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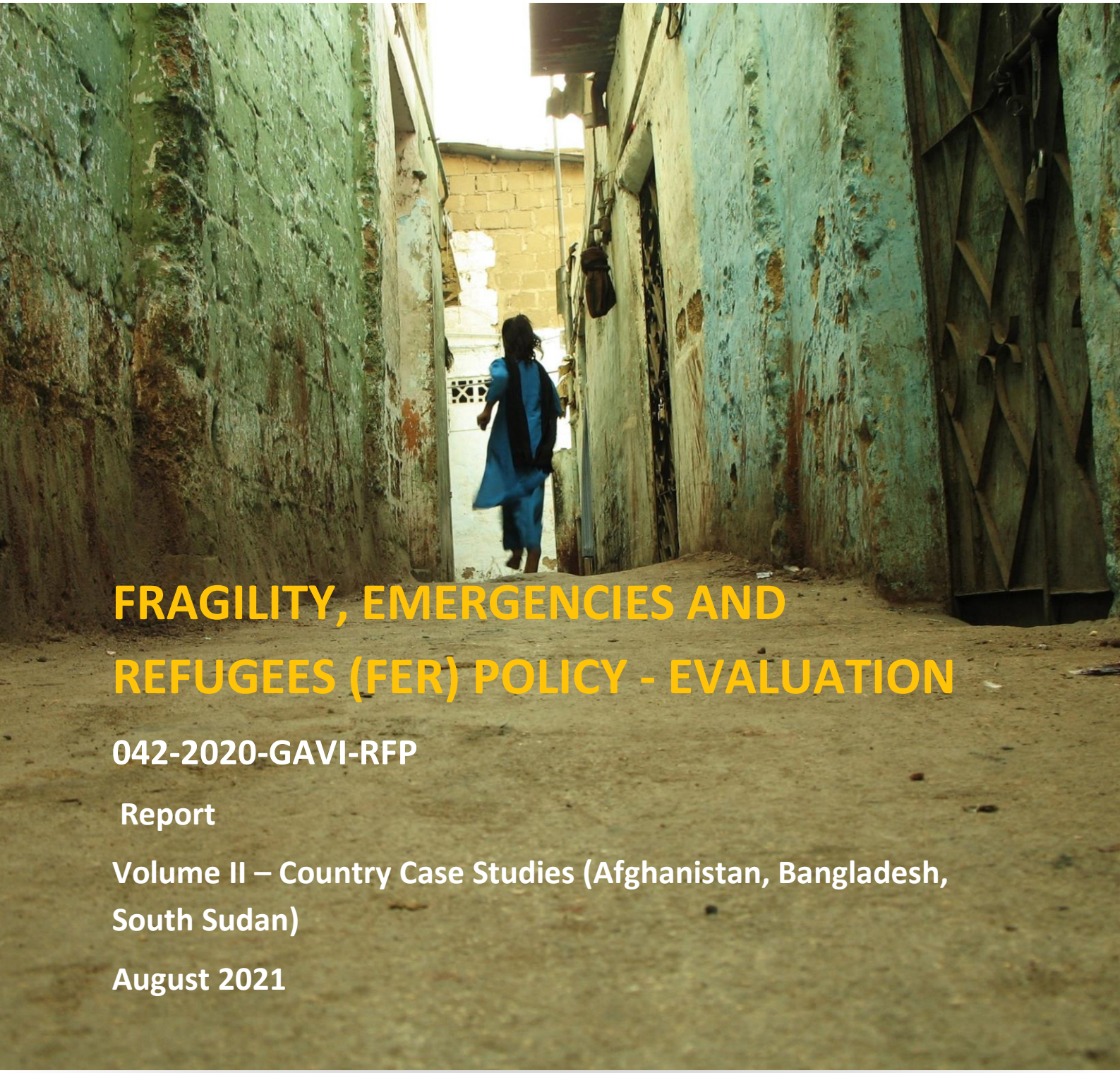

# FRAGILITY, EMERGENCIES AND REFUGEES (FER) POLICY - EVALUATION

## 042-2020-GAVI-RFP

**Report**

**Volume II – Country Case Studies (Afghanistan, Bangladesh, South Sudan)**

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# ABBREVIATIONS

| | |
|---|---|
| ACT | Alliance Coordination Team |
| BMGF | Bill and Melinda Gates Foundation |
| BPHS | Basic Package of Health Services |
| CEO | Chief Executive Officer |
| CEPI | Coalition for Epidemic Preparedness Innovations |
| CERF | Central Emergency Response Fund |
| COE | Challenging Operating Environment |
| CSO | Civil Society Organisation |
| CTA | Country Tailored Approach |
| DAC | Development Assistance Committee |
| DQIP | Data Quality Improvement Plan |
| DRC | Democratic Republic of Congo |
| ECHO | European Commission Humanitarian Aid Office |
| EPI | Expanded Programme on Immunisation |
| FCS | Fragility and Conflict Situations |
| FCV | Fragility, Conflict and Violence |
| FER | Fragility, Emergencies and Refugees |
| FY | Financial Year |
| Gavi | Gavi, the Vaccine Alliance |
| GDP | Gross Domestic Product |
| GFF | Global Financing Facility |
| GNI | Gross National Income |
| GPEI | Global Polio Eradication Initiative |
| HDPF | Health Development Partners Forum |
| HDP Nexus | Humanitarian-Development-Peace Nexus |
| HMIS | Health Management Information System |
| HPF3 | Health Pool Fund |
| HSIS | Heath Systems and Immunisation Strengthening |
| HSS | Health Systems Strengthening |
| IASC | Inter-Agency Standing Committee |
| ICG | International Coordination Group on Vaccine Provision |
| IDP | Internally Displaced Persons |
| IFRC | International Federation of Red Cross and Red Crescent |
| INGO | International Non-Governmental Organisation |
| IOM | International Organization for Migration |
| IRC | Independent Review Committee |
| JA | Joint Appraisal |
| KII | Key informant interview |
| M&E | Monitoring and Evaluation |
| MIC | Middle-Income Country |

| | |
|---|---|
| MoPH | Ministry of Public Health |
| MoU | Memorandum of Understanding |
| MSF | Médecins Sans Frontières / Doctors Without Borders |
| NGO | Non-Governmental Organisation |
| OCV | Oral cholera vaccines |
| OCHA | Office for the Coordination of Humanitarian Affairs |
| OECD | Organisation for Economic Cooperation and Development |
| OG | Operational Guideline |
| PHC | Primary Health Care |
| PO | Programme Officer |
| PPC | Programme and Policy Committee |
| QA | Quality Assurance / Quality Assurer |
| RFP | Request for Proposals |
| RSS | Republic of South Sudan |
| SAGE | Strategic Advisory Group of Experts on Immunisation |
| SCM | Senior Country Manager |
| SIA | Supplementary Immunisation Activities |
| TCA | Targeted Country Assistance |
| TEC | Technical Expert Committee |
| TOR | Terms of Reference |
| UHC | Universal Health Coverage |
| UN | United Nations |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| VHRD | Very Hard-to-Reach Districts |
| VPD | Vaccine Preventable Disease |
| WEF | World Economic Forum |
| WHO | World Health Organization |
| WUENIC | WHO and UNICEF National Immunisation Coverage |

Three deeper dive case studies that were conducted for Afghanistan, Bangladesh and South Sudan are presented here. Each of the studies describes the context and focusses on the following questions: a) The model: relevance of the FER policy, b) The implementation and Gavi's contributions to efficiency and effectiveness, c) How did the Gavi FER policy influence the intended results, d) What was particularly successful, and e) What was particularly challenging?

# 1 AFGHANISTAN

## 1.1 COUNTRY CONTEXT

The total population of Afghanistan was estimated in 2019 at 35,688,787 with an infant mortality rate of 66 (deaths < 1 year per 1000 births, 2015) and a child mortality rate of 91 (deaths < 5 years per 1000 births, 2015)[1]. Around a quarter of the population (24%) resided in urban areas and 55% was below the poverty line[2]. Afghanistan remains heavily conflict affected with many returnees and internally displaced persons (IDP), and large portions of provinces and rural districts beyond the access of the government. The health system remains donor dependent, and the government has contracted out health service delivery to International Non-Governmental Organisations (INGO) to overcome these access constraints. With government allocation to the public health services being less than 4% of the Gross Domestic Product (GDP), Afghanistan is classified as **a fragile country**, and is therefore eligible for flexibilities under the FER policy. Afghanistan is in the Initial self-financing phase.

**Gavi set out to support the Afghanistan health system strengthening (HSS), through the HSS Joint Appraisal conducted in March 2016,** by engaging with the Ministry of Public Health (MoPH) in collaboration with UNICEF and WHO. The consolidated HSS3 funding was US$62.2M and comprises of US$47.5M core HSS grant (approved in 2016) plus US$14.7M HSS approved through FER policy under fragility (approved in 2019) for period 2019-21. An 18 months no-cost extension for the Afghanistan HSS3 grant and a 15-month no-cost extension for the Data Quality Improvement Plan (DQIP) grant to December 2021 was approved in March 2020. Under Gavi standard policies, an HSS grant can be extended at no additional cost to Gavi for 12 months only. However, under the flexibility of the FER policy it was found appropriate to extend this period to 18 months. The requested extension aims to allow a smooth transition and avoid gaps between the two HSS grant cycles. Afghanistan has recently started the process to develop a new HSS proposal and future vaccine support requests (5-year HSS 2021-2025).

**National Afghanistan immunisation rates remain low below targets and there is significant variance between districts, and urban and rural settings**. The national immunisation schedule consists of BCG, DTP-HepB-Hib (Penta), HepB birth dose (HepBB), OPV, IPV, MCV, PCV, Rotac, Td and TT. Afghanistan introduced Hib vaccines in 2009, PCV in 2013, IPV in 2015, and Rotavirus vaccine in 2018 and experienced continuous improvements in coverage between 15% and 30% since 2004. A decrease in coverage of around 10% was noted since HSS3 was developed in 2015[3], except for polio. Despite stable polio coverage, polio transmission was reported in 6 provinces with 21 cases in 2018 of which 16 cases were zero OPV. The main causes for declined coverage included the return of 3 million refugees from Pakistan and Iran, 2 million IDPs due to drought and conflict, increased poverty levels[4] and increased conflict. HepB has seen a steady increase in

[1] Gavi Afghanistan country information sheet https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/afghanistan

[2] Sources: Gavi Joint Appraisal Report Afghanistan 2019; Gavi country fact sheet; WHO and UNICEF Afghanistan estimates of immunisation coverage, 2019 revision.

[3] Source: Gavi HSS Flex v0331

[4] World Bank: from 37% in 2013 to 55% in 2017

coverage from 18% to 37% between 2015 and 2019[5]. In general, annual coverage rates for the other antigens as of 2017 remain low varying from 39% for MCV2 to 78% for BCG. A 2018 survey showed that only 50.7% of Afghan children were fully immunised.

Afghanistan has also applied for Gavi support for the introduction of Rota Virus Vaccine (RCV) in RI in Q4 2018 and CCEOP[6] for cold chain but there is no routine RCV immunisation in Afghanistan. There are fluctuations in coverage rates per antigen per district or province. For example, in 2018, around 32%, of the districts reported Penta3 coverage of less than 80%, 33% reported between 80%-95% and 35% more than 95%. At the provincial level, 14 provinces (41%) were below the national average of 61% for Penta3 and 16 provinces (47%) were below the national average of 60% for MCV2 with rates ranging from 3% in Urozgan to 89% in Nimroz for Penta3 and 22% in Urozgan to 87% in Nimroz for MCV2[7].

## 1.2 THE MODEL: RELEVANCE OF THE FER POLICY?

**The FER policy is pertinent to working in Afghanistan in terms of providing high levels of flexibility, increased operational capacity and developing tailored immunisation approaches matching local priorities and context.** In 2019, Afghanistan was invited to apply for the HSS support of 50% beyond the country allocation to advance coverage and equity in fragile countries (also known as HSS Flex) for the entire 5-year HSS3 envelope**. In addition, a no cost extension of 18 months was approved.** Under additional vaccine doses, measles vaccines were procured to target refugees/returnees from Pakistan. As part of integrated campaigns, in 2019, there was an approval under FER to bundle different vaccinations and other primary health care interventions as part of the polio campaign. Country informants stated that Gavi has been proactive in approving FER flexibilities with a greater risk appetite to overcome the complexities in delivering immunisation activities in conflict areas.

'Gavi is flexible to us to focus on the needs of the programme so we can adjust to urgent issues', [country KII].

The application of the FER policy in Afghanistan allowed expansion and strengthening of the HSS3 and improved targeting of priority geographical areas with tailored approaches to increase coverage and equity. The HSS flex specifically targeted the 6 fastest growing cities, with a Penta 3 coverage ranging from 29,6% in Kandahar urban to 80,1% in Mazaar urban, as well as 9 polio and conflict affected provinces with varying Penta 3 coverage from 3,1% in Uruzgan to 80,5% in Kunar[8]. The FER policy allowed for a tailored strategy including (1) strengthen fixed immunisation services by deploying additional female vaccinators in public health facilities; (2) provide outreach immunisation and social mobilization services to better reach hard to reach populations, returnees, internally displaced population and people living in poor slum and peri-urban areas; and (3) involvement of the private sector to increase capacity beyond the public system. The HSS Flex aimed at adding 35 new vaccinators for public facilities, 144 for private facilities and 56 vaccination teams for outreach immunisation activities.

**The approach to partner with the IFRC/Afghan Red Crescent Society (ARCS) seemed particularly pertinent to improve coverage and equity by focusing on opposition-controlled areas (in 2018).** Gavi brought on board the IFRC/ARCS to improve access to immunisation in non-government-controlled districts. There are areas where other actors are not present, and where ARCS has built a reputation of absolute neutrality and impartiality under the different regimes. ARCS immunises children through a mix of approaches that have proven effective during decades of work in conflict-torn Afghan regions such as: Mobile Health Camps,

[5] https://www.who.int/immunization/monitoring_surveillance/data/afg.pdf
[6] Cold Chain Equipment Optimization Platform
[7] Gavi Joint Appraisal Report Afghanistan 2019
[8] AHS data 2018

Mobile Health Teams, Wall Fence Clinics, Routine Immunisation Posts, Community Vaccination Catch Up and Grandmother Committees. These are integrated approaches with strong and field-proven demand generation built-in, such as culturally appropriate communication, a small packet of services beyond EPI, full involvement of local opinion leaders, with long and appropriate access hours. In the context of very hard to reach districts (VHRD[9]) investing in different mobile strategies was seen as more appropriate and effective as compared to creating new health facilities with a too small catchment population that are likely financially unsustainable. Gavi's commitment to the tailored approaches through a partnership with the IFRC/ARCS is seen as promising. But since it is a recent agreement, it is premature to conclude on performance of this partnership and approach.

**Concerns regarding potential duplication of both funding and operations were raised by several partners** as there are several parallel systems and partners relying on multiple donors. For example, Gavi is not a member of the Health Development Partners Forum (HDPF) and Gavi´s attendance would contribute to reduced duplication and help improve coordination. The Global Polio Eradication Initiative (GPEI) was also listed as a competing program. However, Gavi approved flexibilities under FER to combine RI to Polio outreach through funding community mobilisers, training and logistics in Urozgan, Helmand and Kandahar provinces. This was reported as an effective joint effort with the Bill and Melinda Gates Foundation (BMGF). Also, the HSS Flex proposal took into account the presence of the NGO managed basic and extended packages for health services (BPHS and EPHS) in RI fixed centres and a review was conducted to prioritise gaps and avoid duplication.

## 1.3 IMPLEMENTATION AND GAVI'S CONTRIBUTIONS TO EFFICIENCY AND EFFECTIVENESS

**The HSS3 incurred significant grant implementation delays but through the FER policy Gavi approved an exceptional no cost extension of 18 months[10] beyond the 12 months extension allowable by policy.** The main reasons for delays in grant implementation included the increasing rate of insecurity since 2017, delays in contracting the design for warehousing construction and obtaining construction permits from provincial authorities, and negotiating the MoU with IFRC/ARCS. By mid-June 2020, there remained US$30M worth of activities in the HSS3 consolidated budget to be implemented, an estimated 37% HSS utilisation rate. The more critical activities to be implemented during the extension included: (i) reaching children in the very hard-to-reach and VHRD areas to be implemented by the IFRC/ARCS, (ii) strengthening the urban immunisation services, (iii) close coordination of RI-Polio synergetic efforts (jointly with BMGF), (iv) deployment of CCEOP, and (v) HSS construction works and cold chain components to be implemented by UNICEF. Country based informants repeatedly stated the continuously changing environment, particularly the insecurity, which impacts predictability and makes any form of planning impossible.

**Developing robust monitoring and evaluation and future Joint Appraisals (JA) for FER was constrained by data quality and time availability.** While the policy and application processes and guidelines were well communicated and disseminated to core Alliance Partners, concerns were raised around the depth and extent of data requirements for the JA's. Data is significantly unreliable in Afghanistan, and numbers are reported to be inflated. Moreover, there is a conscious effort towards reducing the burden of reporting in an effort to develop an easier approach to JA which is timely and less dependent on quantitative data. The

[9] The polio eradication community uses (V)HRD as (very)High Risk (for polio) Districts, which is a combination of high risk of polio transmission and the presence of (potentially) antagonistic AGE, and sometimes difficult terrain. The humanitarian community uses (V)HRD as Very Hard to Reach Districts which mainly signifies the presence of (potentially) antagonistic AGE. In the target provinces these definitions largely overlap.

[10] Gavi Request for approval of no-cost extension of the AFG HSS3 and DQIP grants, 20 March 2020.

JA was drafted by WHO/UNICEF in collaboration with the MoPH and underwent several revision cycles involving different level actors which resulted in a lengthy process.

"Nobody can give information around financials here in this country", [country KII].

**Many pockets of populations remain uncovered** despite the expanded programme on immunisation (EPI) services being provided through both fixed and different mobile strategies implemented through different agencies across different areas of control. The implementation effectiveness is hindered by several constraints which include insecurity and control by groups with difficult relationships with the immunisation teams. Afghanistan continues to experience conflict, natural disasters and mass population movements in one of the longest protracted complex emergencies. The seasonal fighting also blocks the access of the immunisation teams while Afghanistan´s mountainous terrain limits access to rural populations. Often, immunisation campaigns have long planning cycles and encounter obstruction when control shifts to non-state armed groups. In addition, some communities are hesitant to vaccination particularly for polio. This results in population subgroups that are not well monitored yielding unreliable estimations of coverage results. The 2018 report on Nationwide Measles Supplementary Immunisation Activities[11] shows a total administrative coverage rate of 92% for the country with rates per province varying from 64% for Urozgan to over 95% for Kandahar. The percent coverage by district shows 64% of districts with above 95% coverage. The reasons behind not achieving the target in the rest of the districts might be incorrect denominators (high/low), pockets of unreached populations due to insecurity, and displacement of populations.

"If a health system operates at a 50% only, we cannot expect EPI to work at a 100%", [country KII]

**Partnership development, the Alliance Partner capacity and procedural administration impacts the implementation.** While the direct partnership with CSOs is seen as valuable in bringing innovative and tailored approaches, Gavi reported that it took months to establish a partnership with IFRC/ARCS and for it to be approved by the parties. UNICEF's and WHO's in-country capacity was also reported as insufficient (average HSS utilisation of 51% and 52% for UNICEF and WHO respectively between 2017-19) and together with the high turnover of staff it impacts effectiveness. In general, there have been major challenges in attracting skilled staff to work in such an insecure environment despite the availability of Targeted Country Assistance (TCA) resources through Gavi. In 2020, Gavi linked its support to ACASUS mapping and data management. While this aims to strengthen the current gaps in population and health data quality, informants question the prospects for sustainability of this highly technological project. In general, country informants report positively to the engagement of Gavi staff although a permanent country presence would have been preferred.

## 1.4 HOW DID THE GAVI FER POLICY INFLUENCE THE INTENDED RESULTS?

**There is significant uncertainty around where the under-immunised and zero dose children are and how many there are.** Gavi respondents questioned the equity of focusing on a small number of remote hard to reach children as opposed to targeting antigen gaps within larger more accessible populations, especially in terms of opportunity costs. Population data dates from the last population census conducted in 1979 and numbers tend to be inflated due to "pay for performance" modalities of contracts with NGOs. The Gavi funding and support of ACASUS was intended to improve data quality and subsequent mapping and monitoring of service delivery.

[11] Measles control & elimination program in Afghanistan, Report on Nationwide Measles Supplementary Immunisation Activities (MSIAs), 2018

**In country respondents reported that outbreaks and emergencies were supported but both planned and supplementary immunisation activities had long planning cycles.** The resulting strategy has been to schedule in Supplementary Immunisation Activities (SIA) every 2 or 3 years a nation-wide catch up for IPDs, refugees and returnees. Country informants claim that due to this approach, they are now in a better position compared to their neighbouring countries in terms of handling measles outbreaks.

"We are able to respond to emergencies because of Gavi" [country KII]

**There is a strong agreement from respondents that Gavi's FER policy in Afghanistan improves access to immunisation including in urban, rural and hard-to-reach settings.** The comprehensive approach of expanding fixed and community-based outreach vaccination across the public and private sector, strengthening existing data and surveillance, demand generation activities, joint micro-planning, supporting accredited vaccinator trainings, and upgrading health facilities is regarded as the most efficient and effective way forward.

**Linking the FER flexibilities to population or health system outcomes is always difficult to appraise due to several constraints.** Gavi respondents confirmed that there are difficulties in attributing specific activities and outcomes between different Gavi's grant including FER. Attribution of results was never the intention of Gavi support. There is also limited access to reliable and adequate subnational data to analyse subnational immunisation outcomes; and numbers vary significantly between the reported data from the Health Management Information System (HMIS) and WHO and UNICEF National Immunisation Coverage (WUENIC). In Afghanistan, the Gavi FER grant is tailored to specific geographical areas and population groups but the data analysis from the Grant Performance Framework remains mostly focused on national and not subnational level outcomes. Despite some of the limitations, the data in **Table 1** below that was obtained from the Gavi Afghanistan Grant Performance Framework, demonstrates to a certain extent improvement in coverage at national and subnational level over the 2016-2020 period.

Table 1 - Trends in coverage - Afghanistan

| Afghanistan | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Penta3 coverage | 81% | 82% | 87% | 87% | - |
| Penta3 coverage specific to HSS | | | | 87% | 85% |
| Penta3 coverage in 6 cities (76,476) | | | | 36% | 78% |
| Pneumococcal Coverage | 77% | 81% | 84% | 83% | |
| IPV Coverage | 81% | 80% | 86% | 85% | |
| MCV 1 | 75% | 78% | 82% | 75% | |
| MCV 2 | 51% | 51% | 60% | 52% | |
| Rota | | | 60% | 73% | |
| Drop Out Rate - Penta 1 and Penta 3 | 12% | 13% | 13% | 8% | |
| Drop Out Rate - PCV 1 and PCV 3 | 11% | 11% | 14% | 11% | |
| Drop Out Rate - RV 1 and RV last dose | | | 21% | 12% | |
| Percentage of districts or equivalent administrative area with Penta3 coverage greater than 80% | 44% | 68% | 68% | 76% | |

*Source: EPI reports*

The Penta3 coverage at the national level increased from 81% to 87% but Penta3 specific to HSS areas decreased from 87% to 85% (from 2019 to 2020). However, Penta3 in the 6 targeted cities increased significantly from 36% to 78% from 2019 to 2020. National MCV1 increased from 75% to 82% (from 2016 to

2018) but followed a decline to 75% in 2019. Districts with a Penta3 coverage greater than 80% increased significantly from 44% to 76% (from 2016 to 2019). Also, the number of health facilities offering immunisation increased significantly from 56% in 2017 to 92% in 2020[12].

## 1.5 WHAT WAS PARTICULARLY SUCCESSFUL?

**As a result of the FER policy Afghanistan was granted a 50% HSS extension. The flexibility led to several innovative approaches,** such as the identification of target populations including those living in the gold mining sites, informal settlements, areas with compromised security, refugee camps, areas with high migration rates, border areas with large nomadic and displaced populations and refugee camps. In addition, house-to-house and site-to-site (schools and mosques) vaccination, and social mobilisation was provided by vaccination teams in close collaboration with local elders, Mullahs, and opinion leaders to address social barriers and hesitancy.

**The advance planning behind the regular SIA's in Afghanistan is a good working modality for Gavi to provide support for specific vulnerable groups of IDPs, refugees and returnees.** The house-to-house Measles SIAs and Polio campaigns allowed the combination of wider health package delivery, including food assistance, increased community confidence and built-up demand for the service.

**There is enthusiasm for the innovative working modality with IFRC/ARCS in accessing better the rural VHRD's**, however this partnership is still in too early stages to adequately analyse performance and results.

## 1.6 WHAT WAS PARTICULARLY CHALLENGING?

**Cultural and security barriers to accessing health care remain important challenges.** Demand generation for vaccination is challenging not only because of issues of security and access, nomadic life and displacement, but also because of customs that forbid women from travelling or receiving homebased immunisation without a male relative being present.

**Another key challenge is the general lack of access to primary health care, the primary vehicle for immunisation.** Only 60-65% of the population have access to primary health care leaving many communities well outside facility-based care.

**Restrictions on outreach and mobile activities implementation.** The absence of such activities highly impacts the objective of reaching the "zero dose children". There is little prospect for regular and sustained outreach activities in settings where political control shifts between armed groups. Gavi is trying to address this through the ARCS partnership.

> "For us is how to work with anti-government elements, all the vaccinators are recruited in consultation with anti-government elements. This is the major element of problem we face", [country KII].

[12] The Health Facility Assessment reported however a decline from 85% in 2019 to 60% in 2020

# 2 BANGLADESH - COX'S BAZAAR

## 2.1 COUNTRY CONTEXT

Bangladesh is not considered a fragile country but the Rohingya refugee crisis of 2017 made the country eligible for additional Gavi support under the Emergency and Refugee classification of the FER policy. **Bangladesh has made immunisation a top priority programme and has reported greater than 90% coverage for most antigens**. The national immunisation schedule consist of BCG, DTP-HepB-Hib (Penta), OPV, IPV, MR (measles-rubella), PCV, Rotavirus, and Td. Bangladesh introduced Hib vaccines in 2009, PCV in 2015, IPV in 2015, and Rotavirus in 2020. The country reports high coverage rates that appear to be stable over time. With the exception of IPV, all vaccines appear to have constant coverage rates of 97-99% between 2017 and 2019. Gavi and the government have had a long and productive engagement to boost coverage and improve performance in hard-to-reach areas and high-risk groups. IPV and PCV were both introduced with Gavi support. With the support from Gavi, Bangladesh piloted the introduction of HPV and plans to apply for a national scale-up.

**In August 2017, large numbers of Rohingya started crossing into Cox´s Bazar district to escape the violence in Myanmar. Under the FER policy Bangladesh has requested six flexibilities to support refugees and seven clarifications between 2017 and 2020.** Over several weeks 800,000 refugees arrived and established a large camp in Bangladesh's Cox's Bazar district. The UN cluster system was activated under a level 3 emergency and many agencies expanded their regular operations into emergency response. The Rohingya had significantly worse immunisation rates than Bangladesh´s host community, and this subsequently resulted in several outbreaks of VPD including diphtheria, measles, cholera and varicella. These outbreaks were forecastable given the low immunisation coverage, highly congested camp, and the poor nutrition status. Four of the six flexibilities requested were for operational costs and additional vaccine support (doses). **Table 2** below shows the flexibilities granted to Bangladesh.

Table 2 - Flexibilities granted - Bangladesh

| Type of flexibility | Description |
|---|---|
| **Additional Vaccine cost** | A total of more than 1.6m various doses provided between the period 2017-19, worth approximately $3m |
| **Additional Operational support** | 1,687,700 vaccines doses (Penta, PCV, MR, IPV) were the additional vaccines provided for the refugee camps). Gavi provided an Additional Operational Cost cash grant through WHO and UNICEF for 2018 in the amount of US$451,257 |
| **Co-financing waiver** | Between 2017-2019 a co-financing waiver (replenished) valued at $850,000 was granted to Bangladesh |
| **Additional HSS support** | Additional HSS support valued at $3.4m was approved for period 2019-2021 |
| **Additional TCA support** | In additional to UNICEF and WHO TCA, Bangladesh received approximately $200,000 additional TCA support[13]. |

[13] From document review it remains unclear if this TCA was specifically for the refugee population or part of the regular envelope for Bangladesh

## 2.2 THE MODEL: RELEVANCE OF THE FER POLICY?

**In Bangladesh, the FER policy has allowed Gavi to contribute to the overall humanitarian response plan for refugees through its Alliance Partners WHO and UNICEF.** The FER policy is pertinent in the Rohingya crisis, and a strength of the HSS is the clearly delineated plan to support refugees under the FER flexibilities in parallel to Gavi's development agenda in Bangladesh. As a result of the FER policy, Gavi provided vaccine doses to a refugee population that had very low to no immunisation coverage, and underwent several outbreaks of VPDs (**see table 2**). Gavi provided operational cost support of $0.65 per target child to deliver those vaccines. While the FER policy requires governments to co-finance vaccine doses, Gavi granted a co-financing waiver of refugee vaccines in 2017 and 2018, given the unprecedented influx. In addition, Gavi provided $3,4 additional HSS funding specifically for the Rohingya refugee and as separate grants to UNICEF and WHO to strengthen routine immunisation and support vaccination campaigns.

## 2.3 IMPLEMENTATION AND GAVI'S CONTRIBUTIONS TO EFFICIENCY AND EFFECTIVENESS

**Despite the significant efforts in conducting multiple vaccination campaigns as well as strengthening the routine immunisation activities, the immunisation strategies between 2017 and 2019 were not fully sufficient in preventing VDP outbreaks.** Through WHO and UNICEF, Gavi supported catch up and outbreak vaccination campaigns following measles and diphtheria outbreaks in the camps.

An **outbreak of diphtheria** occurred in November 2017 into early 2018 and three vaccination campaigns between December 2017 until March 2018 were conducted with a diphtheria toxoid containing vaccine (children aged 6 weeks to 15 years) and a pentavalent (DPT-HepB-Hib) vaccine (children 6 weeks to 7 years). UNICEF procured with its own resources Td vaccines in response to the diphtheria outbreak, as Gavi could only support additional Penta under its FER policy. While diphtheria cases are still reported (last confirmed case reported in week 1, 2021[14]; last death reported October 2019 [15)], the immunisation activities seemed effective in preventing further diphtheria epidemics in the camps.

A two-week MR campaign started on 16 September (135,519 children between 6 months to 15 years). Due to the continued influx, epidemiology and the **ongoing measles outbreak** (1743 measles cases were reported from September to December 2017), additional campaigns were conducted from 18 November to 2 December 2017 (354,982 children between 6 months to 5 years). Government routine supply of vaccines was used, with the expectation of replenishment of vaccines through Gavi. During 2019, WHO reported a low measles coverage[16] and an increasing trend of new measles cases[17]. During week 1 in 2020, 264 suspected measles cases were reported and new campaigns were initiated (6 months to <10 years). In addition, WHO and partners developed an EPI micro plan[18] to address the challenges from both the demand and supply side. Efforts included periodic program review, improved social mobilization and community engagement, capacity building of vaccinators, the introduction of an e-tracker for online registration of children and defaulter tracing, strengthened VPD surveillance through existing platforms (DHIS2, EWARS), and periodic intensification of routine immunisation. While the measles epidemic of 2020 has been controlled, ongoing measles cases are reported throughout 2020 and 2021[19].

[14] https://reliefweb.int/sites/reliefweb.int/files/resources/ewars-w25-2021.pdf
[15] https://reliefweb.int/sites/reliefweb.int/files/resources/ewars-w25-2021.pdf
[16] https://www.who.int/health-cluster/countries/Bangladesh/Bangladesh-HS-Bulletin-July-Dec-2020.pdf?ua=1
[17] https://reliefweb.int/sites/reliefweb.int/files/resources/ewarsw12020.pdf
[18] Gavi, WHO, UNICEF EPI consultative meeting and review of the Micro plan for FDMN's, 23 December 2020.
[19] https://reliefweb.int/sites/reliefweb.int/files/resources/ewars-w25-2021.pdf

**Gavi also provided support to routine immunisation through vaccines and operational costs.** EPI activities commenced, targeting children <2 years of age with pentavalent , PCV, IPV, BCG, and MR. Pregnant women are also vaccinated against diphtheria and tetanus (Td vaccine). There are about 72 outreach sites and 58 fixed EPI sites providing routine vaccination. Around 240 vaccinators are supporting the vaccination to children and pregnant women. Around 1500 immunisation sessions are held each month. About 64,270 children under 2 years of age and more than 43,000 pregnant women receive routine vaccination and the new-born cohort is over 30,000.

**Informants stated that the immunisation strategies were not sufficiently tailored to the specific vulnerabilities of the refugee population as recommended in the WHO framework for Vaccination in Acute Humanitarian Emergencies** (here further referred to as the WHO framework). The low immunisation coverage among the refugees, the density of the camps and the poor nutritional status were important risk factors for VPD outbreaks. Negotiating expanded target age groups was reported to be difficult, some campaigns came in later than preferred (measles in 2020) and the initial routine EPI activities were hampered by vaccination hesitancy, high dropout rates, and limited community engagement. An earlier application of the WHO framework, including '*rapidly reducing the risk',* and *'Strategies such as mass vaccination campaigns, expanded target age groups, and reduced courses for certain vaccines',* led by tailored *'community engagement'* would have been more appropriate and likely more effective in preventing VPD outbreaks. WHO and UNICEF informants confirmed they were aware of the FER policy, the eligibility criteria for tailor made responses and the WHO framework, and stated that the discrepancies between WHO´s framework and operational choices were mostly due to mandatory alignment to national immunisation strategies and decision making. With the 2020 micro planning, nearly three years after the initial influx, decisions were made to expand cold chain points, increase RI immunisation days in fixed sites from 2-3 days to 4-6 days, increase outreach sessions to 4 days a week, and intensifying catch-up strategies.

**Vaccine hesitancy and a lack of awareness were significant demand barriers in the refugee population and demand generation activities were hampered by alignment to government policy and the limited community engagement activities.** This was a significant operational challenge. The FER policy is based on the application of global best practice guidelines which recommends strong community engagement for demand generation. Health partners stated that a presence of Gavi in Cox's Bazar would have allowed a better understanding of the immunisation gap between the national programme and the Rohingya refugee program. The implementing partners stated that Gavi's influence may have helped resolve this operational challenge. Governments can be flexible, and some opportunities can be negotiated by explaining the operational impact and global best practice. During 2020, dropout rates were 12% for BCG to Penta 1, 19% for Penta 1 to 3, and 31% for MR 1 to MR 2[20]. Only with the EPI micro plan in 2020, community engagement strategies were adapted appropriately including expanding and training of Community Health Workers (CHW), incorporating volunteers from the refugee population, revising and translating the immunisation card in local language, and monthly meetings with the CHWs. This was seen as a positive step in tackling demand barriers.

**The Covid-19 pandemic significantly impacted further progress on immunisation coverage.** In 2020, new measles cases had dropped to 36 by week 11[21] due to Covid-19. But since mid-April immunisation services were withheld in the camps. Almost all outreach services were suspended and the few immunisation fixed sites that continued their activities experienced a very low number of beneficiary visits. Access to camps was

[20] Source: 2020 MSD report - Annex 2 - FDMN progress report

[21] Source: EWARS on https://reliefweb.int/sites/reliefweb.int/files/resources/ewarsw112020.pdf

affected and vaccinators saw their work disrupted. Social mobilization and awareness on vaccination got affected due to social rumours, superstitions and religious myths.

## 2.4 HOW DID THE GAVI FER POLICY INFLUENCE THE INTENDED RESULTS?

**Gavi applied the FER policy to the refugee crisis resulting in the following additional funding.** Bangladesh received operational cost support, additional vaccine support, additional HSS support and a co-financing waiver. Overall, the FER policy has unlocked an additional $5,501,508 and this resulted in an additional 1,687,700 vaccines delivered (Penta, PCV, MR, IPV) during the period 2017-19. Gavi has also provided a two-year co-financing waiver for Bangladesh for the period 2017-19; i.e. an equivalent of $849,500 indirect financial support. In addition, in 2018, Gavi has provided an additional cash grant to support operating costs at approximately $451,257. Gavi also provided $1,1 million as an additional HSS grant, which covered the period beyond 2019.

Table 3 - Summary of resources that benefited Bangladesh through FER Policy

| Flexibility | 2017 | 2018 | 2019 | Total |
|---|---|---|---|---|
| **Operational Cost** | $ - | $ 451,257 | $ - | $ 451,257 |
| **Additional Vaccine Support** | $ 2,227,500 | $ 668,500 | $ - | $ 2,896,000 |
| **Co-financing waiver** | $ 129,000 | $ 535,500 | $ 185,000 | $ 849,500 |
| **TCA support** | $ - | $ - | $ 200,000 | $ 200,000 |
| **Additional HSS support** | $ - | $ - | $ 1,104,751 | $ 1,104,751 |
| **Total** | | | | **$ 5,501,508** |

**Gavi's strong national HSS ambitions, and the strong national immunisation program with its high coverage rates risk to mask the low coverage rates and immunisation inefficiencies (during 2019 and 2020[22]) in the Cox´s Bazar refugee camp**. CSOs questioned whether Gavi is aware of the low immunisation rates in the camps and how its monitoring and evaluation activities capture this data. There are challenges in data quality and reporting, and some key informants suggested that there is an emphasis to report high EPI indicators. Most outcome indicators in the Gavi's GPF are national level outcomes and report very high coverage (>100%).

Indicators targeting the refugees are few, provide data on children 0-11 months only, and there are differences with health cluster data. Despite the significant immunisation efforts, the GPF reports coverage rates below (**Table 4)** the recommended targets[23] in refugee health: Penta 1 coverage of 78% (2018), 83% (2019) and 78% (2020). Penta 3 coverage was 60% (2019) and 55% (2020). MR 1 was 69% (2018), 72% (2019), 69% (2020). And dropout rates for Penta 1-3 was 23% (2019) and 29% (2020).

[22] https://www.who.int/health-cluster/countries/Bangladesh/Bangladesh-HS-Bulletin-July-Dec-2020.pdf?ua=1

[23] (Source: Sphere Handbook 2018, UNHCR) The emergency standard - at least 95% of children aged between 0/6 months and 15 years have received polio and measles vaccinations in the emergency phase; The long-term standard: Once routine immunisation services (EPI) have been established, at least 90% of children aged between 0 and 12 months have received 3 doses of either (a) DPT or (b) Pentavalent vaccine

Table 4 – National coverage trends in Bangladesh[24]

| Bangladesh | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| Penta3 coverage national | 98% | 98% | 98% | 98% |
| Penta3 coverage in HSS targeted areas | - | - | 98% | 99% |
| Penta3 coverage in refugees | - | - | 60% | 55% |
| Pneumococcal Coverage | 97% | 97% | 97% | 97% |
| IPV Coverage | 11% | 17% | 75% | 92% |
| MCV 1 | 97% | 97% | 97% | 97% |
| MR1 in refugees | - | 69% | 72% | 69% |
| Drop Out Rate - Penta1-3 | 1% | 1% | 1% | 1% |
| Drop Out Rate - Penta1-3 refugees | - | - | 23% | 29% |

## 2.5 WHAT WAS PARTICULARLY SUCCESSFUL?

**The FER policy has allowed Gavi to contribute to the overall humanitarian response plan for refugees through its Alliance Partners WHO and UNICEF.** The FER policy is pertinent in the Rohingya crisis, and a strength of the HSS is the clearly delineated plan to support refugees under the FER flexibilities in parallel to Gavi's development agenda in Bangladesh.

## 2.6 WHAT WAS PARTICULARLY CHALLENGING?

**The humanitarian system and the UN system are not always perfectly aligned in reality and donors like Gavi can play a constructive role in challenging under-achievement.** While Bangladesh has shown significant intent in hosting this large population, the immunisation strategies at onset were not sufficiently tailored to the high risks of the Rohingya refugees and this likely contributed to several VPD outbreaks. Three years after the crises MCV and DTP coverage rates are still significantly lower than recommended refugee health targets. Donors have the capacity to negotiate with governments on using best practice guidelines under FER grants. During interviews informants made recommendations on how to move forward and further improve immunisation coverage**.** These included, mass vaccination upon arrival, extended age categories, and RI strategies that are adapted to the specific risks of the Rohingya refugees. Most informants, including WHO and UNICEF, proposed the implementation of an independent evaluation in Cox's Bazaar best practice in acute emergency settings. A direct agreement with UNHCR and CSOs with strong rapid response capacity were reported as a potential parallel partnership to improve effectiveness and efficiency in vaccination campaigns.

[24] Grant Performance Framework reports

# 3 SOUTH SUDAN

## 3.1 COUNTRY CONTEXT

**The Republic of South Sudan (RSS) remains a highly fragile country affected by frequent VPD outbreaks, refugee and IDP movements, and other emergencies**. The total population of South Sudan was estimated in 2019 at 13,776,652 with an infant mortality rate of 60 (deaths < 1 year per 1000 births, 2015) and a child mortality rate of 93 (deaths < 5 years per 1000 births, 2015)[25]. Around 80% of the population lives in rural areas[26]. The country has been experiencing a protracted crisis since December 2013[27] which, by the end of August 2017 had affected around 7.5 million people. Over 3.9 million people have been displaced with 1.9 million internally displaced and 2 million in neighbouring countries. Health service delivery has experienced disruptions with destruction of health service infrastructure and looting of cold chain equipment. Access to population remains heavily impacted by insecurity, poor road infrastructure, seasonal flooding, and conflicts[28]. Government allocation to public health services dropped from a very low 2% to 1% in the Financial Year 2019/2020 national budget.

**The national immunisation schedule in RSS consists of** BCG, DTPHibHepB (Penta), OPV, IPV, measles Td and TT. Coverage rates are generally low and constantly varying from around 39% for IPV to 52% for BCG. DTP3 is estimated at 49% and MCV1 at 49%. There is no routine immunisation for PCV and ROTAC[29]. There are fluctuations in coverage rates per antigen per district per year. For example, the percent coverage rates for DTP3 per district varied from 0.05 in Morobo to >95% in Rumbek East in 2017, from 0 in Khorflus to >95% in Tonj South in 2018 and from 0 in Khorflus to >95% in Nagero. Of concern, the national EPI survey undertaken in 2017 found that the proportion of fully immunised children (by card) was only 18.9 percent.

**Gavi remains the main funder of vaccination services in the country.** Gavi supports the MoPH and its Alliance Partners since 2004 with a first HSS1 grant in 2009, HSS2 in 2014, HSS3 as well as additional HSS support of 50%. The country is in the self-financing phase and has received a Gavi Board approved co-financing waiver from 2017 until 2020. The government of South Sudan, according to its own reporting, has difficulty executing its budget and delivering on its planned outcomes. In total under FER**, South Sudan has requested five flexibilities between 2017 and 2020 that were all approved.** Two of the four flexibilities requested were for operational costs including one for a yellow fever outbreak, and another for a measles campaign.

## 3.2 THE MODEL: RELEVANCE OF THE FER POLICY?

**Under the FER policy, the Government of South Sudan requested $16,113,437 of additional HSS grant to increase Penta 3 immunisation coverage in South Sudan from 26% to 50%[30]** (in 18 months for the period July 2019 – December 2020). This request was complementary to the existing HSS grants. To implement this grant, the government works through the existing array of NGOs who provided health services in health districts. This approach capitalized on the increasing stability in the country and utilizes the existing partners and the consortium initiatives (e.g. Health Pooled Fund 3 – HPF3). While additional HSS funding was

[25] Gavi South Sudan country information sheet https://www.gavi.org/programmes-impact/country-hub/africa/south-sudan
[26] World bank data 2019
[27] https://www.afro.who.int/sites/default/files/2018-06/South%20Sudan%20Situation%20Report%20Issue%20No.%2020_June%202018.pdf?ua=1#:~:text=South%20Sudan%20has%20been%20experiencing,are%20refugees%20in%20neighboring%20countries.
[28] From Republic of South Sudan national expanded programme on immunisation multi-year plan 2018-2020
[29] https://www.who.int/immunisation/monitoring_surveillance/data/ssd.pdf
[30] based on WUENIC

requested in March 2019, a first disbursement was only made in October 2019. MOH requested more time to finalise and negotiate the activities hence implementation of activities started in January 2020. The additional HSS funds for a duration of eighteen months according to the Decision Letter have therefore been spent since October 2019 to March 2021 (this is also stated in the Decisions Letters that Gavi signed with its partners, IOM, HPF3, Crown Agents and UNICEF).

**Gavi's support to RSS through supporting the HPF3, IOM and Crown agents is highly relevant as it is responding to the health needs of the people of South Sudan, including immunisation, and aligned to policies and plans of the government of RSS.** In October 2019, Gavi joined the Government's Health Pool Fund (HPF3[31]), as well as supported IOM, and Crown Agents with an aim to support RI through high priority health facilities in and around Protection of Civilian sites and, provision of immunisation services at specific nutrition treatment centres where mothers regularly access nutrition. These specific health facilities were appropriately selected based on criteria including the number of unvaccinated children and the number of visits by mothers accessing reproductive and maternal health services. An Advisory Steering Committee of HPF3 donors including Gavi, was established to regularly engage with the MoH and ensure alignment to government policy and planning. Monthly meetings were held to discuss programme priorities and implementation challenges. HPF3 is responding to the huge health needs of South Sudan, exacerbated by many years of conflict and economic crisis, by supporting the implementation of the government's policies, strategies and plans, most notably the Basic Package of Health & Nutrition Services (BPHNS). The key expected outputs focussed heavily on women and children including through strengthening (1) service delivery, (2) health systems, (3) community engagement and (4) nutrition services. Specific focus was on targeting returnees and IDPs in close collaboration with the Health cluster, hard-to-reach communities (e.g. cattle camps, peri-urban settlements, military barracks), the provision of flexible funding to 900 functional health facilities (~$50/monthly) to overcome last-mile transportation barriers, as well as the use of Open Data Kit technology to obtain real-time immunisation performance data.

**The FER HSS planning process was well-coordinated, comprehensive and complimentary across several partners.** The FER HSS application was designed by an in-country committee that included multiple UN agencies and NGOs and this was reported to have been efficiently facilitated. The process mediated between partner roles, funding allocations, geographical presence and partner capacity; there was evidence of reflection on risk appetite, transparency and prioritisation and the proposal was tailored to the complex access barriers of South Sudan. It emphasised on the acute shortages of qualified health workers, the severe access barriers in reaching populations, the limited and inefficient outreach activities, limited cold chain infrastructure, and poor data management severely impacting accurate coverage estimates and proper performance monitoring. By joining the HPF3, Gavi is supporting 8 of the 10 states in South Sudan covering the area where 94% of the unimmunised children (over 200,000 infants) reside, providing opportunities for population impact.

"This FER policy brought a kind of energy to the existing partners also to bring in the practical issues from the field and to advise, how we can support together". *[Country KII]*

[31] The South Sudan HPF is a multi-donor funding mechanism, currently comprising of DFID (the lead donor), Canada, EU, Sweden and USAID. It has a Steering Committee chaired by the Government of the Republic of South Sudan's (GRSS) Ministry of Health (MoH). Day to day management is provided by a contracted fund manager through a consortium led by Crown Agents. Implementation is carried out in 23 smaller geographical areas, in eight out of ten former states, by contracted NGOs – Implementing Partners (IPs) - using existing MoH facilities and health staff.

## 3.3 IMPLEMENTATION AND GAVI'S CONTRIBUTIONS TO EFFICIENCY AND EFFECTIVENESS

**Gavi's support to HPF3 has improved on FER principles like 'coordination', 'complementarity' and 'prioritisation' but also access to hard-to-reach populations.** The FER application is seen as a better practical articulation of the FER ambitions where the previous approach of working only through government and core Alliance Partners was seen as less tailored to address immunisation challenges in South Sudan's complex context. It has brought Alliance Partners and extended partners together in coordinating immunisation activities and focusing on hard to reach and fragile populations. The approach to supporting CSOs through the HPF3 also promotes the FER´s flexibilities towards engaging non-governmental partners (FER policy 5.7.d.). Across informants this was seen as the most effective current model to operate in South Sudan.

**Gavi's 'flexibility' principle is recognised by most informants and was described as an important tool to operate in South Sudan's continuously changing environment.** The changing environment makes planning challenging and Gavi, applying a flexible approach to supporting South Sudan, is seen as a more flexible donor compared to other donors. However, some areas were reported as under addressed or funded such as human resources (incentives based), community-based activities, and cold chain availability in the periphery. Nonetheless, the overall picture suggests an effective use of flexibilities to adapt to the context.

> 'Planning doesn't work here. Six months of the year the *country is flooded, the other six months there is fighting'. [Country KII]*

**Gavi processes were reported to be reasonably streamlined, though heavily relying on data requirements and with a labour-intensive process to develop the proposals and plans.** Partners were, in general, happy with the processes and commensurate to the scale and complexities of the programme. The potentially competitive nature between the core Alliance Partners and the additional partners was well deescalated and managed.

**There are delays in implementing the HSS2 grant and WHO absorption capacity remained low across 2017 to 2020.** The Gavi HSS2 grant (2014) was delayed until 2015, with the first 2 years (2015-2016) of implementation being further delayed. This resulted in a no-cost extension granted in 2017. A decision was taken to conduct the reprogramming of the HSS2 grant for the remaining years re-prioritising activities for further implementation in 2018-2019. WHO also requested a no-cost extension for the first two years of implementation ending on 31 December 2017. WHO HSS utilisation rate was 37% (2017), 49% (2018) and 41% (2019). Reasons for delays included the ongoing insecurity as well as the appropriate capacity to absorb.

## 3.4 HOW DID THE GAVI FER POLICY INFLUENCE THE INTENDED RESULTS?

**Gavi has been deliberately innovative, flexible and instrumental in achieving the current state of immunisation in the South Sudan challenging environment**. Under the FER policy Gavi has granted an additional $22,395,202 USD to the RSS over the period 2017-2019. This included $4,671,429USD of operational cost and $8,423,773USD as TCA support. (overall TCA support, no additional TCA support has been provided under FER)

Table 5 - Additional resources granted under FER[32]

| Flexibility | 2017 | 2018 | 2019 | Total |
|---|---|---|---|---|
| **Operational Cost** | $1,246,247 | $- | $3,425,182 | $4,671,429 |
| **Additional Vaccine Support** | $- | $- | $- | $- |
| **Co-financing waiver** | $- | $- | $- | $- |
| **Additional HSS support** | $- | $- | $9,300,000 | $9,300,000 |
| **Total** | | | | **$ 13,971,429** |

**Through the arrangement of supporting HPF3, RI is now integrated within PHC services and intensified in almost half of the health facilities in priority counties managed by the HPF3.** This resulted in 1,498 additional vaccinators recruited and received incentives, increased fixed and outreach vaccination sessions from 8,393 per month in (2019) to 14,615 per month (in 2020), increased number of mentorships through supportive supervision sessions from 263 (2019) to 706 (2020), increased number of health facilities with active cold chain equipment improved from 686 to 757. Also, 54 counties were facilitated to conduct quarterly performance review meetings involving implementing partners and the vaccinators (increased from 0 to 46 counties having regular quarterly review meetings), and in 7 out of 10 states, quarterly EPI performance bulletins were developed by state officers and shared with county teams and the vaccinators. The percentage of facilities with adequate immunisation staffing was estimated at 80% in 2020.

**There are significant positive trends in immunisation coverage at the HSS targeted county level but it is too early to observe improved coverage at national level between 2017 and 2020.** Specific to the Gavi HSS targeted areas, Penta3 increased significantly from 45% to 60%. Accumulative across 2019 and 2020, Gavi's support resulted in 512,650 surviving infants who received a third recommended dose of pentavalent vaccine in the 54 HSS targeted counties and Juba urban area. This exceeded the outcome target with 138%[33]. While the total number of surviving infants increased from 450,566 (2017) to 599,605 (2019), it declined again to 474,382 in 2020. However, the Penta 1-3 dropout rates declined from 30% to 18%. This is a significant result as most national immunisation national coverage rates declined across the three years due to issues of inaccessibility, communal conflict and population movement.

Table 6 - Trends in national coverage data South Sudan

| South Sudan | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| Penta coverage national | 59% | 56% | 45% | |
| Penta3 coverage HHS targeted areas | - | - | 45% | 60% |
| IPV Coverage | 54% | 50% | 41% | |
| MCV 1 | 75% | 59% | 42% | |
| Drop Out Rate - Penta 1 and Penta 3 | 24% | 23% | 21% | |
| Drop Out Rate - MCV 1 and MCV 3 | 100% | No data | 100% | |
| Percentage of districts or equivalent administrative area with Penta3 coverage greater than 80% | 30% | 26% | 18% | |

[32] Various sources - Decision letters, Joint Appraisal reports, Memos, tracker etc.
[33] Data sourced from Grant Performance Framework Reports.

## 3.5 WHAT WAS PARTICULARLY SUCCESSFUL?

**The HPF3 and broader partnerships allowed a better outreach into hard-to-reach communities, and generated more demand, and this contributed to improved coverage rates**. Gavi's support to HPF3 is mostly implemented by CSOs. Such CSO's provide high proximity to difficult to reach populations and are often operational in conflict areas. Supporting the HPF provided direct immunisation support to such areas and contributed to increasing immunisation rates. Specific to the 54 HSS targeted areas, Penta3 increased significantly from 45% to 60% and this should be seen as a significant gain over a very short period of time in this highly complex environment.

## 3.6 WHAT IS PARTICULARLY CHALLENGING

**At federal, state and most particularly at county level, several systemic challenges continue to impact on effectiveness, efficiency, and sustained HSS results.** These include the local human resource attrition, the difficulties in expanding and maintaining cold chain, the geographical barriers and the ongoing insecurity.

# 4 LESSONS LEARNED – GENERAL FROM COUNTRY CASE STUDIES

The evaluation team lists below the key lessons learned across the three country case studies.

1. The FER policy has enabled Gavi to seek coherence and effectiveness in its programmatic approach towards covering the hard-to-reach areas and population groups most in need for vaccination. This was successful through joining pooled funding mechanisms that resourced joint programmes, thus providing Gavi access to key non-government partners that can cover hard-to-reach, conflict and opposition-controlled areas.
2. These partners and new partnerships, including with humanitarian (UN) agencies and other (I)NGOs and CSOs, enable creating key entrance points to localised and tailored solutions that would otherwise not be in the realm of Gavi. The country case studies show recent promising developments in establishing partnerships.
3. While applying flexibilities under the FER policy it is important for Gavi to join the country humanitarian cluster coordination platform. This allows Gavi to extend the possibility for coherence and increase coverage. The search for coherence enables Gavi to improve programme complementarity with other donors and governments, programme prioritisation and coordination in-country. Not joining these platforms seems a missed opportunity.
4. Gavi could be more instrumental through presence (capacity) and influence in-country, negotiating with governments, solving operational issues, and facilitating the implementation of the WHO framework in countries that, for example, apply strict government alignment requirements on immunisation. The country case studies show that this practice has ultimately increased community engagement, a premise under the FER policy seen by Gavi to progressively create demand and increase vaccination coverage.
5. Absorption and utilisation by Alliance partners (UNICEF and WHO) is relatively low due to slow adaptability in response to rapidly changing environments in insecure, violent and conflict affected areas.
6. While Gavi is successful in unlocking and providing funds, it could be more successful, using its importance and weight, in negotiating strategies with the government or playing a prominent role in situations where humanitarian and UN systems are less aligned.
7. The country case studies show that the application of flexibilities through the FER policy allows for triggering immediate immunisation responses that can be quickly organised, also in continuously changing environments.
8. HSS additional funding through the FER policy enables tailored approaches and reaching targeted areas, increasing coverage and equity in access. In addition, HSS helps support the fundamental pillars of the health system, including integrated services at lower tiers or EPI necessities and administration.
9. The greater risk appetite under the FER policy allows Gavi to be proactive in seeking solutions in conflict affected and opposition-controlled areas.
10. The country case studies show that the use of national figures can mask local needs. The use of indicators for localised areas should be leading programme decision making and efforts to obtain these data are thus paramount. However, the country case studies also show that the requirement for using quality data hampers quick responses, decision making and trigger lengthy negotiation and approval processes (Joint Appraisals; Alliance partner implementation). This is a balancing act that asks for higher risk appetite, a principle of the FER policy.