Technical Brief, December 2023

Analysis of Selected African Union Member Countries' Progress towards Sustainable Financing of Immunisation.

Key Messages

- Most of the selected countries had low tax revenues and high debt levels which reduced their public fiscal space and affected allocations to all sectors including health and immunization. There is need to manage these economic factors promptly and proactively through stronger public finance management systems.
- Countries that had low UHC service coverage and therefore reduced access to essential health services including immunisation services, also had relatively higher child and infant mortality rates. There is significant value in increasing investments in the broader health systems to improve overall quantity and quality of health sector services.
- The health sectors of most of the selected countries heavily relied on donor funding and/ or out-of-pocket payments. As such, there is need for the governments to increase their investments in health and immunization through financing mechanisms that are more sustainable and provide financial protection.
- Immunisation coverage was lowest in conflict affected regions thereby showing the negative impact of political instability.
- The poor had the lowest immunization coverage and highest child mortality rates which emphasizes the need to address financial barriers to accessing care, and the need for pro-poor and equity enhancing financing mechanisms and policies.
- Most of the spending in immunization is on procurement of vaccines and therefore countries can make savings through innovative approaches such as switching to WHO approved cheaper vaccines, supporting countries capacities to locally manufacture vaccines and improving efficiencies in procurement.

Introduction

Immunisation is a success story for global health and development as it saves millions of lives every year at relatively low costs. In addition, its benefits have been shown to have a greater impact on the poor who bear a higher burden of vaccine preventable diseases[1]. However, each year, about 20 million infants do not receive the full course of the basic vaccines, with over 50% of them not receiving any vaccines[1,2]. Given that a larger proportion of these children are in Africa, African leaders committed to supporting immunisation during the Addis Declaration on Immunisation in 2016[3]. The goal was to ensure that every African benefits from immunization. We therefore set out to assess the progress in implementation of the Addis Declaration in 10 selected countries through reviewing the status of their immunisation financing including factors affecting adequate financing for immunization. To do so, we reviewed secondary data from various sources including global and country-based immunisation and health databases, published peer reviewed and gray literature.

This brief is based on the following report: PATH & WACI Health, 2023. Analysis of Selected African Union Member Countries Progress towards Sustainable Financing of Immunisation

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KEY FINDINGS

Economic Profile

Most of the countries had low tax revenues and high debt levels as shown by Tax to GDP ratios that were below 15% and Debt to GDP ratios that exceeded 50% respectively. This potentially reduced the public fiscal space and reduced allocations to all sectors including health and immunisation (Figure 1).

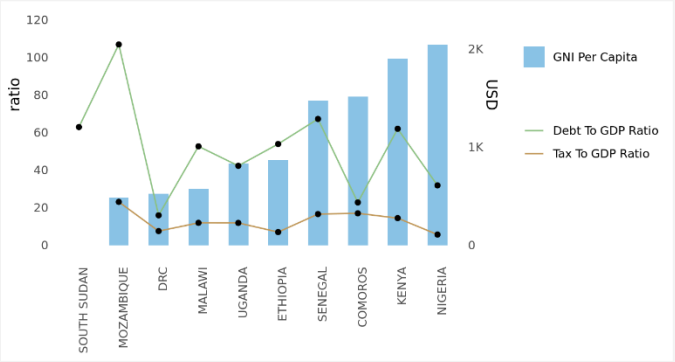

Figure 1: Economic Contexts in the Cluster

Source: WHO, IMF, Analysis by Consultant

Health System Performance

Most of the countries with low UHC Service Coverage indices (Nigeria, South Sudan, DRC, Mozambique) implying reduced access to essential health services including immunisation, also had relatively higher infant and under five mortality rates. (Figure 2)

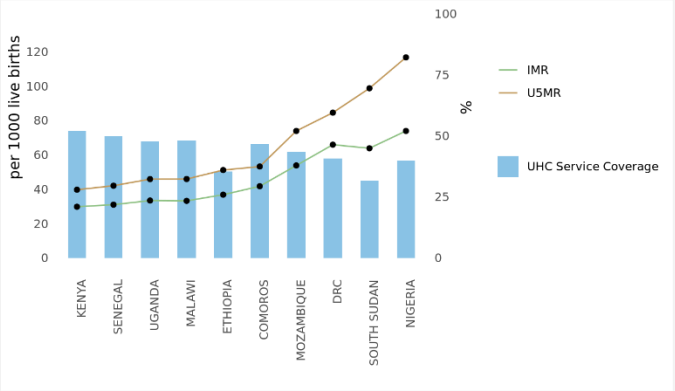

Figure 2: Health System Performance in the Cluster

Source: World Bank, WHO, Analysis by Consultant

Health Financing

The ten countries had low government prioritization of health services, including immunization services. This was because, none of the countries met the USD$ 86 threshold for per capita spending on health, the Abuja threshold of 15% of government expenditure to health, and none spent more than 5% of GDP on health. (Figure 3).

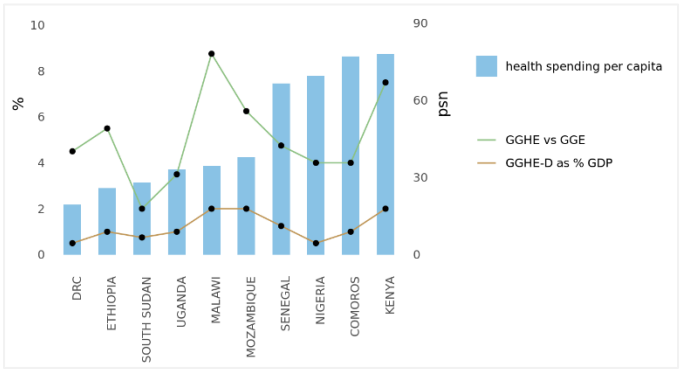

Figure 4: Health Financing Contexts in the cluster

Source: WHO Global Health Expenditure Database, Analysis by Consultant

In addition, funding of the health sector including immunization services largely relied on donor contributions and/or out-of-pocket payments in several countries. For example, donor contributions accounted for more than 40% in Uganda, Malawi, South Sudan and Mozambique. On the other hand, out of pocket payments contributed more than 40% in Nigeria, Comoros and Senegal. Insurance schemes (Social Health Insurance and Voluntary Health Insurance) were the least contributors to financing within this cluster (Figure 4).

Source: WHO Global Health Expenditure Database, Analysis by

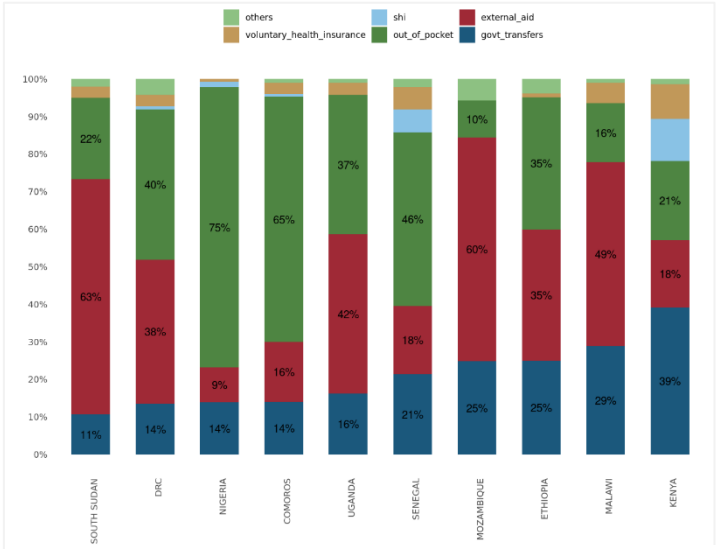

Figure 3: Health Financing Sources within the Cluster

Consultant

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Immunisation coverage

Generally, immunization coverage rates were lowest in conflict affected regions, that is, Nigeria, Ethiopia, DRC and South Sudan (Figure 6).

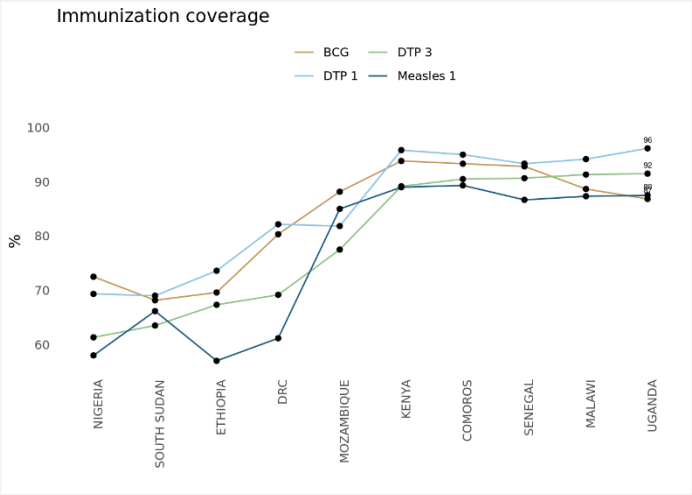

Figure 6: Immunization Coverage trends

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

Equity in coverage

There were disparities in child health outcomes (under-five mortality rates and DTP3) based on income level. Differences in under-five mortality between the richest and poorest groups was highest in Nigeria and DRC, and lowest in South Sudan and Ethiopia. The lowest under five mortality rate (<40) was recorded among the richest group in Senegal and Kenya, while the highest was noted among the poorest group in Nigeria (>150). (Figure 7).

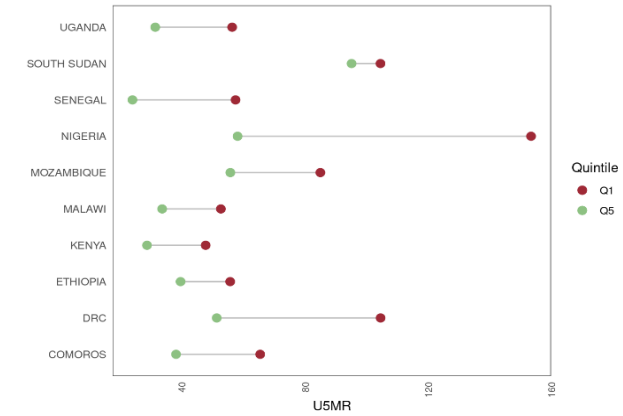

Figure 7: Equity analysis of U5MR in the cluster

Source: WHO Equity Database

Disparities in DTP3 coverage between the richest and poorest groups was highest in DRC, Ethiopia and Comoros, and lowest in Uganda and South Sudan. DTP 3 coverage was highest in Senegal and Kenya in both income groups, and lowest in South Sudan, Uganda and Nigeria. Interestingly, in most countries with low DTP3 coverage (Nigeria, Mozambique, Uganda and Malawi), the richest group had the lowest coverage, while in most countries with higher DTP3 coverage, the poorest populations had the lowest coverage. (Figure 5)

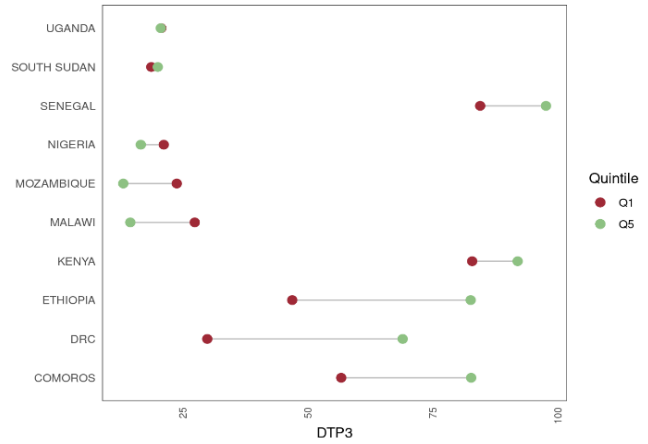

Figure 5: Equity analysis of DTP 3 Coverage

Source: WHO Equity Database

While paucity of data limits analysis of zero dose levels in all 10 countries, available data shows that the greatest differences between the richest and poorest groups in zero dose proportions were in Nigeria, DRC and Ethiopia.

Immunisation Financing

a. GAVI Eligibility

Only 2 countries within the cluster were in the accelerated transition phase while the majority were in the Initial Self-Financing Phase per the GAVI eligibility guidelines for 2023[4] captured in table 1 below.

Table 1: Gavi Eligibility Assessment (2023)

GAVI Transition Phase	Countries
Initial Self Financing (US$1085 GNI p.c.)	Mozambique, DRC, Malawi, Uganda & Ethiopia; S. Sudan*.
Preparatory Transition (>US$1085 <US$1730 GNI p.c.)	Comoros, Senegal
Accelerated Transition (US$ 1730 GNI p.c.)	Kenya, Nigeria
Fully Self Financing	None

Source: GAVI, World Bank Group, Analysis by Consultant

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b. Government Financing of Routine Immunization Services (Including Vaccines)

There was significant donor dependence in immunization financing within this cluster. Government funding accounted for about 25% of all immunization financing within this cluster of 10 countries implying a high donor dependency. Senegal had the highest relative government contribution (44%) while DRC (9%), Comoros (12%) and South Sudan (12%) had the least government contribution to immunization financing (Figure 8).

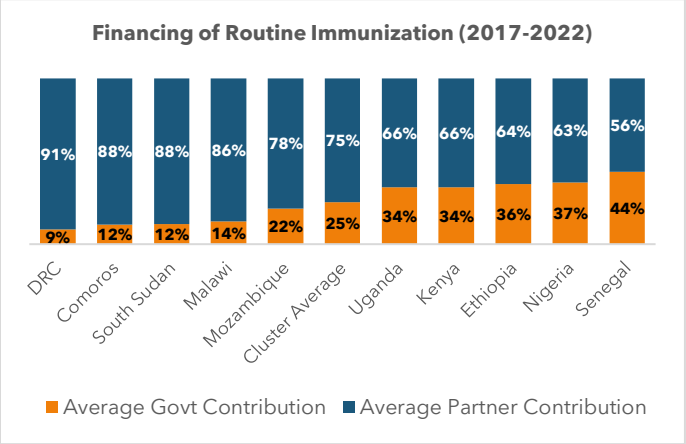

Figure 8: Financing Sources for Immunization services

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

In 2022, Nigeria and Kenya had the highest government financing to Routine Immunization accounting for 55% and 50% respectively, while Comoros had the least government financing at 14% (Figure 9).

While donors vary across the countries, GAVI, WHO, and UNICEF were the most consistent and declared donor sources of immunization financing captured in the respective Country Multi-Year Planning (CMYP) tools.

Private sector contributions were not visible within the existing CMYPs and are likely minimal, if monetary.

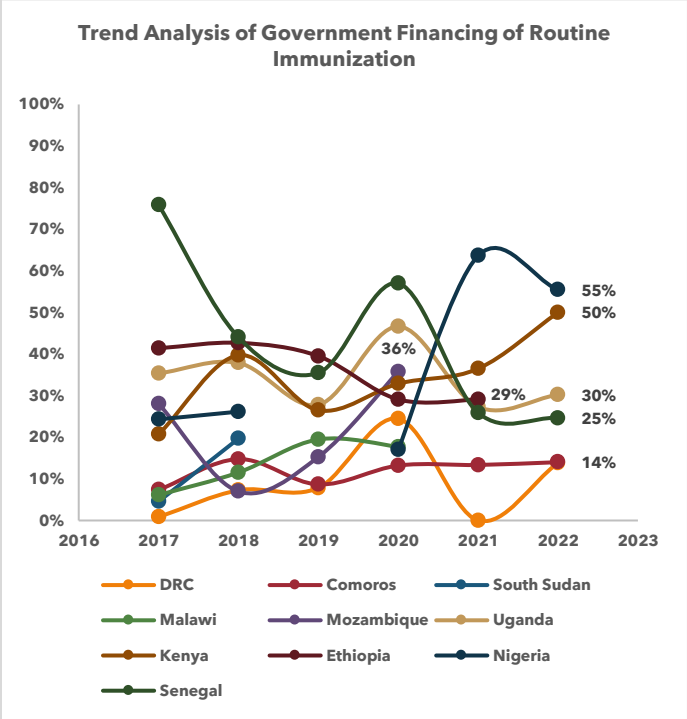

Figure 9: Trends in Govt. Financing of Immunization

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

Generally, immunisation spending within this cluster of countries was low. For example, the spending on routine immunisation services accounted for less than 5% of all the spending within the health sector and less than 10% of government spending on health. Further, spending on vaccines accounted for less than 1% of all the spending within the health sector and less than 3% of all the government spending on health (Figure 10).

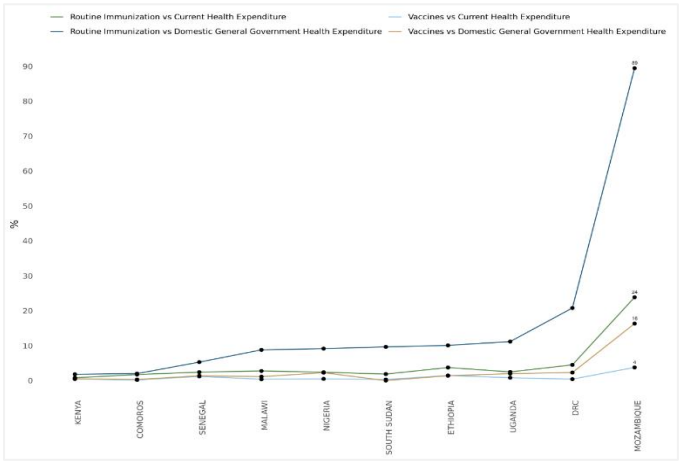

Figure 10: Immunization spending within the cluster

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

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Procurement of vaccines alone consumed a large share of immunisation spending as it ranged between 41% and 50% (Figure 11).

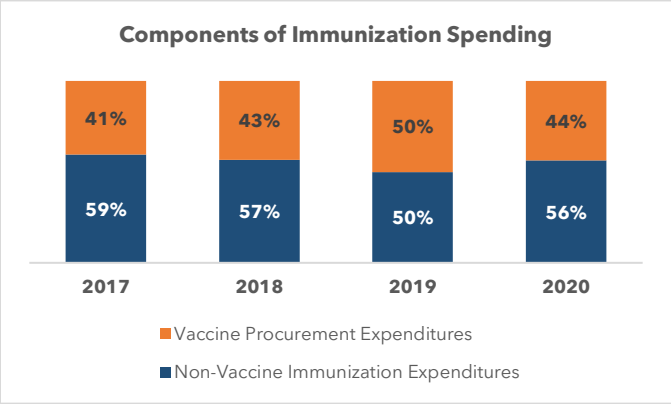

Figure 11: Components of Immunization Expenditures

Source: WHO/UNICEF, Joint reporting forms, Analysis by Consultant

RECOMMENDATIONS

Short Term Advocacy Recommendations

- Capacity-building among country immunization teams and Civil Society Organizations (CSOs) for immunization financing (forecasting, economic evaluation, budget cycles, expenditure tracking).
- Strengthen CSO capacity for Immunization advocacy and accountability.
- Advocacy for stronger political goodwill and prioritization of immunization.
- Advocacy for increased health and immunization budgets to cover routine and new vaccines.
- Sustained advocacy for country immunization teams to develop, implement and monitor costed national and subnational immunization plans.
- Improve sector-wide and immunization data management for evidence-based planning and financing of immunization services.
- Leverage technology for efficient vaccine delivery and strengthening of immunization management systems.
- Foster strategic collaborations for immunization services at local, regional, and global levels such as the Africa Vaccine Markets Accelerator (AVMA) and the Partnership for African Vaccine Manufacturing (PAVM)[1] under the GAVI Alliance and African Union.
- Advocacy for increased engagement of the private sector in immunization services e.g. through public private partnerships.

Medium- and Long-Term Advocacy Recommendations

- Advocacy for public finance management (PFM) reforms for effective public debt management, enhanced tax administration etc.
- Advocacy for pro-poor and equity-enhancing financing mechanisms and policies e.g., publicly funded health insurance schemes that cover immunization, and subsidies for indigents.
- Incentivize and promote domestic vaccine manufacturing e.g. favorable investment environment for domestic vaccine manufacturers e.g., regulatory framework, tax incentives, guaranteed domestic and regional demand *etc*.
- Increase investments towards strengthening and integrating existing health systems, particularly primary health care, to ensure populations have access to essential health services, including immunization.
- Strengthen governance systems for accountability of immunization finances and services at national, subnational and community levels.
- Advocacy for multisectoral investments to address the drivers on inequality e.g., poverty, nutrition, infrastructure, security, education.
- Address and mitigate against drivers of political instability, and natural disasters.

References

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