FOR DECISION

This paper describes the design of the proposed new performance based funding window – Incentives for Routine Immunisation Strengthening (IRIS). IRIS is designed as a follow on programme to GAVI's Immunisation Services Support window. IRIS aims to increase accountability for results and value for money, while minimising to the extent possible the reporting and management burden imposed on countries. The objectives of IRIS are to:

- Improve routine immunisation coverage, as measured by DTP3
- Increase equity in immunisation coverage

The key design features of this programme are as follows:

- In their proposals to GAVI for IRIS support, countries will present detailed plans for how performance incentives will be cascaded to lower levels of the system in order to accelerate improvements in coverage and equity.
- Countries can receive an annual fixed payment, as well as performance payments for achieving gains in DTP3 coverage.
- Countries will be responsible for managing activities conducted with IRIS funds.

Based on a simulation involving 13 of the 14 countries that qualify for IRIS support[1] (i.e., with DPT3 coverage less than 70 percent), it is estimated that IRIS will cost approximately US$ 68 million over the 2012-2015 period and support the immunisation of 5.4 to 7.6 million additional children. Under this simulation, nine of the 13 countries would surpass 70% DTP3 coverage and thus qualify for GAVI support for new and underused vaccines.

With regard to IRIS, the PPC recommends the following **decision** be taken by the GAVI Board:

"Taking into account the potential risks associated with IRIS, the Board decides to:
1. Move forward with implementation of IRIS by opening a new window of support for countries with DTP3 coverage of less than 70%;
2. Close the existing ISS window, subject however to fulfilling any existing commitments to eligible countries for ISS support;
3. Use WHO/UNICEF estimates as the data source to measure country progress against the coverage milestones;
4. Conduct additional exploratory work to provide the appropriate support to India and Nigeria."

[1] For the costing estimate, India was not included as funding for India has been accounted for through the funding cap.

FOR DECISION

Detailed Design of Proposed New Window: Incentives for Routine Immunisation Strengthening (IRIS)

Background

1. At its May 2010 meeting, the Programme and Policy Committee (PPC) requested that the GAVI Secretariat work with partners to develop a detailed design of the proposed new IRIS window for presentation at the Committee's October meeting. To address this request, the Secretariat worked with a sub group of its performance based financing task team to develop the detailed design of IRIS, as described in this paper (see Annex 1). The PPC reviewed the detailed design of IRIS during its October meeting.[2]

Overview

2. IRIS represents a performance based aid approach that requires countries to specify in their proposals for IRIS support how they will ensure that incentives are cascaded down to lower levels of the system to reach actors who have a large influence on immunisation coverage rates. IRIS builds on the strengths of GAVI's Immunisation Services Support (ISS) window and addresses its limitations, where feasible. IRIS is designed to increase accountability for results and value for money, while minimising to the extent possible the reporting and management burden imposed on countries.

3. IRIS is structured to provide both predictable annual funding and performance payments linked to achieving coverage targets. Both positive and negative incentives are incorporated. Positive incentives come in the form of payment for achieving performance milestones, while negative incentives discourage countries from backsliding below performance milestones that they have previously achieved. A series of performance milestones allows countries the opportunity to earn one or more performance payments each year and over the duration of IRIS support.

4. Annex 2 describes how IRIS addresses limitations of the ISS identified by the Performance Based Financing Task Team.

Objectives

5. IRIS is intended to support the achievement of programme objective 2.2.1 in the GAVI Alliance business plan for 2011-2015: increase coverage and equity of routine immunisation in countries with DTP3 coverage of less than 70%.

6. Specifically, the objectives of creating a new performance based IRIS window are to:

- improve routine immunisation coverage, as measured by DTP3

[2] The PPC paper also included a proposal for an additional equity-based payment component to the design. This component was considered by the PPC as too complex to implement and thus was not recommended. As such, it has been removed from the programme design.

- increase equity in immunisation coverage

Who can apply for IRIS support

7. Following the PPC's recommendation from May 2010, IRIS will focus for the time being only on those countries with DTP3 coverage <70%, as measured by the latest WHO/UNICEF estimates available at the time that countries submit their application for IRIS support. Once countries are approved for IRIS support, IRIS support will continue through 2015 even if they raise their coverage above 70% prior to 2015.

8. According to the latest DTP3 coverage and GNI estimates, 14 countries[3] qualify for IRIS support at the present time. Annex 3 contains a table summarising demographic, financial and immunisation-related data from these countries. If other countries that are currently above 70% DTP3 coverage fall below this threshold level, they would qualify to apply for IRIS support.

9. It is proposed that the criteria for determining who can apply for IRIS support be re-assessed in the future, in light of the lessons learned with IRIS, the observed trends in immunisation coverage among countries that do not qualify for IRIS and the GAVI funding situation. At such time, an assessment should be made regarding whether it would be appropriate to expand IRIS support to additional countries, beyond those with <70% DTP3 coverage.

Structure of IRIS window

10. National governments would submit applications to GAVI for IRIS support. IRIS reflects a performance based aid approach, in which a portion of the amount of money transferred from the GAVI Alliance to the recipient country would be conditional on the country's achievement of a series of performance milestones. Rather than including a separate "investment" and "reward" phase like the ISS, IRIS would include an annual fixed payment and an opportunity to receive additional funds based on performance. The fixed and performance payments would be provided annually under the window, rather than after a specified investment period.[4]

11. Application guidelines for IRIS support would require countries to specify how they would use IRIS funds—both fixed and performance payments. The guidelines would also require that countries specify what other resources at country level would be used to implement the plan described in the application submitted for IRIS support. In addition, guidelines would require countries to specify how they intend to use IRIS support to improve equity in immunisation coverage by reducing disparities present within the country. The disparities addressed within the proposal should be specific to conditions within the country and may include for example inequities related to geography, poverty, gender or other issues. Consistent with the GAVI

[3] Central African Republic, Chad, Guinea, Guinea Bissau, Haiti, India, Lao, Liberia, Mauritania, Nigeria, Papua New Guinea, Somalia, Uganda, and Yemen

[4] The current ISS design includes a two year investment phase in which funds are provided irrespective of performance, and then a performance phase in which all funds are entirely conditional on performance. Annex 2 includes a description of the rationale for changing this component of the original ISS design.

Alliance's gender policy,[5] countries are encouraged to address gender inequities where they are present.

12. In order to support countries to manage the complexity of IRIS, the GAVI Alliance will facilitate the application process through close engagement with countries and provision of active technical cooperation.[6] Following each successful application, a grant agreement will be established between the country and the GAVI Alliance that clearly lays out the different roles and accountabilities of relevant entities.

13. What occurs with the IRIS money once received by the country depends on the specific plan of the country, as described in its application. However, a successful proposal must include a clear and feasible plan for how countries will ensure that incentives are cascaded down to lower levels of the system. Countries will be able to choose from a menu of options for cascading incentives to lower levels of the system, including:

> 13.1 Performance based contracting with non-state entities, such as civil society organisations or private sector for-profit entities that are well placed to help deliver results
>
> 13.2 Incentives to local administrative authorities who have the power to take action that can lead to increasing coverage and equity
>
> 13.3 Incentives to health workers, health facilities or communities for increasing the number of children immunised
>
> 13.4 Incentives to poor households for ensuring that their children are fully immunised

14. These options are not mutually exclusive; a country may incorporate, for example, both supply side and demand side incentives. Countries that want to pursue other types of programme innovation may propose alternative means of intervening in incentive environments based on their assessment of needs. The outcomes of interest are immunisation specific, but the interventions used to increase coverage and equity may be broader.

15. Payments will be comprised of two types: i) annual fixed payments provided as long as process conditions are met, and ii) performance payments.

16. **Fixed payment.** The fixed payment will be paid to countries annually. The amount of payment will be equal to US$ 1 per surviving infant in low income

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[5] The goal of GAVI Alliance's Gender Policy is to promote increased coverage, effectiveness and efficiency of immunisation and related health services by ensuring that all girls and boys, women and men, receive equal access to these services.

[6] The GAVI Alliance business plan includes a Secretariat budget request for $258,000 in 2011 to coordinate implementation of IRIS. In addition, WHO has submitted budget requests for 1) identifying and addressing major inequities in immunisation coverage in countries and to support a process to plan and implement activities to reduce the inequity ($289,000), and 2) for building capacity within countries with coverage below 70% to improve their ability to reach and vaccinate more than 70% of infants ($602,000).

countries and $0.50 per surviving infant in lower middle income countries, as classified by the World Bank (see classifications in Annex 3). Countries will receive a minimum fixed payment amount of $100,000, if they have fewer than 100,000 surviving infants. In year 0, this fixed payment will be transferred to countries upon approval of the application by the GAVI Alliance Board, as long as all requirements associated with the Transparency and Accountability Policy are met. In subsequent years, receipt of the fixed portion will depend on the extent to which the country has met the following conditions:

- Timely submission of complete Annual Progress Report, including reporting on the use of IRIS funds in the previous year and activities conducted per the plan described in the country's application for GAVI support[7]
- Satisfactory utilisation rate of IRIS funds
- Adequate financial management and reporting, as required under GAVI's Transparency and Accountability Policy

17. **Performance payments.** For each 5 percentage point improvement in DTP3 coverage over baseline countries will earn a performance payment for achieving a 'milestone'.[8] The performance payment will be equivalent to $20 for each additional child immunised by the country in achieving that milestone. It is worth noting that this amount is equal to the amount of the fixed payment given to low income IRIS countries (i.e., $20 for 5% of surviving infants is equivalent to $1 for 100% of surviving infants). The size of the payment per milestone will be established in advance based on the number of surviving infants in the baseline year and will remain the same for each of the subsequent years. This simple design allows countries to earn performance payments for multiple milestones in one year. It avoids the challenge of individual negotiations about targets and rewards countries for reaching milestones. It is straightforward to calculate and provides a simple metric for GAVI and countries to use to determine performance.

18. **Backsliding penalty.** To guard against backsliding, countries that backslide below milestones that were previously reached and paid against will be penalised by forgoing the fixed payment for the subsequent year. Payment for subsequent milestones will only begin again once the country regains lost coverage and surpasses the next milestone in the sequence. In addition, countries that do not demonstrate progress in increasing immunisation coverage will be required to present an assessment of weaknesses and a plan for improving performance in the

[7] It is acknowledged that plans sometimes need to be changed and that countries will be permitted to explain in their annual reports why their annual activities diverged from what had been planned up to three years earlier. As part of its review, the monitoring Independent Review Committee will deem whether adjustments made to plans are credible, sensible and well justified. This may require adding capacity to the monitoring IRC in the area of data quality.

[8] Performance payments are only paid based on reaching milestones of five percentage point increments over baseline. If a country increases coverage by three percentage points over baseline, for example, no performance payment is made. However, if a country increases coverage by seven percentage points the first year and three percentage points the second year, the country would receive one performance payment the first year (for passing the 5 percentage point threshold, relative to baseline) and another performance payment the second year (for passing the 10 percentage point threshold, relative to baseline).

subsequent period. Existing support mechanisms, including regional working groups, will be used to support countries in assessing weaknesses and preparing plans for improvement. As appropriate, consultants with expertise in performance based financing may be engaged to provide support also. Countries that face exceptional circumstances beyond their control (*force majeur*) may be exempted from the backsliding penalty when sliding below milestones previously attained.

Application process

19. IRIS proposals will be reviewed by the “new proposals” Independent Review Committee (IRC). This may require the addition of technical experts in performance based financing for the review of IRIS proposals. Options will be explored for linking the review of IRIS applications with the review of HSS Funding Platform proposals. Linking the review of the two applications provides an opportunity to consider both proposals within an appropriate context and to ensure that appropriate linkages are established between the two.

Monitoring process

20. The review of results will be incorporated into GAVI’s existing monitoring IRC process. As part of the performance review process, countries will be required to report on cash utilisation rates and levels of progress in implementation of the plans specified in proposals as part of the Annual Progress Report. Also, as a cash-based programme, IRIS falls under GAVI’s Transparency and Accountability Policy. Thus all financial management and reporting requirements specified under the Transparency and Accountability Policy will be required under IRIS.

Source of data to determine performance payments

21. Three different data sources could be used to measure results for the performance indicator against which payments would be made: country administrative data,[9] WHO/UNICEF Estimates of National Immunisation Coverage and household survey data. All three data sources have limitations.

22. The PPC recommended that the GAVI Alliance base its payments for coverage milestones on the WHO/UNICEF estimates, which is consistent with the use of WHO/UNICEF estimates to determine which countries qualify for IRIS and GAVI support for new and underused vaccines. The GAVI Alliance will invest in additional data assessment and verification activities—including a revised data quality audit—in order to strengthen country data systems and to provide additional information to help inform the process through which WHO/UNICEF coverage estimates are produced. These strengthening actions will seek to make the WHO/UNICEF estimates more sensitive to annual changes in immunisation coverage, particularly in the case of countries for which WHO/UNICEF have pegged their estimate to a

[9] Official country estimates could be used in place of administrative coverage. The two estimates are the same in most, but not all countries.

household survey rather than an administrative data source.[10] Strengthening actions will include:

- Assessment of validity of country administrative data through a revised data quality audit tool[11]
- Enhanced country participation in the assessment of data from different sources, the adjustment of administrative data as appropriate and the estimation of national immunisation coverage. This could include enhanced participation by CSOs; and
- Leveraging of more frequent household surveys, as appropriate.[12]

23. As part of the GAVI Alliance Business Plan for 2011 and 2012 (item 1.1.2.2), WHO will support improvements in the management, analysis and reporting of country administrative data, update data quality standards and assist in revising country coverage estimates which deviate from WHO/UNICEF estimates. As appropriate, these activities will focus on IRIS countries.

24. WHO/UNICEF estimates are sometimes revised retrospectively for specific countries—this can occur, for example, when new data sources become available that indicate that immunisation coverage may not have been accurately described by the original WHO/UNICEF estimates for the time period in question. If this occurs for any of the countries participating in IRIS, the GAVI Secretariat will work with WHO, UNICEF and the country to determine the most logical and equitable way to adjust the baselines and targets used for making performance payments.

Link with other performance based financing initiatives

25. Many countries, including those that qualify for IRIS, are considering results based financing initiatives to address supply and demand side constraints. Some have begun to design and pilot implementation, and a number are in the process of national scale up. DTP3 coverage is included as an indicator in almost all but the highest coverage countries. IRIS applications will require countries to describe results based financing initiatives underway in their countries and how incentives to improve DTP3 coverage can be incorporated into, build on, and complement broader health systems strengthening initiatives that introduce incentives. Countries will be encouraged to channel IRIS funding through national incentive systems and to build on existing results reporting and verification processes, where applicable.

Phase out of ISS

[10] When WHO and UNICEF peg their estimate to a household survey, in some cases they maintain their estimate for the country on a flat line until another survey is available, or until they see evidence that indicates that the country's administrative data have become more credible.

[11] The revision of the immunisation data quality audit tool began in 2010 and will be completed in 2011. Opportunities will be explored to use the revised DQA to assess the credibility of relative changes over time in coverage levels reported by administrative data systems, in addition to the credibility of the absolute level of coverage reported in a specified year.

[12] Surveys will need to be financed through government resources or the leveraging of investments from other development partners.

26. Given the limitations of the current ISS programme and taking into account the results from the Second GAVI Evaluation, the Secretariat recommends that starting immediately, no new applications for ISS support or extension of current ISS support be supported.

27. For countries that qualify for IRIS support, ISS support would conclude after programme year 2011. For countries that do not qualify for IRIS support, ISS support will continue to the end of a country's current ISS commitment, as approved by the Board. A list of Board approved commitments of ISS support for future years is included in Annex 4. The estimated financial cost for these commitments is $27 million between 2011 and 2015.

Estimated financial costs

28. Based on a simulation involving 13 countries, it is estimated that IRIS will cost approximately US$ 68 million over the 2012-2015 period and support the immunisation of 5.4 to 7.6 million additional children.[13] Nine of the 13 countries would surpass 70% DTP3 coverage and thus qualify for GAVI support for new and underused vaccines.

29. The budget envelope for this scenario is shown below for each year and for the entirety of the 2012-2015 period. This simulation is based on the assumption that the 13 countries will:

- Apply in 2011 and be approved for IRIS support starting in 2012
- Meet all of the conditions required to receive the fixed payments each year, and
- Achieve one coverage milestone per year on average, with no backsliding

Table 1 Approximate budget envelope for 13 countries,[14] 2012-15 (in million US$)

	2012	2013	2014	2015	Total 2012-15
Fixed payment	$6.9	$6.9	$6.9	$6.9	$27.6
Performance payments	$10.2	$10.2	$10.2	$10.2	$40.8
Total	$17.1	$17.1	$17.1	$17.1	$68.4

30. It is noted that the above is an 'optimistic' scenario. Some countries that qualify for IRIS may elect not to apply; others may apply but not have their applications funded on their first attempt. Others may submit successful applications but fail to meet the conditions required to receive the fixed payments each year, or they may not reach the ambitious number of coverage milestones assumed above. It is therefore likely that the amount disbursed under IRIS, and the number of additional children immunised, would be less than the amount estimated above.

[13] India was not included in the simulation, given its large population size relative to other IRIS-qualifying countries.
[14] Includes Central African Republic, Chad, Guinea, Guinea Bissau, Haiti, Lao, Liberia, Mauritania, Nigeria, Papua New Guinea, Somalia, Uganda, and Yemen.

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India and Nigeria

31. The costs and impact of implementing IRIS in India are not included in the projections above. Given India's large population size relative to other IRIS countries, it is proposed that a consultation with India be conducted in which other options are explored. One option may be for India to implement a pilot IRIS-type programme on a small scale, relative to its population; this may entail conducting IRIS in one or two states. Other options could involve a catalytic action that is developed through consultation with the country.

32. While Nigeria is included in the projections above, Nigeria—like India—has higher GNI per capita and a larger population size than the majority of IRIS countries. The constraints to increasing immunisation programme performance in large population, lower middle income countries tend to be different than those in other IRIS countries. Given this, consultations to date have recommended that the GAVI Secretariat conduct additional exploratory work to assess the suitability of the IRIS approach in Nigeria.

33. The suitability of IRIS to India and Nigeria will be assessed as part of a comprehensive strategy addressing each of these countries.

Health Systems Funding Platform

34. IRIS is complementary to GAVI's support for health systems. IRIS and the Health Systems Funding Platform are similar in that both seek to catalyse improvements in immunisation coverage and equity. They are different in that the Platform represents an investment in a country's health plan through a harmonised approach involving other global partners. Although funding through the Platform will be disbursed to countries based on demonstrated progress on a year-by-year basis, many of the systems strengthening activities financed through the Platform aim to produce long term improvements in the overall strength and capacity of the health system. In contrast, IRIS responds to the immediate need to support countries to raise their DTP3 coverage above 70% in order to meet the filter requirement for accessing GAVI support for new and underused vaccines. IRIS and the Platform are thus complementary—one addresses longer term systems-strengthening needs through harmonised and aligned approaches, while the other responds to the immediate need to support countries to reach 70% DTP3 coverage.

Gender policy

35. One objective of IRIS is to increase equity in immunisation coverage. Country proposals will address disparities specific to each country context. Where gender is a barrier to access, IRIS has the potential for positive impact.

Limitations and risks

36. IRIS is not a magic bullet. As demonstrated in multiple evaluations and peer-reviewed studies, ISS—like many development programmes, both performance

based and otherwise—has achieved mixed results. Many countries achieved large gains in increasing the reach of their immunisation programmes while receiving ISS support, but many other countries did not. There is a clear rationale for projecting that IRIS will likely help catalyse some participating countries to increase their routine immunisation coverage. However, the following limitations and risks are noted:

- There is a variety of reasons that countries are under 70% DTP3 coverage; IRIS is designed to address some of these causes, particularly those related to incentive environments. A number of fundamental barriers to increasing coverage are not likely to be addressed through IRIS. Eight of the 14 IRIS-qualifying countries are currently classified by the World Bank as facing "fragile situations".[15] IRIS can help address dysfunctional incentive environments that often exist in fragile situations, but IRIS cannot address their root causes.

- IRIS represents a fairly light touch approach from the standpoint of the GAVI Alliance. The transaction costs for countries will vary, depending on what countries propose to do in their applications for IRIS support and how current systems within the country operate. For countries that have experience with incentive based programmes, the added burden of implementing the plan presented in the country's IRIS application is not likely to be great. For countries for which these types of programmes are new, the transaction costs are likely to be larger. IRIS applications should be consistent with existing country-defined priorities and build upon existing country systems.

- Cash-based programmes entail inherent risks. Risks include misappropriation, other forms of financial mismanagement, dependence on external funds and substitution of government investments in immunisation programmes.

- All performance-based programmes are vulnerable to challenges in measurement of the performance indicators against which payments are made. Perfect immunisation coverage measurement systems do not exist. The WHO/UNICEF estimates, like all data sources, are subject to measurement error and other limitations.

Next Steps

37. Following Board approval, the GAVI Secretariat would begin the development of application forms, application guidelines, monitoring guidelines and the application and review mechanism in consultation with partners. The development process will include country consultations with IRIS qualifying countries. Funding of IRIS would commence in 2012.

38. Further exploratory work on the suitability of IRIS to India and Nigeria would be conducted within the context of the comprehensive strategy for India and Nigeria.

[15] CAR, Chad, Guinea, Guinea Bissau, Haiti, Liberia, Somalia, Yemen http://siteresources.worldbank.org/EXTLICUS/Resources/511777-1269623894864/FS_List_FY11_(August_8_2010).pdf. Accessed September 2010.

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39. The closing of the ISS window would be communicated to countries immediately.

Request to Board

40. The PPC recommends the following decision be taken by the GAVI Board:

"Taking into account the potential risks associated with IRIS, the Board decides to:

- *Move forward with the implementation of IRIS by opening a new window of support for countries with DTP3 coverage of less than 70%;*
- *Close the existing ISS window, subject however to fulfilling any existing commitments to eligible countries for ISS support;*
- *Use WHO/UNICEF estimates as the data source to measure country progress against the coverage milestones;*
- *Conduct additional exploratory work to provide the appropriate support to India and Nigeria."*

Annexes[16]

1. Members of GAVI Alliance Performance Based Financing Task Team
2. Summary of means through which IRIS seeks to address limitations of the ISS identified by the Performance Based Financing Task Team
3. Demographic, financial and immunisation-related data from IRIS-qualifying countries
4. List of Board approved commitments of ISS support for future years

[16] Additional materials are available upon request, including a description of the theory of change underpinning IRIS, a summary of the advantages and disadvantages of using different data sources to measure performance and a justification of the payment formulas that have been defined.

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ANNEX 1 Members of GAVI Alliance Performance Based Financing Task Team

Name	Institution at the time that Task Team convened
Joan Awunyo Akaba	Ghana Coalition of NGOs in Health
Cristian Baeza	McKinsey and Co
Rena Eichler, Chair*	Broad Branch Associates
Peter Hansen, Coordinator*	GAVI Secretariat
Jorn Heldrup*	GAVI Secretariat
Lidija Kamara*	World Health Organisation
Dan Kress*	Bill and Melinda Gates Foundation
Benjamin Loevinsohn	World Bank
Daniel Low-Beer	Global Fund to Fight AIDS, TB and Malaria
Ahmad Jan Naeem	Ministry of Public Health, Afghanistan
Ingvar Theo Olsen*	Norad
Louis Rusa	Ministry of Health, Rwanda
Jane Soepardi	Ministry of Health, Indonesia
Diana Weil	Stop TB Partnership
Prashant Yadav	Massachusetts Institute of Technology-Zaragoza Logistics Program

*Denotes that individual was member of sub-group that developed detailed design of IRIS for presentation to PPC in October.

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ANNEX 2 Summary of means through which IRIS seeks to address limitations of the ISS identified by the Performance Based Financing Task Team

Limitation of current ISS window	Means of addressing limitation through IRIS
There is little evidence that the incentives that national governments receive through ISS have cascaded down to lower levels in such a way that incentives for managers, health workers and communities are aligned with the achievement of positive outcomes	ISS provides a very clear incentive for a national government—and more specifically a national immunisation programme—to immunise more children. However, there is little evidence to indicate that these incentives have systematically cascaded down to lower levels of the system. For many key actors whose actions have a direct influence on immunisation outcomes, ISS rewards do not systematically align incentives with the achievement of positive outcomes. In order to address this limitation, IRIS requires countries interested in participating to present a clear and feasible plan for how incentives will be cascaded down to the interface between the service delivery system and users. Countries may choose from a menu of options—including for example provision of incentives to health teams for immunising a greater number of children and provision of cash transfers to poor households for ensuring that their children are fully immunised—or they may propose their own performance-based scheme to achieve results.

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Limitation of current ISS window	Means of addressing limitation through IRIS
Receipt of ISS rewards is determined not only by immunisation programme performance but also by the rate of growth of the cohort of surviving infants in a country	The ISS evaluation concluded that the strongest determinant of receipt of rewards is the rate of growth of the cohort of surviving infants in a country (Abt 2007). If a country's population grows by 2-3% per year, as is common in many GAVI eligible countries, the country can receive a large ISS reward even if coverage is stagnant. Countries that have a declining population may not receive rewards even if they achieve increases in coverage. In order to address this limitation, the transfer of cash rewards from the GAVI Alliance to countries through IRIS will be based on increases in coverage rather than increases in the number of children immunised. This prevents potential conflicts from emerging between competing health goals and avoids placing countries that have achieved reductions in their population growth rates at a disadvantage. Furthermore, given the importance of herd immunity, the ultimate goal of an immunisation programme is to reach a high proportion of the target population rather than simply a large number of children. It is also easier to compare coverage data to other data sources used to independently assess the accuracy of reported performance, such as coverage estimates from WHO/UNICEF and household surveys. WHO/UNICEF and household surveys provide estimates of the proportion of children immunised, but not the number of children immunised.
The current design of the ISS represents an "all or nothing" approach in which countries receive all investment phase money irrespective of performance, and then enter a phase in which all of the money is at risk.	Rather than building in an investment phase in which no money is at risk and a reward phase in which all money is at risk, IRIS provides a specified percentage of the money on a fixed basis and a specified percentage on an at risk basis (ie, conditional on performance) from the beginning. This reduces the risk that countries will receive no money when falling just short of the target. Since a large majority of countries have received ISS funds previously, there is no clear rationale for having a separate investment phase in which no money is at risk.

Limitation of current ISS window	Means of addressing limitation through IRIS
The extent to which reported results are independently verified is sub-optimal.	Rather than be based on administrative data, IRIS reward payments are based on WHO/UNICEF coverage estimates, with strengthening actions undertaken to make the WHO/UNICEF estimates more suitable for use within a performance based financing programme. WHO/UNICEF estimates examine country administrative data, household survey data and data from other sources as appropriate. IRIS will also incorporate a revised data quality audit tool.

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ANNEX 3 Demographic, financial and immunisation-related data from IRIS-qualifying countries

IRIS eligible countries													
Country	2009 Total population	2009 Number of births	2009 Number of surviving infants	2009 GNI per capita, Atlas Method (US$)	World Bank income classification	2009 DTP3 coverage (Official country estimate)	2009 DTP3 coverage (WHO/UNICEF estimate)	Year of DHS or MICS Survey	Type of Survey	Poorest quintile DTP3 coverage[17]	Least poor quintile DTP3 coverage	Next planned DHS or MICS survey
Central African Republic	4,422,397	154,412	138,490	450	Low	76	54	2006	DHS	62	22	2010 (MICS)
Chad	11,206,152	507,728	442,582	610	Low	75	23	2004	DHS	42	5	2010 (MICS)
Guinea	10,068,721	397,047	359,306	350	Low	85	57	2005	DHS	61	38	
Guinea Bissau	1,610,748	65,923	58,588	250	Low	82	68	2006	MICS3	76	55	2010 (MICS)
Haiti	10,032,620	273,968	256,944	n/a	Low	NR	59	2005-06	DHS	72	45	
India	1,198,003,273	26,787,426	25,371,306	1,180	Lower middle	NR	66	2005-06	DHS	82	34	
Lao	6,320,429	171,614	163,548	880	Low	67	57	2006	MICS3	59	29	2010 (MICS)
Liberia	3,954,977	148,569	134,792	160	Low	92	64	2007	DHS	72	30	
Mauritania	3,290,631	108,991	101,171	960	Low	64	64	2007	MICS3	60	53	2010 (MICS)
Nigeria	154,728,895	6,080,761	5,425,718	1,140	Lower middle	79	42	2008	DHS	76	8	2011 (MICS)
Papua New Guinea	6,732,157	208,460	198,234	1,180	Lower middle	64	64	n/a	n/a	n/a	n/a	
Somalia	9,133,124	401,771	358,657	n/a	Low	51	31	2006	MICS3	29	5	2010 (MICS)
Uganda	32,709,864	1,502,037	1,394,271	460	Low	83	64	2006	DHS	65	64	
Yemen	23,580,222	861,202	813,275	1,060	Lower middle	86	66	2006	MICS3	95	40	2010-11 (DHS)

NR = Not reported

NB: Papua New Guinea conducted a national immunisation survey in 2005-06, but the survey did not produce disaggregated estimates of coverage by household wealth status.

[17] Poorest and least poor quintiles defined in terms of household wealth status.

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Annex 4 List of Board approved commitments of ISS support beyond 2010

Country	Year Board approved commitment of ISS support ends[18]	Qualifies for IRIS support?
Benin	2011	
Bolivia	2011	
Cambodia	2015	
Cameroon	2011	
Central African Republic	2012	Yes
Comoros	2011	
Cote d'Ivoire	2011	
Gambia	2011	
Ghana	2011	
Guyana	2012	
Korea DPR	2011	
Lesotho	2011	
Madagascar	2011	
Mongolia	2012	
Myanmar	2011	
Nepal	2011	
Nicaragua	2011	
Rwanda	2012	
Senegal	2011	
Sierra Leone	2011	
Sudan South	2011	
Togo	2011	
Zimbabwe	2011	

[18] The year refers to the programme year, rather than the year of disbursement of reward monies (i.e., for a country whose support expires in programme year 2011, the final review of performance against targets and disbursement of reward money would occur in 2012).

FOR DECISION