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U.S. Global Health Policies in Focus
Getting to Zero: Saving Children's Lives with Vaccines
Kaiser Family Foundation
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JOSH MICHAUD,: Good afternoon, and welcome to the Kaiser Family Foundation's webcast series, U.S. Global Health Policy In Focus. We're coming to you live from our broadcast studio in Washington, D.C. I'm Josh Michaud, Associate Director for Global Health Policy at the Kaiser Family Foundation. In Focus brings you discussions and takes your questions about current issues and debates concerning the U.S. government's role in global health. Each live webcast features leaders in their fields, sharing their views and experiences. Today, we are very pleased to have an expert panel to discuss vaccines in child health.

Protecting children's lives through vaccines is a cornerstone of global health, and a key component of U.S. efforts to help end preventable child death, and eradicate polio. While there's been great progress on expanding access, many children around the world still do not receive recommended vaccines. What are the key issues for the U.S. government, the multilateral institutions, non-governmental organizations, and country governments, in supporting vaccination programs now, and going forward?

Here to talk about this are our four experts: Ariel Pablos-Méndez, Assistant Administrator for Global Health at the U.S. Agency for International Development; Carolyn Miles, President and CEO of Save the Children; Seth Berkley, CEO of

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The GAVI Alliance; and Amanda Glassman, Director of Global Health Policy at the Center for Global Development. Welcome to all of you, and thank you very much for being here.

SETH BERKLEY: Thank you.

ARIEL PABLOS-MÉNDEZ: Thank you.

JOSH MICHAUD: To our audience, today's conversation is a live webcast, and we encourage you to submit your questions to us along the way, by emailing infocus@kff.org, or via twitter, using the hashtag #kffglobal. I'll be monitoring the questions as we go.

I'd like to start the conversation by talking about where we are in the context of broader child survival efforts. The United Nations estimates that the number of deaths among children under five declined from 12 million in 1990, to 6.9 million in 2011, but many countries still have a way to go to reach the millennium development goal for our MDG 4, of reducing child mortality rate by two thirds, between 1990 and 2015. Ariel, I know USAID has placed a strong emphasis on child survival in its global health efforts. From your perspective, what have been some of the key milestones up until now, and what would you say is the vision for USAID on child survival, going forward?

ARIEL PABLOS-MÉNDEZ: Well, thank you, Josh. Child survival is indeed a summary indicator for our work in international development and for our work in global health.

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It's really the addition of our work from nutrition, family planning, malaria, to immunization. As such, success and progress depends on broad mobilization and broad indicators. You noted that there's been a lot of progress in child survival, and we are working very hard to accelerate progress towards 2015, but at the same time, this big success has allowed us to envision both end games for child and maternal mortality. We do see the possibility, in our generation, to bring down the mortality levels in the world to those that we enjoyed in rich countries.

This was, indeed, the thesis that brought together the call to action last year, to end preventable child death, a year ago, exactly, this week. In that, the U.S. government joined with the governments of India, the governments of Ethiopia, with UNICEF, and many other partners, to put forward this vision; a vision that has been followed by a lot of momentous developments at country level and at global level. We are building, of course, and put a lot of efforts in this space, especially the every woman, every child mobilization of the U.N., and related partnerships, and building it along the word that we have been doing for decades in this space.

We have seen now, from the early countries that came here now, 170 countries had pledged now, support for the promised renewal that was launched at the call to action a year ago. Global plans have followed in nutrition, in newborn, in

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pneumonia, and diarrhea, and more important, in immunization at the country's levels, that also follows the UN Commission on Lifesaving Commodities, that was launched at the UN General Assembly last September. I have been particularly excited about the efforts that we have seen in Nigeria, in India, in Ethiopia, in the Middle East, coming up, also in many other countries in Africa, because, as we will take political leadership and globalization, and the manifestation of that is taking place across—the range of the activities that I mentioned before, including, as I noted before, immunization, which is one of the most important parts of our strategy.

JOSH MICHAUD: Great. Well, I want to turn to Carolyn now, and ask you, as leader of an organization that is squarely focused on child survival, among other things, what do you make of the progress and the momentum in child survival, generally?

CAROLYN S. MILES: Well, I think, as Ariel mentioned, the child survival rates are a great indicator, not only of what's happening for children, but of what's happening for a country. If a country decides that their children are going to survive, that's obviously a great indicator for development. We're very hopeful, but I would say, also pushing for more action on child survival. If you look, there are about eight of the Countdown countries who have already reached that reduction of two thirds of child mortality that we are looking for in MDG 4, but there are an awful lot of countries that have

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not gotten there. There is a lot more that has to be done, in order for countries to make it, and to get to that two-thirds reduction.

One of the areas that is so critical, I think, for child survival, is in that newborn period, and down that first month of life, now actually, makes up about 43-percent of the under five deaths. That number is a hard one to move, and Save the Children, and many others, are spending a lot of time on that issue.

One of the things that we found that really does move the needle for newborns is frontline health workers. It's also incredibly important in vaccination campaigns, so, making sure that we actually have trained frontline health workers that can get to that last mile, which is where a lot of these kids do die, and mothers die, and make sure that they can deliver basic interventions. They are extremely important in vaccinations as well, and in making sure that delivery happens. We've found that, from a child survival standpoint, frontline health workers are really the heroes in this story. Countries are the ones that are really getting behind—countries like Ethiopia, Nepal, where they are training literally tens of thousands of frontline health workers, are the ones that are really able to make the difference, at the end of the day, in saving kids' lives.

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JOSH MICHAUD: Right. I think we are going to come back to that point a little bit later, and talk about health systems, and the role of vaccination programs there.

There's also a discussion around what may succeed the MDGs, of course, and the post-2015 agenda. Seth, your organization, in its mission statement, has saving children's lives in there, and I know you have been part of that discussion, around what comes after the MDG deadline of 2015. Where do you think child survival is placed, and perhaps vaccines, in particular, in that discussion and the reports that have been already published?

SETH BERKLEY: Thanks, Josh. A couple of points on that; first of all, as we think about post-2015, one of the critical issues is making sure that we don't slow down in the 923 days that we have left.

JOSH MICHAUD: Right.

SETH BERKLEY: We will not, at the end of 2015, know what the results of that are. It's important; we won't see those results until 2016, 2017, so we won't be able to measure. What we measure in 2015 will be results into 2013 or 2014, so we have to keep that in mind.

There has been a lot of discussion about the centrality and importance of health, and that's the number one point; we have to make sure health remains as center. You need to have a healthy planet, and you need to have healthy people, and those

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two need to be integrated. Either one alone isn't enough; they need to go together.

One of the things that's been discussed is the fact that we need to take a life cycle approach, and not only think about healthy children, which is what we are talking about here, but also maximizing healthy life among adolescents, among young adults, and the elderly, because we're seeing a demographic transition, and this is how we have to think about it, going forward.

JOSH MICHAUD: Right.

SETH BERKLEY: We've been advocating for a new indicator called "the fully immunized child," and it's really about resetting how we think about immunization. Traditionally, we think about DPT3, because that's the third contact that you have for that particular vaccine, or measles as the vaccines we measure, and those vaccines, we have pretty good coverage; you're talking in the mid-80s for the world. Today, we have these new powerful vaccines against diarrhea, against pneumonia, against diseases such rubella and meningitis, and WHO today recommends 12 vaccines. If we ask the question how many children are fully vaccinated, we don't know the answer, because we don't measure it that way. If we modeled it, it's probably around 3 or 4-percent. One of the things we would like to see is almost a global reboot on how we think about immunization. What we would like to do is really

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accelerate moving these vaccines out, so that we can get them to the children, to allow them to live lives that are to their full potential, and without the normal diseases that would occur during this period, including the effects on families' finances, et cetera.

JOSH MICHAUD: Right, great. Well, Amanda, you've been an observer of this process, and I'm sure, have some opinions about this. What do you think about the progress made on child survival and the policy discussions that are going on, going into 2015 and beyond?

AMANDA GLASSMAN: Well, obviously, the progress has been very dramatic. That said, we have some really ambitious goals on the table right now. The question is whether our budgets match those ambitious goals, and particular, when I look at the U.S. government's budget request. We have 145 million for GAVI, for example in FY13, a little bit more for polio eradication, but that amounts to about 2-percent of our total Global Health Budget. If it's the case that vaccine preventable diseases account for 30-percent of the preventable child deaths, then you might hope to see a bit more effort on that, and maybe we will see that when the replenishment comes around.

I think the other big issue is, as Ariel points out, in a number of places, aid is less and less important in this effort. The question becomes how do countries, themselves, set

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their priorities for spending? Do they prioritize what's most cost effective, and then, what role does affordability play? There, GAVI has always had a role in effecting price of vaccines, and things like that. I think those are the two key issues I would like to see something happens on, in the next couple of years.

JOSH MICHAUD: Okay. We can turn now, to talk about vaccines and immunization in a little bit more detail. There's an estimated 22 million children who don't receive all the recommended vaccines. You're saying between maybe 3 and 5-percent of children are not fully immunized, and 1 in 5, or maybe 30-percent of child deaths, are still caused by vaccine preventable diseases. Let's talk about the roles of your various organizations, and successes that you've had, and the ongoing challenges for increasing access to global vaccinations.

I'm going to turn to you, Seth, first. GAVI is a unique multilateral institution and partnership that's focused on increasing access to immunization in poor countries. Tell us a little bit more about GAVI's approach, and its current strategy and priorities.

SETH BERKLEY: First of all, GAVI is a public private partnership, so the critical issue here is trying to take the best of the public and private sector, and having them work together, to try to get these vaccines out. GAVI doesn't have

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anybody on the ground; it works with partners on the ground. That's how it can be so efficient; our overhead rate is 3-percent. Our goal has been to try to get these new vaccines out into the system.

We had a replenishment in June of 2011, and that really kick-started us, but it's this year that we're really hitting that inflection point. A couple of statistics; in the first 12 years of GAVI, we distributed about a billion doses of vaccines. In this year alone, we will distribute 600 million. We had 152 product launches in the first 12 years, this year, around 54 launches, and we've actually added three new programs; we have six programs now, three new ones this year, so a massive acceleration.

Had we had pneumo and rota at the time of the original Millennium Development Goals, and had those been implemented, we would probably be meeting our child survival goals now. As Amanda has said, vaccines relate to a huge amount of the burden that's there.

You also mentioned the fact that there are many children that are unimmunized, and the 22 million are children that haven't received DPT3; that's the indicator measure. The largest number of those are in India, who produces most of the world vaccines. Since they have been able to eradicate polio there, they have been emboldened, and now you see a new effort to try to bring some of the tools used in polio, some of the

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micro-planning and other work, and focus it on routine immunizations. I have great hopes on what India's going to be able to do, and this is something we're trying in Nigeria, as well. How do we bring the different arms of immunization together? Traditionally, you have a polio program, and a measles program, and a new vaccine program, and a routine. What we are trying to do is say how do we synergize, how do we work together on the ground, so that each of those programs strengthens the others, rather than competes for resources and time.

JOSH MICHAUD: Yes, I think we are going to come back to this question about India, and some other middle-income countries. I think it is a fascinating one, and that's where many of the children who remain unimmunized, as you say, are found.

First, I wanted to ask Ariel about the U.S. government's support for vaccination programs. Through the work of USAID and CDC and other agencies, it's been a major supporter of global vaccine efforts. In fact, in 2011, USAID Administrator Rajiv Shah called vaccines the greatest public health investment we can make. The U.S. made, the same year, a three-year pledge to GAVI of 450 million dollars. How would you say the U.S. approaches its work in this area, and what are the priorities for vaccines, globally?

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ARIEL PABLOS-MÉNDEZ: Thank you. Immunization is clearly one of the best investments in public health. It has been in this country the last century, and it has clearly been showing that value around the world. GAVI has been an innovative way to bring about new vaccines into the developing world, and it is a very successful model. GAVI and immunization, then, really, is at the center of many of the priorities for USAID, from any preventable child death, which, as we said before, immunization is key. Also, the business model of GAVI writes what we call the economic transition of health. International development is succeeding. Many countries are moving from low-income to middle-income, as we speak. That dynamic is a very important source for us to play successfully, for long term and sustainable success immunization and child survival.

The other thing, for us, in the second term, in particular, brought along in recent years, has been value for money, and the business model that GAVI brings about does exactly that. How we work, in addition to supporting the core mission and the core financing of GAVI, and we very much remain committed to the mission, and we certainly work with our congress to continue to support GAVI, in years to come.

The other part is, really, the countries, of course, and, as Seth pointed out, they do not have teams on the ground. We do have at USAID, many nations and Foreign Service officers

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working around the world. We work with governments to make sure that we have immunization policies, capacity to deploy the various programs in an integrated fashion on the ground. We also work to mobilize the amount: that is crucial, as we have heard, and so is the commodities are important. The vaccines are important, but so are the systems, as well as the communities being mobilized.

In the 24 priority countries, which include the poorest countries to rich countries, where we are concentrating our efforts today, basic immunization coverage was barely 40-percent, has increased more than 50-percent in the last 20 years. We had to continue to expand, as we have said before, because fully a quarter of all child deaths today could be prevented with current vaccines, vaccines that exist already, and we certainly hope they will continue to work to have new vaccines for whatever is possible. Already, today, we can do more, so our commitment, our support for administration and for GAVI remains as strong as ever.

JOSH MICHAUD: Right, and that's a perfect transition to this idea. There's certainly coverage gaps in poor countries, that remain, but getting back to this idea about middle-income countries, and, Amanda, you've pointed out in some of your work, a perhaps surprising finding, that there are middle-income countries, which actually have lower vaccination coverage rates than some poorer countries. What are the

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reasons for this, and what are the ways that we can get around these barriers?

AMANDA GLASSMAN: Well, one reason is that GAVI and UNICEF and their partners have been very successful. That's a really good reason that the low-income countries have done so well in vaccination coverage. When you look at some of the middle-income countries, they are not much richer than some of the GAVI-eligible countries, especially those that are slated to graduate. They face really different prices per dose of vaccine, even through UNICEF, as a purchaser. If you are the Philippines, for example, you have about \$100 difference in your GDP per capita, compared, to say, Honduras, which was eligible for some time. Your price is many more times, is \$16 a dose, versus something like 3; that's another reason why. It might be a cost effective intervention, but it's not necessarily an affordable intervention, at least in the short term. I think that's another big reason why we see lags in adoption, in middle-income countries.

JOSH MICHAUD: Okay. Well, I'm going to throw it open now, to everyone, to really address this: how do we, as a global health community, international community, governments, both donor governments, and also the governments in the countries where there remain gaps, address this gap problem, and that, of course, is both the poor country gaps and the middle-income—yes, Seth.

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SETH BERKLEY: Can I follow up on that point?

JOSH MICHAUD: Yes, please—

SETH BERKLEY: Our sustainability model is based on the following facts. Our countries are countries with less than \$1,550 gross national income. The idea is, if you are very poor country and you have \$200 or \$300, you do not have the financial bandwidth to be able pay for these new vaccines. One, is we try to bring the price down, as Amanda has talked about, through a market shaping effort to get better prices, but still, there's not enough money. That's where GAVI comes in; we co-finance those vaccines. They still pay; they pay \$.20 a dose, the poorest countries. As they get wealthier, they begin to have an increase in that copay, and then as they cross the \$1,550 dollar threshold, they then go through taking over the full cost.

What's important about that is that, at the time of graduation, it doesn't mean they necessarily are prioritizing, although that's what we want to do, but they have the fiscal bandwidth. On average, the country has to spend 0.6-percent of their health budget on the vaccine program, to cover those children, which we think is affordable, within the fiscal envelop, but not necessarily prioritized. As Amanda said, if you're a country that isn't GAVI-eligible, now you're paying a much higher price for your vaccines, that number will be much higher. We are in the midst of a discussion for, not only our

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graduating countries, but perhaps, to have tiers, so when they get finished with GAVI, they don't leap up into the open market, but have a slow increase, that will make it sustainable. Could we include other countries in those tiers, could we move towards Ramsey pricing, to allow people to access that? That might do some of this balance from, where we have a situation that's funny, where the wealthiest countries have access to vaccines, the poorest countries do, and then, in the middle, you have a gap, and that's where a lot of the poor people live. This is something we're investigating.

JOSH MICHAUD: Go ahead, Carolyn.

CAROLYN S. MILES: I think, Josh, just to pick up on this point of inequities, we talked at the beginning about 2015, and about what has to change post-2015, and I think this issue of inequity is the major issue for the post-2015 framework, whatever that looks like. A lot of us have been talking about zero-based goals; getting child mortality, essentially, to zero, maternal mortality to zero, every child able to learn, those kinds of goals, because I do think that while the Millennium Development Goals have been terrific, in terms of getting us focused, they have driven some of this inequalities, in some ways. The places that are easy to reach, and the kids that are easy to reach, have been reached. Now we are left with the seven million kids who are dying every year, that are much harder to reach. Whether that means they're in

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rural areas and much harder to reach in that way, or they are in these middle-income countries, and middle-income countries are focusing on the easier to reach kids, I do think this issue of inequality is the one that we all have to be thinking much more forcefully and thoughtfully about, because those are going to be the hardest goals to reach. I think, when we, at Save the Children, think about this, we think about how we work with countries on those hardest to reach families, the poorest families, whether you are in a middle-income country, or whether you're in a very low-income country. It's about the poorest and the most marginalized people in any of those places where we are working and that takes a different strategy.

JOSH MICHAUD: It's about a different approach for organizations such as Save the Children and for the donor governments, and also, commitments, to a greater degree, from the countries' governments themselves; would you say all of those would be—

CAROLYN S. MILES: I think all three of those things—I would say, probably, most importantly, and Ariel touched on it as well, the countries, themselves, deciding that these are the things where they're going to put their priority, and their kids are not going to die of preventable diseases, and mothers are not going to die in childbirth, and kids are going to be educated, and making sure that goes along with that decision, comes the decision to really do everything you can to reach the

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poorest. I think that's what you see in India. I think that is the crux of the issue.

SETH BERKLEY: I had a conversation with Tony Lake yesterday and it was interesting, because he makes the point that's so powerful on this, is that we have a moral ethical reason to deal with this health equity but also, because those people have less access to treatment, less access to other interventions, to other prevention, that they may be more expensive to reach, but the effects of reaching them are much higher. Actually, it's not only an equity issue; it also is an issue of having an effective effect on disease burden.

ARIEL PABLOS-MÉNDEZ: A critical point on that, if I may—

JOSH MICHAUD: Yes.

ARIEL PABLOS-MÉNDEZ: Clearly, equity is going to become more and more important within countries. Between countries, inequalities will be reduced dramatically, but within countries, that is going to be the challenge. It is interesting that, also, we heard before that before, that some poor countries are getting better coverage than middle-income countries, because of the efforts on the poor. Then you have also, the fact that the payoff of those investments are greater. A critical point is that, when you look at the annual rate of reduction in child survival, increasing years, as we are indeed reaching those more marginalized kids, the successes

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are accelerating, which is paradoxical. In part, it is because of those reasons that, although, we are investing to reach all, the gains are greater.

Also, I like to think that societies that were used to accepting that a kid will die are changing their mind, and that mindset shift transforms everything, when the expectation is that a child or a mother shouldn't die. Then communities, families, everybody, just do everything differently and better. I would like to think there's a normative shift on the expectation on the risk of dying and surviving of mothers and children around the world, in many of these countries, which contributes, along with many other forces, to accelerate progress. We certainly hope that the efforts that we are committing to now, will carry on, because they are essential, but also, that the countries, increasingly, will have more of that. We have to make sure that, in those graduations, in those transitions, success is sustainable, is equitable, is efficient, and that is why, in addition to delivering service today, we need to help those countries build health systems for the future, and continue to advocate, and through diplomacy, to make sure that those efforts carry on into the future.

JOSH MICHAUD: Right. I don't know if you had a comment on this, Amanda. I did want to get to a question that was emailed in, which may relate to this. Someone emailed a question in, asking: how do we synergize vaccination programs

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on the ground, to strengthen effectiveness of vaccine distribution and implementation? Is this a problem, where we have a fracturing of various vaccine delivery systems, even just thinking about vaccines alone, and is there a way that synergizing of these systems can lead to greater outcomes or greater impact from the programs?

SETH BERKLEY: Absolutely, some specific examples, and one of the things we've seen is polio eradication is an absolutely critical priority for all of us. But, in cases where you've gotten close to the end, and you're doing frequent SIAs, special immunization activities, to try to reach campaigns, to try to reach kids, you're pulling health workers out there, focused on trying to do that, and so they're not getting routine immunization. You see routine immunization numbers go down. That doesn't help either the health of those children, or it doesn't help polio eradication, because if you eradicate polio, and you have a low coverage, then you're at risk of having reimportation. What you need to do is make sure that that work is done in synergy, and so there's been a whole new effect. A new Endgame Strategy for polio includes now having people working on polio spend 50-percent of their time trying to strengthen routine, as well. It's taken the micro-plans that are going on, and asking the question, not only where children are being missed for polio, but where are they being missed for the other vaccinations, as well, and by doing

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that, and by being conscious of that, then you can lift up both programs at the same time. This is going to be very important to polio, but as each country is able to finally eradicate polio—we saw this in India. Now, India is using some of the techniques that it has used to reach the hard to reach, and are going in and now doing routine immunization in those places, and having dramatic acceleration of coverage, because those are exactly the pockets that need the coverage.

JOSH MICHAUD: I'm glad you brought up—yes, go ahead.

CAROLYN S. MILES: To pick up on one point that Seth brought up, I think one of the things we have to remember, and I mentioned this before, vaccines don't deliver themselves; there have to be people who are actually engaged in that, and your point on taking health workers off of one thing to put them on the other; one of the things that has to go along with this increase in vaccines and focus on vaccines, are these community health workers? We estimate there's a need for 4 million more of them are needed, right now, well-trained supported health workers, that can actually deliver all of these interventions. Because they are just as a shortage, you can't actually physically do all the work that we need to do right now, without them, and, as I said, the vaccines don't deliver themselves. We've got to be able to have the human resources, along with the medical resources, if you will.

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JOSH MICHAUD: Right. Is this the rate-limiting step, as it were, for polio eradication? There are certain countries, of course, which have not been successful interrupting polio transmission, and they are Afghanistan, Pakistan, and Nigeria, of course. I wanted to ask you, Carolyn, what you think are the barriers remaining for those countries? Polio is a very specific intervention and effort to try to eradicate by 2018, this disease, which affects children, of course. What are the remaining barriers and how can they be addressed in those countries, or other countries, as well?

CAROLYN S. MILES: Well, I think one is the human resources. I don't think that is the only barrier in those countries, but I think the human resource piece is definitely very important. I think the strengthening of the health system in those countries is key. Security issues are key in those countries, unfortunately. Save the Children certainly has seen that. There have been targeting of vaccination workers in those countries, and so that is a very real thing, and that's a real struggle in terms of—again, I think the answer there is that—and we're starting to see it in Afghanistan and Pakistan, where the country, the government, is stepping up and protecting those vaccinators. You've got to also change, I think, the public perception of what the vaccinations are all about. I think that's the perfect illustration of why you need this grassroots mobilization. You need communities to actually

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be saying, we want our children to be vaccinated; we know what this does. There's a whole education process there, for moms and parents, and that has to happen.

JOSH MICHAUD: Yes.

AMANDA GLASSMAN: I think there's a really interesting issue around the interaction between poor households and households that live very far away from health service providers, and the kinds of barriers they face to accessing care, particularly in Afghanistan, Pakistan, and Nigeria, that, in general, we think if we bring it, they will come. We've seen time and again that that's not the case, and it's not just true about vaccinations, it's true of preventative health care in general, because it comes with a cost, and the benefit is not totally evident. It's the prevention of something; it's not very tangible to families. I think there are a lot of really interesting things going on with poor households, to try to incentivize demand and access to immunization; conditional cash transfer programs. These are things that are happening successfully in Pakistan, but haven't been connected with vaccination programs, so that's something to explore for the future, I think.

SETH BERKLEY: Let me add two other things to Carolyn's list, because I think the issue of data, and having accurate data, is absolutely critical. This is something that cuts across all fields, as part of strengthening the health system,

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but if you really want to be able to know where you're missing children, who's been immunized, what's happening, you have to have good data, and many of these countries don't have good data systems.

The other thing I'd add is the supply chain, which includes, obviously, people working in there, but it includes transport, it includes cold chain storage, it includes a range of other issues, and even today, some of the accounting that's being done, is being done by pencil and paper. It takes a really long time to get up and down the system, and therefore, you don't have real time data, that allows you to have managerial interventions to improve the system. These are things that technology can improve, and it's important that we modernize the supply chain, and bring that up to standards that so many other things are at this current time.

JOSH MICHAUD: Yes, Ariel, go ahead.

ARIEL PABLOS-MÉNDEZ: Yes, indeed, you will hear about the importance of health systems. Diagonal progress has been alluded to. To speak to vertical interventions, they leave a value, but they need to do it in a way that also strengthens the system, as opposed to undermining the system. We have heard about many of those components already, and on the whole, still regarding the supply, which is paramount, and the development of mobilization is equally important. The success of India, in some regions in India, people—even when you reach

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other households, they will still not want your vaccine. How do you translate that into effective mobilization, successful community engagement? USAID worked a lot with the Indian program on polio to ensure that rejections in some parts of the countries came down from 40-percent to 2-percent; very important. The system has to also mobilize demand, so that in India has successfully removed from the list of polio endemic countries.

JOSH MICHAUD: Right.

ARIEL PABLOS-MÉNDEZ: We are now close to having the whole region in south East Asia, also be declared, polio-free. The three countries you mentioned are still the hardest countries to see the polio endgame. And nonetheless, the number of cases from 2011, which was 650, has come down last year to 222, so even there, the communal governments, despite all the challenges, are working to do this. Luckily, I think the real endgame for polio will require a rethink of polio immunization approaches that will strengthen health systems, as opposed to weakening health systems. We are now at the threshold for very exciting development for the immunization world, with polio, with GAVI, routine immunization, all coming together to strengthen local systems across all of the dimensions we heard of just now.

JOSH MICHAUD: Right. Well, I'm going to turn to you, Amanda. I know you thought a lot about this: targeted

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programs, versus the broader health systems, and we can stay on this topic for a little bit longer. What do you think have been some of the lessons you can draw from previous experiences on this topic? Can we, through these programs, achieve the balance we want, of targeted programs and their outcomes, and strengthening the health system in which they occur?

AMANDA GLASSMAN: Well, I think first, the outcome that we hope to achieve by those vertical programs, are the outcomes of health systems, right? The health system is to deliver certain kinds of services, so that's why DTP3 coverage has been used for so long, as an indicator of the health of the health system. We're all pulling in the same direction, in terms of the outcomes.

The question is how does implementation happen. I would say that, at least on the literature side, it's not very clear that one is better than the other, and experience somehow suggests, especially with vaccination, that, in some cases, a vertical program makes sense. Probably not a measles, a polio – each vaccine with its own program, but certainly, vaccination programs have been run well, in a vertical sense. That said, there is obviously things that you can do across the health system that would be totally supportive of health system goals. The example on supply chain, I really admire this work that GAVI is doing on this, with the bar codes. Someone said to me the other day that we can track a banana from the tree it was

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grown on to any supermarket in the world, but we can't necessarily track our medical supplies in the same way. I think that's the way to go, when we think about strengthening health systems, thinking about those transverse functions that are going help everybody.

SETH BERKLEY: Believe it or not, we can put the vaccines in bananas, but that's a whole other topic.

JOSH MICHAUD: I know you have thought a lot about this health system-strengthening question, so yes, I want to turn to you, Seth.

SETH BERKLEY: Well, I wanted to go back to what Carolyn said, and I think, for me, trying to strengthen at the country level, the demand is absolutely critical, and she talked about that. One of the interesting things is, if you have these kinds of vertical—even in the vaccine space, which you have as families come, and they see the same people coming over and over again for one vaccine, where they don't see disease. Meanwhile, children are dying of other things around them. As we bring them together, this will not only strengthen the system and create synergies, but it also helps with the demand, because people say, well, now I understand, you are doing something that helps my community. That has been one of the challenges; as we get closer to eradication, people don't see the diseases anywhere, they don't understand why there's such an intense push, and the question is asked well, who is

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this for. Is it really for us, as a community, or is for something else, but as long as you are continuing to bring them new interventions, then they see a reason for it.

Just to get them to the health system side—what's really important is that we build strong health systems that sustain over time, for a range of issues. If a vertical program does it on a project basis, and then doesn't leave anything behind, that's a failure. If it builds a system that then is able to be used for other things, whether it be strong data, whether it be human capital, as you've brought up so many times, whether it be better supply chain, whether it be transport, and those are used by other systems, then that builds the system, and also the planning, and I can't emphasize that enough, because a lot of the problems in countries is about planning and logistics, and understanding how to set up the systems to make it work, and that's true, no matter what commodity you're dealing with. Ariel, at the beginning, talked about the need for other commodities to come in. In a sense, we are building the systems that can handle those commodities.

JOSH MICHAUD: Yes, we had a question come in, specifically asking about, on this topic, the link between vaccine delivery programs and safe water and sanitation. I know this is an issue for polio of course, but more broadly, this is an aspect of this broader system strengthening. Is there an overlap there, or can there be more done to perhaps

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integrate those programs? Do you see anything, any fertile territory for integration there, or is this another aspect of health system strengthening, in general? I am going to throw it out there.

AMANDA GLASSMAN: I think it makes sense for water and sanitation programs to target their interventions to those areas that have the highest disease prevalence and incidence, and that's not always been the case, because if you're trying to invest in piping and things like that, what you're doing is adding on to the existing pipes that might be in a peri-urban area, for example. That is not where disease is highest, and it's just because you have different objectives. The question is, for those multi-sectoral agencies, like the banks, the multilateral development banks, or like USAID, that do have cross sectoral work, is there a possibility you're to target interventions so that they become synergistic in that way? I would say that water and sanitation are important for outcomes, but not part of the health system, right; obviously very synergistic with health system improvement, but—

SETH BERKLEY: We can't hold them against them each other. One of the debates that occurs, for example, when there is a cholera outbreak, always is, is the solution for the cholera outbreak a vaccine, or is it water and sanitation. Well, the answer, obviously, is both. What you're trying to do is get the rotavirus vaccine, which is the largest cause of

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diarrhea in all sites, in the first year of life, to try to protect those children, but that doesn't mean you say, okay, they're not getting rotavirus, so we don't have to worry about safe water, which has a whole range of other important issues. Both are disease causation issues, but also, over the longer run, about women's labor cost, and the times they're spending carrying water around, et cetera, et cetera. I think these are synergistic. The challenge is, excellence can't be the enemy of the good, and we have to make sure we get the most cost effective interventions out, even if they're not done in a fully synergistic fashion.

ARIEL PABLOS-MÉNDEZ: We have to do both, really, and with more, as Seth pointed out, credibility; when you just go with one thing, you just get some intangible outcome; it's hard. When you are doing multiple things that help, then that's important. Water and sanitation, as you were also pointing out, is something that goes beyond health. The gains from having clean water goes beyond just the health outcome, so we have to work with many other sectors to be successful. I also believe it's part of the world international development strategy. Integration and the evidence for integration is always tricky. We do need more adherence, we know, and more evidence to what possibilities are there for alignment of those efforts, and we certainly do so, working with countries together. At the end, it is a manner of not bringing just one

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thing. If you only come to do polio eradication, to the community, you'll probably not have that community very engaged, even for polio itself.

CAROLYN S. MILES: I just want to bring up one point, in terms of this integration, that I think makes it really difficult; is that the donors, the streams of funding, generally, are not integrated. I think we have to look for ways to do that integration. Back to this issue of inequality, maybe there are more opportunities for us to look at the poorest communities, and the places where you've got a whole list of issues, whether it's the cleanliness of water, or the disease burden in those areas, or the education rates, particularly in those poorest communities, and try to get the donor streams a little more aligned, so that we're really trying to reach the hardest to reach. That might be a way to align, because right now, we have very much stove piped donors.

JOSH MICHAUD: In your mind, do you have examples of where that might have worked in the field?

CAROLYN S. MILES: Well, I can think of a couple of places in Nepal, for example, where there's been more coordination, in terms of looking at the poorest communities all along the southern border, where we've really been able to bring together partnerships that are—and it's not just Save the Children, it will be other organizations as well, and you've had a very robust type of development there. It really has

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made a huge difference in those communities, because you've had those different sectors that are coming together, but it takes--first of all, it takes a government that says we actually up for that, and then it takes different donors and different organizations to actually want to work together, on those things.

SETH BERKLEY: Nepal also has a national strategy, there, and as a result, people are funding the health systems through that national strategy, and there is coordination, but that goes back to having the planning, having the systems in place to be able to do that, and then to be able to deliver against systems.

ARIEL PABLOS-MÉNDEZ: That's why integration is important, as we said, as countries are moving up the economic development ladder, then system strengthening becomes more and more important. I am happy that GAVI has become a leader in health systems strengthening, even from the window of immunization. USAID has invested in this a long time. We have an office now dedicated to health systems strengthening. Then from governance, to financing, to human resources, are appropriate for a setting to information systems, and I think we have grown a lot in measurement, from population, to epidemiology, to National Health accounts; we now have information technology, cell phones, GIS, we are at the verge of a new revolution in measurement, and I think, especially

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because of the nuances of where exactly the countries are, things are happening. So you can target your interventions - and value for money, clearly, is one of the justifications - but also because you will reach those who need the right solutions at the right place, at the right time.

AMANDA GLASSMAN: One avenue forward too, so that we get out of the "how each country does it", because each country will have its own approach to dealing with these issues; they understand their reality best, and instead, move towards paying for the improvements in the shared goal. This is something, of course, at the Center for Global Development, we've thought about a lot, but instead of checking receipts and paying against receipts, should we, instead, be paying against-

SETH BERKLEY: Outcomes.

AMANDA GLASSMAN: -coverage, or outcomes. Honestly, GAVI leads on that, with immunization strengthening services in the earlier generation, and is now moving forward on a new pay for performance scheme. Measurement is really important; independent and credible measurement is really important on that. I think that's one way to achieve this integration, and not create so many perverse incentives associated with you earmarked streams of financing.

JOSH MICHAUD: We had a question come in, that I wanted to get to, and it was regarding one vaccine which may have its own unique set of implementation and access issues, and that's

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HPV, human papillomavirus. There's a question regarding GAVI's efforts to expand HPV vaccines to Southern Africa, but I think you can talk about HPV vaccines there and in general. What do you see as some of the implementation challenges for that?

SETH BERKLEY: Let me start off, first of all, with how important cervical cancer is. If you look at one of the good news pieces, is that maternal mortality's dropping, so MDG 5 is—we're seeing improvements in maternal mortality, but at the same time, we're seeing increases in cervical cancer, and sometime around now, we're actually seeing, for the first time in history, that there are going to be equal numbers of death from cervical cancer and maternal mortality, and over time, you're going to see less deaths from maternal mortality, which has always been the terrible killer of women in their prime of the lives, and cervical cancer going up. Eighty-five to 90-percent of this is occurring in the poorest countries. In fact, a scorecard was released at Women Deliver, and of the top 10 countries with highest incidences, all of them are GAVI countries, and they are 20, 30, 40-fold higher than the West, so a big and important problem. We now have a vaccine that can be rolled out. The challenge is, you're giving that to adolescent girls, and we don't have delivery systems to reach adolescent girls, so what we're asking countries to do is to come up with a demonstration project in their countries; pick a district, ideally with urban and rural parts, and show that you

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can reach those girls, not just the ones that are being served by whatever mechanism you choose, schools or campaigns, but also that you're trying to reach the girls that are out of school, because they may be at highest risk. Show you can do that with external measurement and a good evaluation, and then take it to scale. The advantage, from a cost effectiveness point of view, if you can link in other interventions, it increases dramatically the cost effectiveness of this, because normally, you only reach women when they are babies, or you reach them when they are pregnant and they're going to be delivering, or around the antenatal period. You don't reach these adolescent girls, so what a great opportunity for health education about some of the topics we've talked about, whether it be about cleaning, clean hands, whether it be about health education, whether it be about maternal mortality, or nutrition, or child health, and so it's a great opportunity. Now, GAVI can't do that, but what've we've done is reached out to other NGOs, other agencies in women's health, in cancer, in other areas, to try to form a partnership to strengthen this work around girls, and that will really make it a special program.

We expect to have only a million girls immunized, because it's starting slow, by 2015, but by 2020, 30 million girls in 40 countries will be vaccinated, so it's going to be a rapid scale up after that.

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JOSH MICHAUD: So is this unique in the delivery world, of actually working through the education system, or working with this age group, for vaccine delivery, is this something then—?

SETH BERKLEY: It's something relatively new. We do it in other places, but it hasn't been done in some of the poorest countries, and one of the challenges, of course, is these are vaccines that require injection, so it's not like an oral vaccine. You do need a trained health worker to engage, but again, that's a really good synergy, if you can get schools working with the health community, then you could end up with real positives. On the other hand, you want to make sure this doesn't take people away from their other tasks, and that's why it's important to have an integrated look at these issues.

JOSH MICHAUD: Okay. Getting back to the polio question, we had a question come in asking about inactivated polio vaccine. Of course, in order to get to polio eradication, countries will have to introduce the inactivated polio vaccine, the shot, and the question asks as IPV, or inactivated polio vaccine, introduction, will be the most ambitious in history, what is being done to ensure that it will be successful, when it does happen? Is there a role for the U.S. government, for GAVI, for others? Who is responsible for making this work and making it work right?

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ARIEL PABLOS-MÉNDEZ: Well, there have been a lot of discussions on this issue. Clearly, the Global Eradication of Polio campaigns foresee these new challenges. It was understood early on by many experts. Now that we are reaching the stage in which the oral version of the vaccine— and the campaign mode, will no longer be sufficient long-term, because the oral vaccine of the laboratory virus may lead to cases of polio. The question changes when the numbers go down, to have an approach that will not lead to those side effects of the simpler, cheaper vaccine. That's a big challenge. There will be financial issues in the case of IPV, and that's why we think GAVI can play an important role in thinking through that challenge, but also, it may be an opportunity, it will need to now link to routine immunizations. It will be an opportunity for polio and the resources and attention of this important priority, to strengthening health systems. That decision has been made; the world will have to move on this, long-term. Many countries that are still struggling with some of the other basics will really have to grow up a lot in this phase, and it will take time. Those are things that are now being discussed actively by the whole community, in which the U.S.A. and GAVI, and WHO and Gates, and many others, are asking how we are going to be doing this. It will require additional types of resources and investments, and deployments of systems, that we were not doing before in poor countries. We've been doing

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this, as you know, in rich countries, and so it is not that we don't know how to do it, it's just going to be something added to where we were until recently, in most countries.

SETH BERKLEY: It raises a set of policy issues, as well, that are important, because we not only have to get it out to the countries that want it, but we also have to make sure that there's regulatory approval for it, that there's scale up of manufacturing capabilities and capacity. We want to make sure that the price is at as low a level as we can get it. We want to make sure the implementation doesn't interfere with the implementation of other vaccines that are being introduced into routine immunization. There are both synergies that can occur, that Ariel talked about, but we also want to make sure that there are no problems with it. The GAVI board, at its meeting last week, discussed this, and gave the go-ahead for us to work with the different partners, in planning how we move forward. They haven't yet made a firm decision on whether GAVI will actually be the implementing arm of doing that or not, but what they really wanted to understand is what were the policy issues related to this, how would it be managed, how would it be integrated. We're going to be working over the next time period with countries, to try to decide about that.

As I started off and said, there is a huge acceleration in what GAVI's trying to do, so we have managed large numbers of introductions in a short period of time. One of the

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questions to this is, is it every country at the same time, or is it going to be a prioritized set of countries, and that is currently being worked on now, but that will be very important to have the decision as carried through.

JOSH MICHAUD: Okay, well - excuse me. We are getting short on time, and I wanted to make sure that we got the opportunity to look forward, and I'm going to throw this question out to all of you. What are some of the key milestones that are coming in the next few months, years, related to child health and vaccines, in particular, that the global health community should be paying attention to, engaging with, and focusing on, as we go forward? Ariel, do you want to start?

ARIEL PABLOS-MÉNDEZ: Sure. I think that we have some micro issues here in Washington, but globally, the post 2015 agenda will be crucial. I think there's been an embrace of the possibility of ending preventable child and maternal deaths in our generation. While we are very happy for that, we have to make sure that this gets translated to specific targets, and accountability, all within cost; how do we go about doing that. That will be important. Likewise, a lot of this success will be increasingly depending on the countries themselves. Even though there may be a subset of countries with failed states and weak systems, where we had to continue to do a lot of the more basic humanitarian to early development stage,

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increasingly it will be about those countries really taking the reins of their health systems, and as they are growing, the financing for health. It is now reaching sufficient levels to pay for not only immunization, but all the basic types of life-saving interventions. So I would say those countries are important, and we are very, very happy in seeing so many of those countries stepping up to the plate, not only for 2015, but beyond. I think shaping up, the 2015 agenda will be essential for our success, long-term.

JOSH MICHAUD: Yes, go ahead, Seth.

SETH BERKLEY: Yes, one of the exciting things that's going to happen on the immunization front is, we've mostly finished with pentavalent rollout. We just did Somalia; first time in Somalia in 35 years that they've introduced a new product. August is going to be Indonesia, and then early next year, we going to see Southern Sudan, which will be the last of the GAVI-eligible countries to bring pentavalent forward. I think that's a really big milestone, to have taken a vaccine and driven it forward, and get it out to many countries that are difficult to work in, whether it be North Korea, or Yemen, or Myanmar, and being able to engage in those systems, as Ariel has talked about.

The other thing that's going to happen is we are taking a look now at what new vaccines might be engaged. We'll see more data from malaria coming up. As you know, there was some

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disappointment in the younger age groups, versus the older age groups, in the efficacy of the vaccine. We will find out more data on how long that vaccine lasts, and what its role might be, as well as a range of other vaccines that we're going to be looking at. In addition to the post 2015, I think in this acute period, there's going to be an opportunity to ask the question, what can we do in the future? We'll be having our mid-term review in October of this year, where we're mid-term through our replenishment cycle, and really be taking a look at all of the GAVI programs. How have we done against the indicators and the promises we've made? We're very data driven; we'll be very clear and transparent on that. Then, where are the challenges and how can the global community come together to try to move those challenges forward, so, I think an exciting time.

JOSH MICHAUD: Great. I'm going to turn to you, Carolyn, and ask what your thoughts are.

CAROLYN S. MILES: Yes, I think for Save the Children, there's both the period to get to the end of 2015, and there's the post period. I think the focus on those children in the countries where we work, that are, again, the most marginalized, we will continue to be doing that, and then, up until 2015, to try to move the needle. Only eight countries have gotten there so far, on child survival. We have huge list of countries still to get to, in terms of that two-thirds

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number. Then, looking beyond, it really is about this idea that, can we set some goals that a child born in 2015 will have a very different future than a child that was born back in 2000. I think the way to get there is the zero based goals. That is the thing, in my mind, that's going make the biggest difference for kids. That is going entail some very different strategies. We talked a lot about a lot of them, here today; whether that's human resources, or whether that's integration, or—I think the business sector has a huge role to play in a lot of the work. We didn't touch on that too much today, but I think there are huge opportunities there for us to work with the business sector. I think, putting out those kinds of ambitious goals, and those kinds of goals where people say that's something I can really get behind. We will get some other actors that actually aren't as engaged as we could get them, around those kinds of things. Ending the deaths of kids is something we can get a lot of people around.

JOSH MICHAUD: Yes.

ARIEL PABLOS-MÉNDEZ: Right. If I may add to this—

JOSH MICHAUD: Yes.

ARIEL PABLOS-MÉNDEZ: —because we are now really contemplating that possibility. There is still a lot to be done, but that, we believe, is going to be achieved. We will see, also, a shift from survival to well-being in children, also; it will not be enough to save the lives of children. We

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will need to nurture those lives, so that they have the right development, strong beginnings, that they are protected against abuse and violence, that they are placed with nurturing families, that the location is right, and they have the future they deserve, that life is only the beginning of that promise we made to our kids.

JOSH MICHAUD: Right. Well, I am going to turn to you, Amanda, for the last words. What do you see, looking forward? What are you excited about? What are you worried about? What do you think the challenges are, going forward?

AMANDA GLASSMAN: Well, I think if we are going to end preventable child deaths, we have to track our money to those interventions that are really going to make a difference for that goal. Looking at the USG budget in this area, I think is the really key issue that we have to think about in the future. Then, the zero goals, they are great for advocacy. The question is if the countries in Africa that halved child mortality over the past 10 years, if they're able to do that again over the next 10 years, we would still have a bunch of countries that wouldn't meet the goal. The question is, are we setting countries up for failure, particularly if we're not going to adequately finance some of these things? That would just be my concern that we continue to make our budgets reflect our policy priorities.

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JOSH MICHAUD: Okay. Well, I think we will have to leave it there. I would first like to thank all of you, Seth Berkley, Amanda Glassman, Carolyn Miles, and Ariel Pablos-Méndez, for being here today and sharing your perspectives. I would also like to thank our audience for your questions. You will find additional resources on today's In Focus on our website, kff.org, and we encourage you to share the video and transcript with your own audiences. We also hope that you will join us for future webcasts of U.S. Global Health Policy In Focus.

I'm Josh Michaud, of the Kaiser Family Foundation.
Thank you.

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