

SUBJECT:	COUNTRY PROGRAMMES STRATEGIC ISSUES
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Section A: Overview

1. Purpose of the report

- 1.1 This report provides an update by the Gavi Secretariat's Country Programmes Department and its Alliance partners on their joint in-country work.

2. Recommendations

- 2.1 This report is for information only.

3. Executive summary

- 3.1 2015 is a **transition year** as the Alliance concludes the 2011-2015 strategic period and gears up to implement the 2016-2020 strategy.

- 3.2 The Alliance has focused strongly on delivering on the objectives of the **2011-2015 strategy**, by:

- completing the introduction in all Gavi eligible countries of pentavalent vaccine, which protects against diphtheria, tetanus, whooping cough, hepatitis B, and the haemophilus influenza type B bacteria;
- accelerating the delivery of new vaccines, in particular rotavirus vaccine (which protects against diarrhoea) and pneumococcal vaccine;
- helping to strengthen the capacity of integrated health systems to deliver immunisation;
- increasing the predictability of global financing and improving the sustainability of national financing for immunisation.

3.3 The central pillars of the **new strategy** are improving immunisation-related coverage and equity, and ensuring financial sustainability of country programmes. Building on lessons learnt from the current strategy, the Gavi Secretariat and the Alliance partners will adopt a country-centric approach, in which all interventions are tailored to the needs, contexts and opportunities defined within each country's multi-year immunisation plan. The aim is to enhance each country's sense of ownership, strengthen political commitment and increase equitable, sustained vaccination coverage.

3.4 **A transition year across the Alliance:**

- (a) The Alliance has been ensuring progress towards the goals in the 2011-2015 strategy, while improving support for each country's needs, through enhanced coordination and alignment between the **Strategic Goal Management teams**. Discussions on how best to harmonise the Management teams' work are ongoing.
- (b) Revisions to the **grant application, monitoring and review processes** are continuing. These reinforce Gavi's increased country-centric approach and aim to facilitate bottom-up planning and tailored approaches to countries through joint appraisals.
- (c) A number of important **initiatives and changes** in the area of financial risk management and strengthening of grant management are currently implemented within the Secretariat's Country Programmes Department. These will ensure that the Secretariat has the right resources, tools and procedures in place to deliver on the current and new strategy.
- (d) Work is ongoing to develop **Performance Frameworks**, agreements between each country and Gavi on the key metrics that will be used to monitor performance during grant implementation.

3.5 **Highlights of the Strategic Goal work areas:**

- (a) ***Strategic Goal 1 (SG1): Accelerate the uptake and use of underused and new vaccines by strengthening country decision-making and introduction.***
- (b) Support continues for **vaccine introductions** at country level. Since the last update, 26 new routine and campaign introductions and 4 demonstration introductions have taken place. All 71 countries that have applied have now been recommended for inactivated polio vaccine (IPV) support, a major achievement supporting the broader Global Polio Eradication Initiative (GPEI) goals. In addition, the first introduction of Japanese encephalitis (JE) vaccine took place in the Lao People's Democratic Republic (Lao PDR) in April this year and Ghana became the first country to apply for introduction of conjugate meningitis A (Men A) vaccine into its routine immunisation programme.

- (c) As the Alliance gears up to **shift** its focus from vaccine introductions to **improving coverage and equity**, it is taking stock of how Alliance partners can most effectively provide support. To this end, Gavi is continuing its engagement with GPEI in the Polio Endgame Strategy to leverage polio assets in support of routine immunisation strengthening in 10 polio and Gavi-focus countries. This engagement is fully aligned with the transition to Gavi's new strategy and provides valuable lessons about effective country support approaches. To date, 9 of the 10 countries have developed robust, fully costed national plans under the WHO's Expanded Programme on Immunisation (EPI), derived from comprehensive multi-year plans (cMYPs) that detail activities to improve immunisation coverage in high-risk districts and are endorsed by government coordination bodies. These nationally owned plans detail how WHO and UNICEF polio assets should support coverage improvement and form the basis for defining additional technical support needs.
- (d) With every new planned introduction, Alliance partners continue to work with national immunisation programmes to use new vaccine introductions as an opportunity to review their performance and identify critical areas requiring improvement to ensure high-quality, **sustained vaccine introductions**. Work is ongoing to support prioritised inclusion of those areas for improvement in the country yearly plans. Vaccine introduction grants (VIGs) will allow countries to fill critical gaps in areas such as cold chain capacity, front-line vaccinator and supervisor training, and vaccine stock management.
- (e) ***Strategic Goal 2 (SG2) Contribute to strengthening the capacity of integrated health systems to deliver immunisation.***
- (a) Since 2013, the Alliance's approach to health system strengthening (HSS) has centred on **catalytic** interventions that improve immunisation outcomes, including coverage and equity.
- (b) Twelve proposals were recommended for approval by the Independent Review Committee (IRC) in 2014, bringing the total to **78 active HSS grants in 66 countries**. Eleven additional proposals have since been recommended for approval, including five recommended for approval during the March 2015 IRC round that are pending finalisation of specific clarifications before they are approved by the CEO. The IRC has reported that the quality of proposals is improving, which will strengthen overall immunisation outcomes. Recent proposals recommended for approval by the IRC focus on service delivery (32%), health and community workforce (17%), procurement and supply chain (17%), and health information systems (15%).

(c) **HSS support** is being increasingly **customised** to country needs with a focus on moving beyond proposal development to working with countries and monitoring implementation throughout the grant life-cycle. This is particularly critical where intermediate results are not achieved or grants are under-implemented. Since 2013, the alliance has required strengthened M&E frameworks. Six countries have reported against the new M&E data requirements, achieving 40 to 60% of intermediate results. Gavi anticipates reports on intermediate results from 21 countries in 2015. Understanding is growing of how past Board decisions are translating into actions by countries. Along with greater support from partners, including civil society groups and the private sector, this will help ensure that investments are removing key bottlenecks and improving immunisation outcomes.

(f) ***Strategic Goal 3 (SG3) Increase the predictability of global financing and improve the sustainability of national financing for immunisation.***

Under SG3, **financial sustainability work has remained on track** and Alliance and its partners have stepped up significantly their engagement with graduating and underperforming countries. All countries that defaulted in 2013 have paid their arrears and avoided suspension of their vaccines. Ten graduation assessments were conducted in 2014 and eight of those countries have subsequently developed graduation plans. Gavi and its partners continue to encourage governments to devote more public spending to immunisation programmes.

(g) ***Country-specific work***

(a) Country Tailored Approaches have been developed for a limited number of countries under the 'fragile states policy'. As Gavi focuses on strengthening stewardship and proactive grant management, it is gradually moving towards more **customised, tailored approaches** for all countries.

(b) The Alliance is beginning to implement a more **proactive, bottom-up approach** to identifying each country's technical assistance needs. The redesign of the Business Plan process (now Partnership Engagement Framework) and the linking of discussions on technical assistance to the joint appraisal findings embody this strategic shift.

(c) The Secretariat has embarked on **leveraging non-Gavi partners** such as the Global Fund more broadly and systematically, and taking advantage of the benefits of partnerships. This work has been focused on overlapping areas such as fiduciary risk management and health system strengthening.

- (d) The **Ebola outbreak** highlighted the importance of tailored approaches and the need for the Alliance to be flexible and nimble in its response to country contexts. The Alliance is implementing the Gavi Board-approved elements contributing to EPI and health system recovery efforts in the three most affected countries. All the affected countries have been visited and plans are being developed to meet their needs, including reprogramming of HSS as well as catch-up campaigns for measles (see separate paper discussed under item 8).

4. Risk implication and mitigation

- 4.1 **Insufficient expansion of human resources** could affect the quality of Gavi's country programmes, their ability to implement key changes and focus on the most strategic areas (e.g. risk management), and their ability to deliver against demands from active programmes that have doubled in scope in two years and are expected to grow substantially in the coming year. The Alliance is seeking to draw on partners' resources to address shortfalls, but it takes time for new or redeployed staff to contribute effectively.
- 4.2 A new architecture for the business planning and budgeting process may require a realignment of Alliance partners' roles and responsibilities to ensure that they focus where they have comparative advantage. While this process will produce numerous benefits, the quality of the Alliance's work could be affected by insufficient human resources or **insufficient capacity** to implement the necessary changes in the short term. Alliance partners' core resources will be targeted to address potential shortfalls.
- 4.3 A number of **programmatic risks** have been identified throughout the work undertaken in the Country Programme Department, including adverse events following immunisation (AEFIs), co-financing and stock-outs (vaccine shortages), as well as necessary mitigation actions. Detailed descriptions of risks and mitigation strategies are included in this paper.
- 4.4 There is a risk that the Alliance will not be able to achieve its **coverage and equity targets** by the end of 2015. Partners and business plan resources are increasingly being targeted to prevent such a shortfall. HSS guidelines for activities that will have direct impact on coverage and equity have been improved, and the inclusion of intermediate indicators will enhance Gavi's ability to monitor results, which would be critical.
- 4.5 The requirement to roll out **IPV in 71 countries** over a short period has led many countries to concentrate on this vaccine, with some **impact on other Gavi programmes**. A small number of countries have delayed introductions in order to harmonise their plans to include IPV,¹ either by combining introductions or by allowing sufficient spacing between them. Countries may also have postponed applications for other vaccines in order to concentrate on IPV. The impact of IPV on other programmes has

¹ See further information in Annex A.

now largely been absorbed, but the effect of next year's planned discontinuation of trivalent oral polio vaccine (tOPV) and switch to bivalent OPV (bOPV) is still unknown. The switch will require the withdrawal and destruction of all doses of tOPV in all Gavi countries over two weeks in April 2016. GPEI has started preparing for the switch. Gavi is receiving early signals that immunisation staff and systems will be heavily involved with the switch in 2016, with likely impact on Gavi programmes.

4.6 Vaccine management at country level remains a significant risk area, as highlighted by four separate incidents in the last few months.

- (a) Ghana (in January 2015) and Ethiopia (in April 2015) experienced fires in their central medical stores; in the case of Ghana the loss of vaccines and/or vaccine products (syringes and safety boxes) is estimated at US\$ 1,473,000²; we are still awaiting further details to determine the full extent of loss in Ethiopia. The Ethiopian government has however confirmed that the stocks were insured, as required under Gavi's policies, and is working with the insurer to confirm how much of the loss will be covered.
- (b) A non-functioning cold room discovered in a central warehouse in Pakistan in February 2015 resulted in loss of 1.3 million doses of pentavalent vaccine; early reports suggest that it is due to supervision negligence. Upgrades of the services are underway. Finally, in February 2015, DRC expressed reluctance - based on an expert's advice - to use a stock of 578,000 pentavalent vaccines that had reached stage 2 of their (type-7) vaccine-vial monitor (VVM)³; the government requested UNICEF to take back the full stock.
- (c) The Alliance has been swift in responding to these incidents. For the fires, this involved collaboration with the Ministry of Health and local partners to quantify the impact of the fires and make appropriate arrangements to replace the commodities lost. In DRC, intensive multi-partner discussions and negotiations allowed MoH concerns over the vaccine's safety to be mitigated and a sound plan for vaccine usage to be developed and implemented.
- (d) The Alliance is also working on upstream mitigation efforts. Examples include reviewing overall cold room and storage improvements that need to be implemented with immediate effect, or ensuring that countries have the necessary insurance policies in place to protect against incidents like fires.
- (e) The Secretariat is reviewing procedures with the Audit & Investigations and Legal teams to ensure the Alliance can mitigate the risk of similar incidents in the future and ensure we are protected against any losses.

² No vaccines were lost but EPI commodities, including syringes, child health records, safety boxes and cold room equipment, were destroyed.

³ Stage 2 represents a VVM that has received some heat exposure but is still usable; VVM 7 is a moderate stability VVM, able to withstand 7 days at 37 degrees Celsius.

5. Financial implications: Business plan and budgets

- 5.1 Funding for all above described activities, measures or interventions is budgeted for in the Gavi Business Plan for 2015 or in Gavi's supported budget.

Section B: Content

6. Introduction

- 6.1 The main body of this paper begins with an update on how Gavi is implementing the **current strategy** and **gearing up for the new strategy**. This includes Gavi's new grant application, monitoring and review (GAMR) approach, potential revisions to the structure of the Strategic Goal Management Teams and changes in the Gavi Secretariat.
- 6.2 The second section highlights recent developments in **three of the four strategic goals** (Strategic Goal 1: the vaccine goal; Strategic Goal 2: the health systems goal; and Strategic Goal 3: the financing goal) set out in Gavi's 2011-15 strategy. More detailed information on implementation of each goal is provided in Annexes A to D.
- 6.3 The third section provides an update on recent developments in four of the most **complex, highest-priority countries** in the Gavi portfolio: Pakistan, the Democratic Republic of Congo (DRC), Nigeria and India.

7. Implementing the new strategy across the Alliance

- 7.1 The Alliance is seeking to better align its interventions under the new strategy by improving planning and coordination. Historically, the business plan has been the key mechanism to plan, coordinate, fund and manage the activities of Alliance partners. The Secretariat and Alliance partners are proposing to replace the Business Plan with a **Partner Engagement Framework (PEF)**. This more country-centric approach, the product of intensive discussions across the Alliance, seeks to enable longer-term planning and funding of core Alliance activities and provide more flexibility in responding to country needs. It also aims to be a platform for broadening the Alliance, aligning it better with the activities of other donors and partners, and improving accountability across the Alliance, especially at country level. Through the PEF, the Alliance will establish bottom-up, country-driven and country-focused planning of technical assistance and interventions. The PEF will enable Gavi to increase clarity on roles, responsibilities and coordination among partners at country and the regional level and, ultimately, increase its impact at the country level by improving coverage and equity.

New grant application, monitoring and review approach

- 7.2 The **ongoing redesign** of how Gavi monitors and reviews grants provides the Alliance with an important opportunity to strengthen its engagement with countries and refine its approach to performance. Recent work has

focused on two core areas: improving the joint appraisal process and developing the Performance Framework approach. The work draws on feedback from a 2014 consultations with partners, High Level Review Panel members, and stakeholders in countries and partner organisations.

- 7.3 Feedback on **joint appraisals** highlighted the value of this approach as it fosters stronger collaboration between government and Gavi stakeholders. It also stressed the need for greater clarity on the purpose of the joint appraisal, more guidance on the process, greater flexibility to enable alignment with country cycles, and a revised joint appraisal report template (to better distinguish the joint appraisal from an EPI review and to focus on achievements against grant objectives).
- 7.4 In March 2015, the Secretariat released **new guidance materials** and a revised report template for the joint appraisal process. All countries will conduct a joint appraisal starting this year, although the approach will vary by country depending on factors such as complexity of the grant portfolio, risk, co-financing, graduation and opportunities to link with other review processes. Gavi has developed key principles that all joint appraisals should follow to ensure the quality of the process and its outcomes. The joint appraisals will identify key areas where additional investments and efforts are needed and will give countries greater say in the process.
- 7.5 The **Performance Framework**⁴ is an upfront agreement between a country and Gavi on the indicators and targets that will be used to report on and monitor grant implementation. The Performance Framework is intended to focus country reporting, improve grant monitoring and enable more systematic review of performance at the time of funding renewal.

More effective Strategic Goal Management Teams

- 7.6 The need to scale up Gavi's operations under the new strategy will necessitate strong coordination among Gavi's previous four Strategic Goals as well as better alignment with the overarching immunisation goals of the Global Vaccine Action Plan (GVAP). Within this context, the Gavi Secretariat organised a meeting in early February between Strategic Goal Management Teams 1, 2 and 3 to discuss **harmonising** the teams' work to improve coverage, equity and sustainability. This was complemented by a one-day retreat that gathered WHO and UNICEF staff from global and regional levels and the Gavi Secretariat. Several guiding principles emerged from the discussions,
- the focus of Alliance engagement must be redirected to the country level;
 - the Alliance must take a long-term view of engagement with countries, allowing country-specific flexibility while providing predictable, longer-term support;

⁴ The Performance Framework includes agreed indicators and the related baseline, target, data source and reporting schedule

- Gavi Secretariat processes and procedures must be aligned with national budget and planning cycles to permit bottom-up planning and resource mobilisation for national annual immunisation plans;
- the focus of management and oversight of country assistance should move from the global to regional level. Existing Regional Working Groups could play an expanded role in coordination, oversight and dealing with country immunisation issues.

Changes within the Secretariat's Country Programmes Department

7.7 To ensure that the Secretariat has the capacity, tools and procedures needed to deliver on the current and new strategy, Gavi's Country Programmes (CP) department is implementing a number of important initiatives and changes:

- (a) Grant management **resources** in the Secretariat are being reinforced. A capability-building programme is being developed to further train Senior Country Managers (SCMs). The number of SCMs is being increased to balance management, workload and distribution of high-risk countries. Countries are being reallocated among SCMs to manage risk better and enable SCMs to cater better to their countries' specific contexts. Gavi has now dedicated SCMs for three of the most complex countries, Nigeria, DRC and Pakistan)
- (b) CP has started recruiting a new **Programme Finance** team, responsible for providing financial expertise to the Country Support Team and ensuring compliance with Gavi's fiduciary policies, procedures and practices. In parallel, CP and other Secretariat teams are revising, developing and implementing systems, processes and tools to optimise Gavi's management of fiduciary and financial risk. An enhanced risk and impact stratification of Gavi-eligible countries is also being developed. This will help CP and Alliance partners make more informed decisions on staffing needs for countries at the Secretariat and country level.
- (c) To enhance responsiveness to countries, a **Country Team Approach** is being implemented in the Gavi Secretariat. Under this new approach, every Gavi-supported country will have an assigned focal point within the different Secretariat grant support functions (Legal, Programme Finance, Grant Performance Monitoring, etc.). The SCM will lead and coordinate the Country Team, which will have joint responsibility for grants over their full cycle. By drawing on its skill mix, the Country Team will be able to achieve high-quality decisions and results, effectively resolve grant management issues, and conduct integrated, robust risk management. Implementation began in late 2014 with two pilot Country Teams, for Nigeria and DRC. The full, formal launch of the new approach is scheduled for mid-2015.

- (d) Since January 2014, CP has been working on developing a set of **Operational Guidelines (OGs)**. The purpose of the OGs is to outline the way Gavi manages different activities and steps of the grant cycle – from grant submission to graduation and grant closure. OGs provide guidance to SCMs and country teams on how they should function together. They define roles and responsibilities. The development of the OGs is an important and broad-ranging initiative to ensure that Gavi’s grant management processes are applied consistently, efficiently and transparently.
- (e) Gavi and the **Global Fund** are working to enhance the existing collaboration between the organisations on country issues. Gavi teams working on HSS, country support and risk are meeting periodically with their Global Fund counterparts to share knowledge and experiences, and further plan specific areas of collaboration. This includes:
 - (a) further aligning (e.g. on HSS) to increase effectiveness and reduce complexity for countries;
 - (b) sharing knowledge and capabilities, such as intelligence from country missions;
 - (c) aligning audit plans to enhance combined impact;
 - (d) enhancing collaboration on financial and fiduciary risk management (e.g. senior leader workshop to discuss the respective approaches to risk; shared fiduciary agent in DRC); and
 - (e) providing special attention to collaboration of Secretariats’ Country Teams in a few focus countries: DRC, Nigeria, Ethiopia, Guinea, Sierra Leone and Liberia.

8. **Strategic Goal 1: Accelerate the uptake and use of underused and new vaccines by strengthening country decision-making and introduction**

- 8.1 This section provides an overview of Alliance wide activities related to implementing Strategic Goal 1, including an update on indicators measuring progress towards the goal, as well as activities gearing up to the new strategy (further information is provided in Annex A).

New vaccine introductions

- 8.2 Between the last update (August 31, 2014) and March 31, 2015, there were **26 new routine and campaign introductions**: 8 for pneumococcal conjugate vaccine (PCV), 3 for rotavirus vaccine (RV), 5 for inactivated polio vaccine (IPV), 1 for measles second dose, 5 for measles rubella (MR), 3 for meningitis A (Men A) and 1 for yellow fever (YF). Four demonstrations of human papillomavirus vaccine (HPV) also started. For detailed updates on each vaccine programme, please see Annex A.

Making the transition to the 2016-20 strategy

- 8.3 As the Alliance moves towards increasing coverage under its new strategy, **Pentavalent (Penta) vaccine programme** is now becoming one of the strategic areas of focus. Beyond the achievement of to achieve Gavi's coverage goal for this vaccine and thus contributing to the DTP3 GVAP goals, Penta coverage is directly linked to the coverage of three other key Gavi vaccines that are co-delivered with it: Pneumococcal, Rotavirus and IPV.⁵ To achieve these goals it is necessary to continue to lower barriers to coverage for Penta, for example by responding promptly to questions about the safety of the combination vaccine, and by countering reluctance to use multiple injections or the reluctance of healthcare workers to open multidose vials in small immunisation sessions.
- 8.4 All 71 countries, including India, expected to apply for support for **IPV introductions** have now been recommended for approval by the IRC. As of 31 March, implementation has started in five countries and it is estimated that by the end of the year, the Alliance will have started rolling out the programme in the remaining 66 countries. The number of forecasted IPV introductions in 2015 exceeds the highest number of introductions any other vaccine programme reached in one year (16).⁶ In addition, all countries have applied within 14 months of the Board approval of the IPV programme. Successfully managing applications, introductions and initiating roll-out has required extensive work by all Alliance partners. Given the unprecedented speed of uptake and roll-out of the IPV programme, availability of adequate vaccine supplies is proving increasingly challenging. UNICEF's Supply Division is aiming to ensure that there are no unnecessary delays that could lead to delays in reaching the targets agreed in the polio eradication strategy and strategic plan. Gavi and the GPEI are also working to ensure that IPV introductions are implemented in time for a coordinated global switch from trivalent oral polio vaccine to bivalent oral polio vaccine (tOPV-bOPV), expected to take place in April 2016. At the moment introduction plans are on track, but some delays may be faced because of IPV supply constraints. Special attention is being given to monitoring and minimising delays in other Gavi vaccine programmes resulting from the IPV introduction or the planning for the switch. In December 2014, the Gavi Board decided to provide twelve months of catalytic IPV support to India and the country and partners have been working together to keep the introduction on track for October 2015. The Gavi Secretariat expects to be able to formally approve the application in Q2 once UNICEF SD's tender for locally licensed IPV is concluded and a formal agreement with GPEI donors is in place for the additional funding required for India.
- 8.5 The first wave of **HPV introductions**, including 13 demonstrations and one national roll-out, **provided lessons enabling redesign of the**

⁵ Pentavalent vaccine can be administered with PCV, RV, and in the future IPV.

⁶ RV programme in 2014

Alliance's in-country work. They have highlighted the difficulty of obtaining of accurate target population estimates, in particular for out-of-school girls and especially in contexts where it is illegal not to enrol children in school. A better understanding of the delivery costs associated with various strategies is another lesson. The Alliance HPV sub-team monitors and analyses these findings to facilitate implementation and to incorporate these findings in the programme design. Countries display a growing interest in integrated programmes that allow for joint delivery with HPV vaccines of other commodities, such as tetanus toxoid vaccine, health education material, or deworming medication. Such integrated approaches would require more concerted effort across the Alliance to provide countries with all necessary support during implementation. Lessons from HPV integration efforts (needs for clear plans, accountability and funding for integration, required multi-departmental engagement) can also be used to plan for integration of other disease control interventions, such as rotavirus, Hib and pneumococcal vaccines.

- 8.6 After intense preparatory work across the Alliance, in April 2015 Lao PDR became the first country to launch the **Japanese encephalitis (JE) vaccine** in a campaign to be followed by domestically-financed introduction into its routine immunisation programme. Ghana is becoming the first country to apply for the introduction of **Men A vaccine** as part of its routine immunisation programme for 2016. The latter introduction will present an important step for the Alliance, away from supporting only preventive campaigns towards funding routine immunisation in the 26 endemic countries, which is expected to reduce related deaths, avoid significant disability and produce considerable economic benefit.
- 8.7 There are **renewed efforts to roll out PCV and RV in all countries eligible and interested**. Currently, there are 58 approvals for PCV and 41 for RV. In countries that have not yet applied for support for PCV and RV, the Alliance will help countries reach evidence-based decisions on introduction and product choices, and help them to identify and overcome programmatic challenges.
- 8.8 Plans have been put in place to **prepare for the recovery of immunisation programmes in Ebola-affected countries**. During the second quarter of 2015, recovery activities within EPI departments are being carried out in Liberia, Sierra Leone and Guinea. The aim is to reverse the drop in coverage caused by the Ebola outbreak – which led to a quarter of a million children being underimmunised– with particular focus on measles vaccinations.
- 8.9 The Alliance is working to improve **quality and efficiency of short-term demand forecasting, procurement processes and delivery solutions**. A revised operational process will be implemented during 2015 to ensure more accuracy and detail in demand forecasting and thus improve the quality of planning for vaccine programmes. Optimisation of procurement processes is also currently being explored, following benchmarking work in 2013. A more transparent and precise process of defining countries'

annual vaccine dose requirements has been rolled out for Penta, based on a better understanding of countries' stock levels. The same approach will be extended to other high-value vaccines, such as PCV, to optimise vaccine dose allocation plans and cash management. Finally, better delivery solutions are being explored that can reduce wastage and missed opportunities for immunisation, while increasing safety and improving efficiency of immunisation sessions. Pilot use⁷ of a new compact prefilled auto-disable injection (cPad) delivery tool and multiple presentations for the same vaccine in a country are being assessed.

- 8.10 UNICEF's Programme Division (PD) continues to support new vaccine introductions, taking advantage of the training opportunities and media visibility of introductions to **mobilise communities, improve the quality of health workers' interpersonal communication, and generate demand** for new vaccines and/or routine immunisation (RI). In the case of PCV and RV introductions, UNICEF continues to provide complementary programming including messages about "healthy actions" (including RI) for preventing and treating pneumonia and diarrhoea. UNICEF also provides in-country communication and social mobilisation support for supplementary immunisation activities (SIAs) and HPV demonstration projects, and works closely with government counterparts and partners on national preparedness for potential crisis communications and media management. The focus of UNICEF communication and social mobilisation support for EPI and new and underutilised vaccine implementation (NUVI) has likewise been shifting in 2015 from vaccine introductions to longer-term strategies for community engagement and demand stimulation to improve coverage and reduce dropouts.
- 8.11 Alliance partners have developed an implementation plan for the 2015-2020 **Gavi Supply Chain Strategy**, which was approved by the board in June 2014. The plan details the critical steps that would be taken in 2015 and results anticipated through 2020 in order for immunisation supply chains to provide potent vaccines efficiently in Gavi countries. The five fundamental building blocks the strategy promotes are: 1. immunisation supply chain leadership; 2. immunisation supply chain data for management, 3. better cold chain equipment, 4. continuous improvement plans, and 5. immunisation supply chain system design. Establishing these fundamentals in countries will help increase coverage and equity, goals of Gavi's new strategy.
- 8.12 Implementation of the Gavi supply chain strategy and the associated support to countries is accelerating through intensive efforts of Alliance partners and the Secretariat. The work combines both assistance tailored to individual countries and strategic elements at the global level. A controlled temperature chain (CTC), which allows vaccines to be kept outside a traditional 2°C–8°C cold chain for a limited period of time, was successfully implemented in the Gavi-supported Men A campaigns of three countries in West Africa. A CTC allows improved coverage and

⁷ A pilot project is currently under way in Kenya.

equity by extending the reach of health care workers beyond the usual limits of the cold chain. The East African Community is progressing with establishment of a Centre of Excellence for health supply chains at Rwanda University with support from the German government. The centre will provide critical, institutional support to strengthening the management of supply chains across the region, and will help reinforce the enabling work on Leadership, Management and Coordination in the new strategy. Such regional focus is complemented by work at the global level to develop a curriculum for executive supply chain training by a UPS Corporation secondee. Gavi's work on the supply chain "fundamentals", including data and design of supply chains will be further amplified by the the proposed Cold Chain Equipment Optimisation Platform.

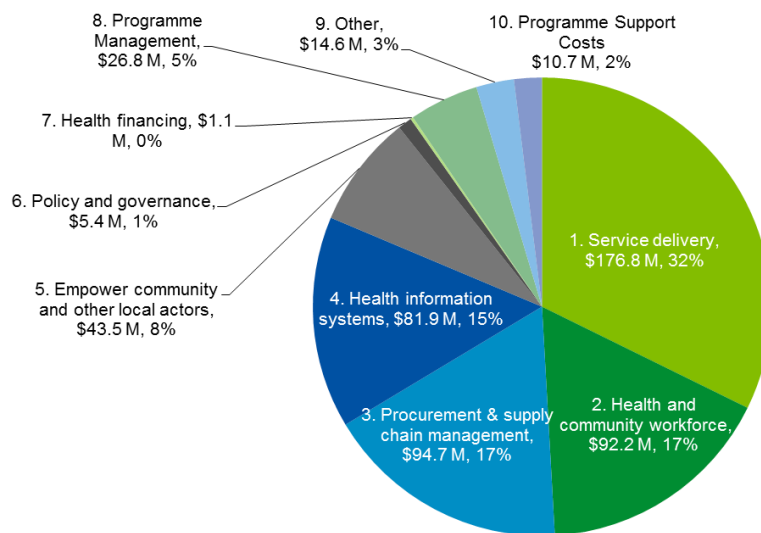
9. Strategic Goal 2 – Contribute to strengthening the capacity of integrated health systems to deliver immunisation.

- 9.1 This section provides an update on interventions related to implementing Strategic Goal 2 and increasing coverage and equity (further information is provided in Annex B).

Health System Strengthening

- 9.2 The **transition of the HSS portfolio** continues from grants awarded under the Board's 2007 HSS decision (which more broadly supported health services outside of immunisation). The Gavi Board approved a **new approach to HSS** in 2012. All grants should have an increased focus on supporting interventions to improve immunisation outcomes and include a performance-based funding approach (HSS/PBF) by 2017/2018. Of current grants, 67% were awarded under the 2007 decision, while HSS/PBF grants totalling US\$ 311 million have been approved for 30 countries.

Chart 1: Proposed investments from 31 HSS grants (2011-2014)



9.3 Gavi's grants have been noted to **strengthen health systems beyond immunisation**. For example, the 2014 Joint Appraisal in DRC found that HSS-supported activities were complementary to those supported by other funding sources, and served as a catalyst for the implementation of the national plan. In Sri Lanka, HSS funds were used to rebuild public health services in ten conflict-affected districts of the northeast, which contributed to increased coverage in those areas. Activities included repairing clinics, training healthcare workers, and procuring equipment. In Lao PDR, Gavi support has helped to support improvements in the MNCH information system which were launched in Gavi supported districts and three central hospitals. The system enrolls individual pregnant women and new-borns using a barcode registration system, allowing follow up of infants for vaccination.

9.4 Six HSS/PBF countries reported in 2014.⁸ The data on **intermediate results** is too limited to allow for a conclusive analysis on results and outcomes. Yet they show that countries achieved targets 60% of the time for training of health workers and for supply chain infrastructure and management, 47% of the time for service delivery, and 40% of the time for outreach and community mobilisation. Data on utilisation of HSS funds show that service delivery activities had the highest rate of implementation at 71%. Health and community workforce activities had the lowest rate, at 25%. Bottlenecks to implementing health and community workforce activities included delays in the procurement of service contracts (Afghanistan) and a lack of competent trainers (Comoros).

⁸ Countries were Afghanistan, Burundi, Comoros, Lao PDR, Rwanda and Zimbabwe. Data on performance of Gavi's HSS/PBF grants is rapidly increasing each year, allowing the Alliance to further measure portfolio performance and results. In 2015, reports on implementation of HSS/PBF grants are expected from 21 countries.

- 9.5 As part of all approved proposals, the Alliance will build help countries to establish more comprehensive **Performance Frameworks**, which will be used to report on and monitor performance during grant implementation. The Frameworks will be developed in 2015, with support from the newly established Grant Performance Monitoring team in the Secretariat. Performance Frameworks will play a key role in ensuring that indicators are clearly linked to grant objectives and that verifiable data sources are available to measure progress.
- 9.6 From 2014 onwards, HSS guidelines require an **end-of-grant evaluation** and strongly recommend **mid-term evaluations**. These provide an additional source of data on grant implementation, achievements and challenges. The health facility surveys being conducted in 2014/2015 in four countries will provide a baseline for future HSS evaluation activities. Repeat surveys scheduled for 2016 will provide useful insights to track HSS results and outcomes.
- 9.7 One of the main challenges related to assessing HSS investments is **data weakness at country level**. Some countries need to strengthen data on baselines for their targeted intermediate results. DRC has prospectively planned through its new HSS grant to use health facility assessments for provincial and national baselines throughout the grant cycle. Discrepancies between administrative data presented by the country and data from the WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC) remain a challenge for Performance-Based Funding approaches, although alternative data verification methods have been included in the 2014 guidelines.
- 9.8 Despite such challenges, the Alliance is working hard to ensure that investments are catalytic and reflect value for money. The Alliance is enhancing data collection and **exploring mechanisms to strengthen data quality at country level**. These efforts should help the Alliance to articulate results, outcomes and achievements related to HSS investments more concretely.

Country Case Study: Additional support to HSS grants in Madagascar and Mauritania

A review of work by John Snow, Inc. (JSI) and Agence de Médecine Préventive (AMP), which were contracted by Gavi to help countries collaborate with other local partners, illustrates the benefits of Gavi's support in two countries, Madagascar and Mauritania. In Madagascar, JSI played an instrumental role in helping the Ministry of Health to finalise vaccination policy, develop a Gavi HSS proposal and plan for vaccine introductions. JSI also successfully advocated for increased immunisation financing. In Mauritania, AMP helped identify barriers to implementing a Gavi HSS grant, including insufficient technical assistance and lack of transportation to conduct supportive supervision and other field activities. Despite these challenges, Gavi HSS support has been successful in several ways, including building staff capacity in supportive supervision and maintenance of cold chain equipment. AMP support also facilitated

the approval of the HSS grant work plan by the interagency coordination committee (ICC), which ensures that in-country stakeholders are aware of and support planned HSS activities and timelines in order to better facilitate grant implementation.

Country Case Study: Pooled funding in Nepal

Gavi is participating in pooled funding mechanisms in Nepal and several other countries. An evaluation on whether or not to continue to participate in these will be undertaken once more data has been collected. In March 2015, Cambridge Economic Policy Associates Ltd. and the Health Research and Social Development Forum completed an evaluation of whether Gavi's HSS support to Nepal through the pooled funding mechanism had met its four objectives of improving (1) human resources for health (HRH), (2) service delivery, (3) district health service delivery in 15 low-performing districts and 25 municipalities, and (4) physical assets and logistics management.

In terms of results, Nepal has made significant progress on Millennium Development Goals (MDG) 4 and 5 (reducing child and maternal mortality), on immunisation coverage and on selected HSS indicators under the second Nepal Health Sector Programme (NHSP-II), but inequity persists in health service provision and immunisation coverage. Good progress was achieved in strengthening human resources for health and in establishing systems and controls for procuring pharmaceutical supplies. Gavi's HSS support to Nepal through the pooled fund is well aligned with Gavi's mission and objectives related to immunisation, and its integration within broader HSS is a top priority in the country, both in policy and practice. A key benefit of funding through a pooled mechanism is that it provides a seat at the policy-making table, but Gavi has not fully taken advantage of this opportunity due to limited Secretariat capacity and ineffective representation by in-country partners.

The report concluded that the channelling of Gavi's HSS support to Nepal through the pooled funding mechanism has been of added value to Nepal and has afforded a number of advantages to Gavi, including leveraging its limited HSS funds and reducing transaction costs, while not overly diluting its immunisation focus, and adhering more strongly to aid effectiveness principles. The report recommends that Gavi continue to provide HSS support to Nepal through a pooled fund and consider this approach for other Gavi-eligible countries.

Based on the positive experience with NHSP-II, in March 2015 the IRC recommended approval of Nepal's proposal to support NHSP-III with US\$ 36.5 million from July 2015 to June 2019.

- 9.9 Through HSS support, GAMR, PEF and more active grant management, Alliance partners are also working to **strengthen governance at the country level**. This aim is aligned with the new strategy, which has identified country leadership, management and coordination, as well as building political commitment as critical ways of achieving the overall

objectives. HSS support will increasingly play a key role in reinforcing national planning cycles and guidelines to support effective immunisation delivery. HSS support is also being utilised to analyse bottlenecks so that countries can identify key barriers to immunisation delivery and develop mitigation strategies. There is a focused effort on improving donor harmonisation and alignment at country level; these efforts demonstrate the catalytic role that Gavi can play in strengthening health systems within target countries.

Country Case Study: Improved partner coordination and governance in Benin

The HSS grant being implemented in Benin (US\$ 8.4 million in 2014-2018) is the first experience in francophone Africa in which the government is supported jointly by Gavi, the World Bank, the Global Fund and bilateral partners (in this case, the United States and Belgium). The coordinated effort finances an integrated health care and prevention package across 34 health areas in the country. The Performance-Based Funding element is part of the approach used in the partnership. The approach also benefits from one Financial Management Entity and one Monitoring and Evaluation Framework. Under this strategy, an HSS coordination unit was established by the World Bank in October 2013, and later reinforced with the integration of the Global Fund and Gavi HSS support. The coordination unit, which supports programme implementation, is based in the Ministry of Health and co-financed by partners. Benin's second HSS grant was recommended for approval by the IRC in February 2014 and funds were disbursed in August 2014. While such a coordinated approach took more than two years to establish, starting with World Bank involvement in 2012, it allows for improved coordination among partners and is expected to produce, in the long term, greater impact and an enhanced efficiency due to the synergies created.

- 9.10 The Alliance is also working closely with **civil society organisations** (CSOs) to deliver immunisation services, as CSOs complement the critical involvement by communities in immunisation. Since the Board decided in June 2012 to consolidate Gavi's support to CSOs under the HSS window, 27 HSS proposals have been recommended for approval by the IRC. (For further information see the paper *CSO Engagement in Gavi's HSS Grants*).
- 9.11 Gavi and **the Global Fund** held joint retreats on HSS in December 2014 and March 2015 which identified a number of areas for closer programmatic collaboration, including policies on salary and top ups, supply chain activities, and data surveillance.

Coverage and equity

- 9.12 As Gavi begins the transition to its new strategy, Alliance members are revising ways of supporting countries make sustainable improvements in their immunisation coverage and equity. In line with the need to adopt a country-centric focus, no single global strategy is being created. Instead,

tailored, country-specific strategies to concretely increase coverage and equity levels are being developed for **selected countries**. For example, work has begun with Uganda through its national EPI review and cMYP development process. Alliance members will seek to engage with similar processes in a diverse range of countries as the transition to the new strategy continues.

Country Case Study: Mozambique

Mozambique is one of the 10 countries with the widest gap in DTP3 coverage between the poorest and richest populations. Disparities also exist according to caregivers' level of education and whether they live in rural or urban areas. The most significant differences in coverage are between provinces. Zambezia Province is the poorest province and the most vulnerable, according to a vulnerability analysis. The province is also home to the largest number of underimmunised children and women. UNICEF has helped the Mozambican EPI programme to analyse why Zambezia Province has so many underimmunised children. Barriers that were identified were irregular immunisation services at health centres and irregular outreach services (Brigadas Moveis). Root causes were identified as lack of financial resources to conduct outreach activities at the district level, insufficient cold chain equipment in health facilities, and insufficient numbers of qualified health staff. Demand-side barriers include lack of knowledge of benefits for vaccines.

Based on this analysis, Mozambique introduced the Reaching Every Community Approach, with health facility-driven micro-plans, a strong community link and an active search for children eligible for vaccinations. During the micro-planning exercise, each health facility identified the gaps in transportation means and health worker numbers that needed to be filled to enable to implement the micro-plans. Funding was provided to conduct the micro-plans. The strategy has been adopted for nationwide scale-up and is included in Gavi HSS funding.

10. Strategic Goal 3 – Increase the predictability of global financing and improve the sustainability of national financing for immunisation

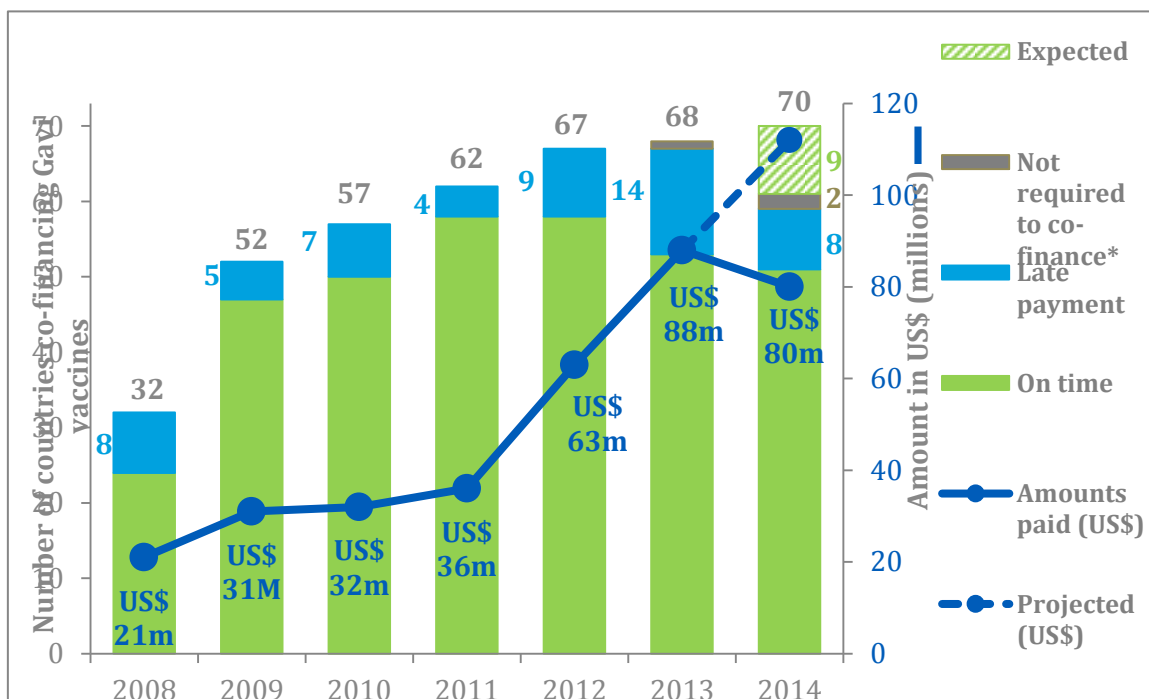
- 10.1 This section provides an update on work carried out under Strategic Goal 3, in particular with respect to the Alliance work on co-financing, financial sustainability and graduation. The review of the eligibility, graduation and co-financing policies was an important task in 2014. The experience and lessons learnt from implementing these policies shaped the recommendations proposed in the policy papers. The application of the proposed recommendation will intensify the Alliance work on sustainability in the next strategic period (e.g. engaging earlier with countries to transition Gavi support, engaging with new partners to ensure comprehensive sustainability, such as the World Bank and Global Financing Facility), tailoring support to facilitate transitions, etc.

Co-financing

- 10.2 In 2014, co-financing remained on track and the Alliance stepped up significantly its engagement with graduating and underperforming countries.
- 10.3 All countries that were in **default** for 2013 paid their arrears in time to avoid a suspension of their vaccines. The number of countries that required co-financing continued to increase in 2014, reaching 70 countries. Because of the Ebola epidemic, Sierra Leone and Guinea were not considered in default, and are in the process of being granted a waiver as per a Board approved process. Of the remaining 68 countries, 51 had fulfilled their commitments on time. This includes Liberia that had fulfilled its co-financing requirements despite the Ebola epidemic. Out of the 17 countries⁹ that were in default, 12 made partial payments for their 2014 co-financing obligations and/or paid off their arrears from the previous year. Only five countries made no contribution to the cost of co-financed vaccines in 2014: Côte d'Ivoire, Guinea-Bissau, Haiti, Lesotho and South Sudan. As of today eight countries have paid off their arrears: Djibouti, Guinea-Bissau, Haiti, Lesotho, Tanzania, Kenya, Zimbabwe, and Papua New Guinea. To date, US\$ 80 million have been transferred against the 2014 co-financing obligations (Chart 2), out of the US\$112 expected. The transferred amount 12% of Gavi's support for vaccines requiring co-financing.

⁹ Angola, Congo, Rep., Congo, DR., Cote d'Ivoire, Djibouti, Ghana, Guinea-Bissau, Haiti, Kenya, Lesotho, Pakistan, Papua New Guinea, South Sudan, Tanzania, Uganda, Vietnam, Zimbabwe.

Chart 2: Countries co-financing by year



10.4 The trend of **increasing levels of co-financing amounts paid on time has continued** over 2014. The amount transferred on time was US\$ 73 million, which is a 16% increase in comparison to 2013, when \$US 63 million was co-financed on time. The number of vaccine programmes paid on time increased slightly as well, from 111 in 2013 to 116 in 2014. While the amount and number of programs co-financed on time has increased, the proportion of countries paying on time remains similar (79% in 2013 vs. 75% in 2014). This is a result of the increase in overall requirements: the number of programmes that required co-financing has been increasing steeply over the past few years, and rose by more than 20% from 2013 to 2014. In terms of US dollars, co-financing requirements increased by 55% from \$78m in 2013 to \$112m in 2014. Therefore, countries are co-financing more, but the absolute arrears gap for 2014 is also higher than in previous years, so defaulter countries will need to make greater efforts to come out of default.

10.5 From early diagnosis of information gathered by the Immunisation Financing and Sustainability Task Team (IF&S TT), it seems that the **major reasons for default** appear to be of mixed origin: administrative/process-related barriers, limited resources available for vaccine procurement, and weak political commitment/prioritisation of immunisation. Seven of the 2014 default countries had also defaulted in 2013 and had to pay their arrears during 2014, which may have exacerbated pressure on those countries' budgets in 2014. About half of them made also partial payments towards 2014 co-financing while paying off the arrears for the previous year. The ongoing review of co-financing will propose policy options to avoid this cycle of defaults.

- 10.6 Five **defaulters are graduating countries**. Two of those countries, Vietnam and Papua New Guinea (PNG), are first-time defaulters. The reasons for Vietnam's default are administrative and should not constitute a major barrier. For PNG, budget allocation for immunisation is not a problem. However, the country has weak institutions, and due to cash flow constraints for emergency purchases, the country had used the co-financing funds for OPV stock outs, and measles outbreaks. Angola, Congo Republic and Ghana are repeat defaulters and, while paying off the arrears of previous years, are not able to mobilise funding for the current year of co-financing¹⁰. Ghana's situation is particularly worrying since it has not yet entered graduation and has been a repeated defaulter. The country also benefits from many Gavi-funded vaccine programmes and the amount of co-financing required is particularly challenging.
- 10.7 To **address the default situation**, countries were informed of their default status and the IF&S TT is coordinating follow-up actions. Of the 9 countries still in default, five are not expected to require special efforts to pay their arrears or prevent an immediate default for 2015. Some of these countries have already made partial payments, and Pakistan and Vietnam has committed to pay off its 2014 arrears in the very near future. Pakistan and Vietnam also managed to secure approvals for additional resources needed to fulfil its 2014 commitments and is proceeding with the procurement. The other four (Angola, Congo Republic, Ghana and South Sudan) are expected to experience difficulty mobilising funding or overcoming administrative bottlenecks and may require a greater level of engagement from the Alliance, such as high-level political advocacy. For each country still in default, a roadmap will be developed to allow systematic and strategic follow-up.
- 10.8 The IF&S TT has been increasing its engagement with defaulters and countries struggling with financing immunisation. The IF&S TT identified 12 countries¹¹ at risk and developed a **methodological framework for guiding assistance**. Joint Alliance missions have been conducted to assess countries' immunisation financing systems and to identify barriers to fulfilling co-financing requirements. As a result, countries have developed action plans for strengthening their immunisation financing processes. The experience of Country-Tailored Strategies will be evaluated in the second half of 2015 and lessons will inform the development of roadmaps to intensify support for countries to strengthen their immunisation financing systems.

¹⁰ For Angola and Congo Republic this is particularly concerning, as they pay already a high share of total annual vaccine requirements and a default has negative implications on their stock levels and potentially the number of children immunised.

¹¹ Guinea, Guinea Bissau, Haiti, Kenya, Lao PDR, Madagascar, Malawi, Mozambique, Niger, Pakistan, Sierra Leone and Sudan

Graduation

- 10.9 In 2014, the Alliance made substantial and rapid headway towards more comprehensive engagement with graduating and soon-to-graduate countries. After the Board approved in December 2013 the **new approach to graduating countries**, the Alliance started a graduation dialogue and carried out assessments in 10 countries.¹² Graduation plans were developed in eight of those countries. Graduation financial support was approved by Gavi for three of those,¹³ while five are still pending approval. In 2015, 13 countries are expected to start the process to develop graduation plans.¹⁴ One of those countries, Sri Lanka, conducted a graduation assessment mission in February and is finalising its graduation plan.
- 10.10 The intense involvement with graduating countries in 2014 allowed for a rapid **fine-tuning of the approach**. The Alliance has developed standardised templates for comprehensive graduation assessments, agendas and graduation plans. In addition, the pre- and post-graduation process was further developed to allow for best possible before and after missions. Given the focus on completing as many assessments as possible within the remaining half a year following the PPC approval of the roll-out, the internal Secretariat process for approving graduation plans has reduced the ability to quickly disburse funding for the graduation grants and implement the action plan. A new process has now been put in place to remove bottlenecks.

11. Country updates

- 11.1 This section starts with general overview of how the Alliance is gearing up for its new strategy and then provides an update on three of the most complex, highest-priority countries in the Gavi portfolio. The last section provides an overview of the Alliance's work in the three countries most affected by Ebola.

General overview

- 11.2 To gear up for Gavi's new strategy and respond to the enhanced emphasis on risk management, the Alliance is making concrete changes to how it works with countries, including the new grant application, monitoring and review approach described above and a **more proactive and country-tailored approach to grant management** and technical assistance.
- 11.3 While the specificities vary by country, common themes of ongoing and planned work include:

¹² Angola, Bhutan, Bolivia, Congo Republic, Georgia, Ghana, Guyana, Honduras, Moldova, and PNG.

¹³ Honduras, Guyana, and Moldova.

¹⁴ Armenia, Azerbaijan, Indonesia, Nigeria, Solomon Islands, Timor Leste, Uzbekistan, Vietnam, Nicaragua, Mongolia, Sri Lanka, PNG, and Ghana.

- (a) ensuring attention to **equity** as well as **coverage** – for example through ensuring heightened focus on low-performing districts;
- (b) ensuring that immunisation **financing and sustainability** remain on the political agenda, through high-level, multi-partner missions to advocate for immunisation with senior decision-makers, such as in Pakistan, and by developing an advocacy and communications platform for in-country advocates;
- (c) ensuring **effective technical assistance** to overcome implementation bottlenecks, including a special focus on supply chain and data;
- (d) engaging with **partners** more broadly (e.g., bilaterals, JSI and AMP) and more systematically, for example through multi-country collaboration with the Global Fund on overlap areas, such as fiduciary risk management and HSS;
- (e) focusing more closely on building and sustaining **country governance**, management, leadership and coordination, for example via interagency coordination committees, health sector coordination committees, ministries of health and finance, and civil society groups;
- (f) **managing fiduciary risk** by insisting on appropriate documentation and reporting, holding disbursements if needed and putting in place fiduciary agents where warranted (e.g., in DRC and Nigeria) to ensure appropriate funds management and strengthen national financial management capability.

11.4 The remainder of this section provides an update on the most complex, highest priority countries in the Gavi portfolio – Pakistan, DRC, Nigeria and India – while including some illustrations of the above themes. For each country, it highlights the context and recent developments, key successes and challenges, past and upcoming learning opportunities, and the next steps that should be taken.

11.5 Pakistan

DTP3 WUENIC coverage	Graduation and co-financing status	Country-tailored approach
2013: 72% 2012: 72%	<ul style="list-style-type: none"> • Graduation: intermediate country • Co-financing : in default for 2014 	Yes: developed; being approved
Gavi support		
<i>Active vaccine support:</i> <ul style="list-style-type: none"> • Penta – 2008-2015 • PCV – 2012-2015 • Measles campaign – 2013-2015 • IPV – 2015-2018 	<i>Active cash support:</i> <ul style="list-style-type: none"> • HSS 1 – 2007-2016 • 	<i>Pending support:</i> <ul style="list-style-type: none"> • HSS 2 will be submitted in 2015 (and be aligned with National Immunisation Support Project (NISP))

Country context / key developments:

- 11.6 Pakistan is the **largest recipient** of Gavi support to date, with over US\$ 842 million committed to 2019, and one of the largest Gavi-eligible countries, with an annual birth cohort of 5.7 million children. Pakistan is not on track to reach MDG4 or its national immunisation targets because of major problems with routine immunisation. Only 54% of children receive a full course of vaccines and there are substantial disparities between regions, leaving 2.7 million children under-immunised in 2015.
- 11.7 **Polio** is still a major challenge for Pakistan, which is now one of only two countries with endemic polio. It accounted for 306 of the 359 polio cases worldwide in 2014, and 22 out of the 23 cases of wild polio viruses detected to date in 2015. While there is remarkable political attention to polio and its eradication, routine immunisation still needs to be strengthened as part of the polio end-game strategy.
- 11.8 The **devolution** of Pakistan's health system has led to problems because it blurred responsibilities between the federal and its 4 provincial governments, particularly for vaccine financing, procurement, policy development and programme management.

Successes:

- 11.9 To raise the profile of routine immunisation and highlight the many challenges involved in strengthening it, Gavi conducted an **Alliance-wide high-level mission** to Pakistan in February 2015. It included the Gavi Chief Executive Officer, the WHO Director for the Eastern Mediterranean Region, UNICEF's Deputy Executive Director, President of Global Development at the Bill and Melinda Gates Foundation, and other Alliance partners. The mission generated strong and encouraging political support for immunisation. Prime Minister Nawaz Sharif agreed to establish a National Task Force on Nutrition, Sanitation and Immunisation, declaring that "mother and child safety through proper immunisation and better nutrition are a major priority for the government". Follow-up efforts are now being made to see this materialise. Meetings were also held with the Chief Ministers of Punjab, Khyber Pakhtunkhwa Provinces and the Secretary of Health from Baluchistan Province and the Governor of Sindh Province to highlight key actions required to strengthen routine immunisation.
- 11.10 **Preventive measles supplementary immunisation activities (SIA)** have been conducted in Sindh, Khyber Pakhtunkhwa, Punjab, Azad Jammu and Kashmir (AJK), Baluchistan and Islamabad. Gilgit-Baltistan Provinces (totalling 0.4 million children under the age of 10) started its campaign late in May 2015. The only region that has not moved forward on its measles SIA is the Federally Administered Tribal Areas (FATA), with 2.44 million children below 10.
- 11.11 As a result of the Mission, Pakistan signed in May its long overdue **Partnerships Framework Agreement** with Gavi.

Challenges:

- 11.12 There is a general agreement between Federal government and provinces for central procurement of vaccines and payment of co-financing shares of Gavi. The details of how this agreement would be implemented following expiration of the Seventh National Financial Commission Award remains unclear.
- 11.13 Pakistan is back in Gavi **co-financing default** status for 2014 due to legal challenges that have since been resolved. There are plans to resolve this by the end of 2015. This is the third consecutive year that Pakistan has fallen into default status.
- 11.14 Through the **effective vaccine management (EVM)** improvement plan exercise, a non-performing cold room in a central warehouse was discovered with large volumes of Penta vaccine. The country has taken initial steps to identify the main reasons for this oversight and to avoid similar incidents in the future. Administrative and criminal disciplinary action has been taken. The Alliance has encouraged the country to include the EVM improvement plan's recommendations into its new HSS application, which is expected later this year.
- 11.15 **Turnover of EPI staff**, including managers, has resulted in a management and supervision gap in most parts of the country.
- 11.16 **Security** remains a concern and limits outreach and programme delivery efforts in several areas of the country.

Learning – past and future:

- 11.17 The key to future success of immunisation programmes in Pakistan **is to strengthen routine immunisation** through strong political commitment at national and provincial level, and innovation in programme management and delivery. There should be more focus on provincial performance through programme reviews and joint missions.
- 11.18 **Polio and routine immunisation** should work hand in hand, with attention directed to routine immunisation coverage. As a result of the February high-level mission, polio Emergency Operating Centres will expand their mandate to include surveillance for routine immunisation.

Next steps:

- 11.19 Problems in **last-mile delivery** are among the key bottlenecks for immunisation in Punjab Province. The Chief Minister working with some external partners has initiated several simple interventions to ensure that vaccinators routinely conduct outreach and focus their time on routine immunisation activities.
- 11.20 **Strengthening community engagement** to build vaccine demand, and providing managers with tools for “micro-planning”, are important interventions that the country can include in its new HSS proposal.

UNICEF is supporting development of a communication framework for creating demand. The Alliance and other partners are also working with Pakistan to reduce vaccine wastage and improve wastage management.

11.21 Democratic Republic of Congo (DRC)

DTP3 WUENIC coverage	Graduation and co-financing status	Country-tailored approach
2013: 72% 2012: 72%	<ul style="list-style-type: none"> Graduation: low-income country Co-financing: in default for 2014 	Yes, implemented since end 2013
Gavi support		
<i>Active vaccine support:</i> <ul style="list-style-type: none"> Penta – 2008-2015 PCV – 2011-2015 YF – 2002-2015 IPV – 2015-2018¹⁵ Measles campaign 2013-2014 HPV demo – Q4 2015-2016 	<i>Active cash support:</i> <ul style="list-style-type: none"> HSS 1 – 2007-2015 HSS2 – 2015-2019 Additional fund for supply chain strengthening as per CTA agreement: 2014-2016 	<i>Pending support:</i> <ul style="list-style-type: none"> ¹⁶ MenA SIA – application reviewed and approved by IRC in March 2015. Final approval is subject to full payment of 2014 arrears of co-financing. w

Country context / key developments:

11.22 DRC Country Tailored Approach is being implemented. CTA allowed funds to be invested in a strategic way with a focus on strengthening the national systems: M&E system as part of joint effort with other donors such as DFID and The Global Fund; and in strengthening Supply chain system offering an opportunity for integration of other health products such as essential medicines.

11.23 The Africa monthly immunisation update issued by the WHO Regional Office in February 2015 showed that more children were immunised with Penta3 in DRC in 2014 (2,751,198) than in 2013 (2,683,905).

11.24 Despite the positive trend, EPI in DRC is struggling with many challenges. Government delays in disbursing immunisation funds have limited the availability of traditional and new vaccines and syringes, causing a major bottleneck.

Successes:

11.25 The country is revitalising the RED approach by antenna,¹⁷ which has yielded promising results in the most difficult areas. This approach, initiated by the Bill and Melinda Gates Foundation, is further supported

¹⁵ IPV is planned to be introduced in three phases: 27 April (launch), 23 June and 25 August 2015.

¹⁶ Delay is due to the process of setting up the new fiduciary agent.

¹⁷ The “antenne de santé” is the level of the DRC health system situated below “health zones”.

through the polio Immunisation Systems Management Group, as it also uses the polio assets for routine immunisation strengthening.

- 11.26 Implementation is continuing of the HSS2 grant, including the additional funds allocated by Gavi for supply chain strengthening under the DRC Country-Tailored Approach (approximately USD \$53 million). This will support the construction of a vaccine hub in Kinshasa and regional depots in Kisangani and Lubumbashi that should ease supply chain bottlenecks by allowing DRC to receive vaccines through three ports of entry (vs. just Kinshasa currently). HSS support will also help resolve problems identified in the 2014 EVM relating to all categories with a score below the 80% minimum threshold, such as buildings, cold chain capacity, equipment, vaccine management, maintenance and transport.
- 11.27 Gavi continues to strengthen its collaboration with partners to achieve greater efficiency and impact, and manage risk jointly.
- (a) The Global Fund and Gavi together have put in place and jointly supported a new fiduciary agent (GIZ), which has been operating since 1 March 2015. This approach aims to support the ongoing reform to strengthen the internal controls and fiduciary management of MoH's Division of Administration and Finance.
 - (b) A MoU was signed by UNICEF, the Global Fund, the World Bank and Gavi to enhance alignment and harmonisation, especially as it relates to supporting the national results-based funding programme.¹⁸
 - (c) Gavi is also regularly engaged with the donors' group (GIBS, Groupe Inter-Bailleurs Santé) to integrate vaccines with essential medicines to ensure more synergies and complementarity.
- 11.28 To improve management of Gavi grants to DRC, a cross-Secretariat DRC country team was established in December 2014 and conducted a joint monitoring visit in February 2015.

Challenges:

- 11.29 DRC is in Gavi co-financing default status for 2014, as of 15th April, US\$ 4.6 million paid out of US\$ 6.7 million.
- 11.30 Insufficient quantities of GAVI-supported vaccines were available in 2014 due to a late re-adjustment of the country's targets and due to the non-payment of co-financing obligations. In addition, the important quantities of PCV13 needed for DRC coupled with insufficient transport capacity as well as limited storage capacity in Kinshasa have led to a fragmented delivery of PCV13. This in turn resulted in insufficient doses of PCV13 being available at the provincial level. This issue was discussed with the MoH and in-country partners in March 2015. A revised and tailored shipment plan was developed to prevent the reoccurrence of this issue in 2015.

¹⁸ A first joint field visit was conducted at the end of March 2015 to Equateur, DRC's first province benefiting from result-based funding.

11.31 DRC suffers from major cold chain system and capacity challenges:

- (a) Only 15% of the cold chain is functional, mainly due to the lack of funds for fuel. Were the funds available, an estimated 40% of the cold chain would be functional. Provinces are responsible for funding the fuel for the cold rooms and refrigerators, but not all provinces are fulfilling their obligation. The other challenges are related to defective equipment and lack of replacement parts in addition to lack of funding to cover all relevant health centres with cold chain equipment.

GAVI's investment in supply chain will allow country to procure solar equipment and solarisation of some existing cold rooms. This will address partially the issue above.

- (b) Distribution of vaccines and consumables is a general concern, with an average EVM score of only 57%. The transport of vaccines is an issue, as transporters have lost trust in the MoH due to delayed payment of bills.
- (c) The 2014 EVM reports that there is a general lack of continuous temperature recorders, coupled with general deficiencies in recording, archiving and securing management data.

11.32 It was discovered in February 2015 that 518,000 doses of Penta vaccine (with VVM7) are at risk of not being used before VVM status switches from stage 2 to stage 3. The MoH, according to the latest distribution plan developed by EPI, Gavi, NMGF, UNICEF and WHO, will distribute the doses in six big cities across six provinces and use African Immunisation Week to absorb the remainder. It will also send a sample to a lab for testing. The Secretariat is closely monitoring the situation together with WHO and UNICEF. As of 30th April, doses were already distributed to the six big cities and are being used. No issue was reported.

11.33 Gavi supported a data quality review workshop in October 2014. A data quality improvement plan was developed to guide priority interventions and investments. However, since the last census was in 1984, defining the target/denominator is a challenge.

11.34 Although vaccination is free, out-of-pocket expenditures in some provinces remain difficult to control, as health workers charge parents for other services.

Learning – past and future:

11.35 Many partners are working or contributing to the same activities. This causes double funding for activities. Gavi's strategy is to work jointly with partners and strengthen its collaboration with in-country, regional and global partners to better align its interventions.

11.36 A joint field visit to Equateur end of March 2015 with MoH, Gates Foundation, World Bank, UNICEF, UNFPA, The Global Fund allowed partners to see the geographical challenges and on the need to work

together using a tailored approach for this province where access to health services is low due to the geography and lack of adapted logistics.

Next steps:

11.37 As a follow up to the joint WHO, Gavi, UNICEF, World Bank and Gates Foundation mission that took place end of March with a focus on supply chain issues; partners are working jointly on areas where integration with essential medicines and other commodities is possible. Furthermore, Gates agreed to provide technical support to DRC on the design of the boat, funded by GAVI, which will transport vaccines, essential medicines and other commodities from Kinshasa to Kisangani along the Congo River. The boat will have also a small mobile clinic will allow integration with family planning interventions that Gates is willing to fund.

11.38 As a follow-up to the data quality review, the implementation status of key activities will be monitored, including the data quality improvement plan, during the joint appraisal planned for July 2015.

12. Nigeria

DTP3 WUENIC coverage	Graduation and co-financing status	Country-tailored approach
2013: 58% 2012: 26%	<ul style="list-style-type: none"> Graduation: graduating (2020) Co-financing: on track 	Yes: implemented since 2013
Gavi support		
<i>Active vaccine support:</i> <ul style="list-style-type: none"> Penta – 2012-2015 PCV – 2014-2015; Phase 1 introduced Dec. 2014; Phase 2 scheduled Apr. 2015 Measles campaign – 2013 Men A campaigns – 2011, 2013, 2014 YF campaign – 2013, 2015 YF routine – self-financed IPV – 2015-2018; introduced Feb. 2015 	<i>Active cash support:</i> <ul style="list-style-type: none"> HSS 1/ISS reprogrammed – 2013-2015 	<i>Pending support:</i> <ul style="list-style-type: none"> HSS2 – reviewed, approval on hold due to CPA Measles SIA 2015 campaign – application recommended for approval at March 2015 IRC

Country context / key developments:

12.1 A 2013-2014 cash programme audit (CPA) by Gavi revealed systemic weaknesses in internal financial controls at the National Public Health Care Development Agency (NPHCDA), Gavi's main implementing partner in Nigeria. Gavi has requested repayment of US\$ 2.2 million of misuse, cooperation on an extended audit (to be conducted in 2015) and installation of a fiduciary agent in NPHCDA. While agreement has been secured on the latter two items, Gavi and the Federal Government of Nigeria (FGN) continue to discuss an arrangement for repayment. Gavi maintains a hold on (1) further cash-based support to the government, and (2) approval of any new support pending an agreement on repayment, completion of the extended audit and installation of a fiduciary agent.

- 12.2 At the recent Gavi Board retreat, the Executive Committee agreed that approved introductions should continue (i.e. PCV and IPV) and that it would consider approving support for a measles campaign in fall 2015 to minimise the outbreak risk. However, EC approval would be contingent on demonstration by the country and Alliance Partners of a robust risk mitigation strategy that would ensure the conduct of a quality campaign and minimise fiduciary risk.
- 12.3 Nigeria's general elections took place on 28 March 2015. A new government is constitutionally required to be in place by 29 May 2015. Gavi's CEO will undertake a joint high-level visit with partners to Nigeria once the new government is in place to discuss resolution of the CPA and advocate for high-level political commitment to routine immunisation.
- 12.4 A national health care worker strike in late 2014/early 2015 affected the delivery of routine immunisation services, but the exact impact on immunisation coverage, if any, is yet to be determined. Workers in most states have now returned to work.
- 12.5 The global decline in oil prices has severely affected government budgetary resources, including for routine immunisation. The FGN has applied to the World Bank for a US\$ 200 million emergency loan to cover vaccine and operational costs for 2015. Immunisation financing and sustainability will feature prominently in Gavi's graduation support to Nigeria.

Successes:

- 12.6 Nigeria is nearing its one-year anniversary (24 July 2015) without any reported new wild poliovirus case. The February 2015 introduction of IPV into the routine immunisation system was a critical step in the polio end-game for Nigeria. Twelve states plus the Federal Capital Territory have introduced IPV thus far and the government has set the target of 25 May 2015 for the completion of the national rollout. There is a renewed focus on strengthening routine immunisation through the polio legacy model.
- 12.7 Nigeria began the introduction of the PCV in 11 states in December 2014. This was the first of a three-phase introduction. Phase two, targeting an additional nine states, is scheduled to begin in late May 2015. The final phase will take place in 2017, dependent on global vaccine supply availability. Phase one is reported to have gone reasonably well despite the national health care worker strike, with all states completing the roll-out with the exception of Rivers State, where the strike continues. NPHCDA is planning a post-introduction evaluation exercise for the first two phases in September 2015.
- 12.8 Gavi's HSS grant has funded the installation of 1,656 solar direct drive refrigerators in health facilities across Nigeria – a significant contribution to cold chain capacity. Approximately 95% of installations are now complete, with a small remainder delayed due to insecurity or lack of site readiness. This builds on investments in the supply chain system (performance

management, redesigned distribution for select states and inventory management from national to state levels) made by both the Gates Foundation and UNICEF Nigeria.

- 12.9 Nigeria has seen substantial improvements in coverage from 2012 to 2013. DTP3 WUENIC coverage increased from 26% to 58%. A reduction in vaccine stock-outs and the introduction of the pentavalent vaccine are key contributors.

Challenges:

- 12.10 The predominant challenge facing Gavi's programme in Nigeria remains resolution of the CPA. The hold on cash-based support to government has slowed implementation, as funds have had to flow through partners. The delay in the general elections (originally scheduled for 14 February) has also resulted in some programme and audit delays.
- 12.11 A second challenge is Nigeria's change to graduating country status three years ahead of schedule due to the rebasing of the country's GDP in April 2014, which revised the size of the country's economy upwards by 89%. Discussions on graduation have also slowed due to the audit and the elections, but there are now plans for a one-day Graduation Workshop in July 2015 to begin official graduation discussions in close collaboration with partners. 2015 is also the last year that Nigeria may apply for new vaccine support; applications for the rotavirus vaccine, meningitis A routine, and a HPV demonstration project are expected in September. Approval of new support will be contingent on the resolution of the CPA as described above.

Learning – past and future:

- 12.12 High-level commitment by a country's political leadership is a critical factor in programme success. This has been difficult to achieve in Nigeria over the past few months, largely at sub-national levels, because of the general elections, but the commitment of the EPI Department at NPHCDA and Alliance partners to vaccine introductions have ensured progress. Gavi's planned 2015 high-level visit will aim to further galvanise the necessary political support needed to reinforce the routine immunisation programme and the Gavi-Nigeria partnership.

Next steps:

- 12.13 As soon as a new government is in place, the priority will be working with the government on the extended audit and fiduciary agent. The Federal Ministry of Health has designated focal persons in the ministry and NPHCDA to work with Gavi on both projects. Audit fieldwork is scheduled to begin on 8 June 2015, and is expected to last approximately six weeks. Gavi is working with the Global Fund for the joint installation of a fiduciary agent this year.
- 12.14 A full graduation assessment mission and development of a graduation plan for Nigeria is another priority. The planned July visit for the graduation

workshop will define the scope of the graduation assessment to be undertaken with Alliance partners soon thereafter.

13. India

DTP3 WUENIC coverage	Graduation and co-financing status	Country-tailored approach
2013: 72% 2012: 72%	<ul style="list-style-type: none"> India is projected to cross the eligibility threshold as of January 1, 2016. The normal co-financing policy does not apply so Gavi will develop a framework to transition out of support within a context of an overall India strategy. 	No
Gavi support		
<i>Active vaccine support:</i> <ul style="list-style-type: none"> Penta – 2011-2015 	<i>Active cash support:</i> <ul style="list-style-type: none"> HSS 1 – 2014-2016 	<i>Pending support:</i> <ul style="list-style-type: none"> IPV – 2015-2016; approved Dec. 2014

13.1 Country context / key developments:

- (a) India's birth cohort of 27 million children is more than three times the size of Nigeria's, the second most populous country in the Gavi portfolio. India accounts for nearly a third of the world's share of underimmunised children (about 7 million) and 20% of child mortality. Paradoxically, India also has a large vaccine manufacturing capacity. From 2012 to 2014, Gavi purchased vaccines from Indian manufacturers for more than US\$ 800 million.
- (b) Within two months of coming to power, the newly elected government announced in July 2014 its intention to introduce four new vaccines: measles rubella (MR), inactivated polio vaccine (IPV), Japanese encephalitis vaccine (for adults) and rotavirus vaccine. The government also renewed its commitment to improve coverage and equity. In April 2015, the Ministry of Health launched Mission Indradhanush ("Rainbow"), which seeks to immunize hard-to-reach populations in 201 districts (see below). These commitments provide an unprecedented opportunity to improve coverage and equity and scale up access to life-saving vaccines in India.
- (c) Contrary to its previous stance to self finance, India unexpectedly submitted an IPV application, which was approved by the Gavi Board in December 2014 and by GPEI in March 2015. India will receive 12 months of catalytic support to ensure timely IPV introduction in October 2015 in accordance with the timelines of the polio endgame strategy. The government has confirmed to GPEI its intent to sustain IPV introduction from its own resources after this period.

- (d) Consistent with its earlier expression of interest to Gavi, India applied for MR campaign support in January 2015. Given its routine and measles coverage data, however, India does not meet Gavi's eligibility criteria.
- (e) India is projected to cross Gavi's income eligibility threshold in 2016 and the Board will need to decide how to manage India's transition out of Gavi support over the coming years. Currently all Gavi support to India is due to stop at the end of 2016, five years before the country graduates.
- (f) The CEO visit to India in the end of April focused on detailed discussions with Government and Alliance partners on the progress of immunisation (see section 13.2 below) and the development of a strategic framework for engagement with India for 2016-2020. The Ministry of Health and Family Welfare (MoHFW) is fully aligned with the basic principles of Alliance engagement has made a strong political commitment to support this endeavour.
- (a) At its meeting in May 2015, the PPC fully endorsed the Secretariat's proposal to develop a strategic partnership with India. The framework will be based on India's priorities in improving coverage and equity, introduction of new vaccines and Gavi's efforts in market-shaping. The framework will be fully aligned with Gavi's business plan and strategy for 2016-2020. It will be presented to the PPC in October 2015 for review and recommendation to the Board in December 2015.

13.2 Successes:

- (a) The final phase of pentavalent vaccine scale-up in the remaining 14 states is planned to start in June 2015. The inclusion of India's 2015 demand of 90 million doses in overall Gavi penta procurements has partly¹⁹ contributed to market-shaping and resulted in a price reduction to US\$ 1.40 per dose for India. After this final year²⁰ of penta support, the programme will be entirely self-financed.
- (b) The Ministry of Health and Family Welfare (MoHFW) demonstrates a strong sense of ownership in implementing the HSS grant (US\$ 107 million from 2014 to 2016), in cooperation with WHO, UNICEF and UNDP. The ministry's priorities include investing in the supply and cold chain; a comprehensive advocacy and communications component; the establishment of a national monitoring and evaluation platform; benefiting from the polio experience to strengthen routine immunization; and enhanced surveillance and monitoring of vaccine-preventable diseases.

¹⁹ Thanks to the significant increase in volume of doses as well as other market-shaping activities e.g. pre-payment, the price reduction was achieved, and this price is available to other Gavi countries.

²⁰ Indian financial year 2015-2016

- (c) The focus of the HSS grant on low-performing states and districts has significantly influenced the national coverage and equity agenda. MoHFW launched Mission Indradhanush (“Rainbow”), an intensified immunization drive over four months – from World Health Day, April 7, until July 2015 – to improve full immunization coverage (FIC, comprising seven vaccines) in 201 low-performing districts. The current national FIC coverage is 65%; the government has the ambitious target of reaching 90% by 2020.
- (d) India held an interstate workshop for four high-priority states in October 2014, within the framework of the India Action Plan for the Prevention of Pneumonia and Diarrhoea (IAPPD). The workshop was followed by state-level planning exercises in Bihar and Madhya Pradesh and a presentation of the IAPPD plans to another five states in January 2015. A monitoring framework based on scorecards is being set up in the context of the Reproductive, Maternal, Newborn, Child and Adolescent Health strategy (RMNCH+A).

13.3 Challenges:

- a) India still has substantial inequities that are masked by average coverage figures. The partners will need to focus some of their support specifically on the implementation of Mission Indradhanush and other activities needed to reach equitable coverage in high-risk districts.
- b) There have been delays in disbursing the HSS grant as India is yet to sign the Partnership Framework Agreement. This will result in delays in programme implementation. Although India has quickly adapted the HSS grant in support of Mission Indradhanush, some other elements of the grant are likely to be delayed.
- c) Despite a formal communication by GPEI to government of India assuring 12 months of catalytic support to ensure timely introduction of IPV, there have been procedural delays in firming up an agreement with Gavi. This is likely to result in delays in introducing IPV.

13.4 Lessons learnt:

- (a) The national scale-up of pentavalent vaccine underlines India’s commitment to fully self-finance the vaccine when Gavi support ends. Subsequent to a catalytic investment of \$265 million from Gavi, India is expected to continue financing the programme at \$120 million per year.
- (b) The coordination and quality of state preparedness assessments across 12 states to facilitate the penta roll out in November 2014–March 2015 was an exemplary practice that should be applied further (e.g. with the IPV introduction).

13.5 Next steps:

Gavi will initiate intensive discussions with the government of India over the coming months on the details of future collaboration. Based on these discussions, a comprehensive strategy will be developed for review by the PPC in October and for decision by the Gavi Board in December.

14. Ebola – please refer to the separate paper on Ebola to be discussed under item 14 of the Board agenda

Section C: Implications

15. Impact on countries

15.1 Various ways in which the Alliance's work in countries impacts countries have been discussed throughout the above text.

16. Impact on Gavi stakeholders

16.1 Various ways in which the Alliance's work in countries impacts Gavi stakeholders have been discussed throughout the above text.

17. Impact on Gavi Secretariat

17.1 Various ways in which the Alliance's work in countries impacts the Gavi Secretariat have been discussed throughout the above text.

18. Legal and governance implications

18.1 There are no specific further legal or governance implications.

19. Consultation

19.1 No specific consultations have been carried out to facilitate this work beyond those mentioned throughout the above text.

20. Gender implications

20.1 There are no further gender implications beyond those discussed throughout the above text.

Section D: Annexes

Annex A: Vaccine Programmes update

Annex B: Sources and definitions of performance metrics

Annex C: Strategic Goal 2 update

Annex D: Revised Categorisation Methodology for Proposed Activities in Approved Gavi HSS Grants

Annex E: List of Acronyms

Annex A: Vaccine Programmes update

1. Pentavalent Vaccine (DTwP-HepB-Hib)²¹

Key programme statistics (programme start date 2006)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	73*	0	~11	73
Coverage	56%*	~69%	~69%	~69%*
No. vaccinated ²²	236M	~52M	~196M	~288M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10.

**All forecasted data are subject to changes as a consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions. Coverage estimates for the current Strategy period reflects the estimated coverage in 2015.

- 1.1 After having reached in July 2014 the milestone of introduction in all 73 Gavi-eligible countries, it is expected that Penta will completely replace DTP vaccines by 2016 (except for booster doses). The 2015 rollout in India is critical in this regard: Gavi will finance the entire rollout for the Indian financial year 2015-2016 ending in April 1, 2016. Gavi has contracted Indian suppliers to provide ~100m doses over these 12 month.
- 1.2 The focus of activities in 2015 has switched from introductions to coverage and equity and effective vaccine management with particular focus on the following areas:
 1. Managing Penta programme grant renewal process for the 67 different grants represents a considerable operational challenge given the scale (~230m doses with a value of USD \$0.4b), and the complexity (18 graduating, 14 intermediate and 35 low-income countries – all requiring different approaches). The establishment of a validation process for stock levels and open vial vaccine wastage allowed for an improvement of the estimates of country doses requirements and consequently of demand and size of Gavi's financial liability both in terms of disbursements and size of the stocks.
 2. Resolving and investigation of specific programmatic challenges such as vaccine vial monitor (VVM) changing colour at central level and resulting in concerns being expressed by the Ministry of Health (MoH) on the quality of the vaccine.

²¹ 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.

²² Estimates include number vaccinated with GAVI direct and catalytic support.

3. Assessment of the benefits of mixed presentation being used – where a study of two different vial sizes in the same country is being carried out. A mix of 1 dose and 10 dose vials has been introduced into 4 districts in Kenya, with the primary goal of reducing missed opportunities in remote settings and outreach activities while minimizing cost and cold chain challenges. The study is being conducted by JSI and results are expected in Q3 2015. They should help inform country decisions about the feasibility and potential programmatic benefits of using a mix of presentations; they should also offer insights into the challenges and opportunities in conducting outreach.
4. Penta in Uniject autodisable injection system (Uniject) or compact prefilled autodisable device (cPAD): a learning phase is currently being designed to evaluate cPAD's in-country programmatic impact and feasibility, as well as its cost-effectiveness through introductions into a subset of Gavi countries. The evaluation to be conducted by a consulting agency in 2015-17 will allow the assessment of the potential benefits of this innovative delivery solution: reduced wastage, increased safety, and increased efficiency of immunisation sessions.

Pneumococcal Conjugate Vaccine (PCV)

Key programme statistics (programme start date 2010)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	46*	~5-8	~53	~56
Coverage	31%*	~40%	~40%	~40%
No. vaccinated ²³	50M*	~31M	~80M	~80M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10.

**All forecasted data are subject to changes as a consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions. Coverage estimates for the current Strategy period reflects the estimated coverage in 2015.

- 1.3 The PCV programme continues to scale-up rapidly. With the introduction of PCV in Georgia in November 2014, Gavi reached an important milestone – the 45th PCV introduction and consequently the Strategic Goal 2011-2015 for “Number of PCV introductions in Gavi countries” more than one year ahead of schedule. Of 58 approved countries, 50 have introduced PCV, including Nigeria in December 2014 (Phase 1) and Bangladesh in March 2015. An additional 2-5 countries are expected to introduce this year, and 2-4 more in 2016.

²³ Estimates include number vaccinated with GAVI direct and catalytic support.

- 1.4 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, achieving a key objective of the AMC framework in having this unprecedented supply scale up in just 5 years. Development of 4-dose vials with preservative is also in progress with both manufacturers. This presentation would minimise storage requirements in line with Gavi countries' needs but will also need to have an improve price point to make up for potentially greater wastage. A country consultation will be carried out in 2015 in order to assess country demand of this new presentation.
- 1.5 Efforts will continue towards supporting some of the 15 AMC-eligible countries that wish to access pneumococcal vaccine through the AMC and have not yet done so. Five of these 15 countries are not eligible to apply due to DTP3 coverage eligibility criteria, and others are not considering the introduction at this point (due to supposed low disease burden or affordability concerns, for example) but a small number of countries remains eligible and has expressed interest in introducing this vaccine in their routine immunisation system in the near future. The Secretariat will work with Alliance partners to support them.
- 1.6 With ~70% of the 73 Gavi countries having already introduced PCV, the focus of the programme is also shifting towards efficient management of the programme with special focus on stock management and increasing coverage levels. Key to this is the roll-out in large countries, such as Nigeria, and optimisation of programme implementation. Another key priority moving forward will be to ensure programme sustainability as countries start to graduate from Gavi support in the 2016-2020 period.

Rotavirus Vaccine (RV)

Key programme statistics (programme start date 2008)

	Actuals*	Forecasts**		
		Programme start – 2014	Year 2015	2011-2015 (Strategy Period)
No. of countries	34*	2-4	~38	~42
Coverage	16%*	~24%	~24%	~24%*
No. vaccinated ²⁴	22M	~17M	~38M	~39M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10

**All forecasted data are subject to changes as a consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions. Coverage estimates for the current Strategy period reflects the estimated coverage in 2015.

²⁴ Estimates include number vaccinated with GAVI direct and catalytic support.

- 1.7 As of March 2015, one country has introduced and three additional countries are forecasted to introduce by the end of the year bringing the total number of introductions to 38. However, countries are still facing delays for various reasons, e.g., Sao Tome and Principe and Lesotho were delayed to 2016 due to resubmission of applications and Central African Republic and Liberia due to lack of country readiness. It is anticipated that Nigeria will apply in the September 2015 round.
- 1.8 The uncertainty surrounding large countries introductions (e.g., Nigeria, Uganda, Myanmar, and DRC) is creating challenges in managing supply in a situation of constant unbalance of demand that is skewed towards the 2 dose schedule vaccine.
- 1.9 Product preference imbalance continues to be an issue due to high demand for the 2-dose schedule vaccine; the Alliance is nearing the maximum Rotarix supply capacity. The situation risks to worsen in the near future because of the uncertainty surrounding large countries introductions (e.g., Nigeria, Uganda, Myanmar, and DRC) and since there is uncertainty around the question of whether there is a willingness to introduce with a 3-dose vaccine schedule if the 2-dose schedule vaccine is not available. Regardless of the product preference imbalance, many new rotavirus vaccine products currently in the short- to medium-term pipeline follow a 3-dose schedule and are forecasted to become available towards the end of the 2016-2020 period.²⁵ It is important to ensure appropriate communication regarding vaccine supply to countries as new information becomes available.

Human Papillomavirus (HPV) Vaccine

Key programme statistics (programme start date 2013)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	13 demo* 1 national	10 demo 1 national	~25 demo ~2 national	~25 demo ~2 national
No. vaccinated ²⁶	0.3M*	~0.8M	~1.1M	~1.1M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10.

**All forecasted data are subject to changes as a consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions. Coverage estimates for the current Strategy period reflects the estimated coverage in 2015.

- 1.10 Countries' continue to learn through the HPV demonstration programme. Seven countries introduced the vaccine in 2014 (which brings the total to 13 countries) and ten more demonstrations are scheduled to start in 2015

²⁵ See Market Shaping paper for more details on future suppliers of rotavirus vaccine

²⁶ Estimates include number vaccinated with GAVI direct and catalytic support.

including countries from the Western Pacific and South East Asia regions. The vaccination of 1 million girls, an important milestone for the HPV vaccination programme, will be reached when Uganda implements the planned national introduction by the end of 2015. An additional 3-8 countries are expected to introduce in 2016, which includes four countries transitioning from the demonstration project phase to nationwide introduction.

- 1.11 The demonstration evaluation reports required from countries start being received as countries move from year 1 to year 2 of the programme. Countries have used these reports in end of year 1 review meetings to assess their delivery strategy and identify improvements for year 2 delivery. Initial informal country coverage reports from the demonstration programmes have been encouraging, and results from at least two population based coverage surveys confirm that the requirement of 50% coverage for fully immunised girls²⁷ in demonstration districts has been surpassed. Additionally, the adolescent health assessment reports have identified adolescent health interventions opportunities for integration with HPV vaccination in three countries. These interventions include tetanus toxoid vaccination, health promotion messages and deworming.
- 1.12 Concerns about the vaccination of out of schools girls, especially where it is illegal to have children not enrolled in school, in addition to the need for reassessment of the original vaccine delivery budget estimates in particular for outreach, reflect the learning nature of the project for Gavi and countries alike. Furthermore, two out of the first six countries that introduced demonstrations in 2013 faced setbacks due to the Ebola outbreak. For the other four countries 2015 will be a bridging year to ensure continuity of vaccination in Demonstration districts before transitioning to national HPV roll out. To address the need for greater clarity on the transition process from Demonstration to National support, Gavi and partners have created information letters, fact sheets, and coordinated technical assistance efforts aimed at strengthening the process.

²⁷ Fully immunised girl denotes girls vaccinated with 2 or 3 doses of HPV vaccine with at least a 6 month interval between the first and last dose.

Inactivated Polio Vaccine (IPV)

Key programme statistics (programme start date November 2013)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	1*	70	~71	~71
No. vaccinated ²⁸	1M*	~27M	~27M	~27M

* The number of countries with active programmes in 2014 is based on actuals. The number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10

**All forecasted data are subject to changes as a consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions. Coverage estimates for the current Strategy period reflects the estimated coverage in 2015.

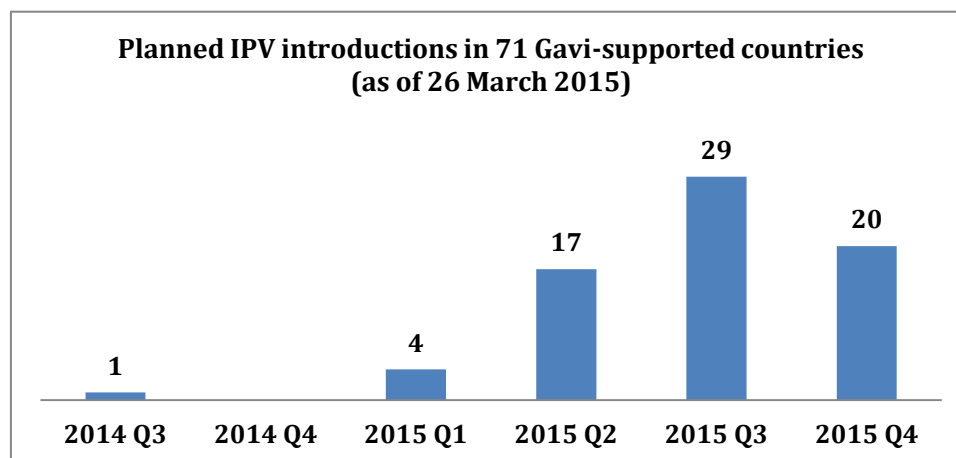
- 1.13 The implementation of the IPV programme has continued at a rapid pace. In November 2014, 37 countries were reviewed and recommended for approval by the IRC, taking the total to 64 countries within only a year of the Gavi Board's decision to support IPV. In January 2015, Gavi received applications from a further 7 countries. Gavi is expecting to support IPV programmes in 71 of the 73 Gavi countries and has therefore received all of the expected applications within only 14 months of the programme's initiation, demonstrating the extraordinary progress and commitment of countries, Alliance partners and the Secretariat to meet the Polio Eradication and Endgame Strategy IPV introduction target.²⁹
- 1.14 India was originally expected to entirely fund its own IPV programme. However, in September 2014, the country submitted a Gavi application for support for the period 2015-2018. Following discussions with GPEI and partners, the Gavi Board decided to provide India with 12 months of catalytic support to procure vaccines so as to enable India to meet the target deadline. This decision is subject to the availability of additional GPEI funding for India, sufficient responses to the IRC recommendations on India's application and a commitment from the Government of India to fund the programme after Gavi support ends. A letter was recently received by the Polio Oversight Board from the Government of India confirming their decision to finance the programme at the end of Gavi support. The Gavi Secretariat expects to be able to formally approve the application in Q2 once UNICEF SD's tender for locally licensed IPV is concluded and a formal agreement with GPEI donors is in place for the additional funding required.
- 1.15 The accelerated rollout of IPV has begun and there have been five Gavi supported introductions by 31 March): Nepal, Comoros, Senegal, Nigeria, Bangladesh (a joint introduction with PCV). The IPV programme is on

²⁸ Estimates include number vaccinated with GAVI direct and catalytic support.

²⁹ Ukraine had introduced prior to Gavi support becoming available. Georgia has decided to self-fund and will introduce a combination vaccine containing IPV.

track to have introductions in all of the Gavi supported countries by the end of 2015, in line with GPEI's Endgame Strategy:

Chart 3: IPV introductions planned by quarter



1.16 A key challenge for 2015 will be ensuring supply availability during the period of accelerated rollout. There have been a number of important developments:

- (a) In November 2014, WHO revised its guidance on the application of the WHO Multi-Dose Vial Policy for for IPV. This revision means that indicative wastage rates are reduced from 50% to 20% for the 10-dose vial and from 30% to 15% for the 5-dose vial. The change in guidance will only apply from May 2015 once the manufacturers have moved the Vaccine Vial Monitor (VVM) from the cap to the label.
- (b) In November 2014, WHO pre-qualified a five-dose IPV vial. Countries now have a choice between a ten-dose, a five-dose and limited amounts of a single dose vial, although there is currently only one supplier of each type of presentation.
- (c) In March 2015, the manufacturer of the 5-dose vial informed UNICEF SD of a reduction for 2015 of 8 million doses³⁰ to the available 5-dose vial supply due to a production issue. This supply reduction was mitigated by delaying nine countries in the lower risk groups (Tiers 3 and 4) to Q4 2015 (by approximately 3 months).. While this will require flexibility from countries regarding their IPV introduction dates, this mitigating action means that it is expected that there will be enough supply to introduce IPV in all countries by end 2015.
- (d) Indonesia's first preference is to self-procure from a local manufacturer. However, the local manufacturer is experiencing delays in setting up its technology transfer agreement with the supplier of the bulk and this risks delaying Indonesia's IPV introduction to 2016. High level advocacy is currently underway by WHO and it is hoped that a solution will be found in the coming months.

³⁰ Reducing the expected supply for the 5-dose vial from 35 to 27 million doses

- (e) IPV has also been used in Supplementary Immunisation Activities (SIAs) in polio endemic countries in 2014 and 2015 in support of polio eradication. This demand was not originally included in UNICEF SD's tender forecast and in 2014 a cap for SIA supply was set at 8 million doses for 2014-15 and this volume has been delivered. Given the success of these strategies to help interrupt the transmission of wild Polio Virus as well as the circulation of vaccine derived strains, the Eradication and Outbreak Management Group of the GPEI is requesting an additional 1.5 million doses in 2015. Given the supply constraints, the request was reviewed and approved by GPEI's Strategy Committee and resulted in four countries being asked to delay their IPV introductions to October 2015 due to supply constraints of the 10-dose vial presentation.
- (f) An IPV supply prioritisation group of the Immunisation Systems Management Group (IMG) has been created to manage these changes and to advise UNICEF SD on how to prioritise IPV supply for use in routine immunisation programmes. Available supply is being prioritised for continuing programmes, as well as by IPV risk tiers and country preparedness to introduce.
- 1.17 Given all of the recent programmatic changes, Gavi is revising its IPV financial forecast and plans to review this twice per year, in line with other Gavi vaccine programmes. The forecast will be submitted to the Audit and Finance Committee in May and the June 2015 Board.
- 1.18 In January 2015, WHO's Executive Board confirmed that the preparations for the withdrawal of type 2 OPV are on track. It will be implemented through a globally synchronised switch from trivalent OPV (tOPV) to bivalent OPV (bOPV) scheduled for April 2016 in the 149 countries and 7 territories currently using OPV. A final decision on the date will be made by the WHO Strategic Advisory Group of Experts (SAGE) at its October 2015 meeting. While Gavi does not specifically support OPV programmes, the global switch from trivalent to bivalent OPV will potentially cause some disruption to overall routine immunisation programmes. Gavi is currently in discussion with GPEI and partners to what role – if any – Gavi may play to help mitigate any negative consequences.
- 1.19 Efforts continue through the Immunisation Systems Management Group (IMG) of the GPEI and its Routine Immunisation (RI) sub-group to support 10 polio and Gavi focus countries and leverage polio assets to strengthen RI services. Partner polio staff has been playing a broader role in supporting immunisation. They have benefited from training and their terms of reference (TORs) specifically require that they spend at least 50% of their time on RI activities. Accountability frameworks are being put in place to monitor progress. Focus countries are currently finalising their integrated immunisation plans for 2015 and having them reviewed by ICCs. The IMG RI subgroup is providing oversight and review of national plans to ensure that the role of polio assets in immunisation strengthening is explicitly described.

- 1.20 As part of the Polio Legacy initiative (the fourth Strategic Objective of the Polio Eradication and Endgame Strategy), an independent assessment of polio staff time in 4 polio focus countries illustrated the magnitude of support for broader immunisation services which polio staff already provide, with approximately 50% of staff time devoted to non-polio activities. The scope of this work has been expanded to assess the involvement of polio assets in the 6 remaining focus countries. Results will provide an important independent measure of GPEI's transition to RI strengthening.

Yellow Fever Routine EPI and Mass Campaign Programmes

Key programme statistics (programme start date 2010)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries - Campaigns	14*	0	7	14
No. of countries - Routine	17*	0	0	17
Coverage - Routine	13%*	~16%	~16%	~16%
No. vaccinated - Campaigns ³¹	88M*	~6M	~44M	~93M
No. vaccinated - Routine	79M*	~11M	~41M	~90M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10.

**All forecasted data are subject to changes as a consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions. Coverage estimates for the current Strategy period reflects the estimated coverage in 2015.

- 1.21 By the end of 2015 mass campaigns will have been organised in 14 WHO 'high risk,' countries in Africa,³² with 8 of those having covered national level. The continuing supply constraint leads to a situation where no new application for mass preventive campaigns can be expected in 2015. Sudan will continue with phase 2 after having completed phase 1 campaigns in December 2014 and reaching approximately 7.5 million children. Nigeria had initially planned a campaign in 5 states in 2013

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

³² 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 yellow fever 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 (source WHO 2013)

aiming to reach 17,022,917 people but because of the global yellow fever vaccine supply shortage, the country reduced this effort to three states and only reaching 9,6 million people. YF vaccination was integrated with oral polio vaccine OPV in Cross Rivers in Nigeria because a suspected case of YF had been reported in that area.³³

- 1.22 WHO is working on a paper for the World Health Assembly which proposes a resolution on the comprehensive prevention of yellow fever epidemic. As part of an effort that seeks to collect relevant lessons, WHO is also conducting a study to further understand the costs of preventive and outbreak response campaigns.
- 1.23 The current YF vaccine supply situation has slightly improved and Alliance partners are working closely and have been prioritising routine EPI and outbreak response. YF routine coverage has remained low: approximately 6 of the 13 high risk countries reported less than 80% coverage in 2013, even after having conducted successful mass campaigns.

Meningococcal A (Men A) Conjugate Vaccine – Campaign Programme

Key programme statistics (programme start date 2010)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	15*	5	~14	~17
No. vaccinated ³⁴	~219M*	~44M	~244M	~263M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10.

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

- 1.24 So far, fifteen of the 26 endemic countries of the meningitis belt have received Gavi support for mass campaigns reaching a population of approximately 219 million by end of 2014, covering approximately more than 80% of the at-risk population in those countries. Specific communication and mobilisation strategies were implemented to reach this age-group. The immediate impact of the mass campaigns is substantial: outbreaks related to Men A serogroup have reduced drastically in all vaccinated countries and no new cases of Men A serogroup have occurred in the vaccinated districts after the campaigns. Research studies consistently demonstrate high impact of the vaccination campaign on disease and carriage. The high impact of this vaccine in Chad where after immunisations the incidence of meningitis A dropped by 94 percent is a good example of the impact of this programme. The remaining 11 endemic

³³ Joint WHO and UNICEF 2013 progress report

³⁴ Estimates include number vaccinated with GAVI direct and catalytic support.

countries will be reached by 2017/2018 with a total of 263 million individuals vaccinated.

- 1.25 Three countries used a controlled temperature chain strategy in some districts during mass preventive campaigns. The MenAfriVac 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. According to a study conducted by WHO in Chad in 2012, the economic benefits of this approach are significant, as they reduce the need to strictly rely on the cold chain throughout the campaign and substantially reduce the need to produce icepacks for the transport of the vaccine.
- 1.26 The paediatric indication for the conjugate Meningitis A vaccine was prequalified by WHO in December 2015. Countries will start introducing the vaccine into their routine immunisation programme from 2016 onwards. To sustain the gains achieved through the successful mass preventive campaigns, the Alliance will support countries in the roll out of this vaccine into routine programmes.

Measles Containing Vaccines

The Gavi Alliance continues to support routine measles second dose for a period of five years; measles rubella campaigns and introductions into the routine programme; measles supplementary activities for six large countries at risk for outbreaks; and finally the outbreak response fund to the Measles & Rubella Initiative. The December 2014 Board asked Gavi to review the contribution made by Gavi so far, and to propose a holistic and coherent strategy going forward. This strategy will be presented to the PPC in October and the Board in December. This Board is presented with a separate paper with a request for additional measles Supplementary Immunisation Activity (SIA) for two countries: Ethiopia and DR Congo, urgently in need to commence an additional SIA within the next 12 months. (See item 8: Measles Supplementary Immunisation Activities).

Measles Second Dose

Key programme statistics (programme start date 2007)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	14*	4-7	20	22
No. vaccinated ³⁵	25M*	~11M	~28M	~34M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10

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

Measles Rubella

Key programme statistics (programme start date 2013)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of countries	12	4-6	~20	~20
No. vaccinated ³⁶	145M	~45M	~191M	~191M

* The number of countries with active programmes in 2014 is based on actuals. The number vaccinated is based on estimates.

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

Measles Supplementary Immunisation Activities (SIAs)

Key programme statistics (programme start date 2013)

	Actuals*	Forecasts**		
	Programme start – 2014	Year 2015	2011-2015 (Strategy Period)	Programme start – 2015
No. of SIAs	5*	~1-2	~7	~7
No. vaccinated ³⁷	70M*	~47M	~118M	~118M

* The number of countries with active programmes in 2014 is based on actuals. The coverage rate and number vaccinated in 2014 is based on the Gavi Strategic Demand Forecast v10**All forecasted data are subject to changes as a consequence of revision of historical coverage data, progression of the programme and revised forecast assumptions.

1.27 Between 31 August 2014 and 31 March 2015, 5 countries (Tanzania, Burkina Faso, Yemen, Solomon Islands and Myanmar) have conducted

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

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

³⁷ Estimates include number vaccinated with GAVI direct and catalytic support.

MR SIAs, Viet Nam has completed most of its MR SIA, and Tanzania and Yemen have introduced MR vaccine into routine immunisation. Solomon Islands targeted everyone from 6 months to 29 years of age in their MR SIA in response to a large measles outbreak. The 15-30 year old portion of the target population was funded by the Measles & Rubella Initiative using outbreak response funds. Afghanistan will conduct a measles SIA this year, and Nigeria has requested a second Gavi-funded measles SIA to be conducted later this year. Ethiopia has also applied to Gavi for funding for a second measles SIA. However Gavi was unable to consider the application because the current budget allocated for this window assumes Ethiopia will only receive support for one measles SIA.

- 1.28 While Sierra Leone was approved for measles second dose support, the timing of when the country will be able to re-establish the immunisation system sufficient to prepare for and introduce measles second dose is uncertain.
- 1.29 Supply coordination remains a high priority given the large demand and the single supplier for MR vaccine. Gavi is actively involved in the Supply Coordination Group of the Measles and Rubella Initiative, chaired by UNICEF SD. This group is monitoring the quantities of vaccines needed and the timing of SIAs in large countries planning SIAs in 2015, including for example Kenya, Nigeria and Ethiopia, as well as it is continually revising forecasts for the coming years.

Japanese Encephalitis (JE)

Key programme statistics ((programme start date 2013)

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

- 1.30 Lao PDR has been the first Gavi country to introduce Japanese Encephalitis (JE), with the campaign running from 30 March - 10 April. Cambodia was approved for JE support by the IRC and, awaiting a EC decision, is scheduled to introduce in January 2016. Additionally, Nepal applied for JE support, also for introduction in 2016.
- 1.31 Gavi and partners including WHO, UNICEF, PATH and BMGF are closely coordinating the country introductions and campaigns. Close coordination

is necessary due to the long lead time required by the manufacturer and subsequent need to ensure vaccine doses are available and reach the country in time. A revised position paper on JE was recently released by WHO reiterating the importance of a one-time wide age campaign followed by integration into the routine immunisation programme. However, a national campaign and subsequent introductions may not be appropriate for all countries. The VIMT JE subteam agreed that countries should be encouraged to apply even if new risk areas may be identified in other geographies in the future. The Gavi NVS application guidelines have been updated accordingly.”

- 1.32 The Alliance is also closely monitoring India’s plan to vaccinate adults since this would impact the supply availabilities for other countries as well as interest from other countries for JE. With recent review of the Cost of Goods Sold (COGS), there has been an increase in the price of JE vaccine applicable for Cambodia and Nepal.

Cholera

- 1.1 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 2M doses for the July 2014 to July 2015 period. The period has been then extended to December 2015 to reflect the lower vaccine supply availability. After this time, UNICEF SD will become the procurement agent for the OCV stockpile. UNICEF SD will be releasing a request for proposal (RFP) for OCV doses in Q2 2015.
- 1.2 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. A second supplier has recently submitted Product Summary Files to WHO for prequalification. However, the availability of vaccines to improve the evidence base on OCV use in time for the next VIS may prove difficult.
- 1.3 The International Coordination Group (ICG) has approved doses for Chad in November 2014; however the country decided not to conduct the campaign. In early March, Malawi requested doses for a reactive campaign of 160,000 persons and it is anticipated that Mozambique and Haiti will request additional doses from the stockpile. Overall, the inclusion of OCV as an integrated cholera control measure remains new. As the vaccine becomes more widely used and positive data on feasibility of use and health impact is shown, demand is expected to increase.
- 1.4 Following the revitalisation of the Global Task Force on Cholera Control (GTFCC), and along with it the OCV working group, Gavi and WHO merged the VIMT Cholera subteam and GTFCC OCV working group. The OCV working group’s overall objective is to plan and monitor all aspects of the implementation of OCV campaigns for cholera control. It has been agreed that OCVs can be deployed through the global cholera stockpile in emergency and non-emergency settings. The mechanism for emergency

use is managed by the ICG, while the OCV working group can be used to formally review country requests for use in non-emergency settings. Partners, along with Gavi, are currently developing criteria and conditions for the release of OCV.

- 1.5 In January 2015, Gavi launched a request for proposal for the Vaccine Investment (VIS) learning agenda for which OCV was a component to fill critical evidence gaps and to better inform consideration for potential Gavi support in the 2018 Vaccine Investment Strategy (VIS). Since this launch, Gavi has received 15 Letters of Interest for OCV and will convene an adjudication committee in April to review and select the proposals.

Annex B: Sources and definitions of performance metrics

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

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 C: Strategic Goal 2 update

This Annex provides supplementary information on the progress towards Gavi's Strategic Goal 2. It summarises the Alliance's coverage and equity improvements and Health System Strengthening (HSS) support.

Coverage and Equity

- 1.6 This section starts with an analysis of challenges to increasing coverage and closing the equity gap before summarising the Alliance's work in the areas of equity and gender. The final sub-section provides a summary and outlook to the Alliance's current and planned work on improving coverage and equity levels in Gavi eligible countries.

Challenges

- 1.7 Among the main challenges in many countries to increasing coverage and closing the equity gap include the non-availability of funding for the implementation of Reaching Every District and Reaching Every Child strategies, delayed or insufficient investments in supply chain management systems, issues in human resource management, insufficient involvement of communities in immunisation strategies at scale, and in some countries insufficient or late mobilisation of funding for vaccines and injection supplies (traditional vaccines and co-financing of new vaccines). Going forward Gavi will need to consider ways to strengthen support to countries in all these respects to support the countries in closing these gaps. It will also be critical to ensure that the traditional EPI partners are strengthened and that efficiencies in their work are increased.
- 1.8 Improving coverage and equity levels both at a country and the global level will also require an increased focus on strategic enablers that support the advancement of the agenda. To this end the Alliance will be working on strengthening governance, leadership and management of key in-country stakeholders to enhance these stakeholders' capacity to reach so far unreached populations and to thereby enhance coverage rates. In addition there will be a focus on strengthening engagement with CSOs who will also be key partners in supporting the equity and coverage agenda.

Equity

- 1.9 In the current Gavi Business Plan, Alliance partners, and particularly UNICEF, have worked with 10 countries to analyse the drivers of inequity in immunisation. This work found that main drivers are geographic, socio-economic and linked to the education of the caregiver. Inequities due to gender are of a much lesser extent and only important in limited number of countries. UNICEF led the development of a framework for equity assessment and strategy development that could be mainstreamed in Gavi support. The new Gavi strategy provides an opportunity to better identify the needs in Alliance partners to help countries address equity

barriers. Alliance partner staff at headquarters, regional and country level may need to be strengthened and made more efficient in this respect.

- 1.10 The framework for equity assessment and strategy described above includes:
- (a) Review of inequities in coverage
 - (b) Identification of communities affected by inequities in the EPI
 - (c) Identification of main barriers to vaccination for these underserved communities
 - (d) Development of strategies to be adopted, e.g. Reaching Every Community
 - (e) Mainstreaming equity in policies and vaccination plans (cMYPs, Annual EPI plans, HSS and NUVI proposal etc.)

Gender barriers to immunisation in HSS proposals

- 1.11 In November 2013 the Board approved a revised Gender Policy with an increased emphasis on gender-related barriers to immunisation. The 2013 revision of the HSS application guidelines reflected this revision by requesting countries to describe whether and how each proposed objective relates to equity and gender related barriers. This was emphasised further in the 2014 guideline revision which requested countries to label in their proposed budget whether each activity is gender-related.
- 1.12 18 HSS proposals using the 2013 and 2014 revised guidelines have been recommended for approval by IRCs since November 2013. Of these, 8 (44%) defined a gender-related barrier to immunisation. Examples include the relationship between maternal education and immunisation, and the work burden placed on mothers. Seven of these 18 proposals (39%) included a budget for gender-related activities, such as, in Sudan, for a study of the effects of gender on accessing healthcare services and, in Ghana, for an activity to sensitise community leaders and men on the importance of immunisation. Seven proposals (39%) included gender-related indicators, such as the proportion of non-immunisation resulting from parents (mothers) lacking relevant information.

Improving Coverage and Equity under the New Strategy

- 1.13 The Alliance is working to develop its approach to better support countries towards sustainable improvements in immunisation coverage and equity. Through a consultative process with a global task force of Alliance partners, the group has identified key principles for the work, including: Agreement that the intent is not to create a single global "strategy" but instead to identify the cross-cutting global interventions, such as changes to Gavi's policies and processes, that could improve Gavi's support. In

parallel, a central focus will be the development of tailored country-specific strategies to concretely move the needle within priority countries.

- 1.14 The group has also been working to align on a common framework to identify barriers to coverage and equity improvements and define interventions. A select number of priority countries with high number of unimmunised children, including Uganda, Ethiopia, Democratic Republic of Congo, Madagascar and Nigeria has been identified as coverage and equity focus countries.
- 1.15 For these focus countries a desk review, using a standardized diagnostic tool based on the six health systems building blocks, is being undertaken to better understand the country specific barriers to and enablers of increased coverage and equity rates. This includes in particular an in-depth analysis of these countries' EPI reviews, Post Introduction Evaluations (PIEs), Effective Vaccine Management (EVM) assessments, comprehensive multi-year plans (cMYP) and other in country-work. A comprehensive list of country specific unmet needs and successes is being identified that will help inform all further work in these countries. This work will be performed by agencies with strong presence in the respective countries. The work will then be validated by a broader set of Alliance partners and will serve as the base for further in-country discussion and prioritisation.
- 1.16 In addition, and to ensure that the Alliance's coverage and equity related work is thoroughly grounded in country-level needs, a series of EPI consultations have been initiated in the selected countries. These will both help create country-specific roadmaps to align partner support around an agreed set of interventions, and will also inform the global discussion. The first wave of consultations has and will be held in Uganda, Ethiopia and Madagascar and the findings from these countries will further inform the Alliance's 2016 activities in those countries. The first such consultation took place in Uganda through a national EPI review. Uganda is developing a new cMYP this year in advance of a new HSS application in 2016.
- 1.17 There were important strengths identified which position Uganda well for sustainable improvement including each facility having a bank account into which it received directly funds for operational and outreach services and well established computer-based health management information system (DHIS2). Challenges identified which would slow sustainable improvements in coverage and equity were consistent with the areas of focus emphasised in Gavi's strategy, including outdated supply chain equipment requiring monthly fuel deliveries instead of solar energy, limited use of the collected data for programmatic decisions, and the need to invest more heavily in management, coordination, and capacity building of staff.
- 1.18 Gavi will take a phased approach to conducting additional EPI consultations - EPI managers have voiced a strong desire to conduct such consultations and the Alliance is in conversation with interested countries to work on potential timing.

- 1.19 Recognising the need to incorporate the findings of these consultations into the cross-cutting global dialogue, the group has identified an initial list of specific supportive interventions that could enable improved Gavi programming for countries, including:
- (a) Simplifying complex planning processes and converging in a single EPI plan which will align all country activities and donor and partner support;
 - (b) Better aligning Gavi planning cycles and funding streams with country plans
 - (c) Creating a standardised approach to assess management capacity at country level and developing clear plans to fill those gaps
 - (d) Exploring how political leaders can be engaged to accelerate progress on immunisation and strengthen Inter-Agency Coordinating Committees (ICCs)
- 1.20 Additionally, the Secretariat has ongoing work to streamline grant management processes and enhance the stewardship role of Senior Country Managers (SCMs). The Joint Appraisals will be a key tool in terms of gathering country data and will help the Secretariat to direct resources more effectively to needs.

Health Systems Strengthening support to countries

- 1.21 This section provides an overview of HSS support provided to countries. It starts with an update on recent IRC proposal approvals and an overview of HSS categories of support before providing an overview of committed, approved and disbursed funds, the utilisation of funds as well as reported implementation of HSS activities.

IRC proposals approval

- 1.22 The new application Independent Review Committee (IRC) approved 12 HSS applications in 2014. All ten applications submitted to the February and June 2014 IRC rounds were approved while the November 2014 IRC approved only two out of six HSS proposals (Mali and Senegal). The reason for the lower approval rate in the November 2014 IRC can be attributed to the change in decision categories to “Approval with recommendations” and “resubmission with explanations” which resulted in more proposals being classified as ‘resubmission with explanations’. This was done for consistency across all windows of support and to reduce long delays to resolve conditional approvals. Instead, countries are encouraged to address IRC comments such that modified elements of their proposals can be reviewed at the subsequent IRC round.
- 1.23 Although the percentage of approvals was lower in the last IRC, the November IRC commended the improved quality of proposals, M&E frameworks and results chains, the inclusive and participatory proposal development process, and the completeness of applications. The IRC also

identified weaknesses in applications including continuing challenges aligning between NVS, HSS, and in-country planning cycles and policies; insufficient integration of lessons from a country's previous HSS grants; and the importance of further focus on equity and demand side generation strategies.

- 1.24 Alliance partners and the Secretariat are working to address these concerns through strengthened business plan support to countries, updates to the 2015 Application Guidelines, development of CP Operational Guidelines, and updates to the guidance for the 2015 Joint Appraisal process. Further efforts in areas such as demand generation strategies will be developed through Gavi's new strategy.

Categorisation of HSS funding

- 1.25 The Alliance partners have revised the methodology for categorising the activities in HSS proposals. While the main categories remain the same (e.g. Procurement & Supply Chain Management, Service Delivery), the sub-categories within these have been refined for consistency and clarity. See Annex D for the revised categorisation methodology and a description of the main changes. Table 1 below shows trends in how countries are now proposing to use Gavi's HSS support³⁸, indicating clearly that most funding is invested in service delivery; Health and community workforce; procurement & supply chain management and Health information systems.

Table 1: Allocation of Gavi HSS commitments by grant category

	2006-2009 (54 grants recommended for approval) ³⁹		2011-2014 (38 grants recommended for approval)		2014 (5 grants recommended for approval) ⁴⁰	
	Amount	%	Amount	%	Amount	%
1. Service delivery	\$263.8 M	48%	\$176.8 M	32%	\$45.5 M	47%
2. Health and community workforce	\$120.1 M	22%	\$92.2 M	17%	\$12.2 M	13%
3. Procurement & supply chain management	\$21.8 M	4%	\$94.7 M	17%	\$16.0 M	17%
4. Health information systems	\$38.9 M	7%	\$81.9 M	15%	\$14.5 M	15%
5. Empower community and other local actors	\$23.2 M	4%	\$43.5 M	8%	\$4.7 M	5%
6. Policy and governance	\$18.7 M	3%	\$5.4 M	1%	\$.9 M	1%
7. Health financing	\$5.2 M	1%	\$1.1 M	0%	\$.2 M	0%

³⁸ This does not include grants recommended for approval by the IRC in 2014 which are pending approval subject to clarifications. This analysis is based on proposed HSS budgets and work plans, not on implemented activities, and it does not reflect changes to the commitments or budgets over the life of HSS grants.

³⁹ A total of 55 HSS grants were recommended for approval by IRCs from 2006-2009. This analysis does not include Nepal's first HSS grant (recommended for approval in 2007), which was channelled through a pooled funding mechanism.

⁴⁰ This analysis does not include 7 HSS grants that have been recommended for approval by IRCs but are pending CEO approval. This is because HSS grant budgets can change during the clarifications process.

8. Programme management	\$23.3 M	4%	\$26.8 M	5%	\$2.5 M	3%
9. Other	\$23.6 M	4%	\$14.6 M	3%	\$.2 M	0%
10. Programme support costs ⁴¹	\$8.5 M	2%	\$10.7 M	2%	0	0%
11. Budget variance ⁴²	\$6.6 M	1%	\$.1 M	0%	\$.1 M	0%
Total	\$553.7 M	100%	\$547.7 M	100%	\$96.8 M	100%

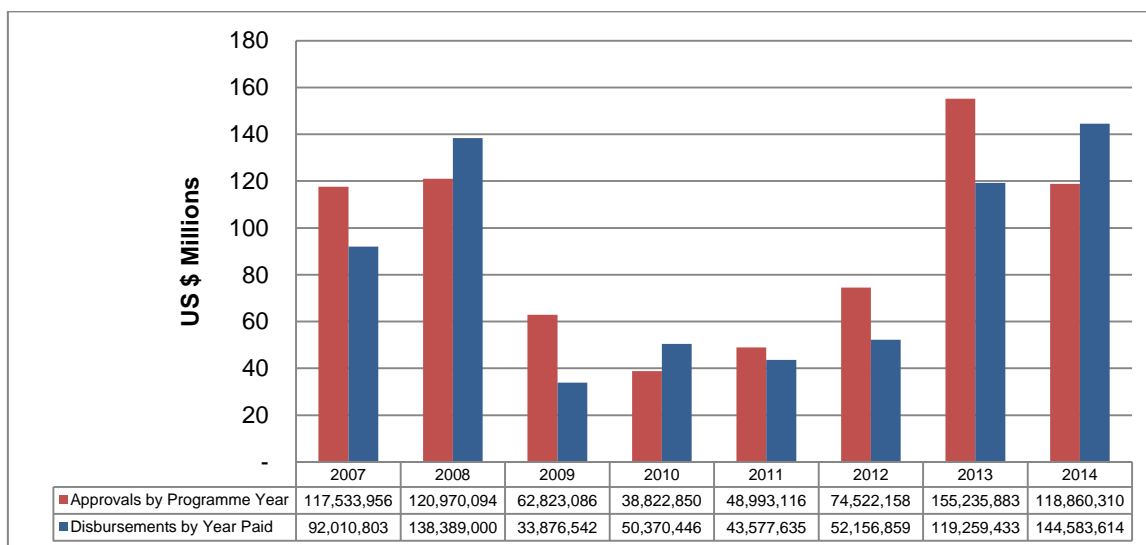
Committed, Approved and Disbursed

1.26 As of December 2014, Gavi committed a total of USD \$1.1bn for HSS grants from 2007 through 2018. Total HSS approvals from 2007-2014 were USD \$738m, of which USD \$661m (90%) were disbursed by December 31, 2014 (See chart 4). Expenditures on all cash programmes for 2014 totalled USD \$277m (21% of all Gavi programmes). This includes 2014 expenditures on HSS (USD \$144m), vaccine introduction grants (US\$ 32 million) and other cash programmes (USD \$101m). The 3 year rolling average of cash programme disbursements is 20% which is consistent with board guidance of 15-25%.

⁴¹ The Programme Support Costs category captures the costs paid to partners to support implementation, if countries have included this in their HSS budget proposal.

⁴² Budget variance of proposal relative to Gavi commitment (e.g. due to incomplete budget at proposal stage, which was more frequently the case in older HSS grants)

Chart 4: HSS Grants Approved and Disbursed, 2007 – 2014.



1.27 On average disbursements for HSS grants were made 14 months after IRC review. The main factors affecting the time between IRC review and disbursement are pending clarifications that need to be addressed by countries, delays in previous HSS grants, delays in signing of Partnership Framework Agreements and changes in internal Gavi review and approval processes, particularly to strengthen fiduciary oversight. Through the Grant Management Process working group, the Alliance is continuing to working towards reducing delays and improving approval and disbursement timelines. Gavi and Alliance partners are also looking into ways to improve timeliness of disbursements, such as relative to national budget cycles, following the first grant year.

Utilisation of funds

1.28 Countries with approved HSS grants have in the past proven to have some difficulties in utilising the funds in a timely manner. In 2013 for example, annual expenditure as % of funds available amounted to only 47%. This constitutes an upward trend from previous years (28% for 2011 and 39% for 2012). To ensure a continuation of the upward trend and further improve the performance WHO reviewed bottlenecks to Gavi HSS grant implementation as reported by countries in their 2012 – 2013 APRs. Findings have highlighted the following main challenges: (1) Disbursement of funding come late in the calendar year; (2) Country related governance and administrative issues; (3) Input constraints and/or changes to workplan due to competing priorities; (4) External factors to the health sector (political insecurity, military crisis, etc.).

1.29 The Gavi Secretariat is now working with Alliance partners to provide increased technical assistance to countries to address these bottlenecks and thereby increase the utilisation of funds. For example, Alliance partners will work together to provide assistance to countries for financial and procurement management systems. The Alliance will also work to improve the procedures for timely grant disbursements and better

alignment with country fiscal years, national operational budgets and health sector work-plans so to ensure better access to funding. Additionally, with increased audit resources within Gavi, there is a mandate to increase the number of monitoring reviews in country, early on in grant implementation, which in turn might allow the Secretariat to identify potential issues sooner and to provide better support to resolve them. Going forward, the Secretariat anticipates providing a standard set of analyses to inform the status of financial implementation.

Reported implementation of HSS Activities by expenditure in 2013

- 1.30 Five of Gavi's first HSS Performance-Based Funding (HSS/PBF) countries (Afghanistan, Comoros, Lao PDR, Rwanda and Zimbabwe), reported on grants according to the expenditure on activities in the countries' work plans. These reports were submitted to Gavi on the HSS/PBF reporting form that accompanied 2013 APRs (see Table 2 below).
- 1.31 Using the activity categorisation methodology discussed above, one can calculate the rate of expenditure-based implementation (actual expense divided by approved budget) by activity category (see Table 2 below). This analysis shows that *service delivery* activities had the highest rate of implementation at 71%. *Health and community workforce* activities had the lowest rate of implementation at 25%. Bottlenecks that countries reported in implementing *health and community workforce* activities included delays in the procurement of service contracts (Afghanistan) and a lack of competent trainers (Comoros). There was also little or no budget within the categories of health financing and policy and governance.
- 1.32 The Gavi Secretariat expects to receive updated HSS/PBF reporting from 21 countries following the submission of Annual Progress Reports in 2015. Progress on 2014 implementation will be provided to the PPC in October 2015.

Table 2: Expenditure-based implementation of 2013 activities, shown by grant category, for Afghanistan, Comoros, Lao PDR, Rwanda and Zimbabwe

Grant Category	Total Approved Budget (\$)*	Total Actual Expense (\$)*	Implementation rate (Expense/Budget*)
1. Service Delivery	\$2.26 M	\$1.60 M	71%
2. Health and community workforce	\$3.94 M	\$0.99 M	25%
3. Procurement and supply chain management	\$0.36 M	\$0.18 M	49%
4. Health information systems	\$0.51 M	\$0.30 M	59%
5. Empower community and other local actors	\$0.36 M	\$0.15 M	40%
6. Policy & governance	\$0.05 M	\$0.02 M	48%
7. Health financing	\$0.00 M	\$0.00 M	-
8. Programme management	\$1.60 M	\$1.16 M	72%
Total	\$9.08 M	\$4.40 M	48%
<p>*Approved budget and actual expenses are for the planned activities in the country-defined reporting period. Activities were omitted if the country clearly indicated that the activity was not planned for this reporting period.</p> <p>*Burundi reported on 2013 implementation but did not provide an activity based financial report.</p>			

Annex D: Revised Categorisation Methodology for Proposed Activities in Approved Gavi HSS Grants:

The Alliance partners have revised the methodology for categorising the activities in HSS proposals. While the main categories remain the same (e.g. Procurement & Supply Chain Management, Service Delivery), the sub-categories within these have been refined for consistency and clarity.

- Category 1 (Service Delivery) now includes supportive supervision, the procurement of medical equipment, and all operational costs of immunisation service delivery. Compared to previous estimates of the portfolio allocation for 2011-2014, the portion of the portfolio allocated to this category has increased from 21% to 32%.
- Category 2 (Health and community workforce) now includes all types of training, including training related to the supply chain and training related to data reporting and analysis. This category no longer includes supportive supervision activities. The portion of the 2011-2014 portfolio estimate that falls in this category has decreased from 19% to 17%.
- Category 3 (Procurement and supply chain management) now includes all supply chain management activities (such as EVMs) but does not include supply chain training or investments in Logistics Management Information Systems (LMIS), which fall under Category 2 and Category 4, respectively. It also does not include the procurement of health commodities such as medicines. The estimated portion of the 2011-2014 portfolio that falls in this category has decreased from 26% to 17%.
- Category 4 (Health information systems) now includes all IT procurement (unless specifically for HSS grant management), as well as all data systems investments. The estimated portion of the 2011-2014 portfolio in this category has increased from 13 % to 15%.

In addition to the category revisions, this analysis is also based on a slightly different set of grants than the previous version of the analysis. Previously, grants were incorporated into the analysis once they had been recommended for approval by the IRC. In the updated analysis, grants are not included unless they received final approval from the CEO. This is because budgets can change during the clarifications process.

Annex E: List of Acronyms

APR	Annual Progress Report
AEFIs	Adverse Events Following Immunisation
AMP	Agence de Médecine Préventive
bOPV	bivalent OPV
cMYP	comprehensive multi-year strategic plans
CPA	Cash Programme Audit
cPad	compact prefilled auto-disable injection
CSO	Civil Society Organisations
DRC	Democratic Republic of Congo
DTP3	Diphtheria-tetanus-pertussis
EPI	Expanded Programme on Immunisation
EVM	Effective Vaccine Management
FMA	Financial management Assessment
GAMR	grant application, monitoring and review
GPEI	Global Polio Eradication Initiative
GTFCC	Global Task Force on Cholera Control
GVAP	Global Vaccine Action Plan
HSCC	Health Sector Coordinating Committees
HSS/PBF	HSS Performance-Based Funding
HPV	Human papillomavirus vaccine
ICC	Inter-Agency Coordinating Committees
ICG	International Coordination Group (cholera)
IRC	Independent Review Committee
IPV	Inactivated polio vaccine
JEV	Japanese Encephalitis vaccine
JSI	John Snow, Inc.
LMIS	Logistics Management Information Systems
IMG	Immunisation Systems Management Group
Men A	Meningitis A vaccine
MCV	Measles-containing vaccine
MR	Measles Rubella
NUVI	New and Under-utilised Vaccines Implementation
NVS	New Vaccine Support
OCV	Oral Cholera Vaccine
ORI	outbreak response immunisation
PCV	Pneumococcal conjugate vaccine
PEF	Partnership Engagement Framework
Penta	Pentavalent
PIRI	Periodic intensification of routine immunisation
RFP	Request for proposal
RI	Routine Immunisation
RV	Rotavirus vaccine
SARA	Service availability and readiness assessments
SIA	Supplementary Immunisation Activities
tOPV	trivalent OPV
TORs	Terms of reference

UNICEF PD	UNICEF Procurement Division
UNICEF SD	UNICEF Supply Division
Uniject	Uniject autodisable injection system
VIMT	Vaccine Implementation management team
VIS	Vaccine Investment Strategy
YFV	Yellow Fever Vaccination
VVM	vaccine vial monitor
SAGE	Strategic Advisory Group of Experts