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Planning for Immunization Programme Sustainability in the South-East Asia and Western Pacific Regions

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Annexes

ACRONYMS AND ABBREVIATIONS

CHE	Centre for Health Economics, Chulalongkorn University, Bangkok
CVP PATH	Childrens' Vaccine Programme; Programme for Alternative Technologies in Health
FSP	Financial Sustainability Plan
GAVI	Global Alliance for Vaccine Initiative
GDP	Gross Domestic Product
GIVS	Global Immunization Vision and Strategy
Hib	Haemophilus type B
IEG	Institute of Economic Growth, New Delhi
ISS	Immunization System Support
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millenium Development Goals
MNT	Maternal and Neonatal Tetanus
MOH	Ministry of Health
cMYP	Comprehensive Multi Year Plan
RWG	Regional Working Group
SEAR	South-east Asia Region
TA	Technical Assistance
WHO SEARO IVD	World Health Organization South East Asia Regional Office, immunization and Vaccine Development

UNICEF	United Nations Childrens' Fund
UNICEF EAPRO	UNICEF East Asia and Pacific Regional Office
WPR	Western Pacific Region
WHO WPRO	World Health Organization Western Pacific Region
WHA	World Health Assembly

1. INTRODUCTION

In May 2005 the World Health Assembly (WHA) endorsed the Global Immunization Vision and Strategy (GIVS) and confirmed the global commitment to immunization as a tool for achieving the Millennium Development Goals (MDG). Stakeholders and partners from both the public and private sectors have joined in support of immunization for decreasing child mortality, improving the health of populations and contributing to poverty reduction.

To increase the chances of effective, efficient and sustainable immunization systems, all countries eligible for Global Alliance for Vaccine Initiative (GAVI) funding have been encouraged to develop financial sustainability plans (FSPs). All GAVI eligible countries in the South-East Asia Region (SEAR) and the Western Pacific Region (WPR) have either already prepared FSPs or are in the process of doing so. In order to take this process forward, based on the lessons learned from the FSP exercise from a global perspective, it is apparent that a more developmental integrated planning approach needs to be adopted. Implementing GIVS will require comprehensive and realistically costed multi-year plans (cMYPs) that can be integrated into broader health planning cycles, linked with the broader health sector. Such plans may be used for resource mobilization within domestic budgets as well as external sources (such as GAVI and bilateral donor partners). This workshop therefore aimed to bring together representatives from nine and six countries respectively from the SEA and WP regions, partners and institutes for dialogue on multi-year immunization financing planning, technical assistance, research and commitment to action. Annexes 1 and 2 detail the Agenda and List of Participants respectively. An overview of the FSP process to date and details on FSPs are available at http://www.who.int/immunization_financing.

2. BACKGROUND

The SEA Region: As part of the GAVI funding process, seven countries of the SEA Region (Bangladesh, Bhutan, DPR Korea, Indonesia, Myanmar, Nepal and Sri Lanka) have successfully completed their FSPs. India has

drafted a cMYP that has been costed and planned for resource mobilization.

The WP Region: Four countries of the WP Region (Viet Nam, Cambodia, Mongolia and Lao PDR) all submitted FSPs in 2004 and are in the process of implementing their FSPs. Various training meetings at regional and country levels have supported this process in both regions. All these countries have also drafted cMYPs, but very few of these plans were costed out, integrated with other health sector plans or budget cycles and many expire within the next year.

General: Previous FSP drafting processes included training participants from countries and providing direct technical assistance (TA) either from WHO regional offices or from international consultants. Neither of these two options for technical support is sustainable. Two institutes in the SEA Region – the Centre for Health Economics, Chulalongkorn University, Bangkok (CHE) and Institute of Economic Growth, Delhi, India (IEG) – have therefore been approached and involved with this process. This, together with a pool of regional consultants, has created a 'loose network' of technical support on immunization financing and health economics, which may be used for technical support as the need for planning process, training or research becomes apparent. It is hoped that the capacity and numbers involved within this network will increase through continued support from development partners.

In April 2005, a meeting of the two institutes, WHO Headquarters, Geneva and regional consultants in the Regional Office helped identify ways of strengthening technical support for countries to increase chances of immunization programme sustainability.

The FSPs will now be incorporated into the costing and resource mobilization parts of the cMYPs. Devising these will require considerable TA to countries over the next two years. Although the process should be seen as completely separate, applications for GAVI II funding (starting in 2006) requires every country to draft a cMYP which has been fully costed out and includes resource mobilization plan.

Partner agencies within the Regional Working Groups (RWGs) and the regional networks of support will now not only be used to assist Member States in capacity building for planning for sustainability, but also costing and financially analysing the cMYPs.

3. JUSTIFICATION FOR THE MEETING

As part of the GIVS, approach which was ratified by the Health Assembly, this meeting was crucial to compare experiences on planning and financing, as well as to identify gaps in technical assistance for countries drafting cMYPs in the future. This was the first time that regional institutes, consultants, global partners and country representatives had an opportunity to meet together on this issue. The meeting was timely, given that

- Many countries will be applying for GAVI II funding in 2006;
- Many countries will be drafting cMYPs in 2006;
- The GAVI decision to support the process is being finalized, and
- The FSPs now need to be integrated into cMYPs.

The method of providing country overviews and identification of problems together with identifying regional and global support was necessary. This inter-regional process aimed to increase collaboration between partner agencies and institutions in both regions.

4. MEETING OBJECTIVES

Overall objective: To increase the regional capacity to draft comprehensive immunization multi-year plans (cMYPs).

Specific objectives

(1) To provide an update on country experiences with the immunization FSP process, identify remaining gaps in information and devise possible implementation strategies;

(2) To provide an update of regional immunization and global support mechanisms available for financial issues concerning and devising cMYPs;

(3) To draft a plan of action to support country request for assistance in drafting their cMYPs; and

(4) To strengthen and increase the capacity of the regional immunization financing network.

The technical sessions and working group sessions spread over three days are highlighted in the agenda **(*Annex 1*).** An additional WHO – UNICEF meeting was held on the fourth day to review the mechanisms of strengthening joint work in support of country cMYP processes.

DAY 1
Aim of the day: To highlight country and region-specific immunization financing overviews, identify barriers to financial sustainability, gaps in information and trends in regional immunization financing to lead the way into comprehensive Multi-Year Planning and GAVI II application process.
DAY 2
Aim of the day: Provide an overview of GIVS, introduce the comprehensive and costed MYP process and identify country needs and institutional support to these processes.
DAY 3
Aim of the day: For partners to respond to country requests for assistance and finalize action plans. The SEAR RWG meeting and WPR country review.

5. PLANNED MEETING OUTCOMES

(1) A plan of action for 2006 - 2007 detailing for technical assistance for country cMYPs (that includes costing and resource mobilization); and

(2) Institutional assistance and support is identified

6. INAUGURAL SESSION

The Dean of the Faculty of Economics, Chulalongkorn University welcomed the participants to the workshop and gave an overview of his university's capacities. Representatives from UNICEF's East Asia and Pacific Regional

Office and WHO Regional Offices of South-East Asia and the Western Pacific also welcomed the participants and commended the collaboration between UNICEF, WHO and regional institutes, particularly the Centre for Health Economics, Chulaongkorn University (CHE). The addresses, delivered on behalf of respective regional directors, emphasized:

(1) The need for adequate sustainable financial resources for immunization systems to function effectively which requires careful and considered resource planning;

(2) Reasons behind the FSP process initiated by GAVI to increase the capacities of all the GAVI eligible countries to plan and manage resources in a sustainable manner;

(3) How the FSP process had brought into focus the need for accurate costing and budgeting within the cMYP process. This is an essential exercise for countries either planning their internal budgets, proposals for donors or within basket funding such as sector-wide approaches; and

(4) As GAVI partners, WHO and UNICEF are fully committed to the FSP and cMYP processes.

The addresses concluded with the hope that this meeting would act as a catalyst for bi-regional and intercountry information exchanges and strengthen the network of support available for countries' planning processes.

7. LOOKING BACK: EXPERIENCES WITH FSP

A brief summary of the FSP and cMYP processes and experiences in the SEA and WP Regions was presented by Dr Baoping Yang, Regional Adviser, EPI, WPR office. This was followed by individual country presentations on experiences with the FSP and cMYP processes to date.

7.1 Country Presentations

Participants were able to learn from cross-country experiences and were able to identify new approaches and processes that may be adopted to further strengthen the FSP processes moving forward into cMYPs. There was

an overall recognition for the need to develop fully-integrated and costed cMYPs for strengthening immunization programmes within the overall Global Immunization Vision and Strategy framework (GIVS).

All country presentations outlined the process adopted in preparing the FSPs, with some indicating the process of integrating the FSP into the cMYP. Despite the obvious diversity between countries in the two regions, all presentations highlighted the common themes of the importance of achieving financial sustainability, identifying programme costs, identifying funding shortfalls, and mobilizing domestic and external resources with an overall focus on improving programme efficiency.

The experiences in planning for immunization programmes in both regions also highlighted the need for costing and financing immunization plans as an integral part of broader health planning from the outset.

More specifically, the country presentations highlighted:

- How the FSPs had helped their respective countries strengthen capacity at all levels and undertake projections of cost and fund requirements for advocacy with policy-makers;
- Barriers to implementing the FSPs. A major barrier identified by most countries included personnel capacity issues with no over-all coordinator of planning processes, low numbers of staff, low capacity of staff in health economics, staff having multiple tasks and frequent staff turnover;
- The nature of assistance needed in the preparation of FSPs and cMYPs. These generally related to training, funds and technical assistance. The larger countries pointed out the need for the preparation of sub-national plans, for which they had only limited capacity to undertake the planning and costing
- Some FSP activities were adversely affected by unforeseen factors such as the Tsunami, economic and political instability, and unanticipated increase in cost of vaccines;
- The need to boost, wherever possible, domestic production of vaccines and decrease reliance on international markets;
- The importance of contingent planning of alternative scenarios for possible fund reallocation ;

- The increased role of the private sector, community and vaccine industry; and
- The importance and need for advocacy and good epidemiological information on which to base policy decisions.

7.2 SEAR Experiences with the FSP and cMYP Processes

Out of a total of nine GAVI-eligible countries, eight developed FSPs and one (India) developed cMYP that was fully costed and resources mobilized appropriately. The GAVI Financing Task Force approved a proposal from the Regional Office to support the FSP process together with regional partners and institutes. The Regional Office therefore engaged the two regional institutes to support the process at regional and country levels in the South-East Asia Region. The two institutes; Centre for Health Economics, Chulalangkorn University, Bangkok (CHE) and the Institute of Economic Growth, New Delhi (IEG) were joined by a representative from the London School of Hygiene and Tropical Medicine (LSHTM) at this meeting to consider possible areas of future bi-regional collaboration, research and support. Besides this institutional support, health economists from India and Indonesia were also involved in the FSP process. This loose network of support was key to the provision of technical support for the process and future areas of possible research, training or in-country support.

During the institutes' visits to countries, their FSP support included:

- Review of barriers to financial sustainability;
- Provision of recommendations to countries on how to implement their FSPs;
- Identification of core indicators for financial sustainability;
- Raising the profile of costing and financing in planning for immunization; and
- Identifying gaps in information of immunization financing

Summarizing the lessons learnt from country experiences based on assessments in the last 18 months, the following were identified as part of the FSP process in the SEA Region.

Things that went well in the SEA Region's FSP process:

- Good use of a standard costing tool, leading to strong costing analysis;
- Brought ministries together for planning processes;
- Gave a clear overview of needs to health planners and donors;
- Stimulated interest and possible research in immunization economics;
- Low use of 'western'-based consultants;
- Created a regional support network for financing issues concerning immunization;
- Institutional involvement in the process; and
- Improved inter-agency linkages.

Things that did not go so well in the SEA Region's FSP process:

- Some countries perceived little incentive to 'own' the process, the incentive was to provide something for GAVI that would be 'passed' by the IRC. This led to requests for well-qualified consultants who could write the FSP on behalf of the country;
- Training government staff directly, due to frequent rotation or promotion;
- Weak sustainability part of the plans;
- Difference between global and regional expectations and actually getting the work done at country level; and
- Lack of awareness of the importance of FSP principles among partners and ministries

The future identified needs based on lessons learnt during the FSP process include:

- An increased need for in-country technical assistance on immunization financing within the cMYP process;
- Increased need for linking the FSP to broader health sector multi-year planning principles, budgets and planning cycles; and
- Identified key research needs on immunization financing.

In order to strengthen immunization systems to protect children from vaccine-preventable diseases, funding needs not only to be from regular and reliable sources, but should also flow efficiently and transparently.

7.3 Experiences of the WP Region with the FSP and cMYP processes

Initial immunization costing and financing project in the WP Region was first spearheaded by the Asian Development Bank in 1998, under the Asian Vaccine Initiative. This included comprehensive financial assessments in several Western Pacific and Central European countries between 1998-2000.

The FSP process was limited to GAVI eligible countries, and was not used as a programmatic tool in other countries. It focused on immunization services. There are efforts under way in countries that have undergone the FSP process to go through similar processes for other health programmes including family planning, TB, malaria and reproductive health services.

Of the 37 countries in the WP Region, four countries developed FSPs and 16 countries drafted cMYPs in 2005. However, only four of these countries confirmed linkages of their MYPs to broader health sector plans.

Common FSP findings and process themes in the WP Region countries:

- There has been a continuous increase in country programme costs resulting from program me improvements and introduction of new vaccines;
- The amount of external resources has been unpredictable;
- Most programme inefficiencies are due to high wastage rates, poor outreach planning and expensive campaigns;
- All countries were trained on the FSP guidelines, tools and process in 2004 at regional FSP workshops;
- Country staff rotation and attrition resulted in country requests for technical assistance following regional training workshops and further in country training;
- Technical assistance to countries was provided by regionally based institutes and consultants;
- There was varied government ownership of the FSP process;

- The FSPs did not necessarily lead to increased resources, in particular from bilateral partners s at the country level;
- The FSPs provided increased clarity of costs and evidence of government funding of immunization inputs;
- The FSPs catalyzed collaboration between ministries, agencies and ICCs;
- The use of standardized costing and financing tool helped managers to identify the main immunization programme cost-drivers, which allowed for building different scenarios and for analysis; and
- The FSP helped raise issues of programme efficiency.

Countries in the WP Region that are more donor dependent were reported to be more likely to report having cMYP. In some countries, the document was first prepared to fulfil of donor requirements, and in others, the MYPs were modified to meet donor requirements. In many instances, external consultants or partner agencies were involved in drafting the MYP. The regional analysis of MYPs led to some concerns regarding accountability when targets included in the cMYP were not met, and in monitoring and implementation of MYPs.

Needs identified within countries of the WP Region

- MYPs should be built on FSPs, where FSPs have already been developed;
- For countries that have not yet developed FSPs, a cMYP should be drafted ;
- Countries need to establish stronger linkages between the FSP and cMYP processes with broader health sector planning and budgeting processes;
- National and sub-national capacities in planning, programme costing and financing should be improved to better use existing national capacities;
- Country ownership of the FSP and cMYP processes should be ensured and country accountability in implementing and monitoring FSPs and cMYPs should be improved; and
- Roles of different service providers should be defined and processes for integrating costing and financing information with other health programmes and initiatives should be identified.

7.4 The SEA Region's perspective of immunization financing analysis and regional trends

A study on the SEA Region's perspective of immunization financing analysis - key regional trends noted in the FSP process were presented. (Details can be found in Annex 3). This examined FSPs in seven countries (Bangladesh, Bhutan, DPR Korea, Indonesia, Myanmar, Nepal and Sri Lanka) and the cMYP costing in India. The study was undertaken (i) to allow for some in-depth analyses of resource requirements, review of trends in financing and vaccine coverage, and (ii) to enable identification of specific immunization financing issues for a country.

Some highlights of the study included:

- Interpretation of data is complicated as GDP per capita varies greatly between countries;
- Figure 1 shows that the regional average cost of routine immunization with DTP3 in 2004 was US$ 23 per child immunized, and was expected to rise to around US$ 27per child by 2013. But these figures tend to hide large differences between countries, which vary between US$ 10 and US$ 40 per child. (see individual country reports in Annex 3).

Figure 1: ***Routine Costs***

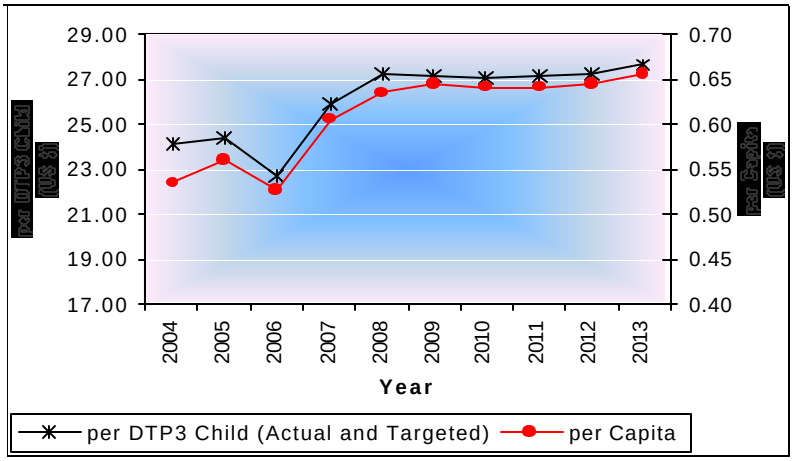

Figure 1: Average cost of routine immunziation for DTP3 in Bangladesh, Bhutan, DPR Korea India, Indonesia, Myanmar, Nepal and Sri Lanka.

Source: FSPs from all countries except India – costing component of cMYP

- Most of the cost of vaccination is related to fixed-site delivery. The proportion of costs related to SIAs is expected to reduce substantially by 2013 (approximately 5% , down from around 25% in 2004)
- Countries work in the context of large proportions of budget needs being not secured: less than 50% of future needs is considered as not being secured; and
- GAVI fund-allocations in the Region vary widely: GAVI-dollars per surviving infant range between US$ 2 (India) to US$ 39 (Bhutan).

The study showed clearly that FSPs provide a wealth of details on costing of immunization programme, but there is a clear gap related to data on sources of future funds. The gaps between programme needs and secure funding will need to be addressed, possibly by increasing support from government, GAVI and other donors, increasing programme efficiency, and decreasing vaccine costs.

7.5 Institutional Perspective: Centre for Health Economics, Chulalongkorn University, Bangkok (CHE)

Based on visits and technical assistance to DPR Korea, Myanmar and Indonesia CHE identified key issues and some barriers to financial sustainability, including:

- Countries have a limited availability of domestic resources (not necessarily at macro levels, but also issues with fund flows). They rely on a limited number of external partners such as GAVI, UNICEF, WHO, JICA and DFID.
- Vaccine costs were not always reflected as a line item in the government budget

- Human resource capacity in the field of EPI economic analysis is limited; and
- Inefficiencies in national immunization programme with high wastage rates, sub-optimal staff effectiveness, lack of communication and IT systems.

Identified urgent need: Immunization programmes need simple financial indicators to monitor and evaluate progress. Suggested examples include:

(1) Cost of NIP as proportion of total government expenditure;

(2) Percent immunization coverage per province;

(3) Funds committed to NIP in the last year as per cent of the total; and

(4) Vaccine wastage rate.

Potential areas identified for further research included:

- Financial burden of vaccine-preventable diseases;
- Disease burden studies – especially those connected with new vaccines such as haemophilus influenzae type B (Hib), and rotavirus;
- How to practically integrate immunization planning into different health care systems;
- Monitoring and evaluation of implementation under various health care systems;
- Developing and managing financial health information systems; and
- Political advocacy of FSP of the Immunization Program.

7.6 Institutional Perspective: Institute for Economic Growth, New Delhi (IEG)

Based on visits and provision of technical assistance to Bhutan and Nepal, the IEG presented their findings.

Main issues identified:

- Data problems, such as conflicting data on target population data;
- Unreliable data on coverage and wastage rates;
- Time constraints limited an in-depth analysis of barriers, but lack of in-country technical capacity could be identified as one of the key barriers for countries to develop FSPs; and
- Lack of country ownership, both related to the process of developing a FSP and to the content of the FSP.

Recommendations:

- Barriers to financial sustainability of immunization should be identified by in-country staff, with 'outsiders' only used to facilitate processes;
- More time should be allocated for an in-depth analysis of barrier review; and
- The FSP has potential to address costing issues beyond immunization.

7.7 Review of the FSP process in the SEA and WP Regions: Other issues

During discussions, the following issues also were repeatedly raised:

- More country and regional interaction with the vaccine industry was required to provide long-term projections of vaccine demand, clarity on vaccine prices at country level and for countries and regions to be able to negotiate this price
- Fresh policies with regard to vaccine production need to be developed including the possibility of shifting vaccine production from the costlier areas to the less costlier ones;
- Government ownership was crucial if the FSPs are to be successfully implemented ;
- To have an FSP *per se* was not enough. High-level advocacy (supported by appropriate studies such as cost-effectiveness /

benefit analysis) with policy- makers and donor partners was crucial; and

- The FSP process needed to be reviewed in the context of lower costs of combination vaccines.

8. LOOKING FORWARD: GIVS, GAVI II AND PLANS FOR COMPREHENSIVE, COSTED MYPs

8.1 GIVS, MYP Costing and MYP Process

An overview of GIVS was presented, which is summarized at http://www.who.int/vaccines/givs. GIVS offers a menu of options from which countries can select key strategic areas that correspond with identified needs. GIVS is not meant to be prescriptive, but offers guidance for countries as an over-arching framework for immunization planners for the next 10 years.

Countries are encouraged to work the totality of GIVS and link the assessment of needs to the development of the cMYP. With a data-driven analysis, countries should be able to determine gaps and needs. From this analysis countries should be able to choose the appropriate strategies and actions from GIVS.

Technical overviews were also provided on how to practically go about making a cMYP, which included the aspects of costing and practical in-country steps needed for drafting and costing a cMYP. Participants especially found this session very useful with question and answer session on how to practically go through the process of drafting an in-country cMYP.

8.2 GAVI II

An update on the analysis performed on GAVI Phase I support and results of the GAVI BOARD MEETING held in June 2005 were presented. However, key decisions on application dates, procedures and fund flows will not be known until the next board meeting in December 2005.

Recommendations made to the GAVI board for new and under utilized vaccines:

- An in-depth assessment of the consequences of future, new and under- utilized vaccine introduction will be required at the GAVI II application stage when countries apply for GAVI II funding;
- GAVI will provide support for at least 10 years for new and under-utilized vaccines;
- A plan of government co-financing, with increasing government contributions until 2015, will need to be built into every future application; and
- GAVI will focus on encouraging manufacturers to reduce prices.

Recommendations made to the GAVI Board for Immunization System Support (ISS):

- Flexibility of ISS funds in Phase 1 was widely supported and important to continue in GAVI Phase II;
- Countries appreciate the incentive approach to ISS, but have limited understanding on how it works;
- A single indicator for measuring performance was welcomed;
- All GAVI eligible countries should be eligible for ISS;
- Additional support will be required to maintain coverage rates and reach the 'hard to reach';
- There are still differing views on whether funds should be used beyond immunization; whether to have guidance on use of funds; and how to link to performance; and
- Country partners will be encouraged to provide more predictable support.

Given the short time-frame for action, countries and some partners felt that some key issues needed clarification by GAVI as soon as possible; co-financing bridge financing, health systems strengthening (HSS), transition plans from Phase I to Phase II and the three investment case areas (polio, measles and maternal neonatal tetanus).

Concerns were raised about continued high cost of vaccines (particularly combination vaccines) and queries were put to GAVI regarding the possible reduction of cost. Participants were advised that a working group was soon to conclude findings which were geared around future availability of vaccines and formulations as well as potential cost and procurement. While it was not possible to share the tentative results, participants were assured that the final results would be shared by the year-end, through the RWG.

As GAVI is also concerned about the absence of price reductions of combination vaccines in phase I, it is planning longer-term support in phase II - support for 10 years, rather than five. It was felt that five years was too short to have countries take on a new vaccine and absorb the high cost as part of their programme. This area of development was taken positively by countries. However until the final procedures for Phase II are clarified, it is difficult for countries to fully understand implications or plans on the part of the countries to seek additional support.

8.3 Group work

Country groups had time to discuss in detail possible plans for drafting and costing multi-year plans. This process included facilitated discussions to identify possible technical support required, possible processes and timelines. Group rapporteurs presented findings, but there was little time for feedback, and there was still some lingering confusion about the two tools (cMYP and FSP). Therefore this session continued into Day 3 which provided the necessary extra time for countries to understand the technical process of drafting cMYPs. Summaries of the group work which detail the possible technical assistance and possible timelines of action are shown in Annex 4. This highlights the identified needs for completing cMYPs, revising FSPs and future integration into cMYPs.

9. OVERVIEW OF GLOBAL AND REGIONAL SUPPORT MECHANISMS FOR THE CMYP PROCESS AND FINANCIAL SUSTAINABILITY

9.1 World Bank

The World Bank made a presentation on 'Fitting cMYP with the health sector'. This emphasized the need for:

(1) ***Evidence-based decision-making*:** The cMYP document is able to provide governments clear estimates of resources needed and gap in financing, evidence-based data on resource allocation based on cost-effectiveness/cost-benefit analysis;

(2) Stronger links between the c-MYP and SWAPs / MoH budgeting processes; and

(3) FSPs to inform annual budgeting processes.

The World Bank highlighted the type of assistance that may be available through this process, which includes: directing funding support for programmes, policy dialogue between ministries of health and ministries of finance, capacity building training and selective technical assistance to a few selected countries.

There is also a flagship training course on financial sustainability offered by the World Bank Institute, and this may be used for capacity building in the countries. As an institution, the World Bank clarified that it was open to suggestions and ready to assist in the development of training modules to work with in–country institutions such as universities to develop their training capacities. The World Bank would help further the dialogue between MoF and MoH by helping to mobilize external as well as internal resources.

9.2 Academic institutes and NGOs

Presentations were made by key selected institutions; the London School of Hygiene and Tropical Medicine (LSHTM); CVP-PATH; CHE and IEG.

The LSHTM identified four areas of research gaps: mix of domestic and external funding; scaling up of immunization services; mobilizing efficiency gains; and trade-offs between cost-efficiency and affordability of the vaccine. Evidence shows that cost-efficiency data are neither sufficient nor necessary to introduce a new vaccine. A brief introduction to LAVI (Local Alliance of Vaccines and Immunizations) was given for potential consideration for more locally-based sustainability planning.

The other institutes provided an overview of the support already being provided by them in preparing of FSP documents for immunization to selected countries under the SEA Region, and WHO-supported/initiated

projects with potential expansion to countries in the WP Region. The institutes highlighted how their resources may be effectively tapped for technical, training and research purposes.

The CVP-PATH presented a summary of their support for the process which included in-country costing work, global distance training initiative and membership of RWGs. Their distance learning packages are available at Http://www.Aim-e-learning.stanford.edu

9.3 Regional Working Group (RWG)

A brief overview of the RWG under GAVI initiative gave a historical perspective on membership of GAVI alliance, organization of GAVI Board, GAVI secretariat, Vaccine Fund and relationships between different entities at country level (ICC), regional level and headquarters (e.g IRC, board, etc.). The RWG has a fluid structure, role and responsibilities and these have changed over time. Given clearer roles and responsibilities under GAVI II, the RWG will probably be the main focal point for technical assistance requests.

10. CONCLUSIONS AND THE WAY FORWARD

10.1 Financial Sustainability Lessons Learnt and Recommendations for The cMYP Process

Successes of the FSP process included:

- The FSPs provided an increased level of clarity on costs of immunization and provided evidence of government inputs in programmes;
- The FSPs were instrumental in catalyzing collaboration between ministries and agencies;
- The use of a standardized costing tool, which helped to identify the main cost drivers, allowed for different scenarios and could be used as a management tool;
- The FSP helped to develop costing and planning of projected activities; and
- The FSPs helped in raising issues of increasing programme efficiency.

The following are the challenges to implementing the FSPs and integrating them into cMYPs:

- The FSPs do not automatically lead to more resources. Rather, they highlight the need for more advocacy at political levels;
- Management capacity and competing priorities within the health sector were the major obstacles;
- Training needs to be better planned and organized with clarity on how, who, where and for what;
- Linking FSPs with broader health systems planning will be problematic but needs to be addressed;
- More investment in immunization will be required if new initiatives are to be initiated. (e.g. rubella, JE, tetravalent, pentavalent, hepB vaccinations);
- Data on denominators need to be made
- available
- Assumptions need to be clarified within the FSP process.
- More work is required on how links with other programs (global fund promoting FSP for TB/malaria/HIV) can be best established and on how sector-wide coordination, and coordination of plans with fiscal years can be improved;
- The effects of decentralization need to be taken into account better; and
- The creation of an in-country financing group, who would be tasked with the actual detailed planning work would be an advantage.

The following priority areas were identified for the cMYP process:

- Advocacy for appropriate policy dialogue;
- Technical assistance related to the development of the cMYP
- Research: broader sample of data collection, cost-effectiveness;
- Training on how to use the tools, particularly at national and sub-national levels in larger countries; and
- Linking the programme planning approach with costing

10.2 Institutional Collaboration

There was an opportunity during the meeting for institutes to meet and exchange experiences and possible collaborative ideas on immunization financing training, research and support. The CHE and IEG confirmed their support for collaboration with partners in the areas of costing, research, training and in-country technical assistance as the cMYP process got under way. The LSHTM, a health economics institute in Jakarta and possible linkages with an institute in Dhaka all add exciting possible collaborative opportunities in training, research and in-country support over the next few years. Collaboration will need to be coordinated by the RWG, as GAVI support is likely to flow through this mechanism.

Recommendations

(1) Every country (GAVI eligible or not) is encouraged to draft cMYPs that are practical, linked to other national planning and budgeting cycles and that are simply monitored. The possible use of the GIVS framework and the cMYP tool with its costing component may be beneficial.

(2) In an effort to strive for financial sustainability, countries that have drafted FSPs could use these to inform and feed into the planning approach with cMYPs. The cMYPs should then be used to mobilize resources from domestic and external sources through high-level policy dialogue. During the cMYP process, countries should review vial sizes, wastage rates and efficient planning in service delivery to aim for increasing programme efficiency.

(3) Training is required to increase the capacity of staff to perform costing, budgeting and financing functions at national level and in India, Indonesia and China at sub-national level.

(4) Requested support for cMYP processes will be coordinated by RWGs. This will include liaison with academic institutes and consultants who should ensure that countries drive and own the cMYP process themselves, and link it to the broader planning and budgeting cycles. A framework for action is proposed in Annex 4.

(5) Requests for research projects involving immunization financing issues will also be coordinated by the RWGs and include liaison with academic institutes.

Annex 1

PROGRAMME

Monday, 12 September 2005

Aim of the day: *to highlight country-and region-specific immunization financing overviews, identify barriers to financial sustainability, gaps in information and trends in regional immunization financing to lead the way into comprehensive multi-year planning and GAVI II application process*

08.30 – 08.50	Welcome addresses:
	Dean of the Faculty of Economics, Chulalongkorn University
	Senior Programme Officer, UNICEF (East Asia and Pacific Regional Office)
	WHO Representative to Thailand
	(on behalf of Regional Director, WHO South East Asia Regional Office)
	WHO Regional Adviser for Expanded Programme on Immunization
	(on behalf of Regional Director, WHO Western Pacific Regional Office)

Session 1: Overview of country-specific experiences with the FSP process to date

Chair: Miloud Kaddar **Rapporteur: Lidija Kamara**

09.00 – 09.25	Introductions, aims and objectives: ***Baoping Yang(WHO WPRO)***
	Regional overview of FSP/MYP process in SEAR: ***Craig Burgess (WHO SEARO)***
	Regional overview of FSP/MYP process in WPR***: Manju Rani (WHO WPRO)***
09.25 - 10.45	Country presentations – Bangladesh, Bhutan, Cambodia, India
	6-8 slide overview of FSP/ immunization costing process focusing on development, challenges in implementation, impact on outcomes and capacity gaps

10:45 – 11.00	Questions and answers
11:15 - 12:40	Country presentations – Indonesia, Lao, Maldives, Sri Lanka, Thailand and Mongolia, Myanmar ***6-8 slide overview of FSP/ immunization costing process focusing on development, challenges in implementation, impact on outcomes and capacity gaps***
12.40 – 13.00	Questions and answers
14:00 - 15:30	Country presentations - China, Nepal, Vietnam, Papua New Guinea ***6-8 slide overview of FSP/ immunization costing process focusing on development, challenges in implementation, impact on outcomes and capacity gaps***
15:45 - 16:15	**P**lenary session - opportunity for questions, intercountry learning and drawing together common lesson / themes/gaps in information or capacity for sustainable immunization planning**.**

Session 2: Regional overview of immunization costing and financing trends and identification of institutional support needs of regions and countries

Chair: Raj Kumar **Rapporteur: Jos Vandelaer**

16:15 – 16:30	The South-East Asia Region's perspective of immunization financing analysis – key regional trends noted in the FSP process ***Beena Varghese (independent consultant)***
16.30 – 16:45	Institutional perspective ***Siripen Supakankunti (Centre for Health Economics, Chulalongkorn University)*** Country visits – identification of barriers to immunization sustainability and potential solutions suggested, based on analysis and research and training needs
16.45 - 17:00	Institutional perspective ***Indrani Gupta (Institute of Economic Growth, New Delhi)*** Country visits – identification of barriers to immunization sustainability and potential solutions suggested, based on analysis and research and training needs

17:00 – 17: 45	Summary of financial sustainability session and identification of priority areas for way forward • *Country specificities versus regional commonalities in immunization costing and financing* • *Priority areas for immunization costing and financing follow up and implementation* • *Identification of institutional support to region and countries* ***Craig Burgess (WHO SEARO) and Manju Rani (WHO WPRO)***
17.45 – 18.00	Wrap up, summary of the day and looking forward to tomorrow ***Raj Kumar (CVP PATH) and Jos Vandelaer (UNICEF)***

Tuesday, 13 September 2005

Aim of the day: *Provide an overview of givs, introduce the comprehensive costed myp process and identify country needs and institutional support to these processes*

08.30 – 08.40	Overview and objectives for the day ***Jos Vandelaer (UNICEF)***

Session 3: To provide an update on GIVS, GAVI II and links to the comprehensive MYP process

Chair: Pem Namgyal **Rapporteur: Basil Rodriquez**

08:40 – 08:50	Overview of the Global Immunization Vision and Strategy (GIVS) ***Julian Bilous (WHO HQ)***
08:50 – 09:20	Linking GIVS to immunization programme multi-year planning and financial sustainability processes • Overview of the cMYP tool and how to use it with the GIVS checklist to formulate a country's multiyear plan ***Jos Vandelaer (UNICEF) and Lidija Kamara (WHO HQ)***
09:20 – 09:50	Introduction to the cMYP costing tool ***Miloud Kaddar (WHO HQ)***
09:50 – 10:00	What does GIVS mean for countries? ***Francois Gasse (UNICEF HQ) and Basil Rodriquez (UNICEF EAPRO)***

10:00 - 10:15 Questions and answers

10:45 – 11.15 Lessons Learnt from GAVI I and implications on GAVI financing policies

- Bridge Financing
- GAVI Phase II co-financing
- GAVI Board decisions
- GAVI Phase II and links with GIVS
- Links with health systems
- System wide barriers

Abdallah Bchir (GAVI secretariat)
(GAVI Financial Task Force)

11:15 - 11:45 Questions and answers session on GAVI I Lessons Learnt and GAVI II

11:45 - 12:00 Introduction to group work on FSP integration into cMYPs and cMYP planning
Craig Burgess (WHO SEARO)

12:00 – 13.00 **Country group work** – each country reviews the cMYP document and costing tool. In doing so, answers 6 questions:

(1) When does your current multi-year plan run out and when do you plan to start developing your new multi-year plan

(2) 2)What preparatory work needs to be done before developing your next cMYP and who would be responsible for the different aspects (desk reviews, situational analysis, updating FSP costing and financing information, linking to health sector plan, etc)

(3) What gaps in information are envisioned for developing the costed cMYP?

(4) How do you propose these gaps be addressed?

(5) What support is required to draft and cost your countries cMYP?

(6) What timeframe can this be planned in?

Group 1: China and India

Facilitators: Julian Bilous, Abdallah Bchir, Damien Walker, Indrani Gupta, Craig Burgess, Devendra Gupta

Group 2: Bangladesh, Bhutan, Nepal and Sri Lanka

Facilitators: Pem Namgyal, Balaji, Cornejo Santiago, Beena Varghese

Group 3: Lao, Vietnam and PNG

Facilitators: Miloud Kaddar, Basil Rodriquez, Jos Vandelaer, Manju Rani, Anne McArthur

Group 4: Myanmar, Mongolia Cambodia

Facilitators: Francois Gasse, Siripen Supakankunti, P. Manisri, J.S. Kang, Viroj Tangcharoensathi

Group 5: Maldives, Thailand, Indonesia

Facilitators: Steve Landry, Lidija Kamara, Susan McKinney, Raj Kumar, Chutima Suratdecha

14.00 – 15.00	Country group work (continued)
15.00 – 15.30	Groups report back with summaries of answers and plenary discussion on cMYP needs required and timelines
15.45 – 16.15	Groups report back (continued) with summaries of answers and plenary discussion on cmyp needs required and timelines

Session 4: Overview of global and regional support mechanisms for the cMYP process and FS

Chair: Francois Gasse **Rapporteur: Manju Rani**

16.15 – 16.30	Linking immunization financing initiatives to the broader health sector ***Cornejo Santiago (World Bank)***
16.30 – 16.45	Overview of key global immunization financing research gaps and possible support ***Damien Walker (Senior Health Economist, London School of Hygiene and Tropical Medicine)***
16.45 – 17.00	Overview of possible institutional support ***Siripen Supakankunti (Centre for Health Economics, Chulalongkorn University)***

17.00 – 17.10	Overview of possible institutional support ***Indrani Gupta (Institute of Economic Growth, New Delhi)***
17.10-17.20	Linkages to global training initiatives and opportunities ***Anne McArthur (CVP PATH)***
17.20 – 17.30	Questions and answers
17.30 – 17.45	Regional Working Group processes ***Pem Namgyal (WHO SEARO)***
17.45 – 18:00	Recap of the day
	Summary of agreed points of cMYP and FSP actions for countries
	Proposed institutional support and next steps Francois Gasse (UNICEF, HQ) and Manju Rani (WHO, WPRO)

19.00: The Western Pacific Region-Country Meeting In Chulalongkorn University

Wednesday, 14 September, 2005

Aim of the morning: for partners and institutions to respond to country requests for the cMPY process and immunization financing issues

Chair: Jos Vandelaer **Rapporteur: Craig Burgess**

09.00 – 09.15 Overview of the morning, ***Jos Vandelaer (UNICEF)***

09.15 – 09.30	Review of country requests for assistance, review of institutions, partner and RWG capacity to provide this assistance, ***Manju Rani (WHO WPRO)***
09.30 – 09.45	Review of potential partner support and RWG mechanism • Increasing GAVI secretariat – RWG links • Overview of GAVI issues ***Basil Rodriquez (UNICEF EPRO)***
09.45 – 10.30	Drafting regional plans of action for support to cMYP process and immunization financing research / training with timeline & budget

11.00- 12.45	Drafting regional plans of action for support to cMYP process and immunization financing research / training with timeline & budget
12.45 – 13.00	Summary of agreed points of partner actions and institutional support ***Jos Vandelaer (UNICEF) and Craig Burgess (WHO SEARO)***

Aim of the afternoon: The South-East Asia and Western Pacific Regions' Working Group meetings

14.00 – 16.30	The South-East Asia Regional Working Group
14.00 – 16.30	The Western Pacific Regional Working Group

Annex 2

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Annex 3

THE SEA REGION COUNTRY ANALYSES

Tables 1 and 2 provide a summary of major health and economic indicators and summary of GAVI allocations for countries in this Region. The following sections summarize the countrywide analyses of trends on projected routine costs (excluding campaign) providing an indication of the variation in resource requirement across different years for different countries in the Region.

Table 1: *Major Economic and Health Indicators – countries in the SEA Region*

Countries	GDP $billion		Per Capita GDP $		Population million		Total Health Expenditure million		Routine Immunization expenditure million		DTP Coverage %	
	2001	2005	2001	2005	2001	2005	2001	2005	2001	2005	2001	2005
Bhutan	0.54	0.81	789	1,087	0.7	0.8	12.3	26.1	0.7	1.0	88	97
Nepal	5.3	6.6	229	262	23.2	25.3	239.0	300.0	12.5	13.9	80	90
Myanmar	7.7	9.2	150	167	51.1	55.4	30.6	42.2	4.6	11.1	73	82
DPR Korea	11.0	11.7	491	481	22.4	24.3	506.0	691.0	4.9	10.1	62	75
Sri Lanka	15.7	20.1	836	1,015	18.7	19.7	610.0	740.0	5.2	7.5	99	100
Bangladesh	47.6	55.7	368	403	130.0	138.0	1,800.0	2,200.0	52.0	80.0	69	85
Indonesia	181.1	252.1	887	1,164	204.0	216.7	5,430.0	7,110.0	50.5	69.8	91	86
India (2003)	600.0		545		1,100.0		36,000.0		300.0	400.0	70	

Source: FSP data tool, except for India and Sri Lanka
India: World Bank country report and HNP indicators for 2003
Sri Lanka: WB country data for 2004 for GDP and total health expenditure
Myanmar: WB reports a total HE of 2.2% of GDP at $169m unlike reproted in the FSP

Table 2: ***Summary for GAVI fund allocations – update from July 2005***

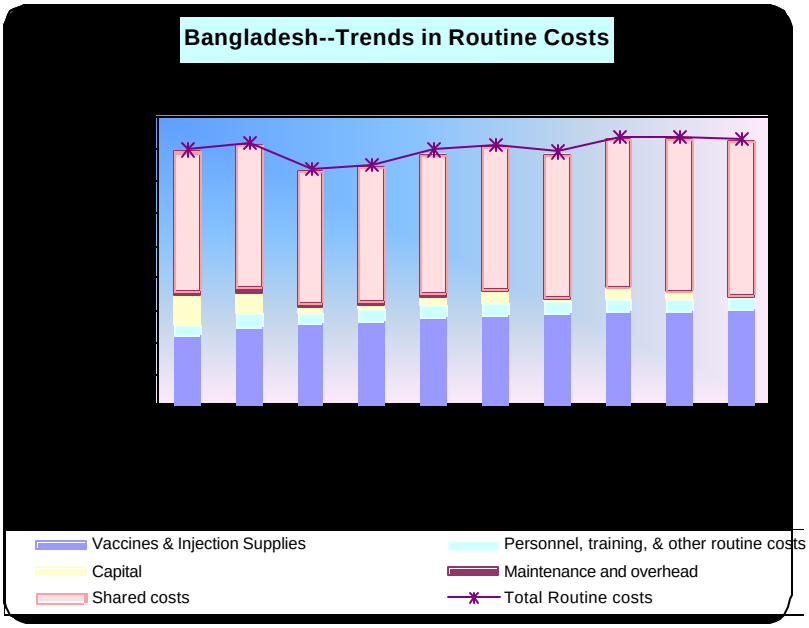
Countries	Surviving infants at approval	DTP3 coverage	ISS (5 years) $	Start year	INS (3 years) $	Start year	Vaccine fund (5 years) $	Start year	Vaccines	Other $	Total $	Total NIP as % of GDP	% financed by govt	% new vaccines by GAVI	GNP-per-capita $
Bhutan	15,902	88%			25,500	2003	487,500	2003	DTP-HepB	100,000	613,000	3.9%	5.0%	100%	600
Sri Lanka	322,366	99%			845,000	2003	2,974,000	2003	HepB	100,000	3,919,000	3.6%	100.0%	77%	850
DPRK	441,096	63%	3,315,500	2003	761,000	2002	2,909,000	2003	HepB	100,000	7,085,500	2.5%		100%	478
Nepal	727,764	72%	5,146,000	2002	1,353,500	2002	12,011,000	2002	HepB	100,000	18,610,500	5.2%	29.0%	100%	230
Myanmar	1,271,239	70%	7,902,500	2002	2,674,000	2002	21,506,500	2003	HepB	100,000	32,183,000	2.1%		61%	147
India	24,460,000	55%			24,201,500	2003	15,708,000	2002-03	HepB 10ds	100,000	40,009,500	5.1%	98.0%		545
Indonesia	4,570,828	90%	16,005,000	2003	10,745,500	2003	13,249,500	2002	HepB uniject	100,000	40,100,000	2.4%	99.0%		710
Bangladesh	3,662,915	67%	26,974,000	2002	8,116,500	2004	27,305,000	2003	HepB	100,000	62,495,500	3.5%	86%	38%	380

* Approximate calculation based on FSP data input sheet information

Bangladesh

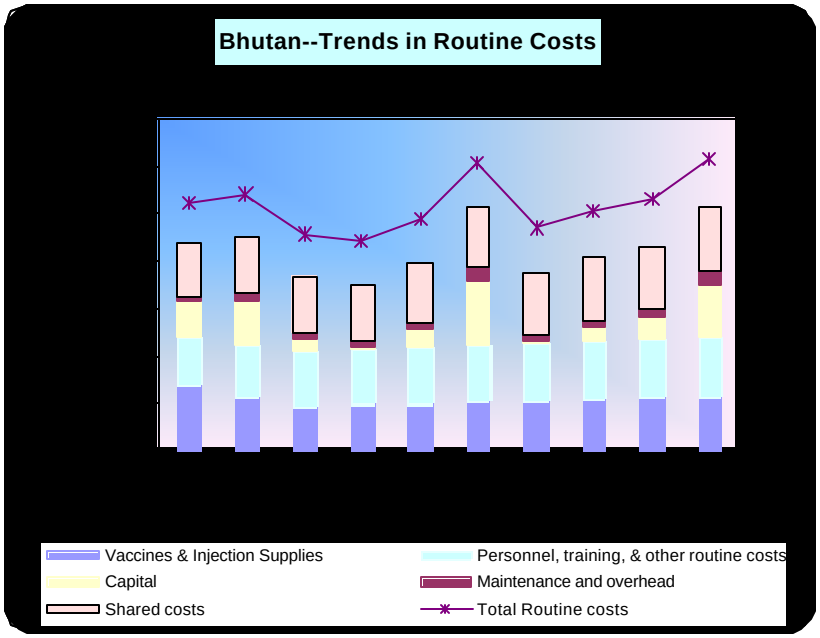
Bangladesh is a riverine country that lies in the northe-astern part of South Asia. It has a population of 138 million with a per capita GDP of US$ 403 (Table 1). The country projected total health expenditures of almost US$ 2 200 million in 2005, of which almost US$ 80 million was projected for routine immunization services. Bangladesh was expected to receive US$ 62.5 million of GAVI funds, the largest allocation among countries in the SEA Region. Of this, US$ 27 million were for the purchase of HepB vaccine and another US$ 27 million for strengthening immunization services in the country (Table 2).

The analysis of cost categories of the projected immunization budget showed that the vaccine cost was projected to be 20% to 25% of the routine cost. Direct personnel cost was a small fraction of the total projected costs, however, costs for shared personnel accounted for more than 50% of the total projected requirements. These shared costs were shown as an EPI allocation as the workers spent some proportion of their time on EPI related work. However, the salaries of all Government of Bangladesh field workers come from the government's revenue budget but not specifically from EPI budget. It is unclear if the allocation shown here were cost based on time spent on EPI tasks or if this was the total cost for shared personnel. Excluding this large proportion of the cost would reduce the projected resource requirements quite significantly: from $80 million to around $35 million. Therefore, it is important that this cost allocation is clarified and actual costs based on time allocation for EPI included in the cost projections. Other categories like capital costs and maintenance costs were projected to be minimal.



Bhutan

Bhutan, a land-locked country, had a population of 0.73 million with a GDP of US$ 761 million in 2004 (US$ 810 projected for 2005) (Table 1). The total health expenditures showed significant increase from US$ 12.3 million in 2001 to US$ 26.1 million in 2005. Despite the hilly and difficult terrain, the DTP3 coverage was commendable at 88% in 2001 and was expected to be 97% by the end of 2005. The total immunization program cost in 2005 was expected to be $1.01 million (Table 1). They have targeted future sustainability of health care in the country, as the most critical components of primary health care and in order to fulfil this objective have set up a trust fund having US$ 18 million presently with a targeted amount of US$ 24 million. The income from the trust fund is expected to fund purchases of essential medicines and vaccines.

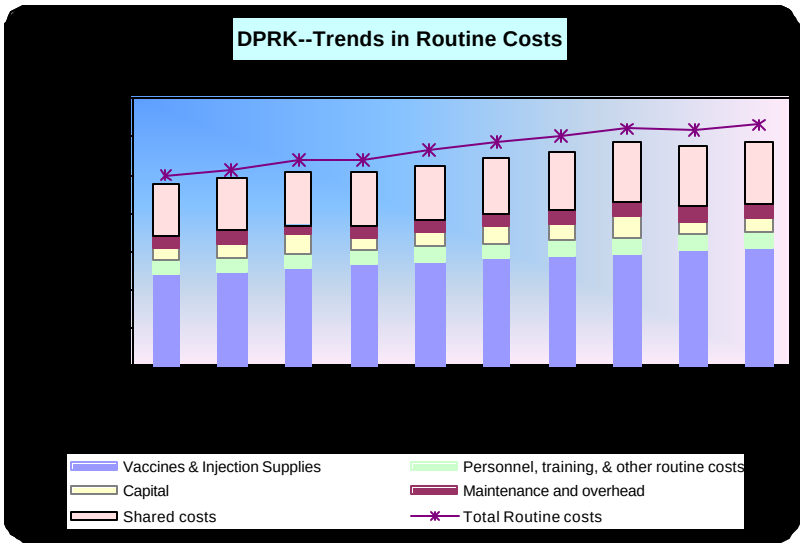


In the data provided by Bhutan, direct personnel costs and vaccine costs contributed to almost equal shares of 20% to 25% of the total cost. Capital costs towards vehicles and cold chain do appear to be significant in some years, however, it is unclear if the projections have fully estimated the transportation costs required for the country. The remainder of the routine costs was attributed to shared building costs that are not depicted here. Maintenance and overhead costs appeared to be a small fraction of the total projected costs, and it was unclear if these were adequate to achieve the targeted increase in vaccine delivery. Routine costs were projected with significant declines from 2005 to 2007, mainly due to a lowering in vaccine and capital costs. The population growth does not seem to support the cost projections and no procedures/methods of cost reductions are articulated which might explain this anomaly.

DPR Korea

The Democratic People's Republic of Korea had reported a GDP of US$ 11.7 billion for 2005, not much higher than the US$ 11 billion for 2001, suggesting a very low reported economic growth in the country. It has a population of around 24 million comparable to Nepal. However, it has a

much higher per capita GDP of around US$ 481. The country reported a total health expenditure of US$ 691 million, comparable to Sri Lanka, and almost US$ 11 million towards routine immunization expenditure. It also reported a doubling of expenditure between 2001 and 2005, mainly due to the introduction of HepB vaccine in its routine EPI programme. GAVI funds of around US$ 7 million were allocated to the country between 2002 and 2007, with almost 3 million having been allocated for Hep B vaccine and 3.3 million for infrasructure development (Tables 1 and 2).

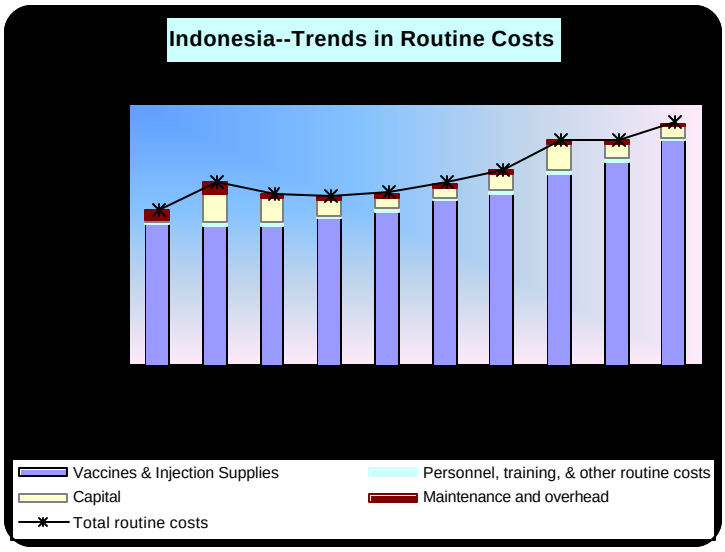


For DPR Korea, the above graph shows that vaccine costs accounted for half of the future resource requirements and together with other shared costs made up the majority of the routine costs. Hence, a reduction in vaccine costs would be extremely beneficial to DPR Korea. The very low contribution of personnel costs remains inexplicable especially in view of the high allocations to vaccine costs. It is likely that the personnel costs were either grossly underestimated or that most of them costs are shared and are paid by government revenue and therefore, not reflected here. Allocations to capital costs although small were provided for every year in the future, thereby suggesting continuous improvements in infrastructure and cold storage, etc.

Indonesia

Indonesia, the second largest country in the Region after India reported a total GDP of US$ 252 million, and an improved per capita GDP of US$ 1 164 as compared to US$ 881 in 2001. The total health expenditure showed an increase from US$ 5 430 million in 2001 to US$ 7 110 million in 2005. Although Indonesia is much larger than Bangladesh with almost double the population, it has projected lesser expenditures for immunization than Bangladesh—projected to be US$ 69.8 million in 2005 (Table 1).

The graph below shows that in Indonesia, vaccines made up almost 75% of routine costs. Capital costs did appear as a small-cost category for almost all the years. This situation arises either out of inadequate data on other costs or the rationale behind this allocation for vaccine alone needs to be investigated in detail especially as the costs for vaccines were not such a large component of the total routine costs for other adjoining countries. Personnel costs appear to be singularly underestimated. GAVI funds alone accounted for up to US$ 40 million, of which US$ 16 million were ISS funds for strengthening of immunization services and US$13 million for Hep B vaccine. It was unclear how the ISS funds were being used in Indonesia.

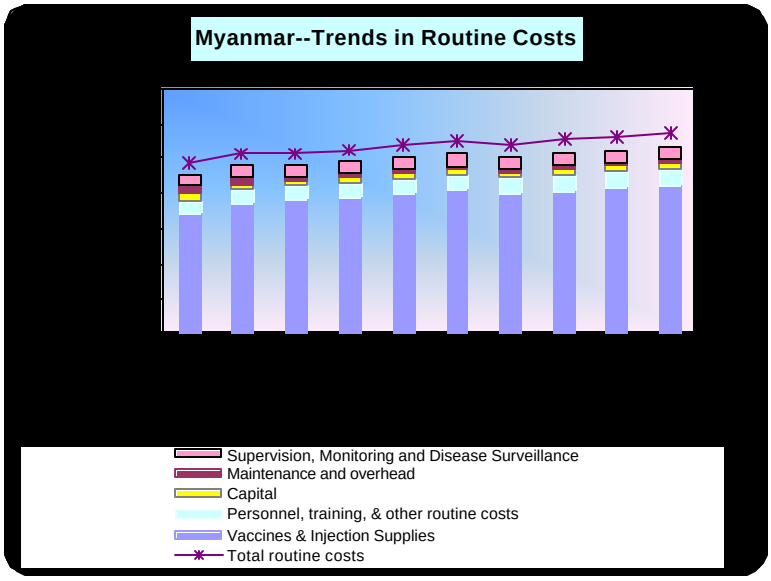


As can be seen from the rest of the regional data, vaccine costs are not the sole component of the routine cost. Hence, it is important to obtain more clarification about the absence of other cost categories for Indonesia's immunization programme.

Myanmar

Myanmar is a relatively small poor country in the Region with 55.4 million people, a reported total GDP of US$ 9.2 billion, and a per capita GDP of US$ 167. The total health expenditure reported in FSP data tool (0.05% of GDP) differs significantly from the World Bank country reports (2.2% of GDP). The latter appears to be more similar to the regional trend. The total routine immunization expenditure was US$ 11.1 million in 2005: anincrease from US$ 4.6 million in 2001, most of this increase was attributable to the introduction of HepB vaccine in 2003. The country also reported a continuous increase in the DTP coverage from 73% in 2001 to 82% in 2005 (Table 1). GAVI allocations had been significant at US$ 32 million, of which US$ 21.5 million were for vaccine alone and US$ 7 million for strengthening of immunization services (Table 2).

The graph below shows that like in Indonesia, vaccine costs accounted for 90% of total future requirements. Either this situation arises out of inadequate data on other costs or the rationale behind this allocation for vaccine costs needs to be investigated in detail especially as the costs for vaccines are not such a large component of the total routine costs for other adjoining countries. Capital and personnel costs appeared to be underestimated, or the country had other sources of funds that provided for health care infrastructure. However, they were not accounted for as part of EPI costs. Unlike other neighbouring countries, Myanmar had projected some costs towards supervision, monitoring, and disease surveillance.

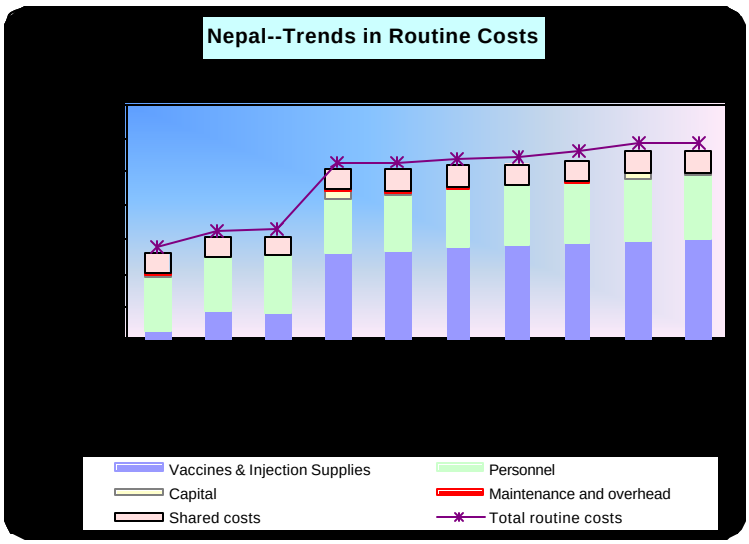


Nepal

Nepal is another small country in the subcontinent with a population of 25 million and a per capita GDP of US$ 262. However, the country expends almost 5% of its GDP for health care expenditures and 5% of those expenditures on routine immunization services (US$ 12.5 to US$ 13.9 million). This is reflected in its excellent DTP coverage of 90% projected for 2005 (80% reported in 2001) (Table 1). GAVI fund allocations of US$ 18.6 million are reported of which US$ 12 million are for introduction of HepB vaccine and US$ 5.1 million for strengthening immunization services (Table 2).

The graph below showed the distribution of routine immunization expenditures projected over the next nine years. Nepal envisages a sharp increase in its vaccine cost from 2008 onwards as it has projected the possible introduction of the expensive Hib vaccine in the EPI schedule. Until 2008, personnel costs would contribute as the largest component of the routine cost followed by vaccine and then shared costs for personnel. This perhaps reflects the extensive outreach programme in Nepal that allows for the high DTP coverage in the country. From 2008 with the projected introduction of Hib vaccine, vaccine costs would become the

largest cost component followed by personnel costs. However, it is unclear if the country has underestimated its need for capital expenditures to maintain the extensive immunization programme or if capital expenditures are not part of routine immunization services and are provided by a different programme.

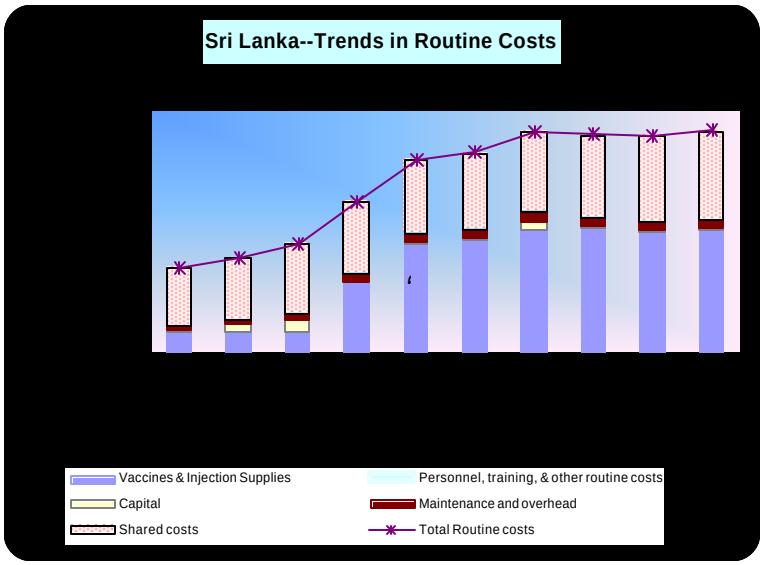


Sri Lanka

Sri Lanka is one of the better-off economies in south Asia with a total GDP of US$ 20.1 million and an estimated per capita GDP of US$ 1 015 in 2005. The economy has reported steady growth although the recent Tsunami resulted in significant losses. The country reported a total health expenditure of US$ 610 to US$ 700 million between 2001 and 2005 and of this only US$ 5.2 to US$ 7.5 million were spent on routine immunization programme (Table 1). However, Sri Lanka has one of the most efficient programmes with almost full DTP coverage for its children. Most of the GAVI allocations --US$ 2.97 million out of US$ 3.91 million were for introduction of HepB vaccine in the country (Table 2).

The routine cost allocation graph showed that vaccine costs would become an important cost category after 2008 when Sri Lanka would introduce Hib vaccine - a new and expensive vaccine into the EPI programme. Most programme costs were from shared personnel costs

indicating the role of outreach workers shared by other primary health programmes. Like other countries in the Region, surprisingly Sri Lanka did not project any major capital cost categories into the future. This could be either an underestimation of costs or an indication of availability of good infrastructure in Sri Lanka.



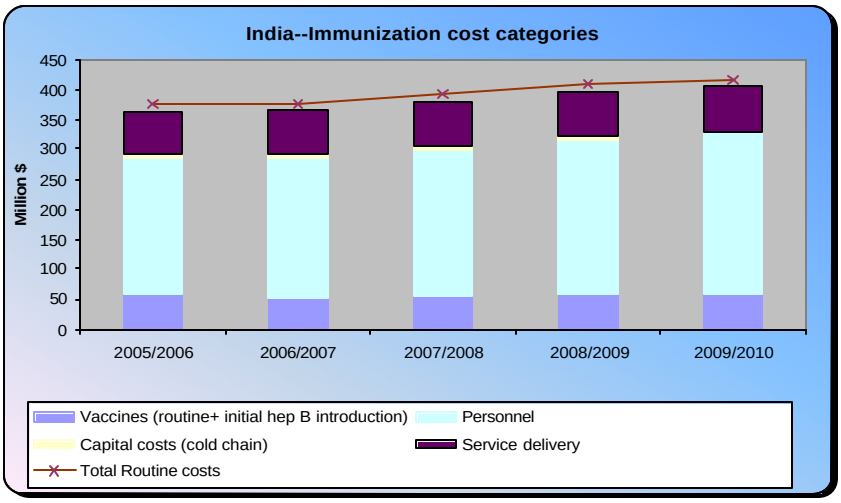
India

India, the largest country in the Region reported a total GDP of US$ 600 billion in 2003 with an expected annual growth of 7% to 8%. The country had an annual health expenditure of US$ 3.6 billion of which US$ 400 million was projected as routine immunization expenditure in 2005 (Table 1). The GAVI allocation of US$ 40 million to India has been for small-scale pilot introduction of HepB vaccine in few districts and urban areas and for AD syringes (Table 2).

India, in place of an FSP, had produced a five-year multi-year immunization plan (MYP) with details on cost estimates for different immunization categories and their respective sources of funds. In other words, this was different from the typical FSP that was prepared to highlight the future resource requirement and to highlight the gaps in funds for the

projected programme. As per the MYP, (graph below) for the India immunization programme until 2010, personnel costs remained the largest component of future requirements (60% to 64%). Vaccines remained a smaller component of the total costs mainly because the calculation was based on the assumption that Hep B vaccine will only continue to be used in districts and cities under the pilot project.

However, with GAVI support, a phased scale-up plan for HepB vaccine is being considered. This would increase the resource requirement substantially: use of monovalent HepB vaccine for HepB expansion in 11 states in India would increase the programme expenditure by almost US$ 118 million. Using tetravalent vaccine at the current price (US$ 1.25 per dose) would increase costs by US$ 297 million, almost doubling the total immunization budget. Sustaining the supply of this vaccine beyond the proposed GAVI support would require more planning and identification of reliable sources of funds.



Annex 4

GROUP WORK SUMMARIES FOR COUNTRIES

	Bangladesh	Bhutan	DPR Korea	India	Indonesia
Current MYP information	**2001-2005** **Strengths:** Contained some strategic direction, referred to occasionally for subsequen t plans Technically quite robust; **Weakness:** No stakeholder involvement in development of MYP; only developed because GAVI needed; Costing incomplete or inadequate, never updated and implementation of immunization activities not linked to MYP	**2002-06** Drafted by a WHO consultant with district visits and review **Strengths:** Complete Govt acceptance, easy to implement, covered all important aspects of the program, discussed at ICC meetings, most milestones achieved **Weaknesses:** needed more donor involvement;	**2001-2006**	**2005-2010**	**2002-2006**
Future MYP dates	Will synchronise with HNPSP October 2005 - 2008	December 05 Will synchronize with the National five year developmental plan 2006-2010	2006-2011 FSP will need integrated into the cMYP	2010-2015	2006-2011
FSP re-submission?	No, but FSP needs to be incorporated into new cMYP	No	Yes, minor revisions made and resubmitted	FSP 2002-2013	No, but FSP only includes two provinces and will need expanded
Training needs (in country or within an institution)	Costing, budgeting and financing	Costing, budgeting and financing	Multiple, but basics of costing, budgeting and financing	Sub national level - in costing budgeting and financing	Will start activities in Feb 06

	Bangladesh	Bhutan	DPR Korea	India	Indonesia
Technical assistance needs	Future cMYP and current FSP will need linked to HNPSP and annual operations plan Health economist (?Dhaka University) to assist with strengthening costing Devise more comprehensive monitoring indicators	Future cMYP will need new annual indicators and include more detailed monitoring action plan and stronger donor involvement in development Costing and budgeting Will need a facilitator for the process	Future cMYP will need to link with overall donor strategies within a complex environment Health economist and facilitatory support	Will use FSP as basis for developing future cMYP Devise simpler monitoring indicators	MYP and expansion of future cMYP will need to happen in parallel How to synchronise the FSP and cMYP in a complex decentralized system - determining sample size for cMYP development Advocacy and communications
Possible research needs	Disease burden studies and CEA	Hib disease burden study	None identified	HIb disease burden studies; economic analysis of Hep B introduction and vaccine pricing CEA	CEA MMR and JE (underway), Pentavalent, Hib and Rota
Responsibility for drafting the cMYP	EPI department	EPI team	EPI team	Immunization division	EPI team
Timeline of cMYP activities	Start in Oct 05 and will finish Jan 2006, for MYPn to be ready Mar 06	Dec 05 – April 06, for MYP to be ready in Oct 06	April 06 – Sept 06 to finish cMYP by Oct 06	None required, but training will take place at sub – national level	Not made, given polio, measles, Tsunami and Avian flu activities ongoing. Potentially mid 06 for a minimum of 9 months
Estimated budget for drafting cMYP	Unknown, but could be in region of $20,000	Unknown	Unknown	None	
Potential partner support in country	WHO, UNICEF Dhaka university	WHO, UNICEF, JICA	UNICEF, WHO	WHO, UNICEF, World Bank, CVP PATH, Immunization BASICS	WHO, UNICEF, World Bank, CVP PATH

	Bangladesh	Bhutan	DPR Korea	India	Indonesia
Institutional or RWG support requested	Potential facilitatory support and review of finished product by RWG. Regional institutional financing network	Potential facilitatory support and review of finished product by RWG. Regional institutional financing network	Potential facilitatory support and review of finished product by RWG. Regional institutional financing network	None, but IEG and regional network can provide assistance with training and discrete research projects as required	Team requested to synchronize FSP and cMYP. Process will take at least 9 months. Budget and proposal may be submitted to RWG for consideration and support for translation, facilitation, costing, data collection and analysis and pre-review Jakarta University health economics institute

	Maldives	Myanmar	Nepal	Sri Lanka	Thailand
Current MYP information	NO MYP available, but would like to develop one	2002-2006	2002-2007 This was developed by MoH in 2002 with no outside consultant. Developed mainly for GAVI application; **Strengths:** Internally developed and complete government ownership; Most of the milestones achieved / close to accomplish-ment; milestones referred to during ICC meetings **Weaknesses:** Costing and financial projections not accurate or detailed enough; No regular updates, erratic partner support	2002 – 2005 **Strengths:** Internally developed and complete government ownership; included in health sector planning and budgetary process; Most of the milestones achieved; **Weaknesses** : No Costing and financial projections; too vertical (it didn't include others in health sectors). The plan included indicators for monitoring It was updated	MYP 2005-2009. MYP is costed but budget discussions every year. Soc Econ Dev Plan (Health Plan) All budgeting is based on Gvt funding and is not inclusive of donor funding. Action Plans developed every yr (National and subnational levels)

	Maldives	Myanmar	Nepal	Sri Lanka	Thailand
Future MYP dates	Need to orient national staff first and explore further value of cMYP. This may help clarify decision making process on introduction of new and under utilized vaccines	2007-2011	2007-2011 The new cMYP will need to be more regularly updated and linked to national developmental plan	2006-2009 Work already starting and will need integration of the FSP	No need to revisit MYP, but may need to revisit annual plan more relevant for detailed costing and financing. Vaccines procured through Nat HI fund not budgeted for in EPI MYP)
FSP re-submission?	Not applicable	Yes – major revisions made and resubmission in late 05	Yes – major revisions and resubmission in Dec 05	No – submitted	Not applicable
Training needs (in country or within an institution)	Costing, budgeting and financing	Costing, budgeting and financing. Many alumni from CHE in MoH	Costing, budgeting and financing. Assistance will be required from IEG.	Costing, budgeting and advocacy	None identified
Technical assistance needs	Any possible cMYP will be linked to a comprehensive health sector plan	FSP will need integrated into the cMYP Devise more comprehensive monitoring indicators	FSP will need integrated into the cMYP Devise more comprehensive monitoring indicators	Facilitation assistance	None identified, already have close links with CHE
Possible research needs	None identified	None identified	Disease burden studies of Hib, Rota, JE, Pneumo, rubella. Equity and CEA	Economic analysis on use of smaller vial sizes; Disease burden of Hib, rota and pneumo	None identified, but ongoing research
Responsibility for drafting the cMYP	EPI team	EPI team	EPI team	EPI dept.	EPI Dept
Timeline of cMYP activities	Still to decide	Activities start first quarter 06 with retreat and finish plan by last quarter 06	Started draft of new plan. This will need reviewed in first quarter, aiming for completion in July 06	Complete by July 06	2009

	Maldives	Myanmar	Nepal	Sri Lanka	Thailand
Estimated budget for drafting cMYP	Unknown	Unknown	Unknown	Unknown	Unknown
Potential partner support in country	WHO, UNICEF	WHO, UNICEF	WHO, UNICEF with some local health economist	WHO, UNICEF	-
Institutional or RWG support requested	May request RWG review of cMYP, if produced	Will request facilitatory support for retreat and assist in drafting cMYP. Will require further visits from CHE to help integrate the FSP with the cMYP	Will request RWG review of cMYP and IEG visits to assist in costing and integrating the FSP into the cMYP	May request RWG review of cMYP and IEG visits to assist in costing and integrating the FSP into the cMYP May require assistance with facilitation of process	No request expected

	Timor-Leste	China	Cambodia	Lao PDR	Mongolia
Current MYP information	2003 – 2007 In need of more accurate costing	2001 – 2005 as part of the initial GAVI application	2006-2008	2001-04 Annual plan for 2005 developed with in-country partner agencies.	2002-2010. Includes detailed projected cost estimates for years 2004-10. However these need reviewed to reflect proposed pentavalent vaccine introduction.
Future MYP dates	2008-2011	Not GAVI eligible in Phase II. Has a FSP developed as part of GAVI. Has looked at funding structure by different government levels—which is forming basis for a new immunization financing law.	2009-2012	2005 -2009 Urgently need to draft	2010 onwards

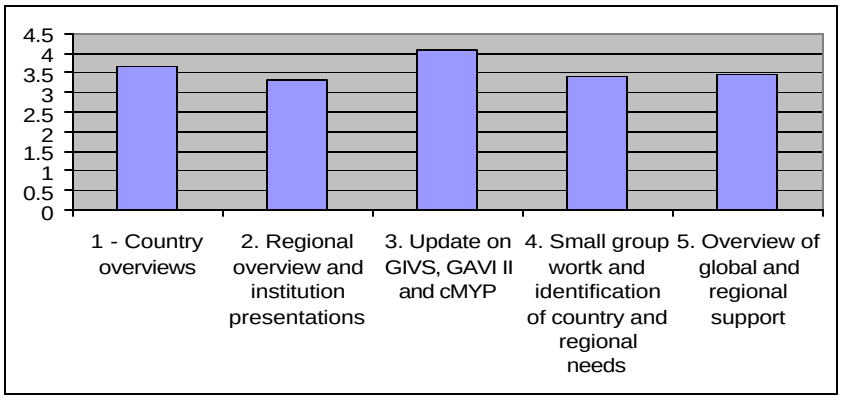
	Timor-Leste	China	Cambodia	Lao PDR	Mongolia
FSP re-submission?	GAVI eligible, have support from UNICEF and Immunization BASICS	No	No. Comprehensive FSP is well linked with MYP and linked to broader health sector plan already	NO, but FSP not used as a programmatic tool. However FSP will be used to inform the new cMYP	In process
Training needs (in country or within an institution)	cMYP costing, budgeting and financing – to decrease current fragmented approach to immunization	Costing, budgeting and financing at sub-national level	May require some refresher training in costing, budgeting and financing	Costing, budgeting and financing along with advocacy	None identified
Technical assistance needs	May require further support before 2007 on budgeting and costing in immunization	Training in costing and planning at sub-national level	None identified	No more financial analysis required but overall facilitation of cMYP will be required	None identified
Possible research needs	None identified	None identified	None identified	None identified	None identified
Responsibility for drafting the cMYP	EPI department	EPI department	EPI department	EPI department	EPI department
Timeline of cMYP activities	2007	Will consider new MYP in early 2006. Have requested copies of MYP in India	2008	2005 as soon as possible	2009
Estimated budget for drafting cMYP	Unknown	Unknown	Unknown	Unknown	Unknown
Potential partner support in country	UNICEF, Immunization BASICS, WHO and NGOs	WHO	UNICEF, WHO, CVP PATH	UNICEF, WHO	WHO, UNICEF
Institutional or RWG support requested	May request RWG for training on costing and budgeting through CHE or consultant	May request RWG support for facilitation	May request RWG for refresher training in 2007	Will request support through RWG	May request through RWG for costing, budgeting training

	PNG	Viet Nam
Current MYP information	Annual plans before	2004-2008
Future MYP dates	2006 – 2010 cMYP is being developed	2009-2012
FSP re-submission?	Not applicable	No FSP is linked ped as part of GAVI. The FSP is linked to their MYP and is regularly updated and used for resource mobilization
Training needs (in country or within an institution)	Basic costing, financing and budegting	
Technical assistance needs **Possible research needs**	Consultant recruited to facilitate the cMYP process None identified	
Responsibility for drafting the cMYP	EPI department	
Timeline of cMYP activities	Drafting complete by end of 05	
Estimated budget for drafting cMYP	Unknown	
Potential partner support in country	UNICEF	
Institutional or RWG support requested	May request further support for review of final MYP	

Annex 5

FEEDBACK FROM PARTICIPANTS

Figure: ***Feedback from participants – scoring from a maximum of five per session***



Forty six feedback forms were received from sessions 1 and 2 and 38 feedback forms from sessions 3,4 and 5. These suggested that participants were generally satisfied with the outcome of the meeting scoring an overall average of 3.6 (out of 5) for all five sessions. The graph above shows scores (out of maximum five) for each of the sessions.

GENERAL COMMENTS RECEIVED

The registration process, and administration and management were generally regarded as good. Special mention was made of the warm and hospitable Chulalongkorn staff, the catering and the venue room. However some had difficulty in viewing the screen.

Most recognized the agenda was full, leading to time constraints with some rushed presentations, especially towards the end of the day. Some suggested that in future country presentations should be scattered throughout the days.

Many felt that it was important that this was not limited to GAVI-eligible countries.

SESSION 1 :COUNTRY REVIEWS (46 FEEDBACKS)

Most of the feedback was excellent and participants felt this was a great opportunity to share experiences between regions, although some felt the regional overviews were too short.

Many participants wanted to see how other countries, finance mechanisms worked in more detail.

Good time management helped increase the efficiency of presentations of varying styles.

More time for a summary session and time for questions and answers at the end of each session that elaborated on lessons learnt and more in-depth analysis would have been useful.

SESSION 2 : REGIONAL OVERVIEW AND INSTITUTIONAL PRESENTATIONS (46 FEEDBACKS)

Some would have liked this session to be less academic, and more concise and clear with more practical plenary sessions including suggestions (eg. comparing financial indicators across countries, use of user fees or import taxes), and not so rushed for time.

However others felt it was an extremely useful session with a broad overview, friendly dialogue and wished it could have gone on longer.

SESSION 3 : UPDATE ON GIVS, GAVI II and cMYP (38 FEEDBACK FORMS)

Most regarded this session as the best as it was clear, concise, practically relevant / useful, and simple. Specific mention was made of the clear GAVI presentation, although there were frustrations that GAVI II plans remain unclear until December 2005. Many wanted to see the discussion move beyond purely costing issues to include financing aspects also.

SESSION 4 : SMALL GROUP WORK AND IDENTIFICATION OF COUNTRY AND REGIONAL NEEDS (38 FEEDBACK FORMS)

Opinions varied, depending on which group the feedback was from and this variability seemed due to variability in facilitators and how well countries had prepared for this session in advance. However, most felt that small group work was always preferable to plenary sessions and it provided good discussion in an environment conducive to exchange of information between countries. Some felt they wanted more time to discuss the practical aspects of planning immunization programmes, while others felt that a simple checklist could have been used in a shorter space of time.

Opportunities to consult facilitators individually for a longer period of time would also have been beneficial

SESSION 5 : OVERVIEW OF GLOBAL AND REGIONAL SUPPORT (38 FEEDBACK FORMS)

Some felt this session deserved more time for discussion, and that the presentations were too rushed. More time could have been spent on this session, due to its importance for country support and felt the session was too rushed. However most felt that it still managed to provide a lot of information in a very short space of time and gave a fresh perspective on the support available in the Region.