REPORT OF THE NEW PROPOSAL INDEPENDENT REVIEW COMMITTEE TO THE GAVI ALLIANCE SECRETARIAT ON THE REVIEW OF APPLICATIONS

Geneva, Switzerland

March 13-22, 2018

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List of Acronyms

AEFI	Adverse Event Following Immunization
BCC	Behaviour Change Communication
C4D	Communication for development
CC	Cold Chain
CCE	Cold Chain Equipment
cMYP	Comprehensive Multi-year Plan on Immunization
EPI	Expanded Programme on Immunization
EVM	Effective Vaccine Management, an assessment tool
HPV	Human Papilloma Virus
HR	Human Resources
HSIS	Health Systems and Immunization Strengthening
HSS	Health Systems Strengthening
ICC	Inter-agency Coordinating Committee
IRC	Independent Review Committee
MCV	Measles Containing Vaccine
M&E	Monitoring and Evaluation
MenA	Meningococcal A vaccine
MNCH	Maternal Neonatal and Child Health
MoH	Ministry of Health
MR	Measles-Rubella vaccine
NITAG	National Immunization Technical Advisory Group
NVS	New and underused Vaccine Support
RI	Routine Immunization
SAGE	Strategic Advisory Group of Experts on Immunization
SCM	Senior Country Manager
SIA	Supplementary Immunization Activity
SMS	Short Message Service
TA	Technical Assistance
UNICEF	United Nations Children's Fund
VIG	Vaccine Introduction Grant
WHO	World Health Organization
YF	Yellow Fever vaccine

1.0 BACKGROUND

The 1st Independent review committee (IRC) meeting for 2018 was held in Geneva, Switzerland between March 13th and 22nd, 2018. The IRC session comprised of 12 on-site and one off site reviewers with expertise in immunization, cold chain and logistics, maternal neonatal and child health, adolescent health, health systems strengthening, reproductive health, program management, epidemiology, monitoring and evaluation, financial analysis, behaviour communication change and gender. The IRC also had two dedicated finance reviewers who focused on in-depth financial reviews of the budgets submitted by applicant countries and one governance mechanism reviewer who examined ICC and NITAG functionalities. ***(See Annex 1 for list of members).***

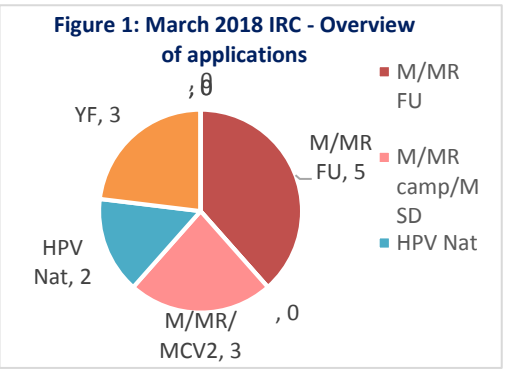
The Independent review committee members focussed on the following specific tasks:

- Review country specific funding requests and supporting documentation for applications for vaccine introductions and campaigns to support countries through efforts to strengthen the coverage and equity of immunization.
- Review funding requests and supporting documentation, including Health Sector Plans, comprehensive Multi Year Plans and supporting documents as applicable to each country.
- Provide the Gavi Secretariat with evaluation reports and recommendations for each country.
- Provide the Gavi Secretariat with a consolidated report of the review, including recommendations for improving funding requests, including planning, budgeting, M&E, financial management, gender and equity considerations.
- Provide the Board and the Alliance partners with recommendations for improving the processes relating to Gavi policies, governance, and structure.

2.0 REVIEW METHODS AND PROCESSES

2.1 Review process and key outcomes

Figure 1: March 2018 IRC - Overview of applications



The IRC reviewed a total of **13** applications from **10** countries. 10 (77%) were recommended for approval. Applications reviewed included requests for support for the following vaccines: Measles 2nd dose routine introduction (1), MR routine introduction with catch-up campaign (2), M/MR follow-up campaign (5), HPV national introductions (2) and Yellow Fever campaigns (3).

Review methods included independent peer review with daily plenaries and subsequent consolidation of findings. The IRC further strengthened the system of internal quality checks to ensure consistency of decisions. The IRC also utilized the country dialogue process through e-mail clarifications with countries.

Decisions were made according to two decision categories – **approval** (with issues to be addressed) and **re-review of outstanding issues** with clear action points. The re-review category replaced the resubmission category to further demonstrate the review process as a continuing engagement process with countries.

Criteria for review include the extent to which proposals (a) meet mandatory requirements, (b) principles of support as specified in Gavi guidelines, and (c) contribution to achieving Gavi mission and strategy.

Key review outcomes: The main outcomes per country application are summarized in Table 1below: Table 1 below:

Table 1		Summary Outcome per country application		
Country		M/R support requests	Other vaccine requests	Recommendation outcome
1	Cameroun	MR follow up		Approval
2	Côte d'Ivoire		HPV routine + multi-age cohort	Approval
3	DR Congo		YF preventive mass campaign	Approval
4	Ghana		YF preventive mass campaign	Re-review
5	Kenya	MR follow up		Re-review
			YF expansion	Approval
6	Mali	Measles 1+2 dose		Approval
		Measles follow up		Approval
7	Niger	Measles follow up		Approval
8	Sierra Leone	MR 1+2 dose + catch up		Approval
			HPV routine + multi-age cohort	Approval
9	Uganda	MR 1st dose + catch up		Approval
10	Zimbabwe	MR follow up		Re-review

The quality of proposals submitted by countries continues to improve and most especially with the increased availability of epidemiological analyses by countries in M/MR support application. The IRC commends the efforts of the Secretariat and Alliance partners for their technical support to countries and continued efforts to improve the process. The continued availability of email/telephone dialogue with countries further provides opportunities to demonstrate these improvements.

2.2. Good practices

The IRC especially noted progress by countries in terms of improving data quality and operational plans, lessons learned are being incorporated in particular from HPV applications, improvement in quality of epidemiological analyses within measles vaccine applications, and better and feasible work plans. Specific country examples include:

HPV National Introduction applications from both Côte d'Ivoire and Sierra Leone HPV National scale up building on systems from a sustainability perspective through entry/synergies with School health platforms. There are plans to co-administer TT with HPV across both countries. This provides strategic opportunities to further strengthen integration of services and increase uptake.

The IRC had consistently called for technical support to countries in analysing and using their measles epidemiological data to inform strategic interventions to improve coverage in previous meetings. **It notes that countries have made significant and commendable progress by improved epidemiological analyses seen in recent M/MR campaign applications.** These applications reflect the increased support by vaccine implementation focal points, SCM and technical partners to the countries. However, there needs to be better strategic linkages to inform proposed planned interventions and activities. There remain missed opportunities to further improve reaching zero- and one- dose children as most interventions as currently proposed cannot guarantee optimal performance. Available sub-national data and better analyses on outbreaks should drive tailored/focused approaches based on the key gaps/epidemiological evidence and be able to maximize coverage via implementation of a range of interventions.

2.3 Feedback on work processes

2.3.1. The IRC commends the Secretariat for its responsiveness to enhance better workload distribution. The improved scheduling provided enough time to conduct internal quality checks and ensure consistency across reviewed applications. The IRC also notes the better-spaced review window period, the continued use of the country dialogue processes and the ever-increasing efficiency of the support process before, during and after the review. The IRC commends the improved quality of pre-screening by all Gavi teams.

2.3.2 Budgets and Templates

Whilst significant work and technical support is on-going to improve the budget template and application, the majority of budgets received from countries did not include the right details (e.g. unit costs, budget assumptions) to inform the IRC. From the review, countries appear challenged to use the new budget template. There is a need for Gavi to present the guidelines and explain how to use the template and also to provide technical support to countries. More scrutiny is expected at all levels on the screening of the submitted budgets.

2.3.3. Use of the country dialogue process

The IRC continued to engage countries during the review process using country dialogue mechanisms. During this review window, four countries were further contacted via email for further clarifications with varying quality and usefulness of country responses.

3.0 Key Findings
3.1. New Vaccines Support and Campaigns

Measles and Rubella vaccines

During this March 2018 review, a total of seven countries applied for measles or measles-rubella (M/MR) support. Five countries applied for measles-containing vaccine (MCV) follow-up campaigns, targeting a standard follow-up campaign age-range (9 to 59 months). Three of these five applications were recommended for approval and the remaining two (Kenya and Zimbabwe) were requested to submit their applications for re-review. Two applications (Sierra Leone – initial application, Uganda – re-review) for a MR catch-up campaign with subsequent MR introduction into the routine immunization were recommended for approval. Funds requested amounted to US$ 22.67 million for operational costs, and the total amount recommended for five countries is US$ 17.52 million.

Issue 01: Translating Epidemiologic Analyses to Tailored Strategies

During this round, countries submitted improved epidemiologic analyses with their applications, in accordance with IRC recommendations made over the last two years. The IRC commends countries for the improvements in the epidemiologic analyses submitted. However, these data lacked adequate interpretation and did not translate into tailored strategies to reach un-vaccinated and under-vaccinated children. For example, the applications provided scant evidence that the findings from the last MCV campaign (i.e. post-campaign coverage survey, technical report), routine MCV immunization coverage data, or data from measles outbreaks were being used to target populations and geographic areas with lower coverage with data-driven, context-specific strategies.

The importance of developing tailored strategies using robust epidemiologic and programmatic information is particularly salient in countries that have achieved good measles control (i.e. Zimbabwe, Kenya). For this, high quality immunization data and disease surveillance systems are essential. Failure to devise tailored strategies to reach the chronically unreached in these already well-performing contexts will make further improvements highly unlikely. In addition, these countries must focus on increasing currently suboptimal MCV2 coverage with strategies other than the standard follow-up campaigns. The IRC noted inadequate attention was given to strengthening routine activities for MCV2 in these countries.

Recommendations:

- Technical partners should support countries to interpret and use epidemiologic analyses and programme evidence to design tailored approaches to measles control that target 0- and 1-dose children who have missed out during routine immunization and previous campaigns. These tailored strategies should be appropriately budgeted as the strategies required to reach the chronically unreached may have higher cost implications.
- Further investment and technical assistance is also required through partner support to improve the quality of immunization data and disease surveillance systems since these systems are vital to developing tailored strategies.
- Partners should work with countries to evaluate outcomes from using these strategies and the findings should be used to inform updates to MCV routine and campaign guidance. Finally, there must be stronger focus and further investment on improving currently sub-optimal MCV2 coverage since high coverage of a routine second MCV dose is crucial to reducing the reliance on frequent, high-cost campaigns.

Issue 02: Missing post-campaign surveys

Only three of the seven countries submitting M/MR campaign applications during this round included funding requests for the post-campaign coverage survey in their Gavi supported operational support budget (Mali, Sierra Leone, and Uganda). In the situations where the country has indicated that the survey will be funded by government or partners rather than Gavi, there is a real risk that the survey will not be conducted or will not be conducted in a timely enough manner to be useful as was the case for two countries during this round (Uganda, Niger).

Recommendations

- Gavi should ensure that both the post-campaign coverage survey and post-campaign technical report from recent campaigns should be submitted as mandatory application documents. This will assist the IRC in assessing the appropriateness of campaign strategies selected by the country.
- In addition, given the key role of the post-campaign coverage survey in assessing the effectiveness and value of a campaign, Gavi should request countries to include the cost of the post-campaign coverage survey in their operational support budget to be funded by Gavi.

Yellow Fever vaccines

Two countries (Ghana, DRC) applied for support for yellow fever (YF) vaccine preventive campaigns, while one country (Kenya) applied for an expansion of routine YF vaccination to two additional counties. The applications from Kenya and DRC were recommended for approval, while Ghana was requested to submit their application for re-review.

Issue 03: Precautions to vaccination

Despite the higher risk of serious adverse events following immunization (AEFI) and the higher risk of severity of serious adverse reactions following YF vaccination in people older than 60 years of age, both DRC and Ghana initially planned to target persons up to 99 years of age. DRC later changed the target group to 9 months to 60 years, but Ghana maintained the upper age limit of 99 years without providing adequate justification. The increased rate of serious and severe AEFI in persons older than 60 years of age may result in significant absolute numbers of serious adverse reactions reported during a nationwide campaign, which along with coincidental events commonly occurring in that age group, threaten to impair confidence, undermine the entire campaign, and may negatively reflect on the routine programme.

For pregnant and breastfeeding women, Ghana indicated they would exclude pregnant women from the campaign target group, but did not specify their intentions for breastfeeding women. The DRC application was unclear as to whether pregnant and breastfeeding women would be included in the target group for the campaign.

Recommendations:

- The IRC recommends that countries conducting YF preventive campaigns use the upper age limit for vaccination of 60 years unless a clear risk-benefit analysis provides a strong rationale

for increasing this upper age limit. For pregnant and breastfeeding women, countries should note that in areas where YF is endemic or during outbreaks, the benefits of YF vaccination are likely to outweigh any theoretic or potential risks of the vaccine.

- The IRC therefore encourages countries applying for YF preventive campaigns to submit the risk-benefit assessment (as per WHO SAGE recommendations) used to determine the exclusion/inclusion of pregnant and breastfeeding women in the target population to be vaccinated.
- In addition, countries are encouraged to devise a timely AEFI monitoring system during campaigns and ensure that the monitoring is maintained at least four weeks after the campaign, which they should present within a detailed and budgeted plan.

Issue 04: Fractional Dosing

There was an outbreak of yellow fever in Kinshasa DRC in 2016, linked to importations from Angola. In a reactive mass vaccination campaign, the country used fractional doses of the yellow fever vaccine, as recommended by WHO in June 2016, achieving 97.8% coverage, confirmed by post campaign survey. In the upcoming four-phase preventive vaccination campaign, the country plans to revaccinate the Kinshasa population due to limited evidence on long term protection from yellow fever fractional doses.

Recommendation: The IRC recommends that the country places the campaign in Kinshasa in the last phase and conduct only if deemed necessary after careful consideration of updated scientific evidence on duration of protection with yellow fever fractional dosing.

HPV vaccines

Two countries, Sierra Leone and Côte d'Ivoire, submitted applications for national HPV vaccine rollout during this IRC round. Both chose 9-year-old girls as their routine cohort, and included a multi-age cohort of girls aged 10-14 years in the first year of vaccine introduction in line with WHO SAGE recommendations. Of note, Sierra Leone opted to deliver HPV vaccine in the initial year using a campaign delivery style, leveraging child health days that occur twice annually. Both countries integrated HPV vaccine delivery with school health programming and should be commended for using the rollout of HPV to strengthen this important public health platform. In Côte d'Ivoire, a school health program is currently being scaled up and the application provided concrete plans on how adding HPV vaccine would strengthen this process. In Sierra Leone, the country is planning to use the introduction of HPV to restart the administration of tetanus toxoid (TT) in schools.

3.2 Coverage and Equity

Addressing equity gaps (gender barriers, geography, poverty, mothers' education, etc.) must be evidence driven. While the IRC observes closer attention to equity issues, a number of countries still confuse sex-disaggregated data and gender barriers. The fact that there is little discrepancy between the number of baby girls and boys being vaccinated does not mean that there are no gender barriers to a mother or female caretaker taking a child to a clinic. The IRC was pleased to note one country that considered the role of men in family decision-making. Since 2016, efforts have been made by the government of Uganda and development partners to ensure that within communication for

development (C4D) plans, men are specifically targeted to support their families in vaccination uptake and demand generation.

Issue 05: Effective planning to reach the increasing number of unreached children in different circumstances: Many of the countries presenting at this meeting of the IRC are dealing not only with refugees but also internally displaced persons. While some of the proposals reflected these populations, the IRC expressed concern about further "human flow" poised on borders and the challenge of planning in this context. The IRC notes that many un-vaccinated children live in urban slums. Coverage and equity studies in each country should clearly identify these urban unreached populations, and tailored approaches used to reach them. The IRC is interested in reaching the unreached child, or "the last mile child". It considers that micro-planning and coverage studies can contribute to the understanding of coverage and equity gaps by clarifying groups affected by vaccine rumours, refusals, or hesitancy. Although some countries' cMYPs report pockets of vaccine hesitancy, the scope of hesitancy was not defined and there was no consideration for addressing it in the submitted applications.

Recommendations:

- The IRC reiterates the November 2017 recommendations that:
  - The Gavi Secretariat should further clarify guidance to countries and communicate that **gender-related** barriers refer primarily to barriers to women caregivers' ability to seek vaccination for their children, rather than to coverage gaps between male and female children;
  - Technical assistance by partners should support countries to identify and address barriers to women caregivers' ability to access vaccination services for their children, such as mobility, autonomy in household decision making, and health worker attitudes;
- The IRC recommends sharing the good practice from one country of C4D targeted to males in family decision-making about immunisation. This is important in view of the lower coverage of children whose mothers have little or no formal education;
- Gavi and its partners should keep an eye on populations at risk of being overlooked: out of school girls for HPV; refugees out of refugee camps; underserved urban and peri-urban populations; and those internally displaced due to food/political insecurity;
- Gavi and partners should assist countries to incorporate into their national vaccination programmes a plan to define the extent, monitor, and address vaccine hesitancy.
- The IRC recognises that evidence for tackling the equity barriers may be context-specific and recommends that Gavi should support in-country collaboration between vaccination programmes and relevant local or regional research institutions to maximise efficiency and equity in vaccination services. This could also include partnering with collaborating international institutions/universities and their graduate students/researchers to work on Measles coverage and other areas in immunization e.g. in Uganda.

3.3 Supply Chain and Waste Management

The March 2018 round of IRC received 13 applications from 10 countries for NVS, including routine and campaigns. The successful execution of these campaigns will generate the expected wastage of 174 million syringes and 1.9 million of filled safety boxes (as planned by the countries). In contrast to

this large volume of waste created, the total planned budget for waste management was $4.7 million (for managing the load of 174 million syringes) or an average of $1.4 per 100 syringes (one safety box).

Table 2: Quantity of waste generated through activities proposed under the March 2018 IRC window.

Country	Support	Target Pop.	# doses	# safety boxes	budget for waste management (US$)	budget/box (US$)	Method
Zimbabwe	MR follow up	2,056,643	2,282,873	27,650	1,638	0.06	Burn & bury
Côte d'Ivoire	HPV	2,424,054	3,450,200	40,000	0	0.00	Burn & bury + incineration
Cameroon	MR follow up	3,275,427	3,635,600	43,001	56,659	1.32	Burn & bury + incineration
Sierra Leone	HPV MR1+2	3,537,346	4,175,418	48,050	21,229	0.44	Incineration
Niger	Measles follow up	4,058,853	4,505,400	54,575	209,659	3.84	Burn & bury + incineration + private factory
Ghana	YF campaign	5,771,054	6,405,870	77,600	333,405	4.30	Burn & bury + incineration
Kenya	MR fu, YF exp	7,308,780	8,483,468	88,650	36,820	0.42	Burn & burry + incineration
Mali	M 1+2, Mfu	6,153,236	10,474,400	125,800	24,272	0.19	Burn & bury + incineration
Uganda	MR1 + catch up	17,800,366	21,820,719	242,675	35,278	0.15	Burn & bury + incineration
DRC	YF	91,502,831	101,568,200	1,230,100	4,003,650	3.25	Burn & bury + incineration + private factory

Issue 06: Weak/insufficient plan to manage waste

Large quantities (est. 174 million syringes) of hazardous waste will be generated with new introductions and campaigns. However, there is weak/insufficient infrastructure and poor planning (and budgeting) around waste management by most of these countries as illustrated in the charts below.) The destruction of waste by incineration has been retained by all countries, using incinerators or burning pits. Countries like DRC and Niger, plan to treat part of the waste through factories. Environmental protection approaches are not considered for immunization waste management. Waste disposal budgets vary from 0 (Côte d'Ivoire) to 4.3 US$ (Ghana) per safety box. At country level, neither budget nor specific activities are encouraging enough to support the needed focus on management of waste.

Figure 2:

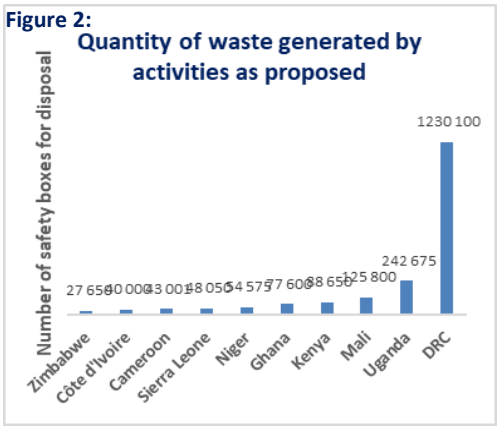
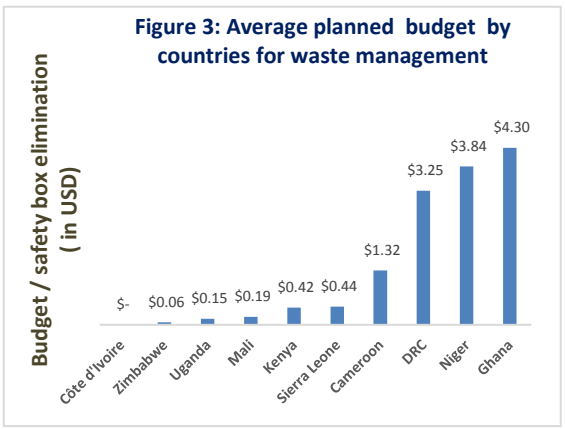


Figure 3: Average planned budget by countries for waste management



Recommendations

a) Gavi and technical partners should actively promote/support good practices implemented by countries (DRC, Niger): use of private factories, accurate waste management plan;

b) Gavi should urgently review application guidelines to ensure proper planning and budgeting for waste management by countries.

c) Countries need to be strongly encouraged and technical supported to adequately budget for strategic and specific activities to address the identified gaps on waste management.

Issue 07: Lack of information regarding vaccine storage capacity at district and facility level

The proposals include some analyses and details about the national store capacities but limited details about lower levels. The EVM reports at times shows the scores of lower levels in E3- Cold chain and transport capacities below 80% which serves merely as an indicator as a potential problem. In addition, some of the EVM assessments are often more than 4 years old. This makes it further challenging for the IRC (or the countries for that matter, to know the issues at lower levels) to assess the readiness for campaigns at lower levels.

Recommendation

- Countries to conduct gap analysis at district and HF level using existing CCEI or conducting capacity assessment and ensure sufficient resource is allocated to provide support to safely accommodating vaccines at service point with ad-hoc measures.

Issue 08: Lack of tailored supply chain strategy for ensuring vaccine to under-vaccinated, vulnerable population and hard-to-reach areas

There is a lack of supply chain strategies (or lack of description in proposals) for ensuring supply chain arrangements for specific settings such as insecure zones, IDP/refugee camps, nomadic areas, and hard-to-reach settings. These situations may require the implementation of tailor-made methods, which may require additional equipment, activities and resources (fast chain, increased ice production, use of high-performance passive containers).

Recommendation

- For specific settings, proposals to reflect adequate resource mobilization and tailored activities based on supply chain gap analysis prior to campaign.

3.4 Budget Reviews and Financial Sustainability

Gavi standard budget format and guidelines

The Gavi new budget template was tested in the 2017 June and November IRC sessions. In general, countries made good use of the template at least for the applications reviewed at the November 2017 IRC session. Despite the fact that the new budget format has been improved compared to older versions, several countries failed to submit adequate and appropriate budgets during this March 2018 IRC.

The screening process revealed the difficulty for these countries to comply with the standard Gavi template format especially for Mali, Niger, Kenya, Côte d'Ivoire, DRC, and Cameroun. For most of these countries, SCMs had to remind countries or the PF team had to populate the budgets submitted with older formats or separate excel sheets into the required budget format.

In general, countries are struggling with the new format and tend to use the old budget format or numerous separate excel sheets to indicate their funding request to Gavi. The disparity on the sources of information makes it onerous for the IRC finance cross-cutters to get a comprehensive picture of the resource requirements for the countries. In addition, some countries like DRC and Uganda provided budget requests which conflict with the final target populations. These budget requests were calculated based on target populations beyond the ones indicated in applications or other source documents.

Another recurrent weakness is related to the cost categorization. Some cost groupings do not add up and provide a mixed picture of the overall budget. For example, advocacy and social mobilization costs in the Uganda budget were included under health information and systems. Other miss-match of cost groupings include HR, travel and programme management.

However, some countries have made genuine efforts to provide their funding requests using the appropriate budget formats. Examples include Uganda, Sierra Leone, Zimbabwe, Ghana and DRC which have all made good use of Gavi template and provided meaningful costing assumptions and additional excel sheets to back up submitted budgets.

With the exception of the above-mentioned countries, the costing assumptions focus only on budget line items above $100,000 and Gavi Secretariat screening does not query figures below this threshold.

Issue 09: Budget Format and Norms

- Compared to the November 2017 round, 50% of the NVS budgets submitted by countries (such as Cote d'Ivoire, Kenya, Mali, Niger, Cameroun, etc.) in this round were poorly completed (with inconsistency in final budget figures, lack of unit costs and detailed costing assumptions, inappropriate cost groupings, etc.);
- Two countries with the biggest budget requests for this round (DRC - $54 million, Uganda - $10 million) provided conflicting target population figures to calculate the budget ceilings;
- To comply with Gavi Operational Guidelines on HR, countries like Cote d'Ivoire, Uganda, and DRC provided UN system norms for per diems and salary scales which are above Government and civil service standards. Cameroon provided a list of EPI staff salary which is also inappropriate.

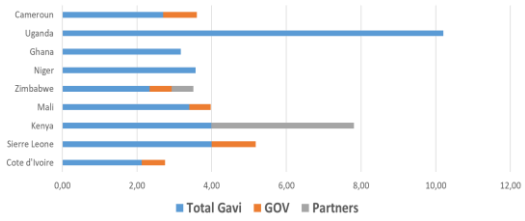
Recommendations:

- Gavi should consider providing additional budgeting-related technical support to countries during proposal development phase, including tapping into available TA mechanisms (PEF/TCA/LMC and extended partners);
- Countries should be encouraged to use government domestic standards on per diems and salaries and reflect these rates in the budgets submitted to Gavi.

Issue 10: Insufficient and/or lack of financial contributions to complement Gavi funding efforts

Most countries provided limited information on third parties' financial contributions (Government, EPI partners, etc.). Only Kenya and Zimbabwe actually provided EPI partners' contributions in their cost projections. Eight out of 10 countries (80%) submitted NVS budgets (introductions and campaigns combined) without any mention of partners' financial contributions to the planned activities. Only Kenya (71%) and Zimbabwe (25%) have included partners' funding in their budgets. As illustrated by the chart below, 50% of the countries - Cameroun (33%), Côte d'Ivoire (29%), Zimbabwe (25%), Sierra Leone (26%) and Mali (16.5%) provided their planned Government contribution to the NVS activities. DRC, Ghana, Niger and Uganda did not provide any information on Government contributions despite the high financial requests from DRC and Uganda. The 8 other countries were silent about traditional EPI partners' funding for planned activities. However, Cameroun (33%), Côte d'Ivoire (29%), Sierra Leone (26%) and Mali (16, 5%) have indicated the planned Government contributions in their respective budget requests. Large government contributions in some countries with history of challenges in mobilization funds for EPI also pose a risk to NVS activities, notably MR campaigns. It is commendable when needs-based or cost-effective budgeting approaches have been used by countries to fulfil their financial needs with the Gavi envelope. However, this has to be clearly stated in the narrative of the application or in the budget notes.

Figure 4 Proportion of Government and Partners' Contributions to investments in countries (Introductions and Campaigns)



Recommendation:

To ensure synergies and complementarity, countries should provide *transparent disclosure of any secured or potential funding* in addition to Gavi resources on their NVS budgets (VIG, OPs Costs)

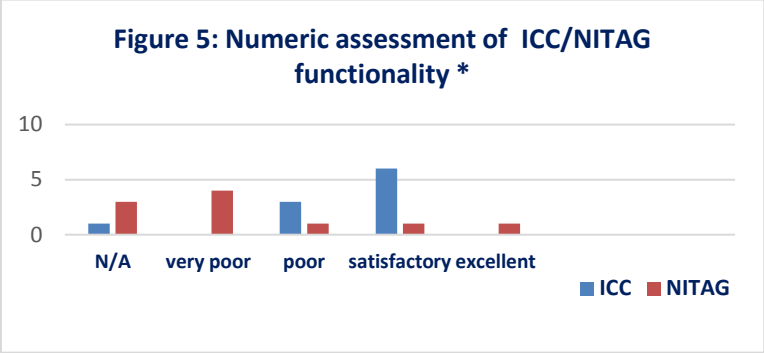
Issue 11: Mechanism of Gavi Fund Channelling

The IRC noted that a number of countries have experienced financial management problems with Gavi cash support. The fact that Gavi now has a clear policy and tools for assessing program capacity and for auditing use and management of Gavi funds at country level is contributing to identifying weak budget management and unjustified use of Gavi funds. For fragile countries and countries with weak financial management capacities and high financial risk, local partners such as WHO and UNICEF are assisting in receiving and managing Gavi grants. We noted in this round that only 2 countries (Ghana and Niger) are managing their Gavi funds. For DRC, funds for YF are channelled through Government. For Zimbabwe funds are channelled through a pool funding arrangement used by most Development Partners. For the remaining countries, Gavi funds are channelled through partners under different modalities. This proportion of 8 countries is relatively high and is of concern in terms of ownership, accountability, and sustainability.

Recommendations:

- Gavi should make sure that risk mitigation measures outlined in the PCA assessments are reflected by enhanced financial management mechanisms for recipient countries;
- Gavi and technical partners should increase efforts to strengthen in-country financial and programme management capacity and systems.

3.5 Governance



Gavi has made a commitment to strengthening country coordination fora to ensure better delivery on immunisation and health sector goals. It is in the first year of a more deliberate engagement in technical assistance for ICCs and NITAGs. Strong country fora demonstrate country ownership and a willingness to work closely with other stakeholders. They are an important contribution to EPI sustainability as partner countries move towards transition. This commitment was clearly reflected in the documentation reviewed at this IRC. Gavi has included a review of ICC, NITAG, and other fora in the TORs for Programme Capacity Assessments (PCAs). The PCAs, in turn, have influenced the Grant Management Requirements (GMR) signed between Gavi and the countries. For the purpose of this exercise, the IRC made a "rapid assessment" of the fora in the ten countries reviewed.

3.5.1 ICC

In the IRC review, 6 out of 10 ICCs were found to be "satisfactory" which means that some improvement is needed. Three were deemed "poor" with significant improvement required. One, activated in 2017, is too new to assess.

In 9 of the 10 countries, recent Programme Capacity Assessments have made recommendations for the Grant Management Requirements. The PCAs most often expressed concern that ICCs met to review and approve proposals to Gavi but were not always used as fora to "provide strategic direction, oversight, and transparency" to the Expanded Programme on Immunisation. In most cases, Gavi and Partners are or will be supporting technical assistance to assist in defining (or in some cases, redefining) the terms of reference and operating guidelines for the ICC including membership, periodicity, and agenda for meetings.

In reviewing ICC minutes, it is clear that the annual Joint Appraisal exercise is a good opportunity for ICC members to have a broad discussion on the effectiveness of a national EPI, its strengths and weaknesses, and future sustainability. At the end of one such discussion, it was agreed to invite the Ministry of the Family and Women's Affairs to join the ICC. In another country, the ICC reviewed how the Government intended to address vaccine hesitancy with national legislation making it mandatory to have children vaccinated.

3.5.2. NITAG

The IRC values NITAGs for their ability to evaluate applications from the cost effectiveness and scientific perspectives. In the IRC "rapid" review, 4 out of 10 NITAGs were deemed non-functional although a decree or TORs for NITAG exist for 3 of these 4 countries; one NITAG was poor, one was satisfactory, and one (Uganda) was functioning very well and relied on by its Ministry of Health to prioritise vaccines for the EPI (a good practice).

In addition, three NITAGs were launched with introductory workshops during 2017 so they are too new to assess. However, the IRC was disappointed to learn that one of the newly launched NITAGs has a very limited view of its mandate, choosing not to review a proposal because it did not propose a new vaccine. The IRC questions this decision because, the country would have benefited from having this body of experts review the detailed epidemiological analyses generated and provide associated recommendations on tailored strategies.

Issue 12: NITAGs should be established as scientifically independent from the ICC or other fora where the broader health sector stakeholders may be represented. At the same time, the IRC recognizes that "one size does not fit all" and it may not be feasible to have fully functioning NITAGs in all countries.

Recommendations

- Gavi and partners should continue to invest, on a long horizon, in strengthening coordination fora at the country level.
- Gavi and partners should systematically use the six WHO process indicators to do annual monitoring of the functionality of NITAGs.
- Gavi and partners, especially WHO, need to consider how to assist countries without a functioning NITAG. Options could include:
    - Gavi and technical partners to urgently support the capacity building of existing NITAGs
    - Establishing inter-country or sub-regional technical advisory groups (TAGs) for neighbouring countries that do not have the necessary expertise to have a national TAG (e.g. for some countries in francophone West Africa) or use the regional TAG (e.g. the African Regional Immunisation Technical Advisory Group (RITAG)) for countries without NITAGs.
    - Engage regional experts to bring regional technical and scientific experience to bear /encourage inter-country networks that exchange national experiences (South Asia is a good example)
    - Technical partners and country level leaders should ensure that there are regular technical/scientific consensus meetings.

4.0 Conclusions

The IRC commends Gavi leadership and Secretariat, along with technical partners, for their commitment and responsiveness to support countries in adopting strategic processes with the aim of raising standards as especially demonstrated by the quality of HPV national introductions and the use of epidemiological analyses to inform planning for measles vaccination campaigns. However, there is a need to raise the bar and further encourage countries to better use data from epidemiological analyses to strategically inform proposed planned interventions and activities for greater returns on investments in children reached and lives saved.

The IRC strongly encourages countries to assess the risk-benefits of yellow fever immunization in adults over 60 years using available scientific evidence to drive proposed interventions. Technical partners should further encourage countries to closely follow efficacy and effectiveness studies on fractional dosing since re-vaccination may prove unnecessary.

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Annex 1: List of IRC Reviewers

NO.	Name	Nationality	Profession/Specialisation	Gender	French Speaking
1.	Aleksandra Caric	Croatia	Independent Consultant	Female	
2.	Benjamin Nkowane	Zambia	Independent Consultant	Male	
3.	Bolanle Oyeledun – **CHAIR**	Nigeria	CEO, Centre for Integrated Health Programs	Female	
4.	Charles Wiysonge	Cameroon	Director, South African Cochrane Centre, South Africa	Male	X
5.	Linda Eckert	USA	Professor, University of Washington (Gynaecology)	Female	
6.	Miloud Kaddar	Algeria	Independent Consultant (ex WHO)	Male	X
7.	Osman David Mansoor - off-site	New Zealand	Public Health Physician, Regional Public Health, New Zealand	Male	X
8.	Ousmane Amadou Sy	Senegal	Independent Consultant	Male	X
9.	Philippe Jaillard	Benin/France	Independent Consultant	Male	X
10.	Ranjit Dhiman	India	Independent Consultant	Male	
11.	Sandra Mounier-Jack – VICE CHAIR	France/UK	Associate Professor London School Hygiene and Tropical Medicine (Health Policy)	Female	X
12.	Zeenat Patel	Canada	Independent Consultant	Female	
13.	Diana Rivington	Canada	Independent Consultant	Female	X