POLIO GLOBAL ERADICATION INITIATIVE

Sustaining a Polio-free World: A strategy for long-term success

Stakeholder consultation report

June 2025

Contents

INTRODUCTION

Sustaining a Polio-free World: A strategy for long-term success defines the global technical standards that will be needed after certification of the eradication of wild poliovirus type 1 (WPV1) and the elimination of circulating vaccine derived poliovirus type 2 (cVDPV2). This technical strategy supports the integration of polio-essential functions into national governments and other health and immunization programmes with the support of agency partners.

The first version of the strategy was noted at the Seventy-first World Health Assembly in May 2018 under the title *Polio Post-Certification Strategy* (PCS). Since then, many changes have necessitated a revision of the document. A team was assembled in 2024, with a first draft (Draft 1) socialized in September 2024. This report provides an overview of the consultation process, presents changes that have been incorporated and summarizes responses to stakeholder feedback.

Why revise the *Polio Post-Certification Strategy*?

Several developments prompted revision of the strategy.

- ***A new GPEI Polio Eradication Strategy***: In 2020, changes to the epidemiologic landscape prompted the GPEI to redefine the path to through two goals: certification of WPV1 eradication and certification of the elimination of cVDPV2. Later in 2024, the Polio Oversight Board approved an extension of the strategy to cover the period from 2022–2029. The strategy for *Sustaining a Polio-free World* aligns its goals and objectives with the eradication strategy to ensure a continuum of planning to achieve and sustain a polio-free world.
- ***New technologies:*** The revised strategy incorporates the novel oral polio vaccine type 2 (nOPV2), which was rolled out in 2021, and the hexavalent vaccine, which received Gavi Board approval in 2023. Additional tools, such as other novel vaccine types and direct detection, are anticipated during this strategy.
- ***New frameworks:*** The revised strategy is also informed by new and updated frameworks: the Immunization Agenda 2030 (IA2030), Gavi 6.0, the Emergency Response Framework (ERF), the Health Emergency Preparedness, Response and Resilience (HEPR) platform, amendments to the International Health Regulations (IHR) and the Lusaka Agenda.
- ***Changes to global health:*** Since COVID-19, global health has undergone seismic shifts. An increase in outbreak-prone diseases, rising health hazards due to climate change and steep challenges in fragile and conflict-affected areas increase vulnerability to polio. Furthermore, the recent withdrawal of assistance by donor governments has contributed further shocks to the aid ecosystem that historically has supported global health initiatives, including polio eradication.

Strategy revision working groups	
OPV cessation	Concepción Estívariz (CDC) Ondrej Mach (WHO)
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What is the timeline for the strategy for *Sustaining a Polio-free World*?

The revision process included multiple rounds of feedback and revision. After Draft 1 was shared with a broad set of stakeholders, the team addressed all feedback and shared an updated version of the report with the Strategy Committee (Draft 1.5) and Polio Oversight Board (Draft 2). Draft 3 will be shared with Member States and regional bodies in June 2025 (see **Next steps**).

PARTICIPANTS

A wide range of stakeholders, identified by the GPEI Strategy Committee, were engaged to review a revised Draft 1. ***Thank you to all who contributed their time and thoughtful input to this process.***

- Chinese Center for Disease Control and Prevention
- Civil society organizations (CSOs) via the United Nations (UN) Foundation and Gavi, the Vaccine Alliance
- Disease modelling agencies: Imperial College, Institute for Disease Modeling, Kid Risk and the London School of Hygiene and Tropical Medicine
- Gates Foundation teams, including Immunization, Polio, Vaccine Development, and Policy, Advocacy and Communications teams
- Gavi, the Vaccine Alliance
- Global Commission for Certification of the Eradication of Poliomyelitis (GCC)
- GPEI Global Programme Support (GPS) teams, including Gender Mainstreaming, Surveillance, Vaccine Supply, Finance, Containment, Polio Research & Analytics, Outbreak Response and Preparedness, Resource Mobilization, Global Communications and Political Advocacy teams
- Immunization Agenda 2030 (IA2030) Coordination Group (IACG) and relevant working groups (e.g. Essential Immunization, Monitoring and Evaluation, Outbreak Preparedness and Response), with representation from US Centers for Disease Control and Prevention (CDC), Gates Foundation, Gavi, John Snow Inc., United Nations Children's Fund (UNICEF) and the World Health Organization (WHO)
- Independent Monitoring Board (IMB) / Transition Independent Monitoring Board (TIMB)
- Major donors: Australia, Canada, European Commission, France, Germany, Islamic Development Bank, Japan, Monaco, Saudi Arabia, United Arab Emirates, United Kingdom and the United States of America
- Other global health initiatives (e.g. Measles and Rubella Partnership, Yellow Fever Initiative)
- Regional technical advisory groups (to be engaged, where possible, during Member States Consultation)
- Rotary International
- Strategic Advisory Group of Experts on Immunization (SAGE) and the SAGE Working Group on Polio
- UNICEF, including Immunization, Polio, Health Emergencies Preparedness and Response team at UNICEF headquarters; Regional Office Immunization and Polio teams
- UN Foundation
- US Centers for Disease Control and Prevention (CDC), Polio and Immunization Teams
- WHO, including regional offices and relevant departments (e.g. immunization and health emergencies programme teams)

CONSULTATION METHODOLOGY

Throughout revision, the GPEI partnership prioritized active engagement and consultation with a broad group of stakeholders. Such consultations are key to shaping the three primary goals and ensuring the strategy as a whole is well-rounded, inclusive and well-socialized.

The 2024–2025 revision has two rounds for gathering stakeholder feedback on the strategy: a first round of broad stakeholder review and a second round of consultations with Member States.

Round 1: Stakeholder review

September–November 2024

Stakeholders received Draft 1 and were asked to provide feedback by:

- sharing comments and feedback via email;
- submitting a marked-up version of the draft with track-changes;
- completing an online survey, responding to a series of questions (**Annex A**); or
- participating in a bilateral meeting (e.g. webinar or teleconference).

The strategy revision working group also held calls, meetings and consultations with key GPEI groups and decision-making bodies, such as the Strategy Committee and Polio Oversight Board, as well as dedicated sessions with stakeholders, including donors and civil society organizations. A high-level timeline of the consultation schedule can be found in **Annex B: Consultation schedule (2024-2025)**.

DRAFT 1: Initial stakeholder review

The first iteration of the revised strategy (Draft 1):

- reflected changes that were needed given a new GPEI eradication strategy;
- revised objectives and activities based on developments since the 2018 strategy,
- flagged decisions that are anticipated across the strategy's goals, objectives and activities;
- presented updated details on planning for bivalent oral polio vaccine (bOPV) cessation; and
- provided early thinking on future governance models to succeed the GPEI.

Two new chapters were added:

- ***Governance and accountability*** discussed options for future governance; and
- ***Cost estimate*** presented the methodology for an estimate that was still in development.

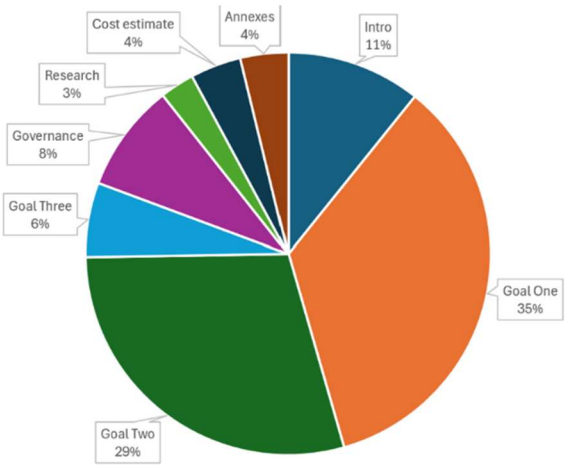
Round 2: Member States consultation

June–September 2025

Many stakeholder comments affirmed country ownership as the heart of this strategy. To ensure that countries are actively engaged in the strategy's development, a second round of consultations has been planned for engagement with Member States starting in June 2025. During these consultations, a revised draft will be shared with WHO Member States to gather input and feedback and answer questions. This feedback will then be shared with strategy working groups to address as revisions to the final strategy (see **Next steps**).

STAKEHOLDER FEEDBACK ON DRAFT 1

More than 800 comments were received, with the majority of comments related to Goal One, Goal Two and the strategy's introduction.



Process for reviewing stakeholder feedback

Each comment was logged and shared with co-chairs of the working groups, who met to discuss how the feedback should be addressed. When a follow-up with stakeholders might help clarify issues, co-chairs liaised directly with the individual or organization.

Common feedback themes

1. **Details on implementation and ownership:** Stakeholders broadly looked for assurances that planning for implementation will be underway soon. They want to know who will lead in developing and executing plans for areas such as bOPV cessation, surveillance and outbreak response.
2. **On preparatory activities and investments:** Stakeholders noted that the strategy defines some activities that will begin before it launches. They asked for details on planning for implementation, including what needs to happen in the lead-up to the strategy.
3. **Relationship to transition:** Some stakeholders expressed confusion over how this strategy relates to the Polio Transition Strategic Framework and its Global Vision. Many asked: how will transition work, who will do the work, and how will it be funded?
4. **Framing beyond polio and across the global health architecture**: There was a general push from stakeholders for an approach beyond polio and for stronger framing within the broader global health architecture, for example by looking to lessons learned from country transitions in other programmes, as well as alignment with IA2030, Gavi 6.0, HEPR and the Lusaka Agenda.
5. **Future risks and risk mitigation**: Risks within each goal and their related mitigations received consistent attention by stakeholders, with many providing additional input and clarification.
6. **On the role of countries in the strategy**: Stakeholders expressed that countries should be at the heart of the strategy. Some wanted to see fragile, high-risk countries receive greater focus as a key risk to the overall strategy; others suggested that interventions flagged for fragile countries could be universally recommended. Many wanted to see tiers related to country-level risks.
7. **Country readiness:** Many stakeholders wanted to see more focus on country readiness through routine immunization strengthening and increased capacity to support surveillance, outbreak preparedness and response, especially for fragile, high-risk countries. Stakeholders highlighted the importance of ensuring mechanisms for short- to mid-term support for countries that will not be able to fully assume responsibility for delivering polio-essential functions in the near term.
8. **Contingency planning:** Several stakeholders noted they would like to see more details around contingency planning if the current GPEI eradication goals are not met.
9. **GPEI dissolution and future governance**: Many stakeholders agreed on the need for a phased approach. Some encouraged a risk averse approach to timing needed for "co-ownership" to transition from the GPEI Eradication Strategy to the strategy for Sustaining a Polio-free World.

The rest of this report describes in detail how stakeholder feedback was addressed in Drafts 2 and 3.

Broad changes to the strategy (for Drafts 2 and 3)

Renaming the strategy

The name of the strategy was updated from "Polio Post-Certification Strategy: A risk mitigation strategy for a polio-free world" to "Sustaining a Polio-free World: A strategy for long-term success" to reflect programmatic changes to certification milestones. In the Polio Eradication Strategy 2022–2029, the GPEI established goals for certification of WPV1 eradication and certification of cVDPV2 elimination. Global certification of all polio types is now set to occur within the strategy for Sustaining a Polio-free World. As this strategy no longer starts *post-certification* but instead contains key milestones toward the global certification of all types, the strategy was renamed. Stakeholders were surveyed to gather options, with the final name receiving approval from the GPEI Strategy Committee.

Updates to *Governance and accountability*

The *Governance and accountability* chapter was also revised to reflect stakeholders' preference for a future governance model that evolves over time, shifting from more centralized to more decentralized leadership after bOPV cessation and certification of circulating vaccine-derived poliovirus types 1 and 3 (cVDPV1 and cVDPV3) elimination. This will allow the governance model to be responsive to changing risks, remaining milestones and ongoing progress with polio transition as countries fully assume delivery of polio-essential functions. While the Polio Oversight Board is set to decide on GPEI dissolution in September 2025, decisions on future governance will not be made until all relevant stakeholders, including agencies within and outside of the GPEI partnership, assess how best to sustain a polio-free world.

Governance review

To better assess the existing governance model and to inform future planning, the GPEI has commissioned a governance review, to be conducted in the summer of 2025.

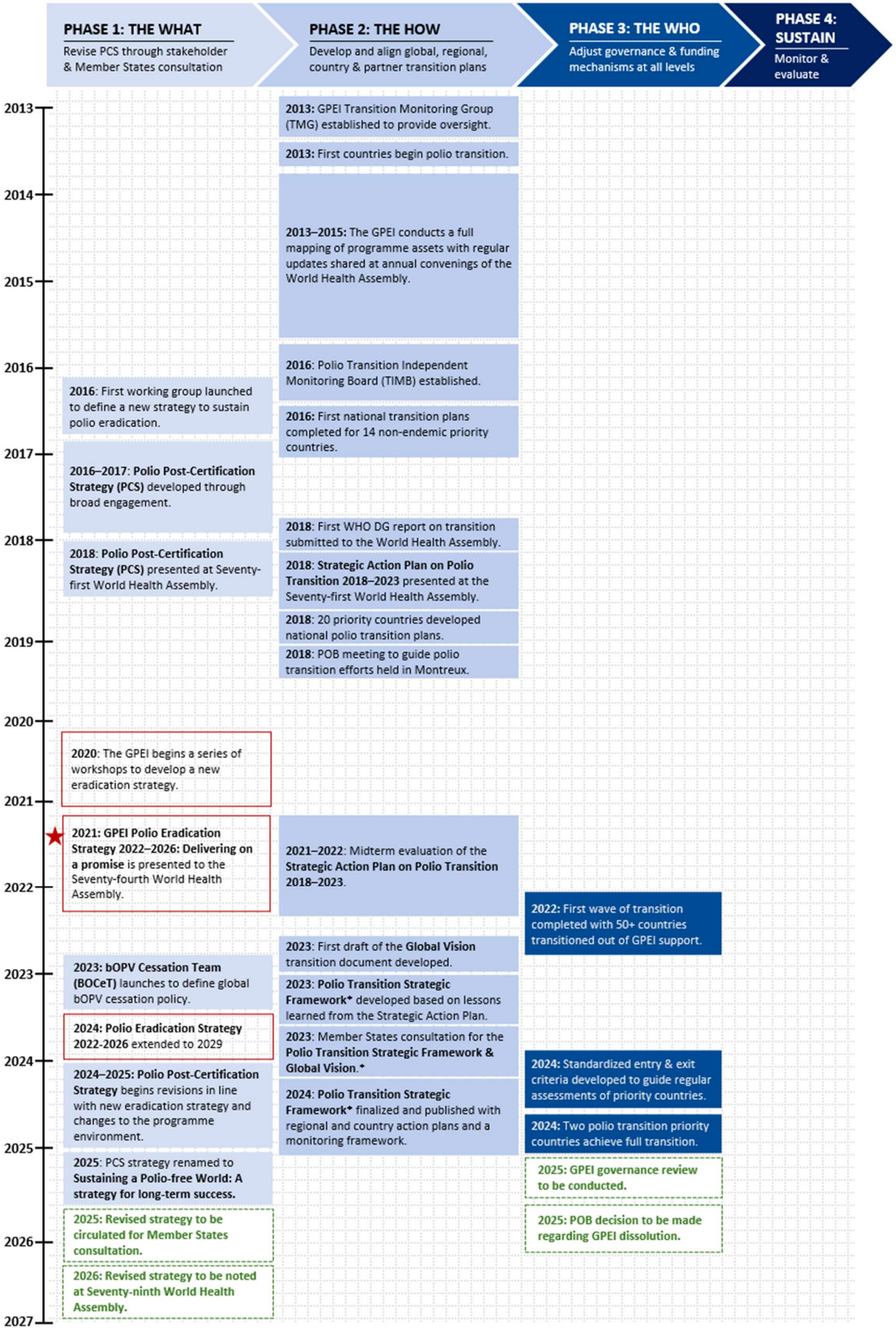
Updates to the cost estimate

A revised *Cost estimate* chapter was included in Drafts 2 and 3 to present a global estimate for the strategy. The cost estimate benchmarks historical and current funding trends under the GPEI's framework for financial resource requirements while integrating updated assumptions. Select costs like vaccine procurement will be incurred before the strategy starts, so GPEI leadership will also need to consider these impending resource needs.

A roadmap for future planning and implementation

In response to feedback, the strategy was revised (in Drafts 2 and 3) to include a roadmap for a phased planning process that focuses on what essential functions will be needed to support a polio-free world (Phase 1), how they will be transferred or transitioned (Phase 2), and who will be critical partners to implementing activities needed to achieve and sustain polio eradication (Phase 3), with a final phase in which future governance supports monitoring and evaluation to sustain polio eradication (Phase 4). The roadmap provides clarity on when implementation details that are beyond the scope of a technical strategy will be defined.

This roadmap also outlines these steps so a host of partners – from national governments to other programmes – can mobilize and prepare for the eventual dissolution of the current GPEI partnership, which has organized the eradication effort since 1988. Planning has already been underway for Phase 1 (the What) and Phase 2 (the How). A three-year period of overlap with the Eradication Strategy will allow for further planning and implementation toward Phase 2 (the How) and Phase 3 (the Who), to support a smooth transfer from the current GPEI structure to a future governance structure.


PHASE 1: THE WHAT
Revise PCS through stakeholder & Member States consultation
PHASE 2: THE HOW
Develop and align global, regional, country & partner transition plans
PHASE 3: THE WHO
Adjust governance & funding mechanisms at all levels
PHASE 4: SUSTAIN
Monitor & evaluate
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2013: GPEI Transition Monitoring Group (TMG) established to provide oversight.
2013: First countries begin polio transition.
2013–2015: The GPEI conducts a full mapping of programme assets with regular updates shared at annual convenings of the World Health Assembly.
2016: Polio Transition Independent Monitoring Board (TIMB) established.
2016: First national transition plans completed for 14 non-endemic priority countries.
2016: First working group launched to define a new strategy to sustain polio eradication.
2016–2017: Polio Post-Certification Strategy (PCS) developed through broad engagement.
2018: First WHO DG report on transition submitted to the World Health Assembly.
2018: Strategic Action Plan on Polio Transition 2018–2023 presented at the Seventy-first World Health Assembly.
2018: 20 priority countries developed national polio transition plans.
2018: POB meeting to guide polio transition efforts held in Montreux.
2018: Polio Post-Certification Strategy (PCS) presented at Seventy-first World Health Assembly.
2020: The GPEI begins a series of workshops to develop a new eradication strategy.
2021: GPEI Polio Eradication Strategy 2022–2026: Delivering on a promise is presented to the Seventy-fourth World Health Assembly.
2021–2022: Midterm evaluation of the Strategic Action Plan on Polio Transition 2018–2023.
2022: First wave of transition completed with 50+ countries transitioned out of GPEI support.
2023: First draft of the Global Vision transition document developed.
2023: Polio Transition Strategic Framework* developed based on lessons learned from the Strategic Action Plan.
2023: Member States consultation for the Polio Transition Strategic Framework & Global Vision.*
2023: bOPV Cessation Team (BOCeT) launches to define global bOPV cessation policy.
2024: Polio Eradication Strategy 2022-2026 extended to 2029
2024: Standardized entry & exit criteria developed to guide regular assessments of priority countries.
2024: Two polio transition priority countries achieve full transition.
2024: Polio Transition Strategic Framework* finalized and published with regional and country action plans and a monitoring framework.
2024–2025: Polio Post-Certification Strategy begins revisions in line with new eradication strategy and changes to the programme environment.
2025: PCS strategy renamed to Sustaining a Polio-free World: A strategy for long-term success.
2025: GPEI governance review to be conducted.
2025: POB decision to be made regarding GPEI dissolution.
2025: Revised strategy to be circulated for Member States consultation.
2026: Revised strategy to be noted at Seventy-ninth World Health Assembly.

Detailed feedback and responses

Overall strategy framing

Feedback	Team responses
Strategy timeline	
Why a 10-year strategy?	SAGE has recommended continued use of inactivated polio vaccine (IPV) for 10 years after bOPV cessation. If SAGE changes this recommendation, the current or future versions of the strategy will reflect those changes.
The strategy timeline is not consistent with the latest GCC recommendations (for certification of elimination of cVDPVs followed by certification of eradication of all types of VDPVs).	The strategy notes that the certification of cVDPV1 and cVDPV3 elimination will occur before the global certification of all polioviruses, with both occurring in the post-cessation stage. The timeline figure has been revised to clarify that certification of cVDPV1 and cVDPV3 elimination is planned before global certification. This is based on GCC guidance that global certification of cVDPV *elimination* (for all three types, with cVDPV2 certified first) will need to occur first before global certification of cVDPV *eradication* (for all types).
Will the use of OPV in an outbreak reset the clock for global certification?	This will be decided by the GCC with input from the programme and SAGE. At the time of publication, the strategy will reflect their latest determination around all certification requirements, milestones and timelines.
The strategy states that it doesn't assume which eradication goal will be achieved first, but there are places throughout where it seems to contradict that point.	*Strategy planning* must begin before the completion of the GPEI Eradication Strategy, even as the strategy for Sustaining a Polio-free World will launch after Eradication Strategy goals. If the Eradication Strategy timeline changes or if Goal Two (cVDPV2 elimination) is achieved before Goal One (WPV1 eradication), the strategy will still begin after the two goals are achieved.
Transition	
There are too many strategies, including the polio transition framework. The GPEI should create a one-pager (umbrella) on a 'suite' of strategies.	The strategy revision team has worked with the Resource Mobilization Group (RMG) and Global Communications Group (GCG) to develop a one-pager to avoid confusion and support the Member States consultation.
Who is providing dedicated support for countries that are heavily reliant on GPEI for their health systems to build transition plans?	Some countries may primarily need technical support and/or may be able to independently finance or co-finance certain functions, whereas other countries may need to more heavily rely on technical or financial support. In these cases, support from WHO and other stakeholders is provided to national governments as they lead in the development and implementation of transition plans (see p. 11 of the Polio Transition Strategic Framework).
GPEI's transition planning has felt insufficiently focused on what is realistic for countries and global partners. Given global resource constraints, are 'gold standards' realistic in this context?	The technical standards of this strategy are informed by what is necessary, based on the epidemiology, to keep the world polio-free. As maintaining these standards may pose challenges, transition planning (led by national governments in coordination with global partners) and activities need to be tailored to what is feasible in the local context of funding, government commitment, etc., including through integration of polio-essential functions into broader national health systems to help detect and control outbreaks, strengthen routine immunization and ensure countries remain polio-free.
Preparing the way for the Sustaining a Polio-free World strategy	
The strategy says some elements will need to start before cVDPV2 elimination. Who will decide what needs to be started when, and under what budget?	The Polio Oversight Board (POB) is the key decision-making body that will endorse the pathway from current GPEI Eradication Strategy to the strategy for Sustaining a Polio-free World. The strategy working group has developed a roadmap with planning phases that has been reviewed and approved by the Strategy Committee (SC) and the POB at their 24 March meeting. The strategy will have its own budget, as defined by the *Cost estimate* chapter.
Draft 1 is written as though a switch will flip at the start of the strategy, with new commitments / actions required from partners and countries. Can it instead frame what is needed alongside a process by which GPEI will build a coalition with shared responsibility and ownership?	The strategy document focuses on what needs to be continued to achieve and sustain a polio-free world. The subsequent phases (how will activities be implemented and who will implement them) need to be led by a broad coalition that brings together GPEI, immunization, emergencies agencies, donors, etc. A massive transition effort such as this is never a flip of a switch, hence the three years of overlap with the current eradication strategy and ongoing discussions with GPEI leadership and stakeholders. WHO has been supporting countries to plan and implement polio transition, and this work will continue before the strategy can be implemented.

Feedback	Team responses
Country ownership	
The inability of fragile and high-risk countries to assume ownership of polio functions should be highlighted as a major risk. If country readiness is left unaddressed, it could become a risk of failure for the strategy itself due to unrealistic planning and decision-making.	The strategy addresses risks related to transition throughout each goal chapter. Managing these risks is addressed by the WHO Polio Transition Strategic Framework, which provides an "ownership and accountability matrix" to define roles and responsibility across the country, regional and global level (see p. 14 of the Polio Transition Strategic Framework). For fragile and high-risk countries, the framework will provide for ongoing support from partners and other stakeholders to ensure polio-essential functions aren't compromised during the 10-year period.
Since timing for certifying WPV1 and cVDPV2 is unknown, countries should be guided to start their own planning process.	The GPEI Eradication Strategy sets a timeline for the certification of WPV1 eradication (2027) and cVDPV2 elimination (2029) that may be adjusted based on the epidemiology. Until both goals are achieved, countries will continue to transition after achieving country-level certification, with GPEI support provided to high-risk, fragile countries, while other polio transition priority countries will receive ongoing support from WHO and partners to complete their transition.
Regional support	
In addition to global and national levels, regional entities are important and help to align with shifts in public health.	Regional entities are critical in sustaining a polio-free world, and several strategy chapters (goal chapters, governance and accountability) detail both regional and national bodies in their recommendations. For this reason, regional committees will be key stakeholders in the Member States consultation process.
Global health architecture	
What has been the involvement so far of these groups? IHR, GHSA, HEPR, IA2030	The IA2030 Coordination Group (CG) and relevant IA2030 subgroups have been included in stakeholder consultation. Bodies that were not included in Draft 1 can be engaged in Member States consultation period.
New IHR amendments do not require immediate Article 6 Notification for nonparalytic detections. Will "diseases requiring notification " be updated to include ES and non-confirmed cases?	There is no decision at this point to update Article 6 of the IHR requirements. If there is a proposal to change IHR requirements, it will go to the IHR and the GCC for decision-making.
How does the strategy envision the global health landscape when some frameworks (IA2030 and GAVI 6.0) will expire before implementation begins?	The strategy outlines technical standards needed to maintain a polio-free world. Future partners, including national governments, will decide how the standards will be implemented and incorporated into the relevant frameworks given changes to the global health landscape.
We would like to see more explicit reference to other global health initiatives. How will the future governance arrangement fit into the larger global health architecture?	Draft 3 now includes a roadmap that outlines a phased approach to planning with a designated phase for defining future governance and monitoring mechanisms. It is the responsibility of the future owners and organizations to determine the right governance structure given the existing or future global health architecture. Where it is helpful, these documents are referenced.
Strategy assumptions	
What will happen if the assumptions (around completion of Goals One + Two) are not met? Is there future planning if progress is not made in the next year?	The GPEI will need to determine alternative scenarios and options if the eradication strategy timelines for WPV1 and cVDPV2 are not met. This is not part of the scope of the strategy, which will be triggered only after the achievement of both these goals.
If [eradication] is not achieved, what parts of the strategy for Sustaining a Polio-free World would still be relevant for a control programme?	The strategy outlines essential polio functions that will need to continue after achieving success with WPV1 and cVDPV2. If there is a decision to move to a control programme, then the strategy can serve as a starting point, but the parameters for surveillance, SOPs for outbreaks, vaccine strategy, bOPV cessation timing, etc., will most likely need to be reviewed and adjusted.
Future revisions	
Significant changes in technologies, policies, and contexts are expected, which will necessitate substantial revisions to the strategy. Its current level of detail is hard to justify as revising it will require considerable resources.	The fundamentals to reach global certification and maintain a polio-free world will not change. If this revision of the strategy is compared to the previous one, changes are reflected in the assumptions, activities and costing and not the goals, risks and functions. Further revisions will not require significant effort or time, yet it will be critical to ensure that this strategy remains a living document which is updated as programmatic conditions change. Additional guidance will be provided by GCC, SAGE and other groups that will impact implementation (i.e. when to withdraw bOPV, length of time to continue polio immunization after cessation). Many of these activities should be absorbed into other health strategies and initiatives.

Goal One: Protect populations

Feedback	Team responses
Population immunity (pre-cessation)	
What is the estimated level of coverage for IPV for each country before we stop bOPV use?	The level of population immunity to stop poliovirus circulation varies by country and within countries. Reaching >95% coverage is considered an enabler for bOPV cessation rather than a trigger as it is unlikely all countries can achieve this, particularly with inaccessible and conflict-affected populations.
At what level will immunity be assessed – global, national, local?	Population immunity estimates will be based on coverage with three doses of OPV (OPV3) and supplementary immunization activities (SIAs) in the five years before cessation. Estimates will draw on data from the province level, where possible, or the country level.
Can the strategy define a precise set of actions for all countries to boost population immunity?	The strategy does not define specific activities to increase population immunity in each country before bOPV cessation because they vary by country and subnational area. These should be included in country-specific action plans.
To reach high coverage, would it help to set incentives for countries to switch to hexavalent?	Countries eligible for Gavi support have the opportunity to introduce the hexavalent vaccine and to switch from standalone IPV. However, introduction needs to be accompanied by efforts to increase coverage to such levels to ensure high immunity.
What if [pre-cessation SIA] coverage is low?	Activities to increase population immunity should be included in country-specific action plans. While such activities will vary by country and subnational area, achieving high routine immunization coverage may be achieved, for example, with three doses of bOPV before cessation or through pre-cessation SIAs.
Does making population immunity an enabling factor and not a trigger for cessation set up for the problems that came from the 2016 switch?	According to SAGE, coverage with two doses of IPV (IPV2) is not a trigger as delaying cessation until all OPV-using countries reach >95% coverage would likely result in VDPV cases. National and global stakeholders should aim for the highest coverage as part of broad system strengthening and monitor delivery to hard-to-reach, under-immunized populations.
With the hindsight of switch, two doses of IPV (IPV2) may not be enough in countries where coverage is under 50%. What does GPEI recommend?	IPV2 coverage under 50% will not provide sufficient protection to reduce paralytic cases for cVDPVs post-cessation. Therefore, strengthening routine immunization to reach 95% and monitoring delivery to hard-to-reach, under-immunized populations is recommended. For countries that do not reach IPV2 coverage of at least 80%, additional pre-cessation SIAs are recommended.
Will SAGE recommend IPV use outside of routine immunization for outbreak response?	SAGE has recommended IPV use outside of routine immunization in limited areas with a high number of zero-dose or under-immunized children (i.e. inaccessible or conflict areas where it's difficult to conduct multiple SIAs in a short time).
Will resources be available for pre-cessation campaigns?	Pre-cessation SIAs will be included in the strategy's cost estimate and they will be a part of resource mobilization efforts.
bOPV cessation planning	
Why does the strategy encourage globally synchronized bOPV cessation instead of asynchronous cessation?	Both approaches were assessed. Although the trivalent oral polio vaccine (tOPV) switch evaluation considered regional cessation based upon programmatic feasibility, the latest modelling analyses have shown that asynchronous cessation increases the risk of cVDPVs and the likelihood of large uncontrollable outbreaks.
Can SAGE's country tiering, which includes a history of polio outbreaks, also consider other VPD outbreaks?	Countries with cVDPV outbreaks and persistent WPV may have outbreaks of other VPDs. However, because specific factors increase the risk of cVDPV in some countries but not others, modellers use only prior polio outbreaks in assessments.
Cessation planning must include immunization partners, governments and others beyond GPEI (as written).	Agreed. The responsibility of cessation planning, implementation and monitoring (of pre-cessation SIAs) requires partnership capacity from the global to the local level. Objective 1.1 was revised to reflect this.
When will the plan for bOPV cessation be developed? Is there a timeline?	The bOPV Cessation Team (BOCeT) has been reviewing lessons learned from the tOPV switch evaluation and discussing epidemiological considerations since early 2023, and they are continuing to develop policy recommendations for endorsement by SAGE. Implementation plans will be developed through Member State engagement as the GPEI gets closer to cessation.

Feedback	Team responses
What body will decide on bOPV cessation? If GPEI no longer exists, will this be decided by the WHA?	SAGE will monitor bOPV cessation triggers and enablers and support the decision to go (or not go) forward with bOPV cessation. It is yet to be determined which groups or organizations will take the decision to move forward with cessation.
What will happen with bOPV cessation when/if we are using OPV in an outbreak response. This doesn't have much visibility in the strategy, yet it could have important consequences.	The strategy sets as its assumption that cVDPV2 elimination will be certified before the strategy begins, which means type 2-containing OPV (OPV2) will not be in active use. While we expect some post-cessation outbreaks of cVDPV1 and cVDPV3, monovalent OPVs (mOPVs) would be used, with bOPV used only if mOPVs or nOPV1/nOPV3 are not available.
The 2016 switch and bOPV cessation	
How will an effective go/no-go decision be set to determine whether bOPV cessation should proceed?	BOCeT and the SC will finalize recommendations for cessation governance, including the role of SAGE and GCC who are expected to provide guidance on the go/no-go decision. An accountability framework and a decision-making body will be established with guidelines on what needs to be reviewed, who will provide data and who will make decisions.
Given the failure of the 2016 switch, it may be difficult to get endorsement by the World Health Assembly of the bOPV cessation plan as currently envisioned.	Epidemiological analysis and modelling suggest globally synchronized cessation is the best course of action, even if it's hard to implement. The GPEI will strive for endorsement by the Health Assembly, with Member States actively engaged early in the process. However, countries can move to an all-IPV schedule at any time based on SAGE's endorsement in March 2025. SAGE has also endorsed a tool that will help countries understand the risks of such a move to help with the decision-making process.
Modelling	
Is synchronized cessation a better approach given the gaps between 2016 modelling and post-switch outbreaks?	Modelling analyses conducted by drawing upon data from the last 20 years shows a higher risk of cVDPV1 and cVDPV3 emergences in countries that remove bOPV prior to their neighbours.
Modelling cited in Draft 1 was before 2020. COVID immunity gaps and the switch may not be reflected in them.	Models are continuously updated with new information. They are discussed with the BOCeT team and fed into materials for the SAGE working group. Additionally, a new KidRisk/CDC study (in press) will also be referenced.
Language	
Obj. 1.1 has so many overlapping concepts – e.g. triggers, enablers, principles and considerations. It creates confusion for the reader.	These terms were discussed by BOCeT to avoid errors with different interpretations of pre-requisites and triggers that occurred with the tOPV switch. The terms were presented and endorsed by the SAGE in September 2023 and March 2024.
Country context or readiness for cessation	
For the strategy to be adaptive to country context, would a tiered approach to cessation be useful?	We are using a tiered approach for determination of pre-cessation SIA needs (Activity 1.1.1) and for estimating risks and related needs for surveillance and outbreak response (Tables 5 and 6).
Should there be a standardized audit or a review process to assess country readiness for cessation, similar to the process used for nOPV2?	Global monitoring for bOPV cessation lies with the GCC and SAGE. For each trigger, SAGE and GCC will review data submitted by the responsible stakeholders and countries before they sign off on the achievement of population immunity, vaccine availability and surveillance enablers.
Routine immunization / EPI	
Many countries and subnational areas have yet to reach high coverage. Routine immunization should be a priority.	Agree. Draft 3 emphasizes the need to build and sustain routine immunization coverage, inclusive of IPV coverage.
Hexavalent	
Is there already ongoing collaboration with Gavi on hexavalent?	There is collaboration with Gavi and GPEI to identify which countries would bring the best impact for potentially limited funding for hexavalent supplies. Countries eligible for Gavi support have the opportunity to introduce the hexavalent vaccine and to switch from standalone IPV. Gavi also supports strengthening of primary health care and routine immunization to achieve immunization coverage goals.
Are there incentives for suppliers to produce more hexavalent and for countries to switch?	There is expected to be additional supply by the time the strategy comes into effect, which would allow all countries to switch to hexavalent.

Feedback	Team responses
Vaccine delivery	
Efforts to increase polio immunity through routine immunization are failing in many contexts. How will what is being proposed be different?	Some recommendations to achieve higher coverage are similar to current strategies. However, the strategy recommends the integration of polio functions and a shift toward reprioritizing these efforts. Revisions also refer to continued support for hexavalent and enhanced vaccination for pockets of lower IPV coverage.
How will the prioritization of zero-dose approaches be supported and by which organizations?	Zero-dose efforts and National Immunization Strategy (NIS) support are currently provided by several partners, and we expect that support will continue with integration of polio. Phases 2 and 3 of this process will focus on governance, roles and responsibilities and accountabilities.
Vaccine supply	
What is GPEI doing to ensure there is sufficient vaccine supply?	To ensure a healthy supply of polio vaccines, the GPEI developed the Polio Vaccine Security Framework that draws upon lessons from past shortages (IPV and type 2-containing vaccines) during the tOPV-to-bOPV switch to define the communication, coordinated planning, economic incentives and risk mitigation strategies needed to ensure uninterrupted vaccine supply.
Integration	
Other programmes try to integrate with polio to improve their reach. It's unclear how it will work post-GPEI.	The GPEI has historically had impressive access to communities. However, after WPV1 eradication, cVDPVs will take increasing focus, driven principally by low routine immunization coverage. In this context, scaling up and sustaining high polio coverage will require integration with other primary health care services. IA2030 focuses on ensuring that sustainable immunization programmes are an integral part of primary health care. In addition, the Health Campaign Coalition is working with countries to improve integration of campaigns.
It may strengthen the strategy to address the five shifts of the Lusaka Agenda. Can the strategy map out activities that will be aligned and support these shifts?	This is a good suggestion for future planning related to implementation. The strategy outlines a shift from a vertical approach to a more integrated approach and it addresses strengthening primary health care, moving toward greater domestic resourcing and allocation, joint and coordinated approaches to containment.

Goal Two: Detect and respond

Feedback	Team responses
Surveillance standards	
Details around surveillance implementation are not addressed – for example, how to strengthen vaccine-preventable disease (VPD) surveillance for polio standards?	We agree there is a lot of implementation work to be done – and especially related to strengthening VPD surveillance. These details, however, are out of scope of strategy document. They will be described in a future standard operating procedure (SOP) or implementation guide.
Why is "three years" given as a minimum for high-risk countries to report on their surveillance data after bOPV cessation?	While the GCC has amended a previous certification standard from "three years of non-detection" to a "flexible period of at least two years," cVDPVs will likely be harder to detect. In areas with suboptimal surveillance, a three-year period is considered long enough to detect circulation if there is any, and so the strategy uses "at least three years."
Many polio-free, IPV-only countries rely on enterovirus surveillance (EVS), not acute flaccid paralysis (AFP) or environmental surveillance (ES). Will EVS be sufficient for early detection?	Some countries may not be reporting all AFP cases but that does not mean they do NOT have AFP surveillance and would not detect or report polio-positive AFP cases. Countries relying on EVS (e.g. Europe, US) also have wastewater surveillance that is good at detecting polioviruses.
What if countries can't sustain these standards long term, particularly as they experience change?	The WHO Polio Transition Programme evaluates countries to assess their capacity for country ownership, and the GPEI routinely assesses surveillance risk to identify "new' high-risk countries.
There is currently high turnover of surveillance staff. How will staff with technical knowledge be maintained in the 10-year period of the strategy?	The GPEI Surveillance Group recognizes and is currently addressing rapid turnover of surveillance (and laboratory) staff. Questions related to how this work will be done is out of scope for a strategy document.
Laboratory surveillance	
The strategy states that the Global Polio Laboratory Network (GPLN) should continue to function as it does, but will there be resources to ensure continuity?	The strategy is focused on what is needed for polio-essential functions and highlights cost estimates, including for labs. Fundraising and advocacy, while extremely important, are beyond the scope of the strategy.

Feedback	Team responses
With the dissolution of GPEI, there is a risk that global coordination and technical assistance for the GPLN will weaken.	The strategy describes "what" needs to be maintained (laboratory infrastructure and human resource [HR] capacity). "How" these laboratory systems should be maintained will be defined in the next planning phase.
Activities for Obj 2.1 only emphasize detection. It is equally critical to report and share information with global health agencies.	Edits have been made to make clear the linkages between laboratories that report results to designated agencies and officials that respond to the alerts.
Surveillance data	
What is the timeline for integrated information systems? Will the new data system be trialed before the end of the GPEI?	We are not "switching" data systems as much as potentially merging data systems. This process will be detailed as part of a separate phase of planning (between Phase 2 and 3).
Surveillance data is defined as being stored and disseminated through POLIS (Polio Information System). What is the mechanism for sequence data?	The Poliovirus Nucleotide Sequences (PoNS) database that is currently being rolled out will be the database for storing poliovirus sequences. This system will likely be fully operational by the end of 2025. The PoNS Steering Committee is planning for its long-term use, but this detail is beyond the scope of the strategy.
Surveillance risks	
Almost all of the mitigation measures are tough to implement now, while the GPEI is still overseeing things.	We agree that implementation or the "how" will be very challenging for surveillance. That said, this document is only focused on the "what" needs to be done to set the technical standards needed to strengthen and maintain surveillance.
Where is cross-border coordination and surveillance in the draft, especially as border areas are common reservoirs?	Cross-border communities were added into the risk table for clarity. We consider them a high-risk population.
Global monitoring of surveillance	
Will surveillance be actively monitored after GPEI dissolution?	Yes, surveillance will need to be actively globally monitored, but the details of who and how will be defined in future planning phases.
Country ownership of surveillance	
While the strategy needs to take a polio lens, the vulnerability for countries is that the wider system for infectious diseases is at risk without polio resources.	We agree. However, the reality is that we do NOT have a global pan-surveillance framework. The best fit would be to cross link the strategy with IHR, WHO-ERF, comprehensive VPD surveillance framework and national or regional surveillance strategies, as the strategy recommends. These can be mutually complementary rather than being mutually exclusive.
Most countries have a five-year lead time on national health plans (NHPs). Decentralized systems need more time to incorporate standards.	We agree it will take time for these systems to mature and adapt. GPSAP 2025–2026 prepares the way for the strategy with immediate and medium-term activities. Implementation will be defined in a future planning phase.
Surveillance and fragile, high-risk countries	
Many countries are not currently able to support core surveillance capacity, especially fragile and high-risk countries. This is a major risk. What will be done to support surveillance in these cases?	This is highlighted as a major risk. The strategy's costing estimate anticipates global financial support to some high-risk countries that will be unable to sustain surveillance with domestic funding. A budget line in the cost estimate provides support to high-risk countries as one way to mitigate these risks. The Polio Transition Strategic Framework provides a mechanism for ongoing support from partners and other stakeholders to ensure polio-essential functions aren't compromised. More details on how strategies will be implemented will be defined in the next phase of planning.
Integration of surveillance with other programmes	
Are there countries where the AFP surveillance system is stronger/better equipped than the VPD system, so that the integration will run better the other way round?	Many countries have stronger AFP surveillance than VPD surveillance due to dedicated funding for polio. However, the decision to integrate polio into the existing VPD surveillance system is promoted because it folds the system with funding that will shrink or disappear (as polio is eradicated) into the system with potentially more sustainable funding.
Why is VPD discussed for integration with polio surveillance and not integrated disease surveillance and response (IDSR)?	Polio surveillance may integrate with IDSR in the future. The most common pathway has been VPD surveillance as it is also case-based with lab results linked to case-data (as with measles). In most countries, IDSR links to an aggregate data system with or without lab confirmation or linkage of lab results to case data. Given this, IDSR does not always reconcile data with a case-based system. These two systems can complement each other, and indeed some countries have combined the two systems through electronic-IDSR or eIDSR (e.g. Uganda).
Can more details be provided on integration with wastewater surveillance?	This exploratory initiative, still in its infancy, is outlined in the GPSAP 2025–2026. Future updates to the strategy will include more details on integration with wastewater surveillance.

Feedback	Team responses
Outbreak response activities, modalities	
Why are only cVDPV1 and cVDPV3 targeted, not other polioviruses?	All VDPVs are addressed. After bOPV cessation, however, the risk will be higher for type 1 and type 3 polioviruses.
Regarding a 120-day target: Has the current inability to stop outbreaks been analyzed to identify ways to mitigate delays in the future?	Outbreaks that have not been stopped in 120 days can be attributed to multiple reasons: funding, vaccines, operational challenges, insecurity. In the future, an emergency roster and the timely availability of funds and vaccines will be crucial. Additionally, outbreak response (OBR) SOPs will be updated for the post-cessation period.
Will the regional/global team be a dedicated polio team or embedded in other programmes (IVB/WHE)?	Polio outbreak response operations will be embedded within other programmes, but the strategy foresees some core HR capacity within the initial years after bOPV cessation to be decreased gradually to ensure timely and quality outbreak response.
Integration of OBR with other programmes	
Will WHO Health Emergencies (WHE) be the primary response partner in the pre-cessation, post-cessation and post-certification era?	This is the planned arrangement, and an internal concept note is underway to define integration of WHO polio eradication programme with the health emergencies programme.
How will strong linkages [between poliovirus surveillance and OBR + VPD/WHE] be developed?	The outbreak response objective (Obj 2.2) has been revised to reflect linkages with the strategies outlined in the surveillance objective (Obj 2.1). See Tables 5 and 6 in the revised draft.
Guidelines in the Emergency Response Framework (ERF) aren't pathogen-specific. How will polio-specific response be addressed?	The ERF already includes an SOP for a VPD outbreak (Annex 5) which will be followed. Further, detailed response protocols will be defined by the OBR SOPs for polio in the post-cessation era. The updated SOPs will be available and tested before bOPV cessation and will complement the ERF.
How well does the ERF function? Does it confer confidence that an outbreak would be dealt with effectively?	The ERF has been enhanced in 2024 and is well-functioning. Furthermore, during the first four years of the strategy, core HR has been budgeted to ensure that polio outbreak/events are responded to efficiently.
Outbreak response support to countries and regions	
How will the GPEI support the development of national preparedness and response plans?	Every year, countries update national preparedness and response plans, which are endorsed in-country and by regions (through the Regional Certification Commission [RCC]). To support their development, specific guidance will be developed and made available.
How can the programme ensure country-level SOPs are updated for the post-cessation period?	To ensure the relevance and applicability of updated SOPs, countries will receive guidance through webinars and technical support. WHO will work with national ministries of health to update and test their national preparedness and response plans.
How will support be provided to fragile, high-risk countries?	Support to high-risk countries will be provided with the multi-disciplinary technical assistance team that will be available at global and regional levels. In addition, timely donor support will be explored.
How will training be maintained to facilitate learning and sustain capacity across regions?	Online training modules will be available and outbreak response SOP training will be provided to support core capacity at the regional level and in high-risk countries.
Vaccine stockpiles	
mOPV stockpiles are mentioned. Is there a plan to go back to mOPV, given the risk of seeding?	Post-cessation stockpiles will target only one poliovirus type: nOPV2, nOPV3, nOPV1. Only in the event that nOPV1 and nOPV3 are not available will monovalent vaccines (mOPV1 or mOPV3) be used in response.
How will stockpile requirements be determined with enough time to ensure adequate supply?	There have been a lot of lessons learned from nOPV2 stockpiles. The GPEI will need to improve modelling to better understand where outbreaks may occur and the scale or response. The plan is also to maintain a buffer stock of around 200 million doses that would be available for unexpected events.
Who will release OPV in the future? And how will stockpiles be managed?	The WHO Director-General will continue to release OPV vaccine, and the release process will be further refined, adjusted and integrated into SOPs. The Global OPV Stockpile will be integrated within the global stockpile operations of the WHO health emergencies programme. WHO will lead vaccine forecasting, working with UNICEF Supply Division.
Outbreak response funding	
Governments often don't have response funds set aside. A pooled pandemic response fund may help.	Agreed. Global health partners and organizations will need to decide how future pandemic or emergency funds will be raised and supported.

Goal Three: Contain polioviruses

Feedback	Team responses
Containment guidelines	
Given experience over the last decade, accidental release from a facility (a breach or environmental contamination) is likely to occur, but the activities described in the strategy will not address these risks.	This risk is addressed in the Global Action Plan for Poliovirus Containment (GAPIV), which specifies requirements that poliovirus-essential facilities (PEFs) and their host countries must adhere to and that a national oversight body or national authorities of containment (NACs) must verify. Although this level of guidance is beyond its scope, the strategy supports the long-term goal of safe, secure poliovirus containment, consistent with GAPIV.
Facilities retaining poliovirus	
What is the plan to reduce the number of PEF facilities? There appears to be a lack of willingness to say no to countries that want PEFs.	While designated PEF facilities have fluctuated since the launch of the Containment Certification Scheme (CCS), their number has been reduced when a stricter certification system was put in place. Many facilities, realizing that implementing GAP would be too onerous, have decided to finish work with poliovirus and destroy/transfer materials before the deadline (end-2026), when the achievement of a full containment certificate (CC) is required. Some countries also realized that maintaining capacity for GAPIV audits may be out of reach and decided to no longer pursue hosting PEFs.
Should an additional risk address countries which did not enter into the CCS process and may have facilities with infectious or potentially infectious poliovirus materials?	Two kinds of facilities share this risk. (1) For facilities that handle poliovirus infectious material while operating without a valid containment certificate and/or under unknown containment conditions, a mitigating action is through the empowerment of NACs to validate that the appropriate biorisk management requirements are implemented by facilities and to suspend work, revoke or withdraw certificates for those facilities that do not make progress in achieving/maintaining a certificate of containment. (2) For non-polio and polio facilities that continue to collect, handle and retain potentially infectious materials (PIM) in the absence of containment oversight, the risk is being addressed through revised PIM Guidance, as well as advocacy, outreach and education to ensure it is appropriately implemented.
The mitigation activity to “cultivate/foster positive relationships” between key stakeholders may not be enough to ensure PEF compliance. Can legal and regulatory mechanisms be considered?	Some countries have laws to prohibit facilities from retaining poliovirus without demonstrating GAPIV compliance, but many do not. In countries without legal frameworks, compliance should be incentivized through the limitation of vaccine procurement or the publication of research results only from facilities demonstrating effective GAPIV compliance.
GPLN laboratories	
What will be the containment status of the Global Polio Laboratory Network (GPLN) in the future? Will GPLN labs be required to become PEFs?	Today, most GPLN laboratories are non-PEFs and must follow the PIM Guidance for short-term retention of materials potentially infectious for poliovirus. Once poliovirus is confirmed, infectious materials must be transferred to a PEF or destroyed. This arrangement is likely to remain through the post-cessation period unless the PIM requirements and oversight changes. Fewer GPLN laboratories (25 of 146) have been designated as PEFs by their host countries and must follow GAPIV guidance. Only these labs will be allowed to retain polioviruses requiring containment long-term.
Future governance	
What will governance and oversight of containment look like in the cessation, post-cessation and post-certification era?	Oversight for containment will be decided by WHO Member States, with either the GCC continuing to provide global oversight for the certification of facilities retaining poliovirus infectious material or WHO assessing facilities in a similar role as it has in assessing facilities retaining variola virus.
Does WHO expect to extend the CWG mandate?	As long as GCC exists and retains containment oversight, the mandate of the Containment Working Group of the GCC (GCC-CWG) is expected to continue. Future governance may include the provision of containment oversight by WHO, should that mandate be given by Member States.
Country ownership and role of the NAC	
What is the role of national authorities on containment (NACs) in the period defined by this strategy?	As long as poliovirus infectious material requiring containment is retained, NACs should continue to audit and certify PEFs that meet containment requirements, unless WHO Is given the mandate to oversee this process at international and national level.
The capacity of the NAC should be considered carefully. It will pose a challenge to most countries without legislation and dedicated funding.	One solution is the development of a harmonized international certification system (like what applies to ISO standards) that PEFs request and pay for, as it gives them access to a certain market (publication of research results, marketing of vaccines, etc.).

Feedback	Team responses
Containment safeguards	
Why is environmental surveillance (ES) around a PEF not a requirement of GAPIV?	Environmental testing around PEFs is not a requirement under the current GAPIV. However, as most GAPIV requirements are not prescriptive but risk-based, evidence may be provided by the facility (or requested by the audit team) for the control of release though environmental testing around the PEF at specific frequences and catchment sites. Environmental testing around PEFs may become a requirement in a future version of GAP.
The expectation that countries will be able to maintain 90% immunization rates in perpetuity (in the post-eradication context) is not a viable target.	Only SAGE has the authority to recommend a change to the IPV coverage requirement. In the context of containment safeguards, immunization coverage applies for a set population that surrounds a PEF in a designated geographical area as determined by a risk assessment conducted by the NAC. Countries hosting PEFs are expected to sustain these immunization safeguards, and countries neighbouring PEFs should consider their implementation as well. The GCC monitors to confirm countries and PEFs uphold the safeguards. Countries that cannot maintain the requested levels of population immunity should reconsider their plans to host PEFs.

Research activities feedback

Feedback	Team responses
Impact of research on the strategy for Sustaining a Polio-free World	
Do we need to update any models that drive critical decisions about pre-, immediate post-, or longer-term post-cessation periods?	Modelling is constantly updated to reflect the current situation. More recently published modelling papers are available and have been added to the document, where appropriate.
Will research in the pipeline require a need to review this strategy in the next 10 years?	The research chapter provides a snapshot of what is currently in the pipeline but will evolve over time. All research activities should be well-tested and reviewed for implementation viability, and any new innovations and activities should go through a cost-benefit analysis review. As the strategy is revised, future research innovations will be taken into account.
Can the Vaccine Security Framework help with coordination between manufacturers and researchers?	New coordination efforts are underway across vaccine supply (VSG), research (PRAG) and containment (CG). As part of the framework, manufacturer consultations are held once per year by the VSG and PRAG. These linkages across supply and research help to establish vaccine needs and secure supplies for outbreak response and routine immunization.
In the future, can research synergies be identified and enabled with other immunization organizations (e.g., Gavi, CEPI, etc.)?	PRAG coordinates polio research within GPEI and beyond. These synergies are therefore already established – and will be further strengthened in the future.
Suggested topics for goal-related research	
Should there be a mitigation strategy to address nOPV1/nOPV3 development?	Mitigation strategies are being addressed through bOPV cessation planning. Currently, the clinical development of nOPV1/3 and tnOPV are ongoing with anticipated pre-qualification assessment in 2028/2029.
Should goal-related research also include the contribution of ES to faster outbreak closures and the sensitivity of ES as outbreak detection tool?	The eradication strategy employs ES, and the GPEI works to improve, expand and optimize ES as needed. The future owners of the strategy at the time of implementation should decide the role of ES in outbreaks.
Should goal-related research include alternative approaches, such as serum collection, to monitor functional immunity?	This is no feasible way forward for serum collection, and it is thus not reflected in the draft.
Suggested topics beyond the scope of the strategy	
Impact of climate change on polio. Training, research, development support in low- and middle-income countries. Shared sequencing data, especially for modelling spatial spread of transmission and inferring surveillance quality.	These topics have not been integrated into the research section as they are out of scope of the strategy document.

Governance and accountability feedback

Feedback	Team responses
Broad stakeholder input	
Reviewers flagged the importance of consulting a broad range of stakeholders to develop a fuller picture of the risks of future partnership models.	A broad range of stakeholders were engaged for feedback on Draft 1, including GPEI groups, donors, CSOs and broader immunization and health emergencies groups. A consultation with Member States will take place in 2025, including engagement with countries through regional and country levels of WHO and UNICEF. The POB has also commissioned both a governance review of the current structure and options for a future structure.
Organizational approach to the chapter	
We suggest moving this section to the beginning of the document rather than the end since the governance model will be central to success.	A new Executive Summary with high-level messaging on governance was included in Draft 2. The governance chapter appears later in the strategy as governance supports the essential functions needed to sustain a polio-free world, and such governance can be defined after knowing what is required.
The “core principles” are not just governance issues, but rather fundamental pre-conditions.	The revised draft now details fundamental pre-conditions as “prerequisites.”
Defining a future partnership	
We think it’s urgently necessary to think about governance in a more concrete way: which stakeholders (by name) will collaborate for which goal? What responsibilities will each have?	This is an important step in implementing the strategy. A new section on a phased approach to implementation was discussed with the SC and will be taken forward to the POB for their input and decision on how and whom will need to take forward future planning and implementation.
What is wrong with the current partnership that it needs to be dismantled and not improved upon?	The issue is not whether something is wrong with the current partnership, but rather that sustaining a polio-free world cannot continue to rely on GPEI in its current form as a vertical programme. Broader stakeholder involvement and ownership – particularly from immunization, health emergencies and health systems strengthening actors – will be essential, along with greater integration of polio into health programmes and governance structures to ensure synergies, efficiencies and strengthened national health systems.
The strategy mentions transitioning responsibilities from the GPEI to other stakeholders but lacks details on how this will occur. A phased approach would support a smoother transition and minimize risks.	A new “roadmap” process outlines how transition and implementation will proceed. The draft has also been updated to present governance as evolving over time, starting with centralized leadership and shifting to a more decentralized leadership as risks decrease and more countries assume full responsibility for delivering polio essential functions. A co-ownership period is proposed to precede the full shift to the new governance model.
A full partnership review prior to the dissolution of GPEI is recommended. This would allow the partnership to review its roles and responsibilities.	The POB has commissioned both a governance review for the current structure and an analysis of options for a future structure. These will inform decision-making on GPEI dissolution and support strategy implementation.
Fragile country contexts	
It is hard to imagine polio activities being prioritized in fragile contexts with urgent needs and few resources. Should GPEI consider global/regional funding for this purpose?	The draft has been updated to clarify mechanisms for support to countries that cannot self-finance in the short to mid-term, as outlined in the Polio Transition Strategic Framework. However, the GPEI partnership, new and existing owners of the future governance structure and the broader global health community will need to identify funding streams to support countries that cannot self-finance the maintenance of polio essential functions.
Governance options	
Reviewers favoured an initially centralized model for quality surveillance and centrally coordinated outbreak response, shifting after key milestones to a more decentralized option. An overarching body may be needed to support accountability.	The draft has been updated to reflect governance options as evolving across time, starting with centralized leadership after GPEI dissolution and evolving into decentralized leadership as risks decline and more countries assume full responsibility for delivering polio essential functions. A global coordinating entity is envisioned across the various options, with the size adjusted based on the functions required, to support accountability.
Future models should be discussed in relation to long-term financing. If development banks take on a bigger role in financing country systems (e.g. surveillance), other models may be considered.	As part of the phased roadmap, partners (existing and future) will need to determine how best to fund the polio-essential functions and should employ different options, including development banks.
How does governance relate to resource mobilization? Who is responsible for fundraising, especially in the decentralized options?	Resource mobilization helps to ensure time-limited and sustainable financial support for countries that will not be able to fully assume polio-essential functions in the short to mid-term. Over time, as polio-essential functions become fully integrated into national health systems, the global governance structure will assume a reduced role in resource mobilization and technical assistance with the exception of fragile or conflict-affected countries, where continued external support will remain over the longer term.

Cost estimate feedback

Feedback	Team responses
Changes since Draft 1	
Strategy activities will need to be costed, but it seems like not all needs have been identified.	Draft 3 has been revised to include a high-level estimate of all resources required to successfully implement the strategy.
Scope and approach	
Costs are typically estimated at an activity level as a subset of interventions. In the strategy, interventions are "activities," with the estimates at a higher level than operational costing.	Operational/activity-level costing will need to be fleshed out with on-the-ground reality as implementation planning is underway (Phases 2 and 3), with prioritization based on all mobilized resources.
Why is country-level costing not included in the cost estimate?	The cost estimate is a global estimate that provides a rough "order of magnitude" scale of required resources. Additional cost modelling will be needed as the funding picture becomes clearer and as country readiness is further assessed.
Will regional/country-level costing be done separately and will the process be led by countries/regions? Is this expected to be included in country transition plans?	Country-level costing will be done separately, and the process will be led by countries and regions as part of transition planning and through the development of national health plans. When the strategy starts, countries will need to review where they are in relation to the latest Gavi policy and available resources to support for surveillance, as countries are expected to contribute to both vaccine procurement and surveillance.
The strategy for Sustaining a Polio-free World and the GPEI multi-year budget	
The cost estimate needs to factor in activities currently funded by both FRR and non-FRR if they are expected to continue.	The cost estimate considers all required activities to successfully implement the strategy, including activities currently funded outside the financial resource requirements (FRR).
Will these strategy costs be added to the eradication strategy multi-year budget (MYB) for activities that will need to start before the launch of the strategy? There is a risk of parallel fundraising for two different strategies.	The cost estimate includes both the preparatory investments required before certification and the activities that will follow certification. These costs should be viewed and communicated as part of a continuum toward eradication and global certification – complimentary to, not separate from, the current strategy and its MYB. It should not be seen as a parallel activity.
Why does the strategy need a separate budget when it overlaps with GPEI?	Once the governance structure is finalized, there will be an opportunity to align budget needs with the appropriate implementing parties.
Financing	
While acknowledging that there is still a large amount of uncertainty, how should we think about funding and costs in the future?	The strategy defines what activities are required in the pre- and post-cessation periods and in longer post-certification period. To resource activities, a variety of resource mobilization approaches will be needed.
Will the cost estimate provide details on whom will absorb the costs?	The purpose of the cost estimate is to provide partners and donors with a scale of resources required. It is agnostic of whom will implement the strategy, which will be defined in a future phase of planning.
While the strategy outlines future financing needs and acknowledges potential challenges related to wavering financial commitment, it lacks concrete details on how to ensure financial sustainability.	The cost estimate provides the scale of required resources. Additional work remains to make the investment case to donors across the global funding landscape and to operationalize the strategy based on available resourcing. Ensuring financial sustainability will require a variety of resource mobilization approaches and greater integration into national and global health strategies.
As written, the strategy is not attractive to donors. The GPEI should consult with a broader range of programmes, as the current approach to resource mobilization is inadequate in the context of the global funding landscape.	The strategy (and activities required to plan for its implementation) is costed to support communicating the full cost of eradication and global certification (which is a continuum and should not be seen as a parallel activity). The strategy is attractive to some stakeholders and donors as it launches the process for integrating polio functions into other global health programmes.
Financing for fragile contexts	
This GPEI needs to accept that many countries will not be able to fund these ongoing activities and that countries will have other priorities. How does the strategy intend to accommodate this (e.g. safety net, revolving funds model)?	With a dedicated budget line to support high-risk countries, the cost estimate does not assume that every country will transition to full self-financing. A new roadmap also defines a future phase for deciding governance, accountability and funding. Additionally, the Polio Transition Strategic Framework will have standardized and routinely updated guidance around support to countries not able to fully finance polio-essential functions.
Investment case	
When will the investment case be shared? Prior to affirmation of strategy at the World Health Assembly?	An investment case will not be shared prior to notation of the strategy at the Health Assembly. The GPEI along with future owners will need to determine how an investment case is developed and communicated.

Feedback on annexes

Annex A: Stakeholder engagement	
Which stakeholders and sub-agencies have been engaged thus far? e.g. countries (MOH, MOF, MOP), development banks, CSOs, etc.	The strategy revision process has engaged many stakeholders including technical and advisory groups, CSOs, and other immunization and health emergencies partners at the global, regional and country levels. WHO will also lead an effort to consult the Member States.
A lesson from COVID-19 and ACT-A is that the implementing countries that did not feel consulted felt no desire to align/implement. How will the strategy be co-designed to ensure countries do not feel it has been 'cooked' without their input?	A dedicated Member States consultation period (Q2-Q3 2025), led by WHO, will engage regional and country offices, inclusive of government and partner colleagues.
Annex C: Country risk classification	
Why is [OPV3 coverage for high-risk middle-income countries (i.e., <65%)] lower? This is not in agreement with risk tiering for BOCeT.	Noted, and the reviewer is right. The table is outdated and has been revised in Draft 3 (before Member States consultation).
Would it be useful to also include measures of surveillance capacity and fragility in risk classification of countries in Annex C?	This risk has been included in the strategy's second risk category (risk of undetected transmission). Further details regarding assessing surveillance sensitivity will be worked out as the GPEI reaches closer to the strategy's launch and will be a gradual change from updated versions of GPSAP.
What's the rationale for differentiating risk by country income? Is the income level of a country enough to determine that a vaccine manufacturing site would be high risk?	Noted, and the reviewer is right. The table is outdated and has been revised in Draft 3 (before Member States consultation).

NEXT STEPS

In April 2025, WHO briefed Member States to introduce the strategy revision and upcoming plans for the Member States consultation that will take place in Q2-Q3 2025. The final version of the strategy will be presented for notation at the Seventy-ninth World Health Assembly.

DRAFT 3: Member States consultation

Revisions based on first round of stakeholder consultations went to the Strategy Committee and Polio Oversight Board (as Draft 2) for their comment and review.

A revised Draft 3 will be used for consultation with WHO Member States to ensure the final strategy is both technically robust and practically applicable to country contexts. The WHO Member States consultation process will be complemented by engagements with national technical experts through regional and country levels of WHO and UNICEF.

New sections added since Draft 1:

- an updated executive summary;
- a roadmap figure to provide the latest thinking on planning for implementation; and
- revised chapters for *Governance and accountability* and *Cost estimate.*

Next steps for the revision of the strategy for *Sustaining a Polio-free World* can be found below.

Date(s)	Milestone	Description
June to July 2025 (TBC)	Draft 3 shared with Member States for written feedback	WHO will share Draft 3 with Member States to gather written feedback on the strategy.
July 2025 (TBC)	WHO information session with Member States	WHO will update Member States on the feedback received and how it will be addressed.
June–September 2025	Regional/country engagement with national experts by WHO and UNICEF	WHO and UNICEF will utilize regional and country platforms to gather additional feedback from national experts at relevant meetings.
September 2025	Decision by the Polio Oversight Board on GPEI governance	The Polio Oversight Board will meet and make a final decision on timeline for dissolution of GPEI governance.
January 2026	158th WHO Executive Board	WHO will present the draft strategy to Member States for any final comments.
May 2026	Seventy-ninth World Health Assembly	WHO will present the revised strategy to the Health Assembly. A side event will take place to socialize the strategy.

For additional information or questions related to the strategy for *Sustaining a Polio-free World*, please contact us at poliopcsteam@gmail.com.

ANNEXES

Annex A: Draft 1 survey questions

The questions below were provided to stakeholders via an online survey to provide a structured format for any feedback. General questions were also included as a "reader's note" in Draft 1.

1. Which of the following do you represent?
    - Country: partner organization
    - Regional office
    - Donor
    - Global: organization working on polio
    - Global: organization working on immunization, emergencies, etc.
    - Global: oversight or expert body

General feedback (required)

2. Does the Strategy appropriately reflect risks and challenges in the post-certification era? If not, which ones would you suggest including and/or removing? What additional strategies or activities should be reflected in the goals to help protect populations, detect and respond to polio events, or contain polioviruses?

3. Are there future policy decisions or dependencies that should be accounted for in the document? If yes, please describe below.

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

5. The name of the document – "Post-Certification Strategy" – may need to be updated to reflect that we will no longer have global certification of all polio types happening at once but rather, they will occur at different timeframes. The updated PCS will begin in the successful completion of the current Polio Eradication Strategy (2022-29), which will be at the time of certification of cVDPV2 elimination. Do you think the name needs to change? If so, do you have suggestions for a new name for the Strategy?

    - Keep the name as is: "Post-Certification Strategy"
    - Rename to "A strategy to sustain a polio-free world"
    - Other

Section-specific feedback (optional)

6. Would you like to provide feedback on any of the specific goals or sections of the Strategy? If yes, you can skip ahead to any section below.

7. *Goal 1: Protect Populations*

    1. Do you think the risks and challenges described in Goal One address key risks in protecting populations? If not, what else do you think should be considered?

    2. Do you have general comments on Goal One? If yes, please describe below.

8. *Goal 2: Detect and respond*

    1. Do you think the risks and challenges described in Goal Two address the key strategic issues around surveillance? If not, what else do you think should be considered to adequately address surveillance issues in a post-polio world?

2. Do you think the risks and challenges described in Goal Two address the key issues around outbreak response? If not, what else do you think should be considered to adequately address response issues in a post-polio world?

3. Do you have general comments on Goal Two? If yes, please describe below.

9. *Goal 3: Contain polioviruses*

    1. Do you think the risks and challenges described in Goal Three address the key issues around poliovirus containment? If not, what else do you think should be considered to adequately address containment issues?

    2. Do you have general comments on Goal Three? If yes, please describe below.

10. *Research Activities*

    1. Are the descriptions and the information provided of 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 below.

11. *Governance and Accountability*

    1. Do you think the core principles and mandatory elements described in Governance and Accountability address the key issues that must be considered for any post-GPEI partnership model? If not, what else do you think should be considered to adequately address future governance issues?

    2. Which option is the strongest / most preferable for the period immediately after GPEI dissolves?
        - Option 1a: centralized – “GPEI revisited” model
        - Option 1b: centralized – Global Partnership model
        - Option 2a: decentralized – Vertical governance model
        - Option 2b: decentralized – Horizontal governance model
        - Other?

    3. Please describe your choice above, including any additional pros and cons considered.

    4. Do you have additional comments on the Governance and Accountability section? If yes, please describe below.

12. *Cost Estimate and Financing*

    1. 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 financial requirements in proper context for various stakeholders? If not, what additional topics do you feel need to be addressed in this section?

    2. Do you have additional comments on the Cost Estimate and Financing section? If yes, please describe below.

Annex B: Consultation schedule (2024–2025)

The strategy working group held regular meetings with GPEI groups and joined dedicated sessions with donors and other key stakeholders, some of which are listed in the high-level timeline below.

2024 consultations

Date	Meeting	Objective	Participants
3 Apr 2024	Strategy Committee (SC)	Present the revision workplan and introduce working groups	SC members and deputies, Global Programme Support (GPS) co-chairs, strategy working group
22 May 2024	Polio Oversight Board (POB)	Discuss polio transition	POB members, donors, WHO and UNICEF regional directors, SC members, other key stakeholders, leads of strategy working group
17 Jul 2024	POB	Present strategy and flag areas for upcoming decision-making	POB members, donors, WHO and UNICEF regional directors, SC members, other key stakeholders, leads of strategy working group
12 Sep 2024	SC	Present Draft 1 for review before stakeholder consultations	SC members and deputies, GPS co-chairs, strategy working group
11 Oct 2024	USAID-convened discussion (Part 1)	Present strategy timeline and essential functions; discuss country readiness	USAID, country representatives (Nepal, India, Somalia), World Bank, Asian Development Bank, CDC, Gavi, UNICEF, WHO, bOPV Cessation Team (BOCeT), strategy working group
16 Oct 2024	POB	Present updates, review strategy timeline, discuss next steps	POB members, donors, WHO and UNICEF regional directors, SC members, other key stakeholders, leads of strategy working group
5 Nov 2024	USAID-convened discussion (Part 2)	Follow-up on discussions about country readiness	USAID, country representatives (Nepal, India, Somalia), World Bank, Asian Development Bank, BOCeT, strategy working group
7 Nov 2024	Civil Society Working Group	Present strategy, gather feedback on Draft 1	UN Foundation, Gavi, Civil Society Working Group on Polio Integration and Transition (CGPP, CRS, ICD, JSI, PATH, Rotary International)
7 Nov 2024	bOPV Cessation Team (BOCeT)	Present an update on strategy and gather feedback on Draft 1	CDC, Gates Foundation, Gavi, UNICEF, WHO, Georgia Institute of Technology, Imperial College, Institute for Disease Modeling, London School of Hygiene and Tropical Medicine, Pasteur Institute of Tunis, PATH, leads of strategy working group
13 Nov 2024	Regional check-in	Present strategy, gather feedback on Draft 1	WHO Eastern Mediterranean Regional Office (EMRO), strategy working group
20 Nov 2024	Resource Mobilization Group (RMG)	Present strategy, discuss financing and donor engagement	RMG, WHO, UNICEF, Rotary International, strategy working group
20 Nov 2024	Donor representatives	Present strategy, gather feedback on Draft 1	USAID, European Commission (with INTPA), France, UK, Canada, strategy working group
21 Nov 2024	Global Certification Commission (GCC)	Present strategy, request feedback on Draft 1	GCC, BOCeT, strategy working group
2 Dec 2024	Regional check-in	Present strategy, gather feedback on Draft 1	WHO African Regional Office (AFRO), strategy working group
9 Dec 2024	Transition and Governance Working Group	Provide updates on Draft 1 feedback, discuss proposed edits on governance	CDC, Gates Foundation, Gavi, Rotary International, UNICEF, WHO, UN Foundation, USAID, strategy working group

BOCeT = bOPV Cessation Team; CDC = US Centers for Disease Control and Prevention; CGPP = CORE Group Partners Project; CRS = Catholic Relief Services; GCC = Global Commission for Certification of the Eradication of Poliomyelitis; GPS = Global Programme Support; ICD = Initiative for Community Development; INTPA = International Partnerships (European Commission); JSI = John Snow, Inc.; POB = Polio Oversight Board; SC = Strategy Committee; UK = United Kingdom; UNF = United Nations Foundation; UNICEF = United Nations Children's Fund; USAID = US Agency for International Development; WHO = World Health Organization.

2025 consultations

Date	Meeting	Objective	Participants
24 Jan 2025	SC	Discuss roadmap and upcoming POB decision on GPEI dissolution	SC members, SC deputies, GPS co-chairs, strategy working group
12 Feb 2025	SC	Present on stakeholder consultations, discuss renaming strategy, receive guidance	SC members, SC deputies, GPS co-chairs, strategy working group
24 Mar 2025	POB	Share update on key themes from stakeholder feedback, review outstanding questions/decisions, discuss next steps (Member State consultations and inputs/decisions needed from POB)	POB members, donors, WHO and UNICEF regional directors, SC members, other key stakeholders, leads of strategy working group
14 Apr 2025	Member States briefing	Present strategy and upcoming Member States consultation process	WHO Member States, WHO Polio Programme

GPS = Global Programme Support; POB = Polio Oversight Board; SC = Strategy Committee; UNICEF = United Nations Children's Fund; WHO = World Health Organization.