

Developing a strategy to support new vaccine introduction in Middle Income Countries

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Developing a Strategy to Support New Vaccine Introduction in Middle Income Countries

Background/rationale

Strategy outline

Progress to date

Next steps

UNICEF's Strategy: Addressing Inequity

UNICEF's development of a Middle Income Country (MIC) strategy is consistent with its inequity-fighting mandate and agenda

- UNICEF's 2010 position paper **“Progress for Children: Achieving the MDGs with Equity”** re-committed UNICEF to addressing disparities in children's survival, development and protection among the world's developing regions and within countries

- **Nearly 75% of the world's poor live in countries classified as MIC** (in contrast, in 1990, over 90% of world's poor lived instead in Low Income Countries (LIC))¹

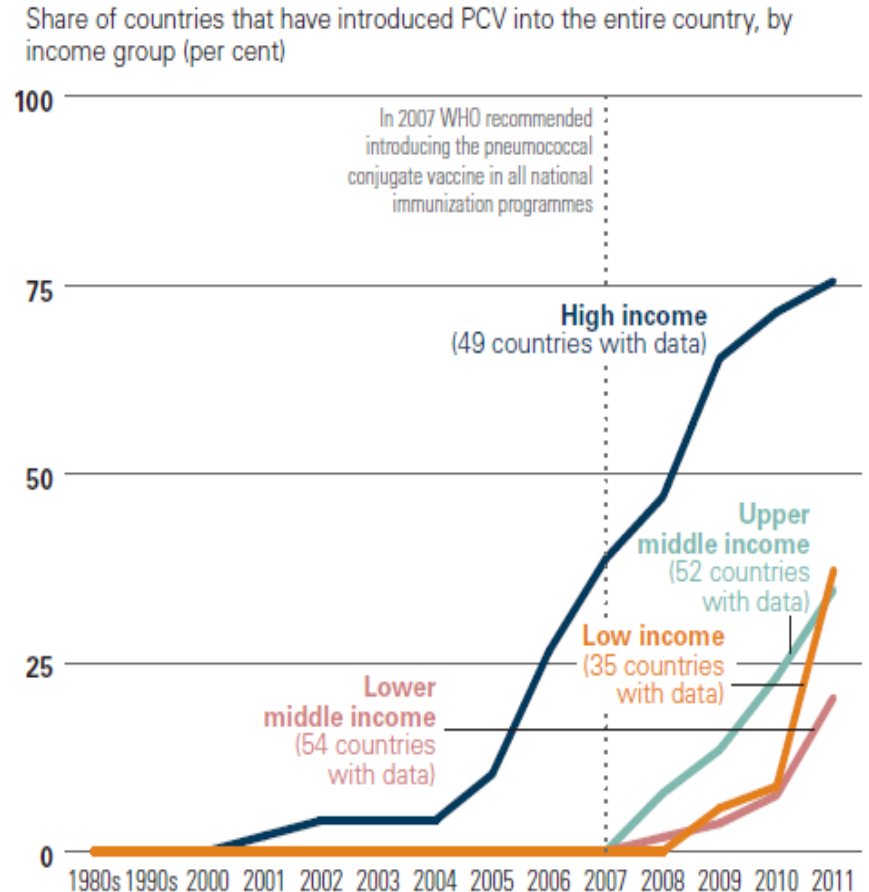
- 21 of the 54 countries categorized as Lower Middle Income (LMIC) are GAVI-eligible; the remainder and all of the Upper Middle Income Countries (UMIC) are either **unable to access GAVI support** or may be “graduating” in a few years

- Although UNICEF programmatic focus has traditionally centered around those countries in the LIC band, accelerating economies still have **“many children left behind”**

1) Source: Institute for Development Studies, Global Poverty and the New Bottom Billion: Three Quarters of the World's Poor Live in Middle Income Countries, found at <http://www.ids.ac.uk/index.cfm?objectid=D840B908-E38D-82BD-A66A89123C11311F>

New Vaccine Adoption in MICs

- Increasing disparity between rates of or plans for new vaccine adoption in MIC versus GAVI-eligible countries and HIC
- UNICEF's strategy primarily focused on the introduction of new, high-cost vaccines: **PCV, HPV, Rotavirus**

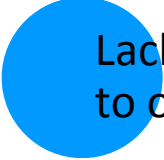


Note: Income groups are based on the World Bank July 2011 classification and are applied for the entire time series (see http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Low_income).
Source: WHO Department of Immunization, Vaccines and Biologicals 2011.


Factors Affecting New Vaccine Adoption in MICs



Lack of **access to affordable new vaccines** (or even knowledge of comparators)




Lack of comparable advocacy and technical advisory/assistance compared to other countries



Sustainability / lack of funding sources (both internal budget and external support)

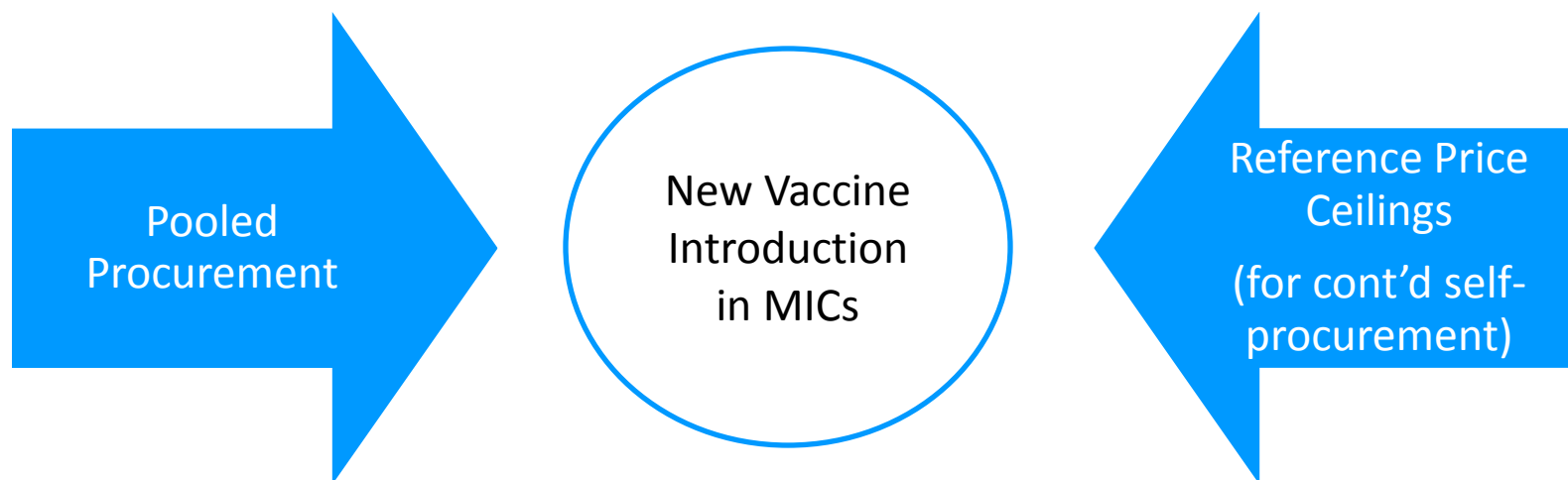


Uneven political will, in some countries



Variable institutional capacity (NITAGs, procurement capacity, burden studies, etc.)

Hybrid Strategy



- ❑ Providing aggregated demand forecasts to industry, availability and product information to countries, pooling procurement and establishing reference pricing
- ❑ “Time-limited” intervention with the aim of countries incorporating these vaccines in their regular vaccine procurement processes within a few years
- ❑ Expect initially small, but evolutionary and flexible process
- ❑ Key Dependencies:
 - ❑ Iterative country demand forecasting
 - ❑ Advocacy
 - ❑ Funding options to support volume guarantees, etc.
 - ❑ Complementarity with regional initiatives (e.g. WHO/EMRO PVP)
 - ❑ Partner engagement

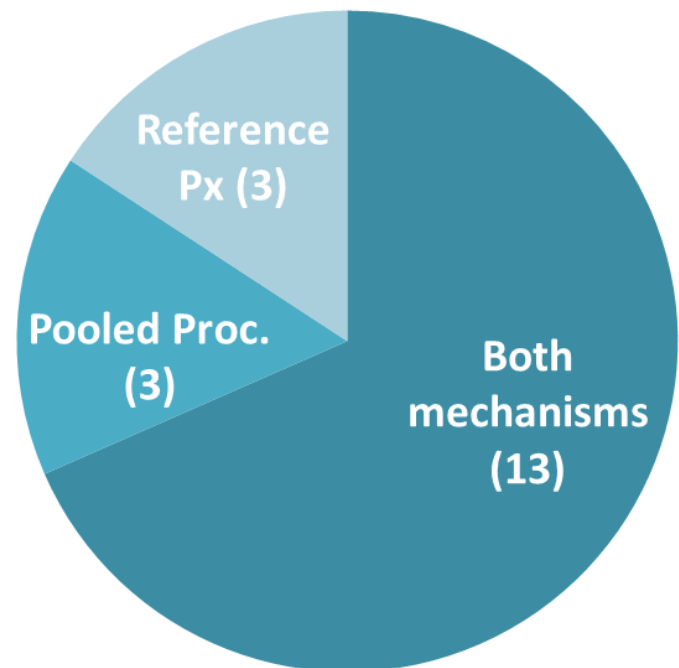
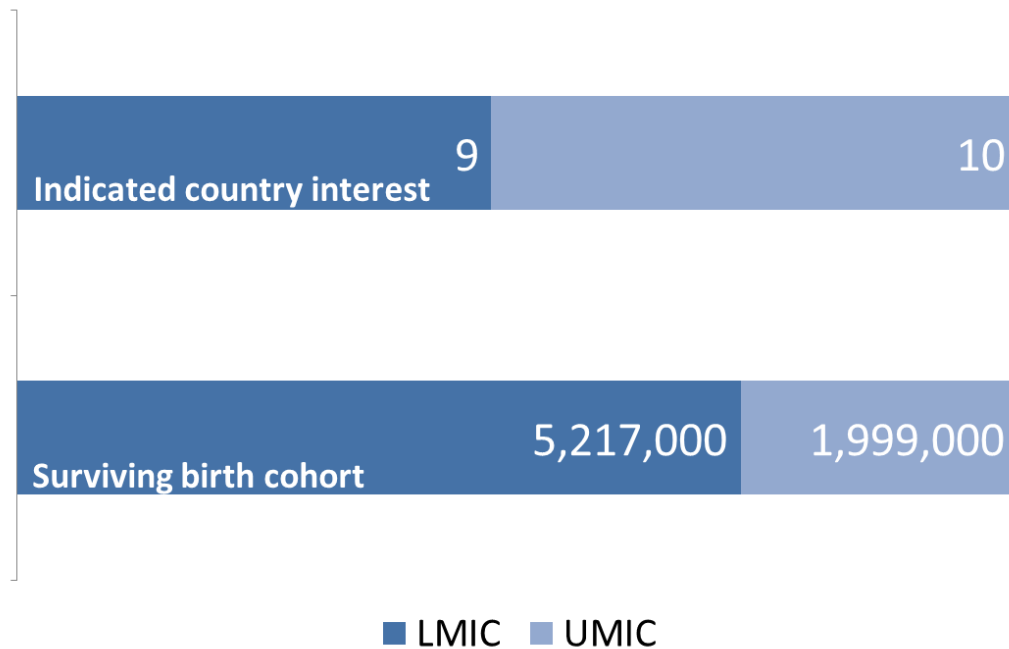
Sizing the Opportunity to Help Children

LMICs (GNI → \$1,006 - \$3,975)			Total Birth Cohort	90% Birth Cohort
Angola	Kosovo	Samoa	8,555,000	7,699,500
Armenia	Marshall Islands	Sri Lanka		
Bhutan	Micronesia (Fed States)	Swaziland		
Capo Verde	Moldova	Syria		
Congo	Mongolia	Tonga		
Egypt	Morocco	Turkmenistan		
Fiji	Nauru	Tuvalu		
Georgia	Niue	Ukraine		
Iraq	Philippines	West Bank / Gaza		
Kiribati				
Less:	Indonesia			
	India			
	TACRO LMICs			
	GAVI-eligible (GNI < \$1,520)			
UMICs (GNI → \$3,976 - \$12,275)				
Albania	Jordan	Montenegro	5,487,000	4,938,300
Algeria	Kazakhstan	Namibia		
Azerbaijan	Latvia	Palau		
Belarus	Lebanon	Romania		
Bosnia-Herzegovina	Libya	Serbia		
Botswana	Lithuania	Seychelles		
Bulgaria	Macedonia	South Africa		
Equatorial Guinea	Malaysia	Tunisia		
Gabon	Maldives	Turkey		
Less:	China			
	Iran			
	Russia			
	Thailand			
	TACRO UMICs			
Total			14,042,000	12,637,800

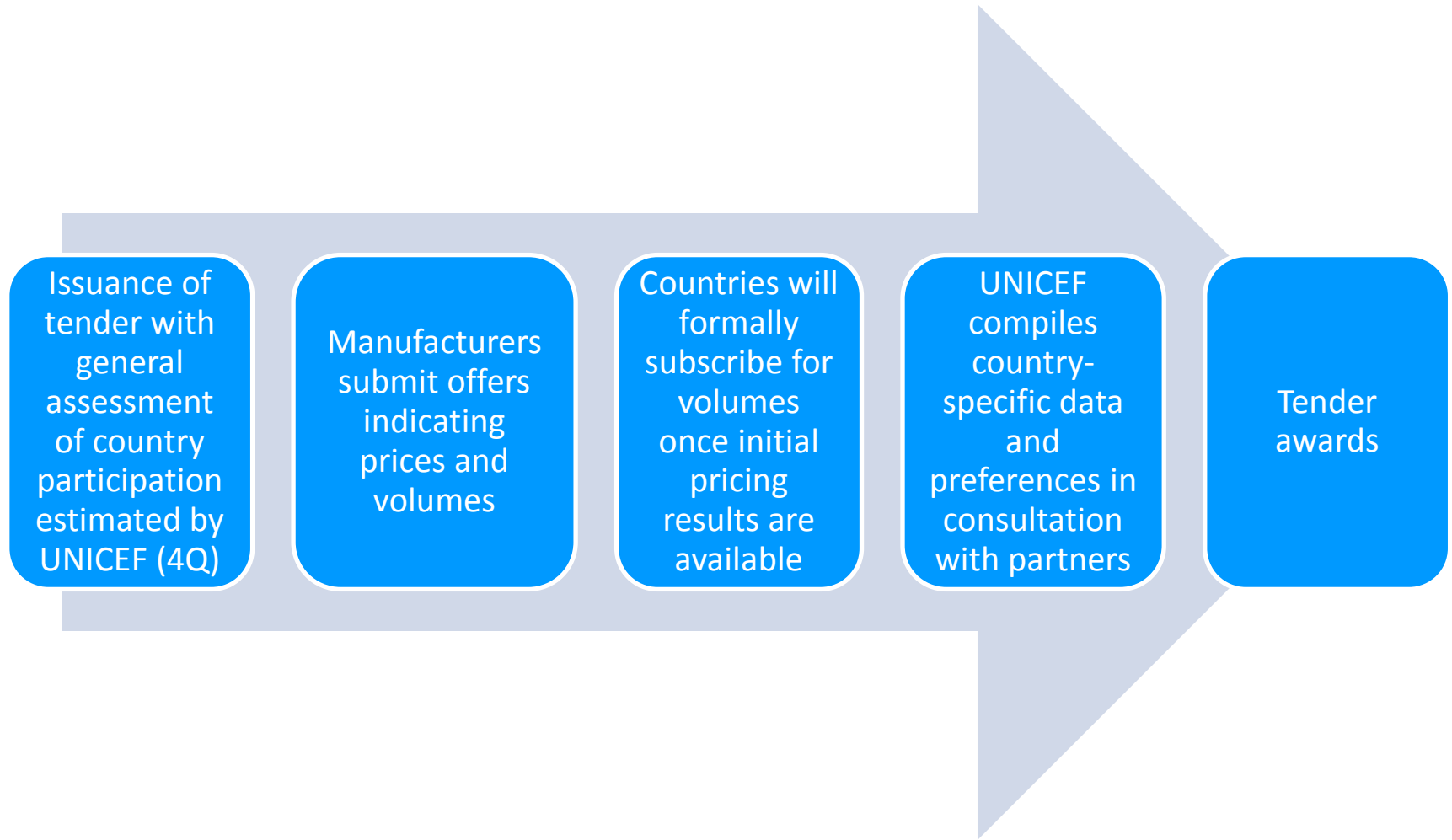
Consultation Process

Date	Process Item
25-26 January	Industry consultation where initial strategy was presented
5 March	Informal polling of UNICEF Regional Health and Immunization Advisors including view of appropriateness and initial country preferences to two “bookends” of options.
12 – 13 March	Presentation of initial considerations and proposed options at WHO “Meeting of the Minds” meeting in Geneva. Options were discussed with participants (including WHO, GAVI, NGOs, Consultants and Academia).
Mid-to-late March	Initial Qualitative Feedback Received from UNICEF Regional Offices and construction of “Summary Feedback” document which was re-distributed to Regional Offices; Hib-containing, Rota, PCV, HPV Preferences and future introduction plans reported; initial discussions regarding country / regional preference for two conceptual options.
April	Construction of draft strategy document incorporating available feedback and select country data points or known preferences.
16 May	Distribution of completed draft strategy document to UNICEF Regional Offices (Regional Directors, Health Advisors and Immunization Advisors); Regional Offices have shared with country offices.
16 May	Presentation of draft strategy at WHO NUVI Conference (Marrakech) and discussions with select countries and partners , including WHO, GAVI, Morocco, Bhutan, Philippines, Moldova.
Early-to-Mid June	UNICEF SD begins receiving multiple inquiries regarding ability to provide access to Cost Estimates and procurement of new vaccines include PCV, HPV and Rotavirus from select Middle Income Countries.
7 June – 19 June	2 nd Round of consultation with all UNICEF Regional Offices and written feedback provided from countries especially from MENA, WCARO, ESARO in response to draft strategy. Alternatively, feedback verbally provided via RO
27 June	Second industry consultation where two conceptual bookends of “pooled procurement” & “reference price ceilings” were discussed
July 2012	Issuance of non-binding Interest Assessment surveys to ALL MICs through ROs; collected country preference for participation in pooled procurement vs. reference price ceilings and product specific preferences (HPV, Rotavirus, PCV)
August – October	Continued consultations with Countries, UNICEF Country Offices, Manufacturers, and Partners. Joint WHO-UNICEF Presentation to EMRO RC ; Presentation to PAHO TAG on Immunization; Consultation with MSF
September – November	Finalization of Procurement Strategy Implementation Plan and Drafting of Tender Document
Q4 2012	Anticipated launch of MIC tender (HPV, PCV, Rotavirus)

Early Country Indications on Strategy Preferences



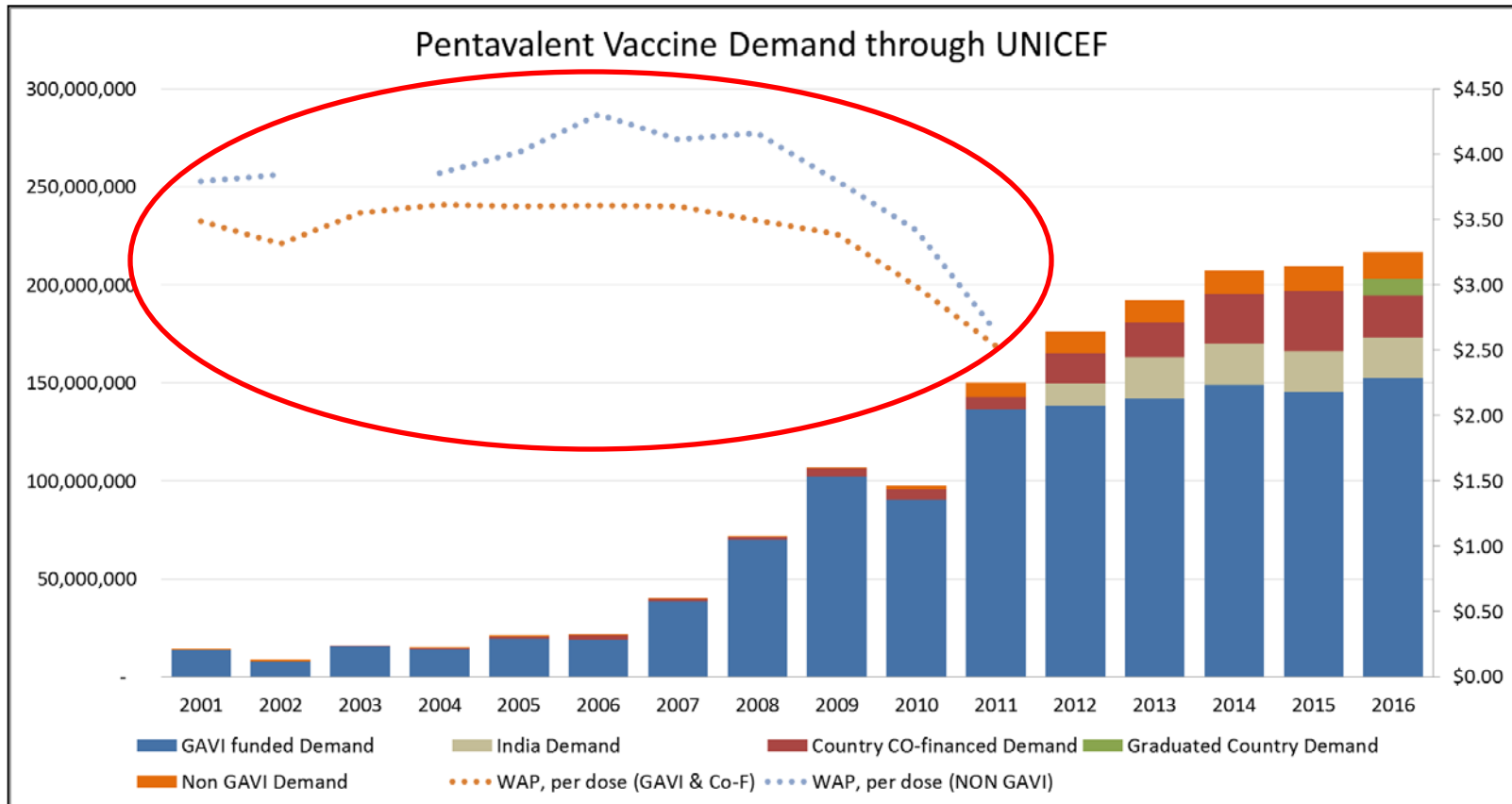
Planned Tender Process



Anticipated Pricing Results



Pricing Precedents – DTP-HepB-Hib



Pentavalent pricing has always had a difference for non-GAVI and GAVI pricing, but they have followed similar trends and have increasingly converged

Conclusion

- Expect Q4 2012 tender launch for PCV, Rotavirus, and HPV vaccines
- Collaborative development of country demand forecasts for desired vaccines (incl. quantity, preferences and timing)
- Countries to consider various sources of funding for new vaccine introduction
- Alignment with partners critical for supporting MICs
- Continued engagement with industry to develop models to support sustainable vaccine introduction

Thank you