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Draft background text on regional implications of the new polio strategic plan

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1. In May 2013, the 66th World Health Assembly endorsed the *Polio Eradication and Endgame Strategic Plan 2013-2018*which was established in response to WHA Resolution 65.5 that requested the Director-General to develop a comprehensive polio endgame strategy. The new Plan provides a concrete timeline for completion of the Global Polio Eradication Initiative (GPEI), by eliminating all paralytic poliomyelitis, due to both wild and vaccine-related polioviruses. The four principal objectives in the Plan are: (i) detection and interruption of all poliovirus transmission; (ii) strengthening of immunization systems and withdrawal of OPV; (iii) containment and certification of all poliovirus; and (iv), development of a comprehensive legacy plan. *Due to the goal of stopping all polio disease, the Plan has substantial near-term implications for both polio-infected and polio-free countries, particularly the 125 countries that use only the oral poliovirus vaccine (OPV) for routine immunization.* This paper introduces the regional implications of the Planin the near-term, particularly to accelerate preparations for global type 2 oral poliovirus vaccine (OPV2) withdrawal, including the introduction of at least 1 dose of inactivated poliovirus vaccine(IPV) into routine immunization schedules globally, and to inform the development of the GPEI legacy plan.

OPV2 withdrawal

2. Although wild poliovirus type 2 was eradicated globally in 1999, the type 2 virus component of the oral polio vaccine (OPV2) causes the majority of circulating type 2 vaccine derived poliovirus (cVDPV2)outbreaks and vaccine-associated paralytic poliomyelitis (VAPP) cases. The importance of withdrawing OPV2 as soon as possible globally was reinforced by the detection in 2012 of polio outbreaks due to a cVDPV2 in Chad, Democratic Republic of the Congo, Kenya, Nigeria, Pakistan and Somalia.In addition to eliminating the leading cause of cVDPV outbreaks, OPV2 withdrawal will immediately eliminate at least 40% of the global burden of approximately 250-500cases of VAPP per year. The Strategic Advisory Group of Experts on immunization (SAGE) recommends that all countries introduce at least one dose of IPV in advance of the replacement of trivalent OPV with bivalent OPV (type 1 and 3) for routine immunization. The *Polio Eradication and Endgame Strategic Plan 2013-2018*targets global introduction of IPV by the end of 2015 to facilitate global OPV2 withdrawal as soon as possible thereafter. The introduction of at least 1 dose of IPV at the DPT3 contact will boost population immunity against type 2 poliovirus and maintain a polio-primed population following OPV2 cessation. This will in turn reduce the risk of a cVDPV2 emergence at the time of OPV2 withdrawal and improve the response to type 2 monovalent OPV (mOPV2) campaigns in the event of a type 2 polio outbreak after OPV2 withdrawal. The introduction of IPV could also accelerate wild poliovirus eradication as it boostsboth humoural and intestinal immunity to wild virus 1 and 3 in previously OPV-vaccinated children.

3. To enhance IPV affordability and availability, WHO and its GPEI partners are working to reduce the price of IPV for the polio endgame. The current UNICEF-procured price for IPV is US$3.25/dose. WHO

anticipates that the near-term price for the 73 GAVI-eligible and graduate countries will be approximately US$ 1.00/dose and between $1.30-$1.50/dose for low and middle income countries. Looking forward, further IPV price reductions tobelow US$ 1.00 per dose may be achievable – for example, either through use of fractional dosing with intradermal (ID) delivery of one fifth of a full dose of a current IPV product, or intramuscular administration of a new IPV product containing an adjuvant. GPEI is working with multiple manufacturers on these and other options, targeting a price of between US$ 0.50 and US$ 0.75 per dose within 36−48 months. A number of manufacturers are planning to develop IPV-containing hexavalent products, which could be available and priced for public sector use in developing countries as early as 2020. WHO and its GPEI partners continue to support the transfer to developing countries of new production technology for IPV using Sabin-strain polioviruses. It is expected that Sabin-strain IPVs will become available in some countries during the period of implementation of the new strategic plan. The current IPV-containing hexavalent presentationsusean acellular pertussis component. As this is a more expensive type of pertussis formulation, the price isUS$20-40/dose.The development of an IPV-containing hexavalent vaccine using whole-cell pertussis, which would be affordable to low and middle income country markets, is not expected before 2020.

4. A multi-faceted IPV financing strategy is being developed to assist countries in planning for the introduction of 1 dose of IPV into their routine immunization programmes by the end of 2015. This strategy includes a combination of GAVI-assisted procurement, subsidized pricing for introduction in some low and low-middle income countries that are not GAVI-eligible, and self-procurement of low cost products by others. To establish a comprehensive global financing and supply strategy for fast-track IPV introduction using current whole-dose IPV products, WHO and its GPEI partners will need country-specific IPV introduction plans and timelines by the end of 2014.For further information on IPV introduction, please consult 'Planning for IPV Introduction- Frequently Asked Questions'.

Legacy Planning

5. A primary goal of legacy planning for the Global Polio Eradication Initiative (GPEI) is to ensure that the knowledge, capacities, processes and assets created by the programme will continue to be of broader benefit to other public health programmes after the completion of the eradication initiative. Such potential benefits include capitalizing on the ability the GPEI has developed over the past 25 years toaccessmost of the chronically unreached, marginalized and most vulnerable populations in the world. This has provided health workers and volunteers with the opportunity to vaccinate children with OPV and also provide a range of other basic health services. In addition, this far-reaching access has resulted in a global surveillance and response capacity for both health and humanitarian emergencies in some of the world's most demanding settings. Thus a key aim of the legacy planning process is to establish consensus by end-2015on the extent to which the GPEI's capacities should be used to benefit other health priorities beyond the planned completion of the polio eradication initiative in 2018-2019.

6. As a basis for GPEI legacy planning, beginning in mid-2013 an extensive consultativeprocess is being implemented with WHO Member States, GPEI implementing partners, donors and other stakeholders in both the GPEI and other international health initiatives. These consultations will inform the

development of a comprehensive legacy plan, and, where appropriate, national and/or regional legacy plans by end-2015. At the request of the WHO Executive Board, an independent study of all of the WHO-contracted human resources (HR) for the GPEI is also underway to help planfor the management of these resources in the context of programme completion by 2018-2019. This study willalso inform the development of legacy plans.

7. With the planned completion of the GPEI in 2018 and subsequent programme closure, there are three potential scenarios for the programme's legacy. These scenarios also have implications for the management and use of the extensive resources that were created and deployed for polio eradication. Consequently, in 2013-14 the perspectives of WHO Member Statesare needed on which of the following three scenarios should drive legacy planning for the GPEI:

i. *Scenario 1:* the knowledge generated and lessons learned through the polio eradication initiative should be well documented and disseminated to benefit other health priorities, but the programme should plan to sunset its other assets and resources at the time of programme closure or shortly thereafter;
ii. *Scenario 2:* following GPEI closure there should be a transition of the lessons, assets and resources of the programme to benefit other existing and relevant national, regional and/or global public health programmes (e.g. global disease surveillance and response capacity, routine immunization strengthening, new vaccine introduction).
iii. *Scenario 3:* following GPEI closure there should be the establishment of a new global initiative or programme with an equity focus that would utilize the assets, lessons learned and resources of the GPEI primarily to sustain access to chronically missed and underserved populations for priority health interventions.

8. Upon establishing consensus on the appropriate scenario to drive legacy planning, this consultative process will be used to further develop that scenario into a specific GPEI legacy plan(s). This will include consultations with countries and regions to understand health priorities and to explore how GPEI lessons, assets and resources could be of potential benefit to those priorities.