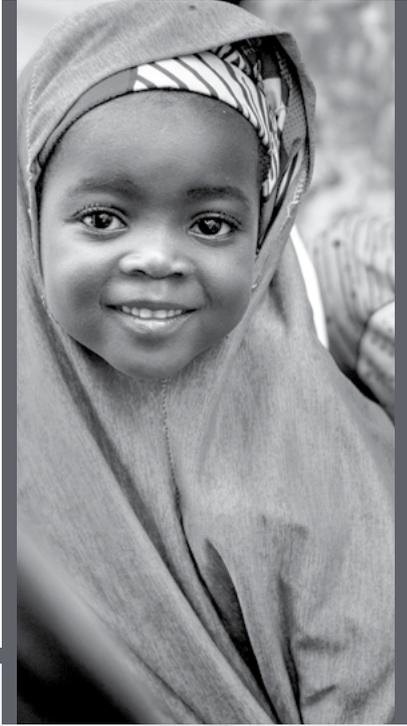


POLIO GLOBAL ERADICATION INITIATIVE

Polio Eradication Strategy 2022–2026

Executive summary





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ERADICATION
INITIATIVE

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Polio Eradication Strategy 2022–2026: Executive summary.

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OVERVIEW

Over the last decade, the Global Polio Eradication Initiative (GPEI) made steady progress on the path to eradication. Wild poliovirus types 2 and 3 (WPV2 and WPV3) were declared eradicated in 2015 and 2019, respectively; the World Health Organization (WHO) South-East Asia Region was declared free of poliovirus in 2014; and most recently, the WHO African Region was certified free of wild poliovirus (WPV) in August 2020. However, the final steps towards eradication have proven the most difficult.

To ultimately achieve a polio-free world, the GPEI has re-envisioned the endgame pathway with an urgent call for collective ownership and accountability across the GPEI partnership and with governments, communities and all other stakeholders.

Answering the call

The GPEI faces programmatic, epidemiological and logistical challenges that demand new approaches to place the partnership and impacted countries on an emergency footing.¹ In 2019, the GPEI put forth a strategy that presented guidance to eradicate polio,² but negligible progress and waning population immunity in high-risk countries and regions have contributed to a deteriorating epidemiological state, as past approaches have proven insufficient.³ In the final two endemic countries, Afghanistan and Pakistan, wild poliovirus type 1 (WPV1) persists alongside circulating vaccine-derived poliovirus type 2 (cVDPV2). Globally, cVDPV2 outbreaks have accelerated in countries that have been free from WPV1, with outbreaks occurring in four of the six geographical regions of WHO.⁴

To permanently interrupt polio transmission and protect the historic gains the world has made, the GPEI has launched a new strategy to transform its approach – by employing all opportunities to vaccinate children, build collective ownership and accountability of the eradication effort, and ensure a level of urgency commensurate with the 2014 designation of polio as a Public Health Emergency of International Concern.⁵

Achieving eradication through collective ownership and accountability

The **Polio Eradication Strategy 2022–2026** offers a comprehensive set of actions to strengthen the GPEI so it is fit for purpose. To be successful, the programme must operate with an emergency tempo while it also becomes more accountable to the collective partnership, more responsive to the intersecting needs of impacted communities, more welcoming of sociological, anthropological and health economic expertise, and more integrated with social and health programmes that deliver critical interventions to vulnerable populations. These actions, many of which are underway in 2021, will empower the GPEI to meet challenges head-on and achieve and sustain a polio-free world.

This strategy builds on two primary goals based on the current state of the eradication effort: **Goal One to permanently interrupt all poliovirus transmission in endemic countries** and **Goal Two to stop cVDPV transmission and prevent outbreaks in non-endemic countries**. To achieve these goals, the GPEI will transform its approach in each region and country through five mutually reinforcing objectives.

Strategic objectives



Create urgency and accountability to generate greater political will by re-envisioning the GPEI's relationship with governments and systematizing political advocacy.



Generate vaccine acceptance through context-adapted community engagement that reduces refusals and increases community commitment to child immunization.



Expedite progress through expanded integration efforts with a broader range of partners in immunization, essential healthcare and community services.



Improve frontline success through changes to campaign operations, including the recognition and empowerment of the frontline workforce.



Enhance detection and response through sensitive surveillance that provides the programme with critical information for action.

¹ For a high-level list of current challenges, see Fig. 3 and 4 in this report.

² Global Polio Eradication Initiative (GPEI). Polio Endgame Strategy 2019–2023: Eradication, integration, certification and containment. Geneva: World Health Organization; 2019 (<https://polioeradication.org/who-we-are/polio-endgame-strategy-2019-2023>, accessed 10 April 2021).

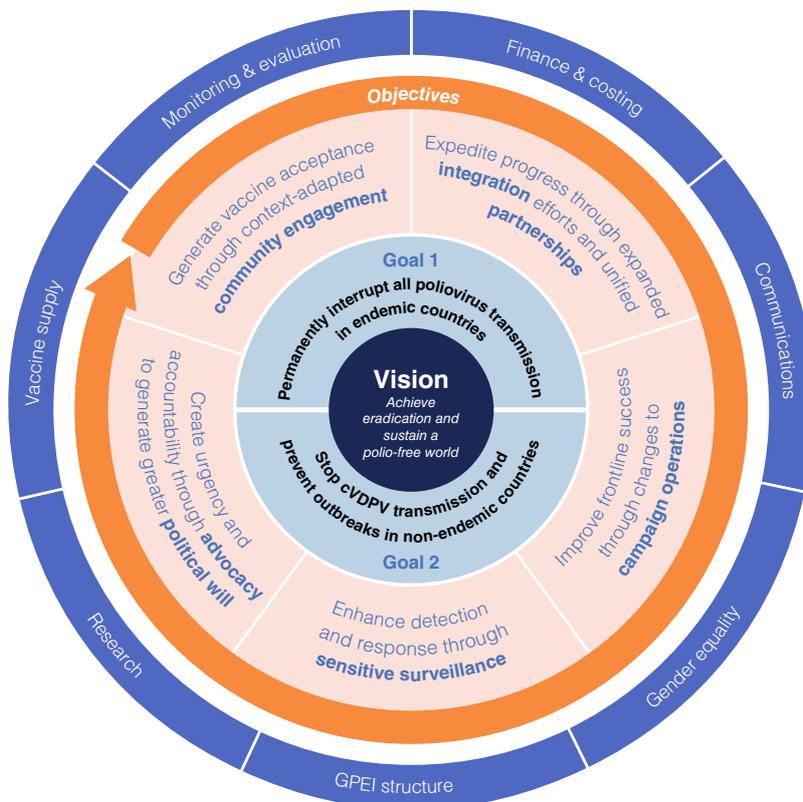
³ For more on the insufficiency of past approaches, see Global Polio Eradication Initiative (GPEI). Independent Monitoring Board. The world is waiting: Nineteenth report; December 2020 (<https://polioeradication.org/wp-content/uploads/2020/12/19th-IMB-Report-The-World-is-Waiting-20201223.pdf>, accessed 10 April 2021).

⁴ In 2020, 140 WPV1 cases were reported in Afghanistan (56) and Pakistan (84), and 1418 cVDPV2 cases and isolates were reported through acute flaccid paralysis surveillance (971) and environmental surveillance (447), with the most consequential outbreaks in Pakistan (135), Afghanistan (269), Chad (98), Democratic Republic of the Congo (75) and Côte d'Ivoire (71).

⁵ WHO statement on the meeting of the International Health Regulations Executive Committee concerning the international spread of wild poliovirus. Geneva: World Health Organization; 5 May 2014 (<https://www.who.int/mediacentre/news/statements/2014/polio-20140505/en>, accessed 10 April 2021).

The goals and strategic objectives are supported by essential functions that contribute to an enabling environment, which include GPEI structure, gender equality, communications, vaccine supply, research, monitoring and evaluation, and finance and costing. The holistic approach pursued by the strategy is captured below (see **Fig. 1**).

Fig. 1. Polio Eradication Strategy 2022–2026 strategic framework



Source: WHO.

While the GPEI must perform each activity and deliver each service to completion, activities will be prioritized differently according to regional and country contexts, particularly as the GPEI works to integrate more effectively with other health and social programmes (see **Fig. 2**).

Across all modalities and regions, the GPEI will better reflect the needs, voices and capabilities of the spectrum of stakeholders needed to achieve eradication. By emphasizing urgency in all activities, by rebalancing capacity and decision-making towards regional and country teams, by empowering staff closest to the realities on the ground, and by becoming a willing and responsive partner to governments, communities and other health initiatives, the polio programme and its partners will collectively generate greater accountability and increased ownership of eradication efforts.

Fig. 2. Integration modalities and regions

	Pandemic response, including support to COVID-19 vaccine delivery, <i>wherever the GPEI is needed</i> .
	Integrated service delivery in the high-risk districts of <i>Afghanistan</i> .
	Integrated service delivery for priority communities in <i>Pakistan</i> .
	Multi-antigen immunization campaigns to increase immunity to vaccine-preventable diseases.
	Coordination with Gavi and the Expanded Programme on Immunization on the “zero-dose” initiative, including in outbreak response.
	Acceleration of the transition of polio-essential functions in <i>areas where polio is already integrated</i> .

Source: WHO.

COVID-19: A case study in emergency action and effective partnership

When COVID-19 emerged in 2020, countries with a strong GPEI presence were able to use expertise and infrastructure put in place by the polio programme to coordinate an effective COVID-19 response. Thousands of polio workers shifted their focus to help contain the spread of the SARS-CoV-2 virus. Polio emergency operations centres (EOCs) quickly pivoted to respond to COVID-19 through surveillance, contact tracing and specimen transport, provision of soap and hand sanitizer, distribution of training materials for medical personnel and frontline workers, and engagement with community and religious leaders and media on mitigation measures.[†]

In Nigeria and Pakistan, GPEI assets were especially valuable. In Pakistan, polio labs provided COVID-19 testing and sequencing, the polio call centre became (and remains) the national COVID-19 call line, polio staff trained more than 18 600 health professionals, and polio community mobilizers engaged 7 000 religious leaders and 26 000 influencers. In Nigeria, COVID-19 response teams used EOC data systems and analytics to track and visualize primary health care delivery, which helped identify gaps and target catch-up services.

To support pandemic response while delivering polio and broader immunization and surveillance activities, the GPEI and the Expanded Programme on Immunization (EPI) accelerated their integration initiative and launched an interim Programme of Work for Integrated Actions in the context of COVID-19 (iPOW).[‡] The iPOW provides guidance to synergize polio eradication and EPI efforts in mutually beneficial areas.

In the coming years, countries may continue to depend upon GPEI support to combat COVID-19 or other health emergencies. By building upon this spirit of cooperation, joint planning and emergency response, polio eradication can be achieved amid competing health priorities and a resource-limited environment.

[†] Nearly 50 countries reported polio support for COVID-19 in the African Region (36), the Eastern Mediterranean Region (8) and the South-East Asia Region (5), totalling US\$ 26.7 million as of June 2020. See Contributions of the polio network to the COVID-19 response: turning the challenge into an opportunity for polio transition. Geneva: World Health Organization; 2020. (<https://www.who.int/publications/item/contributions-of-the-polio-network-to-the-covid-19-response-turning-the-challenge-into-an-opportunity-for-polio-transition>, accessed 12 April 2021).

[‡] See Global Polio Eradication Initiative (GPEI). Polio Eradication and Essential Programme on Immunization Interim Programme of Work for Integrated Actions in the context of the COVID-19 pandemic. Geneva: World Health Organization; 2020 (<https://polioeradication.org/wp-content/uploads/2020/09/Integration-POW-under-Covid-v2.0.pdf>, accessed 12 April 2021).



Goal One: Permanently interrupt all poliovirus transmission in endemic countries

WPV1 persists in Afghanistan and Pakistan, which represent a single epidemiological block due to deep social, cultural and economic ties and large-scale cross-border population movement. In Afghanistan, restrictions to house-to-house immunization campaigns in southern areas have resulted in more than 1 million children missing scheduled vaccinations since May 2018, including “zero-dose” children who have received no essential immunization. In 2019 and 2020, respectively, 90% and 75% of WPV1 cases originated in inaccessible areas. In Pakistan, progress has been impeded by vaccine hesitancy and a misalignment between challenges on the ground in priority areas and programme efforts to overcome these challenges. Specifically, ineffective engagement with Pashto-speaking communities, which represent 15% of Pakistan’s population, has accounted for a disproportionate burden (81%) of WPV1 cases over the last 10 years.

Interrupting WPV1 in Afghanistan and Pakistan requires an emergency posture from the GPEI, governments and all polio eradication partners. Modelling suggests that a failure to eradicate WPV1 in these last two endemic countries could result in a global resurgence in wild polio transmission, leading to 200 000 new polio cases annually within 10 years.

To protect the investment generations have made in polio eradication, **Goal One** offers a pathway towards permanently interrupting WPV1 transmission (see **Fig. 3**).

Fig. 3. Goal One objectives and strategic pivots

Programme challenges	Strategic pivots	
<ul style="list-style-type: none"> Over 1 million children in southern Afghanistan are inaccessible to the polio programme. Polio eradication is not prioritized by national or provincial governments. Lack of trust in the polio programme and vaccine contributes to hesitancy, particularly among some Pashto-speaking communities. Polio campaigns are not consistently delivered with high quality, resulting in chronically missed children. 	 Political advocacy	<p>Systematic advocacy with all to gain and maintain access in Afghanistan.</p> <p>Intensified advocacy with provincial governments in Pakistan.</p>
	 Community engagement	<p>Multidisciplinary research into vaccine hesitancy and community mistrust.</p> <p>Alliance-building with priority communities for co-design, ownership and delivery of gender-responsive programme innovations.</p>
	 Campaigns	<p>Well-trained, appropriately supported and motivated workforce that meets the needs of the community.</p> <p>Innovations in monitoring to enable faster data feedback loops and improve quality.</p>
	 Integration	<p>Enhanced reach of both essential and supplementary immunization in priority communities and high-risk areas by delivering vaccine(s) alongside basic services.</p> <p>Strong partnerships with governments, communities and adjacent health and related programmes to support access and reduce missed communities and zero-dose children.</p>
	 Surveillance	<p>Improved timeliness for detection – from case onset to final results.</p> <p>Established pathway towards a sustainable integrated surveillance system.</p>
	 Enabling environment	<p>Increased representation and empowerment of women at every level and across all areas of the programme.</p> <p>Targeted assistance for country programmes through the GPEI hub.</p>

Source: WHO.

Under the **Polio Eradication Strategy 2022–2026**, the programme will shift from current need-based approaches to embrace systematic and pragmatic political advocacy efforts. In Afghanistan, access to missed children will be gained and maintained by engaging all local actors to ensure that polio activities remain apolitical and that all children, regardless of where they reside, are protected from polio. In Pakistan, the programme will use every available opportunity to ensure polio eradication remains a top public health priority for the government, including the National Task Force chaired by the Prime Minister, the Provincial Task Forces chaired by provincial chief ministers, and direct engagement by world leaders and the Polio Oversight Board in all appropriate forums.



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To increase vaccine acceptance, the GPEI will identify at a granular level the dynamics driving hesitancy. Through multidisciplinary approaches that include intersectional gender analysis and social and behavioural change methods, the programme will design targeted interventions in underserved areas with high levels of mistrust. Locally tailored community engagement initiatives, including communication for development (C4D), will contribute to an enabling environment by building alliances with communities to encourage leaders and influencers to become champions for eradication.

Country programmes will also prioritize the co-delivery of polio vaccines with other antigens and health interventions, such as the distribution of vitamin A and deworming tablets or the dissemination of maternal and child health promotion materials. In underserved communities within the high-risk districts of Afghanistan and the highest-risk districts of Pakistan, the programme will prioritize integrated service delivery, as responding to community needs will foster trust. In inaccessible areas of Afghanistan, where house-to-house campaigns are banned, integrated service delivery will provide a lynchpin of the strategy to ensure high immunization coverage. In both endemic countries, close collaboration with nongovernmental organizations (NGOs) and reputable private entities will help reduce zero-dose children by increasing the access to and utilization of essential immunization, implementing and increasing birth-dose oral polio vaccine (OPV) coverage in health facilities, and understanding and responding to the underlying drivers of vaccine refusal. This will be facilitated through integrated operational microplans, enhanced supportive supervision and monitoring of outreach activities, harmonized social mobilization and health promotion efforts, and new proactive technology to support operations.

To improve immunization campaign quality, the GPEI will support government efforts to ensure the right vaccinators and supervisors are in place with appropriate safeguards and to generally strengthen campaign monitoring mechanisms. In both Afghanistan and Pakistan, the GPEI will aide and accelerate government efforts to adopt digital tools that provide greater precision, enable faster data feedback loops and simplify data collection while ensuring attention to sex-disaggregated data. More specifically, the GPEI will scale up technology to identify gaps in microplanning and roll out expanded intra-campaign monitoring to strengthen information for action.

Collectively, these approaches will improve the effectiveness of programme operations, change the way the programme listens and responds to communities, and increase local, provincial and national stakeholder commitments to eradication. Through their respective National Emergency Action Plans, Afghanistan and Pakistan have set ambitious milestones to achieve WPV1 eradication, and the GPEI will support country efforts to fully implement these plans.⁶ Targeted assistance for country programmes will be provided by the GPEI hub for Afghanistan and Pakistan.

⁶ National Emergency Actions Plans are available on the GPEI website via dedicated country pages for Afghanistan (<https://polioeradication.org/where-we-work/afghanistan>) and Pakistan (<https://polioeradication.org/where-we-work/pakistan>).

Goal Two: Stop cVDPV transmission and prevent outbreaks in non-endemic countries

In April 2016, following the 2015 declaration of WPV2 eradication,⁷ a global switch from the trivalent oral polio vaccine (tOPV) to a bivalent oral polio vaccine (bOPV) containing only types 1 and 3 was implemented to remove all live-attenuated type 2 vaccine and its associated risk. The switch and delays in introducing inactivated polio vaccine (IPV) into essential immunization in all regions led to decreasing immunity to type 2 poliovirus. As a consequence, outbreaks of cVDPV2 have become as great a public health threat as WPV1, with more cases of cVDPV2 than WPV1 annually since 2017. Between 2019 and 2020, cVDPV2 cases tripled; the virus continued to spread across the African Region, with outbreaks spanning from the Atlantic to the Indian Ocean; virus from the Philippines spread domestically and regionally to Malaysia; and virus in Afghanistan and Pakistan spread to the Islamic Republic of Iran and Tajikistan. While 27 outbreaks have been declared closed by the GPEI in the past two years, the scale and speed of disease spread pose a risk for global polio eradication that must be eliminated.

In this context, **Goal Two** outlines significant adjustments in strategy and tactics to put the GPEI and impacted countries on an emergency footing to meet the target of stopping cVDPV2 transmission (see **Fig. 4**).

Fig. 4. Goal Two objectives and strategic pivots

Programme challenges	Strategic pivots	
<ul style="list-style-type: none"> • Large-scale, rapidly expanding VDPV outbreaks. • Waning type 2 immunity. • Delayed detection and poor-quality campaigns. • Limited political momentum and accountability for stopping outbreaks. • Decreasing programme resources – human and financial. • Shifting country and donor priorities, due in part to COVID-19. • Better tools needed to address VDPV 1 & 3. 	 Political advocacy	Engage government and political stakeholders via integrated health advocacy to ensure emergency posture, resourcing and joint accountability for timely and effective outbreak response.
	 Surveillance	Implement technical innovations in surveillance and sample analysis to more rapidly detect, sequence and initiate response activities.
	 Campaigns	Improve campaign planning and execution with nOPV2 through optimized response scope, mobile money payments, campaign digitization and other innovations.
	 Community engagement	Engage nomadic and settled communities both before and during outbreak campaigns.
	 Integration	Ensure success of the Gavi zero-dose strategy and leverage multi-antigen campaigns .
	 Enabling environment	Support global health emergencies with near-term focus on COVID-19.

nOPV2 = novel oral polio vaccine type 2; VDPV = vaccine-derived poliovirus.
Source: WHO.

Under the **Polio Eradication Strategy 2022–2026**, government ownership and accountability for stopping outbreaks in partnership with the GPEI will be required to shift cVDPV2 outbreak response to true emergency footing. Through regular government and political stakeholder engagement, systematic integrated health advocacy approaches and the utilization of regional platforms and local partners, the GPEI will bring clarity and urgency to cVDPV2 challenges, as well as help identify under-immunized populations and work with governments and immunization partners to address health system weaknesses. The GPEI will also work with countries to establish mechanisms to hold the GPEI and country governments accountable for outbreak response outcomes. This will ensure that regional, national and provincial leaders know polio is not finished; that they have a role to

⁷ Global Polio Eradication Initiative (GPEI). Global eradication of wild poliovirus type 2 declared. Bali: World Health Organization; 20 September 2015 (<https://polioeradication.org/news-post/global-eradication-of-wild-poliovirus-type-2-declared>, accessed 12 April 2021).



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play in ensuring that eradication is achieved; and that by investing now to finish the job, they are also investing in other health and development priorities.

The introduction and scale-up of a new vaccine for type 2 virus – novel oral polio vaccine type 2 (nOPV2) – for outbreak response is a primary focus of this new strategy. Because of the anticipated reduced risk of nOPV2 seeding new outbreaks, it will be possible to increase the scope of vaccine use in OPV2-naïve populations and allow countries to stop transmission and prevent spread outside response zones.

To complement high-coverage response activities, technical innovations in surveillance and sample analysis will support quick and reliable outbreak detection. Expanded environmental surveillance and community-based surveillance networks alongside the scale-up of digital tools, mapping, and population modelling will ensure broad and effective coverage. Faster sample analysis will be achieved through: direct detection and country-level sequencing; sample tracking to identify and resolve transport bottlenecks that disproportionately impact countries without sample analysis capabilities; and the continued development of rapid detection and sequencing methodologies.

Furthermore, campaign planning and execution will be improved through a range of activities, such as: risk assessments and planning to ensure optimal outbreak response; rapid gender analyses to shape outbreak response and support vaccination outcomes; the continued rollout of mobile money payments for vaccinators to improve the satisfaction and motivation of the frontline workforce; and overall digitization from campaign planning to intra- and post-campaign monitoring. The GPEI will also pursue new partners to engage with nomadic and other mobile communities both before and during outbreak campaigns, listening to families and linking them to other services and programmes. Success through these new approaches will be enabled by ensuring a stronger role for women through their increased participation in programme oversight, management, supervision and delivery with clear targets to measure these objectives.

To empower the regions and countries most impacted by cVDPV outbreaks, focused support will be provided to the African and Eastern Mediterranean Regions where the GPEI will expand its outbreak management teams, especially cadres of GPEI staff (rapid response teams) who can mobilize to support countries within 24–48 hours of an outbreak being confirmed. Other regional mechanisms to hold the GPEI and countries accountable will be pursued, such as ministerial subcommittees for the African and Eastern Mediterranean Regions, which will promote shared responsibility for stopping outbreaks among neighbouring countries.

The GPEI will also transform how it delivers vaccines to children in and beyond outbreak countries. While polio “stand-alone” preventive campaigns will continue, the GPEI will increasingly integrate bOPV with other activities, such as Child Health Weeks and other planned and supported supplementary immunization activities (SIAs), to improve programmatic and cost efficiency. Close coordination with the Expanded Programme on Immunization (EPI), Gavi, the Vaccine Alliance, and other immunization and humanitarian partners during and following outbreak response activities will allow joint utilization of emergency structures, access agreements, microplanning and messaging. This broadened approach to integration will support essential immunization, particularly in under-immunized communities, and leverage multi-antigen campaigns to maintain WPV-free status.⁸ The GPEI will collaborate with key global partners to develop a common digital platform for multiple health initiatives to use in campaign planning, operations and reporting. On emergency response and pandemic preparedness, the GPEI will work closely with other global programmes to ensure that polio outbreak teams support the rollout of COVID-19 vaccines and ongoing surveillance and risk communication.

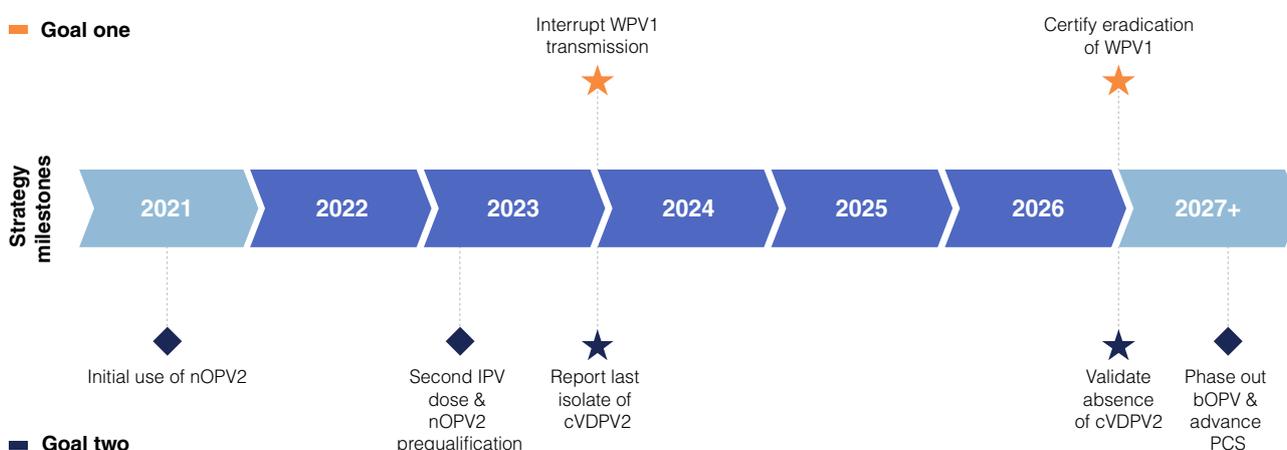
⁸ This attention to deprived communities where large numbers of zero-dose children reside is an opportunity for collaboration and efficiencies with Gavi. See Gavi, the Vaccine Alliance. Phase V Strategy (2021–2025). Geneva: Gavi, the Vaccine Alliance; 2019 (<https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025>, accessed 12 April 2021).

MILESTONES AND MEASURES FOR SUCCESS

The **Polio Eradication Strategy 2022–2026** has set aggressive benchmarks to measure progress towards eradication, which include interrupting WPV1 transmission (Goal One) and reporting the last isolate of cVDPV2 (Goal Two) by the end of 2023, with certification of WPV1 eradication and validation of the absence of cVDPV2 by the end of 2026 (see **Fig. 5**). Because of the unprecedented uncertainties and risks that the partnership faces, this timeline functions as a budget and planning tool and will require regular appraisal.

As the COVID-19 pandemic demonstrated, sudden and unexpected events can drastically set back progress towards GPEI goals. Emerging risks that may delay interruption and certification include: poor operational performance; lack of government engagement and commitment; waning donor confidence; and insufficient support in local communities and civil society. The GPEI will rely on a combination of strengthened and newly created accountability mechanisms (such as quarterly scorecards) to ensure that delays, challenges and areas of continued underperformance are expeditiously identified and corrected.

Fig. 5. Polio Eradication Strategy 2022–2026 planning and budgeting timeline



PCS = Post-Certification Strategy.
Source: WHO.

To track progress and adjust to unforeseen risks, a new Monitoring and Evaluation (M&E) matrix has been developed. The matrix uses quantifiable milestones, outcomes and key performance indicators (KPIs) to monitor progress, identify weaknesses and hold all partners, including governments and GPEI agencies, accountable for their commitments and responsibilities. A separate risk register maps interrelated threats to the success of the new strategy. To better integrate within global health monitoring, this M&E system contributes to and is aligned with the monitoring framework of the Immunization Agenda 2030 (IA2030).⁹

Global technical leads will regularly track M&E indicators and outcomes, and the Polio Oversight Board will review goal-level milestones on a quarterly basis.

Achieving the last milestones for WPV1 certification will mark the formal launch of the Post-Certification Strategy (PCS).¹⁰ Steps have already been initiated towards PCS implementation and include long-term integrated polio surveillance, response capacity, essential immunization and containment. Implementing and monitoring long-term poliovirus containment in facilities with appropriate safeguards will be key to maintaining a polio-free world. In 2015, WHO Member States committed to containing all type 2 polioviruses, including Sabin and Sabin-like strains, in designated poliovirus-essential facilities (PEFs). Similar commitments will be made for types 1 and 3. Facilities designated as PEFs will need to meet and maintain the required safeguards and allow periodic assessment by auditors and national authorities for containment.¹¹

Further preparations required in each of these strategic areas that are critical to sustaining eradication are outlined in the strategy and include transition planning for polio-free countries.

⁹ Implementing the Immunization Agenda 2030: Draft framework for action through coordinated planning, monitoring & evaluation, and ownership & accountability. WHO Immunization, Vaccines and Biologicals (IVB). Geneva: World Health Organization; 2020 (<https://www.who.int/publications/m/item/implementing-the-immunization-agenda-2030>, accessed 12 April 2021).

¹⁰ Global Polio Eradication Initiative. Polio Post-Certification Strategy. Geneva: World Health Organization; 2018 (<http://polioeradication.org/wp-content/uploads/2018/04/polio-post-certification-strategy-20180424-2.pdf>, accessed 12 April 2021).

¹¹ See GAPIII: WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use, third edition. Geneva: World Health Organization; 2015 (http://polioeradication.org/wp-content/uploads/2016/12/GAPIII_2014.pdf, accessed 12 April 2021).

ENABLING ENVIRONMENT

Successful execution of the **Polio Eradication Strategy 2022–2026** requires an enabling environment created through efficient operational structures, critical commitments to gender-responsive programming and operations, carefully managed vaccine supply, ongoing investments in research innovations, financial modelling and resource mobilization.

GPEI structure: Innovations and transformations within the endemic countries and outbreak regions will be accompanied by an evolution of the programme to a “regionalized” structure. Under this new strategy, the GPEI will streamline its organization and move decision-making authority closer to where programmes are implemented. National-, provincial- and district-level teams will receive staffing priority and determine field-level actions; regional offices will provide technical advisement and administrative and logistical support; and global offices will carry out research, define technical guidance, provide high-level advocacy, mobilize and manage resources, and provide assistance to regions and countries when local resources are insufficient to overcome a challenge. The updated structure will systematically bring in new partners where they have comparative advantage, as when Gavi joined the GPEI as a core partner in 2019 to support immunization outcomes. These organizational changes will also establish mechanisms to hold the GPEI, its partners and countries accountable for making progress.

Gender equality: Programmatic improvements, structural change and staff empowerment will be further advanced through continued implementation of the GPEI *Gender Equality Strategy 2019–2023*, which addresses gender-related barriers to vaccination and the empowered engagement of women.¹² The GPEI’s commitment to gender-responsive programming is well-aligned with IA2030 and Gavi’s Gender Policy;¹³ joint action on gender equality and immunization with key immunization partners will be critical.

Communications: Additional efficiencies have been achieved with the formation of the Global Communication Group, which bridges C4D, crisis and emergency risk communication and external communications. Since its creation, the group has developed and implemented tools, strategies and campaigns to engage key stakeholders, address vaccine hesitancy and misinformation, strengthen community engagement and vaccine demand, and manage the complex disease and vaccine narrative introduced by COVID-19.

Vaccine supply and research: Above all, eradicating polio requires a diversified and fully funded polio vaccine supply, composed of bivalent and monovalent OPVs to stop endemic polio transmission, mitigate the risk of transmission, and prevent and respond to potential outbreaks; a global stockpile of OPVs to respond to poliovirus outbreaks that may occur after global certification of WPV eradication and after OPV withdrawal from essential immunization; and inactivated vaccines to protect populations from polio-induced paralysis. Additionally, the GPEI will accelerate the development of novel OPVs types 1 and 3 and new IPV products and will continue to ensure that the GPEI’s containment management group has the necessary resources for the safe handling and storage of vaccine.

Finance and costing: Preliminary cost estimates to fully implement this strategy and achieve WPV interruption in two years project a US\$ 5.3 billion requirement over the next five years, which includes a US\$ 3.7 billion incremental budget increase (2022–2026). Key cost drivers include surveillance, outbreak response and preventive SIAs, integrated health services, vaccine supply, and the staffing of country, regional and headquarter offices. The timeline to interrupt transmission and the duration and scale of continued vaccine-derived poliovirus (VDPV) outbreaks are the riskiest assumptions within this estimate and, together, largely determine the trajectory of spend over the coming years.

¹² Global Polio Eradication Initiative (GPEI). *Gender Equality Strategy 2019–2023*. Geneva: World Health Organization; 2019 (<https://polioeradication.org/wp-content/uploads/2020/10/Gender-Strategy.pdf>, accessed 12 April 2021).

¹³ Immunization Agenda 2030: A global strategy to leave no one behind (IA2030). WHO Immunization, Vaccines and Biologicals (IVB). Geneva: World Health Organization; 2020 (<https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030>, accessed 12 April 2021). Gavi, the Vaccine Alliance Gender Policy, Version 3. Geneva: Gavi, the Vaccine Alliance; 2020 (<https://www.gavi.org/sites/default/files/programmes-impact/Gavi-Gender-Policy.pdf>, accessed 12 April 2021).

■ NEXT STEPS

This executive summary will be noted for the Seventy-fourth World Health Assembly in 2021, and Member States will be actively engaged through the Health Assembly in the finalization and rollout of the strategy, as it is set to begin in 2022.

The challenges of the next five years require utmost determination and unified commitments from GPEI agencies, governments and global, national and local stakeholders. Through an emergency focus and a more integrated approach to delivering critical health interventions to polio-affected and at-risk countries and regions, the GPEI will achieve a polio-free world – and remind the global community of the enormous achievements that can be gained through collaborative engagement and collective pursuit.



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