2010 Work Plan Information / Update

Introduction

The GAVI Alliance 2007-2010 Strategy had four strategic goals:

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

For the 2007-2010 Strategy, the GAVI Alliance developed a work plan to fund activities in support of the strategic goals and implemented by the multilateral partner agencies (primarily WHO, UNICEF and the World Bank), by the Accelerated Vaccine Introduction Initiative (AVI) Technical Assistance Consortium (TAC) and the GAVI Secretariat. The work plan contained over 100 activities organised around 17 outputs, with a total budget of US$ 297 million over the four-year period. Activities and corresponding budgets were developed on an annual basis in 2007 and 2008 and on a bi-annual basis for 2009-2010.

This document is a consolidated report on the 2010 work plan and provides some of the highlights of the 2010 progress under each output. It is based on the reporting provided by WHO, UNICEF, World Bank, AVI TAC and the GAVI Secretariat. The paper includes an annex summarising the progress against the 2010 work plan targets. Of note, indicators and targets changed over time during the 2007-2010 Strategy and some were never defined. As noted by the Phase 2 Evaluation (2007-2010)[1], a process to define and track performance indicators was not applied systematically for all areas in the work plan. This has been addressed in the 2011-2015 Strategy and there is now a comprehensive set of indicators and deliverables that have been defined (Refer to www.gavialliance.org/vision/strategy).

Performance management and reporting was also flagged as an area for improvement in the Phase 2 Evaluation. A number of steps have been taken in 2011 to address this including the development of comprehensive indicators and targets, and quarterly performance tracking and reporting.

Technical/Narrative reporting

This report highlights the main areas of progress by the Secretariat and Partners in 2010 per output, under each strategic goal. WHO and UNICEF submitted detailed mid-year and annual progress reports in 2010 to the Secretariat, both narrative and financial, reporting against a set of activities and deliverables. AVI TAC submitted a 2010 activity report. The World Bank provided a more general narrative at the strategic goal level. The Secretariat reported against its own activities.

[1] Evaluation can be found on http://www.gavialliance.org/results/evaluations/gavi-second-evaluation-report/

STRATEGIC GOAL 1: Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner

1.1 GAVI ISS support will reach an increased number of countries and countries that have received support including those with specific demographic, social or programmatic features will have increased and/or maintained high coverage

By 2010:

- 86% of GAVI eligible countries had received ISS support (against a target of 95%).
- 71% of GAVI eligible countries receiving ISS support increased coverage by 5% or more (against a target of 90%) since 2000.

The aim of this output is to increase and sustain DTP3[2] coverage levels in GAVI-eligible countries. Activities to achieve this include increasing/maintaining immunisation services support (ISS) uptake, implementing strategies to improve coverage, providing technical assistance to fragile countries and countries with large numbers of un-immunised children, and improving data quality and reporting.

ISS support: By the end of 2010, the GAVI Alliance Board had approved US$ 337.2 million for the ISS programme. In 2010, all GAVI-eligible countries submitted their Annual Progress Reports (APRs) to GAVI on implementation progress with ISS funding and related improvements, including timely reporting from fragile states.

Strategies to improve coverage: The Reaching Every District (RED) Strategy is being widely implemented by countries as a means of addressing coverage weaknesses. WHO support includes training workshops, technical and financial support to countries to implement key activities at district and health facilities. The implementation of the RED Strategy with a focus on the district-level micro planning and development of national plans for scale up and reaching the unreached remain core to UNICEF activities, in addition to scaling up immunisation in Countries with a Large Number of Un-immunised Children (CLUCS) and fragile states. In 2010 UNICEF organised an internal review of immunisation in 10 countries with large numbers of un-immunised children, with the objective of harmonising country support and national strategies to further reduce the cluster of the un-immunised population.

Over 55 countries carried out additional immunisation activities through Child health Days/Weeks and other acceleration efforts in 2010.

Data quality and reporting: The WHO/UNICEF coverage estimates were updated with 2009 data and revised where new information available. The data was completed and published on the WHO website in September 2010.[3]

In 2010, 13 countries conducted a national workshop or received technical support to improved data quality, in addition to the regional activities to train on Data Quality Surveys (DQS) and data quality improvement. There were slight delays conducting planned DQSs in the European region due to the polio outbreak in 2010. Technical assistance was provided to a number of countries in coverage data monitoring including Bangladesh and India.

In addition GAVI partners are revising the data quality assessment tool, which is used to verify immunisation coverage data. The revised tool will help validate national administrative coverage data systems to ensure that coverage estimates are accurate.

[2] Three doses of the diphtheria-tetanus-pertussis vaccines
[3] http://www.who.int/immunization_monitoring/routine/immunization_coverage/en/index4.html

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

By the end of 2010, GAVI committed US$ 568 million to help strengthen health systems in 53 of the world's poorest countries. The work contributing to this output aims to ensure that HSS investments are harmonised, aligned and contribute to removing health systems barriers in order to increase access to immunisation and other health services.

HSS design and development: In 2010, WHO provided implementation support to countries that have been approved for HSS. Forty countries submitted an Annual Progress Report to GAVI. The remaining 14 countries have been approved but not received funding and thus could not report on implementation of HSS support. In addition, 22 GAVI-eligible countries are being supported in International Health Partnership (IHP+) processes.

Six inter-country training workshops were conducted for all countries with GAVI-HSS grants on capacity building of country teams to strengthen policy dialogues in all WHO regions in developing as well as implementing National Health Policy and National Health Development Plans.

HSS implementation: Through its regional and country offices, WHO supported 45 GAVI HSS inter-country/regional workshops and meetings in 2010, which provide the opportunity to asses technical assistance needs in health systems to better coordinate and harmonise support in country planning and implementation.

In 2010 the World Bank undertook activities in 11 countries in Africa and 6 countries in other regions. Activities included determining barriers to accessing immunisation services; technical assistance in developing a performance-based financing program; developing a human resources for health policy and strategic plan; and studying the income and geographic disparities in vaccine coverage.

In 2010, the HSFP advanced in accordance with implementing countries' planning cycles. There is ongoing technical advice being provided and support to the policy and process in preparation for development of the HSFP with partners. In Ethiopia, Nepal, Uganda and Vietnam, where new planning cycles started, the Platform partners worked with governments and civil society to assess national health plans. In Nepal, GAVI signed a Joint Financing Agreement as part of a pooled donor fund. In 2010, the partners worked closely with Ethiopia, Uganda and Vietnam to secure funding for their national health strategies.

1.3 GAVI countries that have received CSO support have improved CSO engagement with relevant stakeholders and increased access to quality health services and interventions

In November 2006, the civil society organisation (CSO) funding window was approved as a pilot by the GAVI Alliance Board. By the end of 2010, GAVI had committed funds totalling over US$ 21 million to involve local CSOs in the planning and delivery of immunisation services, and to encourage cooperation between the public sector and civil society.[4]

Two workshops that the Secretariat planned for 2010 were postponed to 2011: a workshop with Francophone civil society organisations; and a joint GAVI and CSO constituency country visit.

[4] Of which approximately US$ 700,000 of type A support had been allocated to 10 countries and approximately US$ 20.4 million in type B support has been approved for 7 countries.

Most activities will conclude between the end of 2011 and mid-2012. In 2011, GAVI plans to conduct an evaluation to measure the effectiveness of the CSO pilot, which will help inform decisions on future support.

1.4 GAVI countries will have developed and satisfactorily implemented comprehensive policies and strategies on immunisation injection safety and related waste, supported by a monitoring and evaluation framework

The GAVI work plan support to injection safety and safe disposal planning, implementation and monitoring has been instrumental in assuring that the vaccines support given to countries is complemented with adequate safety practices.

A WHO study was completed in 2010 to document the impact of the use of Auto Disable (AD) syringes in the Expanded Program on Immunisation (EPI) since the year 2000 on the number of cases of HIV, hepatitis B and hepatitis C transmitted through unsafe injections in children. GAVI support to injection safety has contributed to a decrease in such cases.

With GAVI support, WHO is supporting activities including developing technical guidance materials for assessing the quantities and types of waste produced in different facilities, creating national action plans, developing national healthcare waste management (HCWM) guidelines and building capacity at national level to enhance the way HCW is dealt with in low income countries.

Highlights from 2010 include:

- 10 priority GAVI countries have developed national plans, policies, norms and standards.
- An advocacy paper was produced at a regional workshop in Cameroon requesting countries in the region to support health care waste management activities.
- Best practices have been documented and capacities provided through trainings in more than 20 countries.

STRATEGIC GOAL 2: Accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security

The first four of the five outputs that make up Strategic Goal 2 relate to the Accelerating Vaccine Introduction Initiative (AVI).[5] The initiative has inter-related work streams of activities required to meet each of the outputs below. AVI was operationalised in January 2009 and project implementation scaled up significantly in 2010.

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

The purpose of work under this output is to ensure the availability of appropriate vaccines for use in developing countries. It includes activities focused on strengthening regulatory mechanisms, building sufficient supply and capacity, developing supply agreements with suppliers and ensuring vaccines are appropriate for use in GAVI countries.

Regulatory mechanisms: Pre-qualification of the two pneumococcal conjugate vaccines was completed through a fast-track mechanism in 2010 making it possible for one GAVI-eligible country (Nicaragua) to introduce a pneumococcal vaccine the same year. Two rotavirus vaccine candidates had previously been prequalified by WHO and in 2010 one GAVI-eligible country (Guyana) introduced a rotavirus vaccine.

[5] AVI is composed of WHO, UNICEF and the AVI Technical Assistance Consortium (TAC), and managed by the GAVI Secretariat.

In 2010, 3 new vaccines within the GAVI portfolio of products were prequalified:

- MenAfriVac, Meningococcal A conjugate, Lyophilized 10 dose vial vaccine, the Serum Institute of India Ltd (June 2010)
- Pneumococcal conjugate vaccine, 10 valent, 2 dose liquid vial, GSK (March 2010)
- Prevnar 13, Pneumococcal conjugate vaccine, 13 valent, 1 dose liquid vial, Pfizer (August 2010)

A WHO prequalification database to monitor applications submitted to WHO was finalised in 2010 and data is now systematically uploaded.[6]

WHO conducted assessments of four countries' National Regulatory Authorities (NRAs) in 2010 and worked with a further six countries to develop their institutional development plans that will allow them to ensure quality of vaccines being used in-country and also, where relevant, to be eligible to export domestically-produced vaccine to other GAVI-eligible countries.

Strategic supply and demand forecasts: As part of AVI, the Strategic Vaccine Supply (SVS) team activities focused on providing in-depth understanding of demand and supply dynamics and drivers for the GAVI portfolio of vaccines. During 2010, the SVS team provided GAVI with strategic demand ad adjusted forecasts for all nine vaccines in the GAVI portfolio. Two versions were delivered (in January and August) in advance of key GAVI Alliance meetings and a third version was begun in late 2010. Also in 2010 the team delivered a draft version of supply forecasts for pneumococcal, rotavirus and pentavalent vaccines to provide an initial overview of the global supply available. During 2010, the development of the new integrated vaccines forecasting suite (IVFS) platform progressed with delivery in November 2010.

Through inter-country workshops and individual country visits WHO has supported all regions to strengthen countries' capacity for assessing vaccine demand and supply thus enhancing their ability to manage their vaccine stocks optimally. Examples in 2010 include: the launching of a feasibility study to establish pooled vaccine procurement in the Eastern Mediterranean region, and joint work with UNICEF Bangkok Regional Office and Supply Division on the demand forecast and planning in Pacific island Countries.

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

Activities to support country level decision-making include proving technical support on the introduction of new vaccines, and generating and disseminating information for local policy decision-makers and technical staff.

Health and economic impact data: Global estimates of the number of cases of severe illness cases and deaths due to *Haemophilus influenza* type b (Hib) and *Streptococcus pneumoniae* for the year 2000 were published by WHO in September 2009. These estimates are being updated for the year 2008 (after widespread introduction of Hib and partial introduction of pneumococcal vaccines) and will be available for public use in 2011.

Support for country level decision-making: No application round was held in 2010 by GAVI, therefore no formal applications were prepared. However, WHO continued to provide support and advice to countries considering introducing new vaccines. Examples of activities in 2010 include: providing consultancy and advocacy support to accelerate decision-making on introduction of new vaccines in seven countries in the European region.

[6] http://www.who.int/immunization_standards/vaccine_quality/PQ_vaccine_list_en/en/index.html

Work on the Vaccine Product Selection Menu was completed by WHO, in collaboration with UNICEF and other global and regional partners, and all decision-making tools and materials are grouped in one area of the NUVI web-site.[7]

In 2010 UNICEF provided technical support to 13 countries (against a target of 10) to make evidence based decision on new vaccine introduction and to design and prepare new and underused vaccine support applications. In addition, UNICEF is working to maximise the benefits of pneumococcal conjugate vaccines (PCV) and rotavirus, by using their introduction to enhance other aspects of pneumonia and diarrhoea control. The approach was further endorsed by the 2010 World Health Assembly (WHA) resolution on pneumonia.

Vaccine data packaged and presented to decision makers: In 2010 AVI TAC extended its scope to include support for GAVI resource mobilisation as well a strengthening GAVI country communications.

Some of the activities in 2010 include:

- Development of regional and country targeted materials (Kenya, Nicaragua, Tanzania country briefing packets).
- Building advocacy coalitions (advocacy training at the Pan African Parliament).
- Delivery of key advocacy and communications messages (media tour of Rwanda one year after pneumococcal vaccine roll-out).
- Supporting the execution of regional and country-specific events (materials development for World Pneumonia Day).

Introduction preparedness assessments: WHO has been supporting countries to assess their cold chain status and vaccine management capacity in preparation of introducing new vaccines in 2011 through the global development of standardised tools, inter-country workshops to train countries in the implementation of these tools, and through technical support provided in countries in the use of the new tools. In 2010 WHO supported Effective Vaccine Management Assessments (EVM) in 14 countries (plus two states in India) and cold chain assessments in 10 countries, meeting the 2010 targets in both instances.

Global policy guidance: A global guidance document was updated and published in April 2010 in a Vaccine supplement, which also contains articles from 15 countries about specific National Immunization Technical Advisory Groups (NITAGS) as a means of sharing information between countries. WHO regional offices continue to support and conduct country workshops and meetings on NITAG establishment and strengthening.

2.3 Country introduction of the vaccine

Activities around this output include ensuring availability of in-country cold chain capacity, enhanced vaccine management capability, operational policies, heath care worker training, large country strategies and communication strategies.

Given that there was no application round in 2010, no new countries have been in a position to apply or receive GAVI support for new or underused vaccines. The WHO focus was redirected to providing support to countries with pending application decisions including responding to conditions proposed by the GAVI Independent Review Committee (IRC) for country applications.

Health care workers training for vaccine introduction: Due to the lack of country introductions in 2010, limited health care worker training was conducted in countries. However, WHO continued to prepare training materials for pneumococcal and rotavirus vaccines.

[7] http://www.who.int/nuvi/Vaccine_intro_resources/en/index.html

Enhance country human resources technical capacities: UNICEF continues its interagency work to support developing country capacity in building Cold Chain and Logistics systems (CCL) systems. UNICEF hosted a CCL Guidance Workshop in October 2010 to review and synthesise CCL guidance available, identify gaps and resolve discrepancies, and provide a dissemination platform for users on the ground.
UNICEF supported WHO in the development of the new Effective Vaccine Management Assessment tool. This also includes support for the first Global Effective Vaccine Management Training in Cairo in July 2010. Twelve Logistics and Supply Managers from 12 GAVI-eligible countries participated in the training.

At country level, a range of CCL-system strengthening activities was supported by UNICEF in 2010, including:

- Support to develop a National Maintenance Plan for the CCL in DRC.
- A Vaccine Management Training for 33 provincial cold chain managers in Indonesia.
- Technical cold chain support and funds provided to Yemen, North and South Sudan and Djibouti.

Large countries: In 2010, WHO supported DRC to prepare for introduction of PCV13 in 2011 by developing a detailed calendar of pre-introduction activities and specifically assessing the readiness of the cold chain for the vaccine. Extensive discussions have been ongoing with the Governments of Pakistan and India to assist these countries in their decision-making processes.

Extensive support was provided by WHO in Kenya to enable the country to introduce PCV10 vaccine which had certain conditionalities around its prequalification. Such support was provided in the area of safety and programmatic monitoring and in intensified training for health-care workers.

In 2010 AVI TAC's Large Country Introduction team focused on India and Nigeria. Activities included: mapping of the decision-making process, country consultations, and country-level advocacy.

Communications strategies implemented at community level: Example of Communication for Development (C4D) work conducted by UNICEF in 2010 includes: scale up of overall C4D capacity, strategic planning and coordination, while providing specific focus on immunisation, new vaccines and meningitis in the Western and Central African Region; a Central and Eastern Europe/Commonwealth of the Independent States regional initiative to strengthen national heath communication and promotion capacities from a health systems strengthening perspective.

2.4 Platform for sustained use of the vaccine established

Activities in this area include surveillance, vaccine safety and crisis communications.

Surveillance: In 2010, the visibility of the Invasive Bacterial Disease (IBD) and rotavirus surveillance networks has been increased through the WHO-supported workshops and meetings. During 2010, WHO received rotavirus surveillance data from 55 countries (both GAVI-eligible and non-eligible) that had been provided with technical support by WHO Regional Offices. In addition, WHO received IBD surveillance data from 47 countries. Global Surveillance Bulletins that describe and synthesise the 2009 data were drafted, distributed to partners, and posted on the WHO website.[8]

[8] http://www.who.int/nuvi/surveillance/resources/en/index.html

WHO has entered into contracts with Regional Reference Laboratories (RRLs) in all regions and with two Global Reference Laboratories (GRLs) so that these bodies can assist countries in the quality assurance of their laboratory processes to ensure quality data is available to all at the global, regional and country levels.

Vaccine safety reviewed and monitored after introduction: Training materials for causality assessment of Adverse Effects Following Immunization (AEFI) monitoring have now been fully revised and are available together with a pool of trainers covering all WHO regions. Training in AEFI monitoring has been conducted in four WHO regions in 2010.

The safety profiles of three GAVI-supported vaccines (rotavirus, yellow fever and meningococcal A) were reviewed at the Global Advisory Committee on Vaccine Safety (GACVS) in 2010.

Impact of adding new vaccines on routine immunisation: In 2010, post-introduction evaluations (PIE) were conducted in 12 countries in three WHO regions (against a target of at least five countries). The PIE tool was published in 2010 and provides a systematic method for evaluating the impact of the introduction of a vaccine on the existing immunisation system in a country.[9]

Crisis communications: AVI TAC provided GAVI with updated crisis communications planning in 2010. Media monitoring allowed AVI TAC to proactively identify and prepare responses to crisis communications-related issues that emerged in 2010.

2.5 A healthy vaccine market established for all GAVI sponsored vaccines

GAVI's operating model uses innovative and catalytic investments to shape vaccine markets. Shaping markets has been implicit in GAVI's previous strategies but the Board decided to make it a specific goal in the Strategy for 2011-2015 to provide a renewed focus on this area of work.

In 2010 GAVI began work to update the supply strategy that was developed in 2005 for HepB/Hib-containing vaccines. Since 2005 GAVI there have been several changes in GAVI's portfolio, the supply landscape and procurement processes. In February 2010, GAVI's Programme and Policy Committee began a review of GAVI's overarching Vaccine Supply and Procurement Strategy for 2011-2015 and requested that a time-limited task team be formed to steer the review. The task team's final recommendations were presented to the Programme and Policy Committee (PPC) at its meeting in May 2011.

The Director of the Strategic Vaccine Supply team of AVI joined the UNICEF Supply Division Procurement Reference Group (PRG) for both pneumococcal and rotavirus vaccines to provide a connection between the work done by the SVS team and key procurement decisions for the two vaccines.

STRATEGIC GOAL 3: Increase the predictability and sustainability of long-term financing for national immunisation programmes

3.1 Improved sustainability of new vaccines and immunisation programs

The aim of work under this output is to ensure the financial sustainability of vaccines and national immunisation programmes at country level will be improved through increased and more predictable funding and through integration of immunisation support within national planning and budgeting systems.

[9] http://www.who.int/nuvi/PIE_tool/en/index.html

By 2010:

- 90% of GAVI-eligible countries fulfilled their co-financing commitments on a timely basis (against a target of 85%).
- 46 GAVI-eligible countries had fulfilled their co-financing requirement and an additional 8 countries voluntarily co-financed, leaving 5 countries in default.
- 51 GAVI-eligible countries (71%) were required to co-finance GAVI supported vaccines. Of these 100% included GAVI co-financing in their multi-year plans.

Country co-financing: In March 2010 the PPC appointed a time-limited Co-financing Task Team made up of technical experts drawn from many of GAVI's constituencies, to steer the review of the co-financing policy. The policy was revised in close consultation with ministries of health and finance in implementing countries. The GAVI Alliance Board in December 2010 approved the revised co-financing policy with the new co-financing obligations taking effect in 2012.

Highlights from 2010 include:

- The number of countries co-financing nearly doubled from 32 in 2008 to 56 in 2010 (mandatory and voluntary); co-payments amounted to US$ 31.3 million (including voluntary contributions), representing 10% of total GAVI vaccine support to the co-financing countries.
- At of the end of 2010, five countries were in default. GAVI worked with the countries to resolve the issues and to-date in 2011, three countries have come out of default.
- In 2010, seven countries showed their commitment by co-financing ahead of the required starting date, and four countries paid more than required.

Improved alignment of new vaccine applications with national plans:

In 2010, WHO supported 26 countries to update their comprehensive multi-year plans (cMYP)[10] to include updated plans for new vaccine introduction, request continuation of GAVI support though the annual progress reporting process and to include the revised co-financing policy. [11] In March 2010 in Copenhagen, WHO European region office organised a Workshop on Updating National comprehensive Multi-Year Plans on Immunization and Annual Progress Reporting for GAVI-eligible countries. In collaboration with WHO, UNICEF provided assistance to six of the GAVI-eligible countries in the WHO European region whose cMYPs needed to be updated in 2010. The UNICEF Regional Office for Eastern and Southern Africa together with WHO organised three separate workshops to support 15 countries in the development and updating of cMYPs. The workshops also focused on sustainable financing of immunisation and vaccine procurement.

In support of the GAVI co-financing policy implementation and revision, WHO conducted an analysis of 55 cMYPs and a review of the immunisation financing trends in GAVI countries with the analysis of information derived from the WHO-UNICEF Joint Reporting Form (JRF). The annual analysis of the JRF indicators[12] shows that:

- 93% of GAVI-eligible countries had a line item for purchasing vaccines (an increase from 68% in 2000).
- 86% of GAVI-eligible countries had a line item for immunisation supplies.

[10] The national immunisation comprehensive multi-year plans (cMYPs) are developed on a 3 to 5 year rolling basis depending on national immunisation/health programme planning timelines. The cMYPs are a requirement for countries applying to GAVI for any type of support, and are intended to demonstrate that GAVI support is integrated into national planning and budgetary (for co-financing) processes.
[11] The cMYPs are available at http://www.who.int/immunization_financing/en/
[12] http://www.who.int/immunization_financing/analysis/en/

On the co-financing implementation, the cMYP analysis conclude that on average co-financing represent a small amount of routine immunisation costs for GAVI countries (2.6% of routine immunisation; 3.4% of routine vaccines; and 3.6% of new and underused vaccines). This shows that co-financing at current levels is affordable by countries (2010-2014 data over five year period). The analysis was finalised in 2011 with the Gates Foundation.

Improved integration of immunisation financing requirements within national plans and budgets: In 2010 the World Bank finalised a study with the Government of Pakistan on the relative cost-effectiveness and financial implications of introducing Hib, pneumococcoal, rotavirus, and HPV vaccines. The purpose was to provide the necessary evidence-base for the Government of Pakistan to make decisions about future new vaccine introduction.

The World Bank hosted a workshop in May 2010 on progress with co-financing policy implementation and on dissemination of new knowledge on immunisation financing and sustainability. The workshop featured: 50 representatives from ministries of health, finance, and planning; EPI managers; and partner agencies. A presentation was made on the Pakistan cost-effectiveness study and the Immunisation Financing Toolkit draft was shared at the meeting. The Toolkit was finalised in October 2010 and posted on the World Bank, WHO and GAVI websites.[13]

At country level, work by the World Bank supporting financial sustainability/innovative financing was carried out in nine countries.

3.2 Increased donor government commitments made to innovative financing mechanisms

The aim of work under this output is to secure additional global commitments to immunisation through innovative financing mechanisms[14].

- **Advance Market Commitment** (AMC): 2010 represented a pivotal year in the AMC's development and implementation with the celebration of the first introduction of AMC pneumococcal vaccines in GAVI countries. In 2010 two pneumococcal conjugate vaccines became available for procurement under the AMC and the first supply agreements were signed. The first shipment of AMC pneumococcal vaccines was delivered in Kenya in September 2010. In December 2010, Nicaragua became the first country to introduce the vaccine in its routine immunisation programme.

- **IFFIm:** By the end of 2010, eight donors had committed approximately US$ 5.9 billion to the International Finance Facility for Immunisation (IFFIm) over 23 years, with Australia pledging to commit A$ 250 million. In November 2010, IFFIm entered the Australian capital markets for the first time. In 2010, GAVI received US$ 320 million in IFFIm funds.

  An IFFIm donors' meeting was held in June 2010 to update donors on potential for how an enlarged/enhanced IFFIm could contribute to GAVI's funding needs. Opportunities to create partnerships with impact investment asset managers, mobile telephone operators and financial institutions are being explored and form part of the terms of reference that were completed for a Gates Foundation-funded consultancy

[13] http://www.gavialliance.org/about/gavis-business-model/country-commitment-to-co-financing/
[14] Innovative financing is defined as "any mechanism by which immunisation efforts (or GAVI) can attract new sources of investments for immunisation outside of the traditional channels (traditional channels are Government and EC funding)".

to enable prioritisation and development of two-to-three new innovative finance initiatives.

3.3 Increased levels of multi-year government and private contributions

Mobilising sufficient financial resources to meet country demand and support national immunisation programmes remained a top priority for GAVI in 2010. The two main events held in 2010 were: the High Level Meeting on Financing Demand in the Hague in March, chaired by the Netherlands; and the October GAVI Call for Action and Resources meeting in New York, co-chaired by Norway and the USA.

- By 2010, GAVI's donor base consisted of 18 public donors[15], the Bill and Melinda Gates Foundation, the "la Caixa" Foundation and other private donors.
- In 2010, direct contributions from 11 donor governments amounted to US$ 253 million.
- In 2010, foundations, private individuals and organisations, including the Bill & Melinda Gates Foundation and the "la Caixa" Foundation, contributed US$ 80 million.

In September 2010, the Republic of Korea made its first contribution to GAVI with a donation of US$ 1 million over three years. New, multi-year commitments were also made in 2010 from Australia, Canada, Ireland, Luxembourg and the United Kingdom.

Exploratory work on potential new donors, including Japan, China and countries in the Middle East is ongoing in 2011.

STRATEGIC GOAL 4: Increase and assess the added value of GAVI as a public-private global health partnership through improved efficiency, increased advocacy and continued innovation

Work under this strategic goal aims to ensure that GAVI remains a leader in best practice international development and continues to demonstrate innovation in the way that it operates as an Alliance.

4.1 GAVI eligible countries supported efficiently

- **Regional Working Groups** (RWGs): Regional working groups and national Interagency Coordinating Committees (ICCs) continue to coordinate and support the implementation of GAVI policies in eligible countries. The RWGs normally meet twice a year and in 2010 RWG meetings were conducted in all six of the WHO regions, supporting GAVI countries to prepare their annual reports to GAVI on the implementation of GAVI support

- **Transparency and Accountability Policy** (TAP): In 2010 GAVI undertook Financial Management Assessments (FMAs) in 18 countries, selected on the basis of a TAP risk assessment as well as the size of the grant.

- **Aid effectiveness:** GAVI is actively represented in relevant major aid effectiveness initiatives and fora: in the International Health Partnership and related initiatives (IHP+) Steering Committee; the Organisation for Economic Co-operation and Development (OECD) task team for health as a tracer sector; and the Global Programmes Learning Group. In addition, there is active participation in the development of global monitoring indicators (Development Assistant Committee and

[15] This includes both direct and IFFIm and AMC donors.

IHP+). In addition, in 2010 GAVI sought to advance the International Aid Transparency Initiative to ensure developing countries have access to comparable data on aid commitments and disbursements.

4.2 Seamless performance management system functioning

- **2011-2015 Strategy and Business Plan:** In 2010, under the guidance of the Executive Committee, the GAVI Secretariat coordinated the development of the 2011-2015 Strategy and Business Plan. GAVI's Strategy, approved by the GAVI Board in June 2010, draws on lessons from the previous 10 years and sets the roadmap for the next stage of the Alliance's mission. In November 2010, the GAVI Board approved a Business Plan and budget designed to implement the Strategy and ensure that GAVI's day-to-day activities deliver on its overall mission. In 2011, there will be a transition to a performance reporting system under the 2011-2015 Business Plan.

- **Performance Based Funding:** In response to the PPC's guidance, a paper on the design of the proposed new performance based funding window Incentives for Routine Immunisation Strengthening (IRIS) was completed with the input of the Performance Based Financing Task Team. In November 2010, the GAVI Alliance Board agreed to pilot IRIS and requested that the PPC define the implementation of the pilot.

- **Independent Review Committee (IRC):** Four Monitoring IRC reviews were held in 2010: A teleconference in January to complete the review eight of 2008 Annual Progress Reports (APRs), an in-person Monitoring IRC in June to review a total of 58 APRs in 2009 (excluding ISS window, pneumococcal requests), one teleconference in August to review India APR 2009 together with its revised pentavalent introduction plan and one in-person review in September to review a total of 54 APRs in 2009 (13 new APRs, 41 old APRs) for all ISS windows, all pneumococcal requests and the remaining HSS/CSO, pentavalent/yellow fever requests. The review outcomes and financial implications were integrated into four Programme Funding Plan papers and submitted to the Audit and Finance Committee and the Executive Committee. There was no proposal review in 2010.

- **Data Warehouse:** The year 2010 was characterised by the planning and designing of the Data Warehouse. In 2011 data became accessible by the Secretariat.

- **AMC Baseline**: Following the publication of the AMC Monitoring and Evaluability Study, the GAVI Secretariat commissioned the Swiss Centre for International Health in 2008 to conduct a Baseline Study for the pneumococcal vaccine Advance Market Commitment. The AMC Baseline Study was published on the AMC website in December 2010.

- **Monitoring and Evaluation:**

    - In November 2010 the GAVI Alliance Board discussed the **GAVI Phase II Evaluation** Report and the management response. The report sets out the main findings of an independent assessment of the Alliance's achievements against its four Strategic Goals in Phase II (2007-2010). Follow-up activities to the evaluation are included in GAVI Business Plan and will be discussed by GAVI management in 2011.

    - The **review of the Independent Review Committees** and Secretariat response were presented to the PPC in May 2010 for discussion. In June

2010 the GAVI Secretariat issued a management response to the review. The Secretariat has developed an implementation plan and the progress update has been presented verbally to the PPC in September 2010.

- **IFFIm Evaluation**: In 2010, at the request of the IFFIm Company Board the GAVI Secretariat commissioned the consultancy HLSP to carry out an evaluation of IFFIm to assess whether the IFF concept is proven and whether the IFFIm pilot has worked. The report was published in 2011.

4.3 Increased awareness of immunisation as a means to reach the Millennium Development Goals including the benefits of the Public-Private Partnership (PPP) mode of development

The GAVI business model was promoted in key stakeholder fora in 2010. Activities and outcomes included: a plenary and press conference at the World Economic Forum; positive GAVI references in the 2010 G8 Muskoka Initiative outcome document; involvement in the preparation for the MDG Summit and references in the outcome document; a joint side event with UNICEF at the MDG summit to mark progress on MDG 4; participation on the Decade of Vaccines coordination steering committee; continued active engagement with CSOs in the donor arena and CSO networks; and new and revised publications (*Investing in immunisation through the GAVI Alliance: the evidence base* and *Results and Opportunities* brochure) feature effectiveness of GAVI business model. Positive media coverage was generated around GAVI's resource mobilisation meetings in The Hague and New York, the first anniversary of introduction of PCV7 by Rwanda as well as the global launch of GAVI-funded pneumococcal vaccine in Nicaragua.

4.4 Innovative policies and processes developed and implemented

- **Gender:** Progress was made in 2010 with regards to the implementation and monitoring of the GAVI Alliance Gender Policy. In June 2010 the Board approved the Guidelines on the GAVI Alliance Board Gender Balance, which seek to integrating GAVI's Gender Policy into the Board nominations process and, in particular, to assist the Board in achieving greater gender balance. Also in 2010, two studies were commissioned to review the gender-related barriers to immunisation, and the link between GAVI's work and women's health. In December 2010 the Secretariat recruited the consultancy InDevelop to design the gender Help Desk, which will provide capacity building and technical assistance, and help to ensure that gender issues are considered in all areas of GAVI's work.

- **Civil Society:** At a meeting of civil society representatives in March 2010, a CSO constituency structure was set-up including a 15 to 20-person steering committee and a civil society forum with open membership. In October 2010 the steering committee met for the first time, providing an opportunity to formalise the structure of civil society engagement with the Alliance.

- **Policy Development**:

  - The PPC appointed the Prioritisation Task Team to develop a system for ranking country proposals recommended by the IRC and for informing prioritisation decisions among the vaccines in GAVI's portfolio. In June 2010 the GAVI Board approved the **Prioritisation Mechanism**, which will be used to guide GAVI's funding decisions when resources are restricted.

  - In June 2010 the Board adopted the **Programme Funding Policy**. Under the policy GAVI will ensure sufficient resources are available to cover any new

programmes as well as all previously approved programmes for the coming two years.

Details on the revised Vaccine Supply and Procurement Strategy, and the revised Co-financing Policy, are found under the outputs 2.5 and 3.1 respectively.

4.5 Secretariat organised to deliver efficiently to advocate and innovate

A survey was conducted to assess board member understanding of GAVI Alliance programmes, procedures and processes and evaluate the effectiveness of the governance transition. The results were presented and discussed at the June 2010 Board meeting.

Annex: Work Plan 2010

The table below summarises the progress against the 2010 work plan targets as they were defined at the time. A traffic light assessment shows those targets that were met or not met, along with additional details if relevant.

Legend for traffic light:

- Target met
- Below target
- Significantly below target

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

Level: output	Indicator (definition)	Target (2010)	Actual (2010)	Status
1.1 GAVI ISS support will reach an increased number of countries and countries that have received support including those with specific demographic, social or programmatic features will have increased and/or maintained high coverage	% of GAVI-eligible countries that have received ISS support	95%	86%	
	% of GAVI-eligible countries receiving ISS support that have increased coverage by 5% or more since 2000	90%	71%	
1.2 Countries with HSS support will have made improvements to their health system to deliver immunisation and other child health interventions	% of GAVI-eligible countries that have been approved for HSS support by 2010	50%	71%	
1.3 GAVI countries that have received CSO support have improved CSO engagement with relevant stakeholders and increased access to quality health services and interventions				
1.4 GAVI countries will have developed and satisfactorily implemented comprehensive policies and strategies on immunisation injection safety and related waste, supported by a monitoring and evaluation framework	% of GAVI-eligible countries that have a national policy for waste from immunisation activities by 2010	Not defined	89%	[16]

[16] Although no target has been defined, the overall assessment in that area is that although policies have developed in GAVI supported countries, the implementation is lagging behind as noted in the Phase 2 Evaluation report.

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

Level: output	Indicator (definition)	Target (2010)	Actual (2010)	Status
2.1 Sufficient quantity of safe, effective, appropriate vaccine to meet demand	Number of GAVI-eligible countries that have introduced Hepatitis B vaccine into their national EPI schedule by 2010[17]	72	67	
	Number of GAVI-eligible countries that have introduced routine Yellow Fever vaccine according to WHO recommendation by 2010[18]	27	17	
	Number of prequalified rotavirus vaccines that are available by 2010	2	2	
	Number of prequalified pneumococcal vaccines that are available by 2010	2	2	
2.2 Countries make well-informed decisions on introduction of the vaccine	Country approvals in 2010	Not defined	No application round in 2010	
2.3 Country introduction of the vaccine	Number of countries introduce rotavirus vaccine by 2010	9	4	[19]
	Number of countries introduce pneumococcal vaccine by 2010	14	3	[20]
2.4 Platform for sustained use of the vaccine established	Platform for sustained use of the vaccine established	Not defined	AVI established	[21]
2.5 A healthy vaccine market established for all GAVI sponsored vaccines	A healthy vaccine market established	Not defined		[22]

[17] All GAVI-eligible countries should introduce Hepatitis B vaccine in accordance with WHA resolution 45.17 (1992).
[18] List of GAVI eligible countries recommended by WHO to introduce Yellow Fever vaccine in routine EPI: Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Togo, Uganda, Bolivia, Guyana.
[19] Explanation for delays include: WHO's Strategic Advisory Group of Experts (SAGE) recommendation on rotavirus vaccines came in 2009; pause in GAVI applications through 2010.
[20] Explanation for delays include: Pneumococcal vaccines not prequalified until 2010; pause in GAVI applications through 2010.
[21] Although no target had been defined, the purpose of this output was to develop the AVI platform. The efficiency and effectiveness of this platform will be assessed in the 3rd phase of GAVI.
[22] Although no target had been defined, this area was identified as a weakness by the Phase 2 Evaluation.

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

Level: output	Indicator (definition)	Target (2010)	Actual (2010)	Status
3.1 Improved sustainability of new vaccines and immunisation programs	% of GAVI-eligible countries that developed cMYPs or equivalent strategic immunisation plans	100%	100%	
	% of countries with co-financing in their cMYPs	80%	100%	
	% of countries that came out of default from 2009 to 2010	100%	100%	
	% of GAVI-eligible countries that fulfilled their co-financing commitments on a timely basis	85%	90%	
	% of GAVI-eligible countries that had a budget line item for vaccines	Not defined	93%	[23]
	% of GAVI-eligible countries that had a line item for immunisation supplies	Not defined	86%	[24]
3.2 Increased donor government commitments made to innovative financing mechanisms	Total (cumulative) commitments secured from governments for the IFFIm by 2010	US$ 4 billion	US$ 5.9 billion	
3.3 Increased levels of multi-year government and private contributions	Size of donor base: number of government donors	Not defined	18[25]	
	Proportion of donor funding that is multi-year (3 years or more)	75%	68%	
	Total funding in 2010	Not defined	US$ 696 million[26]	
	Direct contributions from public donors in 2010	US$ 370 million	US$ 253 million	
	Private fundraising by 2010	US$ 30 million	US $20 million	

[23] Although no target defined, the indicator can be considered on track.
[24] Although no target defined, the indicator can be considered on track.
[25] This includes both direct and IFFIm and AMC donors.
[26] This includes direct contributions and proceeds from IFFIm and AMC.

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

Level: output	Indicator (definition)	Target (2010)	Actual (2010)	Status
4.1 GAVI-eligible countries supported efficiently	Number of Financial Management Assessments (FMAs) at various stages of completion	Not defined	18	
	Regional Working Group Meetings (RWG)	Not defined	6	
4.2 Seamless performance management system functioning	Seamless performance management system functioning implemented	Not defined		[27]
4.3 Increased awareness of immunisation as a means to reach the Millennium Development Goals including the benefits of the Public-Private Partnership (PPP) mode of development	No indicator defined			
4.4 Innovative policies and processes developed and implemented	Policies and processes developed and implemented by 2010	Not defined		[28]

[27] Identified as a weakness: Phase 2 Evaluation.
[28] Multiple policies developed such as Prioritisation Mechanism, Gender, Eligibility, Donation, Phase 2 Evaluation, GAVI Strategy 2011-2015, AMC, IFFIm Evaluation, Co-financing, Vaccine Investment Strategy, Health System Strengthening Review.