

A BALANCING ACT

RISKS AND OPPORTUNITIES AS POLIO AND ITS FUNDING DISAPPEARS



RESULTS

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All mistakes are the responsibility of the author.

AUTHOR

Laura Kerr, Policy Advocacy Officer (Child Health), RESULTS UK.

CONTRIBUTING AUTHOR

Leila Stennett, Campaigns Director, RESULTS Australia.

For more information please contact laura.kerr@results.co.uk

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EXECUTIVE SUMMARY

“ There is not widespread understanding or agreement on the true extent of the risks and opportunities that the end of polio programme entails¹

Polio eradication will hopefully be certified in the next three years and the Global Polio Eradication Initiative (GPEI) will then wind down and cease to exist. Of GPEI’s annual budget of around US\$1 billion, 95% is spent in 16 countries, and GPEI funding in these countries will halve between 2017-2019.² Funding from GPEI is already declining and will stop in 2019, apart from in endemic and a small number of high risk countries.

But what will the impact be and what happens after GPEI? Their investments have had an impact beyond eradication efforts and have supported key elements of routine immunisation systems. With this new phase it is critical to ask if countries have the ability to provide polio immunisation and polio essential functions at the level required to ensure the world remains polio free. What will the impact be on already fragile and weak immunisation systems which result in only 7% of children in the world’s 73 poorest countries being fully immunised?³

A Balancing Act explores the fine line which exists between the successful eradication of polio and the risks that exists as GPEI winds down. There is a once in a decade opportunity to refocus global efforts on strengthening routine immunisation.

ASSESSING THE GAPS OF GPEI WIND DOWN:

SURVEILLANCE:
70% of global funding for surveillance comes from GPEI.⁴

LABORATORY NETWORKS:
146 polio laboratories which make up the Global Polio Laboratory Network, of which 84% are accredited in the Measles and Rubella Laboratory Network, are at risk of being dismantled when support from GPEI ends.⁵

HUMAN RESOURCES:
In four countries GPEI funding accounts for over 50% of total WHO staffing costs.⁶

IMMUNISATION SYSTEMS:
Without GPEI funding, the full EPI programme in South Sudan will collapse.⁷

Rethinking how to achieve global health goals, such as universal immunisation, can be daunting, especially when restricted within large global programmes and financing mechanisms. Yet the scale of the wind down of the GPEI partnership is something that has never happened before. The size of potential funding gaps and the impact this could have on existing systems, provides the ideal opportunity to re-evaluate how disease eradication and vaccine preventable disease systems have been functioning; how can countries, donors, and technical agencies work together to find the practical solutions to the challenges which have stalled immunisation rates for the last eight years.

Only deliberate actions and urgent efforts now by GPEI partners, Gavi, bilateral donors, and the wider immunisation community can address the challenges and risks; and ensure the historic investments in polio eradication are leveraged, seizing the chance to transform global efforts to avert vaccine preventable diseases.

These efforts, must consider three barriers which could prevent this opportunity from being taken;

Underperforming routine immunisation systems
There is a risk that weak immunisation systems might be unable to mainstream polio essential functions into current services or have the budget capabilities to do so. Average government expenditure on routine immunisation as a percentage of the total immunisation budget in the 16 priorities countries (excluding Somalia) is just 31%.⁸

Simultaneous transition
Eight of 16 countries are simultaneously facing transition from Gavi, compounding pressures on domestic resources for immunisation over the next three years.⁹

Seismic shift in approach
There needs to be a shift from disease eradication with a focus on mass campaigns, towards a systems and routine services approach. This will challenge fundamental thinking and existing systems.

Two case studies, Nigeria and Pakistan, exemplify the fragile equilibrium which exists between eradication and the wind down process. They also demonstrate that, even in this difficult situation, opportunities to strengthen immunisation systems do exist but the political will, alongside a costed and funded transition plan, are necessary for this to happen.

The dissolution of a partnership the size of GPEI is unprecedented. For the wind down of GPEI to be successful the remaining gaps must be comprehensively analysed, the challenges imminently and directly addressed, and transition plans funded and implemented, all before current financial resources end. Unsuccessful and mismanaged transition not only puts past investments at risk but raises the likelihood that the opportunity to strengthen routine immunisation will be missed.

CALL TO ACTION

GPEI wind down should be a political priority. We recommend a high-level meeting take place on the side-lines of WHA 2018 to explore the barriers, gaps, and challenges which need to be urgently addressed, not only to ensure a polio free world, but also to ensure the unique opportunity to strengthen routine immunisation must not be missed.

RECOMMENDATIONS

GPEI should increase awareness and analysis:
Work with partners to increase awareness of the impact and challenges of wind down especially beyond staff working directly on polio transition. Ensure increased involvement of immunisation and health systems experts in polio oversight committees at a global and regional level to ensure immunisation stakeholders are aware of what will be required post-eradication to ensure a polio free world.

GPEI and Gavi must coordinate their transition processes:
Initiate an independent evaluation of the joint impact of GPEI and Gavi transitions in the eight countries facing simultaneous transition. Gavi must include GPEI wind down as standard within transition assessments and the annual Joint Appraisal, and consider how existing Gavi support could be used to support critical components of the immunisation infrastructure.

GPEI partners finalise and communicate their transition plans:
Increased coordination at a country level between EPI staff and polio staff is required to enable a more comprehensive

understanding of wind down on immunisation and polio services especially at a community level. Each partner must work with their regional and country staff and the staff of other GPEI partners at global, regional and country level to ensure plans are adequately reflected in country transition plans.

Bilateral donors influence and provide support:
Donors such as the UK and Australia should use their positions on the Boards of Gavi and many polio and GPEI technical working groups to highlight the opportunity to use GPEI wind down to strengthen routine immunisation programs, and provide technical and financial support to build capacity for transition planning and implementation.

National governments to increase immunisation resources:
Countries transitioning from GPEI need to increase domestic resources for immunisation within a growing national health budget, and work with partners to develop national final, costed, and funded transition plans.

1 INTRODUCTION

The world is closer than ever to achieving one of global health's greatest success stories – the eradication of polio. Cases of polio have never been lower, with only 11 cases in the first 9 months of 2017.¹⁰ Since its creation in 1988, the Global Polio Eradication Initiative (GPEI) has played a decisive and fundamental role in this achievement.

At the same time, basic immunisation rates are the highest they have ever been – with 86% of all children in 2016 receiving three doses of diphtheria-tetanus-pertussis (DTP3) vaccine.¹¹ The introduction of the Expanded Programme on Immunisation (EPI) in 1974, and the creation of Gavi, the Vaccine Alliance (Gavi) in 2000 have together ensured two to three million lives are saved every year through immunisation.¹² These global triumphs must be celebrated but they cannot be taken for granted.

Three countries remain polio endemic (Afghanistan, Nigeria, and Pakistan),¹³ 19.5 million infants still miss out on basic vaccines, and routine immunisation systems need strengthening.¹⁴ Four out of the five Global Vaccine Action Plan (GVAP) immunisation goals are substantially off track and progress remains too slow for most goals to be reached by 2020.¹⁵

Collective investments through GPEI and Gavi have reached US\$36 billion and contributed enormously to the achievements made to date, but at a time when there are still serious concerns with the strength of immunisation systems, donor financing for immunisation is changing.¹⁶

When polio is eradicated GPEI will have fulfilled its mandate and will wind down, ceasing to exist. 95% of GPEI's annual expenditure is spent in 16 countries and funding to these countries will decline by more than half between 2017 and 2019.¹⁷ These countries are in the process of transitioning away from GPEI support which will end in 2019 for all counties except those in which polio is endemic or considered to be high risk.

This process poses a critical juncture for both polio eradication and immunisation. The next few years require a careful balancing act: GPEI wind down provides the chance to seize

a unique opportunity to strengthen routine immunisation this century, yet at the same time it could equally become the biggest threat to the progress made to date.

What comes next after GPEI? What will the impact be on a countries' ability to provide polio immunisation as part of their routine immunisation programmes? What are the biggest risks these countries face? What needs to be done to ensure services are not affected and these countries are able to take full ownership of their polio and immunisation programmes before funding ends?

In this report, we will explore the current situation, in the context of changing donor financing. We will also explore the external factors such as weak routine immunisation systems, simultaneous transition from Gavi, and changing approaches to immunisation which pose significant barriers to the success of transition from GPEI.

Following this we will review the wind down process; looking at progress being made in planning and preparation as well as considering best practice principles which could enhance the probability of success in the next few years. GPEI's annual budget is around US\$1 billion, and we will look at what elements of the polio and EPI programme this is currently supporting, pre-empting some large gaps which could result if countries cannot transition these into their routine immunisation systems. Challenges to this transition process are already emerging, which will be demonstrated in two country case studies: Nigeria and Pakistan.

The risks and challenges to polio and immunisation in the next three years are serious. However, if overcome, and with deliberate efforts to look beyond simply changing financing, there is an unprecedented opportunity to rethink what is needed to strengthen routine immunisation, ensuring the millions of children who currently miss out, have access to life saving vaccines. Ensuring more children are protected from vaccine preventable diseases is a stepping stone to strengthen health systems and drive global progress on the health related Sustainable Development Goals (SDGs). For many reasons, it is an opportunity which should not be missed.



Photo: Tom Maguire/RESULTS UK

2 THE OPPORTUNITY, BENEFITS, AND BARRIERS TO STRENGTHENING ROUTINE IMMUNISATION

“The consequences of losing polio assets would include the likely reversal of EPI progress in the 16 priority countries, as well as globally¹⁸

When the World Health Assembly (WHA) set out their polio eradication plans in 1988, they acknowledged the central role routine immunisation has for polio eradication and the equally important role polio eradication should play for routine immunisation.

The WHA resolution, which led to the creation of the GPEI, highlighted that eradication would be “facilitated by the continued strengthening of the Expanded Programme on Immunization within the context of primary health care.”¹⁹ In this context, they recommended that:

"Eradication efforts should be pursued in ways which strengthen the development of the Expanded Programme on Immunization as a whole, fostering its contribution, in turn, to the development of the health infrastructure and of primary health care."²⁰

The statement highlights that Member States had intended for polio eradication efforts to be grounded in immunisation and primary healthcare. Member States recognise this as an opportunity to have complimentary impacts on both eradication and routine immunisation and both are interlinked. This was further recognised in the Polio Eradication and Endgame Strategic Plan 2013-2018 (PEESP)²¹ which sets out “at least 50% of time of field personnel funded by international partners of GPEI should be dedicated to strengthening immunisation systems.”²²



Photo: Tom Maguire/RESULTS UK

2.1 THE OPPORTUNITY – WHY NOW?

Global immunisation rates are now the highest they have ever been; however, they have not changed significantly in eight years.²³ There is an urgent need to strengthen routine immunisation systems to address this and the Strategic Advisory Group of Experts on Immunisation (SAGE) have stated that “there is a need to intensify global efforts to promote immunization and address the systemic weaknesses that are limiting equitable access to life-saving and life-changing vaccines.”²⁴

Doing things differently in global health is not always easy. Once systems and ways of doing things are established it can be hard to change direction. Historic investments in immunisation from GPEI and Gavi have vitally changed immunisation for the better. The challenges which exist now require more than just increasing donor support. They require increased country ownership including political will, sustainable financing, and improved programme delivery.²⁵

Increased immunisation rates should rightly be celebrated as one of global health’s greatest achievements, but the perception that success is inevitable could lead to complacency and a reduced focus on immunisation. This could lead to the achievement of full immunisation for all children through routine immunisation becoming an orphaned idea; lost in the middle of global disease eradication efforts and new donor interest in health systems strengthening, especially as competition for donor financing increases. Slipping coverage rates in some historically high-performing countries also indicates that political support for immunisation could be “dwindling” in some countries.²⁶

Vaccines for all is included in Sustainable Development Goal 3 as a key indicator of universal health coverage (UHC) but crucially, the importance of routine immunisation systems in achieving this goal is often missed. The wind down of GPEI provides a golden opportunity to rethink why routine immunisation systems are failing – and, crucially, who they are failing.

2.2 LEVERAGING HISTORIC GPEI INVESTMENTS

There are a number of ways GPEI funding has already supported routine immunisation systems. If deliberate actions are taken to leverage these past investments by integrating and transitioning elements where appropriate, routine immunisation systems could continue to benefit for years to come.

- ◆ **Human Resources:**
In an evaluation of polio-funded workers in ten countries, 47% of their time was spent working on immunisation goals beyond polio, with an additional 22% of their time being spent on routine immunisation.²⁷
- ◆ **Surveillance and Laboratory Networks:**
The Global Polio Laboratory Network (GPLN) consists of 146 WHO accredited polio laboratories in 92 countries across the six WHO regions.²⁸ These laboratories identify and confirm cases of polio but they also undertake other functions for measles, yellow fever, as well as maternal and neonatal tetanus.
- ◆ **Social Mobilisation Networks:**
Over 20 million volunteers have been mobilised globally to deliver and communicate the importance of essential polio vaccines. Volunteers know local conditions and concerns, are trusted by local communities, and can often reach children who could not be reached with regular immunisation efforts or other health services.
- ◆ **Outbreak Response:**
The ability to quickly identify cases of polio and respond efficiently to an outbreak is a key feature of GPEI partners work. Emergency operation response teams and units for polio, including their extensive micro-planning and rapid response systems, are already being built on in some countries for other diseases, routine immunisation, and wider global health security.

Investments in polio have not automatically been used for, or contributed to, the strengthening of routine immunisation. On the basis of where past polio investments have had a

AN OPPORTUNITY TAKEN: USING POLIO SYSTEMS TO RESPOND TO EBOLA IN NIGERIA

Polio outbreak control and response systems were used for identifying and containing the Ebola outbreak in 2014 in Nigeria.²⁹ The Emergency Operations Centre (EOC), set up to track polio cases, was quickly deployed to track and monitor Ebola cases. Standard operating procedures used for polio, including contact tracing, case management, infection prevention, laboratory services and point-of-entry and exit procedures, as well as the use of a strong social mobilisation unit, ensured the outbreak in Nigeria never reached the epidemic scale occurring in other countries with only 19 confirmed cases.³⁰ The EOC model has now been used to set up the National Emergency Routine Immunisation Coordination Centre (NERICC) and in states with the lowest coverage, State Emergency Routine

Immunisation Coordination Centres (SERICC). Using lessons from the polio EOC system it will use similar operating procedures to tackle extremely low routine immunisation rates in Nigeria.

The response to Ebola using the EOC in Nigeria was only possible through donor support and political will, and the same result would be “difficult to replicate in other situations without ready resources.”³¹ Similarly the NERICCC will need considerable resources, from domestic and from international sources, if it is to achieve its goals. In both circumstances, committed government leadership and measured actions, have taken the opportunity to transition polio assets to achieve wider global health and immunisation goals.

positive impact (or not) on routine immunisation, we can learn and understand where current polio assets can, and should be, integrated into sustainable and country owned immunisation systems. What GPEI and partners have learned will provide important lessons for future eradication and elimination efforts and help provide solutions to improve routine immunisation.

2.3 THE BENEFITS OF INVESTING IN IMMUNISATION

Strengthened routine immunisation systems would not only ensure more children are immunised and survive but also open up a number of additional benefits for donors and countries – compounding the impact that taking this opportunity could have on countries’ immunisation and health systems.

Investments in immunisation provide excellent value for money - in terms of lives saved, life-long health benefits, and economic productivity - as well as having a catalytic impact on the health system. For every US\$1 invested in immunisation, at least US\$16 is returned directly in reductions in healthcare costs as well as avoiding lost wages and lost productivity due to illness and death. The benefit

increases to US\$44 when considering the value of living a healthier, longer life, free from disability.³²

Routine immunisation systems are the cornerstone of primary healthcare in the community. It provides the structures and systems to reach every child through multiple points of contact over the course of at least one year, driving equitable approach to service delivery and; increasing the number of opportunities for both children and their care-givers to access available health services beyond immunisation. Further, the physical infrastructure can be used to transport other medical supplies, trained health workers can deliver other health services, and data can be gathered on where people are and what health services they are receiving.³³

Strengthening routine immunisation is not just an opportunity for higher immunisation rates but a chance to drive critical progress towards the achievement of health for all and crucial to achieve UHC and child mortality targets set out in the Sustainable Development Goals (SDGs).

2.4 THE OPPORTUNITY TO STRENGTHEN ROUTINE IMMUNISATION – THE BARRIERS

The impact of declining financing will not simply require an increase and reallocation of more domestic resources for activities which GPEI has historically funded. Many activities will also need to be integrated into wider country-owned routine immunisation systems at the same time as that system itself may be facing changes. There are three main barriers which will challenge the success of this wind down process and could prevent the opportunity to strengthen routine immunisation from being taken.

WEAK ROUTINE IMMUNISATION SYSTEMS

Weak immunisation systems provide the strongest reason to ensure effective transfer of polio eradication resources, but similarly their weaknesses could disrupt the whole wind down process. Only 7% of children receive all 11 WHO-recommended vaccines in the world’s 73 poorest countries,³⁴ leaving millions of children, who are not fully immunised, vulnerable to many vaccine preventable diseases. For example, only 64% of children globally receive the second dose of the measles vaccine and only 47% receive the rubella vaccine.³⁵ Newer vaccines which protect against pneumonia and diarrhoea have coverage rates of less than 50%.³⁶

The GVAP set ambitious global targets for immunisation within this decade including polio eradication by 2015 as well as other elimination goals for maternal and neonatal tetanus, measles and rubella. All of these goals have been or are likely to be missed.³⁷ Failure to reach these individual targets reflects of weak routine immunisation systems around the world. Strong and functioning routine immunisation systems will be needed to ensure continued high coverage rates with the polio vaccine, without this, a polio-free world could be at risk.

At the core of the GVAP are targets to improve the coverage and equity of basic immunisation – measured by three doses of the diphtheria, tetanus and pertussis vaccine (DTP3). The 2015 target was for all countries to reach 90% coverage with all districts achieving 80%.³⁸ In 2016, only 67% of countries met the 90% target.³⁹ The average DTP3 coverage rate in GPEI’s 16 priority countries is just 71%, well below the GVAP 2015 target (see graph 1), and only Bangladesh has over 90% coverage and above 80%

in all districts.⁴⁰ Immunisation systems in these countries are not as strong as they could be, and may struggle to take ownership of the essential elements of the polio eradication programme which must continue. This must be considered alongside the addition to the need to expand and increase coverage of 11 WHO recommended vaccines to ensure all children are fully immunised.

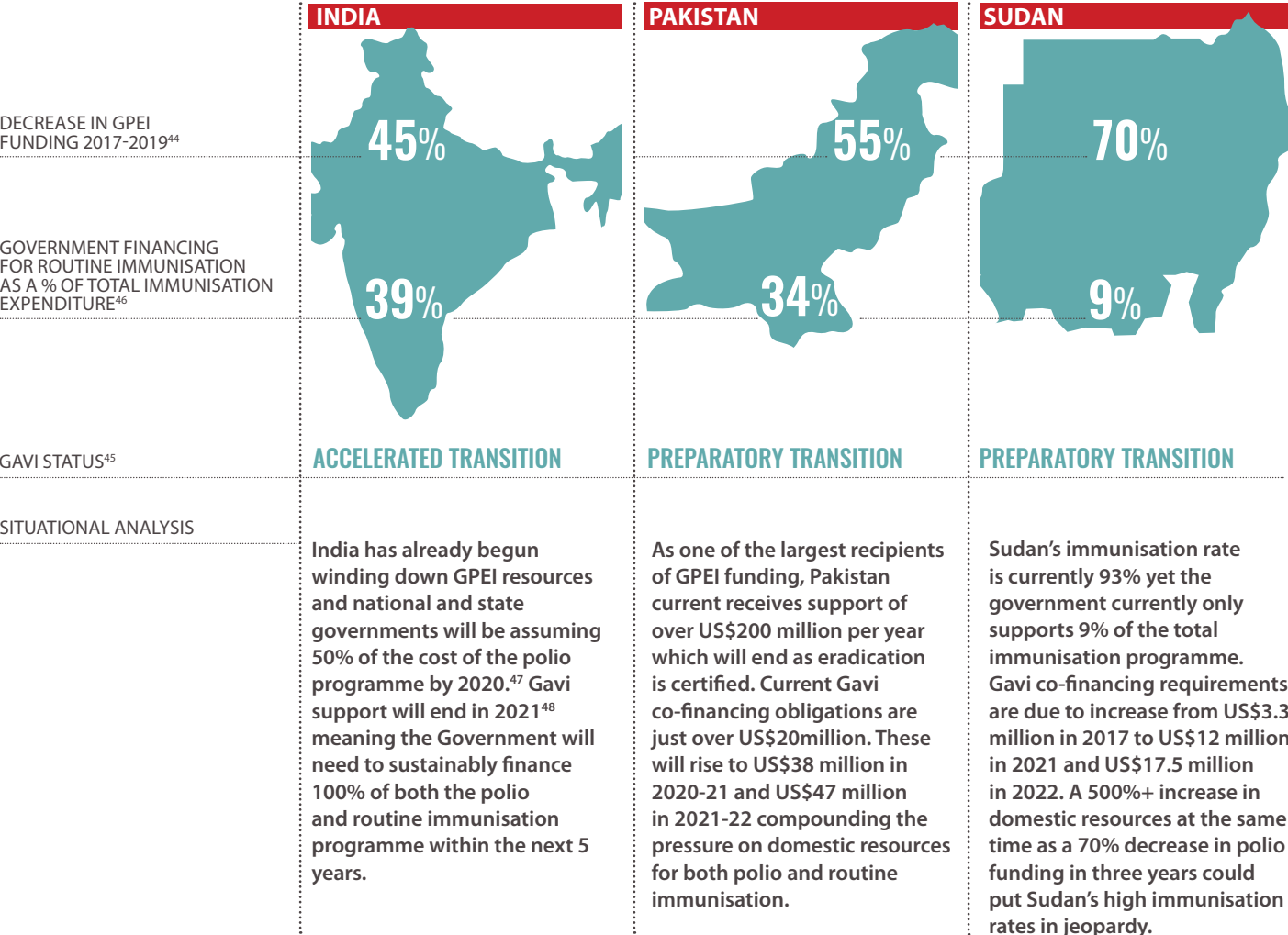
SIMULTANEOUS TRANSITION

Changing donor financing from GPEI and Gavi places a double burden on immunisation systems - eight of 16 GPEI priority transition countries are currently in Gavi’s preparatory or accelerated transition stages.⁴¹ Both organisations have their own transition processes and donor reporting requirements, and require additional staff and financial resources to manage the transition process to ensure success and sustainability.

Gavi’s model aims for sustainable vaccine financing. Even the lowest-income countries are required to co-finance vaccines purchased with Gavi’s support. The transition process increases a countries’ co-financing obligations as soon as they reach the World Bank middle income threshold when they enter ‘preparatory transition’. When countries sustain an income level of US\$1,580 per person for three years, they would start accelerated transition, in which Gavi phases out vaccine funding over five years.⁴² Gavi support is different to GPEI as it directly co-finances vaccines rather than supporting human resources and programmes. Combined with the planned reduction in the role of GPEI, the requirements on countries to take ownership of multiple different elements of their immunisation systems could place unmanageable obligations, especially considering restricted immunisation and health budgets. This puts at risk a successful GPEI wind down as well as further weakening of routine immunisation systems.⁴³

An analysis of three of the eight GPEI priority countries currently going through transition from Gavi highlight how difficult raising domestic resources simultaneously for Gavi co-financing and to continued support for polio essential functions could be, and what could be at risk for the EPI programme if resources cannot be raised.

FIGURE 1: 3 GPEI PRIORITY COUNTRIES CURRENTLY GOING THROUGH SIMULTANEOUS TRANSITION FROM GPEI AND GAVI



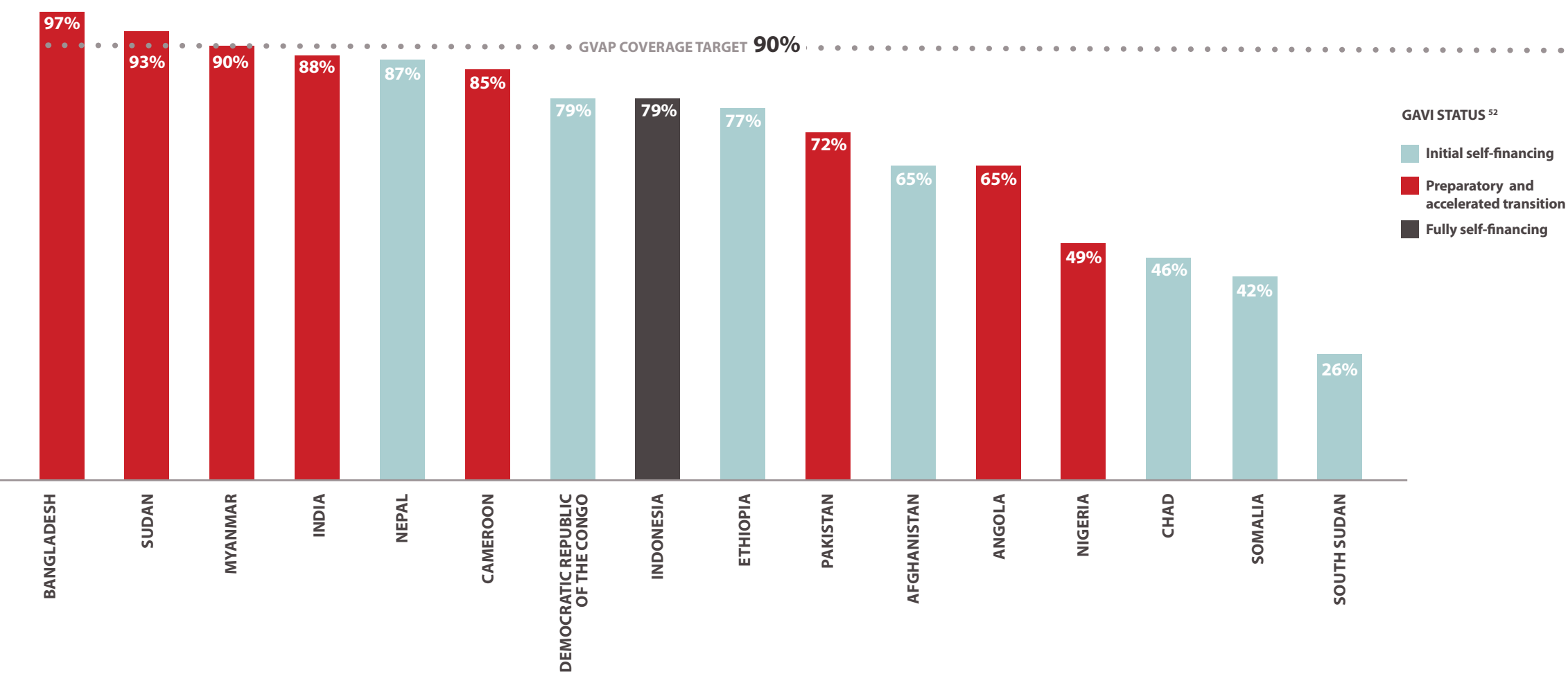
It is also worth noting that support from World Bank is also changing in four of the 16 priority countries. Cameroon, Nigeria and Pakistan currently have blended finance, from both International Development Association (IDA) and from the International Bank for Reconstruction and Development (IBRD) and are therefore accessing less concessional financing than if support was from IDA alone.⁴⁹ India will completely transition from IDA in financial year 2018.⁵⁰

These countries will also face transition to less concessional support from the regional development banks (the Asian

Development Bank and the African Development Bank) and reduced bilateral support from donors which target assistance toward low-income countries. Multiple external funders changing or reducing support amplifies the challenge to national health systems of maintaining, let alone increasing, access to and quality of services.

Simultaneous transitions heighten the challenges on domestic resources and, if they prove unmanageable, remove the scope for any opportunities to be operationalised.

GRAPH 1: ACHIEVING GVAP TARGETS: IMMUNISATION RATES⁵¹ AND GAVI TRANSITION STATUS IN 16 GPEI TRANSITION PRIORITY COUNTRIES



CHANGING DIRECTION – A VERTICAL TO A HORIZONTAL APPROACH

Immunisation campaigns are very important to reach missed children with vaccines, particularly in the hardest to reach places, and to respond to outbreaks of vaccine preventable diseases. They are, by nature, supplemental immunisation activities (SIAs) - an additional and top-up to routine immunisation. Core immunity to polio and other vaccine-preventable diseases are built by a long-term, functioning and sustainable routine immunisation system.⁵³

This targeted approach is what has brought the world closer than ever to polio eradication but the Independent Monitoring Board (IMB) recognises that heightened

investment and focus on routine immunisation, as the original WHA resolution recommended, could have had a positive impact, and even a “rocket boost” on eradication.⁵⁴ For example, “if the country [Pakistan] had even a half-competent routine immunisation programme in its reservoirs, polio would be long gone.”⁵⁵ The opportunity to strengthen routine immunisation, for both polio eradication and wider vaccine goals, has been already been missed in some cases.

As polio eradication draws nearer one of the challenges is that the type of vaccination for polio is also changing. The current polio eradication campaigns rely primarily on the oral polio vaccine (OPV) which volunteer vaccinators can deliver. However, many countries are implementing or have

implemented the Inactivated Polio Vaccine (IPV), which does not contain a live virus and therefore removes the prospect of contracting polio from the vaccine. While IPV is more effective, it is an injectable vaccine and requires health professionals for its delivery.

For the world to remain polio-free, routine immunisation systems need to deliver IPV for at least ten years after polio eradication is certified.⁵⁶ “Increasing polio immunity by vaccines provided through the [routine immunisation] system is one of the important pillars of polio eradication.”⁵⁷

A shift in focus from campaigns to routine immunisation is not a simple one, and requires a fundamental change in service

delivery. Routine immunisation programmes cannot be funded or implemented vertically. They involve multiple building blocks including, but not limited to, a robust cold and supply chain, trained health workers, and community outreach. Strengthening routine immunisation involves maximising the reach of vaccines, managing effective and efficient programmes, mobilising communities, and monitoring surveillance and programme performance.⁵⁸ The delivery of vaccines through the routine immunisation system is fundamentally different to delivering SIAs, due to the requirements for sustained activities and systems in routine immunisation.

Many of the building blocks of a routine immunisation programme may be funded from different team budgets within the Ministry of Health and cannot be as easily funded by donors. This is especially the case when considering the sustainability of a routine immunisation system and training health workers.

When considering the best way to achieve the eradication and elimination goals in the GVAP, and to address stalling progress towards coverage and equity goals, a fundamental shift in approach is required away from vertical disease eradication efforts towards routine immunisation. Within a strong functioning primary healthcare system; when polio eradication efforts have often been ‘siload’ and separate from routine immunisation a change in direction may not be easy.

The magnitude of this shift in funding, thinking, and programming must not be underestimated. It requires commitment from countries to invest in strengthening immunisation systems and adapting to changing funding and support. It also requires recognition from donors of the importance of strengthening routine immunisation for disease eradication and elimination efforts, including increased technical support targeted at the main building blocks of the EPI programme.

Considering the extent of the change in approach needed and the challenges to achieving this, there is a stark risk that the opportunity to rethink approaches to immunisation may not be taken, and that difficulties in changing approaches could risk the final stages of eradication and the wind down of GPEI.

3 THE WIND DOWN OF GPEI

“On paper, transition may sound fairly straightforward. It is anything but”⁵⁹

Once polio is eradicated, the GPEI will have fulfilled its mandate. Polio eradication is achieved when there are no cases of wild poliovirus for three years and at this point the GPEI partnership will be wound down and cease to exist. Transition is the process that the GPEI partners and countries are currently going through as resources from GPEI decline towards this end point.

The PEESP sets out the GPEI’s main objective around transition (previously called legacy planning): “ensure that the world remains permanently polio-free and that the investment in polio eradication provides public health dividends for years to come.”⁶⁰

Some essential polio functions will need to continue even after eradication to sustain a polio free world. Polio-essential functions will need to be maintained and mainstreamed into sustainable routine immunisation systems. These functions include continued polio immunisation (high coverage rates of IPV will be required for at least ten years), detection (surveillance, and laboratory systems), as well as the capacity to respond to a possible polio outbreak.

IMPACT OF GPEI WIND DOWN IN NUMBERS

US\$330m DECLINE IN FUNDING THROUGH GPEI IN 2017⁶¹

DECLINE IN OVERALL FUNDING BY
GPEI BETWEEN 2017 AND 2019⁶² **>50%**

REDUCTIONS IN GPEI IN FUNDING FOR SOUTH
SUDAN AND THE DEMOCRATIC REPUBLIC OF CONGO **>70%**
BETWEEN 2017-2019⁶³

60% OF THE WORLD’S UNIMMUNISED INFANTS LIVE IN
GPEI’S 16 PRIORITY COUNTRIES⁶⁴



Photo: Tom Maguire/RESULTS UK

3.1 MAIN ELEMENTS OF GPEI WIND DOWN

The PEESP sets out three main elements of GPEI wind-down that will need to be considered if the transition process is to be considered successful:⁶⁵

MAINTAIN AND MAINSTREAM POLIO ESSENTIAL FUNCTIONS

These will be set out in the Post-Certification Strategy (PCS), which will be presented to the World Health Assembly in May 2018 and which will provide the high-level guidance for maintaining a polio-free world after global eradication. Three main functions have been identified as core to this effort:

- ◆ **Contain polio virus sources:**
Ensure potential sources of poliovirus are properly controlled or removed.
- ◆ **Protect populations:**
Withdraw the oral live attenuated polio vaccine (OPV) from use and immunise populations with IPV against possible re-emergence of any poliovirus.
- ◆ **Detect and Respond:**
Promptly detect any poliovirus reintroduction and rapidly respond to prevent transmission.

The aim is for these functions to be mainstreamed. It is likely that additional donor funding, post GPEI, will be required to ensure that these functions continue in certain countries. While out with the scope of his report, this is an underlying concern which must be taken into consideration throughout the transition process and will need to be urgently addressed if gaps are to be averted and services mainstreamed before GPEI funding ends.

WHERE FEASIBLE, TRANSITION CAPABILITIES, PROCESSES AND ASSETS TO SUPPORT OTHER HEALTH PRIORITIES

Building on GPEI's existing impact on immunisation and health services is a crucial element of polio eradication legacy. Not all elements of existing polio funding and programmes will need to continue. Transition planning must also take into account the indirect impacts which GPEI funding has been supporting, and consider which of these also need to, or would be desirable, to continue. Leveraging

existing systems and assets to benefit the wider health system is fundamental to the success of transition and long-term impact.

CAPTURE KNOWLEDGE AND DISSEMINATE LESSONS

The GPEI and partners have extensive knowledge on a wide range of disease eradication and control activities. Many elements of this are transferable to routine immunisation programmes and other health services. These include: reaching hard to reach and high risk populations, engaging and mobilising communities, building trust in difficult situations, cross border cooperation, and transporting vaccines through the most difficult cold chains. The positive, as well as the negative, experiences of the last 30 years should be captured and shared widely with immunisation and health stakeholders, to ensure a lasting legacy for other health interventions.

3.2 THE TRANSITION PLANNING PROCESS

The Independent Monitoring Board identified the need to start thinking about the transition process and GPEI wind-down in 2012 and shortly afterwards the PEESP followed with the first concrete details, and objectives around wind down.⁶⁶ However, it was not until a GPEI four-year budget was released in May 2016, that the extent of the financial changes starting as early as 2017, were clearly articulated.

There are three main elements to the transition planning process:

1 GPEI OVERSIGHT, MANAGEMENT AND MONITORING

GPEI will not be able to manage all elements of the wind-down and transition process, since it will require close engagement of other non-GPEI stakeholders, but it does have a responsibility to oversee and facilitate the wind down of its current investments.⁶⁷ It has created (or is refocusing existing) monitoring and accountability mechanisms to oversee and drive the transition planning and implementation process:

- ◆ **The Polio Oversight Board (POB), comprising the heads of agencies of core GPEI partners, oversees the implementation of GPEI transition planning. This ensures that the most senior leadership of partners are informed and involved in the transition process.**

GUIDING PRINCIPLES TO SUCCESSFUL WIND DOWN

There are a number of over-arching principles which all parties involved in GPEI wind down should apply to ensure it is a success, not just for a polio-free world, but for increasing access to immunisation for millions of vulnerable children.



- ◆ **Transition Management Group (TMG - previously Legacy Management Group)** oversees, tracks and supports progress in country level planning in the 16 priority countries. The TMG also has a task team focusing on documentation and dissemination of polio lessons-learned.
- ◆ **The GPEI Strategy Committee** is tasked with coordinating the agency plans for the implementation of the Post-Certification Strategy (PCS) to make sure that the polio essential functions are mainstreamed to sustain a polio-free world.⁶⁸
- ◆ **The Independent Monitoring Board (IMB)** monitors and guides process towards the interruption of polio globally. Using this model the POB created the **Transition Independent Monitoring Board (TIMB)**, to monitor and guide development of implementation of country transition plans and ensure that stakeholders are involved in the correct process and are independent of GPEI partners and staff. The TIMB produced its first report in July 2017 (*The End of the Beginning*), which poses multiple questions to the polio community about

the process so far and highlights key challenges that urgently need to be addressed.

A recent issue of the Journal of Infectious Diseases was dedicated to the issue of transition and points out: "There are now serious efforts being made to responsibly wind down the programme to the benefit to national and global priorities. Further detailed technical work is now needed if we are to achieve the full potential of wind down."⁶⁹

Even with this increased attention, progress has been, and continues to be too slow,⁷⁰ putting the success of transition at risk.

2 GPEI PARTNER (AGENCY) PLANNING

In January 2016, the Polio Oversight Board (POB) asked all GPEI partners to develop transition plans "assessing risks associated with the decrease in polio funding, proposing relevant risk-mitigation measures, and where possible, leveraging on opportunities."⁷¹ Partner agencies are in the process of producing these internally and "are coordinating as appropriate."⁷² This process is being managed by the GPEI strategy committee.

Between March and July 2016 GPEI partners increased their staff capacity three fold in order to manage transition,⁷³ and GPEI wind-down has become one of the principal key risks for the WHO.⁷⁴ A newly formed WHO-wide Post-Polio Transition Planning Steering Committee, which includes a dedicated human resources working group within this, aims to mitigate the human resources, programmatic and operational capacity risks associated with the loss of polio funding and to explore opportunities that can help contribute to other health programmes currently benefiting from polio infrastructure – all in line with PEESP transition objectives.⁷⁵

Other GPEI partners are actively assessing the impact that GPEI wind-down will have on their organisations, making it timely for them to equally evaluate how future support could be targeted towards other health priorities. These plans for transition are still at an early stage and will not take a written or public form.

3 COUNTRY PLANNING

Most importantly and GPEI's principal priority for transition planning is at the country level, where the effects of wind-

down will be felt most acutely. Countries, with support from GPEI partners, have been encouraged to lead their own transition planning processes.⁷⁶ This is to ensure transition plans fit with the countries' broader health needs and objectives.⁷⁷ GPEI's 16 transition priority countries, are being given the most attention and support due to the extent of GPEI footprint in those countries and the impact of the decline in resources will have.⁷⁸

The GPEI produced transition planning guidelines which countries have used to develop their transition plans.⁷⁹ The guidelines encourage planning to commence immediately in all polio-free countries. In the endemic countries, the guidelines recommend initial discussions begin now, with the transition planning process beginning one year after the last case of polio when the polio virus is considered to be interrupted.⁸⁰ Some country governments are driving this process, while other countries have been slower to respond, focussed on existing challenges and competing priorities. Only seven of 16 priority countries have drafted costed transition plans.⁸¹ No country has a finalised and funded transition plan.⁸²

REGIONAL PLANNING – A IMPORTANT CONSIDERATION FOR COUNTRY AND AGENCY PLANNING

The regional impact of GPEI wind down will be significant in some countries and for human resources within GPEI partners. It is important that deliberate efforts are made to ensure this is part of the analysis and planning within both country and agency planning.

An estimated 90% of WHO-funded immunisation staff and infrastructure in the African region are funded from resources from GPEI.⁸³ In this region, all WHO polio funded staff are immunisation officers and work across a broad range of vaccine preventable disease activities in support of the Regional Strategic Plan for Immunisation 2014-2020. All of the African Region's 47 WHO country offices receive seed surveillance funding from the GPEI on a quarterly

basis. This is used for active surveillance for polio and other vaccine preventable diseases.⁸⁴ This will be maintained until eradication, but the level of subsequent support is uncertain.

In the WHO's South-East Asia Region, measles and rubella elimination regional goals within the GVAP, are most at risk. The WHO is concerned that coverage of measles and rubella vaccines could stagnate or decline, and that a reduction in funding will impact on the quality of surveillance for these diseases.⁸⁵ Further, the introduction of new vaccines could be compromised as GPEI funding to support polio networks has been contributing to the training, evaluation, and surveillance of adverse effects following immunisation activities.⁸⁶

90% OF WHO-FUNDED IMMUNISATION STAFF AND INFRASTRUCTURE IN THE AFRICAN REGION ARE FUNDED FROM RESOURCES FROM GPEI



Photo: Nicholas Axelrod/RESULTS UK

4 THE RISK OF UNSUCCESSFUL GPEI TRANSITION

“ There is not widespread understanding or agreement on the true extent of the risks and opportunities that the end of polio programme entails⁸⁷

The dissolution of a partnership the size of GPEI is unprecedented, in terms of financing, human resources and programmatic support.⁸⁸ For the wind down of GPEI to be successful the remaining gaps must be comprehensively analysed, the challenges imminently and directly addressed, and transition plans implemented, all before current financial resources end. All of these must be considered alongside the three over-arching barriers to success: existing fragile immunisation and health systems, pressures from simultaneous GPEI and Gavi transition, and the challenges of shifting focus from disease eradication to routine immunisation. Unsuccessful and mismanaged transition not only puts past investments at risk but raises the likelihood that the barriers won't be overcome and the opportunity to strengthen routine immunisation will be missed.

4.1 WHERE ARE THE GAPS?

The potential financial and programmatic gaps which will be left when GPEI funding ends are still being evaluated, but the risk to services is clear. The SAGE 2017 Assessment Report of the Global Vaccine Action Plan identified “a significant risk that wider surveillance and routine immunization programmes, and hence global health security, could be compromised during polio transition.”⁸⁹

As GPEI support is delivered largely through GPEI partners such as UNICEF and WHO and often takes the form of human resources rather than grants, it can be difficult to identify what the financial gap will be and governments could be largely unaware of the current level of support. There are also serious difficulties at the country level understanding what gaps could exist for the delivery of health services, especially ones at the community level and those which are currently not integrated into government health systems.

There are a number of key areas identified below which need urgent specific attention to ensure reduced funding does not negatively impact essential elements of the EPI programme. If addressed correctly, they also provide an opportune moment to efficiently improve routine immunisation.



Photo: Tom Maguire/RESULTS UK

DISEASE SURVEILLANCE

70% of global funding for surveillance comes from GPEI.⁹⁰

The global polio surveillance system, supported by laboratory networks, finds and identifies cases of polio.⁹¹ Surveillance will need to continue for many years; it is essential before eradication to certify there have been no cases and post-eradication to confirm that status remains.

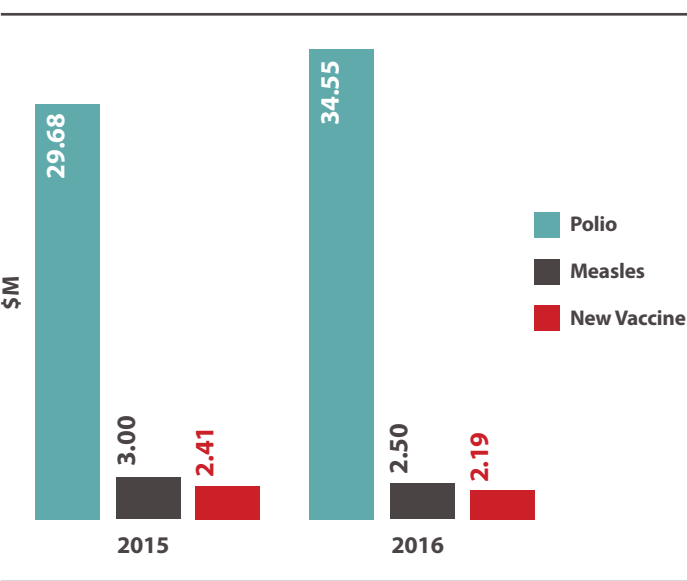
Globally, disease surveillance is underfunded. In many countries, there is no funding at all for surveillance beyond polio. 70% of all global funding for surveillance comes from GPEI.⁹²

Regional and country surveillance systems that monitor vaccine-preventable diseases are heavily reliant on polio funding:

- ◆ At the WHO African regional level, polio funding makes up more than 90% of all funding for surveillance and laboratory networks (see graph 2) and there is currently no funding for yellow fever or maternal and neonatal tetanus surveillance.⁹³
- ◆ In Nepal, GPEI funding supports the surveillance programme for all vaccine-preventable diseases and is the backbone of the WHO’s vaccine-preventable disease (VPD) programme in the country.⁹⁴
- ◆ In the Democratic Republic of Congo, GPEI-funded surveillance officers spend about a quarter of their time on surveillance for other vaccine-preventable diseases.⁹⁵

Early detection of vaccine preventable diseases outbreaks is crucial to preventing epidemics. Underestimates in official reporting of diseases pose a threat to global health and hampers a country’s ability to address the causes and respond accordingly. A lack of investment in this area could threaten global health security, leading to epidemics spreading under the radar and ultimately costing countries and donors more in response costs, as well as weakening the overall EPI programme. Changing in financing is the opportune moment to evaluate what is needed to develop stronger surveillance for all vaccine-preventable diseases.

GRAPH 2: POLIO, MEASLES, AND NEW VACCINE SURVEILLANCE AND LABORATORY FUNDING IN WHO AFRICAN REGION (2015-2016)⁹⁶



LABORATORY NETWORKS

146 polio laboratories which make up the Global Polio Laboratory Network, of which 84% are accredited in the Measles and Rubella Laboratory Network, are at risk of being dismantled when support from GPEI ends.⁹⁷

The Global Polio Laboratory Network (GPLN) was set up in 1990 to distinguish between cases of Acute Flaccid Paralysis (AFP) caused by polio and AFP caused by other diseases. The Network now consists of 146 WHO accredited polio laboratories in 92 countries across the six WHO regions.⁹⁸The Global Measles and Rubella Laboratory Network has built on the GPLN system, and the networks have overlapping staff, management capacity and resources.⁹⁹ Damage to these networks could have a serious long-term effect on the GVAP’s elimination goals for these diseases.

Laboratories are an integral part of the surveillance system that identify types and strains of disease, confirm outbreaks and epidemics, and monitor trends. Without laboratories, outbreaks can go undetected which can lead to larger and more serious epidemics. They face increasing pressure as eradication nears as there is more emphasis on confidently confirming there have been no cases. With a smaller number of cases, identifying and responding quickly to even a possible case is critical.

As laboratories are part of the surveillance system, there is a lack of donor interest, coupled with a lack of domestic investment, especially for staff and maintenance costs. There are serious concerns that laboratory staff capacity will be drained once GPEI ceases to exist.¹⁰⁰

HUMAN RESOURCES

In four countries GPEI funding accounts for over 50% of total WHO staffing costs.¹⁰¹

Vaccines do not deliver themselves; immunisation systems are run by people - from the community level right through to regional and global headquarters. Many personnel funded through GPEI have become integral members of staff within WHO or UNICEF, delivering services non-exclusive to polio, or have become integrated with government polio and immunisation teams. The wind-down of GPEI will seriously affect GPEI partner’s workforce capacity, in particular WHO and UNICEF, well beyond polio programme activities.

With 1,346 staff positions funded through GPEI, the WHO faces a dramatic reduction in human resources between now and 2019.¹⁰² This will be acutely felt at the African regional level, where 74% of these positions will be lost.¹⁰³ Currently, 40% of all WHO staff at the African level are funded through GPEI.¹⁰⁴ This will have the biggest impact on immunisation personnel which are 86% funded through polio finances.¹⁰⁵ The loss of these positions, if the WHO is not able to find alternative sources of financing, will undoubtedly put further pressure on the continent with the lowest average immunisation rates: Africa is home to six of the eight countries in the world with immunisation rates of less than 50%.¹⁰⁶

PRESSURE ON IMMUNISATION STAFF AND STAFF BUDGETS IN OTHER REGIONS

EASTERN MEDITERRANEAN REGION

16% FUNDED THROUGH GPEI

SOUTH-EAST ASIA REGION

7% FUNDED THROUGH GPEI¹⁰⁰

ANGOLA, CHAD, DEMOCRATIC REPUBLIC OF CONGO AND NIGERIA

50% WHO'S STAFFING COSTS FROM GPEI¹⁰⁷

PAKISTAN

48% WHO'S STAFFING COSTS FROM GPEI¹⁰⁹

UNICEF STAFFING LEVELS

237
STAFF

+

266
CONSULTANTS

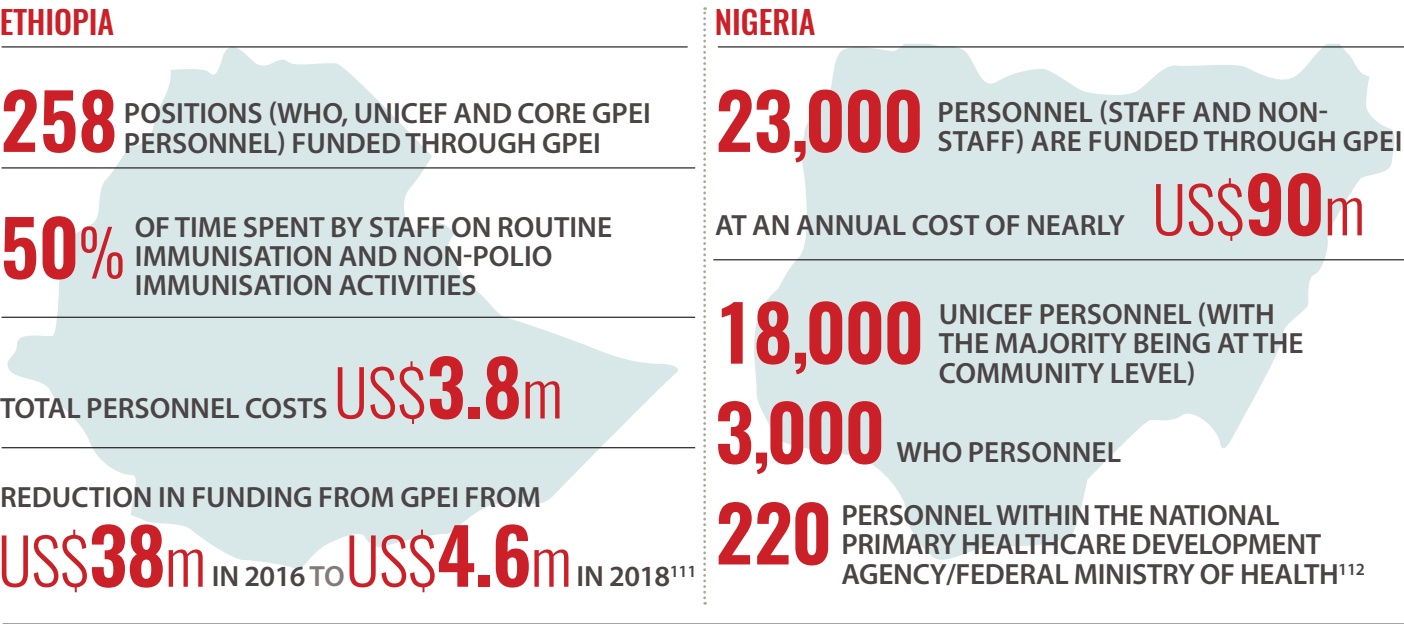
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52%

OF ITS GLOBAL IMMUNISATION WORKFORCE FUNDED THROUGH GPEI.¹¹⁰

THESE FIGURES DO NOT INCLUDE THE THOUSANDS OF UNICEF COUNTRY STAFF WHO MAY ALSO BE FUNDED FULLY OR IN PART THROUGH GPEI

FIGURE 2: HOW FINANCIAL CHANGES WILL AFFECT STAFF LEVELS INVOLVED WITH PROGRAMME IMPLEMENTATION



Asset mapping exercises being undertaken by countries as part of the transition planning give an important insight into how financial changes will affect staff levels directly involved with programme implementation at the country level. Some initial results include: see Figure 2.

When leaving a legacy for other health services is a primary objective of the PEESP, it is worrying there is “no clear path to transitioning human resources from the polio eradication effort to other responsibilities.”¹¹³ The transfer of all polio funded staff should not be automatic. Disease eradication activities and systems require different assets, training, and principles to routine immunisation.

As a high number of staff work non-exclusively on polio eradication activities, it is crucially important to evaluate what elements of their current role, especially within the routine immunisation system, will be affected when GPEI funding ends. Their future has the potential to disrupt immunisation services and poses one of the most significant challenges in moving from vertical diseases eradication efforts to a systems approach for polio vaccination. However, managed correctly, these staff members could be further trained and integrated into routine immunisation systems to increase service delivery.

IMMUNISATION SYSTEMS

Without GPEI funding, the full EPI programme in South Sudan could collapse.¹¹⁴

South Sudan is an extreme example of the possible catastrophic impact the cessation of GPEI could have. It is illustrative of a number of challenges which will apply to a much larger number of countries, especially if not addressed in the early stages of changing donor financing.

Surveillance and laboratory systems and human resources are examples of elements of an immunisation system. Many other elements exist, but all must function collectively for vaccines to reach all children. Changing donor support to even one element could negatively impact routine immunisation systems: “sudden discontinuation of their [GPEI] employment would potentially disrupt the immunization programmes... and create setbacks in capacity and effectiveness that would put children at higher risk for vaccine-preventable diseases.”¹¹⁵

Immunisation systems are already underfunded and fragile in many of GPEI’s 16 priority countries. Government spending as an average percentage of the total spent on routine immunisation in these 16 countries is just 31%¹¹⁶ and four countries have immunisation rates of less than 50%.¹¹⁷ Seven countries are also on the World Bank’s Fragile Situations list.¹¹⁸ Changes in donor financing have the potential to impact directly on already stretched immunisation budgets, as well as services provided by the EPI programme, especially in countries where GPEI funding is currently used to support the full immunisation system. Redirection of funds from a vertical approach into immunisation systems will not be automatic or, in many cases, simple.

Facts and figures only tell part of the story and don’t describe what the changes will mean at a community level and with service delivery within the whole system. South Sudan, a fragile and conflict affected country¹¹⁹ with one of the lowest immunisation rates in the world (26%), is facing a reduction in funding from GPEI which could destroy its full EPI programme.

In the middle of a civil war, South Sudan’s population has very little access to essential health services. GPEI funding is supporting polio campaigns that reach an impressive 80% of the population. It supports 703 staff; the main function of 502 of these staff positions is implementation and service delivery.¹²⁰ GPEI funded personnel, spend approximately 27% of work time on polio eradication but the rest of their time is spent on routine immunisation, new vaccine introduction, maternal and child nutrition, and responding to humanitarian emergencies. 60% of staff are trained in routine immunisation.¹²¹ Consequently, GPEI funding and partner support is being used to support the full EPI programme. With a 70% reduction in GPEI funding between 2017 and 2019, on top of a 50% reduction between 2016-2017,¹²² and at least \$370,000 additional donor funds required to complete the transition planning programme,¹²³ there is little hope for country ownership of the immunisation programme once funding from GPEI ends.

Without continued donor support, country health officials told the TIMB that the routine immunisation “will fail.”¹²⁴

4.2 URGENT CHALLENGES TO BE ADDRESSED

The wind down of GPEI is not a future challenge. It is a process that is happening now; staff and funding levels are already changing and having an impact at country and regional levels.¹²⁵

To optimise investments historically made in polio eradication, to prevent regression on immunisation gains, and to meet the objectives set out for wind down, there are a number of substantial challenges which must be urgently overcome. The risk to winding down successfully already exist in these cases.

LACK OF SECURE FUTURE FINANCING FOR THE TRANSITION PROCESS AND POST CERTIFICATION

The 2017 GPEI replenishment in Atlanta raised important funds to allow the GPEI to continue their activities beyond the original life of the PEESP to 2019.¹²⁶ The current budget is now expected to protect current activities until the end of 2020 when polio will hopefully be certified as eradicated. Beyond this, funding requirements to support polio eradication activities (if needed), to implement the post-certification strategy, or what will be required to support transition activities is unclear.

The post-certification strategy, when finalised in May 2018, will set out the technical requirements to ensure the world remains polio free. This will then need to be translated into individual country context and built into ongoing transition planning. These requirements will then need to be analysed to assess what the financial requirements are. This strategy will only focus on funding for polio essential functions. How the other services which are beyond the polio essential functions and the source of funding for part of immunisation system remains unclear. What resources will be required during the wind down of GPEI to integrate staff and resources to strengthen immunisation systems, is still uncertain.¹²⁷

Financial gaps that cannot be filled by domestic resources need early identification, while budget cycles and the time required to commit new funding also need consideration. As transition plans are still under development, it is currently unknown what financial support will be required, and there is risk that costed transition plans will remain unfunded.¹²⁸ The less time there is to implement strategies to avert financial gaps, and less time to consider more efficient and effective ways to finance routine immunisation.

LIMITED TECHNICAL CAPACITY FOR TRANSITION

Even with guidelines and technical support from the GPEI, the process still requires high-level government ownership with dedicated staff and technical knowledge to ensure the planning process is comprehensive from both a financial and programmatic perspective.

Once the plan is finalised, it needs to be implemented. The technical capacity to undertake post-eradication activities may not exist, be readily available nor may the finances be available to train or employ expert staff. For example, technical staff within Pakistan will need to have the expertise to adapt systems to cope with a 50% decrease in GPEI funding between 2017-2019.¹²⁹ This is a concern that has already been raised by India, a country with high-level political will to take over the polio programme. India has reported that their staff do not have the time or technical capacities to operationalise what is required for transition.¹³⁰ Increasing staff capacity for transition could create long-term expertise within the relevant government department which could be equally beneficial for other donor transitions.

LACK OF AWARENESS AND UNDERSTANDING OF THE IMMINENT CHANGES

There have been recognisable efforts to increase awareness of the upcoming changes such as the attention GPEI wind-down received at the WHO Executive Board and World Health Assembly in 2017. However, outside the polio community and for those without a role dedicated to transition, awareness is low. Many immunisation stakeholders are completely unaware that there will be a reduction in funding from GPEI in coming years, with the wider health community unaware of the potential impact this will have for health financing and immunisation services.¹³¹

In some countries, stakeholders are sceptical about whether or when polio or Gavi funding will actually stop.¹³² This not only prevents timely transition planning but reduces the likelihood that countries will take advantage of this moment to evaluate their funding needs for immunisation. Without awareness of the situation, the political will and leadership required to drive solutions will not exist, and prevent progress being made.

INSUFFICIENT GOVERNANCE STRUCTURES

The various GPEI and WHO strategic and oversight committees, which include some of the world's foremost experts on polio, will be crucial to the success of GPEI wind-down. To avoid

polio transition discussions happening only within the polio community and theoretically within an 'echo chamber', and to ensure the impact of wind-down is considered in the context of immunisation and health systems, these committees must be representative of the wider immunisation and health sector.

Currently, many of the GPEI oversight committees are dominated by polio experts and staff from GPEI partners themselves, which could create personal and organisational conflicts of interest. Staff in these committees represent the views of organisations who are losing large amounts of financing, and in many cases staff positions are at risk.¹³³ GPEI programmes are dependent on the committees' decisions and some question whether this is conducive to make tough decisions.¹³⁴

GPEI will cease to exist when global eradication is certified. There will however continue to be a need for strategic oversight to implement the Post-Certification Strategy (PCS) and ensure the world remains polio free.

4.2 TURNING RISKS INTO OPPORTUNITIES

The challenges, which the polio and immunisation communities face as a result of GPEI wind down, increase the chances that the opportunity to look at the potential to embrace a unique opportunity in global health will be missed.

Increasing pressures on laboratories and surveillance systems, a reduction in institutional staff time and capacity, and a lack of funding and technical knowledge to implement transition plans effectively, if left unaddressed and in the context of the underlying barriers of poor immunisation systems, simultaneous transition from Gavi, and fundamental shifts in approached to immunisation, pose significant risks to the successful wind down of GPEI and threaten eradication efforts themselves. They also threaten progress, or even regression, on global immunisation goals.

Additional challenges are likely to develop as financing for GPEI declines. Proactively addressing both current, and adapting to, future challenges will allow GPEI and its partners to collaboratively find achievable solutions to ensure the vision of the Sustainable Development Goals and the Leave No One Behind agenda are reached.



Photo: Tom Maguire/RESULTS UK

5 CASE STUDY NIGERIA

“ In light of the funding pressures that will come not just from the withdrawal of GPEI funding, but also the Gavi graduation process, it would be very difficult for the country to ignore the need for a well thought out transition plan.¹³⁵

With the highest number of unimmunised children in the world, the wind down of GPEI poses a severe risk for routine immunisation in Nigeria. If mismanaged transition could damage the existing weak immunisation system, leaving even more children unimmunised and vulnerable to disease. However, it also poses a unique opportunity to leverage the historic impact and assets of GPEI to strengthen the existing fragile routine immunisation system.

5.1 WEAK AND FRAGILE IMMUNISATION SYSTEMS

A weak primary healthcare system, underfunded programmes, low numbers of health workers with frequent health worker strikes, and weak oversight at lower levels of government are consistent challenges which is leaving millions of children vulnerable to vaccine preventable diseases.¹³⁹ Nigeria's immunisation infrastructure urgently needs to be improved; national storage capacity must double by 2020 to ensure the country's vaccine needs are fulfilled.¹⁴⁰

The re-emergence of wild polio cases in 2016 was indicative of the fragility of polio immunisation and surveillance systems and the IMB is worried Nigeria's current polio surveillance system and the data produced from this is a “major threat to global [polio] eradication.”¹⁴¹

5.2 THE IMPACT OF GPEI INVESTMENTS ON ROUTINE IMMUNISATION

Support from GPEI has been critical and essential in Nigeria for many years, for both polio eradication efforts and wider immunisation activities, especially in the northern and conflict affected areas.¹⁴² They include, but are not limited to:

- ◆ Support for 23,269 staff who undertake a wide range of services, primarily at the Local Government Authority (LGA) level or lower, and largely providing services in the community.¹⁴³ A recent survey indicated polio-funded staff spent 88% of their time on routine immunisation activities.¹⁴⁴
- ◆ GPEI funding has also helped increase the number of primary healthcare centres with functional cold chain equipment from around 1500 to



IMMUNISATION RATES

40% OF ALL CHILDREN ESTIMATED TO RECEIVE NO VACCINES AT ALL¹³⁶

7m CHILDREN ARE BORN IN NIGERIA ANNUALLY,¹³⁷ POSING EXTREME LOGISTICAL AND FINANCIAL CHALLENGES TO ENSURE INFANTS ARE FULLY IMMUNISED WITH ALL 11 WHO RECOMMENDED VACCINES

COST OF PURCHASING AND ADMINISTERING THREE DOSES OF DTP TO EVERY INFANT WILL RISE FROM

\$45.66 IN 2013 TO **\$65.11** IN 2020¹³⁸

Photo: Tom Maguire/RESULTS UK

6340, but there is an absence of funding for further improvements.¹⁴⁵

Without a final costed and funded transition plan which mitigates the risk of lost funding for these activities, and many others, there is a risk that the impact on routine immunisation will be unexpected and unplanned for, and a weak health system will not be able to respond appropriately to fill the gaps.

5.3 IMMINENT RISKS TO A SUCCESSFUL GPEI WIND DOWN

In 2016, Nigeria along with Pakistan received the highest funding from GPEI among all priority countries – US\$247 million.¹⁴⁶ Between 2017-2019 Nigeria’s funding from GPEI will decline by almost 40%.¹⁴⁷ After 2019, secure funding for polio is unknown. There are five main challenges which pose the largest risk to a successful wind down of GPEI resources in Nigeria, which if not addressed could not only risk a polio free world but have a catastrophic impact on an already struggling routine immunisation system.

1 Eradication vs Transition

Ensuring polio eradication should remain the priority for Nigeria, but this must be done in partnership with planning for a polio-free country. Prior to 2016, Nigeria had made important advancements in polio transition planning, sharing its best practices in running transition simulations in Ethiopia and South Sudan.¹⁴⁸

After the 2016 outbreak, efforts have refocused on financing and on eradication, which has affected progress on transition planning. Public communication on GPEI wind-down has halted, though transition planning continues, due to concerns of seeking donor support for eradication and transition before eradication is certified in the country. This decision will affect stakeholder awareness of the changes, which could affect the success of GPEI wind-down. Eradication and transition are a recognisable threat to each other and success is reliant on both elements being realised in the next three years.

2 Difficulties in Raising Domestic Financing

The economic situation in Nigeria has been, and will continue to be, a considerable factor in its ability to increase domestic resources and take ownership of previously supported GPEI and Gavi funded programmes.

After a rebasing of the economy in 2014,¹⁴⁹ Nigeria officially became a middle-income country. Despite a 57% increase in GNI between 2010 to 2014, the economy has now contracted and the World Bank predicts a growth rate of only one percent in 2017.¹⁵⁰ However, even while Nigeria’s economy has been growing, their tax base has remained limited. In 2013, the latest year for which data is available, tax revenue as a percentage of GDP was only 1.5%. This is low compared to over 10% in other countries with similar GDPs per capita.¹⁵¹

At the same time, the Federal Health Budget has been inconsistent from a high of 9% of the government budget in 2007 to between 5-8% over the last decade.¹⁵² This is far from the 15% agreed by African leaders at the Abuja Conference, a target Nigeria has not met in any of the years since it hosted the conference.

As domestic funding for vaccine procurement is solely a Federal Government expense, a restricted Federal Health Budget is a limiting factor in Nigeria’s ability to increase domestic resources to address changing donor financing. The unreliability of the health budget is also troublesome; in recent years, the government budget has not been signed off until the middle of the year, with appropriations not coming until weeks or even months later. In 2017 only 20% of budgeted funds had been disbursed by September.¹⁵³

3 Simultaneous Transition from Gavi and GPEI

Nigeria relies heavily on donor support for its immunisation system.¹⁵⁴ Between 2016-2020 there is a US\$1.45 billion financing gap for the EPI programme based on secure funding.¹⁵⁶

From 2017, Nigeria must increase its co-financing obligations to Gavi by 20% each year until 2022, when it must take full responsibility for all vaccine procurement costs. In 2017, Nigeria’s co-financing obligations were US\$46 million.¹⁵⁷ In 2022, without Gavi support, Nigeria will need to budget for an additional \$138 million to cover previously supported vaccines.¹⁵⁸ Nigeria is currently relying on World Bank loans to meet existing Gavi co-financing obligations with 100% of the co-financing for the pentavalent and pneumococcal vaccines in 2016 coming from these mechanisms.¹⁵⁹ A further five-year loan from the World Bank to support immunisation activities is being considered.¹⁶⁰

With difficulties in raising domestic resources for immunisation within a stretched health budget, there is a “serious question mark whether Nigeria could transition successfully” from Gavi support,¹⁶¹ even before reduced funding from GPEI is

considered. Polio and immunisation programmes run in parallel, rather than jointly and transition planning mimics this.¹⁶² Despite some definitive actions in 2017, to begin assessing the simultaneous nature of transition, a lack of consistent and coherent communication between teams within the NPHCDA, donors, and stakeholders continues to pose problems.¹⁶³

4 Complexities in Immunisation Budgeting

Beyond procurement, all other elements of the routine immunisation system are a shared financial responsibility between the Federal Government, State Governments and Local Government Authorities (LGAs).

Donor financing comes through different channels, directly at the Federal level (Gavi) or targeted at different states (bilateral and philanthropic donors), or even through organisations who have presence in many different States and LGAs (GPEI partners). This makes identifying where financing gaps will be left as donor financing changes difficult. These figures will also be dependent on securing Federal and State budgets for immunisation which are often not predictable.

As GPEI funding largely goes through partners, with large amounts spent directly on human resources, it is difficult to estimate the scale of impact GPEI wind down will be on services and where and to what level domestic resources, or alternative sources of funding will be needed. The financing gap for immunisation is constantly changing.¹⁶⁴

Within a restricted health budget, the impact of raising domestic resources for immunisation must be considered alongside the impact this could have on other health commodities and services. Currently, immunisation procurement accounts for an estimated 40% of the total capital budget available to the NPHCDA at Federal level.¹⁶⁵ When considering the higher cost of IPV compared to OPV, the introduction of new vaccines, and the number of vaccine doses needed to address inequities and increase coverage, the space to allocate increased domestic resources is limited. For example, in 2016, the Federal government only allocated US\$2.37 million of the US\$15.3 million needed for family planning commodities with donors largely filling this gap.¹⁶⁶ This gap is expected to be US\$13.9 million in 2018 as Government financing of family planning commodities is expected to decrease further.¹⁶⁷

5 Lack of Awareness of Timeline and Impact

Awareness of GPEI wind-down, including the timeframe and the scale, is low, even among immunisation experts. The National

Immunisation Financing Task Team (NIFT), set up primarily to address financing for immunisation, is focused on domestic financing needs for immunisation and within this the financial requirements associated with transition from Gavi. Members are not considering the impact of GPEI funding changes within their current financing assessments and needs over the next five years.¹⁶⁸ However, if GPEI funding is not included within this large unexpected financing gaps will emerge.

With financing changes happening imminently but transition planning still not complete, awareness of the impact, especially at State and LGA level, and what is required to address any gaps which will be left is not fully understood or comprehensively documented.

5.4 REALISING THE OPPORTUNITY TO STRENGTHEN ROUTINE IMMUNISATION

The new Executive Director of the NPHCDA recently declared immunisation a national emergency. Now is an optimal time to utilise this new focus on routine immunisation within the context of GPEI wind-down and recognise they are completely reliant on each other’s successes. If this is not done now, Nigeria could continue to struggle with one of the world’s worst immunisation rates for many years.

5.5 RECOMMENDATIONS FOR THE GOVERNMENT OF NIGERIA:

- ◆ Urgently develop and implement an immunisation financing plan that considers both Gavi transition and GPEI wind-down and is built on reaching all children with all 11 WHO recommended vaccines.
- ◆ Immediately undertake an impact assessment, at both the Federal, State and LGA level, that analyses current assets and services supported by GPEI funding and identifies anticipated gaps in service delivery.
- ◆ The President, State Governors and senior officials at a national and state level should provide strong and visible support to address the challenges of transition from GPEI and Gavi.
- ◆ Federal and State Governments should implement a sustainable financing plan and move towards the Abuja target of allocating 15% of budgets to health.

6 CASE STUDY PAKISTAN

“Pakistan is working hard to eradicate polio, it’s a big and important thing for us to do. We stand with the rest of the world and we do not want our children to die”¹⁶⁹

Pakistan has made significant progress towards polio eradication; the number of cases have declined from 206 in 2014 to 20 in 2016, and only five in the first 9 months of 2017.¹⁷⁰ The Government of Pakistan has confined polio to three areas - the Khyber-Peshawar corridor, Karachi and the Quetta block.¹⁷¹ While Pakistan is now very close to interrupting transmission of polio, cases of wild polio virus persist, and surveillance data related to sewerage sample analysis indicates that on average 15-16% of samples show Wild Poliovirus (WPV). Unless further action is taken to prevent the presence of the virus in the environment, and the withdrawal of funding for concentrated activities for polio eradication as GPEI wind down, the disease could resurface.

Funding from GPEI is expected to decrease by more than 50% between 2017-2019,¹⁷² and funding will end completely when GPEI as a partnership is dissolved, as early as 2020. With declining resources, moving successfully towards eradication poses significant challenges for Pakistan.

6.1 THE IMPACT OF GPEI INVESTMENTS IN ROUTINE IMMUNISATION

“The results of GPEI have proven that anything is possible.

Lubna Hashmat, CEO of the Civil Society Human and Institutional Development Programme in Pakistan.

The GPEI has led to innovations and service improvements in Pakistan for both polio eradication and routine immunisation. Investments have supported the establishment of the polio surveillance system, which not only actively seeks out cases of polio in the community, but has integrated surveillance activities within health facilities, increased capacity among health staff and the use of indicators to measure the quality of surveillance which has benefited the whole immunisation system.¹⁷³ Investments have also supported cold chain upgrades, as well as ongoing repairs and maintenance.¹⁷⁴

Polio eradication teams have also increased outreach to and mapping of vulnerable populations. This information provides a valuable data set on populations that other health services do not reach, including those living in urban slums, pastoralists, and socially-marginalised groups. GPEI has also supported the creation of a grassroots workforce that delivers multiple health services throughout the country.¹⁷⁵



Photo: WHO Pakistan/ Anam Khan/RESULTS UK

Women, who are part of this workforce, have played a crucial role in the country's eradication effort, as vaccinators, Lady Health Workers (LHWs), social mobilisers and administrators within the polio programme. These jobs have provided vital income for many families, increasing women's confidence and sense of personal competence, and ensured ethnically diverse and mobile populations were served leaving a lasting impact on communities.¹⁷⁶

6.2 THE CHALLENGES OF GPEI WIND DOWN IN PAKISTAN

As wild poliovirus is still circulating in Pakistan, eradication efforts take precedent over transition planning. Yet, funding from GPEI is reducing, and will significantly decrease over the next three years. Transition is happening now and cannot be ignored. There are three challenges which should be addressed as soon as possible, if there is to be any chance of achieving a long lasting and positive impact for immunisation in Pakistan.

1 Lack of Prioritisation of Immunisation Staff

The determination to reach every child in Pakistan with the polio vaccine, largely through mass immunisation campaigns, is the main reason there have only been 5 cases in the first 9 months of 2017. The discrepancies which exist as a result of this enormous effort is something that could haunt routine immunisation for years to come.

The number of full-time equivalent workers delivering polio vaccines in Pakistan is approximately 10,500, compared with 16,300 people delivering routine immunisation, making polio vaccinators 39% of the vaccine workforce.¹⁷⁷

Large financial gaps between polio funding and immunisation have led to equally large discrepancies between polio immunisation and routine immunisation rates, which could be problematic as GPEI funding declines. "The gap between the polio vaccination rate (which has reached 96% of children) and the routine immunisation rate (58%) shows the potential for a possible return of polio and a lack of progress in reducing other vaccine-preventable diseases, when the funding ceases."¹⁷⁸

Addressing differences in the working conditions, remuneration, support and resources available between polio workers in comparison to EPI workers is a challenge,

and a risk to the long-term integration of polio funded workers into government routine immunisation systems.

“From the start there has always been a slight tension between the EPI and polio staff. The salaries are different, the perks are different, the facilities are very different and the resources and priorities given to polio are much higher. EPI staff are dealing with all antigens but just polio staff are properly supported. This makes the EPI staff feel bad.”¹⁷⁹

A recent study from Karachi concluded that addressing this discrepancy between funding for polio and other health services could be a key opportunity to address sustainability challenges in Pakistan enabling polio elimination. Investment in short-term improvements to routine immunisation and sanitation in polio-endemic areas could result in a longer-term focus on broader health-service improvements.¹⁸⁰

The size of the polio workforce and difficulties in matching remuneration indicates that the Government of Pakistan could not readily absorb the financial or human resources devoted to polio eradication and should actively look for the most efficient way to transfer and integrate assets and resources to benefit the routine immunisation system.

With the majority of deaths in children under the age of five from diseases that are on the regular vaccine schedule, improving the routine immunisation system and shifting from a vertical disease eradication model is critical and urgently needed to tackle vaccine preventable diseases.¹⁸¹

2 Reliance on Donor Financing

GPEI is the largest external health investment in Pakistan.¹⁸² In 2017, GPEI funding through WHO and UNICEF for polio eradication is US\$256 million,¹⁸³ approximately one quarter of total GPEI spending and 4% of total health spending in Pakistan.¹⁸⁴

Pakistan's economy has been growing at an average annual rate of 3.5% in the 2007 to 2016 period. However, a limited taxation base means that this growth does not translate into a significant increase in capacity to fund services (taxation collections are relatively low at 12.4% of GDP). Government spending in key sectors such as health and education is less than 3% of GDP in each case, and is significantly lower than most other countries.¹⁸⁵ Therefore, Pakistan relies on international funding - total ODA per year for health in 2013 to 2015 on average was \$US 315 million,¹⁸⁶ or about 5% of total health spending.

International funding for both ongoing polio vaccination and routine immunisation for Pakistan would need to continue following polio eradication to ensure essential polio function and other vital immunisation services continue, as well as crucial transition services. An interviewee noted that the following is required:

“Adequate funding needs to be provided to countries up to the point of formal eradication. People need to be employed at the country level to oversee the process of transition. Pooling resources from several sectors would also assist in a successful transition.”¹⁸⁷

3 Lack of Transition Planning

Since Pakistan is not yet polio free, its priority is stopping transmission rather than transition planning.¹⁸⁸ In fact, transition planning will not begin until Pakistan has been polio free for a year and transmission of the virus has been declared interrupted. With the latest case of polio being recorded (at the time of publication) in August 2017, transition planning will not fully begin in earnest until at least August 2018 – just over a year before the most significant changes in funding from GPEI will be felt. Even though Pakistan is in the early stages of Gavi transition and not expected to enter accelerated transition until around 2021, there are still pressures on domestic

financing which will need to be considered. A well thought out transition plan which assesses the risks alongside the financial and programmatic gaps is needed but will need to be designed in a very short space of time.

By contrast India began planning for the reduction of GPEI resources, even before polio was eradicated. India has maintained its polio free status and provides support for the importance of transition planning before eradication is certified as an essential component in sustaining the achievements of the eradication campaign.¹⁸⁹ The Indian Government and civil society organisations have both indicated their ongoing transition process would have been smoother if they had started thinking, planning and assessing funding streams more comprehensively during the eradication phase.¹⁹⁰

6.3 REALISING THE OPPORTUNITY OF GPEI WIND DOWN

Pakistan has already started integrating the benefits of the polio eradication programme into the routine immunisation and health systems, leveraging the impact of historic polio investments from GPEI. This is an important first step as financing changes to overcome the significant challenges and to ensure wind down has a positive impact on the suitability of routine immunisation.

“In the last 2-3 years, action to improve synergies between polio and routine immunisation has taken place – sharing population and surveillance data with routine immunisation programs, for example. This has led to a 10% increase in vaccine coverage in the Punjab province (the most populous province), taking overall coverage to 80%.”¹⁹¹

The routine immunisation programme has also started using the mapping of children who are missing services from the polio eradication programme for other health services. Other key opportunities include allocating more vaccinators to routine immunisation, involving local and national civil society organisations, and to achieving increased collaboration among different international agencies supporting the health system. While not all resources for polio eradication should be integrated into the national health system, at least 15-20% of polio funding (for surveillance, mapping and accountability) could be integrated into the health system.¹⁹²

However, this is just the beginning of an integrated approach with polio vaccination with routine immunisation and it will take several years before the benefits from the polio eradication programme could flow through to other areas of health.¹⁹³

Beyond immunisation, the public-sector health system would benefit from the following characteristics of the polio eradication campaign - improved disease surveillance; increased community outreach, the increased role of women in service delivery; improved training and supervision of health workers; and mechanisms to track missing children.¹⁹⁴

Current financial support, beyond GPEI, could also be leveraged throughout the wind down of GPEI to improve immunisation and health services. Gavi and the Global Fund also provide significant funding to Pakistan, and are likely to maintain Pakistan's eligibility for support to at least 2025.¹⁹⁵ Both institutions contribute to health system strengthening activities which should be play a part in planning for health assistance once GPEI financing ends. With Gavi's considerable existing investment in Pakistan and immunisation globally, leveraging GPEI assets such as surveillance and laboratory networks for broader vaccine-preventable disease surveillance and programme monitoring will be critical for Pakistan to sustain the gains made to introduce new vaccines and increase the coverage and equity of traditional EPI antigens. WHO, UNICEF and the World Bank all support immunisation and the health system and will need to continue to engage in support of Pakistan's federal and state governments throughout the transition process.¹⁹⁶

Maintaining these benefits will require an investment from both the Pakistan Government and international agencies which assist Pakistan. The leading multilateral source of funding to Pakistan is IDA, and the leading sources of bilateral

assistance are the United States and the United Kingdom. A reallocation of some of the assistance from these donors to health and vaccination could support a higher priority by the Government of Pakistan for child health.¹⁹⁷

6.4 SECURING SUCCESS

The near eradication of polio in Pakistan is a testament of the will and dedication of both the people and the Government of Pakistan. The political priority given to polio is evident in the appointment of Senator Ayesha Raza Farooq, as the Prime Minister's focal person for polio eradication. "Polio is high on the political agenda and knowledge of polio is strong among parliamentarians...The government is very committed and working very hard to eradicate the disease."¹⁹⁸

Building on this political will provides an unparalleled opportunity to leverage interest and dedication to polio to ensure there is a legacy for routine immunisation. Achieving this potential will require action by the Government of Pakistan and civil society to increase knowledge and understanding of GPEI wind down as well as on the importance and safety of routine immunisations.

GPEI investments have supported key elements of Pakistan's national polio programme and have the potential to serve national and global health objectives, including child vaccination and health security goals. As Senator Farooq, the Prime Minister's Focal Person on Polio Eradication in Pakistan noted, the following obstacles could limit the benefits from use of these assets:¹⁹⁹

- ◆ **Lack of common understanding on transition both in terms of final goal and the processes.**
- ◆ **Sudden withdrawal of donor resources (both financial and technical).**
- ◆ **Critical health system and immunisation infrastructure gaps at operational level could prevent the benefits from the data the polio campaigns have collected from being achieved.**
- ◆ **Potential reluctance in accepting the culture of performance management and accountability in the operating systems of Government as well as partner organisations.**



Photo: Sanjit Das Panos Pictures/RESULTS UK

Stakeholders in Pakistan take pride in being part of the international effort to eradicate polio, which also reflects a goal of improving the prospects of children to grow up without the burden of other diseases.

6.5 RECOMMENDATIONS FOR THE GOVERNMENT OF PAKISTAN:

Provide for the transfer of vaccinators to routine immunisation and seek coordinated support for vaccination between Gavi and other international agencies supporting the health system.

- ◆ **Increase communication about the importance of all routine vaccines and how families can obtain**

immunisations (including free availability, location and recommended frequency of vaccination).

- ◆ **Urgently undertake an asset mapping of current GPEI funded assets and conduct a transition impact assessment, to see where changes will leave gaps which could impact on service delivery and where there are opportunities to integrate assets into the Pakistan health system.**
- ◆ **Begin transition planning now. Work with international donors on the resource requirements to ensure that post-eradication, Pakistan remains polio free and for using assets (including cold chain and surveillance), systems and lessons from polio eradication to strengthen the immunisation system.**

7 CONCLUSION AND RECOMMENDATIONS

In May 2017, Member States at the World Health Assembly passed a resolution “strengthening immunization to achieve the goals of the global vaccine action plan” which:

“[recognises] the significant progress achieved towards polio eradication and the significant contribution of the polio-related assets, human resources and infrastructure, which should be transitioned effectively, to the strengthening of national immunization and health systems²⁰⁰

With the acceptance and recognition of the need to invest in and use GPEI wind down to strengthen routine immunisation, a lack of response to this opportunity would fail to protect the 19.4 million unimmunised children in the world, and threatens to heighten global inequities and ability to extend vaccine coverage to under-served populations.²⁰¹

If this opportunity is to be taken, concerted efforts are needed to find solutions to three principal barriers which also risk a polio free world and the success of GPEI wind down. These are weak and fragile immunisation systems unable to cope with additional polio immunisation pressures, simultaneous pressures on domestic financing with Gavi transition, and the fundamental shift from delivering vaccines through campaigns to within routine immunisation.

Who is involved in the different GPEI transition processes going forward and how the activities linked to these will be funded will also shape progress towards the PEESP transition objectives.

GPEI partners and the international community cannot avoid the difficult questions which will come up throughout these processes; especially around the potential impact GPEI wind down could have on routine immunisation if countries are unable to take ownership of essential elements of the programmes, and about the existing and future challenges which will urgently need to be tackled.

With GPEI funding ending in some countries as early as 2019, what happens now will dictate the legacy of GPEI, as well as the future of routine immunisation systems. Achieving both will require a careful balancing act. It is a once in a lifetime opportunity to rethink the financing, programmes, and approaches which are needed to address weak routine immunisation systems which are leaving children behind.



Now is the time to leverage the success of polio eradication efforts, building on expertise, systems and knowledge, and using existing commitments and investments to strengthen routine immunisation, driving progress towards reaching the GVAP goals, and child health targets within the Sustainable Development Goals. Only by doing this can we ensure that millions of children are able to survive and thrive beyond their fifth birthday.

7.1 CALL TO ACTION

GPEI wind down should be a political priority. We recommended a high-level meeting take places on the side-lines of WHA 2018 to explore the barriers, gaps, and challenges which urgently need to be addressed, not only to ensure a polio free world, but also to ensure the unique opportunity to strengthen routine immunisation must not missed. The meeting should involve:

- ◆ Heads of all GPEI partner organisations.
- ◆ GPEI Strategy Committee.
- ◆ CEO, Gavi, the Vaccine Alliance.
- ◆ President of the World Bank Group.
- ◆ Heads of State and Ministers of Health and/or Finance from the 16 GPEI priority countries.
- ◆ Bilateral donors, especially the leading donor to GPEI and Gavi (including but not limited to The United Kingdom, United States of America, Norway, Germany, France, Australia and Canada).
- ◆ Civil Society from transitioning countries.
- ◆ Global Civil Society

7.2 RECOMMENDATIONS

GPEI

- ◆ GPEI must work with its partners to increase awareness of the impact and challenges of wind down in the 16 GPEI priority transition countries beyond staff working directly on polio transition at national level.
- ◆ Initiate a joint independent evaluation with Gavi of the combined impact of GPEI and Gavi transitions in the eight countries facing simultaneous transition.
- ◆ Seek World Bank technical assistance to undertake a comprehensive analysis of the systems impacts and financing gaps expected from GPEI’s withdrawal.
- ◆ Ensure increased involvement of immunisation and health systems experts in polio oversight committees at a global and regional level.
- ◆ Urgently communicate the level of resources and changes to the governance systems which will be required post-eradication to ensure a polio-free world.

GPEI PARTNERS

- ◆ Each partner must urgently finalise their transition plan and communicate this to their regional and country staff and the staff of other GPEI partners at global, regional and country levels to ensure this is adequately reflected in country transition plans.
- ◆ Increase coordination at a country level between EPI staff and polio staff to enable a more comprehensive understanding of the impact of wind down on immunisation and polio services, especially at a community level, to ensure continuity and expansion of sustainable service provision.

GAVI

- ◆ Extend support for IPV until 2030 and include this as one of the core vaccines supported in the next Vaccine Investment Strategy.
- ◆ Include GPEI wind down analysis within transition assessments and the annual Joint Appraisal as standard.

- ◆ Improve coordination between GPEI and Gavi transition planning at the country level.
- ◆ Consider how existing Gavi support could be reallocated to maintain critical components of the immunisation infrastructure previously supported by GPEI, such as surveillance and laboratory networks.

BILATERAL DONORS

- ◆ Donors, such as the UK and Australia, should use their positions on the Boards of Gavi and GPEI technical working groups to highlight the opportunity to use GPEI wind down to strengthen routine immunisation programs and ensure historic investments leave a lasting legacy.
- ◆ Donors will need to provide technical and financial support where necessary to build technical capacity for transition planning and implementation.
- ◆ Assistance should also be given to ensure sustained or improved rates of immunisation in their partner countries.

NATIONAL GOVERNMENTS

- ◆ Increase domestic resources for immunisation within a growing national health budget.
- ◆ Finalise costed transition plans which consider likely reductions in GPEI and Gavi support.
- ◆ Use GPEI wind down as an opportunity to evaluate financing and challenges to immunisation to strengthen routine immunisation as part of comprehensive primary healthcare system.

ACRONYMS

AFP	Acute Flaccid Paralysis
CDC	the US Centres for Disease Control and Prevention
DTP	Diphtheria, Tetanus, and Pertussis (vaccine)
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunisation
Gavi	Gavi, the Vaccine Alliance
GDP	Gross Domestic Product
GPEI	Global Polio Eradication Initiative
GPLN	Global Polio Laboratory Network
GVAP	Global Vaccine Action Plan
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IPV	Inactivated Polio Vaccine
IMB	Independent Monitoring Board
LHWs	Lady Health Workers
LGA	Local Government Area
NIFT	National Immunisation Financing Task Team
NERICC	National Emergency Routine Immunisation Coordination Centre
NPHCDA	National Primary Healthcare Development Agency
OPV	Oral Polio Vaccine
PCS	Post-Certification Strategy
PEESP	Polio Eradication and Endgame Strategic Plan
POB	Polio Oversight Board
SAGE	Strategic Advisory Group of Experts on Immunisation
SDGs	Sustainable Development Goals
SERICC	State Emergency Routine Immunisation Coordination Centre
SIA	Supplemental Immunisation Campaigns
TIMB	Transition Independent Monitoring Board
TMG	Transition Management Group
UHC	Universal Health Coverage
UNICEF	United Nations Children’s Fund
WHA	World Health Assembly
WHO	World Health Organisation

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ABOUT RESULTS UK

RESULTS UK is a non-profit advocacy organisation that works to create the public and political will to end extreme poverty. RESULTS' focus is on educating and empowering people - whether they are ordinary citizens or key decision-makers – to bring about policy changes that will improve the lives of the world’s poorest people. Our advocacy focuses on areas that have the most potential to make a difference. RESULTS UK has a track record of expertise in education, global health and economic opportunity.

ABOUT RESULTS AUSTRALIA

RESULTS is part of an international, non-partisan and non-profit organisation that has been working in Australia for 30 years through a combination of staff-led and grassroots-driven advocacy. We work with federal parliamentarians and through the media to generate public and political will to end poverty. We focus our advocacy on global health issues such as tuberculosis (TB), HIV, malaria, polio, child health, vaccines and nutrition, as well as education and microfinance.

ABOUT ACTION

RESULTS UK and RESULTS Australia are partners of ACTION, a global partnership of advocacy organisations working to influence policy and mobilise resources to fight disease of poverty and achieve equitable access to health. ACTION partners work across five continents in both donor and high burden countries.

Founded in 2004, ACTION began as a partnership of independent, locally-established civil society organisations working to mobilise new resources against tuberculosis (TB). Building off successes in fighting TB globally, ACTION expanded its efforts to include child survival, with a focus on expanding access to childhood vaccines and increasing the political will and investment needed to fight childhood undernutrition.

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RESULTS UK, 31-33 Bondway, London, United Kingdom, SW8 1SJ
+44 (0)207 793 3970 | www.results.org.uk | [f](#) results.uk | [t](#) @resultsuk

RESULTS AUSTRALIA, PO Box 7329 Warringah Mall NSW 2100