Enabling functions

10.1 Successful execution of the Polio Eradication & Endgame Strategic Plan 2013-2018 will require collaboration across GPEI partners, national governments, donors and other relevant organizations and institutions. While national governments will primarily be responsible for the successful execution of the Plan at the local level, the GPEI and its partners will lead on a set of enabling functions to facilitate the successful execution of country operations. These functions are:

1. Strategic planning and priority setting
2. Resource mobilization and advocacy
3. Financial resources and management
4. Vaccine security and supply
5. Research and policy development

The GPEI is responsible for a set of enabling functions to facilitate successful country operations. These are:

- Strategic planning & priority setting
- Resource mobilization & advocacy
- Financial resource management
- Vaccine supply
- Research & policy development

10.1 STRATEGIC PLANNING AND PRIORITY SETTING

10.2 The GPEI's spearheading partners (WHO, Rotary International, CDC and UNICEF) and the BMGF are responsible for providing overall technical direction and strategic planning for the management and coordination of the GPEI, including the development of strategic plans for the GPEI and the delivery of accompanying budgets. Global strategic plans are developed by national governments in conjunction with the partner and donor community to ensure that national and stakeholder priorities are reflected. Once finalized, the spearheading partners and the BMGF work to ensure that all components of the strategic plans are implemented. This includes oversight of technical support for strategy implementation and a leading role in monitoring and evaluating all aspects of the plans.

10.3 Technical assistance is deployed to fill capacity gaps when relevant skills are unavailable within a national health system, to build capacity and to facilitate international information exchange. This technical assistance ensures sufficient human resource capacity for immunization campaign planning (including microplanning, logistics, forecasting and supply management) and maintaining the AFP surveillance network.

10.4 The GPEI has historically been required to change agreed plans and cancel immunization campaigns due to unpredictable funding. In the event that sufficient funds are not available to fully support the GPEI budget in 2013 and 2014 when the focus is upon achieving the interruption of WPV1 and WPV3, available resources will be allocated according to the following priorities:

Priority 1	core staff (12 months of funding)
Priority 2	Surveillance and Laboratory Network (6 months)
Priority 3	endemic country SIAs (6 months)
Priority 4	outbreak response (3 months)
Priority 5	high-risk/other country SIAs

WHO/Thomas Moran

From 2015 onwards, resource allocation priorities will be updated to reflect a greater emphasis on Objectives 2 and 3, in particular product development and preparation for IPV introduction.

10.2 RESOURCE MOBILIZATION AND ADVOCACY

The integrated resource mobilization, advocacy and communications strategy aims for:

- **traditional donors to maintain or increase their commitments;**
- **new and non-traditional donors to be activated;**
- **polio-affected countries to increase their domestic financial contributions;**
- **innovative financing mechanisms be identified and exploited.**

10.5 The GPEI's spearheading partners and the BMGF have developed a strategy to obtain long-term, predictable funding for the 2013-2018 period. This will ensure that the lack of funding is not a barrier to the Plan's implementation and thus to polio eradication. The integrated resource mobilization, advocacy and communications strategy aims for:

- traditional donors to maintain or increase their commitments;
- new and non-traditional donors to be activated;
- polio-affected countries to increase their domestic financial contributions;
- innovative financing mechanisms be identified and exploited.

10.6 Sustainable financing will require renewed commitments from governments and development partners as well as the recruitment of additional country support. The participation of civil society organizations is critical, as is the importance of individual and private-sector giving, such as that provided by Rotary International. Significant financial support comes from some polio-affected countries, which should be further strengthened. National governments should continue to play a leading role in identifying resource needs and sources of self-financing and coordinating with immunization partners to track the effective, efficient use of resources.

10.7 Resource mobilization is increasingly coupled with advocacy and communications activities to ensure donors have confidence that the GPEI will deliver and that the benefits of a polio-free world are worth achieving. A key element is ensuring ongoing confidence from partners, countries, donors, influencers and the engaged public, so each player remains supportive of the GPEI and committed to the long-term strategy. The GPEI is working with a broader set of advocacy partners, e.g. the Global Poverty Project,[31] with the capability to reach younger audiences and new markets. Additionally, the partnership has invested in reaching a wider set of influential people – former politicians, technical and scientific leaders, well-known business leaders, academics and others – to inform them about the immediate window of opportunity to eradicate polio and employ both their voices and their networks in support of the programme.

10.8 To support the Plan, coordinated advocacy efforts will be developed and implemented, targeting the polio-endemic countries, high-risk countries and polio-free areas. The advocacy efforts will address three areas:

[31] *See http://www.globalpovertyproject.com/.*

WHO

Grand Imam of Al-Azhar receiving Muslim Scholars to discuss children rights to be protected by vaccination.

- ensuring the sustained, high-level commitment of polio-endemic and high-risk countries' national governments to provide oversight and accountability for the full implementation of their national Emergency Action Plans and to allocate domestic financing;
- ensuring consistent commitment and ownership by subnational governments (provincial, state and lower levels as relevant) to closely evaluate the planning, implementation and monitoring of polio eradication activities and to take immediate and appropriate actions to address local challenges;
- securing the support of the global community, including donor governments, multilateral organizations, private-sector organizations, civil society partners, the media and relevant religious institutions, to advocate with polio-affected governments and communities. This includes the engagement of multilateral fora, such as the African Union, the Organisation of Islamic Cooperation, the Commonwealth, the United Nations General Assembly, the Economic Community of West African States, the BRICS (Brazil, Russia, India, China and South Africa), and the Gulf Cooperation Council, to encourage polio-affected and high-risk countries to effectively implement their national plans and, when needed, to provide confidence to communities to allay their concerns about polio vaccinations.

10.9 Leading Islamic scholars and Muslim technical experts, under the aegis of Al-Azhar University, have formed an Islamic Advisory Group to leverage the historically strong role played by Islamic leaders in global eradication. This group will periodically assess the remaining and emerging socio-religious and political challenges to polio eradication in the remaining polio-affected parts of the Islamic world and propose solutions. Members will advocate within their constituencies and provide guidance on the social and religious responsibilities to protect children from vaccine-preventable disease and to eradicate polio. The work of this group will inform the efforts of relevant actors, such as the Organisation of Islamic Cooperation, the Gulf Cooperation Council, the Islamic Development Bank, other senior Islamic religious scholars and GPEI partner agencies and stakeholders.

10.10 Significant advocacy will also be necessary to engage the 145 WHO Member States to ensure the coordinated switch from tOPV to bOPV in their routine immunization programmes, to effectively implement the post-eradication elements of the Plan and to support the polio legacy planning process at the national, regional and global levels to ensure outcomes that are supported by the World Health Assembly.

10.3 FINANCIAL RESOURCES AND MANAGEMENT

The financial requirement for the activities contained in the Plan is projected to be US$ 5.5 billion.

10.11 The financial requirement for the activities contained in the Plan is projected to be US$ 5.5 billion. This figure does not include Government of India funding of approximately US$ 1.23 billion, or any other national or in-kind contributions (see *FRR*). This projection takes into account various scenarios and has been projected in consultation with relevant global, regional and country stakeholders.[32] An interagency resource mobilization strategy is being implemented with rigorous weekly follow-up to help mobilize funding commitments for 2013-2018. This strategy will be reviewed and revised after the Global Vaccine Summit to ensure the continued coordination of advocacy and resource mobilization activities. The US$ 5.5 billion cost model includes the following key assumptions:

- interruption of residual WPV transmission by the end of 2014;
- complementary OPV campaigns to boost type 2 immunity before the tOPV-bOPV switch and additional coverage as needed between 2014 and 2015, declining post-interruption;
- introduction of at least one dose of IPV in routine immunization prior to the tOPV-bOPV switch;
- human resource surge capacity to support eradication efforts in remaining polio-endemic and high-risk countries;
- maintenance of outbreak response capacity through 2018;
- maintenance of 2013 levels of technical assistance, social mobilization, global laboratory requirements, and research and product development through 2018;
- maintenance of environmental surveillance through 2018;
- stockpile projections for 2014 and 2016 based upon existing contracts.

The key budget drivers are:

- the number of OPV campaigns;
- vaccine costs;
- technical assistance to countries;
- surveillance and laboratory costs;
- outbreak response capacity and stockpiles;
- IPV use in routine immunization.

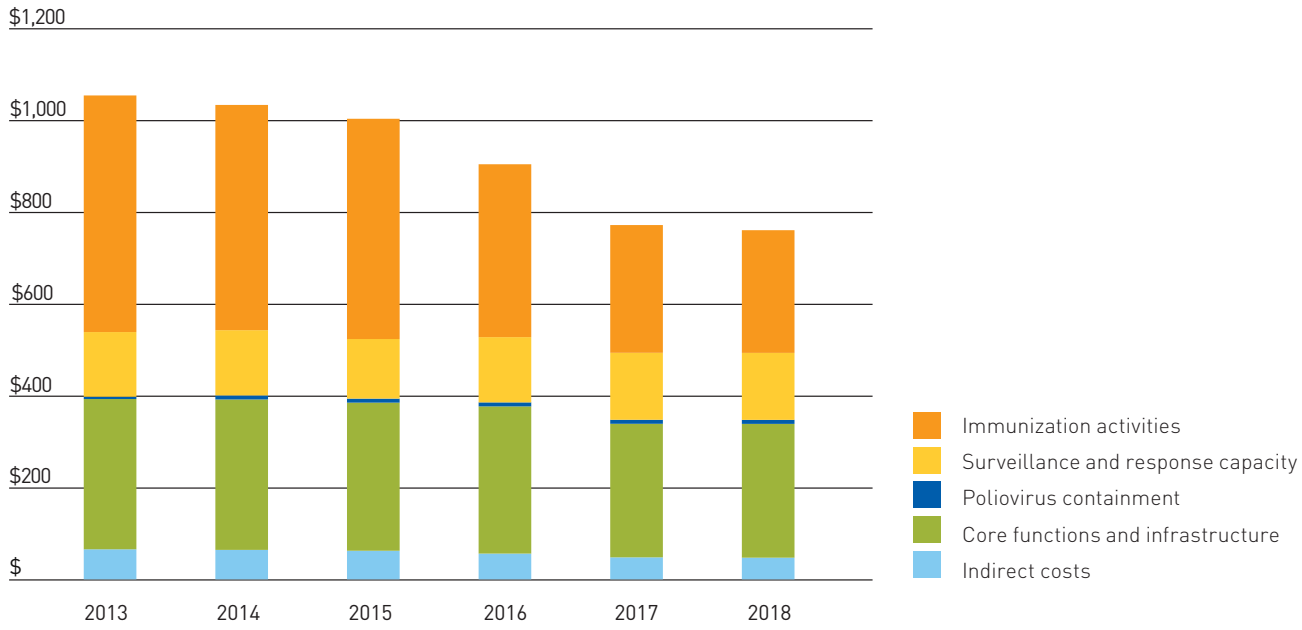
The main cost components (Figure 18) are:

- immunization activities (OPV campaigns and IPV in routine immunization): 44%;
- surveillance and laboratory activities, response capacity, containment and certification: 16%;
- technical assistance: 19%;

[32] *An adjusted year of interruption of transmission would increase/decrease costs accordingly; however some flexibility is built into this budget.*

- core functions (including surge capacity, research and development, ongoing quality improvement) and other indirect costs: 21%.

Figure 18: Plan budget by category, 2013-2018
(in US$ millions)



Source: GPEI, Key Elements of the Financial Resource Requirements 2013-2018, 14 February 2013. Available at http://www.polioeradication.org/financing.aspx.

10.12 During the eradication and endgame period, OPV campaign activity will remain high through 2015 and then gradually decline. Technical assistance and surveillance costs will remain relatively stable. Some costs, such as those for innovation and campaign quality improvement, will decrease following the interruption of transmission. Other costs, such as the use of stand-alone IPV in routine immunization, will continue well after interruption of WPV globally.

10.13 The financial requirements for the period will be presented in an accompanying *Financial Resource Requirements (FRR)* document with corresponding costs and underlying assumptions per major budget category. The financial requirements will be reviewed and updated quarterly and the proportion of requirements under key budget categories adjusted as progress against key milestones is evaluated.

10.14 Although costs have not been modelled beyond 2018, reduced levels of continued funding will be needed beyond polio eradication certification in 2018, including limited OPV campaigns and technical assistance continuing into 2020 as bOPV is withdrawn globally. Additionally, the GPEI expects certain costs associated with containment, surveillance and lab expenses to continue for up to five years post-certification.

10.15 The GPEI has continually evaluated costs throughout the implementation of polio eradication activities and sought opportunities to ensure the good stewardship of available resources. An independent Value for Money (VfM) study for the GPEI was conducted from mid-2012 to early 2013. The study identified opportunities to create efficiencies and shift resources to other areas, improve risk-mitigation measures, enhance forward planning, discuss cost-sharing with other initiatives and expand the use of best practices to achieve greater value for money.

10.16 The VfM study findings included near-term opportunities to improve OPV buffer management and vaccinator training quality/frequency over the next 12 months; medium-term opportunities to adjust the scale of operations as areas become polio-free (improving target population estimates and optimizing SIA frequency) over the next one to two years; long-term opportunities to be captured in the legacy planning process and implementation of the legacy plan over the next two to six years; and best-practice opportunities where there is already good value for money that could be capitalized upon and expanded (i.e. cost-sharing, reaching the hard-to-reach, leveraging new technology). The near-term opportunities represent maximum potential cost savings of up to 6% for OPV costs (buffer management) and up to 3% for operations costs (training frequency). The medium-term opportunities represent maximum potential cost savings in the area of SIA campaigns of up to 11% through improving target population estimates, or up to 8% for optimizing the frequency of SIAs campaigns. The long-term opportunities could represent up to 13% cost savings in the area of technical assistance by optimizing expenditure on personnel, or up to 21% in cost increases to technical assistance avoided (risk-reduction) through improved long-term planning for the use of GPEI infrastructure and activities. The value of technical assistance that benefits other initiatives or areas is estimated to be up to 21%.

10.17 The VfM study improved the GPEI's understanding of the major cost drivers underpinning the FRRs, the key challenges to controlling costs and the potential risks that could result in cost increases if not managed. Overall, through the process of developing the FRRs and conducting the VfM study, the date of interruption of transmission was identified as having the single biggest impact on the overall budget. The findings of the VfM study provide useful recommendations on the tools, planning processes and risk-mitigation measures the GPEI can apply to ensure that the budget envelope is respected, in particular during the period leading up to the interruption of WPV transmission.

10.4 VACCINE SECURITY AND SUPPLY

10.18 Sufficient supply of OPV (bOPV and tOPV) to meet the global requirements for SIAs and the routine needs of countries is a key programmatic priority. The programme must have the capacity to respond to changing demand requirements due to epidemiological shifts in the virus, outbreaks in any one type and increased target populations, while also meeting global demand requirements for routine immunization. As the GPEI procurement partner, UNICEF has long-term arrangements with multiple suppliers to meet the projected demand and will endeavour to maintain a continuous buffer of 70 million doses of OPV to meet outbreak response and other unplanned vaccine requirements.

10.19 OPV demand projection is based on the annual SIA calendar and estimated routine immunization requirements[79], for UNICEF-procuring and non-UNICEF procuring countries. Long-term supply arrangements are in place in line with the projected SIA and routine demand for UNICEF-procuring countries in support of the implementation of the Plan. Supply is monitored continuously, with monthly and quarterly reviews to ensure supply by type meets planned SIA activities and is sufficient to meet routine needs. To support activities under Objective 2 – OPV2 withdrawal, ensuring a switch from tOPV to bOPV and providing one dose of IPV – supply requirements will be carefully planned in advance, including ensuring sufficient bOPV and IPV to support the tOPV-bOPV switch. Concurrently, global vaccine supply will be taken into consideration to ensure non-UNICEF procuring countries are able to access sufficient OPV supply for the tOPV-bOPV switch.

OPV demand projection is based on the annual SIA calendar and estimated routine immunization requirements.

10.5 RESEARCH AND POLICY DEVELOPMENT

10.20 An intensified research agenda has underpinned many of the approaches outlined in the Plan and will be critical in its implementation. Strategically guided by the Polio Research Committee (PRC) and the SAGE, the core elements of the research work are designed to accelerate eradication of the remaining WPV transmission and to ensure the necessary strategies and products are in place to manage the long-term poliovirus risks associated with the polio endgame.

10.21 To facilitate the tOPV-bOPV switch (and help prepare for the eventual cessation of all OPVs in routine immunization), the research agenda will help drive the risk management strategies through the implementation of the necessary prerequisites for the switch (validation of persistent cVDPV type 2 elimination and WPV2 eradication; stockpile of mOPV type 2 and response capacity; surveillance and international notification of Sabin, Sabin-like and cVDPV type 2; availability of licensed bOPV in all OPV-using countries; affordable IPV options for all OPV-using countries; and containment Phase II for cVDPV type 2 and WPV2 and Phase I for Sabin type 2). The work to ensure the availability of affordable IPV options includes the realization of low-cost IPV options (i.e. new intradermal fractional dose and adjuvanted IPV formulations, Sabin IPV formulations and possibly new delivery technologies, e.g. needle-free administration).

10.22 Ongoing and new research projects are evaluating innovative methods to improve operations – particularly to help address persistent SIA coverage and surveillance gaps. A specifically established cross-partner Interagency Innovation Working Group is coordinating work to ensure innovative solutions to help address identified systemic challenges. Examples include assessing technologies such as GIS to more adequately identify missed areas or population groups during SIAs; evaluating community perceptions to communications strategies; examining the role of older age groups in outbreak settings; assessing the use of cellular-phone technology for data transmission in LQAS and to help prompt active AFP surveillance; and expanding the role of environmental sampling.

Ongoing and new research projects are evaluating innovative methods to improve operations – particularly to help address persistent SIA coverage and surveillance gaps.