



**Report to the
GAVI Alliance Board**
12-13 June 2012

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| Subject: | India strategy update |
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| Agenda item: | A |
| Category: | For Information |
| Strategic goal: | Affects all strategic goals |

Section A: Overview

1. Purpose of the report

- 1.1 The purpose of this report is to update the Board on the progress with regard to the development of a customised strategy for India.

2. Recommendations

- 2.1 The paper is for information only. A detailed paper with financial implications will be presented to the Executive Committee for approval later in the year.

3. Executive summary

- 3.1 This is an exciting phase for the GAVI-India relationship. Since the GAVI Board meeting in November 2011, we have stepped up our engagement with India. Buoyed by the success in interrupting polio transmission, India is demonstrating a new vigour in its commitment to strengthening its immunisation programme.
- 3.2 Given India's size and the scale of its own resources, GAVI's approach continues to be catalytic, with an emphasis on working with India to enhance the ambition and effectiveness of India's own immunisation programme.
- 3.3 Currently India is working on a request for GAVI support to strengthen the health systems in weaker states thus enabling them to scale up pentavalent vaccines nationally. A subsequent request for catalytic support to introduce measles-rubella vaccine is expected. The decision to introduce pneumococcal and rotavirus vaccines will be based on the successful outcome of clinical trials and other debates currently underway in India, partially supported by GAVI partners. We are closely following these activities and have offered to assist in any way we are able, including support if necessary.
- 3.4 India will also continue to be a priority for GAVI's market shaping strategy which will include advocating for the strengthening of the National Regulatory Authority (NRA) and encouraging the entry of manufacturers to supply current and potential future GAVI-supported vaccines.

- 3.5 GAVI will continue to build on the political advocacy efforts in collaboration with Alliance partners to inform evidence-based policy decision making and improve the quality of public debate over immunisation issues.
- 3.6 A detailed action plan with financial implications will be presented to the Executive Committee for approval in October 2012.

4. Context

- 4.1 India has the highest birth cohort¹ (26.6 million) amongst GAVI-eligible countries and accounts for the largest number of unimmunised children (7.23 million) globally.² Nigeria, the next populous country in GAVI's portfolio has a birth cohort of 6.1 million. The WHO-UNICEF estimate for national DTP3 coverage rate for India is 72%, which is lower than the average of 78% for GAVI-eligible countries. In addition, there are wide inequities in coverage between and within the Indian states. National Family Health Survey-3 (2005-06) reports DTP3 coverage for Tamil Nadu is 95.7%, whereas it is 30% for Uttar Pradesh. The ministry of health is committed to strengthening the capacity of these low coverage States to improve immunisation coverage.
- 4.2 A Task Team (TT³) led by the Ministry of Health in India, prompted by the GAVI Large Country Task Team model, is currently developing a proposal for GAVI support for strengthening cold chain capacity in weaker States and vaccine logistics and supply chain management. This will enable scaling up of pentavalent vaccine nationally, sustain the gains of polio eradication efforts, and improve coverage of routine immunisation. GAVI's support will be fully aligned with India's current priorities for, '*intensification of routine immunisation*'. India is expected to self finance further improvements in its health systems once the process is established.
- 4.3 India, with an annual immunisation budget of around \$500 million, self-finances almost 100% of the immunisation programme. Previous GAVI support to injection safety and Hepatitis B monovalent vaccine have been successfully scaled up nationally with domestic budget. Gol has proposed to increase public health expenditure from the current 1.2% to 2-3% of GDP (approximately US\$42 billion)⁵ and will self-finance GAVI-funded activities beyond the support period.
- 4.4 Recent decision by the Governing Board⁶ overseeing the flagship health programme – National Rural Health Mission (NRHM) – to approve additional domestic resources to polio eradication and approval to roll-out pentavalent vaccine in six additional States is a testimony to India's renewed commitment. This gives confidence to GAVI on securing continuation of the programme from possible scale backs in future.

¹ <http://www.who.int/vaccines/globalsummary/immunisation/countryprofileselect.cfm>

² GAVI (2011): "Report to the GAVI Alliance Board 16-17 November 2011, Country Programme Update".

³ The existing Immunisation Action Group (IAG) chaired by the Health Ministry with select membership from development partners, professional bodies, academic and research institutions, CSOs and Department of Biotechnology will work as a TT. GAVI will be invited as an observer when necessary.

⁴ India has declared 2012/13 as the year of 'Intensification of Routine Immunisation', in response to a Call for Action from the WHO SEAR Ministerial meeting in Delhi in August 2011.

⁵ India's GDP in 2010 is US\$1.7 trillion (World Bank statistics). Assuming that the public health expenditure increases to 2.5% of the GDP, this amounts to approximately US\$ 42 billion.

⁶ The Governing Board is known as the Mission Steering group or MSG.

- 4.5 India will also continue to be a priority for GAVI's market shaping strategy. This stems from India being the most important emerging market manufacturing base, as well as its size of birth cohort and the potential impact on demand. GAVI's market shaping priorities in India include: (i) advocating strengthening of the National Regulatory Authority (NRA); (ii) encouraging quality pentavalent vaccine manufacturing; (iii) encouraging the entry of new manufacturers to supply GAVI-supported vaccines; and (iv) encouraging accelerated but responsible development of GAVI-related new vaccines.
- 4.6 GAVI will explore options to engage with non-traditional donors in India, in keeping with its objective to diversify its donor base. This is based on India's growing importance as one of the fastest growing economies, with a booming private sector and vaccine manufacturing industry, but also significant health challenges.
- 4.7 GAVI's advocacy efforts will ensure that decision makers at central and state levels have sufficient access to, and confidence in, the scientific and public health evidence behind policy choices as well as useful tools to make informed decisions.

5. Next steps

- 5.1 Next steps for GAVI support to India include:
- (a) Support GoI plans for scale-up of pentavalent vaccine to other states, up to the approved budget of US\$165 million. GAVI will also consider any other GoI proposals for new vaccine introduction on a catalytic basis, (e.g. MR vaccine). India's potential graduation in 2015 will have implications in terms of future GAVI support to India for the planned rollout of pneumococcal and rotavirus vaccines.
 - (b) GoI to submit a funding proposal to GAVI for health systems strengthening for consideration by the independent Review Committee (IRC) in Q3 of 2012.
 - (c) Continued political advocacy and strategic engagement to support India and collaborate with Alliance partners to build on the growing momentum on making immunisation a priority.

6. Conclusions

- 6.1 The next three years present a unique opportunity for GAVI to support India's ambition and priorities for immunization. GAVI will also engage with India in mobilising resources from the government/ non-traditional donors, supporting the development of high quality vaccine suppliers, and assisting in immunisation advocacy and communication.

Section B: Implications

7. Impact on countries

- 7.1 GAVI funding is intended to strengthen India's Universal Immunisation Programme (UIP) with the objective of increasing immunisation coverage beyond the current level of 72%. This would help to sustain the gains of polio eradication and preparing for new vaccine introduction. Initial focus with catalytic GAVI support will be on building

health systems capacity in low performing/ weaker States. This experience will inform national scale with India's own resources. Targeted advocacy support will help build sustained political commitment to immunisation and a better informed public discussion of the potential of new vaccines.

8. Impact on GAVI Stakeholders

- 8.1 The budget for health systems strengthening and introducing MR vaccine will be firmed up when India is ready with their plans. A separate budget will be required for implementing plans for advocacy and communication, resource mobilisation, and market shaping goals. There may be a need to augment in-country partner capacity to oversee the full range of activities.
- 8.2 GAVI's long term financial forecast, presented to the GAVI Alliance Board in April 2012, assumes India's "graduation" from GAVI support at the end of 2015. The updated forecast reflects the most recent thinking around vaccine rollout and cash support consistent with the information shared in this paper.

9. Risk implications and mitigations

- 9.1 Delays might result from possible changing priorities of Gol as it finalises the 12th five year plan (2012-2017) and draft comprehensive Multi Year Plan for immunisation (cMYP) 2012-2017, and changes in support provided by other donors/ partners. The Secretariat will work closely with Gol and partners to minimize any delays and their impact.
- 9.2 In addition, anti-vaccine lobbyists in India have been highly critical of new vaccine technologies for many years. They have been quite active in questioning the decision to introduce new vaccines in the media, and more recently through Public Interest Litigation (PIL) in case of pentavalent vaccine. GAVI should be mindful of this landscape with regards to the development and implementation of a customised strategy for India.

10. Legal or governance implications

- 10.1 This paper is for information only and at this stage there are no legal implications.

11. Consultation

- 11.1 The India led Task Team comprising of in-country partners and local experts have initiated consultations on the next phase of GAVI support. This builds on extensive consultations carried out by the Large Country Task Team (LC_TT – established by GAVI's Programme and Policy Committee to advise on India and Nigeria) in 2011. Further discussions will be required with relevant partners in India and at HQ level to gain clarity on roles and responsibilities while finalising the operational plans to ensure GAVI's added value.

12. Gender implications / issues

- 12.1 Equity and gender equality are amongst the guiding principles of the draft cMYP 2012-17, focusing on reaching the poorest and underserved populations to reduce any existing disparity in services, including based on gender. GAVI's support through

vaccine funding and health systems strengthening will contribute towards gender equality.

13. Implications for the Secretariat

- 13.1 The Secretariat will need to work closely with GoI and partners in the ensuing months for active engagement with potential non-traditional Indian donors on resource mobilisation; the government, partners, CSOs and the broader immunisation community on advocacy and communication; and the vaccine industry and related regulatory authorities on market shaping. These activities will require a greater level of involvement from Secretariat departments and GAVI's senior leadership, particularly for advocacy and resource mobilisation.

Section C: Resources to meet demand for India in 2012-15

14. Indicative budget

- 14.1 A total budget of US\$165 million has been approved for GAVI's support to the scale-up of pentavalent vaccine introduction in India until 2015.
- 14.2 A detailed action plan with financial implications for supporting health systems will be reviewed by an Independent Review Committee (IRC) and their recommendations will be presented to the Executive Committee for approval in October 2012.