Addressing Health Systems Barriers to Immunization

Outcome of Consultation with Countries

Geneva, 27 October 2003
DRAFT

Global Alliance for Vaccines and Immunization (GAVI)

BACKGROUND

Immunization is one of the most cost-effective means to increase life expectancy and is alongside girls' education and access to clean water and sanitation a key intervention for raising productivity and reducing poverty. Immunization has been shown to be correlated with increased height and weight among 12 year olds and improved test scores and language abilities.

The GAVI Board has identified efforts to address system-wide barriers to immunization as a workplan priority for the GAVI alliance in 2004-05. The principal approaches are to seek alignment at global level of key health sector development partners, promote alignment across global initiatives that face similar barriers, and work with selected countries to find the best options where the GAVI alliance can add value over and beyond the work of individual partners. Such efforts will facilitate sustainable scaling-up of immunization and other essential services and contribute towards the achievement of the Millennium Development Goals.

As lead responsible for the development of this workplan area, NORAD with the GAVI Secretariat organized on 27 October in conjunction with the Second Consultation on Macroeconomics and Health (CMH) a one-day Consultation with the following objectives:

- Obtain input from Countries and Global Partners on the most critical and common system-wide barriers to immunization;
- Identify areas where alignment and synergies with other global efforts should be sought;
- Help define areas of most potential and "added value" on which the GAVI alliance should focus in 2004-05.

The meeting was organized as a series of panel discussions, each addressing one of the groups of system barriers identified in the McKinsey Study[1]. A Consultation paper containing statements aiming to describe barriers typically encountered at national level served as background material.

This report summarizes the key issues and the main outcomes of the discussions - as captured from the panel presentations, the plenary discussions and participants' feedback forms. It will inform GAVI workplan activities in 2004-05.

[1] Achieving our immunization goal", prepared by McKinsey & Co. for the GAVI Board in April 2003

PERSPECTIVES AND ISSUES

The Millennium Development Goals will not be reached unless system-wide barriers hampering the delivery of health and other social services are effectively addressed. The work of the Commission on Macroeconomics and Health underscores the lack of political will to sufficiently increase spending on health at sub-national, national and international level as perhaps the most critical barrier to improved health in low-income countries. Removing financial constraints will however not be sufficient and progress also hinges on the ability of countries to increase the capacity of their health sector. In particular, the human resource crisis brought about by AIDS (especially in Southern Africa), the migration of health workers, and the effects of structural reforms on intrinsically frail civil service systems constitute a second fundamental barrier that needs to be addressed in a short, medium and longer-term perspective.

The Consultation paper was found to provide accurate statements on critical system barriers to immunization at country level and useful as an entry point for discussion. It was emphasized that all these system barriers are inter-connected and that advocacy and communications in particular cut across all barriers. Missing elements related to the importance of underlying contextual factors (such as the effects of political stability on political and financial commitment, and of public trust and government credibility on the overall utilization of public health services) and the need to place sustainability at the centre when designing, implementing and evaluating efforts. The need to collaborate with other sectors and to seize the opportunities of potential spin-offs of non-health efforts such as establishment of birth registration systems was also noted.

Country contributions confirmed that the situation at national level is extremely dynamic**. Despite their challenges, countries are driving the process of addressing system-wide barriers, adapting to new situations and technologies, and finding workable ways of handling the fragmentation of development efforts.** Country experiences are under-valued and under-utilized, and the Consultation confirmed the existence of a rich base of potential best practices.

- Uganda has immunization as one of 12 priority components in its Uganda Minimum Health Care Package (UMCHP). The program receives support from presidential level and immunization data is routinely provided to political leaders alongside data on AIDS. Immunization costing data and scenario options have been prepared by the health ministry through the GAVI/FSP process and have catalysed discussions with the finance ministry. Funding from the Poverty Action Fund (PAF) is increasingly being used for priority programs at sub-national level including immunization. The SWAp mechanism has increased transparency and trust among stakeholders.

- Though not yet optimally implemented, Mali is delivering a complete intervention programme to populations with limited access to health centres. Such a multi-purpose approach to delivery engaging several programs and sectors has helped define support needs and drive logistics and training efforts. The re-establishment of community committees has contributed to increase service coverage.

- Ghana has through its reform efforts started to address human resources issues head-on, by reforming organizational structures and posts, organizing management training and focusing on individual and institutional development. Identification of a package of interventions has been crucial for guiding the process. Broader efforts are underway to address the serious brain drain between professions, from the public to the private sector, and internationally).

- Haiti's national communication plan for immunization for 2003-07 aims to improve quality of services and change behaviour of parents and personnel. Indicators to monitor progress have been established, and innovative approaches such as media management and crisis management efforts initiated. Task forces from central level have helped to launch campaigns and establish local partners committees in the districts.

- Though still short of the target of 15% set by African Heads of State in Abuja (April 2001), Tanzania allocates 12% of its national budget to health with funds targeted towards regions most in need. In Tanzania (as the case is in Uganda) a completed immunization certificate has become a requirement for school enrolment. The Tanzania presentation stressed the need for countries to assess the benefits and risks presented by global opportunities before moving ahead with new initiatives. National ownership and strong management capacity at central level is key to handle technical and donor requirements.

A multitude of efforts involving bilateral agencies, UN agencies, the World Bank system, foundations, NGOs and global initiatives are underway to address system-wide barriers. While there is some room and scope for working in parallel, the Consultation confirmed the need for building on and seeking synergies with existing efforts rather than initiating new immunization-specific efforts at global level:

- WHO is strengthening its normative function and collaborative role with Member States in addressing system-wide barriers. Acceleration of priority efforts (such as the "three by five") will be designed based on Country Health System reviews and seeks to build on and strengthen national health systems. The newly established Health Metrics Network (HMN) is a response to the explosion in tools and data with only limited system strengthening benefits.

- The World Bank includes immunization into its policy dialogue with countries and its support to health sector projects and budget support initiatives (PRSC). DTP3 coverage is used as a trigger for measuring progress in the social sector in many PRSPs and as a proxy for quality of basic health services and health system performance. Efforts have been initiated to benchmark immunization performance in selected countries in order to promote learning between high- and low-performing countries and optimise Bank investment in immunization. Comprehensive efforts related to health manpower issues are also underway.

- Through its country programs of cooperation, UNICEF is supporting the planning and implementation of services using locally appropriate modes of service delivery including family and community based care, population oriented services and campaigns. Intensified efforts have recently turned towards analysing and addressing local bottlenecks using data available at peripheral level. As part of the GAVI workplan 2004-05, UNICEF is coordinating efforts to work with governments in seven large-population countries to increase coverage through intensified district level planning and expansion of services.

- Roll-Back Malaria (RBM) is looking at rapid scale-up of malaria control tools i.e. insecticide-treated bed nets, intermittent preventive treatment, prompt and effective case management and malaria surveillance, initially in countries that are ready to demonstrate and document success. There is a potential to improve interactions between immunization and malaria efforts in several areas in particular linking malaria prevention to antenatal and EPI services.

- BRAC in Bangladesh is an example of the critical importance NGOs can play as advocates and mobilizers for improved health and development at local level and as service providers in particular to marginalized populations. New approaches are needed so that Governments better support and make more use of local NGOs.

- The private sector is a critical partner in the delivery of health services in many countries. More work is needed on private/public interaction and how to effectively maximise service delivery in both sectors.

There are clear parallels between current global initiatives and previous global efforts such as Health For All and Universal Childhood Immunization (UCI). Lessons learned should be applied so that current efforts can be sustained over the longer-term, at least until 2015. Putting a moratorium on new global initiatives and working through existing frameworks was suggested as a way to reduce the burden on countries and individuals and reduce fragmentation of efforts.

GAVI as an alliance of partners working together to increase the use of vaccines in low-income countries cannot take on all system barriers but can be useful in bringing partners together in a joint effort to address some few specific issues and promote harmonization of partner approaches at country level. Its ability as an innovator and a convener has been demonstrated through the work on financial sustainability, data quality, and performance-based financial support.

The Consultation emphasized the need to **support national priority setting and decision-making processes and embed partner actions within national strategic and policy frameworks.** Realistic goals for the immunization program should be set within the short, medium and long-term of a SWAp and/or PRSP, making sure that national immunization plans are fully integrated with these. This will promote consistency and sustainability of approaches, synergies and accountability across stakeholders and levels, and reduce the burden on systems and individuals.

While broad-based efforts to reach all segments of the population with vaccines need to continue, **there is scope for an increased emphasis on pro-poor approaches and actions.** Marginalised groups typically use public services less frequently, suffer worse health and carry a disproportionate disease burden load. Immunization carries a pathfinder potential in making more use of the power of its data (from health information systems, household surveys and disease surveillance), disaggregated by gender, age, geography and income groups to be made available to stakeholders and help guide efforts to reach marginalised and underserved groups. NGOs can play a critical role in this area.

Several participants noted that GAVI should consider formulating short-term and longer-term goals for addressing system-wide barriers, considering realistic timeframes for action and impact, partners ability to influence processes, available resources and the work of other initiatives. In the short-term, the workplan 2004-05 will serve as a platform for GAVI action. Formulation of longer-term efforts could be done as part of the strategic plan development for 2005-2015.

POTENTIAL AREAS OF FOCUS 2004-05

Recognizing that the specific types and magnitude of barriers vary *between* and *within* countries and that flexibility in analysis and identification of solutions at local level is required, the Consultation allowed to focus in on potential areas at national level outlined below where the alliance can provide an added value (defined as coordination and consensus-making; funding; innovation; advocacy and communications) and where there could be potential to see progress/results in the short-term. This is summarized in annex 1.

At global level, these are times of tremendous opportunity for focus on investment and driving alignment. The agenda should build on country abilities to cope with the complex agenda of system strengthening. GAVI can make strategic contributions across global initiatives and mainstream

development efforts, focusing on MDG and Poverty Reduction goals, as well as among partners within the GAVI framework, using the comparative advantage of the different partners to link the immunization effort with system and service strengthening efforts. It is also time for becoming more concrete on human resource barriers, mapping what needs to be done and engaging in joint efforts within a common framework.

Political and Financial Commitment

GAVI efforts are carried out by partners in the alliance and not by GAVI as a distinct entity. National coordination mechanisms (the immunization-specific interagency coordination committee (ICC) or other similar Government-led coordination mechanism set within higher-level strategic frameworks) is a reflection at country level of the global partnership. In the short-term, there is scope to **strengthen national coordination mechanisms and use them as entry points for addressing system-wide barriers to immunization**.

Taking into account the country-specific context, potential actions would include clarifying relationships and harmonizing and establishing effective links to broader frameworks and processes such as a SWAp.

The following areas may benefit the most from special GAVI focus and contribute to reinforce the essential functions of a national coordination mechanism:

- Following-up on availability and predictability of funding (domestic and external)
- Monitoring of performance at sub-national level including coverage and financial allocation/disbursements/use, and
- Establishing pathfinder actions to identify and reach poor and marginalized groups.

Another potential area for GAVI focus is to **make available immunization pathfinder experiences for other programmes and the broader health sector**. As already seen in some countries, the work on financial sustainability (which is a requirement for GAVI/Vaccine Fund support) has been expanded to the costing and financing of other high priority interventions or to a defined minimum package of interventions. This could contribute to better-informed policy choice in dealing with competing priorities and to leverage financial support from finance ministries.

Physical Infrastructure and Equipment

The strength and reach of the health infrastructure vary greatly between and within countries. Local analysis and cost-effectiveness considerations are required when deciding on optimal service delivery strategies. While the most sustainable and cost-effective way to provide vaccines and other commodities is through an integrated delivery of services at fixed sites (e.g. health centres), close-to-client services provided through outreach activities constitute in many settings a critical element to improve access.

Partner efforts are underway to strengthen district micro planning for immunization and revitalise outreach activities, i.e. the WHO and UNICEF “RED” strategy of Reaching Each District. Population-oriented outreach services are also the focus of attention for a range of other initiatives and programs that seek to deliver interventions or services. .

GAVI can provide an added value by **encouraging and documenting cross-program collaboration and focusing on areas critical to the quality and sustainability of outreach approaches,** including:

- links to broader district planning, budgeting and monitoring processes

- costing of outreach services and assessment of their cost-effectiveness
- definition of interventions including the curative/preventive care mix
- exploring how to engage the private sector, in particular NGOs
- targeting marginalized and poor groups including urban and peri-urban poor and ethnic minorities.

Monitoring and Information Systems

Immunization programs have traditionally been at the forefront of producing and using data to inform program decisions. The data quality audit (DQA) introduced by GAVI to support the implementation of a performance-based reward system has helped uncover system weaknesses in national information systems, especially at peripheral level. GAVI will in 2004-05 continue to invest in data quality through DQA activities and by transforming the DQA into a self-assessment tool for self-administration at country level.

There was general agreement that there is scope for **working on immunization sub-systems as a way to support broader efforts to establish user-friendly quality monitoring and evaluation systems for the health sector and the PRSPs and MDGs**. Experiences with using immunization data (e.g. DTP3 coverage) as part of a small sub-set of indicators for measuring district performance and providing feedback to politicians and decision-makers could be looked into.

Another area to further explore is the use of **benchmark approaches to immunization coverage at sub-national level as a way to identify and address system bottlenecks for priority interventions and programs.** In addition to shifting the focus to sub-national level, this could provide opportunities to link up with performance-based schemes beyond immunization and help Governments and donors in prioritising and allocating resources.

Management of Delivery / Human Resources

At global level, GAVI can help **push the comprehensive human resource agenda forward by contributing to the efforts underway at WHO, the World Bank and the Rockefeller Foundation (i.e. the Joint Learning Initiative).**

At national level, while an immunization entry point offers limited opportunity to influence macro-policies, there is room for positive change in areas traditionally under the influence of the EPI program and its external partners. GAVI could add value by **establishing a body of evidence and of best practices, share pathfinder experiences, and seek to harmonize partner efforts in the areas of training/capacity development and of incentives.**

Many countries experience an overload of in-service training resulting in significant costs and dubious benefits. This is brought about by a fragmented approach to capacity development in health, a lack of coordination between programs, the unfortunate practice of using training activities as a way to provide staff incentives, often worsened by donor pressure and earmarking of funds.

Staff motivation is critical for effective delivery of services. In resource-poor settings with low and insecure salaries, the use of incentives in vertical programs such as immunization has tended to skew priorities and made programs vulnerable to drops in external sources of funding.

The work will focus on establishing a body of evidence through operational research on **best practices in Human Resources** including on:

- Training/capacity development and
- Use of staff incentives

Social Mobilization and Demand Creation

Advocacy and demand creation are critical for maintaining the focus on immunization and protect its place in the basic package of cost-effective life-saving interventions. This becomes the more important in view of the current environment with competing priorities and tension between curative and preventive services.

Advocacy, social mobilization and communication are cross-cutting issues that need to accompany and support partner efforts in all areas, both on the supply side to increase quality, continuity and trust in the delivery of services and on the demand side to increase awareness of the benefits of immunization and to encourage the use of services. Promoting the use of a "coverage language" based on immunization data could in this respect both advance the rights agenda and help in transforming program information into tools for advocacy.

GAVI's added value may lie in **promoting synergies between various initiatives, including immunization initiatives,** both in advocacy efforts targeting decision-makers and in communication and mobilization efforts towards communities and families. Expanding the collaboration between local governments and NGOs may be important.

ANNEX 1: POTENTIAL AREAS OF FOCUS 2004-05

Focus at global level (Target 1 in the workplan)	System wide barriers	Focus areas at national level (Targets 2&3 in the workplan)
Contribute with GAVI pathfinder experiences to macro-level development and advocacy efforts in particular in the areas of human resources, monitoring, and increased investment in health Collate and disseminate best practices documented through country-level activities Seek to harmonize efforts to address system barriers by global alignment of major health development stakeholders, both within GAVI and with other global initiatives	**Political and Financial Commitment**	Strengthen ICC or other mechanisms with similar **national coordination function** and harmonize with broader processes (SWAps, PRSP), and use as a partnership entry point for addressing system barriers, in particular: • Pro-poor actions • Availability and predictability of financial resources • Monitoring of financial and program performance at sub-national level Use immunization specific work on **financial sustainability as a pathfinder** that can be applied to costing and financing other high priority services, with a focus on predictability and on informed policy choices in dealing with competing priorities Note: importance to set this within national strategic frameworks to drive synergies and coordination in a context of multiple initiatives and stakeholders
	Physical Infrastructure and Equipment	Focus on cross-program collaboration and sustainability of **close-to-client services** (e.g. outreach services), as critical element to improve access • Links to district level planning and budgeting processes • Cost-effectiveness of strategies • Engagement of private sector including NGOs Note: link to social mobilization/demand, balance between preventive/curative, supply availability
	Monitoring and Information Systems	Use **district level data** to identify and address system bottlenecks to priority interventions and programs Note: potential of focusing on immunization sub-systems and support efforts on comprehensive health sector systems and link with PRSP and MDG processes
	Management of Delivery / Human Resources	Establish through operational research body of evidence on **best practices in Human Resources** including on (a) training/capacity development and (b) use of staff incentives
	Social Mobilization and Demand Creation	Promote **synergies across immunization and non-immunization initiatives** Note: not a stand-alone topic, links to all other areas.

ANNEX 2: LIST OF PARTICIPANTS

A. Countries

Azerbaijan	Dr. Abbas Valibayov, Deputy Minister of Health Dr. Ali Babayev, National Coordinator for Health Life Style
Bhutan	H.E. Lyonpo Dr. Jigmi Singay, Minister of Health Mr. Karma Tshiteem, Deputy Secretary, Ministry of Finance Mr. Daw Tenzin, Director, Department of Planning, Ministry of Finance
Cambodia	Professor Sann Chan Soeung, Vice Director of the National Maternal & Child Health Center and Program Manager, National Immunization Program
Ghana	Dr Sam Adjei, Deputy Director-General, Ghana Health Service (Lead Discussant)
Haiti	Dr. Patrick Delorme, Director EPI, Ministry of Public Health (Lead Discussant)
Kenya	Dr. Stanley S. Sonoiya, Assistant Director of Medical Services and Head of Kenya EPI Programme
Malawi	Dr. Richard Bakali Pendame, Principal Secretary for the Ministry of Health and Population
Mali	Mr. Youssouf Konate, National Director of Health, Ministry of Health (Lead Discussant)
Nepal	Dr. B.D. Chataut, Director General, Department of Health Services, Teku
Senegal	Mr. Birahime Diongue, Coordinator, Programme of Integral Health Development, Ministry of Health b.diongue@sentoo.sn
Tanzania	Dr Ali Mzige, Director, Preventive Services, Tanzania (Lead Discussant)
Uganda	Dr. Francis Runumi Mwesigye, Commissioner Health Services, Planning, Ministry of Health, Uganda. (Lead Discussant) runumi@yahoo.co.uk
Viet Nam	Professor Do Si Hien, Manager, Viet Nam National EPI Program
Yemen	Dr. Abdul Karim Shaiban, Deputy Minister for Medical Services

B. Partners

Bilaterals

CIDA , Canada	Dr. Montasser Kamal, Chief, UN Health-Related Institutions Unit,

	Multilateral Programs Branch montasser_kamal@acdi-cida.gc.ca
DANIDA, Denmark	Dr. Jorn Heldrup, Senior Health Adviser, Ministry of Foreign Affairs jorhel2@um.dk
DFID, UK	Ms. Rachel Arrundale, Senior Policy Adviser, Global Health Partnerships r-arrundale@dfid.gov.uk
Netherlands / MFA	Mr. Anno Golema, Health Advisor, Social Policy anno.galema@minbuza.nl
NORAD, Norway	Dr. Sigrun Mogedal, Senior Adviser sigrun.mogedal@norad.no
HeSo (NORAD)	Dr. Paul Fife, Advisor, Centre for Health and Social Development (HeSo) paul.fife@heso.no
	Mr. Ingvar Theo Olsen, Advisor, HeSo ingvar.theo.olsen@heso.no
SIDA, Sweden	Ms. Rebecka Alffram, Programme Officer, Health Division Rebecka.alffram@sida.se

Multilaterals

UNICEF	Dr. Jean-Marie Okwo-Bele, Senior Advisor and Team Leader of Immunization Plus jmokwobele@unicef.org
WHO	Dr. Farman Abdullayev WHO Liaison Officer in Azerbaijan fma@who.baku.az
	Mr. Richard Bumgarner, WHO Consultant on Macroeconomics and Health bumgarnerr@cox.net
	Ms. Tracey Goodman, Technical Officer, Vaccines & Biologicals goodmant@who.int
	Dr. Patrick Kadama, EIP kadamap@who.int
	Ms. Lidija Kamara, IV&B, FCH kamaral@who.int
	Dr Olivier Ronveaux, IV & B, FCH ronveaux@who.int
	Dr. Sergio Spinaci, CMH, SDE spinacis@who.int
	Dr. Michel Thieren, HMN, EIP thierenm@who.int

The World Bank
Mr. Joseph F. Naimoli
Senior Health Specialist, Health Nutrition & Population, Human Development Network
jnaimoli@worldbank.org

NGOs

BRAC (Columbia University)
Professor Mushtaque Chowdury, Director of Research and Evaluation Office
mc2218@columbia.edu

Children's Vaccine Program at PATH
Mr. Alan Brooks, Senior Program Officer
abrooks@path.org

Global Initiatives

RBM
Dr Patience Kuruneri
kurunerip@who.int

Other Organizations

Harvard School of Public Health
Professor David Canning
dcanning@hspph.harvard.edu

C. Resource Persons

Countries

Cambodia
Dr Mean Chhi Vun, Deputy Director General of Health, MOH
mchhvun@online.com.kh & mchhivun@bigpond.com.kh

Gambia
Dr. Khatib Njie, Independent Consultant
abhatibnjie@hotmail.com

Ghana
Dr. Dela Dovlo, Independent Consultant
dovlod@yahoo.com

Tanzania
Dr. Ali Mzige, Director, Preventive Services, MOH, Tanzania
amzige@hotmail.com

D. GAVI Secretariat

Dr. Tore Godal, Executive Secretary
tgodal@unicef.org

Dr. Mercy Ahun, Principal Officer
mahun@unicef.org

Mr. Bo Stenson, Principal Officer
bstenson@unicef.org

ATTACHMENT

Selection of countries for system wide barriers work

Introduction

One of the key objectives of the GAVI 2004/5 work plan on system barriers is to seek harmonization of efforts to address system wide barriers of major health stake holders within GAVI and other initiatives. Within GAVI, other agencies have also identified system wide barriers as a major issue and there are efforts to work within countries to address these issues. Efforts should be explored on how to bring the work of the different partners, both within and outside GAVI together on this issue.

UNICEF is using the marginal Budgeting for Bottlenecks, MBB, in selected countries to identify country/province specific "implementation constraints" of health system and estimate the "marginal costs" to overcome them. MBB uses existing information available for selected tracer interventions to identify the "bottlenecks," (weakest links in the chain of conditions), and debate various options to address them. Work has started in eight countries and there are plans to include more countries in this initiative.

In reaching its target of reaching 3,000,000 people infected with HIV by the end of 2005, **WHO** intends to use work with health systems to address the issues in a sustainable fashion. The target countries for this initiative will be indicated in early December, 2003.

The **World Bank** will soon initiate a plan to target selected countries to support improvement in immunization coverage in Africa using system wide approaches. The selection of countries is based on immunisation performance over the past five years. A matrix was used to select a range of countries from high to low performance.

Please see the list below for selected countries

Selected Countries, UNICEF & WB

WB	UNICEF
1. Mauritania	**Mauritania**
2. Ethiopia	**Ethiopia**
3. Mali	**Mali**
4. Senegal	**Madagascar**
5. Burkina Faso	**Benin**
6. Rwanda	**Sierra Leone**
7. Cameroon	**Ghana**
8. Kenya	**India (Madhya Pradesh)**
9. Cameroon	

Proposed countries for system wide barriers selection - GAVI

High performers		**Low Performers**	
Coverage	Country		
70 – 89% Countries have achieved a consistent increase of coverage (0 -3% points) between 97 - 2002	Tanzania Rwanda Burundi Ghana Bhutan	**70 – 89%** High performers, but negative annual rate of change in past five years	Vietnam Malawi
50 – 69% More than 3% point increase annually from 97 - 2002	Togo Uganda	**50 – 69%** Mixed performance, some with stagnating coverage, failed DQAs, or very wide confidence interval	Lao Kenya Madagascar *Yemen
< 50% Traditionally low performing countries, but with consistent increase in coverage from 97 - 02	Mali §Burkina Faso Sierra Leone	**< 50%** Traditional low performers	Haiti Niger Chad CAR

§Burkina Faso failed DQA
*Yemen did not fail the DQA