Global Polio Eradication Initiative

Partnership profile

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Summary

Short description

In 1988, the World Health Assembly (WHA) adopted the eradication of poliomyelitis (polio) as a public health target. This led to the creation of the Global Polio Eradication Initiative (GPEI). The GPEI is led by national governments and four spearheading partners:

- World Health Organization (WHO)
- United Nations Children's Fund (UNICEF)
- Rotary International
- US Centers for Disease Control and Prevention (CDC)

The GPEI is one of the largest Global Public-Private Initiatives (GPPIs) or public-private partnerships for health in the world.

The main strategy for polio eradication is vaccination of all children. The vaccine used to this end in developing countries is Oral Polio Vaccine (OPV). OPV is easy to administer and relatively cheap. In developing countries where routine immunization programmes are lacking, polio vaccination is implemented through National and/or Sub-National Immunization Days (NIDs and SNIDs). These are single-day mass vaccinations campaigns, involving the mobilization of millions of volunteers to reach all children.

The annual number of detected polio cases has been reduced from 350,000 in 1988 to less than 800 in 2003. Over the same period, the number of polio-endemic countries decreased from more than 125 to only six: Nigeria, India, Pakistan, Niger, Afghanistan and Egypt.

Partnership policy

The GPEI gradually evolved and a broad-based GPPI was not anticipated at the outset. First, Rotary International started its own programme in 1985 called PolioPlus to raise funds for the procurement of OPV. However, it was soon realized that the distribution and administration of OPV needed more attention. Rotary International, the WHO and UNICEF started working together and the CDC joined in the mid-1990s. There has never been a formal agreement about the tasks and responsibilities of different partners in the GPEI. Nonetheless, there seems to exist a broad consensus about partners' roles.

The **WHO** is the lead organization of the GPEI and provides overall technical direction and strategic planning. It is responsible for implementation and monitoring of the GPEI Strategic Plan and has a lead role in resource mobilization, donor coordination, advocacy and public communications.

A main role of **UNICEF** is the procurement and distribution of OPV. It also provides technical assistance to developing countries and supports advocacy and communications.

The **CDC** is a main financial donor and provides technical expertise. It conducts research on polio immunization policies and seconds scientific staff to the WHO, UNICEF and polio-endemic countries.

Rotary International provides large funds. Later on, lobbying for donor government support became a major role too. Members of the Rotary use their personal networks to mobilize volunteers for NIDs.

The vaccine industry (five major corporations worldwide) has an important role as well. It has to maintain sufficient manufacturing capacity for OPV until polio eradication. After that, OPV will no longer be demanded.

GPEI partners perceive that the added value of the partnership is high. The GPEI is in the first place a partnership between funding and implementing organizations, so the added value mainly consists of large additional resource mobilization. There are complementarities among organizations in the

implementation of polio eradication activities too. However, these are secondary to the complementary roles of funding and implementing organizations.

Funding and OPV donations

Apart from the CDC and Rotary, major GPEI donors are the World Bank and the governments of the UK, Japan and The Netherlands. Some contribute to the WHO and UNICEF, others make bilateral contributions to poor countries. At present, annual budgets of the GPEI are $300-400 million. Total external financial contributions for the period 1988-2005 amount to $3 billion.

Although the GPEI has a large budget for vaccine procurement, the WHO requested OPV donations from manufacturers because funds were still insufficient. Companies that made donations include Aventis, Chiron and GlaxoSmithKline. The OPV donations were small compared to total OPV use. For example, in 1999 Aventis signed a tripartite Memorandum of Understanding with the WHO and UNICEF for a donation of 50 million OPV doses over three years, while it sold 275-300 million doses annually. Global OPV production, all of which was purchased for the GPEI, was about 2 billion doses per year. Aventis explained that it would not be able tot sustain the donation of its entire OPV production, as the WHO requested.

The procurement value at preferential prices of 50 million doses of OPV, one of the largest company donations, was about $4 million. In financial terms, the private sector component of the GPEI therefore mainly consists of contributions from private foundations, not from individual companies. Some indicate that donations to the GPEI may be relatively unattractive for companies, because they cannot become major partners. Other GPPIs like the Global Alliance for the Elimination of Lymphatic Filariasis (GAELF) and WHO Programme for the Elimination of Sleeping Sickness (WPESS) have obtained much larger donations from companies.

Integration into health systems

The vertical approach of NIDs, focussed on one disease and weakly integrated into the national health systems in developing countries, has been criticised because it would be drawing resources away from these systems instead of strengthening them. In contrast, GPEI partners perceive that focussing on the clear target of polio eradication has been beneficial and helped to mobilize resources. Hence, conflicting perceptions exist about the desirability of a narrow programme with high-profile goals.

Governance

The GPEI is governed in an informal way by the four spearheading partners, with the WHO in a lead role. There are bi-annual meetings with high representatives. The partnership does not have a board, but there exist several management and advisory groups. Among them is the Technical Consultative Group (TCG), which provides technical advise and supervises research and strategic planning. The Interagency Coordinating Committee (ICC) coordinates the input of partners and assists countries with the management of polio eradication activities. Partners indicate that the GPEI is functioning well and that there is no need for a more formal governance structure. Companies do not have a role in the governance of the GPEI. A special committee of the WHO reviews all offers for donations from companies on potential conflicts of interests.

External transparency about governance of the GPEI, advisory bodies for polio eradication, and the conditions for OPV donations is very low. This cannot be fully explained by the GPEI's informal governance structure.

Contents

List of acronyms

AACPE	Ad Hoc Advisory Committee on Poliomyelitis Eradication
CDC	US Centers for Disease Control and Prevention
GAELF	Global Alliance for the Elimination of Lymphatic Filariasis
GAVI	Global Alliance on Vaccines and Immunization
GPEI	Global Polio Eradication Initiative
GPPI	Global Public-Private Initiative
ICC	Interagency Collaborating Committee
IPPPH	Initiative on Public-Private Partnerships for Health
IPV	Inactivated Polio Vaccine
MoU	Memorandum of Understanding
NID	National Immunization Day
OPV	Oral Polio Vaccine
PAG	Policy Advocacy Group
SAGE	Strategic Advisory Group of Experts
SNID	Sub-National Immunization Day
TCG	Technical Consultative Group
TFI	Task Force for Immunization
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization
WPESS	WHO Programme for the Elimination of Sleeping Sickness

Introduction

This report forms part of a broader research project on the role of companies in public-private partnerships (PPPs). Such collaborations have become an increasingly important way to stimulate sustainable development. The research project aims to contribute to a better understanding of the rationale, functioning and effectiveness of these partnerships.

This report describes and analyses the Global Polio Eradication Initiative (GPEI), a Global Public-Private Initiative (GPPIs) for health. GPPIs are a specific type of public-private partnerships. The report focuses on the role of private sector partners in the operations and governance of the GPEI. It does not evaluate outcomes or effectiveness in much detail, nor does it provide an analysis of each company's approach to GPPIs for healthcare in general. These issues are addressed in separate reports by SOMO, including three reports on individual companies (Aventis, GlaxoSmithKline, Merck & Co).[1] These reports relate their involvement with GPPIs to the core-business of the companies and to broader company strategies and policies for corporate social responsibility. Field studies on the implementation of the GPPIs in developing countries, conducted by partner organizations of WEMOS, form part of the broader research project.[2]

[1] See http://www.somo.nl.

[2] At the release of this report, the reports of the field studies were still being edited. When they are finished, they will be placed on the WEMOS website, http://www.wemos.nl.

1 Short description of the GPEI

In 1988, the World Health Assembly (WHA) adopted the eradication of poliomyelitis (polio) as a public health target. This led to the creation of the Global Polio Eradication Initiative (GPEI), which claims to be *'the largest public health initiative the world has ever known'*.[3] The GPEI is led by national governments and four spearheading partners. These are the World Health Organization (WHO), Rotary International, the US Centers for Disease Control and Prevention (CDC) and United Nations Children's Fund (UNICEF).

The main strategy for polio eradication is vaccination of all children. The vaccine used to this end in developing countries is Oral Polio Vaccine (OPV). OPV is easy to administer and relatively cheap. However, in extremely rare cases (less than 1 in a million doses), the live attenuated virus in OPV can cause vaccine-associated polio. For this reason high income countries prefer Inactivated Polio Vaccine (IPV) for regular immunization and OPV will not be used anymore after polio elimination.[4]

In developing countries where routine immunization programmes are lacking, polio vaccination is implemented through National and/or Sub-National Immunization Days (NIDs and SNIDs). These are single-day mass vaccinations campaigns, involving the mobilization of millions of volunteers to reach all children and administer the vaccines.

Since the start of the GPEI, the annual number of detected polio cases has been reduced from 350,000 in 1988 to less than 800 in 2003. Over the same period, the number of polio-endemic countries decreased from more than 125 to only six: Nigeria, India, Pakistan, Niger, Afghanistan and Egypt.[5]

The GPEI is an example of a Global Public-Private Initiative (GPPI) or public-private partnership. In financial terms, the private sector component of the GPEI mainly consists of contributions from private foundations, not from individual companies.[6]

[3] http://www.polioeradication.org/history.asp.
[4] http://www.polioeradication.org/vaccines.asp.
[5] http://www.polioeradication.org/history.asp.
[6] Interview with B. Keegan, CDC, 3 September 2004.

2 Partnership policy

2.1 Establishment of the GPEI

The GPEI gradually evolved and none of the major partners anticipated at the outset that such a broad-based partnership would eventually be established.

Rotary International decided in 1985 on a 20-year programme to support polio vaccination, called PolioPlus. The end of this programme, in 2005, would coincide with the 100th anniversary of the organization. At the start of the programme, the Rotary was convinced that if it would be able to raise enough funds for the procurement of OPV to immunize children during a period of five years, this would have a major impact and perhaps lead to eradication of polio. In the period 1985-1988 Rotary International gained support from Rotary units worldwide for the PolioPlus programme and raised substantial funds.

However, the efforts of the Rotary fell short of controlling the disease. The organization realized that a focus on vaccine procurement was insufficient and that the distribution and administration of OPV needed more attention. Reaching all children was far more difficult and also more expensive than buying the required amount of vaccines. The Rotary then recognized that a partnership with other organizations was needed.

The GPEI was established in 1988, after the World Health Assembly called for the eradication of polio, and the Rotary International automatically became a partner organization. The CDC joined the Rotary, WHO and UNICEF as a spearheading partner in the mid-1990s.[7]

2.2 Roles and contributions of partners

The GPEI has four spearheading partners: the WHO, UNICEF, Rotary International and CDC. The WHO is the lead organization of the GPEI, and the WHO and UNICEF are the main implementing partners. There has never been a formal agreement about the tasks and responsibilities of different partners in the GPEI.[8] Nonetheless, there seems to exist a broad consensus about the roles of GPEI partners[9] and they are described in the GPEI strategic plan for 2004-2008.[10] These are summarized below.

- The **World Heath Organization (WHO)**. As the lead organization of the GPEI, it provides overall technical direction and strategic planning for GPEI activities. The WHO is responsible for the implementation of the GPEI Strategic Plan and has a key

[7] Interview with W. Sergeant, Rotary International, 4 October 2004.
[8] Interview with W. Sergeant, Rotary International, 4 October 2004.
[9] Interview with B. Keegan, CDC, 3 September 2004.
[10] WHO (2003). *GPEI Strategic Plan 2004-2004.* See http://www.polioeradication.org/content/publications/2004stratplan.pdf.

role in monitoring and evaluation. It is also the lead agency for resource mobilization, donor coordination, advocacy and public communications.

- **United Nations Children's Fund (UNICEF)**. A main role of UNICEF is the procurement and distribution of polio vaccines (OPV only). The organization also provides technical assistance to countries and supports the infrastructure that is needed to keep the vaccine at the required temperature during distribution, the so-called 'cold chain'. UNICEF is a key partner in advocacy and communications.

- The **US Center for Disease Control (CDC)**. The CDC is equivalent to a Ministry of Health for the US. It is currently the largest donor of the GPEI. It has an important technical role as well. The CDC conducts research on polio immunization policies and provides epidemiology and research expertise. Furthermore, the CDC seconds scientific staff to the WHO, UNICEF and polio-endemic countries and supports the global network of polio laboratories. It has a key role in disease surveillance.[11]

- **Rotary International**. Initially it was involved in funding only, but later advocacy became a major role too.[12] People affiliated to the Rotary have many connections with politicians all over the world. The Rotary used these connections to increase support from the US government for polio eradication. Hence, the Rotary had an important role in bringing in the CDC. The Rotary also sought to enhance support from other countries, including Japan, the UK, The Netherlands, Germany and Italy. Furthermore, members of the Rotary use their personal networks to mobilize volunteers for NIDs. Because of this function, Rotary Clubs in for example India have an very important role in the GPEI.[13] The Rotary is involved in every mass campaign and has raised millions of volunteers.[14] It does not have a technical role.[15]

- **Governments**. The WHO indicates that national governments are the *'owners and beneficiaries of the GPEI'*.[16] In principle, a country's Ministry of Health is charged with the task to implement the polio programmes at district and village level.[17]

- **Vaccine manufacturers**. There are only five major vaccine corporations worldwide and the vaccine industry has a critical role in supplying sufficient quantities of OPV. This is especially important because most companies are eager to phase out OPV production, as there will be no demand for OPV anymore after polio is eliminated.

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[11] Interview with B. Keegan, CDC, 3 September 2004.
[12] Interviews with L. Muller, WHO, 24 September 2004; W. Sergeant, Rotary International, 4 October 2004.
[13] Interview with W. Sergeant, Rotary International, 4 October 2004.
[14] WHO (2003). *GPEI Strategic Plan 2004-2004*, p35. See http://www.polioeradication.org/content/publications/2004stratplan.pdf.
[15] Interview with W. Sergeant, Rotary International, 4 October 2004.
[16] WHO (2003). *GPEI Strategic Plan 2004-2004*, p35. See http://www.polioeradication.org/content/publications/2004stratplan.pdf.
[17] Interview with B. Keegan, CDC, 3 September 2004.

Companies generally supply vaccines to UNICEF at preferential prices. There is close cooperation with UNICEF and the WHO in the forecasting and delivery of vaccines. Some companies have made OPV donations too.[18] Aventis, one of the vaccine suppliers, adds that it has a role in advocacy as well. The company engaged in a social mobilization campaign to raise public awareness of the eradication campaign.[19] Vaccine manufacturers do not have a role in the governance of the GPEI.[20]

2.3 Funding of the partnership

The GPEI funding requirements for 2004-2005 have been estimated at US $765 million for two years. As of December 2003, confirmed and projected contributions up to 2005 totalled $635, leaving a funding gap of $130 million.[21] In early 2003, some activities for polio eradication could not be carried out due to financing shortfalls. [22]

Total external financial contributions to the GPEI for the period 1988-2005 amount to approximately $3 billion. These contributions are additional to the domestic resources allocated by polio endemic countries. For the entire 1988-2005 period, the largest donors are the US government (CDC and USAID) and Rotary International, which provided over $500 million each, followed by the World Bank and the governments of the UK, Japan and The Netherlands. Public sector funding constitutes 65% of total external contributions, multilateral funding 15% and private sector funding 20%.[23]

In financial terms, the contribution of the private sector to the GPEI mainly consists of grants from Rotary International, the Gates Foundation and UN Foundation. Direct contributions from individual companies, including product donations, account for less than 1% of total support. [24] The only individual companies that provided large contributions (above $1 million) were the vaccine manufacturers Aventis and Wyeth and diamond corporation De Beers.[25]

2.4 Added value of the partnership

[18] Interview with B. Keegan, CDC, 3 September 2004.
[19] Interview with S. Gilchrist, 13 May 2004.
[20] Interviews with B. Keegan, CDC, 3 September 2004; L. Muller, WHO, 24 September 2004.
[21] WHO (2003). *GPEI estimated external financial resource requirements 2004-2008 as of December 2003*. See http://www.polioeradication.org/content/publications/2004_frr.pdf.
[22] WHO (2003). *GPEI Strategic Plan 2004-2004*. See http://www.polioeradication.org/content/publications/2004stratplan.pdf.
[23] WHO (2003). *GPEI estimated external financial resource requirements 2004-2008 as of December 2003*. See http://www.polioeradication.org/content/publications/2004_frr.pdf.
[24] Interview with B. Keegan, CDC, 3 September 2004; in certain years, the share of company contributions may occasionally have been larger than 1%.
[25] Interview with L. Muller, WHO, 24 September 2004.

Individuals from the different spearheading partners indicate that the added value of the partnership is high. It is pointed out that each partner has unique strengths and together they can work more effectively. The WHO and UNICEF alone do not have all required skills and resources, so the cooperation with other organizations is extremely useful.[26]

It seems that two contributions from other partners are most essential. First and foremost, the financial resources from Rotary International and other donors. The GPEI started originally as a funding partnership, in which the Rotary contributed funds for the eradication of polio and the WHO and UNICEF implemented and coordinated the polio eradication programmes. These complementary resources and the division of roles – financing and implementation – still form the basic rational of the partnership. Second, the advocacy and lobbying efforts of the Rotary have helped to increase support for the programme and put polio eradication higher on the agenda of governments. Again, there is a division of roles here between supporting and implementing organizations.

The basic rationale of the partnership is therefore that it has strongly increased support for the polio eradication programme of the WHO and UNICEF. The programme itself is still managed mainly by the WHO. This might explain why the programme seems to be functioning well, according to partners, without a formal structure for the governance of the GPEI or for the representation of different constituencies.

There are complementarities among partner organizations in the implementation of polio eradication activities as well. These include the technical expertise contributed by the CDC, the networks of Rotary clubs for the mobilization of immunization volunteers, and the maintaining of production capacity by vaccine manufacturers. However, these synergies are secondary to the collaboration between supporting and implementing organizations described above.

2.5 Transparency

Transparency about the partners involved with the GPEI and the terms of cooperation between different partners is low. A full list of partner organizations is not available and only major donors (above $1 million) are mentioned in GPEI documents. This implies that only those vaccine manufacturers that have made OPV donations are mentioned individually in GPEI communications, even though the vaccine industry is regarded as a separate category of partners.[27]

[26] Interview with B. Keegan, CDC, 3 September 2004.
[27] See WHO (2003). *GPEI Strategic Plan 2004-2004.*

3 OPV donations

3.1 WHO's policy on donations

Although the GPEI has a large budget for vaccine procurement, The WHO requested OPV donations from vaccine manufacturers because funding for polio eradication was still insufficient. When the GPEI was started in 1988, the WHO aimed at the global eradication of polio by 2000 through large-scale large scale vaccination campaigns. However, in the late 1990s it realized that this target would not be reached. The WHO then sought to double the amount of vaccinations and this sudden large increase led to a funding shortage.[28] The need for additional contributions, among others in the form of product donations, is recognized among GPEI partners and therefore OPV donations from vaccine manufacturers are seen as an appropriate contribution.[29]

3.2 Aventis' policy on donations

Several vaccine manufacturers have made OPV donations to the WHO and UNICEF. These include Aventis, Chiron and GlaxoSmithKline. Aventis made the largest contribution and had donated 120 million vaccine doses since 1997.[30] The donations of Aventis will be described in some more detail.

Initially, the WHO asked Aventis to donate all the vaccines it produced. Aventis argued that it would not be able to sustain this. The company then asked for a specific region with limited resources, to which it could donate a part of its production. The WHO identified 5 African conflict countries to receive donations from Aventis. Together these countries needed 50 million doses for a period of three years.[31]

During the peak years 1999-2001, Aventis sold 275-300 million doses of OPV annually to UNICEF at preferential prices. This was in addition to the donation of 50 million doses for these three years. The total quantity of global OPV administration amounted to about 2 billions of doses a year, which was at maximum global production capacity. In 2001, nearly 2 billion doses of OPV were administered during national and sub-national immunization days.[32] UNICEF purchases the vaccine at approximately $0.08 per dose. Hence, the value of this donation at UNICEF procurement prices was around $4 million. Although the donation of 50 million doses was a rather small share of total OPV administration, Aventis points out

[28] Interview with S. Gilchrist, 13 May 2004.
[29] Interview with B. Keegan, CDC, 3 September 2004.
[30] http://www.chiron-vaccine.com/company/4_570.php; GPEI Strategic Plan 2004-2008, p37.
[31] Interview with S. Gilchrist, 13 May 2004.
[32] WHO (29 March 2002). *Progress towards the global eradication of poliomyelitis, 2001*. In: Weekly epidemiological record, 17*(13)*, 98-107.

it was a significant amount when compared to its own annual sales of the 300 million doses.[33]

Unlike preferential pricing, donations of vaccines are not a standard practice. Aventis believes that donations are not a sustainable long term solution, because countries would become dependent on such donations. This would be an undesirable outcome for these countries as well as for the company. It considers the donations to the GPEI as a special case, because the WHO sought to quickly expand immunization campaigns without an accompanying increase in donor funding. [34]

3.3 Motivation and interests of corporate partners

Aventis explains that the main benefits of philanthropic programmes, like the OPV donations, are an enhanced corporate image and the sense of pride that it creates. This helps to motivate employees.[35] This is also the motivation for OPV donations that GPEI partners generally perceive. As a general rule, Aventis has not been able to determine the financial value of these benefits, but there is a general recognition that the philanthropic activities do yield benefits.[36]

Yet some indicate that donations to the GPEI may be less attractive for corporations than contributions to other GPPIs, because they cannot play a major role. This may have made it more difficult to get larger donations from companies. It could not be found whether being a smaller partner is less attractive because any donation would seem small when compared to for example the funding from Rotary International, or because the companies do not have influence in GPPI policies. Still, it appears that other GPPIs like the Global Alliance for the Elimination of Lymphatic Filariasis (GAELF) and WHO Programme for the Elimination of Sleeping Sickness (WPESS) have been more successful in obtaining contributions from private companies. Concerns about sustainability did not stop companies from making large contributions in the case of these GPPIs.

The potential influence of donations on procurement preferences is not an issue in the case of the GPEI, because UNICEF buys all OPV that is globally produced. OPV is not a large business for pharmaceutical companies either.[37] Business interests in IPV supplies are much larger and will further increase when countries switch from OPV to IPV after polio eradication, but IPV is not procured by UNICEF. Hypothetically, present donations of OPV could have some influence on future IPV purchases by enhancing company reputation. In

[33] http://www.aventis.com.
[34] Interview with S. Gilchrist, 13 May 2004.
[35] Interview with S. Gilchrist, 13 May 2004.
[36] Interview with S. Gilchrist, 13 May 2004.
[37] Interview with B. Keegan, CDC, 3 September 2004.

this respect it is important to note that donated vaccines mention the name of the donor company.[38]

3.4 Conditions of cooperation for OPV donations

Aventis signed a tripartite Memorandum of Understanding (MoU) for the GPEI with the WHO and UNICEF for each donation. After internal discussion in the WHO,[39] these were not disclosed. The company does not publicly release the agreements either, [40] but the public policy manager of Aventis Pasteur, the Vaccines division of Aventis, was willing to explain the contents of the most recent MoU.[41] These can be found in Annex 1. Adherence to the agreement is monitored by the other partners.

The valuation of drug donations for tax purposes is important, because in some cases the tax exemptions granted for drugs donations may cost the US government even more than the procurement of preferentially priced drugs or generics.[42] In the case of Aventis Pasteur, however, donations are generally expenses that are written off and do not qualify for tax exemptions, [43] so this problem does not occur.

Communication on the value of vaccine donations is another issue, which is usually not linked to valuation for tax purposes. Aventis reports that this issue is sometimes complicated. Negotiations on the communicated value of the OPV donations in 1999 between WHO and Aventis took several months, because of the large difference between price levels. UNICEF purchases the vaccine at approximately $0.08 per dose, while its sales value in high income markets is between $1-2. Aventis initially took the position that communication on the donation should be at the value to the company, which would be the high market price. As Aventis wrote: '*We felt that it was only fair that this should be recognised by the recipients of the donation. We were concerned that otherwise the value of the 50 million doses would be trivialised, and would not be recognised by the public for its true value in any other market.*' [44] Yet the WHO insisted that the value of the donation to the organization was not more than $4 million. In the end, the WHO and Aventis agreed in a Memorandum of Understanding that Aventis would not attribute a financial value to it in its communications.[45]

[38] Subhankar, Sanghamitgra, D.P. Poddar, & U.K. Bhadra (2004). *A case study report on the pulse polio initiative in Murshidabad district, West Bengal, India.* West Bengal Voluntary Health Association.
[39] Telephone call with O. Rosenbauer, 23 August 2004.
[40] Communication with S. Gilchrist, June 21, 2004.
[41] Interview with S. Gilchrist, May 13, 2004.
[42] A. Guilloux (October 2000). Hidden price tags: disease-specific drugs donations, costs and alternatives. MSF.
[43] Statement of the CFO of Aventis Pasteur, mentioned in communication with S. Gilchrist, May 15, 2004.
[44] Communication with S. Gilchrist, June 21, 2004.
[45] Interview with S. Gilchrist, 13 May 2004.

4 Governance of the GPEI

4.1 Governance structure and advisory bodies

The GPEI does not have a Governing or Coordinating Board. Instead, the GPEI is governed in an informal way by the four spearheading partners, with the WHO in a lead role. The WHO and UNICEF work together on budget proposals. The Rotary and CDC both work directly with the WHO and UNICEF and keep each other informed.[46] The informal coordination of the GPEI is well accepted by all partners.[47] Various partner organizations indicate that the GPEI is functioning well and that there is no need for a more formal governance structure.[48] There are occasional partner consultations, which are mainly intended to keep partners up to date about progress and resource requirements of the GPEI. [49] It could not be found which partners attend these meetings. It is perceived that national governments are indirectly involved in the governance of the GPEI through the annual World Health Assembly (WHA) of the WHO.

There are regular meetings of the four spearheading partners. Since about 6 years, there are bi-annual meetings between the WHO, UNICEF, Rotary. Each organization sends two high representatives. These meetings were an initiative of the Rotary and take place at the Rotary International headquarters. The meetings are also rather informal and they are not documented.[50] Hence, it could not be found what issues were discussed and what decisions were taken at these meetings.

Companies do not have a role in the governance of the GPEI and public partners state that companies have no influence on GPEI policies.[51] Therefore it is highly unlikely that the involvement of private companies leads to conflicts of interests. The WHO consults the OPV manufacturers for strategic planning of vaccine production. There is formal consultation once a year.[52]

Although there does not exist a partnership board, the GPEI does have a number of formal management and advisory bodies. The main groups are shortly described below.

- **Technical Consultative Group (TCG)**. The TCG provides technical advice to the partnership, including for post-eradication polio immunization options. It supervises research and strategic planning. The TCG meets on an annual basis and consists of 6

[46] Interview with B. Keegan, CDC, 3 September 2004.
[47] Interview with B. Keegan, CDC, 3 September 2004.
[48] Interviews with B. Keegan, CDC, 3 September 2004; W. Sergeant, Rotary International, 4 October 2004; L. Muller, WHO, 24 September 2004.
[49] GPEI Partner Consultation, Meeting Summary and Conclusions (23 September 2004). See http://www.polioeradication.org/content/meetings/consultation_200409/partnerconsultationreport.pdf.
[50] Interview with B. Keegan, CDC, 3 September 2004.
[51] Interviews with B. Keegan, CDC, 3 September 2004; L. Muller, WHO, 24 September 2004.
[52] Interview with L. Muller, WHO, 24 September 2004.

international experts on immunisation, surveillance and disease eradication. In each of the 6 WHO Regions, a similar group exists to review regional progress in polio eradication, routine immunisation and surveillance strengthening. The Global TCG reports to the WHO Director Vaccines & Biologicals and the Strategic Advisory Group of Experts (SAGE).[53]

- **Global Commission for the Certification of the Eradication of Poliomyelitis**. This commission, functioning at the global level, supervises country certification. It is an independent body with representatives of six regional divisions, the Regional Certification Commissions. These in turn supervise National Certification Committees.

- **Interagency Coordinating Committee (ICC)**. Tasks of the ICC include coordinating the input of partners, advocacy and communications, fundraising, and monitoring progress towards polio eradication. It assists the Ministries of Health that manage the eradication activities at the local level with plans and budgets. The ICC of the GPEI has been copied by other GPPIs like the Global Alliance on Vaccines and Immunization (GAVI).

Other formal advisory bodies include:

- the Steering Committee on Research for the Development of Post-Eradication Immunization Policy;
- the Global Laboratory Network;
- the Task Force for Immunization (TFI);
- the Scientific Advisory Group of Experts (SAGE);
- the Ad Hoc Advisory Committee on Poliomyelitis Eradication (AACPE);
- the interagency Policy Advocacy Group (PAG). The PAG coordinates the international advocacy and resource mobilization efforts of the GPEI.[54]

4.2 Financial structure

Donor governments contribute funds in different ways. Some mainly provide funds through multilateral channels, whereas others provide direct bilateral support. The US CDC, for example, makes direct grants to the WHO and UNICEF. People involved with the GPEI indicate that there have been no problems about specific countries or regions for which no funds were available.[55]

Rotary International makes grants to the WHO and UNICEF. The WHO and UNICEF discuss their requests and funding needs for the GPEI with the Rotary three times per year.

[53] DFID (20 September 2001). *The Global Polio Strategic Plan Submission.*
[54] WHO (2003). *GPEI Strategic Plan 2004-2004.* See http://www.polioeradication.org/content/publications/2004stratplan.pdf.
[55] Interview with B. Keegan, CDC, 3 September 2004.

Various bodies of the Rotary review the requests of the WHO and UNICEF, after which the Rotary decides on the grants.[56]

All donations from private companies to the WHO go through the legal department of the WHO. The WHO has a special committee that reviews offers for donations from private companies and applies the WHO's *Guidelines on interaction with commercial enterprises for health outcomes*.[57] These guidelines specify that 'in developing relationships with commercial enterprises' 'staff should always consider whether a proposed relationship might involve real or perceived conflicts of interest' and therefore recommend 'a step-by-step evaluation of the commercial enterprise'.[58] There have been cases where donations were refused. For instance, a donation from a certain foundation, tied to a company with interests in the operations of the WHO, was not accepted.[59]

4.3 Monitoring and evaluation

There have been two major evaluations of the polio initiative in 2001, including a thematic evaluation commissioned by the WHO.[60] Probably the subject of these evaluations was the polio programme of the WHO, not the GPEI. The reports of these evaluations are not publicly available.

4.4 Transparency

Transparency about the governance of the GPEI is remarkably low. This is partly a consequence of the informal nature of the GPEI. There are no reports of the informal bi-annual meetings of the spearheading partners, for example, and an explication of the governance structure of the partnership (or the inexistence of a formal structure) is not mentioned in GPEI documents. However, the informal governance of the GPEI does not provide a full explication. On the GPEI website, only two reports of TCG meetings and one of an AACPE meeting are posted. Minutes or reports of other meetings and the composition of advisory bodies (other than the TCG) are not available. Names and addresses of TCG members and additional information on partnership governance could not be disclosed without prior internal discussion in the WHO, and was in the end not provided.[61] This is strange, as it would be small effort to provide a short explication of the partnership structure or post the 2001 evaluations of the polio initiative on the website, for example, while this would substantially increase transparency.

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[56] Interview with W. Sergeant, Rotary International, 4 October 2004.
[57] Interview with L. Muller, WHO, 24 September 2004.
[58] WHO (30 November 2000). *Guidelines on working with the private sector to achieve health outcomes*, annex, p3.
[59] Interview with L. Muller, WHO, 24 September 2004.
[60] WHO (2002). *7th TCG Meeting, 9-11 April 2002*. WHO/V&B/02.12. See http://www.polioeradication.org/content/publications/TCG7report.pdf.
[61] Telephone call with O. Rosenbauer, 23 August 2004.

5 Controversial issues

There has been some criticism on the implementation of polio eradication through National Immunization Days (NIDs). These NIDs are a vertical approach, focussed on one disease and hardly integrated with existing health systems. For example, one critique notes that in some cases UNICEF's regular Expanded Programme on Immunization (EPI) was negatively affected by the GPEI, because scarce resources were drawn away towards polio NIDs. In India, both polio and measles vaccine coverage would have decreased since the implementation of NIDs.[62]

GPEI partners did not feel that this criticism was correct, for several reasons.[63] First, there would not be a good alternative for focussing on a clear target like disease eradication. According to the partners, other approaches are less successful. By focussing on the target of polio eradication, the partnership got a high public profile and this has helped to obtaining funding. While this has been a benefit in the case of the GPEI, it also seems to imply that GPPIs in general are likely to focus on goals with high public recognition. This would mean that other programmes, with results that are less visible or more difficult to measure and communicate, cannot count on equal support.

A second reason why the criticism on the GPEI approach would be exaggerated, according to GPEI partners, is that the achievement of polio eradication requires broad activities, including unprecedented collaboration between laboratories in over 100 countries. This collaboration goes beyond a vertical approach. It was also mentioned that there has been an influence beyond polio programmes. For instance, the GPEI has provided cold chain equipment that can be used for other vaccines as well and it has stimulated the use of computers and e-mail in the public health sector in developing countries. It is not clear how these will be maintained after the funding for GPEI activities stops, though.

It was emphasized that attempts to fully integrate the GPEI in existing national health systems in developing countries would have compromised the outcomes of the programme, because these systems were too weak.[64] In principle, the Ministry of Health of each country is charged with the task to implement the polio programmes at district and village level. However, where the health systems are too fragile integration has been difficult or impossible. Extreme examples in this respect are Somalia and Sudan, where the programme has been implemented without any government involvement. It is obvious that in these extreme cases attempts to use and build local infrastructure would not have been wise. Regarding the question whether the GPEI could have done more to support health systems, though, even GPEI partners perceive that the programme has been marginally successful.

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[62] O. Razum, J. Liyanage & K. R. Nayar (10 February 2001). *Difficulties in Polio Eradication (correspondence).* In: The Lancet, Vol. 357, p476.
[63] Interview with B. Keegan, CDC, 3 September 2004.
[64] Interview with B. Keegan, CDC, 3 September 2004.

6 Analysis and conclusions

The Global Polio Eradication Initiative (GPEI) is in the first place a partnership between funding and implementing organizations. Although not formally specified, the roles of different partners are quite clear. The rationale for the partnership is also quite clear: it addresses a funding shortage. The implementation of the polio eradication programme is still managed by the World Health Organization (WHO), and the GPEI mobilizes support for this programme. As a consequence, the GPEI functions without a formal governance structure and only the main four partners have a role in the governance of the partnership.

The contributions of vaccine manufacturers to the GPEI are quite limited. Although their commitment is required to maintain production capacity for Oral Polio Vaccine (OPV), vaccine manufacturers mainly have a supplier role. This contrasts with other Global Public-Private Initiatives (GPPIs), in which pharmaceutical companies often have a more central role in governance and implementation. In many other GPPIs, companies also make larger donations or financial contributions in absolute terms (donations with a higher financial value) as well as relative terms (company contributions form a larger share of total GPPI resources).

It seems that the controversies about the vertical approach of the GPEI, meaning that it is focussed on one disease and hardly integrated with existing health systems, reflect a deeper conflict of perceptions and priorities. For some, eradication of the disease is most important, whereas for others the strengthening of national health systems has the highest priority. Apparently, there is no agreement about the effects of a vertical approach on the success of the programme, nor about the desirability of focussing on high-profile goals.

External transparency is important to assess the governance of GPPIs, including how potential conflicts of interests are dealt with, and to assess the effects of the conditions of cooperation that have been agreed. Transparency about governance of the GPEI, advisory bodies for polio eradication, and conditions for OPV donations is very low. This cannot be fully explained by the informal governance structure of the GPEI. Although partners may not perceive low transparency as a problem and the probability of conflicts of interests is relatively low compared to other GPPIs, it is not clear why the WHO is so reluctant to provide this kind of information about the GPEI.

Annex 1: Memorandum of Understanding for OPV donations

Contents of the most recent Memorandum of Understanding (MoU) for the GPEI between Aventis, the WHO and UNICEF.[65]

- The MoU specifies that Aventis Pasteur agrees to donate a certain amount of OPV to WHO/UNICEF, and specifies the period of the donation and its use. The last agreement, for example, dates from 2002 and mentions that quantity of 30 million doses, to be used between 2002 and 2005. The donation will be used in the five selected countries if appropriate. (This last phrase has been formulated to allow for flexibility regarding the use of the donation in other countries, if for some reason less than 30 million doses are administered in the selected countries).
- It specifies that the donations will be delivered free of charge, sets delivery times, etc.
- It identifies one person as the responsible manager for the GPEI at Aventis: the public policy manager of Aventis Pasteur.
- It contains a detailed clause on public communications, which includes restrictions on external communications, contains standard messages, specifies the use of logos and brand names, etc.
- It allows for the name of the sponsor to be visible on the medicine donation packages, as a form of recognition for its the contribution.
- It has an annex which specifies the time-schedule of the donations. In the last agreement, the donation of 30 million doses is spread over four years, in which 2.5, 14.5, 6.5 and 5.5 million doses will be delivered, respectively.

[65] Interview with S. Gilchrist, May 13, 2004.

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