SUBJECT:	**COUNTRY PROGRAMMES STRATEGIC ISSUES**
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1. Executive Summary

1.1. **This is a cover note to the Country Programmes update that was submitted to the Programme and Policy Committee (PPC) in October 2015. It provides information on several strategic issues raised during the PPC's discussion of the Country Programmes update and poses questions to the Board for its deliberation**. More detailed information on the Alliance's in-country operations, activities, achievements and challenges and particularly on the Alliance's work to increase coverage, equity and sustainability in the Gavi supported countries is provided in the attached Country Programmes update to the PPC, as well as in its Annexes A through D. The Annexes also provide more detail on the implementation of each of the Strategic Goals 1, 2 and 3 as well as an update on the Alliance's operations in 4 key countries, the Democratic Republic of Congo, India, Nigeria and Pakistan. A further annex to this cover note (Annex 1) gives an overview of the World Bank Group's engagement through the Gavi Alliance, January 2015-November 2016.

1.2. The Secretariat has also taken note of the comments and opinions expressed by PPC members with respect to the content and structure of the Country Programmes update to the PPC. In order to provide further guidance to the Secretariat the PPC has agreed that it would take time to discuss and align among PPC members on the content and structure of future updates at a PPC retreat which will be held before the May 2016 PPC meeting.

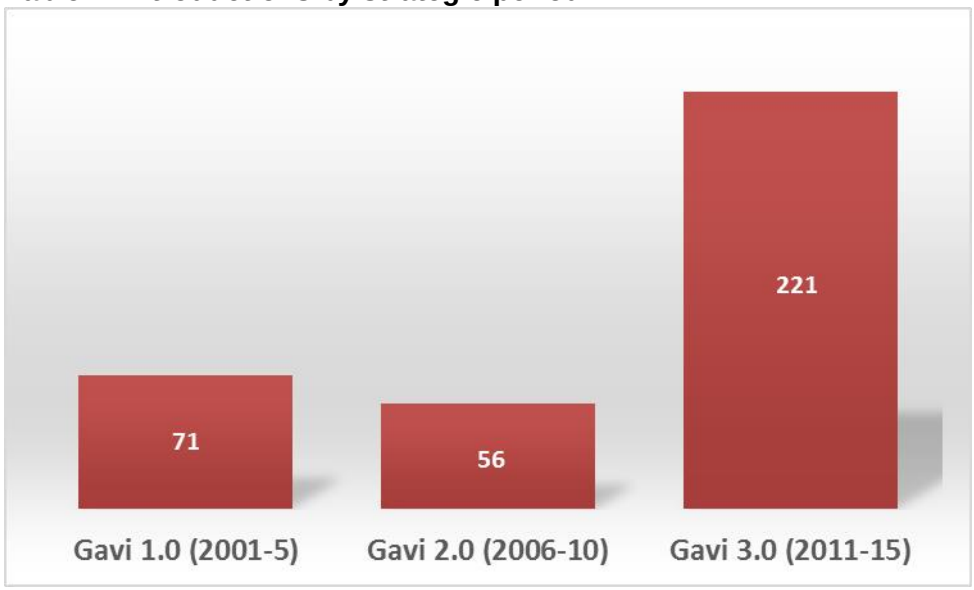
2. Content

Introductions

2.1. During the current strategic period the Alliance has focused strongly on delivering on the objectives of the 2011-2015 strategy, in particular to **accelerate the uptake and use of underused and new vaccines**. All

introduction targets were achieved by 2015 for pentavalent, pneumococcal and rotavirus vaccines[1]. Inactivated polio (IPV) and Japanese encephalitis (JE) vaccines were introduced in 23 and 1 countries respectively, and the Gavi Board approved the oral cholera vaccine stockpile. The Alliance has introduced ~53 vaccines in 2015 so far[2] and is projected to introduce a further ~26 to reach ~79 by the end of the year.

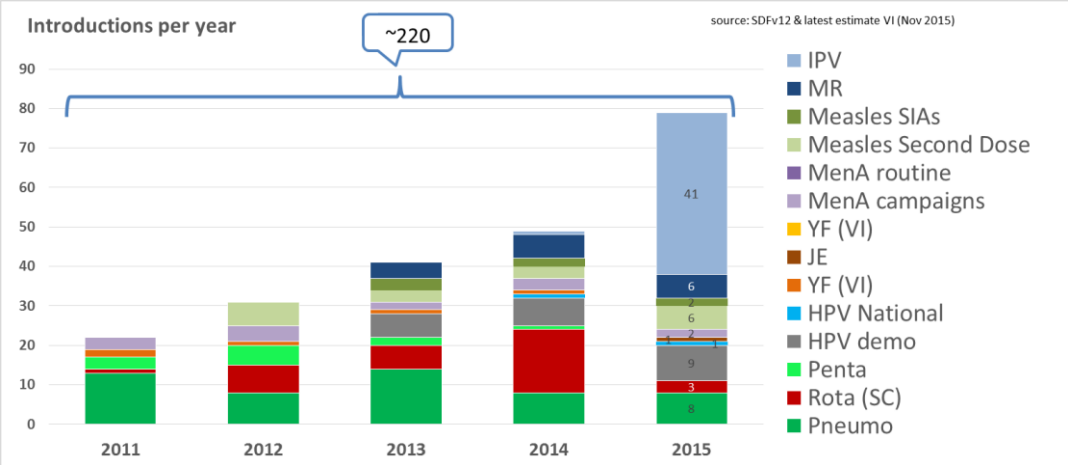
Table 1: Introductions by strategic period



2.2. This raises the total number of introductions over the strategic period to over 221[3] (including all vaccine programmes) making this the **busiest strategic period so far** in the history of the Alliance and 2015 the single busiest year to date.

[1] They were reached in 2014 for Penta, PCV and rota
[2] As of 3 Oct 2015
[3] Including routine introductions, Supplementary Immunisation Activities (SIAs), HPV demonstrations and campaigns

Table 2: Introductions per year



2.3. Yet, **the introduction agenda is far from being over**. The number of programmes which Gavi supports has grown from a low base of 3 to a list of 11 different vaccine programmes[4], to which possibly Ebola and Malaria could be added. Over the coming strategic period it is anticipated that ~200 new vaccine routine introductions, campaigns, HPV demonstrations and Supplementary Immunisation Activities will take place, including the completion of pneumo and rota roll outs, the ramping up of national roll outs for HPV, Measles containing vaccines and MenA routine introductions and completing the introductions in eligible countries for Yellow Fever.

Strategic Question 1**:** *The ~200 anticipated introductions, if appropriately planned and managed, can provide an opportunity to strengthen routine immunisation programmes. Yet in some cases introductions of new vaccines might also divert attention or resources required to improve the coverage and equity of existing vaccines programmes. Given this context, how can the Alliance ensure that decisions on new vaccine introductions are taken consistently with the key goals of increasing coverage and equity and of strengthen existing EPI programmes?*

Coverage targets

2.4. Gavi is **behind on the coverage targets** set for pentavalent, however, as key large countries, including India and Indonesia, complete their roll out the final target will be reached, albeit a year late. Gavi is also not on track to achieve the 2011-15 coverage targets for pneumococcal (40% coverage by 2015) and rotavirus vaccines (31% coverage by 2015). The primary driver for the lower than anticipated PCV3 coverage was supply constraints. However, supply constraints are now easing and **PCV3 coverage is expected to catch up to targets** quickly when large countries, such as Bangladesh and Nigeria, complete their national roll-out. It is also important to note that in 2014 PCV3 coverage in countries that have introduced prior

[4] Vaccine programs currently classified as 11 in total: (1) Penta (2) Pneumo, (3) Rota, (4) HPV (5) YF (6) MenA, (7) Measles containing (2nd dose, Measles SIA), (8) Rubella (MR), (9) Injectable Polio Vaccine, (10) Japanese Encephalitis (11) Cholera vaccine stockpile. The classification can be expanded to include sub-programs.

to 2014 was 73%, which indicates that PCV programmes are performing on par with Penta. Rota last dose coverage for the Gavi 73 countries initially suffered from supply constraints due to strong country preference for the 2 dose **Rota** product, yet these constraints are now easing and **coverage is expected to increase in 2015** when 16 new countries will have a full year of coverage data. For countries that have introduced prior to 2014 average coverage is 88%, showing the strength of the rotavirus programmes in these countries.

Country uptake of rotavirus and pneumococcal vaccine

2.5. The Gavi rotavirus market **historically faced supply constraints** due to strong product preference for the 2 dose Rota product. This product currently represents approximately 91% of Gavi's total 2015 demand due to its programmatic suitability with the existence of vaccine vial monitor, 2 doses per course, and smaller cold chain requirements. Due to increases in manufacturer capacity, supply is currently higher than demand by approximately 5 million doses in 2015. **Supply is expected to remain higher than demand** until large countries such as Nigeria, Bangladesh, and Pakistan introduce rotavirus vaccines in the next strategic period.

2.6. **29 countries that could or could have applied for rotavirus vaccine have not yet done so**. Of these countries, 14 are currently eligible to apply for Gavi support based on their GNI and DTP3 coverage. 5 of the 29 countries have DTP3[5] coverage below 70% and are therefore not eligible to apply, and another 10 countries have transitioned out of Gavi support.

Table 3: List of countries that have yet to apply for rotavirus vaccine split into 3 categories: (i) Eligible to apply for Gavi support based on GNI and DTP3 coverage; (ii) Ineligible due to low DTP3 coverage; (iii) Ineligible due to transitioned out of Gavi support

Eligible (14)		Low DTP3 (5)	Transitioned (10)	
Afghanistan	Korea DPR	**Chad**	Azerbaijan	Timor-Leste
Bangladesh	Kyrgyzstan	**Guinea**	Bhutan	Ukraine
Benin	Lao PDR	**Nigeria***	Cuba	Vietnam
Cambodia	**Myanmar**	**Somalia**	**Indonesia**	
Comoros	Nepal	**South Sudan**	Mongolia	
Congo DR	**Pakistan**		**PNG**	
India	Solomon Isl		Sri Lanka	

*Nigeria has already been granted an exception to apply for rotavirus vaccines
Bold indicates Tier 1 or 2 PEF country

[5] Nigeria is included as one of the five even though they are eligible to apply for Gavi support based on the Country Tailored Approach.

2.7. **Causes identified for why the remaining countries are not applying for rotavirus introductions include declining diarrheal disease burden and mortality, low vaccine effectiveness**[6] **/ competing prevention measures** (e.g., oral rehydration solution, WASH, exclusive breastfeeding), **uptake of multiple vaccines, lack of sustainable financing, and the cycle of low supply and demand**.

2.8. **15 countries of the Gavi 73 eligible countries have not yet applied for pneumococcal vaccine**. Of these, 4 countries are currently eligible based on their GNI and DTP3 coverage. 4 of the 15 have DTP3 coverage below 70% and therefore are not eligible to apply and another 7 countries have transitioned out of Gavi support.

2.9. **The Alliance is currently considering potential approaches to address the issues that impede the country uptake for both rotavirus and pneumococcal programmes.** Some potential solutions being explored include collaboration with Alliance partners to develop better understandings of relevant in-country discussions for countries eligible for Gavi support (14 and 4 countries for Rota and PCV, respectively) or assisting with developing necessary information to enable informed decisions while leveraging existing work streams (e.g., Coverage & Equity, Strategic Focus Areas, and Cold Chain Optimisation Platform), increasing global advocacy, exploring programmatic feasibility of new products, and incorporating immunisation into a package of interventions to address diarrheal and pneumonia diseases.

Strategic Question 2*: Diarrhoeal disease can be addressed through a comprehensive approach that uses Rotavirus vaccine as one of its key tools. Given the above outlined current limitations of the Rotavirus vaccine, how can the Alliance best pursue and incentivise the use of Rotavirus immunisation as appropriate as part of an integrated approach?*

Pro-active Vaccine Management

2.10. In 2001-2005 the scope of Gavi was limited to only 3 new & underused vaccine programmes. Today there are 11 programmes and the actual number of active vaccine grants being managed is now over 300[7], with an additional ~200 anticipated by 2020. Similarly, the **increase in scale and scope of Gavi supported programmes** can also be appreciated when considering the magnitude of deliveries which will increase from ~1000 shipments / per year to ~2000 shipments / year over the next 5 years. In addition, the annual value of supplied vaccines now amounts to over ~US$1bn (compared to ~ US0.5bn in 2010).

2.11. The increased scale and magnitude of programmes has resulted in increased complexities in running the 'back-office' to support the approval, financing, tracking and management of these programmes. **Improvements**

[6] WHO position paper states 40% - 60% efficacy in countries with high child mortality and high or very high adult mortality.

[7] This is constituted by over 200 introductions that took place during Gavi 3.0 (2010-15) and by the programmes that are still active from Gavi 1.0 (2000-05) and 2.0 (2005-10).

to the processes and systems to support the related operations are being continually implemented. Similarly, with the increased scale and scope of Gavi supported programmes and the majority of Gavi investments going into the purchase and supply of vaccines, efficiencies in the area of dose calculations, wastage and stock management are becoming more important and are addressed as part of the Secretariat's continuous move towards **more country centric, outcome focused and pro-active grant management**.

(a) ***Improved operational forecast***: by using real time shipment data from UNICEF Supply Division (SD) combined with Country's Annual Progress Reports (APRs) and by forward calculating country stock needs, the Secretariat has been able to better forecast dose requirements. Piloted for pentavalent programme, and now rolled out for the routine vaccine programmes this revised methodology helps to facilitate discussions with countries around targets, buffer amounts and appropriate stock levels and assists in determining the number of doses which will be re-supplied in the future year. Some examples[8] of where this approach has been used constructively are: Bangladesh - agreement to reduce buffer by 2.6m doses; Ethiopia – agreement to reduce target by 3.0m doses and Pakistan - agreement to increase shipment by 3.9m doses. Going forward, the process will be further developed and systemised.

(b) ***Establishment of an enhanced planning process with Alliance partners and other relevant stakeholders***: building on the vaccine dose calculation methodology (a triangulation of shipments, stocks and administered doses) the Secretariat plans to systematise its yearly country planning process through a collaborative planning process that involves all Alliance partners and the relevant Secretariat functions, including finance, vaccine implementation and market shaping. The objective of the revised process is to better manage Gavi's financial liabilities, improve planning processes with manufacturers and to manage more proactively indicators, such as open vial wastage rates and buffer stocks as well as to establish or re-enforce more effective vaccine management practices, such as the open vial policy and the use of multiple presentations.

[8] In addition to the 3 examples laid out in the text, each year there are several adjustments (of varying size as a % of annual demand) which are discussed with the country to agree the vaccine dose quantities.

(c) ***Procurement process with UNICEF SD is being established***: The Secretariat has also acted upon the main findings of a 2013 benchmarking exercise that looked into the readiness of supply of vaccines. A process is being established with UNICEF SD that authorises UNICEF SD to proceed with the planning of shipments to countries and to place purchase orders for the 2016 vaccine programmes for grants that have been reviewed by the High Level Review Panel in October 2015 (replacing a system where Decision Letters issued to countries with copy to UNICEF constituted the authorisation from Gavi to UNICEF to initiate procurement). The new process will allow UNICEF to conduct early shipment planning discussions with countries to facilitate timely delivery as well as ensure more prudent management of Gavi resources and commitments.

Strategic question 3*: Given that Gavi's most important investments are made in the purchase and supply of vaccines, and that any improvements in terms of dose calculations, stock management and wastage rates will net considerable dividends, does the Board think there is any other area that should be considered in addition to the activities outlined above?*

IPV and polio legacy

2.12. Overall, the introduction of IPV is progressing well and in-line with the ambitious targets set by the Polio Endgame strategy. Nevertheless there have been significant **vaccine supply delays**. Decreased supply availability coupled with increased demand for IPV use for campaigns in endemic settings and vaccine requests from India and Indonesia have necessitated intense management of the situation by the Immunisation Systems Management Group (IMG) **to mitigate the impact of delays and prioritise introductions** in countries that are most at risk of a type 2 vaccine derived poliovirus outbreak. As a result and in spite of concerns raised by several countries, including India, SAGE has recently confirmed that the polio eradication programme is on track to meet its April 2016 timeline for the globally synchronised switch from tOPV to bOPV, which will greatly reduce the risk of vaccine-derived polio cases by removing the poliovirus type2 component. Nevertheless, at this point it is expected that approximately 20 countries (19 Gavi supported countries) will introduce IPV after the tOPV to bOPV switch date[9] The supply is currently expected to remain constrained into 2017.The supply situation continues to be closely managed by WHO, UNICEF SD the GAVI Secretariat and the allocation of products is managed on a daily basis across the 71 countries supported by Gavi and 126 countries globally that introduce IPV.

2.13. The recently confirmed **tOPV to bOPV switch** that is to take place between 17 April and 1 May 2016 **is in itself a programmatic and logistical challenge for countries**. For this reason, the Secretariat and Alliance partners are treating this period with some caution as it is expected that

[9] Indonesia is the only high risk country to introduce IPV after the Switch as a result of their plan to self-procure from the local manufacturer, which encountered delays in making IPV available. Plans are in discussion to bridge the gap through alternative procurement to ensure an introduction in July 2015.

other immunisation programme activities, such as performance reviews and other new vaccine introductions, will be affected in the weeks running up to and following the switch. For this reason, activities are recommended to be conducted either well before or after the OPV switch.

2.14. Gavi is also receiving an increasing number of requests to **clarify its position on polio legacy,** as GPEI funding for partner immunisation staff in high-risk countries begins to ramp down. Given the shared partners and donors across GPEI and Gavi, an Alliance view on the topic is required.

2.15. To date, the Secretariat's view has been the following:

(a) Gavi does not have the **financial bandwidth nor the strategic mandate** to take over polio assets in countries;

(b) Any staff recruited would have to have a clear plan to be integrated into a country's HR system;

(c) Any Gavi engagement must remain **anchored in the 2016-20 strategic focus of improving equitable and sustainable immunisation coverage** and of strengthening routine immunisation systems. The data skills including micro planning and surveillance may be also important;

(d) A **country-driven, country-specific approach** is necessary in shared focus countries to understand the role that repurposed and right-sized polio-funded staff should play to strengthen immunisation systems and coverage and equity outcomes;

(e) **HSS and PEF Tailored Country Assistance (TCA) are the key financial instruments** by which the Alliance can support, within the available resources, countries and regions to mainstream key functional areas of polio assets important for RI strengthening and improving coverage and equity.

Strategic question 4: *Does the Board agree with Gavi's proposed approach to the polio legacy?*

Implications of existing HSS investments for the new strategic period

2.16. The PPC asked for further understanding of how HSS investments and committed funds will assist to sustainability improve coverage and equity. Gavi invests the majority of its funding in vaccines, and up to 25% of its funding in cash programmes, of which Health Systems Strengthening grants are one part. HSS reflected only 11% of Gavi's programme expenditures in 2014, and is projected to be only 13% in 2015. In addition, given that Gavi provides up to five year HSS grants, the tail of ongoing investments made under the current strategic period will extend into much of the new strategic period. The ability of HSS to fully catalyse Gavi's coverage and equity goals should be considered in these contexts.

2.17. HSS spending in the next strategic period is projected to be approximately US $1.25 billion, including investments in the three Ebola-affected

countries, which is projected to reflect approximately 16.7% of programme expenditures. On a programmatic year basis, as of third quarter 2015, Gavi had committed US$ 345 million to HSS over the period 2016-20, including US$ 147 million in 2016, US$ 95 million in 2017, US$ 73 million in 2018 and US$ 30 million in 2019. In addition, a number of new country applications are being considered at the November 2015 Independent Review Committee (IRC) and in 2016 such that 60-80% of the HSS funds for 2016-2020 are anticipated to be committed by end 2016. This highlights the importance of anticipating the transition to the new strategy, as already begun, and creating additional flexibility, where appropriate, for existing grants to be adjusted in light of elements of the new strategy.

2.18. As Gavi approaches the new strategic period the Secretariat and partners have begun to align to the new strategy and strategic focus areas:

(a) *Creating additional flexibility for adjustments to existing grants.* Countries are being given additional options to re-allocate funds to emerging priorities.

(b) *New guidelines.* Issuing new application guidelines for 2016 aligned to the new strategy and strategic focus areas.

(c) *Analysing existing grants.* The analysis considers alignment of existing HSS proposals to the new strategy. Looking forward, it will assist the partners to better focus support during HSS proposal development, inform the IRC review process, and strengthen implementation support of grants. It is anticipated that the outcomes of the analysis will be available for consideration at the next PPC meeting.

(d) *Policy review on Direct Financial Support.* The October PPC considered a paper on the policy review of Gavi's Direct Financial Support (e.g. HSS Grants, Vaccine Introduction Grants, and Operational Costs) that will come to the Board for decision in June 2016. The policy review will be critical to ensuring that Gavi's policies and processes are aligned to deliver on the new strategy, including the allocation of HSS funds between countries, targeting of funds, and how to improve efficiency between HSS and other types of direct financial support. Among the considerations anticipated, will be creating sufficient flexibility once implementing the new policy to allow existing grants to be adjusted while not undermining ongoing priority investments.

Political will and sustainability: Angola and Congo

2.19. 4 countries (Bhutan, Honduras, Mongolia and Sri Lanka) are expected to transition successfully out of Gavi support by the end of this year. Nine countries (Angola, Armenia, Azerbaijan, Bolivia, Congo, Georgia, Guyana, Kiribati and Moldova) will partially transition from Gavi support by the end of 2015 and thereby fully finance one or more vaccines in 2016. The majority are projected to fully finance the vaccines introduced with Gavi support without major challenges. Five of them have never defaulted on their co-financing obligations, and two have only defaulted once. However, two

countries, **Angola and Congo, given their history of arrears and level of co-financing obligations, are at significant risk of programme discontinuities with potentially important negative repercussions on immunisation coverage and equity** (table 4).

Table 4: History of default and key programmatic characteristics, by country

Countries	History of default	WUENIC DTP3 coverage (2014)	% of districts achieving >80% DTP3 coverage (2014)
Angola	2011, 2012, 2013, 2014	80%	46%
Congo, Rep.	2012, 2013, 2014	90%	77%

2.20. In 2016, Congo will have to independently pay for pentavalent, PCV and yellow fever vaccines, while co-financing over 60% of the remaining programme (rotavirus). Angola will have to fully fund its pentavalent programme starting in 2016, and to co-finance over 60% of the other two programmes (PCV and rotavirus). Both countries are expected to fully transition out of Gavi support by end of 2017. In Angola, a payment plan was developed with the country in Q2/2015 under which 2014 arrears and 2015 co-financing requirements should be paid by the end of December 2015. However, as of 18 November 2015, the country still had US$ 8.5 million in arrears related to its 2014 co-financing obligations, and had not yet made any payments towards its 2015 requirements. With respect to Congo, the country has paid close to 67% of its 2014 obligations. However, the majority of this disbursement was made only in October 2015 and, similarly to Angola, it has not yet made any payment towards its 2015 co-financing requirements (table 5). The consequence of this situation is that both countries are facing stock outs for a number of vaccines given that co-financing in practical terms means co-procurement of vaccines.

Table 5: Co-financing payments and arrears, by year, by country

	Angola		Congo, Rep.	
	2014	2015	2014	2015
Co-financing requirement	$9,413,000	$12,642,000	$2,382,000	$2,828,500
Amount paid	$912,616	$0	$1,617,885	$0
Pending payment	*$8,500,384*	*$12,642,000*	*$764,115*	*$2,828,500*

Note: all numbers in USD

2.21. **The significant delays in the payment of 2014 co-financing obligations have led to critically low stock levels for certain antigens in both countries.** As the share of vaccines financed by Gavi decreases, delays in

the payment of co-financing obligations can lead to supply disruptions. Both countries now face critically low stock levels and the imminence of stock-outs. Importantly, this is a pattern which can also be observed for other non-Gavi vaccines (e.g., BCG, measles, etc.), suggesting a broader issue with immunisation financing. In Congo, the situation is equally concerning. BCG has been reported to be out of stock nationwide, and a stock-out of pentavalent vaccine has also been declared at the central level. In the immediate future, it is expected that the recent payment of USD 1.6 million related to its 2014 co-financing obligations will allow the country to momentarily address its immediate supply needs for the next 4-5 months.

2.22. **In response to these challenges, the Secretariat and Alliance partners intensified their engagement and advocacy with both countries during the course of 2015**. Dedicated conference calls involving the Secretariat, Alliance partners and national EPI staff have been regularly organised to monitor local conditions, coordinate responses and design joint follow-up actions. A number of high-level political initiatives were also launched to engage key national decision makers and stakeholders. Gavi's Deputy CEO planned a visit to Congo in April 2015 but her visit could not take place due to competing travel plans by the Minister. In May 2015, Gavi's Deputy CEO raised the importance of a timely resolution of co-financing arrears in bilateral meetings with the Ministers of Health of both Angola and Congo during the World Health Assembly. Two Alliance missions to Angola in July and September met with a broad array of stakeholders involved in immunisation financing, including the Central Bank, Ministry of Finance and Parliamentarians. Most recently, Gavi's CEO held bilateral meetings at the margins of the United Nations General Assembly in September 2015 with Angola's Vice-President as well as with Congo's Minister of Plan to advocate for the immediate payment of 2014 and 2015 co-financing obligations, and to stress the importance of establishing stronger institutional mechanisms to ensure the funding of immunisation programmes in the future. A technical mission to Congo planned for the second half of October had to be cancelled due to political unrest in the country and a multi-partner high-level mission, comprised of Gavi's CEO and senior-level representatives from WHO, UNAIDS and the Global Fund, that was to meet with Congo's President on 6 November to discuss the need for greater domestic investments in health, was blocked at the last minute from the country's side. The Secretariat and partners are also currently following up with Angola's senior leadership to ensure continued political momentum. In both countries, transition plans are being adapted with a greater emphasis on reinforcing the necessary institutional mechanisms and channels which are critical for the long-term sustainability of immunisation financing.

2.23. At the time of writing, there is no evidence of incoming payments from either country to meeting their 2014 arrears. As per current Gavi policy, if a country remains in default for more than one year, the Gavi Board will decide the suspension of support until the co-financing arrears are paid in full. This implies, unless 2014 arrears are paid in fully 31 December 2015, suspension of future commitments of Gavi support for the rotavirus

programmes in Congo and for PCV and rotavirus vaccines in Angloa. Gavi will resume its support once all arrears are fully paid.

2.24. As oil-exporting countries, both Angola and Congo Republic have been negatively impacted by the substantial fall in oil prices observed over the past 12 months. Nevertheless, available data and budget analyses do not indicate the presence of extenuating circumstances that could warrant a waiver of their co-financing obligations. In particular, in both cases, total vaccine expenditures are expected to account for less than 1% of general government expenditures in health in 2015 (table 6). This suggests that vaccine costs can be absorbed within the available fiscal capacity and do not represent a major obstacle for the long-term sustainability of their immunisation programmes. Ultimately, the long-term sustainability of immunisation programmes in both countries rests on the adequate prioritisation of health and immunisation needs by the relevant political authorities.

Table 6: Vaccine costs (all vaccines) as % of General Government Health Expenditures

	2015	2016	2017	2018	2019	2020
Angola	0.5%	0.6%	0.6%	0.7%	0.6%	0.6%
Congo, Rep	0.5%	0.8%	0.9%	0.8%	0.8%	0.8%

Strategic Question 5: *Given the above described situation in Congo and Angola as well as the Alliance's numerous interventions to build strong political commitment to these countries' EPI programmes, (a) what more should the Alliance do, especially given the lack of engagement from Congo Republic, and (b) given risk that both countries may not meet their co-financing requirements for this year or maintain their investments after transition, how should we prepare for the real possibility of programmes failing?*

3. Annex

Annex 1: Overview of the World Bank Group's engagement through the Gavi Alliance - January 2015-November 2016

Overview of the World Bank Group's engagement through the Gavi Alliance

January 2015-November 2016

In its partnership with the Gavi Alliance, the World Bank Group is helping Gavi countries to identify key constraints and opportunities to achieving universal health coverage (UHC), while sustaining progress towards immunization outputs and outcomes. The WBG's Gavi sustainability program comprises two pillars: 1) comprehensive health financing system assessments (HFSAs); ii) case studies and policy dialogue. The work is embedded within the WBG's analytical and advisory work program and contributes to the ongoing dialogue that the Bank already has with Ministries of Health, Ministries of Finance, social insurance agencies, and other relevant stakeholders. A summary of the work program is given below.

Health financing system assessments

An important part of Gavi's 2016-2020 strategy is to increase effectiveness and efficiency of immunization delivery as an integrated part of strengthened health systems. Thus, a key area in which the WBG is helping Gavi to achieve this goal is through comprehensive health financing system assessments (HFSAs). In the first half of 2015, the WBG team spent several months reviewing and critiquing health financing system assessments to better understand the strengths and weaknesses of the tools and approaches that have been used at both the health sector and within immunization and other vertical disease programs. This review helped to inform the development of the HFSA protocol. The development phase took several months and was a collaborative process that involved several World Bank Group global practices, as well as country teams, accounting for more than 35 people in total. Members of the Gavi Alliance have also reviewed the tool and provided input, particularly on the immunization-related aspects of the protocol. Below is an update on the structure and process of the HFSA, and details of country applications.

The structure of the HFSA

The analytical work for the HFSA is organized into two major phases to promote standardization, while allowing for flexibility across countries. The first phase of the HFSA is referred to as the **core assessment** which focuses on the country context, UHC outcomes, health financing functions, and health financing inputs. Questions about public financial management and institutional capacity run through most of the modules. This series of modules helps country teams to answer questions such as: to what extent is the country achieving equitable service coverage and financial protection in a way that makes efficient use of resources? Is domestic-sourced financing sufficient to cover resource needs? Are budgets executed in a way that ensures predictability of financing and alignment with country plans? Is financing pooled and utilized equitably and efficiently? Do purchasing arrangements promote efficiency and provider responsiveness? Do public financial management rules and practices pose any constraints to flows of resources throughout the system? To what extent do PFM systems promote accountability and promote good governance? This core assessment draws on data from public expenditure reviews, NHAs, PETS, QSDS, and household and facility surveys, as well as international databases, country reports, policies, and key informant interviews.

In addition to the core module, Gavi countries also undertake the **immunization assessment**, which draws from standardized databases such as the WHO and UNICEF Joint Reporting Form (JRF) and the Comprehensive Multi-Year Plans (cMYP), but also examines how constraints in the broader health system affect the immunization program. Sample questions that can be answered from the analysis include: Do UHC benefits include coverage for immunization that are currently financed by Gavi? Will these interventions be adequately financed from domestic sources in the foreseeable future? Are there

mechanisms for updating immunization benefits as new technologies become available? Are all providers within the health system empaneled to deliver immunization services? Are there mechanisms to ensure adequate supply-side readiness? Do countries have the capacity to procure and monitor implementation of interventions and of results? Are there challenges related to public financial management, and how do these problems affect immunization financing and service delivery? Are there equity considerations in managing the Gavi transition, especially in terms of sustaining access for vulnerable population sub-groups? How can the country expand fiscal space for health to ensure that sufficient resources can be invested at all levels of the health system, including at the primary care level where immunization is often delivered? The HFSAs are helping to answer these questions and to generate policy dialogue to overcome some of these challenges. Additionally, the assessments aim to identify where targeted technical assistance be needed in order to help overcome some of the transition challenges.

In addition to the core assessment and immunization assessment, other drill-down assessments may be conducted for select topic areas that have been identified as constraints. For example, if a core assessment identifies that PFM constraints are hindering progress towards UHC and sustainability of immunization, a PFM drill-down assessment could be conducted. To date, the WBG has drafted drill-down assessments on fiscal space, provider payments, sustainability of externally financed disease programs, and PFM. Additional drill-down assessments will be drafted in the coming months, in response to issues identified through HFSAs.

The process of conducting the HFSA

The WBG has paid particular attention to ensuring the process by which the HFSA is conducted is embedded in the country program, and that policy makers are engaged at each step of the process. The HFSA is therefore embedded into the country partnership strategy and goes through all the necessary peer review processes and government approvals to ensure quality control and alignment with country priorities. This engagement ensures that the HFSAs are not a donor-driven exercise but instead are driven by demand from governments, and that findings are owned by governments and used to inform policy decision-making in the context of transitions. This process is also in line with Gavi's strategic enabler of country leadership, management and coordination.

Throughout the assessment, consultation meetings are typically held to review findings from the assessment and to reach consensus on the constraints and opportunities. Additionally, after the core assessment and immunization module are applied, a review and prioritization process is held to identify issues that should be explored in more detail (in Phase 2 of the assessment). This review process helps to reach consensus on the constraints to achieving UHC and sustainability of immunization program, and while identifying key issues that need to be explored through **"drill-down" assessments.**

It is expected that the assessments conducted to date will feed into a broader process taking place in country, such as strategy development, strategy review, policy dialogue, project preparation, etc., depending on the country circumstances and stage of planning. Many countries graduating from Gavi will also be embarking on a process of transition planning to ensure sustainability of externally financed disease programs as the country transitions away from donor assistance. An overview of the progress made on the health financing system assessment protocol is included in Table 1.

Table 1. HFSA products that have been produced by the WBG with Gavi assistance

HFSA Core protocol	Guides the user through a series of modules, comprised of questions that can be answered through collection of indicators and qualitative data. The assessment is organized around health and health system outcomes, health financing functions, and health system inputs, and contains 12 sub-modules.
Immunization assessment protocol	Guides the user through a series of modules, comprised of questions that can be answered through collection of indicators and qualitative data to better understand the constraints and opportunities within the immunization program. The assessment also links to the core module to identify how constraints in the broader system affect the immunization program. The protocol contains 11 sub-modules.
Resource site/users' guide for core module and immunization module	Provides guidance to the user on analytical tools and methodologies, and includes links to publically available databases, references to resources, examples from country applications, advice on data visualization and presentation. The document will be updated regularly to capture best practices and country experiences implementing the HFSA and other analytical work.
Other HFSA drill-down modules	Drill-down assessments on fiscal space, provider payments, PFM and sustainability of externally-financed disease programs have been drafted.
HFSA database	The WBG has built on an initiative already underway in the East Asia and Pacific region to develop a database of all the core indicators that are included in the HFSA protocol. The multi-year, multi-country database includes key health financing and health outcome variables from the IMF, WHO, WDI, ICTD, IHME, JRF, and other databases. Using a Stata program, the WBG Health Financing Group has been assisting country teams in populating figures and graphs. The purpose of the database is to help country teams carrying out assessments by populating standardized indicators, as well as tables and graphs that inform the narrative around the Gavi transition.

Country applications

The WBG is currently implementing health financing system assessments in Ghana, Indonesia, Sri Lanka, Georgia, Papau New Guinea and Vietnam. Highlights on these assessments are included in Table 2.

Table 2. Highlights from country applications

Indonesia	• WBG engagement focuses on transition financing issues as the country transitions from Gavi and Global Fund support • Main programmatic counterparts include MOH Secretary General, MOH Center for Health Financing; BPJS (insurance agency), Bappennas (Ministry of Planning), and the EPI unit within the Ministry of Health • The country team has spent several months conducting the HFSA core protocol and immunization assessment and have produced a draft of the assessment; assessments focus on bottlenecks associated with budget process, structure and execution (vis a vis decentralization) • Outstanding questions and data gaps are being addressed through PER, Quantitative Service Delivery Survey (QSDS), Public Expenditure Tracking Survey (PETS), District Health Accounts (DHA) analysis (to examine levels, trends, allocative and technical efficiency of public expenditures; to explore health financing flows through district health offices; and to assess supply-side readiness of public and private facilities, as well as barriers to access) • Immunization section of QSDS focuses on staffing, catchment area (for Puskesmas only) utilization and outcome indicators; service availability; infrastructure readiness; facility financing (for Puskesmas); programmatic focus; medicines and commodities availability; diagnostic capabilities

	• The WBG has held a number of consultation meetings and a policy seminar on transitions (sustainability of immunization, HIV/AIDS, TB and malaria have been highlighted during those discussions and measurement of outputs and outcomes for these programs serve as tracers for measuring progress to UHC). The full list of meetings is included in Annex 2. • One EPI unit staff member attended a UHC Flagship course in Colombo, Sri Lanka. • The country team has had a discussion with the Gavi Secretariat to explore the idea of conducting a graduation mission after a dissemination meeting in Indonesia.
Ghana	• WBG engagement focuses on UHC, and specifically aims to improve efficiency of service provision and equity of service utilization under the NHIS, and to support the Ghana NHIA to develop evidence-based health insurance policies for in the context of UHC • Broader health financing system assessment looks at the entire health system, including services such as immunization that are offered outside the NHIS. • Main programmatic counterpart has been NHIA, MOF, but more recently, Ghana Health Service has been engaged, given the transition from Gavi assistance • The country team has spent several months conducting the HFSA core assessment and immunization assessment; informal consultation meetings have been held with the government at various stages of the project. • An in-depth study on pharmaceuticals was planned as part of the HFSA, given that pharmaceuticals have been identified as one of the biggest areas of inefficiency in Ghana • Specific attention is being given to PFM issues in the assessment, and the WBG is coordinating with the PFM governance team as they begin a study to examine the PFM bottlenecks in the health and education sector.
Sri Lanka	• Given that Sri Lanka has nearly universal vaccination rates, the HFSA focuses on the lessons that can be applied to other countries. The dialogue around the assessment is focusing on how the system can increase efficiency and overcome challenges in public financial management in order to increase investments and sustain gains made at all levels of the health system (including primary health care, where immunization services are delivered). • Given that the EPI program is fully integrated in the preventive health system, the drill-down assessment focuses on primary health care, rather than immunization specifically. This approach responds to the government's request that the assessment not focus disproportionately on immunization but instead focus on constraints facing sustainability of the entire sector. • The country team has spent several months completing the HFSA and is currently collecting budget data at the provincial level, where one third of health expenditures are made. An effort is being made to track down data on the original budget, budget revisions, fund requests, funds granted, expenditure, and liabilities, for recurrent and capital budgets separately. • A household survey has been introduced to fill gaps in data collection and to examine out-of-pocket expenditures and patterns of utilization for care at all levels of the system (including primary care). This survey helps to understand health seeking behavior and to explore the extent to which the poor are benefitting from publicly provided services, within which immunization is offered. • The assessment is also revealing that absorptive capacity constraints, including in the area of public financial management, limits the extent to which the country is able to address new health system challenges such as NCDs. These constraints affect overall sustainability of the health sector and therefore affect the extent to which the government will be able to sustain the gains made in immunization and other priority programs.
Georgia	• WBG engagement focuses on UHC reforms and transition issues as the country transitions from Gavi (2017), Global Fund support (2017), and USAID support for health in 2015. • Key issues addressed by WBG program feed into Gavi assessment, including: the recent policy reforms around health insurance, which now covers 91% of the population with a defined set of benefits (including immunization); Issues around weak public spending and inefficiencies, which directly affect public sector allocations for GAVI and GF priorities as the transitions draw to a close.

	Improving efficiency and integrated these services into mainstream service delivery will be critical for ensuring successful transitions. • Main programmatic counterparts include Ministry of Health, Labour and Social Affairs (MOHLSA), Ministry of Finance. Key partners include WHO, UNICEF, USAID (although phasing out), as well as GF and Gavi. • A desk review has been conducted and the database has been used to populate quantitative indicators. The country team has begun data collection and policy consultations are planned for 2015 and 2016.
PNG	• The government has given approval to conduct the HFSA and immunization drill-down assessment in the country. • The country team has begun collecting data but have been finding it challenging to collect any data related to the immunization program, given that all data on immunization require approvals from the highest level of the government. The Secretariat is aware of this problem and is helping to facilitate access to information.
Vietnam	• The government has given approval to conduct the HFSA and immunization drill-down assessment in the country. A desk review is underway and the database is being used to populate quantitative indicators.

Case studies

The World Bank Group has also been asked to conduct a series of case studies to identify cross-cutting issues that can inform country policy dialogue in graduating countries. These case studies support Gavi's program objectives of i) supporting graduating countries and ii) helping countries to mobilize resources.

A key concern in countries that are moving toward UHC and also transitioning away from external financing, is how domestic financing can be mobilized, either through existing or "innovative" financing schemes. However, there is very little evidence of the impact of these innovative financing schemes on measures such as additionality, efficiency, and public financial management. To inform policy dialogue in countries transitioning from Gavi and other development assistance, the WBG has conducted a review of innovative financing schemes. The review covers four categories of financing instruments, including: earmarked taxes; bonds and debt instruments; private sector markets and partnerships; and private sector philanthropy. Instruments that have been used to finance or create markets for vaccines and immunization were included in the review, e.g., the International Finance Facility for Immunization, and Advanced Market Commitments (AMCs) for new vaccines. The review specifically addresses *how much* has been raised through these mechanisms, *where* the instruments have been used, and *what* some of the implications have been of the financing instruments. The review also discusses some of the arguments for and against the introduction of earmarked taxes for health. Findings are summarized in a PowerPoint presentation.

The review on innovative financing mechanisms has also informed a series of case studies on earmarked trust funds. Several countries with a high HIV burden have introduced earmarked trust funds for HIV/AIDS. For example, Kenya, Tanzania, Zimbabwe, Uganda and Zambia have all set up trust funds to protect HIV/AIDS spending. A similar trend seems to be underway in countries aiming to secure financing for immunization, with countries setting up either private trust funds or ring-fenced government funds in Mongolia, Nepal, Uganda, Senegal and Cameroon. The WBG has therefore started a study to better understand the rationale for introduction of trust funds, as well as the structures of the funds and the political economy in which they were introduced. The review will also conduct case studies in a few countries to assess the implications of the trust funds on additionality of resources, efficiency (both administrative and allocative), and public financial management (whether the funds contribute to

fragmentation and rigidity of resource allocation). The WBG aims to complete the case study by the end of the fiscal year.

Finally, the WBG is conducting a case study in Estonia and two other countries (to be confirmed) to better understand how health care reforms such as decentralization, or the move from input-based (line item) financing for pharmaceuticals, to strategic purchasing of health care (output-based financing) affects procurement of health commodities, including pharmaceuticals and vaccines. The shift toward strategic purchasing often results in providers having to utilize their own independent budgets to purchase health commodities. While shifting the risk to providers creates opportunities to increase efficiency and optimize allocations to health by focusing on local health sector priorities, providers may have a reduced market share (relative to central procurement), a limited capacity to negotiate prices, and reduced access to information about the cost and availability of such medical supplies. This affects access to and availability of efficient, affordable and good quality health commodities. Similarly, decentralization of the procurement of health commodities gives rise to duplication and inefficiencies, due to the effects of factors such as individual health care provider's reduced market power, lack of capacity and reduced access to information.

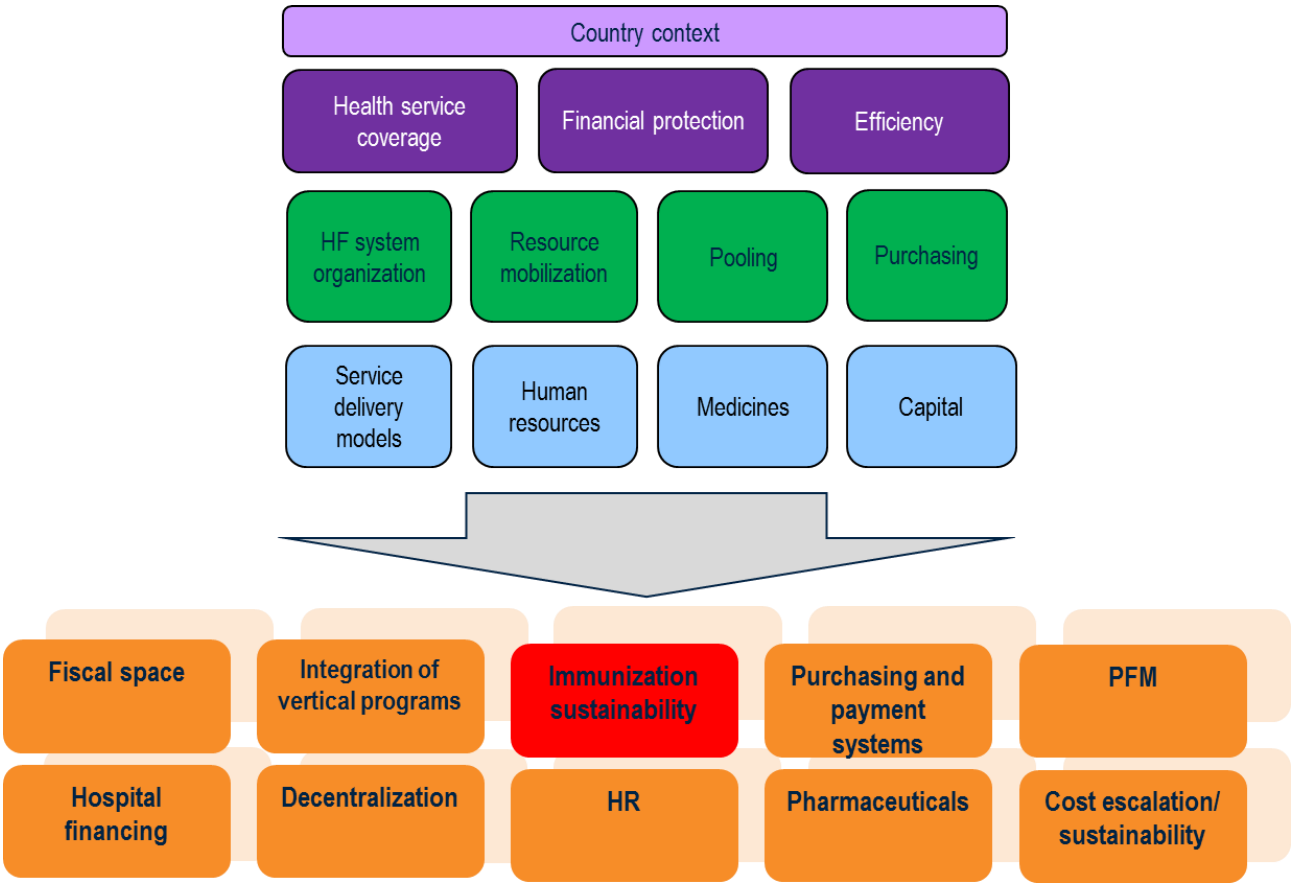
This series of case studies therefore aims to examine policy options that countries can introduce and mechanisms and best practices for purchasing and supply chain management that can be adopted by health care providers to increase access to efficient, sustainable, affordable and good quality health commodities by mitigating the effect of fragmentation in health commodity procurement. Given that fragmentation can affect the supply and affordability of any health commodity, e.g., pharmaceuticals, vaccines, and medical supplies, the study has relevance for countries that are graduating from Gavi assistance and other externally-financed disease programs. Estonia was selected as the first country because evidence shows that Estonia has been relatively successful in mitigating the effects of fragmentation. The first round of key informant interviews took place in Estonia during the week of November 2, 2015.

Policy dialogue and graduation planning

The WBG is also contributing to Gavi's objective of supporting graduating countries by contributing to policy dialogue, in collaboration with the Gavi Alliance. WBG teams have joined a graduation assessment and the graduation mission in Ghana and led the working group on sustainability of health financing. A senior economist also joined the transition mission in Sri Lanka and contributed to the joint aide-memoir and transition plan.

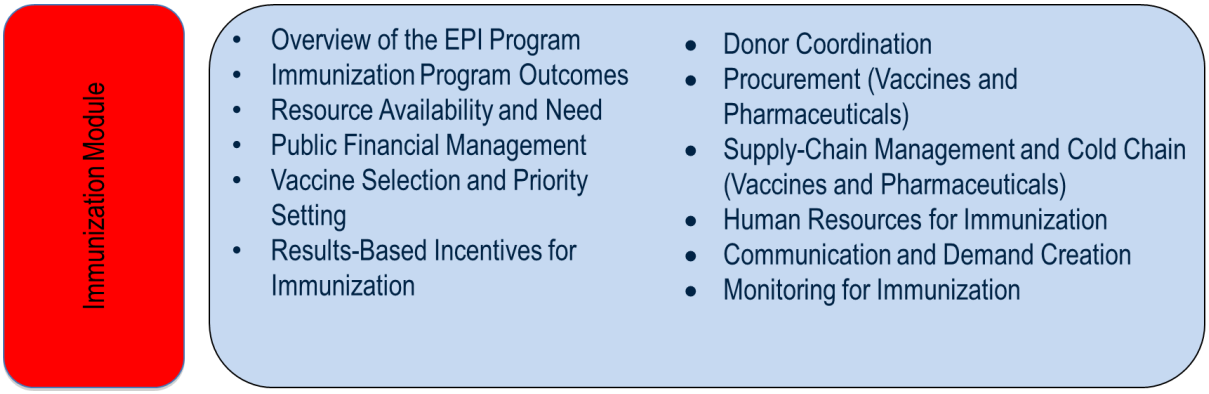
The WBG contributes regularly to both the Institutional and Financial Sustainability working groups and the Strategic Focus Area Sustainability working group and staff members have attended face-to-face meetings in Geneva and participated in regular phone calls. Through these interactions, WBG is often asked to link Gavi Alliance partners to the dialogue taking place through the WBG's programs. For example, the WBG has strengthened its engagement in the Republic of Congo to identify both short-term and long-term approaches to securing financing for immunization in the face of the oil crisis. Members of the health team have also attended meetings in Geneva with the Gavi portfolio manager for Republic of Congo. Gavi has requested that the Bank collaborate and align efforts on regulation, quality and procurement of vaccines and has also sought support from the Bank's country office to facilitate the dialogue with the Ministry of Planning and Finance, and to provide analysis on the macro-fiscal situation in the country. The Bank has also been in discussions with the government to include minimum budget allocations to health, and possibly securing immunization financing, through the Development Policy Loan. Finally, the WBG team has also been asked to provide comments on the transition plan, which will be revised on the next Gavi mission.

Annex 1a. Structure of HFSA: Core Module and Drill-Down Modules



***Country context includes:** macro-fiscal; poverty and social determinants of health; structure of public administration; PFM; health system organization; overview of health policy; health outcomes and demographics

Annex 1b. Overview of immunization drill-down assessment



Annex 2. Meetings and policy consultations held in Indonesia in the context of transitions

1. Participation of one MoH EPI unit staff member in UHC Flagship course in Colombo, Sri Lanka (April 2015)
2. Consultation discussion on overall scope of work on transition planning with HIV-UHC working group (June 2015)
3. Consultation meeting on HFSA immunization sub-module assessment, Ministry of Health EPI Unit (July 2015)
4. Policy Seminar on UHC and transition financing in TNP2K on UHC (September 2015)
5. Consultation meeting on QSDS and transition planning for ATM, Ministry of Health (September 2015)
6. Consultation meeting on QSDS and transition planning for immunization, EPI Unit Ministry of Health (November 2015)
7. Consultation meeting on MDTF transition planning with ATM and EPI unit (November 2015)

SUBJECT:	**UPDATE ON COUNTRY PROGRAMMES AND COVERAGE AND EQUITY**
Report of:	Hind Khatib-Othman, Managing Director, Country Programmes
Authored by:	Henri van den Hombergh, UNICEF, Michel Zaffran, WHO, Stefano Malvolti, David Salinas, Alan Brooks, Santiago Cornejo
Agenda item:	04
Category:	For Information
Strategic goal:	SG1 - Vaccines, SG2 - Health systems, SG3 - Financing

Section A: Overview

1. Executive Summary

1.1 2015 is a **transition year** as the Alliance concludes the 2011-2015 strategic period and gears up to implement the 2016-2020 strategy. Over the last strategic period the Alliance has worked hard to continue to roll out live-saving vaccines in the world's 73 poorest countries. **All vaccine introduction targets were surpassed** in 2015: all 73 countries have introduced pentavalent vaccine; 51 countries have introduced pneumococcal conjugate vaccine and 35 countries have introduced rotavirus vaccine. 36 introductions have already taken place in 2015[1] and ~45 are forseen to take place until the end of the year bringing the number of total introductions during this strategic period to ~226.

1.2 The **WHO/UNICEF Estimates of National Immunisation Coverage** (WUENIC) for 1980-2014, published in July 2015, show **encouraging progress** in the 73 Gavi-eligible countries. For the first time, average coverage exceeded 80%, with 81% of children receiving three doses of a diphtheria-pertussis-tetanus (DTP) containing vaccine.

1.3 **Significant challenges remain,** however, to ensure full and equitable vaccination coverage within and across countries and to sustain these gains. Nearly 15 million children a year in the 73 countries are still not being reached with three doses of a DTP-containing vaccine and only 15 countries (21%) have over 80% with 3 doses of a DTP-containing vaccine in every sub-national district.

1.4 In order to advance the coverage and equity agenda **Gavi's 2016-2020 strategic focus is on accelerating the equitable uptake and coverage** of vaccines and on ensuring the **sustainability of programmes**.

[1] As of 15.09.2015

Refocusing the Alliance's support to address these challenges will require building on lessons learnt during the current strategic period.

1.5 This report provides **examples of the Alliance's efforts to increase the equitable vaccination uptake and coverage** in Gavi-eligible countries, including the 17 countries that were the focus of the Gavi Alliance Business Plan 2011-2015. The report also describes the Alliance's efforts to ensure the sustainable transition of countries that soon will no longer qualify for Gavi support.

1.6 As in previous updates this report provides an update by the Gavi Secretariat's Country Programmes Department and its **Alliance partners** on their **joint in-country work**. While previous such updates have been structured according to Strategic Goals 1, 2 and 3, this update takes a more holistic view. It has been reshaped to take stock of the Alliance's work over the current strategic period, to describe the Alliance's efforts to transition to the next strategic period and to provide an outlook on the Alliance's work within the framework of the new strategy, highlighting the Alliance's refocused efforts to increase coverage and equity in the Gavi 73 countries. Annexes A through D provide more detail on the implementation of each of the Strategic Goals 1, 2 and 3. No specific questions are being presented to the PPC in this update, yet the Alliance is looking for feedback on the revised form of this update.

Section B: Content

2. The 2011-2015 strategy period: Investing for equitable uptake and coverage

WHO and UNICEF time series with estimates of immunisation coverage shows encouraging results

2.1 During the current strategic period the Alliance has focused strongly on delivering on the objectives of the 2011-2015 strategy, in particular to **accelerate the uptake and use of underused and new vaccines.** All introduction targets were achieved by 2015 for pentavalent, pneumococcal and rotavirus vaccines. Inactivated polio (IPV) and Japanese encephalitis (JE) vaccines were introduced in 21 and 1 countries respectively, and the Gavi Board approved the expansion of the oral cholera vaccine stockpile. The Alliance has introduced 36 vaccines in 2015 so far and is projected to introduce a further 45 by the end of the year. This raises the total number of introductions over the strategic period to 226 (including campaigns). Annexes A and B present the unprecedented scale of the introduction and use of new vaccines as well as the support provided under Gavi's evolving health system strengthening (HSS) model. The Alliance has also begun to move towards providing tailored assistance to increase coverage in eligible countries.

2.2 The WHO/UNICEF Estimates of National Immunisation Coverage (**WUENIC**) for 1980-2014, published in July 2015, **show encouraging progress**. The

revised estimates show that more children than ever are being reached with three doses of a DTP-containing vaccine in the Gavi 73[2]:

(a) In 2014, 81% of children in the 73 Gavi-eligible countries received three doses of a DTP-containing vaccine. This was the first time that average coverage exceeded 80%.

(b) Average coverage in the Gavi 73 has risen over 20 percentage points in the 15 years since Gavi was created (it was 60% in 2000).

(c) The number of children receiving three doses of a DTP-containing vaccine has increased by 6% since 2010 to over 60 million children – given growth in coverage and population (the number of children in Gavi countries has also grown by 3% since 2010).

(d) Coverage with a DTP-containing vaccine has increased by 3% since 2010, the baseline for this strategic period. Gavi's 2011-2015 strategy target is a 6% increase by the end of 2015.

(e) The number of Gavi countries with over 90% coverage with three doses of a DTP-containing vaccine, in line with the target of the Global Vaccine Action Plan (GVAP), has risen to 32, from only 13 countries in 2000.

(f) Coverage of new vaccines is also increasing as countries scale up their programmes. In 2014, coverage with three doses of pneumococcal vaccine reached 28% and coverage with a full course of rotavirus vaccine was 15%. In 2010, coverage for both vaccines was only 1%. However, the Alliance is not on track to achieve the 2011-2015 coverage targets for these vaccines, largely due to supply constraints and delayed roll-outs in a few large countries.

Encouraging progress in key countries

2.3 A key driver for the recent increase in immunisation coverage has been **progress in four countries** with large populations, which together are home to nearly half of all children in the 73 Gavi-eligible countries: the Democratic Republic of Congo (DRC), Ethiopia, India and Nigeria.

[2] These estimates are based on data officially reported to WHO and UNICEF by Member States as well as data reported in the published and grey literature. WUENIC data estimates are inevitably affected by the quality of the available primary coverage data.

(a) **DRC**: Coverage with three doses of a DTP-containing vaccine rose to 80% in 2014 from 74% in 2013 and just 60% in 2010, although data quality remains a challenge. The reported increase comes as a result of joint efforts by the Ministry of Health and its partners. Following an external EPI review and Effective Vaccine Management Assessment in 2012, DRC, with support from the Alliance, developed a comprehensive multiyear plan based on the recommendations made in these reviews as well as on lessons learnt from its polio work. Weekly calls were organised by WHO's African Regional Office with staff from the Ministry of Health and immunisation partners at the national, regional and global level to jointly monitor the implementation of the EPI plan. The programme has largely focused on strengthening routine immunisation activities and on intensifying activities in areas with high numbers of non-immunised children. Gavi's HSS grant was reprogrammed in 2013/2014 to support the implementation of the EPI workplan which includes data quality improvement complementing support from other partners and in line with DRC's country-tailored approach. Another factor that contributed to the success of the programme was the alignment of Gavi support to CSOs with HSS support for demand generation. Despite the overall positive trend in coverage many challenges remain in DRC (see Annex D on DRC).

(b) **Ethiopia**: Coverage rose to 77% in 2014, from 72% in 2013 and 61% in 2010, although data quality challenges remain. A positive trend is that the administrative data is decreasing progressively to more clearly align to the WUENIC estimates reflected above. 2014 coverage estimates show an important increase from a 2012 survey that showed only 65% coverage with 3 doses of a DTP containing vaccine. The survey led to strong commitments from the government and immunisation partners came together in a national Routine Immunisation Improvement Plan (RIIP), with the aim of achieving at least 80% coverage in 90% of the districts in each region. The government and its partners have increased their focus on regions and zones with large numbers of unvaccinated children, leading to an overall rise in coverage, while using Gavi's and other resources to invest in critical elements of sustainable improvements. For example, the health extension workforce has been expanded with catalytic support from Gavi for training and deployment, such that tens of thousands of staff now funded by the government are embedded in communities, providing a basic package of primary health services within their communities including vaccination, birth registrations, tracking of defaulters, growth monitoring, deworming, etc. The supply and procurement system has also been simplified and integrated with Gavi's and Alliance partners' support by positioning distribution hubs closer to and delivering directly to health centres and by improving real time stock visibility through more complete scaling up of a Health Commodities Information Management System.

(c) **India**: Coverage has increased to 83% in 2014, from 79% in 2010 and 72% in 2009. To improve data quality, the national Universal Immunisation Programme, with support from WHO and UNICEF, conducted a comprehensive subnational data review in early 2015, which led to an upward revision of its WHO-UNICEF time series of official coverage estimates from 1998 to 2013. The increase in coverage reflects the strong commitment of the Indian government to improve access to immunisation and other basic health services in the country. Since 2014 the Ministry of Health and Family Welfare has focused on 12 under-performing states, with the support of a Gavi HSS grant and Alliance partners. The ministry is addressing constraints to coverage and equity by using the experience and workforce acquired in its polio campaign to increase routine immunisation; it is improving micro-planning and social mobilisation, investing in the cold chain and strengthening monitoring and evaluation. A mid-term evaluation of the HSS grant at the end of 2015 will guide implementation in 2016. In April 2015 the government launched Mission Indradhanush ('Rainbow'), a coverage and equity initiative in 201 districts. The government has replicated and scaled behavioural change interventions pioneered through Gavi's HSS support across all targeted districts. Within four months, 2 million children were fully immunised through this initiative. It aims to increase full immunisation coverage[3] from currently 65% to 90% by 2020.

(d) **Nigeria:** Coverage in Nigeria increased to 66% in 2014 from 63% in 2013 and 54% in 2010 as a result of efforts by the government, Alliance partners and development partners. Polio efforts have been harnessed to boost routine immunisation, and investments have been made in the supply chain and the cold chain. The successful introduction of PCV and IPV in 2014 have also reinforced the country's EPI programme. The Alliance continues to work with the National Public Health Care Development Agency and partners to ensure maximum support, making new disbursements for vaccine introductions that will improve the overall immunisation programme and continuing campaigns through UNICEF and WHO. In light of the country entering the first Gavi transition phase in 2017, it is critical to enhance the Alliance's relationship with the Ministries of Health and Finance to ensure optimal support to the country in this process.(see update on Nigeria in Annex D).

2.4 Other countries that have helped improve the overall immunisation coverage include **Congo**, which has increased its coverage to 90% in 2014 from 79% in 2010, mainly by:

(a) Focusing government and partners' vaccination efforts on the two cities that are home to more than 70% of the population (Brazzaville and Pointe Noire);

[3] Full immunisation coverage in India includes OPV3, BCG, DTP3/ penta, measles.

(b) Improving availability of vaccines by strengthening the supply system through the construction of new cold rooms in Brazzaville and Pointe Noire through Gavi Immunisation Service Support rewards;

(c) Increasing sensitisation to reduce opposition to vaccination in the population;

(d) Using vaccine introductions and campaigns to mobilise the population and implement catch-ups;

(e) Implementing intensive or supplementary immunisation activities, especially through the mother and child week financed by UNICEF.

2.5 Congo is, however, in a critical position. It is due to transition out of Gavi support at the end of 2017 and therefore responsible for taking over the complete costs for its pentavalent, yellow fever and pneumococcal vaccine programmes at the beginning of 2016, putting the country under pressure to increase its immunisation budget. Congo is in arrears on its 2014 co-financing payments leading to current stockouts for pentavalent and yellow fever vaccine. Alliance partners are working closely with the government to solve these problems.

2.6 **Vietnam's** immunisation coverage in 2014 was 95%, up from just 59% in 2013. Coverage was low in 2013 because of a political decision to suspend a Gavi-supported pentavalent vaccine for five months after deaths that were reportedly due to adverse events following immunisation (AEFI). Investigations assisted by WHO did not reveal any association between the vaccine and the deaths. The health minister and Gavi's chief executive discussed the potential consequences of replacing the current vaccine with a costlier one, which also helped facilitate the country's decision to restore the original vaccine in the Expanded Programme on Immunisation (EPI). The return to high coverage underscores the strength of Vietnam's immunisation programme as well as the positive way the country dealt with a complex AEFI situation.

2.7 **Ghana's** coverage increased to 98% in 2014 from 91% in 2010. In-depth interviews at the regional and district levels have revealed that Alliance support has benefited peripheral areas, a large driver for the increase in coverage, by:

(a) Increasing immunisation coverage through mop-up activities in poorly performing districts;

(b) Supporting hard-to-reach districts;

(c) Training newly recruited staff in the districts;

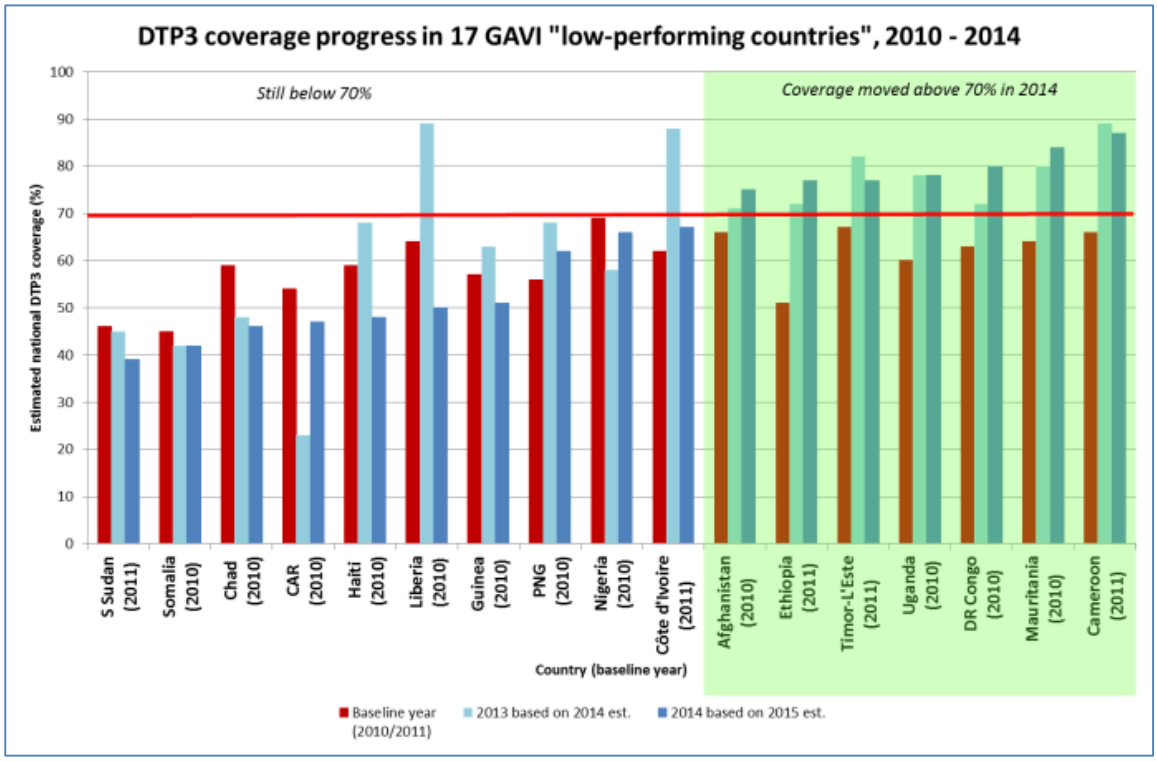
(d) Improved monitoring and supervisory visits at the regional and district levels, including support to the Community-based Health Planning and Service Zones.

Targeting 17 priority countries through the Gavi Alliance Business Plan

2.8 In addition to overall investments made through Gavi's vaccine and HSS grants, the Alliance has made targeted investments in 17 priority countries through the Gavi Alliance Business Plan 2011-2015. The business plan identifies activities to be undertaken by key Alliance partners to help achieve the 2011-2015 strategic goals. The 17 countries were selected by the Board in 2010 because their coverage with 3 doses of a DTP3 containing vaccine was below 70%. These countries have received technical assistance to reinforce national planning, with a focus on improving coverage. In countries with large numbers of polio funded staff within WHO and UNICEF (Afghanistan, Chad, DR Congo, Ethiopia, India, Nigeria, Pakistan, Somalia and South Sudan), these staff were increasingly re-focussed on supporting routine immunisation efforts. Additional key activities supported by WHO included the improvement of data quality (India, Nigeria, Chad), development of monitoring tools and accountability frameworks for staff (Pakistan, Nigeria, DR Congo, India), support in the management and expansion of immunisation supply chain and logistics systems, the introduction of new vaccines and provision of direct health service support in conflict countries such as Somalia, South Sudan and CAR.

2.9 The average coverage with 3 doses of a DTP containing vaccine in these countries increased to 70% in 2014 from 61% in 2010. Coverage with 3 doses of a DTP-containing vaccine rose in Afghanistan, Ethiopia, DRC, Mauritania and Nigeria, but coverage of one dose of measles vaccine (MCV1, the other primary indicator of routine immunisation coverage) stagnated in the low 60%s. In seven countries, including Afghanistan, DRC, Nigeria and Uganda, coverage has been above 70% for the last two years. One strategy that has, for example, supported this positive trend in Afghanistan is the training of volunteer Community Health Workers (CHW) in Afghanistan for targeted areas mostly inhabited by nomadic populations; 1,239 CHWs have completed training with the support of a Gavi HSS grant. This led to 4,892 cases of acute respiratory infection being treated and 21,831 children being referred for immunisation. Coverage with 3 doses of a DTP containing vaccine in the targeted areas has increased from 16% to 41%. In Timor Leste, coverage has been increased through targeted investments in supply chain management, including procurement and distribution of 220 refrigerators, and in service delivery.

Figure 1: Coverage with 3 doses of a DTP containing vaccine in 17 Gavi "low-performing countries"



2.10 In other countries in this group, such as South Sudan, coverage fell over the entire period, while Haiti, Guinea and Liberia had important declines mainly in 2014. In South Sudan, an intensification of civil conflict has severely hindered the vaccine programme. Going forward, a new HSS grant will be used to strengthen the EPI programme. Haiti reported stockouts and problems implementing outreach activities. In response the Alliance has established closer communication channels with PAHO and MoH to get systematic information on stocks, and has worked to build capacity of MoH by sharing the cost for one logistician embedded in the MoH. The Alliance has also intensified its monitoring of the HSS grant which funds the implementation outreach activities so that in 2015 most of the activities were implemented that had been delayed in 2014. Guinea and Liberia suffered severely from the Ebola virus outbreak, which halted immunisation and health services in some affected areas. Subsequent catch-up routine immunisation activities and campaigns, supported by additional Gavi funding, have closed the susceptibility gap in these countries. WHO and UNICEF teams in the Ebola affected countries were instrumental in designing and implementing the EPI recovery plans and conducting supplemental activities to reduce the susceptibility gaps, especially against measles

Identifying persistent challenges in coverage and equity

2.11 Despite this progress, significant coverage and equity challenges remain:

(a) Nearly 15 million children per year in the 73 Gavi-eligible countries are still not being reached with 3 doses of a DTP containing vaccine.

(b) Coverage with 3 doses of a DTP containing vaccine remains under 80%, in over one-third of the 73 countries, including several large countries such as Afghanistan, Nigeria and Pakistan.

(c) MCV1 coverage, a critical foundation for efforts to control, and ultimately eliminate, measles, has stagnated at 78% since 2010.

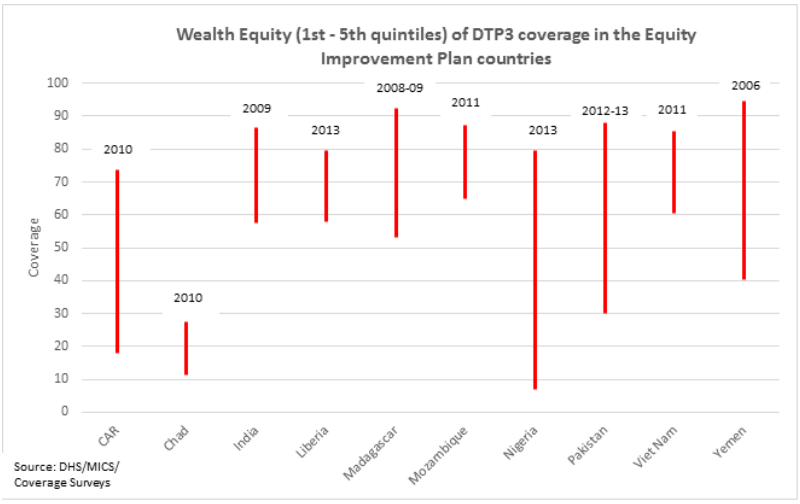
(d) Gavi is also not on track to achieve the 2011-2015 coverage targets for pneumococcal (40% coverage by 2015) and rotavirus vaccines (31% coverage by 2015), primarily due to supply constraints of preferred products and/or delayed roll-outs in a few large countries, including Bangladesh, Nepal and Nigeria. Pakistan and Uganda have completed their phased roll-outs of both PCV and RCV. Rotavirus vaccine coverage that suffered initially from supply constraints and more recently from delayed roll out is expected to increase given the high number of introductions over the new strategic period.

(e) **Equity** remains a challenge in most countries with only 15 of the Gavi 73 having over 80% coverage with three doses of a DTP-containing vaccine in every district (the primary GVAP measure of equity).

(f) Equity between wealthy and poor parts of the population also shows that, while from 2010 to 2015 equity has increased from 51% to 57% across all 73 Gavi-eligible countries, there is still much to do to reach the target of 62%.

(g) Over the current strategic period UNICEF has provided targeted supported to 11 countries that had been selected as they had the highest difference in coverage with 3 doses of a DTP containing vaccine by wealth quintiles (see figure 2 below). In these countries there are wealth differences in coverage with 3 doses of a DTP containing vaccine ranging from a high of 73% point difference (in Nigeria) to a low of 16% point difference (in Chad).

Figure 2: Wealth inequity in coverage with 3 doses of a DTP containing vaccine in 10 UNICEF "inequity countries (no data for PNG)

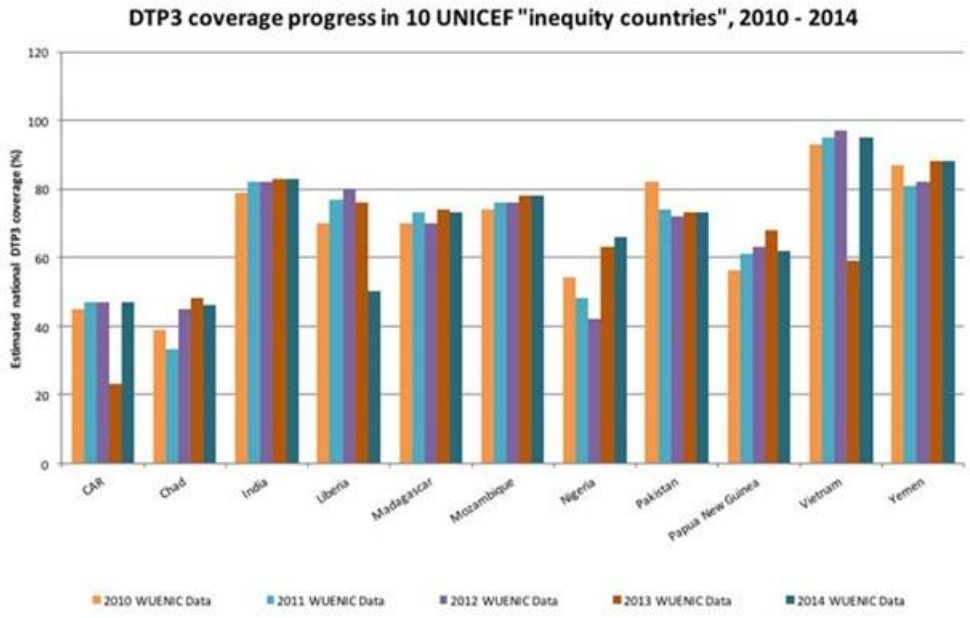


(h) UNICEF's support for the 11 priority equity countries has focused on using the knowledge about immunisation inequities to make visible the communities affected, thus promoting awareness and accountability within the country. This has resulted in the identification of "roadblocks" that entrench these inequities by hindering service delivery and community demand, and in the development of plans to remove these roadblocks, integrated in national EPI plans to microplans in every health centre. In all countries, this process has begun with an initial immunisation equity assessment that has identified a variety of equity gaps, for example concerning the urban poor (Liberia), remote rural communities (Chad, India, Madagascar, Mozambique, Nigeria and Pakistan) or ethnic minorities (Vietnam). Much of the subsequent work has involved shifting from the traditional "Reaching Every District" focus to one of "Reaching Every Community", to ensure that planning, service delivery, monitoring and resource allocation are "inclusive" of the unique needs of children in these most marginalised communities.

(i) Building on the lessons learnt in these 11 countries the Alliance will build up its support to increase the equity of immunisation programmes in Gavi eligible countries in this and other areas, including immunisation inequities arising from differences in residence (urban vs. rural, province, district, health centre catchment), birth order, mothers education level, and gender.

National coverage with 3 doses of a DTP containing vaccine has increased in five (5) countries, remained static in four (4) countries and decreased in two (2) countries from 2010 to 2014 (see figure 3 below).

Figure 3: Coverage with 3 doses of a DTP containing vaccine in 10 UNICEF "inequity countries"



2.12 There is also still a lot to do to achieve equity between countries in access to vaccines:

(a) 20 countries have not yet introduced pneumococcal vaccine, so that about 36 million children still do not have access to this vaccine and over half of Gavi-eligible countries have not yet introduced rotavirus vaccine. Gavi will work closely with relevant countries to introduce these vaccine during the next strategic period.

(b) 23 countries have yet to introduce a second dose of measles vaccine (MCV2), so that 20 million children have access to it.

(c) Up to 23 remaining countries are anticipated to apply for Rotavirus vaccine in the next strategic period, which if achieved would bring the total number of fully immunised children to 246 million children by 2020.

(d) 35 countries eligible for HPV support have not yet applied for it, so that about 21 million adolescent girls still do not have access to this vaccine. Of these 35 countries, 16 became eligible for a one-time application opportunity with the approval of the transition policy in July.

Gavi's 2016–2020 strategy: Improving coverage, equity and sustainability, and managing risk

2.13 Addressing the challenges described above is the focus of Gavi's 2016-20 strategy. The Alliance will do so by working within three key dimensions:

(a) **Inter-country**: by enabling greater equality in the uptake and introduction of new and underused vaccines across countries;

(b) **Intra-country**: by focusing on specific initiatives and targeting investments that will increase equitable access and coverage of vaccines within countries;

(c) **Gavi Secretariat**: by taking stock of business processes, strategies and ways of working to ensure a robust organisation that can better support countries and deliver on the goals of the new strategy.

2.14 Over 220 vaccine introductions are expected to take place in Gavi-eligible countries over the next strategic period. Gavi support for these introductions will be a critical contribution to averting an estimated 5 million to 6 million deaths.

2.15 In addition to continuing key vaccine introductions, Gavi will strengthen coverage and equity during the next strategic period through an approach with four elements:

(a) More country-centric and proactive grant management, including simplification of Secretariat processes

(b) Differentiated prioritisation of 20 countries;

(c) Partners' Engagement Framework;

(d) Defined strategic focus areas.

2.16 I. **More country-centric and proactive grant management**: The Gavi Alliance is re-designing its support and processes to better respond to the individual needs of countries. This includes:

(a) Taking a more holistic and coherent approach to the full package of support the Gavi Alliance provides to countries (vaccine support, cash support, technical support)

(b) Ensuring that the Secretariat's engagement with countries - especially by Senior Country Managers (SCMs) - is focused on more proactively driving coverage, equity and sustainability and managing risk. (See below for more details)

(c) More country-driven and robust assessment of progress and needs at country level through joint appraisals. Joint appraisals were conducted in all Gavi eligible countries in 2015. 46 joint appraisals took place in the country with country, regional and global stakeholder present; 26 were conducted remotely with all stakeholders via teleconference or emails. The information gathered through these tools will help in better targeting technical and financial support. Nevertheless, the Gavi Secretariat is gathering lessons to further improve and simplify the processes, in particular to: clarify the purpose of the joint appraisal and role of stakeholders; strengthen country ownership; reduce duplications with other reports or reviews; and to encourage prioritisation of 3-5 key strategic actions.

(d) Reviewing Gavi's direct financial support to countries (including health system strengthening, vaccine introduction grants, and funding for campaign operational costs) to make it more flexible and coherent and better targeted towards coverage and equity bottlenecks. Recommendations from an ongoing policy review will be brought to the Board in June 2016 (see separate paper on "Review of Gavi's model for direct financial support to countries").

(e) Undertaking more regular and responsive reviews of Gavi grants through the High-Level Review Panel (HLRP), enabling rapid re-programming of support as needed, guided by the joint appraisals. In 2015, for the first time, all 73 countries will be reviewed by the High-Level Review Panel.

(f) Improving data quality to track and evaluate progress, for example by using performance frameworks for each grant, including intermediate indicators, Full Country Evaluations, regular coverage surveys and small area estimations. A technical briefing on what has been learned through data improvement activities to date will be presented at the December 2015 Board meeting.

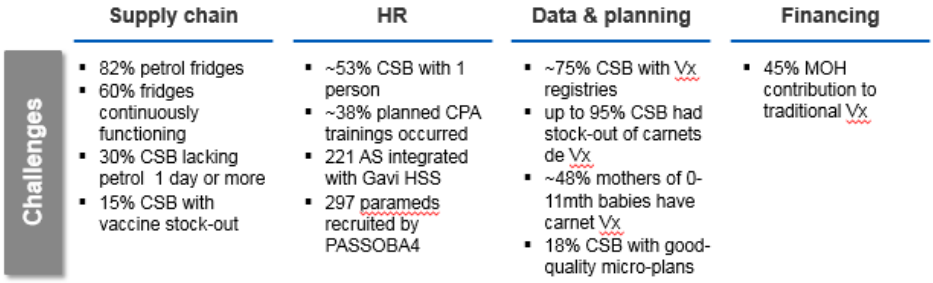
(g) Simplifying processes across the Secretariat to reduce complexity, enable faster decision making, ensure more efficient grant management and alleviate transaction costs for countries. A team in the Secretariat is currently mapping relevant processes to understand where processes might be streamlined and simplified.

2.17 **II. Differentiated prioritisation of 20 countries**: 90% of children who do not receive three doses of a DTP-containing vaccine are in 20 countries, and 75% are in only 10 countries. These include some of the children who are hardest to reach due to their geographical location or social status. As coverage and equity challenges differ from country to country, and variations at the sub-national level are often substantial, Gavi will take a focused approach in these 20 countries with intensified engagement and more tailored support instead of developing a single comprehensive global strategy. The aim is to provide catalytic financial and technical support to enable countries to better articulate and implement their coverage and equity agenda, and to support both enhanced standard approaches and innovations that are necessary to reach those who have yet to be fully immunised. More structured analyses have already been undertaken in several countries to better understand their needs and how Gavi support can be optimised:

2.18 **Uganda**: An Alliance team joined a scheduled EPI review, resulting in recommendations to improve management competencies at each level of the health system; to tailor health workforce capacities, including regular outreach services; to increasing coverage and equity; and to improve supply chain management and equipment, including more efficient, reliable and lower-cost refrigerators that use power sources such as solar direct drive rather than bottled gas. A tailored HSS application is being developed for 2016 to ensure the appropriate follow up to the identified priorities.

2.19 **Madagascar**: A mission to Madagascar analysed bottlenecks to achieving sustainable and equitable coverage. The mission took place in conjunction with a joint appraisal mission. Relevant documents, including an EPI review, HSS proposal, post-introduction evaluations (PIEs) and effective vaccine management assessments (EVMs), were reviewed and, based on that review, hypotheses of potential bottlenecks as well as areas of excellence formulated. Working groups, consisting of a mix of local and international stakeholders, analysed key problematic areas and proposed solutions, including in the area of data, supply chain, personnel and equity. Four main areas of concern were identified:

Figure 4: Areas of concern identified in Madagascar



The outcome of the work was shard with the Interagency Coordination Committee (ICC) and will be used to formulate the next HSS proposal. A follow-up mission is foreseen to target further interventions and select tools to achieve the identified goals.

2.20 **Ethiopia**: A high-level mission, including Gavi, the Global Fund, the European Commission, the United Kingdom's Department for International Development (DFID), Italy and other partners, reflected the importance of scaling up systemic changes under way in Ethiopia. These included:

(a) Completing the implementation of an integrated vaccine and health commodity supply chain system, including a real-time logistics management information system to ensure efficient and reliable levels of stock;

(b) Exploring targeting of measles campaigns to locations where impact would be greatest and to ensure most efficient use of resources;

(c) Exploring continuing to scale up investments by Gavi and the Global Fund to deploy more than 36,000 health extension workers (HEW), including an additional 15,000 HEW who work to reduce drop-out rates as well as to increase equitable access to vaccines;

(d) Fully implementing community-level family health dossiers that improve the quality of immunisation coverage data; and

(e) Integrating Global Fund resources into the Sustainable Development Fund, a pooled fund with Gavi, DFID, the European Commission, Italy and other sources to further increase efficiency and synergies.

2.21 **Pakistan:** A joint appraisal in August 2015 identified priorities for increasing coverage and equity, including:

(a) Embedding relevant staff within Ministry of Health immunisation teams to strengthen management processes and capacity;

(b) Scaling up innovative supply chain approaches, in particular new electronic logistics management information systems providing real-time data on stock levels;

(c) Using Smart phones to track health workers to ensure consistent service provision;

(d) Improving data quality and maximising synergies between polio eradication efforts and routine immunisation; and

(e) Further systematising the role of CSOs in urban slums to address key bottlenecks.

2.22 These efforts illustrate the increasingly systematic effort by Alliance partners to work with countries to prioritise investments that strengthen critical and strategic health system components. These investments are aligned with the investment opportunities identified through the Strategic Focus Area process (see Appendix A).

2.23 **III. Partners' Engagement Framework (PEF):**

(a) Approved by the Board in June 2015, the PEF will ensure that technical support is designed to address each country's individual needs (as identified through joint appraisals, the HLRP and targeted country missions)

(b) The Secretariat recently issued a request for information (RFI) to identify additional partners with the capabilities to support countries address their identified programmatic needs. Over 90 responses were received from various agencies, which will be able to complement the work of existing partners' specific areas and expand on the pool of support available to countries.

(c) The PEF will also include an accountability framework to track how members of the Alliance (Secretariat, partners, countries and donors) perform in delivering the Alliance's shared strategic goals, particularly on coverage and equity.

(d) The PEF and accountability framework will be overseen by a management team comprising the Secretariat, core Alliance partners and selected donors who are co-investing in key countries. The PEF Management Team met for the first time in July.

(e) In June 2015, the Board approved the budget envelope for the foundational support component of the PEF (long-term support to partners for core functions). In December, the Board will be asked to approve the tailored country assistance component of the PEF, which is expected to account for the majority of funding to technical partners.

2.24 **IV. Strategic focus areas (SFAs):** The PEF has identified six SFAs where cross-cutting strategies - beyond only providing specific support to countries individually - can deliver transformational impact. The Board has already approved an Alliance supply chain strategy, which will guide our work in that area, and will be asked to approve a strategy for investments in data in December 2015. Other SFAs include demand generation; leadership, management and coordination; political will; and sustainability (see Appendix A).

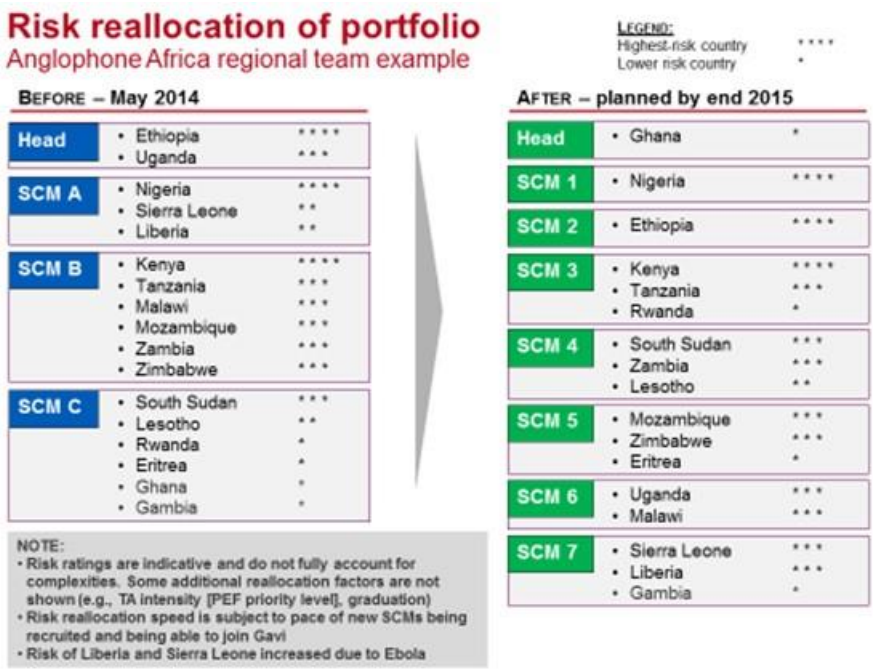
2.25 In addition to working to shift the Alliance focus from vaccine introductions to **improving the coverage, equity and sustainability of vaccine programmes**, the Secretariat is also **enhancing its approach to proactive management of programmatic and financial risks**. This reflects Gavi's responsibility to ensure good stewardship of donor resources. To achieve the dual goal of driving impact (coverage, equity and sustainability) and managing risks, the Secretariat is making a number of strategic changes to its structure, processes and ways of working:

(a) **Proactive grant management:** The Secretariat is working to become more systematic in how it interacts with countries, and raises and helps advance issues of coverage, equity, sustainability and risk management. As part of this, interactions at the key "entry points" for change across the grant cycle (HSS applications, joint appraisals, EPI reviews, transition assessments, etc.) will be prioritised. The Secretariat will also take a more holistic and coherent approach to the full package of support that Gavi provides to countries (vaccine support, cash support and technical support).

(b) **Recruitment in the Country Support team**: Frontline grant management resources are being added to enable this more proactive approach. Five additional SCMs have been recruited since September 2014, bringing their current number to 18. The number of Programme Officers has remained at 5. Going forward the Secretariat plans to add more SCMs to engage more deeply with countries (especially priority countries). It will also add Programme Officers to provide SCMs with increased support and allow them to spend more time advancing strategic, political and technical issues.

(c) **Risk-based SCM portfolio reallocation**: To better balance risk between SCMs, fully dedicated SCMs have been introduced for particularly high-risk and complex countries (Nigeria, DRC and Pakistan so far, with other countries being considered for the future). For other SCMs, country allocations are being adjusted based on risk and the average number of countries they manage is beginning to be brought down. The figure below shows an example of this approach.

Figure 5: Risk allocation of portfolio



(d) **New Programme Finance Team**: A team has been created to provide support and expertise on financial matters to the Country Support Team and ensure compliance with Gavi's fiduciary policies, procedures and practices. The team is also responsible for ensuring that financial risks are identified and effectively managed. It will be fully staffed by October 2015.

(e) **Country Team Approach**: Cross-functional 'Country Teams' have been established for Nigeria, DRC, Pakistan and India to pool skills and capacity across the organisation for more effective oversight and management of Gavi grants. Country teams will be rolled out all priority Gavi countries using a phased approach.

(f) **Capability building of Country Support staff**: A holistic capability-building programme has been developed and is being delivered to ensure that country-facing staff are equipped with the necessary knowledge and skills for effective, consistent management of grants, risk and stakeholders.

(g) **Country risk matrix**: A tool has been developed to systematically assess and monitor the risk of a given country as relates to Gavi support. It will enable key decisions based on risk, e.g., allocations of staff/time, process differentiation. The country risk matrix is currently being piloted and will soon be rolled out.

(h) **Risk management practices**: Processes, tools and systems are being reviewed and revised to ensure enhanced, systematic risk management practices throughout the grant management cycle.

(i) **Collaboration with the Global Fund**: The Secretariat has strengthened its country-specific collaboration with the Global Fund, focusing on areas of joint interest such as fiduciary risk management and health systems strengthening.

(j) **Operational Guidelines**: The Secretariat is systematising its grant management approach through the development and codification of clear, common standards. So far six Operational Guidelines have been approved (compared to none a year ago). All guidelines will eventually be merged into an Operational Manual compendium that covers each step along the grant management cycle.

(k) **Country-level risk management:** The Secretariat is working on a country case-by-case basis to assess programmatic and financial risks, and strengthen its approach to managing these. In DRC for example, the Secretariat has replaced the fiduciary agent, improved its contracting structure to increase independence, and required it to conduct thorough scrutiny or direct payment for high-risk activities (e.g. training, fuel). A Monitoring Review has been conducted, a Cash Programme Audit is in progress and a new (enhanced-scope) Financial Management Assessment is planned by year end. The implementation structure of the HSS2 grant has been designed to transfer key risks to other partners who are better structured to manage such risk (e.g. major tendering and construction to UNICEF, health centre rehabilitation to UNOPS). The Country Tailored Approach focuses on addressing the key programmatic bottlenecks. And discussions are ongoing with WHO and UNICEF to use their provincial offices to monitor activities at intermediate level and below, and report on any programmatic, operational and financial issues

(l) **Country-level coordination and management**: The growing complexity of Gavi's in-country work further underscores the need to strengthen the ICCs/HSCCs and the management abilities of EPI teams. A dedicated position is being created in Country Programmes to take this work forward.

3. Graduation and sustainable financing goals (for more detail see Annex C)

3.1 **Gavi's approach and engagement with countries on sustainability-related issues has evolved considerably during the 2011-2015 strategic period. Historically, the focus of Gavi's approach rested on promoting financial sustainability**, and the cornerstone of these efforts was the co-financing policy, the implementation of which began in 2008. In January 2011, Gavi implemented a "Graduation Policy", which for the first time outlined the process and procedures for "graduating from Alliance support". The graduation process approved by the Board was complemented by the revised co-financing policy and its primary objective was to "to put countries on a trajectory towards financial sustainability". Country co-financing investments and commitment have grown considerably since the initial policy was implemented (Annex C) and is projected to exceed US$ 100 million in 2014.

3.2 Based on the early experiences with Financial Sustainability Plans (FSPs), Gavi developed and introduced a framework for graduation assessments and plans in 2012. A first wave of graduation assessments indicated that the narrow focus on financial sustainability in the "graduation phase" (currently known as 'accelerated transition phase') was insufficient. Ensuring the long-term sustainability of achievements gained with GAVI support required **greater attention to wider programmatic issues in addition to purely financial considerations**. In response to these findings, an intensified framework for engaging with countries was approved by the Gavi Board and its implementation endorsed by the PPC in May 2014. Under the framework, Gavi develops transition assessments to gauge countries' preparedness 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. The roll-out and implementation of this revised framework required considerable "catching up" with countries, as 16 countries had already entered the accelerated transition phase and only had a few years remaining of engagement with Gavi.

3.3 This year the Board made further policy decisions to strengthen Gavi's engagement with countries in transition. Acknowledging the relevance and importance of the work conducted so far, **the Board requested that the Alliance engage countries in transition planning at an earlier stage (e.g., before they reach the accelerated transition phase).** As part of these efforts, and upon the request of the Board, the Secretariat has developed a new **communication strategy** to disseminate Gavi's revised Eligibility and Transition Policy. **A range of new materials has been developed to ensure proactive communication, including new country-specific information sheets, a one-page policy summary and training materials for staff at the Secretariat and other stakeholders.**

3.4 Also in response to the Board request on earlier transition planning, and in line with the 2016-2020 strategy, the Secretariat is now working with partners, through the Sustainability SFA working group, to **consolidate the current piecemeal approach and develop a comprehensive framework** that outlines how the Alliance can more optimally operate to support the long-term sustainability - both financial and programmatic - of country programmes throughout **all phases of Gavi support**. A critical element in this comprehensive framework will be to ensure that the different mechanisms of Gavi support enable long-term sustainability (e.g. HSS, political will SFA, PEF, etc.).

3.5 With the first wave of countries due to start transitioning fully from Gavi support next year, the Alliance is facing a major test of the sustainability of its development model while still ramping-up its engagement with the recently approved policies. By the end of the year, **Gavi's vaccine support will end in four countries** – Bhutan, Honduras, Mongolia and Sri Lanka – as they reach the end of the accelerated transition period. For Bhutan, Mongolia and Sri Lanka, this means fully funding their pentavalent programmes, and for

Honduras, its PCV and rotavirus programmes. Gavi will maintain a limited monitoring role to track how these countries sustain immunisation gains. Figure 6 provides a summary of key financial and programmatic indicators.

3.6 As a group, **these countries** have high-performing programmes and **are on track to successfully transition out of Gavi support**. None of these countries have ever defaulted on their Gavi co-financing obligations, and all are on track to meet their final 2015 payments. Most exhibit very high levels of coverage with 3 doses of a DTP containing vaccine and report having 100% of districts achieving at least 80% coverage.

3.7 In spite of these achievements, a number of **important institutional capacity bottlenecks were identified during transition assessments** and targeted transition support has been provided to mitigate these bottlenecks. Primarily, the support covers activities to:

(a) Address knowledge gaps among health workers;

(b) Develop strategies to ensure that immunisation remains a top political priority and address potential sources of immunisation hesitancy;

(c) Improve the supply chain system (including the cold chain);

(d) Develop evidence-based advocacy materials for immunisation financing (e.g. costing studies); and

(e) Enhance immunisation data quality.

Figure 6: key characteristics of countries fully transitioning out of Gavi support in 2015i

	Bhutan	Honduras	Mongolia	Sri Lanka
Year of initial Gavi support	2002	2004	2004	2002
Types of Gavi support	HSS, Pentavalent, IPV, transition support	HSS, INS,ISS Pneumo, Rota, IPV, transition support	HSS, INS, ISS Penta, IPV Introduction Grant	HSS, INS, Penta IPV, Introduction Grant, transition support
Birth cohort (2015)	14,610	211,027	63,862	371,119
GNI per capita (US$ Atlas method, 2014)	2,390	2,190	4,320	3,400
WUENIC coverage with 3 doses of a DTP containing vaccine (2014)	99%	85%	99%	99%
% of districts achieving >80% coverage with 3 doses of a DTP containing vaccine coverage (2014)	100%	57%	100%	100%
Gavi co-financing status	On track	On track	On track	On track

3.8 In addition, nine countries (Angola, Armenia, Azerbaijan, Bolivia, Congo, Georgia, Guyana, Kiribati and Moldova) will partially transition from Gavi support by 2016 and thereby fully finance one or more vaccines. The majority are projected to fully finance the vaccines introduced with Gavi support without major challenges. Six of them have never defaulted on their co-financing obligations while in the transition phase, and one has only defaulted once. Coverage with 3 doses of a DTP containing vaccine and equity measures, although generally high, are less homogeneous than in the group undergoing full transitions. However, two of these countries, Angola and Congo, are at high risk of not transitioning successfully out of Gavi support.

3.9 Angola and Congo are recurrent defaulters, both are in arrears on their 2014 co-financing payments, and their transition assessments identified a number of institutional and programmatic weaknesses. A payment plan has been developed with **Angola** under which 2014 arrears and 2015 co-financing requirements should be paid by the end of December. However, Angola will have to fully fund one of three vaccine programmes starting in 2016, and to co-finance over 60% of the other two programmes. The country has already reported stockouts of pentavalent vaccine, which have been temporarily addressed by identifying existing supplies in the country. The situation in **Congo** is particularly noteworthy, as the country has paid approximately 8%

of its 2014 co-financing obligations and in 2016 it will have to independently pay for three of its four vaccines, while co-financing over 60% of the remaining programme The Secretariat and Alliance partners have intensified their engagement and advocacy with both countries. The transition plans in Angola and Congo are just being implemented and it will be critical to intensify the Alliance's support to these plans to ensure successful transitions and long-term sustainability. Figure 7 provides a summary of key programmatic and co-financing indicators.

Figure 7: Key characteristics of countries undergoing partial transitions

Countries	**Vaccines fully self-financed as of January 2016**	**Continuing Gavi vaccine support**	**History of default while in Transition Phase**	**WUENIC** coverage with 3 doses of a DTP containing vaccine **(2014)**	**% of districts achieving >80%** coverage with 3 doses of a DTP containing vaccine **(2014)**
Angola	Pentavalent	PCV, Rota	2011, 2012, 2013, 2014	80%	46%
Armenia	Pentavalent, Rota	PCV	-	93%	100%
Azerbaijan	Pentavalent	PCV	-	94%	100%
Bolivia	Rota	PCV	-	85%	43%
Congo, Rep.	Pentavalent, PCV, Yellow Fever	Rota	2012, 2013, 2014	90%	77%
Georgia	Pentavalent, Rota	PCV	-	91%	94%
Guyana	Rota	PCV	-	98%	100%
Kiribati	Pentavalent	PCV	2013	75%	67%
Moldova	Pentavalent, Rota	PCV	-	90%	95%

Annexes *(available on myGavi)*

Annex A: Strategic Goal 1

Annex B: Strategic Goal 2

Annex C: Strategic Goal 3

Annex D: Strategic Goal 4

Appendix to Country Programmes Update

An overview of Gavi's integrated approach to coverage, equity and sustainability of immunisation

1. Introduction

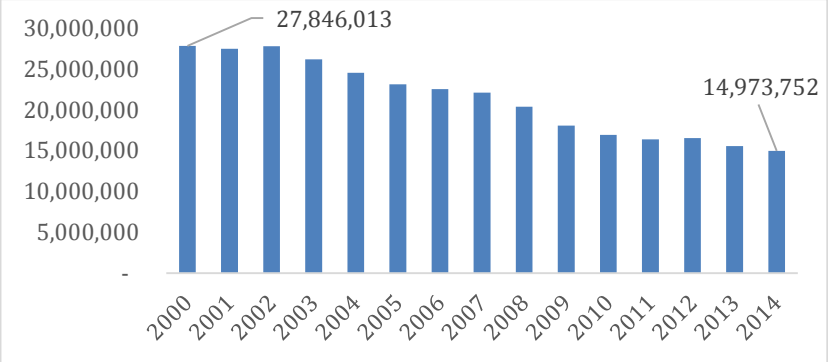
1.1. Gavi was created to accelerate the introduction of new vaccines in the world's poorest countries. It has been very successful, having supported over 300 vaccine launches since the Alliance was created in 2000, and over 200 in the 2011-15 period (exceeding its 2011-15 vaccine introduction targets one year ahead of schedule). This has significantly reduced inequities in vaccine access across countries. At the same time, the Alliance has supported important **progress in improving equity in vaccine access** within countries, with 81% of children in Gavi countries receiving three doses of a DTP-containing vaccine in 2014 (compared to 60% in 2000) and 78% receiving the first dose of measles vaccine (compared to 59% in 2000). This has resulted in the number of under-immunised children in the 73 Gavi countries[1] falling by nearly 50% over the past 15 years (see Chart 1). Today, thanks to higher coverage and population growth, more children than ever are being reached with routine immunisation with over 60 million children in Gavi countries receiving three doses of a DTP-containing vaccine in 2014, 6% more than in 2010.

1.2. Despite this progress, **significant challenges remain** to ensure full and equitable access to immunisation within and across countries. Nearly 15 million children a year in the 73 countries are still not being reached with three doses of a DTP-containing vaccine and many more are not receiving the full schedule of recommend vaccines. The Alliance is not on track to achieve its target of a 6% increase in coverage with three doses of a DTP-containing vaccine by the end of 2015[2] and coverage remains under 80% in more than one third of the 73 Gavi countries (including in several large countries such as Nigeria, Pakistan and Afghanistan). And only 15 countries have over 80% coverage in every sub-national district, the key measure of equity in the Global Vaccines Action Plan (GVAP). Coverage with the first dose of measles vaccine lags behind coverage with three doses of a DTP-containing vaccine and has been stagnant since 2010. Moreover, there is still a lot to do to achieve inter-country equity in vaccine access with over one third of the Gavi 73 yet to introduce

[1] Number of children not receving three doses of a DTP-containing vaccine
[2] Compared to 2010 baseline value

pneumococcal vaccine, over half yet to introduce rotavirus vaccine and fewer than one third having introduced human papillomavirus vaccine (HPV).

Chart 1. Number of under immunised children[3] in Gavi 73 countries, 2000-2014



Source: Gavi analysis based on WUENIC, July 2015 revision; WPP 2012. Based on surviving infants not reached with DTP3

1.3. Given these challenges, Gavi's 2016-20 strategy will have an enhanced focus on **increasing coverage and equity of immunisation**, and **ensuring progress is sustainable** given that more than 20 countries are due to transition out of Gavi support by 2020. This document sets out the key components of the Alliance's strategic approach in and also provides an update on the development of the strategic focus areas (SFAs), a critical component of the approach. Two SFAs (data and Supply chain) are presented to the PPC for decision under separate cover (as is the Partners' Engagement Framework (PEF), another critical element).

2. Scope and design of the approaches

2.1. To enhance equity in vaccine access across countries, Gavi will **maintain its current efforts to accelerate introduction of new vaccines**. The Alliance is projected to support over 200 vaccine introductions 2016-2020.

2.2. The Alliance's approach to **strengthen coverage, equity and sustainability of immunisation within countries has four key elements**:

1. **Enhanced country-centric grant design and review**
2. **Prioritisation of 20 countries – a differentiated approach**
3. **Partners' Engagement Framework**
4. **Transformational initiatives in Strategic Focus Areas**.

2.3. In all these efforts, the Alliance will increasingly focus on **five critical intervention points** – the delivery of three doses of pentavalent (at 6, 10 and 14 weeks) and the first and second dose of measles (at 9 and 18 months). Since pentavalent is co-administered with pneumo, rota, and inactivated polio vaccine (IPV), and and the first dose of measles vaccine is co-administered with rubella, yellow fever, meningitis A and Japanese Encephalitis, thirteen of the fifteen antigens supported by Gavi will benefit from efforts to increase vaccination coverage at these five critical moments.

[3] Ibid

2.4. **Enhanced country-centric grant design and review**: The Alliance is working to strengthen its engagement with countries to better respond to their individual needs (as opposed to a "one-size-fits-all" approach), help drive programmatic improvement and manage risk. Key changes include:

2.4.1. Ensuring our engagement with countries, especially by Senior Country Managers (SCMs), is focused on pro-actively driving coverage, equity and sustainability and managing risk. We are seeking to become more systematic in how we interact based on a holistic strategy for each country which prioritises the key "entry points" for change across the grant cycle (e.g., HSS applications, joint appraisals, EPI reviews, transition assessments);

2.4.2. Taking a more holistic and coherent approach to the full package of support the Alliance provides (vaccine support, cash support, technical support) to ensure it holistically addresses each country's needs;

2.4.3. Supporting a more country-driven and robust assessment of progress and needs at country level through joint appraisals, which are intended to identify a select number of high-priority interventions to address the most critical bottlenecks;

2.4.4. Reviewing Gavi's direct financial support to countries to make it more flexible and coherent and better targeted towards coverage and equity bottlenecks (*see separate paper on "Review of Gavi's model for direct financial support to countries"*);

2.4.5. Undertaking more regular and responsive reviews of Gavi grants through the High-Level Review Panel (HLRP), enabling rapid re-programming of support as needed, guided by the joint appraisals; and

2.4.6. Improving data quality to track and evaluate progress, for example by using performance frameworks for each grant, including intermediate indicators, Full Country Evaluations, regular coverage surveys and small area estimations (a technical briefing on what has been learned through data improvement activities to date will be presented at the December 2015 Board meeting).

2.5. Prioritisation of 20 countries – a differentiated approach: 90% of children who do not receive three doses of a DTP-containing vaccine are in 20 countries, and 75% are in only 10 countries. These include some of the children who are hardest to reach due to their geographical location or economic and social status. As coverage and equity challenges differ from country to country, and variations at the sub-national level are often substantial, Gavi will take a focused approach in these 20 countries[4] with intensified engagement and more tailored support. The Alliance has already launched deep dives in a number of priority countries (see Doc 04 for further details) with two objectives:

[4] Other countries requiring specific C&E support will also be considered. This might include, for example, countries with high coverage, but with a specific equity issue that they would like additional support to address.

2.5.1. Identify and prioritise problematic areas and interventions. In particular, these deep dives will seek to provide catalytic financial and technical support to enable countries to better articulate and implement their coverage and equity agenda, and help develop an appropriate balance of enhanced standard approaches and innovations where necessary to implement that agenda.

2.5.2. Codify new diagnostic tools, approaches and lessons learned that can be applied to other countries including examples of positive deviance which can be scaled-up and transferred

2.6. Partners' Engagement Framework (PEF): Approved by the Board in June 2015, the PEF is the new mechanism for the Alliance to design, coordinate and fund partners' technical support to countries *(*see Doc 05 further details). The objective is to ensure that technical support is designed to address each country's individual needs (as identified through joint appraisals, the HLRP and targeted country missions) as opposed to being defined top-down, and to increase accountability for performance. The three key components of the PEF are:

2.6.1. Foundational support: Long-term funding to partners for core functions. The Board approved budget envelopes for foundational support in June 2015.

2.6.2. Tailored country assistance (TCA): Technical support provided to each country to address their own specific needs. This is expected to account for the majority of funding to partners and the Board will be asked to approve budget envelopes for tailored country assistance in December 2015. The Secretariat recently issued a request for information (RFI) to identify potential partners with the capabilities to provide technical support to countries and received over 90 responses. We are in the process of reviewing countries' needs, as identified through joint appraisals, developing technical support packages to respond to these needs and working with countries and core Alliance partners to identify the most appropriate institution to provide the required support.

2.6.3. Strategic focus areas: Cross-cutting strategies and special investments in specific key areas, where there is an opportunity for transformational impact (see below for further details).

2.7. The Secretariat is developing an Alliance accountability framework which will include performance indicators to track how all members of the Alliance perform in delivering on the Alliance's shared goals, as well as a specific PEF performance framework to monitor the performance of partners in areas for which they receive Gavi funding. The PEF performance framework will be overseen by a management team comprising the Secretariat, core Alliance partners and selected donors who are co-investing in key countries

2.8. **Transformational initiatives in Strategic Focus Areas (SFAs):** As part of the 2016-20 strategy, the Alliance identified strategic focus areas where cross-cutting strategies – beyond providing specific support to countries individually

– can deliver transformational impact. To date, the Alliance has identified six SFAs:

2.8.1. Supply chain

2.8.2. Data quality, availability and use

2.8.3. In-country leadership, management and coordination (LMC)

2.8.4. Demand promotion

2.8.5. In-country political will

2.8.6. Financial and programmatic sustainability

Each SFA will ultimately include an overarching strategy with a theory of change, a set of medium-term goals and, if required, targeted investments. These investments will be channelled through existing and potentially new funding mechanisms as follows:

(a) Direct support to countries through **Gavi grants** (e.g., HSS). Where appropriate this might require changes in grant design and guidelines in order to facilitate strategic investments; The SFAs will be taken into account in the review of Gavi's policy on direct financial support to countries.

(b) Funding to partners through the **Partners' Engagement Framework** for specific activities, which could include new approaches for technical assistance to countries, or innovative activities at global and regional levels.

Development of the SFAs is being closely coordinated with ongoing dialogue to develop tailored approaches in priority countries to ensure that each effort informs and reinforces the other.

3. Status of the SFA workstreams

3.1. Development of the SFAs has been sequenced given limited resources at the Secretariat and among Alliance partners.

3.1.1. The **Gavi Immunisation Supply Chain** (iSC) Strategy was approved by the Board in 2014. Doc 07 provides the PPC with an update on implementation and outlines priorities, planned actions and financial requirements for 2016 and 2017.

3.1.2. The PPC is also being asked to recommend a comprehensive strategy for the **Data** SFA. This is described in Doc 06.

3.1.3. The other SFAs are still being developed, with consultations ongoing, and early thinking on each is described briefly below. Further details on each SFA are available in Annexs A-D.

3.2. **Leadership, management and coordination:** Achieving substantial improvements in coverage and equity requires effective planning, implementation and monitoring of immunisation programmes. This in turn

necessitates strong national leadership, management and coordination. Yet these elements often receive limited attention and investment. Three areas are particularly critical for the effective and efficient management of Gavi grants. If addressed, these can have a catalytic impact on the successful implementation of immunisation programmes but many countries currently face significant challenges across all three areas:

(a) **Management capacity:** EPI teams or departments may be inadequately structured or equipped to strategically plan, manage and monitor programmes effectively (e.g. inadequate staffing and skill mix, gaps in management and leadership capabilities or lack of tools to plan, implement and monitor programmes)

(b) **National coordination fora:** Such fora, such as interagency coordination committees (ICCs) and health-sector coordinating committees (HSCCs) may fail to function as effective coordination and oversight mechanisms.

(c) **Technical capacity:** Immunisation technical advisory groups (such as NITAGs) may not always have the capabilities to support evidence-informed immunisation policy and programme decisions which are sustainable and credible.

This SFA will explore how to improve the functioning of the three **areas of focus** identified above. It will aim to contribute to the following:

(a) Better management of the immunisation programme and Gavi grants by the national[5] **government EPI teams or departments**. Possible fields for future Gavi engagement could include optimising the team size and structure, developing management capabilities / skills, and helping disseminate management tools to monitor programme performance[6]. Related outputs could include, for example, stronger skills and processes in areas such as human resources, financial management and strategic planning, stronger coordination with other relevant government departments and programmes.

(b) Stronger coordination and oversight of Gavi grants (including technical assistance to countries) by local development partners and the government. Possible fields of engagement could include more systematic membership / attendance of **national coordination fora** and support or tools to assist with committee functioning (e.g. through a Secretariat led by the EPI team).

(c) Improved evidence-informed immunisation decisions and policy by national decision making structures. Possible fields of engagement could include support or tools to assist with functioning and evidence-based decision making of **immunisation technical advisory groups**.

[5] Engagement at the sub-national level might also be considered depending on the degree of decentralisation in the country and whether a special focus on certain provinces might help improve equity, for example; this would be subject to availability of funds/support.
[6] Activities to strengthen EPI management capacity for data (e.g. tools) will be further developed jointly with the data SFA.

3.3. **Demand promotion**: Demand-side challenges are often cited as critical barriers in Gavi countries. Interventions in this area have the potential to significantly increase immunisation coverage and equity, complementing the systems-strengthening focus on the supply side. Yet among HSS grants committed by the Alliance in the current strategic period (2011-2015) only 5.7% of funds were to support implementation of demand-side interventions[7]. Common impediments to demand include: (a) Lack of **caregiver knowledge and motivation** to vaccinate. (b) previous **negative experience** with immunisation services (e.g. poor or unequal treatment by health workers); (c) **vaccine hesitancy** in the form of mistrust in vaccines or concerns about side-effects, sometimes driven by religious, cultural or community contexts; and (d) **Lack of relevant research, data** and methods such as Knowledge, Attitudes and Practices (KAP) studies to identify the most relevant target populations and appropriate interventions. The SFA team will explore what role Gavi can play to overcome these barriers and increase demand for immunisation services.

3.4. **In-country political will**: While technical bottlenecks, like infrastructure constraints or HR shortages, may inhibit immunisation progress, strong political leadership can expedite solutions. It is arguable that the need for strong political commitment is even greater as a country approaches 'the last mile' – when seeking to maximise coverage and equity and ensure that the most disadvantaged and vulnerable sections of the population are immunised. The Alliance has helped push immunisation up the political agenda globally and in many countries. Direct leadership representations have influenced political resolve in some environments, but in others, repeated efforts have not been effective. For the most part, immunisation is not prominent on the agenda of national political leaders. Among other reasons this is

(a) due the fact that the value of vaccines and the Return on Investment case is not being broadly recognised or understood

(b) a consequence of immunisation being a victim of its own success – controlling diseases eases the sense of urgency for action; and

(c) a result of competing priorities in other sectors (e.g. agriculture, nutrition, education) and other priorities within health that tend to receive greater attention;

Through the SFA on political will, the Alliance will explore how to build stronger commitment by political leadership at national and sub-national levels to maximise coverage and reach the most disadvantaged and vulnerable populations.

3.5. **Financial and programmatic sustainability**: One of the cornerstones of Gavi's development model is that support to countries is time-limited and catalytic, and that Gavi support for countries diminishes and ultimately ends as their economies grow. Recognizing the scope and complexity of the challenges inherent in this process, the 2016-2020 strategy places a renewed emphasis

[7] 5.7% of all HSS grants approved in the years 2011-15 were for demand-side interventions: $43.1M out of a total $757.1M

on the financial and programmatic sustainability of programmes supported by the Alliance[8]. The Alliance has already made considerable progress in developing key approaches, tools and processes to support transition preparedness and long-term sustainability. In particular, Gavi's new Eligibility and Transition Policy provides a critical platform to help countries identify and address key institutional challenges, particularly through the development and implementation of transition plans.

However, successful transitions depend on a number of enabling conditions – such as robust health systems, strong political commitment at the highest levels and sufficient domestic funding allocations – which often require long-term technical and financial support. Experiences from the first wave of transition assessments indicate that most countries have the fiscal capacity to sustain the vaccines introduced with Gavi support but they reached the accelerated transition phase with programmatic gaps. Furthermore, evidence from the Eligibility policy review process highlighted that some countries might enter this phase with financial and systemic gaps. Building on the experiences to date, the sustainability SFA will explore how to optimize the impact, joint accountability, timely execution and monitoring of current support approaches. Building on the Board-approved **vision** for successful transitions[9], it will also identify approaches to operationalize the Board's request to engage countries in transition planning at an earlier stage and maximize the synergies and impact on sustainability of the different modes of support available to countries (e.g., health systems strengthening [HSS], transition support, other partner support).

Annexes *(available on myGavi)*

Annex A: Sustainability

Annex B: Political Will

Annex C: Demand promotion

Annex D: Leadership, management and coordination

[8] To 'Improve the sustainability of national immunisation programmes' is one of the four strategic goals of the new 2016 – 2020 strategy.

[9] The Board has adopted a **vision** for successful transitions to help guide the Alliance's work: "Countries have successfully expanded their national immunisation programmes with vaccines of public health importance and sustain these vaccines post-transition with high and equitable coverage of target populations, while having robust systems and decision-making processes in place to support introduction of future vaccines."