Polio Transition Planning:

Risks and opportunities of transitioning resources to non-polio public health interventions

Global Polio Partners Group (PPG) meeting
June 26, 2017
Underlying premise:
Transition to other health goals
risk and opportunity

There is a **RISK** to other health goals when GPEI funding stops, as the polio infrastructure is already helping to support other health programmes

There is an **OPPORTUNITY** for current GPEI staff, assets and knowledge to further contribute to other health goals
Most Obvious Candidates for Transitioning of Polio Assets*

- Vaccine preventable-communicable disease surveillance & lab networks
- Immunization system strengthening
- Measles and rubella elimination
- GHS/IHR and Health Emergency capacity
- Maternal & Child Health interventions

* adapted from WHO draft report on Polio Transition Planning to the 70th WHA, April 2017
GPEI presence in over 70 countries, but 95% of personnel footprint in 16 countries

Includes social mobilizers. Does not include national government staff, vaccinators or regional/headquarters personnel.

Note: Philippines, Haiti also have between 1-10 polio funded personnel but are not displayed; no headquarters staff displayed
Source: GPEI partner HR databases, 2014
Polio Funding and WHO AFRO situation

• Overall WHO AFRO workforce:
  o 40% of all personnel are polio-funded
  o 86% of all immunization personnel are polio-funded

• Primary roles:
  o AFP polio and VPD surveillance
  o Central role in the planning, implementation and monitoring / evaluation of SIAs

• Additional support:
  o Lead/ assist the investigation and response to other outbreaks, including cholera, meningitis, VHF, etc
  o Assist in efforts to strengthen routine immunization and in periodic intensification of immunization activities
Polio-Funded Surveillance Officer Responsibilities

Other VPDs:
- Measles/Rubella
- Yellow Fever
- Neonatal tetanus
- Meningitis
- Acute encephalitis syndrome
- Diphtheria
- Cholera
- Pertussis
...and so on

Other Communicable Diseases:
- Bloody diarrhea
- Neglected tropical diseases
- Dengue
- Viral hemorrhagic fevers
- Rabies
- Malaria
...and so on
Surveillance Officer: Responsibilities (2)

Trained by polio in:
- Surveillance
- Outbreak Investigation
- Data management, analysis & use
- Outbreak response

Does many jobs-paid for by polio!
WHO-coordinated laboratory networks

- GPLN: polio

- Networks based on the Polio model:
  - GMRLN: measles and rubella
  - GYFLN: yellow fever
  - JELN: Japanese encephalitis
  - GRLN: rotavirus
  - IBD: invasive bacterial diseases

- Other
  - Influenza
  - Tuberculosis
Global Resource Dependence of VPD/MR Surveillance on Polio

- **Financial**
  - Polio FRR: surveillance/lab costs $102 million per year
  - $111 million annually needed for VPD/MR surveillance to be maintained at status quo (excluding operational costs at country level)
    - $77 million (70%) coming from polio

- **Human**
  - Over 2500 polio-funded staff are supporting VPD/MR surveillance
AFRO: AFP vs measles surveillance current staffing and funding

• AFP Surveillance:
  – USD 12.5 and 16.9 million / year for surveillance activities and lab operations at country level in 2015 and 2016 respectively

• Measles Surveillance:
  – USD 0.5 – 0.6 million / year surveillance and lab operations in 2015 and 2016 respectively
  – USD 0.4 – 0.6 million / year for the purchase of lab reagents and test kits
  – Facing a significant decline in partner funding for measles surveillance/ lab during the past 2 years

• GPEI funding:
  – 355 Polio surveillance officers/ epidemiologists at country level
  – 7 Measles-specific staff (CDC)
    • 3 at Regional-IST level and only 4 at country level

No specified funding provided by YF and MNTE programs for surveillance
Conclusion

- Polio needs VPD surveillance and vice versa
- VPD surveillance already relies heavily on polio
  - Needs further strengthening to meet ambitious goals including measles and rubella elimination
- Careful transition planning and execution will be key to prevent backsliding of the whole polio-VPD surveillance network
Characteristics of the 16 Priority “Polio Transition” Countries

• Most of the world’s unvaccinated and under-vaccinated children
  ➢ 53% of the 20.8 million infants who did not receive measles vaccine in 2015 are in the Big 6 priority measles countries
• Most of the world’s measles cases and deaths (88% of deaths)
• Most of the world’s rubella and congenital rubella syndrome (100,000 CRS cases)

Consequences of losing polio assets – risk that EPI progress in these countries and globally will be reversed !!!
**KEY STEP** to build immunization program capacity is to strategically link:

1. **disease-specific** efforts
2. **health system strengthening** efforts


Health Emergency and IHR Capacity: Building on the Polio Lab and Surveillance Network (>700 labs)
Detection and Response: Polio
Surveillance and Lab Network in Action

• Disaster response: Nepal, Pakistan, India
• Measles case-based response in multiple countries
• Ebola response in Nigeria
• Zika response in Americas (measles labs)
Integration with MCH Interventions

Using Polio Campaigns

Bednets/deworming with albendazole & Polio Campaign -- Niger

Measles & Polio Campaign DR Congo

Polio Drops: >16 million cases of paralysis prevented

Vitamin A in Polio Campaigns >1.5 million deaths prevented
MCH & Polio Transition in India – Role of SMNet

UNICEF and Social Mobilization Network (SMNet) staff have worked in many areas beyond polio and RI.

- Outbreaks of acute encephalitis and measles
- Messaging around early and exclusive breastfeeding, hand washing and use of oral rehydration salts (ORS) and zinc for diarrhea management
- Supporting the integrated health and nutrition days
- Track and promote toilet creation.

To maintain these gains, polio assets, including the (SMNet) are being actively transitioned to a government owned and funded setup to address routine immunization and more.

UNICEF. Beyond Polio: Legacy in Action.
Thank you