POLIO GLOBAL ERADICATION INITIATIVE

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

Strategy consultation report

December 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) – the two goals of the Global Polio Eradication Initiative (GPEI) as defined in its Polio Eradication Strategy.

The Sustaining a Polio-free World (SPW) 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).

Given changes since its initial publication, a team was assembled in 2024 to revise the strategy with multiple rounds of consultations. This report provides an overview of the consultation process, presents changes that have been made and summarizes responses to feedback.

Why revise the *Polio Post-Certification Strategy*?

- ***A new GPEI Polio Eradication Strategy***: In 2020, changes to the epidemiological landscape prompted the GPEI to redefine the path to eradication 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 with the eradication strategy to ensure a continuum of planning is in place to achieve and sustain a polio-free world.
- ***New technologies:*** The revision 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 methods for surveillance, are anticipated for use during the Sustaining a Polio-free World strategy.
- ***New frameworks:*** The revision is also informed by new and updated global health 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.

Strategy revision working groups	
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- ***Changes to global health:*** Since COVID-19, global health has undergone seismic shifts. A surge 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.

METHODOLOGY

The revision process for the Sustaining a Polio-free World (SPW) strategy included multiple rounds of consultation and deliberate touch points with the GPEI Strategy Committee and Polio Oversight Board.

Throughout the revision process, the GPEI prioritized active and inclusive engagement of stakeholders, including technical experts, countries and regions. The 2024–2025 revision process had two separate rounds for gathering feedback: a first round of review by a broad set of stakeholders and a second round of engagement with WHO Member States. These consultations helped ensure the revised strategy was both well-rounded and well-socialized.

Summaries of the feedback received and changes that were incorporated into the strategy appear below. A high-level timeline of the consultation schedule can be found in **Annex A**.

Round 1: Broad stakeholder review

September–November 2024

A broad set of stakeholders received a revised 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 B**); 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, as well as dedicated sessions with external stakeholders, including donors and civil society organizations. Stakeholders who provided feedback in this round are listed in **Annex C**. Their feedback is summarized below and collectively presented with detailed responses in **Annex D**.

DRAFT 1: Broad 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.

Two new chapters were added:

- ***Governance and accountability*** discussed options for future governance; and
- ***Cost estimate*** presented the methodology for an estimate that was in development as an update to the Post-Certification Strategy cost estimate, published in 2018 as a stand-alone document.

Round 2: Member States engagement

June–October 2025

Country ownership is at the heart of the SPW strategy. To ensure that the strategy's development reflects country-level and regional perspectives, Member States were invited to participate in two information sessions held by WHO and provide written feedback on the strategy (Draft 3). In addition, several WHO regional and country offices held dedicated briefings on the strategy to brief national governments. A summary of Member States' feedback is summarized below and presented in **Annex E**.

DRAFT 3: Member State engagement

Draft 3 was shared for engagement with WHO Member States to ensure the final strategy is both technically robust and aligned with country immunization and health emergency systems. The WHO Member State engagement process was complemented by engagements with national technical experts through regional and country levels of WHO and UNICEF.

Notable additions that appeared in Draft 3:

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

STRATEGY GOALS

The strategy for Sustaining a Polio-free World outlines three key epidemiological risks over a 10-year period: (1) vaccine-derived poliovirus (VDPV) emergence leading to outbreaks of circulating vaccine-derived poliovirus (cVDPV) through continued use of the oral polio vaccine (OPV); (2) undetected transmission; and (3) unsafe handling of polioviruses. Operational risks, such as wavering political and financial commitment, are also critical to consider as part of planning and implementation.

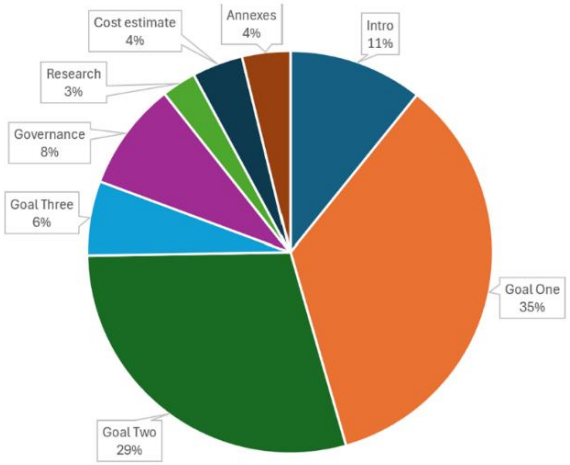
The three goals of the strategy were developed as a risk mitigation plan against these future risks.

- **Goal One:** Protect populations by preparing and implementing a globally synchronized cessation of bOPV use in routine immunization and by providing access to safe, effective vaccines for the long-term protection of global populations;
- **Goal Two:** Detect and respond by promptly detecting poliovirus in a human or in the environment through a sensitive surveillance system and maintaining adequate capacity and resources to effectively contain or respond to a polio event or outbreak; and
- **Goal Three:** Contain polioviruses by achieving and sustaining safe and secure containment of polioviruses in laboratories, vaccine manufacturers and other facilities (such as research institutions) to prevent reintroduction in a polio-free world.

Feedback received through each consultation round was analyzed to present a visual representation of areas of focus for a broad set of stakeholders (p. 5) and Member States (p. 10).

STAKEHOLDER CONSULTATIONS (DRAFT 1)

More than 800 comments were received from a broad set of stakeholders (see **Annex C** for participants), with the majority of comments focused on 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 discussed and decided 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 wanted 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 the strategy formally 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 noted 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 a greater 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 medium-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 to future governance. Some encouraged a risk averse approach to the timing given to "co-ownership" as part of the transition from the GPEI Eradication Strategy to the strategy for Sustaining a Polio-free World.

Annex D details how stakeholder feedback was addressed and responded to in Q2 2025.

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 better capture programmatic changes to certification milestones. In the Polio Eradication Strategy 2022–2029, the GPEI established goals for certification of WPV1 eradication and 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 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. In 2025, the GPEI also commissioned a governance review to assess the existing governance model and to inform future planning. While the Polio Oversight Board will continue to review and determine actions based on key findings and recommendations, decisions on future governance will not be made until all relevant stakeholders, including agencies within and outside of the GPEI partnership, collectively decide how best to sustain a polio-free world. As defined by this chapter, future governance should continue to evolve and not be a one-time shift, requiring instead adjustments at different milestones or decision points.

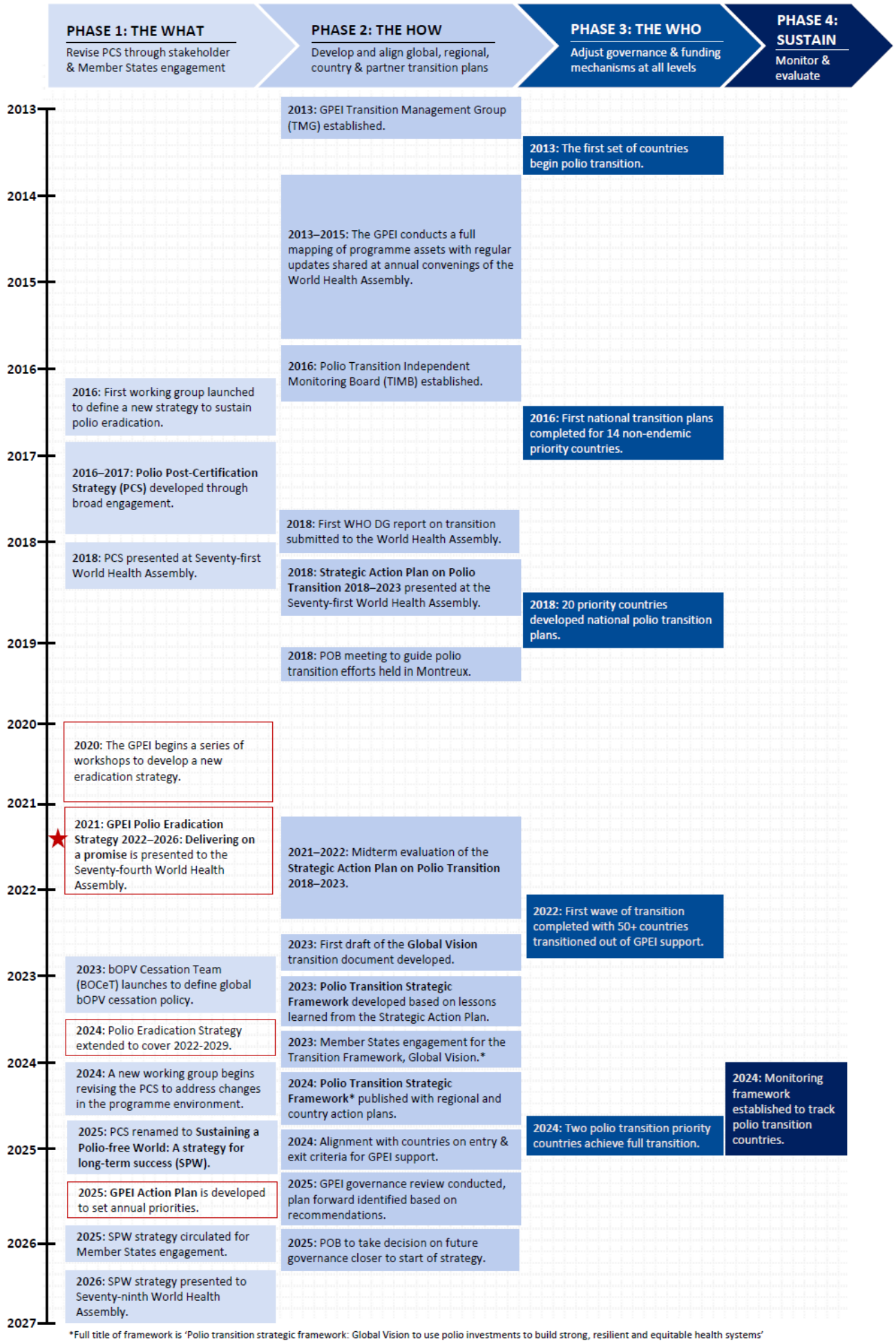
Updates to the cost estimate

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. As select costs such as vaccine procurement will be incurred before the strategy formally launches, GPEI leadership will 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 dedicated to monitoring and evaluation to sustain polio eradication (Phase 4). The roadmap provides clarity on when implementation details (beyond the scope of this technical strategy) will be defined.

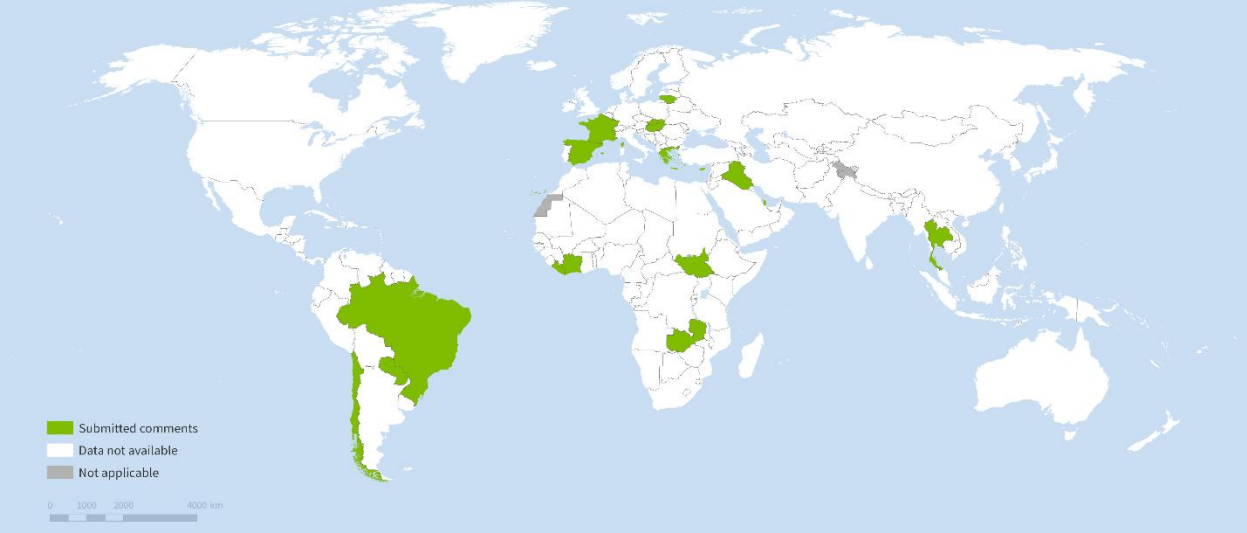
This roadmap also outlines these phases so a host of partners – from national governments to other programmes – can mobilize and prepare for the future evolution of the current GPEI partnership, which has organized the eradication effort since 1988. Planning has already been underway for Phase 1 (the What) and Phase 2 (the How). A three-year period of overlap with the Polio 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.



*Full title of framework is 'Polio transition strategic framework: Global Vision to use polio investments to build strong, resilient and equitable health systems'

MEMBER STATES ENGAGEMENT (DRAFT 3)

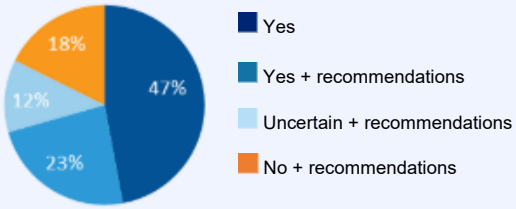
The WHO Member States engagement period took place between June and August 2025. Eighteen Member States provided feedback through formal written responses.



Member States' written responses

Question #1

Does the strategy appropriately reflect risks and challenges that may be faced after certification of WPV1 eradication and cVDPV2 elimination and in the 10-year period after bOPV cessation? If not, which risks and challenges should be included?

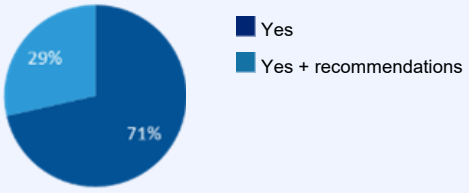


A majority of Member States (70%) responded that the strategy appropriately reflects risks and challenges after certification of WPV1 eradication and cVDPV2 elimination. Some countries emphasized challenges that will need to be addressed through the strategy and its implementation, such as ensuring adequate polio vaccine supplies and stockpiles. Others noted operational risks that represent barriers to the strategy's implementation. These include:

- country-level risks in fragile, conflict-affected and vulnerable settings that range from an increase in economic migration to displacement and inaccessibility due to climate change, geopolitical instability and/or insecurity;
- large-scale cross-border population movement that elevates the risk for international spread and/or the risk of delayed detection;
- recent shifts within the global health architecture and funding environment that will impact the success of the strategy, particularly as these shifts affect agency partners' ability to take up new mandates. Member States also noted that maintaining standards for polio immunization and detection also presents challenges given constrained domestic resources.

Question #2

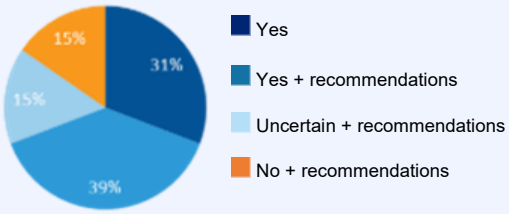
Does the strategy align with your country's current immunization and health security goals and priorities?



Member States unanimously agreed that the strategy aligns with their current immunization and health security goals and priorities. Some countries noted that they already operate within the future state of the strategy, where polio-essential functions are integrated into health systems.

Question #3

Do you have any specific feedback on the considerations for future governance for the period of the strategy? Is the outlined evolving model sufficient to support the delivery of polio-essential functions by national health systems, in line with the evolving risk profile of these functions?



Member States signaled strong support (70%) for an evolving model for governance and accountability to provide flexibility over time in relation to primary epidemiological risks and future challenges and in relation to regional contexts.

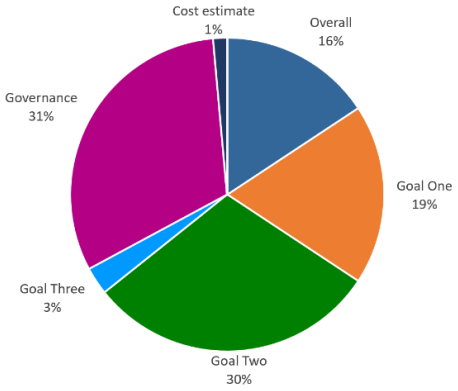
- Member States took up a range of positions on the question of centralized versus decentralized governance. This variation may reflect regional differences that could be effectively leveraged through regionally tailored approaches to governance.
- Member States recognized the role of global support for key functions that include vaccine supply, bOPV cessation, containment, certification of the final eradication milestones, active risk management, high-level advocacy and time-limited support for high-risk and fragile country contexts.
- Member States also noted that monitoring and oversight of implementation must rely on existing national mechanisms to avoid creating another vertical coordination structure. Some Member States recommended that contingency funds could be established at the national level for rapid deployment during VPD outbreaks.

Responding to Member State feedback

Where Member States provided recommendations and country-level considerations, the feedback was catalogued by chapter and shared with the working group for review toward final revisions of the strategy.

Member State feedback is summarized below.

Detailed responses to comments drawn from Member States' formal written responses are provided in **Annex E**.



Chapter	Feedback from Member States
Overall	• The strategy should include more on country-level risks: conflict, environmental risks, extensive population movement, implementation challenges such as limited infrastructure/capacity, workforce shortages. • Regional considerations also factored into Member State responses.
Introduction	• More clarity should be provided on timelines for GPEI dissolution.
Goal One	• More clarity should be provided on timelines for bOPV cessation. • More focus should be provided on operational realities, readiness for bOPV cessation.

Goal Two	• The strategy should more fully address vaccine supply risks.
	• Member States expressed concerns about:
	  ○ cross-border population movements and mass gatherings contributing to a risk of international spread, delayed detection; and
	  ○ sustainability for surveillance systems (community-based surveillance, wastewater surveillance for multiple pathogens, surveillance for immunodeficiency-associated vaccine-derived poliovirus (iVDPV).
	• Greater focus should be given to disaggregated data, integration.
	• Call for stronger articulation of risks and challenges around surveillance and lab.

Goal Three	• Ensure close monitoring of containment standards and vaccine supply.
Accountability & governance	• Member States expressed strong support for an evolving model to promote flexibility and tailor the model to different contexts and phases of the SPW strategy. • Phased shift from centralized to decentralized governance: needs support, could happen regionally. • Emphasize the strengthening of national capacity, avoid verticality and ensure clear roles and accountabilities between countries and other partners. • Monitoring should leverage national mechanisms. • Ensure risk analysis and monitoring are fully articulated. • Some countries preferred a centralized structure; others preferred a regional approach.

Broad changes to the strategy for its final revision

On planning for bOPV cessation and the future evolution of the GPEI partnership

Member States requested clarity on timelines for two key elements of the SPW strategy: bOPV cessation and the future evolution of the GPEI partnership. Both are dependent upon progress with eradication.

bOPV cessation: The strategy emphasizes that triggers are used in lieu of timelines as bOPV cessation is contingent on the achievement of clear epidemiological markers or triggers as endorsed by SAGE. Language has been added, however, to clarify that further information will be provided by the bOPV Cessation Team (BOCeT), developed in coordination with SAGE and in consultation with regions and countries.

Shift from GPEI dissolution to its future evolution: Member States asked that the strategy clearly define the evaluation process and timeline for "GPEI dissolution," as a more defined process could help to ensure the strategy's operationalization and the sustainability of polio-essential functions.

Previous drafts of the strategy referred to this milestone as the "dissolution" of the GPEI partnership. The terminology came out of past guidance from the Polio Oversight Board (POB). During the development of the *Polio Post-Certification Strategy*, the POB took a decision to dissolve the GPEI partnership at global certification. At the time (in 2018), the programme did not have widespread outbreaks of circulating vaccine-derived poliovirus type 2 (cVDPV2), and the global certification milestone that launched the strategy meant certification of all poliovirus types.

The development in 2022 of a new eradication strategy that established two goals (WPV1 eradication and cVDPV2 elimination) reviewed the epidemiological picture and split the cVDPV certification by type. The revised SPW strategy is set to begin after both WPV1 eradication and cVDPV2 elimination are certified. Consequently, the strategy now includes the following milestones: withdrawal of the bivalent oral polio vaccine (bOPV); the elimination of cVDPV types 1 and 3; and the global certification of all poliovirus types.

This change to the epidemiological picture contributes to a changing operational environment. It requires GPEI governance to evolve over time instead of dissolving, with existing and new partners working differently to achieve the remaining milestones and secure a sustainable polio-free world. The GPEI Strategy Committee endorsed a shift in approach to the future *evolution* of the partnership instead of its dissolution. This change has been brought forward throughout the strategy document. The POB will take steps to revise the future governance model closer to the start of the SPW strategy.

Additional updates to the final strategy document

- **Polio vaccine security:** In light of Member States' concerns over vaccine supply, more detail was added in the final document on the Polio Vaccine Security Framework and its approach to ensuring timely, sustained and uninterrupted supply of polio vaccines.
- **Cost estimate:** In response to feedback received from WHO regional offices, a new annex was added to the final strategy to elaborate on the scenario assumptions of the cost estimate.
- **Operational risks:** Additional language was added throughout the introduction and goal chapters to reflect Member States' feedback on additional operational risks that may create destabilizing conditions for the strategy. These include: climate change-related environmental risks, conflict and humanitarian emergencies and their collective impact on migration across national and international borders.
- **Governance:** To respond to feedback from Member States, edits were made to strengthen language around building and bolstering capacity at the national level and risk management. In addition, text was amended to align with the concept of GPEI evolution following the success of the eradication strategy. Many comments focused on implementation (which is outside the scope of this strategy) were noted and will be taken forward during the preparatory planning period for SPW implementation.

ANNEXES

Annex A: Consultation schedule (2024–2025)

The strategy working group held regular meetings with GPEI groups and dedicated sessions with donors and other key stakeholders.

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
20 Jun 2024	Transition and Governance Working Group	Establish the working group, set the stage, initiate discussions on the governance and accountability chapter	CDC, Gates Foundation, Gavi, Rotary International, UNICEF, WHO, UN Foundation, USAID, 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
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; UN = United Nations; 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 engagement 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 information session	Present strategy and upcoming Member States engagement process	WHO Member States, WHO Polio Programme
20 Jun 2025	SC written update	Share update on SPW next steps, including draft that went out for Member States engagement	SC members, SC deputies
29-31 July 2025	WHO South-East Asia Regional Certification Commission	Present strategy and Member State engagement process	WHO Member States
26 Aug 2025	WHO African Regional Committee	SPW discussed as part of polio eradication side meeting.	WHO African Region Member States, WHO polio programme
3 Sep 2025	SC	Present updated thinking and framing around GPEI 'evolution' (rather than 'dissolution') and POB decision needed	SC members, SC deputies, GPS co-chairs, strategy working group
18 Sep 2025	SC	Confirm updated 'GPEI evolution' framing and date for POB decision	SC members, SC deputies, GPS co-chairs, strategy working group
24 Sep 2025	Transition and Governance Working Group	Provide updates on Member States feedback, discuss proposed edits on governance	CDC, Gates Foundation, Gavi, Rotary International, UNICEF, WHO, UN Foundation, strategy working group
5 Nov 2025	SC written update	Share written update on SPW finalization status and next steps	SC members, SC deputies
17 Nov 2025	Member States information session	WHO updated Member States on feedback received and how it was addressed.	WHO Member States, WHO Polio Programme
10 Dec 2025	POB	Discuss evolution of GPEI for SPW strategy	POB members, donors, WHO and UNICEF regional directors, SC members, other key stakeholders, leads of strategy working group

CDC = US Centers for Disease Control and Prevention; GPEI = Global Polio Eradication initiative; GPS = Global Programme Support; POB = Polio Oversight Board; SC = Strategy Committee; UN = United Nations; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

Annex B: Stakeholder survey

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 with 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 C: Stakeholder 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.***

- Civil society organizations 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 the 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)
- Donors including: 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 country-level stakeholders: the National Certification Committees (NCCs) of Bhutan and India
- Other global health initiatives (e.g. Measles and Rubella Partnership, Yellow Fever Initiative)
- Other regional stakeholders: Chinese Center for Disease Control and Prevention
- Regional technical advisory groups
- Rotary International
- Strategic Advisory Group of Experts on Immunization (SAGE) and the SAGE Working Group on Polio
- UNICEF, including Immunization, Supply Division, 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 at headquarters (e.g. immunization and health emergencies programme teams)

Annex D: Detailed feedback from stakeholders (Draft 1)

The responses that appear below were provided by the strategy revision working group in Q2 2025.

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 engagement.
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 transition-related activities need to be tailored to what is feasible in the local context of funding, government commitment, etc., including through the 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 was reviewed and approved by the Strategy Committee (SC) and the POB at their 24 March 2025 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 and 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 includes 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 (currently 2027) and cVDPV2 elimination (currently 2029) that may be adjusted based on the epidemiology. Until both goals are achieved, countries will continue to transition after achieving national 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 the 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 engagement 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. WHO Health Emergencies (WHE) was also engaged during the first round of consultations to gain perspectives aligned with IHR, GHSA and HEPR.
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 this strategy, which will be triggered only after the achievement of both of the eradication 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 the 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 which 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?	The GPEI is 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.	Agreed. 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 the 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 the GPEI expects that support will continue with the integration of polio. Phases 2 and 3 of this process will focus on governance, roles and responsibilities and accountabilities.
Vaccine supply	
What is the 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 – all of which align with the Lusaka Agenda.

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?	The GPEI agrees 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 future standard operating procedures (SOPs) or an 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 future evolution of the 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?	Data systems will not be "switched" as much as they will be potentially merged. 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.	Implementation of this strategy 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. The GPEI Surveillance Group considers 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.	Agreed. However, the reality is that a global pan-surveillance framework is not in place. 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.	Agreed. 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.
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). 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 long-term containment.
Future governance	
What will governance and oversight of containment look like in the pre-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.).

* Note: Two separate Member States (Canada and Australia) provided feedback through their national authorities on containment (NACs).

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 Polio 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 the 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 took place in 2025, including engagement with countries through regional and country levels of WHO and UNICEF. The POB has also commissioned a governance review of the current structure that may help to inform future decisions.
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 governance can only 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 partners will collaborate for which goal? What responsibilities will each have?	This is an important step in implementing the strategy. A high-level phased approach to implementation was discussed with the SC and POB to aid with 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 the 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 future evolution of the GPEI is recommended. This would allow the partnership to review its roles and responsibilities.	The POB 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 evolution 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 the 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 the GPEI budget?	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 who 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 who 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 the strategy's presentation to the Health Assembly. The GPEI along with future owners will need to determine how an investment case is developed and communicated.

Feedback on annexes

Feedback	Team responses
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 engage 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 engagement was led by WHO during Q2-Q3 2025. Regional and country offices, inclusive of government and partner colleagues, were also included in the engagement process.
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 engagement).
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).

Annex E: Detailed feedback from Member States (Draft 3)

Overall feedback

Feedback	Team responses
Structure or approach	
Without deeper customization, the SPW strategy risks being too generalized to address nuanced challenges and vulnerabilities that come with evolving risks. Improving data systems, ensuring continued technical support and strengthening coordination with humanitarian actors will be key to making the SPW strategy truly sufficient in high-risk environments.	The SPW is a global strategy that defines the technical standards and activities needed after the achievement of the GPEI's Eradication Strategy. It is a first step in a larger process toward the integration of polio-essential functions into national systems, with global functions (including risk management) continuing through a governance structure that will adapt to evolving risks. As the partnership moves through this process, future risks will inform governance and implementation decisions to ensure that the world can sustain polio eradication in an-ever evolving environment.
While it is understood that the strategy has a global approach and incorporates various assumptions, challenges, and risks, it may be necessary to develop a complementary strategy at the regional level which considers the specific risk profile of countries.	Regional plans and country national plans should incorporate the polio-essential functions and adjust to local risks as necessary. It will be difficult for a global document such as the SPW strategy or the Polio Transition Strategic Framework to contain all the geographical specific risks. Key to the Polio Transition Strategic Framework's Global Vision, regional strategic plans and country action plans help to guide regions and countries to sustainably maintain polio-essential functions and safeguard polio eradication.
Suggestions were provided to include a preamble on governance considerations that would clearly define the evaluation process.	While a foreword will be part of the final revised strategy, a preamble on future governance decisions will not be included. This will, however, be considered for Phase 3 of the roadmap, as future governance and funding mechanisms are defined for future SPW implementation.
Global scope of strategy (for lower-risk countries)	
Some strategy components may not respond to countries' operational realities. For example, on the transition or transfer of the structures and functions developed for polio eradication to national governments: for many countries, these functions are already integrated. In this sense, the strategy is dissonant with regional structures and systems.	While polio-free countries that have already integrated polio-essential functions into their national systems are not addressed through aspects of the SPW strategy that speak to transition, their continued implementation of global technical guidance in accordance with SPW goals will be critical to safeguard the gains of the polio eradication effort. Such countries also serve as important models for transition and for evaluation of future SPW governance.
Relatedly, low-risk countries face a challenge: maintaining polio-free status requires greater efforts, especially in the face of factors such as immigration and cross-border mobility of people.	The strategy's reference to operational risks related to destabilizing conditions has been updated to include large-scale population displacement and cross-border migration as a risk for countries and regions. The recognition of the risk is critical but the actions or solutions will vary based on geographical context.
Additional risks and challenges (many for higher-risk countries)	
Context-specific challenges to sustaining polio eradication for higher-risk countries: (1) health system fragility due to limited infrastructure, workforce shortages, and reliance on external funding; and (2) conflict and humanitarian contexts which disrupt surveillance and immunization activities.	Operational realities such as these will not be addressed by the SPW as a technical strategy. These context-specific challenges will, however, be critical to SPW implementation and to decisions on future governance, including through the possible engagement of current and new partners that have relevant expertise in responding to such challenges, to support delivery of the strategy's goals.
Context-specific challenges to sustaining polio eradication: (3) strong cross-border surveillance and immunity building in the face of porosity of the boarders and amid increasing economic migration and forced/disaster-induced migrant populations.	The strategy's reference to destabilizing conditions under operational risks has been updated to include economic migration across national and international borders as a risk for countries and regions.
Topics not covered: Climate change and environmental risks heightened by the seasonal flooding and extreme weather events that disrupt immunization and surveillance activities.	The discussion in the introduction of operational risks to the strategy due to destabilizing conditions has been updated to include climate change and environmental risks.
Mass gatherings will be a challenge to sustaining a polio-free world, and a unified international mechanism should be created to reduce the potential risks during such gatherings.	Countries and agency partners alike have expressed preference for avoiding new vertical structures and instead reinforcing national mechanisms. Under IHR, the classification of polio as a PHEIC provides an occasion for countries to require proof of vaccination for visitors. Countries can also operate temporary vaccination points during periods of intensified border crossings or migration to mitigate risk of importation.

Feedback	Team responses
Strategy implementation	
Strong advocacy is needed with non-GPEI agencies/partners and programmes to have an open mind towards polio integration, since most programmes view polio as a vertical programme that, despite being 'heavily funded', did not integrate with other non-polio functions previously.	This will need to be prioritized. GPEI agency partners recognize the importance of these considerations. Under the current GPEI Eradication Strategy and through initiatives such as joint planning with Gavi and EPI, the programme continues to strengthen integration. The maturity of these initiatives will be important groundwork for SPW strategy implementation and relevant to discussions about governance.
The strategy does not sufficiently account for global instability in funding and political will. Without concrete financial commitments and clearly defined funding mechanisms, polio transition efforts remain vulnerable to competing health priorities, limited government allocations and funding decreases.	The strategy recognizes the risk represented by insufficient funding and/or political will. The introduction includes wavering political and financial commitment as a primary operational risk. Within the three goal chapters, insufficient political and financial commitment are included in risk and risk mitigation tables. These operational concerns will be key to SPW implementation and will require all stakeholders to take active roles in problem-solving.

Goal One: Protecting populations

Feedback	Team responses
bOPV cessation	
The strategy should include robust, well-sequenced timelines and milestones to support the successful transition from bOPV to IPV, with particular attention to countries with fragile routine immunization systems.	The timing of bOPV cessation is dependent on progress with WPV1 eradication, which is why the strategy uses milestones and not timelines. Member States should follow global updates (via SAGE) on the triggers for bOPV cessation as a guide to the timing of global withdrawal. Global coordination will be critical, and countries should work to improve polio immunity as per the enabling factors.
The strategy includes strengthening surveillance information systems, but not immunization information systems (IIS). It should emphasize the importance of having disaggregated coverage data to identify pockets of susceptible populations.	Agreed. The risk table for Objective 1.1 now includes using coverage data in immunization information systems (IIS) to identify at-risk populations and optimize vaccine delivery at the subnational level.
Context-specific challenge that should be addressed: strong cross-border immunity building [for pre-cessation campaigns] in the face of porosity of the borders and amid increasing economic migration, as well as forced/disaster-induced migrant populations.	Agreed. The risk table for Objective 1,1 now includes cross-border coordination as a mitigation for reaching high immunity among vulnerable populations impacted by climate and disaster-related migration.
Context-specific challenges that are not addressed: Climate change and environmental risks heightened by the seasonal flooding and extreme weather that disrupt immunization activities.	Agreed. Environmental risks that could impact pre-cessation campaign activities are now included in the discussion of challenges that should be anticipated and responded to as part of planning and implementation for bOPV withdrawal.
Context-specific challenges that are not addressed: humanitarian contexts – e.g., sustaining high population immunity in humanitarian settings is demanding and may contribute to the risk of virus seeding after bOPV2 cessation.	Challenges in reaching conflict-affected populations are included in the risk table for Objective 1.1. Populations may be inaccessible for many reasons, and reaching high-risk groups requires tailored activities that will be addressed through implementation.
A more detailed plan for managing vaccine supply chain disruptions would help to mitigate risks.	Agreed. The risk table now includes reference to detailed planning for vaccine supply which is addressed by the Polio Vaccine Security Framework. To more fully capture this approach, a text panel on the framework has been added to Goal One.
[Member States recognize the need to] strengthen political commitment and ensure that polio remains a national health priority, especially in the period immediately following bOPV cessation as countries may not prioritize polio amid an absence of cases.	Agreed. This is why weakened domestic, political or financial commitment are listed as the first area of risk for Objective 1.1 with multiple activities recommended to ensure successful bOPV cessation despite this risk.
Long-term protection through polio vaccines	
Topics not covered by the strategy: Hexavalent is contraindicated for older age groups. It is important to discuss measures for sustainably responding to health emergencies in older age groups.	While recent SAGE recommendations have indicated IPV use (full or fractional) in outbreak settings as a supplement to OPV (the primary tool due to its ability to induce mucosal immunity), the recommendations only apply to standalone IPV, not hexavalent.

Feedback	Team responses
The integration of polio functions into routine immunization and strengthening of RI systems with the emphasis on IPV, and response activities through nOPV-1, -2, and -3 use entail that: - The novel OPVs and IPV will be easily accessible - There will be transfer of technology for continental/in-country vaccine developments.	On novel OPVs and IPV supply, both will be maintained through the processes outlined in the Polio Vaccine Security Framework. On technology transfer for vaccine developments, this isn't relevant for the SPW strategy as stockpiles will be established for future response to outbreaks. WHO has done tech transfers for Sabin IPV (sIPV) + vaccine-like particles (VLPs). To date, however, there has been no interest in tech transfers from manufacturers on the African continent.
A specific risk communication component needs to be deepened in order to position polio as a priority within their national agendas, especially with regard to early detection and response. This approach is relevant to maintain high vaccination coverage and the impact of migration from countries with lower coverage.	Agreed. The risk table for Objective 1.2 now includes developing a specific risk communication to position polio within national agendas.
We welcome GPEI's current work with Gavi to strengthen IPV/Hexavalent introduction, as part of RI support. These efforts remain a critical pre-requisite for OPV withdrawal and should be intensified.	Agreed. GPEI and Gavi joint planning, outlined at the June and December 2025 joint board meetings, will be important to the SPW strategy. This development (which occurred after Member States received a draft of the SPW strategy) has been added to Goal One.
The current version of the strategy envisages the use of new vaccines (nOPV1 or nOPV3) to respond to a polio episode or outbreak. This could pose an additional risk that we do not encourage. We propose strengthening routine vaccination and rapidly introducing three (3) doses of inactivated polio vaccine into the routine EPI in the form of a hexavalent vaccine.	This comment suggests confusion on guidance for vaccine use. Monovalent OPVs, including nOPV1 and nOPV3, need to be secured through a stockpile as they're effective in generating the mucosal immunity required to interrupt transmission in a polio outbreak. While delivering two doses of IPV through routine immunization is essential to prevent outbreaks, the delivery of IPV-containing vaccines through routine immunization will never stop an outbreak as IPV-containing vaccines, including hexavalent, do not confer mucosal immunity.
On new frameworks, outline explicitly how frameworks like Immunization Agenda 2030 and the Lusaka Agenda will be implemented in practice.	Implementation is out of scope of the SPW as a technical strategy for sustaining polio-essential functions through key future milestones and into the post-certification era. This should be contemplated during the Phases 2 and 3 of the outlined roadmap.

Goal Two: Detect and respond

Feedback	Team responses
External surveillance guidance	
The surveillance vision [should include a focus] on subnational gaps, ensuring timely implementation, and improving data use and analysis for decision-making.	Guidance on how countries can bridge surveillance gaps and leverage data for action is provided in AFP, environmental, and iVDPV surveillance guidelines and the Global Polio Surveillance Action Plan.
In addition to establishing and maintaining an integrated surveillance system, the strategy should also ensure all quality indicators are met.	The SPW strategy relies upon consistent application of global standards defined through surveillance guidance. Such guidance will need to be maintained throughout the GPEI's evolution.
Topics not covered: the possibility of identifying "orphan" viruses with no close genetic links to other viruses and for which epidemiological, laboratory, and surveillance actions should be prioritized.	This is beyond the scope of a strategy. Such guidance is currently maintained by the GPEI Surveillance Group. This work will need to be maintained at the global level and considered within the context of integrated disease surveillance.
Surveillance risks and mitigation measures	
A specific risk communication component is needed to position polio as a priority within national agendas, especially with regard to early detection and response.	Agreed. Developing a risk communication has been added as a mitigation measure to respond to the lack of country prioritization for polio surveillance activities (Table 4).
Context-specific challenges: Surveillance gaps in border, hard-to-reach, rural areas or other logistical barriers. Conflict and insecurity may also contribute to inaccessibility and should be included.	Agreed. Issues related to health access have been added as a possible root cause for missed transmission in discussion of future risks and risk mitigations (Table 4).
Topics not covered: In mitigation measures, develop and maintain community surveillance strategies with active case search for AFP cases in hard-to-reach populations and cross-border communities.	Agreed. Developing and maintaining community-based surveillance among hard-to-reach populations and cross-border communities has been added as a mitigation measure for missed transmission or silent transmission (Table 4).
Surveillance integration that leverages One Health multisectoral approaches will also have to embrace sustainable models which include task-shifting or task-sharing to the communities, e.g. teaching community representatives to perform key surveillance functions.	While the strategy does not use the language of "task-shifting" or "task-sharing with communities," community-based surveillance is included as a mitigation measure for missed detection among hard-to-reach and cross-border populations (Table 4).

Feedback	Team responses
Context-specific challenges: strong cross-border surveillance amid porous borders and increasing economic and disaster-induced migration.	The SPW strategy recognizes IHR (2005) as a foundation for global health security, and the role of IHR is included within the broader public health frameworks that inform the SPW (see the Introduction). Under IHR, the classification of polio as a PHEIC provides an occasion or opportunity for countries to require proof of vaccination for visitors entering a country. Countries can also choose to operate temporary vaccination points at borders during periods of intensified border crossings or migration to mitigate risk.
Topics not covered: Given the intense flow of people traveling between countries and the risk of silent circulation, international travel should be addressed.	
Mass gatherings should be included in the challenges, with a unified international mechanism created to reduce the potential risks during such gatherings.	
[Member States recommended including iVDPV surveillance among mitigations for delayed detection] Surveillance among primary immunodeficiency disorder (PID) patients needs dedicated funding to support detecting silent transmission.	iVDPV surveillance falls under "missed detection" not delayed detection. If countries meet the criteria for being at-risk for iVDPV surveillance, it needs to be implemented based on the latest global guidance.
Country surveillance capacity	
Low-risk countries also face a challenge as maintaining [polio-free] status requires effort, especially amid factors such as immigration, cross-border migration.	Agreed. Countries must maintain capacity to detect poliovirus as a PHEIC but such efforts face challenges. To support sustainability, polio surveillance can be integrated with VPD and wastewater surveillance.
The availability of resources continues to be a major constraint to strengthening wastewater surveillance.	Agreed. Approaches to resourcing the SPW strategy will be covered in future phases related to implementation.
A cost-benefit analysis should be undertaken to compare an investment in polio-ready labs (with a transfer of lab technology and research capacity) versus the costs of sample transport to regional labs.	If countries can't afford to establish and operate polio laboratory capacity with domestic contributions, there will not be financing under this strategy to support a transfer of lab technology and research capacity.
Outbreak response	
Topics not covered: the transparency of information between countries, especially in border areas, should be strengthened in the document, regardless of WHO region.	Strengthening information-sharing and transparency between countries and across borders is essential. This is already addressed in the strategy, with a global dashboard as one option to ensure timely exchange of surveillance and response data regardless of WHO regional boundaries.
The current version of the strategy envisages the use of new vaccines (nOPV1 or nOPV3) to respond to a polio episode or outbreak. This could pose an additional risk. We propose strengthening routine vaccination and rapidly introducing three (3) doses of inactivated polio vaccine into the routine EPI in the form of a hexavalent vaccine.	This comment suggests confusion on guidance for vaccine use. Monovalent *OPVs*, including nOPV1 and nOPV3, need to be secured through a stockpile as they're effective in generating the mucosal immunity needed to interrupt transmission in a polio outbreak. While delivering two doses of IPV through routine immunization is essential to prevent outbreaks, the delivery of IPV-containing vaccines through routine immunization will never stop an outbreak as IPV-containing vaccines, including hexavalent, do not confer mucosal immunity.
It will be important to leverage nOPV1 and nOPV3 in outbreak responses as soon as they become pre-qualified, and plan for them to be included in the global OPV stockpiles post-eradication.	nOPV1 and nOPV3 are planned for the global OPV stockpile post-eradication, and stockpiles can begin being established while the vaccine is under EUL/PQ process. If development or regulatory approval of nOPV1/nOPV3 is delayed, monovalent OPVs will be used.
A more detailed plan for managing vaccine supply chain disruptions would mitigate risks.	While the Polio Vaccine Security Framework has been added to Goal One, Goal Two now includes language on right-sizing stockpiles for bOPV cessation. This work is ongoing.
Topics not covered by the strategy: Hexavalent is contraindicated for older age groups. It is therefore important to discuss measures for responding to health emergencies in older age groups in a sustainable manner.	For health emergencies like polio outbreaks, type-specific OPV will be used. OPVs are the primary tool for inducing mucosal immunity and stopping transmission. Standalone (full or fractional) IPV can be added in areas with persistent transmission, per SAGE recommendations. The recommendations, however, apply only to IPV, not hexavalent.
The potential switch to novel vaccines (e.g. nOPV2) raises concerns about whether global stockpiles and manufacturing will meet unforeseen demands. There is little to no commitment outlined in the strategy to maintain vaccine production at pre-cessation levels or to fund such preparedness and implementation. This oversight could jeopardize timely outbreak response.	The Polio Vaccine Security Framework will help to ensure vaccine supply meets post-cessation demand. The framework uses annual consultations with vaccine manufacturers, modelers and forecasting experts to ensure manufacturers have visibility to inform vaccine production. In the SPW era. vaccines will be sustained at two manufacturers with capacity to meet expected demand. A stockpile of bulk will also be maintained to ensure capacity to rapidly change bulk to finished product.

Feedback	Team responses
[For outbreak risk table, under poor management of outbreak response due to lack of training] Add sharing of lessons and experiences from other countries.	Agreed. Mechanisms for sharing lessons learned and best practices will be valuable to strengthen outbreak management capacity and promote continuous learning and improvement across regions. This is already addressed by the goal language within the strategy.
[For outbreak risk table, under failure to prevent cVDPV transmission and seeding of new virus due to inadequate surveillance] Add ways to improve methods of surveillance in such situations - e.g area of conflicts,	Agreed. The strategy emphasizes strengthening surveillance in hard-to-reach and conflict-affected areas, including the use of community-based surveillance, environmental sampling and partnerships with humanitarian actors to ensure early detection and timely response.
The interaction between federal entities and technical areas [in keeping guidelines up-to-date based on standard operating procedures (SOPs) defined by global experts] allows for the alignment of strategies and continuous improvement of actions to be applied in poliovirus outbreaks, making responses more assertive, timely, and effective.	Agreed. Ensuring regular alignment between federal entities and technical areas with updated global SOPs is essential to strengthen coordination and improve the timeliness and effectiveness of outbreak responses after certification. Conducting polio outbreak simulation exercises (POSEs) and online webinars on updated SOPs could be useful options to support this alignment. These are already included in the strategy.

Goal Three: Contain polioviruses

Feedback	Team responses
Containment timelines	
[Member States] recognize that while OPV continues to be used, polio eradication and poliovirus containment remains elusive.	Agreed. There is an inherent challenge to building a containment system that needs to be in place before eradication is achieved. However, the GPEI Containment Strategy outlines objectives to ensure safe and secure poliovirus containment with milestones that are independent of ongoing transmission. It is critical all PEF-hosting countries prioritize these objectives in advance of containment certification and certification of eradication.
[Member States also recognize] that, apart from country-led delivery, close monitoring is needed at central level with technical and economic support for high-risk regions to ensure containment and vaccine supply.	Containment is a critical workstream of the Polio Vaccine Security Framework which provides a harmonized approach and integrated oversight to support the timely and uninterrupted supply of polio vaccines. By including containment stakeholders, such as national regulatory authorities (NRA) and national authorities for containment (NAC), in annual consultations with vaccine supply management, research and development, modellers and vaccine manufacturers, the framework helps to ensure polio vaccine demand is met while respecting containment criteria. UNICEF, in support of vaccine supply management, provides special attention to the needs of high-risk countries. These efforts will continue as part of the SPW strategy.

Governance and accountability

Feedback	Team responses
Partnership decision on future governance	
Member States asked the GPEI to clarify the timeline for GPEI dissolution, as this will help national governments and partners plan for the transition.	As part of the strategy's finalization, GPEI leadership has adopted a new approach and terminology to define this transformation as an evolution of the partnership instead of its dissolution. This shift aligns with early thinking on future governance and accountability that is expected to evolve over time from centralized oversight to a more decentralized structure as the current partnership adapts to respond to future risks. This shift to an evolution of the partnership helps to expand ownership and oversight beyond polio and allows for a continuum of partners and stakeholders to come in and out of the new governance structure as appropriate.
A more precise timeline for deciding on the new governance model would be beneficial.	While the technical strategy doesn't provide a timeline, the GPEI will use the high-level phased approach for implementation to develop a detailed process and timeline with key partners and stakeholders, as well as country, regional and global representation. A robust deliberative process will be used, in close consultation with technical and advisory groups, leading to the POB taking decisions. As future governance will require the engagement of current and potentially new partners, this process will be expanded to include strong representation of immunization, health emergencies and health system strengthening stakeholders that will be critical to sustaining a polio-free world. To give ample time, this process is expected to launch after the presentation of the SPW strategy at the World Health Assembly in 2026, and decisions on the future evolution of the partnership will be carefully aligned to ensure that successful change management is in place ahead of SPW milestones.

Feedback	Team responses
Member States suggested the strategy should define the evaluation process for a new governance structure.	A new sentence has been added to the risk management section, noting that a structured evaluation process will need to be defined to guide future governance decisions and taken up during Phase 2 of the process and not included in the SPW technical strategy.
The draft strategy remains largely high-level and lacks the specificity needed for real-world implementation. While the document acknowledges that final governance decisions fall outside its scope, early clarity on governance is crucial to successful operationalization and sustainability of polio-essential functions post-certification.	This feedback is acknowledged. The strategy is designed as a high-level global definition of the essential functions. It avoids prescribing specific governance structures to instead allow for future flexibility and determination of models across diverse countries and regional contexts. The need for future decisions on governance is also acknowledged, and having a decision on the timing of the GPEI evolution (shift to a different model) will be very helpful in developing the governance model and take the specific adjustments needed to ensure a smooth implementation.
The rapidly evolving funding landscape for key polio eradication partners may have implications for their capacity to take on new mandates.	The feedback is acknowledged. It will be addressed during the implementation planning phase of the strategy.
Elements and pre-requisites for future governance	
Some Member States expressed concerns about whether the new governance structure would adequately represent technical experts in epidemiology and laboratories.	Technical oversight mechanisms (e.g. GCC, SAGE, TAGs, RCCs, NITAGs) will continue to include epidemiology and laboratory experts. A sentence has also been added to reinforce the need for robust technical input in future governance arrangements.
Risk analysis and management must be integrated into governance and accountability, considering both current and emerging threats, such as geopolitical instability, migration, climate change and their effects on health.	This point is addressed under *Risk management*, where it highlights the need for future governance to monitor current and emerging threats, including geopolitical instability, migration and climate change.
Recommended addition: The success of the evolving model will depend upon continued investment in workforce development, particularly in surveillance, laboratories and immunization.	A sentence has been added in the evolving governance model section to reinforce the importance of investment in workforce development.
[Among functions/activities that will be needed for future global support] Regular high-level advocacy with governments will help to ensure sustained ownership and political will. Governments [could] be encouraged to establish contingency funds within polio programmes to rapidly deploy during outbreaks without compromising core eradication activities.	The importance of sustained high-level advocacy is acknowledged and reflected in *Next steps*. The suggestion on contingency funds has been noted. National-level contingency arrangements will need to be considered as part of implementation planning.
The monitoring and oversight of SPW implementation and progress must rely on national-level mechanisms, particularly through a national committee with relevant public and private sector agencies and key stakeholders.	This point is addressed by reinforcing the role of existing national coordination and oversight bodies such as NITAGs and NCCs. A reference has been added to encourage the use of national mechanisms involving relevant stakeholders to strengthen country-led monitoring and accountability.
Monitoring and evaluation frameworks [need to be] adaptable to programme evolution and national contexts and linked to broader health system performance indicators.	A sentence has been added to emphasize that monitoring and evaluation frameworks should be adaptable to programme evolution and national contexts and aligned, where feasible, with broader health system performance indicators.
The proposed governance model was supported with the following enhancements: that there be clearer delineation of roles and responsibilities between national governments, WHO regional offices and global partners for clearer accountability and coordination.	The feedback is acknowledged. The need for clear delineation of roles and responsibilities is highlighted as one of the prerequisites for shifting to a new governance model.
The success of the governance proposals will depend on adequate financial resources for maintaining immunity coverage among vulnerable populations in high-risk countries with weaker health systems and fragile, conflict-affected areas. Apart from country-led delivery, central monitoring will be needed with technical and financial support to ensure vaccine supply and containment.	This feedback has been reflected across multiple sections: country ownership, evolving governance model and risk mitigation. The SPW strategy, through the Polio Transition Strategic Framework, includes ongoing global support for high-risk and fragile contexts.

Feedback	Team responses
Transition for fragile countries: Defining criteria for dedicated support and expected duration would ensure a smooth transition.	Reflected under polio transition criteria and watch list in "Country ownership and transition support" section and reaffirmed under risk mitigation measures. The polio transition priority and watch list countries are determined based on entry-exit criteria that measure the strength of the national health system, the financing landscape, immunization coverage and epidemiology. The list is subject to regular review.
Models for future governance	
One Member State noted that the future governance model needs to remain flexible. Every country is in a different place with their capacity and systems, so a unified approach might be difficult. The ability to adapt governance to fit local realities while still ensuring continuity of polio-essential activities will be critical.	The strategy presents an evolving governance model that is intended to adapt over time and respond to countries' varying levels of readiness and capacity. It outlines a set of flexible governance options, including regional and country-focused approaches, and emphasizes the importance of tailoring support and oversight to local contexts while ensuring continuity of polio-essential functions.
[Preference was expressed by one Member State] for a centralized structure as the lowest risk option to ensure the continuation of the required activities.	The strategy includes a centralized structure in its discussion of governance options, noting its advantages of continuity, reduced transition risk and preservation of technical capacities. This is one of several viable models and may be appropriate for time-bound functions like bOPV cessation. These decisions need to be taken thoughtfully and deliberately by a wide range of stakeholders, including countries.
[One Member State] suggested a governance model with a regional approach would be appropriate as it allows actions to be adapted to each territory, facilitates cooperation between countries and favors the sustainability of the achievements made in polio eradication. Regional governance would adapt better to risks, strengthen surveillance and response to outbreaks, guarantee timely access to vaccines, and offer differentiated, country-focused support.	The strategy includes a regional approach in the discussion of governance options (Option 4: Integrated regional oversight), noting the benefits of a regionally tailored approach. In response to feedback, the description of this option was strengthened to highlight its potential to facilitate cooperation across countries, enable differentiated support, and enhance sustainability through adaptation to varying national contexts and risk levels.
[The governance structure should support] regional peer learning mechanisms, allowing countries with similar settings to share the best practices and lessons learned.	The description of the *Integrated regional oversight* option now highlights its potential to facilitate regional peer learning and the exchange of best practices among countries with similar contexts. There are differences already between the WHO regions (merging of polio and immunization in EMR) and important to monitor and assess learnings.
The evolving governance model could usefully adapt the pace [of evolution] across WHO regions toward eventually achieving a decentralized governance structure.	Agreed. The strategy's discussion of an evolving governance model section and possible integrated regional oversight (Option 4) allows for variation in pace and approach across WHO regions.
One Member State recommending strengthening existing national structures for monitoring. It is wise to avoid vertical structures and instead take up horizontal ones that offer greater efficiency and also don't limit actions at the country level.	A sentence was added to emphasize the importance of strengthening existing national coordination and monitoring mechanisms as this avoids the creation of parallel or vertical structures and is better aligned with broader efforts to promote integrated, horizontal approaches to health service delivery.
Resources during transition and the shift to future governance	
On the transition from centralized to decentralized leadership, one Member State requested more information on managing and funding this phased shift.	This feedback is acknowledged. While the strategy does not prescribe specific steps, a note has been added that implementation planning will need to consider the management and financing of the phased shift from centralized to decentralized leadership.
[There should be] sustained technical and financial support during the transition period to avoid disruptions in the essential functions. Including sustained domestic financing for polio eradication with targeted technical support for National Polio Committees.	This is addressed in the strategy through references to time-limited financial and technical support, the need for sustained domestic financing, and targeted technical assistance for national coordination mechanisms. A sentence has been added to reflect these considerations more explicitly.

Cost estimate

Feedback	Team responses
Provide more detail on the assumptions behind the cost range (US$ 6.9-8.7B) would aid in planning and fundraising. This can be added as an Annex.	A new annex has been added to the strategy with details on the assumptions behind cost modeling.