SUBJECT:	**2016-2020 STRATEGY: IMPLEMENTATION AND PROGRESS**
Agenda item:	04a
Category:	For Information

Section A: Summary

- This report provides a regular, data driven, update on progress made against implementing Gavi's strategy. This update **focuses in particular on progress on coverage and equity,** drawing from the 2016 WHO/UNICEF Estimates of Immunisation Coverage (WUENIC) published in July 2017.

- The Alliance is on **track for its overall target of immunising 300 million children and averting 5-6 million deaths** in the 2016-2020 Strategy Period. In the first year of its strategy, Gavi-supported **countries immunised 63.9 million children with three doses of DTP-containing vaccine,** [1] **the highest number ever**. Countries also **significantly expanded the breadth of protection** by continuing to introduce and scale up new vaccines. However, WUENIC data showed the **% of children reached with three doses of DTP-containing vaccine (DTP3) and first dose of measles (MCV1) is unchanged,** despite the increased number of children immunised, as the number of children born each year is also increasing. There are challenges with WUENIC data and it may not be sensitive enough to pick up changes in coverage.

- Gavi's support to strengthen health systems via Health System Strengthening (HSS) grants and Partners' Engagement Framework (PEF) targeted country assistance (TCA) will be critical to accelerate progress on coverage and equity. The **Alliance has begun tracking the progress of its support** much more systematically and holistically through grant performance frameworks, financial reporting, TCA milestones, and PEF functions. While these have only been recently implemented and data reporting and quality is still being improved, they are now being routinely used to review grant progress, learn and adjust grants both at country level (e.g., through Joint Appraisals) and at global level (by the Secretariat and High-Level Review Panel (HLRP)). **The Cold Chain Equipment Optimisation Platform (CCEOP) also continues to be scaled up** and a significant share of the equipment requested by countries is to extend the cold chain to previously unequipped facilities. The Alliance is also scaling up its approach to leadership, management and coordination.

[1] Referred to as DTP3 in the rest of the paper.

- Under strategic goal 3, **countries continue to scale up their co-financing** with 2017 on track to be the best ever year in terms of co-financing performance. Five more countries transitioned at the beginning of 2017 and most other countries are on track to transition successfully. The Board will discuss at this meeting how to mitigate key risks to sustainability (following the discussion at its April 2017 Retreat). **Performance on market shaping also continues to be strong** although the Alliance is having to adapt its human papillomavirus programme to manage recent supply constraints.

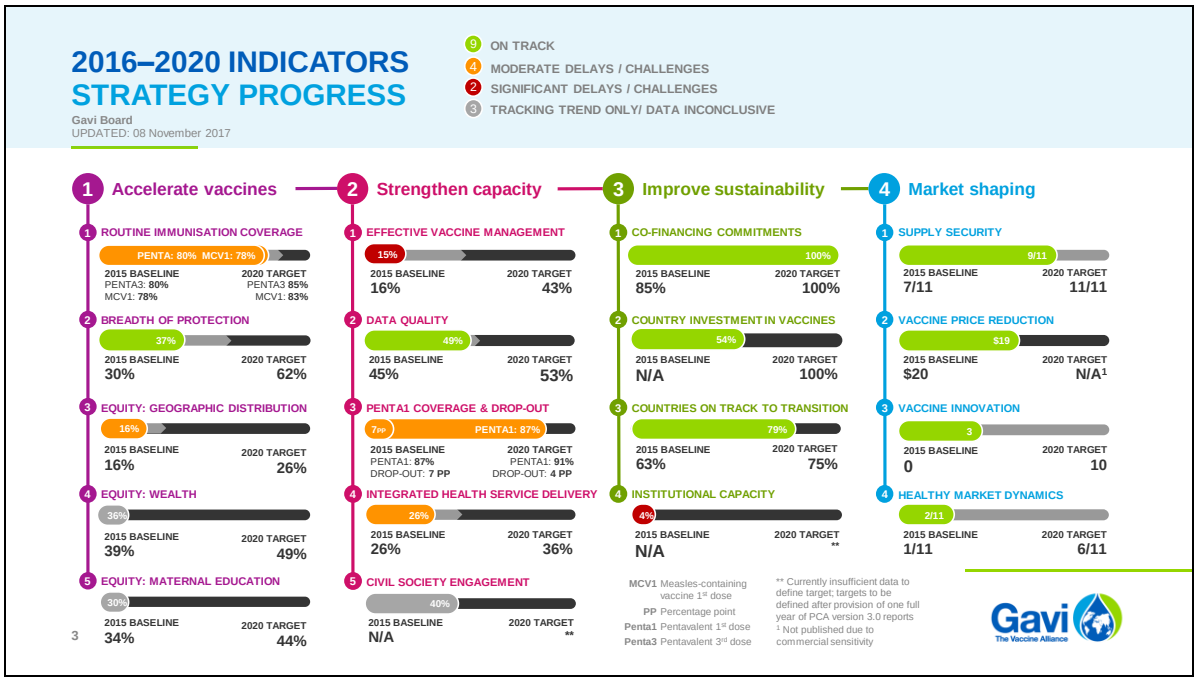
Section B: "Update on Implementation of Gavi's Strategy"

1. Progress against Gavi's mission aspiration

The Alliance is on track to achieve its Mission Progress indicators: under-5 mortality in Gavi 68 countries fell from 65 to 62 per 1,000 live births between 2015 and 2016 (MA1),[2] halfway to the 2020 target. The Alliance is also on track for immunising 300 million children (MA4), and averting 5-6 million future deaths (MA2) and 260 million disability-adjusted life years (DALYs) (MA3) between 2016 and 2020. The percentage of vaccines sustained after transition also remains on track, at 100% (MA5).

[2] Indicator numbering is used throughout the document when referring to Mission Aspiration (MA) indicators, Strategic Indicators (S) or Alliance Progress Indicators (A)

2. Strategic Goal 1 – Accelerate equitable uptake and coverage of vaccines



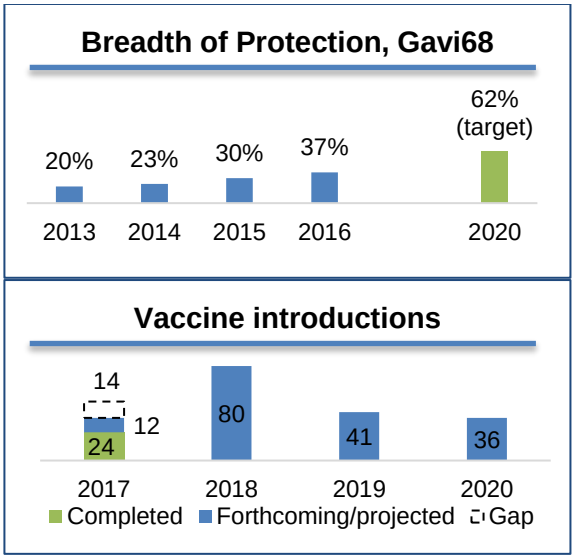
63.9 million children were immunised with DTP3 in 2016, more than ever before and up from 59.5 million in 2010. However, DTP3 coverage across the Gavi 68 has been flat at 80% since 2014 and MCV1 coverage has not changed since 2010 (S1.1).

15.5 million children did not receive DTP3 in the 68 Gavi countries in 2016, a decrease of 0.3 million from the year before. **Three quarters of these children live in 10 countries**, of which seven are currently Gavi-eligible. Of these, Angola, India, Indonesia and Nigeria are in the process of transitioning out of Gavi support.

Progress on geographic equity within countries appears slow. The share of Gavi countries in which all districts have at least 80% DTP3 coverage remains at 17% (S1.3). This data is based on administrative coverage; a strict data quality criterion means that more than half of Gavi countries are excluded from the measure. WHO provided for the first time sub-national data through the Joint Reporting Form process, and continued work with countries to strengthen the quality of administrative data will eventually allow more countries to be included in the future. We also include data on wealth and gender equity. However, since these are measured using surveys that only occur periodically, there is limited new data and the evolution of these indicators is inconclusive at this time. As discussed in the CEO report, challenges with data quality and use remain significant impediments to both accelerating progress on coverage and equity and measuring progress over time.

Children are being reached with a much broader range of vaccines, reducing inequities in vaccine access between countries. Countries delivered 214 million vaccination courses in 2016 – up from 170 million in 2015. Breadth of protection with all Gavi-supported vaccines increased by 7pp to 37% (S1.2), above the trend required to achieve Gavi's 2020 goal. Key drivers of these gains include:

- Inactivated polio vaccine (IPV): number of children reached increased by 21.3 million to 31 million, despite delayed introductions due to supply shortages. Despite this progress, routine coverage of polio vaccines remains a concern as discussed further in the CEO report.
- Measles second dose (MCV2): 5.4 million more children (50% coverage).
- Pneumococcal vaccine (PCV): 4.8 million more children (41% coverage).
- Rotavirus: 2.9 million more children reached (23% coverage).



Continued vaccine introductions will support further increases in breadth of protection. In the year to date, 24 introductions have taken place (A1.1) and the latest estimate for the full year stands at 36 introductions, compared to an initial target of 50. The shortfall in introductions is primarily due to supply issues for HPV vaccines (further discussed under SG4). Over 150 introductions are planned for the remaining years of the strategy period, continuing the ambitious agenda of reaching children with a higher share of recommended antigens.

3. Strategic Goal 2 – Increase effectiveness and efficiency of immunisation delivery as an integrated part of strengthened health systems

Strengthening health systems and institutions will be critical to accelerate progress on coverage and equity to reach the fifth child. To measure the impact of its grants in doing this, the Alliance has rolled out Grant Performance Frameworks for all countries over the past two years. Each of 60 countries reporting now has on average ~15 "tailored" (country-specific)

and ~10 core (standardised) HSS indicators. This data helps identify implementation bottlenecks and to formulate approaches to addressing them (see example from Ghana below). Countries mostly report as planned: 80% of countries achieved the reporting target at the end of last year (A3.7).[3] However, the quality of reporting and achievement of results need to be improved further: approximately half of due indicators can be analysed (up from 38% the year before), for others data is either missing, has no target or is reported as "not applicable" (e.g., survey data not yet collected or grant not yet started). 29% of countries reporting achieved at least 80% of due intermediate results indicators this year (A1.6).

Example: Use of the Grant Performance Framework in Ghana

2015: The Joint Appraisal process identified underserved areas in Ghana where coverage is lower than the national average, based on analyses through the Grant Performance Framework. To address this challenge, the immunisation programme used HSS funds to improve service delivery by using HSS funds for:

- Procuring additional 200 motorbikes and 2 boats to support outreach activities in 53 low performing and hard to reach districts.
- Supporting the active participation of Civil Society Organisations (CSOs) and community volunteers in the delivery of immunisation services, complementing efforts of the World Bank's Community Performance Based Financing scheme.

2016: The GPF review documented progress:

- Community based volunteers had been recruited and inducted in every target district;
- CSOs participated in annual micro-planning meetings and reviews exceed targets
- 60% of targeted communities benefitted from planned outreach activities, and demand generation activities. This was below the target of 65% due partially to a delay in releasing HSS funds from the central to the district level and partially due to the lack of qualified health personnel in hard to reach areas. To address the latter issue, retired midwives were hired to provide outreach in hard-to-reach areas.

Going forward: in 2018, the immunisation programme will prioritise the decentralisation of funds to the district and sub-district level to undertake outreach activities and will also use the annual child health promotion week to promote immunisation services.

[3] Reporting completeness mid-2017 is lower at 53%, but is expected to reach the target of 85% by the end of the year

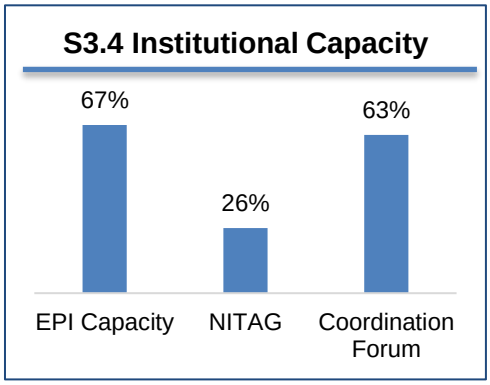
Excerpt: indicators from the 2016 Grant Performance Framework

Indicator	Target	Achievement
Proportion of intervening districts reporting active CSO participation in annual DHMT micro planning meetings and reviews per annum	90%	100%
Proportion of targeted communities with volunteers trained to undertake EPI activities	90%	100%
Proportion of targeted communities benefiting from planned community outreach services	65%	60%
Proportion of targeted communities sensitised on the benefits of immunisation and the need for service uptake	65%	60%

The Alliance has made progress in accelerating disbursements for lower risk HSIS grants. On average, time to disburse (A2.1) has increased slightly to 12.3 months at the end of July, against a year-end target of 9 months. However, this was driven by 8 grants which took longer than 15 months due to delays with Programme Capacity Assessments, audit issues or delayed MR campaigns due to inadequate country readiness, or low absorption of existing HSS funds. The average disbursement time for the remaining 20 grants was 7.9 months, significantly below target. The Secretariat is working to resolve risk-related bottlenecks more quickly including by streamlining arrangements to channel funds through partners as discussed in the Alliance Update.

The share of countries meeting the target on Effective Vaccine Management (EVM) (S2.1) has decreased. This indicator measures the share of countries achieving a score of at least 80% in their latest EVM assessment. The figure has decreased from 16% to 15% since last year, against a target of 21% for 2016. However, two thirds of countries which have conducted two EVMs have improved their EVM score (with an average increase of 10 percentage points) and the share of countries with an EVM >70% increased from 27% to 37%.

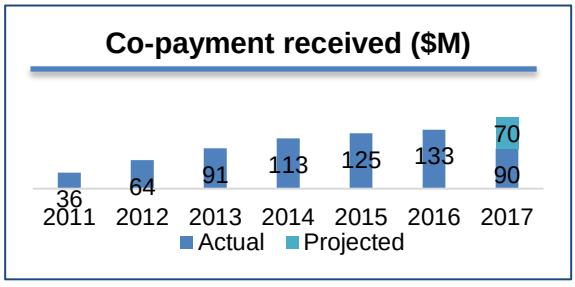
The Cold Chain Equipment Platform (CCEOP) continues to accelerate and is a key mechanism to further strengthen supply chains**.** To date, 38 countries have submitted applications for support (with 20 submitted since the last Board meeting) and 24 countries have been approved, or recommended for approval, representing approximately US$ 196 million in Gavi investment and US$ 77 million in country investment over five years. These applications reflect support for 62,000 pieces of equipment, 26% of which is to extend the cold chain into previously unequipped facilities providing a platform to increase coverage and equity. The Secretariat and partners have worked to shorten CCEOP timelines from 21 months for the first application (from IRC approval to deployment) to a target of 7 months. By the end of 2018, over 20,000 CCEOP refrigerators are due to have been installed.



The Strategy Indicator on Institutional Capacity (S3.4) highlights the importance of continued efforts to strengthen capacity. Out of 25 countries with data to date, only Uganda meets the criteria for having sufficient capacity in the EPI programme, the National Immunisation Technical Advisory Group and a functioning immunisation coordination forum. To help address gaps in EPI and coordination forum capacity, **Gavi started to roll out its approach to strengthen leadership, management and coordination (LMC) in early 2017.** To date, the Secretariat has entered into agreements for management support in 14 countries, mostly with expanded partners, including Aspen Management Partnership for Health, CHAI, Dalberg and Yale University. This includes technical assistance to coordination forums in 10 countries, including Chad, Congo and Guinea Bissau; providing embedded managerial support ('Management Partner') in four countries; launching an innovative management training programme for EPI managers with Yale University and the University of Global Health Equity (UGHE) in Rwanda; and implementing a twinning approach between Timor-Leste and Sri Lanka to foster south-to-south transfer of managerial skills, supported by WHO. Going forward, Gavi will refine and broaden the menu of interventions available to countries and to roll-out across the portfolio based on lessons learned. As highlighted in the Risk & Assurance report and discussed in the CEO report, this area remains a critical focus to accelerate progress on coverage and equity and Gavi is considering whether to roll out a more intensified LMC approach in 3-5 priority countries, with a focus on the sub-national level.

4. Strategic Goal 3 – Improving sustainability of national immunisation programmes

Countries are contributing record figures for co-financing and defaults are at an all-time low. As of end September 2017, countries have contributed US$ 90 million of a total of US$ 160 million in co-financing expected by the end of the year, the highest figures ever achieved. This compares to total co-financing of US$ 133 million in 2016 and US$ 71 million in the first 9 months of the year. Defaults are also decreasing: South Sudan is the only country in default for 2016; the PPC is recommending to the Board to apply a co-financing waiver for the country. These successes coincide with increased engagement of Partners and Secretariat Senior Country Managers with Ministries of Health and Finance in



countries. In addition, transitioned countries are estimated to be investing US$ 50 million in formerly Gavi-supported vaccines in 2017.

The majority of countries remain on track for successful transition, but five were identified in April by the Board as being at risk (Congo, Angola, Nigeria, PNG, East Timor).[4] The PPC has recommended to the Board a tailored transition plan for PNG and an approach to develop such a plan for Nigeria. It has also recommended that the Alliance continue to engage with countries after transition with a focus on monitoring performance and high-level political advocacy for immunisation. It requested more detailed analyses of the risks to successful transition, especially in Angola, Congo, and Timor-Leste.

For the first time in this strategy period, the strategy indicator on countries' investments in immunisation is available (S3.3). 54% of countries have increased their investments between 2015 and 2016, and the average investment per surviving infant increased from US$ 8.60 to US$ 10.90 between 2015 and 2016. The target for 2020 is that investments per child are increasing in all Gavi-eligible countries, over the 2015 baseline. At this time, conclusions from this indicator are tentative, as this is the first year we are measuring the indicator, and a number of external factors, such as vaccine prices or countries included[5] could influence its value.

5. Strategic Goal 4 – Shape markets for vaccines and other immunisation products

The latest financial forecast presented to the AFC highlights **that the Alliance's market shaping efforts are yielding approximately US$ 600 million in savings** for this strategy period compared to the Investment Case presented at replenishment in 2014. Overall, the strategy indicators for market shaping are on track. However, the Alliance continues to face supply shortages in some key markets (and this is a top risk in the Risk & Assurance report).

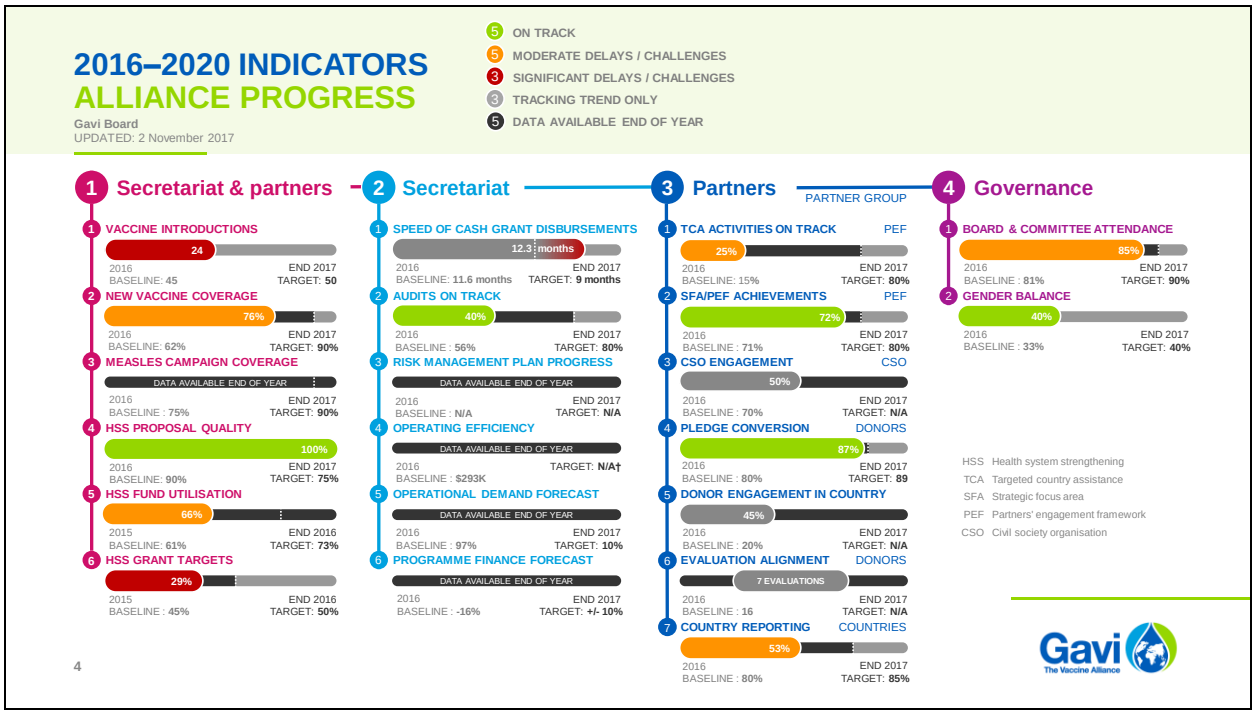
Supply issues put implementation of the HPV strategy at risk. Following Board approval of the revised HPV strategy in December 2016, 9 Gavi countries submitted successful applications with a total target population of nearly 20 million HPV-eligible girls (against Gavi's objective of 40M girls reached by 2020). In June 2017, Merck informed Gavi that it had not planned for the level of production required to support the revised HPV strategy in the short term. To manage this supply constraint, the Alliance has allowed countries to introduce HPV into routine immunisation by immunising a single cohort of girls, while delaying immunisation of additional age cohorts (which was foreseen to take place at the same time in the revised strategy). Countries can either start by vaccinating an older cohort and extend to younger cohorts when sufficient supply is available, or choose to vaccinate a younger cohort from the start. The former approach

[4] Support to Angola and Congo is ending at the end of 2017
[5] Self-financing countries are excluded from the indicator

maximises impact as it means older cohorts are not missed (since Gavi supports immunisation of girls up to 14 years of age only) but is more complex to implement and may be less sustainable. Despite these mitigation measures, the revised goal of 40 million girls reached by 2020 remains at risk and Gavi continues to engage with Merck to seek solutions to the supply issue.

After 3 years of global supply shortages, IPV supply is set to improve in 2018. As a result, 16 Gavi-supported countries that had been delayed since 2015 will be receiving supply and will be able to introduce IPV. Another 13 countries that had experienced stock outs and interruption of programmes will be able to relaunch IPV meaning all Gavi-supported countries should be able to have introduced soon. 30 countries have missed cohorts which will need to be vaccinated as soon as sufficient supply becomes available.

6. Alliance Accountability



Alliance KPI reporting is partially available at this time. The Alliance KPI on TCA activities on track is at 25% (A3.1). This reflects the short timeline between TCA being approved in February, funds being released in April and reporting taking place in June. The indicators on vaccine introductions, HSS grant targets, and time to disburse are discussed under SG 1 and SG 2. The Governance KPIs on attendance and gender balance continue to improve (A4.1 and A4.2), with gender balance close to the target for the first time. A number of KPIs on the Secretariat's performance will become available at the end of the year and reported to the next Board meeting (A1.3, A3.3-3.6). The Secretariat is currently reviewing the quality, timeliness and usefulness of indicators across the entire Alliance Accountability Framework in response to PPC recommendations and potential changes will be brought to the Board in June 2018.

The Secretariat's strengthened Performance Management process is in its second year and has been mainstreamed into work-planning and review processes. As part of the performance management process, key implementation issues are being reviewed and management remedial actions are being defined. The latest review focused in particular on performance disbursing and managing cash grants.

The first draft of the evaluation of Targeted Country Assistance under the PEF has generated key insights on progress to date. The evaluation indicates strong improvements of country ownership, transparency and accountability through the Joint Appraisal process. Involvement of Ministries of Health at all stages of PEF design and implementation and in the reporting process has improved. Partner country offices are receiving

increased resources and increasing their ownership of support to countries to improve Coverage and Equity. However, activities in countries are still described as “business-as-usual,” with little emphasis on fostering transfer of skills or introduction of innovative approaches. The share of staff truly embedded in ministries to provide day to day support remains small. There is further concern about the quality of technical assistance, in particular at the subnational level. The evaluation noted inadequate technical assistance in the areas of supply chain and data. These findings are being discussed with partners to bring about necessary changes.

7. Appendix

The disease dashboard is included in appendix to this paper, for completeness. Since the last time we reported on this dashboard in June, there has been insufficient new data to draw conclusions.