Report of the first stakeholder consultation on the draft polio Post-Certification Strategy

November 2017

Table of Contents

Introduction **2**

Consultation methodology **2**

Participants **3**

Structural changes to version 3.0 ..... **3**

Summary of feedback **4**

General document feedback 4

Goal 1: Contain Poliovirus 7

Goal 2: Protect Populations 9

Goal 3: Detect and Respond 13

Enabling and Cross-Cutting Areas 16

Annex **20**

PCS consultation: Feedback form for Version 2.5 (August 2017) 20

Introduction

The Polio Post-Certification Strategy (PCS) is being developed to define the global technical standards and functions that will be needed to sustain a polio-free world after global certification of wild poliovirus eradication. The development of the PCS was initiated in early 2017 and will be presented at the World Health Assembly in May 2018.

Development of the PCS is being led by a multi-partner expert working group, through a year-long iterative process. A timeline for the development of draft versions of the document throughout the year was created, which included various periods set aside for inputs and stakeholder consultation.

As part of the PCS development plan, the team reserved the month of August 2017 to solicit feedback on draft version 2.5 from an initial group of key stakeholders. These consultations had three main objectives:

1. Invite major polio and immunization stakeholders to input on the draft strategy
2. Engage a range of audiences with varying types of expertise
3. Build a general level of awareness within the global health community that this document is under development and will set general program directions for polio in the post-certification era

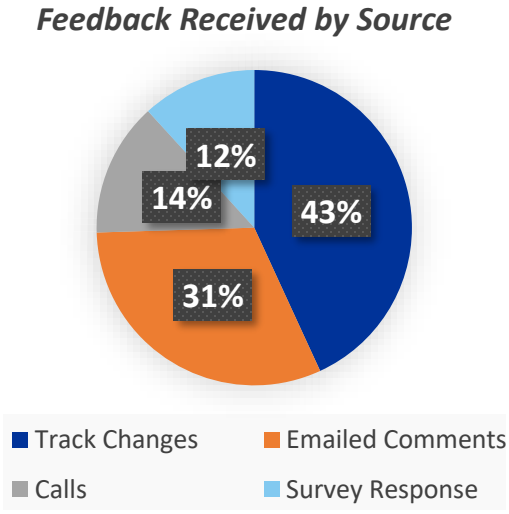
This report provides an outline of the consultation process, stakeholders who were invited to comment, a summary of feedback received, and responses from the authors and content owners of the Strategy in relation to key points raised and questions asked.

Consultation methodology

Feedback on draft 2.5

Each stakeholder identified to participate in the consultation process received an email that included a short description of the purpose of the PCS, the timeline for the consultation process, and draft 2.5 of the PCS. The stakeholders were asked to provide feedback in one of the following formats, of their choice:

- Share comments and feedback via email
- Submit a marked-up version of the draft with track-changes
- Complete an online survey form, responding to a series of questions (refer to the Annex)
- Participate in a webinar or teleconference



In addition to written feedback, importance was placed on facilitating a discussion on the PCS with stakeholders, to resolve any immediate clarifications or questions, and to take added inputs. Accordingly, stakeholders were invited to engage directly with PCS team members on one of several

conference calls, including two webinars that were scheduled to accommodate individuals across multiple time zones.

Each piece of feedback received was added to a general tracking sheet and reviewed by the "content owner" to which it pertained. In areas where questions arose or additional follow-up was necessary, each content owner was responsible for liaising with the individual who had raised the point.

Next steps

The GPEI Strategy Committee (SC) provided their guidance and direction on the stakeholder feedback received at an in-person meeting on 12 September 2017. The PCS team met in-person on 13-14 September 2017 after the SC meeting to discuss and agree on the major points raised in the feedback. The next version of the PCS document (version 3.0) was released alongside this report and is currently available for review.

Participants

The PCS team engaged a wide-range of stakeholders, identified by the GPEI Strategy Committee, to participate in this initial consultation. Overall, the team received feedback from 50+ respondents. Participants included:

- Major donors (Norway, UK, USA, EC, World Bank, UAE, Germany, etc.)
- Polio Partners Group (PPG) co-chairs
- Transition Independent Monitoring Board (TIMB) members
- Global Commission for Certification of the Eradication of Poliomyelitis (GCC)
- Strategic Advisory Group of Experts on immunization (SAGE) chairs (incl. SAGE Working Group on Polio)
- Disease modeling agencies (Kid Risk, Imperial College, Institute for Disease Modeling)
- Gavi, the Vaccine Alliance
- Eradication and Outbreak Management Group (EOMG)
- Global Polio Eradication Initiative (GPEI) partnership agencies, including World Health Organization (WHO) and United Nations Children's Fund (UNICEF) regional offices
- Relevant departments from WHO, including Immunization, Vaccines, and Biologicals (IVB)

Thank you to all stakeholders who contributed their time and thoughtful inputs to this process.

During the next phase of consultation in November 2017, an expanded and more comprehensive group of stakeholders will be offered an opportunity to provide input.

Structural changes to version 3.0

In preparation for the release of version 3.0 of the PCS, the team made several major changes to the document based on feedback from stakeholders and input from the Strategy Committee (SC). These changes are outlined below:

Shortening the document: The context and background sections of the document were shortened significantly, and the team conducted a significant editing process to condense the language and avoid repetition throughout the document.

Writing the executive summary: An executive summary was added to clearly communicate the strategies detailed throughout the PCS. This summary includes information on: purpose/scope of the document, timeline, risks, goals, cross-cutting factors, and a call to action.

Removal of Implementation Guidance: Implementation components of the PCS (e.g. indicators, monitoring, challenges to implementation) have been removed from the document. The SC determined that the GPEI is not best placed to develop the implementation elements of the strategy. This work will, ideally, need to be led by the future owners of the PCS strategy with the GPEI supporting those groups.

Financial model: The PCS no longer includes information on future financial requirements. The financial model itself was removed from the PCS and will act as a standalone initiative.

Governance and Management: The PCS no longer outlines general principles for governance and management. Those details will need to be led by the future owners of the PCS to define and develop implementation plans with support from the GPEI.

Summary of feedback

General document feedback

Feedback summary	Details	PCS response
The document's length can inhibit its effectiveness	The document was too long to be effectively understood. The many technical aspects of the plan overshadowed what the overall requirements of each goal were.	The PCS team utilized several fixes, including using an executive summary to provide a non-technical summary of the strategy and shortening the document by replacing the technical background information in the draft with references to other technical documents.
	Readers who came from policy backgrounds desired a short and succinct section of the document that they could easily engage with and use to inform their advocacy plans.	
Provide more information on implementation planning	Clarify intersections / synergies between the PCS and overall polio transition planning (e.g. the ramp down to eradication).	The GPEI SC decided to remove the implementation elements from the document because it will require input and support from the future owners of the PCS functions which will not be the GPEI partnership. The cross-cutting enabling section has been removed. The introduction includes a section that explains the implementation
	Add more clarification around when and how the PCS implementation planning will be managed.	

Feedback summary	Details	PCS response
		planning and next steps that need to come after this document. It clearly states the responsibility of other groups and organizations outside of the GPEI as well as how it will need to be updated.
Address functions not required for polio after certification	Even if the specific details are not included, the PCS should acknowledge that some polio functions not critical to sustaining eradication may want to be continued after certification through other health initiatives. Failure to maintain some infrastructure that the polio program has helped develop could lead to substantial "missed opportunities".	Acknowledged, the functions are not required for polio after certification and it should be the health initiatives that use these functions to assess the impact and determine how best to address the gaps when polio resources will no longer be available.
Better definition of global certification	Stakeholders wanted clearer communication on whether VDPVs were included in certification and the reasoning behind the decision.	There will be two stages to reaching a poliovirus-free world. The GCC determines specific criteria for certification of WPV eradication which is the first stage. The second stage will be to ensure absence of VDPVs after OPV withdrawal is completed. The SC is exploring separate communications to clarify this more formally.
Elaborate on communications needs	The PCS should highlight communication needs (surveillance, risk communication, social mobilization, etc.) and how those will differ in the post-certification era.	Broad communications needs are noted, but specific strategies will be determined during implementation planning.
GHSA inclusion	Some respondents felt that PCS should be explicitly linked to GHSA (not just IHR) when discussing global frameworks for implementation, but some held the contrary view that all references to GHSA should be removed.	GHSA is included in the PCS with regard to the role that it has for external evaluation of gaps, strengths in national capacity to detect and respond to global health security threats.
Undetected WPV circulation	The PCS should acknowledge a risk of ongoing, missed WPV circulation at time of certification as well as	Undetected transmission is now included as a specific risk category. The GCC will determine specific surveillance criteria for certification.

Feedback summary	Details	PCS response
	intentional release and catastrophic outbreak.	
Bring assumptions forward	The document's assumptions should be moved from the annex to one of the front sections of the document.	Major overarching assumptions are noted in the introduction. Other assumptions have been integrated into the individual goal sections where relevant.
Country decision making	Highlight risk that countries may make rational decision not to invest in IPV or other polio-specific mitigation measures.	Individual country decision making responsibility is noted in the PCS. The PCS team will coordinate with the CPTT to craft country-specific communications detailing the risks and benefits of long-term use of IPV in RI.
Country risk level	Highlight that country risk is dynamic and differs by PV category.	This has been further clarified in v3.0.
Future reviews of recommendations	Recommend that a review be conducted at a certain point in time (3-4 years after certification?) to assess what is working and what is not working.	The PCS is a 'living document' and proposes periods of review, noting that these will ultimately be decided, initiated, and implemented by the future owners of the PCS.
PCS governance	Modeling groups should be imbedded into future PCS advisory and decision-making bodies.	Specific membership and roles for future governance remain to be determined. Modelers may provide relevant inputs but their stake in future outcomes will be different than other decision-making bodies. They should continue to be consulted in the future. This will need to be resolved by the future owners of the PCS implementation effort.
Funding prioritization	PCS (or separate document?) should prioritize program areas for legacy funding; suggest surveillance, nOPV, and stockpiles.	Broad funding priorities are already noted by the proposed PCS strategies. Further prioritization will depend on separate resource mobilization plans and donor agendas.

Goal 1: Contain Poliovirus

Feedback summary	Details	PCS response
GCC/RCC/NCC roles	The PCS needs to discuss the roles and timeline of GCC, RCC, and NCC in containment.	The role of GCC and RCC is now included in 'Activity 1.1.1 – Support the global reduction of facilities retaining poliovirus'. However, these groups will ultimately need to determine their future mandates. We will ask for guidance from the SC on potential roles in oversight of containment activities.
Confusion over containment phases	The status of implementation of containment phases caused confusion and possibly doesn't align with reality.	The graphic and detailed description of GAPIII containment phases has been removed.
Activities I and II	Many groups believed that it is unrealistic that activities I & II will be completed by certification.	The assumption has been changed to address the reality that containment activities are not progressing at the same pace globally, and that, at the time of writing this draft, the GCC had not yet reached a decision on the containment requirements to be in place before certification.
Role clarification	Clarify who will be focal person for containment at country level / link with OB response teams.	Information related to country management and governance is beyond the scope of the PCS, because it requires input and support from the future owners of the post-certification polio functions.
	Include clarification of roles for verification of outbreak finished, removal of mOPV and containment re-instated.	The activities and international oversight bodies involved are now presented more clearly in the text and in a table.
Compliance risk	Compliance may not be good when monitoring containment is left up to the countries.	The GCC-WG (reporting to the GCC) will be an oversight body, and GCC presenting non-compliant facilities to the WHA will be used to enforce country accountability and compliance. The PCS team will consult with other groups to see what else can be added to minimize this risk.
	To make countries accountable for containment, the PCS team should research what international binding law or convention would make state parties accountable for endangering national and global security.	

Feedback summary	Details	PCS response
	National authorities will need to license all PEF facilities to enforce compliance.	The role of National authorities (NACs) overseeing the issue of certificates of containment to PEFs after passing audits is explained, but specific regulatory procedures to enforce compliance at the national level are out of the scope of the PCS.
Emphasize reduction in PEFs	The document should put more emphasis on reducing the number of polio-essential facilities. There is currently no activity related to this in the PCS.	The document now emphasizes this point by including the reduction of facilities as an activity instead of a strategy.
Emphasize training	The document should place more emphasis on education/training/risk mitigation measures.	This was added as new sub-activity to core activities (reduce facilities, support and monitor compliance).
Future facility checks	Continuous searches for poliovirus materials post-eradication should be included as an activity.	Future checks of PEFs are included in the document as inventories are updated after bOPV cessation, any outbreak occurs, or other triggers happen.
Laboratory risk	Include laboratories as a category of risks of PV re-emergence in introduction.	Laboratories are included in 'Risk Category #1: Unsafe handling of any polioviruses'
Containment indicators	The percent of PEFs renewing CC every 3 years is an unclear indicator because the number of PEFs may vary from year to year.	This indicator has been removed.
IPV production risk and new vaccines	At some point (5-10 years) sIPV production in low-hygiene settings may become a risk greater than wIPV production in high hygiene countries. Ideally the tertiary requirement should kick in also for handling OPV at that point.	On sIPV production, the PCS cannot change GAPIII specific guidelines, but this question could be brought up to the CAG for discussion to decide whether GAPIII needs to be revised.
	The document should further highlight shift to VLP for IPV production as well as importance of nOPV.	The research section includes an emphasis on the importance of VLP.

Feedback summary	Details	PCS response
bOPV vs tOPV withdrawal	We know now that not all tOPV was withdrawn and some tOPV has been used after the switch. Will anything be done differently for bOPV withdrawal?	Goal 2 notes that lessons learned from tOPV switch will be applied to bOPV withdrawal. The coordination of containment with group doing sweeps is also proposed.
Sample destruction	More thought needs to go in destruction of samples after outbreaks because labatories destroying samples to comply with containment may cause missing evidence of transmission.	The need of coordination between staff doing containment activities after an outbreak and outbreak response is included in the text.
Relation to Goal 3	Relationships to goal 3 and the co-evolution of the surveillance and the containment system may need to be considered.	A table showing the different links between surveillance and containment is now included.
Include Sabin	Review activity 1.1.1 to include all poliovirus, not only Sabin.	This change has been made.
CAG	CAG should not be mentioned post-certification.	The SC mentioned in previous revisions of the PCS that CAG was likely to continue for some years post-certification.
Vaccine manufacturers	The PCS team should add a paragraph about specific requirements for vaccine manufacturers in context.	This paragraph is not included to avoid excessive length.

Goal 2: Protect Populations

Feedback summary	Details	PCS response
bOPV cessation process changes	The team should consider switch from bOPV to mOPV1 before final cessation.	There are financial (e.g. bOPV already procured), technical (e.g. very few VDPV3s), and practical (e.g. laborious and costly to conduct withdrawal) reasons which justify not transitioning to mOPV1 before bOPV cessation.
	Countries will be reluctant to withdraw bOPV unless IPV supply is available, which makes IPV supply a prerequisite to the bOPV withdrawal.	SAGE and GPEI leadership will need to determine the specific readiness factors for cessation – this will not be ready in time to include in the PCS.

	Control of cVPDV outbreaks should be clearly identified as a precondition for bOPV cessation.	Control of persistent cVDPV outbreaks is already identified as a key readiness criteria for cessation – further specifics remain to be determined by SAGE and GPEI.
	Countries should be actively discouraged from withdrawing bOPV before global cessation (or at least should understand the risks).	The PCS already recommends global synchronization, and additional communication for countries will be developed separately. Synchronized cessation is required to protect countries without strong population mucosal immunity from importations.
Inconsistent IPV recommendations	There is inconsistency between GAPIII and SAGE recs for IPV.	The document now clarifies differences between GAPIII and SAGE recommendations.
	The PCS should set IPV coverage target.	Seroconversion reflects required levels of immunity. Coverage targets are set by GVAP.
More information on fIPV strategy	Costs, resources, and clear public strategy communication for implementing fIPV should be identified.	These costs will need to be determined as countries decide if they will pursue fractional or full dosing. The PCS does not provide specific costs or resourcing estimates. SAGE recommendations for IPV and fIPV are noted. The need for communication on fIPV use is noted, but details on communication strategy are beyond the scope of the PCS.
	The PCS should provide more references to justify the use of fIPV.	For references, see Estivariz CF, et al. Poliovirus vaccination options for achieving eradication and securing the endgame. Current Opinion in Virology 2013, 3:309-315. These are also now noted in the PCS.
	The use of fIPV could be affected by country decisions to go with combination vaccines, and this would affect overall vaccine demand estimates.	The vaccine demand section notes impact of combo or fIPV use.
Pre-cessation SIAs	The PCS should clarify whether funding and vaccines will be available to support pre-cessation SIAs.	Funding responsibility will be decided by the GPEI and future owners of the PCS.

	The plan should consider using both IPV and bOPV for pre-cessation SIAs in inaccessible areas.	Additional use of IPV for pre-cessation SIAs will have to be part of specific future guidelines and based on individual country situation and available IPV supply.
	The document should include how pre-cessation SIAs will be monitored.	There are standard monitoring tools for assessing SIA coverage, but specifics will be part of future implementation guidelines.
	The data from the SIAs prior to the tOPV-bOPV switch should be examined to determine whether the SIAs might increase the risk of cVDPV post-cessation. If there are any doubts, modify w/recommendations that are less prescriptive.	To counter the well-known risk resulting from poor SIAs, the PCS highlights the importance of quality rounds. The PCS team is working with the CRTT that is reviewing the data and lessons from the switch.
Long-term EPI	The PCS should advocate for IPV use to be part of EPI indefinitely.	Countries make national EPI vaccine decisions. Risk data justifies recommendation for IPV use for minimum of 5-10 years.
Two dose IPV schedule	The plan needs further justification for long term 2 dose IPV schedule.	Research study results on the duration of long term immunity from proposed IPV schedule should be available within 1-2 years.
	How does the SAGE two dose recommendation apply to combination vaccine?	Applying SAGE recommendation to combination vaccine needs further review.
Risks communication	The PCS should include a communication strategy outlining long term risks to polio-free world. These risks should be included in the regular curriculum of medical, public health and nursing schools.	The communication strategy will be part of the advocacy and RM plan and the inclusion in school curriculum should be part of the PCS implementation plan.
Emphasis on Lake Chad	The PCS needs to put emphasis on the special scenario of Lake Chad region.	The need for regional approaches to surveillance and response is already part of the PCS. Lake Chad is used as an example.
More information on coverage requirements	Consider making 90% IPV coverage a requirement for district level target not national.	CAG to consider refining coverage requirement, especially for large countries.
	The document needs to include the level of population immunity needed	SAGE has suggested a target of 90% seroconversion which can be attained

	to stop circulation, and what national and district-level coverage that translates into (with the appropriate number of IPV doses).	through the recommended 2 dose schedule. Population immunity required to stop circulation can vary by specific risks for transmission, local environment, etc. GVAP sets coverage targets.
	What is the scientific rationale for 90% seroconversion or 90% coverage targets? What are the consequences for not achieving them?	These are based on programmatic considerations and prior experience. Additional references are now provided for justification of 90% target. Consequence is increased risk for PV emergence and/or transmission.
Commitment to routine immunization	There should be an ongoing commitment to strengthening RI to ensure no poliovirus circulation until IPV is no longer used.	Strong RI is critically important but specifics on strengthening RI are beyond the scope of the PCS.
'Catch-up' IPV	There is an unfinished policy decision regarding the need to provide 'catch-up' IPV for cohorts which have received only 1 dose of IPV prior to cessation.	Catch-up policy to be addressed by SAGE in upcoming meeting and will be included in the PCS when available.
IPV financing	Sustainable financing for IPV should emphasize national responsibilities and role of NITAG.	The PCS already notes national responsibility for IPV decision and funding. Gavi can provide financing option for LICs. Potential mechanisms to lower costs for MICs are already noted in the PCS. NITAGs usually makes decision on vaccine introduction based on technical grounds and may consider cost/benefit; it's up to MoH and governments to make the final decision.
Vaccine coverage guidance	Consider referencing new vaccine coverage guidance. MR serosurvey guidance coming out would be similar to polio in terms of things to consider.	Additional implementation is beyond the scope of the PCS, but we can refer to other relevant guidelines.

Goal 3: Detect and Respond

Feedback summary	Details	PCS response
Sustain active surveillance	Active AFP surveillance should be sustained indefinitely—at least for high risk areas—in order to provide a foundation for other VPDs and ensure adequate sensitivity.	Proposed surveillance approach balances risk and practicality. While recognizing that the extent of the current polio surveillance system cannot be sustained everywhere, the premise of the PCS is that the goal is an integrated system. It is up to each country to determine how best to implement this goal.
	There is concern that high-risk countries will not be able to attain an AFP rate of 2/100k using just passive surveillance at Stage III as currently recommended in the PCS.	A historical review of certified regions indicates that >80% of countries have regularly attained ≥1/100k (and most at or near 2/100k) with passive surveillance. The future situation for high risk countries will need to be monitored, and risk tolerance levels will determine whether there is a need to continue active surveillance.
Roles of GPLN, RRLs, NPLs	Outbreak response ownership and funding are not clear. The document should define future roles of GPLN, RRLs, NPLs.	Outbreak response is clearly a national responsibility; vaccine and TA support will be provided as required. Further monitoring and coordination mechanisms at global/regional levels will need to be identified as part of implementation planning. General laboratory functions are already noted in the PCS. Specific roles will be articulated in the GPLN strategy which is currently being developed.
Country capacity concerns	Skeptical whether many countries will have the capacity or meet even minimum IHR requirements; concern that surveillance quality cannot be sustained as integrated system.	Strong RO and global support will be necessary for countries unable/unwilling to meet standards.
	Reliance on global "Expert Review Committees" in the future as proposed by PCS is unrealistic since workload for high-risk countries may still be quite large.	Future Expert Review Committees will be needed at national level in some countries and regional level in high risk areas.

Reliance on new surveillance types	Stakeholders questioned the PCS's reliance on environmental surveillance since it is not applicable in all situations.	The PCS recognizes the variability of ES sensitivity and applicability.
	Want the document to provide more details on how the re-defined surveillance paradigm will be carried out in the post eradication era.	Surveillance implementation is beyond the scope of the PCS.
	Additional surveillance activities for security compromised populations should be added from recent meeting in Nairobi.	The need for supplemental surveillance strategies is noted in the PCS, but specific tactics will be detailed in the Global Polio Surveillance Action Plan.
	It is premature to identify event-based surveillance as an essential strategy.	EBS has not been fully developed for poliovirus surveillance to date but is a core strategy of implementing IHR requirements and should be an adjunct tool for the future.
Add training details	Rapid Response Team (RRT) needs periodic training.	RRT training should be built into each country's polio response plan.
	The PCS should recommend developing a training plan during the transition period up to certification in order to strengthen national capacity to take on detect and respond responsibilities.	National capacity training is an interesting idea that should be included in transition plans, but it is outside the scope of the PCS.
More tailored outbreak response	Post-certification outbreak response parameters (e.g. # of SIAs, scope) should be decided at national level. The response should be more context-specific (e.g. may not be appropriate for aVDPV?).	Specific guidelines will be developed later, but each response will need to depend on context.
	The document should further highlight that post-certification immunity levels will decline rapidly to unprecedented low levels, and, thus, the team should consider the need for very large-scale responses and even OPV re-start.	The PCS notes that future outbreaks will potentially require larger outbreak responses. Drop in immunity levels is noted. Potential need for re-start will be included in the section on stockpiles.
Refine risk criteria	Country risk classification criteria need to be further explained. Other risk factors may come into play (such as	The country risk criteria were revised for v3.0.

	proximity to countries with VDPV, serotype-specific mucosal immunity).	
	Country risk classification for iVDPV should use prevalence of consanguinity since PID data is unknown in most areas.	The specifics on iVDPV risk categories remain to be determined and were removed from v3.0, but we agree that consanguinity is a valid criterion.
	Country risk assessments should be done at global/regional levels.	Countries (along with regional input) should accept primary responsibility for risk assessment.
	Measles outbreaks should be included as an indicator of PV risk.	Measles outbreaks may indeed be a signal of potential risk for PV (e.g. low coverage) and relevant for countries with poor sanitation, but may not be relevant everywhere, e.g. Europe – which has seen its share of measles outbreaks but is not a high risk for polio.
Preserve surveillance data	"Information management" should be strong on strategies that need to be taken to ensure that surveillance data post certification will be robust.	Information management strategy is further detailed in v3.0. Initial responsibility is at the national level but further data requirements will depend on monitoring responsibilities.
	POLIS should be continued.	
Stricter surveillance criteria	High risk countries (or at least high risk sub-national areas) should have markedly higher expected AFP surveillance standards (e.g >5?).	It may not be realistic to expect even higher levels than current standards; it will be more effective to rigorously monitor high risk countries to meet proposed standards.
	High risk countries should have 'accredited' EOCs, with accreditation criteria including AFP surveillance targets met.	The PCS uses an IHR framework which requires a country to set up an EOC when a PHEIC is detected. County level decisions on how they want to implement their responsibility to detect PV is up to them. Some high-risk countries may have ongoing EOCs at the national or provincial levels which could routinely monitor AFP surveillance targets.
	Future accreditation and laboratory monitoring indicators will need to become even more stringent.	Specific laboratory standards will need to be determined by the GPLN.
Laboratory assays	Laboratories should move away from neutralization assays (which require	The research section notes that work on developing new detection

	live virus) to use of 'pseudo-virus' or 'replicons' as well as with POC testing which can be utilized at district hospital levels.	techniques that will make detection more rapid, efficient, and safer.
ISTs for TA	ISTs should be more involved and should be the first to respond for providing polio specific TA in AFRO for both surveillance and response.	While agency specific roles in the future have not been determined, the PCS does already recommend a role for sub-regional support capacity in high risk areas.
Add implementation guidance	The process / roadmap and steps for a successful transition from vertical to integrated AFP surveillance could be better described.	Details on the implementation process are beyond the scope of the PCS.
	Add recently published WHO guidance on planning and implementing immunization in humanitarian emergencies.	The WHO guidance has been added as a reference.
Containment breach expectations	Countries and facilities rather than GAPIII should provide clear expectations for response to containment breach.	GAPIII provides broad guidance for facility management but individual country regulatory authorities will need to define specifics. Similarly, WHO is developing guidelines for public health response to a containment breach due to the global implications of inadequate national policies.

Enabling and Cross-Cutting Areas

Please note all areas in grey text in the table below are no longer addressed in the PCS document. The SC determined after reviewing all the feedback from the stakeholders that the GPEI is not best placed to even loosely develop the implementation elements of the strategy. This work will, ideally, need to be led by the future owners of the PCS strategy with the GPEI supporting these groups.

Feedback summary	**Details**	**PCS response**
Accountability	Strong governance and accountability is critical for implementation success.	No longer included in the PCS – please see "Structural changes to version 3.0" above
More detail around	Need to have well-defined governance structure to coordinate surveillance,	

Feedback summary	Details	PCS response
governance structure	outbreak response and ongoing support to countries.	No longer included in the PCS – please see "Structural changes to version 3.0" above.
	There is a mismatch between GPEI wind down and the realities of competency required post certification.	
	The document needs to say who will monitor national competency and specifically define who will take on all global and regional responsibilities.	
	Is WHO expected to be implementer of 'last resort' if country does not have sufficient capacity to sustain required surveillance?	
Funding for country level activities	The strategy does not clearly state what is not included or not funded – should an assumption be made that activities at the country level are funded elsewhere? This risk needs to clearly be called out.	No longer included in the PCS – please see "Structural changes to version 3.0" above.
	There is a "moral obligation" with countries where a significant part of the health system is financed by GPEI. It becomes a question of whether the world has a duty in these cases with some responsibility resting at a global level to continue to support fragile countries.	No longer included in the PCS – please see "Structural changes to version 3.0" above.
	There is need for specific resource mobilization for social mobilization, nomadic tracking, and communication networks in high risk countries.	
	The document should clearly identify who will provide support (or implement) required activities if countries either do not have the capacity or choose not to carry them out.	

Feedback summary	Details	PCS response
Additional country plans	Does GPEI have a process to make sure every country has a plan for those needed activities and to mobilize resources to fund them before it ramps down? Currently, only 16 countries are doing the transition. What will happen to others?	The PCS will coordinate with the CPTT for communication to countries.
Future of PCS	Who will be the future owners of the PCS?	No longer included in the PCS – please see "Structural changes to version 3.0" above.
	How will IHR supervise implementation of the PCS?	No longer included in the PCS – please see "Structural changes to version 3.0" above.
Clarify finance model structure and adjust inputs	Need to be clear when we say that elements of the model are "bottom up" – it may be operationally "bottom up", but not from a country-perspective (this can be confusing to readers).	No longer included in the PCS – please see "Structural changes to version 3.0" above.
	For those activities covered within the model, the PCS should clearly differentiate between country-level costs vs. regional/global costs.	
	The cost estimation should include global and regional plus funds to support a limited number of fragile countries.	
	The PCS should include / reference relevant costing tools for country use.	
	It is challenging to build detailed estimates for the major activities for which detailed guidelines (such as AFP surveillance) have not yet been defined. The alternative, using the current planned trajectory to guide the spending ramp is also likely problematic for countries.	

Feedback summary	Details	PCS response
Research additions	Social and behavioral research should explore people's beliefs, attitudes and practices with regards polio and other immunizations before and after certification.	Social and behavioral research is noted in the 'Other Considerations' section of Research Activities.
	Place further emphasis on long term reliance on nOPV for future outbreak response.	The importance of nOPV is noted in the research section and has been highlighted in the response section.
	Post cessation poliovirus IgA could be used as a marker of exposure to live polioviruses.	The cost/benefit of adding the IgA laboratory test was considered as a potential research area.
	Direct detection can detect poliovirus genetic material in cell culture negative samples and, therefore, on average they can be more sensitive.	When/where to potentially use direct detection needs further discussion by SC and GPLN. This depends on risk tolerance as well as cost/benefit analysis.
	It is worth referring to some of the innovations likely to become available in a shorter time frame in the relevant sections under the other goals to provide an indication of likely changes that could take place (referring to the R&D section for details) and their impact on the PCS.	The team has considered incorporating innovations in each goal section as the editing process allowed.
	Include research on expanding current technologies recently introduced for surveillance and SIAs (e.g. GIS).	
Advocacy and resource mobilization	The advocacy section should bring out issues of public information more generally. The team could consider making this section more high-level and strategic rather than operational.	No longer included in the PCS – please see "Structural changes to version 3.0" above.

Annex

The form below was provided to stakeholders to offer a structured format for any feedback. This approach also allowed content owners across each section of the PCS to flag areas on which inputs were specifically sought.

PCS consultation: Feedback form for Version 2.5 (August 2017)

Introduction

The Post-Certification Strategy (PCS) is being developed to define the global technical standards (or "polio-essential functions") that will be needed to sustain a polio-free world after global certification of wild poliovirus eradication. The development of the PCS was initiated in early 2017 and will be presented at the World Health Assembly in May 2018.

At this stage, the document is still very much a draft with some placeholders but contains most of the major components. We want to share this version for your review and comments to help inform the final version. The document will be revised based on the inputs received, and an updated version will be recirculated, before being submitted to the Polio Oversight Board for their review at the end of the year.

This form is provided to help guide and structure the inputs that are being gathered through this current consultation. Kindly note that inputs provided will not be linked to any specific individual or organization, but will be consolidated and considered together.

Thanks in advance for your time and contributions.

General

1. Which of the following groups do you represent?

    a) Country: government
    b) Country: partner organization
    c) Regional office
    d) Donor
    e) Global: Polio-related organization
    f) Global: Non-polio related health organization
    g) Global: Oversight or expert body
    h) Other (specify)

2. Are there additional topics you want covered in the document? Are there topics you would recommend removing?

3. Does the Strategy appropriately reflect risks in the post-certification era? If not, which ones would you suggest including and/or removing?

4. Do you have any general comments on the Strategy? If yes, please describe below.

5. Would you like to provide feedback on any of the specific Goals or Sections of the Strategy? If yes, please continue to the next section.

Goal One – Contain Poliovirus Sources

1. Do you think the strategies described in Goal 1 would help ensure a polio-free world in the post-certification era? If not, what additions or modifications would you suggest?

2. Do you think the risks described in Goal 1 address the key issues around containment? If no, what other risks do you think should be considered to adequately address containment issues?

3. Do you have any general comments on Goal 1 – Contain Poliovirus Sources? If yes, please describe below.

Goal Two – Protect Populations

1. What additional strategies could be included in Goal 2 to help protect populations in case of re-emergence in the post-certification era?

2. Do you think the risks described in Goal 2 address the key issues in protecting populations? If no, what other risks do you think should be considered?

3. Do you have any general comments on Goal 2 – Protect Populations? If yes, please describe below.

Goal Three – Detect and Respond

1. Do you have a clear understanding of how the polio surveillance paradigm will change from the pre-certification to the post-certification era? If not, what additional information (e.g., more description in the body of the text, modifications to Table 5, etc) would be helpful to improve your understanding?

2. What are additional surveillance strategies to include in Goal 3 to ensure a polio-free world by rapidly detecting re-emergence of poliovirus and/or introduction by containment breaches?

3. Do you think the challenges described in Goal 3 address the key issues around surveillance? If no, what other challenges do you think should be considered to adequately address surveillance issues?

4. What additional response strategies could be included in Goal 3 to ensure a polio-free world by ensuring timely and well-coordinated outbreak response activities?

5. Do you think the challenges described in Goal 3 address the key issues around outbreak response? If no, what other challenges do you think should be considered to adequately address response issues?

6. Do you have any general comments on Goal 3 – Detect and Respond? If yes, please describe below.

Enabling and Cross-Cutting Areas

<u>Research Activities</u>

1. Are the descriptions and information provided of the current and future activities adequate to understand how these will help maintain a polio-free world?

2. Do you have additional comments on the Research Activities section? If yes, please describe them below.

Future Financing Needs

1. Do you have any specific feedback on the approach used to estimate the financial resources that will be required to ensure sustained eradication?

2. While there are a number of placeholders for activities and data that are still taking shape, does the outline presented include the elements you agree are needed to put the financial requirements in proper context for the various stakeholders? If not, what additional topics do you feel need to be addressed in this section?

3. Do you have any additional comments on the Future Financing Needs section? If yes, please provide them below.

Advocacy and Resource Mobilization

1. What information and/or strategies will be important to include in this section to generate the support required to absorb the polio essential functions into other health initiatives and have the necessary financial support.

2. Do you have any additional comments on the Advocacy and Resource Mobilization section? If yes, please provide them below.

Optional: Respondent Information

1.Name

2.Organization

3.Email