

## FOR INFORMATION

This document is being provided for information only. It is a consolidated report on the 2009 work plan, within the GAVI Alliance 2007-10 Strategy. It is based on the reporting provided by WHO, UNICEF, World Bank and the GAVI Secretariat. No requests are being made of the Board.

## 2009 Work Plan Information/Update

The GAVI Alliance 2007-10 strategy has four strategic goals.

1. Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner.
2. Accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security.
3. Increase the predictability and sustainability of long-term financing for national immunisation programmes.
4. Increase and assess the added value of GAVI as a public-private global health partnership through improved efficiency, increased advocacy and continued innovation.

For the 2007-2010 strategic plan the Alliance developed a work plan to fund activities implemented by multilateral partner agencies (primarily WHO, UNICEF and the World Bank) and the GAVI Secretariat in support of the strategic goals. This work plan, in the form of a logical framework (available at <http://www.gavialliance.org/documents>) contains over 100 activities in any given year, organised under 17 outputs – with a total budget of US\$297m over the four year period. Activities and corresponding budgets were developed on an annual basis in 2007 and 2008 and on a bi-annual basis for 2009-10. For the purposes of this report, these activities are reported against 17 outputs<sup>1</sup>.

The first part provides some of the highlights of the 2009 work plan under each output (that covers the period 2007-10) and an assessment (by traffic light<sup>2</sup>) of where we are, against the 2009 deliverables/targets of the relevant outputs.<sup>3</sup> The second section of this report summarises the financial implementation of 2009 funds by the Secretariat

<sup>1</sup> The areas of Health Systems Strengthening and the Accelerating Vaccine Introduction Initiative (AVI) are broken down into further sub-outputs

<sup>2</sup> Green: 'Met' the deliverable/targets or that progress is 'on track' in line with the main activities/deliverables; Amber/Yellow: 'Not met' –although progress has been made in some areas the main activities/deliverables have not been met ; Red: 'Major slippage' – significant delays in 2009

<sup>3</sup> This is denoted in the report by a 2 digit number. A sub-output has a 3 digit number.

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and Partners. Given that this is a two year work plan, it is assumed that slippage in activities will be corrected in 2010, as much as is possible.

In summary, out of 17 outputs<sup>45</sup>:

- 11 (61%) were on track/ongoing into 2010
- 5 (28%) progress made in some areas
- 2 (11%) were significantly delayed

### **Technical/Narrative Reporting**

WHO and UNICEF submitted detailed annual progress reports, both narrative and financial, to the Secretariat, reporting against a set of activities and deliverables. The Secretariat reported against its own activities and the World Bank provided a more general narrative at the Strategic goal level. These activities were assessed at activity level and submitted for information to the Programme and Policy Committee in May.

WHO reported progress against the 53 GAVI supported activities (with 67 deliverables). Most activities are on track; however there are delays in areas of assessing/documenting impact, data quality and reporting, generating health and economic impact data to support introduction decisions, training health care workers for vaccine introduction and surveillance. The GAVI Secretariat reported progress against 55 activities<sup>6</sup>. Delays were reported in 16 areas around fundraising, the AMC, civil society and financial management assessments.

UNICEF reported progress against 12 activities (with 17 deliverables). Most activities are on track, with delays in the areas related to technical support around cold chain and logistics (CCL), vaccine management, communication strategies and HSS proposal development and implementation. The delays in the first two areas reflect the progressive building up of capacity and approaches and the partnership work that UNICEF is doing through the CCL Taskforce and the partnership for coordinated communication for pneumonia and diarrhoea.

The World Bank provided narrative at the Strategic Goal level and not against activities/deliverables; hence it is not possible to make an assessment of progress.

The reporting below highlights the main areas of progress by the Secretariat and Partners under each Strategic Goal, as gleaned from detailed activity reports. In

<sup>4</sup> Output 2.1 has 2 lights therefore denominator is 18 for 17 outputs

<sup>5</sup> See Annex A for further summary

<sup>6</sup> WHO and UNICEF were asked by the PPC to develop a deliverables based framework around activities, to measure progress around 26 activities as per the conclusion of the Work Plan Validation Committee. No GAVI Secretariat or World Bank activities were part of the 26.

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addition, where there are 2009 targets, these are discussed. The traffic light is based on an assessment of the reporting provided.

### **Strategic Goal 1: Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner.**

#### **1.1 GAVI ISS support will reach an increased number of countries that have received support**

By 2009:

- 81% of GAVI eligible countries (62 out of 76 countries) had received ISS support (against a target of 90% by 2009).
- 83% of GAVI eligible countries receiving ISS support <sup>7</sup> increased coverage by 5% or more (against a target of 80%) since 2000.
- 75% of countries with a large number of unvaccinated children (CLUC) (6 out of 8 countries) increased coverage by at least 10% since 2000 (against a target of 80%).
- 69% of fragile countries (9 out of 13 countries) increased coverage by at least 10% since 2000<sup>8</sup> (against a target of 80%).

In response to an evaluation of ISS conducted in 2007 and an analysis published in the Lancet, GAVI is developing a next generation of performance based funding programs and has reviewed the data sources for its reward calculations. In 2009 GAVI convened a data task team to review its use of administrative data to calculate ISS rewards.

Among other recommendations, the task team recommended that WHO/UNICEF estimates be used as a check for self reported data. UNICEF and WHO are working to improve immunisation data management and have revised the methodology for estimating immunisation coverage by using additional data sources. The improved methodology will be applied for immunisation coverage estimates in 2010.

WHO provided 27 countries with technical support to help implement the Reach Every District (RED) strategy in priority districts. In India, four states have continued to be targeted for technical support, and WHO routine immunisation officers have been placed in these states to provide sub-national direct support. The Annual Progress Reports and applications from fragile states were supported by WHO staff in six and four countries respectively. UNICEF regional offices scaled up activities to improve immunisation coverage and service delivery at the sub-national level using the RED Strategy in all countries receiving ISS.

<sup>7</sup> DTP3 coverage of first year of ISS support compared with coverage in 2008

<sup>8</sup> For East Timor since 2002 when it became a WHO member state

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In addition, WHO provided support to data quality improvement activities in 14 countries, and in 17 countries (mostly overlaps) these then led to data improvement activities. Another 20 countries conducted follow-up activities to strengthen data quality and monitoring.

### **1.2 Countries with HSS support will have made improvements to their health system to deliver immunisation and other health interventions**

The output around Health Systems Strengthening is further divided into five sub-outputs (See Annex B). Some of the main areas of progress include:

- By 2009, 63 % (or 45) of GAVI eligible countries were approved for HSS support (against 2009 target of 70%). This excludes the nine countries that were recommended for approval by the October 2009 IRC. They will be considered by the Board in June 2010<sup>9</sup>.
- In 2009, 41% of the proposals were approved<sup>10</sup> (against a 2009 target of 65%), all supported by WHO. UNICEF supported 13 countries in preparing HSS applications or support implementation.

To begin to evaluate HSS support to date, the Secretariat commissioned a *HSS evaluation* (see 1.2.4) and a *tracking study* (see 1.2.3). These studies focused on countries that had received funding for at least one year. Overarching recommendations included: GAVI aligning its HSS support more with country budgeting and planning cycles, exploring options to strengthen quality and responsiveness of technical support and strengthened risk management. Moving forward, support for HSS will be channeled through the joint platform with the World Bank and Global Fund for AIDS, TB and Malaria and facilitated by WHO, funded through IFFIm.

The World Bank undertook activities in ten countries in Africa and four countries in other regions, ranging from efforts to strengthen communication around adverse events reporting; feasibility of community-based financing; studies to assess health sector reform on primary health care services; supply chain management and pharmaceutical policy strengthening; Human Resources for Health studies and policy reform; performance-based financing; conducting a cross-country assessment of the impact of primary health care reforms on the delivery of immunisations; and building the capacity in collecting and using reliable and timely health, nutrition and population outcome indicators, including on immunisation and child health.

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<sup>9</sup> Taking the 8 countries into account would bring progress to 74% (Nepal applied for a second round)

<sup>10</sup> A total of 9/21 applications were approved (June IRC – 1/9 proposals were approved; October IRC – 8/13 proposals)

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**1.3 Civil Society – countries that have received CSO support will have improved CSO engagement with relevant stakeholders and increased access to quality health services and interventions.**

CSO funding has been approved for 10 countries. Six countries have been approved for both Type A<sup>11</sup> and B<sup>12</sup> funding: Afghanistan, Burundi, Congo DR, Ethiopia, Indonesia and Pakistan. In addition, four countries have been approved for Type A funding: Cameroon, Togo, Georgia and Ghana.

For Type A CSO support funds \$690,387 has been approved and \$647,378 has been disbursed (about 9% of the investment). All countries (except Burundi due to the Financial Management Assessment process) have received at least their Type A funds.

For Type B funds, \$20,717,504 has been approved<sup>13</sup> (92% of the available budget), with \$10,298,736 disbursed (45% of the investment as part of 1st year instalment) (against a target of 75% rate of disbursement).

A review was taken of the Type A window, given only 10 countries out of 72 applied. The consultation process included survey and phone interviews with 24 countries and input from regional Partners and the Global Fund. The Secretariat in consultation with the CSO constituency decided to move forward by revising the selection criteria to prioritise certain high-needs countries for CSO type A support. The reduction in the number of eligible countries should increase the amount of funding per country, which could lead to more intensive CSO engagement in each country; granting a no-cost extension for two years for CSO support, effective once the November 2009 GAVI board decision on funding new proposals is lifted; and exploring innovative mechanisms by which CSOs could receive funding directly from GAVI in countries selected for the platform for funding health systems.

**1.4 Injection Safety and Safe disposal – countries will have developed and implemented comprehensive policies and strategies on immunisation injection safety and related waste, supported by a monitoring and evaluation framework**

Support to countries in this area has been instrumental in assuring that the vaccines support given to countries is complemented with adequate safety practices. By 2009:

- 72% of GAVI countries have developed and implemented strategies on injection safety. WHO conducted injection safety assessments in five countries and technical support was provided to 27 GAVI eligible countries.

<sup>11</sup> This is a funding envelope of US\$7.2 million was approved to strengthen civil society coordination and enhance civil society representation at global, regional and country level

<sup>12</sup> Originally approved as a financial envelope of US\$22 million, within the HSS window, for civil society groups in 10 'pilot' countries

<sup>13</sup> Includes allocation for Mozambique within GAVI's plans for IHP+ for this country

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- 45% of GAVI countries have developed and implemented a Monitoring and Evaluation framework.
- 85% of GAVI countries have a policy on safe segregation, treatment and disposal of injection equipment. WHO provided technical assistance to develop safe disposal policies in 14 countries.

### **Strategic Goal 2: Accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security**

The first four of the five outputs that make up Strategic Goal 2 relate to the Accelerating Vaccine Introduction Initiative (AVI). The objective of AVI is to drive the sustainable introduction of rotavirus vaccine and pneumococcal conjugate vaccine (PCV) in GAVI-eligible countries. Initial targets are set for 44 countries to launch rotavirus vaccines and 42 countries to launch PCV by 2015. The longer scope for AVI is to establish an organisational platform for the introduction of vaccines that were highlighted in the Vaccine Implementation Strategy<sup>14</sup>. The AVI effort will allow faster uptake for rota and pneumo than Penta. Following board approval in October 2008, AVI was operationalised in January 2009. Reporting has been through the AVI updates to the PPC and Board. This report summarises the information previously provided. In addition, a more detailed AVI report will be going to the June board.

AVI is composed of WHO, UNICEF and the AVI Technical Assistance Consortium, and managed by the GAVI Secretariat.<sup>15</sup> The initiative has five inter-related work streams<sup>16</sup> of activities required to meet each of the outputs below.

#### **2.1 Sufficient quantity of safe, effective, appropriate vaccine to meet demand**

Activities around this output include pre-qualification, building sufficient supply capacity, market price and supply agreements with suppliers, developing a strategic supply strategy and ensuring vaccines are GAVI appropriate.

- Rotavirus: Two vaccines are already approved and marketed, GSK's *Rotarix*<sup>17</sup> and Merck's *Rotateq*<sup>18</sup>.
- As of 2009, four countries have introduced the vaccine - Bolivia, Nicaragua<sup>19</sup>, Guyana, Honduras. An additional three – Madagascar, Malawi and North Sudan



<sup>14</sup> Meningitis A, Yellow Fever, Rubella, Typhoid, Japanese encephalitis and HPV. This was endorsed by the GAVI Board on 29-30 October 2008

<sup>15</sup> In 2009, the Accelerated Development and work plan support activities were successfully combined into the AVI Technical Assistance Consortium

<sup>16</sup> 1. Generate informed country decisions, 2.ensure sufficient supply, 3.secure financing, 4.facilitate country introductions and 5. establish a platform for sustained use

<sup>17</sup> This was licensed in the EU in 2006 and prequalified by WHO in March 2009

<sup>18</sup> This was licensed in the US in 2006 and prequalified by WHO in December 2008 for EMRO and EURO only. It is pending for the rest of the world

<sup>19</sup> Nicaragua has introduced with a donation for Merck with a planned switch to GAVI supported vaccine in 2010

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are pending Board approval (Against a target of 2 prequalified rotavirus vaccines are available to the 9 targeted countries that will introduce by 2010)

- Pneumococcal: Wyeth (Pfizer) launched *PCV7* (Prevnar) in 2001 and it is commercialised worldwide, however it was not made available for sale to UNICEF. On September 25<sup>th</sup>, Pfizer obtained a positive opinion from EMEA for their new vaccine Prevnar PCV13, with US licensure expected in 2010 and WHO pre-qualification by Q3 2010.
- GSK launched *PCV10* (Synflorix) in Europe in 2009 and by the end of 2009 was awaiting WHO pre-qualification of their two dose vial by Q1 2010.
- By 2009, 13 countries had been approved by the Board for pneumo: Cameroon, Central African Republic, Congo Rep, D.R. Congo, Gambia, Guyana, Honduras, Kenya, Mali, Nicaragua, Rwanda, Sierra Leone and Yemen. In 2009, Gambia and Rwanda introduced the vaccine through manufacturer donation. An additional seven are pending Board approval (Against 2 prequalified pneumococcal vaccines are available to the 14 countries targeted to introduce by 2010)

The National Regulatory Assessment (NRA) assessments were conducted by WHO in 5 countries, with a focus on Adverse Effects Following Immunisation (AEFI) monitoring to help establish the safety profile of new vaccines in GAVI-eligible countries. In addition, WHO assisted 25 African GAVI eligible countries through inter-country workshops to develop their NRA Institutional Development plans in order to provide adequate regulatory support for the introduction of GAVI funded vaccines. A global vaccines database had been established in WHO to monitor all vaccines lots released in producing countries using the official NRA lot release system, the database is currently tested with two countries (Cuba and India) and will be gradually expanded to all producing countries. A global WHO NRA database initially developed by WHO had been sustained and further developed using NRA assessment data in order to monitor NRAs progress, identify country needs and plan support to priority countries.

A robust forecast methodology has been developed to better understand the dynamics of demand. The Strategic Vaccines Supply sub-team uses the near term information on application status together with AVI's assessments of country willingness and preparedness to launch to develop and update strategic forecasts of vaccine demand. WHO supported 11 AFRO countries with planning and forecasting and two inter-country workshops were conducted in AFRO, with UNICEF and others, to strengthen vaccine management capabilities including forecasting for traditional and new vaccines.

### 2.2 Countries make well informed decisions on introduction of the vaccine

Activities to support country level decision-making include generating and disseminating information for local policy decision makers and technical staff relevant for decision-making (disease burden data, vaccine characteristics, WHO pre-qualification, supply status, health system status, global policy guidance, finance, awareness raising) and

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providing technical support to countries. This preparation takes place through WHO and UNICEF's global, regional and in country activities.

- In 2009, 15 applications for pneumococcal vaccines<sup>20</sup> and eight applications were received for rotavirus<sup>21</sup>. Out of these, two<sup>22</sup> June applications for PCV were approved by the Board. In October, the IRC recommended seven more applications for PCV and three applications for rotavirus<sup>23</sup>. These are pending Board decision.
- The recently published global disease burden estimates for Hib and Pneumococcal disease<sup>24</sup> include country specific estimates for all member states. Several disease burden tools used to estimate impact and cost effectiveness at country level have been prepared and disseminated among global partners, regional offices of WHO, UNICEF and select countries.
- WHO is involved in ongoing work on global policy setting with the engagement of SAGE in issuing recommendations on new vaccines, and the regional efforts in National Immunisation Technical Advisory Groups (NITAGs) strengthening are bringing rewards in a marked increase in awareness of new vaccines issues at all levels. A recent SAGE (5 June 2009) recommendation to expand the use of rotavirus vaccine in national immunisation programs of all countries.
- In 2009, 41 countries were supported by WHO with decision-making, application and introduction of new (Hib, rota, pneumo) vaccines (against a target of 36 countries by 2010). 32 new vaccine applications were pre-assessed. UNICEF assisted six countries with their decision making and applications for PCV and rotavirus vaccines introduction, jointly with WHO<sup>25</sup>.
- In 2009, vaccine management assessments were conducted in 14 countries (against a target of 6).
- In 2009, 33 countries started or completed cold chain inventories and assessments for new vaccines introduction (against a target of 15).

### **2.3.1 Facilitate country introduction of the vaccine**

Activities around facilitating country introduction include: ensuring availability of in-country cold chain capacity, enhanced vaccine management capability, operational



<sup>20</sup> Benin, Bolivia, Burundi, Ethiopia, Ghana, Madagascar, Malawi, Mali, Nigeria, Pakistan, Sierra Leone, Sudan (north), Tanzania, Uganda, Zambia

<sup>21</sup> Ethiopia, Ghana, Madagascar, Malawi, Sudan (north), Tanzania, Uganda, Zambia

<sup>22</sup> Gambia and Rwanda

<sup>23</sup> Approved and approved with clarification

<sup>24</sup> The Lancet, Vol 374 September 12, 2009

<sup>25</sup> Ethiopia, Madagascar, Malawi, Tanzania, Uganda, and Zambia

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policies (training etc) health care worker training, large country strategies and communication strategies.

The pneumococcal vaccine (PCV7) was launched in Rwanda in April 2009. UNICEF supported Rwanda's cold chain capacity assessment for the introduction of PCV7, with an initial assessment and follow up activities that focused on developing a coordinated communication strategy for pneumonia and diarrhoea, including demand for routine immunisation.

- Eight countries currently have adequate cold chain capacity to introduce vaccines by 2011

Preliminary analysis shows that some 75% of countries have sufficient central store level cold chain to immediately launch one vaccine and 30% of countries sufficient for two vaccines. This and other indicators suggest that while cold chain capacity shortages do exist, with adequate support and success with in-country financing, they can be dealt with by the time of launch. However, this assumes necessary Cold Chain Logistics (CCL) support at the regional and district level and an impact situational analysis is required.

UNICEF revitalised the Cold Chain Logistics (CCL) Taskforce to provide guidance for strengthening and expanding CCL systems to enable new vaccine introductions. UNICEF provided technical support was provided to seven countries to have CCL systems ready for new vaccine introduction. In addition, the WHO stock management tool (SMT) was adapted to include the monitoring of vaccine volume and cold chain occupation. This has been implemented in 30 countries in the Africa Region.

### 2.4 Platform for sustained use of the vaccine established

2009 saw the successful transition of surveillance activities from the ADIPs to WHO with the strong involvement of the national Ministries of Health.

- By the end of 2009, core sites in 56 countries were detecting and reporting on rotavirus disease (39 GAVI and 17 non-GAVI countries) and 56 countries were detecting and reporting on invasive bacterial disease (including Hib and pneumo) (42 GAVI and 14 non-GAVI countries) (*against targets of surveillance system for rotavirus disease and pneumococcal disease in place in 16 countries and 2 countries respectively*).
- In 2009, Post Introduction Evaluations (PIEs) were conducted in 10 countries. For the PCV and rotavirus vaccine introductions, the lessons learned through the introduction of pentavalent vaccines and from the WHO process of PIEs are continually being incorporated.

In addition, AVI undertakes its activities in a manner that builds capacities to support the introduction of future vaccines beyond pneumococcal and rotavirus vaccines. For scientific and economic studies, AVI partners work with local investigators and

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institutions to strengthen local capacity and supply work. AVI is developing innovative tools and approaches to advance the state-of-the-art in forecasting, applicable to both current and future vaccines.

### 2.5 A healthy vaccine market established for all GAVI sponsored vaccines

GAVI's operating model uses innovative and catalytic investments to shape vaccine markets to cultivate and sustain a healthy market. A recent tender for the pentavalent vaccine (GAVI's largest cost driver) for the period 2010-2012 delivered a significant price drop with the weighted average price. A tender took place for pneumococcal vaccines under the conditions of the AMC. Tenders also took place for yellow fever and meningitis. There were no tenders for rotavirus vaccines outside of the PAHO region. Three procurement reference groups were instituted for all of these tenders and discussions were ongoing with manufacturers and others on tiered pricing and optimising pricing for poor countries.

## Strategic Goal 3: Increase the predictability and sustainability of long-term financing for national immunisation programmes

### 3.1 Improved sustainability of new vaccines and immunisation programmes

Comprehensive multi -year plans (cMYP) are national strategic plans for immunisation aimed at streamlining immunisation planning process at national level into a single comprehensive and costed plan. The cMYP or similar national immunisation strategic plan is a key application accompanying document for any GAVI application window including NV, INS, ISS and HSS.

- By 2009, 100% of GAVI eligible countries developed cMYPs or equivalent strategic immunisation plans (*against a target of 90%*). UNICEF Regional and Country Offices in consultation with WHO provided direct support to 22 countries to update/prepare cMYPs.

The implementation of the co-financing policy started in 2008.

- 100% of countries came out of default from 2008 (*against a target of 90%*). By the end of 2008, nine countries out of the 32 countries were classified in 'default' as they did not fulfil their commitments by the end of the calendar year. Throughout 2009, the GAVI Secretariat and the Immunisation and Financial Sustainability Task Team (IF&S) worked with these nine countries to successfully bring them to compliance with the policy and all the countries came out of default by September 2009.
- The IFS task team implemented an Early Warning System (EWS) and follow-up country progress in co-financing. Through this monitoring process seven countries were exempted of their co-financing commitments. Also, through the implementation

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of the EWS, the Secretariat and partners helped the nine countries to come out of default.

By the end of 2009:

- 90% of GAVI eligible countries fulfilled their co-financing commitments (*against a target of 60%*<sup>26</sup>)
- 49 GAVI eligible countries (68%) were required to co-finance GAVI supported vaccines. Of these 100% included GAVI co-financing in their multi-year plans.
- 44 GAVI eligible countries had fulfilled their co-financing requirement and an additional 3 countries voluntarily co-financed, leaving 5 countries in default.
- 85% of GAVI eligible countries had budget line items for vaccines, an increase from 68% in 2000.

UNICEF together with the GAVI Secretariat, WHO and World Bank organised a workshop with 16 countries in Africa region in Dakar, Senegal (May 2009) that yielded important dividends, such as information on systems bottlenecks and issues related to the implementation of the co-financing policy, for the IFS Task Team's efforts to enhance support to countries co-financing vaccines under Phase II.

The World Bank, at country level, carried out financial sustainability/innovative financing work in nine countries. Activities ranged from analytic work on health financing and insurance, assistance with Medium Term Expenditure Frameworks and the development and implementation of health sector Public Financial Management codes and guidelines. Analytical work was undertaken with the Government of Pakistan. The study examined the relative cost-effectiveness and financial implications of introducing new vaccines, including Hib, pneumococcal, rotavirus, and HPV vaccines. The purpose of this exercise was to provide the necessary evidence-base for the Government of Pakistan to make decisions about future new vaccine introduction. The World Bank also supported the revision and updating of the Immunisation Financing Toolkit, originally produced during Phase 1 of GAVI. A draft of the toolkit should be finalised by the end of June 2010.

### 3.2 Increased donor government commitments made to innovative financing mechanisms through IFFIm, AMC

Advance Market Commitment: In June 2009, GAVI, the World Bank, WHO and UNICEF, five national governments and the Bill & Melinda Gates Foundation signed legal documents to formally kick-off the first-ever AMC, designed to accelerate access to vaccines against pneumococcal disease<sup>27</sup>. Implementing countries will provide a small

<sup>26</sup> Calculation based on countries that co-financed (44)/subset of GAVI eligible countries required to co-finance (49)

<sup>27</sup> In the AMC pneumococcal pilot, the governments of Italy, the United Kingdom, Canada, Russia, and Norway and the Bill & Melinda Gates Foundation committed US\$1.5 billion

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co-payment to contribute towards the cost of the vaccines. The World Bank provides fiduciary support, WHO has established the minimum technical criteria for a suitable pneumococcal vaccine and UNICEF will be responsible for vaccine procurement and distribution.

Given that the signature of the AMC legal agreements was delayed until 12 June 2009, the procurement process only started on 4th September 2009 with the issuance of the first Call for Supply Offers, therefore postponing the delivery to 2010. The procurement process was however very successful with four manufacturers responding to the call. The procurement of pneumococcal vaccines through the Pilot AMC will start in 2010. Given the delays in implementing the pilot AMC, exploration of a 2nd AMC was postponed to 2010.

**IFFIm:** From its launch in late 2006 until March 2010, IFFIm has issued US\$2.7 billion in bonds. Initially, it was hoped that donors would commit around US\$7 billion in total over future years, equivalent to roughly US\$4.2 billion in 2006 dollar terms. In reality, the original IFFIm pledges (including the recently signed Netherlands pledge) have committed around US\$5.3 billion for IFFIm, which equated to some US\$3.3 billion in 2006 dollar terms. Approx US\$1.6 billion had been disbursed for GAVI programmes up to March 2010, and the IFFIm rules allow for the disbursement of around another US\$1.2 billion between 2010 and 2015. That would leave just over US\$900 million of capital – the “cushion” – in IFFIm at the end of 2015 which will be available to fund GAVI programmes over time as bonds are paid down and subject to agreement with the donors.

The initial 2009 target for transferring proceeds to programmes was US\$470m, however, only US\$300m was transferred. The 2009 disbursements were lower than expected due to the implementation of an improved financial management processes (TAP), HSS programs being disbursed in 2010 instead of 2009 and requests from UNICEF being slower than expected and being pushed to 2010.

At the start of 2009, there were seven donors to IFFIm - France, Italy, Norway, South Africa, Spain, Sweden and the UK. In June 2009, the Netherlands announced its attention to support core vaccine programmes and signed a grant agreement in December 2010, therefore bringing the total to eight.

In addition, in September 2009, as part of the culmination of 12 months work by the Taskforce on Innovative International Financing for Health Systems, the UK, Australia and Norway made a US\$1 billion announcement<sup>28</sup> to expand IFFIm and specifically substantial investments in health systems.

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<sup>28</sup> This provides around US\$860 million equivalent over future years, which equated to roughly US\$570 million in 2006 dollar terms and which could generate approximately US\$474 million for GAVI/HSS programmes for the period from 2010 to 2015 (depending on the expenditure profile)

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### **3.3 Increased levels of multi-year government and private contributions**

- By 2009, GAVI's donor base consisted of 16 government donors<sup>29</sup>, the European Commission, the Bill and Melinda Gates Foundation, La Caixa and private donors
- In 2009, 3<sup>30</sup> out of 9 direct government donors<sup>31</sup> have multi-year agreements (3 years or more)
- In 2009, *direct contributions* amounted to US\$337.9m (*against a target of US\$400m<sup>32</sup>*)
- *In 2009, Private philanthropic contributions amounted to US\$1m (exc. La Caixa grant US\$5.9m) (against a target of US\$10m<sup>33</sup>)*. This is the first time fundraising outside the La Caixa grant reached seven-figure territory.

There was limited success with the European Commission<sup>34</sup> and Germany funding mechanisms and levels but progress was sustained in the US and UK with an increased US appropriation in 2009. Work started on a long -term agreement with the UK. There was limited progress on an effort to develop a new strategy for the Middle East and other donors due to limited staff capacity and staff transitions.

### **Strategic Goal 4: Increase and assess the added value of GAVI as a public private global health partnership through improved efficiency, increased advocacy and continued innovation**

#### **4.1 GAVI eligible countries supported efficiently**

The Transparency and Accountability Policy (TAP) took effect in January 2009 and aims to significantly reduce the fiduciary risk to GAVI's cash based support. The main elements of TAP include: The Financial Management Assessment (FMA) exercise; strengthened application, reporting and monitoring procedures; development of policy on misuse of funds and the development of an 'early warning system' on the misuse of funds.

By December 2009, ten FMAs<sup>35</sup> were at various stages of completion against a target of 36. This was mainly due to staffing constraints. The TAP team has been able to respond to allegations of, or confirmed, misuse of funds in two countries (Uganda, Zambia) and is

<sup>29</sup> This includes both direct (see below) and additional IFFIm/AMC donors: Canada, France, Spain, UK, Russian Federation and South Africa

<sup>30</sup> Australia, Denmark and Netherlands

<sup>31</sup> Germany, Ireland, Luxembourg, Norway, Spain, Sweden and USA. In addition, the European Commission also has a multi-year agreement

<sup>32</sup> Direct contributions have averaged about \$260 million per year

<sup>33</sup> Private fundraising targets – US\$8 m by 2008, US\$10m by 2009 and US\$12m by 2010

<sup>34</sup> €9.5 million which was signed by end of 2009 (for pneumococcal introduction in 2010 and 2011).

<sup>35</sup> S. Sudan, Senegal, Eritrea, Bangladesh, Nigeria, DRC, Cuba, Pakistan, Azerbaijan, Cameroon

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implementing corrective action. An early warning system is based on our continuous monitoring of each country's financial reporting, our risk profiling model, information generated by FMAs and through information gathering from GAVI partners.

Four regional working groups and five sub-regional working groups were held to facilitate the implementation and acceleration of GAVI policies. 12 national ICC meetings were held across three regions and eight countries expanded their national ICC to include HSS representation.

### 4.2 Seamless performance management system functioning

All the activities under this area were completed. These included:

A *monitoring framework and strategy* was developed to enable the GAVI Alliance to ensure that valid, reliable and useful measures of performance are available and used to support the management of strategy, improvement of programmes, mitigation of risk and reporting of performance meet this critical need. It addresses the GAVI Alliance's diverse information needs, including those related to internal business processes, support to countries and overall effectiveness, efficiency and impact. Work will continue in 2010 to implement this.

The Request For Proposal for the GAVI Phase II evaluation was awarded and based on insights from the Phase I and ISS evaluations, the Secretariat undertook a review of the IRC process to assess the extent to which the IRC was 'fit for purpose'<sup>36</sup>. A *grant making framework* for global grant agreements was developed.

Two new proposal and two monitoring *Independent Review Committee (IRC) reviews* were held during the year. The new proposals IRCs piloted the joint review of HSS with new vaccine support.

In addition, the Secretariat supported the establishment of board evaluation advisory committee. The committee met once in 2009 and provided ongoing advice through emails and conference calls.

### 4.3 Increased awareness of immunisation as a means to reach the Millennium Development Goals

A strategy was presented to the GAVI Alliance Board meeting in June 2009. The Board confirmed that the scope of the Alliance's advocacy and communications outreach should be in the three environments of immunisation, health and development in order to

<sup>36</sup> Purpose is defined as the ability of the IRCs to conduct robust and independent technical appraisals of country applications and make funding recommendations to the GAVI Board/Executive Committee. The fit refers to the ability and suitability of the IRC model, in terms of its design and execution, to satisfy this purpose and deliver results.

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better deliver GAVI's core mission. It also committed to strengthening engagement of all Alliance partners in collective communications and advocacy efforts.

In addition, in November, GAVI convened a 400 participant forum in Vietnam, with many satellite events. The events developed a broad momentum among partners and champions, setting the scene for the 10th anniversary year and the high-level donors meeting in the Hague. The Hanoi events also provided a new momentum to civil society engagement in GAVI.

### 4.4 Innovative policies and processes developed and implemented

In 2009, the Secretariat coordinated the development of two new policies – one related to eligibility and graduation and the other to donations for pharmaceutical products<sup>37</sup>.

1. Eligibility - In November, the Board approved the GAVI Alliance eligibility policy with a GNI per capita threshold of US\$ 1,500 according to World Bank data to be published in 2010; from 2011 onwards the threshold will be adjusted for inflation annually. The policy contains provisions for graduation – whereby countries graduating continue to receive support for the duration of their proposal.
2. Donations policy - The new in-kind donations policy was approved by the November Board. This was a revision of the vaccine in-kind donations policy to replace the policy the GAVI Alliance Board adopted in 2000. The paper reviewed the benefits and risks of receiving donations and in particular the special circumstances that may justify acceptance of a donation.

The Secretariat also developed a gender implementation plan in early 2009. Activities conducted to date include a review of the evidence base on gender and immunisation (in collaboration with WHO and PATH), revision of the annual progress report to include a gender component), and inclusion of gender in key documents and outreach. The Secretariat has also reviewed and adjusted its Human Resources manual and is supporting the governance committee in their efforts regarding gender balance in the board.

### 4.5 Secretariat organised to deliver efficiently to advocate and innovate

The Secretariat successfully implemented the launch of the GAVI Alliance as an Independent Swiss Foundation. The Secretariat developed an entirely new administrative platform to support the Alliance, including the consolidation of the GAVI Fund with the GAVI Alliance. The main deliverable for 2009 originally was conducting a survey to assess board member understanding of GAVI Alliance programmes, procedures and processes and an evaluation of the effectiveness of the governance transition. This was then revised when the Governance Committee determined that a self-assessment through a streamlined and simple learning tool would help the board

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members determine how well the Board and committees were functioning. The Audit and Finance Committee and the Programme and Policy Committee undertook the exercise in the second half of 2009 and the full Board and other committees will follow during the first half of 2010.

### **Financial Reporting**

In 2008, a bi-annual work plan and budget was developed for 2009 and 2010 and approved at the October Alliance board meeting totalling US\$78.3m for 2009 and US\$79.3m for 2010<sup>38</sup>.

At the GAVI Alliance Board meeting in June 2009, in the light of the global financial environment the Secretariat and work plan partners committed to reduce work plan expenditures. These savings were largely achieved by reducing the costs of activities, with limited impact on activities.

Based on unaudited GAVI financial information and preliminary uncertified reporting from implementing partners:<sup>39</sup>

- WHO reported a 2009 financial implementation rate of 83% (*Budget: US\$41.5 Actual: US\$34.6m*).
- The GAVI Secretariat reported a financial implementation rate of 71% (*Budget: US\$9.6m Actual: US\$6.8m*).
- UNICEF reported a financial implementation rate of 87% (*Budget: US\$6.8m<sup>40</sup> Actual: US\$5.9m<sup>41</sup>*).
- The World Bank financial reporting is done on a cumulative contribution basis (2007-09). As a result it is not possible to assess an implementation rate on an annual basis. As of December 31, 2009, 65% of a total contribution of US\$7,951,398, US\$5,176,823 has been disbursed. The remaining balance has either been committed or will be in 2010.

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<sup>38</sup> However, as highlighted to the Board at that meeting, these budget totals included placeholder budgets of \$7.3m per year for outsourced activities to support the Accelerated Vaccine Initiative (AVI). This contract for these activities, which has been awarded to PATH and is called the AVI Technical Assistance Consortium (AVI TAC), frontloads activities resulting in higher payment schedules than the placeholder (\$15m and \$10.7m for 2009 and 2010 respectively). Thus the real work plan budgets became \$85.3 million for 2009 and \$82.1 million for 2010 (this was further reduced to US\$74.9m after savings of 10% were requested).

<sup>39</sup> In general, it is difficult to make a link between the progress of the deliverable and the financial spend, given the format of reporting, which varies by institution. Per the agreements reached with the Fund, WHO reports financially at the objective/output level but the narrative reporting is by deliverable. UNICEF provides an estimate based on disbursements and commitments. The World Bank reports on a cumulative contribution basis rather than an annual basis

<sup>40</sup> The budget cut for 2009 was offset against the 2010 payment

<sup>41</sup> This is made of US\$2.6m disbursed and US\$3.3 committed

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Figure 1: 2009 work plan budget by Partner (activities and salaries)

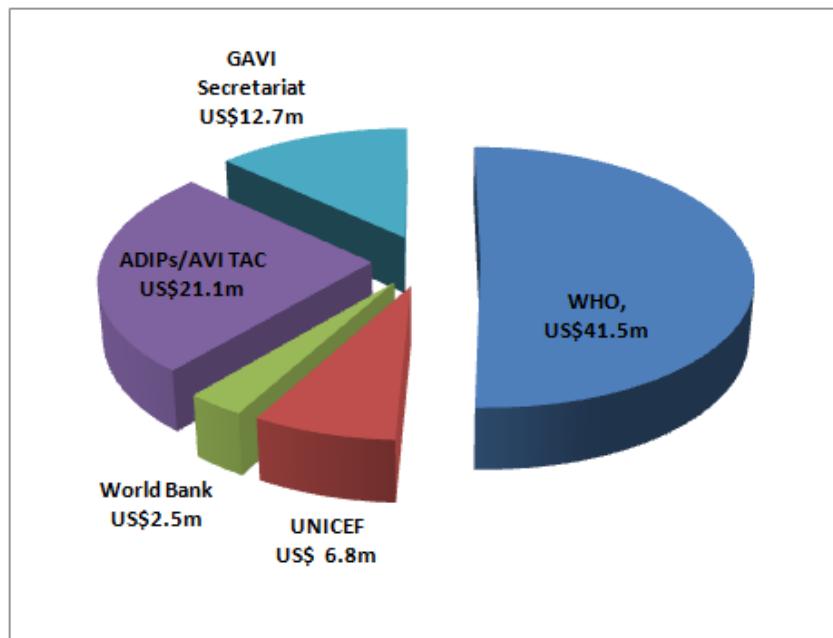
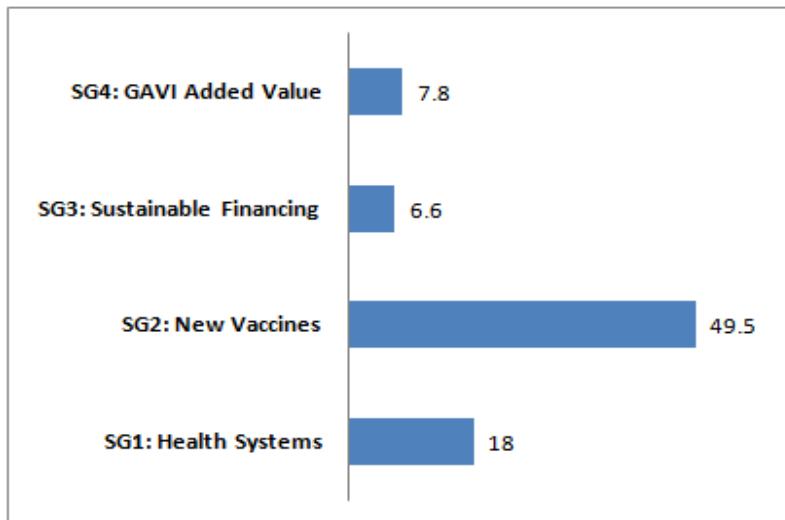


Figure 2: 2009 work plan budget by Strategic Goal (activities and salaries)



**ANNEX A****Summary of Traffic Light Assessment**

Strategic Goal 1 Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner	
1.1 GAVI ISS support will reach an increased number of countries that have received support	Green
1.2 Countries with HSS support will have made improvements to their health system to deliver immunisation and other health interventions	Yellow
1.3 Civil Society – countries that have received CSO support will have improved CSO engagement with relevant stakeholders and increased access to quality health services and interventions	Red
1.4 Injection Safety and Safe disposal – countries will have developed and implemented comprehensive policies and strategies on immunisation injection safety and related waste, supported by a monitoring and evaluation framework	Green
Strategic Goal 2: Accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security	
2.1 Sufficient quantity of safe, effective, appropriate vaccine to meet demand	Rota Pneumo
2.2 Countries make well informed decisions on introduction of the vaccine	
2.3 Facilitate country introduction of the vaccine	
2.4 Platform for sustained use of the vaccine established	
2.5 A healthy vaccine market established for all GAVI sponsored vaccines	Yellow
Strategic Goal 3: Increase the predictability and sustainability of long-term financing for national immunisation programmes	
3.1 Improved sustainability of new vaccines and immunisation programmes	Green
3.2 Increased donor government commitments made to innovative financing mechanisms through IFFIm, AMC	Yellow
3.3 Increased levels of multi-year government and private contributions	Red
Strategic Goal 4: Increase and assess the added value of GAVI as a public private global health partnership through improved efficiency, increased advocacy and continued innovation	
4.1 GAVI eligible countries supported efficiently	Yellow
4.2 Seamless performance management system functioning	Green
4.3 Increased awareness of immunisation as a means to reach the Millennium Development Goals	Green
4.4 Innovative policies and processes developed and implemented	Green
4.5 Secretariat organised to deliver efficiently to advocate and innovate	Green

**ANNEX B****HSS Sub-Outputs**

Below is reporting under each sub-out for Health Systems Strengthening.

**1.2 Countries with HSS support will have made improvements to their health system to deliver immunisation and other health interventions**

**1.2.1 GAVI HSS design and development – design of HSS investments contribute to removing health systems barriers to increase access to immunisation and other Maternal and Health Child Services**

- By 2009, 63 % (or 45) of GAVI eligible countries were approved for HSS support (against 2009 target of 70%). This excludes the nine countries that were recommended for approval by the October 2009 IRC. They will be considered by the June 2010 Board<sup>42</sup>.
- In 2009, 41% of the proposals were approved<sup>43</sup> (against a 2009 target of 65%), all supported by WHO. UNICEF supported 13 countries in preparing HSS applications or support implementation.

WHO conducted 58 country missions, 37 GAVI HSS inter-country and regional training and capacity building workshops/meetings and 19 workshops/missions to assist member states in implementing GAVI policies. Pre-reviews were conducted for all 2009 applications.

**1.2.2 GAVI HSS monitoring – GAVI HSS is monitored and implementation challenges are identified**

- In 2009, 68% of Annual Progress Reports were sufficient or approved but pending the submission of financial statements or audit reports (against a target of 50%).
- In 2009, 46% of approved GAVI HSS countries were approved for funding (against a target of 65%). However, 22% of approved GAVI HSS countries have not received funding due to various reasons<sup>44</sup>.
- 28% of approved GAVI HSS countries are engaging in IHP+ processes and 33% of approved GAVI HSS countries have a pool or SWAp mechanism. This has led to the increase of unified HSS approaches that supports primary health care.

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<sup>42</sup> Taking the 8 countries into account would bring progress to 74% (Nepal applied for a second round)

<sup>43</sup> A total of 9/21 applications were approved (June IRC – 1/9 proposals were approved; October IRC – 8/13 proposals)

<sup>44</sup> These range from IFFIm/board timings and decision making, requirements for FMAs, inadequate information on APRs, difficult country negotiations related to either OFAC regulations or negotiations to Partners (e.g. DPRK, Myanmar, Cuba, North Sudan, Somalia and Pakistan) and inadequate information on banking details

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During the February 2008 Board meeting, the HSS task team and the Secretariat highlighted the need to provide ‘real time’ information on how countries were planning and implementing their HSS proposals (from both programmatic and financial points of view). The purpose of the *tracking study* was to respond to this need and ensure that there was enough ‘real time’ information to guide the direction of the GAVI HSS investment. The methodology focused on the implementation of activities and progress towards results using country-selected indicators that may not have been available in annual progress reports or the evaluation. The tracking study was undertaken in six countries (Nepal, Kyrgyzstan, Ethiopia, Zambia, Vietnam and DRC). The final report was delivered in October 2009 and the results were used to inform the paper on HSS Joint Programming that went to the November GAVI Alliance Board.

### **1.2.3 GAVI HSS implementation – Receiving countries have access to timely technical support from Partners and funding to implement proposals**

- It can take one week to a month for countries to receive requested support (2009 HSS regional focal point survey)
- Funds can take from 4 weeks to 10 months to over a year to reach a country
- No. of regional and sub-regional capacity building activities undertaken were: 58 country missions to support GAVI HSS proposals or implementation; 37 GAVI HSS inter-country and regional workshops and meetings; 19 meetings, workshops and country missions to assist member states in implementing GAVI policies.

### **1.2.4 GAVI HSS evaluation - Findings and recommendations from the HSS evaluation generate evidence to refine and improve HSS processes**

The mid-term evaluation evaluated the period December 2005-2008. It was completed in September and presented to the Board in Hanoi, along with a management response. The evaluation included 21 countries and processes at all levels. It gave credit to the need for such an investment and the objectives of GAVI HSS remaining valid. It highlighted several strengths including: flexibility, easy to use, addressed country needs; process of designing proposals was relatively straight forward and generating an inclusive process. However several weaknesses were identified that included weakness in the design of monitoring and financial management, variability of technical support provided to countries, lack of intimate knowledge of implementation and financial consequences at country level and greater need to learn and manage knowledge.

### **1.2.5 GAVI HSS knowledge generation and management**

A partnership to create a *knowledge bank* was established between the Swiss Centre for International Health /Swiss Tropical Institute (SCIH/STI) and Liverpool Associates in

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Tropical Health /Liverpool School of Tropical Medicine (LATH/LSTM) in collaboration with the “Supporting Policy Relevant Reviews and Trials” (SUPPORT) group at the South African Medical Research Council. The aim of this was to improve access to unbiased evidence for decision-makers.

The Bank is to be developed in three phases: Phase I – Selection of two or three priority topics; Phase II – Creation of the Knowledge Bank and Phase 3: Ongoing management and piloting of the Knowledge Bank. Phases I and II have been completed.