

Independent review committee  
Report for the GAVI Board

March 19, 2014

## Table of Contents

<b>Executive Summary</b> .....	<b>iii</b>
Main Recommendations.....	iv
<b>Introduction</b> .....	<b>1</b>
<b>Summary of country requests and the IRC’s recommendations</b> .....	<b>2</b>
Table 1: Recommendations on specific country requests .....	4
<b>Thematic Analyses</b> .....	<b>6</b>
Health system strengthening proposals.....	6
Gender and equity.....	8
Responses to conditions .....	10
A brief summary of the request from India .....	11
Strengthening cold chain logistics .....	12
Coverage and data quality .....	13
New guidelines for the IRC to recommend either “Yes” or “No” .....	14
Monitoring and evaluation.....	15
<b>Annex 1: IRC Members</b> .....	<b>18</b>
<b>Annex 2: IRC recommendations on specific country requests</b> .....	<b>19</b>
<b>Annex 3: Overview of HSS proposals</b> .....	<b>24</b>
<b>Annex 4: Budget analysis for new HSS proposals</b> .....	<b>26</b>
<b>Annex 5: Key country-specific findings on gender and equity</b> .....	<b>27</b>
<b>Annex 6: Maps showing marked sub-national inequalities in coverage</b> .....	<b>30</b>

### *Acknowledgements*

The IRC team would like to acknowledge the indispensable support provided by the GAVI Secretariat, including the Country Responsible Officers, the HSS team, the M&E team, the management team and the administrative staff.

### *Acronyms*

APR	Annual Progress Report
CCL	Cold chain logistics
CRO	Country Responsible Officer
CSO	Civil Society Organization
GAMR	GAVI's grant application, monitoring and review approach
HSS	Health System Strengthening
IRC	GAVI's Independent Review Committee
M&E	Monitoring and Evaluation
Men A	Meningococcus serogroup A vaccine
MR	Measles-rubella vaccine
MSD	Measles second dose
NVS	New vaccine support

## Executive Summary

### *Background and Process*

A group of ten reviewers constituting GAVI's Independent Review Committee (IRC) met from 27 February to 7 March, 2014 to review requests from 14 countries and make recommendations to the CEO or GAVI Board concerning these requests:

- Five new applications for health system strengthening (HSS) support;
- One resubmission of an application for measles second dose (MSD) support;
- Five responses to conditions previously recommended by the IRC;
- Four requests which were presented as Annual Progress Reports (APRs). Most notably, this included a request for procurement of pentavalent vaccine for nationwide scale up in India. GAVI has given a ceiling of US\$ 230 million for this purpose.

Reviewers assessed requests based upon the requirements as specified in the relevant GAVI guidelines for support of HSS, NVS and immunization campaigns and for APRs on such support.

For this meeting, GAVI introduced new guidelines specifying that the IRC was to limit its recommendations on new HSS applications to either "Yes"/"Approve" (with or without comments) or "No"/"Resubmit". Hence, any recommendation of "Approve" would not involve any further review by the IRC.

### *IRC recommendations on specific country requests*

- Of the 5 new HSS applications, the IRC recommended "Approve with comments" for 4 and "Approve" for 1; For the resubmitted application for MSD support, the IRC recommended "Approve with clarification";
- For the five country responses to conditions, the IRC recommended "Approve" without any clarifications for 3 and "Approve with clarifications" for 2;
- For the four requests presented as APRs, the IRC recommended "Approve" without any clarifications for 1 and "Approve with clarifications" for 3.

### *Cross-cutting findings and recommendations of the IRC*

This IRC report also presents findings and recommendations on the following cross-cutting topics:

- (1) **HSS proposals:** Some common positive findings included the strong focus on immunization and consistency of the proposed HSS support with broader national health plans. A frequent shortcoming was the limited discussion of lessons learned from evaluation of previous HSS support. Some other notable findings, positive and negative, concerned the way that HSS applications addressed issues of gender and equity.
- (2) **Gender and Equity:** All five of the new HSS proposals had a stated intention to focus on underserved populations. Yet, the applications had weak discussions of bottlenecks specifically affecting underserved populations and limited explanation of how activities and budgets would focus on these groups. Monitoring and evaluation (M&E) frameworks needed to be refined to better assess and track progress with gender and equity issues.
- (3) **Cold chain logistics:** IRC reviewers noted that HSS applications seldom contain the information (e.g. report of a cold chain inventory) needed to determine if vaccine supply chains are fit for purpose or if improvements are required and needs quantified and

budgeted to ensure the safe storage, management and distribution of vaccines. As a result, HSS investments in cold chain equipment often lack adequate justification. Also of concern, during the last year, several countries proposed to use GAVI HSS funding to procure types of refrigerators which might freeze and thus damage some vaccines (PCV, Penta and IPV).

- (4) **Coverage and data quality:** Six countries reviewed have had persistent problems with lagging immunization coverage (Nigeria, Guinea, Papua New Guinea, DRC, Niger, India) and uncertainties about data quality (Nigeria, Guinea, DRC, Papua New Guinea, Niger, Myanmar, India).
- (5) **Limiting IRC recommendations to “Yes” or “No”:** The consensus among IRC members was that the overall quality of proposals has improved and this is largely responsible for the IRC recommending approval of all requests. At the same time, IRC members concluded that, with the new guidance, several applications which would formerly have warranted “Approve with clarifications” were now recommended for “Approve with comments”. The IRC discussed the implications of this, including follow-up of comments by the Secretariat.
- (6) **Monitoring and evaluation:** GAVI’s transition to a new Grant Application, Monitoring and Review (GAMR) process has important implications for the monitoring and evaluation of country support. While the full IRC will no longer be involved in annual monitoring, the IRC’s understanding of the GAMR process will inform their recommendations on initial approval of country applications. Given the expertise that IRC members have in monitoring and evaluation and their familiarity with country programs, IRC members look forward to briefings on progress with this transition.

## Main Recommendations

Based on the above findings and analyses, the IRC offers the following recommendations:

### *HSS support:*

- Resource allocation to CSOs should be in line with the important role they play for reaching hard-to-reach communities;
- Mid-term evaluation should be mandatory to plan new HSS grants;
- Provide guidance for countries to plan their use of GAVI PBF;
- Provide guidance for HSS funding of incentive schemes.

### *Gender and equity*

- As part of the roll out of GAVI’s revised gender policy, train GAVI staff on gender and equity in health programming; develop case studies to demonstrate best practices for addressing gender and equity issues; and provide guidelines for gender and equity analysis as part of bottleneck studies and development of M&E frameworks
- Assist countries to define baselines and annual targets for “mandatory equity indicators where these have been left blank in M&E frameworks;
- Provide funding to support gender and equity analysis, including at the sub-national level in large states where there are stark inequalities among the states/districts;

#### *Cold chain logistics*

- Countries should have completed an Effective Vaccine Management (EVM) Assessment within the 36 month period preceding the submission of an HSS application.
- HSS applications which include budgetary provision to strengthen vaccine supply chains should include a supply chain upgrade (rehabilitation) plan;.
- Supply chain equipment procured through HSS support should be WHO/PQS prequalified.

#### *For coverage and data quality:*

- HSS grants (and their M&E frameworks) should focus on the lowest performing geographic zones within large countries;
- GAVI should encourage (and finance where necessary) regular, high quality coverage surveys;
- GAVI should encourage countries to make use of HSS support to strengthen the reporting, analysis and use of routine health data. This should include support to strengthen computer-based data management systems;
- Build capacity for analysis and use of data/evidence for decision making (including support of NITAGs)

#### *To assure the quality of HSS support (with IRC recommendations limited to “Yes” or “No”):*

- GAVI Secretariat should continue to provide strong support for proposal development;
- The “comments” offered by the IRC must be concrete and actionable for issues to be addressed in a reasonable period of time;
- GAVI Secretariat should assure adequate follow up of comments: by the CRO, by the “clarifications review panel” and by GAMR’s M&E process. *The IRC should be briefed on these processes;*

#### *To strengthen monitoring and evaluation:*

- GAVI should develop additional guidance on country monitoring;
- Countries should be encouraged to include in their M&E frameworks appropriate (“disaggregated”) indicators for monitoring progress at a sub-national level
- Develop guidance for how the Secretariat is to synthesize findings from multiple sources into the “Cover Note” to GAVI’s High Level Review Panel.
- GAVI should further develop its guidelines for end-of-grant evaluations and find ways to strengthen the rigor of these evaluations;
- The IRC encourages the GAVI Secretariat to provide the IRC with updates on the M&E process under GAMR, as it develops.

## Introduction

### *Process of review*

A meeting of the Independent Review Committee was conducted from 27 February to 7 March in Geneva, Switzerland. The purpose of the meeting was to review requests from 14 countries and make recommendations to the CEO or GAVI Board concerning these requests.

In all, 10 reviewers took part in the review. Reviewers were from a range of disciplines including epidemiology, public health, logistics, health economics, health system strengthening and gender and equity. Following an initial day of orientation, including discussion of the review template, reviews began on the second day of the meeting. Reviews were conducted by a team consisting of first and second reviewers of the overall proposal, a gender and equity reviewer and a cold chain logistics reviewer. Reviewers presented their findings on each country to the plenary and the IRC then reached consensus on their recommendations. After the second day of the meeting, one of the reviewers had to leave due to a family medical emergency. Reviewers were reassigned to cover the pertinent countries.

### *Framework for analysis of country requests*

In all cases, the IRC based its recommendations on the GAVI guidelines for applications. These included guidelines on Health System Strengthening support (HSS – the 2013 version) and on New Vaccine Support (NVS – for the requests for support of Penta introduction, MSD introduction, measles rubella campaigns, and Men A campaigns).

### *Categories of IRC recommendations for specific country requests*

Previous GAVI guidelines for review of HSS proposals instructed the IRC to provide one of 4 recommendations: i) Approve; ii) Approve with level 1 clarifications; iii) Approve with level 2 clarifications; or iv) Resubmit. Level 1 clarifications were to be followed up on by the Secretariat, but required no further review by the IRC. Level 2 clarifications required subsequent IRC re-review. A recommendation for “Approve with a level 2 clarification” of an HSS proposal was analogous to the recommendation of “Approve with conditions” of an NVS proposal – in each case subsequent IRC review was required.

On the first day of the meeting, the IRC was introduced to new guidelines for review of HSS proposals, which instructed the IRC to provide one of 2 recommendations: i) Yes/Approve with or without comments; or ii) No/Resubmit with the rationale. The IRC was instructed on the first day of the meeting that they should not recommend “Approve” if clarifications or conditions were required. However, the nature of “comments” was not discussed further on the first day of the meeting. Subsequent IRC discussions about the new guidelines (internal discussions within the IRC as well as discussions with members of the Secretariat) focused on defining the appropriate role for “comments” (versus a recommendation to “resubmit”) and the process for following up on comments.

For other types of requests (i.e. the resubmission of an NVS application, the responses to conditions and the requests presented as APRs), the IRC was instructed to use the previous

guidelines and recommend either i) Approve; or ii) Approve with clarifications; or iii) Approve with conditions<sup>1</sup>; or iv) Resubmit/insufficient information.

### Summary of country requests and the IRC's recommendations

Fourteen countries submitted requests for GAVI support. As shown by Figure 1, this included 4 countries with low immunization coverage (DPT3 <70%), 5 countries with mid-range coverage (DPT3 = 70% - 89%) and 5 countries with high coverage (DPT3 > 90%).

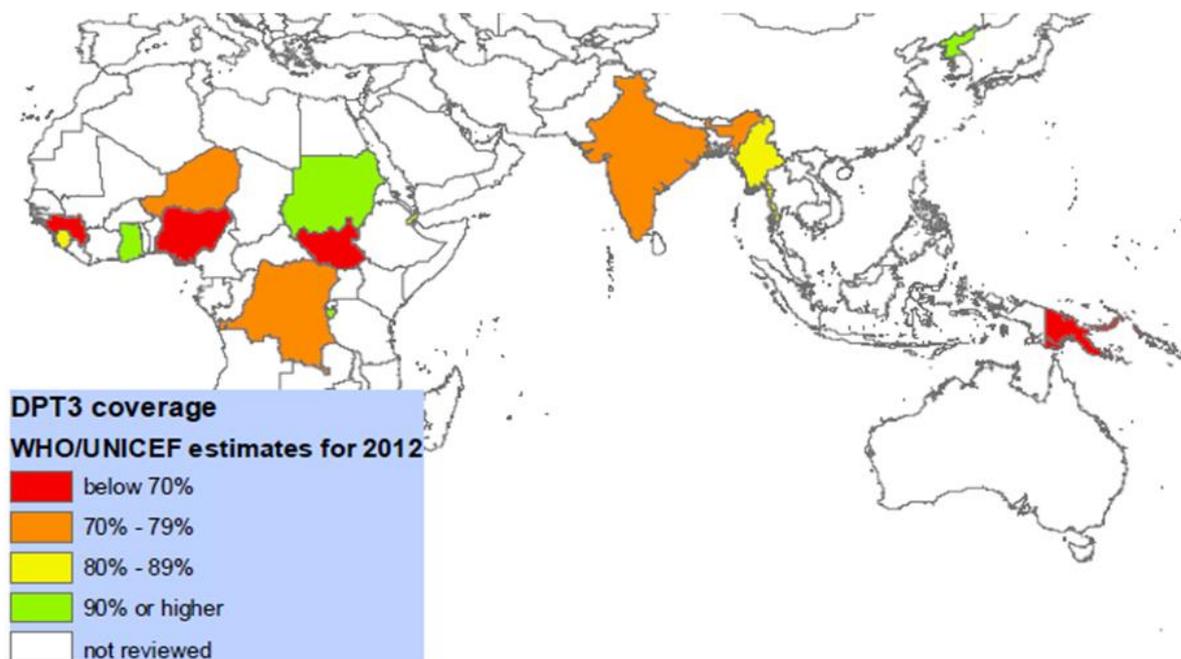


Figure 1: Countries submitting requests for IRC review, Feb-March 2014, by DPT3 coverage

Countries submitted four different types of requests:

- Five new applications for health system strengthening (HSS) support (from Ghana, Nigeria, Niger, Djibouti and Sudan);
- One resubmission of an application for MSD support (from Sierra Leone);
- Five responses to conditions previously recommended by the IRC (from Papua New Guinea, South Sudan, Guinea, DPR Korea and Myanmar);
- Four requests which were presented as APRs (from DR Congo, Nigeria<sup>2</sup>, Burundi and India).

IRC recommendations for these requests are summarized in Table 1 as well as in Annex 2 (in somewhat greater detail). The IRC recommended approval of all requests without recommending any subsequent re-review by the IRC<sup>3</sup>. The IRC included “comments” with their recommendations for approval of 4 of the 5 new HSS proposals. In addition, the IRC

<sup>1</sup> This recommendation is permitted for an NVS application (including either a response to conditions or a resubmission) but not for an APR. For an APR which lacks key information, “Insufficient information” would be recommended rather than “Approve with conditions”.

<sup>2</sup> Nigeria submitted both a new HSS proposal and an APR to request annual funds for the last phase of a multi-year MenA campaign.

<sup>3</sup> Put another way, the IRC did not recommend approval with conditions or resubmission for any of the country requests.

requested clarifications with their recommendations for approval of 5 of the other 10 requests (i.e. responses to conditions and APRs).

For complete information on each request as well as the IRC's findings and recommendations, readers should refer to the individual IRC report that was prepared for each of the 14 countries.

Table 1: Recommendations on specific country requests

Country		Type of request	Type of support / recommendation						
			HSS	CSO	Penta	PCV	MSD	MR	Men A
1	Burundi	APR	Approval with clarifications						
2	Congo, DR	APR		Approval					
3	Djibouti	New proposal	Approval with comments						
4	Ghana	New proposal	Approval with comments						
5	Guinea	Response to cond.							Approval
6	India	APR			Approval with clarifications				
7	Korea DPR	Response to cond.	Approval						
8	Myanmar	Response to cond.				Approval with clarifications		Approval	
9	Niger	New proposal	Approval with comments						
10	Nigeria	New proposal + APR	Approval with comments						Approval with clarifications
11	Papua N.G.						Approval	Approval	
12	Sierra Leone	Resubmission					Approval with		

							<b>clarifications</b>		
13	<b>South Sudan</b>	<b>Response to cond.</b>							<b>Approval</b>
14	<b>Sudan</b>	<b>New proposal</b>	<b>Approval</b>						

## Thematic Analyses

In addition to the country reviews, IRC members summarized findings and offered recommendations on key topics. These thematic reports constitute the remainder of this report.

### Health system strengthening proposals

In 2006, GAVI opened the HSS cash support window in recognition of the fact that strengthening country health systems is critical to achieving GAVI's core mission of increasing access to immunization. With the new five-year strategic plan for 2011-15, the Board made a decision to refocus HSS on immunization to "contribute to strengthening the capacity of integrated health systems to deliver immunization by resolving health systems constraints, increasing the level of equity in access to services and strengthening civil society engagement in the health sector." GAVI's approach to HSS has continued to evolve in the last two years, in response to a number of challenges faced in the planning and implementation of the HSS cash support window, and an increasing emphasis on demonstrating results in the form of improved immunization outcomes, through a Performance Based Framework.

The proposals for HSS support under review by the Feb-March 2014 IRC are the result of recent discussions within the GAVI Board and other work by the GAVI Secretariat. They represent the 4<sup>th</sup> generation of GAVI HSS support.<sup>4</sup>

The IRC reviewed 5 new applications for HSS cash support, 1 APR that was brought forward from the April 2013 review and one response to conditions. Annex 3 provides an overview of each of these proposals and the IRC's recommendations while Annex 4 summarizes key aspects of their budgets. All were recommended for support. The total financial implications for the new HSS applications totaled US\$178,665,367.

#### **1. Focus of the HSS and consistency with overall national health strategy**

Applications were generally well aligned to national health plans. All applications had a strong focus on immunisation. Two applications supported primary care more broadly in addition to supporting immunization. The other three applications were more highly focussed on strengthening routine immunisation. In general the bottleneck analyses were well conducted although they typically identified constraints that applied nationwide without describing well the special constraints responsible for the low coverage among the underserved populations that the proposals intended to target.

IRC reviewers found little that was innovative about the proposed activities to be funded. With a majority having an emphasis on procurement of equipment, proposed strategies for strengthening the health system more widely were often weak – with the exception of the proposals from Niger and the Sudan where HSS support would help increase access to PHC services.

There were no links of HSS grants to NVS. This made it appear as if these different proposals were made in parallel to each other, rather than being part of an overall plan.

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<sup>4</sup> The "first generation" of HSS grants, those approved until 2010, were specifically targeted at bottlenecks/barriers in health systems that make it difficult to improve the provision of, and demand for immunisation and other child and maternal health services. However, there was no specific requirement for country applications to show a direct link between proposed activities and improved immunisation coverage, nor to demonstrate a clear results chain or theory of change. For this reason and due to other delays in cash disbursements and implementation, seventeen of the old grants were "reprogrammed" over 2010-2012 to be "second generation" HSS grants. The "third generation" is comprised of the HSFP grants starting with one pilot in 2011.

Similarly there was little or no reference to other donors' interventions, such as those of the Global Fund in countries where several partners currently fund HSS activities.

## 2. Proposals' focus on underserved populations

All new HSS proposals targeted low coverage communities, either through the selection of regions or districts with low immunisation coverage or by targeting specific groups of underserved populations. Although the overall aim of all the applications was always to focus on these underserved populations, they often lacked details on the mechanisms by which funding would be channelled to sub-national levels and how these populations would be reached. Likewise the M&E frameworks included few indicators of sub-national performance that would allow measurement of performance of locally targeted activities. This topic is discussed further in the following section devoted to gender and equity issues.

## 3. Possible lack of CSO involvement

Almost all HSS proposals outlined in their rationale the vital role of CSOs in achieving immunization objectives in remote areas and hard-to reach communities. However, the important role to be played by CSOs was not reflected in the budget that was allocated to CSOs except for Ghana (CSO budget = 4% for Nigeria, 2% for Niger and less than 1% in Sudan). The IRC was concerned that GAVI policies promoting the involvement of CSOs in immunization programs are not substantially reflected in country plans and programs. This topic is also discussed in the following section devoted to gender and equity issues.

## 4. Evaluation of HSS

Overall and due to the lack of previous requirements, there was insufficient assessment of previous HSS support – with lessons learnt not being well described. This was an issue, especially in the case where applications were building on a previous HSS grant, and were planning to deliver very similar activities. The need for continuity of support has resulted in challenges in management of some HSS grants (e.g. the Burundi APR had to be brought forward to avoid a gap in funding of the national PBF scheme).

For the current applications, end-of-grant evaluations were planned and budgeted for by 4 of 5 countries (not Niger) although the overall budgets would have been under-resourced with a planned budget of \$150,000 or less (see Table 2). No proposals planned for mid-grant evaluations (to make mid-course corrections and prepare for future HSS proposals). No other HSS grant evaluations (e.g. those supported by the WB or GFATM) were mentioned, even when basket funding was implemented (Burundi).

**Table 2: Planned budget related to evaluation activities in new HSS grants**

<b>Countries</b>	<b>Djibouti</b>	<b>Sudan</b>	<b>Nigeria</b>	<b>Ghana</b>	<b>Niger</b>	<b>Totals</b>
Mid-term Evaluation	0	0	0	0	0	<b>0</b>
End-of Grant Evaluation	\$110,000	\$100,000	\$150,000	\$100,000	0	<b>\$ 460,000</b>

## 5. Motivational policies

Some HSS proposals include some allowances or incentives for the EPI staff or district health staff involved in program implementation. Although the total budget was specified for this type of reward, there was generally no detail on the type of motivational scheme involved and the staff targeted. It was also difficult to differentiate salary costs of HSS grant management personnel from the costs associated with these incentive schemes. The allocation of funds to program management varies significantly between applications from 4% to 25%.

Policy or guidance would be useful for countries, GAVI Secretariat and IRC reviewers on how to design and review incentive schemes to be funded by HSS support. Otherwise, there is a risk that large disparities in personal rewards might be interpreted as unfair or

inequitable - both between countries and within programmes in countries. As an example of the later problem, there was originally an incentive scheme planned for HSS staff in Burundi that was recently extended to EPI staff, after previous IRC comments.

## **6. Sustainability**

As was observed by the November 2013 IRC, all applications reviewed by the present IRC exhausted the budget ceilings set by GAVI. The sections on sustainability in countries' applications provided only general comments on how to address sustainability issues. As a result, it would be advisable for GAVI to monitor government funding to EPI as an indicator of sustainability.

In the case of Burundi in which GAVI is a major funder of the national PBF scheme, it is particularly critical to ensure that the scheme is funded over a significant period and that sustainability is considered.

## **7. Other issues**

There was no consideration of GAVI PBF in applications and its possible impact on activities. Note that a discussion of this topic was not requested from countries.

IRC members felt that reliable budgeting and costing of HSS activities remains a challenge for all parties: the countries, the Secretariat and the IRC reviewers. Although the template provided alongside the HSS guidelines contains all relevant budget sections required for the review, there is a general feeling that countries complete the template only partially or inappropriately. IRC reviewers found the budgeting tool to be user unfriendly – for example, they had difficulty reviewing them to identify unit costs of specific items.

Some HSS applications (Niger, Sudan and Djibouti) include rehabilitation/renovation of health facilities. However, no specific rehabilitation plan is attached to substantiate the associated costs. Given that many donors are reluctant to fund construction of buildings or properties, GAVI should provide guidelines for rehabilitation/renovation plans including requirements for evidence (e.g. special studies) supporting the design and costing of these activities and guidelines on how to manage contracts for construction/maintenance and for procurement of furniture and supplies.

### **Recommendations:**

1. Resource allocation to CSOs should be in line with the objective to reach hard-to-reach communities
2. Mid-term evaluation should be mandatory to plan new HSS grants
3. Provide guidance for countries to plan their use of GAVI PBF
4. Provide guidance for HSS funding of incentive schemes -- need for consistency with national policy to avoid distortions

## **Gender and equity**

There is a new GAVI Gender Policy effective January 1, 2014 which states that “GAVI should support countries to assess, and when relevant address, gender-related barriers to accessing immunisation services.” None of the proposals reflected GAVI’s new gender policy which is still in the implementation planning stage. Only two of the four HSS countries declared an intention to undertake a gender and equity analysis: Burundi has yet to report on the analysis of a coverage study undertaken in 2013 while Sudan has included a national study to identify gender-related barriers in the national health system, including in immunization services in its application. The other four countries presented gender blind

proposals.

All six countries submitting HSS applications (including Burundi's HSS APR) promised a focus on underserved populations and low coverage regions (see Annex 5 which summarizes key findings from review of gender and equity aspects of each of these applications). Most proposals included lists of underserved groups (pastoralists, nomads, remote rural zones, etc) but included very little information on the particularities of the underserved population (the particular nature of the bottleneck and the size of the population to be served). Equity issues were not included in the terms of reference for bottleneck studies (Nigeria – see Annex 6). Where the application stated that the focus would be on certain districts (Niger) or states (Nigeria), it was difficult to determine what funding was being targeted to the sub-national level. The companion M&E framework did not include targets at the sub-national level. It was not clear whether sub national performance monitoring systems are in place for a federal nation such as Nigeria.

It should be noted that all HSS countries included the mandatory equity indicators in their M&E frameworks but in four country frameworks baseline information and annual targets were left blank. (See Annex 5). It is expected that the Secretariat and Alliance Partners will assist countries to meet these mandatory requirements to the extent possible.

With regard to the other proposals considered, seven were related to the lifting of conditions and there were no changes in gender and equity analysis from the original IRC review. However, the India Pentavalent scale up proposal was complex to review from the equity perspective. Coverage surveys in India show stark inequalities in immunization coverage by state/district (see Annex 6) yet the proposal did not indicate an intention to collect information or set targets at the sub-national level. India provided another long list of underserved groups but this was not translated into detailed action plans or reflected in the monitoring and evaluation framework.

## **Recommendations**

1. The approval of GAVI's revised gender policy and the roll out of GAMR are opportunities to train GAVI staff, in particular CROs, on gender and equity in health programming to better equip them for dialogue with countries and partners on addressing gender equity gaps in proposals to GAVI. GAVI could develop case studies on gender and equity and health issues to guide countries and to demonstrate what equitable access to health services means in different contexts, drawing on lessons learned by GAVI and Alliance partners. Consider adding an extra day at regional meetings for capacity strengthening of country level EPI managers on gender and equity in health programming with a focus on practical measures to reach equity in immunization. Provide guidelines for gender and equity analysis as part of coverage studies, bottleneck studies, and M&E frameworks.
2. Provide funding, as appropriate, to support gender and equity analysis, including at the sub-national level in large states where there are stark inequalities among the states/districts.
3. Assist countries to define baselines and annual targets for "mandatory equity indicators" where these have been left blank in M&E frameworks.

## Responses to conditions

The IRC reviewed responses to conditions from five countries: DPR Korea, Guinea, Myanmar, PNG and South Sudan. The conditions were quite different for the five countries, as summarised in the table below.

Country	Support	Types of conditions
DPR Korea	HSS	Size of budget for HSS management unit, equity lacking in results chain, undefined roles of TAs
Guinea	MenA	Cold chain, inconsistency in campaign budget, no inclusion of MenA in cMYP
Myanmar	PCV+MR	Cold chain, size of target populations, waste management during MR campaign
Papua New Guinea	MSD +MR	Lack of evidence for routine coverage exceeding 80%, campaign funding gap, no inclusion of MSD and MR in cMYP, lack of evidence of financing MR in routine
South Sudan	MenA	Funding gap, campaign plan lacking details, vaccine supply timeline unrealistic

The IRC granted approval to all five countries after having reviewed their responses. The quality of the responses and the efforts made by the countries when replying however varied widely. DPR Korea provided an extremely detailed response and numerous small changes to the HSS proposal were made to comply with the conditions. Guinea similarly responded well by providing a very detailed plan for managing the supply chain of MenA vaccine during the campaign and they made substantial additions to their cMYP. The responses of Myanmar and PNG were less elaborate. In both of the cases certain conditions were not met, but after gathering more information the IRC still agreed to approve the conditions. In the case of Myanmar, the IRC realised that it would not be possible for the country to adjust its target population according to UN figures, as this is a very sensitive issue in the country. For PNG, the November IRC had asked for details about a hepatitis B sero survey, which reportedly shows coverage above 80%, which is a GAVI pre-condition for applying for rubella vaccine. This survey was not provided, but after seeking advice from a CDC rubella expert, the IRC still decided to grant approval. South Sudan responded only briefly to the conditions with a short letter from the Minister of Health. While the conditions were not fully met, the IRC decided to approve support for the MenA campaign in light of the crisis situation in South Sudan, but laid out several requests to the Secretariat to follow up and support the country to address the conditions raised.

### *Reflections on the conditional approval procedures*

Both during this and previous IRCs, the reviews of response to conditions have posed certain challenges. It has for instance been the case that the stipulations seemed relatively less important for reviewers of conditions than for the original proposal reviewers. Moreover, the true meaning of the conditions can be difficult to understand for reviewers who were not part of the first review. They are often not clearly formulated and several of the conditions given to a particular proposal can appear overlapping. We have identified a number of possible reasons for this. First, the proposal reviewers can be caught in details when reviewing several different documents during a very short time period. Secondly, the proposal reviewers do not have sufficient time to address the issues adequately. Thirdly, during IRCs, there has traditionally not been a plenary to review conditions once they are drafted and consolidated by a set of reviewers. Lastly, during the original proposal review

there have been instances when all key documents have not been provided to the reviewers, such as a full set of cMYPs, EVM reports and improvement plans. In the present review we found that several issues were to some extent clarified better to us by the CROs than from the country submissions. We have reflected that a reason why the proposal reviewers were not convinced by certain issues might be that the CROs need to remain objective and reviewers are concerned about relying too much on CRO briefings at that point in time.

### **Recommendations:**

In the future, conditional approvals will not be given anymore. Instead, some proposals will be approved with comments. When formulating the comments, we recommend:

1. Comments must be concrete and actionable for issues to be addressed in a reasonable period of time.
2. During IRC meetings, efforts should be made to allow time for consolidating comments and discuss these in the plenary. It is likely that the risk of misunderstandings about the intention of the conditions will be reduced if inputs on the exact wording are received from co-reviewers.

### **A brief summary of the request from India**

India is the final GAVI country to apply for nationwide pentavalent vaccine introduction. GAVI is currently funding pentavalent vaccine in nine Indian states. Tamil Nadu and Kerala introduced in December 2011, and Karnataka, Puducherry, Goa, Gujarat, Jammu and Kashmir and Haryana during 2012 – 2013. India applied for pentavalent vaccine in September 2008 and was approved in June 2009. With the APR reviewed by the present IRC, India asked for nation-wide expansion until mid 2016: 11 states plan to introduce in October 2014 and 16 states in April 2015.

Their proposal calls for targeting an additional birth cohort of 22 million.

Approximately five million children per year are currently receiving pentavalent vaccine with GAVI support in the above mentioned nine states. The new pentavalent introduction plan specifies a total birth cohort of 27.4 million for 2015 and 2016.. Hence, an additional birth cohort of 22 million children will be covered by the new request. However, the IRC notes that the figures presented by India are not accurate because, with vaccine introduction in October 2014, only the last three months of the annual cohort will be covered.. Moreover, when estimating the number of doses requested, India has used a coverage rate of 100% and unrealistically low wastage rates. The Secretariat needs to work with country planners to clarify the size of the target population for each year and the number of doses needed.

India submitted a high quality new cMYP and pentavalent vaccine introduction plan

The request covers the period from mid 2014 – mid 2016. The documentation submitted suggests that the amount of vaccine required will cost roughly ~ US\$ 456 million. GAVI has a remaining limit of about US\$ 230 million for pentavalent vaccine in India. However, as mentioned above, the number of doses needed has been over-estimated and with more exact dose calculation, it is likely that the two amounts will converge. This is a clarification asked for by the IRC

## Strengthening cold chain logistics

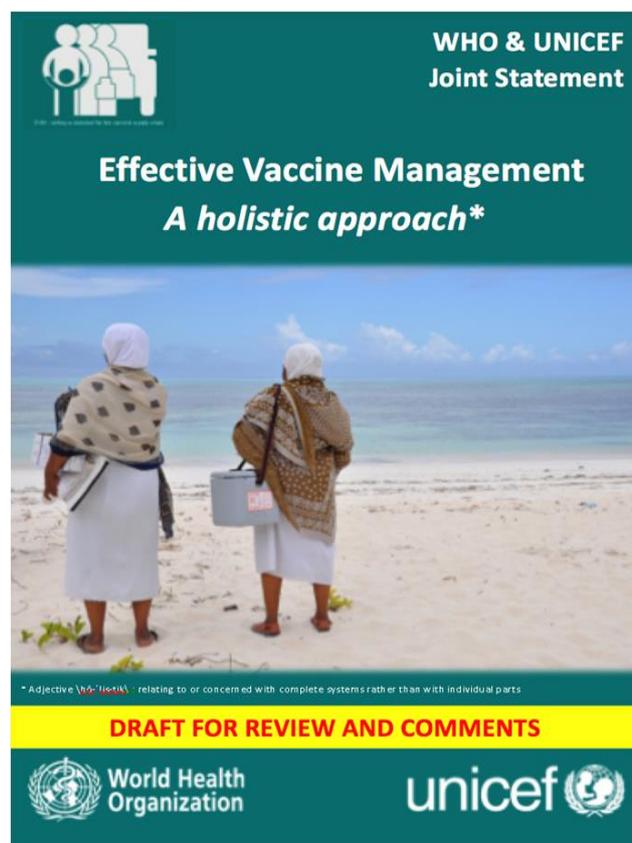
Twelve of the 14 countries reviewed indicated issues and inadequacies related to their cold chain. One country (PNG) indicated that their cold chain was fit for purpose to introduce MR. The DRC review was specific to CSO support and cold chain issues were not discussed. There are known to be major issues with the adequacy of the cold chain in DRC, however.

Applications tended to focus on storage capacity limitations and the need for equipment rather than vaccine management and distribution issues. EVM assessments indicate that vaccine supply chain and logistics deficiencies are frequently maintenance related, or related to the management of stock, temperature monitoring, distribution etc.

In general, insufficient information is generated and communicated to GAVI through its application process for there to be a detailed assessment of measures to strengthen vaccine supply chains and logistics. Demands for cold chain equipment to meet storage capacity needs being perhaps the single exception. The IRC also noted that several countries whose applications have been reviewed in the last year (Niger, Mali, Burkina Faso, Senegal ) proposed to procure refrigerators that may freezing and damaging PCV, Penta and IPV.

**Recommendations:** Several strategies are recommended for consideration.

1. Adopt the Holistic approach to EVM assessments as outlined in the draft Joint WHO/UNICEF document circulated in January 2014. This approach proposes a mechanism to broaden the findings of the present EVM process such that essential information required to produce supply upgrade (rehabilitation) plans can be generated. GAVI support for this process is strongly encouraged.
2. Supply chain logistics support from GAVI could be isolated from the HSS application process and offered as a specific window of support from GAVI to countries. This window would provide scope for countries to address needs in each area of the 9 criteria presently assessed by the EVMA and would provide an enabling mechanism for countries to adopt the holistic approach indicated above.
3. GAVI could contribute to the market shaping of supply chain logistics equipment, specifically in the areas of vaccine storage, temperature monitoring, vaccine stock management and supply chain data management technologies.
4. The GAVI Alliance partnership should adopt and comply with a common approach for supply chain strengthening. For example: UNICEF should procure only WHO/PQS prequalified products with GAVI funding; UNICEF should systematically follow the WHO



guideline to orient procurement cold chain equipment towards solar direct drive vaccine storage technologies in situations where electrical energy supply is unreliable or not available; disposal equipment for immunization waste should be bundled with vaccine supply (as safety boxes are now); transport strategies should include provision for outsourcing services through guarantee backed lease arrangements.

The review of the 14 applications further reinforce the key recommendation for cold chain logistics of the November IRC which stated:

**“Cold Chain Logistics:** Support the integration of tools, monitoring strategy, and inclusion of innovative technologies and financing mechanisms to ensure that countries can accurately project gaps in their supply chain and any need for equipment or transport and maintenance infrastructure when introducing new vaccines and undertaking campaigns.”

## Coverage and data quality

Findings from this small subset of GAVI countries confirm *persistent challenges*:

Coverage:

- There is great variation in immunisation coverage between and within countries. For example, in Nigeria the DPT3 coverage ranges from three percent (3%) in Sokoto state to 84% coverage in Imo state.
- Progress has been notably slow in several countries with large numbers of unimmunised children: Nigeria, India, Papua New Guinea.

Data quality:

- For some countries, large discrepancies persist between WHO/UNICEF & official estimates of immunization coverage: Nigeria, Papua New Guinea.
- For some countries, large discrepancies persist between UN and official estimates of the number of surviving infants: Myanmar
- The computer-based data management systems being adopted by many ministries (Ghana, Nigeria, others), do not yet reliably compile immunization data

### Recommendations:

1. HSS and other support should focus on the lowest performing provinces within large countries
2. GAVI should encourage (and finance where necessary) regular, high quality coverage surveys (including analysis of gender and equity barriers)
3. GAVI HSS funding should support the strengthening of HMIS including computer-based data management systems: Nigeria, Ghana
4. GAVI should support the strengthening of capacity for analysis and use of data/evidence. This should include support of NITAGs.

## New guidelines for the IRC to recommend either “Yes” or “No”

On the first day of the meeting, the IRC was oriented to new GAVI guidance specifying that for each new HSS proposal the IRC should recommend to the GAVI Board either i) “Yes” (“Approve”) with or without comments; or ii) “No” (“Resubmit”) along with a rationale .

GAVI’s written guidance specified that the IRC should recommend “Yes”/“Approve” if “the application meets the large majority of criteria as detailed in the sections described below, and the IRC deems that the criteria which are not met can be satisfactorily addressed by countries and the GAVI alliance within a reasonable period of time to enable effective implementation and achievement of goals and objectives.” In contrast, the IRC should recommend “No”/“Resubmit” if “The proposal demonstrates lack of specific information and clarity in a significant number of areas.”

On the first day of the meeting, the IRC was instructed that they should not recommend “Approve” if clarifications or conditions were required. It was explained that there will be at least 3 IRC meetings spread throughout the year giving countries the opportunity, where the Board asks for resubmission, to improve on the shortcomings identified in the IRC report and have the proposals re-reviewed.

The nature of “comments” was not discussed further on the first day of the meeting. Subsequent IRC discussions about the new guidelines (internal discussions within the IRC as well as discussions with members of the Secretariat) focussed on defining the appropriate role for “comments” (versus a request for resubmission) and the process for following up on comments.

On the fourth day of the meeting, the IRC met with Peter Hansen, GAVI’s Director of Monitoring and Evaluation, to discuss the new guidance and how to apply it. Peter summarized his advice to the IRC in an email:

“.. the bar for approval is quite high, ... any issues remaining to be fixed in proposals that are recommended for approval should be fairly minor and readily actionable within a reasonable period of time. Whether we call them comments or clarifications doesn’t matter very much – what matters is that the IRC flags what issues need fixing, and then the Secretariat will follow through on these issues to make sure they get addressed. That is consistent with the back office grant management function that the Secretariat already fulfils. The more concrete and specific the IRC feedback is, the better. When these issues get communicated to countries, they will be communicated as ‘issues that need fixing’. So I would encourage the IRC to view them in that light, rather than worry about technical differences between shades of meaning of ‘comments’ or ‘clarification’. We don’t have to use either term—as long as we capture issues that need fixing in concrete and specific terms, we have what we need.”

Peter Hansen noted that until now there has been a “clarifications review panel” which has reviewed progress with efforts to address clarifications requested by the IRC (i.e. when the IRC recommended “approve with clarifications”). A similar function will likely now be required to follow up when the IRC recommends “approval with comments”.

At least one IRC member expressed concern that a recommendation of “No”/“Resubmit” might be quite discouraging to those who had developed a proposal that was generally sound but in need of refinement. The complex, participatory process of developing a good HSS program might then lose momentum.

The consensus among the IRC members present was that if a proposal would previously have been recommended for “Approval with clarifications” then, with the new guidance, the IRC would likely now recommend “Approval with comments”. At least one IRC member expressed concern that some proposals which previously might have been recommended for “Approval with conditions” (i.e. needing subsequent re-review by the IRC) might now be recommended for “Approval with comment”.

The IRC discussed the implications of the new guidance:

- **Prior to IRC review**, there needs to be robust technical support for proposal development. The IRC saw evidence that the Secretariat and partners are providing such support. It should be reiterated that the consensus among IRC members was that the overall quality of proposals has improved and this is largely responsible for the IRC recommending approval of all requests;
- **The IRC, when recommending “Approval with comments”**, must assure that comments are written clearly and explicitly to specify concrete tasks for the proposal development team and the Secretariat to follow up on. These must be tasks which can be realistically completed in a reasonable period of time.
- **Follow up of comments**, will be important at three levels: by the CRO, by GAVI’s “clarifications review panel” and by GAMR’s M&E process

#### **Recommendations:**

1. GAVI Secretariat should continue to provide strong support for proposal development;
2. Documents related to the cold chain (e.g. EVMA, update of EVM improvement plan, CC inventory if available) must be included with the proposal;
3. The “comments” offered by the IRC must be concrete and actionable for issues to be addressed in a reasonable period of time;
4. GAVI Secretariat should assure adequate follow up of comments: by the CRO, by the “clarifications review panel” and by GAMR’s M&E process. *The IRC should be briefed on these processes.*

### Monitoring and evaluation

The IRC was briefed by the Secretariat on its GAMR (Grant Application Monitoring and Review) process which is currently being rolled out through 2014. The IRC’s understanding is that this process relates specifically to the proposal review for new grants and grant monitoring processes; evaluation is not addressed in this process. Going forward, the IRC will be involved during the approval process of new grants but no longer involved in the annual monitoring of those grants. The one exception is for the one or two selected IRC members who will sit on the High Level Alliance Review Panel which will review the Secretariat’s findings for each grant that will be summarized in a four-five page Cover Note. The annual review process will be conducted internally by the Secretariat through the examination of quantitative and qualitative inputs. Figure 2 below depicts the annual monitoring process:

**Figure 2: Annual grant monitoring inputs**

Secretariat **monitors** annually:



- Performance Framework—online, including indicators from the HSS M&E Framework
- Annual Progress Report (APR to be replaced with an “Annual Report”)-- quantitative
- Joint Appraisal Report (team led by CRO with country & partners) - qualitative
- Risk Assessment

### Cover Note to High Level Alliance Review Panel

Review of the M&E Frameworks included in this round of new grants suggests that there has been a marked improvement over submissions in years past. The requirement to use the six mandatory outcome indicators is a welcomed addition because in addition to tracking grant progress (and achievement of GAVI’s mandate) it also allows the Secretariat to monitor progress across its grant portfolio. Nonetheless, the countries continue to need guidance in the development of other robust indicators which measure both quantity and quality to accurately assess progress toward the achievement of both interventions/activities and grant objectives.

Evaluations are incumbent upon the countries to consign and conduct. With the new proposals reviewed by this IRC, the budgets for baseline and endline evaluations have been in the range of \$100,000 to \$150,000 each. At the same time, countries are scheduling annual health facility surveys (using WHO’s SARA methodology); community-based assessments, including knowledge, attitudes and practices (KAP) of beneficiaries, EVM assessments, and the like. There has been little indication in the new proposals or the current GAMR guidance on how the results from these various surveys and assessments will be triangulated and synthesized into one comprehensive report at baseline or endline. GAVI’s latest guidance requires countries to plan for an end-of-grant evaluation for all newly proposed HSS grants “using existing review mechanisms to the extent possible”. The rough guidance is for countries to allocate five to ten percent of the overall budget for all M&E activities. However, there is no further guidance on the resources or methods likely to be needed to conduct a credible evaluation.

### Recommendations:

1. GAVI should use consistent and conventional terminology to differentiate between the following: application review versus monitoring versus evaluation;
2. GAVI should develop additional guidance on country monitoring (e.g. a designated M&E specialist and monthly /quarterly reporting systems are likely to be necessary)
3. Distinguish between country-level, secretariat-level and external/independent monitoring and evaluation. The needs for country level monitoring are ongoing whereas at the Secretariat level, monitoring occurs annually. If countries have a skilled M&E Officer, he/she would be available to track data on a monthly basis and report findings to the programmers who can make more immediate adjustments to implementation as needed. On a quarterly basis, monitoring reports should be shared with the ICC, again, to allow for mid-course corrections should they be needed.
4. One of the greatest needs and challenges will be the annual synthesis of information. GAVI should consider developing guidance for how to combine the various data inputs into one synthesized report at each level (country, Secretariat, and external evaluation). For example, for *secretariat level monitoring*, during the annual review process there will be a need to analyze (and triangulate) data from the performance framework, the annual report, and the risk assessment (and other country inputs such as the EVM) into the Joint Appraisal Report.

5. GAVI should further develop its M&E guidelines to fully address and strengthen the rigor of end-of-grant evaluations. Comprehensive evaluations will help to better document achievements and derive best practices and lessons to inform the preparation of future grants
  - Larger grants should have baseline evaluations to compare with end-lines. The application of quasi-experimental study designs with counterfactuals is encouraged to allow GAVI to gauge the effectiveness of the interventions it supports to meet grant objectives.
  - External evaluators should be consigned to conduct evaluations and present no conflict of interest with the findings or outcomes of the evaluations.
  - Detailed guidance is needed on evaluation TORs and methodologies
6. The IRC encourages the GAVI Secretariat to provide the IRC with updates on the M&E process under GAMR, as it develops.

## Annex 1: IRC Members

1. Alejo Bejemino  
Consultant Cold Chain and Logistics (Philippines)
2. Annette Bongiovanni  
Principal, Health Practice Lead  
International Business & Technical Consultants, Inc. (USA)
3. Linda Eckert  
Professor Obstetrics and Gynaecology, University of Washington (USA)
4. Ulla Griffiths  
Lecturer in Health Economics, London School of Hygiene and Tropical Medicine  
(UK, Denmark)
5. Terry Hart  
Consultant Vaccine Management, Cold Chain and Logistics (, France)
6. Sandra Mounier-Jack  
Lecturer in health policy, London School of Hygiene and Tropical Medicine (UK)
7. Bob Pond, chair for this IRC meeting  
Consultant Public Health/Epidemiology (USA)
8. Diana Rivington  
Consultant Gender and Equity  
Senior Fellow, University of Ottawa (Canada)
9. Ousmane Amadou Sy  
Consultant Financial Management, Executive Director OASYS (Senegal)
10. Charles Shey Wiysonge  
Consultant Epidemiology/Vaccinology (Cameroon, South Africa)

## Annex 2: IRC recommendations on specific country requests

Abbreviations:

New = New proposal

APR = Annual Progress Report

RTC = Response to conditions

Appr = Approval

Clar = Approval with clarifications

Resub = Resubmission

Comm = Approval with comments

Country	Document reviewed	Requested support / recommendation							Comments/Clarifications/	Description of the requested support
		HSS	CSO B	Penta	PCV	Men A	MSD	MR		
Burundi	APR	Approval with Clarifications							Clarifications: <ol style="list-style-type: none"> <li>1. The country is requested to rigorously reference each activity in a systematic manner. The country is to use the same objective and activity numbering as in original approved proposal and provide related revised budgets accordingly for comparison and future tracking. Country to also include lead implementer for each activity (for example, CSO)</li> <li>2. The country is requested to clearly label activities related to Burundi PBF funding scheme</li> <li>3. Please submit an update on the implementation status of the EVM improvement plan or a report of a cold chain equipment inventory</li> </ol>	\$161,483 for HSS support during Q1- 2015
Congo, DR	APR		Approval						Comments: Country given guidance on the subsequent HSS proposal now being developed	\$2,118,601 for CSO Type B extension
Djibouti	New	Approval with							Comments:	\$3.4 million of HSS support for 2014 to 2018

		comments							<ol style="list-style-type: none"> <li>1. Review and finalise the M&amp;E framework, in terms of indicators, baseline, data source and intermediate indicators (equity indicators missing, some sources and baselines are missing). Consider including sub-national indicators. Baselines and targets should be in line with the national M&amp;E framework.</li> <li>2. Provide CSOs terms of references and clarify contracting arrangements.</li> <li>3. Re-assess management costs in the light of the reduction in overall budget. Provide details and justification of the management costs.</li> <li>4. Clarify objectives and contracting arrangements of technical assistance activities.</li> </ol>	
Ghana	New	Approval with comments							Comments: <ol style="list-style-type: none"> <li>1. Conduct EVMA no later than September 2014 with vaccine supply chain rehabilitation and maintenance plan. Amend budget for vaccine management as necessary;</li> <li>2. Collect baseline data for M&amp;E framework;</li> <li>3. Review the need for the 2015 cold chain inventory and review the amount budgeted for MLM training;</li> <li>4. Measures to involve public private partnerships should be defined</li> <li>5. Evaluate HSS 1 support</li> </ol>	US\$18,040,000 for 2014 - 2018

### IRC RECOMMENDATIONS - March 2014

Abbreviations:

New = New proposal

Appr = Approval

Comm = Approval with comments

APR = Annual Progress Report

Clar = Approval with clarifications

RTC = Response to conditions

Resub = Resubmission

Country	Document reviewed	Requested support / recommendation							Comments/Clarifications/	Description of the requested support
		HSS	CSO B	Penta	PCV	Men A	MSD	MR		
Guinea	RTC							Approval	Comments to the Secretariat: Budget inconsistencies persist. Confirm that the country will use the budget in the introduction plan	US\$ 2,321,536 for operational costs + vaccines
India	APR			Approval with clarifications					1. Clarifications: 1 Estimate vaccine doses needs on a state-by-state level, using state-specific target populations (surviving infants), coverage rates and wastage rates. The requested number of doses needs to be justified in this way. 2. Estimate the exact number of doses being requested from GAVI and the number of doses that will be procured by the Indian Government during the period 2014-2016. This should be shown for each state. 3. The weaknesses in the vaccine cold chain are of major concern to the IRC. The GoI has plans to address this as a priority action. The MoH is requested to: <ul style="list-style-type: none"> <li>Prepare an implementation plan to improve vaccine storage standards at GMSD and State Central Stores where pentavalent vaccine will be stocked. This plan should be submitted with the forthcoming APR.</li> <li>Submit to the GAVI Secretariat the National Cold Chain and Vaccine Logistics Action Plan (NCCVLAP) due to be completed in August 2014.</li> </ul>	US\$ 230 million for procurement of Penta vaccine

Korea, DPR	RTC	Approval							Comment: Consider reinstating P4 technical experts	US\$26.06 million over 5 years
Myanmar	RTC				Approval with clarifications			Approval	Clarification: submit a report of the comprehensive cold chain assessment and the replacement and expansion plan	US\$ 14,932,791 for MR campaign + US\$ 1,216, 846 for MR VIG + US\$ US\$ 17,991,000 for PCV10 vaccine + US\$ US\$ 1,210,746 for PCV VIG
Niger	New	Approval with comments							Comments: 1. submit rationale for selection of 21 high priority health districts; 2. Provide evidence that disbursement procedures of the "Fonds Commun" permit timely access to funds by the lower level implementing partners; 3. Submit a Risk Mitigation Plan to address the key risks described; 4. Submit an updated inventory and status of the cold chain equipment at all levels; 5. Submit an update on the EVM improvement plan	US\$ 40.07 million of HSS support over 5 years

## IRC RECOMMENDATIONS - March 2014

Abbreviations:

New = New proposal

APR = Annual Progress Report

RTC = Response to conditions

Appr = Approval

Clar = Approval with clarifications

Resub = Resubmission

Comm = Approval with comments

Country	Document reviewed	Requested support / recommendation							Comments/Clarifications	Description of the requested support
		HSS	CSO B	Penta	PCV	Men A SIA	MSD	MR SIA		
Nigeria	New	Approval with comments					Approval with clar		<p>HSS comments:</p> <ol style="list-style-type: none"> <li>1. Conduct external evaluation of HSS 1 before commencing HSS2 activities;</li> <li>2. Conduct operational research/piloting to improve the DQA approach;</li> <li>3. Confirm that cold chain equipment to be procured meets gaps identified by the 2012 cold chain inventory;</li> <li>4. Refine the M&amp;E framework (as detailed in the report)</li> </ol> <p>Men A clarification:</p> <ol style="list-style-type: none"> <li>1. Clarify the size of the target population</li> </ol>	HSS: US\$ 83.9 million over 5 years; Men A campaign: US\$ 17,529,808 operational costs + \$21,556,500 for vaccine
PNG	RTC						Approval	Approval	<p>Recommendations to country:</p> <ol style="list-style-type: none"> <li>1. Conduct a coverage survey;</li> <li>2. Revise the immunization schedule to give MCV1 at 9 months of age</li> </ol>	US\$ 187,328 for MSD VIG + US\$ 187,328 for MR VIG + US\$ 1,952,549 for MR campaign
Sierra Leone	Resub						Approval with clarifications		Clarification: Define the target age group	US\$ 209,287 for VIG + US\$ 121,205 for vaccines and supplies for 2015
South Sudan	RTC						Approval		<p>Comments to the Secretariat:</p> <ol style="list-style-type: none"> <li>1. Follow up with partners to solicit support;</li> <li>2. Obtain copies of the updated cMYP</li> </ol>	US\$ 4.7 million for operational costs + cost of vaccines and supplies
Sudan	New	Approval								US\$ 33,231,766 for 2014 to 2018

### Annex 3a: Overview of HSS proposals

Country	Type of application	Cash support requested (US \$)	GAVI budget ceiling (US \$)	Potential to strengthen the health system	HSS approach	Outcome	Comment
<b>Djibouti</b>	HSS new application	3,400,000, but total budget 3,648,000	3,400,000	+	Support to extend Results-Based Financing approaches in 6/18 health districts, in full alignment and partnership with other key development partners	Approval with comments	This is the first HSS application for Djibouti. Proposal is very focused on strengthening routine immunisation, notably in lower performing areas. Management and TA costs high.
<b>Ghana</b>	HSS new application	18,059,296	\$18.04 million	+	Strengthen HR, planning, surveillance & financial management with support for logistics, service delivery & demand generation.	Approval with comments	The biggest component of the budget, 63%, is allocated to service delivery, followed by management and HMIS costs (23%)
<b>Niger</b>	HSS new application	40,070,000	\$40.07 million	++	21 priority districts are targeted to support an enhanced access to primary health care. In line with national health plan, 30 health posts will be upgraded into health centres.	Approval with comments	33% of total budget dedicated to equipment and construction and 19% for cold chain equipment. Only 2% for activities delivered by CSOs.
<b>Nigeria</b>	HSS new application	83,904,305	\$84 million	+	It will focus on strengthening routine immunisation in low performing states by enhancing ward committees, human resources, cold chain and outreach. Plans activities in 18 mostly low performing states.	Approval with comments	No discussion at all of the special supply-side bottlenecks responsible for immunization coverage of less than 10% in 3 of 18 targeted states and less than 20% in 6 of 18 states
<b>Soudan</b>	HSS new application	33,231,766	\$33.24 million	++	Improving immunization outcomes through expansion and strengthening of primary health care by ensuring equitable access for children, Women of Childbearing Age.	Approval	High CSOs involvement. Plan to foster more integration of services and less verticality in various HS functions.
<b>DPR</b>	Response to	\$26,039,480	\$27.53m	++	Building on the training and scale up of	All 8	The original IRC might have benefited

<b>KOREA</b>	conditions	(2014)			clinical IMCI and cold chain in HSSI, DPRK's proposed HSS2 will scale up community IMCI, improve service delivery and HMIS, focus on waste management, and continue to train including MLM. The plan is poised to strengthen the whole health system, not only EPI.	conditions were satisfactorily met.	from a better understanding of the country context which might have couched some of their queries especially those related to the need for a robust PMU and minimal COS involvement. It is beneficial to have an HSS expert review HSS submissions.
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### Annex 3b: Overview of HSS section of the APR

Country	Type of application	Cash support requested (US \$)	Total committed amount (US \$)	Potential to strengthen the health system	HSS approach	Outcome	Comment
<b>Burundi</b>	APR (brought forward from May 2013)	161,483 (Q1-2015)	\$3.6 million	++	Support to extend Results-Based Financing approaches in 6/18 health districts, in full alignment and partnership with other key development partners	Approval with clarifications (APR in two part approval)	70% of the \$6.9 million spent in 2013 dedicated to Burundi PBF fund. Issues around sustainability of the country wide scheme in 2014 and 2015. Performance of GAVI grant through M&E framework will be assessed in May 2013.

#### Annex 4: Budget analysis for new HSS proposals

Country	Support	CSO involvement	% budget for CSO	% equipment and construction	% cold chain and supply	Comments
<b>Djibouti</b>	HSS new application	Limited and unclear	5.6%	8%	7%	
<b>Ghana</b>	HSS new application	Strong	11%	17%	15%	
<b>Niger</b>	HSS	Very Low	2%	33%	19%	
<b>Nigeria</b>	HSS new application	Limited and unclear	4.3% excluding local consultancies	5%	21%	Including outsourcing for cold chain
<b>Sudan</b>	HSS new application	Unclear	1%	28%	1%	

Note: Percentages have been calculated based on the individual activities budgeted by countries and thus may be in some cases be subject to interpretation based upon how the activities were described in the application

## Annex 5: Key country-specific findings on gender and equity

Country/(vaccine)	CSO Rep on ICC Yes=1 N = 0	Sex disaggregated data reported Yes= 1 No= 0 Plan to = P	Gender related barriers identified, analysed and addressed Yes= 1 No= 0 Plan a study = P		Equity related barriers identified, analysed and addressed Yes= 1 No= 0 Plan a study = P		HSS mandatory equity indicators included with baselines & targets Yes=1 No = 0 N/A = Not applicable		Gender blind proposal Yes=1 No = 0	Comments
			Identified/analysed	Addressed	Identified/analysed	Addressed	Included	Baseline & targets		
<b>HSS + HSS APR</b>										
Burundi - APR	1	0	P	0	P	0	1	0	0	<ul style="list-style-type: none"> <li>Socioeconomic indicator in M&amp;E framework without baseline/targets</li> <li>Coverage survey, including gender and equity analysis, promised in the 2012 APR, but not reported in 2013 APR.</li> </ul>
DPR Korea - Review of Conditions	0	P	0	0	1	1	1	0	1	<ul style="list-style-type: none"> <li>Socioeconomic indicator in M&amp;E framework without baseline/targets</li> <li>Plan to disaggregate the data by sex</li> </ul>
Djibouti	0	0	0	0	1	1	1	0	1	<ul style="list-style-type: none"> <li>Geographic equity indicator in M&amp;E framework without baseline/targets</li> <li>Equity related barriers identified but not analysed</li> <li>CSO involvement may assist with underserved groups</li> </ul>
Ghana	1	1	0	0	1	0	1	1	1	<ul style="list-style-type: none"> <li>Equity related barriers identified but not analysed</li> <li>Sex-disaggregated data collected through MICS</li> </ul>
Niger	1	1	1	0	1	0	1	1	1	<ul style="list-style-type: none"> <li>Equity related barriers identified but not analysed</li> <li>Focus on 21 districts with low penta coverage</li> <li>Sex-disaggregated data collected through MICS</li> </ul>
Nigeria	1	0	0	0	1	1	1	0	1	<ul style="list-style-type: none"> <li>Socioeconomic indicator in M&amp;E</li> </ul>

											<ul style="list-style-type: none"> <li>framework without baseline/targets</li> <li>CSOs involved at the Ward Development Committee level</li> <li>Nigeria is a federal state: deep geographic inequities in coverage - HSS to address geographic inequity by focus on 960 wards in 18 states</li> </ul>
<b>Sudan</b>	1	0	P	0	1	1	1	1	1	0	<ul style="list-style-type: none"> <li>A national study will be conducted to identify gender-related barriers in the national health system, including in immunization services</li> </ul>
Other Proposals Reviewed											
Country/(vaccine)	CSO Rep on ICC Yes=1 N = 0	Sex disaggregated data reported Yes= 1 No= 0 Plan to = P	Gender related barriers identified, analysed and addressed Yes= 1 No= 0		Equity related barriers identified, analysed and addressed Yes= 1 No= 0		HSS mandatory equity indicators included/linked to results chain intermediate outcomes? Yes=1 No = 0 N/A = Not applicable		Gender blind proposal Yes=1 No = 0	Comments	
			Identified/analysed	Addressed	Identified/analysed	Addressed	Included	Linked to intermediate outcomes			
<b>DR Congo (CSO)</b>	1	0	0	0	1	0	N/A	N/A	1	<ul style="list-style-type: none"> <li>No change in G&amp;E from July 2013 IRC</li> </ul>	
<b>Guinea (MenA) Review of Conditions</b>	1	P	0	0	0	0	N/A	N/A	1	<ul style="list-style-type: none"> <li>No change in G&amp;E from November IRC</li> </ul>	
<b>India (Penta scale up)</b>	1	0	0	0	1	0	N/A	N/A	1	<ul style="list-style-type: none"> <li>Broad geographic and socioeconomic inequities but lack of specific actions/targets by underserved region/group</li> <li>Key performance indicators will be disaggregated by gender, geography (urban slum, urban, rural) and wealth, where relevant</li> </ul>	
<b>Myanmar (PCV,</b>	0	0	0	0	0	0	N/A	N/A	1	<ul style="list-style-type: none"> <li>No change in G&amp;E from</li> </ul>	

<b>MR camp, Rubella)</b>										November IRC
<b>Papua New Guinea (MSD, MR camp, Rubella)</b>	1	0	0	0	0	0	N/A	N/A	1	• No change in G&E from November IRC
<b>Sierra Leone (MSD)</b>	1	P	1	1	0	0	N/A	N/A	0	• No change in G&E from November IRC
<b>South Sudan (MenA)</b>	1	N/A	N/A	1	1	1	N/A	N/A	0	• No change in G&E from November IRC

Equity related barriers identified but not analysed

### Observations

GAVI's goal is equity in immunization, i.e. that gender inequity and other barriers do not prevent the fullest possible reach in immunization coverage. Most countries, whether they collected sex-disaggregated data or not, reported parity in coverage of boy and girl babies in under age two routine vaccinations. However, they do not report systematically on how they intend to tackle the variety of barriers facing getting a child to a vaccination point.

Disadvantaged groups are not addressed in many applications e.g. early marriage (care-givers/adolescents), refugees/IDPs, out-of-school girls, nomads, pastoralists. Lack of description of disadvantaged groups – who are they, where are they, how many? Due to the lack of description it is very difficult to assess whether the strategies to reach them are appropriate.

Annex 6: Maps showing marked sub-national inequalities in coverage

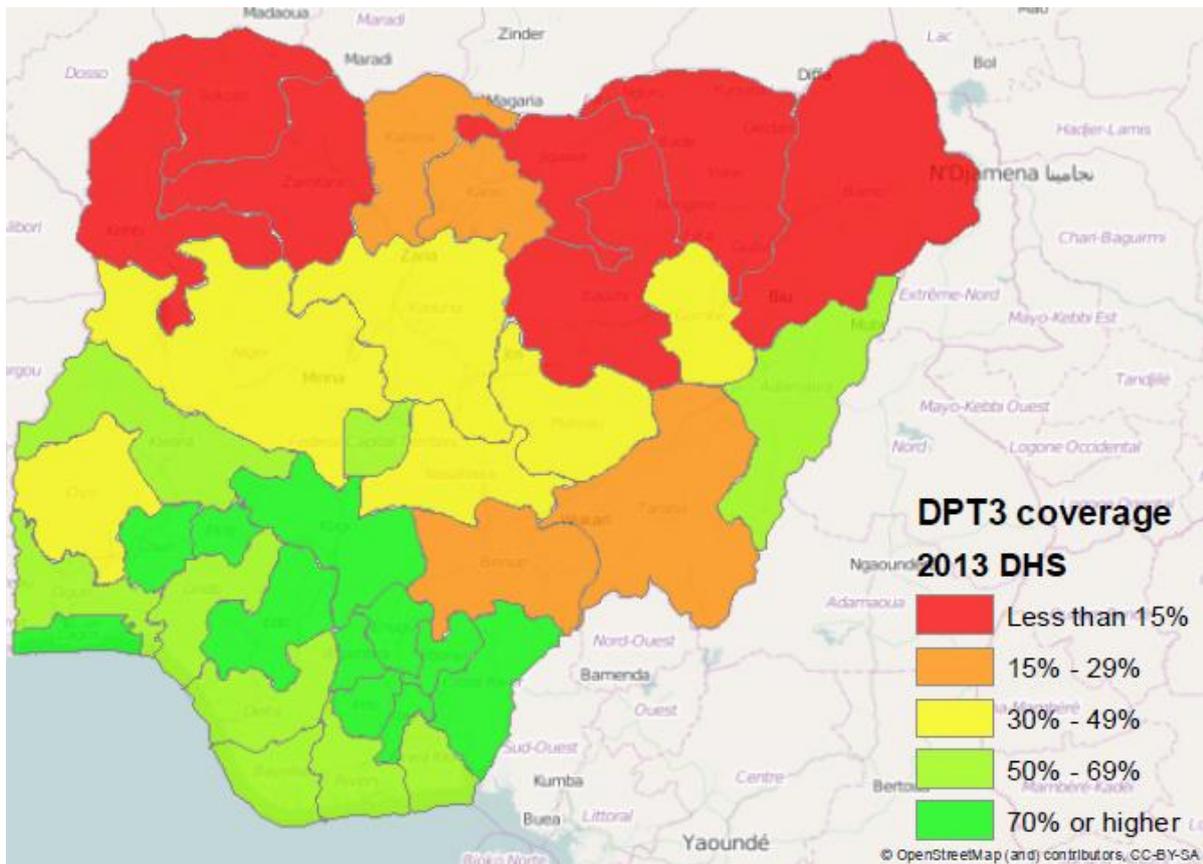


Figure 1: DPT3 coverage in Nigeria, by state, DHS 2013

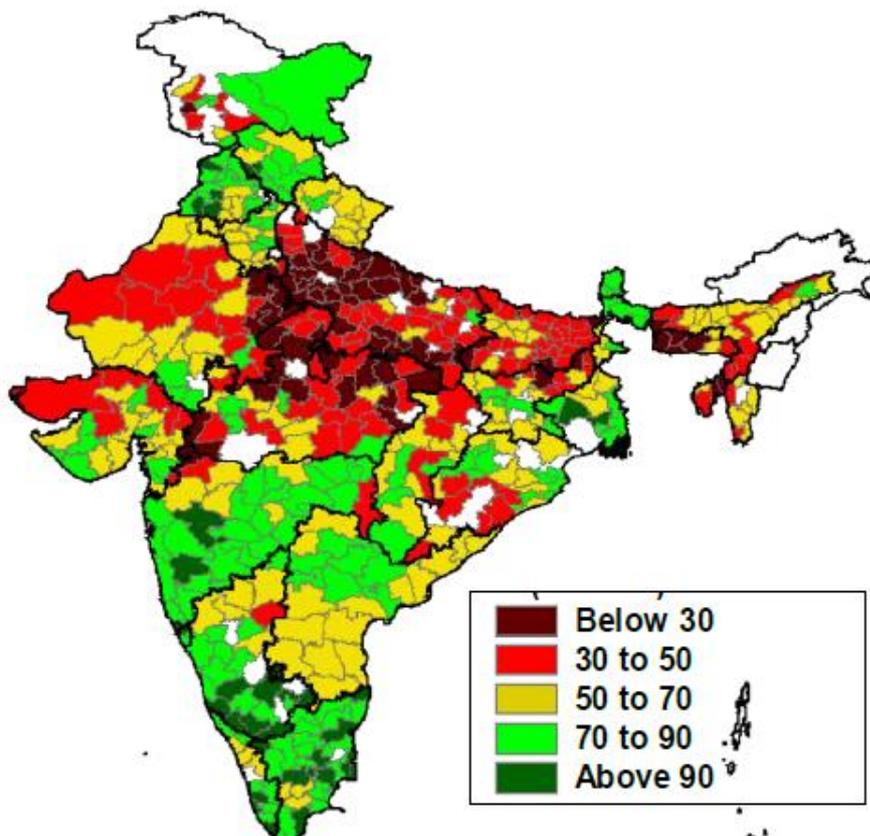


Figure 2: Coverage of fully immunized children in India, by district, DLHS 2007-08