Information Note on the Budgetary Aspects of Polio Eradication and Polio Transition

March 2019

This Information Note responds to questions raised during the recent Programme Budget and Administration Committee and the Executive Board on the new GPEI five-year 2019-23 strategy and budget, their place in WHO's Programme Budget 2020-2021 and GPW investment case, and their relation to WHO's Strategic Action Plan for Polio Transition 2019-2023.

What is polio transition?

For more than 30 years, the Global Polio Eradication Initiative (GPEI) has financially supported the WHO global polio eradication programme. When eradication of polio is eventually declared, GPEI funding will end. Many countries have benefitted from continuous GPEI support beyond polio, in the areas of immunization, non-polio surveillance, laboratory services, and emergency response to outbreaks. Polio transition is a process to sustain and mainstream these critical polio-functions post-eradication, to not only sustain a polio-free world but to continue strengthening immunization systems and emergency preparedness, detection and response capacities, especially in countries with vulnerable populations and weak health systems.

The process involves defining and costing essential polio-supported activities and making plans to transition them onto other domestic or external sources of support before or at the time that polio is eradicated and GPEI financing ends. The essential public health functions necessary to achieve and sustain polio eradication include far-reaching surveillance and immunization systems, and outbreak detection and response capacities. Besides maintaining a polio-free world, keeping polio-funded core infrastructure intact will enable broader public health gains such as immunization intensification and integrated disease surveillance.

Recognizing that GPEI-supported core functions are essential to sustain a polio-free world, WHO has taken two pivotal steps to preserve them. First, it has developed the Strategic Action Plan on Polio Transition 2019-2023[1], which supports countries to develop national plans that serve as roadmaps to sustainability, with core capabilities defined and costed. Second, WHO has put some of the cost of GPEI-supported essential public health functions that came out of the national strategic action plans – $227 million in 2020-2021 and a total of $667 million through 2023 – onto its base budget. This reflects WHO's commitment to ongoing support for critical core public health functions that are currently finance by GPEI.

[1] Document A71/9.

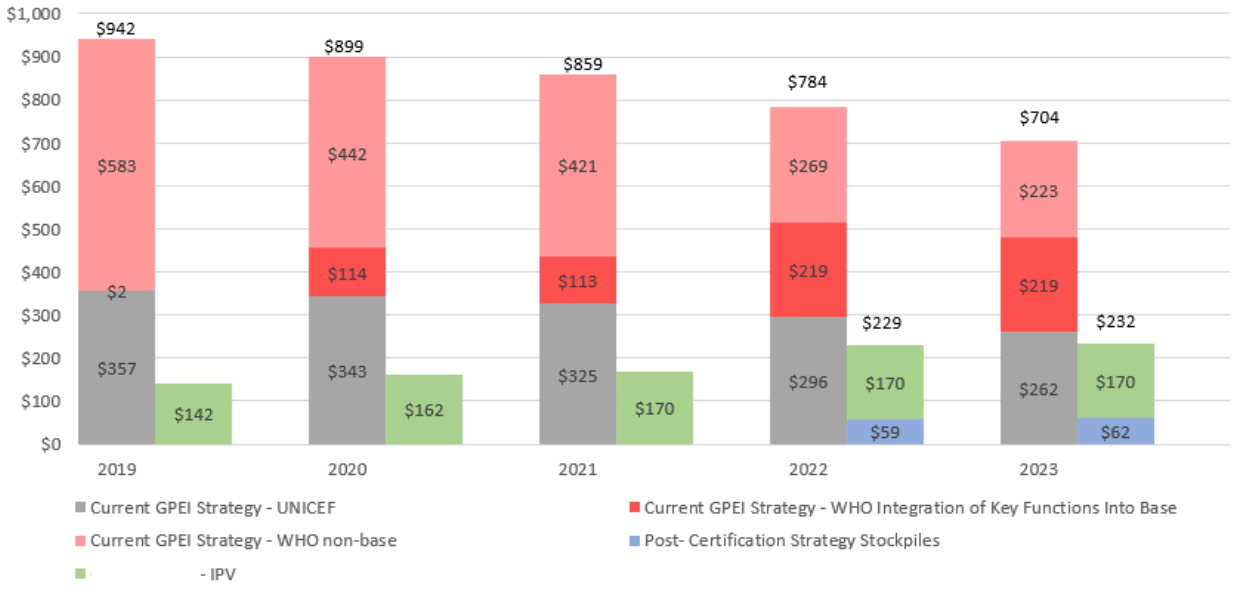
GPEI Budget 2019-2023 in relation to WHO GPW 2019-2023 and PB 2020-2021

The WHO Investment Case to support the Global Programme of Work (GPW) 2019-2023 includes $1.2 billion for polio eradication and $667 million for polio transition[2]. These figures were based on the expectation that transmission of the wild poliovirus would be interrupted in 2018 and the world would be certified polio-free in 2021. When transmission of the poliovirus was not stopped in 2018, the Polio Oversight Board adopted a new GPEI budget in September 2018 that extended the polio eradication program until 2023, with a five-year budget (from 2019) of $4.2 billion (for all partners).

The WHO portion of the new GPEI budget is $2.6 billion, excluding pre-certification costs – an increase of $738 million from the combined figure for Polio and Polio Transition in the Investment Case for the GPW. The effect of the GPEI's extension on the proposed WHO PB 2020-2021 is an increase of $163 million, with all in the non-base portion of the polio. Significantly, the GPEI budget subsumes both the base and non-base portion of the WHO budget, since activities within the WHO base are also part of the overall GPEI budget and strategy 2019-2023. Moreover, the GPEI has committed to fundraise for all these resources.

Overall cost to achieve and sustain polio eradication

The $4.2 billion five-year GPEI budget 2019-2023 is represented in Figure 1 below by the bars that are pink and grey (respectively WHO and UNICEF, the GPEI's two implementing partners). The green bar shows additional, non-GPEI outlays integral to achieving and sustaining eradication and costed in the new polio strategy, made up of two components. The first is the cost of IPV, estimated to be $814 million between 2019 and 2023, which Gavi will use core resources to fund in 2019 and 2020, and continue to support through 2025 subject to the availability of funding and approval of country financing arrangements. The second component, starting in 2022, is the one-time cost of $121 million to have oral polio vaccine stockpiles (OPV) in place for use post-certification. Together, GPEI, IPV and OPV bring the overall cost to achieve and sustain polio eradication to $5.1 billion.



[2] Plus, an estimate of $420 million in one-time post-certification costs that is outside of the GPEI, since revised downward to $162 million, as shown in the graphic.

Funding of Polio Transition

Within the pink bar representing WHO is a darker segment that shows the shift of polio-supported costs for essential functions onto WHO's base budget, i.e. $227 million for the biennium 2020-2021[3] and $667 million total through 2023, as previously discussed. The increase in 2022-2023 is due to endemic countries and regions shifting from polio-centric to developing and implementing national plans to sustain core functions in 2022, after the expected interruption of the wild polio virus. Of the base budget requirements of $227 million in 2020-2021, domestic funding of approximately $52 million is foreseen, which would reduce the fundraising requirement to $175 million for transitional activities for the biennium. It is also expected that countries will gradually reduce their reliance on GPEI support over the next four years as transition plans are implemented, and alternative, sustainable sources of support are found.

Avoiding potential duplication between GPEI and WHO budgets

Member States have requested guarantees from both GPEI and WHO that there is no potential duplication between GPEI and WHO polio transition budgets. During the transition, the essential public health functions that remain the responsibility of WHO will become embedded in base programs with links to the broader UHC agenda, and the GPEI budget would be reduced by a corresponding amount. Thus, starting from PB 2020-2021, the cost of the core essential functions will be either budgeted within non-base budget for polio-centric countries, or in WHO base budget for transition countries but not simultaneously in both places so that double-counting in the budget and duplicate fund-raising efforts are avoided.

The results structure of the Proposed programme budget 2020-2021 includes a specific output (2.2.4 Polio eradication and transition plans implemented in partnership with the Global Polio Eradication Initiative) where both polio budgets will be accounted for (base and non-base) to avoid the duplication and allow clarity and transparency of the budget and funding. In addition, there will be regular ongoing oversight by both GPEI and WHO. The WHO undertakes to keep Member States fully informed on this issue.

Where is polio transition leading us?

The ultimate goals are clear:

1) Sustaining a polio-free world after eradication of polio virus;

2) Strengthening immunization systems, including surveillance for vaccine-preventable diseases, to achieve the goals of WHO's Global Vaccine Action Plan, and;

3) Strengthening emergency preparedness, detection and response capacity in countries in order to fully implement the International Health Regulations (2005).

Within this approach, there is the concept of a strengthened EPI with sustainable funding support to meet the post-polio requirements. Additionally, during the implementation phase of the polio transition strategic action plan, there is the concept of improving health outcomes by converging different programmes and financial resources in polio, WHO health emergencies programme and Primary Health Care at sub-national level in countries.

[3] As requested during the EB discussions in Jan. 2019, a PB20-21 budget breakdown by country and by essential function is provided in Annex.

Polio eradication and transition at a glance

- GPEI/Polio Eradication has been extended through 2023
- The program is funded through 2019, thereafter new resources must be mobilized
- From 2020, if GPEI funding is constrained, priority will be given to 1) endemic countries 2) outbreak countries 3) highest risk, most vulnerable countries (per GPEI Risk Assessment Task Team ratings – see also Annex for budget breakdown by risk rating)
- For all other countries in transition due to receive polio funding, maintaining surveillance capacity – staff and operations and lab – and outbreak detection and response capacity are the priorities.

Transition planning and implementation

- Transition planning should continue uninterrupted regardless of GPEI's extension,
- There is a no clear break between the end of polio eradication and the beginning of transition, rather the process is ongoing, and in many countries transition and eradication overlap.

What happens if there is a funding gap caused by insufficient GPEI and domestic funding?

- The move onto WHO's base budget is an indication of an ongoing commitment and gives an assurance of ongoing support
- While the GPEI will budget and finance (if possible) the continuation of the most polio-essential functions), non-endemic, non-outbreak countries should prepare to co-finance transition plans and core activities as soon as 2020
- In fragile countries where domestic co-financing may not be realistic, GPEI has committed to prioritising the required financial resources during PB20-21
- In the meantime, transitioning countries can use GPEI funding to re-orient their polio-supported activities in accordance with their transition plans, **provided that polio-essential functions necessary for certification are not weakened**
- Transition plans can also serve as an advocacy tool – an investment case with a roadmap – to attract new, external sources of support
- If GPEI and domestic funding fall short of the $ 175 million polio transition funding gap for PB20-21, then the gap will be met at the appropriate time through a combination of other contributions to the base budget, as well as, where possible, a rationalisation of the budget to remove lower priority activities.

Examples of polio assets and infrastructure that can contribute to overall systems strengthening:

- ✓ Expertise and lessons-learned from polio's extensive experience with Supplemental Immunization Activities (SIAs) can be used to strengthen broader immunization aims
- ✓ The GPEI's network of coordinating mechanisms and advocacy bodies at the national level—such as EOCs, presidential task forces, etc.—can all be leveraged to support non-polio emergency response
- ✓ Skills and expertise present in polio can benefit many programs - identifying and reaching high-risk populations; local-capacity building to target chronically unreached children; microplanning; using data and evidence to drive programmatic decisions; applying robust monitoring and supportive supervision systems for program quality
- ✓ Sensitive poliovirus surveillance can be sustained through integration with comprehensive vaccine-preventable disease (VPD) and communicable disease surveillance system

- ✓ The GPEI's significant operational presence on the ground in countries offers ready-made local knowledge and contacts to make a significant contribution to outbreak and emergency responses.

Annex - costs of essential functions to integrate into national health structures and WHO programs

RATT* Risk	Countries	Essential Functions	PB 2020-21
High	Cameroon	*Surveillance and Laboratory*	*1,930,664*
		Core Functions & Infrastructures	*1,464,382*
		TOTAL	**3,395,047**
High	Chad	*Surveillance and Laboratory*	*1,849,697*
		Core Functions & Infrastructures	*3,600,303*
		TOTAL	**5,450,000**
High	DRCongo	*Surveillance and Laboratory*	*9,285,906*
		Core Functions & Infrastructures	*3,904,104*
		TOTAL	**13,190,010**
High	Somalia	*Surveillance and Laboratory*	*10,127,013*
		Core Functions & Infrastructures	*2,687,461*
		TOTAL	**12,814,474**
High	Syria	*Surveillance and Laboratory*	*2,216,501*
		Core Functions & Infrastructures	*591,316*
		TOTAL	**2,807,817**
High	AFRO - Other High-risk countries	*Surveillance and Laboratory*	*1,677,483*
		Core Functions & Infrastructures	*1,521,287*
		TOTAL	**3,198,770**
High risk countries		*Surveillance and Laboratory*	*27,087,264*
		Core Functions & Infrastructures	*13,768,854*
		TOTAL	***40,856,118***
Medium	Ethiopia	*Surveillance and Laboratory*	*1,312,294*
		Core Functions & Infrastructures	*4,499,706*
		TOTAL	**5,812,000**
Medium	South Sudan	*Surveillance and Laboratory*	*3,611,933*
		Core Functions & Infrastructures	*938,071*
		TOTAL	**4,550,004**
Medium	Angola	*Surveillance and Laboratory*	*10,694,560*
		Core Functions & Infrastructures	*3,455,106*
		TOTAL	**14,149,666**
Medium	Iraq	*Surveillance and Laboratory*	*3,327,029*
		Core Functions & Infrastructures	-
		TOTAL	**3,327,029**
Medium	Yemen	*Surveillance and Laboratory*	*2,927,160*
		Core Functions & Infrastructures	-
		TOTAL	**2,927,160**
Medium	Indonesia	*Surveillance and Laboratory*	*1,324,330*
		Core Functions & Infrastructures	*63,670*
		TOTAL	**1,388,000**

RATT* Risk	Countries	Essential Functions	PB 2020-21
Medium	India	*Surveillance and Laboratory*	*37,287,026*
		Core Functions & Infrastructures	*18,331,655*
		TOTAL	**55,618,681**
Medium	Myanmar	*Surveillance and Laboratory*	*1,912,100*
		Core Functions & Infrastructures	-
		TOTAL	**1,912,100**
Medium	AFRO - Other Medium risk countries	*Surveillance and Laboratory*	*5,367,944*
		Core Functions & Infrastructures	*4,868,121*
		TOTAL	**10,236,065**
Medium risk countries		*Surveillance and Laboratory*	*67,764,377*
		Core Functions & Infrastructures	*32,156,329*
		TOTAL	***99,920,705***
Low	Sudan	*Surveillance and Laboratory*	*3,842,116*
		Core Functions & Infrastructures	-
		TOTAL	**3,842,116**
Low	Bangladesh	*Surveillance and Laboratory*	*4,520,000*
		Core Functions & Infrastructures	
		TOTAL	**4,520,000**
Low	Nepal	*Surveillance and Laboratory*	*2,654,000*
		Core Functions & Infrastructures	-
		TOTAL	**2,654,000**
Low	AFRO - Other Low risk countries	*Surveillance and Laboratory*	*8,722,908*
		Core Functions & Infrastructures	*7,910,697*
		TOTAL	**16,633,605**
Low	EURO countries	**TOTAL**	267,000
Low risk countries		*Surveillance and Laboratory*	*19,739,024*
		Core Functions & Infrastructures	*7,910,697*
		TOTAL	***27,916,721***
Total Countries		*Surveillance and Laboratory*	*114,590,664*
		Core Functions & Infrastructures	*53,835,880*
		TOTAL	**168,693,544**
African Region			13,725,556
Eastern Mediterranean Region			**
South-east Asia Region			3,816,710
European Region			2,202,000
Western Pacific Region			2,083,000
Americas			938,000
Total Regions			**22,765,266**
Headquarters			35,898,000
Grand Total			**227,356,810**

*RATT is the GPEI Risk Assessment Task Team. ** The focus of the EMR regional office is on eradication thus no transition costs in 2020-21