monitor progress. The integration and transition plans on paper are harmonized and logical; however, the operationalization has not been well thought through according to several informants. There is also an apparent lack of “detail and granular explanations” for how transition will play out in reality, what is being transitioned and to what, and intermediate steps to full integration.

¹⁷⁰ WHO High-level Regional Consultation on Polio Transition African Region, Geneva 27 January 2020, Meeting report; WHO High-level Regional Consultation on Polio Transition, Eastern Mediterranean Region, Cairo, 4-5 Sep 2019, Meeting report, WHO Joint Meeting of HQ and SEAR Polio Transition Steering Committee, 23 Oct 2019.

¹⁷¹ WHO, Polio Transition Strategy Communications, August 2021 version 3.

157. Most stakeholders seem to agree that **integration needs to be in place before transition to government and that integration represents the critical link or pathway on how to move from a vertical eradication programme to transition.** It was expressed that in the polio transition steering committee there is consensus on the importance of integration for sustaining essential structures and supporting the broader health system strengthening agenda. However, the “difficulty is getting a definition of integration at such a high level” as it was stated that this should be determined at country level based on the actual situation on the ground. **In some countries integration of polio within primary health care might be the optimal and sustainable solution, in other countries integration with immunization and/or health emergency programmes represent a more viable and immediate step.** The fact that countries of SEAR have progressed more on the transition to government in terms of domestic financing for polio infrastructure, (especially India and Bangladesh) speaks to the overall finding that **integration is a key vehicle for transitioning responsibility and ownership to governments.**
158. There is a **high level of recognition around the necessity for “what to do”** with regard to integration and transition vis-à-vis other programmes and initiatives, but despite its high aspirations, the operational question of **“how to do it” remains a challenge.** Operationalizing the transition plan in an integrated and coordinated way is critical to ensure that the assets of the eradication efforts are not lost.
159. Yet some few key donors supporting GPEI tend **still to prefer a “vertical programme roll out” vis-à-vis integration until eradication has been achieved and cVDPV outbreaks are controlled** to a greater extent. These different perceptions among key stakeholders create uncertainty on the approaches and timing of integration and present possible barriers to integration. Lack of trust in WHO to deliver through an integrated approach was mentioned by a few informants, explaining that **the lack of concrete milestones and targets for integrated approaches and polio transition hampered trust.**
160. **There are signs of insufficient communication and coordination with partners, donors and Member States.** Annual meetings, such as the World Health Assembly, along with Regional Committee and other meetings, provide fora for Member States and the larger polio response stakeholder community to learn about progress on transition within the regions. However, communication is not optimal with several informants from GPEI, WHO programmes, and other key polio stakeholders citing the example of their shock and dismay when AFRO issued separation letters to over five hundred polio-funded staff in 2021 without proper consultation and agreement with GPEI. **Some donors stated that there was insufficient engagement with stakeholders on polio transition.** They felt they were left in the dark after the Montreux meeting when WHO promised to go back and work on a transition plan “yet they [the donors] from 2018 until earlier this year [2021] heard nothing, no follow up.”
161. Similarly, donors and key stakeholders acknowledged that **while some progress has been made in polio transition, the limited detailed and systematic information on progress or lack of progress made it difficult to respond to crises** in personnel management and changes in epidemiology such as cVDPV outbreaks. Some donors have expressed unhappiness with the level of communication, misreading the polio epidemiology developments and some expressed a perceived “lack of inclusiveness of donors and partners”; others mentioned a “lack of clarity on how GPEI and transition efforts are meant to work in tandem”. Key informants noted “disconnects at technical programme level, parallel GPEI and Polio Transition Programme activities that are not harmonized and interpret data differently”.
162. Several key informants mentioned quite directly that **the transition efforts have been siloed and left for WHO to manage alone** a sense that “WHO sort of owns it alone”, which has created

confusion and inefficiencies. Lack of ownership of transition by GPEI and the importance of better coordination with GPEI was repeatedly mentioned and it is incumbent on GPEI to be engaged in transition as the quality, pace and progress of transition is directly related to eradication.

Continued verticalization and power dynamics within WHO

163. The polio programme at WHO has always had its own programme and administrative structures and over several years a budget representing approximately 20% of the total WHO budget. Examples of the high degree of verticalization of the polio programme include having an entire administrative back-office, and despite a coordinated central resource mobilization department in WHO headquarters, a separate resource mobilization team for polio in headquarters. **Longstanding challenges to integrating polio assets and functions into other departments, especially at headquarters levels, but also in AFRO and EMRO to some extent were mentioned by many key informants. At WHO country level however, integration of polio staff and infrastructure has been pursued for a long time and is much more visible.** Despite evidence of regularly convened meetings involving WHO staff across various departments to discuss polio transition, key informants noted that limited collaboration between key departments at WHO headquarters, specifically polio, immunization, and health emergencies, was hampering efforts of integrating polio essential functions into other services/functions. Some key informants mentioned that the polio transition team itself is a siloed structure, with limited ownership of transition in the rest of the Organisation. Country Offices noted the value of headquarters leading by example.
164. **Challenges of integration persist in all directions.** The polio team felt that there was “very little appreciation for the footprint of the polio programme across the house” – citing the example of polio being mentioned as a footnote in the WHO headquarter organogram¹⁷².
165. Reasons cited by key informants for these integration challenges include **persisting power dynamics, satisfying the donors, weak WHO leadership and physical separation.** Several key informants used the words “turf war,” “territorial” and “empires” to explain the reasons behind the lack of integration, as well as potential loss of resources, influence and/or responsibility. Moreover, departments or programmes to which integration is envisioned are already overwhelmed with work and inadequate resourcing. Complex dynamics of different departments not agreeing on design of common systems (e.g., surveillance), responsibility of providing technical support to countries, and what WHO base programme budget allocations cover for these functions further compound difficulties in moving forward. Some also expressed that personality issues and conflicts were preventing greater collaboration. The polio programme was further mentioned by some informants to be perceived as a threat by other departments.
166. Several respondents also believe that the main interest of a few key donors and the leadership of WHO is to sustain the vertical structure for polio eradication to “finish the job” and that GPEI has “marching orders” to fully fund eradication and that transition should be integrated centrally. Overall, there is concern that this is a bigger management problem, and that the Organization is not structured to transition a cadre the size of the polio response into WHO. There is widespread agreement that there needs to be “hard talk” about the real commitment to polio integration and transition both within GPEI, among the donors, within WHO and with the Member States.
167. Informants cited the example of EMRO where the GPEI regional polio team and programme is based in Amman, Jordan, apart from the Regional Office in Cairo. This has caused some challenges for integration and optimal use of resources. Yet, other informants mentioned that collaboration

¹⁷² World Health Organization Headquarters organogram (as of 10 May 2021).

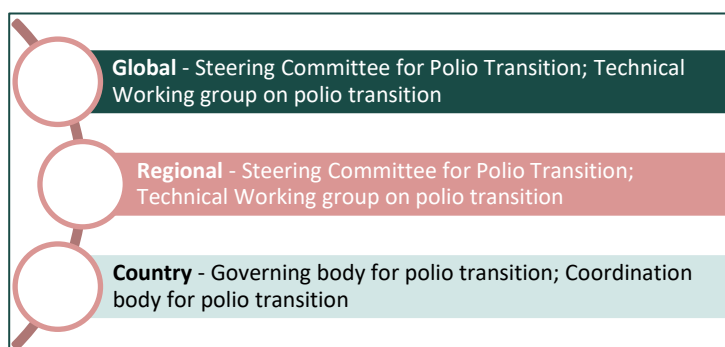
between the office in Cairo and GPEI in Amman has improved lately, with more regular information sharing.

168. **SEAR stands out as the only region where polio was integrated from early on and before the Action Plan was developed.** This early success is attributed by informants to proactive leadership within SEARO and successful negotiations with donors who accommodated the integrated approach. SEARO has also actively looked to diversify their resource mobilization efforts with funding from Rotary and USAID advancing integration aspects.
169. **Programmes and administrative functions are to a large extent already integrated (or have started integration) in many country offices.** Key informants conveyed that WHO country offices do not have the luxury to have separate structures, but need to integrate to use resources efficiently. Examples of integrated approaches in terms of human resources, financing and service delivery were present for all polio transition priority countries, some even prior to endorsement of the Action Plan. Countries in the EMR recently scaled up integration efforts as part of implementing the Integrated Public Health Teams approach (see section 3.3.1). The recent integration of polio for low-risk countries is expected to substantially promote integration in these countries with funding provided by the WHO base budget.

3.2.3.6 Governance, oversight and communication mechanisms on polio transition

In order to assess the effectiveness of WHO management of the Action Plan it is necessary to understand the operation of governance and oversight mechanisms established to guide the process of transition. Polio transition governance has been set up at all three levels of WHO as depicted in Figure 20 with details provided below.

Figure 20: Coordination bodies for polio transition



Global - Steering Committee for Polio Transition

170. The Polio Transition Steering Committee - global level.

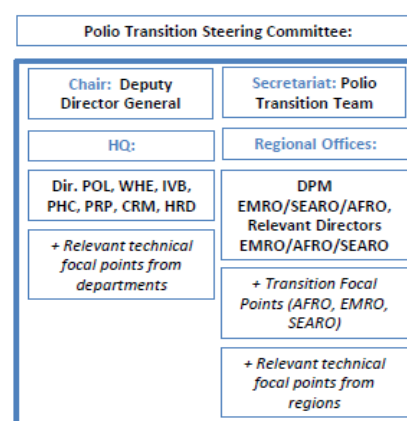
The responsibility of the steering committee at global level is to provide strategic oversight and direction in thrice annual meetings. The steering committee is overseen by the Deputy Director-General and includes directors from relevant programmatic and cross-cutting areas in WHO. Since 2020, prompted by the COVID-19 pandemic, joint meetings have been held between WHO headquarters/regional offices for better alignment and coordination (see Figure 21). The steering committee has specific TORs with a defined standing agenda¹⁷³.

171. Recent key decisions of the steering committee which have been important for progress on polio transition include:

- Mainstreaming of essential functions into WHO base budget (2022/23 planning)
- Response to TIMB recommendations
- Resource Mobilization

172. Irregular meeting frequencies of the steering committee have been observed, with only one meeting in 2021. However, a high-level meeting has taken place involving some of the same stakeholders (i.e. AFRO high-level meeting). The standing agenda as depicted in the terms of reference is not always adhered to¹⁷⁴, particularly those related to polio eradication efforts and progress against the Action Plan M&E indicators.

Figure 21: Polio Transition Steering Committee - global level



¹⁷³ WHO Steering Committee Terms of Reference (ToR), July 2018

¹⁷⁴ WHO Polio Transition Steering Committee meeting, minutes, 4 March 2021; WHO Polio Transition Steering Committee meeting, minutes 15 May 2020; WHO Polio Transition Steering Committee meeting, minutes 20 July 2020, WHO Polio Transition Steering Committee meeting, minutes 25 November 2020.

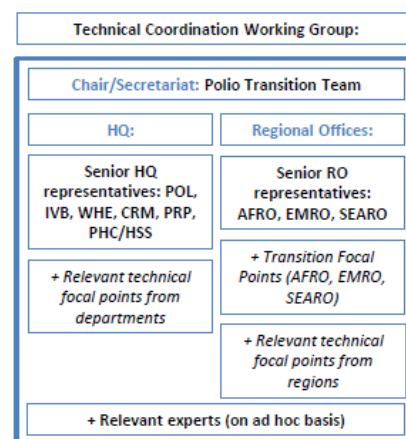
173. Several informants mentioned that the **high-level oversight by the Deputy Director-General has been very positive** and made progress on transition possible. As formulated by a key informant, “In general, having the DDG involved means it is taken serious at a high level. It is an important signal having her lead it from WHO.”



Global - Technical Working group on polio transition

174. **The Polio Transition Technical Coordination Working Group – global level** (Figure 22). The Technical Coordination Working Group aims to unite headquarters and regional offices to ensure programmatic and technical alignment and act as a platform for joint decision-making and information-sharing. The group is scheduled to meet two times monthly.

Figure 22. Polio Transition Technical Coordination Working Group – global level



175. The working group meets regularly and convened 11 meetings in 2021 up until November 2021¹⁷⁵. The forum involves cross-departmental staff mainly from headquarters, but also from regional offices in some of the meetings. Topics discussed covered: country implementation, planning issues (programme budget 2022/23, HR), technical and programmatic priorities (e.g., integrated surveillance, IA2030) and strategic communications, advocacy and resource mobilization. Almost every second meeting in 2021 focused on AFR budget planning and/or resource mobilization was discussed in all meetings.



Regional - Steering Committee for Polio Transition; Technical Working group on polio transition

176. Similar structures (steering committees and technical working groups on polio transition) exist in EMR and AFR to various extents. **In SEAR**, the polio transition discussions take place in other platforms because of polio being integrated fully into EPI. This includes providing a progress report on implementation of polio transition plans to the South-East Asia Regional Immunization Technical Advisory Group¹⁷⁶.

177. **EMRO set up a regional steering committee on polio transition in October 2019** chaired by the Regional Director, with membership from all WHO programmes and departments¹⁷⁷. The committee is leading the regional transition planning and implementation process, as well as conducting high-level advocacy for domestic resource mobilization and integration of essential polio functions into national health systems. Minutes confirm functionality, comprehensiveness and high relevance of topics discussed. A **regional technical working group on Polio Transition in EMRO** has further been established to provide day to day technical support and support countries in the development and implementation of national transition plans¹⁷⁸. **AFRO recently initiated the regional steering committee on polio transition**; however, less evidence was available to the

¹⁷⁵ Who, Polio transition technical coordination meeting minutes, Feb 2021- Oct 2021

¹⁷⁶ Eleventh Meeting of the WHO South-East Asia Regional Immunization Technical Advisory Group. New Delhi: World Health Organization, Regional Office for South-East Asia; 2020

¹⁷⁷ WHO EMRO Key areas of progress on polio transition since September 2019/ update Dec 2021

¹⁷⁸ WHO EMRO, Progress report on eradication of poliomyelitis, [October 2020](#)

evaluation team on its functionality, with one meeting convened in June 2021 with limited scope in discussions as per documented minutes¹⁷⁹.

178. Some key informants who had participated in steering committee meetings at various levels (headquarters and regional level) expressed that they generally lacked decision-making, “meetings are just talking and updating, there is no higher-level processing and no decision-making” and “there are more meetings than decisions on polio transition” with “meetings to discuss the last meeting, and no binding decisions,” “the steering committee doesn’t step back and take the necessary decisions”. It was further noted by the evaluation team that memberships overlapped in some cases and processes could be streamlined to improve effectiveness.
179. An important milestone in AFR is the achievement of having polio transition as a **standing agenda item at the African Regional Committee**, and in 2021 polio transition formed part of a special event to mark one year of a wild polio-free Africa¹⁸⁰. Polio transition is also regularly discussed at the Eastern Mediterranean and South-East Asia Regional Committees while not yet a standing agenda item. **In South-East Asia** this includes providing updates to the WHO Regional Committee for South-East Asia. In its 73rd session the WHO Regional Committee for South-East Asia “called upon Member States with significant polio-funded assets to endorse and implement their transition plans in a timely manner. The Committee emphasized the need for Member States to continuously mobilize domestic resources or alternative funding resources for long-term sustainability of polio infrastructure, as well as to maintain essential polio functions while at the same time contributing towards other public health goals”¹⁸¹.
180. The **WHO Regional Committee for the Eastern Mediterranean** meetings in 2020¹⁸² and 2021¹⁸³ specifically refer to the Action Plan and polio transition and urge Member States to prepare for a polio-free world by implementing polio transition activities, and requests the regional director to “Ensure that polio transition is a key priority for the Organization at all its levels”. Updates on progress or challenges with polio transition were not noted in the Regional committee meeting reports.



Country - Governing body for polio transition; Coordination body for polio transition

181. At country level, different approaches for polio transition governance have been applied. Most countries have a governing body for polio transition and a coordination body for polio transition. In some countries WHO is leading and in others government has taken the lead on polio transition planning.
182. The survey distributed to country level stakeholders, with mainly WHO country office staff respondents, showed the extent to which they agreed that the governance, structures and mechanisms were in place at various level (global, regional and country levels). Around half of the respondents agree or strongly agree at all levels, but with a tendency to agree less at country level (see Figure 23; n=155).

¹⁷⁹ WHO AFRO, Meeting note – AFRO Polio Transition Steering Committee Meeting, 29 June 2021

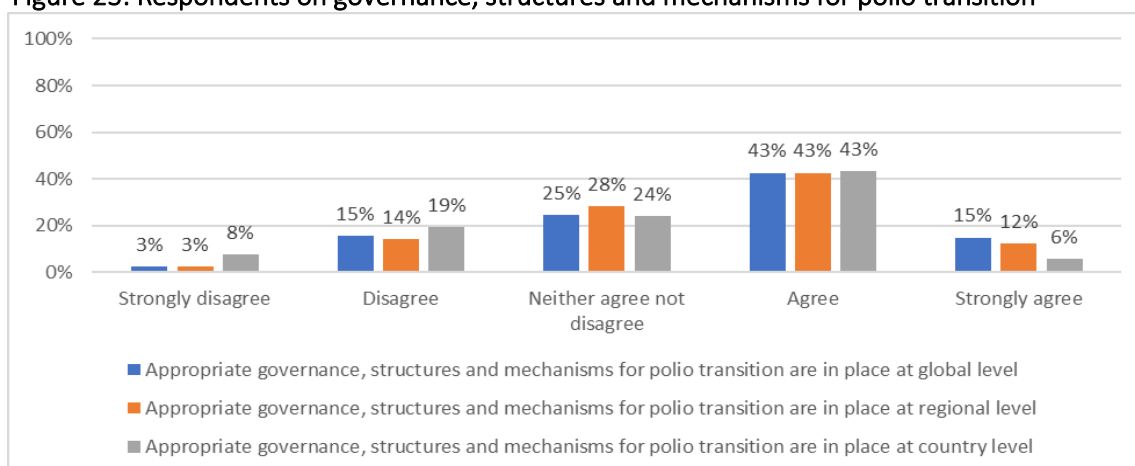
¹⁸⁰ WHO, Polio transition technical coordination meeting minutes - 8 Sep 2021

¹⁸¹ WHO Regional Committee for South-East Asia – Report of the Seventy-third Session. New Delhi: World Health Organization, Regional Office for South-East Asia 2020

¹⁸² WHO Report of the 67th session of the WHO Regional Committee for the Eastern Mediterranean, WHO Regional Office, Cairo, Egypt, 12–13 October 2020, EM/RC67/R1 <https://applications.emro.who.int/docs/EMRC6719E-eng.pdf?ua=1>

¹⁸³ WHO Report of the 68th session of the WHO Regional Committee for the Eastern Mediterranean, WHO Regional Office, Cairo, Egypt, 11–14 October 2021. Cairo, EM/RC68/18-E <https://applications.emro.who.int/docs/EMRC6818E-eng.pdf?ua=1>

Figure 23: Respondents on governance, structures and mechanisms for polio transition



Polio transition roles and responsibilities

183. Through the first joint corporate workplan on polio transition from 2019, **roles and responsibilities on polio transition were defined across the three levels** of WHO¹⁸⁴. Overall roles and responsibilities for polio transition in WHO are described as follows:

- Strategic accountability: HQ and regional steering committees
- Strategic direction: Deputy Director-General, Regional Directors, Steering Committee on Polio Transition
- Technical leads (IVB, WHE, POL): Regional advisors for immunization, emergencies and polio
- Process management and coordination: polio transition team with regional polio transition focal points provides project management, convening, coordinating, reporting to governing bodies and senior management, and monitoring/facilitating workplan implementation
- Oversight: Programme Budget and Administration Committee of the EB; Executive Board; World Health Assembly; Regional Committees and the TIMB.

184. Roles and responsibilities of the regional office¹⁸⁵

- Conduct joint country missions and report back on outcomes
- Develop country-by-country “action plans”
- Assess progress and identify support needs
- Advocate at high levels with priority countries
- Give progress updates at the Regional Immunization TAGs/ polio transition steering committees
- Put polio transition as a standing item on the regional committees
- Meet to reach mutual understanding on what is included in the polio segment of WHO base budget and how to raise resources/communicate impact.

185. **The Polio Transition Independent Monitoring Board (TIMB)** established in November 2016 at the request of the Polio Oversight Board initially for a three-year period. Formal meetings of the Board commenced in 2017. The TIMB was revitalised in 2019 with new membership and new terms of references. The TIMB serves as a sub-committee of the polio Independent Monitoring

¹⁸⁴ WHO High-level Regional Consultation on Polio Transition African Region, presentation by WHO HQ. Meeting report, 27 January 2020

¹⁸⁵ WHO AFRO, Meeting note – AFRO Polio Transition Steering Committee Meeting, 29 June 2021

Board (IMB) but holds its own meetings and issues its own reports. The board has four members and is chaired by the chair of the IMB. (revised terms of reference in January 2020¹⁸⁶)

186. The TIMB has produced five reports since 2017 (three in the period 2018-2022) with recommendations on the way forward for polio transition. WHO has provided management responses and/or status to these recommendations only since the 4th TIMB report from 2020. Table 12 presents the status of WHO addressing recommendations from the 4th TIMB report. In total, 2 of the 10 recommendations have been addressed – e.g. priority countries all have capacity building plans in place, and creating operational “annexes” for the next phase of the new global strategy, Immunization Agenda 2030. Four recommendations are being implemented currently (ongoing), and four recommendations are not being implemented, either because WHO felt it was too early to do so (recommendation 1) or that it was not necessary (surveillance efforts should be focused on the national level and assessing subnational capacity and capability would be too extensive).

Table 12: TIMB report #4 (Nov 2020) - recommendations and responses by WHO

| Recommendation | Status |
|--|--------------|
| 1. A policy decision is urgently needed on whether the GPEI should continue to manage and coordinate all polio functions (eradication, outbreaks, building polio immunity, surveillance, containment) | Not yet done |
| 2. Each of the 20 polio priority transition countries’ plans should be reassessed in the light of COVID-19 | Ongoing |
| 3. The model of integrated public health teams (polio, essential immunization, surveillance, health emergencies) at the country level should be expanded further. | Ongoing |
| 4. A comprehensive human capacity-building plan should be formulated and implemented. | Done |
| 5. A high-level strategic meeting should be convened to explore the creation of a global surveillance network to capture information from primary sources of surveillance data. | Not yet done |
| 6. The establishment of a containment programme within the polio transition planning process offers the opportunity to create a broad-based biosafety and biosecurity unit within WHO. | Not yet done |
| 7. As part of the work on creating operational “annexes” for the next phase of the new global strategy, Immunization Agenda 2030, the global team and their partners should seek to establish how they will drive improvements in essential immunization performance | Done |
| 8. Polio transition should become directly involved with more GPEI activities | Ongoing |
| 9. Each subnational administrative jurisdiction in the priority countries should be assessed for its capacity and capability to contribute to the objectives of polio transition | Not yet done |
| 10. A comprehensive risk register covering all aspects of polio transition planning should be drawn up and published as part of documentation reporting on progress. | Ongoing |

187. The initial mandate of the TIMB came to an end in December 2021, with ongoing discussions to extend until 2023 to coincide with the end date of the Action Plan. The TIMB chair has opened

¹⁸⁶ The terms stipulate that the TIMB “independently evaluate how the integration of public health services is contributing to polio eradication, as well as the progress made towards achieving the three objectives of polio transition, as outlined in the Strategic Action Plan for Polio Transition.”

discussions with WHO on the appropriate timing to sunset the TIMB in part due to challenges of monitoring essential functions once they are integrated into other WHO programmes, the existing Governing Body responsibilities for WHO, and the difficulties of assessing country-level progress on transition during the COVID-19 pandemic.

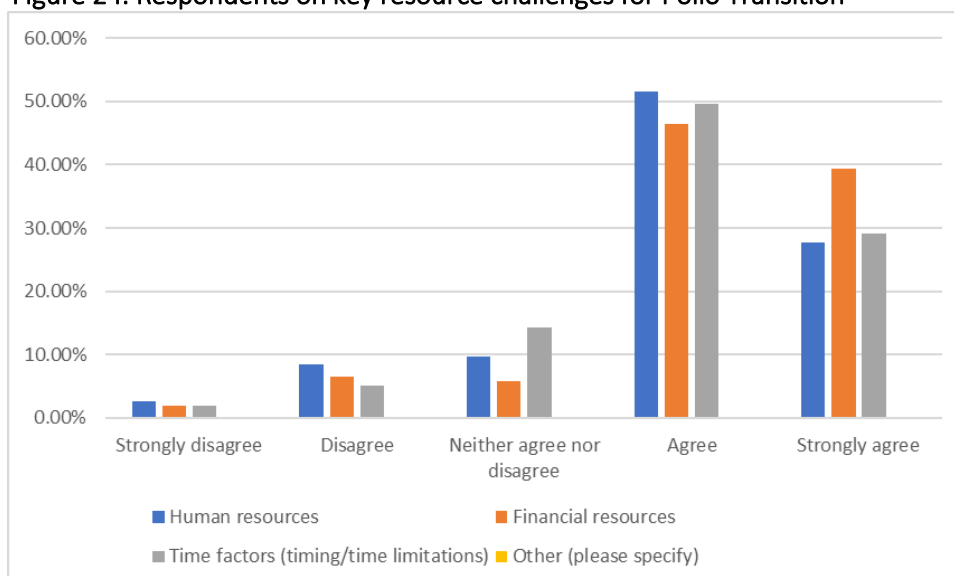
188. **Most donors expressed appreciation of the TIMB monitoring reporting and role** and found it to be an **appropriate additional accountability mechanism**. However, informants expressed that recommendations and milestones could be presented more clearly with endpoints and timelines similar to IMB reports. It was further reflected by some informants for the TIMB to explore how to further obtain country views and to identify broader accountability needs across multiple stakeholders.

3.2.3.7 *Financing of polio transition and resource mobilization efforts*

189. **Guaranteeing adequate financial resources is unequivocally one of the key challenges to successful implementation of the Action Plan**. The challenges to securing sufficient financial resources include **limited commitment of domestic resources from governments to take over funding for polio essential functions, funding fragmentation, limited flexible funds to support integration aspects, and unpredictable funding**. In addition, some external partners mentioned a lack of confidence in WHO’s ability to fundraise substantial resources to sustain essential polio functions under the WHO base budget. Almost all polio transition technical coordination working group meetings in 2021 at global level have had resource mobilization or budget planning as part of their agenda, and the polio transition steering committee meetings at global and regional levels have also been very engaged on financial aspects, budget planning and resource mobilization.

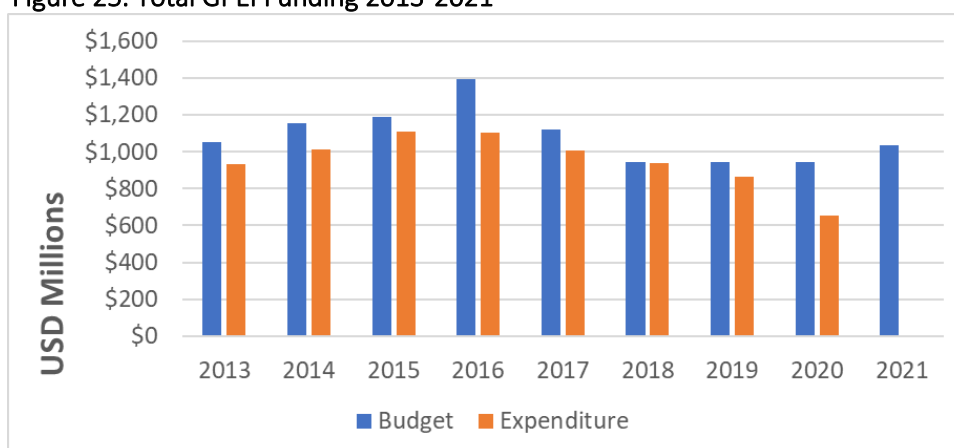
190. Figure 24 below illustrates responses from the survey identifying the key resource challenges for polio transition at country level. **Over 80% felt that financial and human resources were the most critical challenges to transitioning polio** (84% agreeing or strongly agreeing to cite financial resources). This, coupled with an over 70% agreeing/strongly agreeing that that there is limited government ability to absorb costs of essential polio functions is alarming. Therefore, not surprisingly, the majority of respondents felt that donor financial support will be needed to sustain essential polio functions after 2023 (67%). Informants from the AFR countries agreed that governments are not fully committed to sustaining polio functions and that “the ownership by governments is not there.”

Figure 24. Respondents on key resource challenges for Polio Transition



191. Figure 25 below shows GPEI budgets and expenditures from 2013-2021¹⁸⁷. GPEI’s plan was to gradually withdraw its funding at all three levels for polio core essential functions after 2016. **Total budgets (including for campaigns) declined in 2017 and 2018 before levelling off and increasing again in 2021. Expenditures declined in 2020 and were 31% below budget.** This decline in expenditures is attributed to fewer supplementary immunization activities, campaigns, and other immunization activities due to COVID-19 and access issues, diversion of polio infrastructure and staff to the COVID-19 response, and prolonged lead time for vaccine delivery orders¹⁸⁸. In 2021, the total GPEI budget is at 2013 levels. Expenditures for 2021 were not available at the time of the evaluation.

Figure 25. Total GPEI Funding 2013-2021¹⁸⁹



192. **GPEI funding for core essential functions to countries decreased from 2016 to 2021 across the polio transition priority countries** (Table 13 below)¹⁹⁰ The funding decline was greatest in SEAR (87%), followed by AFR (31%), and the smallest in EMR (22%). In SEAR, where the most progress has been made in polio transition, funding to countries was cut by over three-quarters. The funding cuts were lower in AFR, approximately one-third on average, where many cVDPV outbreaks are still occurring and less progress has taken place to prepare for transition out of GPEI funding. The African Region was declared free of WPV in August 2020, which led to the acceleration of the polio funding ramp down in the region. In EMR, despite an overall decrease of around 22%, the funding increased for a few countries (Somalia and Yemen).

Table 13: GPEI funding for core essential functions by country, 2016-2021

| | GPEI 2016-2017 (million USD) | GPEI 2018-2019 (million USD) | GPEI 2020-2021 (million USD) | % change 2016-2021 |
|--------------------|---------------------------------|---------------------------------|---------------------------------|--------------------|
| AFR | | | | |
| Angola | 16.8 | 10.9 | 7.9 | -53% |
| Cameroon | 3 | 3.4 | 3 | 0% |
| Chad | 12.6 | 8.8 | 6.3 | -50% |
| Congo DR | 21.6 | 14.8 | 19.9 | -8% |
| Ethiopia | 21.6 | 14.8 | 8.0 | -63% |
| Nigeria | 153.5 | 86.7 | 131.6 | -14% |
| South Sudan | 9.2 | 8.4 | 6.7 | -27% |
| Average AFR | | | | -31% |
| SEAR | | | | |

¹⁸⁷ GPEI, 2020 Expenditure Report v3 [Annual expenditure reports](#)

¹⁸⁸ GPEI, 2020 Expenditure Report v3 [Annual expenditure reports](#)

¹⁸⁹ Ibid

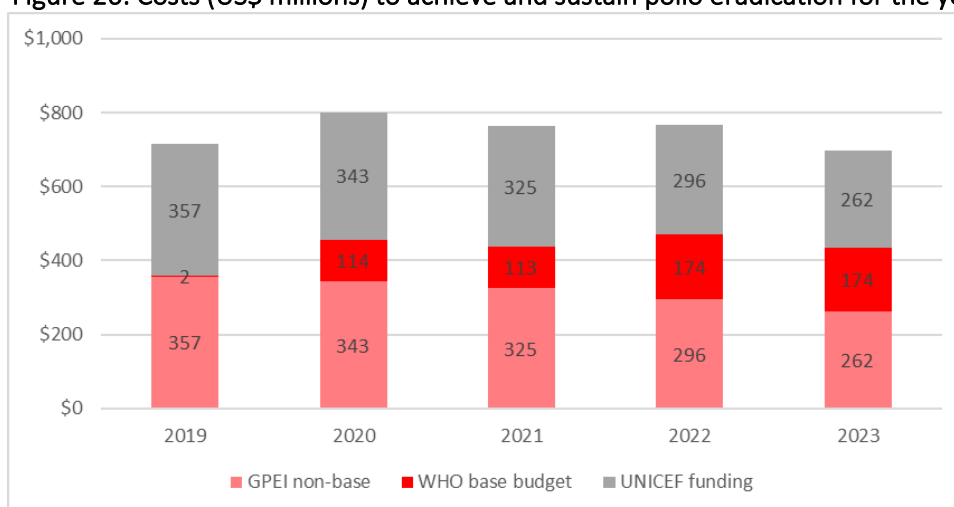
¹⁹⁰ Excluding Afghanistan and Pakistan which are not considered in transition mode.

| | | | | |
|---------------------|------|------|------|-------------|
| Bangladesh | 4.9 | 3.6 | 1.1 | -77% |
| India | 63.5 | 45.7 | 7.0 | -89% |
| Indonesia | 18.6 | 1.77 | 0.52 | -97% |
| Myanmar | 3.2 | 1.9 | 0.66 | -79% |
| Nepal | 6.5 | 2.1 | 0.6 | -91% |
| Average SEAR | | | | -87% |
| EMR | | | | |
| Iraq | 1.4 | 3.6 | 1.0 | -28% |
| Libya | 1.2 | 0 | 0 | -100% |
| Somalia | 10.2 | 13.7 | 16.3 | 60% |
| Sudan | 14.8 | 4.8 | 11.6 | -22% |
| Syria | 2.8 | 3.3 | 1.6 | -43% |
| Yemen | 2.4 | 1.8 | 2.5 | 4% |
| Average EMR | | | | -22% |

193. WHO is gradually increasing, through its base budget, the amount of financing for polio core essential functions and integrating the functions into other services as shown in Figure 26 below. From 2022, polio human resources and surveillance activities will be funded in an **integrated manner** using the WHO base budget across all polio low-risk countries. **Transferring financing of essential polio functions into the WHO base budget 2022-2023 is a great achievement for polio transition.**

194. The WHO base budget that will go towards core polio functions in 2022-2023 is considered bridge funding and contains a mix of GPEI and non-GPEI funding. **The amount financed through the base budget increased from US\$ 227 million in the biennium 2020-2021 to US\$ 348 million in the biennium 2022-2023.** Of the US\$ 348 million, GPEI is financing US\$ 131.7 million through the WHO base budget for support to 11 high-risk polio countries¹⁹¹ (10 transition priority countries in AFR and one in EMRO) and regional functions as well as headquarters¹⁹². In addition to the US\$ 131.7 million, GPEI supports polio eradication efforts in endemic countries and outbreak responses with US\$ 558 million for the biennium 2022-2023 through WHO non-base budget (polio eradication budget segment)¹⁹³. Note that UNICEF funding has declined by 26% from 2019 to 2023.

Figure 26: Costs (US\$ millions) to achieve and sustain polio eradication for the years 2019-2023



¹⁹¹ Angola, Cameroon, Chad, DRC, Ethiopia, Guinea, Kenya, Niger, Nigeria, Somalia, South Sudan

¹⁹² WHO, Member State Information Session, Update on Polio transition, 13 January 2022

¹⁹³ The WHO Programme Budget 2022-2023 has 4 segments: The base segment, Emergency operations and appeals, the polio eradication segment and the special programme segment

Note: of the WHO base budget in 2022-2023 of US\$ 348 million (dark red colour), GPEI had recently communicated funding of US\$ 131 million in total which is not depicted in this figure

195. In the WHO 2022-2023 programme budget, the largest share of WHO base budget for polio transition is for AFR (50%), followed by SEAR (21%), EMR (13%), and headquarters (13%). The largest share of the funding is for improving access to essential immunization (49%) (Output 1.1.3), followed by support by GPEI to 10 polio high priority countries in AFR (38%) (Output 2.2.4) and responding to acute emergencies (11.9%) (Output 2.3.3) . A small proportion of funding is allocated to other regions: WPRO (0.9%), EURO (0.8%), and the Americas (0.3%)¹⁹⁴.
196. It should be noted, however, that the **total GPEI budget has remained essentially the same in 2022 as in 2021** (Figure 26) even though it is now supporting only eleven high-risk countries while the WHO base budget is taking over funding for sustaining essential polio functions in an integrated manner in the remaining polio low-risk countries.
197. **The WHO base budget** is comprised of a mix of funding modalities including the following: 1. assessed contributions (fully flexible); 2. core voluntary contributions – unearmarked; 3. highly specified voluntary contributions; and 4. donor funds that are semi-flexible – e.g., German funds for polio transition planning. The mix of funding modalities means that funding is not fully flexible. Around 25% of the WHO base budget is flexible, however much of it is consumed by fixed costs. This lack of flexibility affects the ability for countries to use the funds for core essential polio functions. Yet, in late 2021, **WHO decided to use flexible funds to support polio transition under the base budget in 2022**. The allocation of the base budget happens at the level of major office, and regions have flexibility in how it is allocated within the region, while regions have been informed that they have to sustain essential polio functions.

Unpredictable funding

198. According to both informants and the document review, the expected GPEI funding available has **fluctuated to an extent that has compromised planning and budgeting for transition**. The additional GPEI funding made available for 2022 was communicated late to WHO and after the budget planning process for 2022-2023 had been finalised. In addition, the guarantee of funding under the WHO base budget came late to countries and regions, towards the end of 2021, again compromising regional and country-level planning. According to the latest update to Member States, GPEI ramp down and transition after 2021, when countries still require its capacity inputs, has created confusion not least of all in AFRO¹⁹⁵.
199. **Budget planning for the biennium 2022-2023 was a very detailed and comprehensive process, in part because of polio transition**. WHO had been informed that GPEI would only fund the two endemic countries after 2022 and the needs for sustaining polio essential functions in all other countries should be covered by the WHO base budget. Countries and regions submitted their budget needs accordingly with polio efforts streamlined and integrated into other health programmes to be covered by the WHO base budget. The process promoted synergies e.g., if there already was an existing emergency response programme, polio could merge with that programme, or they could merge with either immunization or the primary health care programme. However, GPEI partners changed their priorities and in June 2021 after the WHO budget planning process for 2022-2023 was almost complete GPEI communicated a decision to fund an additional 11 polio high risk countries due to persistent high polio risk and recent outbreaks. In 2022-2023, GPEI will thus in addition to continuing support to the two endemic

¹⁹⁴ WHO, Member State Information Session, Update on Polio transition, 13 January 2022

¹⁹⁵ WHO, Member State Information Session, Update on Polio transition, 13 January 2022

countries, continue to fund 10 polio high risk countries in AFR and regional functions as well as Somalia. This includes funding for response, laboratory, GIS, accountability, and coordination¹⁹⁶.

200. Some key informants mentioned that the unpredictable funding and inconsistent messaging from GPEI on the scale down of resources over the last six years had caused confusion and that some countries might prioritise other things with domestic financing when GPEI keeps stepping into support. A few key informants referred to this as “the wolf is coming” idiom, i.e. that polio transition has been discussed for a long time but that funding always becoming available. Key informants expressed that GPEI should be transparent about funding availability, especially after 2023, and be consistent in holding to the plan.

Anticipated funding gaps for polio transition exist across the regions

201. Countries have estimated their funding gaps for financing core polio functions in an integrated manner for low-risk polio countries in 2022-23 after taking into account WHO bridge funding which was recently guaranteed for a 12-month period (2022) but only amounted to US\$ 32 million. Regions had expected that the 12-month guarantee would be the total programme budget for the biennium divided by two years (US\$ 218 million/2 = US\$ 109 million) and were, therefore, disappointed as they had planned accordingly. Two of the regions, SEARO and EMRO, have identified funding gaps for core polio functions in 2022-23, as shown in Table 14. AFRO, on the other hand, is assuming that there will be no financial gap until 2023 for the seven transition priority countries. However, the polio transition plans in AFR are currently being revised making it difficult to estimate the true funding gaps. Also, potential funding gaps are expected for the 37 “polio low risk countries” of AFR after the 12-months guarantee.
202. SEARO anticipates a funding gap of US\$ 45.6 million in 2022-23, most of which is for India, as can be seen in Table 14. The gaps are smaller in other countries in the region, ranging from US\$ 0.14 million in Indonesia to US\$ 2.15 million in Bangladesh. The regional office in SEA also has a gap of US\$ 1.47 million. The percent of the budget that needs to be covered through additional resources is 62%, ranging from 11% in Indonesia to 69% in Myanmar.
203. EMRO anticipates a funding gap of US\$ 23.4 million to fully cover its polio transition budget for 2022-23. The largest funding gap is in Somalia, US\$ 9.3 million, followed by US\$ 3.5 million in Syria. The percentage of the budget that needs to be covered through additional resources is 72%, ranging from 60% in Somalia to 99% in Libya.

¹⁹⁶ Ibid

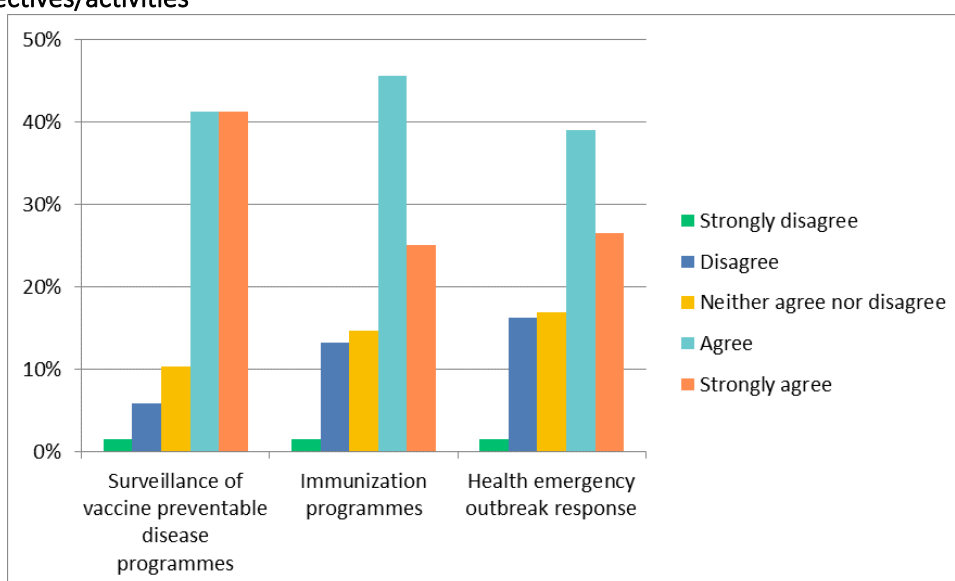
Table 14: Funding gaps for polio transition in SEAR and EMR, 2022-23 (US\$ million)

| | Polio transition budget 2022-2023 | Total available/expected resources | Funding gap for 2022-23 | % Funding Gap |
|----------------------------|-----------------------------------|------------------------------------|-------------------------|---------------|
| SEAR | | | | |
| Bangladesh | 3.87 | 1.72 | 2.15 | 56% |
| India | 60.40 | 20.29 | 40.10 | 66% |
| Indonesia | 1.26 | 1.12 | 0.14 | 11% |
| Myanmar | 1.12 | 0.35 | 0.77 | 69% |
| Nepal | 2.65 | 1.74 | 0.91 | 34% |
| SEARO/IVD | 3.82 | 2.35 | 1.47 | 39% |
| Total SEAR | 73.12 | 27.56 | 45.56 | 62% |
| EMR | | | | |
| Iraq | 4.04 | 0.80 | 3.25 | 80% |
| Libya | 2.61 | 0.04 | 2.57 | 99% |
| Somalia | 15.60 | 6.27 | 9.34 | 60% |
| Sudan | 2.89 | 0.51 | 2.38 | 82% |
| Syria | 4.06 | 0.59 | 3.47 | 85% |
| Yemen | 3.39 | 1.03 | 2.36 | 70% |
| Total EMR | 32.59 | 9.23 | 23.37 | 72% |
| Total EMR & SAR | 104.71 | 36.79 | 68.93 | 66% |

Source: Regional SEAR and EMR offices

204. Respondents paint quite a bleak picture with an overwhelming percentage believing that **potential funding gaps as a result of the scale down of GPEI funding will affect surveillance of VPD** (84.5%), as shown in Figure 27 below (agree or strongly agree). A slightly lower percentage believe that it will affect **immunization programmes** (72%) and **health emergency outbreak response** (68%). In the same vein, some informants have expressed concerns that WHO will not be able to fund the budgets required for sustaining essential polio functions in the future.

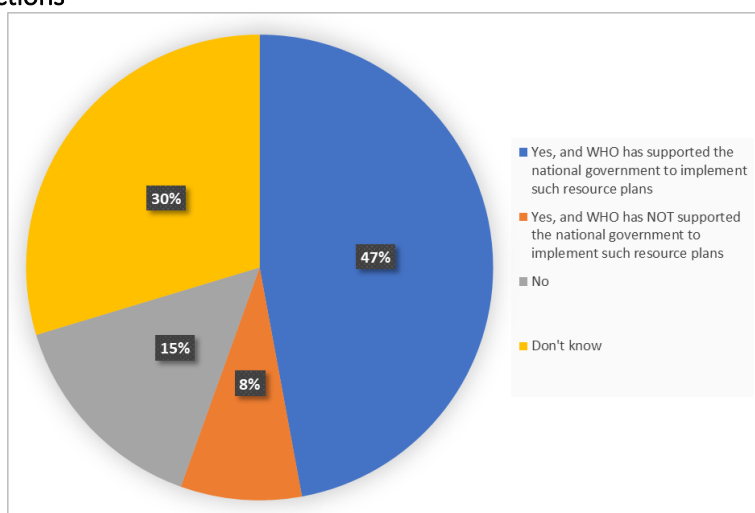
Figure 27: Respondents - Extent to which potential funding gaps would affect different transition objectives/activities



Resource mobilization plans for sustaining essential polio functions

205. Resource mobilization efforts for polio transition are taking place through the Coordinated Resource Mobilization (CRM) department as well as at the regional and country levels. CRM is holding meetings with donors to raise funding to sustain essential polio functions. At the headquarters level, WHO has made a commitment to provide US\$ \$32 million to WHO regions for low-risk countries and is currently conducting resource mobilization to finance US\$ 186 million.
206. Regions are also trying to conduct fundraising to finance the essential polio functions since the headquarter guarantee of US\$ 32 million was US\$ 77 million lower than they expected for 2022 (as mentioned above). The regions are now working to mobilize resources to finance the plans. **Regions are trying to work with donors that are already providing funding to countries to finance essential polio functions** such as GAVI, CDC, USAID and the World Bank. In India, for example, they receive funding from CDC and USAID as GPEI funding has declined. In SEARO, WHO has worked with donors to show them the benefits of integrating polio activities with other services such as surveillance. AFRO is focusing on regional mobilization for the 37 low-risk countries while GPEI is working with the ten high-risk countries in Africa. The regional office has held meetings with donors such as Canada, while GPEI has hired a consultant to focus on advocacy and resource mobilization for its ten high risk countries.
207. At the country level, resource mobilization is discussed in national polio transition plans and most countries have separate resource mobilization plans. Over half of the survey respondents (total respondents = 155) stated that they have resource mobilization plans in place to seek core essential funds, 30% said they don't know, and 15% said that they have no plan, as shown in Figure 28 below. Of the 55% that had plans, 85% of these had support from WHO for the implementation of the resource mobilization plans.

Figure 28: Respondents - Availability of national resource mobilization plans to sustain essential polio functions



208. Tapping into COVID-19 “recovery resources” is a key opportunity for WHO to assist in financing polio transition efforts in the short term. Other opportunities mentioned by key informants is that countries can apply for funding for surveillance through Gavi, since it is a strategic focus area under sustainable immunization coverage and equity¹⁹⁷.

¹⁹⁷ Gavi, [Strategic focus areas](#)

3.2.3.8 Management of human resources scale down

Strategies and plans for scaling down/ integrating/transitioning the polio workforce in WHO

209. The Action Plan emphasized the need for a human resources strategy to be in place in 2018. Its goals should include ensuring that: (1) all polio personnel have a timely and clear understanding of the process of transition planning; (2) all personnel understand the impact of transition planning on their career path and are aware of a process to seek clarification and feedback; and (3) non-polio personnel are aware of the process and the impact on WHO programmes and finances¹⁹⁸.

210. It is not clear to the evaluation team if this human resource strategy was developed. However, the evaluation found evidence that gaps in the scale down and integration of polio personnel have prevailed. Several informants mentioned to the evaluation team that the task of integrating a highly vertical structure such as the polio programme staff was enormous and a very sensitive issue which needs someone at the highest levels to take hard decisions.

211. There also seems to be **conflicting ways of implementing the scaling down strategies at various levels in WHO**. AFRO has seen the largest cuts in human resources and has furthermore focused on reducing the liabilities to WHO and to a large extent shifted long-term positions to short-term positions. However, WHO headquarters key informants express different views on the right strategy. They noted that temporary appointments impact persons you can attract to do the work -it may mitigate WHO liabilities, but also have longer-term consequences. Perspectives included that converting fixed-term posts to temporary was not helpful, but rather it was recommended to extend contracts whilst either informing them of a notice period or end the contract (given funding reductions), or to recruit on a different contract/get matched to another post. EMRO had similar issues as AFRO with transitioning staff who sometimes just moved to short-term contracts, rather than reducing the overall number which begs the question whether that is truly transitioning. Some countries (e.g. Nigeria and Somalia) rely extensively on other WHO non-staff contract types (consultants, APW etc), particularly at subnational levels, however this poses questions on quality and institutional learning and must be tackled carefully.

In EMRO the strategic approaches to scaling down reliance on GPEI for polio human resources have been diverse:

- Transformation of staff with national position in place of international position (Libya)
- Cost-sharing of staff across program with integrated functions (Syria)
- Costs transfer from GPEI to other programmes (Yemen)
- Reduction of WHO staff and contractors and transition of functions to government (Iraq)
- Staff reduction to the minimum level for sustaining essential functions (Somalia)
- Expanding the functions of polio staff to other public health functions (Sudan and Somalia 2021)

212. The box shows examples of strategic approaches applied by countries of EMR¹⁹⁹. In SEAR, there have been limited staff reductions and the polio programme was already integrated with other WHO programmes.

213. A **highly debated topic and subject of significant protest** from various stakeholders both internally in WHO and externally was the **issuance of more than 500 termination letters to polio staff across AFR** in early 2021. This was enacted as part of their planned scale down in line with

¹⁹⁸ WHO Strategic Action Plan on Polio Transition, May 2018

¹⁹⁹ WHO EMRO Key areas of progress on polio transition since September 2019/ update Dec 2021

their expected funding cuts from GPEI and obligations of notice periods. Polio partners and some donors were very unhappy and did not agree to this scale down amidst continuing polio outbreaks in the region and also expressed that they had not been consulted and informed about these HR cuts in due time. This reportedly caused significant resistance to polio transition among staff and donors alike. Due to funds then becoming available from GPEI for the ten highest-risk countries in AFR in July 2021, staff have now been informed that their termination notice will be withdrawn when they are matched with a new role. In 37 low-risk countries in AFR, the staff were notified of the suspension of their separation in December 2021, with the confirmation of WHO's 12-month funding guarantee²⁰⁰. Key informants commented that morale had gone down given the "about face" and confusion on funding availability, which was not well handled. Pathways were not fully clear leaving each staff to consider whether to separate or remain for two more years. Several informants pointed to the need for predictable funds and long-term HR planning.

214. WHO conducted functional reviews in 47 countries in AFR along with selected countries in EMR from 2017 to 2019. This process was undertaken to assist WHO country offices to align to global transformation and new organizational strategy processes²⁰¹. This has now been applied to reconcile intra-organizational understanding of how the polio transition bridge funding is intended to be used, as well as the filling of positions identified through the functional reviews²⁰². In the ten high-risk countries of AFR, the plan is to match polio staff to positions identified through the functional reviews²⁰³. The intention is to develop a different kind of workforce, tailored to meet regional priorities and needs. For the remaining 37 polio low-risk countries in AFR, WHO headquarters is providing bridge funding for transitioned functions as mentioned earlier, whilst donor conversations for the remainder of the biennium are ongoing. In AFR, informants revealed that "polio" staff will be fully integrated within other WHO departments as of early 2022.
215. The process to conduct the functional reviews was lengthy; these have now been completed in most countries. **Difficulty in implementing the recommendations from the reviews**, attributed to the lack of WHO flexible funding and resistance internally as well as externally to WHO, were noted. As an example, it was difficult to find sufficient funding for recommended activities if a proportion of it was already earmarked for other activities.
216. The majority of country respondents to the survey (59%) believe **there is a plan for scaling down or transitioning of WHO personnel** in place at country office level. Yet, some countries report that there were **challenges in scaling down polio personnel because of a lack of clarity** on how to implement the plan. In one country, they noted that "changes in WHO, UNICEF, and Ministry of Health [occurred] at different stages and [there was] a misunderstanding of the concept and how to implement the changes agreed upon for polio transition". Part of the problem was that the changes were discussed with the Public Health Directorate, but not with the Human Resources Directorate. As a result, the Ministry of Health could not do what they agreed on and WHO had to transfer funds to the Ministry of Health to pay salaries.

Providing support services to staff affected by transition

217. The Action Plan from 2018 stipulates that WHO would provide a wide-ranging package of support services to staff as well as recognition of their contributions to successful polio implementation. In addition, the WHO Secretariat was to develop a communication strategy in an inclusive process

²⁰⁰ WHO, Member State Information Session, Update on Polio transition, 13 January 2022

²⁰¹ WHO Thirteenth General Programme of Work, 2019-2023

²⁰² WHO, Polio transition technical coordination meeting minutes, 8 Sept 2021

²⁰³ Ibid

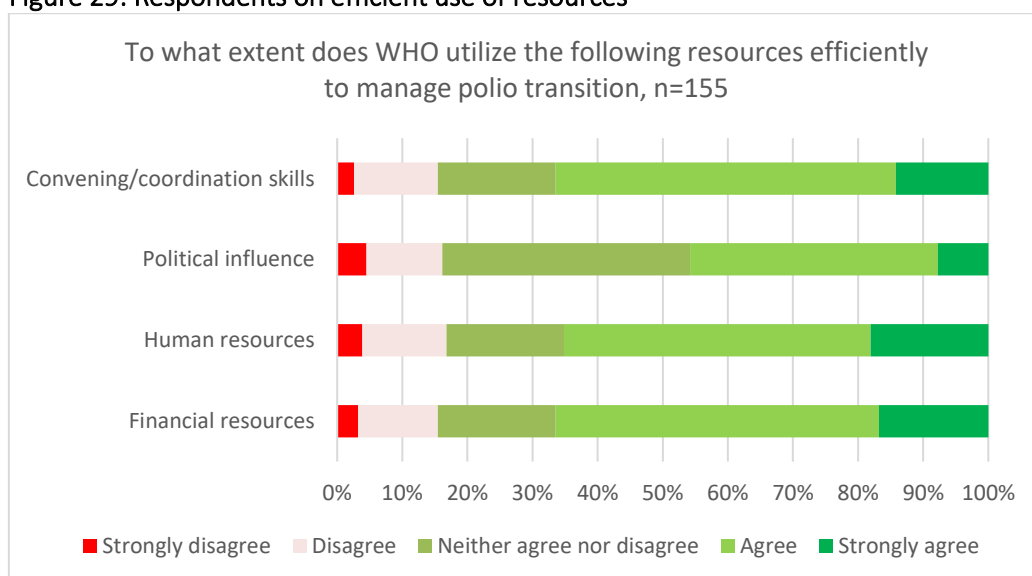
with headquarters, regional and country offices to ensure a consistent message around polio transition and the implications on staffing.

218. In the survey administered to polio transition priority countries **only 39% agree that WHO has provided support services to staff affected by polio transition at country level.** Respondents mentioned that support has been provided mainly for matching, town hall meetings and counselling. Training to re-purpose current polio staff members for broader responsibilities and functions have not been systematically applied. AFRO however initiated programmes to support affected staff members to prepare for work outside the polio programme and has conducted workshops in countries that faced the most reductions in positions.

3.2.3.9 WHO efficient use of resources

219. Respondents to the survey portrayed a **positive outlook on how WHO has utilized resources to efficiently manage polio transition,** with more than 60% agreeing that WHO has used its convening and coordination skills, human resources and financial resources in an effective manner to manage polio transition and 48% agreeing that WHO has used its political influence effectively for polio transition (Figure 29). Of note, respondents to the survey question included mainly WHO country office staff (86%).

Figure 29: Respondents on efficient use of resources



220. Based on the data analysis, the evaluation team however found that efficiency of the Action Plan implementation has been compromised by various factors which mainly included:

- **Lack of implementation of endorsed National polio transition plans:** a lot of resources and time have gone into the development and endorsement of national transition plans in the period 2017-2018, however most were never implemented or stalled and are now again being revised, partly due to COVID-19, political unrest and cVDPV outbreaks, but also because several transition plans were unrealistic in terms of domestic resource capacities and timelines and did not have the ownership required at government levels.
- **Communication gaps and unpredictable funding from donors** hindered proper planning and caused disturbances to the human resource planning, with termination letters sent to over 500 staff, which has affected staff morale and motivation, and now with an ongoing rehiring process.

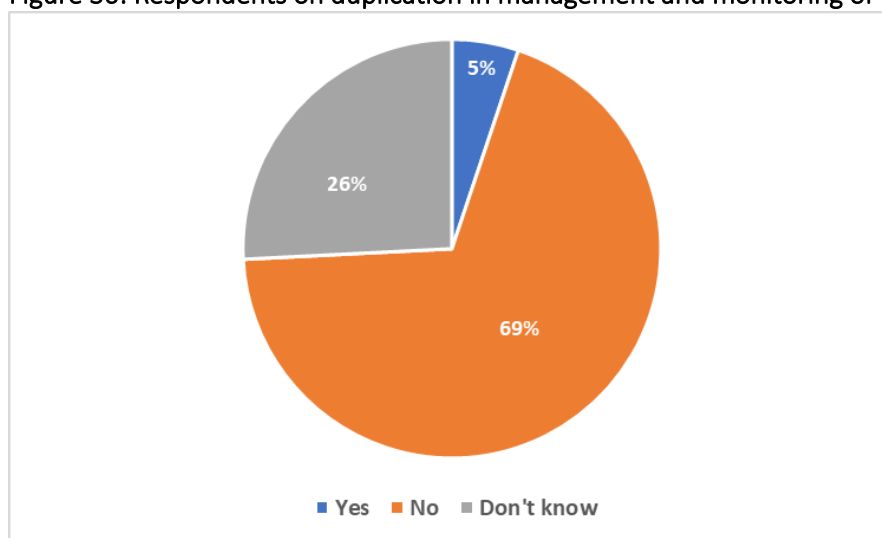
- **Lack of clear agreement among stakeholders** on what polio transition and integration means, what it entails, and how to transition and when to transition, has delayed implementation and created confusion among partners.
- **Limited progress to integrate polio functions across WHO in headquarters and regional offices** has compromised optimal use of resources and synergy potentials.
- **Possible duplication of efforts** (elaborated below)

221. **There were mixed thoughts by key informants on the extent to which duplication of efforts was taking place in relation to polio transition.** Based on informant comments and document review it was noted that duplication of efforts or lack of synergies exist in some instances. One example from a high-level EMRO meeting²⁰⁴ highlighted that in many cases, WHE relies on polio assets, but this is typically conducted in an ad hoc – rather than strategic - manner. There is great variability in how emergency responses are administered which likely results in inefficiencies and “misses.”

222. Some informants felt that **duplication of efforts between polio transition and development partners takes place** at country level. Examples of WHO and Gavi overlap in financing and resource mobilization and that better alignment and synergies are needed were cited.

223. However, in the survey administered to polio transition priority countries, **over two-thirds of survey respondents (69%) do not believe there is duplication** in the management and monitoring of polio transition and only 5% responded that there was duplication, as shown in Figure 30 (n=155).

Figure 30: Respondents on duplication in management and monitoring of polio transition



224. Since the WHO programme budget and GPEI budgets are both providing funding to regional and country offices, there is a risk of duplication. Which was also stated in a 2019 to World Health Assembly report: “important to work closely with the GPEI on detailed analyses of country transition budgets to ensure that there is no duplication between transition budgets and funding

²⁰⁴ WHO High-level Regional Consultation on Polio Transition, Eastern Mediterranean Region, Cairo, 4-5 Sep 2019, Meeting report

of the Initiative and WHO”²⁰⁵. EMRO reported that GPEI funding was considered when distributing polio transition funds..

225. There appear to be several agency-specific polio transition plans in some countries, where integration has advanced. For example, where WHO and other agencies involved have their own “agency” transition plans, including UNICEF.
226. **UNICEF at global level also has its own agency polio transition plan**, the “UNICEF Polio Transition & Post-Certification Management Plan” from 2017²⁰⁶, which is currently being updated. Whereas the overall objectives and strategies are generally in line with the Action Plan on polio transition, some of the key activities are the same as in the Action Plan (support development of country transition plans) and it remains unclear to what extent UNICEF and WHO are synergizing and not duplicating efforts at various levels. Informants at country level expressed that coordination between agencies on polio transition could be improved. A clear division of roles on polio transition between the two agencies is needed at all levels to avoid duplication of efforts and promote synergies.

3.3 EQ3: Potential to contribute to sustainable change

3.3.1 Sub-question 3.1 – Sustainable change in relation to the three key objectives

Summary of findings

The VPD surveillance infrastructure and ability to interpret and use the gathered data for programming and detecting outbreaks and integration (at country level) into wider immunization and outbreak responses is impressive and in the longer term has the potential to be the biggest legacy of polio eradication efforts. However, sustaining these gains is challenged particularly in countries where GPEI funding has dwindled or is expected to dwindle without a guarantee of sustainable funding.

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 countries and regions.

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

227. The polio response is at a critical juncture that requires a balancing act to ensure that the exit of GPEI funding and support that has influenced routine immunization services at country level does not become a major threat to continued integration and transition. This requires a joining of forces to push forward the integration agenda. Critical lessons learned and elements of the successful polio eradication response are planned to be taken forward under transition. Based on documentary evidence and informants, major elements of success for eradication efforts which

²⁰⁵ WHO, World Health Assembly, A72/10, Polio Transition, Report by the Director-General, May 2019
https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_10-en.pdf

²⁰⁶ UNICEF, UNICEF Polio Transition & Post-Certification Management Plan, December 2017
<https://polioeradication.org/wp-content/uploads/2018/01/ppg-ws-presentation-nandy-20171208.pdf>

will influence the prospects of securing enduring results in transition if the right resources are available include the following:

- *Community engagement and mobilization around vaccination services*
- *Integrating broader health communication messages into polio community engagement and mobilization responses including supplementary immunization activities*
- *Quality state of the art laboratory services and sample transport systems*
- *Real-time surveillance (based on a syndromic approach based on active surveillance) and outbreak response capacity, use of data, oversight and monitoring of responses and epidemiological contexts*

However, some key informants stated that WHO “is not joined up well” with respect to health emergencies, immunization, vaccines, and biologicals (IVB) and the polio programme. Communication and planning is strained which makes figuring out the “how to” challenging. The situation is also exacerbated due to difficulties in communicating clearly within WHO and with all relevant stakeholders the “WHO selling points” of the transition and integration approach. As expressed many times, the building blocks are known (as can be seen above), but decisions about the direction to move are less clear. The urgent need for strong management to help define, bring people together, communicate and oversee the operationalization (“how to do it”) are seen as an urgent priority by respondents to ensure sustainability of the polio legacy.

228. The aim of polio transition is to shift ownership of available resources under GPEI, including human resources and infrastructure along with their required funding, to country governments at a period in time where enduring results can be maintained. However, achieving and sustaining routine immunization coverage, sensitive surveillance and adequate outbreak responses remains a key challenge in several polio transition countries exacerbated by uncertainties in the post-COVID-19 environment as all governments try to recover.

3.3.1.1 *Potential enduring results in relation to strengthening surveillance, immunization and emergency responses*

229. The polio programme has achieved a great deal of success in setting up infrastructure, including in fragile countries and those managing health emergencies, to undertake surveillance and use of those data for programming and detecting outbreaks, in addition to engaging in community outreach activities at a house-to-house level. These efforts, if enduring, will help secure the goal of maintaining a polio free world. The frontline orientation and mechanics or “DNA” of polio include: 1) surveillance through a syndromic look at populations and picking up signals for outbreaks, 2) quality samples analysed in a competent laboratory, and 3) significant infrastructure (human-integrated at all levels and other assets) in a host of countries.

230. The approaches employed by the polio programme have had a knock-on effect for other VPDs as cited by informants, for example immunization efforts for DPT3 coverage using actual data to be more tactical, based on real time risk mapping.

231. Integration of surveillance systems vary by region with SEAR, which initiated transition planning before EMR and AFR, showing more diversity in the use of the system and progress toward establishing an integrated system. Integration with wider VPD immunization efforts at the regional and country level has shown positive and potentially sustainable results in regions who began the journey early.

232. That said, all three regions tapped into polio surveillance infrastructure in response to COVID-19 where the initial response was indispensable, and the continued response is anticipated to provide information on vaccine treatment well into the future. Despite the on-the-ground integration efforts, the long-lasting positive effects are dependent upon joint resource mobilization efforts between IVB and polio, which is currently uncharted territory. Additionally, laboratories which serve a critical function in the overall surveillance efforts, often “suffer from a lack of donor interest, coupled with a lack of domestic investment, especially for staff and maintenance costs. There are serious concerns that laboratory staff capacity will be drained once GPEI ceases to exist”²⁰⁷.

233. According to many informants, utilizing the massive infrastructure established under eradication efforts, **has improved the ability to respond to emergencies and can continue to do so in the future**. The response to the COVID-19 pandemic, where polio infrastructure was at the forefront in countries, is a perfect example. It was expressed by several informants that these resources, if adequately integrated and transitioned in a timely manner, for example where a significant footprint still exists in fragile countries, could lead to enduring results. COVID-19 and natural disaster examples in SEAR point to integration of activities with the health emergency teams. However, a few informants expressed concern that “we might have missed the boat on using the polio infrastructure since some of it has been dismantled”.

234. **Maintaining, in a sustainable manner, the polio surveillance infrastructure**, which funds in part comprehensive vaccine-preventable disease surveillance in many countries, in the longer term **has the potential to be the biggest legacy of polio eradication efforts**. Careful operational and integrated planning, which is critical to ensuring the gains in polio eradication, should not be lost during transition, most importantly to ensure its positive influence with respect to VPD surveillance.

3.3.1.2 *External and internal influencing factors affecting ability to sustain results achieved*

235. As discussed extensively in this report the **COVID-19 pandemic** is one of the most significant obstacles affecting results over the past two years, but also a unique opportunity to stage the value of the polio network. The pandemic caused disruption to some transition efforts, including

SIMO networks established in Bangladesh, as an enabler for polio transition

During Phase 1 of the national polio transition plan the surveillance medical officer (SMO) and district immunization medical officer (DIMO/DMCHIO) were merged into the integrated network, Surveillance Immunization Medical officer (SIMO) network. District Coordinators were recruited to oversee the SIMO work. The SIMO network carries out additional responsibilities related to other public health priorities such as:

- Malaria surveillance
- Kala azar elimination programme
- Emerging & re-emerging infectious disease surveillance
- Public health emergency and response

(Bangladesh Country case study – Annex)

²⁰⁷ RESULTS, *A balancing act: Risk and opportunities as polio and its funding disappears*, RESULTS Australia, November 2017

reduced immunization coverage and syphoning of financial resources. However, the pandemic also provided the polio programme with the chance to showcase its infrastructure and emergency response capabilities. For example, in SEAR a workforce of 2 600 was deployed as first responders to the pandemic. Several informants saw this “success story” as an opportunity for the Director-General to engage in and lead discussions on integration of polio and its importance in the pandemic response. The timing of this engagement was seen as critical by informants given governments, particularly now, have competing priorities as a result of the pandemic response. It was expressed that the voice of WHO, and in particular the Director-General at the global, regional and country level, brings the gravitas needed to convene key stakeholders at the same table which should be exploited to push the transition agenda, particularly at this critical juncture of polio transition and the COVID-19 immediate and long-term response. It was further noted to learn from over-reliance on a highly vertical structure (e.g., polio) and lack of integration for the COVID-19 response.

236. During the first two years of Action Plan implementation, and during the COVID-19 onset, outbreaks of cVDPV were notable in AFR and presented a significant threat to achieving objective A of the Action Plan. These outbreaks, particularly in Nigeria, which was further along the transition path than other countries in the region, demonstrated the fragility of the surveillance systems to sustain activities and results post eradication. Whereas the Ethiopian polio transition plan was developed in 2016-2017, subsequent health emergencies (cVDPV2 outbreak COVID-19 pandemic) and political (civil war) crises reduced the government’s ability to implement the plan. Informants expressed that GPEI should have a vested interest in staying engaged to ensure that eradication efforts are not derailed; this despite having “abdicated” their role in transition. There are 37 countries no longer supported by GPEI who are considered “at risk of cVDPV emerging, especially after COVID-19, and we have no idea if the surveillance systems are sustainable” by and large due to less human resources to ensure its operational functioning.

237. The COVID-19 pandemic aside, the **fragility of countries**, particularly in EMR, and the **political unrest**, also pose major threats to sustaining results achieved to date. For example, the number of persons needing humanitarian assistance in EMR has risen by 75% since 2019 due to conflict and national disasters, according to informants. The challenges are exacerbated by trying to ensure that staff who have transferable knowledge and experience continue to work in the fragile states with a transition plan that allows them to stay where they are before they are lost to other countries. Several informants expressed the need to change the narrative that fragile states will be able to sustain essential services without external support. Rather it was expressed that the “footprint of polio” is in the fragile states where efforts are needed to maintain services and focus on prevention of vaccine-preventable disease in these countries “which is best done through integration with emergency management systems” which could also address equity concerns with prolonged financial and technical support.

3.3.2 Sub-question 3.2 – Integration of resources and staff in a sustainable manner

| Summary of findings on sustainable integration of resources and staff |
|--|
| <p>SEAR is furthest along the transition journey, boasting an integrated public health network and strong political will on the part of governments, raising domestic financing for the response in some countries. EMR has the potential to showcase positive results under the Integrated Public Health Teams concept while AFR has shown integration on the ground where polio frontline workers have responded to measles, cholera, yellow fever, meningitis, etc.</p> <p>Sustainable long-term financing poses one of the most critical challenges to sustainability – including uncertainty for funding from donors and other key stakeholders, including Member</p> |

Summary of findings on sustainable integration of resources and staff

States. The **lack of a coordinated resource mobilization strategy**, along with the lack of a clear fundraising map 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 the continued transition efforts if advocated for at the highest level.

Best practices identified by the mid-term evaluation include “Re-tooling staff” – creating a cadre with technical capacity beyond polio for the country, region and globally (e.g., India network responding to Ebola in West Africa; SIMO network in Bangladesh). Other best practices include working with the Health Emergency Programme to establish a roster of people who can be deployed in response to outbreaks and other public health crisis and securing domestic financing for polio transition (mainly in countries of SEAR and Angola)

However, some countries may not be able to maintain polio assets after transition due to various contextual factors that affect in part their ability to mobilize resources and increase domestic financing and capacity. **There is a need for diversified planning and support** depending on country capacity and in recognition that 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.

Although some regions are further along the path toward 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 capacitated to help countries plan and advocate for integration** and sustainable financing for polio transition at the highest levels.

3.3.2.1 Sustainability of WHO resources transitioned from polio programmes

238. **Although some regions are further along the path toward sustainability, the aim of transitioning all 16 (+4) priority countries by 2023 is unachievable.** Sustaining polio functions for the long term necessitates mobilizing predictable funding not least of all at the country level and galvanizing Member States' ownership to ensure that polio stays on the agenda. The departure of GPEI from 57 countries in 2022 (including 37 in AFR), focusing efforts on 11 high priority countries, has left an air of uncertainty about sustaining what has been a “strategic lighthouse programme in the Organization”, built over the past decades. The current goal is to interrupt transmission of WPV by 2026 which translated, for nearly all informants, to an unrealistic 2023 goal for transition. Topping the list of concerns voiced by informants is the challenge of sustaining financing and raising resources for sustaining polio assets after eradication which is a complex task and will require time and a careful unified planning process that “piggy-backs on PHC and other programmes”- a task that has yet to start in earnest despite it being 2022.

239. **Key to sustainable financing and the continued success that polio networks have been afforded, according to different Member States, is the role of WHO, particularly at the regional level, in promoting integration of services.** This comprises engagement by WHO regional offices, with support from headquarters, in advocacy efforts focused on integrated resource mobilization and domestic financing which is at a nascent stage. The exception is SEAR where some countries are further along the self-sufficiency pathway and where the WHO Regional Committee for South-East Asia has actively urged Member States to implement transition plans and advocate to “continuously mobilize domestic resources or alternative funding resources for long-term sustainability of polio infrastructure...”²⁰⁸.

SEA - SEAR is among the most advanced in transition planning, attributed to strong commitment:

- from all levels of WHO
- from Ministries of Health
- to sustainable financing

240. AFR presents a bleaker picture where a lack of advocacy for resource mobilization beyond Ministries of Health, which sometimes feel powerless, is notable. Informants expressed the view that focused advocacy efforts and discussion around mobilization of resources and the broader political will “make Health Ministries feel helpless, powerless and disempowered”²⁰⁹. Without a higher-level political will, for example through engaging parliamentarians in discussions, there is a feeling that dialogue initiated by the MoH will go nowhere. To ensure sustainability, according to informants, WHO needs to think along the lines of a two-step process, 1) in terms of what WHO needs now and 2) what the countries need – a process that takes time beyond 2023.

241. **The question of sustainability from a financial perspective is particularly bleak for fragile states** which informants thought “will never be able to pay for essential services” and for which it is expressed that WHO must seek flexible funding and look into opportunities of tapping into WHE capacities, both in terms of technical capacities and funding. Finally, Member States will need to recognize and be willing to “foot the bill” in such countries – in line with a one size does **not** fit all mantra.

242. **Efforts at headquarters level for safeguarding the budget for transition activities are ongoing; however, the future in part depends on commitments to flexible funding by global partners, Member States** and beyond. Longer-term prospects are unclear. Maintaining funding for the essential polio assets is vital to the journey of ensuring sustainable health systems in countries and to allow them to eventually take over responsibility for maintaining critical functions. Short-term budgetary sustainability appears to be “secured” through the current biennium, but longer-term prospects are less clear. Resourcing transition requires more resources than WHO has, and once those assets are lost at country level, it will be very difficult for domestic resources to pick up the aspiration.

243. According to various informants, if WHO is to function as it should, there **needs to be a “fully flexible funding budget which means transition would be fully flexible”**. Adding to the challenge of securing funding for transition is **the lack of a coordinated fundraising forum together with the polio resource mobilization team**. As neither GPEI as an entity nor its partners report to WHO governing bodies, WHO has little influence over GPEI funding decisions. This points to the challenge of integrating GPEI resources as WHO is a Member State-led organization, thereby affecting donors’ ability “to have a say on their allocation of their funding” without undermining

²⁰⁸ WHO Regional Committee for South-East Asia – Report of the Seventy-third Session. New Delhi: World Health Organization, Regional Office for South-East Asia; 2020

²⁰⁹ WHO High-level Regional Consultation on Polio Transition AFR, Meeting report, January 2022

Member States. There is an expressed need, as voiced by informants, to advocate at a higher level for integrated sustainable financing efforts given this “divide”.

244. The Member States’ Working Group on Sustainable Financing²¹⁰ reporting to the WHO Executive Board, during a meeting held while finalizing this evaluation, was due to bring recommendations to the Board. These recommendations focused on **increasing the portion of flexible funding provided to WHO by Member States** (to eventually be agreed upon by Member States). As stated by informants, “WHO should not miss the opportunity to have a better financing” and should continue to push, with the sustainable finance group, for priorities including increased flexible funding and self-financing from the countries. For sustainable investments to continue in the future, WHO cannot say that transition is a priority and then “not use flexible funding to do it.” Again, advocacy at the highest levels, including to the Executive Board to reach consensus on the way forward for sustainable financing, will make the argument easier to “sell” to the World Health Assembly for potential agreement on flexible polio transition funding.

3.3.2.2 *Countries’ financial self-sufficiency and dedication of budgets and human resources*

245. Polio networks globally present unique features, which if directed to, and supported through, a path of integration, can contribute to sustainable changes beyond polio, including for routine immunization (particularly surveillance) and public health emergency/crisis response, thereby contributing to broader PHC systems and to achieving UHC. However, concerted efforts are needed beyond the 2023 horizon.

246. Global polio eradication efforts have fostered the creation of networks of trained staff and critical assets with an “unparalleled footprint” that are available to provide support to countries beyond the polio eradication remit. These assets are grounded in a cadre of trained professionals able to mobilize quickly, with experience in outbreak response and trusted relationships at the service delivery and beneficiary levels. In certain regions (SEAR and EMR) these cadres, with polio assets at their disposal, already serve a wider function helping to ensure that progress is made on routine immunization and crisis/outbreak response, e.g. response to the COVID-19 pandemic.

247. Additionally, in AFR the polio staff serve as main frontline workers for responding to cholera, yellow fever, and meningitis as well as efforts aimed at deworming and treatment for diarrhoea²¹¹.

248. It was also noted by informants that routine immunization reliance on polio assets is significant in EMR beyond the polio response, including programming aspects, surveillance, vehicles, reaching the most vulnerable children, with immunization services, etc. which beckons for a tailored integrated approach to responding to the needs of children²¹².

249. It is widely recognized, based on key informants and documentary evidence and as previously pointed out in this report, that the COVID-19 pandemic has afforded WHO the opportunity to highlight the competencies and abilities of polio assets which could serve, and in certain places are serving, as a platform to advocate further for integration into wider country PHC and crisis responses platforms. For example, informants stated that COVID-19 has provided an opportunity to look at a different way of organizing surveillance and health systems in countries with polio being “one of those environments where it can be taken up as a trigger”. The key to sustainability

²¹⁰ The Working Group on Sustainable Financing was established by the Executive Board in decision EB148(12).

<https://apps.who.int/gb/wgsf/>

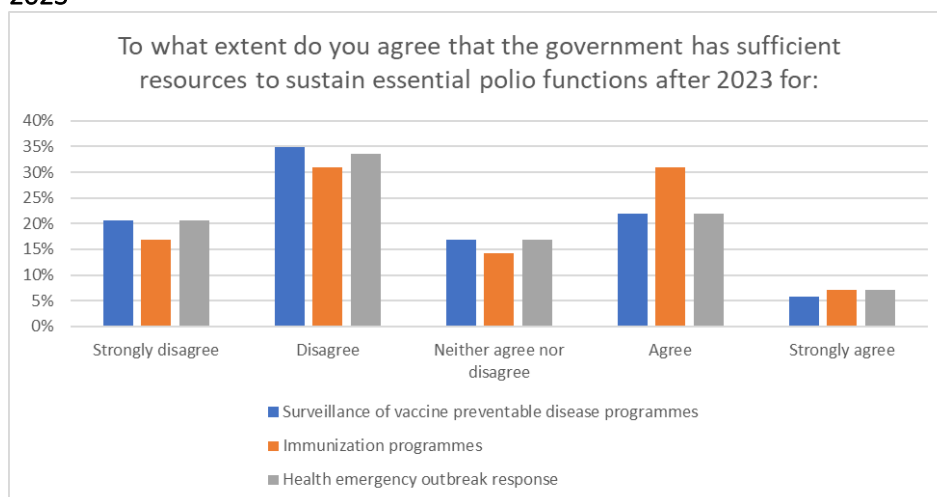
²¹¹ Remarks by the AFR Regional Director, Dr. Matshidiso Moeti, Polio Eradication and Polio Transition Planning, EB148, 12-18, January 2021

²¹² WHO, Polio Transition Steering Committee meeting, 15 May 2020; various key informants

of these efforts, as expressed by key informants, is integration (e.g. in line with the integrated public health cadre in India which is cited widely by informants) of both programmatic and fundraising efforts.

250. **The path to integration and maintaining gains in polio through integration of services to ensure continued surveillance, routine immunization services and response to emergency outbreaks is a longer-term endeavour.** The survey found that continued donor support is needed to sustain polio functions after 2023. On average, 84% of the respondents strongly agree/agree that continued support is needed for surveillance, routine immunization and health emergency outbreak responses. The strong sentiment that governments do not have the resources to sustain efforts in these three areas was evident (Figure 31). Timelines for full transition to governments by 2023 is considered unrealistic, and 10-year plans might need to be developed by some countries.

Figure 31. Respondents' perceptions on governments' ability to sustain essential polio functions after 2023



251. Although India has made considerable progress on the road to integration and sustainability and is considered a success story for polio transition (see box below) the country is still reliant on external support to ensure service delivery.

India - transition success story in the making

India is a success story for transition, having begun the journey over a decade ago. The country transformed its vast polio network into the National Public Health Support Programme (NPHSP) and repurposed the cadre of hundreds of health workers to focus on broader public health responses. They are in the process of developing and refining a model designed to ensure “that government is a well-oiled machine” before handing over the reins, work that remains in progress. The model in part includes:

- “Re-tooling staff” – create a cadre with technical capacity for the region and globally (e.g., responding to Ebola) - “... training and providing team with opportunities to show their work or performance elsewhere is the best things you can do for transition”
- Working with the emergency department to establish a roster of people who can be deployed in response to outbreaks and other public health crisis
- Securing domestic financing – the government commitment to fund WHO to support the NPHSP

However, transition remains a work in progress and will require WHO support for surveillance, oversight (external), monitoring and capacity building in the future. Additionally continued work on domestic resource mobilization and government “take over” of the cadre of staff is a critical next step on the road to sustainability.

252. The ultimate objective of polio transition is for national governments to take over the functions, so far supported through the GPEI network, with domestic funding, thereby shifting the responsibility from WHO to ministries of health. Until governments, typically ministries of health, are in a position to take over, WHO will have to maintain the capacity to support some core functions (e.g. surveillance, immunization, emergency preparedness, detection and response) and also to build the capacity of national teams fulfilling these functions. The scope and duration of WHO support will vary, depending on country capacity which will take time. Steps toward sustainability are evident yet require continued support from an empowered and capacitated regional and country offices able to help with planning and advocating for integration and sustainable financing for polio transition at the highest levels.

3.3.2.3 *Commitments of international community to sustain polio transition efforts beyond the expiry of the Action Plan in 2023*

253. Sustainability remains the “billion dollar question” with some polio stakeholders concerned that countries will be able to maintain polio assets after polio transition. According to informants, decisions around transition funding were reportedly lacking transparency, with an expressed need by donors to push for greater transparency and regular feedback to inform both financial and programmatic commitments. Red flags have been raised within the international community concerning progress on polio (one of the most notable responses was the change in funding levels from the Foreign, Commonwealth and Development Office, UK) which puts pressure on WHO to advocate for further funding including for domestic funding and on Member States to assume an increased role in supporting the transition process. The commitment of Gavi has been steadfast in the polio response from a technical perspective; however, there needs to be more of a financial lens alignment in the future and attention paid to potential duplication of efforts. Gavi, through its Equity Accelerator Funding which focuses on delivery of integrated services, even engaged in a piloted approach to reaching zero dose communities in Pakistan, grounded in coordination between routine immunization and the polio programme, further galvanizing its commitment to maintaining polio transition activities.

254. The US Government funds eradication efforts (through CDC and USAID) and is seen by some informants as “reluctant” to fund transition activities despite the fact that large sums of money go to funding surveillance. Surveillance is a critical activity to ensuring continuation of broader immunization efforts; however, it was stated that USAID funding for surveillance does not and will not include “funding the portion that goes to transition”. As one of the major contributors to the polio response, this lack of commitment, as mentioned by informants, is detrimental to the sustainability of transition efforts. This stance resonates with some in the international community who feel that “polio is already very well-funded”, which translates into “dumping the problem (for transition) on WHO”. Others expressed concern that donors are wanting to guard eradication despite the challenges of maintaining vertical funding in an era of emphasis on health systems strengthening and provision of basic services to all through primary health care and a UHC approach. Other donors, including Member State donors, clearly see the need to fund polio transition. A key informant cited that “donors also need to transition”. And more engagement with donors reluctant to fund transition should be sought. Building confidence among donors in WHO delivering on “sustaining a polio free world” in an integrated way needs to be pursued. This improved confidence will be facilitated with a strong M&E framework of a polio transition action plan with clear, measurable and appropriate output indicators and milestones indicators to track progress.
255. The risks to sustaining gains realized under eradication efforts, if donor commitments are not safeguarded, could be detrimental in the short term, e.g. beyond the currently funded biennium, and also in the long term. Although transition is grounded in integrating systems and transitioning other resources, it remains likely that donor funding, post GPEI, will be required to maintain the level of support needed to ensure a polio free world. That said, the funding landscape includes countries that are transitioning from donor support (or receiving less donor funding) including Gavi support²¹³ along with other external funders shifting their funding priorities. These changes could potentially strain immunization and emergency response budgets, not to mention services particularly where GPEI and Gavi are the main funders of the wider immunization delivery. To that extent, informants expressed the urgent need to advocate in a coherent and coordinated manner, at the highest levels with critical (bilateral) donors, for resource mobilization to support an integrated response to polio transition and encourage those donors to maintain support beyond GPEI funding at the same or increased levels.

²¹³ RESULTS, *A balancing act: Risk and opportunities as polio and its funding disappears*, RESULTS Australia, November 2017

4 Conclusions

256. **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 GPEI.** 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.
257. **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.
258. **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.
259. **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.
260. **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.
261. **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 the 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.

262. **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 the integration of polio, immunization, health emergencies and primary health care in the African Region.
263. **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.
264. **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.
265. **WHO has been working on polio transition, without substantial ownership on the part of the GPEI 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.
266. **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.

267. **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.
268. **The TIMB has provided useful monitoring of the 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. This is particularly important given the sensitivities surrounding polio transition and thus the need for an independent oversight body.
269. 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.

5 Recommendations

5.1 EQ4: Recommendations on the way forward

The 10 recommendations below are organized in four thematic areas:

- WHO regional and country office responsibility and accountability
- Governance, management, coordination and oversight
- Sustainable and predictable financing
- Results monitoring, reporting and learning

WHO regional and country office responsibility and accountability

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.

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.

Rationale for recommendation 1

- Polio transition is largely a country-led process and an “Action Plan” at global level is difficult to design as a tailored, contextualised and “living document” that responds adequately to the specific needs of countries (e.g. massive variations in health systems capacity, polio and immunization indicators, fiscal space of governments, etc. among the countries) causing challenges to adapt to needs and situations at country level. A “vision” guiding regional and country action plans seem more appropriate, with most “actions” to take place at these levels.
- A global common vision on polio transition (i.e. with overall timelines, strategies and financing of transition) is needed with all global stakeholders agreeing based on a polio transition theory of change.
- The current Action Plan is clearly deficient in terms of mainstreaming gender equality, “leave no one behind” and equity concerns.
- The current Action Plan has not supported the required inclusive discussions around the “end game” for where polio eradication gains are integrated to - whether this is stronger PHC, immunization systems and/or health emergency preparedness and response and who shall finance sustaining polio assets going forward in the short term and in the long term.
- Shifting the capacity and decision-making from the headquarters level towards regional and country levels aligns with the strategic shift in the same direction of the 2022-2026 GPEI strategy.

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).

Rationale for recommendation 2

- More time is needed for transition than the anticipated five-year period. To secure the legacy of polio, the polio transition planning and response will need to continue beyond 2023, and for some countries maybe for another decade.
- In light of changes in the new GPEI strategy, persistent outbreaks of cVDPV and COVID-19 paralysis among other key factors affecting polio eradication and transition, it is time to take stock of the transition process and assess what is working and what it not and adjust accordingly.
- Indicators and situations varied extensively across the polio transition priority countries; however, the Action Plan by design did not include differentiated targets, strategies and timelines for transition, which should differ by region/country given the wide contextual differences.
- WHO regional offices are providing support to and oversight of country offices and are closer to transition implementation than WHO headquarters. As polio transition is largely a country-led process, it would benefit from a decreased distance to decision-making which is expected to make transition processes more agile, flexible and adaptable.
- Regional Action Plans are anticipated to promote regional- and country-tailored approaches for sustaining polio assets, identifying context-appropriate strategies, milestones, roadmaps, targets, timelines, and levels and positioning of human and financial resources.
- The WHO Regional Office for the Eastern Mediterranean has shown progress on polio integration and transition efforts, guided by a regional workplan for transition and a functional regional steering committee for polio transition, yet there is a need for more flexibility, responsibility, resources and accountability to deliver effectively on polio transition.

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).

Rationale for recommendation 3

- Regional directors and WRs have been identified through the evaluation as key entry points and decision makers for promoting polio integration and transition.
- Yet, overall decision-making and accountability for polio transition has mainly been concentrated at WHO headquarters level, and budget allocations/financing for polio transition have not matched the needs as expressed and planned for at regional levels.
- Country-level voices need to be heard in polio transition discussions, including on when to redirect strategies and timelines.
- Regional and country ownership for polio integration and transition has promoted implementation of polio transition. There is an opportunity to build on lessons learned from SEAR and the integrated public health teams concepts being rolled out in EMR and from AFR on integration of polio, immunization, health emergencies and PHC.
- Resources and capacity gaps for leading polio transition, including for resource mobilization at regional and country levels, requires attention.
- A communication framework on polio transition has been delayed which caused challenges to implementation of polio transition.

Governance, management, coordination and oversight

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.

Rationale for recommendation 4

- WHO has been working on polio transition, without substantial ownership in GPEI on transition, since 2018 and in a somewhat siloed approach. WHO should focus on strengthening/developing management and coordination structures to enhance the synergy and contribution of WHO and GPEI and other relevant programmes within WHO into the planning and review process at both headquarters and regional level. GPEI has a critical role to play in helping shape transition.
- In order to ensure buy-in for the integration and transition agenda, key donors, Member States and other stakeholders need to clearly understand the benefits and challenges of transition.
- WHO has the necessary presence and convening power to ensure that the right people are at the table when discussing polio transition, including GPEI, however this comparative advantage has not been fully exploited. The timing is ripe for joint coordinated discussions around the way forward given the polio and VPD epidemiological situation and current and anticipated financial constraints. These discussions would enable WHO to effectively advocate for improved ownership of the transition agenda within GPEI, Member States and donors.
- Action is required to consolidate and clarify collaboration between UNICEF and WHO on polio transition, with two separate action plans on polio transition and potential for duplication of efforts and confusion at country levels.
- Reorganized and revitalized decision-making structures should enable frank discussions and concrete decisions with GPEI, partners, donors, and Member States to discuss the Polio Transition Vision and transition timelines, given the changed context and the issue of who will “foot the bill” for polio transition, etc. This requires strong leadership to guide the discussions and ensure accountability of decisions.
- Engagement with non-State actors, including community, CSOs and private sector on polio transition is not fully utilized

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.

Rationale for recommendation 5

- The polio programme remains a highly verticalized structure within WHO, especially at headquarters, and in some regional offices. This verticalized 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 internally in WHO is considered a prerequisite and a key driver for transition of polio assets to national governments. Regions/countries that have managed to actually start transitioning responsibilities of sustaining polio functions to governments have ensured integration internally in WHO before transitioning to government.
- WHO undertook a transformation agenda exercise aimed at changing the way it works across the three levels of the Organization to enhance impact at country level. However, restructuring of polio was overlooked in this exercise which was a missed opportunity for integration within WHO.
- Key obstacles prevent integration of the polio programme within the larger Organization and remains to be addressed by the WHO executive management.
- The rationale for having a separate and siloed polio administrative back-office is weak, and presents a feasible starting point for integration of polio staff in the Organization.
- There is an opportunity for WHO to build on lessons learned from SEAR and the integrated public health teams concepts being rolled out in EMR.
- At country office level, integration of polio staff and functions is progressing in many polio transition priority countries and is expected to be further advanced within the biennium 2022-2023 due to integrated polio funding through the WHO base budget to polio low risk countries
- An overall long-term human resources plan for integration of polio staff is needed for efficient planning at all levels.
- Some countries and regions (SEARO) have made use of polio staff as surge capacity for health emergencies, this approach could be applied in other regions to secure polio capacity.
- Joint annual workplans on polio transition (POL, IVB, WHE, etc.) have fostered accountability.

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).

Rationale for recommendation 6

- WHO's existing polio transition governance and management coordination mechanisms can be improved, particularly as specific polio transition committees do not all regularly meet and a standard agenda to review the polio transition M&E framework progress is warranted.
- Steering committees for polio transition are generally not engaging external partners/other UN agencies which could enhance coordination and communication.
- The TIMB is welcomed by polio stakeholders and is seen as a vehicle for providing evidence for WHO and donors. The TIMB is well positioned to analyse whether reporting is leading to progress and provide recommendations on the way forward with polio transition. However, its effectiveness is reliant on good governance structures and resources as well as good faith that recommendations are acted upon. Accountability mechanisms to act on recommendations in the TIMB reports are not clear.

Sustainable and predictable financing

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.

Rationale for recommendation 7

- Country resource mobilization efforts are being led by the country representatives with support of the regional offices and met with different success across the regions and within the polio transition priority countries. Discussions around sustainable financing are difficult and require the engagement of a vast array of key actors and must be grounded in a well thought through resource mobilisation plan.
- Donors have expressed interest in funding post-COVID resilience programmes, which represents an opportunity to integrate and sustain polio essential functions

- The sustainable financing working group is actively advocating, in part building on experience and recommendations from the pandemic response efforts, for increased flexible and unearmarked funding (including flexible funding from Member States) within the core budget. The case will be presented to the Executive Board for approval before bringing it to the World Health Assembly where Member States need to achieve consensus. This advocacy on the part of the sustainable financing working group, at this point in time, presents an opportunity for polio transition to secure more reliable funding moving forward towards integration and implementation of functional reviews.
- Fundraising for polio remains highly verticalized in WHO limiting synergies and prospects for integration and transition.
- Unpredictable and short-term financing has severely affected planning and implementation of polio transition efforts.
- Inadequate resource mobilisation capacity identified at regional and country levels.

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.

Rationale for recommendation 8

- VPD surveillance has the potential to become the biggest legacy of polio investments.
- The decrease in funding for polio eradication in certain countries and the transition process which will result in the eventual phasing out of resources altogether presents a massive risk to polio gains and the broader health priorities, and particularly surveillance for VPDs.
- The WHO base budget for 2022/2023 is approved but is not yet fully financed. Countries, particularly for the 37 polio low risk countries in Africa, will rely on WHO-mobilising additional resources to sustain essential functions. VPD surveillance is a critical component and funding needs to be guaranteed by WHO for an interim period until sustainable financing options are identified.
- VPD surveillance (including polio) and early warning surveillance and response possess an integration potential, especially in fragile States.

- Donors have expressed interest in funding integrated VPD surveillance and early warning surveillance in which polio can be integrated.
- There is an evident need for more intensive capacity building of government staff and knowledge transfer for improved VPD surveillance activities to ensure ownership of the process and to actively promote the use of polio transition assets.

Results monitoring, reporting and learning

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:

- 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;
- add gender and equity disaggregated data (including zero-dose children) when available or already collected by partners;
- 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;
- agree on differentiated targets for polio transition in regional workplans for all indicators with milestones up to 2023;
- identify more specific and defined activities, with clearer milestones in joint corporate workplans, with active monitoring and reporting.

Rationale for recommendation 9

- The current M&E framework is not available in a final document format but presented in the form of an online polio transition dashboard, however with limitations.
- There is a general need for more clearly-defined and meaningful results indicators with realistic targets and interim milestones that are achievable within the timeframe of the Action Plan.
- Important process indicators are missing or inadequate (e.g. monitoring of implementation status of national transition plans, only trends of GPEI WHO “staff” categories are reported, not other contract types).
- The monitoring and results reporting framework is not supported by data disaggregated by gender or other markers of vulnerability and inequity which impedes design and operational decisions to enhance access and ensure coverage.
- Joint corporate workplans on polio transition are important accountability instruments to track integration of efforts in WHO and ensure roles and responsibilities across programmes, but could be improved by having clearer milestones.

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.

Rationale for recommendation 10

- More information is needed on country readiness to transition to decide on timelines for transition and relevant approaches to be documented on the different pathways for transition and integration.
- Irregular updating of the polio transition dashboard output indicators with discrepancies noted.
- Steering committees on polio transition and transition technical working group meetings tend to focus more on joint workplans than the results indicators. Need to strengthen oversight on output results indicators and steer, accordingly, including trends of new polio outbreaks.
- Reporting to governing bodies have been conducted annually providing important information on progress, but with limited reference to status on results indicators at output level.
- Some donors felt uninformed about the progress of polio transition.