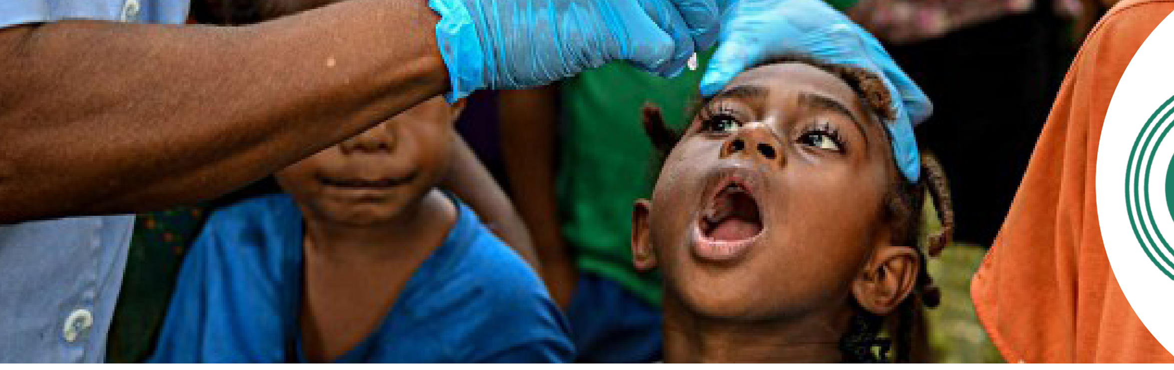

# CLOSER THAN EVER: Sustaining the health gains of polio eradication for a safer future

**REPORT**

*December 2023*

## ACKNOWLEDGMENTS

Global Health Advocates (GHA) is an NGO based in Paris and Brussels specialised in global health advocacy. Its mission is to carry out political advocacy in France and with the EU institutions to ensure policies and resources are effectively addressing health inequalities.

This report was informed by the experience and insights of numerous experts involved in the fight against polio at the local and global levels. GHA would like to thank all the interviewees for having shared their expertise and insightful contribution in Guinea, in Ethiopia, and in Europe. We would like to thank Dr. Clarisse Loe Loumou in particular for her contribution, as well as Dr. Filimona Bisrat, Secretariat Director & Senior Regional Technical Advisor at the Core Group Partners Project Ethiopia, and Dr. Mamadou Kaba Sow, local consultant in Guinea, who conducted interviews with local stakeholders on the ground.

## METHODOLOGY

The present report aims to understand the remaining challenges for global polio eradication and examines how partners can better support countries in their immunisation activities, which are an essential component of polio eradication. This report was drafted on the basis of a desk review of polio eradication strategies, in-country case studies, and interviews conducted with key informants at global, European, and national levels.

We conducted studies in two African countries to evidence the challenges encountered by involved actors and partners in sustaining the advances of polio eradication, and to highlight how international partners and donors can contribute to this effort. The choice of countries, Guinea and Ethiopia, was motivated by the different contexts and challenges that they face when it comes to sustaining the advances in polio eradication. While both were declared polio-free by the WHO in 2008 and 2017 respectively, they remain key high-risk countries[1].

For the complete list of interviewees, please refer to the appendix.

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**For more information, please contact**

Manon Kayser
EU Advocacy Officer
mkayser@ghadvocates.org

Mathilde Pivatal
Advocacy Officer
mpivatal@ghadvocates.org

## ACRONYMS

**AAP**: Annual Action Plans
**AFP**: acute flaccid paralysis
**BMGF**: Bill and Melinda Gates Foundation
**CDC**: Centers for Disease Control and Prevention
**cVDPV2**: circulating variant poliovirus type 2
**EIB**: European Investment Bank
**EPI**: Extended Programme on Immunization
**EU**: European Union
**GPEI**: Global Polio Eradication Initiative
**IPV**: Inactivated Polio Vaccine
**MIP**: Multiannual Indicative Programme
**MoH**: Ministry of Health
**NDICI**: Neighbourhood, Development and International Cooperation Instrument
**NIP**: National Indicative Programme
**UNICEF**: United Nations Children's Fund
**VDPV2**: type 2 vaccine-derived poliovirus
**VPD**: vaccine-preventable disease
**OPV**: oral polio vaccine
**nOPV**: novel oral polio vaccine
**WHO**: World Health Organization
**WPV**: wild poliovirus
**WPV1**: wild poliovirus type 1

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# EXECUTIVE SUMMARY

Although wild poliovirus has been eradicated in most countries, polio remains a threat in countries where vaccine-derived forms of poliovirus still circulate. On the African continent, which was declared WPV-free by the WHO in 2020, the population is still at risk – particularly children with low immunisation rates – as the circulation of vaccine-derived poliovirus remains a concern and as the recent resurgence of wild poliovirus cases makes clear.

As such, it is more than essential to continue investing in the fight against polio, with the ultimate objective of eradicating all remaining strains of the disease. Alongside efforts for polio eradication, this report makes the case that an equal focus should be put on long-term approaches centred around improving overall immunisation rates of the population. As a matter of fact, it makes perfect sense for both to cohabitate as they naturally reinforce one another: investments in polio eradication contribute to strengthening health systems and prepare communities to face future pandemics, while immunisation is an indisputed cornerstone of the prevention of vaccine-preventable diseases, such as polio.

The two case studies help paint the picture of the challenges faced by the African continent in the fight against the disease. In Guinea, polio is symptomatic of the overall challenges faced by the healthcare system, from the country's territorial characteristics to its lack of human and financial resources. To address the situation, the country relies heavily on partners; but their support is often inadequate, short-term, and focused on emergency responses to polio outbreaks. Ethiopia faces similar challenges: the lack of financial resources hampers vaccination activities, including routine immunisation, and financial support from partners mainly focuses on responses to outbreaks, thus not providing the long-term funding that is sorely needed to sustain the gains of polio eradication.

The European Union (EU) has played a key role in the fight against polio over the years as a historical contributor to the GPEI, and, more recently, by putting polio eradication at the core of a new innovative partnership between the European Investment Bank, the GPEI, and the Gates Foundation. What's more, the EU has long been contributing to the strengthening of its partner countries' health systems through its bilateral and multilateral programming. As the cases of Guinea and Ethiopia demonstrate, bilateral programming remains an effective and reliable instrument to respond to countries' priorities and support health systems. The EU should also reaffirm its commitment to multilateral initiatives such as Gavi, whose support to immunisation is key in preventing future disease outbreaks.

As a global health leader, the EU has the capacity and responsibility to make a difference by increasing its contributions to support polio eradication, and by reaffirming its long-term commitment to health by putting greater emphasis on prevention, and more specifically, funding routine immunisation.

# INTRODUCTION

For many, polio is a disease of the past. After the World Health Assembly passed a resolution to eradicate polio, the Global Polio Eradication Initiative (GPEI) was launched in 1988: a public-private partnership led by national governments with six partners, namely the World Health Organization (WHO), Rotary International, the US Centers for Disease Control and Prevention (CDC), the United Nations Children's Fund (UNICEF) Bill & Melinda Gates Foundation (BMGF) and Gavi, the Vaccine Alliance. The collective efforts of partners and donors managed to eradicate 99.9% of the virus.

Poliovirus mainly affects children under five years old and can cause irreversible paralysis in 1 out of 200 cases - even death in the worst-case scenario[2]. Eradication efforts have saved 16 million people and children from paralysis, and saved the lives of over 1.5 million people[3]. Today, there are only a few cases left of one type of wild poliovirus in Afghanistan and Pakistan - where the disease is still endemic - compared to an estimated 350,000 cases in more than 125 endemic countries in 1988[4]. The complete eradication of poliovirus is well within our reach and could represent a historic milestone as the second deadly disease eradicated worldwide, after smallpox in 1980.

However, the COVID-19 pandemic caused massive disruptions to health systems worldwide and led to considerable setbacks in the implementation of routine immunisation activities, including vaccination campaigns. While the world was at a standstill, immunisation rates decreased, and polio cases rose in vulnerable countries - but also in unexpected places. Vaccine-derived polioviruses were detected in London, New York and Jerusalem in 2022, reaffirming what scientists have long known: viruses know no borders[5]. Responding to the COVID-19 pandemic was also a struggle for many countries. Yet, in countries where polio had been a threat, polio infrastructures and polio staff mobilised their know-how to bring a first response to the pandemic, highlighting that the solid network of skills, competencies, and workforce built by the polio communities and GPEI is adept at responding to epidemics and pandemics beyond polio[6].

Since then, world leaders have reaffirmed their commitment to ending polio for good[7,8]. However, the "last mile" has proven hard to reach and faces challenges due to geography, conflicts, poverty, weak health infrastructures, and low immunisation rates. At the same time, circulating vaccine-derived polioviruses (cVDPV) can still spread among communities where the immunisation rates are critically low and can potentially cause paralysis much like the wild poliovirus (WVP). The EU, as a global health leader, has the capacity and responsibility to make a difference by increasing its contributions to the fight against polio, but also by supporting countries' strengthening of health systems and routine immunisation.

# KEEPING POLIO HIGH ON THE AGENDA

Since 1988, the GPEI and other donors have carried out significant work to eradicate WPV and fight cVDPV outbreaks, protecting vulnerable populations against the virus. Eradicating the final 0.1% of WPV cases and stopping the transmission of vaccine-derived poliovirus are now the main objectives of the GPEI. To reach a complete polio-free world, efforts also require sustaining the gains of polio eradication and strengthening health systems worldwide.

## *The triple benefits of investing in polio*

### *Eradicating all remaining forms of polio*

Despite increased efforts and efficient international cooperation, the final steps towards the global eradication of polio seem to be the most difficult. The goal of global polio eradication, originally scheduled for 2023, has been pushed back several times due to multiple challenges, one being the impacts of the COVID-19 pandemic[9].

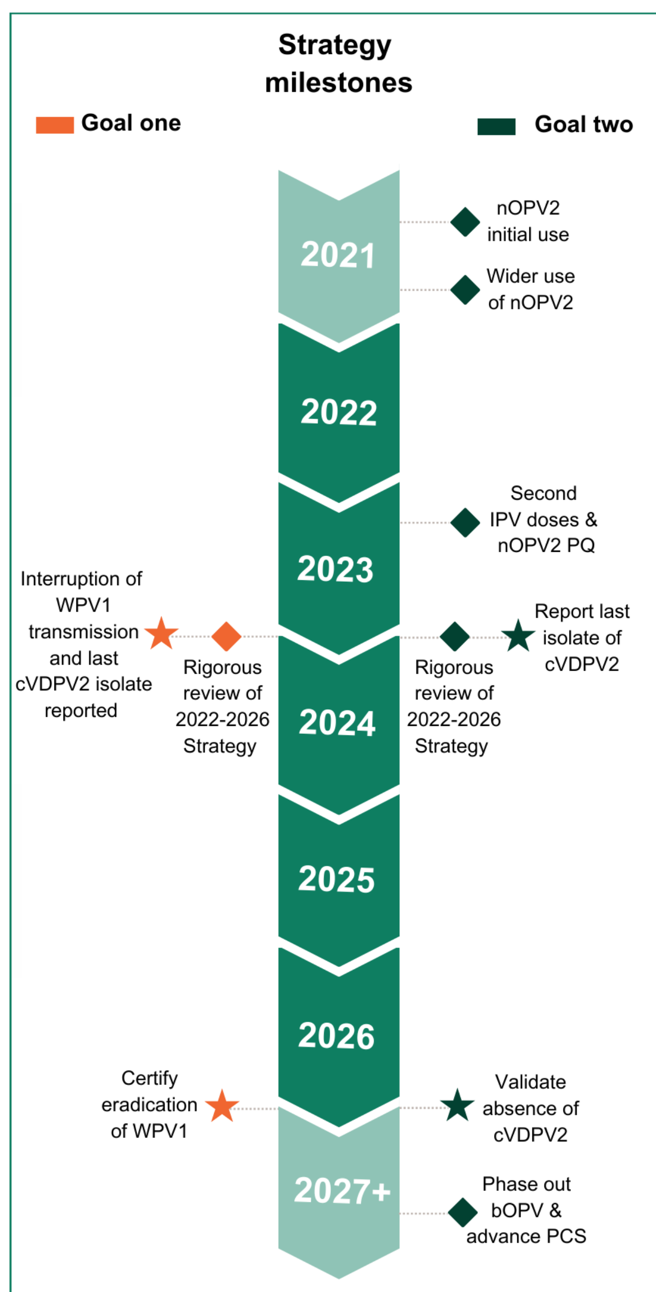
WPV remains a major health concern in Afghanistan and Pakistan. Despite most world countries having been declared WPV-free by the WHO, some are still subject to reinfection. For instance, in Malawi and Mozambique, where there had been no cases of WPV since 1992, the WHO respectively reported 1 and 8 confirmed cases of WPV between November 2021 and December 2022[10].

In 2022, the WHO recorded:

- 30 cases of wild poliovirus globally
- 871 cases of vaccine-derived poliovirus globally

*Source:* WHO AFP/polio data, https://extranet.who.int/polis/public/CaseCount.aspx

However, WPV is not the only source of concern. The circulation of vaccine-derived poliovirus (cVDPV) is now one of the greatest challenges of the fight against polio, and is thus one of the focus of the 2022-2026 GPEI Polio Eradication Strategy[11].




*Source: WHO; Adapted from the Polio Eradication Strategy 2022-2026 planning and budgeting timeline, 2021-2027+ (Global Polio Eradication Initiative)*

Vaccine-derived poliovirus endangers populations and communities with low immunisation rates, including vulnerable people, people living in remote areas, and nomadic populations. As such, polio is a particularly high risk for "zero-dose children", in other words, children who have not received any doses of the recommended essential vaccines[12]. As highlighted by Dr Mohammed

Abdulaziz, Head of the Division of Disease Control and Prevention for the Africa CDC, "Policy makers should not differentiate between WVP or cVDPV. They both need the same weight in prevention and control, and we need to put that on the highest level of priorities."

### Fighting all forms of poliovirus

The eradication of polio in almost all countries has been made possible thanks to the development of efficient vaccines.

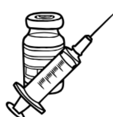
**1 Oral polio vaccine (OPV)**

Composed of attenuated strains of the virus, it stops the transmission of the virus.

+ Easier to administer
+ Less expensive than the IPV

**2 Inactivated polio vaccine (IPV)**

It needs to be injected and prevents people from being paralysed by the poliovirus.



The OPV has been favoured in the fight against polio in many countries and is still used largely by the GPEI to respond to polio outbreaks.*

**The issue at hand**

OPV vaccination has, however, led to the circulation of new strains of the disease, **known as vaccine-derived poliovirus (VPDV)**. These vaccine-derived strains can easily spread among populations with low vaccination rates.

In 2016, the number of circulating VPDV cases exceeded the number of cases due to the wild poliovirus.

**Combatting cVDPV epidemics**

To combat cVDPV, it is necessary to improve vaccination coverage of populations with the oral vaccine (OPV) and introduce the inactivated vaccine (IPV) into routine schedules.

Stakeholders can also switch from the OPV to the **novel oral polio vaccine (nOPV2)**, which protects as well as the previous oral vaccine, while limiting the emergence of cVDPV2 epidemics in low-immunity communities.

This new vaccine got approval from the WHO in 2020 and has since been deployed in many of the Initiative's partner countries.

*Source: GPEI, OPV. Available at: https://polioeradication.org/polio-today/polio-prevention/the-vaccines/opv/*

Polio does not only threaten African or Middle-Eastern countries, where outbreaks are the most frequent. As long as the virus is not fully eradicated, it remains a risk to all, including in polio-free countries if immunisation rates are low. Increased mobility, trade, and migration flows can also facilitate the spread of the disease in previously unaffected areas. In the last two years, traces of vaccine-derived poliovirus were detected in sewage samples in London, in New York, and in the Aceh province in Indonesia, which has been polio-free since 2014. **Polio anywhere is a threat everywhere**: improving polio vaccination coverage through essential immunisation should thus remain a priority for the international community and all global health leaders.

> Until polio is fully eradicated, all countries in Africa remain at risk, as seen with the recent cases in Malawi and Mozambique. And if Africa is at risk for polio infection, the remaining continents will not be protected. COVID-19 has shown us that the world is one village.
>
> *Dr Meseret Zelalem, Lead Executive Maternal, Child and Adolescent Health, MOH Ethiopia*

## *Contributing to stronger health systems*

Investments in polio do not only benefit the fight against this specific disease, but also contribute to supporting health systems strengthening[13].

In more than 30 years of action, the GPEI has helped provide essential polio assets to countries, including tools and functioning infrastructures, knowledge and skilled health workers, and networks of polio community workers which have been established since the beginning of the eradication effort. When integrated by national authorities, these assets contribute to the strengthening of health systems. Safeguarding those assets could thus enable countries to reconcile polio eradication efforts with the strengthening of their health systems as a whole[14].

This process constitutes what the WHO calls polio transition, or, as of October 2023 "sustaining polio investments to build strong, resilient, and equitable health systems"[15].

> It is crucial to mobilise more funding to support activities to combat polio, while strengthening coordination between different actors, taking into account gaps in surveillance, in communication, social mobilisation and in routine vaccination this will contribute to improving vaccination coverage.
>
> *Dr Albert Camara, Deputy National Coordinator of the EPI*

## *Preparing communities for the next pandemic*

The COVID-19 pandemic has highlighted the difficulties faced by health systems around the world in maintaining routine health activities when facing a major global health challenge. It disrupted routine health services and vaccination activities worldwide, contributing to a global decrease in immunisation coverage. Its impact was notably stark on polio circulation: in 2020, 1113 cases of cVDPV were recorded by the WHO, compared to 104 cases in 2018 and 378 cases in 2019[16].

> We need to strengthen community mobilisation at the grassroots level. Beyond polio, this will prepare communities to face all kinds of epidemics.
>
> *Pepe Koivogui, Executive Director of AGIL (Alliance Guinéenne pour les Initiatives Locales)*

Despite this strain on health systems, polio assets have been leveraged by many countries to respond to the pandemic. Polio health workers were for instance involved in the management of COVID-19 cases and disease surveillance activities, specifically thanks to their expertise in the fight against polio[17]. Additionally, infrastructure previously built for polio eradication was reused during the pandemic to manage COVID-19 cases; and the networks of health workers also played a great role in providing health messages to communities to slow down the spread of the disease[18].

## *Routine immunisation and outbreak response: a hand-in-hand approach*

Routine immunisation is a cornerstone of preventing the resurgence of diseases. In 2022, the world experienced several outbreaks of polio, measles, and diphtheria: all three vaccine-preventable diseases, which remain a risk to the lives and well-being of people worldwide[19]. Such outbreaks tend to flare when immunisation rates are low, thus enabling the diseases to spread and contaminate rapidly. Immunisation rates have particularly suffered from the COVID-19 pandemic. While efforts have been made to restore the gains from before 2020, 20.5 million children were still under-vaccinated in 2022, meaning that they did not receive one or more vaccines through routine immunisation services[20].

With higher immunisation coverages, the likelihood of outbreaks is much lower, and this is the case for polio too, especially in countries where the disease has been already eradicated[21]. As highlighted by Stephen Sosler, Head of Vaccine Programme at Gavi, "cVDPV outbreaks [in polio-free countries] usually only take place in places where you have chronically low routine immunisation rates for a long time [...] We need a strong routine immunisation coverage to stay at a zero rate poliovirus, but we especially need a strong routine immunisation to first eradicate and reach that zero." While a targeted response to outbreaks is necessary to prevent the spread of the disease, boosting routine immunisation rates all over requires a longer term developmental approach.

To further improve polio immunisation coverage,

the GPEI has thus been partnering with Gavi to introduce at least one dose of inactivated polio vaccine (IPV) into routine immunisation schedules[22]. The introduction of IPV into the package of vaccine given through routine immunisation activities is key to make sure that every child is protected against polio, and complements the actions of the GPEI in emergency contexts. Yet, support from partners alone will not solve the issue of immunisation rates, which requires that national authorities prioritise routine immunisation in their health policies and budgets. As Dr Mohammed Abdulaziz, Head, Division of Disease Control and Prevention at the Africa CDC states: "Unless over 95% of the population is fully vaccinated, we will not be able to maintain WVP outside of Africa. If we do not work very closely with the Member States to ensure the quality of routine immunisation campaigns, there could be a reintroduction of local transmission of WVP on the continent".

To ensure that polio-free countries can protect the gains of eradication, limit polio outbreaks and better fight outbreaks of other vaccine-preventable diseases, investments in routine immunisation and vaccination are paramount. In Guinea and Ethiopia, two countries that were declared polio-free by the WHO in 2008 and 2017, the low immunisation rates of the population has led to polio outbreaks, leaving them at risk of reinfection.

# Case study n°1: GUINEA

## *At a glance*

Guinea was declared free of wild poliovirus in 2008. Since then, the country remained vulnerable to polio reinfection, with several and frequent reported outbreaks of cVDPV2.

- Guinea has a critically low immunisation rate, which contributes to the prevalence of cVDPV.
- The country's geographical location and territorial features also contribute to the spread of the disease.
- Guinea still suffers from a severe and chronic lack of financing from the government and donors.
- In particular, there is a lack of long-term support on the topic of polio from donors, including from the EU.

# MAINTAINING EFFORTS TO IMMUNISE EVERY CHILD IN GUINEA

Guinea was declared free of wild poliovirus in 2008. Since then, the country remained vulnerable to polio reinfection, with several and frequent reported outbreaks of cVDPV2. National authorities for disease surveillance recorded 43 cVDPV2 confirmed cases in 2020 and 6 cases in 2021, leading the country to organise emergency response campaigns to prevent the virus from further circulating among the population[23].

## *Polio: a deadly symptom of insufficient immunisation rates*

Among the factors that contribute to the prevalence of cVDPV in the country, **the critically low immunisation rate of the population** is one of the most concerning, and many children remain to be vaccinated against vaccine-preventable diseases (VPDs). In 2018, only 24% of children born that year received all recommended essential vaccines, leaving 170,000 "zero-dose children" vulnerable to diseases[24].

Polio is no exception: even though the vaccine has been introduced into routine vaccination activities, many children are not receiving the vaccine and are yet to be immunised against the disease. According to UNICEF, the vaccination coverage for polio in 2022 was lower in Guinea than in the West and Central African Region, which reached 48% and 68% coverage respectively.

> The state and partners have made efforts to ensure that all children are vaccinated in order to break the polio transmission chain. However, there are still children who miss out on vaccination.
>
> *Pepe Koivogui, Executive Director of AGIL (Alliance Guinéenne pour les Initiatives Locales)*

The issue of vaccine hesitancy is also an obstacle to improving vaccination coverage, as highlighted by experts on the ground who stressed the need for action on community mobilisation and raising people's awareness of the importance of vaccination. This is however prevented by the lack of resources allocated to such activities, reducing their efficiency.

## *Territorial challenges to vaccination*

The country's geographical location and territorial features contribute to the spread of diseases. Large-scale international trade and population movements between Guinea and neighbouring countries (like Liberia, Sierra Leone, Senegal or Guinea-Bissau), as well as within the country itself, encourage the circulation of transmissible diseases. The Kankan region, in the eastern part of the country, is a gold-mining zone and attracts people from neighbouring countries which are also subject to polio outbreaks. In addition, the high population density and poor sanitation systems in the major cities, especially in Conakry and its outlying districts, enables the circulation of viruses[25,26].

The low immunisation coverage for vaccine-preventable diseases also stems from territorial inequalities, notably in access to healthcare[27]. The Executive Director of the local NGO AGIL, Pepe Koivogui, highlighted that since health centres tend to be concentrated in urban areas, "urban communities are favoured in terms of access to vaccination services, but the reality in rural areas is quite different", due to the lack of proper structures and services.

The lack of human resources, combined with the poor distribution of human resources further hinders access to healthcare in rural areas[28]. Rural health centres are often understaffed: as such, workers combine duties to not only deliver care but also to roll-out routine vaccination campaigns and to conduct epidemiological surveillance. "In health

centres, it's often just the head of the centre and the EPI agent who support routine vaccination, and that's done with just one motorcycle", explained Pepe Koivugi. During epidemics, health centres are easily overwhelmed, quickly leading to the discontinuation of routine vaccination against VPDs.

Overall, with regards to the challenges faced by the country in immunising its population, Mr Boubacar Sylla, Director of the NGO Club des Amis du Monde, stated that "the cumulative deficits [of the health system] have an impact on the overall effectiveness of the immunisation system, resulting in barriers to the full coverage and effectiveness of immunisation programs". In order for the communities to access health services and vaccination, these issues must be addressed "in a holistic and collaborative manner".

## *Meeting the challenges of the healthcare system: the reality of underfunding*

Though the Guinean government has made the fight against epidemics a priority of its National Health Policy[29] and its National Plan for Health Development[30], more so since the Ebola outbreak of 2014, the country's health system still suffers from a severe and chronic lack of financing coming not only from the government, but also from donors.

Vaccination activities in Guinea - especially targeting people in remote areas and nomadic populations - are costly, requiring health workers to travel to remote areas to vaccinate children. These door-to-door activities require resources, such as vehicles and equipment to maintain the cold chain during vaccination campaigns, and significant human resources to maintain the day-to-day provision of health care in health centres during campaigns.

These costs are often not covered due to a lack of financial resources. The whole health system in Guinea is in need of funding to be able to reach the objectives which have been set by the government over the years. **For instance, the estimated funding gap for the implementation of the National Health Development Plan is 60% for 2023 and 62% for 2024[31].** Guinea struggles to mobilise domestic financial resources to fund its health system. The main source of funding for the health system is out-of-pocket costs for patients, representing 62,2% of health funding, which places a heavy burden on the population[32].

*Community health worker vaccinating children against polio at the Niantanina health centre in the Mandiana health district, Guinea © Dr Mamadou Kaba Sow*

## *Inadequate and insufficient support from partners*

The Ministry of Health relies heavily on external financial partners to finance the health system: more than one quarter of health expenses come from external funding[33]. However, this financial support is not enough: the existing gaps in the national health system are too big to be covered by external funding alone.

Likewise, financial support from partners for polio eradication is often dedicated to organising emergency response campaigns following an outbreak. These campaigns, which are crucial to combat the spread of polio, operate on a short-term basis and solely focus on fighting this

specific disease. For instance, in 2022, over 38% of the GPEI's funds were allocated to emergency responses for polio outbreaks[34]. At the same time, routine immunisation activities remain underfunded and health centres understaffed, which hinders the country's capability of dealing with these outbreaks itself. To support the country's immunisation, Gavi and the GPEI have been working together to introduce IPV into routine immunisation activities in Guinea.

Guinean authorities have expressed regrets at the lack of long-term engagement from partners who usually engage resources for short periods of time, often not exceeding 3 years[35]. This time frame does not allow national authorities to plan long-term health reforms and policies, and increases uncertainty regarding health expenditures. Yet, the fight against polio is one that requires long-term and continuous funding to ensure that eradication efforts are well integrated by national authorities and contribute to building a strong and resilient health system.

Additionally, the authorities bemoan the lack of integration of partners' interventions into existing healthcare activities, which does not help to "rationalise the use of resources and the efficiency of the health system"[36], and the fact that partners do not systematically take into account the countries' priorities when allocating funds. As highlighted by Dr Mamadou Bah, Chief of the Immunisation section from the EPI: "Partners often have a budget for each country, and the country is obliged to follow the dictates of the partners instead of taking into account the real needs of the districts for a better campaign, or to have vaccinated all the children wherever they live". In a country like Guinea, where the immunisation rate of its population is a major health concern, funding from partners should be better tailored to meet the country's health challenges and long-term needs.

## *The EU's support to health in Guinea*

In the fight against polio in Guinea, the European Union indirectly contributes to strengthening vaccination capacities. This is notably illustrated by the EU's support to Gavi, who has worked in Guinea to introduce the first dose of inactivated polio vaccine (IPV) into routine immunisation schedules[37], and by two specific projects: PASA (2013-2017) and PASA 2 (2019-2023), funded through the European Development Fund (10th and 11th EDF), with a total of €43 million directly funded by the EU[38]. With these projects, the EU has been supporting decentralised health structures by providing equipment and infrastructures, staff training, and helping local authorities manage resources. In addition, the EU's support to governance in Guinea should also contribute to improving the management of domestic resources, including in health, which would ultimately benefit the healthcare system[39].

The Multiannual Indicative Programming (MIP) for the 2021-2027 period includes a health objective, namely to "promote access to quality healthcare for the Guinean population, in particular for maternal, child and reproductive health". Yet, the Annual Action Plans (AAPs) for the years 2021-2023 have not supported actions dedicated to health and immunisation, two sectors identified by the national authorities as a major health issue[40].

The EU has previously supported the country with emergency funding. In 2021, it provided €3.2 million for the immediate response to the Ebola outbreak[41], and a further €6 million for the response to the COVID-19 pandemic[42]. The EU's support has been valuable in responding to these crises, but **long-term funding remains necessary to improve the country's capacity to fight diseases, in addition to investing in emergency responses to specific crises**. However, little information is available on the continuation of the PASA projects. With the upcoming MIP review, the EU has the opportunity to keep supporting health projects in Guinea. The financial allocation of the MIP is not yet known for the 2024-2027 period, but given the challenges on the ground, health *should* feature among its priorities.

Overall, efforts to eradicate polio in Guinea are mostly hampered by the challenges faced by the national health system, which prevent the country from maintaining its immunisation levels. These challenges, combined with a lack of domestic financial resources, have led the country to become heavily reliant on external financing, not only for polio eradication but also for the provision of healthcare in general.

# Case study n°2: ETHIOPIA

## *At a glance*

Porous borders, displacements of population and armed conflicts have created a favourable environment for polio outbreaks in Ethiopia.

- The existing funding gap remains the most consistent challenge in protecting the gains of polio eradication.

- Since wild poliovirus has been eradicated in Ethiopia, funds - especially from donors - have decreased, leaving few resources for prevention.

- The EU has been a strong actor in supporting the country's health system, yet more can be done in the coming years to support the country's health infrastructures and protect the existing advances.

# PROTECTING THE ADVANCES IN POLIO ERADICATION IN ETHIOPIA

Ethiopia was certified WPV free in 2017, but several natural and man-made disasters, including a two-year civil war, have weakened the health system and made the country vulnerable to reinfection. This worrying threat requires the attention of the national authorities and the focus of international partners. As Ethiopia was selected by the WHO as a priority country for polio transition, it provides an opportunity to examine how a polio-free country, at risk of reinfection, is working to build on its polio assets to strengthen its health system.

## *A country at a crossroads of challenges*

In the last few years, Ethiopia has been faced with a number of issues, such as armed conflicts, natural disasters, or the COVID-19 pandemic, which have weakened the already underfunded health system[43] and challenged the gains made in polio eradication. The lack of consistent and long-term funding dedicated to polio, combined with the progressive disengagement of international partners, has had further negative repercussions on the fight against the disease.

### *An environment conducive to the development of diseases*

Due to its geographical situation, Ethiopia faces specific challenges which make sustaining the gains of polio eradication and delivering immunisation a difficult task. Its porous borders with neighbouring countries - whose health systems are also weak - creates a favourable environment for the virus to be imported from abroad, and its position as an air traffic and trade hub challenges its surveillance capacity. According to the Poliovirus Outbreak Response Assessment (OBRA) assessment[44] deployed in July 2023, in the past two years, 35 polioviruses were detected in Ethiopia's neighbouring countries, which are facing cases of vaccine-derived polio outbreaks. The porous borders and the displacement of populations have made zones bordering Kenya, Somalia, South Sudan, Eritrea and Djibouti at high risk for importation or transmission of the virus. The latest cVDPV outbreaks occurred in 2020 and 2022 in Ethiopia, and were linked to cases outbreaks in other countries, although as of October 2023, no further cases nor samples have been detected[45].

### *Protecting healthcare in times of conflict*

The conflicts across the country have also tremendously damaged health systems. Destroyed infrastructures and facilities have prevented the rollout of vaccination campaigns and the ability to provide care, with fewer workers available to carry out operational activities. Due to insecurity, vaccination campaigns were not rolled out in some parts of the country between 2021 and 2023[46]. This is particularly concerning for fragile and hard-to-reach regions, which makes the need for rehabilitation of infrastructures and facilities crucial to allow routine immunisation and polio campaigns to take place again.

Additionally, the conflict also halted the country's polio transition plan[47]. Initially drafted by the government with the support of UN agencies and the CGPP, it should have allowed the transition to be completed by 2026. The plan was requested after the WVP-free certification and planned for 2022-2026, but the war in Tigray, the COVID-19 pandemic, and other cumulative emergencies put the plan on hold, making the transition difficult.

> We cannot yet eliminate the current emergencies; it will take some time. And if polio transitions to the government now, it will be another burden for us to manage.
>
> *Mikias Alayu, Team Lead - VPD Surveillance and Response, EPHI*

This multiplication of priorities and emergencies, as well as difficulties in resource allocation, have prevented the government from taking full ownership of this transition. It is expected that the draft plan will be revised and updated to better reflect the current situation. For Darcy Levison, Technical Officer for the Polio Transition Programme at the WHO, it is essential to offer "an intermediate solution for countries, where responsibility for essential functions is not immediately transferred to the governments", but where the WHO or other partners can still provide support until the capacity of national health systems is strong enough to take over the financial and technical aspects.

### *The impacts of the lack of resources*

Currently, the country only has one national polio lab, the Ethiopian Public Health Institute (EPHI) national laboratory, which the OBRA assessment found to be "*deteriorating*". The assessment recommended the construction of a new lab, equipped with adequate supplies, which the existing EPHI laboratory is currently lacking. This hampers surveillance activities, which became suboptimal due to a workforce shortage, a technical gap in vaccine management and surveillance capacities, and inconsistent - and sometimes unreliable - data collection.

These issues are, in part, attributable to the significant funding gap, which remains the most consistent challenge in protecting the gains of polio eradication. The lack of funding impacts the state of the polio workforce, the infrastructures and supplies, and overall, has reduced the government's capacity to ensure that polio remains eradicated in Ethiopia, as well as its capacity to respond to other disease outbreaks. With the needs being much higher than the resources, there is a clear need to mobilise additional resources before the situation further deteriorates.

## *An increasing gap between the needs and the means: the case for long-term support*

The needs for immunisation are not only relevant for polio. Indeed, overall immunisation coverage of the population is suboptimal, creating significant gaps. The increase of other parallel outbreaks, including cholera, measles, yellow fever, dengue and malaria, is an additional challenge and also risks creating competition, both for political attention and resources. For this reason, integration is paramount when looking at immunisation. Yet, since polio has been *officially* eradicated, funds have decreased, leaving few resources to conduct preventive campaigns and ensure that the coverage remains optimal.

### *No cases, no money?*

The absence of cases - while a positive sign at first glance - also creates a paradoxical effect where donors' and the government's focus decreases.

> "In many countries, when you report a case, there is high energy to work on the case and respond to it. But when you don't have any reported case for six months or a year, the donors' and the country's energy goes down. The rationale becomes: if we don't have any cases, why is it a concern? It's not an emergency."
>
> *Dr Parvez, Polio team lead, UNICEF*

Support is needed even when there are no cases, to support the polio campaign continuously in the long-run. When the Ministry of Health requested a preventive polio campaign to the WHO, it was not given the funds to carry it out: "they only had an outbreak response budget for cVDPV 2, and we were requesting a preventive campaign for WVP", said Dr. Zelalem, Maternal, Child and Adolescent Health Lead (Executive Office) at the Ministry of Health.

cVDPV2 outbreaks were reported in the Tigray region in 2021, and in the Amhara region at the end of 2022 - but the response to these cases was largely delayed due to security reasons (for the former) and expired vaccines (for the latter)[48]. The OBRA assessment further states that, "since not

all outbreak responses were executed as planned and there were observed gaps in the quality of conducted responses and Routine Immunisation, the mission is not confident that the overall population immunity is adequate to stop the Poliovirus circulation from re-establishing."

This has been echoed by Dr. Chaudhary Modh Parvez Alam, polio team lead at UNICEF: "In the recent past, there has been reported cVDPV2 cases in neighbouring countries. We are facing high migration from the neighbouring countries due to ongoing conflict, and we also haven't managed to respond to the last two reported cVDPV2 polio cases in Ethiopia. There are high chances of getting some more cases in the near future in Ethiopia. The short-term support is not helping us, we need long-term support." UNICEF supports the polio response in Ethiopia, notably through staff support, financial support and technical expertise.

### *The shortcomings of short-term funding*

UNICEF receives funding from the GPEI for a six-month period, followed by another six months of assessment. This short-term management challenges the ability to hire qualified staff and to train them adequately. According to Dr Parvez, "If you're going to hire someone, you can only pay them for six months. But the issue is also the training: it takes time before the workers can go on the field. If one or two months go into training, there are only five or four months of work, and the expectations are high."

The same issue is also being highlighted by other core GPEI partners. "The scaling down of funds for polio has also affected the activities of the WHO, who had to reduce its staff", says Dr Abay Gebrekidan, National Professional Officer for Immunization at the WHO. "We're towards the end of [polio eradication], but there are so many challenges left and the reduction of funds is really affecting countries." Rotarian Teguest Yilma, Chair of the National PolioPlus Committee in Ethiopia, further notes that "the last mile is the most difficult one. The lack of funds and resources creates a void that leads to losing the progress made so far. Even if outbreaks are identified, it can be hard to respond in time".

*Staff from the polio team at UNICEF Ethiopia, in Addis Ababa © Global Health Advocates*

For all stakeholders, there is a critical need to keep on consistently funding polio prevention and sustain resources in the country even when there are no outbreaks, not only to prevent outbreaks from happening but also to build on the gains of polio eradication.

## *The EU's support to the health system in Ethiopia: restoring health gains*

The Delegation of the European Union to Ethiopia has been a strong actor in supporting Ethiopia's health systems - including before, during, and after the conflict in Tigray.

### *The EU's bilateral investments in health in Ethiopia*

In 2014, the European Commission's National Indicative Programme for Ethiopia, which defined

the general orientations for cooperation between the EU and Ethiopia for the period 2014-2020, had already identified health as a focal sector and endeavoured to "improve health outcomes for all"[49]. The following Multiannual Indicative Programme (MIP), for the period 2021-2027, was drafted and ready for adoption when the war in Tigray erupted in November 2020, putting the process on hold. Instead, the EU adopted Individual Measures which targeted specific needs, including health.

As part of these individual measures, a total of €39,5 million was allocated to health, and was focused on restoring essential health services in conflict-affected areas, through rehabilitation by: i) restoring the health gains and focusing on women and girls, ii) reducing inequalities in health service delivery and utilisation, and iii) strengthening the quality of healthcare at all levels of service delivery tiers[50]. The EU had also been providing funding to the country through budget support, but due to the war, it "froze budget support operations to avoid contributing to Ethiopia's war economy", and budget support should not resume "until clear progress is reported on accountability of human rights abuse"[51].

Nonetheless, the EU remains an active partner in the country: the Individual Measure action complemented the "Social Determinants for Health for Gender Equality" project, which was financed through the European Development Fund for €25 million for the period 2021-2024. The EU also collaborates with different actors, like Member States - including Spain and Italy - to support workforce training in medical specialities, with Expertise France on supporting the rehabilitation of hospitals, and with UNICEF on health facilities and immunisation[52].

## *Looking ahead: strengthening health systems to protect the advances*

At the time of drafting this report, the 2024-2027 MIP for Ethiopia has just been published and reaffirms health as one of the priority areas. While none of these actions and investments target the sustaining of polio eradication gains specifically, the strengthening of health systems is integral to keep on delivering routine immunisation and ensuring that outbreaks do not happen. Habtamu Adane, Health Programme Manager at the EU Delegation to Ethiopia, shared the concern that the impact of the pandemic and the conflict in the country could put the health gains Ethiopia has achieved so far at risk. The priority is thus to protect these gains through health system strengthening and rehabilitation of health facilities damaged or affected by the conflict.

As part of its commitments to global health and to the strengthening of health systems worldwide, the EU has been a major contributor to the Pandemic Fund, established in 2022, whose goal is to mobilise additional resources for pandemic prevention, preparedness, and response (PPR) in low- and middle-income countries[53]. These resources should contribute to strengthening disease surveillance, laboratory systems, and human resources: all which are important to tackle and respond to polio outbreaks. Ethiopia was selected to receive a $50 million grant from the Pandemic Fund, supported by an additional $63 million in co-financing, for the establishment of the "Ethio-Pandemic Multi-Sectoral Prevention, Preparedness, and Response Project" (EPPR). The EPPR "aims to strengthen surveillance systems, enhance the national laboratory system, and ensure the availability of skilled and competent One Health professionals for a sustainable and functional public health system to enable prevention, detection, and response to pandemics"[54]. The project could thus contribute to supporting the core functions of the polio surveillance and response system.

*In Guinea and Ethiopia, the EU has proved to be a major partner in helping both countries to face the challenges met by their health systems. But as a major leader in global health, the EU can do more to support the gains of polio eradication.*

# AFFIRMING THE EU'S LEADERSHIP IN GLOBAL HEALTH BY SUPPORTING IMMUNISATION

The European Union has been a major player in the field of global health, and has played a key role in the fight against polio as a historical contributor to the GPEI. In November 2022, the European Commission reaffirmed its ambition to remain such an actor and contributor through its new Global Health Strategy by continuing to "lead the fight against a range of communicable diseases, especially [...] poliomyelitis"[55].

To this end, and with the goal of "investing in the well-being of all people and reaching universal health coverage with stronger health systems", the Commission seeks to "prioritise global health across all relevant EU budget financing programmes". The EU's contributions to the strengthening of its partner countries' health systems through its bilateral and multilateral programming remains an effective and reliable instrument to respond to countries' priorities and support health systems.

With regards to this commitment, this section examines whether the EU possesses the resources to meet the current challenges of polio eradication, not only to support the efforts in endemic countries, but also to meet the challenge of sustainability. As the country case studies in Guinea and Ethiopia highlighted, progress in immunisation is fragile, and the world will not be protected against setbacks until polio is fully eradicated. With the Strategy's goal of "better prevent[ing] and be[ing] more resilient to face pandemics", the EU should examine how to sustain the gains of polio eradication in the long-term.

## *The EU's support to health through the NDICI*

The Neighbourhood, Development and International Cooperation Instrument (NDICI) – Global Europe Instrument[56] aims to support countries most in need to overcome long-term development challenges in the framework of the EU's external action. The NDICI funds the EU's actions in human development, which includes health, through two channels: thematic and geographic, and both are fundamental to deliver the EU's support. With a budget of €60.39 billion, the geographic pillar allows the EU to foster dialogue and cooperation with third countries and to deliver a response adapted to the priorities of the third countries while reflecting the EU's strategic priorities. The thematic pillar, with a budget of €6.36 billion, is in turn critical to finance global health initiatives.

Both are equally important to ensure that the EU is capable of supporting its partners and their priorities, and to contribute to global health initiatives as a major global health actor. To respond to the challenges of eradicating polio and sustaining the gains of its eradication, the EU should use these instruments effectively to deliver relevant and adequate funding and respond to specific priorities.

## *Investing in bilateral support to health to strengthen immunisation*

The EU's impact on the ground when it increases its bilateral support to health in third countries is indisputable. As seen in Ethiopia and in Guinea, the EU's contribution to the strengthening of health systems through different actions, helps to provide better access to care for all and indirectly reinforces countries' capacities to face disease outbreaks like polio. It is thus crucial that the EU leverages its bilateral programming to enhance the delivery of accessible healthcare in its partner countries, particularly in those with the weakest health systems.

Historically, the allocation of EU bilateral ODA to health has been very low: between 2017 and 2020, it ranged between 2,4% and 4%. The EU's current programming cycle was adopted in the midst of the COVID-19 pandemic, and it was expected that health would feature prominently among the EU's priorities and financing. This was not the case: in

2021, only 4,81% (€770 million) of the EU's bilateral ODA was dedicated to health, which remains too low to deliver on the EU's commitments[57]. Furthermore, in most sub-saharan African countries - where the health needs are the highest - health was surprisingly not identified as a key priority in their bilateral cooperation with the EU, since out of 46 countries in the region, only 17 featured specific objectives related to health.

And yet, when the EU provides substantial support for health to its partner countries, it benefits the partners' health systems as a whole. With the current review of the MIPs, increasing the funding allocated to health and further including health in the programming for countries with weak health systems is an opportunity to deliver on the EU's commitments to global health, and to reaffirm its role as a credible partner.

## *Committing to global health initiatives for a healthier world*

The current NDICI was adopted in the midst of a pandemic which claimed millions of lives. Everywhere, the health and economic crisis revealed and exacerbated the inequalities of access to the most basic services such as health, education, water, sanitation and hygiene or even social protection systems.

The COVID-19 pandemic brought to light the chronic lack of funding affecting these basic social services, a disinvestment that goes back several decades. In this context, relying on geographic programming to deliver on human development is not enough, and must come with support to global health initiatives which contribute to the production and delivery of vaccines and vaccination campaigns, the strengthening of surveillance and health systems, and the quality of supplies and infrastructures.

Over the years, the EU has been a long-standing partner in the fight against polio, having consistently contributed to the GPEI between 1985 and 2021, although the amount of its contributions is lower than other donors, putting it in 6th place after the USA, the UK, Germany, Canada and Japan[58]. Its other contributions to the WHO, UNICEF, and Gavi, have been significant investments in routine immunisation and polio eradication.

| ***Date*** | ***EU contribution to GPEI*** *(in USD million)* |
|---|---|
| 2012 | 7.39 |
| 2013 | 3.05 |
| 2014 | 10.87 |
| 2015 | 12.63 |
| 2016 | - |
| 2017 | 16.11 |
| 2018 | 17.18 |
| 2019 | - |
| 2020 | - |
| 2021 | - |
| 2022 | 21.71 |

*Source: GPEI Historical contributions*

In previous years, the EU's budget dedicated to external action in general, and human development in particular, has been stretched thin, in part due to unforeseen crises, leaving little room for the EU to make polio eradication a priority. However, the EU already supports other global health initiatives, which in turn helps with supporting health systems, surveillance activities, and delivery of vaccines for immunisation.

For instance, the EU has been a significant contributor to Gavi, the Vaccine Alliance. In 2020, during the last replenishment, the European Commission contributed €300 million to Gavi for the period 2021-2025, marking a 50% increase in the Commission's commitment compared to the previous period[59]. With the next Gavi replenishment taking place in 2025, the Commission has the opportunity to reaffirm its commitment to the strengthening of health systems and the production and delivery of life saving vaccines.

With the COVID-19 pandemic, the EU has also sought to invest in instruments to improve pandemic preparedness and response. In 2022, it has pledged €427 to the Pandemic Fund, which should contribute to strengthening disease surveillance, laboratory capacity, and public health workforce. While framed within the broader objective of bringing resources for pandemic prevention, preparedness, and response (PPR),

these activities could directly benefit countries' capacities to respond to polio outbreaks.

The EU Global Health Strategy reaffirms the EU's support to Gavi and the Pandemic Fund, among others, but it also embraces "a new approach, involving innovative finance"[60]. As such, in October 2023, the EU entered a new agreement with the European Investment Bank (EIB) and the Bill and Melinda Gates Foundation (BMGF), with the goal of helping get rid of polio once and for all.

## *A renewed promise through an innovative partnership*

On October 11th 2023, the European Commission, the EIB and the BMGF announced "a new financing partnership" to global health efforts, which includes a renewed commitment to the fight against polio. The expected €1.1 billion financing package includes €500 million to be delivered to the GPEI, specifically to the WHO and UNICEF to "cover polio vaccinations for nearly 370 million children annually, deliver vital health services to children alongside polio campaigns [...] and strengthen health systems to better prepare and respond to emerging health threats"[61]. Focusing on Low and Lower Middle Income Countries (LIC/LMICs), the partnership should cover the full geographic scope of GPEI activities, targeting outbreak countries and endemic countries.

The €500 million delivered to the GPEI will thus contribute to eradicating wild poliovirus in endemic countries, and to stopping cVDPV transmission. At the time of drafting this report, further details of the instrument are not yet known. A number of questions remain, notably on whether a strong monitoring and accountability framework will be developed to ensure that the instrument enables recipient countries to respond to their health priorities, strengthen the delivery of their routine immunisation, and scale-up their capacity to fight VPDs, including polio.

It is also unclear how the programme will support routine immunisation and contribute to the strengthening of vaccination systems in countries where wild poliovirus is non-endemic. In addition, funding is still sorely needed to help countries integrate and properly use the polio assets and functions to strengthen their health systems beyond disease outbreaks. This should be considered in the partnership, to help countries tackle the polio threat beyond eradication in endemic countries.

The signing of this partnership is welcome, as it brings back the EU as a leader in the fight against polio. Nevertheless, it is crucial that the EU's investments in health do not solely rely on innovative partnerships. Notwithstanding innovative instruments, EU bilateral ODA remains one of the best ways to deliver health financing where it is most needed, while helping governments and countries to strengthen their health systems. The EU's programming is not designed to target a specific disease, but supporting the strengthening of health systems and of Primary Health Care (PHC) and Universal Health Coverage (UHC) benefits the fight against all diseases, especially vaccine-preventable diseases like polio. The EU's support to health through both bilateral and multilateral channels remains a reliable and efficient way of contributing to health system strengthening and it should be reinforced.

# OUR RECOMMENDATIONS FOR THE EUROPEAN UNION

The EU, as a leader in global health, can make a significant difference and make the world a safer, healthier place. As such, it is essential that the EU keeps on supporting efforts for polio eradication, while putting an equal focus on long-term approaches centred around improving overall immunisation rates of the population.

**Thus, we call on the EU to:**

1. **Scale-up its support and actions** related to human development, and especially health, in the 2024-2027 **Multiannual Indicative Programmes** (MIPs) and **Annual Action Plans** (AAPs), and **increase the funding** of long-term actions dedicated to health, including immunisation, when drafting the next MIPs, through:
   - Helping train local staff,
   - Strengthening routine immunisation,
   - Supporting infrastructures where needed.
2. **Financially commit** to relevant Global Health Initiatives, like **Gavi, the Vaccine Alliance** and the **GPEI**, in the upcoming replenishments, by matching or exceeding its previous commitments, and committing to supporting the transition programmes and endeavours where relevant.
3. Ensure that the EIB innovative financing instrument **demonstrates accountability and transparency** and that it enables the strengthening of immunisation in recipient countries.
4. In the context of the multiplication of global health initiatives and funds, **encourage** the improvement of existing global health mechanisms to **maximise resource efficiency when tackling epidemics** and vaccine-preventable diseases, including polio.
5. **Encourage all relevant partners** to provide **long-term and continuous funding** to countries that are at risk of reinfection, including through preventive campaigns, and to support national systems in charge of routine immunisation.
6. **Support partner countries** in managing and increasing **domestic resource mobilisation** for health.

# APPENDIX: LIST OF INTERVIEWEES AND ORGANISATIONS

| Name | Organisation | Job title |
|---|---|---|
| **Guinea**[62] | | |
| Dr Albert Camara | Ministry of Health and Public Hygiene, Extended Programme on Immunisation | EPI National Coordinator |
| Dr Bah Mamadou Dian | Ministry of Health and Public Hygiene, Extended Programme on Immunisation | EPI Chief of the Immunisation Unit |
| Dr Sékou Solano | World Health Organisation Guinea | Surveillance Officer |
| Dr Landho | World Health Organisation Guinea | GPEI Coordinator |
| Dr Kpoghomou Gnanga | Ministry of Health and Public Hygiene | Community health agent |
| Pepe Koivogui | NGO AGIL (Aliance Guinéenne pour les Initiatives Locales) | Executive Director |
| Aboubacar Sylla | NGO Club des Amis du Monde | President |
| Dr Balde Boubacar | Guinean Red Cross | Chief of the health department |
| Enrico Colombo | EU delegation in Guinea, Conakry | Responsible of the health portfolio |
| Jacqueline Aribot | Club Rotary Guinea | President of the National PolioPlus Committee |
| Caroline Comiti | French Embassy in Guinea | Regional Global Health Advisor, responsible for Guinea |
| **Ethiopia** | | |
| Mikias Alayu | Ethiopian Public Health Institute | Team Lead, VPD Surveillance and Response |
| Sacha Bootsma | World Health Organisation - Health Cluster | Health Cluster Coordinator |
| Dr. Abay Gebrekidan | World Health Organisation - Ethiopia Country Office | National Professional Officer/ Immunization |
| Dr. Chaudhary Modh Parvez Alam | UNICEF Ethiopia | Polio Team Lead \| Health Section |
| Teguest Yilma | Rotary | Chair of the National PolioPlus Committee in Ethiopia |
| Dr. Meseret Zelalem | Ministry of Health | Maternal, Child & Adolescent Health Service Lead Executive Officer |

| | | |
|---|---|---|
| Yohannes Lakew | Ministry of Health | EPI Advisor |
| Melkamu Ayalew | Ministry of Health | Head of Immunization Service Desk, EPI Manager |
| Aleksandra Tor | Delegation of the European Union to Ethiopia | Programme Officer, Civil Society and Gender |
| Habtamu Adane | Delegation of the European Union to Ethiopia | Health Programme Manager |
| Tekalgn Hailemariam | Ethiopian Orthodox Church Development and Interchurch Aid Commission (EOC-DICAC) | Health, polio and nutrition coordinator |
| Mahdi Bekri | Organization for Welfare and Development in Action (OWDA) | OWDA/CGP Polio Project Coordinator |
| Filimona Bisrat | Core Group Polio Project (CGPP) | Ethiopia Secretariat Director & Senior Regional Technical Advisor |
| Legesse Kidanne | Core Group Polio Project (CGPP) | Deputy Director |
| Dr Ngashi Ngongo | Africa CDC | Chief of Staff and Head of Executive Office |
| Dr Mohammed Abdulaziz | Africa CDC | Head, Division of Disease Control and Prevention |
| Senga Sembuche | Africa CDC | Technical Assistance Team Lead |
| George Momanyi | Africa CDC | Programme Development & Project Design Specialist |
| Sarah Rueda | Embassy of France in Ethiopia and to the African union | Regional Advisor for Global Health (Ethiopia, Djibouti, Sudan, South Sudan, Eritrea, African Union) |
| Tito Rwamushaija | Gavi, the Vaccine Alliance | Senior Country Manager Ethiopia |
| ***Global experts*** | | |
| Clarisse Loe Loumou | CSO Working Group on Polio Transition-UN Foundation | Chair |
| Darcy Levison | World Health Organisation - Polio Transition Programme | Technical Officer |
| Stephen Sosler | Gavi, the Vaccine Alliance | Head of Vaccines Programme |
| Bernd Appelt | European Commission - DG for International Partnerships | International development cooperation officer (unit G4) |

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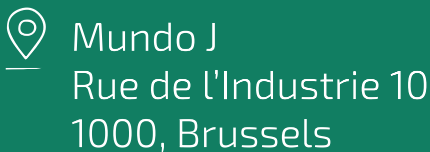
Mundo J
Rue de l'Industrie 10
1000, Brussels

www.ghadvocates.eu

info@ghadvocates.org

+33 (0)9 81 85 33 16

@GHABrussels