



Save the Children

MEASURING PROGRESS ON THE PATHWAY TO UNIVERSAL IMMUNISATION COVERAGE

Gavi's mid-term review

As Gavi partners come together on 10–11 December 2018 at the midpoint of the 2016–2020 strategy, this is a critical moment to assess progress. There is no doubt that Gavi's work has a substantial impact on immunisation and on progress towards the global immunisation goals of the 2011–2020 Global Vaccine Action Plan and the Sustainable Development Goals (SDGs). In its current strategy, Gavi has focused on improving equitable immunisation coverage, with \$7.5 billion committed by donors to make progress on this goal. Two years into this strategy, Gavi has helped low-income countries protect nearly 127 million children against vaccine-preventable diseases through routine immunisation, averting around 2.5 million future deaths. A further 200 million people have also been reached by campaigns supported by Gavi in this period.¹

The focus of the current strategy is a step change towards the goal of ensuring that all children are reached with life-saving vaccination. This requires Gavi, Alliance partners, and countries to do more to strengthen immunisation and primary healthcare systems in reach of all children. It also requires a concerted effort to ensure that countries sustain and grow their immunisation programmes following transition from Gavi support – through increased domestic resources for health, improved capacity to procure vaccines and deliver immunisation, and through shaping the market to ensure more affordable vaccines. This briefing explores progress in these areas, highlighting issues that must be prioritised by the Gavi Alliance for the remainder of the current strategy and that should be an even stronger focus in the next strategic period. However, Gavi cannot achieve this alone. Governments,

Gavi Alliance partners and the wider immunisation community have a clear role and responsibility to drive progress. Urgent and concerted action is needed from all parties if we are to achieve global immunisation goals and ensure that all children are reached with this life-saving intervention.

Efforts must be aligned with national plans and support countries to make progress towards Universal Health Coverage (UHC) and the SDGs – both SDG3² and the 'leave no one behind' agenda. The recently adopted Astana Declaration on Primary Health Care, the development of the SDG3 Action Plan and the high-level meeting on UHC taking place in 2019, provide Gavi and partners with an opportunity and a responsibility to channel their efforts towards reaching SDG3. This vision must frame Gavi's future strategic direction.

Recommendations

Save the Children makes the following recommendations for the remaining two years of the 2016–2020 strategy and for identifying priorities for strategy 5.0.

WE CALL ON THE GAVI SECRETARIAT TO:

- increase efforts to improve technical and capacity support to countries to strengthen health systems that are in reach of all children and to increase domestic financing for health overall (and immunisation specifically), supporting countries to build strong primary healthcare as a first step towards UHC and achieving SDG3
- improve support to countries to improve data collection, including disaggregated data, to identify which children are being excluded so that strategies can be designed to reach them
- continue efforts to ensure countries have and are supported to deliver on comprehensive transition assessments and plans, developed well in advance of entering accelerated transition
- re-examine components and measures of transition preparedness, ensuring they comprehensively assess future sustainability
- increase technical and capacity support to countries (as relevant) to help build procurement and price negotiating capacity, continuing to work with the wider Alliance, including the World Health Organization (WHO) and UNICEF, and in collaboration with WHO's Middle Income Country (MIC) Strategy and the African MIC Action Plan (to be developed)
- play a stronger role in shaping the vaccines markets, using its extensive market-shaping expertise and influence so that prices are affordable in the long term for all countries
- play a stronger market-shaping role, including incorporating market-shaping mechanisms (such as a revised Advance Market Commitment [AMC] model) into longer term strategy, ensuring clear and accountable objectives around spurring innovation and the entry of new suppliers into the market.



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WE CALL ON NATIONAL GOVERNMENTS TO:

- prioritise achieving universal immunisation coverage, turning political commitments into action to accelerate progress
- strengthen policies and actions so that they prioritise children left behind, or not receiving the full schedule of recommended vaccines, including reviewing policies that may inadvertently exclude some children and improving data to identify and tailor responses to children left behind
- improve data collection, including disaggregated data, to identify which children are being excluded, so that strategies can be designed to reach them
- strengthen immunisation systems as part of comprehensive primary healthcare, particularly in poor, under-served and excluded areas
- increase public investment in immunisation while growing primary healthcare budgets, ensuring equitable allocation of resources to neglected regions, areas and groups and that services are provided free at the point of use, towards UHC
- empower communities and civil society organisations to engage in immunisation planning, delivery, monitoring and accountability mechanisms, including transition planning
- develop comprehensive immunisation plans that include transition strategies with clear actions and milestones that will ensure future sustainability, through an inclusive process with national stakeholders, including civil society.

WE CALL ON VACCINE MANUFACTURERS TO:

- lower vaccine prices so that they are more affordable for Gavi and middle-income countries
- increase transparency of vaccine prices and R&D costs not only for vaccines procured by UNICEF and PAHO for Gavi and other countries, but for all vaccines procured by countries
- remain committed to supplying vaccine volumes needed to meet demand and fulfil supply commitments.

WE CALL ON DONORS AND DEVELOPMENT PARTNERS TO:

- increase financial, technical and capacity support to countries to strengthen primary healthcare systems and increase domestic fiscal space for health and immunisation, supporting countries as they move towards UHC
- work together with the Gavi secretariat to increase technical and capacity support to countries to build procurement and price negotiating capacity
- support policy that promotes genuine competition in the vaccines market (including through opposition to patenting practices that impact access) and improved price transparency, including in its work with the private sector
- ensure the remaining AMC funds are used to support the entry of an additional PCV supplier, thereby promoting competition and allowing vaccines to be purchased at a lower price.

Reaching all children

Gavi's vaccine goal: accelerate equitable uptake and coverage of vaccines

Gavi's systems goal: increase effectiveness and efficiency of immunisation delivery as an integrated part of strengthened health systems

Indicators: routine immunisation coverage; breadth of coverage; equitable coverage (geographic distribution, wealth distribution, maternal education)

Gavi's current strategy has equity at its core. Its overarching mission is "to save children's lives and protect people's health by increasing equitable use of vaccines in lower-income countries" and equity is the focus of the first strategic objective. This shift in approach – from prioritising new vaccine rollouts in previous strategies, to now reaching every child with these vaccines – is welcome.³ To help deliver on this, Gavi has intensified work in 20 priority countries with high numbers of under-immunised children and those facing high levels of inequality or conflict.⁴

THE STORY SO FAR

These are all steps in the right direction, but are they yielding the results needed to reach universal coverage? Similar to global trends, improvements in coverage across countries eligible for Gavi support has been slow with only a one percentage point increase between 2015 and 2017.⁵ Based on available data, over half of Gavi countries have national DTP3 coverage below 90% – the global immunisation target agreed in the GVAP⁶ – while in more than a quarter of them coverage has yet to reach 80%. Our projections show that, if national progress continues as per historic trends, nearly half of the countries will still fail to reach 90% coverage by 2020, and still around a third of them by 2030.

Just over half of Gavi-supported countries with available disaggregated data (29 out of 55 of them) show poor performance in terms of equity.⁷ Most of these countries are making progress in closing the equity gap, which is certainly promising. However, based on our analysis, if changes in the equity gap continue as per their historical trends, only three of them will make the equitable progress needed to close that gap to under ten percentage points by 2020.⁸ The outlook is slightly more promising when looking ahead to 2030 – albeit a decade away – with a further nine countries projected to close the gap. A few countries have worrying trends – for example, in Kenya, Lesotho and Indonesia the wealth equity gap is already greater than ten percentage points and is widening. Three of the nine countries currently in accelerated transition from Gavi have high inequalities in coverage (India, Lao PDR and Nigeria). A further two fall into this category when looking at those countries set to enter into accelerated transition by 2020 (Côte d'Ivoire and Sudan). The lack of data to monitor the situation for all countries highlights an even bigger problem: that of being unable to properly identify all children missing out and tailor responses accordingly.



LOOKING AHEAD

There is an urgent need for action to accelerate progress to improve coverage and reach those left behind from accessing immunisation and health services, primarily the poorest and most marginalised children and neglected areas and groups. The equity gap must be closed for all vaccines – both the long-standing vaccines and newer vaccines like PCV – with universal coverage as the measure of success.

Countries must prioritise achieving universal immunisation coverage as part of comprehensive primary healthcare for all. Political leadership and will are critical to creating an enabling environment for health and immunisation system strengthening. However, governments must move beyond commitments in order to strengthen the policies, financing and actions needed to accelerate progress. They must strengthen immunisation systems as an integral part of wider efforts to strengthen primary healthcare, moving towards delivering UHC. There must also be increased focus on improving immunisation and health data (including disaggregated data) in order to inform both services and national and Gavi investments.

Gavi and Alliance partners must continue to improve support to countries if they are to reach their coverage and equity goals. The Gavi Independent Review Committee recently noted that planned activities often don't match inequalities and challenges identified in countries and that technical assistance to some countries may be inadequate.⁹ Gavi-funded activities and technical and capacity assistance must continue to improve and adapt to respond to countries' needs and yield results, including through country portfolio planning work¹⁰ and tailored HSS grants, as well as the Partners Engagement Framework. New and innovative approaches to improving equity should be explored and there must also be strong accountability for all technical assistance in order to mitigate inadequate provision. There must also be a stronger focus on ensuring that technical assistance is truly tailored to country needs and that it builds national capacity, rather than just filling a capacity gap. Through Gavi's next strategy, there must also be a stronger focus on galvanising the political will needed to create an enabling environment to strengthen immunisation and primary healthcare systems, moving towards UHC. Working with partners on this, particularly civil society, is critical.

Ensuring sustainable progress

Gavi's sustainability goal: improve sustainability of national immunisation programmes, eg, through appropriate allocation of financial resources and through preparing for sustained performance in immunisation after graduation

Indicators: countries on track to successful transition; co-financing; country investments in routine immunisation; and institutional capacity

Sustainability is the essence and key measure of success of Gavi's model. Gavi support should be catalytic and time limited, supporting countries to make immunisation gains, while preparing them to carry that progress forward as they transition away from that support. Critical to its success is Gavi's transition approach. With more countries approaching transition, Gavi recognised the need to strengthen its approach through an updated eligibility and transition policy approved in 2015;¹¹ this includes phased transition. While in the 'accelerated transition' phase, countries are on a five-year track towards Gavi support being phased out – a "trajectory towards financial sustainability".¹²

THE STORY SO FAR

Sixteen countries have transitioned from Gavi support,¹³ with nine countries in 'accelerated transition' phase, having surpassed the \$1,580 eligibility threshold for Gavi support.¹⁴ By 2020, two additional countries will enter this phase (one of them is expected to have fully transitioned), with a further 14 countries in 'preparatory transition' phase.¹⁵ However, the transition from Gavi cannot be seen in isolation. Several countries are simultaneously transitioning from other global health funding, intensifying the pressure and financial strain they face. Recent research by the Center for Global Development shows that four countries face potential high fiscal risk from Gavi transition due to additional transitions in the same period,¹⁶ while a further six face moderate risk.¹⁷

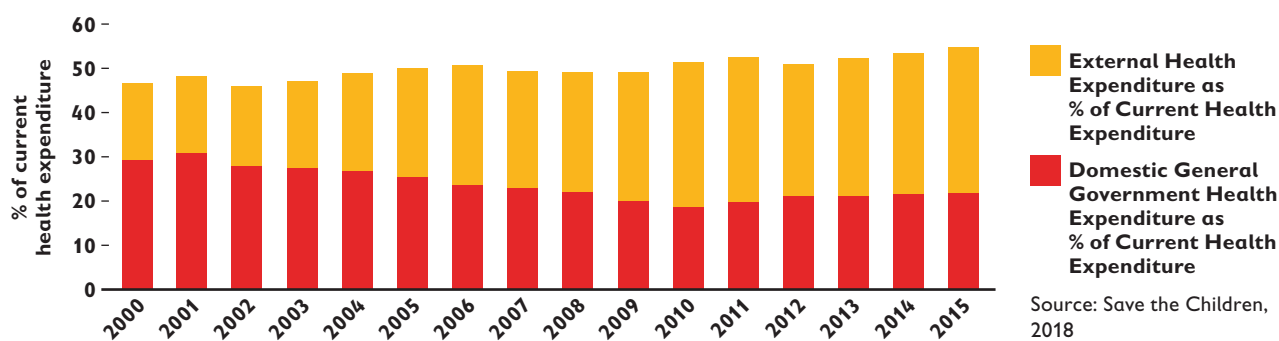
Based on Gavi's most recent assessment of its strategic goals, progress on programmatic sustainability has been insufficient.¹⁸ Out of 15 countries in the accelerated transition phase in 2017, seven did not make enough progress

progress on vaccination coverage to be considered on track.¹⁹ DTP3 coverage is currently below 90% in four of them and not even 65% in two.²⁰ Gavi continues to recognise potential risks to transition due to several countries having previous drops in coverage, and due to conflict and civil instability, natural disasters, and political, economic or institutional challenges. Five countries have been identified by Gavi as facing high transition risk – Angola, Congo, Nigeria, Papua New Guinea and Timor Leste.²¹ Gavi has undertaken work to try to mitigate risks, including starting transition planning further in advance, tailored strategies and post-transition support.

Over 90% of countries met their Gavi co-financing requirements on time in 2017 and over half of Gavi countries have increased government spending on routine immunisation (per live birth), including in two-thirds of current accelerated transition countries.²² Despite this positive trend, it is critical that domestic resource allocation to routine immunisation continues to increase. Government spending in five out of nine current accelerated transition countries made up less than 50% of their routine immunisation budget in 2017. In those countries expected to be in accelerated transition by 2020, only around a quarter were funding at least 50% of their immunisation programme with domestic resources. While Gavi and other external funding is important, it should be catalysing domestic investment. While donor funding for health in low-income countries has increased over the last decade, there has not been the same growth in overall health spending because domestic investment has declined (Figure 1).²³

Co-financing should certainly be a minimum requirement for countries, but is insufficient for ensuring the sustainable domestic immunisation and

FIGURE 1 THE SUSTAINABILITY GAP: THE GROWING SHARE OF HEALTH SPENDING FROM EXTERNAL SOURCES IN LOW-INCOME COUNTRIES (2000–15)



health investment needed for successful transition from Gavi support. While Gavi also measures country investment in routine immunisation under its sustainability goal, this is not measured alongside investment in health systems as part of the strategy monitoring framework,²⁴ with the risk that immunisation funding may be shifted from other essential health priorities.

Even more worrying, overall government budgets are not growing fast enough.²⁵ This is a concern for Gavi, which, like other global health initiatives, has the responsibility to support countries' progress on UHC and SDG3, including as a catalyst for helping them to strengthen primary healthcare systems and to raise more domestic resources to drive progress on this.

In addition to potential challenges with sustainable financing and low and/or inequitable coverage, other transition concerns include poor procurement capacity; weak vaccine regulatory capacity; and limited ability to collect and use market intelligence.²⁶ Moreover, several Gavi countries have yet to introduce newer, more expensive vaccines like Pneumococcal Conjugate vaccine (PCV) and Rotavirus; others have introduced them, with support from Gavi, but high vaccine costs mean countries may struggle to afford them and to sustain coverage once they transition.²⁷ These challenges are recognised by Gavi and provide the rationale for the development of the post-transition engagement approach which the Board approved in November 2017.

LOOKING AHEAD

Gavi recognises the need to start sustainability considerations and transition planning much further in advance, before countries enter the accelerated transition phase, as well as to strengthen transition

planning and measurement.²⁸ This should be critically examined around the review of the Eligibility and Transition Policy taking place in Q4 2019 and as part of Strategy 5.0 discussions.

Transition must focus on both financial and programmatic preparedness and sustainability. Countries must increase domestic investment to strengthen immunisation programmes – both for the purchase of vaccines and to strengthen the health systems needed to deliver them – as part of growing investment in primary healthcare. This is also critical to ensure people can access and use the health services they need, free at the point of use, and that they are protected from catastrophic out-of-pocket health payments. Governments must increase public spending on health to at least 5% of gross domestic product (GDP) to provide comprehensive primary healthcare services, including immunisation.²⁹

Gavi and Alliance partners (including donors) have a role to play in supporting countries to achieve this, working together towards sustainable solutions to problems presented by transition. There must be a concerted effort to ensure that development partners are playing a 'capacity building' role – and not merely 'gap filling' – building the capacity of countries to prepare them for successful transition. They have a responsibility to support UHC and therefore must step up technical and capacity support to countries to increase domestic fiscal space for primary healthcare and immunisation – aid needs to be transformative, strengthening governance and local systems and helping to mobilise domestic public resources. They must also help build countries' capacity for procurement and negotiating vaccine prices and building stronger health systems, providing countries with catalytic support to help them successfully transition and move towards UHC.³⁰

Making vaccines affordable

Gavi's market-shaping goal: shape markets for vaccines and other immunisation products (eg, achieve pricing that is appropriate and sustainable; incentivise development of suitable and quality products; enhance competition and choice; ensure predictable and sufficient supply)

Indicators: sufficient and uninterrupted supply; cost of fully vaccinating a child with pentavalent, pneumococcal and rotavirus vaccines; innovation; and healthy market dynamics.

THE STORY SO FAR

High vaccine prices remain a barrier to achieving universal immunisation coverage. Affordability must be improved for countries to be able to improve coverage and equity, and to sustain and grow their immunisation programmes (including introducing new vaccines) following transition from Gavi support. Organisations operating in humanitarian contexts also need affordable vaccines to deliver immunisation in these situations.

The price of expensive vaccines like PCV is, of course, particularly worrying. Despite negotiating important price reductions compared with high-income country prices, PCV remains the most expensive vaccine in Gavi's portfolio, consuming over a third of the total vaccine package cost for Gavi-eligible countries; it is followed by the rotavirus vaccine which takes up around a quarter of the total cost.

The situation is even more dire for middle-income countries that are not eligible for Gavi support or Gavi-negotiated pricing when self-funding, and are therefore exposed to higher price levels. For example, some lower-middle-income countries report paying \$37–66 for a full course of PCV – nearly four times higher than the Gavi price.³¹ For the rotavirus vaccine, the same countries pay up to three times more than Gavi countries.³² As countries transition from Gavi support, they face the double burden of increasing prices as they become ineligible, in addition to having to fully self fund.³³ These countries may also lack the skills to negotiate better prices and market information to negotiate on a level playing field.³⁴

LOOKING AHEAD

The high cost of vaccines continues to be raised as a problem by governments and development partners.³⁵ More needs to be done to ensure that vaccines are affordable for countries, so that immunisation gains can be expanded and sustained. The situation facing transitioning and non-eligible middle-income countries demands a concerted effort from the global community and a solution that influences the vaccines market overall, not just negotiating lower prices for Gavi-eligible countries.

Vaccine manufacturers must lower prices for Gavi, for countries transitioning from Gavi support and for countries that are not eligible for Gavi support (particularly for the more expensive vaccines like PCV). Manufacturers must be more transparent about pricing. And there must be a healthy vaccines market with sufficient and genuine competition to drive down prices. For example, a third supplier (Bharat Biotech International from India) entered the rotavirus vaccine market in 2018 with a price 37% lower than GSK's product and 70% cheaper than Merck's product.³⁶ This shows the potential impact of new market entrants on vaccine prices. Increasing competition through the entry of new suppliers to the market should be supported through a reformed Advanced Market Commitment (AMC)³⁷ or another market-shaping initiative that also benefits non-Gavi MICs and transitioned countries. Gavi and Alliance partners have a role to play in facilitating this.

Gavi and Alliance partners – with their extensive market-shaping expertise and occupying a substantial space in the vaccines market – must

do more to help shape the vaccines market. There is no doubt that Gavi has had successes in driving down vaccine prices for their procurement – prices have dropped for most vaccines they procure (eg, PCV, rotavirus, pentavalent) or have hovered around relatively low levels for others (meningitis-A, measles, measles-rubella, yellow fever). However, it should also use its expertise, leverage and purchasing power to encourage more affordable and sustainable vaccine prices beyond Gavi-eligible countries.

Gavi and Alliance partners should also help build countries' capacity to negotiate prices – otherwise, the fact that Gavi and Alliance partners have taken on this important role for countries could

end up being a disservice once countries transition. Working with partners, Gavi should also look at how it can offer its expertise and experience to support countries to explore options to pool procurement once they transition from Gavi support, such as an Africa pooled procurement mechanism.³⁸ An enhanced and more comprehensive market-shaping role must be central in Gavi's strategy. This should be in support of WHO's Middle Income Countries Strategy, which has identified improving access to timely and affordable supply as a priority, as well as the African MIC Regional Action Plan (to be developed).

REALISING THE FULL POTENTIAL OF THE ADVANCE MARKET COMMITMENT FOR PCV

The Pneumococcal AMC was designed to accelerate the development and availability of vaccines to developing countries. This innovative funding mechanism creates an incentive to invest in developing new vaccines by guaranteeing vaccine manufacturers a market. It has the potential to transform the vaccine pricing landscape by facilitating the entry of new manufacturers, improving competition and prices for all countries. But this is very much an unfinished story.

IMPACT OF THE PNEUMOCOCCAL AMC

The Pneumococcal AMC has had successes – 59 countries have introduced PCV and 143 million children have been vaccinated.³⁹ The price of PCV has also come down (to around \$9 for all three doses), albeit mainly to the benefit of low-income Gavi-eligible countries. However, the AMC has not been as successful in stimulating new market entrants. While there are new manufacturers in the pipeline, it is not guaranteed that they will enter the market before the AMC comes to an end at the end of 2020 or that there will still be funds available. So far it has only been used to purchase PCV from two manufacturers (GSK and Pfizer), both of whom already had PCV products on the market and new presentations at an advanced stage of development before the AMC started.

The entry of others to the market could increase competition to drive prices lower. The Serum Institute of India is hoping to have its PCV vaccine ready for market in 2020 and has announced that it will sell at \$6 for all three doses – over 30% less than current prices. Two more manufacturers could enter the market in subsequent years.

UNFINISHED BUSINESS

There is currently \$262.5 million in AMC funds still remaining.

There are different options for the future of the AMC. It is critical that remaining funds be used to purchase PCV from a new supplier to truly test the model as a means of increasing vaccine affordability through competition. If, instead, remaining funds are used to accelerate the roll-out of an existing PCV in a particular country, there is a risk that this could create barriers to new manufacturers entering the market in the future as it could embed existing manufacturers' products in these countries,⁴⁰ and at a high price.

Moving forward, market-shaping mechanisms (such as a revised AMC model) should be incorporated into longer-term Gavi strategy, ensuring clear and accountable objectives around spurring innovation and the entry of new suppliers into the market.

Case study snapshots

Kenya's urgent need to increase domestic investment in immunisation

The mission of Kenya's National Vaccines & Immunization Program is to "provide appropriate, accessible, affordable and equitable quality immunization services to the people of Kenya." The government is prioritising universal access, with the SDGs and UHC as guiding principles.

National routine immunisation coverage in Kenya is relatively high at 82%, but shows worrying trends, with an 8% decrease in 2017 from the previous year and a 15% drop from its peak in 2011, when coverage was 96%. While wealth inequalities in immunisation coverage are moderate, regional inequalities are much greater, with coverage as low as 49% in Mandera and 68% in West Pokot.⁴¹ There are also increasing pockets of children being left behind, particularly in urban informal settlements and nomadic and border populations. While PCV was successfully introduced into the routine immunisation programme in 2011 and has had a significant impact on the burden of pneumonia, after reaching 85% coverage following its introduction, this has since declined to 71%.⁴² This follows the downward trend for most vaccines.

There are several challenges to improving equitable vaccination coverage in Kenya. For example, decentralisation and healthcare worker strikes have impacted coverage. Moreover, a lack of adequate cold chain equipment means that nearly a quarter of health centres (2,100 out of 8,500) don't provide vaccination services; security concerns in border areas result in pockets of

unvaccinated children; and inadequate data leads to poor decision-making.⁴³ Another critical challenge is immunisation financing. Kenya has been late on its co-financing payments to Gavi, largely stemming from public finance management issues. Its co-financing requirements are due to nearly double to 13% by 2020.⁴⁴ This is particularly concerning considering significant declines in government spending on routine immunisation, from over 60% in 2010 to only 14% less than five years later.⁴⁵ This is alongside low overall government investment in health. Only 1.7% of GDP was spent on health in 2015 – far below the 5% minimum recommended to provide essential services – and this figure has remained relatively unchanged for five years.⁴⁶

Kenya is currently in the preparatory phase for Gavi transition but is expected to enter accelerated transition in 2021. Without a significant increase in health spending and prioritisation at all levels, there are risks to its ability to be able to maintain, let alone improve, coverage. Domestic investment must increase to strengthen routine immunisation, as part of comprehensive primary health services and moving towards UHC. Gavi support should focus on supporting this and wider efforts to strengthen the health system, including through increasing support for health system strengthening well above Gavi's current level of 8% support. This must be at the core of Kenya's transition planning – building on work that Gavi has started in this area⁴⁷ – to ensure a robust process that will lead to sustainable progress on the path to universal coverage.

Nigeria's challenges in transitioning from Gavi support

Nigeria has the highest number of under-immunised children in the world (4.3 million). Immunisation coverage is extremely low, with not even half of children receiving a full course of basic routine vaccinations.⁴⁸ Based on current trends, our analysis shows that without significant action, coverage won't even reach 50% by 2020. Nigeria is also home to the widest inequalities in immunisation coverage,

with the north of the country falling far behind the south – for example, coverage is nearly five times higher in the South West than the North West, and nearly 28 times higher in Lagos state than Sokoto (80% vs 3% coverage).⁴⁹ Children from the wealthiest households are six times more likely to be immunised than those from poorer households.

RESOURCE CHALLENGES

While many reasons have been given for Nigeria's poor immunisation performance, funding has undoubtedly been a major challenge.⁵⁰ The Nigerian economy was rebased, leading to an 89% increase in GDP in 2013,⁵¹ which put the country well above the threshold for Gavi support and from 2017 on the accelerated path to transition. However, volatility in global oil prices and poor fiscal management have led to subsequent declines in GDP and the country is currently exiting a recession;⁵² as a result it is in a state of economic insecurity.

Domestic investment in the health system is low and out-of-pocket spending is high. Government expenditure on health as a percentage of GDP doesn't even reach 1%, far below the recommended 5% needed to provide essential services. While the government has met its Gavi co-financing obligations, less than a quarter of spending on routine immunisation comes from public funding. 2018 immunisation financing requirements for 2018 indicate that, after accounting for Gavi and government contributions, there is a 14% gap in available funding.⁵³

This funding gap occurs against a backdrop of increasing resource needs for routine immunisation in the country. Over the next ten years it is estimated that around \$3.6 billion will be needed to fund its immunisation programme – including \$2.7 billion for vaccines (\$1.95 billion to be provided by the Nigerian Government and \$773 million from Gavi) and \$850.6 million for routine immunisation systems strengthening and operational costs of supplementary immunisation activities.⁵⁴ This will put a significant burden on financial structures at national, state and local government levels. Nigeria is also facing concurrent transitions from the Global Polio Eradication Initiative (GPEI) and other external funding, significantly increasing the immense challenges to the country's health system and finances.

THE TOUGH ROAD AHEAD TO TRANSITION

Nigeria's forthcoming transition faces significant risks and challenges from its low and inequitable vaccination coverage, poor health outcomes, numerous disease outbreaks, weak and underfunded health system, constrained macroeconomic

environment and poor financial management. Recognising this, the Gavi Board recently agreed to extend Nigeria's transition date by a further seven years (to the end of 2028), with a further \$461 million in funding (bringing the total up to \$773 million).⁵⁵

The Board also agreed to strengthen engagement and transition planning in order to put the country on track to transition successfully, supporting the Nigeria Primary Health Care Development Agency with the development and delivery of the National Strategy for Immunisation and Primary Health Care System Strengthening, 2018–2028 (NSIPSS).⁵⁶ The strategy sets out the country's ten-year plan for “transitioning to financial ownership of the immunisation and primary health care health system”. The development of a costed implementation plan, however, still needs to happen and government funding still needs to be allocated. Implementation of the strategy therefore has yet to commence.

The Gavi Secretariat and Alliance partners have also been requested by their Board to develop an accountability framework for support by the end of 2018, together with the Nigerian government, and to carry out a detailed mid-term review on progress in 2022–2023. Support to the NSIPSS will be supplemented by engagement at the federal and state levels to garner strong political commitments towards transition.

Increased and sustainable funding will be vital to improving immunisation coverage in Nigeria and to ensuring successful transition from Gavi support. There are continued efforts to advocate for increased financing through implementation of the National Health Act. However, with uncertainty around financing for the NSIPSS and reliance on loans to support government financing of its immunisation programme, coupled with poor fiscal space, the situation is precarious. Continued political leadership and strengthened accountability will be critical. While there have been commitments from the highest levels of government, this must be translated to all levels, and continue beyond the elections in early 2019.

Endnotes

- ¹ Gavi, *Gavi 2016–2020 Mid-Term Review Report*. Gavi, 2018.
- ² SDG3: “Ensure healthy lives and promote well-being for all at all ages”
- ³ Gavi, *Gavi’s Strategy*, <https://www.gavi.org/about/strategy/> accessed 4 October 2018.
- ⁴ The ten countries with the most underimmunised children are: Afghanistan, Chad, DRC, Ethiopia, India, Indonesia, Kenya, Nigeria, Pakistan, and Uganda. The ten countries facing high levels of inequality or conflict are: Central African Republic, Haiti, Madagascar, Mozambique, Myanmar, Niger, Papua New Guinea, Somalia, South Sudan, and Yemen.
- ⁵ Gavi, *2016–2020 Strategy: Progress, Challenges and Risks*, Report to the Programme and Policy Committee, Agenda item 03, 18–19 October 2018.
- ⁶ While Gavi has set their target lower than the 90% global target (recently lowered to a target of 84% – <https://www.gavi.org/results/measuring/2016-2020-indicators/vaccine-goal/>), we have argued that this is not ambitious enough and not aligned with globally agreed targets.
- ⁷ Based on a more than 10 percentage point gap in DTP3/Penta3 coverage between children from the poorest and wealthiest households. Inequalities estimates are calculated by aligning the most recent Demographic and Health Survey/Multiple Indicator Cluster Survey data (no older than 2010) to the most recent trends of national rates from WUENIC estimates (WHO/UNICEF Estimates of National Immunization Coverage), by applying the ratio between estimated national averages from household surveys and national rates from WUENIC to the group inequalities, keeping relative inequalities constant, to give an indication of what more recent inequalities likely look like.
- ⁸ These projections are based on current trends and are used to illustrate potential future coverage if things continue as is. They do not account for potential interventions or events that could alter the current trajectory.
- ⁹ Gavi, *Update on key recommendations of the independent review committee and high level review panel*, Report to the Programme and Policy Committee, Agenda item 04, 18–19 October, 2018. Gavi has since taken actions to respond to this IRC recommendation.
- ¹⁰ Previously known as the Country Engagement Framework (CEF).
- ¹¹ Gavi, *Gavi Alliance Eligibility and Transition Policy*, Version 3.0. Gavi, 2015, <https://www.gavi.org/library/gavi-documents/policies/gavi-eligibility-and-transition-policy/> accessed 26 September 2018.
- ¹² Gavi, *Transition process*, <https://www.gavi.org/support/sustainability/transition-process/> accessed 26 September 2018.
- ¹³ This only includes countries that have transitioned under the current policy and therefore does not include Albania, Bosnia-Herzegovina, China, Turkmenistan or Ukraine.
- ¹⁴ Countries with gross national income (GNI) per capita above the \$1,580 threshold (averaged over previous three years) enter a five-year ‘accelerated transition’ period in which funding phases out. After the end of this period, countries become fully self-financing. Countries currently in accelerated transition are: India, Lao PDR, Nicaragua, Nigeria, Papua New Guinea, Sao Tome and Principe, Solomon Islands, Uzbekistan and Vietnam.
- ¹⁵ Countries above the low-income country threshold but below the Gavi GNI per capita threshold (\$1,580 as of 2018) enter ‘preparatory transition’, during which time their co-financing requirements increase by 15% per year.
- ¹⁶ Total funding from global financing mechanisms exceeds 10% of total domestic government funding for health. Two are in accelerated transition or expected to be so by 2020 (Nigeria and Sao Tome & Principe). Two are in preparatory transition or expected to be so by 2020 (Cameroon and Pakistan).
- ¹⁷ Total funding from global financing mechanisms exceeds 5% of total domestic government funding for health. Three are in accelerated transition or expected to be so by 2020 (Côte d’Ivoire, Lao PDR and Timor-Leste). Three are in preparatory transition or expected to be so by 2020 (Cambodia, Myanmar and Senegal). Source: Silverman, R, *Projected Health Financing Transitions: Timeline and Magnitude*, Working Paper 488. Center for Global Development, 2018.
- ¹⁸ Gavi, *2016–2020 Strategy: Progress, challenges and risks*, Report to the Programme and Policy Committee, Agenda item 03, 18–19 October 2018.
- ¹⁹ DTP3 coverage needs to have increased over the last three years to be considered on track. Gavi, *2016–2020 Strategy: Progress, challenges and risks*, Report to the Programme and Policy Committee, Agenda item 03, 18–19 October 2018.
- ²⁰ Based on an analysis of WHO-UNICEF (WUENIC) 2017 immunisation estimates.
- ²¹ All three have defaulted on their Gavi co-financing at least once, with Angola and Congo defaulting for four consecutive years. Source: Gavi, *Gavi Alliance Board retreat*, Discussion starter paper, 5–6 April 2017.
- ²² Between 2010/2011 and 2016/2017. Based on most recent data in this year’s GVAP secretariat report (collected through the JRF mechanism). It should be recognised that Gavi and others have raised concerns about the reliability of JRF data and are investing, together with Global Fund, the Bill & Melinda Gates Foundation and others, in the roll out of more robust national health accounts methodology.
- ²³ Save the Children, *The Importance of Domestic Resources and the Role of Aid in the Financing of Health Systems in Low-income Countries in Providing Essential Health Services for All*. Save the Children, 2018.
- ²⁴ This is looked at as part of ongoing financing discussions with countries, however, it is not part of the strategy monitoring framework. We have argued that this should be part of the framework to increase accountability.
- ²⁵ Manuel, M., Desai, H., Samman, E. and Evans, M., *Financing the End of Extreme Poverty*. ODI, 2018.
- ²⁶ Kallenberg, J, Wilson, M, Newman, R, Nguyen, A, Ryckman, T, Saxenian, H and Wilson, P, 2016. Gavi’s transition policy: Moving from development assistance to domestic financing of immunization programs. *Health Affairs*, 35(2): 250–258; WHO, *V3P: Global Fact Sheet*, Working Document. WHO, 2017.
- ²⁷ For example, among Gavi-eligible countries studied (Bangladesh, Cameroon, Ethiopia, Kenya and Mali), the primary factor driving decisions to adopt new vaccines was to seize the opportunity of Gavi funding. Source: Burchett, HED, Mounier-Jack, S, Griffiths, UK., Biellik, R, Ongolo-Zogo, P, Chavez, E, Sarma, H, Uddin, J, Konate, M, Kitaw, Y, Molla, M, Wakasiaka, S, Gilson, L and Mills, A. New vaccine adoption: qualitative study of national decision-making processes in seven low- and middle-income countries. *Health Policy and Plan*, 27: ii5–ii16.
- ²⁸ For example, Sudan is expected to enter accelerated transition in 2020 and Gavi is already working on several fronts to build policy awareness and political support, and to work on the transition assessment process.
- ²⁹ McIntyre, D. and Meheus, F., *Fiscal Space for Domestic Funding of Health and Other Social Services*, Working Group on Financing – Paper 5. Chatham House, 2014.
- ³⁰ UHC2030, *Sustainability, transition from external finance and health system strengthening*, UHC2030 Steering Committee meeting paper, 4–5 June 2018, Geneva.
- ³¹ Based on published price points in the M14A/V3P vaccine purchase database, lower-middle-income countries pay between \$37 and \$66 for a full course of PCV. Source: V3P database: http://www.who.int/immunization/programmes_systems/procurement/v3p/platform/module1/Public-V3P-Database-Extract_July2018.xlsx?ua=1 Accessed 26 September 2018. Gavi has to date not had a specific role in addressing pricing for these countries.
- ³² Source: V3P database: http://www.who.int/immunization/programmes_systems/procurement/v3p/platform/module1/Public-V3P-Database-Extract_July2018.xlsx?ua=1 Accessed 26 September 2018.
- ³³ While Gavi prices for PCV have been secured for countries for ten years following transition, this locks in a price that is still very much unaffordable for many middle-income countries. The duration for other vaccines varies depending on commitment terms, ranging from one year to ten years.
- ³⁴ WHO, *V3P: Global Fact Sheet*, Working Document. WHO, 2017.
- ³⁵ At the 67th World Health Assembly (WHA) in 2014, many countries requested greater price transparency, information on cost of production, support for improving negotiation capacity and access to lower prices. Vaccine affordability has also been raised by ministers of health at subsequent WHAs and at the Ministerial Conference on Immunisation in Africa in 2016. This was also a key finding from consultations conducted by the WHO MIC Task Force (See: http://www.who.int/immunization/programmes_systems/procurement/v3p/platform/database/en/).
- ³⁶ Based on Gavi Vaccine product profiles: <https://www.gavi.org/library/gavi-documents/supply-procurement/detailed-product-profiles/> Accessed 14 November 2018.
- ³⁷ See box on ‘Realising the full potential of the Advance Market Commitment for PCV’.
- ³⁸ This could be explored, however, recognising the complexities with this – eg, countries would have to agree on the same products and immunisation schedule and have a political commitment for pooled procurement to occur.
- ³⁹ Gavi, *Facts and Figures*, <https://www.gavi.org/about/mission/facts-and-figures/> accessed 24 October 2018.
- ⁴⁰ This of course does not preclude countries from switching products after introductions, but is of course not the ideal situation.
- ⁴¹ Kenya National Bureau of Statistics, *Kenya Demographic and Health Survey 2014*. DHS, 2015.
- ⁴² This has resulted from the devolution process and a near one-year strike by nurses and doctors.
- ⁴³ Government of Kenya, *Overview of immunization program, Kenya*, PowerPoint Presentation. 2017.
- ⁴⁴ Government of Kenya, *Overview of immunization program, Kenya*, PowerPoint Presentation. 2017.
- ⁴⁵ The latest available data is for 2014. Source: WHO, *WHO immunisation financing data*, http://www.who.int/immunization/programmes_systems/financing/data_indicators/en/ Accessed 4 October 2018.
- ⁴⁶ WHO, *Global Health Observatory data*, <https://www.who.int/gho/en/> Accessed 2 October 2018.
- ⁴⁷ Gavi has started to engage with the Governors, in addition to the national level, to ensure political will and full understanding at this level, given the decentralised nature of the system and its financing in Kenya.
- ⁴⁸ Coverage is 42% according to WHO-UNICEF (WUENIC) 2017 immunisation estimates and as low as 33% according to the 2017 Nigeria immunization coverage survey (NICS).
- ⁴⁹ National Bureau of Statistics and UNICEF, *Multiple Indicator Cluster Survey 2016–17*, Survey Findings Report. National Bureau of Statistics and UNICEF, 2017.
- ⁵⁰ Wonodi, C, Stokes-Prindle, C, Aina, M, Oni, G, Oluokowi, T, Pate, MA, Privor-Dumm, L and Levine, O, *Landscape Analysis of Routine Immunisation in Nigeria*. IVAC, 2012.
- ⁵¹ World Bank, *Nigeria Economic Report*. World Bank, 2014.
- ⁵² Government of Nigeria, *National Strategy for Immunisation and Primary Health Care System Strengthening, 2018–2028 (NSIPSS)*. Government of Nigeria, 2018.
- ⁵³ Africa Health Budget Network, *Nigeria National 2018 Immunization Budget Scorecard*. AHBN, 2018.
- ⁵⁴ This does not include the estimated \$200 million needed for the country health information profiles, PHC strengthening, human resources for health, and surveillance. Source: Government of Nigeria, *National Strategy for Immunisation and Primary Health Care System Strengthening, 2018–2028 (NSIPSS)*. Government of Nigeria, 2018.
- ⁵⁵ Gavi, *Gavi board decision*, June 2018 Board meeting. Gavi, 2018.
- ⁵⁶ Gavi, *Gavi board decision*, June 2018 Board meeting. Gavi, 2018.

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