Appendix E. Findings from the Country Visits

1. The countries visited were a purposive sample based on the following (not mutually exclusive) criteria: (a) countries that are pilot countries for the Health Systems Funding Platform, (b) countries where both GAVI and the World Bank have been active in the health sector since GAVI was founded in 2000, (c) countries in which there has been some engagement (collaboration, complementarity, or consultation) between GAVI and the World Bank (based on prior desk reviews and interviews), and (d) countries to which the ImGAVI Trust Fund has provided technical assistance.

MISSION SUMMARY: ETHIOPIA

2. Ethiopia’s immunization coverage rates have been steadily rising over the last 10 years, but most vaccines only cover between 60 and 80 percent of infants. Bacille Calmette-Guerin (BCG) and DTP1 vaccine rates have fallen from 90 to 80 percent over the last few years. The Ethiopian government expects the GAVI-supported new vaccines, such as rotavirus, will help the country achieve single-digit under-five mortality by 2030. However, a gap exists between official immunization coverage and survey-estimated coverage rates raising the question of what happened to the vaccine doses provided. The government, GAVI, and other donor partners need to find ways to ensure effective vaccine distribution and improve coverage.

3. Since 2001, GAVI has disbursed US$ 469 million and committed US$ 740 million for vaccines, health system strengthening, and immunization services support in Ethiopia. The government’s routine immunization spending has increased since 2001 when GAVI funds started. In 2009, the Ethiopian Expanded Program on Immunization’s (EPI) expenditures totaled US$56.7 million with the government financing about 12 percent of routine immunization spending. This increased to 51 percent in 2010 with the government spending US$26 million (US$17 per infant) on routine immunization. (WHO 2013).

4. GAVI-financed vaccines have contributed to the country’s strong reduction in child mortality, and GAVI has been a pioneer in Ethiopia in aligning its finances for HSS. The program disburses into the pooled MDG Performance Fund, which finances the government’s Health Sector Development Program. The government and partners in Ethiopia generally have a positive perception of the GAVI Alliance, in particular for its large-scale, front-loaded, predictable financing for new vaccines, and recent declines in the prices of some new vaccines.

5. The lack of GAVI country presence combined with lack of an effective partnership appears to result in missed opportunities to strengthen immunization results via operational support and health and immunization policy dialogue, for
example on how to speed up immunization in lagging regions and for disadvantaged groups. Immunization is highly inequitable between the highest and lowest income quintiles in Ethiopia. In 2011, there was a substantial gap between the poorest and richest income quintiles with nearly 15 and 50 percent respectively of 1-year-olds immunized. There are also large urban/rural gaps in Ethiopia. In 2005, NDHS data illustrated that 10 percent of children in Affar had adequate immunization coverage whereas nearly 90 percent were adequately covered in Addis Ababa.1

6. The World Bank has supported immunization in ways that are broadly complementary to GAVI’s program. It helps finance health worker salaries under Promoting Basic Services (PBS, a multidonor operation, now in its third phase). This support is clearly enabling for the immunization program. PBS I and II also financed some medical procurement. The World Bank is starting analytical work on basic services for the bottom 40 percent (also the group that doesn’t receive immunization). Thus, World Bank and GAVI support seem broadly complementary.

MISSION SUMMARY: NEPAL

7. Community-based programs were successfully implemented in Nepal, which resulted in full immunization coverage increasing from 43 percent in 1996 to 87 percent in 2011. Currently, most vaccine coverage fluctuates around an average of 85-90 percent. According to the NDHS in 2011, DTP3 coverage was 92 percent and measles was 88 percent among 1-year-olds. The Hib3 vaccine was recently introduced in 2011 and Nepal is scheduled to introduce pneumococcal vaccines in 2014 and rotavirus vaccines in 2016. Pneumococcal disease is the leading cause of pneumonia – Nepal’s number two killer of children under five years of age with 16 percent of total deaths in 2010. Following that, rotavirus, the leading cause of severe childhood diarrhea, is the sixth fatal disease for children under five with 6 percent of the total deaths in 2010. (WHO 2010)

8. Total expenditures on health have historically fluctuated between 5-6 percent of the Gross Domestic Product (GDP) in Nepal, 55 percent of which are out-of-pocket payments. Health expenditure per capita is around $33. The Nepalese government has noted that efficiency will play a huge role in creating additional fiscal space for the health sector. Linking payment to performance may be the best option for the government to get more value for the money spent on health care (World Bank 2012, UHC Forward 2008).

9. The MoH faces funding issues due to the absence of an elected government and a frozen budget. This has caused the health sector to be under-financed. The total amount of disbursements from GAVI between 2001-2012 was around US$ 59 million with US$ 110 million committed. Of this support, 61 percent can be attributed to
vaccine support and 39 percent to financing non-vaccine support such as HSS and immunization services support.

10. The Nepal Health Sector Program 2010-2015 (NHSP II), under the Sector-wide Approach (SWAp) framework, is dedicated to creating equal access to health care and lowering out-of-pocket payments for services, and it is also the basis for the HSFP. The SWAp uses a Joint Financing Agreement ("JFA") to pool funding from five donor agencies (World Bank, GAVI, DFID, Kreditanstalt fuer Wiederaufbau (German Development Bank) (KFW) and Australian Agency for International Development (AusAID) – referred to as Pooling Partners.) The Non-Pooling partners who have signed the JFA are U.S. Agency for International Development (USAID), UNICEF, United Nations Population Fund (UNFPA), and WHO. The agreement has been in effect since August 2010.

11. Nepal was a pilot country for HSFP and is the only country so far where the HSFP has been implemented; however the Global Fund is not a party to the HSFP in the country. Nepal has demonstrated that close donor coordination can be achieved, that joint funding based on a JFA outlining the rights and obligations of pooling and non-pooling signatories is critical, and that the SWAp provides an excellent mechanism in achieving this objective. Although the World Bank is an active member of the Health Sector Coordination Committee (HSCC), it is not a member and does not participate in the ICC.

MISSION SUMMARY: INDONESIA

12. The country’s strong centralized government structure rapidly decentralized in 1999 which led to significant funding increases to the health sector and placed service delivery in the hands of local government. Although the country has made improvements in health outcomes since decentralization, it has been much slower than its peers in maternal mortality, nutritional status, and underweight rates. Inequality remains a problem in Indonesia with 46 percent of the population living below the basic needs poverty line of US$2 per day in 2010 and large gaps in infant mortality rates between the rich and the poor. (World Bank 2012).

13. The Indonesian government considers immunization to be a health priority. Immunization trends have shown relatively little change over the last decade with an average coverage mean around 75 percent. Around 2006, the rates of BCG, DPT, Polio (Pol3) and Hepatitis B (HepB3) vaccine coverage declined. Conversely, measles’ coverage rates have steadily increased since induction from around 75 percent to 90 percent. Pentavalent vaccine has been introduced in Indonesia and Pneumococcal vaccines were planned for introduction in 2013. Although overall immunization distribution has increased from 55 percent to 59 percent between 1997 and 2007, it still remains inequitable across income quintiles and urban and rural populations.
APPENDIX E.
FINDINGS FROM THE COUNTRY VISITS

14. Health spending has been historically low in Indonesia with an average of 0.5 percent of GDP over the last decade and a half since decentralization. With private payments capturing 70 percent of disbursements, the country has struggled with high levels of out-of-pocket payments and informal user fees resulting in little protection against catastrophic spending. However, public spending following decentralization has increased and focused primarily on vertical disease-specific programs, investments in facilities and salaries. Indonesia currently covers a substantial part of immunization costs and is graduating from GAVI support. GAVI has committed US$ 95.5 million to Indonesia of which US$17.5 million in vaccine costs and US$38.3 million in vaccination oriented HSS has been disbursed.

15. As a GAVI graduating country, Indonesia is co-financing support and carries the majority of immunization costs. GAVI is the only partner in health actively supporting the Government’s immunization program. The sustainability of the health financing system faces decentralization challenges. Government has stressed health as a priority sector and increased expenditures; however, sustainability at the central level does not promise sustainability at the provincial and district levels. Unfortunately, there has been inadequate funding from district offices for operational costs.

16. The country will graduate from GAVI in 2015 and has been recipient of both GAVI and World Bank funding. The World Bank and GAVI have both made important contributions to the Indonesian health sector. GAVI support has focused mainly on vaccination financing whereas the World Bank set up programs after decentralization dealing with HSS. The World Bank financed three prominent projects after decentralization focused on direct support for the decentralization efforts and operational costs of immunization. (GAVI 2010). The ICC, which implemented and monitored GAVI support for direct immunization costs merged in 2011 with the HSCC to work on similar issues in immunization, management, and health system objectives. The World Bank used to be a participating member of the ICC, but has been removed in 2010 from the list of signatories due to too little engagement on its part.

17. A comprehensive sub-sector review of immunization activities was completed for Indonesia. At present there is no regular direct communication at the country level between the GAVI and World Bank staff. Other donors expressed regret about this, since enhanced collaboration would be mutually beneficial. The government did not consider the Bank a vital partner with regards to technical assistance for vaccine sustainability. Instead JICA, UNICEF, and the WHO were cited. Development partners expressed an interest in having the Bank participate more actively in regular meetings with the donor community at large in order to coordinate efforts more closely. Indonesia does not use UNICEF for vaccine procurement. Instead it requires single-source procurements from the national supplier BIOFARMA resulting in excessively high vaccine prices.
Mission Summary: Tajikistan

18. With relation to health indicators, Tajikistan has some of the lowest in the region with an infant mortality rate of 34 per 1000.\(^2\) The National Development Strategy in Tajikistan prioritizes the reduction of infectious disease and vaccine-preventable diseases, and the National Immunization Program (NIP) in Tajikistan has deemed immunization as a health priority for the government. A National Immunization Program Review undertaken in 2012 by the Ministry of Health, UNICEF, JICA, USAID, and the Agha Khan Foundation emphasized the need for more health sector funding, equitable health services, better monitoring, and vaccine stock management. Although the government reported the immunization rate between 2008 and 2012 for children under 1 year to be in the high 90s, the Review highlighted serious deficiencies, with 71 percent of children having had all 8 vaccinations, vague monitoring and reporting systems, shortfalls in state and regional funding, aging infrastructure, and limited health worker skills.\(^3\) Surveillance and equity issues were magnified in 2010 by the polio outbreak that occurred after a 13-year absence of the disease. The outbreak also raised concerns about the weaknesses of the routine immunization and the reliability of reported coverage.\(^4\)

19. The government introduced pentavalent vaccines in 2008 with help from GAVI, JICA, and other international organizations. Plans to introduce the rotavirus vaccine have been stalled until 2015 due to financial difficulties and the pneumococcal vaccine should be introduced in 2014-2015.\(^5\) Regardless of the government’s interest, WHO advised against introducing the HPV vaccine at the present time.

20. Total health expenditures have been around 5-6 percent of GDP over the last decade; however, public funds only cover a small proportion causing out-of-pocket payments to be rather high for the European and Central Asian region. According to the World Bank, in 2009 households contributed about 72.4 percent of total health expenditure in the form of user fees and out-of-pocket payments. Informal payments have also been a problem due to the low incomes of health care workers. In terms of immunization, the government only covers 12.5 percent of costs and relies heavily on international donor contributions. Health-sector reforms must be put in place to build a sustainable financing system.

21. There are large inequities in the health service provision of Tajikistan. Tajikistan’s mountainous terrain makes health access difficult for those in hard to reach villages, and childhood malnutrition remains a problem for some of the poorest regions. 2012 immunization data shows large inequities between income quintiles with a 26.8 percent gap in immunization distribution between the highest and lowest quintiles.\(^6\)
22. Currently, the government has only been able to make small obligatory co-payments on vaccination costs; in order to keep within GAVI regulation, the government has doubled its co-payments for vaccine purchases to US$550,000 in 2013. Although the Ministry of Health has requested more funding, the Minister of Finance is reluctant to distribute more money towards health spending. Furthermore, there is little health policy dialogue between the two branches of government. Development partners are unsure of Tajikistan’s ability to finance its own immunization services since GAVI and donors subsidize a majority of the immunization costs. As a result, immunization is consequently under-financed by the government, highly dependent on donors, and lacks political support.

23. The ICC in Tajikistan has not effectively addressed sustainability and HSS issues. Other coordination committees have also been formed to discuss HSS issues and immunization respectively. The World Bank is no longer part of the ICC due to infrequent meetings; however, it is an active member of another committee. WHO’s support is largely limited to technical assistance, UNICEF acts mainly as a procurement agency, and the Bank is absent. The World Bank considers immunization as GAVI’s sole responsibility; however, there has been little engagement between GAVI and the government on strategy and sustainability of immunization activities.

24. Unfortunately, the necessary policy dialogues to reinforce the priority of immunization in the national development agenda and to ensure the financial sustainability of the immunization program have not occurred. As effective childhood immunization constitutes a cornerstone of any healthcare system and is the major intervention to reduce childhood mortality (MDG 4), the vacuum in policy dialogue is not only a lost opportunity for meaningful health sector involvement for the World Bank, but also a critical shortcoming in the partnership with GAVI. Better collaboration between the two organizations and the government could procure health policy aimed at the creation of a more sustainable, equitable health financing system with respect to immunization.