

SUBJECT: COUNTRY PROGRAMMES: STRATEGIC ISSUES

Agenda item: 07a

Category: For Information

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Section A: Overview

1. Executive Summary

- 1.1 This paper is one of two papers (07a and 07b) on strategic issues relevant to Gavi's Country Programmes. This paper, paper 07a, provides key highlights from the Alliance's in-country work that have emerged since the last update on Country Programmes to the Board (more detailed information on the Alliance's in-country operations, activities, achievements and challenges, is provided in Appendices A through F). As requested at the last Programme and Policy Committee (PPC) and Board meetings in May and June 2016 paper 07a also provides an overview of how the Alliance's investments, technical support and grant and risk management all come together to help strengthen coverage and equity, ensure sustainability, and better manage risk in countries. Paper 07b asks the Board to take a strategic decision with respect to additional funding for the Cold Chain Equipment Optimisation Platform.

2. Key programme and country updates

- 2.1 This section provides key highlights from the Alliance's in-country work, focusing on major developments across the portfolio. An overview of performance across the Gavi portfolio of countries against the Alliance's strategy is provided in Doc 03. Going forward, the Secretariat will explore how to make available to the Board a systematic update on progress in every Gavi country.
- 2.2 **Nigeria** is one of the most challenging countries in Gavi's portfolio. It has the second highest number of under-immunised children in the world and DTP3 coverage is below 60%. Recent developments, including a measles campaign which achieved only 84.5% coverage, and the discovery of four case of wild poliovirus which had been circulating undetected since 2011, illustrate the weakness of the immunisation programme. The recent extended audit identified significant misuse and systematic weaknesses, and is yet to be fully closed. Moreover, the country will enter accelerated transition in 2017. To address these issues, the Gavi CEO and Global Fund Executive Director visited Nigeria in July to meet with His Excellency the President, the Minister of Health and the Minister of Finance. During this

visit, Gavi received a commitment from the Ministries of Finance and Health to immediately set up a coordination mechanism to address the systemic weakness identified by the recent audits and to reimburse the misused funds. The latter commitment was subsequently confirmed in a letter from Nigeria's Minister of Finance (subject to inclusion in 2017 budget). Since the visit the government has announced changes in the leadership of the National Primary Healthcare Development agency (NPHCDA) and the new leadership has committed to implementing a comprehensive action plan to strengthen the immunisation programme. Gavi will continue to work closely with the new leadership and is planning a high-level cross-Alliance visit in the first half of 2017 to build on this momentum and help catalyse further progress (additional information is provided in Appendix D).

- 2.3 As of November 2016 **DRC is no longer in default** of its 2015 co-financing obligations. As of October DRC was the only country that still remained in default of its 2015 co-financing obligations (US\$ 8.3 million). While the Prime Minister, in June, ordered the payment of US\$ 1 million each month for the following four months, no payments had been made by September. After extensive follow up by the Gavi Secretariat, a network of parliamentarians for immunisation and in-country partners, the Prime Minister ordered a payment of US\$ 2.5 million for co-financing in October, and a subsequent payment of US\$ 1.5 million in November. Both payments have been confirmed by the UNICEF Country Office (additional information in Appendix D).
- 2.4 **India:** The first year of the new India partnership has been marked by significant progress, with the smooth transition of pentavalent vaccine and IPV from Gavi to Government financing, and self-financed introduction of rotavirus vaccine in four states. Early 2017 will see the roll-out of PCV in 4 of India's states with the highest number of under-immunised children, followed by the first phase of an MR campaign while discussions are under way on introducing rotavirus vaccine to additional states and on the design of the country's final health system strengthening (HSS) grant. The recent pentavalent tender also demonstrated the potential impact of India's programme on market shaping. The large volume increase from India as it scaled up nationally with Gavi's catalytic support, combined with Gavi's large procurement volumes, and an increasingly healthy supply base helped achieve price reductions of approximately 50% from 2017 (additional information in Appendix D).
- 2.5 **Pakistan:** In August, the World Bank formalised its agreement with the Government of Pakistan for the **National Immunization Support Project (NISP)**, the country's overall budget and workplan for immunisation. With a total budget of US\$ 370 million over 5 years, financed jointly by the federal and provincial governments and development partners including Gavi, the NISP will help increase the availability of vaccines in all provinces of Pakistan. The Multi-Donor Trust Fund model, used to fund the NISP, will help ensure a streamlined and sustainable financing structure for the immunisation programme by aligning multiple donor and government sources of funding around the same indicators with tailored targets for each

province. However, Planning Commission documents, known as PC-1s, are required to be approved for the flow of funds to EPI departments in provinces. Only Punjab has to date passed all the required approvals and therefore, for other provinces, no funds can flow for programme implementation at this point. Further, the World Bank has yet to announce the NISP coming into effect, which is pending clearance of all legal opinions received from government signatories (federal and provinces) (additional information in Appendix D).

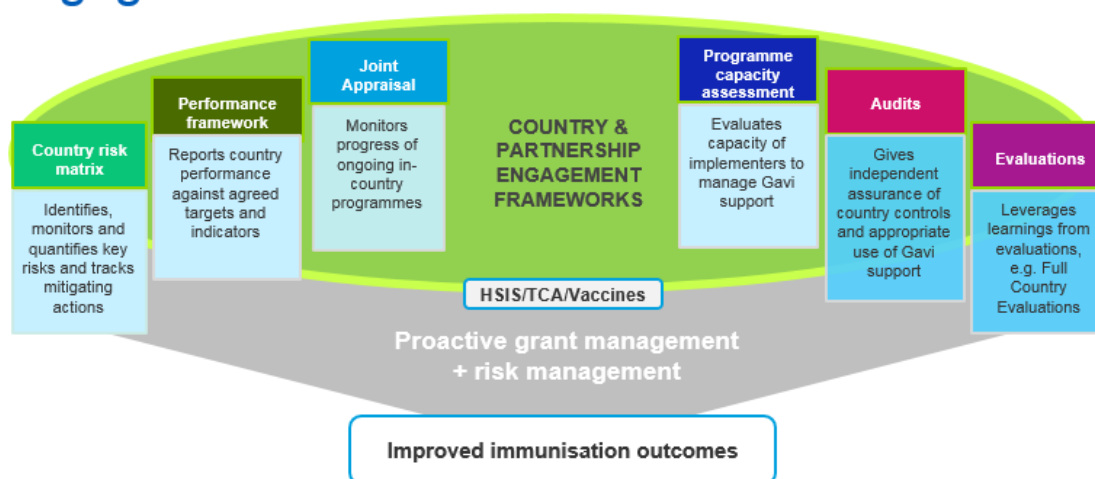
- 2.6 **Niger:** In July Niger fully reimbursed all outstanding funds that had been identified as misused funds through a 2011 Financial Management Assessment and investigation. The final payment of in the amount of US\$ 645,000 brings the total amount of repaid funds to US\$ 2.1 million.
- 2.7 The four countries that have already transitioned from Gavi support have done so successfully. However, among the **countries projected to transition over the coming years several remain at risk of not doing so successfully** (Transition readiness has been identified as one of the top risks for Gavi (see Doc 11)). Penta3 coverage in **Angola** and **Congo Republic** has declined due to a variety of factors including ongoing economic crisis, chronically under-funded health systems and vaccine stock outs due to the countries' delayed co-procurement. Alliance partners and the government, using the countries' transition grants, HSIS and Targeted Country Assistance (TCA) resources, are working closely with in-country partners and other stakeholders to reverse this trend. Both countries are also in the process of applying for HPV and MR catalytic support, which will bring public health benefits but might also increase the programmatic and financial risks for their successful transition. **Indonesia** also has stagnant Penta3 coverage, which could result in them transitioning with a large cohort of under-immunised children while **Papua New Guinea (PNG)** and **Nigeria** (discussed above) are both entering accelerated transition in 2017 with very low coverage. PNG has DTP3 coverage of 62%, vaccine and financial management problems at all levels and a major national public finance and cash flow crisis (for additional information see Appendix C). The PPC has requested a deep dive on transition issues at its May meeting and transition risks may also be a topic at the April Board Retreat.
- 2.8 **Cholera:** In early October, Hurricane Matthew struck Haiti causing devastation and a surge in the number of Cholera cases. As an immediate response and at the request of the country, the Alliance deployed 1 million doses of oral cholera vaccine (OCV) for Haiti. The vaccines are funded through Gavi's support of the global cholera stockpile. The vaccination campaign began on 8 November targeting individuals over 1 year of age in the departments most affected (Sud and Grand'Anse). The vaccination campaign utilises a 1 dose strategy and targets ~800,000 persons with the goal to reduce the burden of cholera. As of 15 November, more than 550,000 persons have been vaccinated.

3. Revised approach to Gavi engagement at country level

- 3.1 Achieving the goals set out in Gavi's current strategy demands effective and efficient scale-up of Alliance's programmes and a change to how the Alliance is doing business. As a result the Alliance's approach has become more **country-centric** with interventions being better tailored to countries' needs, contexts and opportunities, while building **in-country capacity** and strengthening **countries' ownership and political commitment**. Gavi is also more **pro-actively** managing its grants and has significantly strengthened its programmatic and financial **risk management**.

Picture 1

The Alliance has made important changes in how it engages with countries



The Alliance's approach has been revised along three dimensions, seeking to a) **better understand countries' needs**, challenges and capacity gaps (e.g. through Programme Capacity Assessments and Country Risk Matrices); b) better **target Alliance support to address those needs** (e.g. through HSIS, Targeted Country Assistance through PEF and as being piloted through the Country Engagement Framework); and c) support countries and the Alliance to better **monitor** the performance of their programmes and **adapt** accordingly (e.g., through Joint Appraisals, Performance Frameworks, audits and evaluations). To this effect the Alliance has introduced a number of new tools or processes and/or revised existing ones (as shown in picture 1). Many of these new tools and processes are currently being scaled up. Given the newness of some of these processes the Secretariat and Alliance partners are still working on refining and aligning them based on lessons learnt. The following section describes how these tools and processes have been applied in **Kenya** to

advance coverage, equity and the sustainability of programmes and to strengthen risk management.¹

4. Illustrative Example: Kenya

- 4.1 Kenya is a **priority country** for Gavi with 370,000 underimmunised children per year, a birth cohort of approximately 1.5 million children and total Gavi investments of around US\$ 417 million since 2001.
- 4.2 Kenya **faces several challenges**. It devolved its health system in 2013 meaning that immunisation programme implementation is managed by 47 autonomous counties with variable (and frequently low) levels of capacity and varying prioritisation of health / immunisation. DTP3 coverage has declined from 84% in 2013 to 78% in 2015, although data systems are also poor, making an exact determination of coverage challenging. Coverage has declined particularly significantly in certain counties creating growing inequities. The country has just entered preparatory transition which means that its co-financing requirements will begin to grow, and it is projected to enter accelerated transition in 2021. Given historic concerns about financial management capacity and non-compliance with Gavi reporting requirements, HSIS has been channelled through UNICEF since 2011.
- 4.3 The Secretariat's **Coverage & Equity** team (see Appendix E) has prioritised support to Kenya, notably to ensure that the new HSS proposal has a strong Coverage & Equity lens including, for example, a focus on work in urban slums. WHO and UNICEF, together with MOH leadership, are also prioritising work on coverage & equity including a county-level workshop to analyse bottlenecks and develop plans to strengthen equity.
- 4.4 Due to staffing limitations, prior to May 2015, SCM oversight of Kenya changed frequently and the SCM covered 9 other countries. However, there has been an **increased engagement** since the onboarding of an SCM with increased time for Kenya (currently covering Kenya plus only one other lower-risk country) in May 2015, and the establishment of a country team (a team composed of representatives of key technical teams in the Secretariat set up to achieve more effective and efficient management of Gavi grants in Kenya) in the beginning of 2016. WHO and UNICEF have played a key role in supporting the Government of Kenya (GoK) to keep the immunisation programme resilient in the face of devolution since 2013. The Gavi Secretariat has had very active engagement in Kenya since May 2015, and has been working hard with Alliance partners to get Gavi's support in Kenya 'back on track'.
- 4.5 Since Kenya did not provide audit reports to Gavi, Gavi redirected all its cash support via UNICEF from 2011 onwards. Seeing no improvement in Kenya's reporting, Gavi requested a **programme audit** which started in late 2015 to examine past financial management practices and use of Gavi

¹ A detailed description of the new or revised tools and processes and their interlinkages as well as of the challenges and major learnings associated with them may be found in the Country Programmes Update to the October 2016 PPC.

funds, and to highlight areas needing future attention. Among other findings, the audit identified

- (a) a cash balance in country (~ US\$ 250,000) that needed to be returned to Gavi
- (b) inadequately supported expenditures (~US\$1.6 million)
- (c) 586,000 missing doses of PCV, and
- (d) systemic weaknesses in Kenya's financial and vaccine management practices.

4.6 After extensive follow up by the Gavi Secretariat and Alliance partners, the GoK fully reimbursed the unaccounted funds (US\$ 1.6 million) on 13 October, ahead of the 15 October deadline. The Secretariat continues following up on (b), (c) and (d).²

4.7 To build on the audit findings and inform future Gavi support to help address identified weaknesses, a **Programme Capacity Assessment (PCA)** was undertaken in Q1 and Q2 2016. This reviewed the programme, financial and vaccine management capacity of implementing agencies in Kenya to manage funding, programmes and vaccines. It recommended that ultimately HSIS support should again be channelled through government systems once they were sufficiently strengthened. However, given weaknesses in government financial management systems at county level, and following recent revelations of potential fund misuse within MOH, the Secretariat and partners agreed that HSIS support should continue to pass through UNICEF in the short-to-medium term. The audit and PCA recommendations have been translated into a number of **Grant Management Requirements** to strengthen vaccine and financial management and assurance, including:

- (a) Setting up a coordinating unit that is embedded in the Ministry of Health EPI team and that is responsible for overseeing Gavi programming and funds, and potentially that of other donors
- (b) Setting up a temporary independent monitoring agent outside of the ministry that reports directly to Gavi, which supports the GoK to set up the necessary systems, and subsequently will monitor how funds are being managed and how activities are implemented in-country
- (c) Hiring more staff at national and regional vaccine stores and increasing compliance with national stock management standards

² It is worth mentioning that there have been recent reports of potential substantial fund misuse in the Ministry of Health in Kenya following a leaked internal audit report. To date there is no indication that Gavi funds were inappropriately used.

- 4.8 A **Country Risk Matrix** (CRM) is used by the Secretariat's Kenya country team to identify and document major programmatic and financial risks, including issues identified in the PCA and audit, and to help the Alliance prioritise and structure its mitigation actions. The CRM currently identifies three major areas of risk, pertaining to the country's vaccine management, programme governance (MoH management, ICC, HSCC) and financial management and these are key focus areas in the country team's prioritised work plan. The CRM, among others, has also been used to outline the agenda of the annual Joint Appraisal.
- 4.9 **Joint Appraisals** (JA) were held in 2015 and 2016, allowing the country and Alliance partners to take a holistic view of all immunisation programmes ongoing in country. The 2015 JA introduced a **Grant Performance Framework** (GPF), which provides a single, agreed set of metrics and indicators on both vaccine and HSS progress and status of cash grants to measure results and review progress and will be discussed systematically in JAs going forward. Key issues and decisions discussed by the country, partners and the Secretariat during JAs include:
- (a) The 2015 JA helped shape the country's new HSS grant, and the 2016 JA justified the need for Kenya's prioritisation of supply chain activities, and the application to the **CCEOP** (~US\$ 13 million), which was approved by the November 2016 IRC.
 - (b) Prioritisation of **support on data**: the 2015 JA had identified a need to work on the improvement of data quality and 2016 PEF TCA included partner support for data quality accordingly. Data improvement is also an important component of the new HSS proposal.
 - (c) Strengthening of **coordination and oversight** at country level: While an Interagency Coordination Committee (ICC) exists in Kenya, its functionality is limited and it lacks the membership necessary for effective oversight. One practical issue identified by Kenya's Principal Secretary was the need for technical assistance to strengthen the ICC and to support basic secretariat functions. The Secretariat is looking to address this request through its approach to strengthen Leadership, Management and Coordination (LMC – see Appendix F for more details).
 - (d) Work on **sustainability**: Kenya entered preparatory transition this year. JA discussions built on a workshop that had been held in July with Kenyan parliamentarians to advocate for increased domestic resources for health and build political commitment. This message was reinforced when Gavi's CEO subsequently met with a subset of parliamentarians during his visit in August. Parliamentarians had discussed the potential use of legislation to ensure the long-term availability of sustainable domestic funding for health - and particularly immunisation - to be enacted before elections next year. This year's JA discussions stressed the importance of developing a transition plan (with support from Alliance partners, notably the World Bank). The

Alliance has also agreed to align Kenya's co-financing obligations with its fiscal year to help the country meet the annual payment deadline.

- 4.10 Despite these efforts, progress in Kenya's immunisation programme remains a **challenge**, largely the result of the country's devolved health system which has had a significant impact on immunisation coverage and equity. **Strong senior MOH leadership** and Alliance engagement will remain key to improving performance at county level.

Appendices

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| Appendix A: | Accelerating the equitable uptake and coverage of vaccines: Update on Gavi supported Vaccine Programmes |
| Appendix B: | Increase effectiveness and efficiency of immunisation delivery as an integrated part of strengthened health systems: Update on Health Systems Strengthening efforts |
| Appendix C: | Improve sustainability of national immunisation programmes: Update on Co-financing and Transition grants |
| Appendix D: | Update on specific countries |
| Appendix E: | Intensification of Coverage and Equity |
| Appendix F: | Update on Gavi's approach to strengthening in-country Leadership, Management and Coordination (LMC) |

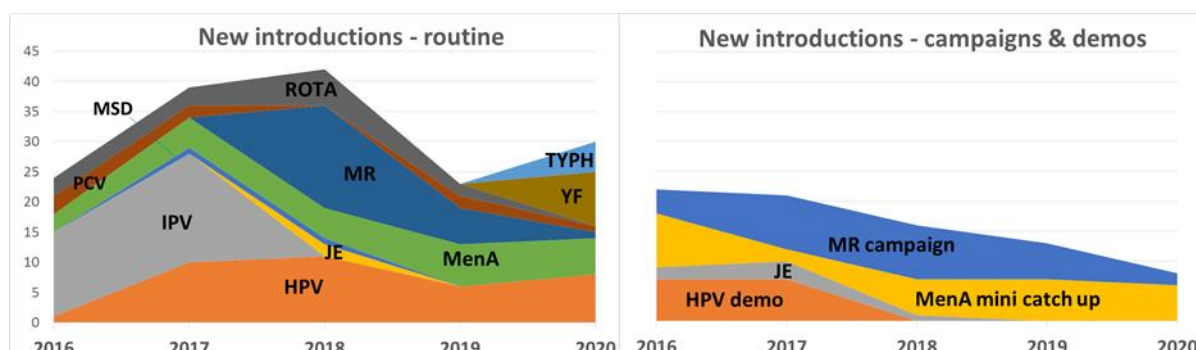
Appendix A: Accelerating the equitable uptake and coverage of vaccines: Update on Gavi supported Vaccine Programmes

1. Introduction

- 1.1 To date there are nearly 300 active vaccine programmes across all Gavi eligible countries. With 200 vaccine introductions envisaged over the 2016-2020 strategic period support for quality vaccine introductions will remain a priority for the Alliance. Each of Gavi's 10 active vaccine programme, whether supported solely as a routine programme, combined routine plus campaign or vaccine stockpile implementation is in a different stage of maturity. This appendix summarises the current status and main strategic issues for each vaccine programme.

2. Introductions and active programmes in the 2016-2020 strategic period

- 2.1 To date there are nearly 300 active vaccine and 100 cash grants across the GAVI eligible countries with a yearly value of vaccine renewals of nearly US\$ 1 billion.
- 2.2 For 2016, ~ 46 new vaccine introductions (NVIs) are expected, with already 41 NVIs having taken place.
- 2.3 For the entire strategic period, more than 200 additional new vaccines introductions are forecasted (see graphic), with introductions into routine programmes accounting for ~ two thirds.



3. Vaccine Programme updates (Vaccine programme updates below are ordered by when a particular vaccine entered Gavi's portfolio of support (earliest to latest).

- 3.1 **Pentavalent vaccine** (diphtheria, tetanus, pertussis (whole cell), Hepatitis B, *Haemophilus influenza b*; routine programme since 2001)
- (a) *Introductions to date:* pentavalent vaccine has been introduced in all 73 Gavi countries since 2014.
- (b) *Strategic issues:* An array of pentavalent vaccine vial sizes is available to countries (1, 2, 5 and 10 dose vials). Gavi is in discussion with several

countries to determine the programmatic feasibility of providing a mixture of vials sizes to respond to different programme implementation scenarios.¹

3.2 Yellow fever vaccine – YFV (routine programme since 2001; support for preventive campaigns and emergency stockpile since 2006) - *Note:* Gavi's support for Yellow Fever vaccine is the subject of two separate Board papers (see the role of Gavi in Yellow Fever and Vaccine Stockpiles papers).

3.3 Pneumococcal conjugate vaccine – PCV (routine programme since 2010)

(a) *Introductions to date:* To date, 57 Gavi countries have introduced PCV with Advance Market Commitment (AMC) support, with recent introductions in Myanmar and Mongolia (the first transitioning country to fully self-fund their PCV programme). India and Haiti have been approved and are expected to introduce within the next 18 months.

(b) *Strategic issues:*

- i. There are currently 14 AMC-eligible countries that have not yet applied for PCV support, but only three countries are Gavi-eligible and meet the DTP3 coverage requirement of >70%: Comoros, Korea DPR, and Tajikistan; these are a priority for the programme and the Alliance. The remaining 11 countries either do not meet the requirement of >70%² or have entered the transition process and need to fully fund the programme from the outset at the AMC tail price.
- ii. Following WHO prequalification and confirmation of AMC eligibility, PCV13 4-dose vials will be available from early 2017 to the ~20 interested countries that have requested to switch from their current PCV presentation. The 4-dose presentation provides a number of benefits for countries, including a lower per-dose price, lower cold chain requirements and possibly increased but likely similar wastage³ (the vial contains a preservative and open, multi-dose vial recommendations can be applied). PCV10 4-dose vials are also expected to become available in Gavi countries from 2018 onwards, with PCV10 2-dose vials being phased out in the same period.
- iii. Efforts are underway to better understand and address the country-specific causes of PCV3 – DTP3 coverage discrepancies of more than 5% points in 12 countries³.

¹ Early data indicates mixed presentations can potentially reduce wastage as well as possibly increase coverage

² Guinea, although it does not currently meet the requirement of 70% DTP3 coverage, is planning to introduce PCV in 2018 through the Country Engagement Framework process. The country would need to meet the 70% DTP3 coverage requirement ahead of the introduction.

³ As per WUENIC 2015 (released July 2016), these countries are Afghanistan, Armenia, Angola, Bolivia, Congo DR, Côte d'Ivoire, Kenya, Lao PDR, Mali, Moldova, Papua New Guinea, and Uganda. This list excludes countries with 2015 introductions or phased introductions (Nigeria) and thus with partial year coverage.

- iv. A SAGE working group on PCV is currently being established in order to review the technical evidence focusing on, among other things, optimal PCV dosing schedules to maximise PCV immune response, herd immunity and impact⁴. The SAGE discussion is scheduled for October 2017; recommendations arising from this discussion may have a substantial implication for Gavi countries (e.g. stronger recommendation towards a 2+1 schedule may have implications for the majority of countries currently on a 3+0 schedule).
- v. Catch-up vaccination of additional age cohorts at the time of introduction to accelerate herd protection and vaccine impact on disease and bacterial carriage is currently under discussion with Alliance and technical partners; it is also part of the scope of work of the SAGE working group on PCVs.⁵ In order to better understand country-level impact and value for money, Gavi and partners have carried out some modelling of PCV catch-up immunisation in Gavi countries; initial results from the modelling indicate a high return on investment.
- vi. Gavi countries are increasingly expressing a preference for the 13-valent PCV; this situation is being closely monitored by the Alliance to ensure a good balance between country preference and PCV supply and will be further discussed as part of the pneumococcal roadmap update that is planned for early 2017.

3.4 Rotavirus vaccine (routine programme since 2009)

- (a) *Introductions to date:* as of November 2016, 41 countries⁶ have introduced rotavirus vaccine into their national immunisation programmes.
- (b) *Strategic issues:*
 - i. Since the last report to the PPC 5 further countries have applied for support to introduce rota, reducing the number of eligible Gavi countries that have not yet applied to 24 (from 29). Two countries introduced in 2016 (Liberia and Sao Tome e Principe) with Gavi support and India started a self-financed Phase 1 of their national roll-out in April. Another 6 countries are planning to introduce in 2017-2018 and 4 countries with large birth cohorts applied in 2016 (Nigeria, Pakistan, DRC, and Bangladesh), which will have a significant impact on vaccine demand.
 - ii. Most countries show a strong product preference for the product following a 2 dose schedule (Rotarix®) largely driven by relevant vaccine characteristics such as cold chain requirements, existence of a vaccine vial monitor, etc. The Alliance is nearing the maximum supply capacity for the preferred vaccine, especially with anticipated introductions in large countries by 2019. The Alliance is responding to this challenge by managing the existing supply and by developing an action plan, including working with manufacturers to understand capacity expansion plans, to

⁴ http://www.who.int/immunization/policy/sage/call_nominations_working_group_pcv/en/

⁵ WHO position paper on PCVs: <http://www.who.int/entity/wer/2012/wer8714.pdf?ua=1>

⁶ Includes countries with self-financed introductions (Kiribati and India in 4 states)

ensure that country product preferences can be met. The strong product preference which led to some supply constraints, compounded with slower uptake in large countries were also the main factors responsible for a lower than anticipated coverage in 2015.

3.5 Human Papilloma Vaccine – HPV (routine and demonstration project with first national roll-out in 2014) - *Note:* An in-depth review of the programme has taken place and programme modifications are presented in a separate paper to the PPC (See HPV paper).

3.6 Measles containing vaccines - MCV (Measles second dose since 2007, MR catch-up campaign and routine introduction since 2013, measles follow up campaigns since 2013; new measles and rubella strategy was approved December 2015)

(a) *Introductions to date:*

- i. By the end of 2015, Gavi-supported measles and rubella programmes had reached 31 countries (20 countries supported for measles second dose, 16 countries for MR catch-up campaigns and 6 countries for measles follow-up campaigns).
- ii. In the first half of 2016, Nigeria completed the second phase of a measles follow-up campaign and Gambia and Kenya conducted wide-age range (9 month-14 years) nationwide MR catch-up campaigns in April and May, respectively. Both countries achieved > 95% survey assessed coverage (Gambia: 97% and Kenya: 96% - preliminary). Since the June 2016 Board, Zambia has carried out an MR catch-up campaign and Congo DR conducted the first two phases of a measles follow-up campaign; the third phase will be completed in late 2016 or early 2017.

(b) *Strategic issues:*

- i. Gavi's involvement in measles efforts started in 2004 when Gavi provided funding to the Measles Initiative (later renamed the Measles & Rubella Initiative - M&RI) for measles SIAs. With Gavi support for measles and rubella being limited in time and scope, the Gavi Board approved a new measles and rubella strategy in December 2015. Under the new strategy, there are four streams of Gavi support for measles and rubella: (1) measles-rubella catch-up campaign for children 9 months-14 years of age, (2) MCV2 and MR introduction into routine immunisation through co-financing, (3) measles and measles-rubella follow up campaigns, and (4) outbreak response fund managed by M&RI.
- ii. Application guidelines for the new measles and rubella strategy were disseminated in early August; 10 countries applied in the September round⁷ and were recommended for approval by the November IRC, with

⁷ Angola (MR catch-up under exceptional catalytic support), Cambodia (MR follow-up campaign), Cameroon (MR2 routine), Côte d'Ivoire (MR catch-up campaign and MR1 routine), Lao PDR (MR2 routine), Mozambique (MR catch-up and MR1), Republic of Congo (MR catch-up under exceptional catalytic support), Senegal (MR follow-up), Solomon Islands (MR2 routine), Tajikistan (MR follow-up campaign).

implementation of approved activities expected to start from early 2017 onwards.

- iii. At its October 2016 meeting, SAGE lifted the MCV1 coverage criteria required by countries to introduce routine MCV2. The application guidelines have been updated accordingly and Gavi will implement this recommendation from the January 2017 application round onwards. This means that more countries will be eligible to introduce routine MCV2 and that Gavi should expect requests for support earlier than forecasted. An update will be provided to the PPC and Board in 2017.
- iv. Work is on-going with Alliance partners to explore ways to better leverage synergies between other vaccines given at the same or similar ages to improve overall immunisation coverage rates (MCV1, YF, menA or MCV2 and menA).

3.7 **Meningitis** (Meningitis A campaign since 2010, routine immunisation since 2016; meningitis stockpile support since 2009)

(a) *Introductions to date:*

- i. The first 2 of 26 endemic countries (Sudan and Ghana) have started to introduce the vaccine into their routine systems in 2016, and Mali is scheduled to introduce by December 2016. In total 6 countries are scheduled to introduce in 2017 (three are approved, Chad, Burkina Faso, CAR), Gambia submitted an application to the September 2016 IRC, and Niger is currently addressing IRC comments from the June 2016 IRC. Nigeria's application was reviewed by the IRC in March 2016 and the country intends to introduce in 2017 subject to the resolution of the ongoing extended audit. 2 countries, Togo and Guinea will be reviewed through the Country Engagement Framework. Alliance partners are working closely with the remaining countries to introduce routine immunisation and avoid accumulating unimmunised cohorts.
- ii. By the end of 2016, 19⁸ of the 26 countries in the African meningitis belt are forecasted to have introduced preventive campaigns. A campaign in Uganda and Central African Republic has just been postponed to 2017 due to country readiness delays. Five countries are yet to introduce⁹ based on a risk assessment that these countries undertake to determine the country level risk of Meningitis A.

(b) *Strategic issue(s):* The Alliance continues to support efforts to monitor serotype prevalence in the meningitis belt to detect the emergence of non-

⁸ 19 countries that have introduced are: Burkina Faso, Mali, Niger, Nigeria, Cameroon, Chad, Benin, Ethiopia, Ghana, Senegal, Sudan, Cote d'Ivoire, Mauritania, Togo, Guinea, DRC, Guinea Bissau, S Sudan, Gambia (to introduce in Nov 2016 is CAR and Uganda)

⁹ Kenya is undertaking a risk assessment in November and will possibly introduce in 2017; Eritrea completed a risk assessment in Q3 2016 and is scheduled to submit an application to Gavi in January 2017; Burundi and Rwanda – WHO and Gavi are negotiating a date with these countries for a risk assessment to be undertaken in 2016; Tanzania - following a risk assessment the country will now only conduct mass preventive campaigns; CAR is scheduled to introduce in Nov 2016 yet its political situation might thwart this introduction.

vaccine strains. For the global stockpile for meningitis vaccines, see the separate paper on Gavi's engagement in stockpiles.

3.8 Inactivated Polio Vaccine – IPV (routine support started in 2014)

- (a) *Introductions to date:* 55 out of 73 Gavi countries have introduced IPV to date. Georgia and Ukraine introduced without support.
- (b) *Strategic issue(s):*
 - i. In November 2013, the Gavi Board approved Gavi providing support for the introduction of IPV in all 73 Gavi countries and routine immunisation with IPV during the period 2014-2018.¹⁰ Global IPV supply constraints have worsened since the last PPC meeting, further delaying roll-out of the vaccine in numerous countries. Supply is expected to remain constrained until at least 2018 and a number of IPV introductions initially planned before the end of 2015 are now delayed at least to 2017. In addition, shipments will be delayed to a number of Gavi-supported countries that have already introduced, causing likely stock-outs.
 - ii. The Immunisation Systems Management Group (IMG) is working to mitigate the impact of these delays, including through a prioritisation of supply to countries that are most at risk of a type 2 vaccine derived poliovirus outbreak (those with low coverage and a history of circulating vaccine derived polio virus). Some countries are also exploring dose-sparing fractional dose strategies; these have already been implemented in 16 Indian states as well as in Sri Lanka. This stream of work will need to be continued together with other components of Objective 2 (RI strengthening and OPV withdrawal) of the Polio Endgame Strategy inclusive of routine immunisation strengthening's convergence with the Polio Transition work. It is therefore important that the approved IPV-specific foundational support to WHO and UNICEF be used flexibly towards the achievement of different components of the Endgame's second Strategic Objective 2.
 - iii. Gavi's engagement with IPV, and the availability of additional funding for IPV support beyond 2018 (in line with the original Board decision) still need to be determined. A timely indication of Gavi's position is essential to allow vaccine manufacturers and national programmes to plan accordingly. Based on the guidance received from the last PPC meeting, the Gavi Secretariat initiated internal consultations, as well as with partners and relevant stakeholders and will report on progress to develop IPV support options beyond 2018 to the PPC in May 2017.

3.9 Japanese encephalitis vaccine – JEV (support for campaigns has been available since 2014 and the Board approved RI programme support in June 2016)

¹⁰ To date, US\$ 289.2 million (67%) have already been committed to support 70 IPV programmes. Funded by donors to the Global Polio Eradication Initiative's (GPEI) programme). The Board decision was in-line with the timelines of the GPEI Endgame Strategy 2013-2018, that recommended that all countries introduce at least one dose of IPV into their routine immunisation programmes by 2015. GPEI donors provided US\$ 429.8 million

- (a) *Introductions to date:* since last PPC update, Nepal, with Gavi support, has conducted JE campaign in the 44 districts that had not previously conducted a campaign, bringing the total number of countries to 3 that have conducted JE campaigns with Gavi support. Gavi has also approved JE campaigns in one province in Indonesia and nationwide in Myanmar in 2017. Viet Nam will conduct the campaign most likely in 2018 with Gavi support. 2 to 3 additional countries are expected to introduce JE as part of their routine programmes over this strategic period.
- (b) *Strategic issue(s):* Currently there is only one supplier of JE vaccines for Gavi support. Careful balance of demand and supply is required as the manufacturer requires 9 month lead time to produce requested supplies.

3.10 **Typhoid conjugate vaccine – TCV** (support was prioritised by Gavi Board as part of the 2008 VIS process)

- (a) *Introductions to date:* To date no country has introduced this vaccine with Gavi support (*no window of support has yet been approved by the Board*)
- (b) *Strategic issue(s):*
 - i. The opening of a support window is contingent on the availability of a WHO pre-qualified conjugate vaccine being available and a SAGE recommendation for use. TCV introductions were forecasted to start in 2020, in 5 countries, however supply may be available earlier than expected with WHO prequalification of a conjugate vaccine for typhoid possible within a year. The timeline for vaccine to be available to countries is possibly earlier, e.g. 2018-2019.
 - ii. The typhoid program definition including target populations (e.g. urban slum and rural areas) would be updated with input from Alliance partners.
 - iii. If no typhoid conjugate vaccine is available by the end of 2017, potential Gavi investment in this vaccine would be re-assessed as part of the next Vaccine Investment Strategy (VIS) process, with prioritisation and investment decisions in 2018.

3.11 **Oral Cholera vaccine – OCV** (supported since 2014)

- (a) *Introductions to date:* Gavi invested in the global OCV stockpile from 2014-2018. As of November 2016, the stockpile has been accessed for both emergency and non-emergency response over 30 times in 16 countries. Annual demand has increased significantly from 300,000 doses in 2013 to 3.7 million doses in 2016¹¹.
- (b) *Strategic issue(s):*
 - i. Following Hurricane Matthew, there was a high risk of increased cholera transmission. The Global Task Force for Cholera Control deployed one million doses to Haiti, targeting ~800,000 people in the Departments of

¹¹ As of November 2016

Grande'Anse and Sud. The vaccination strategy follows a 1 dose vaccination schedule and is targeting areas that are receiving basic humanitarian aid. The remaining doses will stay in Port-au-Prince and be used to vaccinate additional individuals or areas as access and humanitarian aid continues to improve. The vaccination campaigns commenced on 8th November with a large contingent of national supervisors, nurses and health workers, along with PAHO / WHO, International Medical Corps, UNICEF, and other vaccination partners, preparing components of vaccination and providing technical assistance.

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

Note: An update to the HSIS Framework and the Country Engagement Framework will be provided in Paper 02h

1. Introduction

1.1 The first year of Gavi's new strategic period has been a transition period for Gavi's investments under Strategic Goal 2 and the associated work of the Alliance. The Health System Strengthening (HSS) portfolio has further focused on coverage and equity, including in the underlying strategic focus areas (supply chain; data; leadership, management and coordination; sustainability; and demand generation) where Gavi has a comparative advantage in system investments to support sustainable improvements in immunisation. The Secretariat has also been reviewing its processes to improve the efficiency and predictability of approval and disbursements in line with Alliance Key Performance Indicator (KPIs). More systemic changes to Gavi's HSS support are under-development based upon the June 2016 Board HSIS decision and reflected in a dedicated paper to the Board on the Country Engagement Framework (see paper 02h). This is a pivotal year for the growing, and more systematic reporting on HSS investments through Grant Performance Frameworks. As of September, 42% (n=13) of countries reporting on their 2015 results had achieved 80% of their HSS intermediate results, as compared to 7% of countries in the previous year. Gavi continues to implement its Performance Based Funding approach which to date has particularly served to reward countries with high coverage, and will conduct an evaluation once sufficient data is available.

2. HSS Portfolio

2.1 Investments

- (a) Total **HSS approvals** equal US\$ 1.2 billion (2007-2017), of which US\$ 1 billion have been disbursed (81%) by September 2016.
- (b) There are **85 active HSS grants across 67 countries**; 35 (43%) were approved between 2007 and 2011, while 50 HSS/Performance Based Funding grants (57%) were approved between 2012 and 2016.
- (c) The Secretariat is working on an **analysis of timing from IRC recommendation for approval to disbursement of cash grants** as part of the KPI to be reported on for 2016 (see Doc 03). The baseline figure for 2015 was an average of 11.3 months from IRC to first disbursement. As of September 2016, the average for 2016 was 10.4 months. The end of year target was set at 9 months.

- (d) In addition, the Secretariat is also tracking pending disbursements across newly approved and ongoing HSS grants. As of September 2016, there are 35 countries with an HSS approval for 2016 or earlier that is pending disbursement. Delays have mainly occurred due to: 1. financial reasons (48%) related to a financial management assessment, audit, or pending agreement with partners; 2. programmatic issues (48%) such as low grant utilisation or pending budget/work plan, which prevent further disbursements from being made; and 3. an emergency or crisis (4%) related to political instability in the country. These issues are raised and discussed within the country teams and Alliance partners, addressed during Joint Appraisals or other upcoming country visits, with updates given during quarterly regional meetings within the Secretariat.
- (e) Between 2012 and 2015, 26 of 27 HSS proposals recommended for approval engaged **CSOs** in HSS proposal development. Twenty-three of these 27 country proposals also included CSO activities, of which 19 countries have received disbursements as of September 2016. Of the remaining four countries, the grants for Kenya and Malawi have since been cancelled with new proposals submitted in 2016, Nigeria's grant is undergoing further review, and Uzbekistan is pending disbursement.
- (f) Despite the small sample size of six 2016 HSS proposals in total, requested investments continue to suggest a **repositioning of HSS grants** towards immunisation outcomes. Relative to the previous strategic period 2011-2015, HSS investments from proposals recommended for approval in March and June 2016 (from Angola, Cameroon, Eritrea, Kenya, Myanmar and Uganda) have shown an **increased focus on procurement and supply chain management** (from 23% to 27%) and policy and governance (from 2% to 9%); with a relative **drop in emphasis on service delivery** (from 27% to 23%) and **health and community workforce** (from 16% to 12%); and **health information** systems staying essentially level (at 16% and 15% respectively). Gavi continues to encourage countries to invest in human resources to ensure stronger equitable immunisation results.

2.2 HSS grant monitoring, reporting and results

- (a) While all countries now have a **Grant Performance Framework (GPF)** in place, work is continuing to ensure the completeness of these frameworks and to improve the quality of the metrics included.
- (b) Work is also underway to **analyse results and achievements** against reported targets. 31 countries with an active HSS grant have reported against HSS intermediate results for 2015 by September 2016. Of these, 42% (n=13) had achieved ≥80% of their HSS intermediate results. Comparatively in 2015, this figure was as low as 7% of countries. The information provided through the reports will assist the Alliance in making more evidence-based strategic decisions in how funding is allocated.
- (c) Many countries have embraced the new GPF tool and are engaging with the Secretariat and partners in efforts to improve reporting completeness, address gaps and to improve the quality of the frameworks overall.

- (d) 68% of countries (n=48) had reported against $\geq 80\%$ of country-reported indicators (HSIS and NVS support) by September 2016. 42% of countries (n=30) reported against all. This meets the mid-year target of 65%. The end of year target is 75% and it is expected that we will see reporting completeness continue to improve. Ongoing training on the country portal continues, and new features are in the works in order to improve overall reporting and timeliness (such as automated reminders).
- (e) Work is underway to **analyse results and achievements** against reported targets. 31 countries with an active HSS grant have reported against HSS intermediate results for 2015 by September 2016. Of these, 42% (n=13) had achieved $\geq 80\%$ of their HSS intermediate results. Comparatively in 2015, this figure was as low as 7% of countries. The information provided through the reports will assist the Alliance in making more evidence-based strategic decisions in how funding is allocated.

3. Anticipating an evaluation of the Performance Based Funding (PBF) approach

- 3.1 Of the 10 performance payments approved from 2014–2015, five have been disbursed as of September 2016 to Burundi, Laos (two payments), Nicaragua and Zimbabwe. Of the five countries with **2015 undisbursed performance payments**, four countries (Rwanda, Sudan, Tanzania and Timor-Leste) are delayed due to pending budgets, and one (Burundi) due to its political situation.
- 3.2 As well, 21 countries have been assessed in 2016 for PBF eligibility for their 2015 performance. Eight of these countries (**38%**) **are eligible** to receive a performance payment, ranging from US\$ 120,000 to US\$ 2.6 million.
- 3.3 Performance payments are often for a relatively small amount compared to other HSIS grants. The payments are also awarded in the second half of the year after data verification with WHO/UNICEF estimates released in July. For this reason, it is **difficult for countries to integrate these amounts into existing operational work plans and budgets**.
- 3.4 In general, **countries that received a performance payment in the past year(s) are more likely to receive subsequent performance payments** (Burundi, Laos, Nicaragua, Rwanda, Sudan and Tanzania). Countries unable to improve consistency between administrative data and WUENIC estimates continue to be ineligible for performance payments (Burkina Faso and Ethiopia).
- 3.5 This brings into question the benefit of Gavi's current PBF approach. Trends in performance payment eligibility for 2014 – 2016 show that the intention of **incentivising improved coverage and data quality has not been realised**. Instead, the **PBF approach has largely served as a reward to countries with over 90% DTP3 coverage for maintaining high coverage**.
- 3.6 An **evaluation of the PBF approach** is anticipated as discussed in the June 2016 Board HSIS paper once sufficient data is available, likely to be in 2018.

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

1. Introduction

- 1.1 This appendix discusses the performance of countries with respect to the fulfilment of their co-financing obligations and provides an update on the design and implementation of transition grants. While co-financing performance has improved markedly in 2016, the PPC in October 2016 recognised the importance of discussing in greater detail transition-related challenges and opportunities, and a dedicated session on transition will take place at its next meeting in May 2017.

2. Co-financing Performance

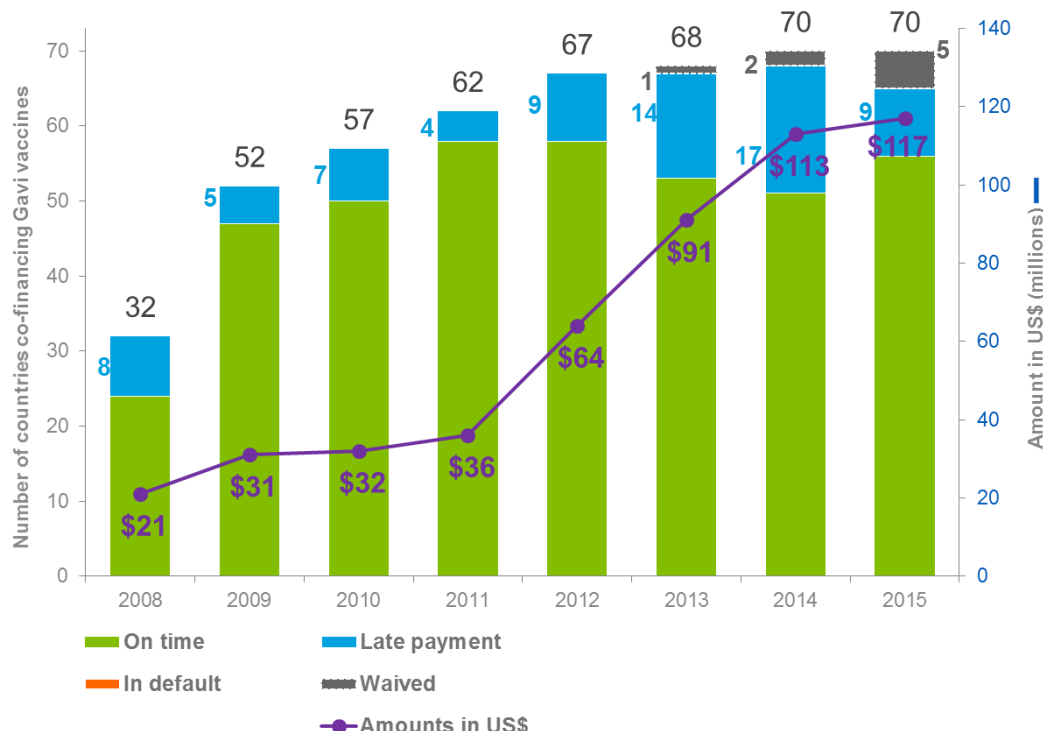
- 2.1 2016 has been the best ever year in terms of co-financing, with countries having paid US\$ 75 million in 2016 co-financing to date as opposed to US\$ 41 million at the same time in 2015 (a 83% increase, compared to a 22% increase in countries' obligations). As shown in table 1, the payment of co-financing arrears has also improved: last year by the end of July, 35% (6 out of 17) of the countries that had defaulted on their 2014 co-financing requirements had not yet paid off their arrears, while by the end of July 2016, only one country (1 out of 10) remained in default of its 2015 co-financing obligations (DRC, discussed in greater detail below). As of November, all ten countries that had defaulted on their 2015 obligations fulfilled them¹. This means that both the absolute number of countries that had defaulted, as well as the relative share of countries still in default by July and by November were lower this year. The total amount transferred to date against the 2015 co-financing commitments amounts to approximately US\$ 117 million. Gavi paid 89% and countries paid 11% of the total costs of new vaccines in 2015.

Table 1 – Comparison of co-financing performance in 2015 and 2016

| | 2015 | 2016 |
|------------------------------|--|--|
| Co-financing payments | US\$ 41 million by November 2015 (30% of total requirements) | US\$ 75 million by November 2016 (45% of total requirements) |
| Countries in default | 6 out of 17 by July, 3 out of 17 by November | 1 out of 10 by July, 0 out of 10 by November |

¹ Two countries, South Sudan and Yemen requested waivers of their arrears.

Graph 1 – Co-financing payments



2.2 As mentioned, **DRC**, a low-income country with a GNI per capita of US\$ 410 in 2015, was the last country to fulfil its 2015 co-financing obligations. Although the country's vaccine expenditures have increased annually since the start of the country tailored approach in 2014, the funds have not been sufficient to meet the co-financing obligations, and the country has still been defaulting every year. With the global economic situation, the country has been buffeted by important economic headwinds and its political situation deteriorated significantly throughout the year with the postponement of elections previously scheduled to take place in December 2016. The Gavi Secretariat and Alliance partners, through the Immunisation Financing and Sustainability technical team (ATT), followed the situation as it unfolded and liaised closely with the government to address the situation. With the recent confirmation of transfers by the UNICEF Country Office, the country has managed to come out of default despite this challenging environment.

3. Update on transition grants

3.1 As part of Gavi's comprehensive transition framework approved by the Gavi Board in late 2013 and introduced in 2014, Gavi works with countries entering the accelerated transition phase to develop transition assessments that seek to gauge countries' transition-readiness on a range of programmatic and financial issues (e.g., financial planning, budgetary execution, procurement and regulatory capacity, decision-making processes, etc.). The Alliance then implements a plan to address any remaining critical institutional bottlenecks – including through additional catalytic support, if necessary. Such catalytic support is channelled through "transition grants" managed by Alliance partners through their local country offices.

- 3.2 By September 2016, ten transition grants have been approved, and fully or partially disbursed (see table 2). The duration of most approved grants is two or three years, while some are for one year only, depending on where countries are in the accelerated transition phase. The size of the grants are small, and vary from US\$ 75,625 per year for Sri Lanka to an average of US\$ 493,000 per year for Bolivia.

Table 2: Transition grants approved, and under development

| Transition grants approved, and fully or partially disbursed | Transition plans under development |
|--|------------------------------------|
| Angola | Azerbaijan |
| Armenia | Ghana |
| Bhutan | Lao PDR |
| Bolivia | Nicaragua |
| Congo | Papua New Guinea |
| Georgia | Solomon Islands |
| Guyana | Timor-Leste |
| Honduras | Uzbekistan |
| Moldova | Vietnam |
| Sri Lanka | |

- 3.3 In most transition grants, the largest share is spent on time-limited, catalytic activities related to improving immunisation performance and service delivery, such as the development of communication strategies and human resources trainings. The second largest share in most grants has been allocated to ensure appropriate vaccine supply, such as setting up a National Regulatory Authority (NRA), strengthening the procurement system, or cold chain-related activities. A relatively lower share has been allocated to addressing financing bottlenecks, but it is expected that, with the considerable stepping up of engagement by the World Bank, these issues will be addressed in greater detail.
- 3.4 As of July 2016, eight countries – Angola, Bhutan, Congo, Georgia, Guyana, Honduras, Moldova, and Sri Lanka – had transition grants under implementation. As previously reported to the Board, in a number of cases delays were observed between the development and actual start of implementation in this first wave of transition plans. However, at this stage adjustments have been made to all relevant plans and revised completion dates have been determined for all activities concerned. Most grants are still in the early stages of implementation due to the aforementioned delays, and thus impact data are limited. However, as mentioned above, an in-depth discussion of transition challenges and opportunities will take place at the PPC in May 2017, when additional data and analyses will be presented for the committee's consideration.

Appendix D: Update on specific countries

1. Introduction

1.1 As requested by the Programme and Policy Committee this appendix provides key highlights from the Alliance's in-country work, focusing on major developments in four of Gavi's most complex countries, Democratic Republic of Congo, India, Nigeria and Pakistan. Going forward, the Secretariat will explore how to make available to the Board a systematic update on progress in each Gavi country.

2. Democratic Republic of Congo

| DTP3 WUENIC coverage | Transition and co-financing status | Country-tailored approach |
|---|--|---|
| 2015: 81% 2014: 80% 2013: 74% | Co-financing : on track | Yes |
| Gavi support | | |
| <i>Active vaccine support:</i> <ul style="list-style-type: none"> - Penta – 2008-2016 - PCV – 2010-2016 - YF – 2002-2016 - IPV – 2015-2018 - Measles campaign – 2013-2014, 2016 - MenA Campaign-2015 (3 provinces) - Yellow Fever response campaign 2016 - Support on Cholera and YF outbreak response 2016 | <i>Active cash support:</i> <ul style="list-style-type: none"> HSS 1 – 2007-2015 HSS2 – 2015 – 2019 CCEOP grant part 1 (to cover 30% of the need) | <i>IRC has approved DRC proposal to introduce Rotavirus vaccine and the part 2 of their CCEOP proposal.</i> |

2.1 Country context / key developments

- a) 2016 is a presidential election year in DRC. This political uncertainty may have an impact on the country's implementation of vaccine programmes and its immunisation performance and might result in a change of leadership in the Ministry of Health. To date opposition leaders have arranged three demonstrations, at the first of which more than 17 people died. The current government resigned and a new Prime Minister was appointed by the Opposition. So far no announcement of the new government has been made. Former ministers have been requested to continue working until the new government is appointed.
- b) The macro-economic situation of DRC in 2016 is worrisome. Gross national income has dropped by 17-30% and the continuing low price

of oil, copper and other mining products which are the main income source for DRC means its economy will not improve soon. This has had an impact on the national budget: in June the prime Minister announced to all ministries a reduction of 30% of their 2016 budget, leading to cuts in salaries and non-payment for some essential activities.

- c) A meningitis A campaign was finalised in May 2016. The first phase of a measles campaign was conducted at the end of August in 8 targeted provincial Health Divisions (Equateur, Mongala, Nord Ubangi, Sud Ubangi, Tshuapa, Nord Kivu, Sud Kivu, Maniema). The Ministry of Health and partners are preparing the launch of the second phase which will target the provinces of Kinshasa, Kongo Central, Kwango, Kwilu and Mai Ndombe. This is planned for 26 September, jointly with the mass distribution of mosquito nets in Kinshasa. The third phase, targeting the provinces of Haut Katanga, Haut Lomami, Lualaba, Tanganyika, Kasai Central, Kasai, Kasai, Oriental, and Sankuru, is planned for November if the security and political situation allows.
- d) DRC has successfully implemented three yellow fever response campaigns, with the largest having taken place in August. The response campaigns were made possible thanks to partners' joint efforts. Gavi contributed to this campaign with a budget of more than USD\$ 13.7 million, including operational costs.

2.2 Successes

- e) DRC is no longer in default of its 2015 co-financing: As of October DRC was the only country that still remained in default of its 2015 co-financing obligations (US\$ 8.3 million). While the Prime Minister, in June, ordered the payment of US\$ 1m each month for the following four months, no payments had been made by September. After extensive follow up by the Gavi Secretariat, a network of parliamentarians for immunisation and in-country partners, the Prime Minister ordered a payment of US\$ 2.5 million for co-financing in October, and a subsequent US\$ 1.5 million in November. Both payments have been confirmed by UNICEF Country Office.
- f) The implementation of DRC's supply chain strengthening project is ongoing. 2500 solar refrigerators, funded through a Gavi HSS grant, have been installed as part of this project and a case study of the impact of the introduction of cold chain equipment on the overall quality of immunisation services in DRC is currently under way (see under next steps).
- g) In addition to the installation of solar refrigerators construction of a Kinshasa vaccine hub started in February 2016 and is expected to be delivered in June 2017. Due to budget constraints, DRC's Interagency Coordination Committee (ICC) endorsed the decision of prioritising the

construction of two provincial warehouses in Lubumbashi and Kisangani and to strengthen the cold chain capacity in Kananga.

- h) The newly restructured Programme Management Unit (PMU), which manages the Global Fund and Gavi grants, is now in place. It consists of three units: internal controls and audit; procurement; and accountant and finance management. The restructuring of the PMU was possible thanks to the combined support of the European Union, Belgian cooperation, World Bank, Global Fund and Gavi. An evaluation of the performance and impact of the PMU will be conducted after 6 to 9 months. In addition Gavi has contracted a fiduciary agent in the 14 high risk provinces, of which eight are focus provinces for Gavi's HSS grant.

2.3 Challenges

- i) Outbreaks: The country is at continuing high risk of yellow fever outbreaks, following the recent outbreak that started in the bordering areas with Angola and that then expanded to Kinshasa province. In response, the Ministry of Health, with partners, conducted a widespread response campaign, to stop the spread before the high transmission season starting in September.

Two cases were confirmed by Institut Pasteur on 15 August in two health zones (Fechi and Mushengue). The country has requested International Coordinating Group (ICG) support and is planning to conduct two campaigns in these two health zones. The Ministry of Health is strengthening surveillance despite recurrent stock-outs of lab reagents in the country.

- j) DRC is also facing a cholera outbreak that started in Equateur and North East Provinces but that has now reached Kinshasa. In response, DRC decided to use cholera vaccine in addition to the WASH programme. The ICG has approved a response campaign targeting 300000 people in Kinshasa. This response, funded by Gavi, was conducted through two rounds of campaigns. According to the WHO Sitrep the coverage was 99.4%. WHO is currently preparing a post-campaign survey.
- k) A new measles outbreak was declared in North Kivu and Katanga. The Alliance has carried out a planned (Alliance-supported) Supplementary Immunisation Activity (SIA) in August (phase1) and mid-October (phase 2) and a phase 3 is planned for later in the year. A coverage survey is currently carried out. It is worth noting that some insecure areas were not targeted by the measles campaign due to difficulties in accessing the area controlled by rebel forces.
- l) Competing priorities in the EPI 2016 agenda: The EPI programme has been managing two polio campaigns in April 2016, two meningitis A campaigns in February and May 2016, the preparation for the measles campaign(s), the switch of oral polio vaccines (tOPV to bOPV) in May

2016, and the yellow fever outbreak response. This has put considerable strain on the EPI programme.

- m) While DRC has successfully introduced IPV, and made the switch from tOPV to bOPV, the country experienced many stock-outs of IPV due to global production constraints. Not having the needed quantities could be a threat for DRC, which was declared polio-free early this year.
- n) Data quality issues: this is a cross-cutting issue in DRC. Gavi is contributing to a multi-partner project to strengthen data quality through deployment of the District Health information system 2 (DHIS2). This is done jointly with the World Bank, DFID, and the Global Fund. The multi-donor project is coordinated through a committee. There remain, however, several challenges related to the inclusion of relevant immunisation indicators into the DHIS2 tool.
- o) This is in addition to challenges related to the quality of data collected and lack of adequate training and motivation of health workers (many of whom do not receive regular salaries).
- p) Mitigation of financial risk: Since January 2016, Gavi has suspended all disbursement to the Ministry of Health and requested MoH to change the bank that hosted Gavi funds due to irregularities in the management of funds and, later, due to signs that the bank was on the brink of collapsing. As of the end of June a total of US\$ 11 million was still held by the bank. After intensive advocacy work in country and a meeting with the Prime Minister, all remaining funds were transferred to a new bank account selected by Ministry of Health.
- q) Given these developments Gavi has reduced the ceiling of amount of cash disbursed to the country and is closely monitoring the cash balance in country.
- r) Audit: Gavi conducted an audit in DRC in 2015. Due to delays in receiving clarifications from the Ministry of Health after sharing the draft report, a final report has not been yet issued. A Programme Capacity Assessment (PCA), covering the Ministry of Health and Civil Society Organisations was also conducted in DRC in July 2016. A draft report was shared at the end of August, and the final report will be issued shortly.

2.4 Next steps

- s) Conduct the second and third phases of the measles campaign and ensure that coverage surveys are done in a timely manner. Monitor the implementation of the Reach Every District (RED) approach in 112 health zones with the highest number of unvaccinated children. Continue to monitor the security situation and prepare a contingency plan in consultation with in-country partners.

- t) Following the above mentioned successful installation of 2500 solar refrigerators, distributed and maintained (including through the training of local health agents) by manufacturers' local service provider, DRC requested an evaluation of the impact of this investment on the overall quality of immunisation services in-country. While DRC's CCE investment has been made prior to the launch of the CCEOP a review of its impact and success will, given the similar programme design, also provide valuable insights into the potential impact of the CCEOP.
- u) The Gavi Secretariat agreed to support DRC MoH in this endeavour by funding an independent study to assess a) the quality of the services provided and the knowledge of staff to conduct preventive maintenance; b) the performance of the selected equipment and c) the early impact at health facilities. Based on a recommendation by the PPC the scope of work was subsequently amended to include a mapping of all partners' investments in supply chain in DRC. Following the launch of a Request for Proposal (RFP) a service provider has been selected. Results of the study will be shared with both PPC and Board respectively in May and June 2017.
- v) The EPI annual review, planned for the end of November, will be focusing on routine immunisation strengthening.

3. India

| DTP3 WUENIC coverage | Graduation and co-financing status | Country-tailored approach |
|--|---|--|
| 2015: 87% 2014: 85% 2013: 83% | Graduation: <ul style="list-style-type: none"> Entering accelerated transition phase in 2017 Transition of penta/IPV in 2016 Co-financing: not applicable | Board-approved India partnership strategy 2016-2021 applies |
| Gavi support | | |
| <i>Active vaccine support:</i> Penta – 2011-2016 IPV – 2015-2016 PCV: 2017-2019 MR campaign: 2017-2018 | <i>Active cash support:</i> HSS 1 – 2014-2017 (no-cost extension from 2016 in discussion) | <i>Pending support: (as part of the new partnership strategy, timing tentative)</i> Rota: 2017-2019 HPV: (pending NTAGI ¹ recommendation) HSS 2: 2017-2021 |

¹ NTAGI – National Technical Advisory Group on Immunisation

3.1 Political context / key developments

- a) Immunisation continues to be high on the political agenda in India. Prime Minister Modi noted the Mission Indradhanush² vaccination initiative as part of an integrated approach to women's empowerment towards health and economic prosperity, in his Independence Day speech on 15 August.
- b) A new Health Secretary had been appointed in July. Mr. C.K. Mishra, former Additional Secretary and Mission Director of the National Health Mission, who had been instrumental in driving the Gavi-India strategic partnership, was promoted to the Health Secretary position.

3.2 Programmatic updates

- a) Newly released WUENIC³ data showed an encouraging trend, with both DTP3 and MCV1 coverage at 87% in 2015 (from 85% in 2014). Routine immunisation concurrent monitoring data showed steady improvements in immunisation coverage across antigens in the last few years. Disaggregated data by residence (urban/rural), religion (Hindu/Muslim), and the castes/tribal system also showed improvements, but gaps remain.
- b) With three phases of Mission Indradhanush completed since mid-2015 to focus on low-performing districts, the Government of India (GOI) estimates a 5-9 point increase in full immunisation coverage (from baseline of 65%). The Government and partners have identified several key success factors, including strong leadership, excellent partnerships between agencies, and intense monitoring and course corrections. These serve as important lessons for sustainable improvements in routine immunisation.
- c) India completed the tOPV – bOPV switch across the entire country in April as part of the polio endgame strategy. The successful implementation of this historical event added confidence to the immunisation programme, which within an 18-month period has completed, initiated or planned introductions of five new vaccines (pentavalent, IPV, rotavirus, PCV and rubella).
- d) The first year of the new India partnership has been marked by significant progress on the Gavi-supported programmes.
 - i. **Penta:** transition of pentavalent vaccine from Gavi to GOI proceeded smoothly, following the Government's on-time completion of its tender process.

² Mission Indradhanush is an immunisation drive launched by the Health Minister in 2014. The goal is to reach full immunisation coverage to over 90% by 2020, by targeting districts where children are missed.

³ WUENIC – WHO/UNICEF Estimates of National Immunisation Coverage

- ii. **PCV:** supported by Gavi's catalytic funding for ~20% of the birth cohort, phase 1 of the vaccine rollout is fast-tracked for Q1 2017. Four large states (UP, Bihar, Rajasthan, Madhya Pradesh) with the greatest number of pneumococcal deaths have been selected to maximise impact.
- iii. **MR:** phase 1 of a large four-phase MR campaign which targets a total of 410 million children over 2-3 years is also planned to start in 2017.
- iv. **Rotavirus vaccine:** discussions are underway for further scale-up in 2017, since the domestically-funded initial introduction in four states in March 2016. A multi-site hospital-based intussusception surveillance network was set up to monitor vaccine safety.
- v. **HPV vaccine:** a few states have expressed interests in introducing HPV using the states' own funding, while NTAGI continues its due process to assess feasibility for nationwide introduction. Gavi is providing targeted technical assistance to ensure successful implementation in selected states, and facilitating pricing discussions with manufacturers.
- vi. **IPV:** following the implementation of the intradermal fractional dose (fIPV) approach in the first eight states (out of 36), GOI has decided to switch another eight states to fIPV approach by October, given the global supply shortage situation. In response to an isolation of vaccine-derived poliovirus type 2 from a sewage sample taken in Telangana state, India conducted a mass campaign using fIPV. The campaign vaccinated over 300,000 children in 6 days, reaching an estimated coverage of 94%. This experience showed that with appropriate preparation, an emergency response of fIPV could be implemented promptly and successfully in case of future outbreaks.
- vii. **HSS1:** Preliminary data from three large states where the Gavi HSS1-supported real-time vaccine stock management and temperature monitoring system ("eVIN"⁴) has been introduced, showed a significant reduction in stock-outs. Decrease in vaccine wastage was also observed. These improvements are attributed to the significant attention paid to the immunisation supply chain system with technology innovations, advocacy, capacity building, and accountability strengthening by Alliance partners. By year-end, the eVIN system will be introduced in 12 states, which make up 40% of the 27,000 cold chain points in the country, or over 60% of the 27 million infant population (equivalent to the size of Nigeria, Pakistan and Indonesia combined).

⁴ Electronic Vaccine Intelligence Network (eVIN)

- viii. **HSS2:** Design for the HSS2 support is underway, to support greater achievements in equity in immunisation. In-country IRC review of proposal is planned for year-end.
- e) Challenges remain, as communication-related issues and apprehension for adverse effects are shown as the main reasons for children being missed for vaccination. Expansion of the immunisation programme with new vaccines can also trigger renewed anti-vaccine movements in country. Gavi will support the GOI in proactive management of negative media and outreach to global disease experts where needed.

3.3 Market shaping update

- a) Gavi partners have built stronger relationships with both the procurement and immunisation programme departments within the Ministry through a series of meetings, workshops and information sharing. Alliance market shaping teams have provided market intelligence information to GOI and received their views on specific markets. These exchanges have improved our mutual understanding of the future demand and supply for specific markets. Areas of most active discussion have been on supply for Pentavalent, PCV, IPV, MR and JE. GOI has confidentially shared the outcomes of several tenders with Gavi to allow the market shaping team transparent, accurate information on GOI procurement outcomes and price points.
- b) The results of recent tenders indicate similar patterns of success and challenges. In the pentavalent vaccine market, the large volume increase from India and steady demand from Gavi, combined with a healthy supply base, have contributed to approximately a 50% decrease in the weighted average prices awarded by UNICEF; with both GOI and UNICEF securing similar prices for the 10-dose vial presentation⁵. The total value of these price decreases to Gavi and countries is estimated to be over \$300 million for 2017-2019 and has achieved the previously described potential savings. In contrast to pentavalent, neither GAVI nor GOI has been able to access sufficient supply of IPV due to global constraints and issues faced by the limited number of suppliers for this vaccine. Manufacturers and Gavi partners are working to improve and expand the supply of IPV globally. MR is available in sufficient quantities to satisfy demand from both Gavi and GOI from one supplier based in India. GOI has recently issued its first tender for MR vaccine, and UNICEF will extend an existing long term agreement with the supplier. The potential for procurement savings based on increased volumes for PCV, driven by introduction in India, is being pursued.

⁵ Calculated from a point estimate of the 2016 price of US\$ 1.15 and the 2017 price of US\$ 0.75 for the 10 dose vial of pentavalent.

- c) Recent tenders issued by GOI have changed their stated tendering and awarding approach. In contrast to awarding all quantities automatically to the lowest priced bidder, the new approach will enhance supply security by spreading supply across more than one manufacturer. This is a positive development not only for the security of supply to GOI, but also in decreasing the volatility of supply availability from manufacturers who are often important suppliers to Gavi countries.
- d) Development of the public sector vaccine manufacturing entities continues to progress and Gavi has begun to build relationships with these manufacturers through a series of in-person meetings. Several public sector entities have the ability and ambition to achieve WHO pre-qualification of vaccines and to become future suppliers to Gavi countries beyond India. This combination of benefits from production efficiency of a substantial volume base in India, while bringing quality standards associated with pre-qualified vaccines, could result in valuable contributions to Gavi's supply base. Gavi will continue to engage with potential new public sector manufacturers to provide current demand projections, market information and assistance as possible. Some risks exist in cases where these new entities intend to enter markets with excess capacity already in place, and their entry could decrease the market size for existing manufacturers, leading to less efficient production and therefore potentially higher cost of goods or market exits. Gavi will continue to engage with all manufacturers and lend market insights and assistance as feasible, while being mindful of the potential market effects, both positive and negative, of the entry of public sector manufacturers.

3.4 Next steps:

- a) On the programmatic front, the near-term milestones for the partnership strategy include completion of design of the HSS2 support by year-end, and PCV and MR campaign launch in 2017. (See Fig. 1 for timeline and milestones.)

Fig. 1 2016-2017 timeline and milestones

| Programme | 2016 | | 2017 | | Key milestone/Update |
|-------------------|------|----|------|----|---|
| | 1H | 2H | 1H | 2H | |
| Penta vaccine | | | | | <ul style="list-style-type: none"> Last Gavi/UNICEF shipment in July 2016; transition to domestic procurement completed |
| IPV vaccine | | | | | <ul style="list-style-type: none"> Last Gavi/UNICEF shipment planned for Q4 2016, followed by transition to domestic procurement |
| PCV vaccine | | | | | <ul style="list-style-type: none"> Proposal approved in Q3 2016 Gavi-supported Phase 1 start in early 2017 |
| Rotavirus vaccine | | | | | <ul style="list-style-type: none"> Domestically funded Phase 1 launched in March 2016 Further scale-up with domestic and Gavi funded timing <i>tbd</i> |
| MR vaccine | | | | | <ul style="list-style-type: none"> Proposal approved in Q3 2016 Gavi-supported campaign Phase 1 start in early 2017 Domestic procurement for routine MR initiated in Q2 2016 (routine MR to start within 6 months of campaign end) |
| HSS1 support | | | | | <ul style="list-style-type: none"> No cost extension to 2017 under discussion |
| HSS2 support | | | | | <ul style="list-style-type: none"> Proposal reviewed by Q4 2016 Implementation start in 2017 |

- b) On the market shaping front, the Secretariat will continue to engage and share information with GOI officials in both the procurement and the programme departments, seeking to continue a relationship based on mutual sharing of information. Next steps will also include completion of procurement savings on PCV based on higher volumes, and engagement with the public sector manufacturers to provide market information and assistance as possible.

4. Nigeria

| DTP3 WUENIC coverage | Graduation and co-financing status | Country-tailored approach |
|--|--|--|
| 2015: 56% 2014: 49% | Transition: country will enter accelerated transition phase on 1 January 2017 Co-financing : on track | Yes, for period 2014-2018, but implementation is on hold due to the audit issues |
| Gavi support | | |
| <i>Active vaccine support:</i> Penta – 2008-2020 PCV – 2012-2020 Measles campaigns – 2013, 2015 MenA campaigns – 2011, 2012, 2013, 2014 IPV – 2015-2018 YF campaigns: 2013, 2017 (subject to availability of vaccines) | <i>Active cash support:</i> HSS1 – 2007-2017 | <i>Pending support:</i> HSS2 was recommended for approval in March 2014. Given that the country context has changed significantly over the past (2.5 years), the country is starting the process of revising the proposal HPV demo, MenA, Rotavirus applications were recommended for approval. Final approval is subject to closure of financial audit. |

4.1 Country context / key developments

- a) The Gavi CEO engaged in a joint mission with the Executive Director of the Global Fund UK, US, Canada, EU and the World Bank, in July 2016 and met with President Muhammadu Buhari, the Federal Minister of Health, and the Federal Minister of Finance. As a result of the meetings the Government of Nigeria provided Gavi with a commitment to reimburse the identified misused funds (US\$ 5.39 million) as well as an action plan of remedial measures to be put in place within NPHCDA.
- b) The leadership at NPHCDA was changed including its Executive Director and 4 directors. A letter of commitment to reimburse the amount in 2 instalments in 2017 (subject to inclusion in 2017 budget) and an action plan were received by the Secretariat in September.
- c) In the context of Nigeria's imminent transition from Gavi support the Gavi Secretariat has further intensified its in-country engagement. During a country visit in October, the Senior Country Manager (SCM),

met with the Chair of the Senate Committee on Health (the Chair) in the presence of the Honourable Minister of Health. During the meeting an overview of Gavi support to Nigeria's immunisation programme over the years was provided. The importance of the Senate Committee making provisions in the Federal Government of Nigeria 2017 budget for immunisation programmes to include the Gavi co-financing requirements and the Government commitment to reimburse the misused funds was also stressed.

- d) During the meeting the Chair also requested that Gavi considers supporting oversight activities by the Nigeria Legislature to ensure accountability in the health sector. The oversight activities will include periodical Value for Money Audits and in-depth Fiduciary reviews of the relevant Ministry, Departments and Agencies. The request will be considered as part of the revised HSS2 proposal.
- e) At the Chair's request, Gavi addressed him a letter providing key information on Gavi support, programme challenges, co-financing requirements, and the amount to be reimbursed for misuse as identified by the audit findings. The Chair responded in a letter in which he voiced strong support, particularly with respect to making funding provisions for (i) the implementation of a Basic Health Care Provision Fund (BHCPF) and (ii) for Gavi co-financing requirements in the 2017 budget.
- f) The Chair further stated that he would support the implementation of the audit recommendations and that he would not hesitate to recommend appropriate sanctions on individuals or the restitution of funds where required.
- g) A Legislative Retreat on Immunisation, Health Financing and the National Health Act took place on 29th October 2016 in which the Chairmen of the House of Representatives Committee on Health Care Services, on AIDS, TB & Malaria Control, on Appropriation, the ED of NPHCDA, representative from the FMOH, ONE campaign, IVAC and many others participated. The purpose of the meeting was to discuss Nigeria's imminent transition from Gavi support and the resulting large funding gap, as well as to explore budgetary and non-budgetary solutions to sustainably finance the immunisation programme. The meeting ended with strong consensus on several key issues. These include the need for (i) the allocation of adequate funds for health, particularly immunisation; (ii) a budgetary provision for the 1% of Consolidated Federal Revenues to finance the Basic Health Care Provision Fund in the 2017 budget; and, (iii) the increase of the proportion of the annual budget allocated to the healthcare sector to 6% in 2017 and to 7.5% in 2018.
- h) The SCM together with the Head of Programme Finance and Head of Immunisation Financing & Sustainability also had extensive meetings with the newly appointed Executive Director (ED) of the National

Primary Health Care Development Agency (NPHCDA). During these meetings the ED, inter alia, recognised the importance of strengthening Nigeria's data systems to allow for realistic planning and implementation of interventions. It was also discussed how to most effectively process the applications for Gavi support anticipated for 2017 (HSS2, CCEOP, HPV national, Measles Second Dose and a measles campaign) and that this would likely be best facilitated through the Country Engagement Framework (see separate paper 02h).

- i) An Action Plan of remedial measures was established based on the audit recommendations. These measures are to be implemented within NPHCDA to address the systemic weaknesses found by the audits in the NPHCDA management of Gavi cash grants. A Programme Capacity Assessment (PCA) was also undertaken to, amongst others, identify the funding mechanism which will provide confidence and assurance that Gavi grants will be utilised as intended and Value for Money is obtained through the grants. The report is expected by mid-December. At the same time, FMOH has commissioned Deloitte to review the processes in FMOH and other parastatals. During the meetings with the ED, it was agreed that the Action Plan, PCA and Deloitte recommendations would form one comprehensive plan for implementation within NPHCDA to strengthen the financial system and internal control weaknesses.
- j) On Gavi support to Nigeria beyond transition, it was agreed that it was essential that the GoN undertook a comprehensive and systematic assessment of partner investments in Nigeria's immunisation programmes, of the expected results of their investments, and of how these efforts align with Nigeria's own investments and strategies. This landscaping exercise will also be helpful in identifying opportunities for synergies with other ongoing processes such as the transition of polio assets.

4.2 Successes

- k) The final phase of Pneumococcal conjugated vaccine roll out was completed in October 2016. The national administrative coverage report will be available in the 2017.

4.3 Challenges

- l) There are systemic weaknesses in the financial and programmatic management of the EPI programme in the country.
- m) The 2016 WHO-UNICEF Estimates of National Immunisation Coverage (WUENIC) were revised retrospectively and the DTP3 coverage for 2015 was estimated to be 56% (the revised estimate for 2014 is 49% vs 66% in 2015 released data). This is 10th lowest globally, below fragile states such as Haiti, Niger, Mali and Yemen. This means the country has almost as many under-immunised

children as India (which has the most globally with over three times the birth cohort of that of Nigeria). The country also faces huge inequities with only one in eight of the poorest wealth quintile receiving three doses of DTP.

- n) There is a wide variation between the administrative data (2015 DPT3 coverage was reported to be 99.8%) and WUENIC estimates, pointing to weak immunisation systems in general and weak data management systems in particular. The government to date has not endorsed the WUENIC estimates.
- o) Due to the continuing economic downturn the federal government is requesting the national assembly to approve borrowing of US\$ 150 million from World Bank to finance polio and routine immunisation over the next two years. Although the country has not defaulted on its co-financing payments, however decreased fund releases for RI services e.g. cold chain, outreach services, supportive supervision, especially at sub-national levels affects service delivery.
- p) Four cases of wild poliovirus type one (WPV1) have been detected in Borno state. These are the first WPV1 detected in Nigeria since July 2014. Genetic sequencing of the isolated viruses suggest they are most closely linked to WPV1 last detected in Borno in 2011, indicating the strain has been circulating without detection since that time. The polio outbreak has been declared a national public health emergency by the Government of Nigeria and a regional public health emergency by the Governments of the Lake Chad sub-region. The response is likely to cause strain on government resources and divert attention from other activities including strengthening routine immunisation. Routine IPV stocks have been diverted for outbreak response in Borno, the country will replenish these stocks after it receives the vaccines from Eradication and Outbreak management group (EOMG).

4.4 Learning – past and future

- q) The new leadership in NPHCDA will establish a Grant Management Unit within the Agency. This Unit will proactively monitor, manage donors' funding in compliance with Government of Nigeria rules and regulations as well as donors' requirements. For this, the Executive Director has requested Gavi for support in the hiring of a senior person with experience in grant management to head the unit and to mentor the staff so that they can assume the role in the next 2 to 3 years. NPHCDA has been asked to submit a formal request for this support and Gavi will consider the funding options either through the revised HSS or through use of utilized funds from previous grants available in the country.
- r) Given that the country is entering the accelerated transition phase in 2017, it will be important to rapid build and validate strong financial and programme management systems at NPHCDA. Appropriate measures and strong mechanism of oversight from the Federal

Ministry of Health will be required to ensure the timely and quality implementation of these measures and ultimately to overcome the systemic weaknesses in the financial and programmatic management of the EPI programme in the country. The Secretariat will put in place a fiduciary agent who will validate the robustness of the NPHCDA financial system for the management of its cash grants prior to Gavi resuming disbursements to government system.

- s) The country plans to introduce several new vaccines in the coming years including Men A, Rotavirus vaccine, and to scale up HPV at the national level. Given the current fiscal situation as well as weak immunisation performance, it is important that appropriate efforts are made to highlight to the government and stakeholders of the domestic resource mobilisation required to fill the projected funding gap of US\$ 1.59 billion for the period 2016-2020 as per the cMYP as well as improve the immunisation programme performance.

4.5 Next steps

- t) The Gavi Secretariat will continue its active engagement with the leadership at the Ministry of Health and within the NPHCDA to ensure the prompt implementation of the remedial actions within the financial management system of NPHCDA and to have a fiduciary agent functioning by mid-January / start of February 2017.
- u) A programme capacity assessment (PCA) consisting of two parts, a desk review and an in-country review is now completed. The report of the PCA findings is awaited. It is expected that the Grant Management Requirements (GMR) document be finalised by end of 2016.
- v) Gavi has started the discussion with stakeholders on the transition and has requested the partners and NPHCDA to map the current support of various partners, this will help Gavi to draw up the details of a tailored support in 2017.
- w) It is proposed to have a cross-Alliance mission to country in Q2 2017 to further strengthen Alliance engagement with the country.

5. Pakistan

| DTP3 WUENIC coverage | Graduation and co-financing status | Country-tailored approach |
|---|--|--|
| 2015: 72% 2014: 72% | Graduation: Preparatory transition phase Co-financing: on track | Yes, being implemented since Nov. 2015 |
| Gavi support | | |
| <i>Active vaccine support:</i> Penta – 2008-2017 PCV – 2012-2017 Measles campaign – 2013-2015 IPV – 2015-2018 | <i>Active cash support:</i> ISS HSS 1 – 2007-2016 HSS 2 – 2016-2018 | <i>Pending support:</i> Rotavirus vaccine – Application was approved by EC in Sep. 2016, communication of approval is pending country meeting its co-financing requirements CCEOP – application approved in November |

5.1 Country context / key developments

- a) Pakistan is the largest recipient of Gavi support to date, with over US\$ 979 million committed until 2019, and is one of the largest Gavi-eligible countries in terms of annual birth cohort (over 5 million children). Only 54% of children receive a full course of vaccines in Pakistan and 1.35 million children do not receive their 3rd dose of pentavalent vaccine. There are substantial inequities in immunisation coverage between and within regions and provinces.
- b) Polio remains a major challenge for Pakistan, which is one of only three remaining countries with endemic polio. It accounts for 16 out of the 32 cases of wild polio viruses detected worldwide to date in 2016 (down from 39 for the same period in 2015). There is significant political attention to polio eradication, and routine immunisation needs to be strengthened as part of the polio end-game strategy and transition.

5.2 Successes

- c) There has been recent progress in immunisation in Pakistan, mainly confined to Punjab, the largest province, with a population of around 100 million. An independent household survey (Nielsen), estimates penta-3 coverage in Punjab at 86% at the end of 2015, which demonstrates a 22% increase in a 12-month period, according to the same source. This significant increase has been achieved by addressing major bottlenecks in immunisation delivery through investment in data for decision making, with provincial leadership driving for enhanced accountability.
- d) Vaccine financing and procurement (of co-financing share and non-Gavi supported vaccines) had been an issue of concern after the

devolution. Following a consensus in December 2015 on pooled procurement, the National Economic Council of Pakistan (ECNEC) approved on 17 March 2016 its vaccine procurement flow of funds by giving 3 options to provinces to pay their share of vaccine cost. Clarity on this was a major step forward in defining roles and responsibilities of federal versus provincial governments. A week earlier, the Council approved the budget and workplan of the National Immunisation Support Project (NISP), with a total budget of US\$ 370 million, to be financed jointly by the federal and provincial governments and development partners in a unique partnership. NISP is the country's overall budget and workplan for immunisation, based on Pakistan's comprehensive multi-year immunisation plan, and has province-specific targets and disbursement linked indicators (DLI). NISP's performance and results framework includes all Gavi core indicators and is finalised with tailored targets for each of the provinces. Partner funding is channelled through a multi-donor trust fund (MDTF), administered by the World Bank, to which Gavi provides US\$ 84 million (HSS-2), pooling resources with other donors (USAID, US\$ 10 million), while BMGF supports a US\$ 25 million buy down on the government's International Development Association loan. The NISP grant and financing agreement was signed on 31st August between the World Bank and government of Pakistan, marking the start of the project. The Project becomes effective as soon as the legal opinions received from the provinces are resolved. To the date of this report, approval of three of four provincial PC-1s (budget and workplan), which allows provinces to disburse funds to their health departments, is pending.

- e) The country submitted an application for cold chain equipment optimisation platform support in September, bringing the 50% required co-investment from NISP resources (both Gavi HSS, USAID and IDA). The Independent Review Committee reviewed the application in November and has recommended it for approval.
- f) A Rotavirus vaccine application was received in May and approved by the Executive Committee in September. An early introduction – through self-financing of initial doses in Punjab – is expected in January 2017 in 6 districts of Punjab followed by a national roll-out.

5.3 Challenges

- g) Disparities in immunisation coverage and equity between and within provinces remain the main challenge in Pakistan. While Punjab reaches an overall 86% DTP-3 coverage, districts like Rajanpur and DG Khan within Punjab lag behind the rest of province. Sindh and Baluchistan struggle at 50% or below. Delivery of immunisation in urban slums and hard-to-reach areas has been a challenge. Pakistan is selected as a focus country for the coverage and equity work of the Alliance and various strategies are being explored for addressing these challenges with engagement of country stakeholders.

- h) Security and access issues also remain concerning and limit programme delivery efforts and outreach in several areas of the country. Health staff involved in vaccination, in particular in the polio programme, continue to be the subject of attacks.
- i) The immunisation service delivery system in Pakistan is not yet functioning cohesively, affecting quality of services, access and demand. Funding for immunisation has not been adequate and disbursements remain unpredictable. Staffing allocation is often insufficient, deployed irrationally and short of required skills and competencies. The vaccine management, supply system and cold chain need further expansion and optimisation.
- j) Pakistan continues to have major issues with immunisation data quality. In the absence of a recent census⁶ and reliable population denominator, administrative coverage lacks adequate validity. Data for monitoring and accountability has improved in parts of the country, in particular Punjab through use of mobile technology, however other provinces are lagging behind. A district-powered immunisation coverage survey will be carried out by WHO in the coming months and the results are expected to be available in the second quarter of 2017. The World Bank will conduct annual coverage surveys, as part of NISP, for the next 4 years.
- k) On the basis of the Country Tailored Approach, Gavi agreed in November 2015 to align its co-financing requirements with the country's fiscal year (July – June). PCV co-financing commitments have subsequently been met through a payment to UNICEF. As the country self-procures its share of co-financing for pentavalent vaccine, a tender process was initiated, but faced constraints due to administrative and legal matters. As a demonstration of the country's political will and financial commitment, Pakistan is in the process of procuring co-financing doses of PCV for 2016-2017 to address its co-financing payments for pentavalent vaccine.

5.4 Learning – past and future

- l) In Pakistan, where health is a fully devolved subject, a province-centric approach to immunisation is more relevant and effective. With the upcoming approval of 5-year provincial workplans and NISP, the commitment of provincial finance ministries to fund immunisation will be secured until 2020.
- m) In Punjab, the following factors have been critical to a rapid uptake of vaccines: strengthened routine immunisation through stronger synergy with polio; comprehensive monitoring, supervision and accountability, enhanced use of technology for better collection and utilisation of data; strong commitment of the province's political leadership to bring the various elements together. This experience is

⁶ The latest census dates back to 1998. A new census is planned for later in 2016 – to be confirmed.

being studied and expanded to other provinces. Khyber Pakhtunkhwa province has started applying part of Punjab's experience. Balochistan is the next province to benefit from Punjab's experience, funded by Gavi.

- n) Partners' capacity to provide timely and effective support has been a concern in Pakistan and is strengthened through the Partners' Engagement Framework - Targeted Country Assistance. A total of 17 staff (9 WHO and 8 Unicef) is supported by Gavi, with the majority based in provinces and Areas. Except for one international and one national position, all posts have been filled.

5.5 Next steps

- o) Efforts continue to ensure provincial PC-1s are approved and monitor the implementation of the National Immunisation Support Project (ensuring predictable financing based on demonstrated results).
- p) Addressing equity and coverage issues with a focus on urban slums.
- q) Enhance the role of the National Interagency Coordination Committee to monitor and conduct oversight of NISP, linked to an ongoing strategic functional review of the federal EPI-programme funded through PEF.
- r) Inform future directions of support for vaccine management and expansion of supply system by the findings of the recently conducted vaccine audit (August 2016), a review of the vaccine logistics management system (conducted by USAID in October 2016) and a supply chain system redesign exercise (led by Unicef, started in October 2016).
- s) Support the country's potential application for measles-SIA in 2017.

Appendix E: Intensification of Coverage and Equity

1. Context

- 1.1 Strategic Goal 1 of the 2016-2020 Strategy sets ambitious goals to increase coverage of the two pillars of routine immunisation (DTP3 and MCV1) and to increase the breadth of protection across all Gavi eligible countries. Gavi also sets equity targets across three dimensions: geography, wealth and gender equality.
- 1.2 Although there has been a significant increase in coverage since 1999 (+20 % points for DTP3), additional gains in coverage appear to be more difficult to achieve. Since 2010, coverage across the Gavi eligible countries has shown a “plateau effect” (+3 % points for DTP3 coverage and no increase for measles-containing vaccines). If historic coverage growth trends persist, the Alliance risks to miss the 2020 coverage target of +5 % points between 2015 and 2020. Reaching the 2020 coverage targets thus requires a significant and sustained effort across all Gavi countries, including in some of the most challenging countries.
- 1.3 The Alliance has already taken various measures to maximise the impact of Secretariat and partners’ efforts to tackle this ambitious agenda, including (among others) by focusing resources on the 20 Partner Engagement Framework (PEF) priority countries with the largest number of unvaccinated children and greatest inequities; supporting work on dedicated “Strategic Focus Areas” to address health system components identified as critical to enhancing equitable coverage; leveraging synergies between Gavi’s different financial support windows through the Country Engagement Framework (CEF); and by adopting a more proactive grant management process.
- 1.4 Secretariat efforts on Intensification of Coverage & Equity (ICE) reinforce the elements described above, strengthening the link between country-level and global/regional initiatives, and providing additional support to those elements as required by country needs to spur measureable, sustainable progress on increasing coverage among marginalised and traditionally under-immunised populations.

2. ICE Methodology

- 2.1 ICE has to date engaged with 10 of the 20 PEF priority countries; the selection and phasing of additional support to these countries was based on a number of criteria that were reviewed by Alliance Partners and the Secretariat’s Country Support Team.
- 2.2 The ICE methodology keeps countries at the centre of the decision-making process – with a focus also on sub-national issues – and seeks to integrate an adaptive approach to problem-solving within existing country and Alliance processes. As illustrated below, these efforts are aligned and integrated into existing Secretariat and Alliance policies, tools, technical support, and funding windows. Working through and in close alignment with the Senior Country

Managers (SCM) and Country Teams the aim is to promote a stronger C&E lens to the core work of the Alliance. ICE support efforts consist of 4 steps:

C&E country summaries

- 2.3 Prior to any engagement and at the request of the Secretariat's Country Support Team, C&E briefings are being developed for each priority country. They leverage the existing body of data and knowledge from government, Alliance partners, and other sources. Existing assessments (e.g. UNICEF equity assessments), quantitative data, programmatic interventions and monitoring information (such as Joint Appraisal (JA) reports) at national and sub-national levels are compiled, analysed, and summarised in country briefs. These are validated by Secretariat country teams and in-country EPI, MoH and partner agencies and serve to deepen the dialogue on C&E priorities and potential solutions.

Diagnostic in-country dialogue

- 2.4 Following the initial validation of C&E priorities by country stakeholders as described above, this step involves focusing on a sub-set of these priorities. Undertaken as part of existing country-led planning and review mechanisms like JAs, HSS planning or reprogramming workshops and comprehensive multi-year plan (cMYP) processes, this enables a more in-depth discussion on the most critical barriers to achieving equitable coverage and seeks to clarify success/failure factors from past experiences to propose a set of actionable steps in a 6-12 month period. In addition to prioritising issues or barriers, this dialogue also supports countries to focus resources on the geographies and populations where they are most needed and where they may be most impactful.

Alignment of support with country priorities

- 2.5 ICE also works to strengthen the inclusion of prioritised interventions for improved C&E in established planning and financing tools, including annual EPI plans and applications for technical, financial, and institutional support from Gavi (HSS, NVS, PEF or extended partner technical assistance) and other donors. Triggers to those prioritised interventions can range from identified needs from technical assistance during the JA process or in cMYPs to country-driven requests that complement or facilitate HSS planned activities. In that respect ICE supports SCMs in their dialogue with countries to ensure that their applications are aligned with the identified C&E priorities, and seeks to ensure that those priorities are appropriately resourced. Rather than creating a separate funding process, these efforts help ensure that existing Gavi resources and funding windows are focussed on C&E.

Track performance and lessons learned

- 2.6 As prioritised activities and interventions are implemented via established Gavi funding envelopes, the ICE supports in-country and cross-country learning about what has proven effective in addressing C&E constraints. This ranges from identification of in-country positive outliers and other asset-based

approaches¹ to south-south technical support or mentoring/coaching. The focus is largely on the *how* as opposed to the *what* – while the purely ‘technical’ solutions to C&E issues are often known, the key question is how to effectively implement them in national and sub-national contexts that are resource- or capacity-constrained; socio-demographically distinct; or otherwise ‘different’; in sum, the places where success to date has been limited. Lessons learnt provide the basis for continued feedback on Gavi processes and policy developments, which contribute to Strategic Goal 1. Examples of these feedback loops have included inputs into revised application guidelines for New Vaccine Support and Cold Chain Equipment Optimisation Platform (CCE OP – see Annex B); design of the new CEF process (see Annex E); hosting discussions on C&E issues for Country Support Team members; etc.

3 Examples of ICE in-country work

- 3.1 In **Haiti**, the **country summary** compiled at the beginning of 2016 has been instrumental to the first ICE-facilitated consultation between EPI and other in-country stakeholders held as part of an HSS1 monitoring visit. Major issues to implement the HSS1 external support include: weak institutions, fragmented health systems, lack of cohesive donor/partner coordination, absorption capacity and poor planning. As a first result of the ICE intervention, concrete **priorities were identified and endorsed** by all stakeholders in-country. Those priorities are centred around 1) cold chain platform and last mile delivery; 2) a delivery model for challenging urban areas; 3) the geographic mapping of service delivery to facilitate identification of neglected communes and enhanced coordination of government/donor/NGO resources; and 4) human resources for vaccination delivery in lowest-coverage areas. During the subsequent JA in June 2016, stakeholders followed up on those conversations and clear linkages were established between **prioritised C&E issues and many of the points discussed during the JA**, especially the HSS reallocation and the PEF TCA priorities for 2017. This process provided the evidence and triggered the request for **additional assistance, which has been approved** to support a three-pronged approach aligned with country priorities: 1) Testing of a revised service delivery model in Cité Soleil (a densely populated and impoverished area of the capital city) with an eye to informing the development of a more comprehensive approach to reaching children in urban slums in the next HSS proposal (planned for early 2017); 2) Development of a tool for the EPI to map service delivery to improve planning, resource allocation, and reduce local-level coverage collapses due to unpredictable withdrawal of support from donors and service providers; 3) Provision of additional support for optimised supply chain management anchored around CCEOP coordination and stock management. In the aftermath of Hurricane Matthew, the implementation of the technical assistance has been delayed, but the commitment from the Ministry of Health (MSPP) and the EPI programme is high and a monitoring visit will happen in early December 2016.
- 3.2 **Chad** has been in the process of applying for a second round of HSS funding since March 2015 and has received ICE support since December 2015. Despite concerted support from Alliance partners, including ICE support to

¹ For examples please see www.positivedeviance.org; see also <http://arise.jsi.com/>

several planned missions in 2016 (including the JA) which **prioritised C&E issues** to be tackled and identified their root causes, Chad's recent HSS and CCEOP proposals were recommended for re-submission by the IRC in July 2016. While the Secretariat is exploring options for next steps, the challenge is to help the country break out of the **vicious cycle of low capacity resulting in rejected applications** subsequently resulting in **unavailability of funds to increase capacity**. Given the evidence of the in-country management challenges, ICE will continue to support the Chad country team efforts to introduce additional medium-term technical assistance for enhanced programme management; improved financial management and controls; and more focussed Alliance support for RI. It is anticipated that these measures – in addition to shifting Chad to the new Country Engagement Framework model – will facilitate improved programme design and thus approval of funding envelopes. Once the fundamentals are in place, emphasis will shift to supporting quality implementation of the country C&E priorities.

- 3.3 The two country examples illustrate the range of different C&E challenges and responses observed across all 10 countries, more evidence can be found in Annex D – country case study of Pakistan.

4 Emergent cross-cutting C&E issues of focus

- 4.1 Although ICE has focussed on supporting Alliance efforts in specific countries, a number of **cross-cutting issues** have come to the fore. Encouraging countries to focus resources on a prioritised set of geographies and interventions will be critical to ensure quality implementation of evidence-based packages of interventions (e.g. RED and REC strategies). Without this prioritisation, available resources can be spread too thinly to yield sustainable improvements in coverage and equity.
- 4.2 In most countries **service delivery** still needs to be **better tailored to specific population groups**. Improvement of service delivery to challenging urban slum areas via tailored approaches has been identified as a major priority in a number of countries that might also require a more systematic investment at regional or global levels to ensure countries are adequately supported. In addition, it will be important to ensure that Gavi resources (including HSS funds) are allocated to urban areas which often have the largest number of under-vaccinated children. Additionally, ensuring that last-mile service delivery personnel are motivated, trained and resourced to conduct outreach is also a major cross-cutting challenge.
- 4.3 Focus on **strengthening routine immunisation for specific antigens such as Measles and Rubella and Yellow Fever** has been identified as an opportunity to increase coverage and to curb drop-out rates through New Vaccine Support. Measles and Rubella and Yellow Fever activities, especially catch-up and preventive campaigns, are still sometimes planned in isolation from other immunisation interventions with inadequate focus on strengthening routine immunisation.
- 4.4 Periodic tracking in the medium-term coverage and equity indicators against targets set based on past trends is often insufficient to drive performance improvements or to evaluate the impact of interventions to increase C&E.

Continuously monitoring and evaluating the performance of core service delivery activities (such as outreach sessions) and targeted interventions can enable countries to more efficiently allocate the resources required to reach realistic C&E targets. Encouraging countries to develop **dashboards for performance evaluation** – based on existing data – and linking sub-national performance with the investment of Gavi and other partner resources will be critical to improving the impact of Alliance efforts to enhance equitable coverage.

- 4.5 While caregivers' value of immunisation is generally high in Gavi countries, in many population group awareness and **demand for immunisation** are insufficient to outweigh practical barriers to completing immunisation schedules. The Demand Promotion SFA, as aligned with the ICE approach, is tasked with promoting and facilitating in-country use of evidence-informed communication and demand-promotion strategies, to improve and sustain equitable uptake of immunisation services, as well as to improve the service delivery in order to overcome practical barriers to access.

Appendix F: Update on Gavi's approach to strengthening in-country Leadership, Management and Coordination (LMC)

1. Context and scope of the LMC approach

- 1.1 Achieving Gavi's 2016-2020 strategic goal of sustainably strengthening coverage and equity will necessitate **strong national 'leadership, management and coordination' of EPI programmes**. This is highlighted as a **strategic enabler of Gavi's strategy**. PCAs, Joint Appraisals and other processes have identified a number of challenges in these areas – yet those have often received limited attention and investment. Consequently, 'Country management capacity' has been identified as one of the **top 4 risks for the Alliance**. Therefore, **Gavi aims to engage and invest more deliberately in strengthening in-country Leadership, Management and Coordination (LMC)** in the coming five years.
- 1.2 Two elements are in the **immediate scope of the LMC approach**. These have a direct effect on the effective management of Gavi grants and a catalytic impact on sustainable delivery throughout the EPI programme:
 - (a) **Government EPI teams at the national level**; the sub-national level would be in scope for countries with devolved structures; and
 - (b) **National coordination forums** such as Interagency Coordination Committees (ICCs) or Health Sector Coordinating Committees (HSCCs)

2. Process update

- 2.1 Starting in autumn 2015, and building on a literature review, a **wide set of consultations** took place amongst EPI managers and other country stakeholders, Alliance partners, implementers of innovative management programmes, academics and immunisation policy experts on the challenges and potential interventions for each of these two elements. The consultations included over 60 interviews and two stakeholder workshops.
- 2.2 The **output** was an initial **'menu' of intervention ideas** that Gavi would support at the country level to **strengthen the Government EPI teams**; and the concept of a **'support package' for the Coordination Forums**. These are envisioned to address the key challenges identified, and are described further below.
- 2.3 Leveraging the input from the consultations, the **Secretariat is currently operationalising the 'menu' and 'support package'** by further detailing the envisioned interventions, developing the relevant guidance for the Alliance and countries, identifying concrete needs in specific countries emerging from PCAs and Joint Appraisals, and engaging with potential implementers on initial roll-out.

3. A 'menu' of intervention ideas to strengthen the Government EPI teams and a 'support package' for Coordination Forums

3.1 The interventions that Gavi would propose to **strengthen the Government EPI teams** are bundled in a flexible 'menu' that will **address the findings from in-country processes such as PCAs and Joint Appraisals**¹. These interventions would complement existing capacity building programmes in countries, and be applied and adjusted based on the country context. Envisioned to evolve over time, the 'menu' would initially include five interventions:

- (a) **Ensuring adequate team capacity:** PCAs and Joint Appraisals show that EPI teams in many countries are not adequately resourced, for example in Malawi and Mozambique. Gavi will work with such countries to ensure that the key positions critical to programme delivery are filled with the relevant profiles². For low income and Phase 1 countries this may include investing through HSS grants to provide time-limited resources to the MoH for critical and specific new positions. The government would fill the positions through transparent and documented recruitment processes³. The Secretariat is currently finalising its operational guidance and HSIS guidelines that would further detail this support, ensuring sustainability and safeguarding Gavi resources.
- (b) **EPI Management Training:** Gavi is considering to contract a partner to implement an innovative training course for EPI managers and core EPI staff. This programme would be strongly linked to managers' daily realities and incorporate the latest insights from adult learning. An advisory panel composed of independent experts, Ministries of Health staff, Gavi partners and Secretariat staff is currently reviewing a number of high level concept notes received from potential partners, including renowned global universities, African and global management initiatives, and implementers in the field of global health. Several countries have already been identified as potential participants including Kenya, Malawi, Eritrea and Mozambique.
- (c) **EPI Management Partner:** A high calibre professional with a strong managerial background would be embedded as a peer-coach in the EPI team for a period of 1 to 2 years. The Management Partner would assist the EPI team on specific management strengthening projects (e.g., strengthening EPI performance management, team reorganisation, resource mobilisation), and would provide day-to-day coaching on key management capabilities. For an initial roll-out Gavi is exploring partnerships with institutions such as the Aspen Management Partnership for Health for focus countries including Timor-Leste and Malawi.

¹ Gavi has designed jointly with partners and countries a voluntary self-assessment survey for countries aimed to diagnose an EPI team's organisational and managerial performance. The draft survey can be applied to complement PCAs and other assessments.

² This includes EPI teams. Depending on country context and need Planning, Finance, and other teams involved in HSS at the Ministry of Health or Ministry of Finance are also in scope

³ Gavi will not get into the business of building parallel hiring mechanisms over the medium to long term.

- (d) **Exchange visits:** Building on the experience of Alliance partners in supporting exchange of best practices between countries, exchange visits will be facilitated by core Alliance partners. They will enable EPI teams to potentially adopt management practices from high performing programmes. This intervention will be further conceptualised in early 2017.
- (e) **Enhance EPI performance management practices:** Suboptimal performance management practices have been continuously identified as impeding programme performance. To address this, institutions with strong experience in this area would provide long-term embedded support to strengthen EPI performance management systems. This would include – as illustrative examples – ensuring follow-up action plans to address key operational bottlenecks, and the facilitation of review meetings with key EPI stakeholders and high-level MoH staff to monitor action. Already implemented successfully in Punjab (Pakistan) this support would aim to create a lasting shift in mindset and behaviours towards a greater sense of accountability. Gavi is currently exploring partnerships with CHAI and other partners for, e.g., Kenya and Uganda.

3.2 The ‘support package’ for in-country Coordination Forums (ICCs, HSCCs or equivalent bodies) would include:

- (a) **Guidance for Coordination Forums:** As part of the 2017 guidelines for NVS, CCE Optimisation Platform and HSIS support, Gavi will provide a set of recommendations and requirements on the mandates, membership principles and governance practices of national high-level Coordination Forums to help ensure their functionality. Basic functionality will be part of Gavi’s eligibility requirements for new support and be reviewed at times of application. Gavi recognises that improving the functionality of Coordination Forums is an ongoing effort for countries that may take some time. Therefore, there will be a degree of flexibility in determining eligibility if countries coherently point out their approach to improve functionality.
- (b) **A set of tools:** This will include a number templates, e.g. for Terms of Reference, agendas, meeting minutes and follow up actions. These will be provided together with the launch of the 2017 guidelines.
- (c) **Extended training and tailored technical assistance:** The functionality of Coordination Forum hinges upon several key factors such as clear Terms of Reference, a good understanding of members’ roles and an effective MoH secretarial function. To strengthen these areas a provider to be identified through an RfP process would provide technical support to >15 countries (e.g. Pakistan, Kenya, Malawi, and DRC) starting in early 2017.

4. Next steps

- 4.1 Gavi will **continue to engage with countries to identify the specific LMC issues.** This will be done through the various processes that have been put in place in the new strategy period, including the PCAs, Joint Appraisals, and the new Country Engagement Framework.

- 4.2 The Secretariat will continue to identify the **most relevant institutions that can deliver the interventions** from above. This will be supported by a set of independent experts where relevant and done in line with the Gavi Alliance procurement processes.
- 4.3 The Secretariat and partners will engage with countries to **match the needs identified with the appropriate interventions**, and ensure that this support is rolled out in a way that is coordinated and aligned with assistance provided by other partners. The support will be monitored and assessed using the same standards applied for other assistance provided under the PEF and HSS.
- 4.4 Lastly, if interventions identified as being of value for a range of countries would need to be funded outside PEF TCA or HSIS, the Secretariat may come back to the Board for approval of a Strategic Focus Area.