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Links to presentations on results of breakout sessions:

Immunization
Outbreak Response
Surveillance
Containment
I. BACKGROUND

1. The World Health Assembly endorsed the WHO *Strategic Action Plan on Polio Transition* in May 2018, which identifies the capacities and assets, especially at the country level, that are required to maintain a polio-free world after eradication, to strengthen immunization systems and emergency preparedness, detection and response capacities. The Strategic Action Plan, with an accompanying roadmap, is budgeted at US$ 667 million within the WHO general programme of work (GPW) and covers 2019 and the two biennia 2020-2021 and 2022-2023.

The Strategic Action Plan has the following three key objectives:

i. Sustaining a polio-free world after eradication of polio virus;

ii. Strengthening immunization systems, including surveillance for vaccine-preventable diseases, in order to achieve the goals of WHO’s Global Vaccine Action Plan;

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

As part of its commitments under the Strategic Action Plan, the WHO convened a meeting of key polio eradication stakeholders in Montreux, Switzerland on 13-14 November 2018, to review the implementation of the plan and discuss possible future governance options (see also section III below).

II. UPDATE NOVEMBER 2018

2. Sixteen countries have been designated as global priorities for polio transition. Of this total, 13 countries have developed national transition plans, 7 of which have been endorsed by their respective Interagency Coordination Committees (ICC). The Strategic Action Plan proposes country-level reviews of polio-funded functions and capacities through joint planning visits by the polio eradication, immunization, emergencies, and other programme areas, to engage governments and partners in finding sustainable funding and to support implementation. A high-level steering committee, chaired by a Deputy Director-General, has been established to oversee the process for WHO, and a dedicated transition team has been established at WHO HQ to support the process. Since the adoption of the Strategic Action Plan, the Global Polio Eradication Initiative (GPEI) has been extended for a 5-year period. The budget estimated for the GPEI extension 2019-2023 is US$ 4.3 billion; with approx. US$ 3.7 billion of this total yet to be mobilized.

III. MEETING OBJECTIVES AND METHODOLOGY

3. As the first of a series of stakeholder meetings planned to guide polio transition, the meeting’s objectives included: clarifying the implications on polio transition of the new 5-year GPEI Strategy; identifying existing and potential financing options for polio transition; evaluating ways of achieving a smooth transition; and discussing options for governance of the polio transition and post-certification process. After plenary presentations, in-depth group discussions took place on
four thematic priorities of polio transition: comprehensive vaccine-preventable disease surveillance; outbreak emergency response, strengthening immunization and poliovirus containment. The meeting closed with a plenary discussion on options for future governance.

IV. POLIO ERADICATION UPDATE

4. The Polio Eradication & Endgame Strategic Plan (PEESP) 2013-2018 was developed to guide the programme to the anticipated goal of polio eradication, with an initial budget of US$ 5.5 billion. To-date, WPV transmission has not been interrupted in Pakistan and Afghanistan. At the time of the Mid-Term Review, the programme was subsequently extended through 2019 with an additional budget allocation of $1.5 billion. A new budget for the period 2019-2023 was approved by the Polio Oversight Board (POB) in September 2018 at the level of US$ 4.3 billion, of which US$ 3.27 billion remains to be mobilized. GPEI is reviewing its strategy in the light of the new 5-year extension. To avoid duplication with the transition costs in the WHO base budget (estimated at US$ 667 million up to 2023 – subject to review depending on the evolving realities in priority countries, as envisaged in the Strategic Action Plan on Polio Transition - the GPEI will fundraise to continue to support the essential public health functions which have so far been financed through polio funding and will need to be sustained after certification.

In recent years, the polio programme has revolutionized surveillance and microplanning for delivering immunization services and thus contributed to the broader immunization agenda. The GPEI 2019-2023 strategy is being developed at a critical time for global immunization, which includes the shaping of Gavi’s new approach to the 2021-25 period and the post-2020 immunization agenda. The polio programme supports broader global health objectives, such as Primary Health Care (PHC), the Sustainable Development Goals (SDGs), Universal Health Coverage, health equity and health systems strengthening (HSS). Polio assets and funding are time-limited, and funding will ramp down within the period of the GPEI new strategy. It is therefore critical that national transition plans be finalized and implemented without delay to leverage the existing public health expertise embedded within polio funded in-country structures to deliver on global vaccine action plan goals as well as other selected national health priority goals. To ensure success also will require national ownership and an increase in domestic funding.

V. REGIONAL PERSPECTIVES ON TRANSITION PROGRESS

5. African Region (AFR): The most recent case of WPV in Africa was detected in Nigeria in August 2016. It is expected that the region will be certified polio-free by 2020. So far in 2018, there have been 41 cases of cVDPV2 detected and 29 samples isolated from environmental surveillance. Seven countries are vulnerable, with low immunity, so there is a risk of importation of WPV from polio endemic countries. Countries in the region have varying capacities in surveillance and immunization, and many have problems of accessibility due to insecurity. Six out of seven priority countries have endorsed transition plans, with a transition investment case developed in the remaining country, Nigeria. Challenges include: low government commitment, competing priorities for existing resources, a need for integration between programmes at regional level, and other simultaneous transition processes (e.g. Gavi and Global Fund).

6. Eastern Mediterranean Region (EMR): Transmission of WPV is ongoing in Pakistan and Afghanistan, with an increase in cases in Afghanistan in 2018 compared to 2017. In Afghanistan the situation is complicated by security risks and inaccessibility of populations. While the transition process is intended to start one year after the detection of the last case of wild polio,
Afghanistan has already developed a framework for transition planning. Sudan and Somalia are among the 16 global priority countries for transition and their transition plans are awaiting finalization. Somalia is a complex emergency with a weak infrastructure and large numbers of children (up to 250,000) living in inaccessible areas. Because of their complex emergency situations, Syria, Iraq, Yemen, Libya have been added as regional WHO priorities for transition. A polio asset mapping has been completed in all four countries and transition plans are to be developed in 2019. Pakistan may develop a framework along the lines of Afghanistan and there is a need for continued engagement with emergency and immunization programmes and donor partners.

7. **South-East Asia Region (SEAR):** The Region was certified polio-free in 2014 and has sustained high levels of population immunity. The last type-2 cVDPV in the Region was detected in Myanmar in late 2015. National Transition Plans have been developed in 5 countries and the government has endorsed the plan in Bangladesh. There is high-level joint WHO and Ministry of Health (MoH) commitment at Regional and country levels for transition planning. In-country governing mechanisms through Interagency Coordination Committees (ICC) have been put into place. There is a need to create opportunities at the global level for engagement with Ministries of Finance and Planning and advocacy with donors/partners for mid-term financing.

8. **Gavi collaboration:** GAVI supports elements of the polio transition process in selected countries. This support is anchored in its 2016-2020 strategic focus on improving equitable and sustainable immunization coverage. It is provided through existing resources, is time-limited and is based on national transition plan timelines. Gavi support can help ensure time-limited transition of key immunization functions consistent with sustained improvements in immunization coverage and equity. Gavi support will provide time for the transfer of financial responsibility, assets and functions to sustainable funding sources (national, international or donor). In the upcoming Gavi strategy (2021-2025), the potential areas of strategic overlap with polio transition could be: introduction of new and underutilized vaccines; achieving sustainable gains in vaccine coverage with equity; and global health security (GHS). Since 2016, outbreak preparedness and response has a stronger focus for Gavi: it includes vaccine support for outbreak-prone diseases like IPV, and surveillance investments and stockpiles.

**VI. THEMATIC PRIORITIES**

9. There is a consensus that polio transition must needs be country-driven, focused, at the appropriate time, on strategic and structured repurposing of the polio network towards immunization and/or other country priority goals. Much of what the polio network has done so far for non-polio goals has been driven from a tactical response to an assessed need within countries (e.g. support to measles SIAs) and not from a grand strategic design. Polio transition addresses the need to shift from a tactical response approach to a strategic design approach.

10. (a) **Sustaining VPD Surveillance beyond polio:** For vaccine preventable disease (VPD) surveillance, most countries have national case-based surveillance in place for polio, measles, and neonatal tetanus. Some countries also have sentinel case-based surveillance for one or more of a variety of other diseases. The polio programme supports much of the VPD surveillance infrastructure in many countries, particularly the cost of laboratory networks, surveillance officers, and field investigations. There is a risk of losing these resources as funding for polio diminishes. A discussion took place on how the current fragmented VPD surveillance could be transformed into more consolidated VPD surveillance. To achieve this agreed goal requires support at a global level, including: development of standards (both for VPD surveillance itself and for related information systems); expansion of laboratory networks; technical support for implementation; and finally, advocacy, costing, and resource mobilization.
11. **(b) Breakout group discussion:** Prerequisites for implementing the transition in the area of VPD surveillance are: government commitment, a robust monitoring framework; in-house coordination within UN agencies and partners; sufficient and sustainable resources; and capture of lessons learned as guidance on potential options. Routine immunization is different from the other three transition priorities, given the cross-cutting nature of routine immunization so needs to be elevated with immunization systems, being a key requirement for polio eradication and beyond. The group agreed that developing a comprehensive VPD surveillance strategy is a prerequisite for resource mobilization, using the current GPEI funding as a bridge and suggested conducting surveillance costing studies from countries and raising resources based on the global and regional business cases. The next step is to develop a framework on options on surveillance transition/opportunities in consensus with regions and countries.

12. a) **Immunization, including bOPV withdrawal:** The overarching goals of transition in the area of immunization include: to ensure polio resources are transitioned to support broader immunization goals; to protect populations from vaccine-associated paralytic polio (VAPP) and circulating vaccine-derived polio viruses (cVDPVs) by effectively preparing and implementing the globally synchronized withdrawal of bOPV; and to provide access to safe, effective vaccines for long-term protection from poliovirus for global populations through policy, supply and access to IPV and bOPV, and by including pre-cessation SIAs with bOPV prior to withdrawal. In line with the recommendations and certification timelines of the Strategic Advisory Group of Experts on Immunization (SAGE), specific goals are:

- To ensure sufficient, reliable and affordable supply of IPV to implement a 2-dose schedule globally prior to certification, implementing future immunization policy to protect populations against poliovirus;
- To plan the global withdrawal of bOPV prior to certification, ensuring the availability of oral vaccines until withdrawal and safe removal and destruction of vaccine after withdrawal, developing and implementing plans (including pre-cessation SIAs) to withdraw bOPV from routine programmes and SIA.

The availability of IPV supply is an important challenge for transition: in 2018, for the first time since 2014, there has been sufficient supply to fulfil all requirements for routine EPI needs. Catch up of currently estimated 43 million missed children will progressively start in 2019, following risk-based prioritization. It is anticipated that continued shortfalls in supply will affect the ability to fully meet all programme requirements beyond routine needs. Although there will be some new suppliers by the end of 2019, UNICEF expects that the supply will not be sufficient to meet all needs for a 2-dose schedule before 2023. The programme is proceeding with risk-based criteria, and dynamic management of priorities is anticipated. There is a new to ensure that key elements of the new GPEI strategy, in particular PCS, are covered in the post-2020 global immunization vision that is currently being developed.

13. **(b) Breakout group discussion:** There are clear regional and country level variations: for example, in SEAR, polio and Expanded Programme for Immunization (EPI) staff work together, whereas in EMR, polio and routine immunization are managed separately. It is important not to delay transition: given the ongoing levels of WPV transmission, we must question our assumptions to-date and move to action, especially with innovations for integration. We should not view transition as an end point, but as a step toward securing a polio-free world and achieving GVAP goals. To be successful we must shift from asking what can routine immunization (RI) do with polio assets? to asking how can RI contribute to eradication? WHO and UNICEF should map out the next steps by: identifying actors and suggesting mechanisms to define the process on how to operationalize transition in targeted countries; mapping parties and stakeholders and identifying overlaps between existing initiatives.
14. (a) *Outbreak response, including vaccine stockpile management:* Recent country outbreak experience indicates that the WHO Emergency Programme (WHE) offers an opportunity to absorb some of the technical capacities of the polio programme. There is a high correlation between priority countries of the two programmes. The existing IASC Health Cluster system unites many of the same partners that are active in polio eradication. Especially in fragile countries, WHE recognizes the importance of keeping teams currently funded by polio on the ground supported by other funding to ensure readiness for responding to outbreaks and other emergencies.

(b) *Breakout group discussion:* Prerequisites for successful transition in outbreak response include: shifting organizational cultures to strengthen emergency response capacities; transferring polio technical and operational expertise to IVB, ensuring that IVB has the resources to support the transfer; continuing high-quality surveillance that feeds into a global alert/response system; enhancing surveillance and readiness in the bOPV period; and using the IHR framework to manage polio detection, reporting and responses. Milestones could include shifting of countries from higher to lower risk categories after certification and bOPV withdrawal. Resources required include a full costing of the GPEI 5-year strategy for eradication, certification and integration and clarity on the roles and responsibilities of implementing partners. Partners to be engaged include GPEI, national governments, WHO POL/WHE/IVB, partners and donors. A next step would be to have a full-day meeting to discuss these issues in more depth, examine costings and to determine who is doing what.

15. (a) *Immunization, including bOPV withdrawal:* The overarching goals of transition in the area of immunization include: to protect populations from vaccine-associated paralytic polio (VAPP) and circulating vaccine-derived polio viruses (cVDPVs) by effectively preparing and implementing the globally synchronized withdrawal of bOPV; and to provide access to safe, effective vaccines for long-term protection from poliovirus for global populations through policy, supply and access to IPV and bOPV, and by including pre-cessation SIAs with bOPV prior to withdrawal. In line with the recommendations and certification timelines of the Strategic Advisory Group of Experts on Immunization (SAGE), specific goals are:

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(b) *Breakout group discussion:* There are clear regional and country level variations: for example, in SEAR, polio and Expanded Programme for Immunization (EPI) staff work together, whereas in EMR, polio and routine immunization are managed separately. It is important not to delay transition: given the ongoing levels of WPV transmission, we must question our assumptions to-date and move to action, especially with innovations for integration. We should not view transition as an end point, but as a step toward securing a polio-free world. To be successful we must shift from asking *what can routine immunization (RI) do with polio assets?* to asking *how can*...
RI contribute to eradication? WHO and UNICEF should map out the next steps by: identifying actors and suggesting mechanisms to define the process on how to operationalize transition in targeted countries; mapping parties and stakeholders and identifying overlaps between existing initiatives.

16. (a) Containment: To minimize the risk of polioviruses being released into the environment and populations, containment establishes biorisk management requirements for laboratories, vaccine production sites, or any other facilities that handle or store poliovirus infectious materials. A key element not only of the Polio Eradication and Endgame Strategic Plan 2013-2018 but also of the Polio Post-Certification Strategy, containment is achieved and maintained by:

- Reducing the number of facilities storing or manipulating PV by identifying remaining PV, destroying unneeded materials and preparing to contain essential materials (ongoing activity);
- Achieving/demonstrating containment of PV in laboratory, vaccine manufacturing and other facilities (not yet started);
- Sustaining containment long term (not yet started).

Unless polioviruses are fully destroyed and not reconstructed ever again, containment activities will need to be extended long-term into the post-certification era. The poliovirus containment programme therefore needs to transition to a WHO department that will ensure its long-term sustainability. For containment, there are no GPEI-supported, in-country functions and assets that need to be transferred, so the transfer is an internal WHO issue. Where the programme is located within WHO should not affect its mandate. However, the containment programme could benefit from a thorough review to determine whether it is fit for purpose or could be improved.

(b) Breakout group discussion: Immediate next steps were identified to frame and guide WHO management decisions on the transition of the poliovirus containment programme:

- Review the poliovirus containment programme;
- Propose a new operating model and structure;
- Discuss with relevant WHO parties (WHE, UHC, HSS);
- Identify timelines and plan activities for GPW13;
- Periodically report back to the WHA.

VII. OPTIONS FOR FUTURE TRANSITION GOVERNANCE

17. For polio transition, there are 10 key requirements for strong programme governance: measurable goals; committed leadership; a strong, integrated partnership; broad-based, inclusive policy-making; a clear, unambiguous model of change; good donor buy-in; global accountability for results; country accountability for results; rigorous measurement and monitoring; and absolute transparency.

18. Three possible models for governance were presented:

- Coordinated partnership
- Alliance or Network
- Unified management structure

19. Discussion: There is a risk that some countries interpret the extension of GPEI as a long-term source of revenue. Whilst donors are committed to eradication, there is also a risk of donor fatigue. Donors want involvement in strategic choices about transition at a global level. Past performance of routine immunization programmes are variable; new strategies are expected. While there is good progress in country plans for transition, there is some doubt about country
ownership of these plans. Staff retention uncertainty must be addressed: transition is about sustaining functions, not sustaining jobs. Even though poliovirus is still circulating, transition should start now; transition can support eradication activities. Countries with continued transmission will still require strong governance through GPEI and the Polio Oversight Board. This issue will require further consultation before concrete proposals can be made at a subsequent key stakeholders’ event.

VIII. CONCLUSIONS

a) Transition action must keep a clear focus on the country level, under a broad global strategic direction;

b) While transition priority countries have progressed well in transition planning, funding to sustain polio assets remains problematic for many fragile or low-resource countries, which will require consideration of a separate continuation of funding;

c) The GPEI extension gives breathing space to implement transition more strategically, but cannot be taken as an opportunity to let up on efforts to transition polio assets;

d) In endemic countries, transition must not detract from eradication; however, light framework planning in endemic countries can help kick-start transition once polio is eradicated;

e) Transition planning can not only strengthen eradication efforts, but can also make an important contribution to strengthening health systems and building emergency response capacity;

f) Gavi is committed to working with eligible countries to determine and potentially support immunization-essential functions at risk due to decreasing polio budgets. Gavi assistance would be through existing country-level resources and time-limited to assist countries to bridge to more sustainable funding sources;

g) Transition support must take into account the differences between countries’ situations and capacities. Countries fall within three broad categories:

a. 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;

b. Lower risk countries but with stable political and public health systems but economic limitations for sustainability, where a faster pace is possible for transitioning capacity-building support, to enhance routine immunization and emergency response capability. These countries may need a mixed model of international and domestic funding;

c. 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;

h) There is a need for more high-level political advocacy on the important opportunity that transition offers for helping achieve broader global health initiatives, including the SDGs, GHSA and UHC;
i) There are several options for the future governance of polio transition, and further consideration is needed before decisions are made in the appropriate fora on this issue;

j) There is a need to accelerate discussions on the pragmatic implications of polio transition, particularly at country level, across three of the four thematic priorities of comprehensive vaccine-preventable disease surveillance, strengthening immunization, and outbreak emergency response. In respect of containment, a follow-up discussion is necessary on the WHO internal transition of the poliovirus containment programme into the appropriate department in order to ensure its long-term sustainability.

IX. AGREED NEXT STEPS

To lead the transition process forward, with the active support of all stakeholders, WHO has committed to:

I. Continue to organize country-level reviews of polio-funded functions and capacities through joint planning visits by the polio eradication, immunization, emergencies, and other programme areas in support of the objectives of the WHO Strategic Action Plan on Polio Transition.

II. Organize a follow-up polio key stakeholder consultation prior to the 2019 World Health Assembly, to include a discussion on future governance options;

III. Ensure polio transition is reflected in the development of the GPEI Strategy;

IV. Work closely with GPEI on detailed analyses of country transition budgets to ensure alignment without any duplication or redundancy between GPEI and WHO transition budgets;

V. Take the lead to convene follow-up discussions in the coming months on the pragmatic implications of polio transition, across the four thematic transition priorities identified at section VI. above, and report back to the next meeting of key stakeholders (see also next step II. above).
## Annex – Summary of breakout group reports on thematic priorities

### Surveillance

**Options**
- Based on country risks status per PCS
- Country maturity GRID, e.g. AFRO business model
- Country priorities and available surveillance platforms
- Movement towards comprehensive VPD surveillance strategy in the 2018 standards

**Prerequisites**
- Commitment of governments
- Robust monitoring framework
- In-house coordination within UN agencies and partners
- Adequate resources and financial sustainability
- Lessons learned and guidance on potential options

**Milestones**
- Alignment of pre-certification and certification
- Low risk/mature countries’ need for strengthening existing integrating systems
- High/risk/low mature countries’ needs for future comprehensive vaccine preventable disease system. Prioritize functional areas for improvement now

**Resources**
- Current GPEI budget as basis/bridge
- PCS budget estimates
- Surveillance costing studies from countries
- Future costing VPD surveillance
- Raise resources based on business case – global/regional

**Who needs to be engaged?**
- Governments, broader than 16 priority countries
- Partners
- Discussions across units within UN Agencies
- New partners

**Next steps**
- Development of framework on options on surveillance transition/opportunities (consensus on ONE voice)
- Discussions with regions and countries
- Stakeholders’ meetings
- Participation in regional discussions
- Advocacy, costing and resource mobilization
- Coordination and linkage of planning documents for PCS, VPD, surveillance, etc.

### Immunization

**General discussion**
- There are clear regional and country level variations
  - Different approaches in SEAR (polio-EPI staff working together) vs EMR (polio teams handle SIAs).
  - Cannot keep holding up transition
    - 2 billion dollars spent in 2 years but cases going up. Must question our assumptions to date and move to action especially with innovations for integration
    - Transition not as an end point, but a step to helping eradicate polio and secure polio-free world
  - Need to better leverage synergies
    - Shift from what can RI do with polio assets? to how can RI contribute to eradication?

**Country level**
- Transition already happening in some countries
- Surveillance is the key function to safeguard within transition
- Need to shift from vertical programme to horizontal integrated system (reaching all missed children with all vaccines, building on UHC platform)
- Support differentiated approaches to countries (endemic vs. non-endemic: endemics not off-limits)
- Integrate management and accountability structure of polio and EPI – mutual benefits: harness top level political leadership, programme strategies and innovations

**Next steps**
- WHO and UNICEF to map out next steps:
  - Identify actors and suggest mechanism for defining process on how to operationalize polio transition in targeted countries
  - Many interested parties and stakeholders, and overlap with existing initiatives
  - Proposed body to
    - Define criteria for which countries or localities to zoom in on
    - Review 10 country plans for RI strengthening and find linkages with 16 country transition plans

Collaborate with polio transition teams to optimize outputs from WHO joint country missions. EPI community to engage in the “integration” section of PEESP 2019-2023 and align/reflect approaches in post 2020+ strategy and vice versa.
### Outbreak response

#### Options

<table>
<thead>
<tr>
<th>WPV</th>
<th>Hi Risk Countries</th>
<th>Low and Medium</th>
</tr>
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<tbody>
<tr>
<td>GPEI</td>
<td>IVB enhanced readiness and surveillance</td>
<td></td>
</tr>
<tr>
<td>Vaccine derived virus</td>
<td>WHE (emergency platform)+GPEI (technical)</td>
<td>WHE (emergency platform)+ IVB (technical)</td>
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</tbody>
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#### Prerequisites
- Culture shift for emergency response (speed and structure)
- Polio technical and operational expertise transferred to IVB (IVB must be fully resourced)
- Surveillance continues at high quality and feeding into global alert/response system
- Enhanced surveillance and readiness in the bOPV period
- IHR framework used to manage polio detection, reporting and response

#### Milestones
- Move of countries down risk categories (e.g. from high to medium)
- 1-year after certification>bOPV withdrawal
- Post withdrawal

#### Resource requirements
- Full costing of GPEI strategy (4 billion, 5 years): eradication – certification - transition
- Clear roles and responsibilities for implementing partners

#### Who needs to be engaged?
- GPEI/POB
- All countries
- POL/WHE/IVB Regional/country level offices
- Partners
- Donors

#### Next steps
- Full-day meeting on these questions
- Costing, who implements and finances

### Containment

#### Options
- Leave containment functions in GPEI/WHO (until when?)
- Move containment functions to a different WHO programme, delinking containment from eradication activities

#### Prerequisites
- Financial support (HR+activities)
- Technical capacity
- Interest of a future host within WHO

#### Milestones
- Completion of Phase I of GAPIII
- Beginning / completion of Phase II of GAPIII
- Preparations for Phase III
- Programme review completed
- New home for containment established

#### Key actors
- WHO (POL, IVB, WHE, HSS, infection control)
- GPEI
- Donors

#### Next steps
- Review of the programme
- Find a new home for containment in HSS?
- Discuss with relevant parties (WHE, UHC, HSS)
- Identify timelines and plan activities for GPW13
- Periodically report back to the WHA.