

SUBJECT: 2016-2020 STRATEGY: PROGRESS, CHALLENGES AND RISKS

Agenda item: 03

Category: For Information

Section A: Introduction

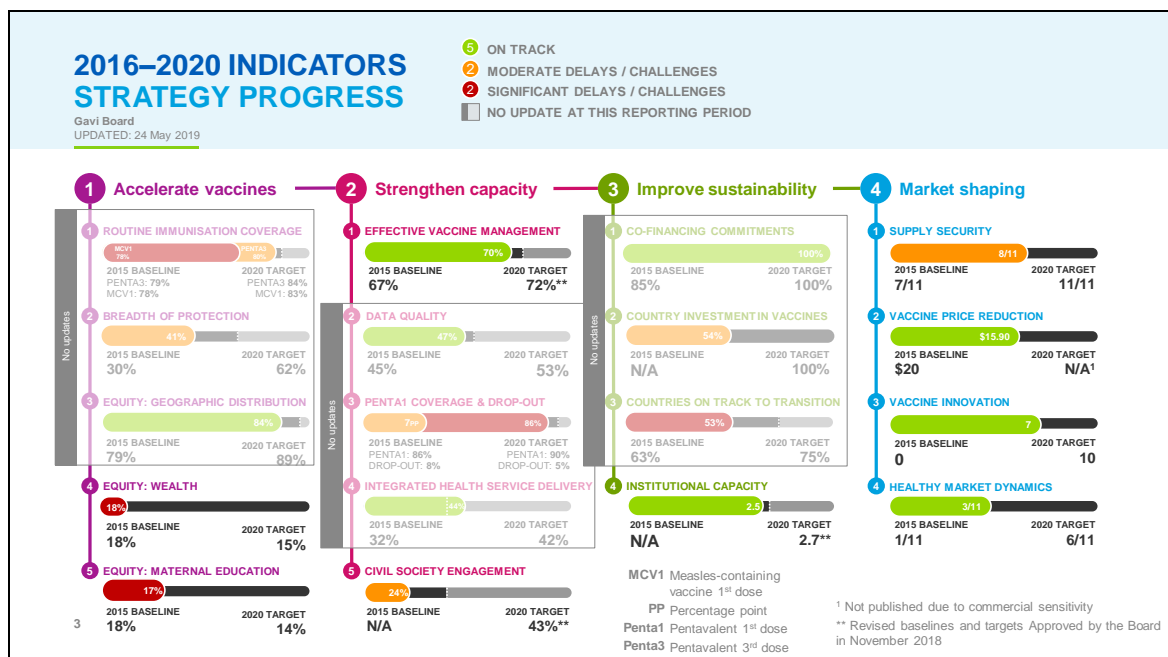
- This report presents a holistic view of Alliance-wide progress, challenges and potential risks¹ in implementing Gavi's 2016-2020 strategy. This paper seeks to rationalise and consolidate many of the previously standalone updates² in order to present an integrated view of progress, including programmatic and financial performance and related risks.
- As WHO-UNICEF coverage estimates (WUENIC) for 2018 will be released only in July, this report provides quantitative updates on a limited number of strategy indicators for which new data is available and in addition a more qualitative perspective of progress across the four Strategic Goals.

¹Associated risks refer to the top risks described in more detail in the 2018 Risk & Assurance Report: <https://www.gavi.org/library/gavi-documents/strategy/gavi-risk-and-assurance-report-2018/>. Gavi's risk profile remains stable with no substantial changes to top risk exposures since then.

² Including: Finance Update, Partners' Engagement Framework Update, Risk Management Update and the Alliance Update on Country Programmes.

Section B: 2016-2020 Strategy: Progress, Challenges and Risks

1. Progress against Strategic Goals



Strategic Goal 1: Accelerate Vaccines

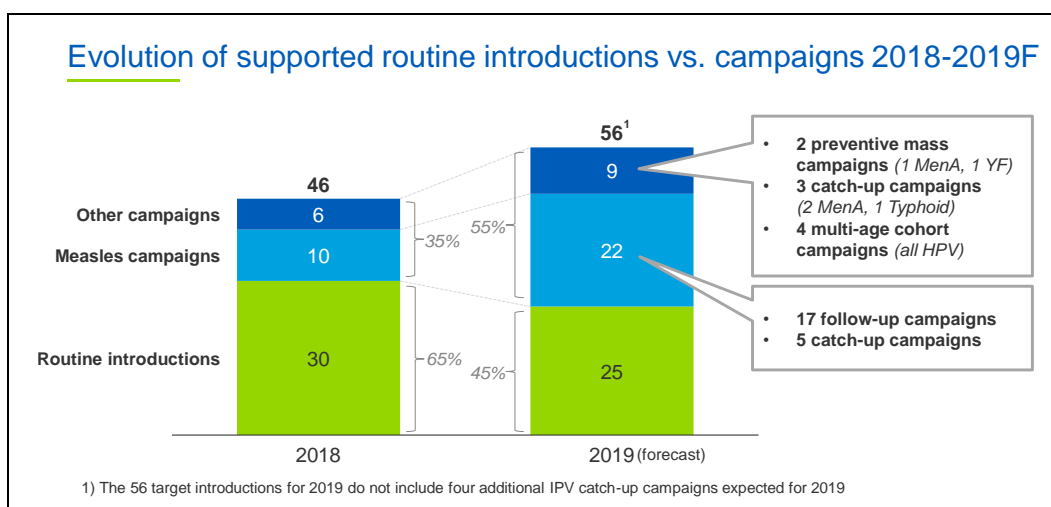
1.1 While updated coverage data for 2018 is not yet available, the pace of vaccine introductions is an important proxy indicator for the Alliance’s progress in increasing breadth of protection. **At the end of 2018, the Alliance has supported 46 introductions (incl. routine introductions and campaigns) against 52 planned. While this represents a 31% increase compared to 2017³ it remains below the original target.** Key causes of delayed introductions include country readiness issues as well as global vaccine supply constraints. As anticipated in the last report, a number of large introductions have been deferred to 2019 including rotavirus in the Democratic Republic of the Congo (DRC) (due to supply constraints), meningococcal (campaign and routine) in Nigeria (due to country readiness) and measles second dose in Ethiopia⁴ (due to country readiness and overlap with HPV (human papillomavirus) vaccine introduction). We observe a positive trend in uptake of newly introduced vaccines with average coverage reaching 95%⁵ of their reference coverage target in 2018 within two years after introduction, up from 92% in 2017. This suggests countries are successfully integrating new vaccines in their routine immunisation systems.

³ In 2017 the Alliance supported 35 routine introductions and campaigns

⁴ The measles second dose routine introduction in Ethiopia took place in February 2019

⁵ Newly introduced vaccines included in the Alliance Key Performance Indicator (KPI) A1.2 definition are PCV (pneumococcal vaccine), Measles 2nd dose, Rotavirus and Yellow Fever

1.2 **The share of campaigns continues to increase.** In 2019, the Alliance aims to support 56 new introductions including 25 routine (mainly human papillomavirus (HPV), measles-rubella, measles, meningococcal and inactivated poliovirus vaccine (IPV) and 31 campaigns⁶. This represents a proportion of 55% of campaigns compared to 35% in 2018. Of the 31 planned campaigns, 22 are measles campaigns, more than twice as many as in 2018⁷. The increasing proportion of campaigns, though in part due to postponement from previous years, still raises the question of prioritisation for countries, for example with regards to introducing other critical vaccines or focusing efforts on sustainably reaching zero-dose communities through strengthening routine immunisation.



1.3 **The quality of measles campaigns remains a concern.** Only 13% of countries with a measles campaign in 2018 met the 95% target coverage⁸. This issue continues to be discussed with WHO, UNICEF and Centers for Disease Control and Prevention (CDC) (who are also Measles & Rubella Initiative (MRI) partners) for remedial actions. Some progress has been observed in the way campaigns are prepared and implemented in certain countries, including conducting pre-campaign readiness assessments and improving post-campaign coverage surveys⁹. Alliance partners have agreed to further strengthen their support for campaign and budget planning, and to ensure that post-campaign coverage surveys happen systematically and in a timely manner. At the recent Programme and Policy Committee (PPC) meeting, Alliance partners were also requested to provide further recommendations on how campaigns could be best managed going forward to ensure they are balanced with routine immunisation. Pakistan is an example where the Alliance made significant efforts to support the country

⁶ including 2 preventive mass campaigns, 4 multi-age cohort campaigns, 17 follow-up campaigns and 8 catch-up campaigns

⁷ Some of those 2019 campaigns are postponed/delayed from implementation in 2018

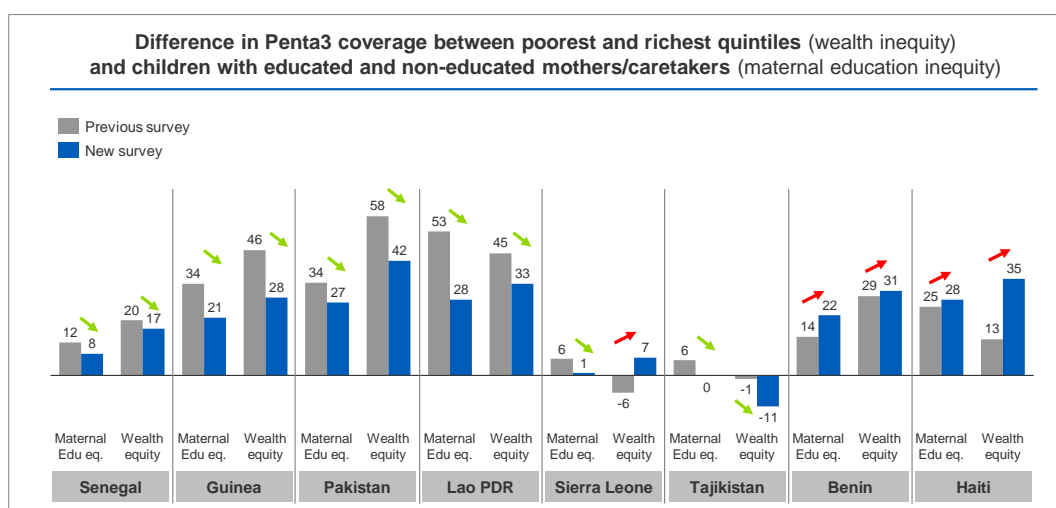
⁸ Of the ten campaign countries, survey coverage data was reported for eight of which only Eritrea reported >95% coverage. Others in the list include Pakistan (93%), Afghanistan (91%), Angola (87%), Liberia (89%), Togo (94%), Ghana (91%) and Mozambique (76%). Preliminary results from Mauritania, indicates that the campaign reached 94% coverage. However, this has not been officially confirmed, so has not yet been included in the KPI.

⁹ Many countries are still not doing prompt independent post campaign surveys

in improving the quality of the recent measles campaign by implementing data-driven microplanning, extensive utilisation of polio resources, and participation of a wide range of Civil Society Organisations (CSOs). As a result, 93% of the target population was vaccinated, a significant improvement on previous campaigns where surveys have been available. However, even in Pakistan, with the Alliance’s full support and the leveraging of polio resources, the target coverage of 95% was not reached.

1.4 Frequent or sub-optimally planned campaigns threatening the capacity of governments to manage routine immunisation services therefore remains a top risk for the Alliance and outside risk appetite, with campaigns being inherently high-risk activities both from a programmatic and fiduciary perspective. To encourage a greater balance between campaigns and efforts to improve routine immunisation coverage, the Board recently approved operational cost flexibilities¹⁰. A number of countries including Zambia, Lesotho, Senegal and Burundi are pegged to use these new flexibilities, with initial lessons-learned expected to be available by mid-year. It remains to be seen how this will translate into progress in reaching coverage targets and more efficient use of resources.

1.5 The availability of new survey data for wealth and gender equity is still limited and thus there is no significant change in these indicators. However, the few data points available show a positive trend. In three countries with new surveys published in 2018 (Guinea, Pakistan and Senegal), wealth and maternal education indicators improved significantly with an average reduction of wealth inequity by twelve percentage points and maternal education inequity by eight percentage points. Since the beginning of the strategic period there has been a total of nine new surveys published¹¹. Wealth and maternal equity improved in five and six of these eight countries, respectively.



¹⁰ To encourage countries to strengthen routine immunisation for measles containing vaccines, countries can apply for M/MR (measles/measles-rubella) operational costs to be used for national and subnational campaigns as well as to enhance routine immunisation activities targeted at reaching missed children

¹¹ of which eight were in countries with a previous survey

- 1.6 **The Alliance continues to work with countries to address inequities in immunisation.** This translates into a more deliberate focus of health system strengthening (HSS) grants and technical assistance to target marginalised subnational areas with a high share of underimmunised and zero-dose children. Out of 18 HSS grants starting in 2018, more than 90% specifically target priority geographical areas, compared to 57% in 2016. The progress on equity indicators in Pakistan speaks to the effect of improved targeting of support. For example, the Alliance has elevated its support to Balochistan and tribal districts of Khyber Pakhtunkhwa with more resources and staff presence and moved its engagement to district level. Union councils with the largest numbers of zero-dose and missed children, including in urban suburbs of Karachi, Quetta, Lahore and Peshawar, are prioritised and targeted interventions are being scaled up. Three priority provinces¹² have seen their DTP3 coverage rates improve by 14 percentage points on average. Country-wide coverage of children in the lowest wealth quintiles has increased from 30% to 49% and coverage of children with the least educated mothers has moved from 51% to 61%. **However, despite this improvement, we will need to observe a similar level of progress across more countries to reach the 2020 targets¹³.** With up to ten new surveys expected for release in 2019 we hope to see movement of the wealth and gender equity indicators in the course of the year.
- 1.7 **At a global level, through the Equity Reference Group, the Alliance works on generating innovative ideas to accelerate progress on equity in immunisation.** In parallel, the Alliance has intensified its work to identify and address specific gender-related barriers. The Alliance's ongoing gender-related work includes an update of the gender policy, mainstreaming gender-related interventions into Gavi's data and demand strategic focus areas (SFAs) (e.g. improving service quality such as interpersonal communication of frontline health workers; increasing awareness through community engagement), updates to HSS and new vaccine support guidelines and a broad advocacy engagement including in a number of global health political and policy dialogues such as the Global PHC (primary health care) conference in Astana and the Global Compact on Refugees.

Strategic Goal 2: Health System Strengthening

- 1.8 **The Alliance's support through its HSS grants and Partners' Engagement Framework (PEF) targeted country assistance (TCA) continues to be more aligned and targeted at addressing specific country bottlenecks that impede progress on reaching under-immunised children.** To further guide this process the Alliance has started to work with countries to formalise country-specific theories of change. These articulate how Gavi's levers of support come together to contribute to a clearly defined set of objectives based on a diagnosis of challenges. The first set of formalised theories of change helped to develop the 2019

¹² Four key provinces prioritised include Balochistan, Sindh, Khyber Pakhtunkhwa and Punjab. Khyber Pakhtunkhwa was the only prioritised province where coverage level did not improve

¹³ If the absolute improvement observed across the 8 surveys were to be seen across the 40 surveys scheduled for the current strategic period, Gavi's 2020 targets could still be achieved

TCA plans and were discussed at the PEF Management Team meeting in January. Moving forward, the Alliance aims to make development of a formalised theory of change an integral part of the full portfolio planning (FPP) and joint appraisal (JA) processes.

- 1.9 **A recent HSS evaluation** found that Gavi's HSS is country-driven and this fosters ownership, alignment with national plans and investments into priority areas. It also found that countries consistently included coverage and equity objectives and activities in their applications, although the related theory of change was not always clear and there was less focus on sustainability. The review found a small, lagged association between HSS support and coverage of multiple routine vaccines (and that this correlation got stronger over time), suggesting that the scale-up in Gavi's HSS support should contribute to continued improvement in coverage over time. However, the reviewers noted the need to approach HSS with a longer time-frame to enable the measurement of actual changes which is currently difficult given HSS' project-cycle timeline. The findings of this evaluation will inform the upcoming funding policy review, discussed further in Doc 07 on operationalising Gavi 5.0.
- 1.10 **Continued efforts to align HSS and TCA are coupled with increased technical assistance provided to countries, including at subnational levels. Funding of technical assistance at the country level by Alliance partners (PEF TCA) continues to increase:** US\$ 95 million has been approved for 2019 of which 70% is committed to WHO and UNICEF (US\$ 31.1 million and US\$ 35.1 million, respectively), an increase from US\$ 85 million in 2018 and US\$ 65 million in 2016. This includes funding of 343 WHO and UNICEF country staff, a 41% increase from 2018. Subnational support continues to increase in line with the Alliance's focus on equity; 72 sub-national staff positions were approved in 2019 compared to 66 in 2018. In view of this, the Alliance is focusing on understanding the link between these augmented resources and the country-level impact, with these considerations feeding into the review of the partner engagement model for Gavi 5.0.
- 1.11 **A recent independent in-country evaluation¹⁴ suggests that further changes to the Alliance's technical assistance model in country should be considered leading up to the next strategic period ('Gavi 5.0').** Key recommendations include (i) the development of a capacity-building and monitoring framework at the country level; (ii) better leveraging partners' comparative advantages and engaging with a greater variety of partners (including local partners); (iii) continuing to ensure technical assistance support is even better aligned with national priorities; (iv) strengthening in-country review mechanisms to empower Expanded Programme on Immunization (EPI) teams to closely monitor implementation of technical assistance by partners; (v) more clearly defining lines of accountability; and (vi) actively facilitating the sharing of lessons learned and best practices within and across countries. In the light of the Board

¹⁴ Evaluation of effectiveness of TCA conducted by IODparc in 2018 in Myanmar and Zambia

recommendations on Gavi 5.0 and the evaluations, the next strategy period will include a focus on further evolving and differentiating Gavi's technical assistance model on the ground (see Doc 07).

- 1.12 **The Alliance's long-term, deliberate and strategic approach to strengthen country supply chains is starting to bear fruit: effective vaccine management (EVM) scores continue to improve with a two-percentage point increase since the last report, achieving an average composite score of 70%**¹⁵. Hence, the Alliance is on track to achieve its 2020 target of 72%. EVM scores indicate a country's capacity to manage its vaccines effectively along its supply chain. Robust and efficient supply chains are a critical driver to reach marginalised populations, as they ensure that vaccines are available and potent across health facilities. In the past year, nine countries conducted a new EVM assessment and all showed an improvement in their composite score, with an average increase of 11 percentage points.
- 1.13 **Improved Cold Chain Equipment (CCE) has been one of the EVM criteria that improved the most since 2014 with an average score above 80%**. A key driver is the scale-up of the Cold Chain Equipment Optimisation Platform (CCEOP). Procurement of high-performing Cold Chain Equipment is now underway for 29 countries and deployment has started in 14 countries with nearly 20,000 units delivered and 12,000 installed at the end of 2018. The Alliance has shortened CCEOP deployment timelines from 20 to 14 months. The Alliance is on track to achieve its target of procuring 65,000 units by 2020 and expects to procure 25,000 units in 2019 alone. CCE deployment contributes to helping countries increase immunisation access to underserved communities: 30% of the units are targeted to extend access to newly equipped facilities. All eight CCE manufacturers are now supplying 'optimal' equipment, with prices offered to UNICEF on average 10% below pre-CCEOP prices. However, there is a concern that the current concentration of supply from two of these manufacturers may lead to higher prices in the longer term.
- 1.14 **Insufficient demand for immunisation remains a top risk**. There is growing awareness that demand-related barriers are critical impediments to reaching under-immunised children, due to factors such as parents' knowledge, quality and accessibility, or gender-related barriers. There is growing evidence of the impact of vaccine hesitancy globally, especially in developed countries (e.g. 98 countries reporting an increase of measles cases in 2018 with many countries citing vaccine hesitancy as a contributing factor). WHO has named vaccine hesitancy as one of the world's top ten global health threats and some social media companies are now actively working to prevent misinformation. The Alliance continues to monitor this risk with work underway in a number of Gavi-eligible countries (including Indonesia, India and Pakistan) to strengthen national capacity to respond to vaccine hesitancy.

¹⁵ Over 67 Gavi-eligible countries. Cuba not included in the analysis since the country has not conducted an EVM assessment.

- 1.15 **The Alliance continues to face challenges in timely disbursement of HSIS support to countries.** Average time for cash grant disbursements in 2018 has increased to 17.5 months¹⁶ (from 13.6 months in November 2018¹⁷) against a target of 9 months. The average has been particularly affected by grants that were put on hold due to reasons beyond the Alliance's control (such as country political context, global supply shortages, and audit suspensions) and were finally disbursed in 2018¹⁸. Excluding these, the average time is 14.6 months. The significantly longer-than-wanted time to disbursement continues to be driven largely by Gavi's enhanced focus on fiduciary risk management approaches. For example, in Malawi, following the Independent Review Committee's (IRC) approval, it took several more months with extensive country engagement to clarify the budget. Moreover, establishment of a joint management unit together with the Global Fund, as per Programme Capacity Assessments (PCA) recommendations, further delayed the disbursement.
- 1.16 **The Secretariat is working on gaining efficiencies and simplifying grant making and management processes to move closer to the target.** This includes investing more in initial planning and ensuring high quality proposals and budgets; setting clearer deadlines to respond to IRC clarifications; and parallel implementation (rather than sequential) of processes such as PCAs, Grant Management Requirements and negotiation of Memoranda of Understanding (MoUs). The Secretariat will further leverage efforts already underway to streamline Gavi's internal approval process in the coming months when a new financial management system is implemented. It is important to note that while first grant disbursements are delayed, subsequent disbursements are not and overall HSS disbursements have increased by 26% in 2018 compared to 2017. Further, and as discussed during the recent Board retreat on Gavi 5.0, the Secretariat is planning a full-fledged process redesign leading up to the next strategic period to streamline grant related processes (see Doc 07).
- 1.17 **The top risk that immunisation-critical public health capacity could be lost due to the winding-down of polio eradication operations remains stable.** With the extension of the global Polio Endgame Strategy (2019- 2023), some of the urgency on transition timelines has been removed or delayed, however, there remain significant uncertainties on the duration of continued GPEI (Global Polio Eradication Initiative) country-level support. National Polio transition plans are of variable quality and not always adequately addressing and prioritising at-risk functions such as vaccine-preventable disease surveillance and laboratory capacity. Countries are increasingly incorporating polio transition plans and asset maps into annual Joint Appraisal discussions when assessing programmatic risks.

¹⁶ Average of 17.5 months in 2018 was based on 32 disbursements during January – December 2018

¹⁷ Average of 13.6 months in 2018 was based on 19 disbursements during January – May 2018

¹⁸ These grants include Burundi, where disbursements were on hold due to the volatile political situation; Zambia, delays due to an ongoing restructuring at the Ministry; Malawi, Nigeria, Senegal and Uganda, which faced global supply shortages

Strategic Goal 3: Improve Sustainability

- 1.18 Gavi’s financial sustainability model continues to show success with increasing levels of domestic resources allocated to vaccine programmes. All countries met their 2017 co-financing obligations in 2017 or cleared arrears in 2018 to avoid default sanctions.** In 2018, co-financing performance has continued to improve with 49 of the 52 countries with obligations due by December 2018¹⁹ meeting their commitments. The three remaining countries, namely Cameroon, Ghana and Sierra Leone, represent the lowest number since the co-financing policy was implemented in 2008. In fact, this consolidates a longer, encouraging trend since 2014, when the number of defaults peaked at 17. The payments received against 2018 obligations represent 95% of the total expected, compared to 90% reported in the 2017. Alliance missions have already taken place in all three countries to strengthen high-level national commitment to immunisation and to develop tailored plans for the payment of the co-financing arrears, which are now being finalised. Initial fund transfers have been made by these countries to UNICEF-SD (Supply Division), but their allocation is yet to be confirmed to update their default status. These missions have also been instrumental to review the root causes of their default and to design measures to mitigate the risk of further defaults. In addition to co-financing, countries’ self-financing of Gavi-supported vaccines has now exceeded co-financing amounts. This is largely driven by India, where Gavi’s catalytic support has helped unlock domestic financing with India self-financing US\$ 238 million in vaccine procurement in 2018, an increase from US\$ 83 million in 2016.
- 1.19 Sustainable transition remains a top risk for Gavi and is actively mitigated with tailored strategies implemented in high-risk countries in 2018 and post-transition engagement.** Out of the five countries originally identified by the Board as being at high-risk for successful transition, Nigeria, Angola and Timor-Leste already have in place tailored special strategies, Papua New Guinea (PNG) will be discussed at this Board meeting (see Doc 08) and Congo Republic has become Gavi-eligible again.
- 1.20 Other countries that transitioned** with high coverage and strong financing performance still have **specific challenges linked to their institutional development, which are being tackled through the post-transition engagement** approved by the Board in November 2017²⁰. Operationalisation of the post-transition support is ongoing, with US\$ 7.6 million already allocated and another US\$ 9-12 million expected through the end of 2020. US\$ 3.8 million has so far been approved for eight countries – Indonesia, Georgia, Armenia, Bolivia, Bhutan, Moldova, Kiribati and Guyana – to provide catalytic support for technical assistance in key

¹⁹ Ethiopia, Kenya and Pakistan co-financing obligations are due by 30 June 2019 due to alignment with their fiscal years

²⁰ The Board approved “continued Gavi Alliance engagement with Phase 3 countries as they sustain and introduce self-financed vaccines and, when requested by Phase 3 countries, fund targeted support to such countries under the Partners’ Engagement Framework (PEF) through a budget allocation for Phase 3 country support up to US\$ 30 million until 2020”

programmatic areas, including supply chain, leadership, management and coordination (LMC) and data, paying special attention to innovative approaches and government commitment to their long-term sustainability. An additional US\$ 3.8 million has also been allocated to design and implement global-level initiatives, in collaboration with partners. This includes funding or co-funding two collaborative learning platforms, one to facilitate sharing of best practices and experiences among transitioning and post-transition countries, and another to strengthen national procurement capacities and systems, which are critical elements for a successful transition. Post-transition support has also been leveraged to implement a joint capacity building effort through a flagship course on transition, financing and sustainability with the World Bank and the Global Fund.

- 1.21 **While country management capacity remains a top risk for the Alliance, we see progress on countries' average institutional capacity score which improved from 2.4 in 2017 to 2.5 in 2018, and is on track to reach the 2020 target of 2.7.** Strengthening countries' institutional capacity remains a key priority and the Alliance has continued to increase its LMC support to countries. Since 2016, LMC support has been provided in 36 countries with interventions focused on enhancement of EPI performance management, embedded management partners in EPI teams, and leadership & management training for EPI senior managers and Ministry offices.

Strategic Goal 4: Market Shaping

- 1.22 Progress continues on the market shaping indicators, with three indicators currently on track and one experiencing challenges.
- 1.23 **The weighted average price for pentavalent, pneumococcal and rotavirus vaccines has continued to decrease to US\$ 15.90** representing a 4% reduction from 2017 and 21% from 2015. In 2018, price for rotavirus decreased by 10% driven by the entry of a new supplier in the market. Average price for pneumococcal vaccine decreased by 3%. For pentavalent, after a 43% price reduction between 2016 and 2017 the focus has been to stabilise prices in the market as there are indications of volatility in an environment of heightened competition.
- 1.24 **With two new products with improved characteristics procured in 2018 the related indicator remains on track to achieve our 2020 target.** The two new products were (i) an oral cholera vaccine (OCV) product labelled for controlled temperature chain (CTC) which allows the vaccine to be stored up to 14 days at temperatures outside of the traditional cold chain and (ii) a new PCV product which reduces cold chain capacity requirements.
- 1.25 **The risk of global supply shortages remains stable and continues to be a top risk for the Alliance.** As anticipated and discussed in previous meetings, three out of eleven markets have experienced supply shortages in 2018: HPV, IPV and rotavirus.

- 1.26 **For HPV, a major supplier has informed of a reduction of its committed doses for 2019 as a result of the significant increase in global demand for this vaccine**, which continues to outpace available supply. HPV introductions planned for 2019 will reduce from 18 to 15 and introductions for 2020 are at risk if supply volumes remain at current expected level. Supply to Gavi-eligible countries may be further at risk in the next few years if global demand for HPV continues to grow as part of the elimination strategy. Based on latest forecasts we estimate that 13 million girls will have been vaccinated during this strategic period against an initial target of 40 million.
- 1.27 **Supply availability for IPV started to improve in 2018, with enough supply to meet routine needs** of countries procuring through UNICEF. However, IPV supply remains constrained overall with volumes available for countries' catch-up immunisation being insufficient to meet requirements in the short term. The IPV supply situation is expected to improve in 2020 and beyond with new manufacturers entering the market.
- 1.28 **In the rotavirus market, mitigation efforts helped reduce the effects of supply constraints of two main suppliers** resulting in limited delays in introductions²¹ and few missed immunisations in countries. Successful mitigation actions have included increased coordination among stakeholders to speed up the delivery of vaccines to the countries that needed them, extensive Alliance collaboration to ensure that countries had the information they needed to manage any potential shortfalls and adjust accordingly, and strong engagement with countries to assess opportunity to change vaccine preference to newly available vaccines. The situation in the rotavirus market is improving with prequalification of vaccines from two new manufacturers in 2018 and a new presentation from an existing manufacturer in 2019. Improvements are expected to continue as the number of presentations is expected to increase to nine by 2020.
- 1.29 **Three markets (Pentavalent, Yellow Fever, PCV) were assessed to be in moderate health in 2018, as in 2017.** Of the eight markets assessed (Cholera, Japanese Encephalitis, Meningitis A, Measles-Rubella, Measles, Rotavirus, HPV, IPV) as low health, three markets (Measles-Rubella, Meningitis A, Japanese Encephalitis) were exposed to low supplier diversity, but considered within acceptable risk levels due to sufficient capacity and strong track record of the dominant supplier. While the indicator is on track with initial forecast for 2018, the Alliance's 2020 target to reach six markets with moderate to high healthy market dynamics remains ambitious, particularly in the context of significant supply constraints that were unexpected at the beginning of this strategic period.

²¹ All 8 countries with planned introductions for 2018-2019 impacted by the supply constraints were offered the possibility to introduce with their preferred vaccine in November 2019. Out of the 8 countries, 3 will introduce earlier with a different vaccine, 2 will introduce in November with their preferred vaccine, and 3 are not expected to introduce before 2020 due to local competing priorities

Update on Financial Forecast 2016-2020

1.30 The table below summarises the Financial Forecast 2016-2020. It indicates that **after allowing for the funding decisions to be considered and all other programmes already foreseen in the forecast, resources of US\$ 255 million could be available for other new investments**, through 2020. This is dependent on donors contributing and extending their pledges through 2020. This amount has been updated to reflect the re-programming of US\$ 350 million in IFFIm (International Finance Facility for Immunisation) proceeds from 2016-2020 to 2021-2025, reducing the amount available for further investments in 2016-2020 by this amount.

US\$ million	Prior Forecast Nov 2018 Board	Change upon updating estimate	Impact of decisions for consideration now	Latest Forecast Jun 2019 Board	Impact of decisions for consideration now / Estimate changes	
Assured Resources	9,376	(80)		9,294		
Allowance for Further Direct Contributions ⁽¹⁾	397	(223)		174		
A Qualifying Resources	9,773	(303)	0	9,468		
	\$9.8 bn			\$9.5 bn		
B Forecast Expenditure	Total excl. Ebola & IPV	8,691	0	6	8,697	54
	Ebola ⁽²⁾	20			20	
	IPV	496			496	(50)
	Total	9,207	0	6	9,213	4
	\$9.2 bn			\$9.2 bn		
A-B Available / (additional required) for future investments	566	(303)	(6)	255	(4)	
	\$0.6 bn			\$0.3 bn		
Available / (additional required) if the Allowance for further Direct Contributions is excluded:					81	
Decisions for consideration at June 2019 Board meeting add up to \$6m (2019-2020) and up to \$54m (2021-2025) excluding IPV updated estimate						
US\$ million	Decision amount	Already in Forecast	Addition to Forecast	Board Document		
(a) UNICEF 2020 Procurement fees - vaccines <i>Investment return: Direct Health Impact</i>	19	19	0	01d		
(b) UNICEF 2020 Procurement fees - CCEOP <i>Investment return: Direct Health Impact</i>	4.3	4.3	0	01d		
(c) Review of the strategy for Papua New Guinea <i>Investment return: Direct Health Impact</i>	6		6	08	54	
(d) Gavi support for IPV Post-2020 ⁽³⁾ <i>Investment return: Direct Health Impact</i>	800	850		09	(50)	
			6			

(1) Allowance for further direct contributions is calculated (per Policy) to maintain an annual level equivalent to that confirmed for 2016-2018 (\$1.46bn) in subsequent years

(2) Reflects only vaccine amount of \$20m estimated for 2020

(3) PPC recommendation to approve only \$800m (\$850m included in forecast approved by the Board in November 2018)

1.31 **Operating expenses and overhead ratios are both slightly higher than originally projected** in November 2017. The **operating expense ratio for 2018 is 7.4%** (from 7.0% forecasted in November 2017) and the **overhead ratio for 2018 is 3.1%** (from 2.7% forecasted in November 2017). The increase in the two ratios is due to the lower than originally forecasted

programmatic disbursement levels, reflecting market shaping gains related to reduced vaccine prices, reductions in vaccine volumes as a result of better stock management by countries as well as the impact of supply shortages and some delays due to country readiness issues.

Annexes

Annex A: Updated Alliance KPIs dashboard