Sixty-Ninth World Health Assembly, 2016
Provisional Agenda Item 15.2 (A69/34) – Global Vaccine Action Plan

Background

Four years ago at the 2012 World Health Assembly (WHA), Member States endorsed the Global Vaccine Action Plan (GVAP), the 2011-2020 Decade of Vaccines framework for improving vaccination for all.[1] The following year, WHA delegates agreed to the proposed GVAP Monitoring, Evaluation and Accountability framework, and asked for additional indicators to be tracked over the course of the decade.

Each year, the WHO Strategic Advisory Group of Experts (SAGE) – WHO's immunization policy-setting body – reviews progress against the GVAP targets (as reported by the Decade of Vaccines Secretariat), and issues an *Assessment Report of the Global Vaccine Action Plan.* The recommendations in the SAGE *Assessment Report* aim to outline corrective actions that the Decade of Vaccines partners and member states can take towards improving progress against the GVAP targets. At this year's World Health Assembly, Member States are invited to note the nine (9) recommendations outlined in the SAGE *Assessment Report*.

Other barriers that limit the success of immunization programmes are omitted from the SAGE *Assessment Report*, such as the need for better adapted vaccines (thermostable, needle-free, etc.), lack of flexibility of target age groups (eg completing the vaccination schedule for children over 1 year that have not completed their full primary series), and recurring issues of vaccine shortages (such as the recent shortage of yellow fever vaccines, and ongoing challenges with lack of adequate inactivated poliovirus vaccine).

It is important to note that last year's WHA was a watershed moment for Member States when Resolution 68.6 (2015) on vaccine affordability and price transparency was adopted.[2] The resolution, originally introduced by Libya, was ultimately co-sponsored by 18 member states[3]; and over 50 governments voiced strong support for the resolution, highlighting their challenges in introducing new vaccines due to the price.

Tenets of the 2015 WHA resolution on vaccine pricing include:

- Increasing publicly-available vaccine price data through transparency measures;
- Monitoring vaccine prices through annual reporting;
- Pursuing strategies such as pooling vaccine procurement in regional and interregional or other groupings, as appropriate, to leverage economies of scale;
- Promoting competition by expanding the number of manufacturers, particularly in developing countries, that can produce WHO-prequalified vaccines; and
- Reporting upon technical, procedural and legal barriers that may undermine the robust competition.

The resolution concluded with a request to the Director-General to report on progress in implementing the resolution to the Health Assembly through the Executive Board in the annual report on the Global Vaccine Action Plan. However, at the 2016 Executive Board (EB) meeting, there was no inclusion of a progress report by the WHO Secretariat on Resolution 68.6 (2015), as

[1] Resolution 65.17 - http://www.who.int/immunization/global_vaccine_action_plan/en/
[2] http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_R6-en.pdf
[3] Countries co-sponsoring the 2015 World Health Assembly resolution on vaccine pricing: Algeria, Bahrain, Brazil, Egypt, Iran, Lebanon, Libya, Morocco, Nigeria, Pakistan, Qatar, Saudi Arabia, Sudan, Thailand, Togo, Tunisia, Venezuela, Zimbabwe.

had been requested by member states. In their interventions at the 2016 EB, member states – such as Jordan, India, and Brazil, among many others – requested WHO to report back on this resolution; the 69th WHA report includes an Annex on Resolution 68.8 implementation to date, however, the report is quite limited and includes activities which were actually implemented before the resolution (e.g the MenAfriVac initiative for meningitis A conjugate vaccine), while no new activities are outlined specifically on vaccine affordability.

MSF is also deeply disappointed that WHO writes in the WHA report that only "limited and unpredictable resources" are available for this work, "preventing a more systematic and comprehensive approach."

MSF requests that the work of Member States in forging this resolution be maintained and that governments request the WHO Secretariat to allocate the needed resources and greatly improve its reporting upon progress towards implementing Resolution 68.6.

Vaccine pricing: a persistent obstacle for member states & humanitarian actors

One area of particular concern that has been repeatedly highlighted by Member States is the challenge of expensive new vaccines.

According to the *lowest* publicly-published prices – prices which are not even available to most countries – the price of fully vaccinating a child has increased by 6,700% over the last thirteen years (2001-2014); and the Decade of Vaccines is expected to cost as much as US$51 billion, almost half of it being the cost of the vaccines themselves. The newer, more expensive vaccines – such as vaccines against pneumococcal disease, diarrhoea and cervical cancer – are often priced out of reach for countries that do not receive donor support, and these countries often do not receive any other assistance to access affordable prices. Countries that are losing financial support through *Gavi, the Vaccine Alliance* (>30% of the Gavi cohort by 2020), also face significant affordability and thus sustainability challenges; they will have to fully self-finance the cost of new vaccines and will be challenged with unpredictable prices once they lose access to lower Gavi-negotiated prices.

One reason why vaccine prices remain high is due to a lack of competition, particularly in the new vaccines market. For example, there are only two manufacturers each for the newest vaccines: Pfizer and GlaxoSmithKline for pneumococcal conjugate vaccines (PCV); GlaxoSmithKline and Merck for rotavirus vaccines; and GlaxoSmithKline and Merck for human papillomavirus vaccines (HPV). **The accelerated introduction of new products on the market to increase competition would lower the price of vaccines and help to make vaccines more affordable for countries and humanitarian organizations. MSF requests that the WHO Secretariat convene its relevant departments and the Government of India around accelerating the licensing and WHO Prequalification of PCV candidates.**

Vaccinating crisis-affected populations: the need to provide immunization services to the most vulnerable

People living in crisis contexts are often the most vulnerable, fleeing conflict zones or natural disasters with ruptured healthcare systems and often arriving in places with similarly fragile systems. **UNICEF has estimated that 2/3 of the world's unvaccinated children live in conflict-affected countries.**

The 2015 SAGE *Assessment Report of the Global Vaccine Action Plan* highlighted the effect of war on immunization coverage in seven (7) countries affected by conflict or natural disaster:

DTP3 NATIONAL COVERAGE FOR 2014 IN THE SEVEN COUNTRIES WHERE MORE THAN 50% OF CHILDREN ARE UNVACCINATED OR UNDER-VACCINATED.

Country	Coverage
Equatorial Guinea	24
South Sudan	39
Somalia	42
Syrian Arab Republic	43
Chad	46
Central African Republic	47
Haiti	48

In countries in which wars and natural disasters have decimated health systems, an unvaccinated diaspora have fled to neighbouring countries or further abroad. There are internally displaced children who cannot access immunization services and areas where ongoing fighting makes vaccination very challenging. WHO has finalized a framework for decision-making about selecting vaccines in acute humanitarian emergencies[1] but more guidance is needed in relation to implementation of sustainable immunization in ongoing conflict or crisis among both internally displaced people and those who have become refugees in other countries.

2015 Assessment Report of the Global Vaccine Action Plan, Strategic Advisory Group of Experts; page 8
http://www.who.int/immunization/global_vaccine_action_plan/SAGE_GVAP_Assessment_Report_2015_EN.pdf?ua=1

In addition to countries in conflict, people crossing borders to flee crisis are also not having their vaccination needs met as they seek refuge in other countries. **Those countries which host refugees, such as countries in the Middle East or African regions, face a double burden related to immunization: the increasing challenge of being unable to afford new vaccines for their own populations (as most of them do not benefit from Gavi nor other donor support), as well as for the influx of refugees.**

While WHO published a framework for vaccinating in acute humanitarian emergencies in 2013, implementation of these guidelines has been slow and sparse[4]. Additionally, with much of the work carried out by the humanitarian community, the inability of humanitarian organizations to purchase new vaccines at the lowest global price also poses a barrier to protecting crisis-affected populations against the most common causes of disease (pneumococcal and diarrhoeal diseases).

Recommendations of 2015 SAGE Assessment Report of the Global Vaccine Action Plan:

To improve immunization coverage especially where many unvaccinated and under-vaccinated children live, including those affected by conflict and crisis, SAGE recommends that:

7. Global, regional and country development partners coordinate and align their efforts to support countries to immunize more children by strengthening their healthcare delivery systems, combined with targeted approaches to reach children consistently missed by the routine delivery system, particularly in the countries where vaccination rates are below 80% and to provide services to populations displaced due to conflict (both internally displaced persons and refugees).

8. WHO provide guidance for countries and partners on implementation of immunization programmes and immunization strategies during situations of conflict and chronic disruption.

http://www.who.int/immunization/global_vaccine_action_plan/SAGE_GVAP_Assessment_Report_2015_EN.pdf?ua=1 Page 4

MSF recommendations:

During 2016 World Health Assembly, MSF wishes to direct Member States to the SAGE recommendations that can increase vaccination services in crises and humanitarian emergencies. Specifically, MSF encourages Member States to:

- Request WHO to convene a forum that engages the pharmaceutical industry to find solutions for the vaccination needs, in particular for new vaccines such as pneumococcal conjugate and rotavirus vaccines, of crisis-affected populations as well as the countries that host refugees.

[4] Vaccination in Acute Humanitarian Emergencies: a framework for decision making (2013), WHO. http://apps.who.int/iris/bitstream/10665/92462/1/WHO_IVB_13.07_eng.pdf

- Request WHO and partners to accelerate opportunities to vaccinate children caught in crisis; and document cases where new vaccines have been used in crisis contexts, and the obstacles to their use.
- Request WHO and its partners, such as Gavi, the Vaccine Alliance, to work on solutions for humanitarian organizations to access the lowest global price for vaccines for crisis-affected populations living in humanitarian emergencies.

Additionally, MSF requests Member States to:

- Request the WHO Secretariat to take the necessary measures to ensure that new vaccine candidates are being prioritized in the technical and regulatory support provided by WHO to Developing Countries Vaccines Regulators (DCVR) in view of their timely licensing and prequalification.
- Request WHO to convene its relevant departments and the Government of India (and its institutions) around accelerating the licensing and WHO Prequalification of Indian PCV candidates, as an urgent global health priority.
- Remind the WHO Secretariat of the 2015 World Health Assembly resolution on vaccine pricing, and the request to the Director-General to improve reporting on progress towards implementing the resolution.
- Request the WHO Secretariat maintain its role as facilitating and administering a global database on vaccine prices.