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MEETING REPORT OSLO

POLIO ERADICATION AND CURRENT TRANSITIONS IN GLOBAL HEALTH

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INTRODUCTION

In 1988, the World Health Assembly (WHA) passed a resolution on eradicating poliomyelitis (polio) worldwide by the year 2000. [1] Yet, twenty years after its initial eradicated. Whilst the partnership of the Global Polio Eradication Initiative (GPEI) has been successful in reducing polio cases from several hundred thousand per year to a few dozen, reaching the last pockets of polio-endemic areas has proven to be challenging. Eliminating the last polio cases requires the partnership to engage in innovative ways internally, with their partners and donors, and with other global health initiatives.

Since the inception of the GPEI, Norway has been actively engaged in the global polio eradication efforts. In addition to contributing a total of USD 291.26 million to the GPEI between 1988 and 2019 – making them the largest non-G7 OECD country contributor – Norwegian Prime Minister and Co-Chair of the UN Secretary General's ADG Advocacy Group, Erna Solberg, has been actively advocating for polio eradication. She has also been encouraging leaders around the world to commit to mobilizing resources to deadline, the disease has still not been ensure a polio-free world. [2] More recently, Norway has embedded their polio priorities within a broader health agenda. It is a major supporter of the Global Vaccine Action Plan, [3] and supports Gavi's work to make Inactivated Polio Vaccines (IPVs) available in priority countries and strengthening routine immunization as a whole. It also works with the World Health Organization (WHO) to progress the transitioning of polio assets to their respective countries.

Against this background, on 12 September 2019, the Global Health Centre (GHC) partnered with Tankesmien Agenda and the Centre for Global Health at the University of Oslo (UiO), to host a policy dialogue in Oslo. The event served to update members of the Norwegian government, academia and civil society organizations on the current situation of polio eradication and transition, lessons learned, and ways forward for different partners – namely the GPEI, global partners and Norway – to both ensure a polio-free world and achieve the broader global health agenda of Universal Health Coverage (UHC). This report elucidates key insights gained from the event.

KEY LESSONS FROM THE POLIO ERADICATION PROGRAMME

As the longest, largest and most expensive global health programme in history, the GPEI allows to draw a number of lessons that are valuable for the broader global health community. These lessons are discussed in detail below.

DELIVERING HIGH-QUALITY SERVICES EVERYWHERE

As Sona Bari, Manager of External Relations on Polio Eradication at the WHO, recalled from her conversation with a community in Northern India, "(…) the polio programme reaches where the rays of the sun don't reach." Sharing the learning of how to reach the hard-to-reach communities will be essential in improving primary health care (PHC) delivery and ultimately achieving UHC. However, more importantly, the polio programme learned that delivering services is not enough.

Quality services must be delivered. Too often, polio campaigns have repeatedly returned to the same village that is fully accessible because they were unable to identify the right children in the first round. Sona Bari stated that failing to deliver quality service has a domino effect on other issues: "From (the) lack of quality flows everything else: lack of trust, community fatigue, stakeholder fatigue… and then that creates a climate where misinformation and politicization of the programme can occur." Delivery of quality services also means realizing that "every solution has an expiry date", and constantly finding new solutions to a problem.

It should be noted that the absence of trust and politicization of the programme was also fueled by incidents witnessed in Pakistan in 2011, when a vaccination campaign was used as cover for tracking down Osama bin laden. This gave credence to previous claims by opponents of vaccination that it was part of a foreign plot to harm people, and had detrimental impacts on future polio vaccination campaigns and the communities' overall attitudes to the campaigns.[4]

> *"(E)very solution has an expiry date. Every solution can't work forever and in all circumstances. What worked in Northern Nigeria won't work in Pakistan. That's a lesson we learned: we need to have new constant ideas."*
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> Sona Bari, Manager of External Relations, Polio Eradication, WHO

From left to right: Sigrun Møgedal, Norwegian Institute of Public Health; Jay Wenger, Bill and Melinda Gates Foundation; Sona Bari, Polio Eradication, the World Health Organization; and Aksel Jakobsen, Norwegian Ministry of Foreign Affairs.

MOVING FROM A TOP-DOWN TO BOTTOM-UP APPROACH

According to Sigrun Mogedal, Special Advisor to the Norwegian Institute of Public Health, another reason for the absence of trust in the polio programme lies in the programme's traditional top-down approach. Communities that reject polio vaccines are those who live in conditions deprived of the most basic services and largely ignored by the government. Polio is only "one amongst many other ills in the community," with many communities also lacking clean water and access to basic healthcare.

Jay Wenger, Director of Polio Eradication at the Bill and Melinda Gates Foundation (BMGF) said the programme has reached a point where communities are rejecting polio drops and demanding for bridges to be built. As the 2018 report of the Independent Monitoring Board (IMB) states, "… (the) refusal of the polio vaccine is not a mere gesture. It is a distillation of the anger that communities feel when polio workers knock on their doors over and over again in the absence of other governmental services."[5]

Re-establishing trust in the polio programme requires a bottom-up approach, not a top-down approach. Such a bottom-up approach needs to account for the context in which polio vaccination takes place. It also requires incorporating the needs of the communities. Importantly, such a bottom-up approach needs to be driven by local, and not external, actors. Hence, the delivery of quality services ultimately means the rethinking of traditional health care delivery services (top-down) to adapt to the interests of the affected communities. As Sigrun Mogedal underlined, there is a need for the global health community as a whole to recognize that a top-down, single focus is not a model for PHC and UHC. This is relevant for not only polio, but for other diseases such as malaria and HIV/AIDS.

DE-MEDICALIZING PUBLIC HEALTH POLICIES

The range of political and social factors recognized as being critical in the final stages of polio eradication clearly demonstrates the need to look beyond medical models of public health and diseases. Instead, it is necessary to adopt a "social determinants of health" perspective. Sona Bari said that with doctors at the heart of the WHO, public health has tremendous faith in medical science. However, the polio programme taught the WHO that biological feasibility is not enough to eradicate polio.

Vaccines can prevent and control the spread of polioviruses. Yet, there are children who cannot obtain these vaccines due to issues related to conflict, geography and migration. There are also children who are accessible, but their parents prevent them from getting polio vaccines due to 'polio drops fatigue'. Such issues require a deep comprehension of structural and social factors that constrain and enable vaccination campaigns. Whilst the WHO is beginning to increase their understanding of cultural and social anthropologists and community groups, much work remains in mainstreaming this idea not only for the polio community, but also to other parts of public health.

ENSURING THE EXISTENCE OF ACCOUNTABILITY MECHANISMS

The GPEI is a unique partnership between core partners contributing each of their areas of expertise: WHO, Rotary International, UNICEF, US Centers for Disease Control and Prevention (CDC) and the Bill and Melinda Gates Foundation (BMGF). This multi-stakeholder partnership has shown flexibility, adapting to changing challenges and evolving new operational and accountability models.

The establishment of the Independent Monitoring Board (IMB) in 2012 has been particularly important as it enabled frank, impartial and critical comments on the

programme, which, as underlined by speakers, would have been difficult, if not impossible, for individual partners to voice. Whilst the extent to which the partnership is able to respond to IMB criticisms remains controversial, the example of the GPEI partnership provides a model framework that future global health programmes could adapt when developing their structures.

POLIO AND BEYOND – HOW TO ENSURE SUCCESS

When the GPEI began in 1988, there were approximately 350,000 reported cases of wild poliovirus (WPV) in 125 countries. Since then, this number reduced by over 99% to less than 3,000 in 2000 – the original year for complete polio eradication – and as of September 2019, when the Oslo dialogue took place, there had been only 73 WPV cases in the year, contained in Pakistan and Afghanistan. From this perspective, the polio case can be seen as a success story.

However, a number of speakers warned that it was too early to celebrate. Sona Bari emphasized that "only zero counts" for eradication. Sigrun Mogedal stated that whilst achieving success is wonderful, maintaining success takes time. She further noted that though the world likes to talk about 'global public goods', there is a need to maintain the goods at both national and global level. In this sense, maintaining a polio-free world is both a national and global public task.

Speakers at the event identified the roles and responsibilities of the GPEI, global partners and Norway in achieving and maintaining a polio-free world, in ensuring that polio remains a global public good, and in leveraging the achievements and lessons-learned to benefit both disease-specific initiatives as well as broader public and global health systems.

From left to right : Jay Wenger, Bill and Melinda Gates Foundation; Stephen Matlin, Global Health Centre at the Graduate Institute; Sigrun Aasland, Tankesmien Agenda; Sigrun Møgedal, Norwegian Institute of Public Health; Sona Bari, Polio Eradication, the World Health Organization; and Aksel Jakobsen, Norwegian Ministry of Foreign Affairs.

GPEI

Develop and Expand Partnerships

The assets the GPEI developed – such as skilled human resources, laboratories, managerial and technical systems – have been used for other health programmes. For example, not only has the polio surveillance system been used to detect Ebola in Nigeria and Sierra Leone, but has also been used to detect other diseases in India, such as encephalitis and the bird flu. Jay Wenger said that moving forward, there is a need for the GPEI to pay closer attention to what the polio programme can do now to help countries move forward in a much broader development framework.

Sigrun Mogedal however argued that instead of asking ourselves how the work of polio can help to achieve other goals, we should ask ourselves how the work done in other parts of PHC, UHC and SDGs may help polio. As a largely vertical programme, the GPEI has not developed relations with other global health and development partners. In Sigrun Mogedal's words, there is a need for the GPEI to "develop (that) friendship with development partners who do other things than polio."

Developing and expanding friendship with other development partners would benefit the GPEI both directly and indirectly. Directly, the GPEI can expand their donor base, a crucial issue as they seek to sustain funding in the final phase of the programme. Indirectly, through increasing engagement with other health sectors, such as immunization and child health, actors and donors active in these areas can recognize the benefits of the polio assets for their own programmes and the importance of maintaining a polio-free world. In other words, expanding the partnership may create the space where actors can realize the synergies between polio and other programmes.

> *"(I) want to have caution here, so that in our enthusiasm to how one can use the polio assets, one doesn't overstretch it but rather think about how those on the ground, together with the polio programme, can be part of going the last mile. Because polio has been single focused, they don't have that many friends around them to do that. They have to develop that friendship with development partners who do other things than polio."*
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> Sigrun Mogedal, Special Advisor, Norwegian Institute of Public Health

Re-Establishing Trust of the Target Communities

Declining trust within target communities, arising from a top-down and medicalized approach, is not only a challenge to the GPEI, but also to other disease programmes. Actors engaged on Ebola, for example, are also discussing how to de-medicalize health, and how individuals in communities affected by Ebola avoid going to the Community Care Centers –where infected persons obtain care and essential needs such as food and drink in isolation – because they mistrust these programmes. Amongst others, the sole focus on Ebola, and neglect for other diseases, contributes to this mistrust.[6] The same can be seen in polio, with parents refusing to vaccinate their children from polio as the government and polio campaigns have failed to address broader societal and health issues. The immunization landscape in general is facing issues of mistrust materializing in the

form of anti-vax sentiments – parents are increasingly unwilling to vaccinate their children, as a result leading to an increase in measles outbreaks in 2019.

Rethink Data Needs

Programmes focused on infection control would benefit tremendously if they, like polio, had the same amount of data available on surveillance, prevalence, targets and treatments. However, the polio programme is currently drowning in data, hampering its effective utilization. Whilst Jay Wenger reassured that much work is being done to ensure data is collected and managed carefully at all levels, Sigrun Mogedal highlighted a critical issue: the data gathered currently serves the top managers and international organizations but not the local health systems. This is reflected in the 2019 IMB report, which says frontline workers must have the best data flowing to them for decision-making and not "be distracted by constantly having to look upwards to supply data for briefings and meetings at global level."[7] If we are to talk about polio assets contributing to the achievement of UHC, there is a need to rethink how the data is being generated and improve its use.

This question of data is crucial and relevant to the wider discussions in global health in two ways. First, it highlights the problem of a top-down approach, with data currently collected for use not by local actors, but by individuals working in international organizations. Second, the experiences gained by the GPEI, involving lessons learned and best practices from data usage in polio, can be shared with those working in digital health more broadly.

> *"We say data is an asset, we can transfer it, but data serves the top managers and international organizations, not the local health systems."*
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> Sigrun Mogedal, Special Advisor, Norwegian Institute of Public Health

GLOBAL PARTNERS

Less Public Pronouncement and More Diplomacy in the Background

Sona Bari underscored the need for global partners to empower local authorities by taking themselves out of the equation. This is a shift in practice, as organizations such as the WHO and UNICEF "love being in the media and talking about how great (they) are." Issues must be seen as local, and responses need to be seen as something that comes from within the community. For instance, when attacks against Pakistani health workers began in 2012, all logos associated with an international agency and US government were removed. The same discussions are present in the field of Ebola. At an Ebola event on 13 May 2019, Emanuele Capobianco, Director of the health and care division at the International Federation of the Red Cross (IFRC) said that there is a need to lower the profile of Ebola responses by, for instance, removing UN logos from cars.[8]

Furthermore, Sona Bari asserted the importance of global partners working behind closed doors with governments, as seen in the successful outcome in Syria with the polio case. She underlined the need for global actors working with a government that has no trust among its populations to encourage them to work with local movements and depoliticize so everything is about the local community. This also relates to the realization that international partners are not

able to force solutions upon local communities, which implies a substantially different approach from the prevailing one.

NORWAY

Using Global Instruments to Move Towards a Concerted Agenda

As has been noted earlier, amongst other ways, Norway supports the polio eradication efforts through supporting Gavi's work to make IPVs available in priority countries. Against this background, Sigrun Mogedal highlighted the following: "The question about how to make optimal use of Gavi together with polio is one of the key things Norway should think about, not just to pay lip service to polio by putting money for IPV in Gavi, but actually trying to use those instruments to move for a more broad concerted agenda." Furthermore, Norway is a major supporter of the Global Action Plan for Healthy Lives and Well-being for All (SDG3), [9] which offers opportunities for Norway to use its position actively with all the partners to be in support of polio synergies and working together. Furthermore, Norway sits on boards of different organizations such as the Global Fund. Norwegian board members need to have a better understanding of how to link the different issues together, particularly in terms of transition planning, funding and domestic finance. Creating such horizontal coordination mechanisms is particularly important with regard to the goal of achieving UHC.

CONCLUSION

As Stephen Matlin, Senior Fellow of the GHC at the Graduate Institute of Geneva concluded, polio is like the "canary in the cage." Polio signals what is working and what is not going well in a health system. It provides the alarms when systems are not reaching all children or services are being rejected. It signals whether international, national and local actors are cooperating effectively to achieve a long-term health priority. Thus, polio eradication is a test of whether the world is ready to deliver the UN SDGs for health.

Aksel Jakobsen, State Secretary of International Development, Norwegian Ministry of Foreign Affairs

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CITATION

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