OWNING IT

TURNING IMMUNISATION COMMITMENTS INTO ACTION

RESULTS

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EXECUTIVE SUMMARY

> We are facing a pivotal moment in history. Right now, the global health community has an unprecedented opportunity to coordinate with governments to develop and implement plans & strategies that will improve the lives of millions of people around the world through universal access to appropriate vaccines

Global Vaccine Action Plan Leadership Council[1]

Immunisation saves between 2 and 3 million lives every year and has played a significant role in the halving of under-five mortality in the last 25 years.[2] More children than ever before are protected against some of the world's deadliest diseases and immunisation is widely recognised as one of the best buys in public health, with a return of up to $44 for every $1 spent.[3]

An increase in donor financing for health and immunisation since 2000 has further improved the number of children who are protected with the full range of World Health Organization (WHO) recommended vaccines. The creation in 2000 of Gavi, the Vaccine Alliance, with its focus on expanding equitable access to vaccines to children in the poorest countries, has substantially increased global financing for expanding routine immunisation programmes as well as accelerating the introduction of new and underused vaccines globally.[4] Through its co-financing mechanism, Gavi also supports countries in their efforts to increase their own domestic financing for immunisation, preparing them for future changes in donor financing.

Despite this, one in seven children still miss out on basic vaccines.[5] The Strategic Advisory Group of Experts (SAGE) on Immunisation, set up to track progress towards global immunisation goals, is "gravely concerned" that progress on coverage and equity is too slow.[6] In 2015, 68 countries fell short of the globally agreed basic immunisation-coverage target of 90%, with a further 51 countries reporting no change or a decrease in coverage from the previous year.[7] Children from the poorest families, those who live in the hardest-to-reach areas, and children in the most vulnerable and marginalised groups are the ones most frequently being left behind.

A number of challenges must be addressed if we are to ensure that no child dies from a vaccine-preventable disease and that progress continues to be made. Addressing inequities and reaching all children, even in the remotest areas requires more money per child to ensure vaccination. The number of vaccines available has more than doubled in the last 15 years, and with the higher price of new vaccines the average cost to fully immunise a child has risen significantly over this time – from US$0.67 in 2000 to US$32.09 for a boy and US$45.59 for a girl.[8] This requires a drastically larger immunisation budget than before.

Further, the increasing cost of implementing a routine immunisation programme comes at the same time as changes in donor financing. It is widely accepted that donor support alone is not enough to achieve the UN Sustainable Development Goals (SDGs), and that only by working in partnership will we achieve these ambitious targets. In this current context of stalled progress towards global immunisation goals, new challenges to scaling up coverage, and changing external financing, it has never been more critical for governments to increase their commitment to, and ownership of, their national immunisation programmes.

Fostering **country ownership** to ensure a successful transition away from donor finance, at the same time as improving global immunisation rates, is a central but achievable challenge. **High-level political commitments to improve both immunisation rates** and the routine immunisation programme are required to ensure the prioritisation of immunisation at all levels of government. **Sustainable domestic financing** for health and, within it, immunisation is needed to support the continuation and improvement of services, especially with the introduction of new vaccines and changing financing from donors. Immunisation programmes need predicable and long-term funding in order to build successful immunisation systems that can be sustained. Political commitments and domestic financing are wasted without the correct technical capacity to turn ambition into action. Improved **policy and programme implementation**, with a focus on equity, is essential if we are to reach all children with WHO-recommended vaccines.

These three elements are interlinked and equally dependent on the success of each other. It is unlikely that a country will achieve the full potential of immunisation without all three together. The responsibility for delivering routine immunisation may lie with national governments, but all immunisation stakeholders, including donors and technical agencies, have an important role to play in supporting increased capacity and advancements towards full country ownership of immunisation programmes in order to ensure that no children die from vaccine-preventable diseases.

RECOMMENDATIONS

FOR DONORS

- **Provide support to countries to increase domestic resources for immunisation and health.**
- **Push immunisation up the global agenda – generating space for political leadership and new commitments that foster country ownership and national action to address inequities.**
- **Increase funding for civil society organisations (CSOs) involved in immunisation and health advocacy at national level, to ensure that they can play an active role in galvanising political will for improved leadership and sustainable financing for immunisation.**
- **Engage with parliamentary forums and ambassador networks to highlight the importance of immunisation and the need for countries to urgently take action to move towards country ownership.**
- **Develop guidelines on donor withdrawal that ensure responsible changes in donor funding, especially in contexts of simultaneous donor withdrawal.**

FOR NATIONAL GOVERNMENTS

- **Prioritise immunisation at the highest political level, using national, regional, and international events to make ambitious statements and commitments in support of immunisation.**
- **Recognise the urgency of addressing stalling progress on the Global Vaccine Action Plan (GVAP) goals by investing in new policies, initiatives, and immunisation staff (at a technical and district level) to tackle inequities.**
- **Prioritise and increase public investment in immunisation as part of a growing health budget to ensure long-term financial sustainability.**
- **Develop and implement financial sustainability plans to guide changes in donor financing and to ensure that co-financing payments are made on time.**
- **Ensure that technical advisory groups, such as National Immunisation Technical Advisory Groups (NITAGs) and Inter-agency Coordination Committees (ICCs), are properly established, supported, consulted, and that they include representatives from civil society.**

1 INTRODUCTION

Child mortality more than halved between 1990 and 2015.[9] This is a tremendous achievement, and one in which immunisation has played a significant role. A combination of an increasing number of vaccines being introduced into the recommended vaccines list and the strengthening of Expanded Programmes of Immunisation (EPIs) around the world has ensured that more children are protected against more of the world's deadliest diseases than ever before.

Immunisation is one of the most cost-effective public-health interventions available, with protection for the individual against deadly diseases being only one of a number of wider benefits that the provision of immunisation provides. Routine immunisation can strengthen the whole health system and drive a more equitable approach to service delivery. As immunisation must reach every child and full immunisation requires multiple points of health systems, this allows other health concerns to be identified and treated, but also ensures that services reach every child and community – which is critical for those frequently left behind.

Furthermore, immunisation programmes are often at the core of the primary-healthcare system. The development of structures and strategies for immunisation – such as the training of health workers, the establishment of procurement systems, and the development of supply chains – can strengthen the whole health system, creating a stronger basis for providing universal health coverage to all.

BENEFITS OF IMMUNISATION

2-3 million LIVES SAVED EACH YEAR[10]

DECREASE FROM
12.6 million to 5.9 million
UNDER-FIVE MORTALITY CASES[11]

$1 INVESTED TO SAVE **$16**[12]

IMMUNISATION IS FOCUSED ON REACHING EVERY CHILD

Despite these advantages, 19.4 million children are still not benefiting from basic life-saving vaccines, and there have only been incremental improvements in immunisation rates over the past five years.[13] Bold leadership from all immunisation stakeholders – including increased financial and technical support, with a move towards country ownership – are needed to address the challenges that still prevent one in seven children from being immunised.

Photo: Adrian Brooks/GAVI

2 THE EVOLVING IMMUNISATION CHALLENGE

> The next four years present unprecedented opportunities for countries to leverage the attention and support that immunization receives and apply it for the benefit of people everywhere. Strident efforts on the part of all countries and immunization stakeholders are required to catch up and achieve GVAP goals by 2020

The Strategic Group of Experts (SAGE) on Immunization, 2016[1]

2.1 PROGRESS IS BEING MADE

Thirty five years ago, only 21% of children worldwide received all three doses of the most basic vaccines against diphtheria, tetanus, and pertussis (DTP). By 2015, this had risen to 86%.[14]

Immunisation has saved millions of lives, allowed more children than ever before to celebrate their fifth birthday, and also moved the world closer to the eradication and elimination of some of its deadliest diseases. From more than 350,000 cases a year in 1988, polio has fallen by over 99% to just 37 cases in 2016.[15] The WHO estimates that more than 15 million people are able to walk today who would otherwise have been paralysed without receiving the polio vaccine.[16] Additionally, global incidences of measles have fallen by 75%, and measles attributed deaths by 79%, between 2000 and 2015.[17] In just 15 years, it is estimated that the measles vaccination has prevented 20.3 million deaths[18] and in 2016, the Americas became the first region of the world to eliminate the measles virus.[19]

However, this progress must not be taken for granted. Such rapid scale up in coverage was due in part to two significant drivers. Firstly, in 1974 the WHO introduced its Expanded Programme on Immunisation (EPI) in order to guide global and national policies to achieve universal immunisation. This provided governments with a set of technical policy guidelines and support to enable the development and scaling-up of strong immunisation systems to deliver the then six essential vaccines. Through these guidelines, countries set up their own EPI departments responsible for their national immunisation systems. EPI teams remain the primary government department responsible

Photo: Nicholas Axelrod/RESULTS UK

for routine immunisation, and are at the heart of nationwide programme delivery.[20] Secondly, the creation of Gavi, the Vaccine Alliance in 2000 dramatically changed the immunisation landscape in an effort to improve global coverage rates and accelerate access to new vaccines in the poorest countries. Gavi provided much-needed additional resources as well as a new partnership model to help make vaccines more affordable to all countries. To date, Gavi has helped avert 8 million future vaccine-preventable deaths and has helped to immunise more than 580 million children.[21] Between 2011 and 2015, it also supported countries in their efforts to expand their routine immunisation schedules to include more of the 11 recommended WHO vaccines, helping introduce 200 instances of new vaccines – four times as many as in the previous five years.[22]

2.2 TRACKING GLOBAL COMMITMENTS TO IMMUNISATION

Multiple milestones since 2010 have helped to raise much-needed political awareness and focus global attention on immunisation, ensuring that it remains an important item on the development agenda.

2.3 OFF-TRACK IMMUNISATION TARGETS AND STALLED PROGRESS

While a record number of children are being reached with basic vaccines, around 19.4 million of them still miss out.[28] After years of increases in immunisation coverage rates, progress has stalled. Since 2010, basic immunisation rates have only increased by 1%.[29] The GVAP's goal-level indicators for 2015 and 2020 constitute the main metrics of global and national immunisation coverage rates, disease elimination, and the development and introduction of new vaccines.[30] GVAP's goals are rightly ambitious, but at the 2015 midpoint four of the five goals are severely off track. In fact, 68 countries fell short of the GVAP 90% basic immunisation-coverage target in 2015, with a further 51 countries reporting no change or a decrease in coverage from the previous year.[31] Projections by Save the Children suggest that only eight of the countries that are currently below the 90% national coverage will reach this goal by 2020.[32] The Strategic Advisory Group of Experts (SAGE), which is responsible for tracking progress on the GVAP, recently called for "strident efforts" to address grave concerns about slow progress.[33] It is clear that without new commitments and determined action, millions of children's lives will continue to be lost from vaccine-preventable diseases.

2010

THE DECADE OF VACCINES

The Decade of Vaccines is an initiative spanning the years 2010 – 2020. Its mission is to extend the full benefits of immunisation to all people – regardless of where they are born, who they are, or where they live.[23] Launched at the World Economic Forum in 2010, it brought together the WHO, the United Nations Children's Fund (UNICEF), the US National Institute of Allergy and Infectious Diseases, and the Bill and Melinda Gates Foundation, who collectively called for the development of a new plan to ensure the discovery, development, and delivery of life-saving vaccines globally. This initiative was given life through the GVAP.

2012

THE GLOBAL VACCINE ACTION PLAN (GVAP)

The GVAP is a framework and commitment approved by all 194 member states at the World Health Assembly in 2012 to realise the full benefits of immunisation and achieve the Decade of Vaccines vision of universal access to immunisation. Guided by six principles, the plan has recommended actions as well as five goal-level indicators for 2015 and 2020, which are used to track global progress on immunisation. These are also used as a marker of the progress that a country is making, setting agreed targets for all WHO member states.

THE SIX GUIDING PRINCIPLES

All WHO regions have turned the GVAP into regional plans, which are designed specifically to address their needs and challenges.

2015

THE SUSTAINABLE DEVELOPMENT GOALS (SDGs)

Global leaders recognised the importance of immunisation, particularly on the path towards universal health coverage (UHC), by including vaccines for all as a main target within Goal 3.[24] The SDGs apply to all UN member states and, by creation, are interdependent, relying on the success of each other; they will only be achieved by taking a holistic approach to sustainable development. Ensuring that immunisation is prioritised will have wider implications for the sustainable-development agenda, particularly its closely related health goals.

2016

THE MINISTERIAL CONFERENCE FOR IMMUNISATION IN AFRICA

The first Ministerial Conference for Immunisation in Africa (MCIA) took place in February 2016. The conference sought commitments and solutions in order to redouble efforts to build strong, sustainable, inclusive immunisation systems and ensure that no children suffers from vaccine-preventable diseases. It provided an opportunity for a wide range of immunisation stakeholders to publicly highlight the lack of progress across the continent, and garnered much-needed political attention for the challenges as well as driving a greater sense of urgency for scaled-up action.[25]

2017

THE ADDIS DECLARATION ON IMMUNISATION

One of the main outcomes of MCIA was the Addis Declaration on Immunisation (ADI), a political statement and pledge by 47 countries containing 10 commitments to ensure that everyone in Africa receives the full benefits of immunisation. In January 2017, the ADI was officially endorsed by member states at the AU Heads of State Summit during the adoption of the Declaration on Universal Access to Immunization in Africa.[26] Since its adoption, an ADI Roadmap has been developed which will be used by multiple stakeholders to drive action on the commitments across the continent.

2.4 CHALLENGES IN REACHING EVERY CHILD

While countries' national basic immunisation rates are higher than ever before and should be celebrated, this achievement often masks vast inequities between wealth quintiles, vulnerable and marginalised groups, and between different districts and communities. For example:

- Less than 5% of all children in Gavi-eligible countries receive all 11 WHO recommended vaccines for infants everywhere.[34]
- In 2015, only 61% of children received the recommended second dose of the measles vaccine, and only 46% of children receive a vaccine against rubella.[35]
- Pneumococcal and rotavirus vaccines, which protect against the main strains of pneumonia and diarrhoea, have only reached coverage rates of 23% and 37% respectively.[36]
- In 2015, of 158 countries that reported coverage rates at a district level, only 53 countries globally had coverage rates above 80% in all districts.[37]

> It is estimated that US$62 bn is needed between 2011 and 2020 to achieve the goals set out in the GVAP and fully fund vaccination programmes across 94 low- and middle-income countries.[43]

Children who live in the hardest-to-reach areas, those living in fragile and conflict-affected states, and marginalised groups are the costliest and most difficult to reach with immunisation, and the most frequently missed from routine immunisation services.[38] Whilst each country's context is unique, there are a number of challenges that countries generally often face:

- As highlighted by SAGE, "one of the most corrosive forces" affecting the lack of progress in countries that have seen little or no progress is low commitment to immunisation at all levels.[39] This has a considerable effect on the level of funding dedicated to immunisation, and subsequently on service delivery.
- The returns of investing in immunisation are often not fully realised by the Minister or Ministry of Finance.[40] This means that even if immunisation is a policy priority for a country's Ministry of Health, it may remain underfunded.
- The introduction of new vaccines into the routine immunisation schedule in order to reach WHO guidelines – in addition to upgrading cold and supply chains, training of vaccinators, and demand-generation campaigns – are all also increasing costs, which can impact on the ability of a country to deliver a full immunisation schedule for all children within a restricted budget.
- Weak health systems, which often result from poor governance, also have a significant impact on the availability of vaccines and the ability of those vaccines to be administered to children.[41] Stock outs, a lack of human resources for health, a broken cold-chain, and poor record keeping are just some of the challenges that prevent children from being vaccinated, especially those in rural and hard-to-reach areas. Full immunisation coverage is only possible where the whole health system is well resourced, functioning, and working coherently.
- Data at a national and subnational level is often poor or missing.[42] This makes it incredibly difficult to know which children are being missed and why.

2.5 PAYING FOR IMMUNISATION

The financing landscape for immunisation has changed considerably since 2000; while donor support for immunisation has increased significantly and country-level commitments are growing, many challenges remain. Further changes are also on the horizon, which will have a vast impact on the achievement of the GVAP goals. Some countries are facing a potential quadruple challenge of having to provide an increasing number of vaccines; cover the increasing cost of the basic package of vaccines; invest in different, expanded, and often more expensive services to tackle inequities and reach every child; and cope with a reduction in donor funding.

FINANCIAL RESOURCES FOR IMMUNISATION

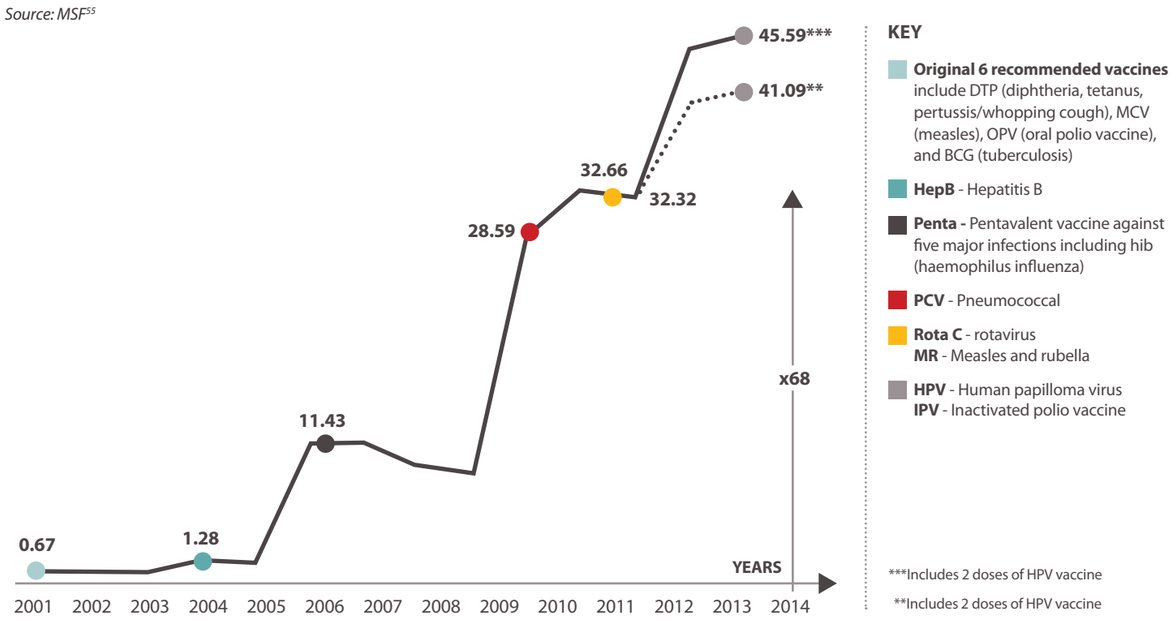
The creation of Gavi in 2000 dramatically increased donor financing for immunisation. By the end of 2015, Gavi had received US$12 billion from donors including national governments, the European Commission, the Bill and Melinda Gates Foundation, and the private sector.[44] US$7.5 billion was pledged in January 2015 to allow Gavi to implement its 2016 – 2020 strategy. In addition to support from Gavi, since 2000 development assistance for health has increased from US$11.7 billion to US$36.4 billion, with immunisation as a percentage of the total donor spend on health rising from 4% to 8%.[45] Integral to the Gavi model is the co-financing of vaccines by national governments. In 2015, this meant that US$113 million in domestic resources was committed to improving immunisation – a threefold increase since 2010.[46]

INCREASING DEMANDS ON LIMITED RESOURCES

While overall financial resources for immunisation have been increasing, this trend has not kept pace with the demands placed on these limited resources – in particular, the number of recommended vaccines that children should receive, the services required to reach all children, and the higher price of new vaccines.

GRAPH 1: **COST OF VACCINES TO FULLY IMMUNISE A CHILD, BASED ON LOWEST PRICE AVAILABLE TO UNICEF**

Source: MSF[55]



The WHO currently recommends 11 basic childhood vaccines, plus human papilloma virus (HPV),[47] to be part of a routine immunisation programme.[48] This has increased from just six in 2000,[49] highlighting how quickly new vaccines have been introduced into routine immunisation schedules. Many of the vaccines introduced in the last 15 years protect against multiple strains of diseases and childhood illnesses such as meningitis, blood poisoning, diarrhoea, and pneumonia. As a consequence, the range of vaccines that a country has to buy and deliver has doubled in less than 15 years.

With an increased number of vaccines to deliver at different times in a child's life, the cost of delivering vaccines, especially for those in the hardest-to-reach areas, has increased. Service-delivery costs are now one of the main drivers of increased immunisation programme costs.[50] Both structurally and geographically, the currently unreached child is harder to identify and access, as they have eluded efforts thus far.Scaled-up demand generation, and improved supply chains and delivery mechanisms will all be required to achieve full coverage.

An increasing number of vaccines, coupled with increasing service costs to reach every child on even more occasions, has led to an exponential increase in the average cost of immunising one child with all WHO-recommended vaccines. In 2000, a child could be immunised with the WHO's recommended six against deadly diseases for US$0.67.[51] The minimum cost has now risen to US$32.09 for a boy and US$45.59 for a girl – a 68% increase in just 15 years (see Graph 1).[52]
Gavi has played a significant and positive role in contributing to the affordability of vaccines for Gavi-eligible countries through agreements with manufacturers, guaranteeing long-term and increased supply and demand. This has allowed it to negotiate the lowest global price for a number of routine immunisations – for example, the cost of fully immunising a child with pentavalent, pneumococcal, and rotavirus has decreased by 43% since 2010, from $35 to $20 in 2015, in Gavi-eligible countries.[53] However, purchase prices for newer vaccines are still significantly higher than for older formulations. This is already creating a dramatic increase in the minimum cost of basic immunisation, and these costs are expected to continue to rise to $60 per child by 2020.[54] For countries that are not eligible for Gavi funding, and therefore the lower Gavi-negotiated price, these costs are already much higher, and further increases are likely in future as new vaccines are developed and tested for other life-threatening conditions such as malaria.

2.6 CHANGES IN DONOR FINANCING

It is now widely accepted that donor support alone is not enough to reach the Sustainable Development Goals, and that only by working in partnership will we achieve these ambitious targets.

In many cases, when a nation moves from being a low-income country (LIC) to a middle-income country (MIC),[56] relationships with some donors change, including the amount and type of support that the country might be eligible to receive. Differing requirements from different donors and multilateral organisations can mean that a country faces changes to its donor financing for health from multiple organisations simultaneously, requiring a potentially significant domestic uplift in resources for health over a short time frame.

While different bilateral and multilateral institutions have different processes and criteria for the transition process, which prescribe when financial and technical support will change in the context of immunisation, the transition and withdrawal of Gavi and the Global Polio Eradication Initiative (GPEI) are likely to have the most impact on achievement of the GVAP goals.

GAVI

Gavi's Eligibility and Transition Policy sets out when countries' co-financing obligations change.[57] The policy is designed to encourage long-term increases in domestic financing through pre-prepared phases in order to move countries towards full country ownership of routine immunisation financing, ultimately removing the need for donor support completely. This route is commonly called the transition process, and ultimately ends in donor withdrawal when countries begin fully self-financing their immunisation programmes.

When a country's gross national income (GNI) per capita is below the World Bank low-income threshold, it is in Gavi's initial self-financing phase. During this time, it pays 20 cents for every vaccine dose. However, once a country has a three-year GNI per capita average above this level but equal to or below the eligibility threshold of US$1,580, it moves into the preparatory-transition phase and co-financing contributions increase by 15% each year. A country remains in the preparatory-transition phase until it averages a three-year GNI above the eligibility threshold of US$1,580, when it enters accelerated transition. This is a five-year phase with an annual step change in co-financing obligations as countries move towards fully self-financing their immunisation programmes (see Graph 2). By January 2017, nine countries had moved through Gavi's transition process and begun to fully self-finance immunisation. These were Bhutan, Guyana, Honduras, Indonesia, Kiribati, Moldova, Mongolia, Sri Lanka, and Ukraine.59 A further 11 are expected to begin fully self- financing by 2020, bringing the total to 20 countries.[60]

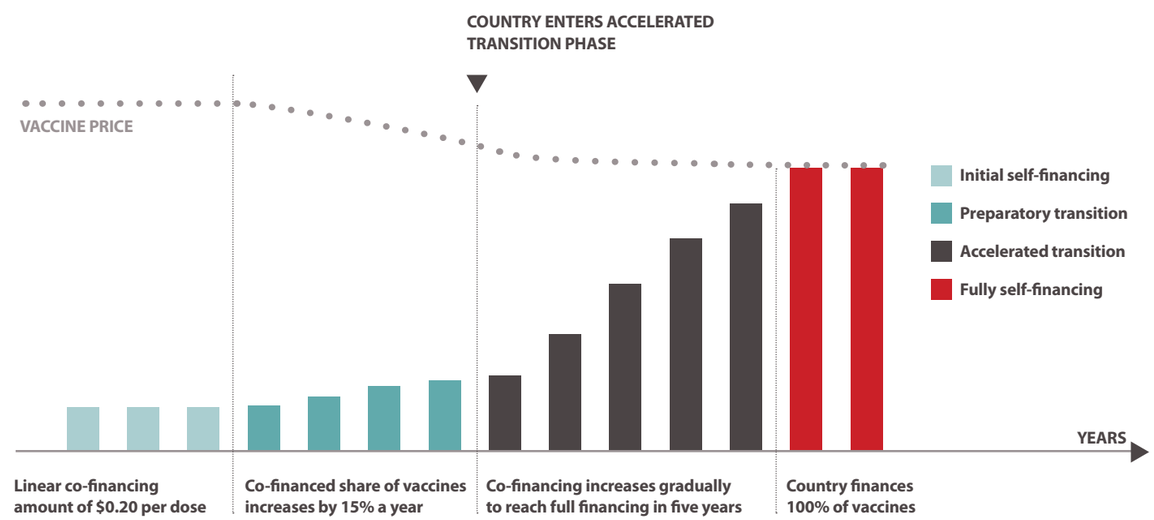
Over the next few years, several countries – representing the highest number of unimmunised and under-immunised children as well as the largest inequities in coverage – are expected to either enter the accelerated-transition phase or to "graduate" from Gavi support entirely, with significant consequences for the required uplift in domestic financing for immunisation. From the examples below, it is clear that withdrawal of donor support too soon could negatively impact on routine immunisation rates, as well as the achievement of the GVAP goals, in countries that are already struggling to reach every child.

- **Indonesia began fully self-financing its vaccines in 2017. It currently has a national immunisation rate of 81%.[61] In 2015, only 64% of its districts achieved DTP3 coverage of over 80%, with 11% districts' coverage rates being below 50%.[62] Estimates suggest that the budget increase in Indonesia required to support vaccines previously co-financed by Gavi would be 1,547% between 2012 and 2018 alone, excluding costs for non-Gavi supported vaccines – thus highlighting the significance of the increase required in domestic resources over a short span of years.[63] Transition could place further stress on the country's routine immunisation programme, which is already struggling with vast inequities.**

- **The Republic of the Congo is in the accelerated-transition phase, and due to begin fully financing its immunisation programme in 2018. However, the recent collapse in the price of oil has dramatically impacted the country's gross domestic product (GDP).[64] This has affected the government's budget, including the national health budget, and**

GRAPH 2: **GAVI CO-FINANCING MODEL**

Source: Gavi[58]



subsequently its ability to meet Gavi co-financing commitments.[65] Consequently, immunisation rates have fallen from 90% to 80% in just one year,[66] and future decreases are expected. Currently, polio and measles coverage is only 80%, leaving the country vulnerable to disease outbreaks.[67] There are serious concerns around how the Republic of the Congo will prevent transition from having further negative impacts on its routine immunisation.

There is also evidence to suggest that transition is happening much quicker than expected in some cases. For example, in 2009 Papua New Guinea was projected to transition out of Gavi support after 2030, whereas it is now on course to begin fully self-financing by 2020.[68] However, there is a real risk that a badly managed and unprepared-for transition to full self-financing could severely compromise immunisation programmes and impact on the achievement of the GVAP goals.

GPEI

With a record low number of cases in 2016, polio eradication could soon become a reality. However, with eradication will come fundamental changes to the way that polio immunisation has been supported since the creation of the Global Polio Eradication Initiative (GPEI) in 1988.

Currently, 20% of the WHO's programme budget (2016–17) and 14% of all WHO staff are funded through GPEI.[69] The WHO's in-country staff, especially in the EPI teams, are often an integral part and technical partner of a national health service. In the WHO AFRO region, 90% of WHO-funded EPI staff are funded through GPEI.[70]

These GPEI-funded staff are frequently involved in the delivery of other health interventions in addition to their polio-eradication activities. One study suggests that they spend on average 46% of their time on polio-related activities; 22% on routine immunisation; and the rest on new vaccine introduction, child health days, measles and rubella immunisation, and other health services – and that they play an important role in immunisation-service delivery in many countries.[71] Accordingly, the winding down of GPEI resources in countries where immunisation teams rely on support from the WHO could potentially impact on wider immunisation and health services in a significant and damaging way.

For example, in Nigeria and Angola, over 70% of WHO country staff are funded through GPEI.[72] Both countries are in Gavi's accelerated-transition stage, struggling with low basic immunisation rates, 56% and 64% respectively, and needing to tackle immunisation inequities while strengthening their routine immunisation systems.

Ensuring that GPEI withdrawal does not create further challenges for immunisation and the wider health systems in these, and other, countries should be considered a paramount priority for governments, donors, and immunisation partners. Now is a crucial time for countries to carefully analyse what parts of their polio infrastructure will be maintained and how they will be financed. Without proper preparation, large financial gaps could result in a negative impact on routine immunisation and wider health services, as well as putting at risk the past investments that have led to polio being on the verge of eradication.

3 CREATING COUNTRY OWNERSHIP FOR IMMUNISATION

> Although the world has seen some achievements in immunisation, global vaccination coverage has stalled the past few years, far too many opportunities to reach unvaccinated children and close the immunization gap are still being missed every day.

Dr Flavia Bustreo,
WHO Assistant Director-General Family,
Women and Children's Health[2]

In the context of stalled progress towards global immunisation goals, new challenges to scaling up coverage, and changing external financing, it has never been more critical for governments to increase their commitment to, and ownership of, their national immunisation programmes. Immunisation services are best provided by national government due to their central role in a country's health system. It is one of the few interventions that require regular contact with a healthcare professional over a set time frame. Immunisations supported through Gavi alone resulted in over 195 million points of contact between a child and a primary-- healthcare system.[73] With approximately 30 vaccines delivered every second worldwide, immunisation also provides an opportunity to deliver many other health interventions.[74] As vaccine programmes should be focused on reaching every child, they provide an element of universality that other health interventions do not, resulting in more inclusive access to multiple health interventions.

3.1 WHAT IS COUNTRY OWNERSHIP?

Country ownership is described as "establishing good governance and… providing effective and quality immunisation services for all", and is one of six guiding and fundamental principles in the GVAP.[76] National governments are responsible for driving progress on immunisation, making the required political, financial and programmatic decisions that can lead to full ownership of an immunisation programme. However, donors and development partners have a key role to play in supporting governments to build capacity and move towards this goal.

Photo: Evi Zoupanos

COUNTRY OWNERSHIP CAN BE FOSTERED BY THREE APPROACHES:

GOVERNMENT LEADERSHIP AND ACCOUNTABILITY

All 194 WHO member states are committed to achieving GVAP goals and targets. High-level political commitments from all countries are needed to ensure that the benefits of immunisation are understood and recognised at all levels of the health service. This includes public statements of commitment and the inclusion of immunisation in national health and development strategies, which also encourage public confidence in the benefits of immunisation.

Public and political engagement – at national, regional, and district levels – which scrutinises policy and holds the government to account on policy and financing.

SUSTAINABLE DOMESTIC FINANCING

Countries should ensure that there are adequate, long-term, predictable, and sustainable resources available to achieve universal immunisation coverage of all WHO-recommended vaccines. Budget analysis and long-term forecasting is important to ensure that money being allocated to immunisation is currently being spent, and that future funds will be available to allow for both equitable coverage and the introduction of new vaccines.

POLICY AND PROGRAMME IMPLEMENTATION

Countries need the technical ability and capacity to turn political will and policies into deliverable programmes. This requires a fully staffed and resourced EPI team, as well as technical staff and health workers at a district and community level who can oversee and deliver routine immunisation programmes. Countries should also draw skills and knowledge from all relevant sources through support for National Immunisation Technical Advisory Groups (NITAGs) and multi-stakeholder Inter-agency Coordination Committees (ICCs).

National coordination and local-level political accountability are key to guaranteeing programmatic impact at a regional and district level and ensuring that no child is left behind.

3.2 CASE STUDY - SRI LANKA

Through government leadership and prioritisation for immunisation at both a financing and policy level, Sri Lanka has taken full-country ownership of its immunisation programme. The National Immunisation Programme in Sri Lanka has ensured exceptionally high immunisation rates, achieving GVAP coverage and equity targets even before they were agreed in 2012. DTP3 coverage has been above 97% since 1990, and over 95% consistently in all regions since 2000.[80] Sri Lanka has prioritised reaching every child, and there has been understanding and backing of high-level decision makers in terms of the value of investing in vaccines.

HOW HAS SRI LANKA MOVED TOWARDS FULL COUNTRY OWNERSHIP?

LEADERSHIP

- Immunisation is a core indicator under the child-health improvement targets, and the most recent national health strategy specifically highlights the fact that vaccine-preventable diseases should not be a public health concern in Sri Lanka.[81]
- Sri Lanka has a National Immunisation Policy (NIP), which guarantees every citizen the right to vaccination. It has prioritised the availability of vaccines and immunisation services, and has a separate budget line for immunisation. This budget line ensures constant financing, designed to guarantee continuity in the delivery of vaccines.

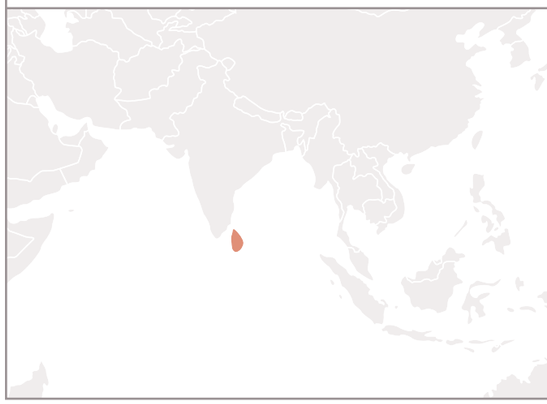
FINANCING

- In January 2017, Sri Lanka became one of only nine countries to successfully transition from Gavi support and begin fully self-financing their immunisation programmes.
- The NIP has been supported by stable domestic financing, at a level much higher than in many other Gavi-eligible countries, and there have been no problems with co-financing obligations.[82] This has been critical as Sri Lanka had to increase its co- financing of new vaccines by 197% between 2012 and 2018.[83]
- Health is 99% funded domestically, with US$127 being spent per capita on health a year.[84] This is well above the WHO recommended amount to achieve UHC.

PROGRAMME

- The government recognises that immunisation is "an integral component of the public health system" and acknowledges the importance of integration at all levels of healthcare service. With a high number of community-based health workers, who have a responsibility to undertake door-to-door visits to ensure that every child is immunised, alongside a strong school-based immunisation programme, Sri Lanka has turned immunisation policy into a strong delivery programme, which ensures that almost every single child is immunised.
- Sri Lanka's Advisory Committee on Communicable Diseases is similar to a National Immunisation Technical Advisory Group, and is considered an example of an "exceptionally well-functioning and influential" independent technical group, which not only advises on immunisation but also provides binding recommendations on public services. It has provided guidance on the recent introductions of inactivated polio vaccine (IPV), HPV, and rotavirus, and as a matter of principle will not approve the introduction of new vaccines without adequate and long-term funding being in place. This ensures the sustainability of the country's immunisation programme.[85]

Through government prioritisation of health, which includes immunisation as a core service, dedicated and increasing domestic resources, and a determination to turn policy into programmes that put reaching every child at the heart of its delivery, Sri Lanka has one of the highest and most equitable immunisation rates in the world.



99% OF CHILDREN HAVE RECEIVED BASIC VACCINES CONSISTENTLY SINCE 2010[77]

COVERAGE IS ABOVE **90%** IN ALL DISTRICTS[78]

GOVERNMENT PERCENTAGE OF FUNDING FOR ROUTINE IMMUNISATION:

74% IN 2015 **100%** IN 2017[79]

GAVI STATUS: FULLY SELF-FINANCING

4 BUILDING POLITICAL LEADERSHIP AND ACCOUNTABILITY

Heads of Government, Ministers of Health, and Ministers of Finance are examples of the kind of decision makers who hold the responsibility and authority to drive progress on immunisation in their own countries. They make the decisions that prescribe which issues are given political priority, and are the ones most often held accountable for meeting global and national targets. Without support from high-level decision makers, a country is unlikely to dedicate the necessary resources to immunisation, invest in its EPI team and health workers, or make the necessary decisions to improve immunisation services that would result in sustainable and improved immunisation rates.

4.1 WHY IS POLITICAL LEADERSHIP CRITICAL?

Political leadership from decision makers at the highest level is needed in order to implement change. Countries that have low immunisation rates are often the ones that lack political guidance and a prioritisation of immunisation, which in turn leads to inadequate financing and weak policy decisions. Leadership from decision makers is essential to drive government choices around what to prioritise, and additionally influences other stakeholders who are critical to improving routine immunisation rates.

Firstly, political leadership on immunisation can help counter the often-held opinion that immunisation and under-five mortality challenges have been largely solved.[86] Heads of government or ministers of health can, through public statements, ensure that these are not forgotten issues and inject a sense of urgency towards solutions in order to address vaccine inequities and stalled progress towards the GVAP goals.

Secondly, it provides confidence in immunisation for a number of stakeholders – including the general public. Official public statements from a country's Ministry of Health helps to install trust in vaccines and immunisation services, which encourages families to ensure that their children are vaccinated.[87] This confidence also extends to other government departments – in particular, the Ministry of Finance – that often do not fully realise the potential, or return, from investing in health, with decisions often solely focused on financial and economic analysis. Political leadership is often required to link the economic and health arguments together, convincing the relevant people that investing in immunisation makes economic sense.

Lastly, political leadership often has a trickle-down effect at the regional and district level. Attention to immunisation at a national level provides encouragement to decision makers at the subnational level to do the same. As many

Photo: Will Boase/RESULTS UK

of the issues with reaching unimmunised children lie at a district level, it is imperative that local decision makers also prioritise overcoming challenges to immunisation delivery. Similarly, the creation of a reliable vaccine supply and effective cold chain requires the attention of a number of different government departments, especially in relation to logistics and infrastructure; this requires actors from all service levels to be involved.

4.2 ENSURING ACCOUNTABILITY

Political leadership also creates public accountability. Public statements and commitments, both in-country and in global forums, can be used by stakeholders and interested parties to hold a government to account for a lack of progress. Parliamentarians, civil society organisations, and the media have an important role to play in ensuring that commitments made by decision makers do not prove to be empty statements. These actors have an important accountability role to play in demonstrating public support or concern and exerting pressure on a government to improve immunisation services and generate the political leadership needed for country ownership.

PARLIAMENTARIANS

Parliamentarians are in a unique position to influence government and decision-making processes directly. They sit on parliamentary health and finance committees, which often make crucial policy and financing decisions about immunisation. Members of parliament also play a representative role for the communities and districts that they represent and should be a valuable channel to bring the reality of the health of the population to a higher level – raising the appropriate concerns and challenges, and demanding change.

CIVIL SOCIETY

Decision makers and parliamentarians are often removed from community issues, through their location in a capital city and/or their social standing. Community groups and civil society have a crucial role to play in both providing important information to decision makers and parliamentarians – to let them know about challenges to scaling up progress on immunisation at a local, district, or regional level – and also in ensuring that existing government commitments are met. Through their understanding of community issues, community representatives and civil society can help to inform better policy decisions, enhancing decision makers' understanding of the situation – especially with regard to vulnerable groups and those children most commonly left behind.

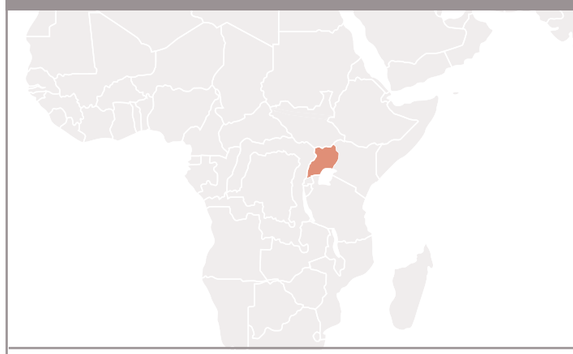
In Kenya, civil society and parliamentarians worked together to ensure that the government committed the necessary funds to the country's EPI programme. KANCO, a health-advocacy non-governmental organisation (NGO), worked with national and county-level decision makers to track resources for immunisation and map these against budget allocations in order to analyse what was being spent on immunisation at each level of government. With this information, KANCO then engaged members of parliament, through parliamentary briefings and events, on why there was a need for legislation to finance immunisation. Through grassroots advocacy training, KANCO also helped to facilitate local constituents' letters and meetings with their member of parliament in order to highlight why immunisation mattered to them. All these activities led to greater parliamentary engagement and interest, which, through debates and statements in parliament, led the government to reallocate Ksh. 250 million to the EPI programme in 2014/15 to improve immunisation services, including the procurement of traditional vaccines, supplementary immunisation-outreach activities, and improved disease surveillance.[88]

4.3 CHALLENGES IN PROVIDING POLITICAL LEADERSHIP

While immunisation is generally not a controversial issue, it often struggles to gather the appropriate level of attention and prioritisation at a national and global level. Countries often face a high number of competing priorities, many of which will similarly require increased finance and dedicated action to address. With high levels of praise for past progress in improving immunisation rates, it can be difficult to argue that immunisation should continue to be a top priority when seemingly much more acute and urgent issues need attention. For this reason, the launch of the Decade of Vaccines and the recent Ministerial Conference on Immunisation in Africa were key moments in highlighting the urgency of tackling immunisation inequities, but opportunities like these at the most senior level are few.

Government leadership cannot be obtained without concrete evidence for action. In the case of immunisation, a recent report (2016) highlighted the fact that for every $1 spent on immunisation a country saved $16 in return in terms of healthcare costs, lost wages and lost productivity due to illness, with this figure rising to $44 when the lifelong impact of people living longer, healthier lives is taken into consideration.[89] However, this evidence and the arguments for investment (from a financial or socio-economic viewpoint) are often not well known by decision makers, making them less likely to see the value in providing political leadership on immunisation. Furthermore, as immunisation provides a much greater value to society in the avoided costs of illness, it is often hard to see visibly the true extent and impact of investing in it.

4.4 CASE STUDY - UGANDA



78% BASIC IMMUNISATION RATE IN 2015[90]

89% OF DISTRICTS ACHIEVING > **80%** COVERAGE[91]

GOVERNMENT FUNDING FOR ROUTINE IMMUNISATION: **49%**[92]

GAVI STATUS: INITIAL SELF-FINANCING

Political leadership, alongside the receptiveness and collaboration of the Ugandan Government and parliamentarians to work together on immunisation, has driven important increases in domestic financing and legislative commitments on the path towards greater country ownership of the immunisation programme.

LEADERSHIP – THE NATIONAL IMMUNISATION ACT 2016

The Parliamentary Forum on Immunisation (the Forum) has been instrumental in driving government leadership on immunisation in Uganda.[93] The Forum highlighted to fellow parliamentarians why investment in immunisation is important to the development of Uganda, and galvanised interest and support across parliament. Parliamentary meetings and roundtables with the Ministry of Finance and the Ministry of Health were organised in order to show support for increased spending on immunisation, as well as encouraging greater collaboration between these two ministries. Technical information, and evidence in support of prioritising immunisation spending, was gathered through engagement with the National Immunisation Technical Advisory Group (NITAG) in order to engage with other parliamentarians and government officials and to build support for the Immunisation Act and an increased policy focus on immunisation.[94]

The National Immunisation Act became law in March 2016, and was designed to fill many of the gaps that were causing immunisation inequities. It created a new method of earmarked domestic and sustainable financing for immunisation, through an immunisation fund. The legislation also created a new government policy that immunisation of all children, women of reproductive age, and other target groups, was to be compulsory. The law was developed in close collaboration with the Forum and the Uganda EPI team. The Forum drove political and government support and the EPI team led the technical terms and functionality, endeavouring for a complementary partnership towards country ownership. Further, advocacy from decision makers themselves was crucial in driving government leadership and approval of the law, and it is recognised that engagement by the Forum with the Ministry of Finance was a core factor in the decision to allow the Act to move forward in parliament.[95]

The Immunisation Act in Uganda is evidence of what can be achieved with dedicated political will and government prioritisation of immunisation. Consequentially, government leadership has resulted in improvements to domestic financing for immunisation (and an increase in domestic spending from 24% to 49% for routine immunisation between 2013 and 2014) and has formed the basis of a new policy outlook more closely dedicated to reaching every child with immunisation.[96] However, whilst these are important steps towards country ownership, the momentum that has been galvanised should be embraced in order to ensure continued progress. This should begin with ensuring that the immunisation fund is implemented, fully funded, and properly disbursed, and that programmes to tackle coverage and inequities are improved.

5 SUSTAINABLE DOMESTIC FINANCING

> If we wish to harness [the] benefits, as well as further economic returns beyond 2020, then we need to see greater long-term domestic commitment towards immunisation

Ngozi Okonjo-Iweala, Gavi Board Chair[3]

When immunisation budgets are underfunded, vaccines are not delivered and children miss out. One study of 94 low- and middle-income countries estimated that there is a US$7.6 billion funding gap for national immunisation programmes between 2016 and 2020 if they are to reach the GVAP goals.[97]

Financial donor support has been instrumental in increasing immunisation rates, but cannot and should not be a substitute for long-term and substantive domestic investments in immunisation and primary healthcare services. The provision of routine immunisation is the responsibility of the government, and must be maintained indefinitely. As countries move towards fully self-financing their immunisation programmes with domestic resources, donors and development partners can provide technical and financial assistance to raise and sustain domestic financing before, during, and after transition in order to help ensure sustainability. Immunisation budgets should be a relatively small and manageable proportion of a national health budget. Recent estimates suggest that only 0.1% of GDP is required to fully finance an immunisation programme, which is around 5% of total government health expenditure. Based on an analysis of 40 countries, this could rise to 8% annually due to the introduction of new vaccines and rising service-delivery costs.[98]

Immunisation programmes by nature need continuous, long-term, and reliable funding if they are to allow for planning and programmatic development in order to improve coverage and tackle inequities. This is because they require considerable investments in infrastructure, supply and cold chain, human resources, and procurement that need long- term financial analysis and budgeting years in advance.[99]

Photo: Adrian Brooks/GAVI

Domestic funding for immunisation is increasing. A recent study in 10 Gavi-eligible countries showed an estimated 150% increase in government funding of routine immunisation in the past 10 years.[100] Gavi co-financing payments have increased threefold since 2010, and are expected to reach approximately US$1 billion in the 2016–20 period.[101]

5.1 A CRITICAL FINANCING JUNCTURE

Immunisation budgets urgently need to grow in order to account for the quadruple challenge outlined earlier in this report: the introduction of new vaccines to ensure that all children receive all WHO-recommended vaccines, the increased cost of new vaccines such as pneumococcal and rotavirus, the higher service-delivery costs needed to reach every last child, and the reduction in donor funding. Unfortunately, a lack of knowledge or understanding of the importance of investing in immunisation, especially from an economic perspective, can lead to a lack of prioritisation of a sustainable and long-term budget line or allocation for immunisation by the relevant ministers of finance or financial decision makers.[102]

Additionally, immunisation-financing decisions are made in the context of the wider health budget. In countries that have immunisation challenges, health budgets are often too low and competition for increased financing between health interventions is high. In 2001, African Union countries pledged to devote 15% of their government budgets to health as part of the Abuja Commitment. To date, only a handful of countries have (inconsistently) achieved this target – with only three surpassing the 15% target, on average, between 2012 and 2014.[103] If countries are going to achieve the GVAP goals by 2020 and address stalled progress, then urgent increases in immunisation funding must form part of a wider increase in their health budgets.

5.2 CONTINUED DONOR SUPPORT

It is important to recognise that even though domestic resources are increasing, there is still a very important role for donors to play if we are to achieve the GVAP goals – especially given the quadruple challenge increasing the cost of equitable immunisation services. Any move away from donor support towards full self-financing of routine immunisation services requires a deliberate and timely process, begun only when certain thresholds are reached that go beyond income status – for example, health indicators. This process should be guided by a multi-stakeholder transition plan in order to ensure that immunisation services are maintained and that there is suitable long-term and reliable domestic financing available to allow for continued improvement and progress towards the GVAP goals.

There is no quick solution to self-financing, and every country has competing priorities and its own fiscal limits.[104] Donor support must continue until such time as there is certainty that a country is prepared for its support to end and for full and reliable services to continue.

The type of support that donors provide also needs to evolve in order to allow countries to enhance and build their capacity as they move towards country ownership and address the unique challenges that transition and eventual withdrawal pose. There is a definite role for donors in supporting the development of country systems and processes – for both sustainable and long-term domestic financing, and in the technical expertise needed across government departments (including, but not limited to, financing, health, and planning) to implement new policies and national improvements for immunisation programmes.

5.3 CASE STUDY - NIGERIA

Nigeria is a lower-middle-income country with one of the world's lowest immunisation rates. It is within the top 10 countries that make up the majority of unimmunised children, and has consistently had problems with subnational inequalities.[108] Children from the highest wealth quintile are 11 times more likely to be immunised, an increase of 20% since 2008.[109] Some of Nigeria's northern states are facing extreme insecurity, which has led to an almost complete disintegration of the health system and dramatically impacted on immunisation rates in those areas. Other challenges include recent elections, economic instability and a recession, and increasing costs for other health priorities such as the prevention of an Ebola epidemic and containment of the current polio outbreak. All of these factors have had a substantial and likely long-lasting impact on domestic resources for health – and, consequently, immunisation and health systems – in Nigeria.[110]

In January 2017, Nigeria entered Gavi's accelerated-transition stage; its domestic co-financing obligations will now increase each year until 2022, when the country is expected to begin fully self-financing its immunisation programme.[111] Government expenditure currently only makes up 24% of the routine immunisation programme,[112] and without significant government commitments to increase domestic financing there are serious concerns that Nigeria will not be able to tackle its immunisation inequities and be ready to self-finance within the next five years.

FINANCING – THE NATIONAL IMMUNISATION FINANCING TASK FORCE

At an inter-ministerial meeting in April 2016, government officials were presented with key facts and figures about immunisation in Nigeria. Immunisation has the potential to save 4.6 million lives over the next 10 years from vaccine-preventable diseases, but Nigeria's government-funding obligations will need to increase almost 450% from US$86 million in 2015 to US$378 million in 2025 in order to achieve this.[113] A number of different domestic financing options are being considered in Nigeria, including federal budget increases, state co-financing, multilateral bank loans, corporate fund raising, and tax levies – all of which need proper analysis of their cost–benefit balance and comparison against the immunisation-financing gap and wider health-financing requirements.

The amount that the government spends on immunisation per surviving infant has dropped from US$17 in 2006 to just US$8 in 2014, and at the same time government domestic resources as a percentage of overall immunisation funding has only increased by 2% since 2011.[114] With an increasing birth cohort, the planned introduction of four new vaccines into the routine immunisation schedule by 2020, and significant increases in Gavi co-financing obligations over the next five years, insufficient attention and efforts to take greater country ownership of immunisation financing poses a serious risk for child health in Nigeria. To address some of these challenges, the National Primary Health Care Development Agency (NPHCDA)[115] set up the National Immunisation Financing Task Force (NIFT) in 2015. Made up of a diverse group of immunisation stakeholders from national and local levels,[116] the NIFT undertakes a variety of advocacy and technical tasks including developing an advocacy strategy with the objective of increasing domestic resources, creating a structure for the setting up and maintenance of a new vaccine trust fund, designing a roadmap to achieve local vaccine production, and providing accountability for NPHCDA immunisation programmes. It is a national platform for multi-stakeholder dialogue and collaboration on the issue of health financing.

The NIFT is currently focusing its attention on ensuring that the federal government commits an appropriate amount of money to the immunisation programme, the creation of an external public-private trust fund for immunisation to complement the existing Public Health Fund, and the development of new strategies to raise domestic resources.[117] The creation of this task force is an important step forward, and a critical tool for addressing the financing challenges that Nigeria is facing in the next few years as donor support changes. If Nigeria does not find ways to dramatically increase its immunisation budget, it will not be able to increase its immunisation coverage and too many children will continue to suffer from vaccine-preventable diseases.

BASIC IMMUNISATION COVERAGE IS LOW AND DECREASING **56%** IN 2015 | DOWN FROM **63%** IN 2009[105]

80% OF DISTRICTS HAVE COVERAGE RATES ABOVE **80%** | **2%** OF DISTRICTS HAVE COVERAGE RATES BELOW **50%**[106]

GOVERNMENT FINANCES ONLY **40%** OF THE ROUTINE IMMUNISATION PROGRAMME[107]

GAVI STATUS: ACCELERATED TRANSITION

6 POLICY AND PROGRAMME IMPLEMENTATION

> No child should be denied the right to highly effective preventive interventions for unfair reasons, including those with economic or social causes. All barriers must be overcome.

Margaret Chan, WHO Director General, 2006-2017[4]

Political leadership and sustainable domestic financing on their own do not result in children being immunised. In addition, strong government policies and procedures are critical in order to turn national commitments into action – and into the actual delivery of vaccines at the community level, to ensure that every last child is reached with all WHO-recommended vaccines. Immunisation must be integrated into a country's national health plan as an essential element of a strong health system. This will ensure that it is prioritised in all relevant policies and discussions in order to allow the greatest benefits from immunisation, for both child health and health systems more broadly, to be achieved.

Procurement, human resources, cold and supply chains, and infrastructure are all important elements within a health system, and are all essential for the delivery of vaccines. Similarly, disease surveillance, outbreak-control mechanisms, responding to health and humanitarian emergencies, and collecting data are also multipurpose health services, which will have an impact on the success of any routine immunisation programme. These services require coordination both internally within the relevant Ministry of Health and with other government departments, to ensure that all parts of the system function correctly and are aligned, when required, to achieve the best results. This coordination should be driven by well-evidenced, technical policies and guidance in order to inform short- and long-term decision making and planning. Many countries are making concerted efforts to formalise their long-term support for immunisation through legislation. Bolivia, Georgia and Vietnam are just some of the nations creating legal frameworks for the operation of immunisation programmes or for procurement through immunisation legislation.[118]

Photo: Sanjit Das/RESULTS UK


Photo: Sanjit Das/RESULTS UK

6.1 DIFFICULTIES IN TURNING POLICY INTO PRACTICE

One of the biggest barriers and challenges to delivering vaccines is a disconnect between agreed, and even legislated, immunisation policies and their translation into the resources and expertise needed to create well-functioning immunisation services. Poor governance, together with a lack of guidance and funding, can lead to logistical, human-resources, and procurement challenges that will adversely affect the quality of services.[119]

EPI teams make the technical decisions on when (and if) to introduce new vaccines, how to respond to outbreaks and health emergencies, and are responsible for addressing inequities and reaching immunisation targets. Unfortunately, they are often inadequately trained; unable to access the resources they need (financially and in terms of staff, data, and analysis); and not regarded as a priority department.[120] This has a direct effect on the teams' ability to turn immunisation policy and initiatives into the delivery of immunisation services in the community. The GVAP calls on all countries to set up a National Immunisation Technical Advisory Group (NITAG) to provide support and technical guidance to policy and decision makers, including their EPI teams, to enable them to make the best evidence-based programme decisions possible.[121] NITAGs also have an important accountability role in ensuring that sufficient budgets for immunisation are allocated and efficiently managed, and also in guaranteeing that immunisation plans are implemented and targets met.[122] Currently, 116 countries have NITAGs or equivalent expert groups, which still leaves too many countries without valuable guidance and support. This means that the EPI team is often missing out on valuable technical information and assistance, which could improve policy implementation. Furthermore, countries do not always make the most of their inter-agency coordinating committees (ICCs) to create better synergies with other government departments.

6.2 CASE STUDY - NEPAL

91% BASIC IMMUNISATION COVERAGE | **90%** OR ABOVE SINCE 2011[123]

87% OF DISTRICTS ACHIEVING > **80%** COVERAGE[124]

GOVERNMENT SHARE OF ROUTINE IMMUNISATION COVERAGE: **22%**[125]

GAVI STATUS: INITIAL SELF-FINANCING

Nepal is a low-income country with a mountainous and difficult-to-navigate terrain. In recent years, it has faced extreme humanitarian disasters that have destroyed large parts of the country's infrastructure. Despite this, immunisation coverage has been above 90% since 2011. Bearing in mind the challenges – such as the distance between cold stores and community health workers, a lack of electricity, and the fact many places are inaccessible apart from on foot – Nepal's immunisation-coverage increase from 72% in 2000 is impressive even without considering wider health-services difficulties. This increase has only been made possible by strong government leadership, prioritising immunisation policies and programmes even in the light of extremely challenging situations.

POLICY AND PROGRAMME IMPLEMENTATION – PRIORITISING IMMUNISATION IN EXTREME CIRCUMSTANCES

The strength of Nepal's National Immunisation Programme was evident in the rapid reaction after the country's 2015 earthquake to ensure that vaccine-preventable diseases did not become another emergency issue to be dealt with. Routine immunisation was prioritised as an essential service that had to continue as far as possible. Within four days of the earthquake, specialist WHO surveillance staff had been deployed in 14 of the districts that were most affected by the disaster in order to ensure that health in those areas did not suffer, and that the necessary immediate actions to tackle any problems were taken. One of the core tasks of these experts was to monitor routine immunisation activities.[128] A quick analysis was carried out on all vaccine stores, with all of them fully functioning again within four months of the quake. Only one vaccine store was totally destroyed, but within one month this had been moved to a temporary structure and back again to a rebuilt, permanent hub.[129] Through the continued prioritisation of health and immunisation, routine immunisation was not largely affected and an emergency measles campaign (as recommended by the WHO immediately in all humanitarian emergencies) was successful carried out "in extraordinary circumstances" in July 2015, just months after the second catastrophic earthquake.[130] The National Immunisation Programme is grounded in UNICEF's Reach Every Community Initiative, and the Government of Nepal has challenged itself to go further with its Full Immunisation Programme. This focuses on prioritising children in the remotest areas and ensuring that they are immunised with all WHO-recommended vaccines, through support for local ownership, community participation in immunisation, and local resource mobilisation.[131]

The Government of Nepal's commitment to delivering vaccines to all children shows exceptional policy and programme detail in order to ensure that geography and other national and local restrictions are not a barrier to achieving its immunisation goal. This policy and programme focus is mirrored by high-level political interest and government leadership that has driven forward important legislative and domestic financing improvements. Similarly to Uganda, Nepal has recently enacted immunisation legislation in order to provide oversight to its immunisation programme and to create new immunisation-financing mechanisms to increase domestic resources.[132] However, even with this advanced acknowledgement of the impact of Gavi transition in the years ahead, and political leadership driving excellent policies and programmes with "leave no one behind" at their heart, there remain existing challenges around general investment in the allocation of domestic financing for immunisation.[133]

7 CONCLUSION AND RECOMMENDATIONS

An increase in donor support for global health and the creation of Gavi in 2000 have driven unprecedented investment in immunisation over the last 15 years, and global immunisation rates are at their highest level ever. However, with 19.4 million children still missing out, there is an enormous amount of work to do before every child is protected against the most common vaccine-preventable diseases. The increasing number and subsequent cost of vaccines, difficulties in reaching children in the hardest-to-reach areas and in humanitarian emergencies and conflict zones, and the changing relationships with donors are all challenges that need to be urgently addressed if we are to stand any chance of achieving the GVAP goals by 2020.

With so many competing international and national priorities, it is unsurprising that the financial landscape for immunisation is changing. Domestic resources for immunisation are increasing, and countries are taking important steps towards self-financing. Donor support will not, and should not, continue indefinitely, but in the years to come it will still have a crucial role in supporting countries to develop financial and technical systems as they move towards greater ownership of their immunisation programmes. This is especially pertinent in countries that are facing simultaneous transition from multiple health donors in close proximity to each other. Without multi-stakeholder engagement and coordination in the next few years, we will move even further away from global eradication, elimination, and equity goals, and children will continue to die needlessly from vaccine-preventable diseases.

Political leadership, long-term, sustainable domestic resources, and strong policy and programme implementation are three elements of country ownership that donors and other stakeholders can support. These would have a considerable impact on the sustainability and impact of routine immunisation services, which would result in more children worldwide being able to celebrate their fifth birthday.

Photo: Tom Maguire/RESULTS UK

RECOMMENDATIONS

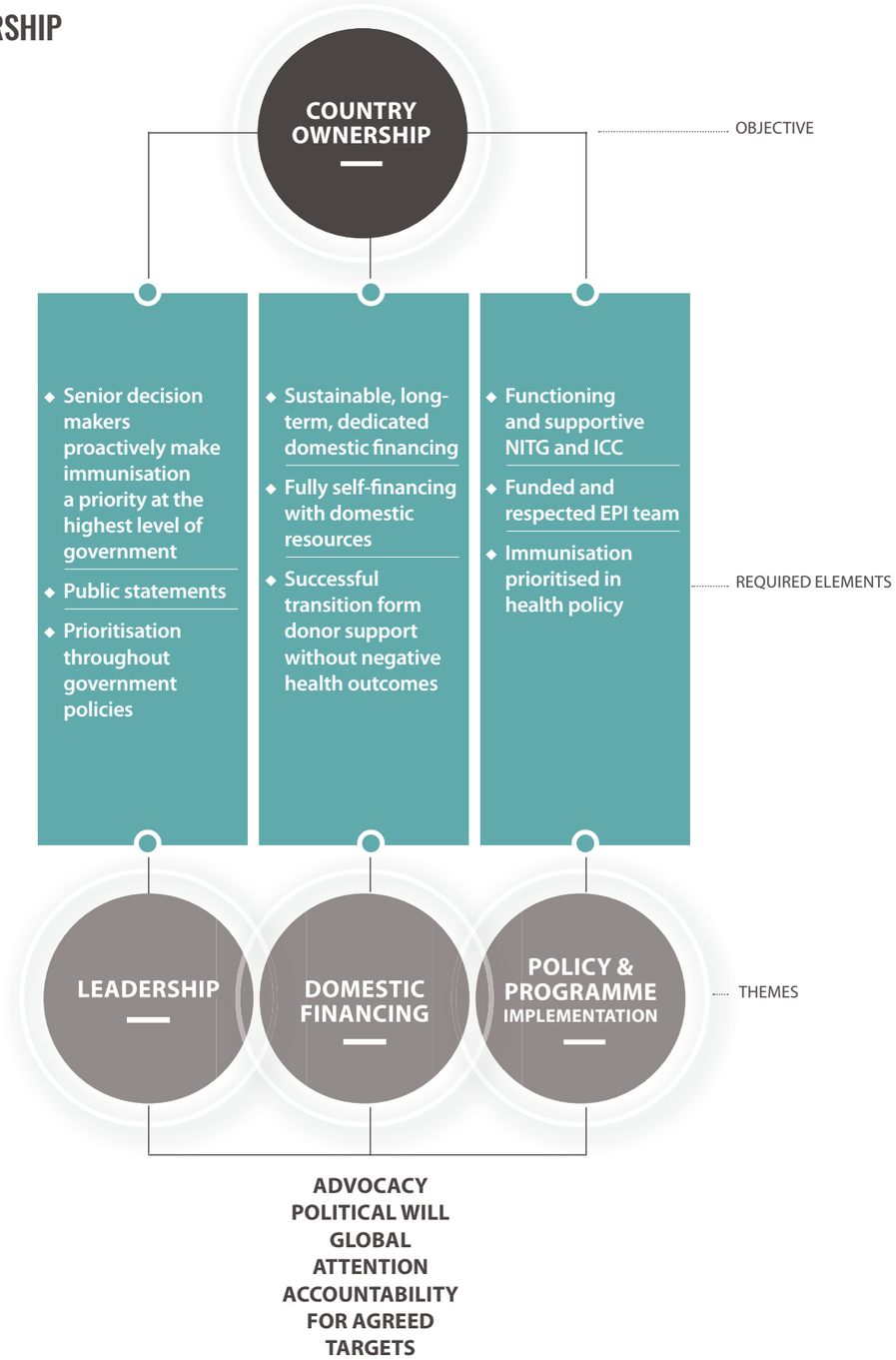
FOR DONORS

- Provide support to countries to increase domestic resources for immunisation and health.
- Push immunisation up the global agenda - generating space for political leadership and new commitments that foster country ownership and national action to address inequities.
- Increase funding for civil-society organisations (CSOs) involved in immunisation and health advocacy at national level, to ensure that they can play an active role in galvanising political will for improved leadership and sustainable financing for immunisation.
- Engage with parliamentary forums and ambassador networks to highlight the importance of immunisation and the need for countries to urgently take action to move towards country ownership.
- Develop guidelines on donor withdrawal that ensure responsible changes in donor funding, especially in contexts of simultaneous donor withdrawal.

FOR NATIONAL GOVERNMENTS

- Prioritise immunisation at the highest political level, using national, regional, and international events to make ambitious statements and commitments in support of immunisation.
- Recognise the urgency of addressing stalling progress on the Global Vaccine Action Plan (GVAP) goals by investing in new policies, initiatives, and immunisation staff (at a technical and district level) to tackle inequities.
- Prioritise and increase public investment in immunisation as part of a growing health budget to ensure long-term financial sustainability.
- Develop and implement financial sustainability plans to guide changes in donor financing and to ensure that co-financing payments are made on time.
- Ensure that technical advisory groups, such as National Immunisation Technical Advisory Groups (NITAGs) and Inter-agency Coordination Committees (ICCs), are properly established, supported, consulted, and that they include representatives from civil society.

COUNTRY OWNERSHIP



ANNEX 1

GVAP SCORECARD
TRACKING PROGRESS ON THE GVAP'S 2015 AND 2020 GOAL-LEVEL INDICATORS[134]

	GVAP GOAL	2015 TARGET	TARGET MET?	2020 TARGET	WHERE ARE WE NOW?
O1	ACHIEVE A WORLD FREE FROM POLIO	Interrupt polio globally (by 2014)	MISSED	Certification of polio eradication (by 2018)	We are closer than ever before to the eradication of polio. In 2010, there were 359 cases in nine countries compared with only 37 cases in 2016 in three countries[135] We will not have eradicated polio by 2018, but positively could have by 2020
O2	MEET GLOBAL & REGIONAL ELIMINATION TARGETS	◆ Neonatal tetanus eliminated in all WHO regions ◆ Measles eliminated in at least four WHO regions ◆ Rubella/congenital rubella syndrome eliminated in at least two WHO regions	MISSED	Measles and rubella eliminated in at least five WHO regions	◆ Only 22 of 40 priority and target countries were verified for elimination in 2015, the third time that a tetanus-elimination target has been missed.[136] In 2015, India eliminated tetanus – illustrating that it is possible even in challenging circumstance[137] ◆ In 2016, the Region of the Americas was the first region in the world to eliminate measles; however, the global 2015 target of fewer than five cases per million population has been missed[138] ◆ Only one of two target regions successful eliminated rubella in 2015.[139] 17 countries introduced the rubella vaccine between 2012 and 2015, with another 17 planning to do so before 2018[140] ◆ These goals are ambitious, and would require a significant increase in resources and concerted multi-stakeholder efforts to achieve
O3	MEET VACCINATION COVERAGE TARGETS IN EVERY REGION, COUNTRY, & COMMUNITY	Reach 90% national coverage in every district with three doses of DTP	MISSED	Reach 90% national coverage & 80% in every district with all vaccines in national programmes, unless otherwise recommended	Unfortunately, only 16 of the 68 countries that did not reach the 90% target are making progress. 51 countries have seen a net decrease or no change since 2000.[141] Without a crucial focus on the children who are left behind, we will not achieve the coverage or national equity targets by 2020
O4	DEVELOP & INTRODUCE NEW AND IMPROVED TECHNOLOGIES	At least 90 low-income and middle-income countries have introduced one or more new or underutilised vaccines	EXCEEDED	◆ All low-income and middle-income countries have introduced one or more new or underutilised vaccines ◆ Licensure and launch of vaccine or vaccines against one or more major, currently non-vaccine-preventable, diseases ◆ Licensure and launch of at least one platform-delivery technology	◆ Since 2010, 99 LICs and MICs have introduced at least one new or underutilised vaccine to their national immunisation programme, and sustained vaccine use for at least 12 months.[142] This is an important step towards all WHO-recommended vaccines being made available to all children ◆ A dengue vaccine has been licensed in multiple countries, and important progress has been made in the development of a malaria, Ebola, and Zika vaccine.[143] With investment in reserach and development continuing to grow, it is hoped that in years to come even more vaccines will be added to the recommended vaccine schedule
O5	EXCEED THE MILLENNIUM DEVELOPMENT GOAL 4 TARGET ON REDUCING CHILD MORTALITY	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate (Target 4.A)	MISSED	Exceed the Millennium Development Goal Target 4.A for reducing child mortality	Globally under-five mortality has decreased by 53% since 1990, from 12.7 million to 5.9 million.[144] A global focus on increasing immunisation is a crucial tool to help achieve the preventable child-death target in the Sustainable Development Goals

ACRONYMS

ADI	Addis Declaration on Immunisation
CSO	Civil Society Organisation
DTP	Diphtheria, Tetanus, and Pertussis (vaccine)
EPI	Expanded Programme of Immunisation
Gavi	Gavi, the Vaccine Alliance
GNI	Gross National Income
GPEI	Global Polio Eradication Initiative
GVAP	Global Vaccine Action Plan
HPV	Human Papilloma Virus
ICC	Inter-agency Coordinating Committee
IPV	Inactivated Polio Vaccine
LIC	Low-Income Country
MCIA	Ministerial Conference on Immunisation in Africa
MIC	Middle-Income Country
NIFT	National Immunisation Financing Task Team (Nigeria)
NIP	National Immunisation Policy (Sri Lanka)
NITAG	National Immunisation Technical Advisory Group
SAGE	Strategic Advisory Group of Experts
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

ENDNOTES

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ABOUT RESULTS UK

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

RESULTS

ABOUT ACTION

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

ACTION

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

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