

The Transformation Agenda

Sustained progress towards Certification of Polio Eradication in the WHO African Region

series

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**The Transformation Agenda Series 4:
Sustained Progress towards Polio Eradication in the WHO African Region**

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Designed and printed in Congo

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FOREWORD

Dear Reader and Stakeholder,

“The Transformation Agenda of the World Health Organization Secretariat in the African Region, 2015–2020”, hereinafter referred to as the Transformation Agenda, was initiated as a bold and ambitious agenda to engender a regional health organization that is foresighted, proactive, responsive, results-driven, transparent, accountable, appropriately resourced and equipped to deliver on its mandate. This means an organization that meets the needs and expectations of its stakeholders – “the WHO that the staff and stakeholders want” – including being responsive and effective in strengthening national health systems; coordinating disease prevention and control activities, as well as outbreak preparedness and response; and launching supranational actions in support of global health security.

The first year of implementation of the Transformation Agenda, 2015, coincided with the planning processes for the preparation of the WHO Programme Budget 2016–2017. It also saw the adoption of the 17 Sustainable Development Goals (SDGs) and 169 targets to guide global development over the next 15 years to 2030, with Goal 3 aiming to “ensure healthy lives and promote well-being for all at all ages”. These afforded the WHO Secretariat in the African Region the opportunity to institutionalize the Transformation Agenda by developing *The Africa Health Transformation Programme, 2015–2020: a vision for universal health coverage*, which serves as the strategic framework for guiding WHO’s contribution to the sustainable development platform in Africa. Its goal is to ensure universal access to a package of essential health services in all Member States of the Region and thus achieve universal health coverage (UHC) with minimal financial, geographic and social obstacles to services.



We are proud of the several achievements made in implementing the Transformation Agenda. In collaboration with our Member States, development partners and donors, progress has been achieved and change effected in three main areas. As regards health security, increased regional and country capacity to promptly detect and effectively respond to public health threats has led to rapid control of most of the outbreaks that have occurred. The efforts made to ensure well-functioning health systems in which all people receive quality and equitable health services without financial and other barriers, are leading to improved access to cost-effective health interventions and improved health outcomes in Member States.

In addition, the efforts made to ensure that the Secretariat undergoes cultural, programmatic and organizational changes in order to deliver on its mandate have led to improved delivery and an emerging organizational culture change, including openly addressing harassment and creating a respectful work environment. We are already seeing fundamental shifts in our ways of working, thinking and engaging with others as well as increased accountability, effectiveness and transparency, and tangible results in countries.

This publication series titled “The Transformation Agenda Series”, seeks to share with you some of the key achievements recorded in specific areas in implementing the Transformation Agenda.

“The Transformation Agenda Series” comprises the following six booklets:

- **The Transformation Agenda Series 1:** Enhancing the Country Focus Approach for Greater Health Impact;
- **The Transformation Agenda Series 2:** Strengthening Partnerships towards Universal Health Coverage;

- **The Transformation Agenda Series 3:** Improved Capacity to Tackle Epidemics – Lessons from the 2016 Yellow Fever Outbreaks in the Republic of Angola and the Democratic Republic of the Congo;
- **The Transformation Agenda Series 4:** Sustained Progress towards Polio Eradication in the WHO African Region;
- **The Transformation Agenda Series 5:** Promoting Efficiency, Accountability and Value for money – the Story of the Managerial Key Performance Indicators; and
- **The Transformation Agenda Series 6:** Moving towards a Stronger Focus on Quality and Results – the Story of the Programmatic Key Performance Indicators.

As we celebrate the gains we have made so far, we express our gratitude to all our stakeholders – Member States, Development Partners, Donors, Foundations and others – for walking the talk with us. These gains need to be consolidated, sustained and indeed stepped up for the remainder of 2019 and beyond.

I strongly recommend these booklets to you all. Electronic copies may be accessed on the website of the World Health Regional Office for Africa at www.afro.who.int.

It is our expectation that the achievements and successes highlighted in the Transformation Agenda Series will spur us all to continuously strive towards ensuring healthy lives and promoting well-being for all our people by achieving universal health coverage, addressing health emergencies, and promoting healthier populations.

Dr Matshidiso Moeti

*WHO Regional Director for Africa
Brazzaville, Republic of Congo*

May 2019



1. BACKGROUND

Poliomyelitis, an irreversible paralyzing viral disease, is caused by three serotypes of wild poliovirus (WPV).¹ In 1988, the Forty-first session of the World Health Assembly (WHA) adopted a resolution² to eradicate all types of poliomyelitis by the year 2000. Since then, there has been a 99% reduction of cases globally.

A region is considered for certification of polio eradication only when all countries in the geographical area demonstrate the absence of WPV transmission for at least three consecutive years with certification-standard surveillance.³ By 2014, the three poliovirus strains had been certified as eradicated in four of the six WHO regions, with the exception of the African and East Mediterranean Regions.⁴

Prior to 2015, the African Region had reported WPV cases each year. As late as 2014, seventeen WPV1 cases were reported from four Member States in the African Region.⁵ This continued transmission in the region posed the risk of exportation of WPVs to other WHO Regions that had been certified to have eradicated polio. Indeed, on 18 June 2014, health authorities in the Republic of Brazil reported detection of WPV1 in environmental sewage samples at the International Airport of Viracopos in Sao Paulo. Genetic analysis of the WPV1 revealed that the polio virus had been an importation from a country in the African Region that had active WPV1 transmission in 2014⁶. This situation constituted a real threat to achieving polio eradication in the African Region and had the potential to reverse the gains made in other Regions and by the global certification efforts.

Among the key challenges in the African Region were the continued transmission of WPVs; suboptimal quality of polio campaigns to interrupt poliovirus transmission; weak

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- 1 <http://www.who.int/biologicals/areas/vaccines/poliomyelitis/en/>.
 - 2 World Health Assembly resolution WHA41.28, global eradication of poliomyelitis by 2000.
 - 3 <http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/certification/>.
 - 4 Global Polio Eradication Initiative Independent Monitoring Board Report, November 2017.
 - 5 WHO weekly polio update, December 2014: 6 cases in Nigeria, 5 cases in Cameroon, 5 cases in Equatorial Guinea and 1 case in Ethiopia
 - 6 Equatorial Guinea

surveillance systems with poor data quality that could not be easily verified; lack of an accountability framework; inadequate resource mobilization, particularly at country level; low population immunity due to weak routine immunization service delivery and weak partnerships.

In addition to the programmatic challenges, localized insecurity and inaccessibility that hindered implementation of planned activities was a threat to programme delivery. This resulted in some populations not having access to polio interventions.

As a result, the programme suffered a major setback in 2016 when four cases of WPV1 were reported from the insecure Local Government Areas (districts) of Borno State in Nigeria from July to August 2016. The trapped population was under heavy insurgency and could not be reached by surveillance and vaccination teams. The areas with insecurity included parts of the Lake Chad Basin countries: Cameroon, Central African Republic, Chad, Niger and Nigeria.

The insecurity caused huge population movements leading to internally displaced persons and refugees which coupled with nomadic migratory patterns, resulted in geographical spread of polio outbreaks to countries across the African Region on 2004–2006 and in 2009.

2. SWEEPING CHANGES TO ADDRESS THE POLIO SITUATION IN THE WHO AFRICAN REGION

Dr Matshidiso Moeti assumed office as the WHO Regional Director for Africa on 1 February 2015. Under her leadership, “*The Transformation Agenda of the WHO Secretariat in the African Region, 2015–2020*” was initiated to breathe new life into the Regional Director’s commitment to transforming the Secretariat into a Regional Health Organization that is foresighted, proactive, responsive, results-driven, transparent, accountable, appropriately resourced and equipped to deliver on its mandate. The four areas of the Transformation Agenda comprised: *pro-results values* (through accountability, transparency and strengthened culture of evaluation of outcomes); *smart technical focus* (effective technical and policy support for all Member States for identified priorities); *responsive strategic operations* (staffing tailored to needs at all levels of the Organization with financing and resource allocation aligned with priorities) and *effective communication and partnership* (improved strategic communication and strengthened effective engagement with other stakeholders).

Assembling the Polio Eradication Programme to deliver results

One of the priorities identified by the Regional Director, in line with the smart technical focus area of the Transformation Agenda was polio eradication. Within her first 100

days in office and as part of restructuring the Regional Office, she established a new *Programme for the Eradication of Polio* in the Office of the Regional Director, to give it the requisite visibility and strong leadership for the polio endgame and legacy. An experienced manager in polio eradication was appointed to coordinate the programme, with the cardinal aim of achieving certification of polio eradication in the African Region within the shortest possible time.

To rapidly establish the new programme and accelerate implementation, the Regional Director convened and chaired an internal WHO management and technical meeting in Brazzaville in August 2015. The meeting was attended by the Director of Programme Management, Directors of Clusters, and relevant AFRO Programme Managers and Unit Coordinators in the Regional Office, as well as Heads of WHO country offices (WCOs) and their polio/immunization focal points from the following priority countries: Angola, the Democratic Republic of Congo (DRC), Chad, Ethiopia, Nigeria and South Sudan.

Based on an evaluation of progress made by countries towards eradication and the performance of the Regional Office, IST and WCO staff working on polio eradication, the polio programme in the Regional Office and ISTs were restructured to provide adequate technical support to Member States and institutionalize an accountability framework for polio-funded staff at all levels. A strategic shift from conducting meetings, workshops and teleconferences to the provision of direct technical support for implementation in countries was made. In addition, high priority was given to the rapid development of robust workplans, strengthening capacity for monitoring and evaluation, and accelerating the deployment of geographical information system (GIS) technologies to monitor implementation of planned activities in the field in “real time” with collected verifiable data and evidence to improve quality.

Ensuring effective support by AFRO and ISTs to Member States based on the paradigm shift

In May 2015, the Sixty-eighth World Health Assembly adopted a resolution⁷ to ensure interruption of WPV transmission; achieve and maintain certification-standard surveillance; introduce inactivated polio vaccine (IPV) before the global withdrawal of the type 2 component of the trivalent oral polio vaccine (tOPV) by May 2016; and ensure proper transition of human resources, infrastructure, best practices and lessons learnt to benefit other public health interventions as part of polio legacy.

With the Regional Director's approval, the structure of the Polio Eradication Programme in the Regional Office and ISTs was modified in 2015 to ensure successful implementation of the World Health Assembly resolution. The purpose was to make the programme more results-oriented with staff accountability as the main driving force, in order to provide effective technical support by both the Regional Office and ISTs, and to effectively engage partners with adequate resource mobilization for full implementation of the programme.

The "beefing up" of the functional organogram of the polio programme at the Regional Office in early 2016 resulted in an increase from 7 staff in 2015 to 20 (185%). In terms of gender representation, there was an increase from 3 female staff to 7 (133%). At the IST level, there was a staff increase from 16 to 26 (63% increase), with female staff increasing from 9 to 13 (45%).

Strengthening collaboration among partners and resource mobilization

After the technical restructuring of the polio programme in February 2016, the Regional Director convened a meeting of the key partners of the Global Polio Eradication Initiative (GPEI), including the United Nations Children's Fund (UNICEF), the Bill and Melinda

⁷ World Health Assembly, Document A68/21/ Add1 – 15 May 2015.

Gates Foundation (BMGF), the United States Centers for Disease Control and Prevention (CDC) and Rotary International in Brazzaville, Republic of Congo. The main purpose of the meeting was to strengthen technical collaboration and mobilization of adequate resources, particularly for rapidly strengthening surveillance and boosting population immunity in localized areas which chronically posed a risk for continued poliovirus transmission.

The meeting resulted in the development of joint workplans and a commitment to provide financial resources for chronically underperforming areas, including insecure and hard-to-reach areas. Following the sharing of good practices and lessons learned among countries in the Region, the meeting, instead of completely reinventing the “wheel”, adopted the strategic approaches and locally “homegrown” solutions from the African Region that had been tested and proven to produce results in challenging situations such as, insecure areas, hard-to-reach areas, and chronically poor performing areas, subsequently referred to as the “Brazzaville Initiative”.

Engaging Member States for robust responses to poliovirus outbreaks in the African Region

Subregional response to the WPV1 outbreak in Borno State in Nigeria: Between July and August 2016, four WPV1 cases were confirmed from the insecure areas of Borno State in Nigeria. Aware of the risk of spread of the WPV1 beyond Nigeria, the Regional Director quickly convened a side meeting with the Ministers of Health of Nigeria, Cameroon, Central African Republic, Chad and Niger, during the Sixty-sixth session of the WHO Regional Committee in August 2016. The meeting resulted in the Ministers declaring the polio outbreak in Nigeria to be a subregional public health emergency of the Lake Chad Basin and committing to stop the outbreak within the shortest possible time.

In addition, the Regional Director, working with other partners, appointed a GPEI Coordinator for the Lake Chad Basin Polio Task Team with the key responsibilities of effectively coordinating multiagency technical support to the ministries of health, mobilizing financial and human resources from governments and partners for implementation of planned activities, working closely with the Multinational Joint Task Force based in N'Djamena, Chad, to quickly improve access in insecure areas, providing weekly and monthly updates on the progress and challenges affecting implementation, and proposing an independent Technical Advisory Group of polio experts (TAG) to be formally appointed by the Regional Director.

No new cases of WPVI have been reported from the subregion since August 2016 indicating that the outbreak was interrupted in the shortest possible time. Furthermore, there was no evidence of geographical spread to neighbouring countries as had been feared.

To ensure sustained interruption of transmission in the subregion, the Regional Director continued to co-chair with the UNICEF Regional Director for West and Central Africa (WCARO), quarterly teleconferences involving WHO and UNICEF heads of country offices. Also, participating in the teleconferences were the GPEI Polio Oversight Board (POB) Chairperson and global technical heads of GPEI partners. The teleconferences were used as a forum to provide updates on the situation on the ground and discuss any managerial or technical bottlenecks. In addition, meetings were convened by the co-chairs at WHO/AFRO, Brazzaville, Congo in February 2017, and at the Lake Chad Basin Polio Task Team in N'Djamena, Chad in June 2018.

Interregional response to circulating vaccine-derived poliovirus (cVDPV2) outbreak in Kenya: cVDPV2 was isolated in the environmental surveillance sewage sample in Nairobi city, Kenya, in March 2018. The virus was genetically linked to the cVDPV2 that was circulating in Somalia and had been circulating undetected in the previous three years.

Based on the success and lessons learned in stopping the WPV1 outbreak in Nigeria and Lake Chad Basin, the Regional Director, in liaison with the EMRO Regional Director, rapidly put in place an Interregional (AFRO/EMRO) Horn of Africa Polio Task Team and appointed a GPEI coordinator for both WHO regions in May 2018 to lead the outbreak response. The terms of reference included coordinating the multiagency technical support to the countries, advocating ownership and leadership by ministries of health for the outbreak response, ensuring the participation of all stakeholders in the response, and facilitating implementation of proven innovations to reach children in insecure areas. In addition, capitalizing on the presence of Ministers of Health at the Seventy-first World Health Assembly in Geneva in May 2018, the Regional Directors of AFRO and EMRO jointly convened a side meeting with the Ministers of Health of Kenya and Somalia, and included Ethiopia due to the perceived risk involving population movements, to prevent spread to other countries. The Ministers of Health of the three countries signed an Interregional Declaration pronouncing the outbreak in Kenya and Somalia a Horn of Africa subregional public health emergency. As a result, resources were mobilized, and synchronized polio immunization campaigns were organized between the countries.

8 Djibouti, Ethiopia, Eritrea, Kenya, Somalia, South Sudan, Sudan and Uganda

No new cVDPV2 has been isolated from the samples taken from environmental sewage sites and no acute flaccid paralysis cases have been reported from Kenya since March 2018 (over a year now). This shows that the outbreak had been stopped in a timely manner. Based on the success of the Horn of Africa Declaration by the three countries, the Intergovernmental Authority on Development⁸ (IGAD) of the African Union, Ministers of Health in the eight IGAD countries, that include the Horn of Africa, convened in Kenya in September 2018 and adopted a Declaration to stop the emergence and spread of polioviruses in their countries.

3. ADVOCACY, GOVERNANCE, AND OVERSIGHT

High–level Advocacy

The WHO Secretariat in the African Region, through its collaborative efforts with the African Union Commission (AUC), has continued to advocate that polio eradication be given the highest priority in the African Region. One tangible result of these efforts has been the declaration of polio eradication as “Our Historical Legacy for Future Generations” by Heads of State at the Twenty-fifth Ordinary Session of the African Union held in Johannesburg, South Africa in June 2015. Following this, the WHO Regional Director for Africa has carried out several high-level advocacy visits to many Member States in the African Region to follow up on this commitment.

During these visits, the Regional Director met with Presidents, Prime Ministers and Ministers of Health and advocated the highest level leadership for polio eradication and encouraged governments to increase their domestic investments for implementing planned activities. For example, during the WPV1 outbreak in Nigeria, the Regional Director visited Nigeria and held high-level discussions with His Excellency the President, leaders of the Houses of Representatives and Senate, and the Minister of Finance for fruitful release of financial resources to implement planned activities.

Governance by the WHO Regional Committee for Africa

The WHO Regional Committee for Africa is the Organization's highest decision-making body in the African Region and comprises Ministers of Health or their representatives from each of the 47 Member States in the Region. The Regional Director is the Secretary of the Committee.

In addition to the provision of updates on polio eradication being a standing agenda item in the plenary sessions of the Regional Committee since 2015, the Regional Director has made the most of the ministerial gathering to organize side meetings and side events on polio to further discuss priority issues geared towards addressing the remaining challenges. For example, during the Sixty-fifth session of the Regional Committee in 2015 in N'Djamena, Chad, the discussions focused on polio transition planning with the seven Member States that account for almost 85% of polio investment and infrastructure⁹ in the African Region.

In 2016, during the Sixty-sixth session of the Regional Committee in Addis Ababa, Ethiopia, the deliberations focused on polio outbreaks in Nigeria and the Lake Chad Basin countries, while in 2017, in Victoria Falls, Zimbabwe, a side meeting was held with all Member States to emphasize the importance of strengthening surveillance with geographical information system (GIS) technologies to provide evidence for achieving certification in the shortest possible time.

During the Sixty-eighth Session of the Regional Committee held in Dakar, Senegal in 2018, the *Framework for Certification of Polio Eradication in the African Region* was presented and discussed as one of the main agenda items. Participating in these discussions was the Chairperson of the African Regional Certification Commission (ARCC). The Framework was endorsed by Member States and the Ministers requested that a country performance

9 Angola, Cameroon, Chad, Democratic Republic of Congo, Ethiopia, Nigeria and South Sudan



scorecard be shared with them periodically till the African Region receives its certification for polio eradication.

Oversight and leadership of polio activities by WHO/AFRO Regional Programme Meetings

Twice every year, the Regional Director convenes and chairs Regional Programme Meetings (RPM) during which polio eradication is a standing agenda item. The RPM is attended by the Regional Director, the Director for Programme Management, Cluster directors, Heads of WHO country offices, Programme managers and Unit coordinators, and Management officers. Its main objective is to discuss issues related to the planning, implementation, and monitoring of programmes of the Secretariat in the WHO African Region.

The RPM also reviews, monitors and evaluates ongoing progress in Member States, discusses bottlenecks and articulates recommendations to ensure implementation of priority actions toward polio eradication at country levels. The RPMs have been used to track progress in implementing the collaborative agreements and decisions made on polio eradication during sessions of the Regional Committee and the Regional Director's high-level polio advocacy visits to Member States.

4. SUSTAINED PROGRESS TOWARDS CERTIFICATION OF POLIO ERADICATION

The Polio Eradication Programme, under the direct oversight and commitment of the Regional Director since she took office in 2015, has made tremendous progress towards certification of eradication

To ensure certification-standard surveillance, the Region has intensified surveillance of suspected human cases using local innovations and technologies to avoid missing any lingering poliovirus transmission. In addition, in order to complement surveillance for suspected cases, the African Region has rapidly expanded environmental sewage surveillance from only 6 countries in 2014 to 23 countries in 2018, accounting for almost a fourfold increase.

The AFRO-Polio Geographical Information Systems (GIS) Technology Centre in Brazzaville, Republic of Congo, was established with funding from BMGF to support surveillance and immunization activities in the field and to monitor in real time if the planned activities and supportive supervision were being carried out. Since the shared data from the field is geo-coded, it allows verification and validation of the submitted data which is critical for improving data quality, particularly for certification of polio eradication. The Centre was officially opened by the Regional Director in February 2017.

The GIS technology is easily adaptable and versatile for any public health event. Since its establishment, the technology has been used to support other interventions outside polio, such as immunizations, cholera outbreaks, meningitis outbreaks, measles outbreaks and measles campaign coverage surveys, Lassa fever outbreaks, EPI coverage surveys, and mortality surveys in inaccessible and hard-to-reach areas.

The technology is relatively cheap, requires very minimal investment and is sustainable. For most participants in the network, the investment is just an android cellphone. As such, the GIS technology has been rapidly expanded to tens of thousands of users in less than 2 years. Due to its user-friendliness, the technology has been expanded to community informants in the hard-to-reach, inaccessible areas and areas without formal health services. As of March 2019, there were more than 6000 community informants in 10 selected Member states on the AFRO-Polio GIS platform.

Using satellite imagery, the GIS technology can also be used to estimate populations so that populations can be well targeted for public health interventions. This is particularly important for planning implementation of health interventions in inaccessible areas.

10 By March 2019, polio -GIS technologies' establishment pending in four countries: Algeria, Cape Verde, Comoros and Seychelles

During the Seventy-seventh session of the WHO Regional Committee for Africa in August 2017, the Regional Director urged Member States to adopt and establish GIS technological innovations for “real-time” reporting of polio surveillance, immunization activities, integrated field supervision and implementation of other health interventions such as disease outbreaks control, among others. The number of Member States with established AFRO-Polio GIS technology increased from less than 5 in 2017 to 43 by March 2019¹⁰.

During their visits to the AFRO-Polio GIS Centre in December 2018, Ministers of Health of the Republics of Congo and Liberia, having observed the versatility of the technology, requested the Regional Director to fast track the establishment of the innovation to

directly monitor surveillance and health services delivery in their countries, straight from their respective offices. One of the ministers remarked, “The innovation is like magic and will be used, beyond polio, to monitor the situation of health care in the districts, mortality such as maternal deaths and availability of selected essential medicines in health facilities, among other uses”.

Local “homegrown” innovations have also been used to reach children in difficult areas. The polio programme envisaged that unless children and populations in underserved areas, such as in insecure, inaccessible, and hard-to-reach areas due to infrastructure challenges and terrain are reached, there would be reservoirs for lingering poliovirus transmission and eradication would not be achieved. One of the locally “homegrown” solutions is the adoption of microplanning for vaccinating children in the shortest possible time, referred to as “*hit and run*”. This means that, as the window of access permits, the vaccination teams go into the inaccessible areas, vaccinate and quickly leave.

Another approach that was adopted is “*wall-fencing*” whereby the vaccination teams repeatedly vaccinate with polio vaccines around the reachable settlements surrounding the trapped insecure areas. For nomadic and mobile populations, the polio programme, with the assistance of other humanitarian and livestock departments, mapped out the transit points for the population movements and conducted transit vaccines. The “*transit vaccination strategy*” is aimed at stopping the transmission of polioviruses along the migratory routes of nomadic population movements.

In extreme situations where surveillance and vaccination activities cannot take place due to insurgency and risk of loss of lives of vaccination teams, as were the situations in Borno State in Nigeria (WPV1 outbreak) and Ituri Province in DRC (cVDPV2 outbreak), the polio teams planned and worked with government military personnel to conduct surveillance and vaccinate children. Polio outbreaks in these situations were halted.

The above innovative strategies have been described in detail, together with the resultant observed positive impact, in peer-reviewed scientific journals,¹¹ as best practices and lessons learned from the Polio Eradication Programme for the benefit of other public health interventions in the African Region.

By March 2019, no WPV1 had been confirmed in the African Region for more than 30 months since the last case in the insecure areas of Borno State in Nigeria, with onset on 21 August 2016; and isolation of WPV1 in a healthy contact of the index case on 27 September 2016. Wild Polio Virus type 2 was declared to have been eradicated, globally, by the Global Commission for Certification of Poliomyelitis Eradication (GCC) in September 2015, more than three years ago¹². The last WPV3 case was reported in November 2012, in Nigeria, more than 6 years ago¹³. These show that tremendous progress has been made on all the three serotypes of polioviruses since 2015 for certification of eradication in the African Region. Furthermore, no WPV1 has been exported from the African Region to another WHO Region since 2015.

Since WPV2 was certified to have been eradicated globally in 2015, the type 2 component of the oral polio vaccine (OPV) has been successfully withdrawn in all Member States in the African Region as part of the “global switch” from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV). Although the global plan before the “switch” was to introduce inactivated polio vaccine (IPV) in routine immunization services, the introduction was affected by global shortage of the vaccine. With the recent increase in global availability of IPV, all Member States in the African Region had introduced IPV in their routine immunization programmes by March 2019.

In 2015, the Global Commission for Certification of Poliomyelitis Eradication (GCC) recommended that laboratory containment of WPV2 and polio vaccine Sabin type 2 be concluded, globally, by April 2016. Containment is a critical component towards eradication to avoid leakage of polioviruses from laboratories into the environment

11 The Journal of Infectious Diseases, Best Polio Eradication Initiative Practices in Nigeria with Support from the WHO, volume 213, supplement 3, May 2016; Polio Eradication Initiative Best Practices in the WHO African Region, volume 34, issue 43, October 2016

12 GCC Meeting Report, Bali, Indonesia, October 2015

13 Global Certification Commission (GCC) Meeting Report, Amman, Jordan, October 2018

and populations which could result in huge epidemics and reverse the gains towards eradication. By March 2016, all Member States in the African Region had implemented laboratory containment according to phase 1a Global Action Plan III (GAP III). The African Region was among the first WHO Regions to finalize laboratory containment with national documentation.

The Seventy-first World Health Assembly passed a resolution (WHA resolution 71.16) in May 2018 for containment of polioviruses and potential poliovirus infectious materials (PIM) by April 2019, with a progress report to be submitted by the WHO Director General to the Seventy-second World Health Assembly in May 2019. By March 2019, PIM containment had been conducted in 40 Member States in the African Region with a technical support plan in place, to complete this in all Member States by April 2019, ahead of the Seventy-second World Health Assembly.

By November 2018, the Africa Regional Certification Commission (ARCC) for Poliomyelitis Eradication had accepted polio-free status national documentation of 40 out of 47 Member States¹⁴. By January 2019, a plan had been finalized for the ARCC to accept documentation of the remaining 7 countries¹⁵ by the end of 2019.

To further accelerate implementation of eradication efforts, AFRO presented the Framework for Certification of Polio Eradication in the African Region to the Sixty-eighth session of the WHO Regional Committee for Africa in August 2018. The Framework, which articulates the priority activities for achieving certification in a timely manner, was endorsed by Member States. With the current momentum, steady progress, a clear framework, strong leadership and commitment, the African Region is on course for certification of polio eradication by the end of 2019 or early 2020.

As per the WHO Executive Board decision¹⁶, since 2017, the African Region has systematically implemented the ramp-down of polio-funded staff in Member States based

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- 14 Seven countries with pending polio-free status: Cameroon, Central African Republic, Equatorial Guinea, Guinea Bissau, Nigeria and South Sudan
- 15 Guinea Bissau in April 2019; Central African Republic, Equatorial Guinea, South Africa and South Sudan in September 2019; Cameroun and Nigeria in December 2019
- 16 WHO Executive Board 2013 Report, Polio Human Resources

on the projected country human resource budget ceilings. On polio transition planning, six¹⁷ out of the seven priority Member States in the Region have finalized their costed polio transition plans. These have been endorsed by their national interagency coordination committees (ICC). Globally, out of the 17 priority Member States for transition planning, only seven Member States have costed and endorsed transition plans. Six out of the seven Member States to finalize the transition plans by December 2018 were from the African Region (accounting for 86% of finalized plans, globally, as of March 2019). The WHO Global Policy Group has commended WHO/AFRO as a good example, among regions, for polio transition planning.

To ensure sustainability of the GIS technological innovations for other public health interventions, beyond certification of polio eradication, the technologies have been institutionalized in the offices of ministries of health in 43 Member States to empower senior management to use the generated real-time data for monitoring the performance of their programmes and take action in a timely manner.

14 Seven countries with pending polio-free status: Cameroon, Central African Republic, Equatorial Guinea, Guinea Bissau, Nigeria and South Sudan

15 Guinea Bissau in April 2019; Central African Republic, Equatorial Guinea, South Africa and South Sudan in September 2019; Cameroun and Nigeria in December 2019

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5. FUTURE PERSPECTIVES

While certification of polio eradication is getting closer, the job is not yet done. One key remaining challenge for achieving certification is how to sustain government and partners' commitment as apathy may start to sink in after several years without detecting polio cases. It is certainly imperative to remain vigilant and rather intensify implementation of planned activities as articulated in the Framework for Certification of Polio Eradication in the African Region which was endorsed by Ministers of Health of all the Member States in 2018.

It is critical that GPEI partners, governments, development partners and donors sustain funding for polio programme certification and post-certification activities to sustain the gains. National polio transition plans have been developed by African countries to transfer knowledge, technologies and innovations, lessons learned and assets from the polio programme to other public health interventions for their benefit. However, funding has not been mobilized for implementation of these transition plans. As the polio eradication programme funds start to dwindle, it is critical that domestic financing be made available to properly transition the assets and maintain them for other priority public health programmes. That, beyond question, will be a great and true Polio Legacy.

In conclusion, the African Region has moved closer to polio eradication certification. No new cases of wild poliovirus have occurred over the past 30 months, with 36 months being the milestone for certification. Forty countries in the WHO African Region have had their polio-free status documentation accepted by the relevant Certification Commission, and support is being provided for the remaining seven countries to have the whole Region certified polio-free by the end of 2019. This progress has been possible owing to

the leadership of national governments, effective collaboration among partners, and the adoption of innovative approaches, including strengthened surveillance and campaigns using geographical information systems. All hands must be on deck as we move to cross the goal line of polio eradication certification in the African Region.









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