Dear Health Ministers... SECURE PCV

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We write to you as a group of scientists and public health experts who have spent decades working on vaccines, child survival, pneumococcal disease prevention, health economics, and immunization delivery in low- and middle-income settings.

We are united by a common concern: while pneumococcal conjugate vaccine (PCV) programs have saved millions of young lives globally, many national programs may no longer be configured in the most cost-effective or impactful way to save children's lives.

PCVs remain among the most important tools for reducing child mortality from pneumonia, meningitis, and sepsis. Their introduction has dramatically lowered invasive pneumococcal disease in many countries and has contributed to declines in antimicrobial-resistant infections and hospitalizations.

However, PCV programs are also among the most expensive components of national immunization budgets. As countries transition from donor support or face increasing fiscal pressure, it is essential that governments periodically reassess whether current products, procurement strategies, dosing schedules, and delivery models are achieving the greatest possible health impact per dollar spent.

We therefore encourage all ministries to work with their National Immunization Technical Advisory Groups (NITAGs) to review their national PCV programs, guided by current epidemiology, market conditions, and emerging scientific evidence.

First, **PCV product choice** deserves renewed scrutiny. The PCV marketplace has evolved substantially in recent years, with multiple products now available at different price points and with differing serotype compositions. Many countries remain locked into procurement arrangements established years ago, before newer and potentially more affordable options entered the market.

In some settings, substantial savings may now be achievable without compromising public health outcomes. Transparent comparative evaluations of price, supply reliability, serotype relevance, cold chain implications, and long-term sustainability are increasingly important.

Second, **PCV dosing schedules** should be reassessed in light of evidence supporting reduced-dose approaches in appropriate settings. A growing body of data suggests that 1+1 schedules — one primary dose followed by a booster dose — may provide strong population protection where vaccine coverage is high and herd immunity is established.

Even though only one country has shifted to a 1+1 schedule - the United Kingdom with impressive results - there are 52 low- and middle-income countries (LMICs)* that meet the criteria defined by the World Health Organization (WHO). Twenty-five of these are eligible for financial support from Gavi, the Vaccine Alliance. As PCV is the most expensive childhood vaccine, reducing doses will generate significant savings.

Governments moving to a PCV 1+1 schedule could use the resulting savings to introduce new vaccines that might otherwise be unaffordable. For example, introducing a PCV 1+1 schedule alongside an RSV vaccine could potentially prevent more child pneumonia deaths at little or no additional cost, particularly when the reduced cost of RSV hospitalizations is considered. Recent estimates show that pneumococcal and RSV vaccines together could prevent 3.4 million child deaths by 2045.

So while not suitable everywhere, carefully considered transition to reduced-dose schedules could generate major savings, lower delivery burden, and free resources for other urgent child health priorities without sacrificing disease control. Importantly, these decisions should be evidence-based and tailored to local epidemiology, surveillance capacity, and health system performance.

Third, we encourage Health Ministers to ensure **PCV programs are part of integrated child health services**. There is increasing interest in integrating the delivery of vaccines with other preventive services, including nutrition (e.g., NutriVax), hygiene (e.g., Successful Beginning), and even antibiotics (e.g., REACH). Co-delivery platforms may improve efficiency, increase uptake, and reduce missed opportunities for vulnerable children. Such approaches must, of course, be balanced against concerns regarding antimicrobial resistance.

We recognize that revisiting established vaccine policies can be politically and technically challenging. Yet responsible stewardship of public resources requires continuous reassessment as science, markets, and disease patterns evolve. Maintaining the status quo is not always the most effective or equitable option.

We therefore urge ministries to commission updated national reviews of PCV policy that incorporate the latest evidence on product selection, schedule optimization, integrated service delivery, cost-effectiveness, and long-term sustainability. These reviews should engage NITAGs, economists, pediatricians, surveillance experts, procurement specialists, and community stakeholders and take advantage of the new tools available, including the Vaccine Prioritization and Portfolio Optimization (VPOP) toolkit.

The goal is not simply to spend less. It is to spend smarter: protecting more children, sustaining public trust, strengthening health systems, and maximizing the health gains achievable from every immunization dollar invested.

The global success of PCVs is one of modern public health's greatest achievements. With thoughtful reassessment and strategic adaptation, that success can become even more sustainable, equitable, and impactful in the years ahead.

Sincerely,

Secure PCV: A Coalition of Vaccine Scientists and Child Health Experts

Learn more: https://stoppneumonia.org/latest/secure-pcv

***52 LMICs eligible for PCV 1+1 dosing**

- PCV average coverage for five preceding years above 80%
- measles (1 dose) average coverage for five preceding years above 80%

Gavi-eligible (25)
Bangladesh
Burkina Faso
Burundi
Cambodia
Eritrea
The Gambia*
Ghana
Kenya
Kyrgyzstan
Lesotho
Malawi
Mauritania
Nepal
Niger~
Pakistan
Rwanda
São Tomé and Príncipe
Senegal
Sierra Leone
Solomon Islands
Tanzania
Togo^
Uganda
Zambia
Zimbabwe

**PCV 79.2%, MCV first dose 79.6%*
~MCV first dose 77%
+MCV first dose 76.8%
^MCV first dose 78.6%

Other LMICs (27)
Albania
Algeria
Armenia
Bhutan
Botswana
Colombia
El Salvador
Fiji
Georgia
Guatemala
Kazakhstan
Kiribati
Malaysia
Mauritius
Mexico**
Moldova
Mongolia
Morocco
Namibia
Niue
Palestine
Serbia
South Africa
Tunisia
Turkiye
Turkmenistan
Uzbekistan

***PCV 79.6%*