Objectives of the presentation

• Transition planning update
  – Context & country priorities relevant to transition
  – Asset mapping
  – Key lessons from polio
  – WHO transition update
  – UNICEF transition update

• Next steps by Govt

• Risks & Challenges identified

• Support needed
India polio free since 2011 & certified in March 2014
- Risk of WPV & VDPV importations from polio endemic countries (Pakistan & Afghanistan) in neighbourhood

Estimated 8.6 million partially vaccinated or unvaccinated children in India; outbreak of measles, diphtheria
- Full immunization India - 65%* (RSOC 2013-14)

India committed to achieving Measles elimination & CRS control goals by 2020
- Estimated 49,000 deaths annually

Ambitious pipeline to introduce new vaccines in 2017

Expanding scope of VPD surveillance
Context: Polio vaccination campaigns

Nationwide campaigns (NIDs)
- Children targeted: ~167 million
- Vaccine used: bOPV

Sub-National campaigns (SNIDs)
- Children targeted: ~75 million
- Vaccine used: bOPV

HR assets deployed during each NID
- Vaccinators deployed: 2.3 mn
- Supervisors: 155,000
Context: Burden of Communicable diseases

India
60% global leprosy burden
50% global kala-azar burden

Lymphatic Filariasis
- 40% global burden of LF
- 255 districts/21 states
- Over 630 million pop at risk

Dengue in entire country

Every Indian child (1-14 years) needs one round of deworming

Third highest estimated burden of Malaria

Weak disease surveillance & outbreak response capacity
• Govt of India committed to attainment of national health goals
  – Measles elimination & Rubella/CRS control by 2020
  – Full immunization 90% by 2020
  – New vaccine introductions: Rota, PCV
  – Communicable disease elimination targets
    • NTDs: Kala Azar - 2017, LF - 2020
    • Leprosy – 2018, Malaria Cat 1 districts by 2020, TB - 2025
  – Reduction in maternal & child mortality
  – IDSP: strengthen detection & response to epidemic prone diseases
Key assets – WHO & UNICEF HR on the ground

- Polio network covers all districts in the country
- Mostly located in state government premises

- 279 locations

Each Field unit has SMO, AA & Driver

- Regional Team Leaders (6)
- Sub-Regional Team Leaders (38)
- Surveillance Medical Officers (206)
- Polio laboratories (8)
- Measles laboratories (14)

Plus 70,000 influencers
30,000 informers for migrants
85,000 children (calling groups)
2,000 religious and educational institutions
15,000 mosques

- 964 field monitors in 12 states to monitor immunization activities & assist with planning

- 7,000+ SMNet manpower in 3 states (UP, Bihar, WB)

- 49 Sub Regional Staff
- 123 District Mobilization Coordinators
- 750 Block Mobilization coordinators
- 6094 Community Mobilization Coordinators

Plus 964 field monitors in 12 states to monitor immunization activities & assist with planning
Key lessons from Polio

- Epidemiological and lab **SURVEILLANCE** of global standards
- Independent data driven monitoring (verification)
- Accountability framework – **State & district task forces**
- **Strong government ownership** developed over time
- **Seamless partnerships**, Donor & partner coordination
- Extraordinary level of **advocacy**
- Strategy – flexible, continuously adapting to local context
- Unprecedented **community & social mobilization** efforts locally supported by UNICEF, CORE, Rotary, WHO, other CSOs, CBOs
- WHO NPSP has **credibility and trust** with district, state and national government
- UNICEF, and CORE supported SMNet have ground-root presence, trust and reach to high risk communities in UP, Bihar, and WB
- Technological **innovations** and local scientific research, guidance by IEAG
- Strengthening government capacities & institutions
GPEI funded staff already spend time on other public health priorities

Time allocation of polio staff to support other health priorities - 2014

Source: Boston Consulting Group - Polio legacy survey of ten countries
Oct, 2014
WHO Transition update

Moving From Polio to Public Health
Transition Planning for WHO-NPSP: Process-Timeline

• **February 2016**: MoHFW (GoI) formally established a Core Group for Polio Legacy Transition Planning for WHO-NPSP

• **April 2016 onwards**: strategic transition plan & workforce strategy development
  – implementation of strategies, including detailed HR, communication & advocacy, and funding plans
  – Fully document lessons learned, mapping of assets
  – 7 regions reduced to 6

• **Dec 2017**:
  – Fleet of vehicles retired with non renewal of 300 SSAs & function outsourced
  – 17 field units closed
## WHO NPSP Transition Options

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>Phase Out</th>
<th>Immunization/VPD Focus</th>
<th>Communicable Disease (CD) Integration</th>
<th>CD Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Focuses on core functions</td>
<td>• Focuses on core functions</td>
<td>• Support additional immunization activities</td>
<td>• Utilizes NPSP expertise to address additional health priorities</td>
<td>• Further expansion of workforce to address entire CD</td>
</tr>
<tr>
<td>• Manageable workload</td>
<td>• Manageable workload</td>
<td>• Aligns with known available funding from GPEI and Gavi</td>
<td>• Builds skills and capacity of workforce</td>
<td></td>
</tr>
<tr>
<td>• Significantly reduces personnel liabilities by 2021</td>
<td>• Significantly reduces personnel liabilities by 2021</td>
<td>• Workload likely to remain manageable</td>
<td>• Potential wider options for funding</td>
<td></td>
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</table>

## RISKS

<table>
<thead>
<tr>
<th>RISKS</th>
<th>Phase Out</th>
<th>Immunization/VPD Focus</th>
<th>Communicable Disease (CD) Integration</th>
<th>CD Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High attrition with potential for loss of high performing personnel</td>
<td>• High attrition with potential for loss of high performing personnel</td>
<td>• Missed opportunities for expansion to other public health needs</td>
<td>• Core goals of maintaining polio free India may be compromised if program transition is rushed</td>
<td>• Risks will accentuate</td>
</tr>
<tr>
<td>• Polio-related activities at risk and reducing the ability to respond if there are WPV/VDPV cases in-country</td>
<td>• Polio-related activities at risk and reducing the ability to respond if there are WPV/VDPV cases in-country</td>
<td>• Increase attrition of SMOs</td>
<td>• Additional activities may overburden workforce</td>
<td>• Increased liabilities for WHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Isolation of NPSP from other WCO activities</td>
<td>• Isolation of NPSP from other WCO activities</td>
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</tr>
</tbody>
</table>

Ref: Transition Plan for National Polio Surveillance Project (NPSP), WHO-India; Meg Thorley & Brent Burkholder 12 June 2016 (page No.34)
Guiding principles for transition (I)

• Reduce financial & HR liabilities - **Gradual scaling down of polio operations**
  – 30% by 2019 and 50% by 2021; reduce liabilities
  – Complete phase out by 2026

• **2017-2021 : Phase 1:** focus on building capacity in mainstreaming essential polio functions, immunisation related activities, NTDs, IDSP and Malaria

• **2022-2026 : Phase 2:** continue technical assistance for immunisation, IDSP, Malaria

• **Assessment of progress**
  – **2018:** review risks and mid-course corrections
  – **2020:** review and forward planning through 2026
Guiding principles for transition (II)

- WHO to take additional responsibilities only if needs and demands are matched with adequate resources

- Discussion with donors:
  - Govt of India
  - BMGF, Global Fund, US CDC, GAVI, Sasakawa,
  - USAID, DFID

- Close collaboration and partnership with government for a smooth transition
  - Government to increasingly finance the program from current 10% ($ 3/30m) to at least 40-50% ($ 8-10/20m) by 2019

- Focus on building government capacity
Demands to WHO/NPSP for Transition to Public Health

Sample of National Program/State Requests in 2015/2016

<table>
<thead>
<tr>
<th>Program</th>
<th>Request Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTD – Kala Azar</td>
<td>Union MoH requested NPSP engagement in monitoring indoor residual spray (IRS) for Kala Azar</td>
</tr>
<tr>
<td>Lymphatic Filariasis Elimination</td>
<td>State government requests MDA monitoring in Bihar</td>
</tr>
<tr>
<td>Leprosy Elimination</td>
<td>National Program request for assistance with post-leprosy case detection campaign evaluation in 14 States (44 districts)</td>
</tr>
<tr>
<td>Non-Polio Immunization Requests</td>
<td>Mission Indradhanush (for RI), Measles/Rubella, HPV, PCV, Japanese Encephalitis, AEFI surveillance</td>
</tr>
<tr>
<td>Malaria Control and Elimination</td>
<td>Union MoH requests NPSP engagement in malaria elimination</td>
</tr>
<tr>
<td></td>
<td>State government, Goa</td>
</tr>
<tr>
<td></td>
<td>Vadodara Municipal Corporation, Gujarat</td>
</tr>
<tr>
<td></td>
<td>State government, Andhra Pradesh</td>
</tr>
<tr>
<td></td>
<td>NVBDCP requests to assist in Assam</td>
</tr>
<tr>
<td></td>
<td>Zika</td>
</tr>
<tr>
<td></td>
<td>National government request to report GBS from AFP surveillance data</td>
</tr>
</tbody>
</table>
Handing over select functions to the government

- Polio laboratory costs ($3 million/yr) handed over to government Jan 2014 onwards
- Investigation of AFP cases being transferred to Govt

Percent AFP case investigation by Medical Officers

<table>
<thead>
<tr>
<th>Year</th>
<th>Govt.</th>
<th>SMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>2014</td>
<td>83</td>
<td>17</td>
</tr>
<tr>
<td>2015</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>2016*</td>
<td>94</td>
<td>6</td>
</tr>
</tbody>
</table>

* Data as on 20 August 2016

Quality Assurance by WHO SMOs
Building new capacities to move to public health

- Going beyond polio, but **SURVEILLANCE** remains core
- Greater focus on building capacities of government staff including transfer of best practices

- Building capacity of Surveillance Medical Officers (SMOs):
  - Epidemic Intelligence Services training in partnership with CDC to prepare for IDSP & outbreak investigations 75 MOs over three years
  - ALL SMOs for transition to public health with geographical focus on specific diseases
  - Leadership and management training

- Building capacity and career transition for AAs
WHO: Budget requirements and anticipated resources, 2016–2021

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Budget requirement</strong></td>
<td>30.83</td>
<td>29.73</td>
<td>26.97</td>
<td>24.41</td>
<td>22.5</td>
<td>21.7</td>
</tr>
</tbody>
</table>

**US$ millions**

- Funding Gap
- UNFIP plus CDC IHR-Measles
- BMGF-AEFI
- GAVI HSS
- Govt of India Labs
- GPEI
- Rent for Delhi NPSP Office
### Summary of funding gap for WHO-NPSP activities for the year 2017-2021

<table>
<thead>
<tr>
<th>Description of the activity</th>
<th>2017 (mil USD)</th>
<th>2018 (mil USD)</th>
<th>2019 (mil USD)</th>
<th>2020 (mil USD)</th>
<th>2021 (mil USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Monitors cost</td>
<td>1.72</td>
<td>2.18</td>
<td>2.63</td>
<td>2.08</td>
<td>1.51</td>
</tr>
<tr>
<td>External Monitors cost</td>
<td>1.30</td>
<td>1.35</td>
<td>1.40</td>
<td>1.46</td>
<td>1.53</td>
</tr>
<tr>
<td>Training cost</td>
<td>0.86</td>
<td>0.85</td>
<td>0.61</td>
<td>0.54</td>
<td>0.53</td>
</tr>
<tr>
<td>Remuneration for Medical Officers</td>
<td>1.60</td>
<td>2.88</td>
<td>3.84</td>
<td>8.40</td>
<td>8.40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5.47</strong></td>
<td><strong>7.26</strong></td>
<td><strong>8.48</strong></td>
<td><strong>12.48</strong></td>
<td><strong>11.96</strong></td>
</tr>
</tbody>
</table>
UNICEF Transition Update
• Discussions National & State government 2013-2016

• Deloitte Evaluation 2013-2014
  
  • SMNet relevant, effective, efficient/value-for-money, sustainable and had critical impact contributing to the larger goal of polio eradication through changing behavior in an efficient, flexible, dynamic manner”.

• Mapping, Lessons and Transition Study (PWC 2015- Jan 2016) - fed into discussions
  
  • lessons and critical factors, mapping geography and roles (current/future potential) and proposed scenarios for consideration. Fed into state discussions.

• National Agreement Nov 2015

• States Plans (PIP) development early 2016
• SMNet Convergent work, gradual - since 2009 RI+ Other MCH interventions (breastfeeding, diarrhea management, handwashing)

• SMNet refocusing on RI particularly, and some broader health, nutrition, sanitation, as per states’ request.

• TORs revised as per discussions with State Govt, WHO, UNICEF (Programmes as per current TORs in SMNet states given below)

<table>
<thead>
<tr>
<th>Uttar Pradesh</th>
<th>Bihar</th>
<th>West Bengal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Routine Immunization</td>
<td>• Routine Immunization</td>
<td>• Routine Immunization</td>
</tr>
<tr>
<td>• Polio Campaigns</td>
<td>• Polio Campaigns</td>
<td>• Polio Campaigns</td>
</tr>
<tr>
<td>• Mother &amp; Child Tracking System registration</td>
<td>• Capacity Building of Field Level workers</td>
<td>• Support in other Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA) services</td>
</tr>
<tr>
<td>• Use of ORS/ZINC in CMC areas</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Structural & Human Resource Transition:

- GOI & UNICEF agreed, UNICEF continue to manage through 3rd party & offer technical support
- Changes in roles of SMNet cadre to fit new priorities (new TORs)
- Results based – agreed performance indicators
- [UNICEF Staff- 19 staff in 3 offices reduced in 2016 to 9, integrating into health. Change management process supported]
Government Engagement Funding & Ownership:

- GOI agreed to fund SMNet progressively until March 2018. Thereafter states to take over/determine funding and role
- States included plans in their Programme Implementation Plans (PIP): UP 2015-2016 (USD .8m); UP & Bihar 2016-2017 (2.1m & 1.5m) & 2017-2018 (4m & 1.9m)
- Specific SMNet (eg Block Mobilization Coordinators) identified to be funded
- In West Bengal - UNICEF will contribute 40% (USD 215,000) of the cost and state will provide 60% (USD 320,000) of the total cost.
Social Mobilization Network (SMNet)
Approximately 7,000 Personnel

No. human resources

- State - 51 coordinators
  - Cost/Year: $0.62

- District - 123 Mobilization Coordinators
  - Cost/Year: $1.39

- Block – 812 Mobilization Coordinators
  - Cost/Year: $4.17

- Community Mobilization Coordinators – Approximately 6000
  - Cost/Year: $2.92
Funding transition

Funding Sources (2014-2018)

- **UNICEF**
- **GOI**
- **GAVI**
- **GPEI**
- **Others (Aus, Jap)**
- **Gap**
### Funding Transition UNICEF

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018*</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>2.7</td>
<td>2.29</td>
<td>TBC</td>
</tr>
<tr>
<td>GOI</td>
<td>2.08</td>
<td>5.4</td>
<td>1.8</td>
</tr>
<tr>
<td>GAVI</td>
<td>1.9</td>
<td>4.9</td>
<td>1.33</td>
</tr>
<tr>
<td>GPEI</td>
<td>4.38</td>
<td>2.65</td>
<td>TBC</td>
</tr>
<tr>
<td>Others</td>
<td>0.08</td>
<td>0</td>
<td>TBC</td>
</tr>
<tr>
<td>Gap</td>
<td>0</td>
<td>0</td>
<td>9.1</td>
</tr>
</tbody>
</table>

All figures in million USD

*Current GOI and GAVI funding is till March 2018.
Next Steps
Steps being taken by MoHFW to address funding gap for WHO & UNICEF

- Direct funding support to WHO NPSP
  - Lab support: to continue @ $ 4m/year
  - Trainings/capacity building workshops: $ 1.0 m/year
  - Support increasing % of core NPSP budget from 2017

- State Project Implementation Plans (PIP) for National Health Mission (NHM) to finance incrementally up to a maximum of:
  - Field monitors: $ 4 m/year
  - External monitors: $ 1.3 m/ year

- MoHFW to facilitate a cross-departmental dialogue with urban health, NTD, malaria and IDSP.

- MoHFW approved 2017-2018 co-funding of SMNet through NHM funding: Uttar Pradesh (UP), Bihar, and West Bengal (WB) states
Risks identified

- Maintaining quality of core polio functions: EPRP: VDPV, Importation, IPV – risk of impairment
- Maintaining support to RI strengthening to reach FIC of 90% compromised
- Capacity building, micro planning, community mobilization affected
- Weak monitoring & supervision
- Support to Measles elimination & Rubella Control impaired
- NUVI (PCV, Rota, MR, JE) quality and coverage, likely to be impacted
- VPD surveillance roll out, risk of impairment
- Other NTDs targeted for elimination, challenged
- Legal litigation, reputational risks and public agitation
- Anxiety and demotivation due to uncertainty
Challenges Identified

- Increasing attrition of HR, especially SMOs, SMNet Coordinators
- Capacity of govt at state & district levels to take over functions performed by NPSP ensuring maintenance of quality
- In a few states critical vacancies of government Medical Officers - making transition difficult
- Maintaining quality of core polio functions
- Pressure to respond to unfunded public health priorities
- Mobilizing sustained core funding in the face of declining GPEI support beyond 2018
- Significant funding gaps beyond 2018/2019 – leading to uncertainty regarding future
- Meetings costs of transition process: consultants, communications, admin support, legal implications, ex gratia payments, outsourcing costs
Support Needed

• Country’s needs and priorities should dictate pace of transition
• Govt of India is committed to sustaining network beyond 2019
• GoI working on arrangements to support part of core WHO NPSP requirements from 2017 to 2021
• Social Mobilization network need for support beyond March 2018
• Donors and developmental partners should help to sustain polio network beyond 2018 for: maintaining Polio free India, strengthening routine immunization, and wider public health gains
THANK YOU