Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	Bangladesh
Reporting period	July 2015 – June 2016
Fiscal period	July to June
If the country reporting period deviates from the fiscal period, please provide a short explanation	*N/A*
Comprehensive Multi Year Plan (cMYP) duration	2014-2018
National Health Strategic Plan (NHSP) duration	2011-2016 2017-2021 (under development)

1. SUMMARY OF RENEWAL REQUESTS

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *PCV in existing presentation*	*Extension*	2017-2018	3,184,230	US$ 2,921,500	US$ 42,354,500
NVS – *Penta*	*Extension*	2017-2018	3,184,230	US$ 1,526,000	US$ 20,743,000
NVS – *IPV*	*Renewal*	2017	2,803,687	N/A	US$ 3,319,00

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	Rota	*9/2016*	*2017*
	HPV (national)	*2018*	*2019*
	HSS3	*2017*	*2017*
	MR catch-up campaign	*2017*	*2018*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT

Health situation

The recent health studies (Bangladesh Demographic Health Survey 2014, Bangladesh Facility Utilization Survey 2014, National Health Accounts 2015 and Coverage Estimate Survey 2014 and 2015) confirm further incremental improvements of the long term positive trends of health indicators in Bangladesh but also point out the well-known structural deficits of the health system (e.g. HR challenges, quality deficits of the public health infrastructure compared to NGO/private

facilities, high out-of-pocket expenditures above 60%, and insufficient reductions of neonatal mortality).

The country is on track to reach the **MDG 4** with an under-five-mortality rate of 46/1,000 (B-DHS 2014, target 48/1,000) and **MDG 5** with a maternal mortality rate of 170/100,000 (target 140/100,000. Source: Countdown 2015). The **neonatal mortality** is still high at 28/1,000 (target 21/1,000). The **nutritional status** (children under five stunting: 36%, underweight: 33%) is ameliorating but malnutrition is considered to be a major underlying cause for child deaths. **Antenatal coverage** for births has increased substantially from 58% in 2004 to 79% in 2014. The proportion of **births delivered at health facilities** has been increasing from 12% in 2004 to the current level of 37%, but remains low. . Finally, although mortality rates have reduced, **significant disparities in utilisation of services** among the wealth quintiles as well as geographic regions persist.

The **total fertility rate (TFR)** is at 2.3 children/woman, but there are large regional differences with values between 2.9 and 1.9 (B-DHS 2011 and 2014). However, TFR is projected to reach replacement levels soon as improvements of the family planning programme are a priority. The total population is projected to peak at over 200 million by 2060.

Economic developments and health financing

The economy of Bangladesh has grown above 6% p.a. in the last years and the GNI p.c. (Atlas method) has increased to US$1,190 (2015). As a lower-middle-income-country Bangladesh has entered Gavi's preparatory transition phase in 2016 and new co-financing requirements will start applying from 2017, after the grace year. The eligibility status of the country is not projected to change in the next five years.

With the overall Gross Domestic Product (GDP) growth, funding in health is also increasing in absolute terms, and in real terms government spending more than doubled in the period 1997-2014. However, the percentage contribution of GDP to health is still very low. Public health spending comprises less than 1% of the GDP and total health expenditure (THE) is 3.5% of GDP (National Health Accounts 2015). Per capita THE of US$27 is relatively low compared to other countries in the region (e.g. Nepal US$36, India US$61). The out-of-pocket expenditure is very high at the level of 63.3% of THE and government spending is around 23% only.

The **budget** of Ministry of Health and Family Welfare (MOHFW) as a percentage of national budget is in continuous decline. MOHFW's share of the national budget reduced from over 6% in FY 2010/11 to 4.31% in FY 2015/16. It thus remains below the sector programme (HNPSDP) target (10%) and the Sixth Five Year Plan target (12%).

The **fiscal space** of the country is restricted given the lowest tax-to-GDP ratios in the world (8.7% in 2011, steadily increasing trend) that limits the government's capacity to translate growth into public revenues. However, domestic resource mobilization is expected to increase as a result of various measures taken by the National Board of Revenue (e.g. VAT collection, larger tax payer basis).

The low health budget allocations also affect the immunisation programme as the total costs are largely covered by external resources. Traditional vaccines and Gavi co-financing obligations are funded by the sector programme and pool funds (Multi-Donor Trust Fund, MDTF).

Health sector programme

The developments of the public health sector in Bangladesh are largely influenced by the **Health, Nutrition and Population Sector Development Programme (HNPSDP, 2011-2016).**

The total revised estimated cost for this 3rd Sector-Wide Approach (SWAp) was about US$ 6.5 billion. Out of this, it was estimated that 78% would be contributed by Government of Bangladesh (GoB) and 22% would be financed by development partners (17% pool fund/Refundable Project Aid (RPA), 5% Direct Project Aid (DPA), approx. US$1.3 billion). The absorptive capacity of the MOHFW has improved in recent years. During the first four years of 3rd SWAp implementation (2011/12-2014/15), utilisation of the annual development programme budget increased from 87% in 2011/12 to 91% in 2012/13, but then declined to 89% in 2013/14, 83% in 2014-15 and 80.69% in 2015/2016.

The sector programme was extended until the end of 2016 and for this the additional resources required are US$150 million for the Multi-Donor-Trust-Fund (MDTF) administered by the World Bank. This additional allocation would also compensate for a shortfall of donor funding compared to the earlier pledges for the programme.

World Bank reporting rates the progress of HNPSDP towards achievements of the development objectives and implementation as moderately satisfactory. The **overall risk** is rated as substantial due to high political, governance and fiduciary risks.

Government and development partners (DPs) have started the process of **preparing the successor SWAp** which should seamlessly continue the support to the health sector in 2017. GoB finalised the Strategic Investment Plan (SIP) for the programme in April 2016, which is of high quality and will be followed by the operational Project Implementation Plan (PIP). The World Bank and other DPs envisage to appraise the SWAp in December 2016 and to obtain World Bank Board approval in February 2017.

The next SWAp focuses on 3 components with 8 strategic objectives which are **1) governance and stewardship** of the health sector (e.g. strategic objective 3: To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage), **2) strengthen the health system** (e.g. strategic objective 5: To establish a high quality health workforce available to all through public and private health service providers) and **3) quality health services** (e.g. strategic objective 7: To improve equitable access to and utilisation of quality health, nutrition and family planning services).

The strategic objectives will be monitored with a detailed **performance framework** (PF) with impact, output and process indicators. It is also envisaged to define Disbursement Linked Indicators (DLIs) and established **performance based financing** mechanisms for the programme.

Gavi will participate in the World Bank appraisal process, and WHO and UNICEF are strongly engaged partners in the in-country processes. The EPI programme is an integral part of the new Essential Service Package (ESP) which was developed until August 2016 and the annual Coverage Evaluation Surveys (CES). HMIS will be used as the data sources for the PF of the programme.

Bangladesh is one of the 12 countries where the Global Financing Facility (GFF) is engaged in supporting a country-driven programme to achieve objectives to improve reproductive, maternal, newborn, child and adolescent health (RMNCAH). It is planned to include GFF resources as part of the pooled funds of the SWAp.

Gavi expects an HSS application by GoB to support the SWAp in early 2017.

3. GRANT PERFORMANCE AND CHALLENGES

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

Gavi has provided support to Bangladesh since 2001 (ISS, HepB) and the currently active vaccine programmes are pentavalent (2009), PCV (2015), MSD (2011), MR (2014), IPV (2015) and HPV (2016).

The EPI programme has identified **6 objectives** as its priorities. These are defined in the cMYP 2014-2018 and will remain unchanged for the time being:

- *Objective 1: Improve immunisation coverage among children under one and child bearing age women*
- *Objective 2: Maintain polio free status*
- *Objective 3: Maintain maternal and neonatal tetanus elimination status*
- *Objective 4: Measles Elimination & Rubella Control*
- *Objective 5: Prevention of diseases protected by new and underused vaccines*
- *Objective 6: Strengthen the Immunisation Health System*

Bangladesh has remained **polio free** since 27 March 2014 and national and sub-national level (divisions) are under the 'low risk' category except the region of Sunamganj in the Sylhet division (medium risk) which will be further analysed using susceptibility and surveillance indicators. The country also maintained **MNT elimination**. The progress and challenges related to the other objectives is discussed in the following section of the document.

Coverage and equity

The immunisation programme in Bangladesh enjoys strong government ownership and is considered high performing. Reported immunisation coverage rates and WHO and UNICEF estimates have remained over 90% for over ten years now.

The CES 2015 reports national coverage for Penta3 at 93.6%; MR/MCV1 at 87.4% and fully vaccinated child[1] as 82.5%. WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC) estimates for DTP3 are 94% and administrative data reports 120%. MCV1 (MCV2) is estimated at 87.4% (80.5%) and administrative data states 120% (115%). IPV1 coverage is estimated at 47% and the low coverage is mainly caused by the introduction of the vaccine in March 2015 and the shortage of IPV supply.

[1] BCG, TT, DTP3, OPV, MCV/MR

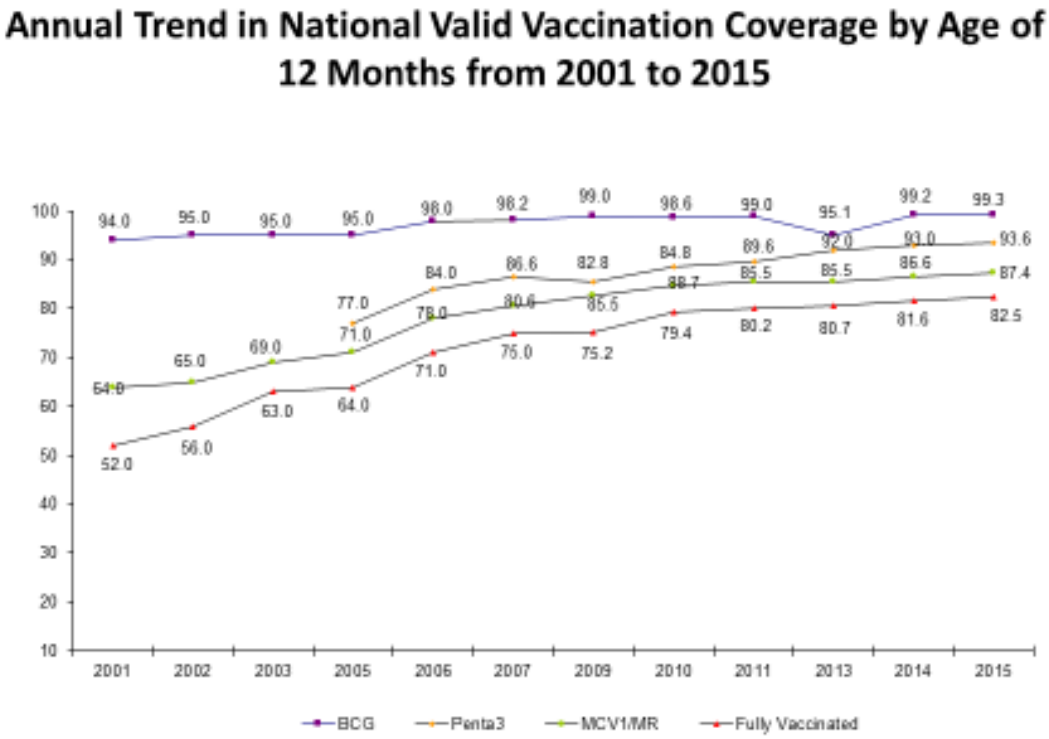
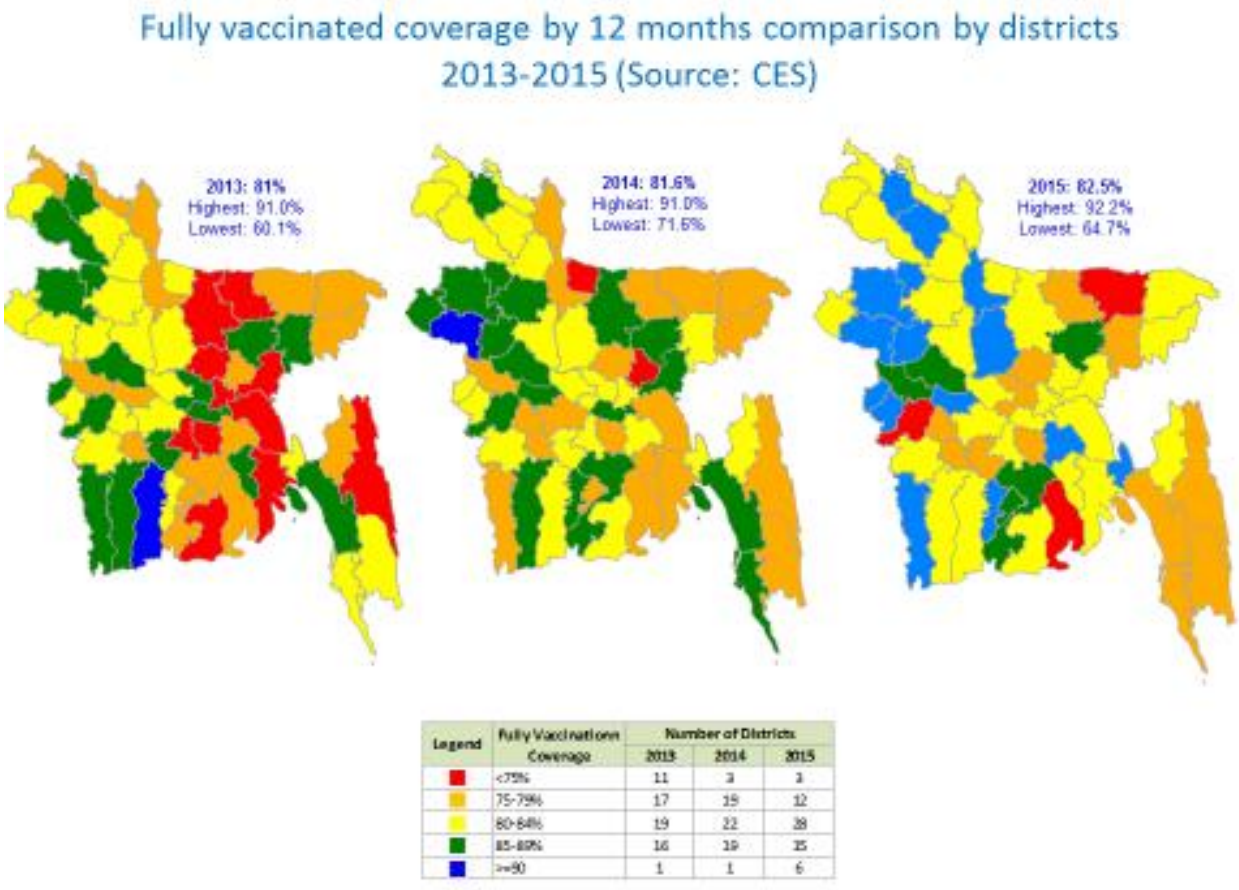


Figure: Coverage Evaluation Survey 2015

The equity of immunisation services also improved in 2015. From 2014 to 2015 the number of districts achieving higher than 90% coverage for the Fully Immunized Child (FIC) increased from 1 to 6, and 49 out of 64 districts are achieving above 80% FIC coverage. All districts (100%) are achieving equal or more than 90% DPT3 coverage. (Figure next page.)



Legend	Fully Vaccination Coverage	Number of Districts		
		2013	2014	2015
	<75%	11	3	3
	75-79%	17	19	12
	80-84%	19	22	28
	85-89%	16	19	25
	>=90	1	1	6

There are no gender discrepancies (Penta3 coverage males is 94.2% and females is 92.9%) and there is not a great variation between rural and urban (91.8% for urban and 94% for rural) (CES 2015). This corroborates the overall excellent coverage and equity situation in Bangladesh.

There are certain pockets with lower coverage rates and existing inequities (notably Sunamganj area in Shylet) which receive more targeted support through the HSS grants.

Data and data systems

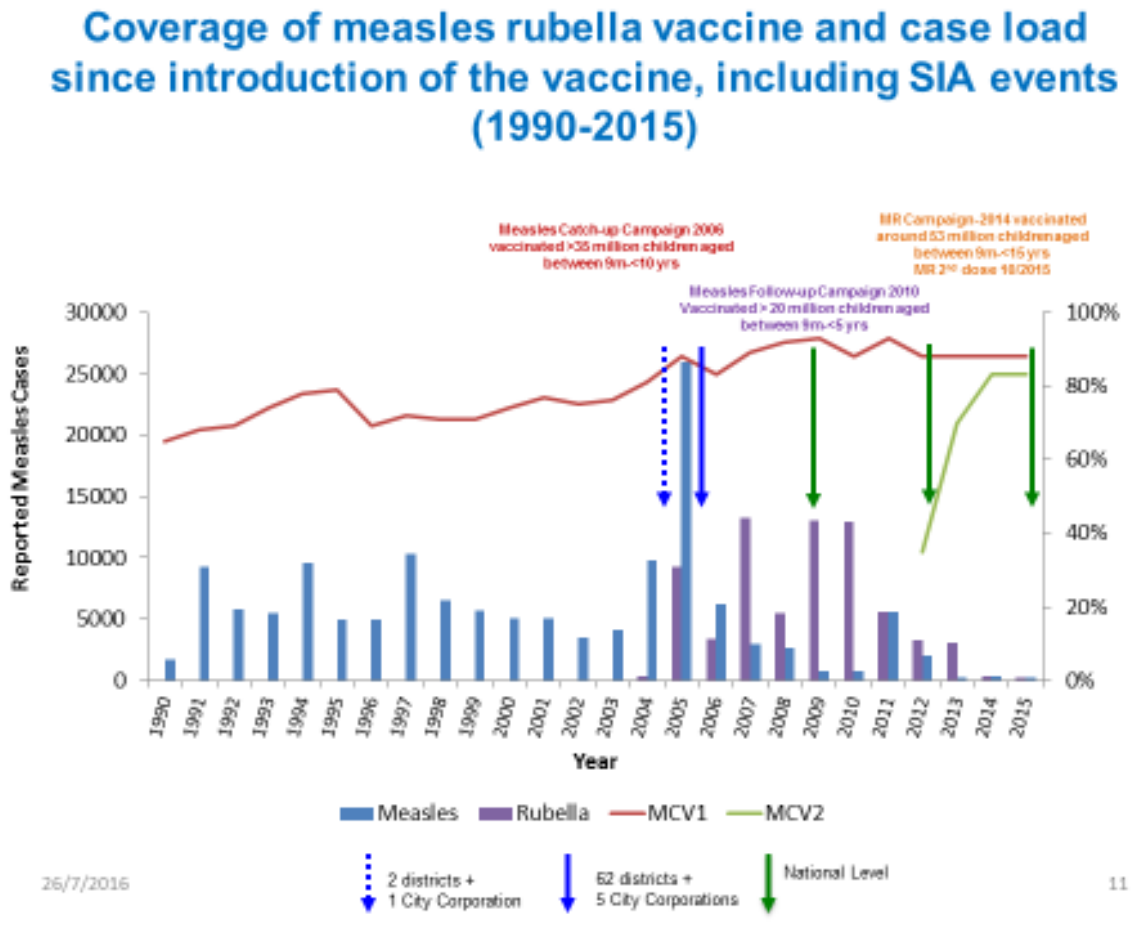
Administrative coverage has repeatedly been reported over 100% in recent years and the underlying cause is imprecise denominators in Bangladesh. This is well known to the EPI programme and the problem is being addressed through a range of activities to improve data quality and training on data. The EPI programme has endorsed at the national level that all districts in Bangladesh should be using the census 2011 conducted by the Bureau of Statistics numbers to project target populations till 2018 to ensure greater consistency in denominators. WHO and UNICEF have been facilitating the implementation of data quality self-assessments across the country and more than half of all districts have been covered in this effort. Trainings are provided to help orientate district managers and other immunisation managers on how to collect and report data on a quality and timely basis. In addition, Bangladesh seeks to validate these data quality self-assessments by requiring surveillance medical officers (SMO) to re-conduct data quality self-assessments (minimum of two per month). Using the same methodology and sample sites, the results are then compared for consistency and issues are discussed with district and immunisation managers. This is an area that warrants further monitoring until the improvements are documented by WUENIC estimates and CES. Monitoring the progress of some key activities related to data quality improvement has been incorporated in the next HSS grant performance framework.

Bangladesh shows ongoing commitment to strong monitoring and evaluation of its immunisation programme. **DHIS2** has been in the process of being rolled-out since 2015, with many key performance indicators for the EPI programme updated on a monthly basis. Bangladesh continues to conduct **annual coverage evaluation surveys**. The last DHS and MICs surveys were conducted 2012-2013.

Update on Vaccine Programmes

MR/ MSD

Following the successful campaign in 2014 (see Joint Appraisal 2014 and 2015 and Full Country Evaluation reports), Bangladesh has shifted to the MR vaccine in routine immunisation and has as a consequence converted MSD to MR support with co-financing obligations. The country has received MSD support since 2011 and is thus not eligible for measles support from 2017 onwards. The following graphs demonstrate the increases in coverage rates and case reductions specifically after the campaigns:



The issues and challenges of the MR programme are currently to achieve and maintain at least 95% national coverage and at least 85% in all districts and coverage in urban areas.

The mains risks to achieving measles elimination are:

- the high incidence of measles/rubella in pockets of low MR coverage areas especially densely populated major urban areas
- that no Supplementary Immunisation Activities (SIAs) in India/ neighboring state of West Bengal have been conducted

- official and non-official population movements from neighboring countries with possible low population immunity setting and
- the end of Gavi MSD support for routine immunisation after 5 years in 2016 which requires increased national financial resources to procure vaccines.

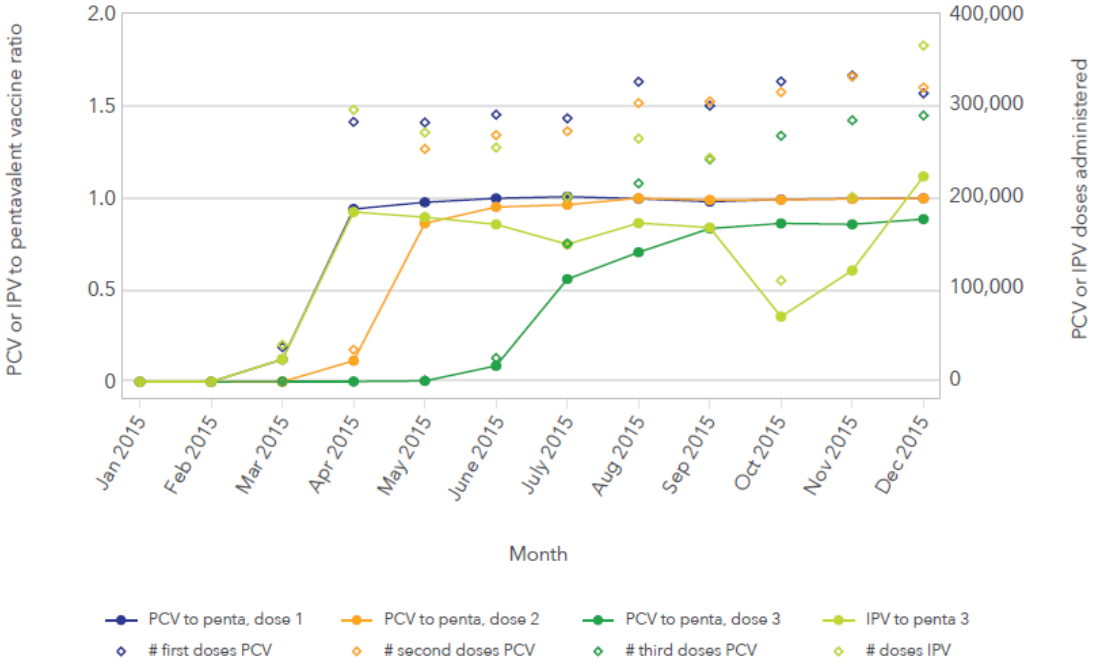
Under the new measles strategy of the Gavi Alliance, which is effective from 2017 onwards, the country is eligible to apply for support for a MR catch-up campaign in January 2017. The rationale for such a follow-up campaign is the **accumulation of susceptibility** in the age group 0-5 years with the current constant routine MR coverage**.**

PCV and IPV post-introduction evaluation (PIE)

PCV and IPV were jointly introduced in April 2015. The PIE for PCV and IPV was conducted in December 2015 and concluded that Bangladesh has a well-performing immunisation programme and the introduction of PCV and IPV vaccines in Bangladesh has been overall smooth. However, with a view to further improving the quality of immunisation services, the evaluation outlined the following key recommendations (among others) and corrective measures have been taken or are underway:

- To monitor the immunisation coverage of PCV 3 and IPV. The immunisation coverage of PCV3 or IPV at the time of the evaluation was low as not a full birth cohort could be covered (WUENIC 2015 PCV coverage at 48%). If this continues to remain unsatisfactory (e.g. large differences with DTP3 and/or drop-out rates PCV1 to PCV3), it will be necessary to investigate causes for the low coverage and consider options to improve it including revision of the schedule.
    - In the beginning of 2016, PCV coverage has further improved and will be re-evaluated with the relevant admin and CES data. The global IPV shortage is affecting the supply and leading to shortages and low coverage. The following graph from the Full Country Evaluation report shows the constant improvements for PCV approaching the target of DTP3 coverage until the end of 2015:

Figure 2: PCV/IPV: Pentavalent ratio from HMIS data in 2015



- Dhaka City Corporation (DCC) was selected as an underperforming region in the data collection and it became apparent that improvements for planning, implementation, monitoring and supervision for all aspects of EPI in DCC, including oversight of NGOs, are necessary.
    - EPI/ WHO as a consequence posted additional surveillance medical officers (SMO) in DCC to improve supervision and increase coverage.

- While improving existing immunisation waste management is a short term measure, it is recommended to consider shifting to incinerators in the long term.
    - Such improvements are planned under the HSS2 programme.

- Inadequate cold chain to introduce new vaccines.
    - Improvements in the cold chain are integrated into HSS2 (implementation of EVM-IP)

- High vaccine wastage was observed (e.g. IPV 37% by December 2015)
    - EPI ensures that Multi Dose Vial Policy (MDVP) is applied to reduce wastage of the vaccines. Wastage rates reduced to X% by (month) 2016. The following table shows the IPV and PCV vaccine wastage rate from March. 2015 to June 2016

IPV and PCV Wastage Rate by Month 2015-2016		
Month	IPV	PCV
Mar-15	48%	20%
Apr-15	42%	17%
May-15	41%	12%
Jun-15	41%	11%
Jul-15	41%	9%
Aug-15	41%	8%
Sep-15	41%	8%
Oct-15	41%	8%
Nov-15	40%	7%
Dec-15	**37%**	**7%**
Jan-16	15%	19%
Feb-16	13%	13%
Mar-16	13%	11%
Apr-16	13%	10%
May-16	13%	10%
Jun-16	**12%**	**9%**

Further recommendations and details are included in the PIE report which was finalised in May 2016.

HPV demonstration programme

Bangladesh applied for the HPV demonstration project in September 2014 and the originally intended start in 2015 was delayed until April 2016 to align with the school year calendar and arrival of supplies. The vaccine type was the bivalent formulation of the vaccine. The project is implemented in the Gazipur City Corporation which is in the vicinity of Dhaka.

The target group are school girls of grade 5 and non-school girls (10 years old, ~30.000 girls in total).The schedule is 2-dose at 6 months interval (April, October 2016). The school-based vaccination programme includes 1,694 schools and community-based vaccination through routine, fixed and outreach sites applies for non-school going girls.

After the first dose no serious adverse events following immunisation (AEFIs) were reported (4 fainting, 1 fever and 1 rash cases) and the coverage was high at 94%.

	School Girls	Out of School Girls	Total
Target	**28,026**	**2,852**	**30,878**
Achievement	**26,762**	**2,346**	**29,108**
Coverage	**95%**	**82%**	**94%**

EPI, WHO and UNICEF are planning for the second dose administration, and the evaluation of the demo programme is envisaged for late 2016.

During the JA mission a field visit to Gazipur was conducted which confirmed the commitment of the health services and school administration to the programme and the acceptance and knowledge of the vaccine by the target group and their teachers.

The programme is also part of the FCE in Bangladesh and interim results will be included in the 2016 report.

Overall Expenditures and Financing for Immunisation

The table below gives an overview on the financing of the EPI programme in 2015 which demonstrates a relatively high dependency on external resources (specifically Gavi at 68%). Even the amounts for co-financing Gavi vaccines (approx. US$4.4 million) and non-Gavi (traditional) vaccines (US$20.3 million) are covered by the pool fund of the sector programme. This has already been pointed out in the JA reports 2014 and 2015.

Expenditure by category (USD)	Expenditures in year 2015	Domestic	Gavi	UNICEF	WHO
RECURRENT COSTS FOR ROUTINE IMMUNISATION					
Gavi supported vaccines	73,709,352		69,369,662		
Non-Gavi vaccines	20,360,310				
Other routine recurrent costs for routine immunisation	3,386,342	2,318,979	228,415	659,640	179,308
Injection supplies (both AD syringes and syringes other than ADs)	3,806,051	3,470,235	335,816		
Personnel	0				
CAPITAL COST FOR ROUTINE IMMUNISATION	891,252			768,539	
Other capital costs					
Total expenditures for immunisation	**102,153,307**	**5,789,214**	**69,933,893**	**1,428,179**	**179,308**

3.1.2. NVS future plans and priorities

The **targets for the vaccine renewals** have been updated and discussed with the EPI programme. There are currently no changes in the presentations planned. Bangladesh would benefit from 5-dose-vials for IPV to reduce wastage rates.

Bangladesh submitted an **application for the Rota vaccine in September 2016** (IRC review in November).

MoHFW/EPI expressed their intention to apply for a **MR catch-up campaign** in January 2017.

Following a successful **HPV demonstration programme** and its evaluations the national introduction is scheduled for 2019 (cMYP 2014-2018).

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

HSS1 (2011-2016, US$13.6m)

The current Gavi HSS grant was originally approved in 2009 and designed with a focus on maternal and child health. After delays (from both Gavi and the country) and re-programming of funds with a stronger focus on immunisation, implementation started in 2011 and was expected to be completed in early 2015. The JA 2015 agreed on a no-cost-extension until the end of 2016.

The programme's objectives are to recruit Maternal and Child Health (MCH) and Immunisation workers (Objective 1), improve their supervision and programme monitoring (Objective 2), close gaps in equipment and physical infrastructure (Objective 3), and improve universal MCH services delivery through strengthened human resource management (Objective 4). It originally targeted 13 low performing districts and was extending during the second phase in 2014 to an additional 19 districts. The PF includes indicators of the HSS1 districts to track improvements in immunisation coverage, equity, utilisation of health services and outputs.

HSS2 (2016-2019, US$33.9m)

The second HSS grant application was re-submitted for the IRC in November 2015. This programme has the following objectives: strengthen Vaccine Preventable Disease (VPD) surveillance and its integration into HMIS (US$13.1m, WHO); improve cold chain and supply chain management system performance (US$20.3m, UNICEF) and program management (US$0.3 million, MoHFW).

An **Effective Vaccine Management (EVM) assessment** was carried out in 2014 and an EVM improvement plan was finalised at the end of 2014. The overall performance of the vaccine management is "very good" with 82% aggregated across all criteria, which is substantially better than the norm. However, there is need to implement and monitor the EVM improvement plan to address risks of parts of the infrastructure operating at its life cycle end and capacity limits and to prepare for the introduction of new vaccines. This will require an increase of more than 70% by 2018 in storage capacity for each of the 3 tiers of the supply and cold chain if IPV, PCV, Rota and HPV are introduced. The EVM improvement plan identified investments of approx. US$20 million for the cold chain, transport, temperature monitoring, Management Information System (MIS), studies for waste management, technical assistance (TA) and implementation support.

Bangladesh will be one of the first countries to adopt the comprehensive EVM (cEVM) approach and it is recommended to establish an EVM secretariat or equivalent.

The component supporting **VPD surveillance and HMIS** will contribute to improvements of coverage and equity of immunisation and strengthen data quality and its utilisation for decision making of the EPI programme.

MoHFW has a budget to monitor and manage programme implementation. The larger portion of HSS funding to government is earmarked for the support of the SWAp 2017-2021.

HSS3 (expected in 2017)

It is expected that Bangladesh will submit an application in early 2017 (through the Country Engagement Framework approach) for the remaining balance of the HSS ceiling for Bangladesh (approx. US$50m) to be channeled into the MDTF (administered by the World Bank). The preparations and appraisal process of the sector programme are described in section 2 (country context) of this report.

3.2.2. Grant performance and challenges

HSS1:

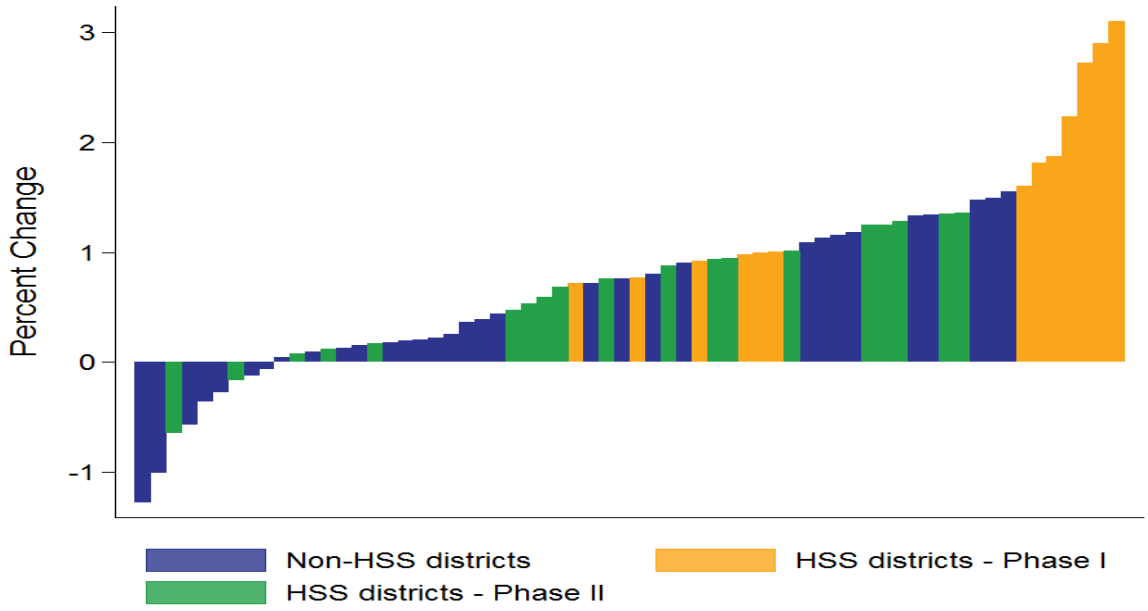
The first tranche of US$7.2 million was disbursed for the financial year 2011/12 and this phase was completed in June 2013 (FY 2012/13). The funds available for the second phase of the programme are US$6.4 million and the residual funds from phase 1 summing up to a total of US$8.3 million.

The HSS funds are fully included in the Operational Plans of the MoHFW and disbursed to government. Financial management and audit issues are mentioned in section 3.4 below.

Many of the notable challenges in implementation of the current HSS grant are well-captured and documented by the International Centre for Diarrhoeal Disease Research Bangladesh (ICDDRB) team as part of the FCE 2014 and 2015. Key challenges for slow implementation and utilisation of funds have been analysed in detail (see JA 2014 and 2015).

Since the 2015 JA, grant implementation has picked up considerably and absorption of the remaining phase 2 funding was at approximately 90% by July 2016 (US$761.000 left mainly for operational costs). The grant is expected to be completed and will be reporting grant closure after December 2016. The country explained that implementation had accelerated due to improved leadership and oversight and the execution of the civil works for cold chain infrastructure and community clinics which had a long lead time for planning and contract awards.

The full country evaluation (FCE) presented positive findings for an above average uptake of the coverage of immunisation in the districts that were covered by the HSS1 grant support:



Change in Penta-3 Coverage from 2010-2014 following HSS grant

Source: Gavi Full Country Evaluation report 2015 (ICDRRB)

The HSS grant has supported districts with less than 80% coverage and has provided support for HR for immunisation services such District Maternal Child Health and Immunisation Officers (DMCHIO), porters and volunteers. This HR support has been considered crucial for the programme, and it was discussed during the JA how these resources could be supported after the end of HSS1. A follow-up action from the JA for Bangladesh MOHFW is to submit a proposal to Gavi on how to finance vaccinators and volunteers after HSS1. Surveillance Medical Officers and District Immunisation Maternal Child Health Officers will continue under HSS2 (VPD surveillance) and these two functions will be combined under the common name of "Surveillance and Immunisation Medical Officer" (SIMO).

The HSS1 grant has also supported transport, equipment and cold chain improvements, construction of community clinic infrastructure, operations and management. There have been consistent delays in the construction component, however the country now reports these civil works have been finalised and handed over by the Health Engineering Department (HED), which will provide updated physical and financial progress reports to Gavi.

Key progress has been made in terms of recruitment and capacity building of EPI staff and volunteers, and equipping cold rooms and storage.

The FCE team has included a facility assessment in their workplan for 2016 to assess the status and utilisation of infrastructure and equipment. Draft reports are expected in the end of 2016.

Reporting compliance in the Country Portal needs to improve significantly. Due to previously inconsistent reporting on HSS1, metrics for the remaining funds and activities for HSS1 were discussed with the country and agree upon. Next expected reporting on progress is expected in May 2016.

HSS2

Funds were disbursed to WHO in July 2016. Initial work has started between the National HMIS, EPI, WHO and UNICEF to agree on the approach for the integration of Web based VPD surveillance to national HMIS system functioning on DHIS2. Pending a finalised request from MOHFW, WHO will initiate global procurement processes for laboratory performance improvement. SIMOs will be placed in 64 districts and 11 city corporations. EPI and WHO are

working together to define operational needs for SIMOs, however during the JA field visit it was evident that the DMCHIO requires vehicle to be fully operational.

Funds were disbursed to UNICEF in August 2016, following the signing of the grant agreement between UNCEF and Gavi. However implementation had already started towards upgrading DHIS2 with real-time Immunisation Supply Chain and Logistics (ISCL) management Information System (MIS). UNICEF supported the GoB for capacity building of 64 district's Supervisor and Cold Chain personnel and are in the process of recruiting a national MIS consultant to support and oversee the process of transition to DHIS2 data management.

According to the EVM assessment, 47 out of 64 districts will need physical infrastructure either in the form of construction, renovation or expansion by 2018. 29 out of 47 districts will need cold room installation. UNICEF has updated the assessment and prioritised facilities for upgrade of cold chain, and in consultation with EPI, the specifications for 12 Cold Rooms for 6 new districts has been finalised. An International Construction Specialist has been recruited to support the project implementation, and a national consultant will be recruited to revise the SOP of Effective Vaccine Management.

The grant PF HSS2 metrics have been further worked on and improved following IRC approval.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

The potential application for a HSS3 grant (approx. US$50 million) supporting the sector programme in Bangladesh has been described in the sections above.

3.3. Transition planning *(if relevant)*

Bangladesh will enter the preparatory transition phase in 2017 (GNI p.c. at US$1,190, 2015) and will remain eligible for Gavi support over the next 5 years. GoB is aware of the increasing co-financing obligations in the next years and has consistently met these obligations in the past. The forthcoming SWAp 2017-2021 will also focus on Universal Health Coverage and health financing and will provide a framework for a comprehensive policy dialogue.

3.4. Financial management of all cash grants *(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

Financial Reporting Timelines

GoB has the following financial reporting timelines:

Report	Due
Annual Financial Report on all cash support for the fiscal year ended 30 June 2016	30-Sep-16
Audited Financial Statements for the fiscal year ended 30 June 2016	31-Dec-16
Individual Quarterly Financial Reports on all cash support for the period 1 July - 30 Sept 2016	15-Nov-16
Individual Quarterly Financial Reports on all cash support for the period 1 Oct - 31 Dec 2016	15-Feb-17
Individual Quarterly Financial Reports on all cash support for the period 1 Jan - 31 Mar 2017	15-May-17

All reports are to be submitted via the Country Portal.

1. Cash Grant Status

The below is a summary of the cash grant status:

Grant Name	Disbursed	Expenditure	Balance	Comments/Action
HSS 2	4,236,051 (WHO) 5,284,875 (UNICEF)	-	-	Disbursed July/ August 2016
HPV Demo	333,500		333,500	As of 31 Dec 2015
HSS 1	13,671,500	4,925,679	8,745,821	$2,172,056 expenditure as per 2011-12 audit report $2,753,622 expenditure on most recent $5.1m reprogramming report. No data on earlier or in between balances available.
VIG - IPV	2,498,000		2,498,000	As of 31 Dec 2015
OPC - Measles	33,586,500	8,270,934	25,315,566	As of 31 Dec 2015
VIG - PNEUMO (PCV)	3,233,500	1,411,143	1,822,357	As of 31 Dec 2015
ISS	23,340,200		23,340,200	No data post 2012
VIG - MEASLES	1,195,500		1,195,500	No data

2. Financial Reporting

Reporting for ISS or VIG: Measles is still outstanding. Furthermore there appears to be incomplete information on overall expenditure for the HSS 1 grant as this is only

included in the Excel based progress reporting. The GoB is requested to provide the cumulative grant life financial reports for the grants mentioned above.

3. **Cash Programme Audit**
   Gavi anticipates that the Cash Programme Audit (CPA) will be finalised soon and the final report and findings will be formalised with GoB. Gavi will engage with GoB to ensure appropriate measures are implemented as per the CPA findings and recommendations are followed to ensure the effective implementation of future programmes.

4. **Remaining Funds and Future Cash Disbursements from Gavi**
   Gavi will require the above outstanding financial reports to be submitted prior to the disbursement of future cash to GoB. Furthermore, given the sizeable funds available in country, Gavi will seek a management decision to determine the appropriate action for the remaining funds of completed grants.

5. **Programme Capacity Assessment (PCA)**
   A PCA is scheduled for Q1 2017. The assessment will built upon fiduciary assessments by the World Bank and other development partners for the sector programme and pool funds.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised strategic actions from previous joint appraisal / HLRP process	Current status
Monitor wastage rates and stock levels to assess whether expected improvements with PCV, IPV and MR are observed.	Improvements through MDVP realised.
M&E: Continue dialogue on ways to address existing denominator challenges and update Gavi Secretariat on plans moving forward.	Efforts ongoing (see section on C&E above). Admin data still reports coverage rates above 100%.
HSS: Submit detailed interim progress report and inform about civil works and infrastructure activities on a quarterly basis.	Progress of HSS1 grant in 2015 and 2016 on track. Reporting compliance needs further improvements and follow-up.
Cash Programme Audit: Follow-up on the results of the CPA as defined in the report of the auditors	CPA report not yet finalised and expected in October 2016.

During the JA 2016 a number of short term recommendations and actions were agreed upon:

Joint Appraisal 2016 Actions	**Responsibility**	**Timeline**
Renew vaccine support for Penta, PCV, IPV. Update Gavi Country Portal reporting	MoHFW, WHO, UNICEF, Gavi	Ongoing End of September 2016
HSS 1 • Submit updated progress report • Submit physical and financial progress reports of civil works to Gavi • Expedite outstanding procurements • Update reporting in Gavi Country Portal • Complete External Audit 2015/16 • Conduct 3 Programme Implementation Committee (PIC) meetings in the final 6 months of implementation • Submit proposal to Gavi on how to finance vaccinators and volunteers for interim period	MoHFW, HED/PWD	End of September2016 Date of External Audit Report to be communicated by MoHFW End of September 2016
HSS2 Submit and discuss quarterly progress report to PIC HSS3 Align preparation with the schedule of the next sector programme until beginning of 2017.	MoHFW, Gavi, WHO, UNICEF	Ongoing
Cash Programme Audit • Finalize CPA report and follow-up on the results • Discuss on utilisation/re-funding of residual cash based programmes (VIG, MR op costs, ISS)	MohFW, Gavi	To be defined in the CPA report (expected in September 2016)

5. PRIORITISED COUNTRY NEEDS[2]

WHO (US$135.000) and UNICEF (US$165.000) have been supporting Bangladesh with technical assistance in 2016 in the areas as summarized in the table below. Both agencies were able to recruit staff on time and make good progress.

The identification of Tailored Country Assistance (TCA) for 2017 either as a continuation of the existing support or with new priorities will follow the Gavi Alliance process. End-year TCA reporting by partners and submission of proposals for 2017 TCA are both due by 30 November 2016.

[2] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

Partner/ Area		Prioritised needs and strategic actions	Status
UNICEF	*Supply chain*	Support to government to implement key EVM IP priorities: - Cold Chain Expansion - Development of Management Information System (MIS) - Development of integrated Immunisation Supply Chain & Logistics system (ISCL)	Support preceding HSS2, ongoing.
UNICEF	*Coverage & Equity*	Support the implementation and final assessment of HPV vaccine demonstration project	Ongoing and evaluations planned
UNICEF	*Coverage & Equity*	Support for evidence based planning and budgeting to address the inequity in geographical and social barriers TA to EPI team in development of evidence based communication strategies to increase demands for immunisation services, particularly by the poor and excluded children	Ongoing
UNICEF	*Coverage & Equity*	TA to district in development of microplanning, monitoring the implementation of corrective actions, supportive supervision, on-the-job orientation and conduct quarterly performance review meeting	Ongoing
WHO	*Vaccine sub-groups*	Technical support to apply for JE vaccine from Gavi in selected districts and implementation of the plan Implementation of the rotavirus vaccine introduction plan Implementation of the HPV vaccine demo PIE for PCV and IPV vaccines, comprehensive EPI review-2018 Continuation of supporting implementation of 2013 EPI review and implementation of recommendation of PCV and IPV PIE, implementation, monitoring and evaluation of reaching every community strategy	Rotavirus vaccine application submitted in September 2016. HPV demo support ongoing. PCV and IPV PIE follow-up ongoing.
WHO	*HSS*	Technical support to prepare the Gavi HSS proposal- II	HSS2 proposal reviewed November 2015, implementation started in July 2015.
WHO	*Data*	-National Professional Officers (NPO's) Immunisation, surveillance and NRA -To provide technical support to Divisional coordinators and SMO's, Medical Officer, IVD -Overall supervision and coordination of EPI and communicable diseases -Medical Officer, Immunisation System Strengthening -Technical support to improve immunisation system strengthening	NPO support is continuing in the mentioned areas, specifically to supervise regional staff (DMCHIO, SMO).

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	The Gavi Secretariat conducted a mission to Bangladesh from 16 – 22 August 2016 to review the supported programmes and have a field visit to the HPV demo site. In the beginning of the mission a meeting with the development partners (Health Consortium) was organized to brief on the JA process. The findings were presented to the Local Consultative Group (LCG) Health (Health Sector Coordination Committee equivalent) at the end of the mission. The JA report was drafted on the basis of inputs by MoHFW, WHO, UNICEF and Gavi Secretariat and circulated for comments.
Issues raised during debrief of joint appraisal findings to national coordination mechanism	The discussion during the LCG Health meeting are reflected in the JA report.
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	NA

7. ANNEXES

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

The JA date of August 2016 was already agreed during Regional Working Group meeting in New Delhi in February 2016. WHO and UNICEF country office participated in the JA mission. Development partners were informed during a Health Consortium (briefing) and LCG Health meeting (de-briefing) on 22 August 2016. A field visit was organised to the HPV demo programme in Gaziphur.

Extensive and excellent support was provided by MoHFW/EPI, district health services and WHO and UNICEF country offices.

The drafting of the report was a collaborative effort by MoHFW/EPI, WHO and UNICEF country office and Gavi Secretariat.

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result