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REAPING THE POLIO DIVIDENDS

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INTRODUCTION

The Global Polio Eradication Initiative (GPEI) – the largest, longest global health programme in history – has required sustained organizational and political effort and developed a complex global partnership. Over the last thirty years, the UK has been the second largest national contributor to the GPEI, investing approximately US$ 1.6 billion out of the total GPEI budget of US$ 15 billion. About a third of the UK's contribution has been made during the last five years. Besides its financial contribution, the UK has also been a technical, political and advocacy partner.

The imminent end of the GPEI and the necessity to optimize the benefits arising from it has wide implications, in and beyond the field of global health. Moreover, it comes at a time when the UK is seeking to reposition its external relationships.

On 13 March 2018, the Global Health Centre (GHC) at the Graduate Institute, Geneva, partnered with Rotary International and the Wellcome Trust to host a policy dialogue in London on the intersections between UK political engagement in health, pressing global health concerns, and global polio eradication and transition efforts. Participants, including representatives from the UK government, Parliament and civil service, academia, the World Health Organization (WHO), non-governmental organizations (NGOs) and the media, highlighted various dimensions of the changing landscape in global health and opportunities for the UK to sustain and strengthen its role in global health as one of its ongoing political priorities. This report elucidates key themes from the discussion in London.

Rt Hon Alistair Burt MP, Minister of State, Department for International Development

IDENTIFYING THE POLIO DIVIDENDS

The London Dialogue identified a variety of potential dividends arising from the polio eradication efforts and how they can be utilized in the future.

POLIO ASSETS

Over the last thirty years, the GPEI has established a number of polio assets, including skilled health workers, managerial and surveillance systems, laboratories and cold chains. Many of these assets can be integrated into the wider health system. The potential dividends from two assets were highlighted at the London Dialogue:

- **Integrated surveillance system:** The polio programme has developed the largest surveillance system in all currently existing health programmes. High quality human and environmental surveillance programmes have been indispensable in identifying areas where the polio viruses circulate. This system should become the bedrock of an integrated surveillance system to detect outbreaks of various diseases or emerging antimicrobial resistances and respond accordingly.

- **Routine immunization:** Participants concurred that children dying of vaccine-preventable diseases is an unacceptable, but solvable, situation. To address this challenge, the GPEI holds two lessons. First, it has taught the international community how to reach the hard-to-reach populations. Presently, 20 million infants are not receiving the benefits of full immunization – 40 percent of these children live in fragile states and challenging humanitarian settings. Learning from the mechanisms and instruments employed by the GPEI can help to reduce this number of unreached children in the future. Second, the GPEI itself has also conducted routine vaccination programmes. By building on these existing mechanisms, routine immunization across the board can be greatly strengthened to reach the hardest-to-reach with essential vaccines. It can also provide the solid foundations on which any future disease eradication efforts can be constructed.

KNOWLEDGE CREATION FROM POLIO ERADICATION

The London Dialogue identified the following lessons learned from polio which can be translated to other health initiatives:

- **Creating effective governance structures:** The GPEI's unique governance structure has led to a strong partnership amongst the core partners – namely WHO, UNICEF, Rotary International, US Centers for Disease Control and Prevention (CDC) and the Bill and Melinda Gates Foundation (BMGF). One reason for this tightness can be attributed to the partnership's 'informal' nature. The GPEI had shown flexibility, including its capacity to evolve, adapt and re-programme in the face of missed eradication deadlines and setbacks. There are valuable lessons to be learned from the governance structure that may be of benefit to other health initiatives.

- **Forging local alliances:** The polio programme's unique capacity to access people in very remote, insecure and fragile environments is largely due to the cooperation of allies at the country and local level. Such allies include religious and political leaders, civil society and many others who have been crucial in negotiating the 'days of tranquillity' to enable vaccination activities despite civil disturbances. These partnerships hold lessons for organizations active in the context of humanitarian crises. Furthermore, these partnerships are of major value for any health programme, particularly where it is important to connect global objectives to the local level, and can be applied to broader child survival work, e.g. around nutrition, water sanitation, hygiene and malaria.

- **Promoting local ownership:** The London Dialogue contrasted the strong ownership of the GPEI on the side of the leading international partners with the occasional low level of local ownership. The issue of local ownership is linked to an unbalanced governance structure. As the WHO pays salaries instead of national authorities, an ownership gap is created. To avoid such practices in the future, international and local partners should discuss issues concerning governance mechanisms that enable self-ownership, self-determination, and empower communities and countries to deliver their agenda sustainably according to their own needs.

Judith Diment, PolioPlus National Advocacy Advisor; Member of the International PolioPlus Committee; and Rotary International Representative to the Commonwealth.

CHALLENGES TO POLIO DIVIDENDS

In order to reap these polio dividends, any strategy must carefully analyse and tackle existing challenges. The London Dialogue foregrounded two major challenges to the smooth transition of these polio dividends:

EVOLVING GLOBAL HEALTH LANDSCAPE

- **Increase of new actors in the polio arena:** Against the background of the Sustainable Development Goals (SDGs), which seeks to link different interventions, new non-polio actors are entering the polio arena. This entrance will require increased coordination to ensure coherence between the programmes of existing and emerging actors.

- **Change in global health security landscape:** With the evolving global health security landscape, actors have to recognize, amongst others, new and re-emerging infectious diseases or the risk of bioterrorism. These developments gave an impetus to strengthening disease control, pandemic preparedness, the International Health Regulations (IHR) as well as core capacities of countries to detect, contain, and inform about disease outbreaks. Such developments highlight the need for appropriate governance of global health security at global and local levels, and point to the importance of effectively transitioning core polio assets and ensuring their integration into countries' public health and emergency response systems.

RESOURCE MOBILIZATION AND POLITICAL SUPPORT

- **Establishing sustainable funding mechanism:** In the context of funding mechanisms, two current transitions pose a challenge. First, as funding for the GPEI phases out, polio stakeholders face the issue of whether both the funding and its mechanisms should be re-allocated within the global health field or re-directed towards other areas. The ending of the GPEI will have major implications for funding streams in multilateral institutions as well as in countries. In the case of WHO, up to 25% of its funding is now derived from the polio programme. Unless new funding channels and mechanisms are created, the impact of the phase-out on WHO will be felt in a wide range of programmes and activities on all levels. Second, several countries that have previously received assistance from the World Bank, Gavi and the GFATM have 'graduated' and are therefore no longer eligible for funding from these organizations. In the absence of national funding mechanisms which could replace this assistance, established programmes – such as vaccination – rest on a shaky foundation.

- **Maintaining political support:** The closure of donor programmes is often accompanied by loss of political support. Participants underscored how the loss of technical support is sometimes more serious than losing money, as this has an impact on the country's capacity to address the health needs of neglected and vulnerable populations. Furthermore, though the visibility and importance of health issues within global political and foreign affairs arenas have increased over the years, they nonetheless tend to remain absent from discussions in other sectors that impact on health. Hence, effort is needed to identify when and how health can be raised in these other agendas.

"As the end of polio draws closer, now is the time to consider how the expertise, capacity and resources that are being built by the international effort on polio can be deployed against a wider range of diseases and to strengthen and protect health systems."

Rt Hon Alistair Burt MP, Minister of State for International Development

CONDITIONS TO REAP THE POLIO DIVIDENDS

- **Continuous advocacy at all levels:** In order to maintain support for both the ending of polio and the transitioning of polio assets, there needs to be increased advocacy, awareness-raising, and communication by the various actors involved. This can be done through both using the achievements and experiences from polio eradication, and developing better data and demonstrating results.

- **Health links with education:** In some cases, education deficits correlate with decisions to reject available health services. Anti-vaccination narratives may be countered through increased levels of education and efforts to develop information and understanding about the need and advantages of health services in general, and vaccinations in particular. The case of polio can serve as an illustrative example.

- **Increased data-gathering and coordination amongst external players:** With regard to the transitioning of health initiatives, there is a lack of data in the public domain that provides a picture of exactly who is leaving from where, and what financing and capabilities this leaves behind. This makes it very difficult to analyse precisely and predict the total impact of a phase-out of financing from the GPEI and other programmes. Thus, greater information exchange and enhanced coordination efforts by the external players is required. Moreover, the non-polio players need to be included in such coordination efforts concerning the transitioning of polio assets. Enhancing information-sharing and including these actors will be crucial to maintain the future commitment of donors to polio. As noted in the London Dialogue, there appears to be a lack of awareness amongst many that most of the donors behind polio eradication are not necessarily committed to transitioning. Thus, including further actors to create new leadership momentum and new channels of support will be crucial.

SPECIFIC RECOMMENDATIONS FOR THE UK

- **Connect actors and facilitate conversations:** The UK is one of the biggest and most respected donors in global health. Hence, it can facilitate conversations on a variety of global health issues. These include, but are not restricted to, discussions on the political and financial commitment for transitioning of polio assets, support for the SDGs and Universal Health Coverage (UHC), the strengthening of global health security, the bolstering of multilateralism, and resourcing of the WHO. The London Dialogue further highlighted that the UK is uniquely placed to fulfil such a role within the Commonwealth, as it has hosted the most recent Commonwealth Heads of Government Meeting and holds the Commonwealth Chair until 2020.

- **Support vaccination and immunization programmes:** Against the background of anti-vaccination narratives and sentiments and the UK's political weight and available resources, the UK was exhorted to maintain its position as a politically and financially steadfast supporter of vaccination and immunization programmes. They can achieve this through strong investments in both research and development (R&D) and education, and supporting long-term planning and development of health systems.

- **Strengthen health systems bilaterally:** The UK should strategize how innovations within the National Health Service (NHS) can be used as an example to encourage other countries bilaterally to reform their own health systems. Such activities might overcome hesitancy in implementing innovative reforms within certain countries. For instance, the UK has built up the National Institute for Health and Care Excellence (NICE) which can serve as a model for other countries.

- **Deploy arguments rooted in British values:** Winning over the public to the cause of sustained post-polio UK investment in transitioning and global health depends on deploying a range of different arguments. These include (a) drawing on the British sense of fairness and dignity; (b) appealing to the self-interest of health security; (c) recognizing the opportunity to capitalize on the UK's strengths in science, technology, and its NHS to export goods and services; and (d) highlighting opportunities to exert soft power through development channels.

From left to right: Laura Kerr, Results UK; Kalipso Chalkidou, Global Health Policy at the Center for Global Development; Josephine Ojiambo, Rotary Club of Westminster West and Commonwealth Secretariat; and Kamran Abassi, British Medical Journal.

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