SUBJECT:	**COUNTRY PROGRAMMES: STRATEGIC ISSUES**
Agenda item:	07a
Category:	For Decision

Section A: Summary

This update:

- Requests the Board to decide to continue support to Yemen despite the country's continuing defaulter status based on a recommendation by the Programme and Policy Committee (PPC) (see under 1 in Section B).
- Presents two programmatic challenges that were discussed by the PPC for further guidance from the Board:
  - balancing risk assurance with the need for timely and predictable HSIS funding, and with ensuring country ownership and sustainability of programmes (see under 2 in Section B).
  - sustaining progress in introducing pneumococcal and rotavirus vaccines (see under 3 in Section B).
- provides a high level cross-portfolio overview of PEF tier 1 countries' performance (see under 4 in Section B) for the Board's information and feedback.

A case study presenting Pakistan's recent progress towards improving equitable and sustainable immunisation coverage and describing how Alliance partners have come together to support the country in reaching more children with vaccines is provided in Doc 07b.

Detailed information on the Alliance's in-country operations, activities, achievements and challenges is provided in Annexes A through F. The PPC also discussed the progress made on the implementation of the Country Engagement Framework (Doc 03b to the May 2017 PPC).

Section B: Alliance Update on Country Programmes

1. Improving sustainability of national immunisation programmes and continued support to Yemen

1.1 As discussed in the Strategy Progress Update, 2016 was a record year in terms of country co-financing for Gavi-supported programmes. However, Yemen is an exception to this trend, having not been able to co-finance due

to ongoing conflict. In 2016 the PPC and the Board found that the exceptional circumstances in the country justified the continuation of Gavi support irrespective of Yemen's defaulter status on its 2015 co-financing obligations (see Doc 02g to the December 2016 Board). At the time of the Board decision Gavi had indicated that it would closely monitor the situation in Yemen.

1.2 Since the situation in the country has not improved Yemen has requested that Gavi support be continued irrespective of its default status on its 2016 co-financing obligations. In order to respond to the country's request in a timely fashion and enable Yemen to plan appropriately, a decision on the continuation of support to the country is required as soon as possible. Given its coverage has fallen, Yemen's existing stocks are expected to be sufficient to cover its needs.

1.3 In view of the above, the Gavi Alliance Programme and Policy Committee recommended to the Gavi Alliance Board that it:

Find that exceptional circumstances in Yemen justify the continuation of Gavi support irrespective of its default status on its 2016 co-financing obligations.

2. Challenge 1: Balancing risk assurance with the need for timely and predictable HSIS funding, and with ensuring country ownership and sustainability of programmes

2.1 Health Systems and Immunisation Strengthening (HSIS) grants are a key tool to enable countries to strengthen their immunisation programmes and improve coverage and equity. The PPC and Board have underscored the importance of ensuring HSIS[1] investments are disbursed as efficiently as possible, and that these should not be unnecessarily delayed by Secretariat or Alliance processes (in line with Aid Effectiveness principles[2]). The Secretariat has reduced the time taken to disburse HSIS funding from 13.6 months (following Independent Review Committee recommendation) in 2015 to 11.6 months in 2016. However, this is still significantly above the target of nine months.

2.2 A key driver of the delay in disbursement of HSIS support has been the Alliance's efforts to enhance management of fiduciary risk. In 2014, the Board approved a new risk policy and a risk appetite statement which specifies that "the Alliance will *not tolerate* misuse of funds, and it will always seek reimbursement for any identified cases. It will manage fiduciary risks through an effective system of controls."[3]

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[1] Under the HSIS Framework, Health System Strengthening (HSS) grants, Vaccine Introduction Grants (VIGs), operational support for campaigns (Ops), and other cash grants supporting immunisation programmes, are collectively referred to as Health System and Immunisation Strengthening (HSIS) support

[2] http://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm; http://www.oecd.org/dac/effectiveness/Busan%20partnership.pdf

3 The Board will consider an updated risk appetite statement at this meeting.

2.3 Following the 2014 Board decision, the Secretariat has scaled up key risk tools including Programme Capacity Assessments (PCAs) and programme audits. Since the Board decision, 19 audits and 34 PCAs have been carried out or are in progress. These have primarily been in higher risk countries and most have identified weaknesses in financial management processes and capacity which create fiduciary risks related to the use of Gavi support. In many cases, disbursement of HSIS funds has subsequently been delayed while countries address these weaknesses (as has been highlighted by the latest Full Country Evaluations).

2.4 To ensure both, timely and predictable HSIS funds and appropriate management of fiduciary risks, the Secretariat is exploring several options, including by drawing on the experiences of the Global Fund and our Alliance partners. Some of these options have implications for countries' ownership of grants and programmes, and thereby potentially for the sustainability of programmes.

(a) In line with its model Gavi's preference and default approach is to provide support through government systems. However, where significant fiduciary risks are identified and where countries do not have sufficient capacity the Secretariat has continued to **channel funding through partner agencies** while simultaneously supporting the country to strengthen its systems and address capacity gaps. In 2016, two thirds of Gavi HSIS support was channelled via Alliance partners in 37 countries (this increased from one third of HSIS support and 20 countries in 2013). This trend was primarily because of increased awareness of and reduced appetite for fiduciary risk, and is likely to continue as strong countries transition out of Gavi support and the portfolio is more focused on fragile and low performing countries. Channelling through partners does not necessarily ensure predictable or timely funding for a number of reasons including partners' own internal accountability administrative and fiduciary risk management processes, additional negotiation needed with governments to administer funding through a "third party", lack of partner capacity to manage the funds (it can for example take significant time to add adequate human resources to the country offices managing the funds) and/or because of the challenges for partners when disbursing in weak and fragile settings. Channelling through partners also adds significant transaction costs (in the form of institutional overhead), might put a considerable burden on partners or strain a partner's relationships with a country and may not necessarily provide Gavi with sufficient assurance as financial reporting is limited. Finally, channelling funds through partners can also undermine efforts to build or strengthen countries' public financial management systems, and limit country's ownership of grants and programmes. In the case of transitioning countries this could potentially pose a risk to countries' successful transition from Gavi support. To address some of the challenges identified above the Alliance is exploring a more systematic approach to partners managing fiduciary risks related to Gavi support, while also enhancing efforts to build country capacity. This includes exploring

how to better use the programme support cost paid to the partners to manage Gavi's support (~7% of Gavi grant) to ensure that appropriate capacity is available at Alliance partners' country offices to manage Gavi funding.

(b) In rare cases, where a **Fiduciary Agent (FA)** is considered to be better placed to build necessary in-country financial management systems and/or where FAs are considered to provide greater transparency over how funds are used in a specific country context, the Secretariat has begun exploring the use of FAs. To date FAs are in place in Uganda, DRC, and Madagascar and planned in Nigeria and Chad. Gavi is also exploring the use of other assurance services, such as Monitoring Agents (MAs), where appropriate. FAs are typically embedded as part of the financial system and therefore provide direct control over how Gavi funds are used while MAs are not embedded and provide assurance through a tailored programme of review and testing of controls and processes. By providing more robust control/ assurance over of fiduciary risk, FAs or MAs can help improve timeliness and predictability of funds. Yet, they come with a cost (FAs cost around 5% or more of the Gavi investment depending on size of grant and scope or work). In addition, both FAs and MAs require significant oversight from Gavi, both before and once installed and it can take time to install them. Further, these agents' primary focus is on risk mitigation rather than on building country systems. However, Gavi's recent approach includes a capacity building component within the contract. In the case of transitioning countries using a FA could potentially pose a risk to countries' successful transition from Gavi support, particularly where FAs do not include a capacity building component. The track record so far in DRC and in Uganda (Madagascar is very recent), is reasonably positive in that they have helped reduce the risk of misuse, built some capacity and enabled more timely and predictable disbursements.

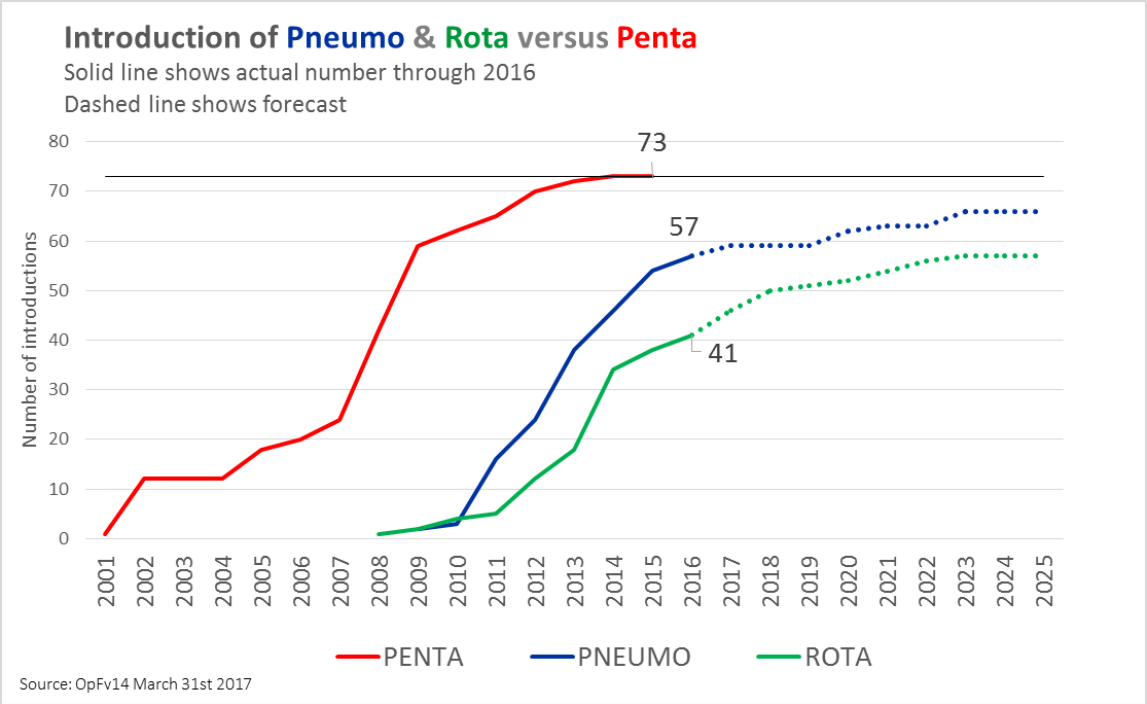
(c) Finally, where appropriate the Alliance could categorise countries based on the level of risk and require lighter processes for countries that have had clean previous audits or have been assessed to be at low risk. This could accelerate timeliness of disbursements in higher performing countries but would not directly address the issue in higher risk countries, which are often those in most need of HSIS support.

2.5 PPC members acknowledged the complexity of this issue and that the risk appetite of key constituencies has shifted over recent years, with some PPC members recommending that the Alliance prioritise the minimisation of fiduciary risk above other considerations. This would for example mean always channelling support through alternative mechanisms (e.g. via partners) whenever there were any questions on the robustness of a country system. PPC members recognised that this could impact the Alliance's ability to disburse funds in a timely and predictable manner to strengthen coverage and equity and/or to build sustainable capacity in countries. Some PPC members further questioned the effectiveness of fiduciary agents in managing Gavi support. Other members noted that funds channelled

through partners are often then disbursed to governments and partners may not always be equipped to closely monitor or report on their use (this also incurs a significant overhead charge). The PPC also noted that managing Gavi support can put a considerable burden on partners. Nonetheless, a number of PPC members indicated that channelling funds through partners is the preferred option in situations where country systems are not sufficiently robust. PPC members asked that the Secretariat pro-actively work with partners to explore a more systematic approach to partners managing fiduciary risks related to Gavi support, including ensuring adequate capacity in partners' offices to manage fiduciary risks, while also enhancing efforts to build country capacity including through the ongoing workstream on leadership, management and coordination.

3. Challenge 2: Introduction of pneumococcal and rotavirus vaccines

3.1 In the 2011-2015 period, Gavi exceeded its vaccine introduction targets (Pentavalent: Introduced in 73 countries (target: 60); PCV: introduced in 54 countries (target: 45); RV introduced in 38 countries (target: 33). By 2016, PCV had been introduced in 57 countries and RV vaccines in 41 countries (as illustrated in the chart below). However, a number of countries (7 for pneumococcal (PCV) and 10 for rotavirus (RV) vaccines) are projected to transition from Gavi support without having introduced PCV or RV vaccines. Furthermore, four Gavi countries are ineligible to introduce these vaccines since their DTP3 coverage rate is below the 70% threshold.



Pneumococcal conjugate Vaccine (PCV)

3.2 India has introduced PCV in a phased approach starting in May 2017 and Haiti is forecasted to introduce PCV in 2018, meaning 59 countries will have

introduced. The remaining 14 (of the 73 Gavi countries) can be grouped as follows:

a) Currently eligible and expected to introduce by 2020. Three countries, Comoros, Korea DPR and Tajikistan, are eligible according as their DTP3% coverage is >70%[4].

b) Not currently eligible, but some of which may introduce by 2025. Four countries, Chad, Guinea, Somalia and South Sudan are not currently eligible since their DTP3 coverage is below 70%.

a) Countries in the accelerated transition phase or countries which have already transitioned from Gavi support. Six countries (Bhutan, Sri Lanka, Ukraine, Indonesia, Timor Leste and Vietnam) are in the accelerated transition phase or have already transitioned from Gavi support; of these, Indonesia is considering self-financed introduction.[5]

Rotavirus Vaccines (RV)

3.3 Two countries (Pakistan[6] and Côte d'Ivoire) have already introduced RV in 2017, and five additional countries (Lesotho, Uganda, Central African Republic, DRC, and Afghanistan) are expected to introduce by the end of the year. In 2018, 3 more countries (Nigeria, Bangladesh, and Benin) are expected to introduce, bringing the total to 51 countries. Some of the 2017 and 2018 introductions may be delayed due to ongoing supply constraints[7].

3.4 22 countries are not expected to have introduced by the end of 2018. These can be grouped as follows:

a) Currently eligible and expected to introduce by 2025. Comoros, Myanmar, Nepal, Kyrgyzstan and Solomon Islands

b) Currently eligible but not expected to introduce by 2025. Cambodia, Korea DPR and Lao

c) Not currently eligible, but some of which may introduce by 2025. Chad, Guinea, Somalia and South Sudan are not currently eligible as their DTP3 coverage is < 70%.

d) Countries in the accelerated transition phase or countries which have already transitioned from Gavi support; none of which will introduce RV with Gavi support. Ten countries (Bhutan, Sri Lanka, Indonesia, Ukraine, Mongolia, Cuba, Azerbaijan, PNG, Timor-Leste and Vietnam) are in the accelerated transition phase or have already transitioned from Gavi support; none of these countries will introduce RV with Gavi support, but some are considering self-financed introduction and are

[4] Gavi's new vaccine support is contingent on countries having DTP3 coverage above 70%
[5] Indonesia is conducting a pilot on PCV and considering national introduction
[6] Pakistan conducted a partial introduction in 6 districts in the Punjab province with their own self-financing. The continued national roll-out starting in around July will be supported by Gavi.
[7] See Annex A

conducting disease burden studies with partner support.[8]

3.5 Obstacles to the introduction of vaccines vary by country, however one challenge is that with constrained health budgets, countries must prioritise these vaccines over other vaccines or health interventions. This, coupled with decreasing disease burden, increasing focus on financial sustainability, and the increasing number of Gavi-supported vaccines, may influence countries to not introduce PCV or RV. Gavi works with the country to enable an informed decision on the introduction of these vaccines and, through the collaborative efforts of partners, offers countries assistance in managing these obstacles.

3.6 For countries with DTP3 coverage of under 70%, Gavi will continue to support the strengthening of their health systems to enhance the probability that these countries will achieve eligibility status and have the opportunity to make informed decisions on the introduction of PCV and RV.

3.7 In their discussion of this topic PPC members noted that a pro-active, evidence-based and country by country approach is needed to sustain progress in introducing these vaccines. PPC members also requested that the Secretariat explore whether countries should be able to apply for new support throughout the accelerated transition process (as opposed to just the first year as is currently the case). Lastly, PPC members indicated that limited catalytic support may be helpful to countries that have transitioned and not yet introduced these vaccines. The Secretariat will explore these possibilities as part of the follow-up to the April Board Retreat, and bring options to the Board for discussion in due course.

4. Country Portfolio Overview

4.1 The Secretariat has explored how to make available to the Board more systematic updates on progress in each Gavi country and across the portfolio of countries. To this end the Secretariat has developed "**country portfolio summary sheets**" ("summary sheets") and a "**cross portfolio overview**", representing a high-level systematic snapshot of performance across key thematic areas to provide additional context and country-specific overviews to inform PPC and Board discussions.

4.2 The cross portfolio overview shows a 'heatmap' (see picture on page 11) of the PEF tier 1 countries' current performance in a number of key thematic areas and captures performance trends through trend arrows. It shows that equity, data quality and number of health workforce are major concerns across nearly all PEF tier 1 countries. It also shows that Nigeria and Chad are the countries that face the most issues, closely followed by Afghanistan, Ethiopia and Pakistan.

4.3 Underlying the cross portfolio overview are country summary sheets, containing general contextual information for each country and additional strategic information across the above mentioned key thematic areas (see

[8] Indonesia and Timor-Leste

picture on page 12 for an example and Annex F for summary sheets for all other PEF tier 1 countries as well as for a description of indicators used in the summary sheets). To date summary sheets have been developed for the ten PEF tier 1 countries.

4.4 The PPC was appreciative of these information sheets and indicated that they were useful, while recognising the challenge of reflecting the full complexity of each country context in a short summary. Going forward and based on PPC 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. The Secretariat would welcome the Board's feedback on the information presented.

CROSS PORTFOLIO OVERVIEW

Area	Afghanistan	Chad	DRC	Ethiopia	India	Indonesia	Kenya	Nigeria	Pakistan	Uganda
Coverage	↗	→	↗	→	↗	→	→	↗	↗	→
Equity	→	→	↗	→	→	→	→	→	→	→
Demand	↗	→	→	↗	→	→	↗	→	→	↗
Supply Chain	→	→	↗	→	↗	↗	→	↗	↗	→
Data Quality	↗	↘	→	→	→	→	↘	→	↗	→
Financing & Sustainability	→	↘	→	→	↗	↗	→	→	↗	→
Financial management & fiduciary risk	→	→	↗	→	→	→	→	↗	↗	→
Programmatic & Insitutional Capacity (LMC)	↗	→	→	→	→	→	↗	→	↗	↗
Health Systems Strengthening	↗	→	↗	→	→	→	—	→	↗	→
Health Workforce	→	↘	→	↗	→	→	→	→	↗	→

India

Country Summary Sheet
Tier 1 country

Country General Information

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

Indicator	Year	Value	Gavi 68 rank
# under-immunised (DTP3)	2015	3.2m	1
% GPF targets achieved	2015	73%	10
# PEF positions funded	2016	11	4

Vaccine introductions	
Introduced	IPV, Penta, Rota*, MR*, PCV*
Expected	

* Selected states only - PCV introduced as of May 14th, 2017 as part of UIP

Gavi commitments vs disbursements (all time)		
Type	Commitments	Disbursements
Cash	$125m	$125m
Vaccine	$615m	$382m

Top 3 Areas for Gavi Engagement

1. Equity - HSS2 grant with a primary focus on low performing states and includes equity-focused targeted interventions (notably for urban & tribal areas)
2. Cold Chain - HSS grant supports cold chain improvements and digitisation of the country's vaccine logistics management system, to improve cost efficiencies in the system with the expansion of new vaccines
3. Demand - HSS grant is being used towards increasing demand (e.g. communication planning and training, institutional system strengthening, CSO partnerships, media engagement)

Area	Status & Trend	Key information
Coverage	⇗	• Coverage has increased in the past few years with 87% DTP3 coverage in 2015 according to WUENIC data, due to increased political will (notably since 2012) to intensify routine immunisation • Lessons learnt from (transitioning) polio efforts are contributing to the strengthening of India's routine immunisation programmes
Equity	⇨	• Key barriers to equity are geographic, urban vs. rural, wealth and linked to the caste system • There are large inequities in wealth and mother's education, with 25 and 26 percentage point differences in DTP3 coverage in 2012. • Mission Indradhanush has been launched by the government in 2014 to focus on poorer performing distracts (in terms of numbers of under-immunised children) • HSS2 is proposing to focus on low performing States and the development of more tailored interventions in urban areas and for
Demand	⇨	• 2/3 of the reasons for children missing immunisation (based on concurrent monitoring data) are associated with factors related to mis-information on vaccination or fear of adverse-events following immunisation • Anti-vaccine sentiments and lobbyists remain a concern in the country • HSS2 proposes to support further efforts around strengthening interpersonal skills of frontline health workers, working for example with Urdu media. However, further efforts to institutionalise the demand generation approach in light of vaccine hesitancy and anti-vaccine issues in country remain.
Supply Chain	⇨	• Latest EVMA assessment in 2013 showed an aggregate score of 53%, though with significant improvement in the past years • HSS1 support has been used to improve supply chain, including by digitising the country's vaccines logistics management system and by making continued EVM assessments • There is a strong commitment by the Government to seek to improve cold chain and further technology advancements (e.g.: eVIN - Electronic Vaccine Intelligence Network and beyond)
Data Quality	⇨	• There is only a 9.3 percentage point discrepancy between administrative and survey data (2014); however, there are still multiple data sources and systems due to size of the country. Data issues go far beyond immunisation • The government is currently making efforts to digitise the way data entries are being done by frontline immunisation workers • Data quality improvement necessitates concerted efforts from different players, beyond those in the immunisation programme
Financing & Sustainability	⇗	• Political will: the government's immunisation budget has doubled in 2017 compared to 2013, though % of GDP invested in public health is currently very low (1.4%) - New Health Policy indicates almost a doubling of the percentage expenditure to 2.5% by 2025. • Gavi support represents 5-12% of the Government's overall immunisation budget (varies depending on the year) • The government has a good track record in sustaining Gavi programmes (as evidenced by Hep B, Penta, IPV, infection safety devices)
Financial Management & Fiduciary Risk	⇨	• Fiduciary risk is overall low in India • Cash is currently not channelled through the government. However, this is not a reflection of fiduciary risk - it is mainly due to the fact that there would be lengthy legal process implications that would ensue if funds are routed through the Government
Programmatic & Institutional Capacity (LMC)	⇨	• Capacity at the national EPI level is limited, so partners' TA support is important. However, progress has been made with the formation of state and district level taskforces on immunisation to guide/monitor programme implementation at the sub-national levels • EPI teams are relatively skilled, but programmatic capacity in the Government and partners are stretched given the significant expansion of EPI with new vaccines • ICC equivalent forums exist but they currently only meet on an ad-hoc basis. Efforts have started to increase frequency of high
HSS grant	⇨	• HSS1 received a no cost extension in 2017. Funds utilisation (81% in 2015) has been lower than expected due to delayed signing of the Partnership Framework Agreement • HSS2 grant proposal is being finalised - mainly focusing on sustainability and cold chain equipment. While HSS1 implementation rates have been good, HSS2 seeks to bring greater emphasis on expected intermediate results
Health Workforce	⇨	• Gaps remain to upgrade knowledge of health workers around vaccination. Training and capacity strengthening are focus areas of HSS2, particularly for frontline health workers (ANMs, ASHAs, AWWs) • Vacancies among frontline workers remain an issue in some states

Annexes

Annex A: Accelerating the equitable uptake and coverage of vaccines: Update on Gavi supported Vaccine Programmes

Annex B: Increase effectiveness and efficiency of immunisation delivery as an integrated part of strengthened health systems: Update on Health Systems Strengthening efforts

Annex C: Improve sustainability of national immunisation programmes: Update on Co-financing and Transition

Annex D: Update on specific countries (Nigeria, India, Pakistan, DRC and Syria)

Annex E: Update on the progress achieved in the Strategic Focus Areas

Annex F: Country Summary Sheets