

SUBJECT:	COUNTRY PROGRAMMES STRATEGIC ISSUES
Report of:	Hind Khatib-Othman, Managing Director, Country Programmes
Authored by:	Jos Vandelaer, Chief of Immunization, Programme Division (UNICEF), Michel Zaffran, Coordinator, Expanded Programme on Immunization (WHO), Stefano Malvolti, David Salinas, Alan Brooks, Santiago Cornejo
Agenda item:	10
Category:	For Information
Strategic goal:	SG1 - Vaccines, SG2 - Health systems, SG3 - Financing

Section A: Overview

1. Purpose of the report

1.1 At its meeting in October of this year the Programme and Policy Committee (PPC) recommended that the Board agenda should include a standing update on the programmatic work of the Gavi Alliance. Following feedback from the Board and Committee self-assessment, and the guidance of the PPC, this paper has been designed to:

- (a) Focus on key achievements, challenges and strategic questions which have arisen since the last Board meeting, to facilitate a more focused and strategic programmatic discussion among Board members. The Country Programmes Update to the October PPC is attached and provides full details of programmatic activities during this period.
- (b) Provide the Board with an opportunity to hear directly from Partners on the work they do as part of the Alliance. The Secretariat invited WHO and UNICEF to provide an update on key activities they have conducted under the Business Plan since the last Board meeting, and to highlight additional achievements, challenges and strategic issues for Board consideration.

1.2 We would welcome the Board's direction on the key questions identified below, as well as feedback on how we can further enhance the structure, format and content of this paper for future Board meetings.

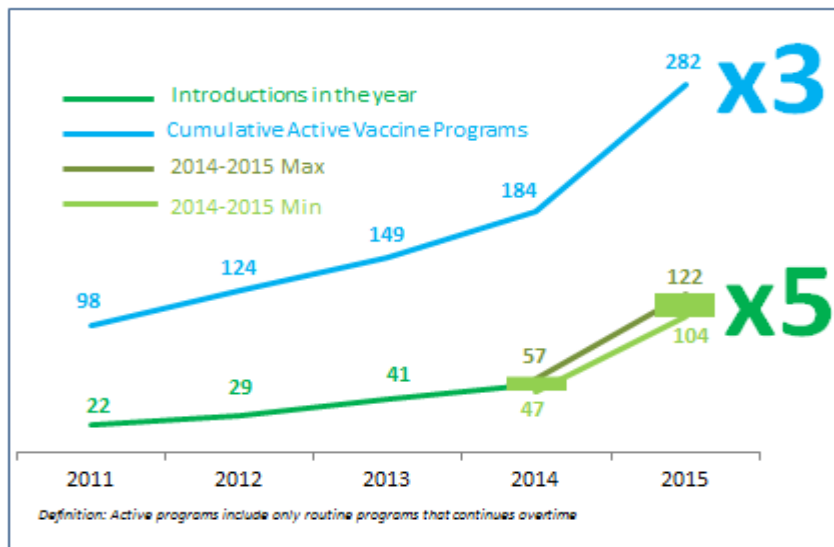
2. Recommendations

2.1 This report is for information only.

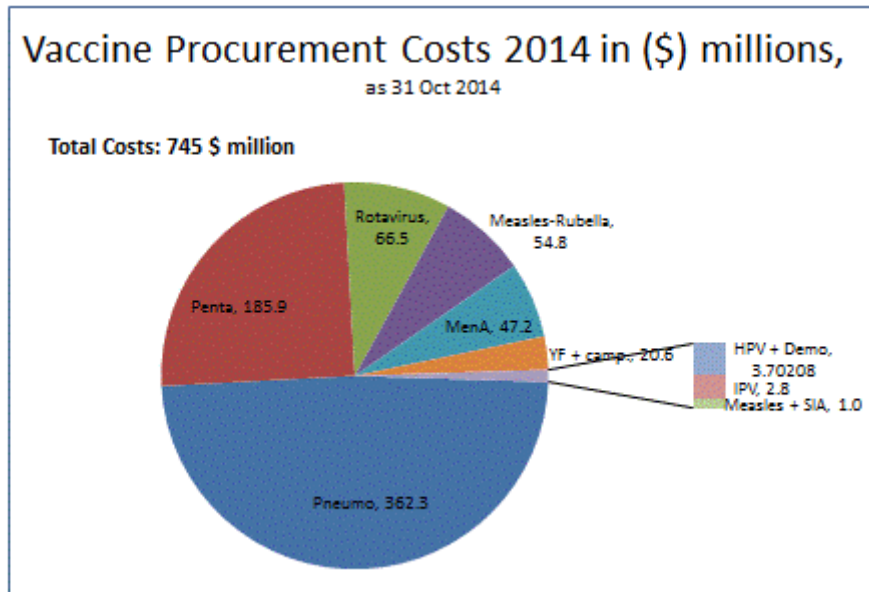
3. Executive summary

Progress on Strategic Goal 1 of the 2011-2015 Strategy

- 3.1 The roll-out of new vaccines is moving forward at an unprecedented pace. We estimate that there will be 50 introductions across 6 key programmes (Pentavalent, PCV, Rota, HPV, Measles and IPV) by the end of 2014. In total, it is expected that there will be 282 active programmes by the end of next year, constituting a threefold increase in the scale of operations over the period 2011-2015.



- 3.2 Between January and October 2014 Gavi invested ~US\$ 745 million across 9 different active vaccine programmes. Our biggest vaccine investments during this period were in Pneumococcal vaccine (49%), Pentavalent vaccine (25%) and Rotavirus vaccine (9%). These three vaccines are forecasted to continue as the largest share of the investment over the next 5 years (~73%).



- 3.3 The IPV programme is progressing well with 65 applications and 2 introductions to date, within a year of the Board decision. This achievement demonstrates the remarkable level of coordination and alignment between Gavi and the Global Polio Eradication Initiative (GPEI). It is anticipated that the roll-out in the 73 Gavi-eligible countries will be completed as planned by the end of 2015. Going forward, we will pay particular attention to ensuring that IPV introductions do not cause delays in other programmes, to strengthening integration between RI and polio assets and to ensuring there is a smooth transition from trivalent Oral Poliovirus Vaccine (tOPV) to bivalent Oral Poliovirus Vaccine (bOPV) in 2016.
- 3.4 With this unprecedented increase in scale of operations, improving efficiency of investments in vaccine procurement is essential to optimising the use of the Alliance's resources. Gavi and UNICEF Supply Division continue to work on the improvement of areas identified in the UNICEF procurement benchmarking performed last year. In particular, the implementation of a more accurate dose calculation and validation process has led to substantial improvement in the management of stock levels. In 2015 we expect to roll out a new Operational Forecast to improve both short term forecast accuracy and utilisation of the Alliance's financial resources.
- 3.5 While vaccine introduction activities have intensified, there have also been delays in introductions in a number of countries, driven by country readiness issues. An analysis was conducted of the PCV and rotavirus programmes to identify some common challenges faced by countries. These include, among other factors, insufficient human resources at the country level, delayed cold chain capacity expansion, political instability and organisational changes in countries, and delays in making funding available at the national or sub-national levels for pre-introduction activities. Gavi is strengthening its coordination mechanisms to ensure

that technical assistance to countries can be delivered more efficiently and effectively. Bottlenecks in Gavi Secretariat's cash disbursement process are also being identified, so that disbursements for future vaccine introduction grants can be made available in good time.

- 3.6 Since the beginning of 2014 the overall PCV supply situation has improved, allowing Gavi to catch up on introductions that had been delayed due to supply constraints. However, global vaccine supply remains a constraint for three of our programmes – rotavirus, yellow fever, and IPV. Reasons for this include limited supplier capacity and suspension of manufacturers (yellow fever), mismatch between country preferred product and supply (Rotavirus) and delayed licensure (IPV). Active management of the issues continues in close collaboration with the Market Shaping team, UNICEF Supply Division, WHO, the Bill & Melinda Gates Foundation and the manufacturers.
- 3.7 Gavi is enhancing its work on response readiness to reported Adverse Events Following Immunisation (AEFI). With the growth of the vaccinated population, the risk that suspected AEFIs fuel vaccine hesitancy is increasing. Gavi is developing an action plan that, within the framework of the WHO's Global Vaccine Safety Blueprint, will equip the Alliance with the right tool to address the issue of vaccine hesitancy. Particular attention will be given to communication as well as to strengthening the surveillance infrastructure. Substantial investments will be needed to strengthen country capacities in this area.
- 3.8 An opportunity going forward is the stronger integration of immunisation programmes with other health interventions. There are ongoing efforts across a broader partnership, including departments within WHO, UNICEF and UNFPA that are not directly working on immunisation, to identify potential activities within the Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) as well as within health interventions targeting adolescents that could be efficiently co-delivered with Gavi-supported vaccinations. Moreover, as part of the Polio Endgame, the Routine Immunisation subgroup of the Immunisation Systems Management Group (IMG) has worked to develop unified annual EPI plans in 10 focus countries, which also have weak routine immunisation systems and large numbers of under-immunised children. These plans seek to integrate immunisation-related programmes and create synergies between polio, new vaccine introduction, measles, and other immunisation initiatives. Further work needs to be done particularly at country level to maximise the efficiencies between GPEI and Gavi initiatives, in particular building upon the strengths of in-country Alliance partners to strengthen immunisation systems. Seizing these opportunities is likely to require reinforced commitment and investment.

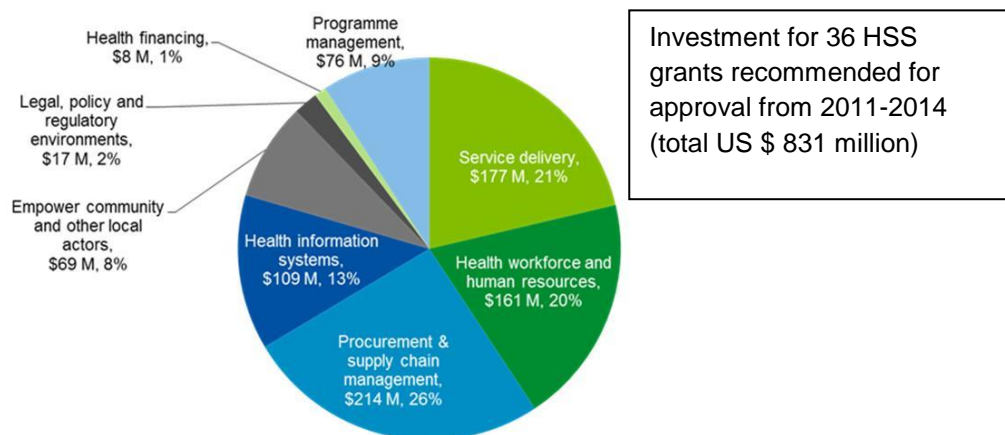
Question for Board discussion: The February 2014 Board workshop on Gavi's 2016-2020 strategy advised that integration should not be a specific focus of our strategy. The PPC and other stakeholders, including several donors, have recently called for Gavi to play a more active role in

promoting immunisation as a platform for other health enhancing interventions (e.g. using HPV as a platform for adolescent health and girls education, or PCV and rota programmes to support delivery of other interventions in the GAPPD). In this context we would like to receive guidance from the Board on how active a role Gavi should play in supporting or driving the integration agenda.

Progress on Strategic Goal 2 of the 2011-2015 Strategy

- 3.9 Strategic Goal 2 is to contribute to strengthening the capacity of integrated health systems to deliver immunisation. Four indicators are used to measure progress against Strategic Goal 2. As indicated below, two of these indicators, DTP3 coverage (2013 rate is 76% with a target of 82% by 2015) and the dropout rate between the first and the third doses of DTP containing vaccine (2013 rate is 11% with a target of 10% by 2013 and 9% by 2015), are still off track. Gavi countries have made progress in reducing inequities in immunisation coverage between the poorest households and the least poor, but still have a gap to reach the 2015 target.
- 3.10 As reflected above, DTP3 coverage remained between 74% and 76% between 2010 and 2013. This, however, masks wide variability both between and within countries. Five large countries (i.e. India, Nigeria, DRC, Ethiopia, and Pakistan) have the greatest number of under-immunised children, totalling 66% of those not receiving three doses of DTP-containing vaccines, while 63% of countries are already achieving or exceeding Gavi's 2015 target of 82% coverage according to WHO-UNICEF estimates. The drop-out rate, as stated above, has remained unchanged, with 11% of children who receive the first dose of a DTP-containing vaccine not getting the third dose, which could reflect insufficient tracing of children, poor quality of services, or other limitations in services.
- 3.11 Ebola is also having a growing impact on implementation of Gavi-supported programmes in West Africa. The Ebola situation has led to a decline in routine EPI coverage in recent months, as was clearly apparent for the first time in the AFRO monthly routine immunisation feedback bulletin of August 2014, (which reported administrative data from January to June 2014). As a result of the ongoing epidemic and based on our internal analysis of existing antigens, a conservative estimate of 2.3 million infants are expected to be under-immunised in the three most affected countries. In addition, some new vaccine introductions have been postponed. Gavi is preparing to support recovery plans to rebuild affected immunisation programmes and implement catch-up campaigns as needed. Depending on the evolution of the epidemic, the Secretariat will launch assessments in 2015 to help tailor future support to affected countries based on their needs. A dedicated paper on Gavi's role in accelerating access to Ebola vaccines, and that also reviews options for additional support and flexibilities, has been submitted to the Board.
- 3.12 Thirty six HSS grants were recommended for approval during the 2011-2014 period. Activities in proposed HSS budgets and work-plans are

grouped into nine Grant Categories, modified from WHO's health systems building blocks. The three largest Grant Categories by total allocated budget are Procurement and Supply Chain Management, Service Delivery, and Health Workforce and Human Resources, with allocations of US\$ 214 million, US\$ 177million, and US\$ 161 million, respectively. We are expecting additional information through service availability and readiness assessment (SARA) reports toward the end of the year or the beginning of next year for DRC. These three categories together represent two thirds of total HSS commitments in the 2011-2014 period. In addition, countries invested 12-15% in data, 9-10% in Programme Management, and 6-8% in Community Empowerment. Data confirm that countries are investing HSS resources across multiple aspects of the health system, and through Civil Society Organisations (CSOs), to achieve immunisation outcomes. Since the June 2012 Board decision to consolidate CSO funding under the HSS window, US\$ 64.2 million (9.86%) is proposed for CSO activities out of the total of US\$ 633.5 million from proposed HSS applications.



3.13 It is important to note that the first two countries, Laos and Burundi, were approved in July 2014 to receive rewards payments as part of Gavi's Performance-Based Funding (PBF) support. PBF is likely to be a critical incentive to encourage countries to strengthen their Monitoring & Evaluation (M&E) systems.

3.14 As of September 2014, Gavi committed a total of US\$ 1.04 billion for HSS grants from 2007 through 2018. Total HSS approvals from 2007-2014 are US\$ 700 million, of which US\$ 634 million (91%) was disbursed as of 30 September 2014. As of late September 2014, forecasts for the year's cash-based Programmes (e.g. HSS, vaccine introduction grants, etc.) totalled US\$ 315 million (23%), which is consistent with Board guidance of 15-25% of our overall vaccine support to countries. Independent evaluations of the first phase of Gavi HSS grants over 2007-2012 have been completed in several countries including Afghanistan, Burkina Faso, Ethiopia, Myanmar (mid-term), and Yemen. Further information on results can be found in the Country Programmes update to the PPC, attached to this paper.

Progress on Strategic Goal 3 of the 2011-2015 Strategy

- 3.15 In the implementation of Strategic Goal 3, Gavi monitors two key indicators: fulfilment of co-financing commitments and country investments in vaccines per child. Another key priority is to provide support for graduation.
- 3.16 Of the 68 countries required to co-finance their vaccines in 2013, 53 had fulfilled their commitments by year-end. There were 14 defaulting countries (one country was given a waiver due to the political and social instability), which was the highest number of defaulters to date. However, only 4 of these 14 countries did not make a payment towards co-financing in 2013. The remaining 10 countries either co-financed their 2012 arrears or made partial payments towards their 2013 commitments. A consequence is a new trend of repeated defaults, where countries default because they have to pay their past arrears first. Gavi followed-up and worked with these 14 defaulted countries and at time of drafting this report, 11 of them had come out of default. The remaining 3 countries (Angola, Pakistan and Zimbabwe) have already made partial payments of their arrears and made commitments to fully pay them. In total countries transferred more than US\$ 75 million towards 2013 co-financing, a 20% increase on 2012.
- 3.17 Most countries are increasing their investments in immunisation (government expenditures on vaccines per surviving infants rose from US\$ 3.78 in 2010 to US\$ 4.28 in 2013). The principle of co-financing in Gavi is one reason for this increase in contributions. However, not all countries are yet fully financing the costs of traditional vaccines. Twenty two countries relied on external donors to finance the full cost of traditional vaccines in 2013. Most of these 22 countries are contributing to co-financing from their domestic resources. As Gavi is working on the long term sustainability and strengthening of EPI programmes the continued reliance on other donors to supply or provide vaccines remains an area of concern.
- 3.18 Gavi is implementing the new graduation approach approved in November 2013. Based on the new approach, graduation assessments were conducted in eight countries and graduation plans were developed to make best use of the new catalytic investments. The Board also approved an additional US\$ 2 million that was assigned to the World Bank. The re-engagement of The World Bank in this area of work will strengthen Gavi's support to graduating countries given the Bank's comparative advantage on issues related to graduation (e.g. leading policy on health financing, conducting macro-economic and cross-sectorial analysis, etc.), including with Ministers of Finance and/or Development.

Question for Board discussion: Given the need for early and systematic engagement with countries, how can we better engage and align all Alliance partners and donors to raise issues of financial sustainability, advocate for greater domestic investments (including in traditional

vaccines) and ensure a unified approach to vaccine financing in Gavi countries?

Cross-cutting issues

- 3.19 The Secretariat has been implementing the new Grant Application, Monitoring and Review (GAMR) approach in a phased manner. The primary focus in 2014 has been on the way the Secretariat reviews the progress of its grants, through the introduction of an in-country, multi-stakeholder Joint Appraisal and the cross-Alliance High Level Review Panel (HLRP) which replaces the monitoring Independent Review Committee (IRC). All countries have now been reviewed for renewal under this new approach. Lessons learned to date include the significant benefit of the in-country appraisal process, the particular value of it being aligned with existing in-country review and planning & budgeting processes, and the need to find the right approach to achieve a balance between conducting such appraisals at the appropriate frequency (which will be country-dependent) and the related increase in Secretariat, partner and country workload.
- 3.20 As part of the Secretariat's enhanced focus on stewardship and risk management, the Country Programmes Department has developed a major programme of work, which is being rolled out progressively as the various components are ready. The programme includes: bolstering the resourcing, staff allocation and country support model (e.g. risk-based country allocations, dedicated support for the three highest-risk/most complex countries, implementation of the 'Country Team Approach' to provide integrated, responsive cross-Secretariat support); implementing a holistic capability-building programme for Senior Country Managers (SCMs, formerly CROs) and other key Country Programmes staff; institutionalising enhanced, systematic risk-management processes; and rolling out new tools, systems and guidance to achieve more proactive, consistent, effective and efficient grant management.
- 3.21 The 2015 business plan for all Gavi implementing partners and for the Gavi Secretariat is being finalised and will be presented to the Board for approval in December 2014. The 2015 plan places a stronger focus on countries and specific deliverables and aims to move the Alliance further in the direction of bottom-up, country-driven and country-focused planning of technical assistance (TA). This is a first step towards a reworked business planning process for 2016 which has already begun.

4. *Review of key Alliance partner activities and issues (section submitted directly by WHO and UNICEF)*

- 4.1 Through support provided under the Business Plan, WHO and UNICEF provide continuous support to countries in all of the areas described above through their HQ, Regional and Country Offices. In particular, through ongoing support in vaccine decision-making, assessment of programmatic readiness, and implementation of immunisation services, WHO and UNICEF have assisted in achieving the substantial increase in the number

of Gavi-supported vaccine introductions. WHO and UNICEF have worked to improve national planning, both strategic comprehensive multi-year plans (cMYPs) and annual operational plans. Increasingly, it is anticipated that these country plans will constitute the basis of all partner interaction with countries. In eleven priority countries, WHO technical support has resulted in seven of these previously poor-performing countries increasing their coverage to above 70%. In four of these countries (CAR, Chad, Liberia and Nigeria) both coverage and equity continue to be unsatisfactory and WHO and UNICEF have ensured maximum synergy to address the identified bottlenecks and strengthen the EPI programme.

- 4.2 WHO and UNICEF EPI programmes are leading the Immunisation Systems Management Group (IMG) effort towards introducing IPV in all countries in advance of the tOPV-bOPV switch, through a very fruitful collaboration with the GPEI and Gavi. WHO is spearheading the Meningitis Vaccine Project (MVP), and together with UNICEF comprehensively supports MenA campaigns and the preparation of future introductions of MenA vaccine into the routine immunisation programmes of African Meningitis Belt countries. Additionally, UNICEF and WHO collaborate in the Measles-Rubella Initiative and work towards Measles elimination and Rubella control.
- 4.3 WHO and UNICEF support countries in the monitoring and periodic evaluation of their immunisation programmes, e.g. through EPI Reviews, Post-Introduction Evaluations (PIEs), Effective Vaccine Management Assessments (EVMS), Data Quality Audits (DQAs) and work towards a further alignment of these assessments and the subsequent updates of the cMYPs and other relevant national health sector plans. The WHO repository is increasingly used as the overriding information platform on operational aspects of Gavi-supported vaccine implementation.
- 4.4 The WHO and UNICEF Estimates of National Coverage (WUENIC), which are based on annually reported data in the Joint Reporting Form (JRF) form the basis of all coverage monitoring by international agencies at the global level, and are used by Gavi in categorising countries and making decisions on PBF. Many other components of the JRF are of value to Gavi, including the systems indicators, the district level coverage and vaccine use. For all Vaccines and Preventable Diseases (VPDs) targeted by Gavi, WHO has been providing technical assistance and oversight to countries in managing their VPD surveillance systems, including acute flaccid paralysis (AFP), measles, yellow fever and hepatitis B surveillance. In respect of the newer VPDs, the WHO-led Invasive Bacterial Disease (IBD) and rotavirus surveillance network has refocused its efforts and now collects and analyses case-based data from 66 quality-ensured clinical IBD sites in Gavi eligible countries for the ongoing monitoring of the impact of Gavi supported Hib and, PCV and 129 sites in Gavi-eligible countries to monitor the Rotavirus vaccine programmes.
- 4.5 WHO continues to assist countries in strengthening their Immunisation Technical Advisory Groups (NITAG) and has helped to increase the

number of fully functional NITAGs to 76 countries globally by the end of 2013. National regulatory agencies (NRA) Institutional Development Plans (e.g. India and Vietnam) are under continuous monitoring and updated quarterly. IDPs include recommendations and support to ease registration of WHO prequalified vaccines through abbreviated procedures, as well as recommendations to expand AEFI surveillance to monitor vaccine performance and increase public confidence in case of serious AEFI. The WHO prequalification of new vaccines continues to assist the Gavi Alliance with ensuring the provision of high quality and programmatically suitable vaccines.

- 4.6 WHO and UNICEF drive integrated VPD approaches through work towards implementing the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) in Zambia, Bangladesh and India and towards integrating cervical cancer and adolescent health approaches. In addition to the integrated community case management components of the GAPPD projects, an integrated approach to communication about VPDs and immunisation in general is promoted, leveraging vaccine introductions and child/family health days to mobilise and educate communities about “essential family practices” including routine immunisation to prevent pneumonia and diarrhea. WHO also works towards future integration of e.g. water, sanitation and hygiene (WASH) activities in advance of typhoid vaccine and vector control and treatment approaches in preparation for the use of malaria vaccines. WHO continuously re-assesses vaccination schedules and provides guidance on the administration of three or more simultaneous injections in light of IPV introduction.
- 4.7 In the Bill & Melinda Gates Foundation (BMGF) funded immunisation supply chain and logistics hub operated by WHO and UNICEF, Gavi has an expert group of technical support that advises and supports countries in the development of their vaccine logistics and management. WHO coordinates the development of new vaccines against Ebola Virus Disease and closely monitors the immunisation situation in the affected countries to support the necessary rebuilding of immunisation systems and the catching up of routine vaccination after the successful control of the epidemic.
- 4.8 It is of particular importance to note that in the first half of 2014 (6 months of data only), UNICEF procured the vast majority of vaccines and related equipment on behalf of most Gavi supported countries (approximately 280 million doses of vaccines and 306 million units of injection safety devices to the value of US\$ 608 million and US\$ 14,5 million respectively). For reference in the whole of 2013 the total was 520 million doses for 70 GAVI supported countries, a value of US\$ 985 million.
- 4.9 In 2014 UNICEF supported the planning and implementation of social mobilisation and communication activities for most Gavi-funded and other vaccination campaigns and 18 new vaccine introductions (2 dual intros, 4 PCVs and 12RVs). UNICEF used vaccine introductions as opportunities to

integrate messages about “healthy actions” or “essential family practices” for the prevention and treatment of pneumonia and diarrhoea within the overall package of communication support for PCV and RV introductions.

- 4.10 UNICEF, over the past two years, has been spearheading Gavi’s work to address inequities in the provision and uptake of immunisation services in ten countries with large inequities between the poorest and richest quintiles, to reduce inequities in immunisation. UNICEF does so through the analysis of inequities, identification of barriers and development of strategies, and complements the Gavi resources with its own substantial equity programming, the testing of innovative approaches and the scaling up of effective interventions.
- 4.11 In 2014, UNICEF piloted an approach in collaboration with governments in 4 countries to identify and remediate financing bottlenecks that hamper service provision and hence cause inequities and/or low coverage.
- 4.12 Finally, UNICEF and WHO serve as two of the main Gavi partners responsible for implementing Gavi’s immunisation supply chain strategy. Together, they have supported 30 countries in conducting Effective Vaccine Management assessments (EVMs) and supported the development of EVM improvement plans. UNICEF and WHO plan to refine and expand these efforts in 2015 and beyond while collaborating with new partners.

Question for Board discussion: On what specific issues would Board members like to hear directly from partners in future reports?

5. Risk implication and mitigation

- 5.1 Gavi is at risk of not achieving coverage and equity targets at the end of 2015. Partners and business plan resources are increasingly being targeted to address this shortfall. Most importantly, the improvement of the HSS guidelines for activities which will have direct impact on coverage and equity as well as the inclusion of intermediate indicators will enhance our ability to monitor results.
- 5.2 The quality of Country Programmes work, its ability to deliver against demands from active programmes that doubled in scope in 2 years and is foreseen to substantially grow in the next year, its ability to implement key changes (new Strategy, GAMR, strengthen the approach to support graduation, new Business Plan approach, etc.) and to focus on the most strategic areas (e.g. risk management) could be impacted by insufficient expansion of human resources compared to its rapidly rising workload.
- 5.3 A number of programmatic risks, such as AEFIs, co-financing, stock outs etc. and their mitigation actions have been identified throughout the work undertaken in the Country Programme Department. Detailed descriptions of the risks and their mitigation strategies are included in the Country Programmes update to the PPC attached to this paper.

6. Financial implications: Business plan and budgets

- 6.1 This report does not lead to financial implications beyond those described in the Programme Funding request and business plan budget that are being submitted to the Board.

SUBJECT:	COUNTRY PROGRAMMES UPDATE
Report of:	Hind Khatib-Othman, Managing Director, Country Programmes
Authored by:	Stefano Malvolti, Director, Vaccine Implementation; David Salinas, Director, Country Support; Alan Brooks, Director, Health Systems & Immunisation Strengthening; Santiago Cornejo, Head, Financial Sustainability and Graduation
Agenda item:	07
Category:	For Information
Strategic goal:	Affects all strategic goals

Section A: Overview

1. Purpose of the report

1.1 This report provides an update on Gavi Country Programmes.

2. Recommendations

2.1 This paper is for information.

3. Executive summary

3.1 Gavi continues to strengthen its coordination and management across the strategic goals (SG 1, 2, and 3) through systematic interactions between the Vaccine Implementation, the Strategic Goal 2 and the Immunisation Financing and Sustainability Management Teams. By creating opportunities for cross-management team participation and by encouraging improved dialogue between teams, immunisation-specific outcomes and harmonisation of initiatives within national plans are better ensured. The Secretariat also continues to reinforce its stewardship role in working with countries and partners to ensure there is stronger alignment to the country context and stronger harmonisation with other development partners.

3.2 To this effect the Country Programmes (CP) team has revised its structures. The Supply Chain Team is now embedded in the Health Systems and Immunisation Strengthening Team and the Financial Sustainability and Graduation team is now more closely tied to the CP Managing Director, a move that allows for speedier decisions and closer collaborations across the Secretariat and with partners.

- 3.3 CP has also reviewed its operating model and staffing with a view to improve its role as a first line of defence in managing fiduciary risk, including by seeking to ensure that the highest risk countries in the GAVI portfolio will ultimately be managed by one dedicated Senior Country Manager (SCM)¹ and that the burden of managing high risk countries will be more equally spread across SCMs.
- 3.4 By the end of 2014 Gavi is projecting to have completed in excess of 50 new vaccine introductions composed of up to 10 new HPV demonstration projects, up to 12 new campaigns and up to 36 new routine vaccine introductions. The Alliance continues to work on consolidating and sustaining its success of implementing vaccines, as we transition into the next strategy and an even greater focus on coverage and equity.
- 3.5 Ten new HSS proposals have been recommended for approval by the IRC for a total of US\$ 405 million since January 2014. Burundi and Lao are the first countries to benefit from HSS Performance Based Funding (PBF) payments. A growing evidence-base of results and analyses of HSS implementation will increasingly inform grant management and help identify bottlenecks to timely utilisation and activity completion. New HSS guidelines issued in February 2014 include requirements for data quality, coverage surveys, end-of-grant evaluations and procurement plans.
- 3.6 CP continues its strong engagement with key countries. In 2014, 3 countries entered the graduation process. Gavi and its partners are closely working with these countries to ensure a smooth transition from Gavi support over the next five years.
- 3.7 Gavi is also, through the Alliance partners at Headquarters and regional levels and through in-country partners, tracking and closely following the situation related to the Ebola crisis, particularly in Guinea, Liberia and Sierra Leone. A Cross-Secretariat team that is working on monitoring the situation in the most affected countries and that works on developing guidance to formulating a Gavi response has been set up.
- 3.8 The programmatic changes introduced under the redesigned Grant Application, Monitoring and Review (GAMR) approach have led to important improvements in the way the Secretariat manages and implements its grants in countries, including through the introduction of the annual in-country, multi-stakeholder Joint Appraisal and the High Level Review Panel (HLRP) which replaces the monitoring IRC. The new process has highlighted the need for greater alignment with in-country reviews and planning processes. It has also posed challenges, particularly in terms of increased workload of the Secretariat in general and the CP Department in particular as well as for Gavi partners.
- 3.9 Negotiations of the 2015 business plan for all GAVI implementing partners and for the GAVI Secretariat are well under way. The 2015 plan places a

¹ The Gavi Secretariat has formally changed the title of "Country-Responsible Officer" (CRO) to "Senior Country Manager" (SCM) and is actively phasing out the use of the term CRO.

stronger focus on countries and specific deliverables and aims at moving the Alliance further in the direction of bottom-up, country-driven and country-focused planning of technical assistance (TA). This is consistent with the aspiration that Business Planning for 2016 onward should generally be conducted in this way.

- 3.10 In addition to the targeted investments through the business plan to support coverage and equity improvements, the Alliance is also looking to strengthen routine immunisation through the full range of its support to countries and engagement with partners

4. Risk implication and mitigation

- 4.1 Please refer to the risk register regularly reported to the GAVI Board².

5. Financial implications: Business plan and budgets

- 5.1 This report does not lead to financial implications beyond those described in the Programme Funding request to be submitted to the Executive Committee.

Section B: Content

6. Gavi support to countries

- 6.1 This section first provides an update on the new grant review approach that has been introduced this year and details in particular the lessons learnt so far through the first wave of its implementation. It also provides an update on five of the most complex, highest-priority countries in the Gavi portfolio – Pakistan, India, Nigeria, the Democratic Republic of Congo (DRC) and Ethiopia – and features a country that has had noteworthy recent developments, Chad. A brief update is also provided on Country-Tailored Approaches.

New grant review approach

- 6.2 The new grant review process, which forms part of the Grant Application, Monitoring and Review (GAMR) reform, has been introduced this year. It is being implemented in a phased approach, both in recognition of the demands it places on existing, already-allocated resources, and to allow ongoing refinement of the design based on lessons learnt. The components introduced to date include:

- (a) A periodic review of recommendations on grant renewal by a High-Level Review Panel (HLRP) composed of senior staff from the Gavi Secretariat, WHO, UNICEF, and IRC members; and
- (b) A yearly appraisal which aims to assess the performance of all forms of Gavi support (Health System Strengthening [HSS] and all types of New

² See at myGavi: <https://beta.gavialliance.org/display/boardgroup/Performance+management>.

Vaccine Support [NVS]), identify challenges and opportunities, review future targets and suggest follow-up actions.³

- 6.3 These new components are a significant and promising shift from past practices: They provide an opportunity to strengthen linkages between HSS and NVS, and to bring together Alliance partners to review performance, consider support renewal, recommend follow-up actions to ensure strong implementation performance, and make the important link to technical assistance provision. Furthermore, when conducted in-country, the appraisal enables discussion of past and continued performance and necessary follow-up actions “in-context”, with more information than is usually available in Geneva, and in the presence of relevant partners who must take forward the actions.
- 6.4 To date the HLRP, under the chairmanship of the Gavi Deputy CEO, has reviewed 39 countries. The panel met twice, on 2 May and 23-25 July, and is scheduled to meet again on 27-29 October to review the remaining countries. The HLRP bases its discussions on country performance and recommendations for renewal on the appraisal report. In 2014, the appraisals have – for reasons of capacity – been implemented as a mix of in-country, multi-partner Joint Appraisals (for 11 countries to date in 2014) and remote Internal Appraisals (for 28 countries). The in-country Joint Appraisal is owned by the ICC/HSCC, facilitated by the Senior Country Manager (SCM, formerly CRO⁴) informed by the Annual Progress Report (APR) and includes inputs from country- and regional-level Alliance partners. The remote Internal Appraisal is conducted by an independent expert (based on a paper review of the APR), revised by the SCMs drawing on their country knowledge, and typically shared with partners at headquarters and regional level for comment and input.
- 6.5 The Gavi Country Programmes department has been central to the development and implementation of the appraisals. Lessons learnt from the appraisals and HLRP include:
- (a) The significant value, in terms of information gathering and multi-partner dynamics, of an in-country Joint Appraisal, and the strong appreciation by country stakeholders of the country ownership inherent in such a process;
 - (b) The large additional workload entailed for the Gavi Secretariat (especially for Country Programmes), partners (at headquarters, regional and country levels) and countries in organising and carrying out a Joint Appraisal. To this effect, the Secretariat will work to analyse the resource implications and to follow up with partners to prioritise the required support to appraisals through the Business Plan 2015. Linked

³ To complete implementation of the full, new GAMR approach, the appraisal will eventually be supplemented by an ongoing, routine programme monitoring function that builds on country mechanisms and by the tracking of a core set of standard indicators across all grants. Both of these will begin to be introduced in 2015.

⁴ The Gavi Secretariat has formally changed the title of “Country-Responsible Officer” (CRO) to “Senior Country Manager” (SCM) and is actively phasing out the use of the term CRO.

to this is the question of how many Joint Appraisals per year it is realistically feasible to conduct, which countries should have a Joint Appraisal at which frequency (with the idea of a differentiated approach), and what the alternative(s) to a Joint Appraisal should be (recognising that the Internal Appraisal model is not ideal and could be improved upon);

(c) The potential to refine appraisal tools and guidance to better support strategic discussions of renewal and make the link to concrete follow-up actions;

(d) The need to align appraisal timing (and, on the back-end, the number and timing of HLRPs) with in-country reviews and planning processes.

6.6 As a next step, the Secretariat is refining the design of the new approach for 2015 building on the lessons learnt. An 'Action Lab' has been planned for late September which will include participation from countries and Alliance partners at all levels, and will be an opportunity to gather lessons and suggestions to inform the refined 2015 approach. Work is also gearing up on other areas of the new approach, such as ongoing, routine monitoring.

Country Issues

Pakistan

6.7 In June 2014, the country revised down its DPT-3 immunisation coverage estimate from 94% to 66%, which is now in line with the most recent survey, the Pakistan Demographic and Household Survey (PDHS) 2012-2013.

6.8 Sindh and Khyber-Pakhtunkhwa provinces conducted the preventive measles SIA (supplementary immunisation activity) in May 2014. The post measles SIA coverage reports from Sindh and Khyber-Pakhtunthwa have yet to be finalised. The remaining provinces and areas plan to implement it between September and November 2014 (but should implementation not be achievable before the rains, it will have to be postponed until early 2015). Civil society organisations (CSOs) are participating in the social mobilisation activities to support a high-coverage SIA.

6.9 In June, the Federal EPI Programme was approved for the introduction of IPV. The nationwide introduction has been scheduled for June 2015, with the rollout in all provinces to take place over a 3-month period.

6.10 At the end of June, the Secretariat facilitated a high-level discussion between Global Polio Eradication Initiative (GPEI) global leadership, WHO Pakistan and Acasus, a DFID funded consultancy firm to the Government of Punjab to support strengthening routine immunization services. The analysis of the Government of Punjab-Acasus project highlights the need to address "last mile" challenges by improving supervision and oversight of vaccinators, using independent data to drive programme decisions and reducing the time vaccinators spend on special polio vaccination

campaigns. Innovations include providing GPS-enabled Android phones to vaccination teams to better monitor activities and designing alternative staffing arrangements of front-line routine immunization vaccinators to minimize the negative impact of frequent polio mass vaccination campaigns on routine immunization services. While still too early for results to be seen, the high political leadership, innovative thinking and improved collaboration with WHO polio staff on the ground provides both lessons and a possible model to be replicated within Pakistan and elsewhere.

- 6.11 Notwithstanding this progress, Pakistan continues to grapple with a confluence of factors affecting the immunisation programme. The ongoing political crisis is impacting the programme including the Global Polio Eradication Initiative; by the end of August, over 117 polio cases had been reported. The security situation is also affecting polio SIAs, which have not been able to be implemented in certain areas of Sindh and the Federal-Administered Tribal Areas.
- 6.12 Furthermore, Pakistan continues to be in default on its 2013 co-financing contribution due to a court case that found that the programme could not use UNICEF services to procure pentavalent vaccine. Should Pakistan remain in default at the time of the next Gavi Board meeting, they are at risk of having their vaccine support interrupted. At this point, Board members would decide whether to apply the default mechanism and interrupt support for the vaccines in arrears. The Federal Ministry of National Health Regulation Services and Coordination has actively pushed to resolve this situation and the current outlook is that the programme will comply with its 2013 co-financing commitment by December 2014.
- 6.13 At the margins of the World Health Assembly (WHA), the CEO and members of the Gavi Board held a high-level meeting with the Federal Minister of Health advocating for increased political commitment to immunisation. While highlighting that health is a fully devolved subject, the Minister committed to resolving pending issues including signing the Partnership Framework Agreement and releasing the US\$ 3.3 million HSS funds that remain with the State Bank of Pakistan.
- 6.14 The CEO and members of the Gavi Board subsequently planned a mission to Pakistan in September to follow up on the WHA discussion. Its objective was to discuss with key political leaders at federal and provincial levels, global partners and academia strategies to generate increased commitment to improve immunisation coverage. The mission also aimed to engage with provincial political leaders to explore the possibilities of subnational direct engagement. In light of the prevailing political situation, the mission has been postponed until the political situation is more stable. Other planned Pakistan missions include participation by the Gavi Secretariat in the National Immunisation Support Program appraisal mission led by the World Bank later this year, as well as a visit early November 2014 also aimed at the signing of the Partnership Framework

Agreement with the Economic Affairs Division, the Ministry of Finance and the Ministry of National Health Services and Coordination.

India

- 6.15 India applied successfully to Gavi in March 2014 for the national scale-up of its pentavalent programme. As part of this, impressive efforts are underway to ensure the preparedness for introduction of the vaccine in an additional twelve states scheduled for October 2014. Concerted efforts are being made through Alliance partners to ensure that India fulfils its commitment to introduce the vaccine in the remaining states in 2015 as planned.
- 6.16 The Government of India, in an exciting development, has announced the introduction of four new vaccines (rotavirus, IPV, MR, JE (adult)) as part of its Universal Immunization Programme, following a recommendation from the National Technical Advisory Group on Immunisation in early July 2014. The Ministry is currently working on resource implications to finance these vaccines and is expected to present a plan to the Mission Steering Group, a decision making body of the Indian government equivalent to the cabinet, later in the year.
- 6.17 The HSS grant (amounting to US\$ 107 million over 2014-2016) is being implemented since January 2014 under the leadership of Ministry of Health and Family Welfare (MoHFW) in cooperation with WHO, UNICEF and UNDP as implementing partners. Its objectives are to achieve improvements in:
- (a) Cold chain management and vaccine logistics (with UNDP and UNICEF);
 - (b) Behavioural change communication (UNICEF);
 - (c) Design of a national M&E framework (UNDP); and
 - (d) Leveraging the national polio programme achievements for routine immunisation (WHO).
- 6.18 The Joint Appraisal conducted in June 2014 has confirmed that good progress has been made during the first six months of implementation of the HSS grant, and that very promising developments are underway for all of the four objectives: for example a tender was launched in two states for an electronic Vaccine Intelligence Network, the national mass media plan for immunization was prepared and released in Quarter 2, and detailed national polio programme data was used to map 400,000 high-risk areas for the use in routine immunization. The MoHFW has demonstrated ownership and collaborated well with the WHO, UNICEF and UNDP.

Nigeria

- 6.19 The most recent WUENIC data report a significant improvement in DPT-3 coverage from 26% in 2012 to 58% in 2013, though these national

estimates mask the large regional and state variations within Nigeria. The completed rollout of the pentavalent vaccine with Gavi support contributed to the increase in coverage.

- 6.20 The most significant development since the last update is Nigeria's rebasing of its GNI per capita in July 2014. This has led to an advancement of Nigeria's date for entering Gavi graduation from 2018 to 2015. The Secretariat will work closely with partners and the country to adapt to this earlier date and put in place a plan for a smooth transition away from Gavi support over the next five years. This development may result in an influx of new vaccine applications in 2015, the final year during which Nigeria is eligible to apply.
- 6.21 While the Gavi graduation process (planned to commence in early 2015) will include a full assessment of routine immunisation financing, the Bill and Melinda Gates Foundation has already launched the process by engaging McKinsey to assist the National Public Health Care Development Agency (NPHCDA) in developing an immunisation financing forecast through 2020. The Gavi Secretariat has contributed significantly to this analysis and forecast. Its preliminary results are sobering, with the overall requirements of immunisation in Nigeria estimated at approximately US\$ 467 million for the year 2020. To put this in focus, there is currently only US\$ 13 million allocated to routine immunisation in the federal budget, though it is generally recognised that more is spent over the course of the year, cobbled together through various means. An analysis of fiscal space in Nigeria will be part of the graduation process. Furthermore, a high-level meeting led by the Minister of Finance is expected in September 2014 to discuss the forecast and a way forward.
- 6.22 The Country-Tailored Approach (CTA) will inform the graduation process, including by allowing Nigeria to apply for new vaccines in 2015 despite having a national coverage rate below 70% providing national financial sustainability can be ensured.⁵ Nationwide pentavalent vaccine introduction was completed in December 2013. This was rolled out in an 18 month period instead of the planned 3 year period. PCV is to be launched in November 2014. 4 million doses are available for 2014, and roll out is planned during 2014 – 2016. Work is also ongoing under the CTA to support the implementation of the National Routine Immunisation Strategic Plan (NRISP), including support to establish and roll out accountability frameworks for NRISP implementation at the state level, advocacy training for national and state stakeholders to increase funding levels and predictability for routine immunisation, and strengthening the coordination between polio and routine immunisation activities.
- 6.23 Work on finalisation of the Cash Program Audit continues, with the goal of finalising the report and findings by early October 2014. Progress was

⁵ To provide context for the consideration of future introductions, nationwide pentavalent vaccine introduction was completed in December 2013. It was rolled out in 18 months instead of the planned 3-year period. PCV is planned to be launched in November 2014, with roll out planned during 2014-2016.

delayed when the final visit to the country by the audit team in August had to be postponed due to the Ebola outbreak. In the meantime introductions have not been delayed, and attention has been given to continuing critical activities while at the same time continuing to exercise appropriate due diligence. One such critical activity is the strengthening of cold chain capacity through Gavi's HSS grant. This investment will ensure the country has sufficient cold chain capacity for the pending introductions of PCV (planned for November 2014) and IPV (December 2014).

DRC

- 6.24 Results from the recent Demographic Health Survey (DHS) published in May 2014 show a 2007-2013 decrease in infant mortality rate from 92 to 58 per 1,000 live births. Immunisation coverage has increased in general with a net decrease in dropout rates, although the survey also highlights significant variations between provinces. In this context, it is pertinent that the Gavi 'HSS2' grant for DRC recommended for approval by the IRC in July 2014 includes strategies aimed at improving coverage and equity.
- 6.25 In addition, implementation of the DRC Country-Tailored Approach (CTA), which started last year, has already enabled a number of positive developments:
- (a) For the first time in the history of DRC, following several high-level advocacy missions from Gavi and partners, the government has committed to finance traditional vaccines and to provide co-financing of Gavi-supported vaccines according to an agreed annual payment plan;
 - (b) DRC has placed high attention on data and allocated 20% of the HSS2 funds to improving data quality;
 - (c) Civil society organisations are more involved in HSS proposal development and implementation;
 - (d) The Gavi HSS2 proposal was developed through a participatory and inclusive approach to better harmonise with other donors' funding – including that of DFID, the World Bank, the Global Fund, the European Union and UNICEF – on topics of supply chain, human resources capacity, and the Results-Based Financing approach in partnership with the World Bank, which are being jointly implemented in selected provinces; and
 - (e) Financial management mechanisms are being strengthened with the implementation of the current health sector financing reform in DRC supported by partners; collaborative efforts by the Global Fund and Gavi are also contributing to strengthening fiduciary and programme management arrangements through joint funding of a fiduciary agent, a programme management unit (CAG in French) and an Internal Auditor position within the Ministry of Health. The contract of the current fiduciary agent has been terminated for reasons of performance and a new fiduciary agent is being recruited under improved legal and

performance-based-funding arrangements. The Global Fund and Gavi have also agreed to sign a joint letter which commits them to strengthen their collaboration on DRC. This reflects the organisations' shared sense of the value of coordinating, sharing information, and jointly pursuing effective use of funds and high impact in a high-risk country such as DRC.

- 6.26 Other activities have also contributed to improving immunisation performance: DRC has successfully completed integrated measles/polio campaigns in August which started in 2013. These campaigns used an integrated approach for planning, training, supervision, monitoring and evaluation to ensure complementarity and to optimise the use of available funds from different donors. This has greatly contributed to increasing immunisation results (polio-3 coverage increased from 58% in 2010 to 66% in 2013, and measles coverage from 67% to 72%) and to strengthening routine immunisation in the country.
- 6.27 Despite these positive trends on immunisation results, some challenges remain and have been highlighted during the Joint Appraisal conducted in DRC in July, which was integrated with the EPI mid-term review. Through this process, CTA measures and the HSS2 grant were used to address identified bottlenecks in supply chain system, availability of vaccines and vaccine financing sustainability. Efforts by parliamentarians with the support of Sabin Vaccine Institute to mobilise resources for immunisation at provincial level and advocate for increasing the immunisation budget also aim to ensure vaccine availability and sustain funding for vaccines and immunisation.

Ethiopia

- 6.28 Ethiopia is the second largest recipient of Gavi funds since inception. The introduction of a number of programs in 2013 (specifically measles SIA, Meningitis A campaign and rotavirus) brings the total Gavi investment value to the country to over US\$ 100 million in 2013, with Gavi currently supporting five antigens and a large HSS grant. The country has also been approved for IPV in 2014, with introduction planned in October 2015.
- 6.29 Immunisation coverage and data quality continue to be major challenges in Ethiopia. The 2012 Ethiopian National Immunisation Coverage Survey reported penta-3/DPT-3 coverage for 2011 of 65%. This is consistent with the rebased WUENIC data of 65% for 2011 (down from 87% in 2010 before the revision). WUENIC for 2012 is at 69% and at 72% for 2013, whereas administrative data report a much higher rate of 83% in 2013.
- 6.30 Following the release of the 2012 survey, which showed lower than expected performance, there was a strong political move that resulted in the establishment in 2013 of EPI as a programme under the Mother and Child Health Directorate (MCHD). A national Routine Immunisation Improvement Plan (RIIP) was prepared in 2013 on the basis of a regional situation analysis, laying the ground for radical measures such as targeted support to the lowest-performing geographical zones.

- 6.31 Ethiopia requested for Gavi's HSS grant to be disbursed to the Millennium Development Goal Performance Fund (MDG PF), a pooled-funding mechanism managed as a sector-wide approach by the Federal Ministry of Health (FMOH) using Government of Ethiopia procedures. The objective of the MDG PF is to provide additional support to the implementation of the Health Sector Development Plan (HSDP IV). The FMA conducted in 2012, jointly with the World Bank, AusAid, the Netherlands and USAID, concluded that by and large the MDG PF functions well and within the accountability framework of the HSDP. The planning and budgeting process is moving towards the objectives of "one plan," "one budget" and "one report." On this basis it was recommended that Gavi sign the Joint Financing Agreement (JFA), joining nine other development partners,⁶ with the caveat that a further reduction in the information gap on resource allocation and strengthening of the information flow were highly desirable.
- 6.32 While the monitoring framework of the HSDP includes a few immunisation performance indicators, the MDG PF has no particular focus on immunisation and adding this priority is a challenge for a donor such as Gavi with no in-country presence. Ethiopia is one of only two countries (the other being Nepal) where the Gavi HSS grant is disbursed to a pooled-funding mechanism, which has very different requirements in terms of approval cycle from the IRC/HLRP-based Gavi model, and a reporting system centred on the national health plan and not specifically on indicators relevant for Gavi. This requires intensive follow up by the Gavi SCM to ensure that an adequate funding allocation is made to immunization services, and the SCM's close review and input into the planning and reporting of the MDG PF.
- 6.33 A second HSS grant tranche of approximately US\$ 32 million was disbursed in Q1 2014, which corresponds to 80% of the country's requested amount, this grant being a Performance-Based Funding HSS grant. A possible performance payment will be discussed by the High Level Review Panel in October 2014.
- 6.34 As a member of the MDG PF, Gavi has been involved in the IHP+ evaluation in Ethiopia, which concluded that IHP+ principles are followed in Ethiopia and appear to provide a framework for continued progress on aid effectiveness. It also recognized the difficulty in accommodating funders that have reporting requirements on utilization of funds for particular diseases or areas, which is the case for Gavi and the Global Fund.

Chad

- 6.35 WUENIC estimates published for Chad in July 2014 show a general increase compared to 2013. Penta-3 coverage estimates increased from 33% in 2011 to 48% in 2013, although there is a 37% difference with the reported 85% administrative coverage in 2013. Challenges with the routine

⁶ UNICEF, Irish Aid, UNFPA, WHO, Spain, DFID, Italian Cooperation, AusAID and the Dutch Embassy.

administrative monitoring system are recognized and were highlighted during the Joint Appraisal integrated with the Chad Country-Tailored Approach (CTA) development process conducted in August 2014. This process recommended more efforts to improve recording and monitoring while also increasing coverage. As part of the Chad CTA, Gavi will jointly implement with the World Bank a Results-Based Financing approach to contribute to improving data quality as well as better harmonisation and synergy with the Global Fund in strengthening the health system. The EPI programme is part of the monthly monitoring meeting chaired by the Prime Minister on health issues including immunisation. This shows the political commitment at the highest level regarding immunisation and vaccines related questions.

- 6.36 Other strategies have been or are being put in place by different partners to support the EPI programme. Part of the Gavi HSS1 support of US\$ 2.07 million has been reoriented to support the EPI annual plan for 2013/2014 to ensure implementation of the Reach-Every-District approach in 10 health districts out of the 40 priority health districts. This is complementary to support provided by UNICEF and the Bill and Melinda Gates Foundation. New partners, including the local Lions Club branch, are also being more engaged by mobilising additional funds to enhance the efficiency of immunisation activities such as the measles campaign that will be conducted in October 2014.
- 6.37 Another challenge affecting immunisation coverage in Chad was highlighted by the Joint Appraisal: it relates to stock-outs for all antigens at the district level, which are mainly due to insufficient estimation of the needs. Gavi and the country are revising immunisation targets based on the new harmonised demographic figures provided by Chad in its Annual Progress Report submitted in May 2014 following the 2009 national census.
- 6.38 Despite all these efforts, Chad is threatened by the situation in neighbouring countries. This includes a wild polio outbreak in Cameroon and refugees arriving from South Sudan and the Central African Republic (CAR) due to the ongoing humanitarian situation in these two countries.

Country-Tailored Approaches

- 6.39 The Secretariat continues to work with countries and partners to identify packages of specific flexibilities to better support fragile countries; these are known as Country-Tailored Approaches (CTAs). Examples of flexibilities sought by a number of countries include assistance to improve country-partner coordination (e.g., Afghanistan), frontloading of HSS investments (e.g., South Sudan) and re-allocation of resources under established grants to facilitate utilisation (e.g. CAR).
- 6.40 Development and implementation of CTAs continue to progress. CTAs for DRC (see above) and CAR have been finalised and their implementation has begun. The implementation of the emergency CTA in CAR approved in March 2014 is ongoing and includes catch-up immunisation campaigns

up to 23 months old. The WUENIC figure of 28% for CAR released in July 2014 calls for the need to now move from an emergency plan to a longer-term tailored approach, and for more targeted and focused support by Gavi to the country. A reassessment of the Cote d'Ivoire situation concluded that this country needs high-level advocacy for financing of traditional vaccines rather than a CTA. The first draft for the Chad CTA was finalised, its main focus is on human resources and alignment of Gavi's HSS grant with the national immunisation plan to combine with other donor's grants.

7. Strategic Goal 1: The Vaccine Goal

- 7.1 Between the last update and 31st of August 16 new introductions have taken place: 1 in South Sudan for Pentavalent vaccine - now supported in all⁷ GAVI eligible countries - 2 for PCV, 8 for Rota, 1 for HPV, 2 for Measles Second Dose and 2 for Measles SIAs campaigns. Seven more introductions are expected in September including the first introduction of IPV with GAVI support, in Nepal.
- 7.2 Vaccination coverage progression is continuing steadily for the three main programs, which however remain behind target.
- (a) For Pentavalent vaccine the 53% estimate for 2013 marks a 10 point increase compared with 2012. By 2015 we expect the coverage to reach 69% (vs. 77% target);
 - (b) For PCV the coverage estimate at the end of 2013 was 21% (+12 points vs. last year) with a projection of 40% for 2015 (in line with the target);
 - (c) For Rotavirus the 2013 coverage was estimated at 7% with a projection of reaching 23% in 2015 (vs. 31% target) still largely affected by demand supply unbalances.
- 7.3 Gavi's investment in the Oral Cholera Vaccine (OCV) global stockpile started in July 2014. In total the Vaccine Alliance now supports 182 active⁸ programs in operation, more than double compared to January 2011 when the current strategic plan started. The level of activity is expected to further increase with the introductions of IPV and the scale up of the other programs, in particular Rotavirus and Measles.

⁷ This number refers only to the GAVI supported programs that are currently active: Routine programs, demonstration programs and stockpile. Campaigns are considered concluded, outbreak response funds are excluded.

⁸ The count comprises all vaccine programs active in countries for routine and demonstration with the exclusion of the two measles second dose supports already terminated (the support lasts 5 years). Campaigns are also not included since the support terminates with the completion of the campaign.

Table 1: Introductions to date by vaccine programme and type
(number of active/completed programs as per September 1st 2014)

	Routine	Demonstration	Campaign	Stockpile	Outbreak response fund
DTwP-Hib-HepB ^a	66				
PCV	42				
YF	17		13	1	
RV	32				
MCV ^b	12		10		1
MenA			12	1	
HPV	1	9			
OCV				1	
IPV					
JEV					
TOTAL	170	9	35	3	1

a. The data includes only active programmes supported by GAVI (PAHO and Ukraine introduced without GAVI support). b. Two countries introduced Measles Second Dose more than 5 years ago and programmes have since been discontinued.

Active programs in red, concluded or about to be concluded programs in blue.

- 7.4 The substantial increase in complexity has required improvement of the global coordination among partners to ensure streamlined support to countries. In alignment with the business plan, work has focused on four areas: (a) **Program sustainability** with strengthening of National Immunisation Technical Advisory Groups (NITAGs) and National Regulatory Authorities (NRAs) for improved detection, assessment and response of Adverse Events Following Immunisation (AEFIs); (b) **Program management and delivery** with improvement of application guidelines and stronger coordination among partners on delivering technical assistance to ensure smooth preparation of new vaccines introduction and rapid increase in coverage; (c) **Supply management** with work on near-term vaccine operational forecasts and streamlined roles and responsibility; (d) **Integrated approaches** with the establishment of platforms that can facilitate better integration of immunisation with other health interventions in particular for adolescent health and prevention of Pneumonia and Diarrheal diseases.

Pentavalent Vaccine (DTwP-HepB-Hib)⁹

Key programme statistics (programme start date 2001)

	Actuals	Forecasts		
	Programme start – 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	72	1	~11	~73
Coverage	53%	~56%	~69%**	~68%*
No. vaccinated ¹⁰	195M	~42M	~196M	~289M

* Number of countries in 2013 is actuals. Other data are forecasts. ** Coverage at the end of current Business Plan period reflects the coverage in 2015.

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.5 With the completion of introductions¹¹ in all 73 Gavi countries the Alliance is now fully focusing on increasing coverage levels. Key to approaching the 2015 target, will be the success in Indonesia and India which are still completing roll out in 2014. Indonesia started vaccination in their remaining states (90% of birth cohort) in May 2014. India has rolled out across 15% of the country and work is on-going to complete the next phase in Oct 2014 (50% of cohort) and April 2015 (final 35% of cohort).

7.6 Several initiatives to achieve coverage increase and program efficiency are being considered; among them two have progressed the most:

- (a) Use in the same country of two different vial sizes - 1 dose and 10 dose vials presentation – with the goal of reducing missed opportunities in remote settings and outreach activities as well as optimising wastage levels.¹² An initial study has now started in Kenya with the support of an external consulting agency¹³. Results are expected in Q1 2015 and should help inform country decisions about the practicality and potential benefits of using a mix of presentations.¹⁴

⁹ Pentavalent vaccine refers to countries receiving GAVI support for Pentavalent vaccine and does not include countries receiving only Hepatitis B or only Hib vaccine support.

¹⁰ Estimates include number vaccinated with GAVI direct and catalytic support.

¹¹ With South Sudan, which introduced in August 2014, all GAVI 73 countries have introduced penta, However Nigeria only completed their phased roll out in Dec 2013, Indonesia commenced the roll out in the remaining 90% of the birth cohort in May 2014, and India should introduce in 11 states in October 2014 and the remaining 15 states in April 2015, once coverage of penta reaches the level of DPT-3 then roll out can be said to be completed.

¹² Low dose presentations can result in lower wastage and improved coverage, due to less reluctance to open vials in small session sizes. 10-dose-vial presentations have a lower cold chain footprint and price per dose, but higher wastage.

¹³ John Snow International.

¹⁴ Interest has been seen from a small number of countries (GAVI and non GAVI) in using a mix (1ds and 10ds) of presentations in their pentavalent program.

- (b) Annual assessment of wastage rates for the 10 dose Pentavalent presentation is providing countries with a wastage rate benchmark. The 2013 performance confirms the 15% average level established in 2012 and 2011. Countries with wastage above this rate will be provided TA to consider adoption of the multi-dose vial policy.¹⁵ The analysis of the 2013 progress reports supports the continuation of the usage of a 15% wastage benchmark in lieu of the 25% historically being recommended for NVS application and program renewal.

Pneumococcal Conjugate Vaccine (PCV)

Key programme statistics (programme start date 2010)

	Actuals	Forecasts		
	Programme start – 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	38	~9-12	~54**	~57**
Coverage	19%	~31%	~40%*	~40%*
No. vaccinated ¹⁶	26M	~23M	~80M	~80M

* Number of countries in 2013 is actuals. Other data are forecasts. ** Coverage at the end of current Business Plan period reflects the coverage in 2015.

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

- 7.7 The scale-up of the PCV programme continues. Out of 57 approved countries, 42 have introduced PCV. Eight countries are still expected to introduce this year, including two large countries – Nigeria and Bangladesh. If all introduce as planned, it would mark the important milestone of 50 introductions by year-end.
- 7.8 2013 WUENIC¹⁷ coverage data estimate that many countries have rotavirus last dose coverage lagging behind DPT-3 coverage after the first full-year of introduction, as previously seen with the early adopter Latin American countries where more time was required to close the gap. Ghana and Rwanda are exceptions. The lower coverage may be due to the implementation of age restrictions previously recommended by SAGE. Corrective action will be addressed by Alliance Partners.
- 7.9 The supply situation for both PCV10 and PCV13 has remained stable. Manufacturers are continuing scale-up of production as planned and are contracted to deliver a total of 140 million doses by 2015, demonstrating a key objective of the AMC framework in having this unprecedented supply scale up in just 5 years. Development of a preserved 4-dose vials to adapt to GAVI countries' needs to minimise storage requirements is also in progress with both producers.

¹⁵ Most countries using the 10ds vial are using the mdvp - the exceptions are a few Asian countries including Indonesia.

¹⁶ Estimates include number vaccinated with GAVI direct and catalytic support.

¹⁷ WHO and UNICEF Estimates of National Immunization Coverage.

Rotavirus Vaccine (RV)

Key programme statistics (programme start date 2008)

	Actuals	Forecasts		
	Programme start – 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	18	~14-16	~38	~42
Coverage	7%	~16%	~24%*	~24%*
No. vaccinated ¹⁸	9M	~12M	~38M	~39M

* Number of countries in 2013 is actuals. Other data are forecasts. ** Coverage at the end of current Business Plan period reflects the coverage in 2015.

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.10 The rotavirus vaccine programme is in the midst of its most significant growth period, with 14 countries having introduced the vaccine this year, and two more to follow in the last quarter. This brings the total number of introductions to date to 32, out of 39 approved countries. The current projection for the total number of country introductions by 2015 is 42, which exceeds the target of 33. The coverage target is not met, however, due to supply-demand imbalances that have affected the programme since the beginning.

7.11 2013 WUENIC¹⁹ coverage data show that many countries have rotavirus last dose coverage lagging behind DPT-3 coverage after in the first full-year of introduction, as previously seen with the early adopter Latin American countries where more time was required to close the gap. Ghana and Rwanda are exceptions. The lower coverage may be due to the implementation of age restrictions previously recommended by SAGE. Corrective action will be addressed by Alliance Partners.

7.12 Product preference imbalance, due to differential programmatic suitability, remains high, which contributes to the continuing supply constrained situation for the 2-dose schedule vaccine. The situation risk worsening in the near future because of the uncertainty of large countries' - Nigeria, Pakistan, Bangladesh and DRC – planned timing for introduction of rotavirus vaccine and likely product choice.²⁰

¹⁸ Estimates include number vaccinated with GAVI direct and catalytic support.

¹⁹ WHO and UNICEF Estimates of National Immunisation Coverage.

²⁰ See Market Shaping paper for more details on long term supply demand balance.

Human Papillomavirus (HPV) Vaccine

Key programme statistics (programme start date 2013)

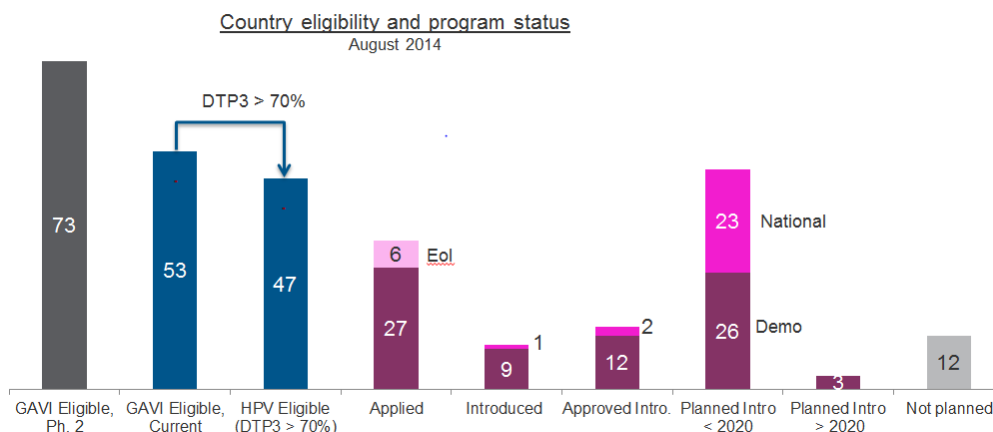
	Actuals	Forecasts		
	Programme start - 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	9 demo 1 national	~10 demo ~1 national	~25 demo ~2 national	~25 demo ~2 national
No. vaccinated ²¹	~<0.1M	~0.2M	~1M	~1M

* Number of countries in 2013 is actuals. Other data are forecasts.

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.13 Countries' interest in the HPV programme remains high: 33 out of the 47 GAVI countries that meet the DPT-3 70% coverage required to be eligible for the HPV program have expressed interest in the programme, and 10 of them have introduced the vaccine, most using the Demonstration pathway to be followed by a national roll-out within 2-3 years. Rwanda introduced the first national HPV immunisation with GAVI support in May 2014, targeting 161,732 girls.

Chart 1: HPV Country eligibility and programme status



7.14 In the first half of 2014 Mozambique, Niger, Tanzania introduced HPV demonstration programmes, targeting 37,218 girls. Six more demonstration programmes are scheduled to launch in Cameroun, Cote d'Ivoire, Gambia, Mali, Senegal, Togo and Zimbabwe during the second half of 2014.

7.15 The simplified 2-dose schedule recommended by the WHO's Strategic Advisory Group of Experts (SAGE) in April 2014 has been reflected in the

²¹ Estimates include number vaccinated with GAVI direct and catalytic support for both demonstrations and national programmes.

updated GAVI HPV programme application guidelines, and even before this updated guidance was already considered for adoption by the largest majority of countries.

7.16 The demonstration project approach has proven very useful to countries and the GAVI Alliance more broadly, since it has enabled a learning by doing approach focused on smaller geographical areas to help improve operational processes in advance of national roll-out. Initial informal country coverage reports from the demonstration programmes are encouraging, but await confirmation from population based coverage surveys that will be available toward year end. Initial lessons are able to be learnt while countries and partners look carefully at the first months of implementation. In particular the following areas have emerged: the need for early planning and for a precise count of the number of girls targeted; strong coordination with the education sector; and budget assumptions reflecting the demonstration nature of the project and learning about specific delivery strategies.

Inactivated Polio Vaccine (IPV)

Key programme statistics (programme start date 2014)

	Forecasts		
	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	~1-3	~71	~71
No. vaccinated ²²	~0.6M	~27M	~27M

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.17 The number of countries applying for IPV is scaling up rapidly. A further 16 countries applied for IPV in May 2014. This brings the total to 27 applications submitted, which were all recommended for approval with comments by the Independent Review Committee. The rapid scale up of applications is expected to continue with approximately 30 applications anticipated by the 15th September deadline. The first IPV introduction is expected in Nepal in September 2014, less than a year after the November 2013 Board decision to support IPV. The IPV programme is on track to receive the applications by all 71 countries by mid-2015.

7.18 In August 2014, GAVI hosted a meeting of the Immunisation System Management Group (IMG).²³ The regions reported significant progress and all of the GAVI-supported countries are currently expected to meet the Endgame Strategy’s end 2015 deadline for IPV introduction. The IMG also discussed plans for the withdrawal of type 2 OPV, implemented through a

²² Estimates only include direct support (Ukraine and India are not forecasted to receive GAVI support).

²³ The IMG is the group responsible for coordinating the work under the Endgame Strategy’s Objective 2, which aims to achieve Introduction of IPV, discontinuation of tOPV and replacement with bOPV and strengthening RI using Polio resources.

globally synchronised switch from trivalent OPV (tOPV) to bivalent OPV (bOPV) scheduled for April 2016. The IMG's workplan will include an in-depth assessment of the actions required to minimise the likely disruption to routine immunisation programmes in the 144 countries currently using OPV.²⁴

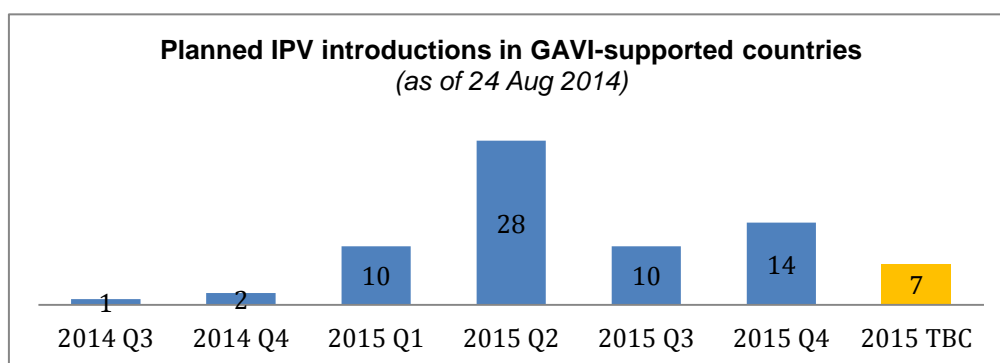
7.19 The balance of supply and demand is currently being reviewed due to a number of recent changes:

- (a) A recent reduction in IPV supply for 2014-2015 due to delayed scale-up of the 10 dose vial production, as well as a delay in the prequalification of the 5 dose vial. The latter has led Bangladesh to postpone introduction from Q4 2014 to Q2 2015;
- (b) WHO is currently evaluating applicability of the multi-dose vial policy to IPV which would allow use of the opened vaccine vial in subsequent sessions resulting in significant reductions of the wastage;
- (c) Should a supply gap be confirmed following the review, the IMG will provide a recommendation to the Polio Steering Committee on principles for prioritisation of the available supply. It is not currently anticipated that the reduction of supply would prevent the achievement of the Endgame's objective regarding IPV introduction;
- (d) There have been some initial reports of countries postponing other applications or introductions in order to prioritise work on the IPV application or introduction plans. The Secretariat and partners have agreed to document this, monitor the situation and provide additional support to countries to mitigate the impact where required. It should be noted that very few countries have opted for joint introductions of IPV with another new vaccine. For instance Nepal has chosen to first introduce IPV and delay PCV introduction by a few months in order to better manage the workload. Case studies of countries that have successfully introduced two vaccines at the same time (Tanzania and Ghana) were produced and shared with countries but so far this does not seem to have led other countries to follow the same approach;
- (e) Some countries have shared concerns with respect to the administration of more than 2 injections in the same session. For this reason Nepal is in the process of implementing a change in schedule moving the 3rd dose of PCV to 9 months of age. Preliminary insights from research work coordinated by the WHO in South Africa indicate that caretakers seem to have minimal concerns for the event of a 3rd injection. Caregivers seem to be more concerned, but this is because they think parents are concerned. Work is starting for better information and training so to avoid that countries implement changes in the schedule not based on solid evidence;

²⁴ As of August 2014, there are 121 tOPV only using countries, 23 sequential IPV/OPV using countries.

(f) Progress has also been made in the routine immunisation strengthening aspects of the Endgame Strategy. With regard to the two primary indicators of the Endgame related to RI strengthening, eight of the ten focus countries have developed an integrated EPI plan with explicit convergence of RI and polio resources (exceptions: Afghanistan and Somalia) and the percentage of under-vaccinated children with DPT-3 has decreased by greater than 10% in 2 of 10 focus countries (WUENIC 2012 vs. 2013; countries are Angola and Nigeria). In addition, IMG grants have been applied for and disbursed to WHO and UNICEF polio networks in focus countries to assist the transition to broader immunisation support. Currently, the Gavi Secretariat is working with the IMG RI and Communications subgroups to develop immunisation strengthening messages and advocacy talking points across partner institutions.

Chart 2: IPV introductions planned by quarter



Yellow Fever Routine and Campaign Programmes

Key programme statistics (programme start date 2010)

	Actuals	Forecasts		
	Programme start – 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries				
(campaign)	13	~1	~7	~16
(routine)	17	0	~2	~19
No.vaccinated ²⁵				
(campaign)	71M	~7M	~35M	~84M
(routine)	70M	~8M	~41M	~90M

* Number of countries in 2013 is actuals. Other data are forecasts.

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.20 By the end of 2014, mass campaigns will have been organised in 14 WHO designated “high-risk” countries in Africa²⁶ with 8 of those having covered

²⁵ Estimates include number vaccinated with GAVI direct and catalytic support.

their entire territory,²⁷ reducing yellow fever burden by 56%. Sudan is planning to start its first mass campaign in the last quarter of 2014. Nigeria conducted its first mass campaign in 3 states in 2013 reaching an estimated population of 9 million; the phase 2 mass campaign has been currently postponed to 2015 as a result of the yellow fever vaccine supply constraints.

7.21 As of 2013 all 13 “priority A” and 4 “priority B and C” countries have introduced yellow fever into their routine immunisation.²⁸ Coverage, however, remains low with 10 countries reporting less than 80% even after having conducted successful mass campaigns.²⁹ No new applications for routine immunisation have been received by GAVI since 2009.

7.22 The current supply situation has slightly improved after suspension of one of the two previously suspended manufacturers was lifted at the end of March 2014. This resulted in additional vaccine availability to support Sudan to introduce its first mass preventive campaign during the last quarter of 2014. However one of the 4 WHO prequalified vaccines is still suspended and the supply situation continues to be tenuous.³⁰ The Alliance partners are working closely together to monitor and prioritise countries to limit risk of disruption of routine immunisation.

Meningococcal A Conjugate Vaccine – Campaign Programme

Key programme statistics (programme start date 2010)

	Actuals	Forecasts		
	Programme start – 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	12	~4	~14	~17
No. vaccinated ³¹	153M	~66M	~244M	~263M

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.23 So far, twelve of the 26 endemic countries of the meningitis belt have received GAVI support for mass campaigns reaching a population of 153 million people aged 1-29 years, covering approximately 80% of the at risk population in those countries. Ivory Coast, Togo and Mauritania are expected to run campaigns in 2014 and South Sudan will now introduce in

²⁶ WHO defines "A" risk countries (n=13) as those reporting ≥ 2 yellow fever outbreaks in the previous 30 years; "B" risk countries (n=12) are countries reporting at least one YF event in the previous 50 years and with evidence of yellow fever virus circulation. 'C' risk countries (n=9) are historically endemic but have not reported an outbreak in the last 50 years.

²⁷ Source : WHO 2013 report Addendum to the strategic Framework for Yellow Fever Immunisation Initiative in Africa 2012-2020.

²⁸ WHO/UNICEF- A Strategic Framework for the Yellow Fever Immunisation Initiative 2012-2020

²⁹ WHO report 2013 (data as of 16-Oct-2013).

³⁰ See the Market Shaping paper for more details on long term supply demand balance.

³¹ Estimates include number vaccinated with GAVI direct and catalytic support.

early 2015.³² Nigeria and Ethiopia will continue their phased campaigns. The last 9 countries are scheduled to introduce in 2016. By then, the Alliance will have reached all 26 countries in the meningitis belt with a total of 263 million individuals vaccinated.

- 7.24 The impact of the Meningitis A Conjugate vaccine has been significant, with outbreaks of serogroup A reduced dramatically in all vaccinated countries. No new cases of meningitis A serogroup have occurred in the vaccinated districts after the campaigns.³³
- 7.25 The WHO prequalification of a paediatric indication for the conjugate Meningitis A vaccine is expected by December 2014 and will kick-start the initiation of the second phase of the programme with introduction into routine programme of the vaccine. Six countries are expected to start routine immunisation and mini catch up campaigns in late 2015. To keep the momentum and strengthen coverage and protection, all 26 endemic countries plan to introduce the vaccine into routine immunisation by 2017.
- 7.26 The Meningococcal A Conjugate Vaccine was developed to meet the needs of Africa's meningitis belt, and can be kept in a Controlled Temperature Chain (CTC) at temperatures of up to 40°C for up to four days. This technical innovation could help increase campaign efficiency and coverage and could save funds normally spent on maintaining the challenging cold chain facilities.

Measles and Rubella-Containing Vaccines

- 7.27 The GAVI Alliance currently supports measles and rubella immunisation with a mix of interventions: 1) wide age Measles-Rubella catch-up campaigns aimed at catalysing countries' introduction of the vaccine into the routine programme, replacing measles vaccine; 2) routine measles second dose support for a period of 5 years; 3) measles supplementary immunisation activities for 6 large countries at risk of outbreaks; and 4) outbreak response fund to Measles & Rubella Initiative.
- 7.28 The security of vaccine supply across all Measles containing vaccines remains risky, with the one producer pre-qualified for MR also being the largest manufacturer of Measles vaccine. It also seems certain that India will also be introducing MR vaccine into the country through a wide age catch-up campaign which could have significant impact on the global supply. A supply coordination group with the participation of all key Alliance partners has been working together to ensure better coordination and prioritisation of supplies and shipments. Efforts are also underway to encourage new entrants into the MR market.³⁴

³² Guinea was also planned for 2014 but is now reconsidering its plan in view of the Ebola outbreak.

³³ Joint WHO/UNICEF Progress Report January – December 2012, Meningitis A Conjugate vaccine Immunisation Campaign.

³⁴ See Market Shaping Update for more details on the long term supply demand balance.

Measles Second Dose

Key programme statistics (programme start date 2007)

	Actuals	Forecasts		
	Programme start – 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	11	~2-3	~20	~22
No. vaccinated ³⁵	16M	~7M	~28M	~34M

* Number of countries in 2013 is actuals. Other data are forecasts.

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.29 From January 2014, two additional countries have introduced measles second dose into their routine system (Tanzania and Senegal) bringing to 13 the total number of countries who have introduced a measles second dose into the routine programme with GAVI support.

7.30 In line with the WHO position papers on measles and rubella, the criterion for GAVI's application for measles second dose has been tightened to MCV1 coverage of 80% for 3 consecutive years whereas previously the requirement was for 1 year. This means that Nigeria will not be able to apply for measles second dose as they will be graduating before their MCV1 coverage reaches 80%.

Measles Supplementary Immunisation Activities (SIAs)

Key programme statistics (programme start date 2013)

	Actuals	Forecasts		
	Programme start - 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	3	1-2	~6	~6
No. vaccinated ³⁶	*	~23M	~70M	~70M

* Number of countries in 2013 not available. Other data are forecasts.

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.31 Ethiopia's SIA has shown an administrative coverage of 98% and coverage survey estimate shows 91% coverage. In spite of this positive result, outbreaks are still ongoing in Ethiopia, highlighting the challenges faced by countries in terms of determining target age groups to vaccinate, reaching >95% coverage and making decisions on next steps.

7.32 Nigeria, achieved 104% administrative coverage, reaching 30.5 million children under 5 years of age.³⁷ This campaign was reported to have

³⁵ Estimates include number vaccinated with GAVI direct and catalytic support.

³⁶ Estimates include number vaccinated with GAVI direct and catalytic support.

³⁷ 2013 IMC Nigeria report.

reached 24% of children who were never vaccinated before and conducted together with a polio campaign. Although an independent evaluation has not yet been conducted, an independent monitoring showed an overall coverage of 92% with 9 states recording more than 10% missed children.³⁸

- 7.33 DR Congo is conducting phased nationwide campaign for children under 10 years of age with GAVI support and other donors such as Measles & Rubella Initiative. The SIA is in its final stage.
- 7.34 Pakistan conducted measles SIA in two states, Sindh and Khyber Pakhtunkhwa in May 2014 with a 6 month delay to the original plan. The postponement was due to changes in governance and management structures. The campaign encountered some challenges due to some serious AEFIs, reportedly from programmatic errors. Pakistan aims to continue the next phases of the campaign in remaining provinces in the coming months. Results in terms of coverage are pending.
- 7.35 Chad conducted its first of the 2-phased national, under-10 years old measles campaign in June 2014. The campaign was brought forward by four months to tackle an on-going measles outbreak. GAVI coordinated closely with M&RI providing intensive technical support. Early indications for the first round give an administrative coverage of 103% reaching 2.44 million children 6 months to 9 years of age. Post campaign coverage survey results for the first phase are awaited. The second phase will be conducted from 13-19 October.
- 7.36 Afghanistan has been approved for an under 5 year old measles SIA planned for February 2015.
- 7.37 In general, countries have reported that routine immunisation strengthening activities were carried out as part of the campaigns, such as social and physical mapping, identification of hard to reach areas, initiation of EPI improvement plan, national cold chain inventory prior to implementation of campaign, intense social mobilisation activities incorporating routine EPI messages, and cascaded training to lower level on vaccine stock and management, surveillance, recording and reporting.

³⁸ 2013 IMC Nigeria report.

Measles Rubella

Key programme statistics (programme start date 2013)

	Actuals	Forecasts		
	Programme start - 2013	Year 2014	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries ³⁹	4	~4-6	~20	~20
No. vaccinated ⁴⁰	26M	~120M	~192M	~192M

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.38 In January 2014, Bangladesh conducted a nationwide MR campaign for children 9 months-14 years, reaching over 53 million children. This brings the total number of countries that have conducted MR campaigns with GAVI support to 5 since the round opening in 2012. Viet Nam, which had planned to conduct the campaign in the last quarter of 2013, faced challenges with registration of the vaccine. This was recently resolved with an active role of the Alliance, and the country will conduct the campaign starting in August 2014.

7.39 Tanzania, Burkina Faso, Yemen and Myanmar will also conduct MR campaigns in the remaining months of 2014. Solomon Islands, which had planned for an under 15 MR campaign will be conducting an under 30 MR campaign with GAVI and M&RI support in 2014.

Japanese Encephalitis

Key programme statistics (programme start date 2013)

	Year 2014	2011-2015 (Strategy Period)	2014– 2015
No. of countries	0	1	1
No. vaccinated		~ 1M	~ 1M

All forecasted data are subject to changes as consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions

7.40 Following the opening of a funding window for Japanese Encephalitis (JE) in November 2013, Lao PDR was the first country to apply for Gavi support for JE. Following its review, the IRC recommended the application for approval. The first GAVI supported campaign is planned for March 2015. Cambodia submitted an Expression of Interest and is expected to apply in the September round for a JE campaign in January 2016.

³⁹ Two countries, Nepal and Lao PDR received vaccine introduction grant from GAVI to introduce MR into routine.

⁴⁰ Estimates include number vaccinated with GAVI direct and catalytic support.

- 7.41 Information on other countries' introduction remains uncertain at this stage although the JE bi-regional meeting held in Bangkok 27-29 May 2014 provided a good opportunity to engage with countries at risk and discuss next steps in their JE control plans. Follow up meetings are planned in a number of countries including Bangladesh and Myanmar. Early discussions with those two countries indicate their interest in conducting JE campaigns in phases, allowing an early introduction in the at-risk areas already identified whilst improving surveillance systems in the remaining areas. The JE sub-team is looking into the programmatic implications for Gavi and countries. An update on this question will be provided for the next PPC.
- 7.42 SAGE will be issuing updated recommendations on JE in its upcoming meeting which may lead to adjustments of the Gavi programme although no major changes are expected.

Cholera

- 7.43 Gavi's investment in the global Oral Cholera Vaccine (OCV) stockpile officially started on 1 July 2014. A Memorandum of Understanding was signed with the WHO for the procurement of 2 million doses for the July 2014 to July 2015 period. After this time UNICEF SD will become the procurement agent for the OCV stockpile.
- 7.44 In terms of demand, to date, the International Coordinated Group (ICG) has approved the deployment of OCV in four occasions: in South Sudanese refugee camps in the Republic of South Sudan in February 2014 and in Ethiopia in August 2014, in Guinea as reported in the last PPC update and more recently in Nepal which is the first Asian country to access OCV through the global stockpile. The integration of OCV as a cholera control measure remains new and unknown. As the vaccine gets used more widely showing its impact, demand will continue to increase. A regional meeting on OCV use with Anglophone African countries was also planned in October 2014 but is postponed due to the current Ebola outbreak.
- 7.45 In consultation with the VIMT Cholera subteam, and in line with the objectives stated during the Vaccine Investment Strategy, OCV deployment through the global OCV stockpile will focus on providing a response to all cholera outbreaks through reactive campaigns in response to emergency outbreaks, pre-emptive campaigns in humanitarian crises (e.g., refugee situations, national disasters) as well as, where possible, pre-emptive vaccination in epidemiologic cholera hotspots, i.e. geographically localised areas within endemic countries overly affected by cholera, in terms of frequency and severity of cholera outbreaks. Hotspots may be implicated as starting points in periodic outbreaks and facilitating transmission to wider geographic areas and populations. Identifying target populations in these specific areas will provide an indication of possible demand for the vaccine which will contribute to meeting the market shaping objective. WHO identified hotspots in six

countries in Africa while the collection of data in the EMRO and SEARO regions is on-going.

- 7.46 In addition, a recent update on production capacity indicates that supply availability from the current supplier will be much lower than anticipated for the 2014-2018 period. This will on one hand limit the availability of vaccines to improve the evidence base on OCV use and on the other hand prove difficult for Gavi to meet its market shaping objective. However this should not impact Gavi's ability to conduct studies to inform the next VIS.

Immunisation Decision Support

- 7.47 With the steady increase in implementation work, the Gavi Secretariat, through the Information Management and Quality Assurance team, is on track with last year's numbers of programmatic activities. As of the end of July 2014, the team has prepared more than 400 programme updates, submitted over 70 individual payments for Vaccine Introduction Grants, Operational Costs and Health Systems Strengthening, validated more than 130 Cash Transfer Notices⁴¹ from UNICEF SD containing more than 500 individual vaccine and device shipment lines, and created more than 150 Decision Letter Annexes.
- 7.48 Efforts have been concentrated on improving the accuracy and efficient flow of information utilised by the Alliance in its financial and operational management of grants and programmes. These include:
- (a) Work is progressing on automating key processes used by the Secretariat;
 - (b) A greater emphasis is being placed on transparency, quality assurance and risk management;
 - (c) Working with the Information Technology department, development of the Country Programmes intranet knowledge space has begun, tying in information, knowledge sharing and processes.
- 7.49 A stronger linkage has been established between programme operations and data, in particular with respect to:
- (a) The challenge of precise short term data on forecasts of doses, stock levels and overall programme performance assessment of countries. This has been tackled in a more integrated fashion with a new tool which is being piloted to look at historical and real time vaccine utilisation providing programme performance allowing more solid evaluation on dose requirements;
 - (b) Refinement of 2014 dose calculations through more in-depth discussions with countries about their dose requirements. As a result, the overall demand for Pentavalent was increased by 2 million doses

⁴¹ Tool used to request funding from GAVI for procurement based on decision letters, issued by country by vaccine by year (programme code).

with 6 countries decreased and 18 countries increased. From the suppliers' perspectives, as the reductions happened to be in mainly countries with a preference for 1ds, there was a 23% reduction in 2014 contracts.

Supply Chain

7.50 The Gavi supply chain strategy approved in June 2014 is reported on as part of SG1 deliverables while having significant implications for Gavi's other strategic goals. This is consistent with efforts by the Alliance partners to manage work under the SG's in an integrated fashion. The supply chain taskforce has been working to establish an implementation plan which will show how the supply chain work fits within the broader Gavi goals today and in anticipation of the Gavi 2016-2020 strategy.

7.51 A number of global-level activities are already underway and early accomplishments include:

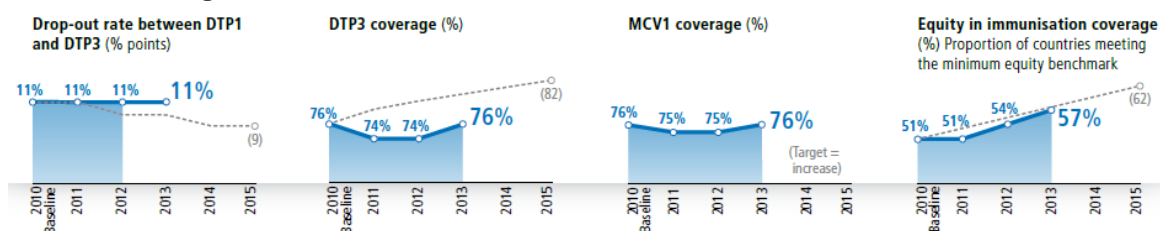
- (a) A landscape analysis and compendium of existing indicators and supply chain management measures has been developed as part of the work to provide guidance to countries on supply chain dashboard development;
- (b) A feasibility study on country utilisation of vaccine barcodes has been conducted by PATH in Tanzania;
- (c) Planning missions have been completed by WHO in support of CTC delivery of Meningitis A vaccine campaigns this fall in Togo, Cote d'Ivoire, and Mauritania;
- (d) The WHO Performance, Quality, and Safety (PQS) group have published target product profiles for advanced solar direct drive refrigerators and WHO has launched a product review section on the TechNet website to help facilitate better feedback from users of cold chain equipment;
- (e) UNICEF and WHO are well into development of a new country support package for cold chain procurement, as well as at least seven new guidance documents for countries on supply chain subjects, including use of temperature monitoring in the cold chain, and preventive maintenance systems for equipment;
- (f) A group including UNICEF, GAVI, CHAI and PATH is working to better forecast cold chain equipment demand.

7.52 Also since the last Board meeting, an independent committee has reviewed applications to the GAVI Supply Chain Fund, supported by the ELMA Foundation and DFID matching fund. The review committee has recommended funding proposals to support supply chain improvements and innovations in Mali, Cameroon, and Niger. Each grant will directly contribute to implementation of vaccines supported by Gavi. The total to be disbursed across all three countries is \$2.9 million.

8. Strategic Goal 2 update

8.1 Strategic Goal 2 is to contribute to strengthen the capacity of integrated health systems to deliver immunisation. Four indicators are used to measure progress against Strategic Goal 2 and Gavi's progress in improving immunisation outcomes. As indicated below, two of these indicators, the dropout rate between DPT1 and DPT3, and DPT3 coverage, appear to be off track relative to 2015 targets. MCV1 does not have a target assigned, but improved in 2013. Gavi countries appear on track to achieve equity targets.

Chart 3: Strategic Goal 2 indicators



8.2 The first sections below provide an overview of HSS Support in country proposals and then report on outcomes and results of HSS support, per Gavi's results framework, including the first performance-based funding (PBF) payments, ongoing lessons arising from GAVI's PBF support, and intermediate results. The second section includes an update on HSS proposals, including commitments, approvals, disbursements, and how countries' plans to utilise HSS support have evolved in recent years. The third section provides data on implementation of HSS support in terms of disbursed funds actually utilised by each country and country reports of activities completed relative to original plans.

8.3 Gavi will continue to focus on ways to ensure timely disbursement of funds, while implementing appropriate grant stewardship, legal requirements and fiduciary oversight. A key area of focus will be to understand how, and how timely, funds are utilised and to identify concrete actions to address bottlenecks to utilisation. This focus will allow Alliance partners to better understand how funds are used by countries to implement activities and realise immunisation results

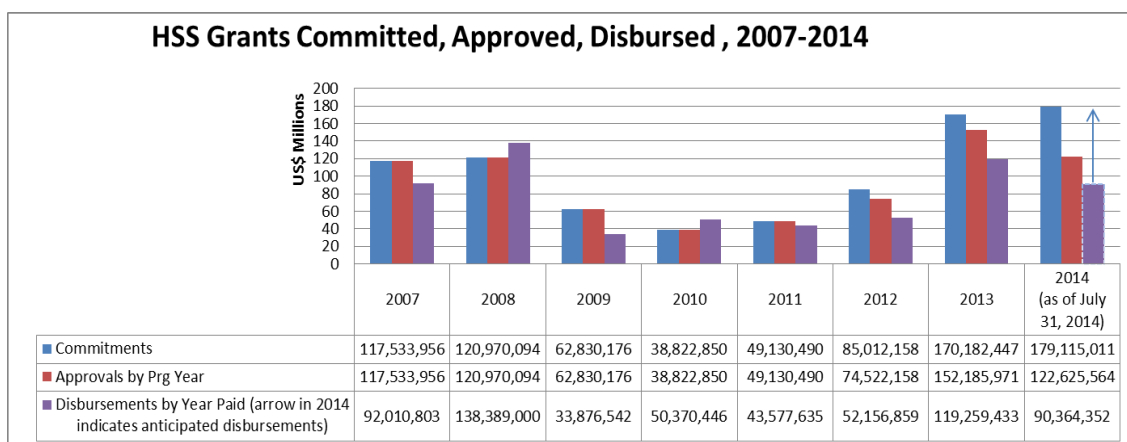
8.4 There are multiple ways to analyse the growing data available to the Alliance related to HSS support and its effect. Data could be analysed, for example, to consider such factors as: immunisation coverage categories (e.g. high, intermediate, and low); region; impact of disasters or other emergencies on utilisation; whether the country or a partner is the recipient of HSS support; and if grant size impacts utilisation – if large grants are more difficult for countries to utilise.

8.5 It is critical to note that many of the analyses presented below are preliminary and will continue to be refined following input from the PPC and partners.

Overview of HSS Support in Country Proposals

8.6 Commitments, Approvals, and Disbursements: as of July 2014, Gavi committed a total of US\$ 1,037,495,051 for HSS grants from 2007 through 2018. Total HSS approvals from 2007-2014 are US\$ 739 million, of which US\$ 620 million (84%) was disbursed as of 31 July 2014 (Chart 4). As of late July 2014, forecasts for the year's Cash-based Programmes (e.g. HSS, vaccine introduction grants, etc.) totalled US\$ 293 million (19.5%), which is consistent with Board guidance of 15-25%.

Chart 4: HSS Grants Committed, Approved and Disbursed, 2007 – 2014. Data for 2014 represent a partial year, through 31 July 2014



8.7 In 2012, the new application Independent Review Committee (IRC) approved or approved with clarifications 71% of HSS proposals. This approval rate increased to 85% in 2013 and to 100% in 2014 as of July. This increased application approval rate can be partially attributed to a stronger pre-screening process, which includes the WHO pre-review and SCM pre-screening of all new proposals. If gaps are identified in the pre-screening period, countries and partners work to refine the proposals prior to submission to the IRC.

8.8 The IRC has approved 10 HSS applications to date in 2014. The most recent IRC, in July 2014, reviewed four new HSS proposals and recommended all for approval with a total value of US\$ 199,878,855 million (Honduras⁴², Democratic Republic of the Congo, Madagascar and Kenya). The main observations from the June/July IRC were that all HSS proposals have an increasing level of technical coherence; however, additional technical support is needed in areas such as selecting evidenced based interventions and leveraging existing interventions.

8.9 Projections in late 2013 estimated that 25 countries would apply in 2014, while it now appears likely that the total for the year will be 18. Several large countries (Afghanistan, Bangladesh and Myanmar) have deferred

⁴²Honduras is the first graduating country to benefit from a recent Board decision to allow graduating countries to access Gavi HSS support for sustainability.

from late 2014 to January 2015 to allow more time to develop their applications. The table below provides a summary of HSS applications approved and upcoming application target dates. Nonetheless, the Secretariat estimates that commitments, approvals and disbursements by the end of 2014 will significantly exceed 2013.

Table 2: HSS Grant Applications for 2014 and 2015 (actual and projected)

2014 Approved Applications	January 2015 Projected Applications
Djibouti, Ghana, Korea DPR, Niger, Nigeria, Sudan, Kenya, Honduras, Madagascar and DRC	Afghanistan, Bangladesh, and Myanmar (deferred from 2014); Congo (graduating country), Cameroon, and Lao PDR
Projected to apply in September 2014	2015 Projected applications (after January IRC)
Cambodia, Chad, Gambia, Guinea, Mali, Sao Tome, Senegal, Nepal (graduating country) and Tajikistan.	Burundi, Central African Republic, Comoros, Côte d'Ivoire, Ethiopia, Eritrea, Guinea-Bissau, Haiti, Liberia, Pakistan, Somalia, Togo, Uganda, and Zambia Graduating Countries: Indonesia and Solomon Islands

HSS Outcomes and Results

Performance Based Funding

8.10 The July 2014 High Level Review Panel reviewed four phase one Performance Based Funding (PBF) countries. Burundi and Lao were recommended and approved for reward payments by the HLRP; Comoros and Afghanistan did not meet the requirements for a reward payment.

- (a) Burundi met the PBF eligibility for a high performing country by meeting the following requirements: maintained its DPT3 coverage above 90% (99% in 2013, compared to 102%⁴³ in 2012), without any districts reporting below 80% (the geographic equity criteria); an average of 93% of coverage reports were submitted by the district level; and administrative data differed by not more than five percentage points from WHO/UNICEF estimates (the data verification criteria). As a high performing country, Burundi's performance based payment was calculated based on 20% of the HSS grant's first year ceiling. The final HSS Performance Payment for Burundi is US \$1,720,000 million. During a September 2014 country visit, Gavi's SCM for Burundi will work with health officials to prepare a budget to detail how to use the reward payment;

⁴³ Burundi is aware of data quality issues and is working with the Gavi Alliance and World Bank to improve data quality.

- (b) Lao met the PBF eligibility requirement for a country with baseline DPT3 coverage of less than 90% and was recommended and approved by the HLRP for performance payments for its DPT3 and MCV1 coverage improvements. Lao's DPT3 coverage steadily increased from 78% in 2011 to 79% in 2012 to 87% in 2013; similar improvements were seen with MCV1 coverage, from 69% in 2011 to 72% in 2012 to 82% in 2013. Additionally, its administrative data was not more than five percentage points different from WHO/UNICEF estimates. The reward is based on US\$ 30 for each additional child vaccinated for each antigen. For 2012 and 2013, 20,402 additional children were vaccinated against DPT3 and 28,077 additional children were vaccinated against MCV1, resulting in a total award of US\$ 1,454,370 million. The SCM will work with Lao to learn how the country plans to use its reward payment;
- (c) Afghanistan and Comoros were also evaluated for a reward payment but were not recommended for approval; Afghanistan's DPT3 and MCV1 coverage rates differed by more than five percentage points from WHO/UNICEF estimates and Comoros' DPT3 and MCV1 coverage declined from the previous measurement year. Afghanistan is eligible for a Country-Tailored approach (CTA) which includes support to address data strengthening. Comoros' SCM will conduct a field visit to assess the country's declining coverage and obtain urgent technical assistance to support resolving project management and structural issues.

- 8.11 The October HLRP will evaluate five additional phase one PBF countries that may be eligible for a reward payment: Tanzania, Zimbabwe, Rwanda, Ethiopia, and Solomon Islands

PBF Lessons Learnt

- 8.12 Phase one PBF countries have now completed one full implementation cycle. Documenting lessons learned is critical to improve the PBF approach and ensure alignment with the new Gavi strategy.
- 8.13 Gavi's PBF approach links performance payments to national level to coverage changes. However, in most countries Gavi's HSS grant supports interventions in a select sample of districts. This may be due, for example, to the size of the grant relative to the size and needs of the country and/or targeting areas where potential for impact is greatest. A few countries have requested that Gavi consider performance payments linked to improvements in coverage in the districts supported by Gavi. This may allow for improved tracking of Gavi impact but could alter Gavi's relationship with countries.
- 8.14 PBF countries report on intermediate results for health system performance. Technical support was provided to phase one countries to strengthen M&E frameworks and incorporate intermediate results into HSS grant applications. Additional technical support and capacity building is needed for countries to continue monitoring these indicators and to

develop new applications. To better understand health system performance and the effectiveness of Gavi's HSS grants, additional planning for results measurement is needed.

- 8.15 The Gavi Board and PPC require a robust data verification method in the PBF approach. Gavi has worked, and continues to work with countries on data quality assessments and methods for data verification. Data verification criteria are checked before a country is eligible for performance payments; many Gavi countries are currently unable to meet these criteria. As described above, Afghanistan was ineligible for a performance payment (given the revised WHO/UNICEF estimates based in a recent coverage survey) despite the country's administrative data showing an increase in immunisation coverage.
- 8.16 Several phase one PBF countries are making specific efforts to include performance-based incentives in their sub-national programming. This includes additional efforts to focus interventions on improving immunisation coverage and equity in response to Gavi's PBF approach.
- (a) Zimbabwe reported developing mechanisms to ensure the number of children reached at every outreach point is documented; this is done by ensuring that all outreach points in the eighteen priority districts are serviced on regular basis. Additionally, defaulter tracking will also be strengthened to increase coverage;
 - (b) Tanzania is targeting hard to reach communities through outreach services and the use of immunisation days as strategies to improve immunisation outcomes. Advocacy and social mobilisation plans are being implemented by primary health care committees and community health workers to reach more children, especially in hard to reach and marginalised communities. In addition, Tanzania uses a portion of its HSS resources for Results Based Rewarding for high performing regions and districts – the top 5 are rewarded with a trophy and a financial reward.

Intermediate Results and Evaluation Findings

- 8.17 As explained above, countries are reporting on intermediate results of HSS grants. Table 3 provides illustrative examples of intermediate results reported by countries for 2013. Intermediate results are part of the results chain for immunisation outcomes – improvements in these intermediate results are expected to improve immunisation outcomes over time.

Table 3 Intermediate Results from Country Reports

Activity Category	Country-Reported Intermediate Results for Gavi HSS grants
Availability of health service infrastructure	<ul style="list-style-type: none"> Burundi: The percentage of health centres in 19 targeted Health Districts having an operational cold chain increased from 88% at the baseline to 99.6%, exceeding the 2013 target.
Availability of supplies & equipment	<ul style="list-style-type: none"> Solomon Islands: The percentage of EPI fridges that are functional with less than 5 days downtime over the year has improved by 15% (from 52% at baseline to 60% in 2013).
Availability of skilled healthcare workers	<ul style="list-style-type: none"> Burundi: The percent of community health workers in 19 targeted health districts trained on an integrated module for health promotion (including immunisation) improved by 72%, (from 47.6% at baseline to 81.7% at the end of 2013), meeting the 2013 target. Afghanistan: The number of community health workers trained to provide Community Based Integrated Management of Childhood Illness (CIMCI) services in 5 insecure areas increased from 0% at baseline to 27%, exceeding the 2013 target.
Data availability and quality	<ul style="list-style-type: none"> Burundi: The timeliness of health district reporting, measured by the proportion of districts whose data are included in the national system after 36 days, improved from 89% to 100%, exceeding the 2013 target.
Stock-out Rate	<ul style="list-style-type: none"> Solomon Islands: 0% of health facilities experienced stock-outs of vaccines in 2013 (though no baseline or target values were provided).

8.18 Independent evaluations of the first phase of Gavi HSS grants over 2007-2012 have been completed in several countries including Afghanistan, Burkina Faso, Ethiopia, Myanmar (mid-term), and Yemen

- (a) In Afghanistan, the evaluation of the first HSS grant documented that 120 sub-health centres and 26 mobile health teams were established with funds from Gavi, and training was delivered to more than 800 health workers. Weaknesses identified included the need for strengthened coordination between HSS and EPI teams, data quality issues, weaknesses in M&E, and financial sustainability;
- (b) In Yemen, funds from the first Gavi HSS grant contributed to integrated outreach services, which helped address gender related barriers to immunisation. Women often need to have male chaperones to visit fixed site clinics; to address this, the program aimed to increase the percentage of female health workers participating in integrated outreach programs by 45% to reach 36% participation. The evaluation documented that typically one third of each outreach service team was female. Of 19 outreach teams surveyed, 16 had at least one female member of staff;

- (c) In Myanmar, Gavi HSS funds contributed to the pilot of a Maternal and Child Health voucher program in 20 townships. The evaluation found a significant increase in utilisation of antenatal care, delivery services by skilled birth attendants, and routine immunisation. This is expected to improve overall immunisation outcomes.

HSS investments in proposals recommended for approval, analysed by activity categories

- 8.19 The following analyses consider the 36 HSS grants recommended for approval from 2011-2014, aligned to the current strategic period and the 2011 Board-defined refocus on immunisation in Gavi's HSS grants. Grants from November 2013 and 2014 to date are highlighted in Annex B to demonstrate changes since the 2013 revision of the HSS application guidelines, which increased the focus on immunisation results and outcomes. Activities in proposed HSS budgets and work-plans are grouped into nine Grant Categories, modified from WHO's health systems building blocks. In the 36 grants recommended for approval by IRCs since 2011, and in 2013 and 2014 specifically, the three largest Grant Categories by total allocated budget are Procurement and Supply Chain Management, Service Delivery, and Health Workforce and Human Resources, with allocations of \$214 M, \$177 M, and \$161 M, respectively. These three categories together represent two thirds of total HSS commitments in the 2011-2014 period.
- 8.20 The analyses reflect that the 2011-2014 budget for HSS commitments for Procurement and Supply Chain is driven mainly by supply chain procurement (\$91 M or 42.3%) and rehabilitation (\$39 M or 18.4%). The budget allocation for Service Delivery is driven primarily by 3 Grant Sub-Categories: \$56 M or 31.7% for improving service organisation and facility management (including conducting outreach activities), \$52 M or 29.6% for transportation system improvements including vehicle procurement, and \$33 M or 18.7% for capital investment in infrastructure including upgrades and renovations. The main Grant Sub-Categories driving the budget for Health Workforce and Human Resources are improving/conducting in-service training of health professionals (\$63 M or 39%) and establishing and strengthening performance-based incentive systems (\$30 M or 18.7%). Please see Annex B for more detailed analysis of HSS Grant Sub-Categories.
- 8.21 After Procurement & Supply Chain Management, Service Delivery, and Health Workforce and Human Resources, the next largest Grant Categories for HSS commitments in the 2011-2014 period are Programme Management, Empowering Community and Local Actors, and Health Information Systems, respectively. The "Empowering Community and Local Actors" allocation is driven largely by Civil Society Organisations (CSOs) for activities such as social mobilisation and demand generation.

HSS investments in proposals recommended for approval, analysed by country vaccination coverage

- 8.22 The majority (60%) of Gavi HSS commitments in the 2011-2014 period were to countries with Intermediate level (70-90%) DPT-3 coverage.
- 8.23 Low-coverage (<70% DPT-3) countries tended to request funds approximately equally for Procurement and Supply Chain (23%), Service Delivery (22%), and Health Workforce (21%) investments.
- 8.24 Intermediate-coverage countries tended to mostly request investment in Procurement and Supply Chain (28%) with smaller amounts in Health Workforce (19%) and Service Delivery (18%).
- 8.25 However, in High (>90% DPT-3) coverage countries, most allocation went to Service Delivery, followed by Procurement and Supply Chain (20%) and Health Workforce (18%).
- 8.26 All types of countries invested 12-15% in data, 9-10% in Programme Management, and 6-8% in Community Empowerment. These data suggest that countries use HSS investments across multiple components of the health system to achieve immunisation outcomes. As this analysis evolves, it may allow Gavi to further strengthen its support in different coverage settings.

HSS grant implementation

- 8.27 The following section provides data and associated analyses related to the implementation of GAVI's HSS grants, building upon the amounts that have been disbursed to countries (as described above). The analyses rely on data reported by countries in Annual Progress Reports. Important limitations to note include that not all countries report on each APR line item (e.g. 40 of 61⁴⁴ countries are included in the analyses reported below); and countries have not been asked to report on spending against specific activity categories. This limits the Gavi Secretariat's ability to conclusively determine whether specific activity areas are consistently under-implemented.

Utilisation of funds disbursed to countries

- 8.28 WHO, the Gavi Secretariat, and Alliance partners are developing a tool to estimate the utilisation of HSS resources in order to better monitor the financial implementation of grants once funds have been received at the country level. The current draft tool includes HSS disbursements by year, country reported expenditure data, and a number of options for categorising analyses.

⁴⁴ The initial analysis only included countries that reported on utilisation of funds in their annual progress reports (APR); Gavi has additional information for the remaining 21 countries, such as information communicated directly to respective SCM. Such information will be included in future reporting.

- 8.29 A preliminary estimate from 2013, suggests that, over 40% (\$45 M) of all HSS funds available to countries were utilised, pro-rated for when the funds were received by countries during the year. This amount includes both newly disbursed funds and those available from previous years. These estimates will continue to be reviewed and additional analyses conducted. If verified, the data suggest that further work is needed by Alliance partners to both understand and address specific bottlenecks to implementation of GAVI's HSS support, and to understand how the implementation may vary such as by coverage level or other country characteristics.
- 8.30 If utilisation of funds is analysed by DPT-3 coverage, preliminary estimates suggest utilisation appears to be positively associated with higher DPT3 coverage countries, as shown in Annex C. This suggests that countries with higher coverage rates have better conditions for spending, but countries with lower utilisation also have the greatest need for support to improve their immunisation coverage. Future analysis could be done to assess the impact Gavi funds have on DPT3 coverage.

Implementation of HSS Activities in 2013

- 8.31 In addition to analysing the utilisation of available funds by countries, as above, the Secretariat has reviewed implementation of HSS activities in PBF countries specifically, as these countries are required to submit detailed reports on use of financial resources to support implementation. In future, as more PBF countries report on HSS implementation, our understanding of implementation progress and constraints will increase.
- 8.32 An analysis of activity completion in PBF countries, based on expenditure reporting (in 2013 APRs), found that 3 reporting countries (Comoros, Lao and Zimbabwe) utilised most of their approved budget for the reporting period in order to implement planned activities. Two countries (Afghanistan and Rwanda) utilised less than half of their approved budget for the reporting period. The most frequently mentioned barriers to using HSS support to implement activities in PBF countries were: putting in place contracts for NGOs or consultants, reprogramming or reallocation of budget, procurement, and a lack of sufficient funds (either due to insufficient budget or on-going considerations to be addressed before disbursement of HSS grants).
- 8.33 In addition to quantitative reporting on the percentage of activity completion, all countries are asked to describe the progress they have made and the constraints they have faced in HSS implementation in the reporting year. The examples below are illustrative of some of the implementation challenges that impact utilisation of HSS grant resources
- (a) Afghanistan: Afghanistan spent less than half of its planned HSS budget in 2013. One of the major challenges was in establishing Mobile Health teams for nomadic populations and training community health workers for nomadic populations. Since then, the program has reported accelerated implementation in 2014;

- (b) Ghana: Ghana also spent less than half of its planned HSS budget in 2013. The country cited decentralisation as a key factor hindering implementation, reporting that “The Government decentralisation programme has been on-going for some time and will affect the sub district certification...the major area of concern was the strengthening of capacity of staff at sub district level in service delivery, planning, finance, procurement, and administration.”

9. Strategic Goal 3 Update

- 9.1 In the implementation of Strategic Goal 3.1, Gavi’s strategy monitors two key indicators: fulfilment of co-financing commitments and country investments in vaccines per child. Another key priority in Gavi’s Strategic Goal 3 (SG3) work is the support for graduation. The following sections discuss the Secretariat’s work on all three subjects.

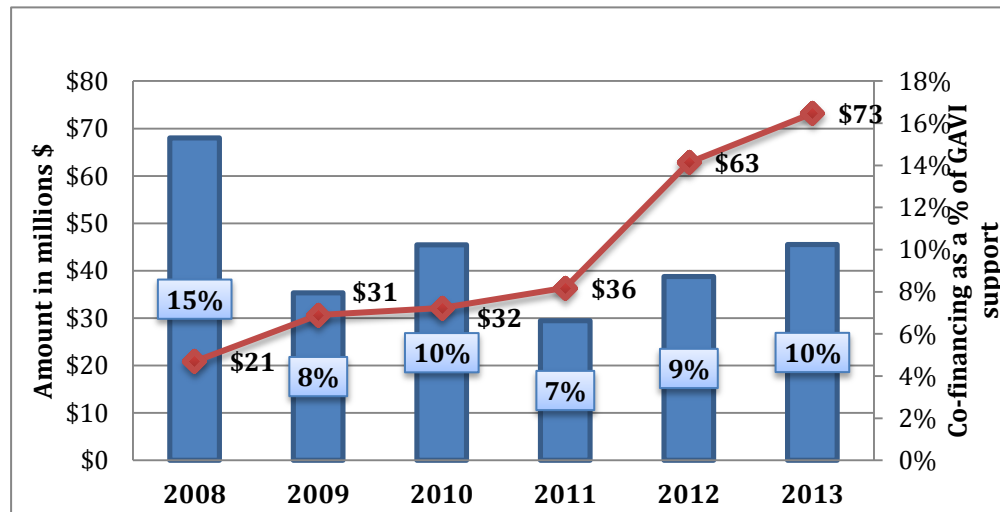
Fulfilment of co-financing commitments

- 9.2 Of the 68 countries required to co-finance their vaccines in 2013, 53 had fulfilled their commitments by year-end.⁴⁵ Special arrangements were made for the Democratic Republic of Congo (DRC) and for the Central African Republic (CAR) to avoid these countries being considered in default. According to the Country Tailored Approach (CTA), DRC fulfilled its total co-financing requirement by purchasing traditional vaccines until 2016. CAR was given a one-time waiver for its 2013 co-financing requirements as it was immersed in a debilitating civil conflict. In spite of that conflict, CAR showed commitment to immunisation by setting up a fund for immunisation and by paying its 2012 arrears. Of the 14 other countries that were in default of their payments,⁴⁶ only four made no contribution towards their co-financing costs during the year (Djibouti, Kenya, Solomon Islands and Zimbabwe). The remaining ten paid arrears from the previous year and/or made partial payments towards their 2013 requirements. The total amount transferred to date against the 2013 co-financing commitments amounts to approximately US\$ 73 M (Figure xx), accounting for 10% of the vaccine support that required co-financing to those countries. In addition, 41% of countries have already made payments for their 2014 co-financing requirements, with 21% having completed the full requirements. The total co-financed to date for the 2014 requirements amounts to US\$25 M.

⁴⁵ As compared to the PPC paper presented in May of this year, this number has changed from 52 to 53. DRC is now included with the countries having fulfilled the requirement, following the conclusion of the negotiation on the co-financing requirements in the CTA.

⁴⁶ These are: Afghanistan, Angola, Cameroon, Republic of Congo, Djibouti, Ghana, Guinea, Kenya, Kiribati, Kyrgyzstan, Pakistan, Sierra Leone, Solomon Islands and Zimbabwe.

Chart 5: Country co-financing amounts and share



- 9.4 The proportion of countries that meet their co-financing commitments in a timely manner is the indicator that the Gavi’s strategy monitors. In 2013, only 79% of the countries (53 countries) co-financed in a timely manner resulting in the greatest number of defaults since the co-financing policy was introduced in 2008 and below the 100% target. This large number of defaulters needs to take into account however the raising of co-financing requirements and payments. Between 2012 and 2013, the total requirements increased by about 20% in terms of co-financing amounts and by 16% in terms of number of programmes that required co-financing. The co-financing amount paid for 2013 by the end of the year exceeded by 34% the amount paid at the end of 2012. Furthermore, even when the payments from 14 countries were still pending, the co-financing amount in 2013 was the same as the total amount remitted against 2012 (including the payment of 2012 arrears).
- 9.5 It is evident that co-financing is increasing at pace and, as a result, the risk of countries defaulting is higher. In 2013, the reasons for defaulting ranged from mostly administrative/process-related barriers, through political will/prioritisation of immunisation constraints, to fiscal challenges in some countries. However, one clear pattern that seems to be emerging is a “vicious cycle of default”– that is, once a country defaults, it is difficult to break out from this status. The “vicious cycle of default” occurs when countries pay their arrears from the previous year to avoid the interruption of Gavi support, but are unable to simultaneously cover the full requirements of the current year. Following this pattern, 70% of 2012 defaulter countries defaulted again in 2013, but they all paid their 2012 arrears during 2013, with most of them also paying partially for 2013. The on-going review of the co-financing policy will look at this issue and propose policy options to avoid this cycle of defaults.
- 9.6 Ten of the 14 countries that defaulted in 2013 have already paid their arrears and have come out of default. The four countries remaining in default are Angola, Congo Republic, Pakistan and Zimbabwe. All of those countries, except for Zimbabwe, have already partially paid their 2013 co-

financing commitments. If these countries remain in default at the time of the next Gavi Board meeting, they are at risk of having their vaccine support interrupted. At this point, Board members would decide whether to apply the default mechanism and interrupt support for the vaccines in arrears. In July 2014, the Immunisation Financing & Sustainability (IF&S) Task Team analysed the 2014 co-financing status and the 2013 defaulters' situation and discussed the next steps to ensure that 2014 requirements were paid on time and that defaulters paid their arrears. The Alliance needs to take urgent action to help the four countries owing their 2013 co-financing requirements to come out of default and avoid suspension of vaccine support.

Country investments in vaccines per child

9.7 The source of information for this indicator is the WHO/UNICEF Joint Reporting Form. WHO submission of validated data for the financial indicators is outstanding. Based on the information self-reported by countries in the Annual Progress Report (APR), about a third of Gavi countries do not pay at all for traditional vaccines. Eighteen countries appear to be constant in relying on external funding for traditional vaccines (See table 10 in Annex D). We observed new countries no longer paying for traditional vaccines (e.g. Sierra Leone, Sao Tome and Principe, Cameroon and Malawi) while on a positive note, three countries (DRC, Lao PDR and Timor-Leste) that started partially paying for their traditional vaccines in 2012, continued the positive trend in 2013. It is important to highlight that the table does not include countries that might be funding only a small share of their traditional vaccines with government resources. A next step for this data is to further explore whether there is a relationship between defaulting countries (in bold) and those countries that are not paying for traditional vaccines. However, it is evident that the lack of government funding for traditional vaccines is an important obstacle to achieving Gavi's SG3 in the 2016-2020 objectives. Gavi will include activities to increase advocacy amongst governments and donors to start addressing this issue in the next strategy.

Graduation

9.8 Following the release of the 2013 gross national income (GNI) per capita information by the World Bank in July of this year, four additional countries, Ghana, Nigeria, Solomon Islands and Vietnam, will move into the graduating countries grouping and will therefore not be eligible for new Gavi support after their grace year in 2015. The four countries will start their graduation in 2015 but, during the grace year, will still be eligible to apply for new support and will keep their co-financing contributions at the intermediate level, prior to starting the graduation ramp-up in 2016. Ghana and Nigeria will constitute priority graduating countries moving ahead, given the economic challenges in the former and the potential impact and magnitude of challenges in the latter.

9.9 In terms of progress on the graduation work, since the last Gavi Board meeting in June, no further missions applying the expanded approach to

graduation were conducted. However, two missions are scheduled in September and an additional three to four missions are planned in October, which will allow reaching the annual target for graduation plans. A tool to support monitoring of graduating countries and the implementation of their plans is being finalised. Following last year's Board approval of a strengthened engagement with graduating countries, the Board also approved an additional US\$ 2 M to engage new partners to support this work. The Secretariat assigned the additional funding to the World Bank. The additional funding under SG3 was used to engage The World Bank for the provision of policy guidance to graduating countries to increase financial sustainability of immunisation.

- 9.10 The World Bank will support Gavi's effort around graduation in 2014 and 2015 through three key activities. First, the Bank will conduct in-depth country assessments in 6 graduating countries: these assessments will leverage tools such as fiscal analysis, public expenditure reviews, public expenditure tracking surveys and systematic institutional assessments. They will focus on immunisation and their findings will be used to guide policy dialogue to advocate for sustainable immunisation financing in these graduating countries. Second, The World Bank will join 9 graduation missions to support the development of graduation assessments and plans. The World Bank will contribute to these missions by building on the existing in-country dialogue in health financing and work with Ministers of Finance. Finally, The World Bank will conduct an analysis to draft a position paper on the role of health insurance mechanisms in financing immunisation service delivery. The experience and collaboration in 2014 and 2015 will serve as a reference point to intensify the role of The World Bank in Gavi's work. Lessons from this experience will be leveraged to shape the World Bank's engagement with Gavi in the upcoming strategic period 2016-2020.

Section D: Annexes

Annex A: Strategic Goal 1

Annex B: Strategic Goal 2 - Activity Categories and Sub-Categories in HSS Budgets Recommended for Approval by IRCs, 2011 – July 2014

Annex C: Strategic Goal 2 - Total average expenditure as a percentage of funds available by DPT3 coverage levels (2007-2013)

Annex D: Strategic Goal 3

Annex A: Strategic Goal 1

A.1 Sources and definitions of performance metrics

Indicators	2012 and before	2013	2014	2015-onwards
# of countries introduced/ing	Vaccine Impl. Team	Vaccine Impl. Team	Vaccine Impl. Team	Draft SDF v.10 base case*
Coverage	WHO Progress report	WHO Progress report	Draft SDF v.10 base case*	Draft SDF v.10 base case*
No of people immunised/ to be immunised	WHO Progress report	WHO Progress report	Draft SDF v.10 base case*	Draft SDF v.10 base case*

Data up to 2013 are actuals. Other figures are projections and are subject to change

* Supply constrained scenario for rota and yellow fever

Definitions

- Introduction: First dose delivered, including ceremonial launch. This also applies to campaigns.
- Coverage:
 - Numerator: number of people reached with last dose of series in the last year – irrespective of age and irrespective of funding
 - Denominator: target population in GAVI 73 for global vaccines in the last year

Annex B: Activity Categories and Sub-Categories in HSS Budgets Recommended for Approval by IRCs, 2011 – July 2014

Background and Methodology

The categorisation of activities in HSS grant proposals is based on the WHO's six building blocks of health systems. The 9 Grant Categories and 47 Grant sub-Categories are presented in table 1 of the Supplementary Guidelines for Health System Strengthening Applications. Since 2013, countries have been asked to categorise their own proposed activities; prior to that, the Gavi Secretariat assigned categories to countries' proposed activities for the purposes of this analysis. Some of the activities proposed since 2013 have been re-classified when necessary to ensure that the same methodology is applied to all grant proposals.

Activities in HSS Grants Recommended for Approval from 2011-2014

Table 6 shows the breakdown of activities in grants recommended for approval since from 2011-present, in November 2013, and in 2014 to date.

The four largest Grant Categories according to the total budget allocation are Category 3 (Procurement & supply chain management, 26%), Category 1 (Service delivery, 21%), Category 2 (Health workforce and human resources, 20%), and Category 4 (Health information systems, 13%). The following tables show the breakdown of each of these Grant Categories into Grant sub-Categories

Table 6: HSS Grant Categories, 2011-2014

	2011-2014 (36 grants)		November 2013 (6 grants using revised guidelines)		2014 to date (9 grants)	
	Proposed amount	%	Proposed amount	%	Proposed amount	%
1. Service delivery	\$177 M	21.3 %	\$20 M	20%	\$87 M	23%
2. Health workforce and human resources	\$161 M	19.4 %	\$17 M	16%	\$75 M	20%
3. Procurement & supply chain management	\$214 M	25.7 %	\$24 M	23%	\$92 M	24%
4. Health information systems	\$109 M	13.1 %	\$17 M	16%	\$49 M	13%
5. Empower community and other local actors	\$69 M	8.3%	\$9 M	9%	\$25 M	7%
6. Legal, policy and regulatory environments	\$17 M	2.1%	\$1 M	1%	\$14 M	4%
7. Health financing	\$8 M	1.0%	\$2 M	2%	\$4 M	1%
8. Other	\$ M	0.0%	\$ M	0%	\$ M	0%
9. Programme management	\$76 M	9.2%	\$13 M	13%	\$34 M	9%
Total:	\$831 M		\$103 M		\$380 M	

Tables 7 through 9 show the breakdown of proposed activities from the three largest Grant Categories (Service Delivery, Health workforce and human resources, Procurement & supply chain management) into Grant Sub-Categories.

Table 7: Service Delivery Grant Sub-Categories

Service Delivery	2011-2014 grants (36 grants)		November 2013 (6 grants using revised guidelines)		2014 to date (9 grants)	
	Proposed amount	%	Proposed amount	%	Proposed amount	%
1.1. Capital investment in infrastructure including upgrading & renovations	\$33 M	18.7%	\$2 M	7.9%	\$20 M	22.8%
1.2. Improve service organisation & facility management, including integrating immunisation services within maternal and child health services [maternal, neonatal and child health (MNCH) and integrated management of childhood illness (IMCI)]	\$56 M	31.7%	\$7 M	33.2%	\$30 M	34.1%
1.3. Improve quality of care, including testing innovative service delivery models	\$13 M	7.5%	\$3 M	14.2%	\$8 M	8.8%
1.4. Improve the transportation system for vaccines and service providers for outreach activities (includes vehicle procurement)	\$52 M	29.6%	\$7 M	34.2%	\$16 M	18.9%
1.5. Improve the waste management system	\$6 M	3.6%	\$ M	0.3%	\$5 M	6.1%
1.6. Support maintenance and operating costs (recurring costs) of the delivery of immunisation services	\$16 M	9.0%	\$2 M	10.2%	\$8 M	9.4%
TOTAL	\$177 M		\$20 M		\$87 M	

Table 8: Health Workforce and Human Resources Grant Sub-Categories

Health Workforce and Human Resources	2011-2014 grants (36 grants)		November 2013 (6 grants using revised guidelines)		2014 to date (9 grants)	
	Proposed amount	%	Proposed amount	%	Proposed amount	%
2.1. Provide pre-service training of health professionals and/or improve pre-service training system	\$10 M	5.9%	\$ M	0.3%	\$5 M	7.2%
2.2. Provide in-service training of health professionals and/or improve in-service training system	\$63 M	39.0%	\$6 M	35.4%	\$23 M	31.1%
2.3. Conduct supervision of health professionals and/or improve the supervision system	\$27 M	16.6%	\$3 M	16.0%	\$14 M	18.0%
2.4. Scaling-up trained workforce (health professionals)	\$6 M	3.5%	\$3 M	19.3%	\$2 M	3.0%
2.5. Address workforce retention of health professionals	\$6 M	3.4%	\$ M	0.0%	\$2 M	2.3%
2.6. Scaling-up volunteer/community health workers	\$3 M	1.9%	\$ M	0.0%	\$ M	0.3%
2.7. Address volunteer/community health worker retention	\$ M	0.0%	\$ M	0.0%	\$ M	0.0%
2.8. Train & supervise volunteer/community health worker	\$17 M	10.7%	\$4 M	21.1%	\$ M	0.0%
2.9. Establish, support and strengthen performance-based incentives systems	\$30 M	18.7%	\$1 M	7.9%	\$28 M	37.5%
2.10. Establish and/or strengthen the human resources management information system (HRIS)	\$ M	0.2%	\$ M	0.0%	\$ M	0.5%
TOTAL	\$161 M		\$17 M		\$75 M	

Table 9: Procurement and Supply Chain Management Grant Sub-Categories

Procurement and Supply Chain Management	2011-2014 grants (36 grants)		November 2013 (6 grants using revised guidelines)		2014 to date (9 grants)	
	Proposed amount	%	Proposed amount	%	Proposed amount	%
3.1. Scaling-up or upgrading procurement and supply management (PSM) infrastructure	\$16 M	7.5%	\$ M	0.2%	\$5 M	5.3%
3.2. Build and/or rehabilitate cold chain facilities	\$39 M	18.4%	\$10 M	40.7%	\$23 M	25.2%
3.3. Procure cold chain equipment	\$91 M	42.3%	\$10 M	42.2%	\$56 M	61.6%
3.4. Procure other immunisation-related equipment and consumables	\$18 M	8.5%	\$ M	1.6%	\$2 M	2.0%
3.5. Improve the supply chain management system for immunisation services, including resources (computers, etc.) and processes (forecasting, storage, distribution, etc.)	\$34 M	16.0%	\$1 M	2.9%	\$5 M	5.8%
3.6. Procure commodities, other than drugs and vaccines (GAVI HSS funds cannot be used to procure drugs or vaccines)	\$16 M	7.3%	\$3 M	12.5%	\$ M	0.0%
TOTAL	\$214 M		\$24 M		\$92 M	

Annex C: Total average expenditure as a percentage of funds available by DPT3 coverage levels (2007-2013)

Total average expenditure as a percentage of funds available by DPT3 coverage levels (2007-2013)			
Coverage	High (90-100%)	Intermediate (70-89%)	Low (<70%)
% of funds expended	61.4%	56%	46.7%
Number of countries	15	18	7

Annex D: Strategic Goal 3

 Table 10: Countries reporting not paying for traditional vaccines from government funds⁴⁷

2011 APR	2012 APR	2013 APR
Afghanistan	Afghanistan	Afghanistan
Bangladesh	Bangladesh	Bangladesh
Bhutan	Bhutan	Bhutan
Burundi	Burundi	Burundi
		Cameroon
Central African Republic	Central African Republic	Central African Republic
Congo, DR		
Comoros	Comoros	Comoros
Djibouti	Djibouti	Djibouti
Eritrea	Eritrea	Eritrea
Guinea	Guinea	Guinea
Guinea-Bissau	Guinea-Bissau	Guinea-Bissau
Haiti	Haiti	Haiti
Korea, DPR	Korea, DPR	Korea, DPR
Lao PDR		
Liberia	Liberia	Liberia
		Malawi
Myanmar	Myanmar	Myanmar
	Niger	
	Sierra Leone	Sierra Leone
	Sao Tome and Principe	Sao Tome and Principe
Somalia	Somalia	Somalia
Timor-Leste		
Sudan	Sudan	Sudan
South Sudan	South Sudan	South Sudan
Zimbabwe	Zimbabwe	Zimbabwe

Source: Annual Progress Report (APR), self-reporting by countries

	= starting to pay for traditional vaccines in the next year
	= stopped paying for traditional vaccines for one year but then started again in the next year
	= no longer paying for traditional vaccines

⁴⁷ In bold – countries in default for that year.