Annex F: Country Summary Sheets

1.1 The summary sheets are intended to provide a high-level systematic snapshot of a country's performance across a number of key thematic areas (e.g. coverage, supply chain, data quality). They provide additional context and country-specific overviews and highlight main challenges to inform PPC and Board discussions.

1.2 Each key thematic area is assessed through a 'traffic light'. For the traffic light assessment, a standardised approach has been applied to assess countries' performance using agreed-upon quantitative and qualitative criteria. For example, to measure a country's performance related to equity, the country's DTP3 coverage differences in wealth, maternal education, and geography are used as standardised proxies to understand the main drivers of inequities within the country. This quantitative assessment has then been complemented with a qualitative assessment by the country team, building on broader assessments and work in this area (e.g. assessing inequities across marginalised groups, urban slums, etc.).

1.3 Wherever possible and to ensure consistency, the Secretariat has used indicators and data sources that align with the Alliance's strategic goal indicators and existing, agreed-upon performance measurements (e.g. grant performance framework target achievement, financial reporting compliance). Data for these indicators have been retrieved from various routine sources, including WHO/UNICEF estimates, DHS/MICs surveys, EVMAs, and other standardised analyses conducted by Secretariat staff.

1.4 As most thematic areas consider performance across several indicators, to obtain the eventual traffic light assessment, each indicator has been given equal weight, and been validated through the qualitative assessment (where applicable).

1.5 In addition to providing a traffic light assessment for each key thematic area, a trend arrow is included to understand if performance in that area is improving, declining, or stagnating. Where possible, trends are measured through quantitative criteria and data (e.g. coverage), but some areas rely on a more qualitative assessment. For example, in a situation where health workforce shortages are particularly compelling, this could be marked as red. However, in view of recent efforts towards developing a health workforce strategy, the trend may show that we are optimistic that this situation is on a more positive trajectory.

1.6 Going forward, the Secretariat is considering refinements to the methodology used for the development of the cross portfolio overview and country summary sheets (e.g. additional metrics to be considered). Based on PPC and Board feedback, the Secretariat is evaluating how to provide country specific information and a cross portfolio overview for all remaining PEF countries, as well as a higher level summary of progress in remaining countries.

1.7 More details on each indicator used, including data sources and assessment thresholds can be found in table 1. All country summary sheets can also be found below.

Table 1: Methodology:

Area	Assessment Type	Indicator	Indicator Definition	Source	Indicator Thresholds	Threshold Source
Country General Information	Quantitative	**# under-immunised (DTP3)**	The total number of surviving infants not reciving the third dose of DTP-containing vaccine at the national level	WUENIC (2015)	NA	NA
	Quantitative	**% GPF targets achieved**	The number of indicators in the grant performance framework fully achieving their target over the total number of indicators due for reporting in a given year	Gavi Records	NA	NA
	Quantitative	**# PEF positions funded**	The total number of WHO and UNICEF staff positions funded by Gavi through PEF support in a given year	Gavi Records	NA	NA
	Quantitative	**Vaccine introductions**	Gavi supported vaccines introduced into the routine immunization schedule from 2001 to 2016 and those expected to be introduced in the routine immunization schedule from 2017 to 2020	Gavi Records	NA	NA
	Quantitative	**Gavi commitments vs. disbursements (all time)**	Total amount of funds (or equivalent dollar amount of vaccines sent) disbursed and committed across all Gavi support, disaggragated by cash support (HSS, CCEOP, VIGs, Ops, etc) and vaccine support (Routine and Campaigns). Disbursements are payments made since Gavi support up to Feb 2017, and Commitments represent approved multi-year budgets.	Gavi Records	NA	NA
Coverage	Quantitative	**DTP3 coverage**	Percentage of surviving infants receiving the last (i.e. third) recommended dose of DTP vaccine at the national level.	WUENIC (2015)	>= 90% (Green), >=70-89% (Orange). <70% (Red)	Green: GVAP Red: Operational Guidelines (70% threshold for new introductions)
	Quantitative	**MCV2 coverage**	Percentage of surviving infants receiving the second recommended dose of measles containing vaccine at the national level.	WUENIC (2015)	>= 90% (Green), >=70-89% (Orange). <70% (Red)	Green: GVAP Red: Operational Guidelines (follows DTP3 70% threshold for new introductions)
	Quantitative	**Breadth of protection**	Average of annual estimates of coverage via the routine immunisation system for the last recommended dose of all Gavi-supported vaccines among all eligible children	Gavi Records	Postive trend (Green), No Change (Orange), Negative trend (Red)	Green/Yellow/Red: Team agreed (Strategic Indicator S1.2 target is not transferable to country-level)
	Qualitative	*Qualitative assessment*	*• WUENIC grade of confidence* *• Related data quality challenges*			
Equity	Quantitative	**Districts above 80% DTP 3 coverage**	The total number of districts or equivalent administrative area with a DTP3 coverage greater than 80% divided by the total number of districts or equivalent administrative area for a given year	Admin JRF (2015)	>= 90% (Green), >=70-89% (Orange). <70% (Red)	Green: Team agreed (GVAP is 80%, Strategic Indicator S1.3 is 100%) Yellow/Red:Team agreed, follows 20pp increments
	Quantitative	**Difference in DTP3 coverage - wealth**	Percentage of DTP3 coverage for highest wealth quintile - Percentage of DTP3 coverage for lowest wealth quintile	Latest Survey	<=10% (Green), >10-<=15% (Orange), >15% (Red)	Green: Strategic Indicator S1.3 Yellow/Red: Team agreed, follows 5pp increments
	Quantitative	**Difference in DTP3 coverage - mother's education**	DTP3 coverage among children whose mothers/female caretakers have completed secondary education or higher - DTP3 coverage in children whose mothers/female caretakers have received no education	Latest Survey	<=10% (Green), >10-<=15% (Orange), >15% (Red)	Green: Strategic Indicator S1.5 Yellow/Red: Team agreed, follows 5pp increments
	Qualitative	*Qualitative assessment*	*• Other key equity stratifiers (eg. marginalized groups, urban slums, etc)*			
Demand	Quantitative	**DTP drop out rate**	Percentage point drop-out between first and third dose of DTP vaccine	WUENIC (2015)	<=5% (Green), >5- <=10% (Orange), >10% (Red)	Green: Teem agreed (GVAP is 10% and determined too high, Strategic indicator S2.3 is 3% and determined too low) Yellow/Red: Team agreed, follows 5pp increments
	Qualitative	*Qualitative assessment*	*• Key barriers to demand* *• Related challenges*			
Supply Chain	Quantitative	**Effective Vaccine Management Score**	Overall composite effective vaccine management score. The composite score is an average of the 9 cirteria scores given in the effective vaccine management assessment.	Latest EVMA	>=80% and above (Green), >=60-79% (Orange), <60% (Red)	Green: Strategic Indicator S2.1 Yellow/Red: Team agreed, follows 20pp increments
	Qualitative	*Qualitative assessment*	*• Main challenges related to supply chain (eg: outdated equipment, temp monitoring, appropriately trained staff)* *• Related effect on supply chain performance*			

Data Quality	Quantitative	**Difference DTP3 coverage in admin & survey**	National administrative DTP3 coverage - DTP3 survey coverage of the corresponding year	Admin JRF (2015) / Latest Survey	<10pp (Green), <10-20pp (Orange), >20pp (Red)	Green: Strategic Indicator S2.2 Yellow/Red: Team agreed, follows 10pp increments
	Qualitative	*Qualitative assessment*	*• Evolution of discrepancy in the past years* *• Level of confidence in the availability, quality and use of data improving in coming years*			
Financing & Sustainability	Quantitative	**Co-financing default**	Assesses if the country met co-financing obligations to Gavi by 31 December of a given year.	Gavi Records	Did not default in 2015 and 2016 (Green), Defaulted in 2015 or 2016 (Red)	Green/Yellow/Red: Team agreed
	Quantitative	**% of routine immunization expenditure funded by the government**	Total government expenditure on vaccines used in routine immunizaiton over total expenditure from all sources on vaccines used in routine immunization	Admin JRF (2015)	>=80% (Green), >=30-79% (Orange),<30% (Red)	Green/Yellow/Red: As determined by commonly-used thresholds by WHO
	Qualitative	*Qualitative assessment*	*• Political will in the country (incl. Evolution of health budget)* *• Reasons for potential default and mitigation strategy*			
Fiduciary Risk	Quantitative	**Misuse of funds in last five years**	Misuse of Gavi funds in the last five years as per Gavi audits	Gavi Records	No (Green), Yes (Red)	Green/Yellow/Red: Team agreed
	Quantitative	**Financial reporting compliance**	The number of financial reports received in a given year over the total number of financial reports required for submission in a given year	Gavi Records	Full (Green), Partial (at least one report submitted) (Orange), None (Red)	Green/Yellow/Red: Team agreed
	Qualitative	*Qualitative assessment*	*• Mitigation strategy in case of mis-use of funds* *• Key reasons for funds channelled through government / partners* *• Details on type of funds channelled through government*			
Programmatic & Institutional Capacity (LMC)	Quantitative	**Insitutional capacity indicator**	Programme capacity assessment score that measures institutional capacity based on 3 criteria: 1) EPI programme capacity 2) effectiveness of cordination fora, 3) NITAG effectiveness	Latest PCA (v3 onwards)	All 3 criteria passed (Green), 2 Criteria passed (Orange), 1 or less criteria passed (Red)	Green: Strategic Indicator S3.4 Yellow/Red: Team agreed
	Qualitative	*Qualitative assessment*	*• Current capabilities of EPI teams (# positions, skills, capabilities, turnover)* *• ICC functioning in the country*			
HSS grant	Quantitative	**% HSS fund utilisation**	Total amount of HSS funds spent over the total amount available in country for a given year. Total amount available is based on total disbursed in given year (adjusted for disbursment month) and total funds leftover from previous year.	Gavi Records	>=80% (Green), >=60-80% (Yellow),<60% (Red)	Green/Yellow/Red: Team agreed, follows 20pp increments
	Quantitative	**% achievement of intermediate results**	Number of tailored HSS intermediate results indicators fully achieving their target over the total number of tailored HSS intermediate results indicators due for reporting in a given year	Gavi Records	>=90% (Green), >= 70-90% (Yellow), <70% (Red)	Green/Yellow/Red: Team agreed, thresholds set based on baseline distribution
	Qualitative	*Qualitative assessment*	*• Main areas for engagement for on-going / upcoming grant* *• Key reasons for high / poor HSS fund utilization and mitigation strategy* *• Key reason for high / poor achievement of results and mitigation strategy*			
Health Workforce	Quantitative	**Nursing and midwife personnel (per 1000 population)**	Number of nursing and midwifery personnel per 1,000 population	WHO (Latest Available)	>=3 (Green), >=1-3 (Yellow), <1 (Red)	Green/Yellow/Red: As determined by commonly-used thresholds by WHO
	Qualitative	*Qualitative assessment*	*• Key health workforce challenges experienced in the country (eg: Vacancy rates, turnover, absenteeism) and their impact on service delivery*			

Afghanistan:

Context: Afghanistan represents an extremely challenging environment for the implementation of an immunisation programme. The security situation impacts access to services and the quality of vaccination campaigns, particularly in the low performing districts of Kunar, Nangarhar, Kandahar, Helmand, and Uruzgan. Other factors contributing to challenging planning and implementation and low and very uneven coverage are: geographical barriers, migration and large nomadic populations, lack of accurate information on the size of the population as well as misconceptions around immunisation and gender related barriers.

Issues: In addition to coverage and equity, data challenges remain an issue. The WHO/UNICEF immunisation DTP3 coverage estimate is 78%. However age, coverage surveys show a much lower coverage of 59.7% (2013) and huge disparities exist between provinces with variations in the percentage of fully immunised children ranging from 2.5% in Farah province to 86.8% in Paktia province.

Next steps: In this context, coverage & equity remains one of the main areas for engagement - with the newly started HSS3 grant funding used for the strengthening of service delivery in hard to reach areas, including through mobile health and outreach services as well as demand generation strengthening. To address the major data issues, Afghanistan was able, due to a country tailored approach, to access its full HSS 2 ceiling with the approval of a Data Quality Improvement Plan (US$ 2.3 million budget). The aim of DQIP is to strengthen administrative data collection capacities and the reporting system, aiming to reduce the gap between administrative coverage data and survey coverage data. Strengthening of the supply chain will also be another main area for engagement and the country will be supported in the re-submission of a CCEOP application planned for September 2017.

Afghanistan

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Initial self-financing	Fragile	Relatively high

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	.2m	17
% GPF targets achieved	2015	66%	15
# PEF positions funded	2016	13	3

Vaccine introductions	
Introduced	IPV, Penta, PCV
Expected	Rota, MR1, MR2

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$117m	$87m
Vaccine	$219m	$167m

Top 3 Areas for Gavi Engagement	
1	Equity & coverage - HSS-3 focuses on reaching children in hard to reach areas, e.g. through mobile health and outreach activities
2	Data quality - $2.3M Data Quality Improvement Plan currently being implemented, with a focus on improving admin data
3	Supply chain - HSS-3 focus on improving and expanding equipment; re-submission of CCEOP in September 2017

Area	Status & Trend	Key information
Coverage	↗	• While WUENIC data show 78% DTP3 coverage, coverage is likely to be lower, given WUENIC grade of confidence is low and recent surveys indicate that coverage is much lower (58% in 2014). Data do however show a steady progress in coverage rates. WUENIC also shows a low MCV2 coverage, with an estimate of 39%. • A Measles campaign that started in 2016 will continue into 2017 and a Polio campaign was conducted in early 2017.
Equity	→	• There are large inequities linked to wealth and mothers' education, with 22 and 17 percentage point differences in DTP3 coverage in 2014. • There are important inequities in coverage between provinces (only 2.5% of children are fully immunised in Farah vs 86.8% in Paktia) as well as between urban/rural. Gender related barriers to access are also important with women not allowed to travel to health centres. • A 2017 coverage survey will provide insights into progress and challenges.
Demand	↗	• While WUENIC data show 5% DTP3 dropout, there are likely issues with this estimate, as WUENIC assigned it the lowest grade of confidence. The most recent survey from 2014 indicated a dropout rate of 15%. • The 2013 coverage survey identified five key barriers to demand: distance to health centers, lack of trust in vaccines, lack of awareness on the value of immunisation, insecurity and gender related barriers. HSS-3 has a strong focus on demand generation through improved communication to populations, employment of female vaccinators etc. • An estimated 8% of Afghan population has no access to health services due to insecurity or geographical barriers.
Supply Chain	→	• Latest EVMA assessment in 2014 shows an aggregate score of 77%. • Key supply chain challenges relate to a lack of equipment in hard to reach, low coverage areas as well as obsolete equipment and insufficient storage capacity. • The IRC in March 2017 requested Afghanistan to resubmit a CCEOP application with stronger analysis underpinning the choice of equipment and deployment plan. The country plans to resubmit in September 2017.
Data Quality	↗	• Data quality is a major and well recognised issue in the country, as evidenced by the large discrepancy between admin and survey data (47 percentage point difference in 2014). • A $2.3 million Data Quality Improvement Plan (DQIP) is currently being implemented, with a focus on improving admin data (e.g. training of health workers on data collection, standardisation of reporting, addressing of denominator issues). • With the implementation of the Data Quality Improvement Plan (DQIP) over the coming 3 years, data quality is expected to improve.
Financing & Sustainability	→	• The MoPH is strongly committed to immunisation, however, fiscal space is restricted with approximately 50% of the national budget spent on addressing security issues, resulting in only 5% of immunisation activities funded by the government. • The country has not defaulted in the past years. However, the EPI programme is completely dependent on donor funding. Introduction of MR has been delayed due to the country's inability to meet the co-financing requirement
Financial Management & Fiduciary Risk	→	• Funds for HSS2 were not channelled through the government. However, following the recommendations of the 2016 PCA, approx. 50% of HSS-3 funds are now channelled through the government. UNICEF receives funds related to cold chain and infrastructure investments (44%) and WHO manages approx. 5%. • Service delivery is almost entirely implemented by NGOs managed by the MoPH. 10 implementing NGOs have been assessed through PCAs. The NGOs were overall found to meet standards for financial management. Action plans based on PCA recommendations have been built into the contracts between MoPH and the NGO.
Programmatic & Institutional Capacity (LMC)	↗	• The EPI team is technically strong, however the team has been understaffed and profiles do not always match the required skillset. • EPI team capacity is improving with 8 TCA funded UNICEF staff embedded (e.g. in M&E, communication) • The ICC functions on a relatively high level - with regular meetings and broad representation. Some further strengthening measures to improve oversight have been implemented following the PCA
HSS grant	↗	• Completed HSS 2 grant showed relatively strong achievement of HSS intermediate results, with 80% of targets achieved. • The country has recently started implementation of the HSS3 support, with a main focus on coverage and equity and supply chain • There were delays in starting HSS3, mainly due to the fact that the PCA process took longer than expected.
Health Workforce	→	• A key challenge relates to the very low density (0.36 nursing/midwife personnel per 1,000 population) and uneven distribution of staff. According to WHO, Afghanistan is well under the minimum level necessary to provide essential services. An estimated 8% of the population do not have access to health services at all. • Service delivery is almost entirely carried out by NGOs and is mostly donor funded

Annex F: Country Summary Sheets

Chad:

Context: Chad's political and economic situation remains unstable and security remains an issue in many parts of the country, effectively restricting access to health services. Chad's DTP3 coverage is one of the lowest in Gavi's portfolio with very weak health systems, as also illustrated by recent Measles outbreaks. For 2017, several campaigns (measles and meningitis) are planned, which might further negatively affect routine immunisation efforts in the country. As the IRC has asked the country twice to resubmit its HSS proposal (next submission expected early 2018) a bridge funding has been agreed on. The purpose of the bridge funding is to build capacity in the central EPI team to, among others, enable the country to re-submit a HSS proposal and to support service delivery.

Issues: Chad is one of the most complex countries in Gavi's portfolio. Its immunisation coverage is poor and has been stagnating for several years. Main barriers to immunisation include geography (e.g. widely dispersed populations, hard to reach areas), and this is compounded by a lack of outreach services and a lack of community awareness (demand) of immunisation services. Chad's overall health system is also very weak, including in particular with respect to its EPI management and coordination capacity. The country's cold chain is weak, particularly at peripheral levels. Further, data quality remains a major issue in Chad.

Next steps: In this context, a major focus will be to increased capacities in the EPI team/MoH health teams through technical assistance (through PEF). In addition, Gavi will be supporting the country in its HSS proposal resubmission. Another key area for engagement will be the management of fiduciary risks, with an audit planned in June 2017.

Chad

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Initial self-financing	Fragile	High

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	.3m	11
% GPF targets achieved	2015	42%	31
# PEF positions funded	2016	7	6

Vaccine introductions	
Introduced	Penta, IPV, YF
Expected	MenA

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$18m	$15m
Vaccine	$49m	$46m

Top 3 Areas for Gavi Engagement	
1	LMC - strengthen capacities and capabilities in the EPI team
2	HSS - Gavi will support the country in re-submitting its application for its next HSS grant
3	Data strenghtening -Gavi and partners will support the country developping a plan to strenghten national HMIS that will be partly funded via in coming Gavi and other partners grants. Data Quality In Deepth Review and EPI Coverage Cluster to be done in 2017.

Area	Status & Trend	Key information
Coverage	→	• The country has one of the lowest DTP3 coverages in the Gavi portfolio, with 55% DTP3 coverage in 2015 according to WUENIC. • Coverage has been stagnating or declining in the past years due to, among others, the country's overall weak health system and low capacity in the MoH and EPI team, and more recently several months of public service disruption due to national strike. • Measles campaigns are regularly taking place in the country (phase 2 is currently ending). The country also plans to undertake a MenA campaign. Campaigns might negatively impact routine immunisation efforts by diverting resources to campaigns.
Equity	→	• Wealth and maternal education inequities remain a challenge, with 16 and 23 percentage point differences in DTP3 coverage in 2010. • Geographic inequities are also a key barrier, with only 60% of districts above 80% DTP3 coverage according to administrative data in 2015. Given major data quality issues, this figure is likely to be much lower. • Nomadic populations and urban poor are particularly affected and remain under-immunised. • As the HSS2 proposal has been rejected, Gavi has unlocked a bridge funding of $750k (approved by IRC in November 2016) -
Demand	→	• Key barriers to demand are often alined to religious affiliations. 53% of the population in Chad is Muslim and a 2015 MICS survey found that vaccine hesitancy ratio is 2,2 times higher in the Muslim population than in the Christian population. Vaccine hesitancy is particularly high within the poor Muslim population.
Supply Chain	→	• Latest EVMA assessment in 2015 shows a low aggregate score of 60% • The country has applied for CCEOP as part of its HSS package - However, HSS will need to be resubmitted in 2018 • As part of the application for the HSS grant, the country is planning to invest in cold chain, logistics and improved supply chain
Data Quality	↘	• Data quality is a major issue in the country - there is a 40 percentage point discrepancy between administrative and survey data, according to latest available survey data in 2010. • Data issues exist at all levels: regarding data collection, data analyses, triangulation, and utilization. The enire HMIS system required major strengthening. Gavi and partners will support the country developping this plan to strenghten national HMIS that will be partly funded via in coming Gavi and other partners grants. Data Quality In Deepth Review and EPI Coverage Cluster to be done in 2017.
Financing & Sustainability	↘	• The country's health budget has been cut by 50% in the past years, reflecting a decrease in oil revenues. As a result, the country's health system is deteriorating (e.g. health workers are not being paid regularly and strikes are frequent). • Despite these challenges, 38% of routine immunisation expenditure is funded by the government, and co-financing obligations have been met on-time. • Political commitment exists, e.g. the President supports cold chain investments and the first Lady is a strong supporter of immunisation efforts
Financial Management & Fiduciary Risk	→	• A programme audit is planned for Q2 2017 and may uncover past misuse of funds • Bridge funding is mainly channelled through UNICEF to decrease fiduciary risks • In addition, financial reporting compliance was only partially met in 2015.
Programmatic & Institutional Capacity (LMC)	→	• A PCA has revealed that the National EPI team is understaffed and lacks the required capabilities to manage the EPI programme - for example, there are only 3 team members with limited skill sets • Similarly, the planning department, responsible to submit the new HSS proposals, is inadequately staffed • ICC is meeting irregularly and does not undertake appropriate quality assurances
HSS grant	→	• HSS proposals have been rejected by the IRC for the past 2/3 years - due to poor quality of submission • Gavi has unlocked a bridge funding of $750k (approved by IRC in November 2016) - originally planned to last until the successful resubmission of the HSS proposal in 2017 (which will now need to be re-submitted in early 2018) • The bridge funding is mainly used to build capacity to enable the country to re-submit a HSS proposal and to support service delivery in some districts
Health Workforce	↘	• Health workforce is a major issue in the country • Due to the irregular payments of salaries the health workforce has been frequently on strike for the past year. This has resulted in interruptions of immunisation delivery services.

Democratic Republic of Congo:

Country Narrative is in Annex D to the Alliance update on Country Programmes

DRC

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Initial self-financing	Fragile	Highest

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	.6m	5
% GPF targets achieved	2015	33%	41
# PEF positions funded	2016	6	9

Vaccine introductions	
Introduced	Penta, IPV, PCV, YF
Expected	Rota, HPV, MenA, MR1

300,000 doses are available for the recent Ebola outbreak

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$290m	$212m
Vaccine	$585m	$463m

Top 3 Areas for Gavi Engagement	
1	RI strengthening to improve overall coverage and equity - including through further improvements to the distribution and storage of vaccines, enhanced HR capacity building, improved demand generation, etc.
2	Data quality stregthening (together with partners) - data quality improvement plan developped in 2015 requires mid-term review, update and power up. DHIS2 needs to be further developped to be more EPI friendly
3	Supply chain - to be further strengthened through HSS2 grant (e.g. through further supply of refrigerators) and through CCEOP

Area	Status & Trend	Key information
Coverage	↗	• Coverage has overall increased (notably for DTP3 and PCV, 81% and 73%, respectively, according to 2015 WUENIC estimates) in the past few years thanks to major efforts in improving vaccine distributions and in monitoring stock outs. However, data quality remains an issue - WUENIC estimates received the lowest grade of confidence. • The country is experiencing disease outbreaks (recent measles, men A, yellow fever) and relies on campaigns to fight the outbreaks (measles campaigns in 2016 and in 2017 and three yellow fever campaigns in 2016). The country will need to strengthen its routine immunisation and introduce second dose for measles.
Equity	↗	• Key barriers to equity are socio-economic (35 and 31 percentage point differences in DTP3 coverage in wealth and maternal education in 2012) and geographic (access to some areas is difficult due to their geographic location or conflict. Some provinces can only be accessed by air and others have low infrastructure, such as low quality of roads). • Part of the geographical equity challenge is being addressed through the HSS2 grant which includes supporting the rehabilitation of health centres in remote areas, providing warehouses at the provincial level and procuring and/or maintaining of vehicles (boats, motorcycles) to reach remote areas.
Demand	→	• Key barriers to demand are linked to security (conflicts around country borders) and to religious affiliations (some populations, e.g. in Katanga, are scared of using vaccines due to their religion's position on immunisation) • The population is often not aware of campaigns currently on-going in the country - this is partly due to communication / planning issues but also partly due to weak demand
Supply Chain	↗	• Latest EVMA assessment in 2014 showed an aggregate score of 61% • In the past, DRC has suffered from important cold chain system and capacity challenges • The HSS2 grant has brought great achievements regarding storage capacity by increasing the coverage of cold chain from 14% to 55% - enabling the country to receive the needed quantity of vaccines, avoid stock outs and be able to introduce the rota vaccine • The country has been approved for CCEOP in 2016 for an additional 2000 solar refrigerators. This would increase the cold chain capacity of the country from 55% to 74%.
Data Quality	→	• Poor quality of health data is a recurring issue in DRC - there is a 32 percentage point difference between admin and survey, according to the latest survey data available (DHS completed in 2014). • A data quality improvement plan was developed in 2015. As a result, data tools and connectivity within the country have been improved. However it requires now a mid-term review, update and power up. • DHIS2 needs to be further developped to incorporate EPI dashbord, data quality app, link with DVD MT and SMT in order to increase utilisation of data and data to be used for timely decision making.
Financing & Sustainability	→	• The country has defaulted in the past years (2015 and 2016) • Although the country's contribution to immunisation expenditure is very low (3%), it has increased over the last year while the overall health budget has substantially decreased in the same time period.
Financial Management & Fiduciary Risk	↗	• A 2015 audit revealed questioned expenditures of approximately $ 1.2 m of Gavi funds. • As a result a fiduciary agent has been installed, and funds have been channelled through partners • In 2015, financial reporting compliance was partially met.
Programmatic & Institutional Capacity (LMC)	→	• The national EPI team appears over-staffed with approximately 130 people. The team's structure as well as team members' roles and responsibilities are in need of review to ensure greater efficiency in the team. • As skilled staff find more lucrative employment outside of the EPI/MoH team, the EPI's overall skill level tends to be low • ICC is very well organised (meeting regularly), however, representation should be aligned with Gavi's guidance
HSS grant	↗	• HSS2 is currently on-going, with a main focus on supply chain, including cold chain equipment (53m$ out of 144m$) • HSS2 has so far been successful (renovation and extension of storage space of 10 regional distribution Stores (CDR) - 5 of which were renovated jointly with the Global Fund. Moreover, 43 health centres have been renovated and construction of 3 vaccine and essential drugs commodity Hubs (warehouses) in Kinshasa, Lubumbashi and Kisangani is progressing) • Achievement of intermediate results was low in 2015 (25%) because only procurement funds have been able to be unlocked - the result is expected to be higher in 2016 as other types of funds have been used as well
Health Workforce	→	• Human resources is a challenge in DRC - there are only .96 nurse/midwife personnel per 1,000 population. Many health workers are not paid regularly or do not at all receive a salary and therefore prefer to engage in activities that guarantee remuneration, such as per diems from campaigns, etc.

Ethiopia:

Context: Ethiopia is the second largest recipient of Gavi funds since inception. Political will is overall strong at the national level, however, due to the decentralised nature of the country, there is a need to work with the sub-national level to advocate for the prioritisation of health and immunisation at sub-national levels. The country has experienced political unrest over the past year with a state of emergency being declared in 2016 following anti-government protests and a cabinet reshuffling at the end of 2016. Gavi HSS funds in Ethiopia are managed through a pooled funding mechanism where the core principle is '1 plan, 1 budget, 1 report'; other contributors to the pooled fund include the UK; Spain; Netherlands; Australia; Ireland; UNFPA; UNICEF; the World Bank; the EU; Italy; WHO; Sweden and Canada.

Issues: Data quality is one of the major challenges in the country, evidenced by significant variations across different sources of data e.g. administrative data (96% DTP3 coverage in 2015) and survey data (53 % DTP3 coverage as per 2016 Demographic and Health Survey). Equity remains a key issue within Ethiopia with significant regional, socio economic and educational inequities. Financing of health is not sustainable as half of the health sector funding is being supplied by donors

Next steps: One of the key areas for engagement is data quality - the government has, for example, worked, through the pooled fund, to invest in strengthening the HMIS and community health information systems. Partner investment is vital to having only one platform for data (data repository). The need to improve data at the national and subnational level is moreover emphasised by the Alliance. Equity remains a key area of engagement - the government is for example targeting pastoral areas (e.g. by improving service delivery) to reach more hard to reach populations. Supply chain remains another area for engagement with a large share of the pooled fund (~80%) being directed at the procurement of health equipment and commodities.

Ethiopia

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Initial self-financing	Not fragile	Highest

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	.4m	6
% GPF targets achieved	2015	73%	8
# PEF positions funded	2016	14	2

Vaccine introductions	
Introduced	Penta, IPV, PCV, Rota
Expected	HPV, YF, MenA, MR1, MR2

Gavi commitments vs disbursements (all time)

Type	Commitments	Disbursements
Cash	$307m	$217m
Vaccine	$739m	$641m

Top 3 Areas for Gavi Engagement

1. Data quality - e.g. The government has worked through the Pooled Funding mechanism to have only one platform for data.TCA allocations to UNICEF, WHO, CDC and World Bank are also aimed at improving data quality
2. Equity - The government has targeted, through the Pooled Funding mechanism, pastoral areas to reach more of the 'hard to reach' populations - e.g. through improving service delivery
3. Supply chain - A large share of the Pooled Funding (~80%) is targeting procurement of health equipment and commodities.

Area	Status & Trend	Key information
Coverage	⇨	• WUENIC DTP3 coverage has increased between 2011 and 2014 - to a level of 86% in 2015. However, 2012 coverage survey was 65% and 2016 DHS survey for DTP3 coverage is far lower (53%) and there is currently a high risk that coverage decreases due to political unrest in the country (a nationwide state of emergency has been in place since October 2016) as well as food supply issues. • Measles campaigns have already taken place in 10 regions. Somali region had a delayed start due to low readiness and the current drought which has delayed implementation.
Equity	⇨	• Key barriers to equity are socio-economic (39 and 34 percentage point difference in DTP3 coverage in wealth and maternal education in 2016, respectively), related to education (there is a drop in Penta3 coverage by 33.7% between those with high and this with no/low education level) and related to geography • There are significant regional disparities with persistently low coverage in pastoral areas of Somali, Afar, and Gambella (a 2015/16 annual Health Sector performance report showed full immunisation coverage of 100% in Addis Ababa while Gambella had the lowest coverage of 55.2%). Of concern is that regions with large population are poorly performing i8n the last DHS (Amhara 63.8%
Demand	⇗	• Key barriers to demand are geographic (with lowest demand in areas where access to health facilities is difficult) • To address some of the demand barriers, the government has taken actions e.g. engaging community and religious leaders, equipping community social mobilisation committees with necessary information on vaccination programmes, strengthening engagement of CSOs, developing and implementing the Routine Immunisation Improvement Plan as a strategy for improving access and creating demand for routine immunisation, and implementing a Health Development Army (HDA) to create awareness and demand for healthcare at community level.
Supply Chain	⇨	• 2013 EVM (64%) highlighted issues in supply chain, including for example weak temperature monitoring, absence of a planned preventive maintenance programme, delays in vaccine clearance, and a lack of control over vaccine distributions resulting in unbalanced stocks at the peripheral facilities. • The transition of vaccine management from the Federal Ministry of Health (FMOH) to the Pharmaceutical Fund and Supply Agency (PFSA) has taken long and the new arrangement is still not fully operational. • Ethiopia is expected to resubmit its CCEOP application in May 2017.
Data Quality	⇨	• Data quality is a major issue in the country, as evidenced by the large discrepancy between admin and survey data (27 percentage point discrepancy between administrative and survey data in 2016) • The government has undertaken efforts to improve the situation (for example through the creation of a single platform for data (data repository), annual data quality audits, service availability and readiness assessments, and the 2017 decision to adopt DHIS2 as the platform for data collection.
Financing & Sustainability	⇨	• Ethiopia has historically fulfilled its co-financing requirements on time (with the exception of a small amount of the country's 2014 obligations that was paid late due to a confusion over the co-financing requirements) • However, nearly half of the health sector support is donor funded which is not sustainable given that Ethiopia is projected to be a lower-middle income country by 2025 • Political will is high at the national level. However, due to the decentralised nature of the country, there is a need to work with the sub-national level to advocate for the prioritisation of health and immunisation.
Financial Management & Fiduciary Risk	⇨	• An audit has been finalised in Feb 2017. It covered the period 1 January 2013 to 31 December 2015. An amount of USD 378,011 was questioned by the audit, related to inadequate management of budgets to ensure that grants are only used for Gavi approved activities. There are also recurring delays regarding invoice submission and payments - showing weak capacity and inadequate supervision • All cash grants (HSS, VIGs and operational costs) are channelled through the government. However, the HSS grant is managed through a pooled funding mechanism; other partners channelling funds through the pooled fund include: the UK; Spain; Netherlands;
Programmatic & Institutional Capacity (LMC)	⇨	• National EPI team is currently not adequately staffed - WHO is currently filling some key positions through secondees • ICC does exist - it meets regularly and includes all relevant stakeholders (CSO, WHO, UNICEF DFID, BMGF, etc.)
HSS grant	⇨	• The HSS grant is managed through a pooled funding mechanism called the Sustainable Development Goal Performance Fund (SDG PF). Gavi monitors the performance of the pooled fund through quarterly updates • Historically, around 80% of the pooled fund have been used for the procurement of health commodities
Health Workforce	⇗	• There is a shortage of skilled human resources, and high turnover of skilled health workers due to low salaries in the public sector • The government has deployed 38,000 health extension workers (HEWs) to the community level to deliver preventive and promotive services, including immunisation.

Indonesia:

Context: Indonesia has transitioned from Gavi support for pentavalent vaccine in 2016. It will receive catalytic support for the introduction of MR and JE (in 2017) as well as for an HPV demonstration project (mid-2017 to mid-2019). The government has requested continued support for the introduction of new vaccines beyond Gavi transition, indicating that mobilising funds for the introduction is challenging, while continuation of funding for already introduced vaccines can be ensured.

HSS implementation, ongoing since 2008, has suffered from poor coordination and management and a very slow rate of implementation. Since implementation has now improved, the country has been granted a no-cost extension for the HSS grant until July 2017. In addition, a two-year plan to sustain the benefits of Gavi support, as Indonesia transitions from Gavi, and advancing the agenda on reaching the unreached, is currently under development using the unspent cash balances from Gavi vaccine and cash support. Partner technical assistance, in some cases financially supported by Gavi, has been instrumental in supporting the EPI programme management to date and will be critical for ensuring the sustainability of investments. Global and regional benchmarks indicate that Indonesia's expenditure on health is very low, currently at 3.1% of its GDP. As Indonesia has transitioned from Gavi financing, it will be necessary to remove certain institutional constraints in order to improve coverage rates and expand immunisation services. Sustaining technical capacities in the MoH, including in such areas as planning, budgeting, surveillance and communication will also be important to sustain immunisation outcomes.

Issues: Equity remains of concern: While there is almost no difference in immunisation coverage by sex, a big gap exists in coverage between wealth quintiles (85% versus 52% between highest and lowest) and there is also wide geographical variation between provinces, with several, such as Papua (35%) and West Sulawesi (58%) being far from their targets. Hard to reach areas are in remote, sparsely populated eastern provinces and in urban slums. Data quality also remains a major issue in the country, as evidenced by the large discrepancy between admin and survey data regarding population estimates.

Next steps: Coverage & equity remains one of the key areas of focus for Gavi engagement, notably through the CESAP (Coverage, Equity and Sustainability Action Plan), aiming to reach the fifth child. As Indonesia has transitioned out of Gavi support, financing and sustainability is the other main area for engagement, with Gavi ensuring that the country has the capacity to finance new vaccine introductions after its transition. In addition, cold chain is a focus with Gavi currently supporting a cold chain inventory in 15 provinces, including assessment, guidelines and trainings for private health providers.

Indonesia

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Fully self-financing	Not fragile	Relatively high

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	.9m	4
% GPF targets achieved	2015	70%	11
# PEF positions funded	2016	2	27

Vaccine introductions	
Introduced	Hep B, Penta, IPV, HPV, JE, MR
Expected	

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$63m	$58m
Vaccine	$113m	$74m

Top 3 Areas for Gavi Engagement	
1	Coverage & equity - ensuring that the immunisation programme reaches the 5th child, through, amongst other CESAP (Coverage, Equity and Sustainability Action Plan) which targets action to districts with high number of unimmunised/partially immunised
2	Sustainability, particularly at sub-national level. Gavi is currently supporting cold chain inventory in 15 provinces, including assessment, guidelines and trainings for private health providers. Gavi also supports the review of immunisation regulations
3	Financing of new vaccine introductions - notably through enhancing the technical capacity of national officers; improving data and surveillance capacity; advocating for immunisation to national stakeholders / decision-makers; and contributing to relevant studies

Area	Status & Trend	Key information
Coverage	⇨	• Coverage for DTP3, measles and polio has remained stagnant for many years (81% for DTP3 coverage and 76% for MCV2 coverage as per 2015 WUENIC data), because Indonesia has been unable to address the challenges of reaching the 5th child. • MR campaign and routine introduction - target 70 million children 9m to 5yr - currently on-going with phase 1 in Java in 2017 (Aug-Sep for campaign and Oct for routine). Phase 2 for rest of Indonesia will take place in second half of the year.
Equity	⇨	• Key barriers to equity are mainly geographic and socioeconomic, e.g. in urban slums and hard to reach areas. For example, DTP3 coverage is <35% in Papua, and <50% in Banten, Maluku, West Sulawesi • There are large inequities in wealth and mother's education, with 33 and 55 percentage point differences in DTP3 coverage in 2011, respectively. • The Alliance has worked to mitigate this through coverage strategies outlined above and included in the CESAP - focusing its action on 31 districts with highest number of under-immunised children. Through the MR campaign the Alliance has also put strong
Demand	⇨	• Demand and public perceptions on immunisation is generally positive but knowledge regarding the immunisation schedule and normal side effects is low, leading to high dropouts. This is compounded by a lack of communication from health workers that are not counselling parents about schedule. • Trend in demands are hard to assess as it highly depends on provinces
Supply Chain	⇗	• Though being at good levels overall (The National Vaccine Store scored a perfect 100%) , there are still some gaps in supply chain at subnational level • All three levels of provincial, district and puskesmas (health centres) show weak performance in especially three criteria (temperature management, stock management and management of information systems and supervisory functions) • As Indonesia has transitioned to fully self-financing status from January 2017, it is not eligible for CCEOP support.
Data Quality	⇨	• Data quality remains a major issue in the country, as evidenced by the large discrepancy between admin and survey data (23 percentage points in 2011). The gap is particularly noticeable in population estimates • MoH is currently piloting a web-based reporting system to improve standardisation of reporting and data quality. However, there is a relatively low level of confidence in improvements in the medium term due to a multitude of parallel systems within MoH, low capacity, and continued challenges with denominator.
Financing & Sustainability	⇗	• Political commitment to health seems to be improving after budget increases for investments in social development (health, education and social protection programmes). • Financial sustainability is strong - the country has never defaulted and has the financial capacity to fund routine vaccines and to introduce new vaccines, though it has requested continued support for the introduction of new vaccines beyond Gavi transition.
Financial Management & Fiduciary Risk	⇨	• NVS support is channelled through the Government, which self-procures • State budget documents are transparent and comprehensive and the budget process is well-defined. • MoH has the capacity to manage large budgets, procurements and multiple funding sources
Programmatic & Institutional Capacity (LMC)	⇨	• The national leadership and management capacity is strong. The EPI team is well resourced and has the capabilities required to manage the EPI programme • Management challenges exist at district level - e.g. variability in management capacity and commitment to immunisation at the subnational level
HSS grant	⇨	• The country currently has seven 7 grants on-going, mainly focused on MR, HPV, JE, IPV and the CESAP. • HSS grant started in 2008 but has been extended due to very slow expenditure • Although recent improvements on monitoring and reporting for HSS, there has historically been poor understanding of results achieved with HSS support • HSS fund utilisation is low due to the bureaucratic system - it takes a lot of time to get approvals. In 2015 only 30% of the HSS fund has been used
Health Workforce	⇨	• Each puskemas (health centre) has its own EPI coordinator. There is however a high turnover, with limited training opportunities and often low capacity • At district level, the turnover is often very high (nurses, midwives, EPI managers, cold chain technicians); inhibiting continuity in healthcare

Annex F: Country Summary Sheets

Kenya:

Context: Kenya's health sector has been negatively impacted by devolution which has resulted in that all of the 47 counties have significant autonomy regarding their health programmes. Health is one of the most decentralised government functions, with all operational aspects of EPI being decentralised to the county level, and only key policy functions remaining at national level. Kenya is just starting a new HSS grant, the previous one having ended in 2012. However, elections will take place in August this year, and it is likely that immunisation related activities will slow down in the run up and aftermath to the elections. Kenya is also prone to natural disasters that can impact immunisation outcomes in the counties - for example the current drought affects a large share of counties

Challenges: Kenya is one of the countries within the Gavi portfolio where fiduciary risk is particularly high - with significant misuse of funds as per 2015 audit ($1.6m). Equity also remains another key challenge, with numerous remote areas and nomadic populations that are hard to reach, and major urban slums. Progress on equity has stagnated in the past few years due to the devolution (counties are frequently not prioritising the provision of immunisation). Supply chain is also a major concern, with poor management of vaccines and record keeping.

Next steps: As a result of the fiduciary risk in the country, Gavi has channelled support only through partners in the past years, and strongly encourages procurement in HSS proposal to be undertaken through partners, with additional assurance than normal (coming at an increased cost to Gavi). Kenya will start a new HSS grant this year, the last one having been closed in 2012. This grant will help addressing coverage and equity issues posed since the devolution. Gavi will also focus on strengthening data quality which has significantly decreased since devolution.

Kenya

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Preparatory transition	Not fragile	Highest

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	.2m	21
% GPF targets achieved	2015	11%	65
# PEF positions funded	2016	4	15

Vaccine introductions	
Introduced	Penta, IPV, PCV, Rota, YF, MR
Expected	HPV, MenA

Gavi commitments vs disbursements (all time)

Type	Commitments	Disbursements
Cash	$60m	$30m
Vaccine	$398m	$394m

Top 3 Areas for Gavi Engagement

1. Fiduciary Risk - Gavi is channelling government support through UNICEF (with increased assurance being conducted by UNICEF) and strongly encourages that HSS procurement to be undertaken through partners. Gavi is also providing HSS funds direct to the CSO partner, KANCO, a PR for Global Fund, with fiduciary oversight provided by an in-country monitoring agent.
2. Health Systems Strengthening - start of a new HSS grant to help address coverage and equity issues and the challenges posed by devolution (the HSS grant will for example prioritise 17 counties with particularly poor C&E, and high number of unimmunised.)
3. Data Quality improvement - To ensure quality data is informing the immunisation programme. The HSS grant will have a focus on data strengthening (e.g. ensure data quality is prioritised and that counties have sufficient data collection tools)

Area	Status & Trend	Key information
Coverage	→	• Coverage for DTP3 is high (89% in 2015 according to WUENIC) - However, it has stagnated / decreased in the past few years (according to admin / JRF data respectively) since devolution in 2013 (commitment and prioritisation of EPI varies widely across the 47 counties) • MR campaign took place in May 2016 with 95% coverage
Equity	→	• Key barriers to equity are mainly geographic with remote arid/semi arid areas and nomadic populations - making it difficult to reach populations. There is also a high number of unimmunised children in urban slum areas, notably in Nairobi. • Wealth and maternal education inequities remain a challenge, with 9 and 16 percentage point differences in DTP3 coverage in 2014. • Since devolution, counties have full autonomy over their health (and immunisation) programmes and immunisation budgets; they vary in their commitment to prioritising immunisation in their budgets.
Demand	↗	• Drop-out rate is overall low (7% in 2015 according to WUENIC in 2015). Main challenges are linked to hesitancy driven, for example, by the Catholic church (mainly during past campaigns) - however, there has been some improvement on this in the past year.
Supply Chain	→	• Latest EVMA assessment in 2014 showed an aggregate score of 56% • The main challenges are poor management of vaccines and lack of record keeping (e.g. history of unaccounted doses of PCV identified through Gavi audit) • Country has been approved for CCEOP - due to start in 2017 • Gavi is facilitating a private sector partnership with DHL to support with developing a VAN (vaccine analytics network) to provide more visibility over vaccine supply chain
Data Quality	↘	• Data quality is one of the key issues in the country - DTP3 administrative estimates (81%) are lower than survey data (90%), which is highly atypical and likely a result of an overestimation of the denominator. • Data quality has decreased in the past years following devolution, with data not being well captured at county level, frequently due to vaccine registers not being available, and lack of trained staff.
Financing & Sustainability	→	• The country has not defaulted in the past few years, however it has paid with delays but only with thanks to UNICEF pre-financing loans and there are questions over the country's ability to finance without this loan. • Kenya is in preparatory transition phase - UNICEF and World Bank are starting to support the development of strategies for immunisation financing sustainability, but this is nascent. • President has reportedly immunisation as one of his top key indicators for health
Financial Management & Fiduciary Risk	→	• There was a misuse of funds of approximately $1.6m as per 2015 audit, although the mis-used funds have been fully reimbursed • Fiduciary risk remains inherently high in Kenya, notably as the country structures are still nascent, and particularly during an election year • Gavi has decided to route funds through UNICEF with enhanced safeguards for at least the next year and, whilst this reduces the residual risk for Gavi in the shorter term, we leave the rating as high risk due to the longer term preference for routing funds through the MoH when the necessary safeguards are in place. Funds are also being channelled directly from Gavi to the CSO partner on the
Programmatic & Institutional Capacity (LMC)	↗	• Political will: MOH leadership is very engaged in immunisation issues and Gavi - Minister is former EPI Manager (from 1990s). • President has reportedly immunisation as one of his top key indicators for health • There is a strong EPI leadership at national level but challenges remain to manage performance in the context of devolution • Gavi has contracted CHAI to enhance performance management practices at county level • Turnover and vacancies have recently been a challenge in EPI teams with a major reshuffle in MOH in Nov 2016 - 7 staff were moved out of the EPI team (including EPI Manager), with only 3 new staff moving in
HSS grant	—	• The country has just started a new grant - the last grant has ended in 2012 The grant will be focused on (1) improving governance and coordination in the devolved system (e.g. by strengthening governance to ensure county governments prioritise immunisation in their budget), (2) providing much-needed training to health workers in the devolved system, (3) strengthening cold chain (e.g. ensure vaccines are well stored) (4) strengthening data quality and management. The grant prioritises 17 counties with particular poor C&E data - notably Nairobi slum areas with high number of unimmunised
Health Workforce	→	• Health worker resourcing tends to be weak due to poor quality of training and irregular payment of salaries • Frequent strikes (for example, by doctors striked for 3 continuous months between Nov 2016 and Mar 2017) can paralyse the health system, including immunisation delivery

Annex F: Country Summary Sheets

Nigeria:

Country Narrative is in Annex D to the Alliance update on Country Programmes

Nigeria

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Suspended	Accelerated transition	Fragile	Highest

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	2.9m	2
% GPF targets achieved	2015	63%	17
# PEF positions funded	2016	7	7

Vaccine introductions	
Introduced	Penta, IPV
Expected	Rota, MenA

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$219m	$203m
Vaccine	$760m	$447m

Top 3 Areas for Gavi Engagement
Note: a "Nigeria strategy" will be developed in the coming months

1. Fiduciary risk - Following the discovery of mis-use of funds by a 2014 & 2015 audit, 30 recommendations have been developed to decrease fiduciary risk, including e.g. embedding a fiduciary agent and a coordination unit in the NPHCDA
2. CEF - Work closely with the country and partners on the country's application under the CEF, which will likely include an application for HSS2, CCE OP, MSD, HPV national and transition grant
3. Data and Demand - as part of next HSS2 grant a major focus will be placed on data improvement and demand creation

Area	Status & Trend	Key information
Coverage	↗	• Coverage remains low but has seen a modest increase over the past years (from 46% in 2012 to 56% in 2015 as per WUENIC data). This is mainly due to the fact that supply for almost all vaccines has improved (after supply shortages in 2011/12) and Gavi support helped to increase service delivery. • There is a wide variation between the administrative data and WUENIC estimates/CES • Country faces disease outbreaks every year (in particular with respect to measles, Meningitis C & W-in 2017), polio resurfaced in 2016. A follow-up measles SIA in 2017 has been planned
Equity	→	• Equity is one of the greatest challenges in the country, notably in terms of wealth and mother education (72.5 and 57.9 percentage point difference in DTP3 coverage in 2012, respectively) . A 2017 survey will allow to assess trends over the past few years, but is expected to show that the situation has remained stagnant. • The government, relying on its admin data, is only gradually acknowledging that there is an issue • Vaccine hesitancy and insecurity (particularly in NE states) in certain parts of the country hinders service delivery
Demand	→	• A key barrier to demand is poverty, illiteracy and poor reach of immunisation programmes, particularly in the northern states and areas affected by conflict • Demand creation will be a part of the next HSS proposal. However, before a strategy for demand creation can be developed, the country needs to improve access to vaccines (including through improving its health system)
Supply Chain	↗	• Latest EVM assessment in 2014 showed an aggregate score of 66% • Supply chain has improved at national level with a new vaccine management system (VAN) put in place to have increased visibility on stocks • However, supply chain is still very weak at the subnational level
Data Quality	→	• Data quality is a major issue in the country, as evidenced by the large discrepancy between admin and survey (48 percentage point difference between admin and survey data in 2014) • The upcoming 2017 coverage survey will assist future planning and investments at national level, including in the area of data improvement.
Financing & Sustainability	→	• Political will: A new Executive Director has joined NPHCDA in January 2017. The new ED visited the Gavi Secretariat in March to share his vision and ambition for the next two years: to re-position NPHCDA so it can fully deliver on its mandate • The sustainability of routine immunisation is not assured - for example, the country pays only 25% of the cost of vaccines itself; moreover, the federal government has reduced the 2017 health budget
Financial Management & Fiduciary Risk	↗	• The 2015 audit revealed misuse of funds on a large scale as well as weaknesses in the country's financial management systems • As a result of the audit, HSS funding was effectively suspended, and campaign funds are channelled only through partners • 30 recommendations have been developed to decrease fiduciary risk, including e.g. embedding a fiduciary agent and a coordination unit in the NPHCDA
Programmatic & Institutional Capacity (LMC)	→	• The EPI team has strong technical capacity but lacks managerial capabilities, yet these tend to be underutilised in a system that has been marred with corruption. In addition, the capacity tends to be concentrated at the central level. • ICC is not fulfilling its role as a strategic oversight body
HSS grant	→	• HSS funds were frozen in 2014 due to the discovery of mis-use of funds. Since then the remaining in-country funds are being used for some priority activities managed by UNICEF. • The country is expected to apply for HSS2 under the CEF in 2017 - it is expected that data and demand will come through as strong areas of focus for HSS2
Health Workforce	→	• There is inadequate human resources for RI. As states are not always able to pay the salaries of health workers strikes are frequent. • Polio campaigns over the years have diverted attention from other routine activities and many health workers prefer to work during campaigns, where per diems are guaranteed • Supervision and mentoring of workers remain very weak • Front line workers often do not have the right capabilities and the health workforce is not spread equally across areas

Annex F: Country Summary Sheets

Pakistan:

Country Narrative is in Annex D to the Alliance update on Country Programmes

Pakistan

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Preparatory transition	Fragile	Highest

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	1.4m	3
% GPF targets achieved	2015	77%	5
# PEF positions funded	2016	17	1

Vaccine introductions	
Introduced	Penta, IPV, PCV, Rota
Expected	

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$208m	$153m
Vaccine	$916m	$806m

Top 3 Areas for Gavi Engagement	
1	Coverage - Gavi's HSS-2 funding, through the National Immunisation Support Project, incentivises increases in immunisation coverage and provides tailored support to sub-national immunisation projects to achieve these outcomes
2	Equity - Pakistan has high inequity within and between provinces. Gavi Alliance and partners provides targeted technical assistance to Provincial programmes in cold chain and demand generation and is piloting new approaches in urban slums
3	Supply chain - Insufficient supply chain was a key gap to improving the coverage of service delivery and is a strong focus of new support (CCE OP), technical assistance (funded positions through Unicef) and a new project to redesign the supply chain system

Area	Status & Trend	Key information
Coverage	↗	• WUENIC data shows stagnating coverage rates (72% in 2015), although some improvements are expected to be shown in an upcoming district-level coverage survey, funded by Gavi. A coverage increase in the largest Province, Punjab (50% of the population), was confirmed via an independent survey in 2016. • There are still outbreaks of diphtheria and measles reported in older cohorts of children that need to be monitored in the upcoming years.
Equity	→	• There are several key barriers to achieving equity in immunisation coverage, including geographic and social barriers, which vary in their impact by regions of the country. • Wealth and maternal education inequities remain a challenge, with 58 and 19 pct. point differences in DTP3 coverage in 2012. • Throughout Pakistan, there are differences between rural and urban coverage with low coverage found in urban slum areas. • Gavi, with partners is developing an urban slum strategy for immunisation and targeting service improvements in Pakistan's largest slum, Karachi
Demand	→	• There are demand issues in Pakistan caused by numerous factors - notably the lack of knowledge of vaccines benefits and a lack of confidence into the system (lack in consistency and availability of government services). • For polio campaigns, vaccinators travel from house to house which raises the expectation that vaccinators will also come to a household for routine vaccination.
Supply Chain	↗	• EVM in 2014 showed a score of 61% - Pakistan has aging cold chain equipment, insufficient number of equipment to improve service availability and reach of services and is currently inefficiently designed with vaccines arriving through one port of entry. • There was a large closed vial wastage incident in 2015. A recent vaccine audit showed that recommendations following the incident were largely incorporated into vaccine management practices - This audit has also provided further recommendations • Pakistan applied for the Cold Chain Equipment Optimization Platform (CCEOP). Gavi is also funding a supply chain system redesign exercise through Unicef to improve the efficiency and coverage of the immunisation supply chain
Data Quality	↗	• There is a 29 percentage point difference between admin and survey, according to the latest survey data available (DHS completed in 2013). • A data quality audit led in 2016 outlined significant issues to be addressed in order to improve Pakistan's administrative data system. • Current denominator data is from 1998, which affects the quality of administrative coverage data. A new population survey is planned for 2017.
Financing & Sustainability	↗	• Pakistan has defaulted in previous years (2015) due to issues in the government procurement system • Two major steps have improved the co-financing arrangement in the last year. (1) The operationalisation of NISP has secured funding for immunisation in budgets until 2020 for vaccines and services. (2) The cabinet has allowed the Ministry to forgo government procurement rules which will allow procurement via UNICEF
Financial Management & Fiduciary Risk	↗	• Between 2011-16 Gavi support was channelled through partners due to the devolution of the health system and the weak financial management capacity of the government. • The current HSS grant is channelled through a Multi Donor Trust Fund managed by the World Bank, which enables disbursements directly to the provincial governments • Through these arrangements Gavi has transferred the management of fiduciary risk to the Bank. It remains to be seen how effective the approach is in addressing provincial FM weaknesses. Until this is clearer the risk level remains high but improving.
Programmatic & Institutional Capacity (LMC)	↗	• The staffing situation of the Federal EPI team has improved with the filling of some vacant positions in the past months. • While the ICC meets regularly, the oversight function of the ICC needs to be further strengthened. Punjab has drastically improved coverage in the last two years by setting up an accountability system under the chief Minister and by integrating polio and Routine programmes.
HSS grant	→	• Devolution required a change in the type of engagement from all partners as provincial governments took over responsibility for health in their provinces. • As a result, the current HSS grant is channelled through a Multi Donor Trust Fund managed by the World Bank, which enables disbursements directly to the provincial governments
Health Workforce	↗	• Major bottlenecks are the lack of qualified health workers, unequal distribution of the workforce and lack of clarity on roles in service delivery (e.g. standardised qualifications to vaccinate children). • Country has improved the accountability of the workforce through the implementation of tracking of vaccinators (e-vaccs). • There are ongoing initiatives to engage 'Lady Health Workers' in Routine Immunisation (programme started in 2015). Polio uses vaccinators which otherwise work on Routine Immunisation in campaigns, affecting their availability for RI.

Uganda:

Context: Coverage has increased from 2006 to 2011 but has been stagnating since. The country has until recently been focused on introducing new vaccines (e.g. HPV, IPV) but is now focussing more on strengthening routine immunisation and coverage/equity. Uganda benefits from strong political support for immunisation, with the government stating its willingness to take on more responsibility for immunisation financing (aiming to create an immunisation fund at national level). However in practice, government expenditure as a proportion of the growing overall immunisation programme is falling despite good overall economic conditions, raising potential sustainability issues.

Challenges: There remain equity issues Uganda, with remote rural, island and mountainous communities lacking access to health facilities. Some ethnic, religious and marginalised/poor groups also have relatively little access, including in the capital (Kampala). Fiduciary risks remain high, with a history of miss-use of GAVI funds – funds were frozen between 2006 and 2013 and increased controls and monitoring/supervision are in place with most of the funds for high risk activities such as procurement (channelled through partners). Health workforce remains a major issue in the country with high vacancy rates (up to 35%) and absenteeism (up to 50%). Supply chain is also a key challenge due to lack of predictable funding flows from central to district and to health facility level, disrupting vaccine distribution from district stores to lower health facilities.

Next steps: Gavi is increasing risk management measures, including by putting in place a new Fiduciary Management Agent and a range of pre-conditions for strengthened systems before HSS2 can start. The new HSS2 and CCEOP (likely to start in July) will address some of the key issues identified above, for example in supply chain. The upcoming JA will be used to focus on solutions to the country's equity and coverage issues and on improving microplanning in 37 key districts (out of 118) with the highest levels of inequities. Gavi will also increase capacity in the EPI team and is supporting better decision making on immunisation in MoH by reviewing existing governance structures and technical groups and by establishing a revitalised ICC by the end of 2017. Gavi will work with wider partners such as World Bank, DFID and USAID to look at how wider Health System programmes (e.g. on HRH and Government health budgeting) can improve immunisation outcomes, particularly at the district level.

Uganda

Country Summary Sheet
Tier 1 country

Country General Information

Gavi funding	Co-financing group	Fragility status	Risk category
Ongoing	Initial self-financing	Not fragile	Highest

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	.3m	8
% GPF targets achieved	2015	48%	25
# PEF positions funded	2016	8	5

Vaccine introductions	
Introduced	HPV, IPV, Penta, PCV
Expected	Rota, MenA, YF, MCV2, MR1

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$39m	$33m
Vaccine	$414m	$273m

Top 3 Areas for Gavi Engagement

1. Equity - The upcoming JA in July 2017 will look at the recent equity findings of a Dec 2016 equity assessment to adjust strategy for 2018+
2. Fiduciary Risk - Putting mitigation risk assurance measures in place, including a fiduciary agent, to ensure conditions are met to unlock the new HSS2
3. Health systems strengthening - HSS2 will start in July and will address supply chain and coverage issues to gain positive immunisation outcomes

Area	Status & Trend	Key information
Coverage	→	• Coverage for DTP3 has historically been growing but is now stagnating (78% as per WUENIC data in 2015). Uganda has introduced several new vaccines lately, and the country has focused on introductions and campaigns rather than strengthening immunisation in hard to reach areas • HPV campaign has taken place in 2015; MenA campaign in January 2017. Rota campaign is currently on hold due to global supply (it will potentially be done by the end of 2017). The country is currently applying for HPV multi cohort campaign
Equity	→	• Some geographical inequities exist : Urban poor, migrants, ethnic minorities, some religious groups (esp. Muslims), those in new settlements, fishing communities, refugees, remote rural, island and mountainous communities, and those having to travel far for immunisation and/or having to pay transport costs ($3) are least likely to be immunised. • Wealth and maternal education remain less challenging with 0 and 3 percentage point difference in DTP3 coverage in 2015, respectively.
Demand	↗	• A key barrier to demand is the weak health education. There are generally low levels of awareness in young men and women (e.g. on HIV prevention) and gender disparities exist (e.g. in access to education). • Though remaining at low levels, demand has increased in the past years
Supply Chain	→	• Latest EVM (79% in 2014) shows supply chain has improved considerably at the national level - however, at district and health facility level little implements have been seen with numerous 'last mile' issues • A key challenge is the lack of predictable funding flows from the central to district and to health facility level, resulting for example in disruptions of vaccine distributions from district stores to lower health facilities • CCEOP has been approved (will start in July)
Data Quality	→	• Data quality is an issue in the country (10 percentage points difference between admin and survey in 2015) - particularly at district/Health facility levels and in determining accurate population/birth data (e.g., for coverage calculations). A Data Quality Self Assessment was carried out in 2013 and found on average districts met only 63% (health facilities 58%) of the required criteria well below the required target of 80%. • Data quality is getting more attention however - with web based and SMS based systems having been trialled in districts and PEF funded efforts by CDC to establish District Information Teams across the country to increase Data quality.
Financing & Sustainability	→	• Political will: The government has indicated that it is willing to become more independent in terms of ownership and financing for immunisation - the government is in the process of creating an immunisation fund at national level. However, in practice revenue from consistent growth in Uganda is not being invested in health and Uganda mainly relies on donor funding • The country has defaulted in 2015 but has paid its obligations in 2016; on time payment is expected for 2017
Financial Management & Fiduciary Risk	→	• Historically, there has been significant misuse of donor health funds (notably Gavi and Global Fund money). As a result, funds had been frozen between 2006 to 2013 • As a result, a large share of funds is channelled through UNICEF (e.g. procurement) and WHO (e.g. MenA campaign) • Since 2013 a Fiduciary Agent (FA) has been in place to oversee the HSS grants. Following a PCA in 2016 the role of the FA has been reinforced. • Until the effectiveness of the FA is demonstrated fiduciary risk remains high
Programmatic & Institutional Capacity (LMC)	↗	• The EPI team faces a staffing shortage in the light of new demands on the EPI system resulting from more vaccines being added to the programme. The managerial capabilities of the national EPI team has improved due to an embedded managerial support by Gates-funded CHAI staff. However, performance management practices remain to be strengthened at the interface between the national EPI team and the districts • The ICC is currently not providing adequate oversight, however the wider health sector coordination is working well
HSS grant	→	• The HSS-1 will end in June. It is mainly focused on construction of staff houses and district medical facilities. The grant has historically underperformed due to procurement and financial management issues however new leadership in MoH has brought it back on track. • Overall HSS1 fund utilisation remains low, following stop-start programme - we plan to decommit unutilised funds at the grants closure in June. • HSS2 and CCEOP will start in July
Health Workforce	→	• Health worker vacancy rates (up to 35%) and absenteeism (up to 50%) is high in some districts - a key driver being the lack of regular payment of salaries

Annex F: Country Summary Sheets