Annex F: Country Summary Sheets

1.1 The summary sheets are intended to provide a high-level systematic snapshot of a country’s performance across a number of key thematic areas (e.g. coverage, supply chain, data quality). They provide additional context and country-specific overviews and highlight main challenges to inform PPC and Board discussions.

1.2 Each key thematic area is assessed through a ‘traffic light’. For the traffic light assessment, a standardised approach has been applied to assess countries’ performance using agreed-upon quantitative and qualitative criteria. For example, to measure a country’s performance related to equity, the country’s DTP3 coverage differences in wealth, maternal education, and geography are used as standardised proxies to understand the main drivers of inequities within the country. This quantitative assessment has then been complemented with a qualitative assessment by the country team, building on broader assessments and work in this area (e.g. assessing inequities across marginalised groups, urban slums, etc.).

1.3 Wherever possible and to ensure consistency, the Secretariat has used indicators and data sources that align with the Alliance’s strategic goal indicators and existing, agreed-upon performance measurements (e.g. grant performance framework target achievement, financial reporting compliance). Data for these indicators have been retrieved from various routine sources, including WHO/UNICEF estimates, DHS/MICs surveys, EVMAs, and other standardised analyses conducted by Secretariat staff.

1.4 As most thematic areas consider performance across several indicators, to obtain the eventual traffic light assessment, each indicator has been given equal weight, and been validated through the qualitative assessment (where applicable).

1.5 In addition to providing a traffic light assessment for each key thematic area, a trend arrow is included to understand if performance in that area is improving, declining, or stagnating. Where possible, trends are measured through quantitative criteria and data (e.g. coverage), but some areas rely on a more qualitative assessment. For example, in a situation where health workforce shortages are particularly compelling, this could be marked as red. However, in view of recent efforts towards developing a health workforce strategy, the trend may show that we are optimistic that this situation is on a more positive trajectory.

1.6 Going forward, the Secretariat is considering refinements to the methodology used for the development of the cross portfolio overview and country summary sheets (e.g. additional metrics to be considered). Based on PPC and Board feedback, the Secretariat is evaluating how to provide country specific information and a cross portfolio overview for all remaining PEF countries, as well as a higher level summary of progress in remaining countries.
1.7 More details on each indicator used, including data sources and assessment thresholds can be found in table 1. All country summary sheets can also be found below.
### Table 1: Methodology:

<table>
<thead>
<tr>
<th>Area</th>
<th>Assessment Type</th>
<th>Indicator</th>
<th>Indicator Definition</th>
<th>Source</th>
<th>Indicator Thresholds</th>
<th>Threshold Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country General Information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td># under-immunised (DTP3)</td>
<td>The total number of surviving infants not receiving the third dose of DTP-containing vaccine at the national level</td>
<td>WUENIC (2015)</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>% GPF targets achieved</td>
<td>The number of indicators in the grant performance framework fully achieving their target over the total number of indicators due for reporting in a given year</td>
<td>Gavi Records</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td># PEF positions funded</td>
<td>The total number of WHO and UNICEF staff positions funded by Gavi through PEF support in a given year</td>
<td>Gavi Records</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>Vaccine introductions</td>
<td>Gavi supported vaccines introduced into the routine immunization schedule from 2001 to 2016 and those expected to be introduced in the routine immunization schedule from 2017 to 2020</td>
<td>Gavi Records</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>Gavi commitments vs. disbursements (all time)</td>
<td>Total amount of funds (or equivalent dollar amount of vaccines sent) disbursed and committed across all Gavi support, disaggregated by cash support (HSS, CCEOP, VIGs, Ops, etc) and vaccine support (Routine and Campaigns). Disbursements are payments made since Gavi support up to Feb 2017, and Commitments represent approved multi-year budgets.</td>
<td>Gavi Records</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Quantitative</td>
<td>DTP3 coverage</td>
<td>Percentage of surviving infants receiving the last (i.e. third) recommended dose of DTP vaccine at the national level.</td>
<td>WUENIC (2015)</td>
<td>&gt;= 90% (Green), &gt;70-89% (Orange), &lt;70% (Red)</td>
<td>Green: GVAP, Yellow/Red: Team agreed (Strategic Indicator S1.2 target is not transferable to country level)</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>MCV2 coverage</td>
<td>Percentage of surviving infants receiving the second recommended dose of measles containing vaccine at the national level.</td>
<td>WUENIC (2015)</td>
<td>&gt;= 90% (Green), &gt;70-89% (Orange), &lt;70% (Red)</td>
<td>Green: GVAP, Yellow/Red: Team agreed (Strategic Indicator S1.2 target is not transferable to country level)</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>Breadth of protection</td>
<td>Average of annual estimates of coverage via the routine immunisation system for the last recommended dose of all Gavi-supported vaccines among all eligible children</td>
<td>Gavi Records</td>
<td>Positive trend (Green), No Change (Orange), Negative trend (Red)</td>
<td>Green: GVAP, Yellow/Red: Team agreed (Strategic Indicator S1.2 target is not transferable to country level)</td>
<td></td>
</tr>
<tr>
<td>Qualitative</td>
<td>Qualitative assessment</td>
<td>• WUENIC grade of confidence • Related data quality challenges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td></td>
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</tr>
<tr>
<td>Quantitative</td>
<td>Districts above 80% DTP 3 coverage</td>
<td>The total number of districts or equivalent administrative area with a DTP3 coverage greater than 80% divided by the total number of districts or equivalent administrative area for a given year</td>
<td>Admin JRF (2015)</td>
<td>&gt;= 90% (Green), &gt;70-89% (Orange), &lt;70% (Red)</td>
<td>Green: Team agreed (GVAP is 80%, Strategic Indicator S1.3 is 100%)</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>Difference in DTP3 coverage - wealth quintile</td>
<td>Percentage of DTP3 coverage for highest wealth quintile - Percentage of DTP3 coverage for lowest wealth quintile</td>
<td>Latest Survey</td>
<td>&lt;=10% (Green), &gt;10-15% (Orange), &gt;15% (Red)</td>
<td>Green/Yellow/Red: Team agreed, follows 5pp increments (Strategic Indicator S1.3 is 100%)</td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>Difference in DTP3 coverage - mother’s education</td>
<td>DTP3 coverage among children whose mothers/female caretakers have completed secondary education or higher - DTP3 coverage in children whose mothers/female caretakers have received no education</td>
<td>Latest Survey</td>
<td>&lt;=10% (Green), &gt;10-15% (Orange), &gt;15% (Red)</td>
<td>Green/Yellow/Red: Team agreed, follows 5pp increments (Strategic Indicator S1.5)</td>
<td></td>
</tr>
<tr>
<td>Qualitative</td>
<td>Qualitative assessment</td>
<td>• Other key equity stratifiers (eg. marginalized groups, urban slums, etc)</td>
<td></td>
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<tr>
<td><strong>Demand</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Quantitative</td>
<td>DTP drop out rate</td>
<td>Percentage point drop-out between first and third dose of DTP vaccine</td>
<td>WUENIC (2015)</td>
<td>&lt;=5% (Green), &gt;5-10% (Orange), &gt;10% (Red)</td>
<td>Green: Team agreed (GVAP is 10% and determined too high, Strategic Indicator S2.5 is 3% and determined too low), Yellow/Red: Team agreed, follows 5pp increments</td>
<td></td>
</tr>
<tr>
<td>Qualitative</td>
<td>Qualitative assessment</td>
<td>• Key barriers to demand • Related challenges</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Supply Chain</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantitative</td>
<td>Effective Vaccine Management Score</td>
<td>Overall composite effective vaccine management score. The composite score is an average of the 9 criteria scores given in the effective vaccine management assessment.</td>
<td>Latest EVMA</td>
<td>&gt;=80% and above (Green), &gt;60-79% (Orange), &lt;60% (Red)</td>
<td>Green: Strategic Indicator S2.1, Yellow/Red: Team agreed, follows 20pp increments</td>
<td></td>
</tr>
<tr>
<td>Qualitative</td>
<td>Qualitative assessment</td>
<td>• Main challenges related to supply chain (eg. outdated equipment, temp monitoring, appropriately trained staff) • Related effect on supply chain performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Annex F: Country Summary Sheets

<table>
<thead>
<tr>
<th>Data Quality</th>
<th>Quantitative</th>
<th>National administrative DTP3 coverage - DTP3 survey coverage of the corresponding year</th>
<th>Admin JRF (2015) / Latest Survey</th>
<th>&lt;10pp (Green), &lt;10-20pp (Orange), &gt;20pp (Red)</th>
<th>Green/Yellow/Red: Team agreed, follows 10pp increments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
<td>Seriousness level: • Evolution of discrepancy in the past years • Level of confidence in the availability, quality and use of data improving in coming years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financing &amp; Sustainability</th>
<th>Quantitative</th>
<th>Co-financing default</th>
<th>Assesses if the country met co-financing obligations to Gavi by 31 December of a given year.</th>
<th>Gavi Records</th>
<th>Did not default in 2015 and 2016 (Green), Defaulted in 2015 or 2016 (Red)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
<td>N/A</td>
<td>% of routine immunization expenditure funded by the government</td>
<td>Total government expenditure on vaccines used in routine immunization over total expenditure from all sources used in routine immunization</td>
<td>Admin JRF (2015)</td>
<td>&gt;=80% (Green), &gt;30-79% (Orange), &lt;30% (Red)</td>
</tr>
<tr>
<td>Qualitative</td>
<td>Seriousness level: • Political will in the country (incl. Evolution of health budget) • Reasons for potential default and mitigation strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fiduciary Risk</th>
<th>Quantitative</th>
<th>Misuse of funds in last five years</th>
<th>Misuse of Gavi funds in the last five years as per Gavi audits</th>
<th>Gavi Records</th>
<th>No (Green), Yes (Red)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
<td>N/A</td>
<td>Financial reporting compliance</td>
<td>The number of financial reports received in a given year over the total number of financial reports required for submission in a given year</td>
<td>Gavi Records</td>
<td>Full (Green), Partial (at least one report submitted) (Orange), None (Red)</td>
</tr>
<tr>
<td>Qualitative</td>
<td>Seriousness level: • Mitigation strategy in case of mis-use of funds • Key reasons for funds channelled through government / partners • Details on type of funds channelled through government</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Programmatic &amp; Institutional Capacity (LMC)</th>
<th>Quantitative</th>
<th>Institutional capacity indicator</th>
<th>Programme capacity assessment score that measures institutional capacity based on 3 criteria: 1) EPI programme capacity 2) effectiveness of coordination fora, 3) NITAG effectiveness</th>
<th>Latest PCA (v3 onwards)</th>
<th>Green/Yellow/Red: As determined by commonly-used thresholds by WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
<td>Seriousness level: • Current capabilities of EPI teams (e.g. positions, skills, capabilities, turnover) • ICC functioning in the country</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HSS grant</th>
<th>Quantitative</th>
<th>% HSS fund utilisation</th>
<th>Total amount of HSS funds spent over the total amount available in country for a given year. Total amount available is based on total disbursed in given year (adjusted for disbursement month) and total funds leftover from previous year.</th>
<th>Gavi Records</th>
<th>&gt;=80% (Green), &gt;60-80% (Yellow), &lt;=60% (Red)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
<td>Seriousness level:</td>
<td>% achievement of intermediate results</td>
<td>Number of tailored HSS intermediate results indicators fully achieving their target over the total number of tailored HSS intermediate results indicators due for reporting in a given year</td>
<td>Gavi Records</td>
<td>&gt;=90% (Green), &gt;70-90% (Yellow), &lt;70% (Red)</td>
</tr>
<tr>
<td>Qualitative</td>
<td>Seriousness level:</td>
<td>Nursing and midwife personnel (per 1000 population)</td>
<td>Number of nursing and midwife personnel per 1000 population</td>
<td>WHO (Latest Available)</td>
<td>&gt;=3 (Green), &gt;1-3 (Yellow), &lt;1 (Red)</td>
</tr>
<tr>
<td>Health Workforce</td>
<td>Qualitative</td>
<td>Seriousness level:</td>
<td>Number of nursing and midwife personnel experienced in the country (e.g. vacancy rates, turnover, absenteeism) and their impact on service delivery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Green/Yellow/Red scores are assigned based on thresholds determined by Gavi and WHO, with Green indicating a satisfactory level, Yellow indicating an area for improvement, and Red indicating a need for intervention. The exact thresholds vary depending on the indicator and the year.
Afghanistan:

**Context:** Afghanistan represents an extremely challenging environment for the implementation of an immunisation programme. The security situation impacts access to services and the quality of vaccination campaigns, particularly in the low performing districts of Kunar, Nangarhar, Kandahar, Helmand, and Uruzgan. Other factors contributing to challenging planning and implementation and low and very uneven coverage are: geographical barriers, migration and large nomadic populations, lack of accurate information on the size of the population as well as misconceptions around immunisation and gender related barriers.

**Issues:** In addition to coverage and equity, data challenges remain an issue. The WHO/UNICEF immunisation DTP3 coverage estimate is 78%. However age, coverage surveys show a much lower coverage of 59.7% (2013) and huge disparities exist between provinces with variations in the percentage of fully immunised children ranging from 2.5% in Farah province to 86.8% in Paktia province.

**Next steps:** In this context, coverage & equity remains one of the main areas for engagement - with the newly started HSS3 grant funding used for the strengthening of service delivery in hard to reach areas, including through mobile health and outreach services as well as demand generation strengthening. To address the major data issues, Afghanistan was able, due to a country tailored approach, to access its full HSS 2 ceiling with the approval of a Data Quality Improvement Plan (US$ 2.3 million budget). The aim of DQIP is to strengthen administrative data collection capacities and the reporting system, aiming to reduce the gap between administrative coverage data and survey coverage data. Strengthening of the supply chain will also be another main area for engagement and the country will be supported in the re-submission of a CCEOP application planned for September 2017.
**Afghanistan**

**Country Summary Sheet**

**Tier 1 country**

<table>
<thead>
<tr>
<th><strong>Gavi Engagement</strong></th>
<th><strong>Key Information</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Top 3 Areas for Gavi Engagement</strong></th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equity &amp; coverage</strong></td>
<td>HSS-3 focuses on reaching children in hard to reach areas, e.g. through mobile health and outreach activities</td>
<td>Data quality - $2.3M Data Quality Improvement Plan currently being implemented, with a focus on improving admin data</td>
<td>Supply chain - HSS-3 focus on improving and expanding equipment; re-submission of CCEOP in September 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Area</strong></th>
<th><strong>Status &amp; Trend</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>- While WUENC data show 78% DTP3 coverage, coverage is likely to be lower, given WUENC grade of confidence is low and recent surveys indicate that coverage is much lower (58% in 2014). Data do however show a steady progress in coverage rates. WUENC also shows a low MCV2 coverage, with an estimate of 39%. - A Measles campaign that started in 2016 will continue into 2017 and a Polio campaign was conducted in early 2017.</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>- There are large inequities linked to wealth and mothers’ education, with 22 and 17 percentage point differences in DTP3 coverage in 2014. - There are important inequalities in coverage between provinces (only 2.5% of children are fully immunised in Farah and 86.8% in Paktia) as well as between urban/rural. Gender related barriers to access are also important with women not allowed to travel to health centres. - A 2017 coverage survey will provide insights into progress and challenges.</td>
</tr>
<tr>
<td><strong>Demand</strong></td>
<td>- Latest EVMA assessment in 2014 shows an aggregate score of 77%. - Key supply chain challenges relate to a lack of equipment in hard to reach, low coverage areas as well as obsolete equipment and insufficient storage capacity. - The IRC in March 2017 requested Afghanistan to resubmit a CCEOP application with stronger analysis underpinning the choice of equipment and deployment plan. The country plans to resubmit in September 2017.</td>
</tr>
<tr>
<td><strong>Supply Chain</strong></td>
<td>- Data quality is a major and well recognised issue in the country, as evidenced by the large discrepancy between admin and survey data (47 percentage point difference in 2014). - A $2.3 million Data Quality Improvement Plan (DQIP) is currently being implemented, with a focus on improving admin data (e.g. training of health workers on data collection, standardisation of reporting, addressing of denominator issues). - With the implementation of the Data Quality Improvement Plan (DQIP) over the coming 3 years, data quality is expected to improve.</td>
</tr>
<tr>
<td><strong>Data Quality</strong></td>
<td>- The MoPH is strongly committed to immunisation, however, fiscal space is restricted with approximately 50% of the national budget spent on addressing security issues, resulting in only 5% of immunisation activities funded by the government. - The country has not defaulted in the past years. However, the EPI programme is completely dependent on donor funding. Introduction of HR has been delayed due to the country’s inability to meet the co-financing requirement</td>
</tr>
<tr>
<td><strong>Financing &amp; Sustainability</strong></td>
<td>- Funds for HSS2 were not channelled through the government. However, following the recommendations of the 2016 PCA, approx. 90% of HSS-3 funds are now channelled through the government. UNICEF receives funds related to cold chain and infrastructure investments (44%) and WHO manages approx. 5%. - Service delivery is almost entirely implemented by NGOs managed by the MoPH. 10 implementing NGOs have been assessed.</td>
</tr>
<tr>
<td><strong>Financial Management &amp; Fiduciary Risk</strong></td>
<td>- The MoPH team is technically strong, however the team has been understaffed and profiles do not always match the required skillset. - EPI team capacity is improving with 8 TCA funded UNICEF staff embedded (e.g. in M&amp;E, communication) - The ICC functions on a relatively high level - with regular meetings and broad representation. Some further strengthening measures to improve oversight have been implemented following the PCA</td>
</tr>
<tr>
<td><strong>Programmatic &amp; Institutional Capacity (LMC)</strong></td>
<td>- Completed HSS 2 grant showed relatively strong achievement of HSS intermediate results, with 80% of targets achieved. - The country has recently started implementation of the HSS3 support, with a main focus on coverage and equity and supply chain. - There were delays in starting HSS3, mainly due to the fact that the PCA process took longer than expected.</td>
</tr>
<tr>
<td><strong>HSS grant</strong></td>
<td>- A key challenge relates to the very low density (0.36 nursing/midwife personnel per 1,000 population) and uneven distribution of staff. According to WHO, Afghanistan is well under the minimum level necessary to provide essential services. An estimated 8% of the population do not have access to health services at all. - Service delivery is almost entirely carried out by NGOs and is mostly donor funded</td>
</tr>
</tbody>
</table>

Annex F: Country Summary Sheets
Chad:

**Context:** Chad's political and economic situation remains unstable and security remains an issue in many parts of the country, effectively restricting access to health services. Chad's DTP3 coverage is one of the lowest in Gavi's portfolio with very weak health systems, as also illustrated by recent Measles outbreaks. For 2017, several campaigns (measles and meningitis) are planned, which might further negatively affect routine immunisation efforts in the country. As the IRC has asked the country twice to resubmit its HSS proposal (next submission expected early 2018) a bridge funding has been agreed on. The purpose of the bridge funding is to build capacity in the central EPI team to, among others, enable the country to re-submit a HSS proposal and to support service delivery.

**Issues:** Chad is one of the most complex countries in Gavi's portfolio. Its immunisation coverage is poor and has been stagnating for several years. Main barriers to immunisation include geography (e.g. widely dispersed populations, hard to reach areas), and this is compounded by a lack of outreach services and a lack of community awareness (demand) of immunisation services. Chad's overall health system is also very weak, including in particular with respect to its EPI management and coordination capacity. The country's cold chain is weak, particularly at peripheral levels. Further, data quality remains a major issue in Chad.

**Next steps:** In this context, a major focus will be to increased capacities in the EPI team/MoH health teams through technical assistance (through PEF). In addition, Gavi will be supporting the country in its HSS proposal resubmission. Another key area for engagement will be the management of fiduciary risks, with an audit planned in June 2017.
## Chad
### Country Summary Sheet
#### Tier 1 country

### Country General Information

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Value</th>
<th>Gavi 68 rank</th>
<th>Vaccine introductions</th>
<th>Fragility status</th>
<th>Risk category</th>
</tr>
</thead>
<tbody>
<tr>
<td>under-immunised (DTP3)</td>
<td>2015</td>
<td>3m</td>
<td>11</td>
<td>Introduced</td>
<td>Fragile</td>
<td>High</td>
</tr>
<tr>
<td>% GPF targets achieved</td>
<td>2015</td>
<td>42%</td>
<td>31</td>
<td>Expected</td>
<td>MenA</td>
<td></td>
</tr>
<tr>
<td># PEF positions funded</td>
<td>2016</td>
<td>7</td>
<td>6</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Vaccine introductions

- **Penta, IPV, YF**

### Disbursements (all time)

<table>
<thead>
<tr>
<th>Type</th>
<th>Cash</th>
<th>Disbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitments</td>
<td>$18m</td>
<td>$49m</td>
</tr>
<tr>
<td>Vaccine</td>
<td>$15m</td>
<td>$46m</td>
</tr>
</tbody>
</table>

### Top 3 Areas for Gavi Engagement

1. **Coverage**
   - The country has one of the lowest DTP3 coverages in the Gavi portfolio, with 56% DTP3 coverage in 2015 according to WUENIC.
   - Coverage has been stagnating or declining in the past years due to, among others, the country’s overall weak health system and low capacity in the MoH and EPI team, and more recently several months of public service disruption due to national strike.
   - Health workforce is a major issue in the country, leading to frequent disruptions of immunisation delivery services.

2. **Equity**
   - Wealth and maternal education inequities remain a challenge, with 16 and 23 percentage point differences in DTP3 coverage in 2010.
   - Geographic inequities are also a key barrier, with only 60% of districts above 80% DTP3 coverage according to administrative data in 2015.
   - Due to major data quality issues, this figure is likely to be much lower.

3. **Demand**
   - Key barriers to demand are often aligned to religious affiliations. 53% of the population in Chad is Muslim and a 2015 MICS survey found that vaccine hesitancy ratio is 2.2 times higher in the Muslim population than in the Christian population.

### Key information

- **Coverage**
  - Latest EVMA assessment in 2015 shows a low aggregate score of 60%
  - The country has applied for CCEOP as part of its HSS package - However, HSS will need to be resubmitted in 2018
  - As part of the application for the HSS grant, the country is planning to invest in cold chain, logistics and improved supply chain

- **Equity**
  - Data quality is a major issue in the country - there is a 40 percentage point discrepancy between administrative and survey data, according to latest available survey data in 2010.
  - Data issues exist at all levels: regarding data collection, data analyses, triangulation, and utilization. The entire HIMS system requires major strengthening. Gavi and partners will support the country developing this plan to strengthen national HIMS that will be partly funded via in coming Gavi and other partners grants.
  - Data quality is a major issue in the country - there is a 40 percentage point discrepancy between administrative and survey data

- **Demand**
  - Latest EVMA assessment in 2015 shows a low aggregate score of 60%
  - The country has applied for CCEOP as part of its HSS package - However, HSS will need to be resubmitted in 2018
  - As part of the application for the HSS grant, the country is planning to invest in cold chain, logistics and improved supply chain

- **Supply Chain**
  - Data quality is a major issue in the country - there is a 40 percentage point discrepancy between administrative and survey data, according to latest available survey data in 2010.
  - Data issues exist at all levels: regarding data collection, data analyses, triangulation, and utilization. The entire HIMS system requires major strengthening. Gavi and partners will support the country developing this plan to strengthen national HIMS that will be partly funded via in coming Gavi and other partners grants.

- **Data Quality**
  - The country's health budget has been cut by 50% in the past years, reflecting a decrease in oil revenues. As a result, the country's health system is deteriorating (e.g. health workers are not being paid regularly and strikes are frequent).
  - Despite these challenges, 38% of routine immunisation expenditure is funded by the government, and co-financing obligations have been met on-time.
  - Political commitment exists, e.g. the President supports cold chain investments and the first Lady is a strong supporter of immunisation efforts.

- **Financial Management & Fiduciary Risk**
  - A programme audit is planned for Q2 2017 and may uncover past misuse of funds
  - Bridge funding is mainly channelled through UNICEF to decrease fiduciary risks
  - In addition, financial reporting compliance was only partially met in 2015

- **Programmatic & Institutional Capacity (LMC)**
  - A PCA has revealed that the National EPI team is understaffed and lacks the required capabilities to manage the EPI programme - for example, there are only 3 team members with limited skill sets
  - Similarly, the planning department, responsible to submit the new HSS proposals, is inadequately staffed
  - LMC - strengthen capacities and capabilities in the EPI team

- **HSS grant**
  - HSS proposals have been rejected by the IRC for the past 2/3 years - due to poor quality of submission
  - Gavi has unlocked a bridge funding of $750k (approved by IRC in November 2016) - originally planned to last until the successful resubmission of the HSS proposal in 2017 (which will now need to be re-submitted in early 2018)
  - The bridge funding is mainly used to build capacity to enable the country to re-submit a HSS proposal and to support service delivery in some districts

- **Health Workforce**
  - Health workforce is a major issue in the country
  - Due to the irregular payments of salaries the health workforce has been frequently on strike for the past year. This has resulted in interruptions of immunisation delivery services.
### Democratic Republic of Congo:

"Country Narrative is in Annex D to the Alliance update on Country Programmes"

#### Gavi General Information

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Value</th>
<th>Gavi 68 rank</th>
</tr>
</thead>
<tbody>
<tr>
<td># under-immunised (DTP3)</td>
<td>2015</td>
<td>6m</td>
<td>5</td>
</tr>
<tr>
<td>% GPF targets achieved</td>
<td>2015</td>
<td>33%</td>
<td>41</td>
</tr>
<tr>
<td># PEF positions funded</td>
<td>2016</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

#### Vaccine introductions

- **Introduced**
  - Penta, IPV, PCV, YF
- **Expected**
  - Rota, HPV, MenA, MR1

300,000 doses are available for the recent Ebola outbreak

#### Gavi commitments vs disbursements (all time)

<table>
<thead>
<tr>
<th>Type</th>
<th>Commitments</th>
<th>Disbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$290m</td>
<td>$212m</td>
</tr>
<tr>
<td>Vaccine</td>
<td>$585m</td>
<td>$463m</td>
</tr>
</tbody>
</table>

### Top 3 Areas for Gavi Engagement

<table>
<thead>
<tr>
<th>Area</th>
<th>Status &amp; Trend</th>
<th>Key information</th>
</tr>
</thead>
</table>
| Coverage | ![Icon] | • Coverage has overall increased (notably for DTP3 and PCV. 81% and 73%, respectively, according to 2015 WUENIC estimates) in the past few years thanks to major efforts in improving vaccine distributions and in monitoring stock outs. However, data quality remains an issue - WUENIC estimates received the lowest grade of confidence.  
• The country is experiencing disease outbreaks (recent measles, men A, yellow fever) and relies on campaigns to fight the outbreaks (measles campaigns in 2016 and in 2017 and three yellow fever campaigns in 2016). The country will need to strengthen its routine immunisation and introduce second dose for measles. |
| Equity | ![Icon] | • Key barriers to equity are socio-economic (35% and 31 percentage point differences in DTP3 coverage in wealth and maternal education in 2012) and geographic (access to some areas is difficult due to their geographic location or conflict). Some provinces can only be accessed by air and others have low infrastructure, such as low quality of roads). 
• Part of the geographical equity challenge is being addressed through the HSS2 grant which includes supporting the rehabilitation of health centres in remote areas, providing warehouses at the provincial level and procuring and/or maintaining of vehicles (boats, motorcycles) to reach remote areas. |
| Demand | ![Icon] | • Key barriers to demand are linked to security (conflicts around country borders) and to religious affiliations (some populations, e.g. in Katanga, are scared of using vaccines due to their religion's position on immunisation).  
• The population is often not aware of campaigns currently on-going in the country - this is partly due to communication / planning issues but also partly due to weak demand |
| Supply Chain | ![Icon] | • Latest EVMA assessment in 2014 showed an aggregate score of 61%  
• In the past, DRC has suffered from important cold chain system and capacity challenges  
• The HSS2 grant has brought great achievements regarding storage capacity by increasing the coverage of cold chain from 14% to 55% - enabling the country to receive the needed quantity of vaccines, avoid stock outs and be able to introduce the rota vaccine  
• The country has been approved for CCEOP in 2016 for an additional 2000 solar refrigerators. This would increase the cold chain capacity of the country from 55% to 74%. |
| Data Quality | ![Icon] | • Poor quality of health data is a recurring issue in DRC - there is a 32 percentage point difference between admin and survey, according to the latest survey data available (DHS completed in 2014).  
• A data quality improvement plan was developed in 2015. As a result, data tools and connectivity within the country have been improved. However it requires now a mid-term review, update and power up  
• DHIS2 needs to be further developed to incorporate EPI dashboard, data quality app, link with DVD MT and IMT in order to increase utilisation of data and data to be used for timely decision making. |
| Financial & Sustainability | ![Icon] | • The country has defaulted in the past years (2015 and 2016)  
• Although the country's contribution to immunisation expenditure is very low (3%), it has increased over the last year while the overall health budget has substantially decreased in the same time period. |
| Financial Management & Fiduciary Risk | ![Icon] | • A 2015 audit revealed questioned expenditures of approximately $1.2 m of Gavi funds.  
As a result a fiduciary agent has been installed, and funds have been channelled through partners  
In 2015, financial reporting compliance was partially met. |
| Programmatic & Institutional Capacity (LMC) | ![Icon] | • The national EPI team appears over-staffed with approximately 130 people. The team's structure as well as team members' roles and responsibilities are in need of review to ensure greater efficiency in the team.  
• Skilled staff find more lucrative employment outside of the EPI/MoH team, the EPFs overall skill level tends to be low  
• ICC is very well organised (meeting regularly), however, representation should be aligned with Gavi's guidance |
| HSS grant | ![Icon] | • HSS2 is currently on-going, with a main focus on supply chain, including cold chain equipment (93$m out of 144$m)  
• HSS2 has so far been successful (renovation and extension of storage space of 10 regional distribution stores (CDS) - 5 of which were renovated jointly with the Global Fund. Moreover, 43 health centres have been renovated and construction of 3 vaccine and essential drugs commodity Hubs (warehouses) in Kinshasa, Lubumbashi and Kisangani is progressing)  
• Achievement of intermediate results was low in 2015 (25%) because only procurement funds have been able to be unlocked - the result is expected to be higher in 2016 as other types of funds have been used as well  
• Human resources is a challenge in DRC - there are only .96 nurse/midwife per 1,000 population. Many health workers are not paid regularly or do not at all receive a salary and therefore prefer to engage in activities that guarantee remuneration, such as per diims from campaigns, etc. |
| Health Workforce | ![Icon] | • Health workforces are generally under-funded and are often not adequately trained. There are also concerns regarding the quality of care provided, particularly in rural areas.  
• The national EPI team appears over-staffed with approximately 130 people. The team's structure as well as team members' roles and responsibilities are in need of review to ensure greater efficiency in the team.  
• Skilled staff find more lucrative employment outside of the EPI/MoH team, the EPFs overall skill level tends to be low  
• ICC is very well organised (meeting regularly), however, representation should be aligned with Gavi's guidance |

### Annex F: Country Summary Sheets

DRC Country Summary Sheet
Tier 1 country
Country General Information

- **Co-financing group**
- **Fiscal self-financing**
- **Fragility status**
- **Frailty rank**
- **Vaccine introductions**
  - Pentax, IPV, PCV, YF
  - Rota, HPV, MenA, MR1

Top 3 Areas for Gavi Engagement

1. Coverage
2. Equity
3. Demand

Key information:

- Coverage has overall increased (notably for DTP3 and PCV. 81% and 73%, respectively, according to 2015 WUENIC estimates) in the past few years thanks to major efforts in improving vaccine distributions and in monitoring stock outs. However, data quality remains an issue - WUENIC estimates received the lowest grade of confidence.
- The country is experiencing disease outbreaks (recent measles, men A, yellow fever) and relies on campaigns to fight the outbreaks (measles campaigns in 2016 and in 2017 and three yellow fever campaigns in 2016). The country will need to strengthen its routine immunisation and introduce second dose for measles.
- Key barriers to equity are socio-economic (35% and 31 percentage point differences in DTP3 coverage in wealth and maternal education in 2012) and geographic (access to some areas is difficult due to their geographic location or conflict). Some provinces can only be accessed by air and others have low infrastructure, such as low quality of roads).
- Part of the geographical equity challenge is being addressed through the HSS2 grant which includes supporting the rehabilitation of health centres in remote areas, providing warehouses at the provincial level and procuring and/or maintaining of vehicles (boats, motorcycles) to reach remote areas.
- Key barriers to demand are linked to security (conflicts around country borders) and to religious affiliations (some populations, e.g. in Katanga, are scared of using vaccines due to their religion's position on immunisation).
- The population is often not aware of campaigns currently on-going in the country - this is partly due to communication / planning issues but also partly due to weak demand.
- Latest EVMA assessment in 2014 showed an aggregate score of 61%.
- In the past, DRC has suffered from important cold chain system and capacity challenges.
- The HSS2 grant has brought great achievements regarding storage capacity by increasing the coverage of cold chain from 14% to 55% - enabling the country to receive the needed quantity of vaccines, avoid stock outs and be able to introduce the rota vaccine.
- The country has been approved for CCEOP in 2016 for an additional 2000 solar refrigerators. This would increase the cold chain capacity of the country from 55% to 74%.
- Poor quality of health data is a recurring issue in DRC - there is a 32 percentage point difference between admin and survey, according to the latest survey data available (DHS completed in 2014).
- A data quality improvement plan was developed in 2015. As a result, data tools and connectivity within the country have been improved. However it requires now a mid-term review, update and power up.
- DHIS2 needs to be further developed to incorporate EPI dashboard, data quality app, link with DVD MT and IMT in order to increase utilisation of data and data to be used for timely decision making.
- The country has defaulted in the past years (2015 and 2016).
- Although the country's contribution to immunisation expenditure is very low (3%), it has increased over the last year while the overall health budget has substantially decreased in the same time period.
Ethiopia:

**Context:** Ethiopia is the second largest recipient of Gavi funds since inception. Political will is overall strong at the national level, however, due to the decentralised nature of the country, there is a need to work with the sub-national level to advocate for the prioritisation of health and immunisation at sub-national levels. The country has experienced political unrest over the past year with a state of emergency being declared in 2016 following anti-government protests and a cabinet reshuffling at the end of 2016. Gavi HSS funds in Ethiopia are managed through a pooled funding mechanism where the core principle is ‘1 plan, 1 budget, 1 report’; other contributors to the pooled fund include the UK; Spain; Netherlands; Australia; Ireland; UNFPA; UNICEF; the World Bank; the EU; Italy; WHO; Sweden and Canada.

**Issues:** Data quality is one of the major challenges in the country, evidenced by significant variations across different sources of data e.g. administrative data (96% DTP3 coverage in 2015) and survey data (53% DTP3 coverage as per 2016 Demographic and Health Survey). Equity remains a key issue within Ethiopia with significant regional, socio economic and educational inequities. Financing of health is not sustainable as half of the health sector funding is being supplied by donors.

**Next steps:** One of the key areas for engagement is data quality - the government has, for example, worked, through the pooled fund, to invest in strengthening the HMIS and community health information systems. Partner investment is vital to having only one platform for data (data repository). The need to improve data at the national and subnational level is moreover emphasised by the Alliance. Equity remains a key area of engagement - the government is for example targeting pastoral areas (e.g. by improving service delivery) to reach more hard to reach populations. Supply chain remains another area for engagement with a large share of the pooled fund (~80%) being directed at the procurement of health equipment and commodities.
Country General Information

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Value</th>
<th>Gavi 6l rank</th>
<th>Vaccine introductions</th>
<th>Gavi commitments vs disbursements (all time)</th>
</tr>
</thead>
<tbody>
<tr>
<td># under-immunised (DTP3)</td>
<td>2015</td>
<td>4m</td>
<td>6</td>
<td>Introduced: Penta, IPV, PCV, Rota</td>
<td>Type: Cash</td>
</tr>
<tr>
<td>% GPF targets achieved</td>
<td>2015</td>
<td>73%</td>
<td>8</td>
<td>Expected: HPV, YF, MenA, MMR1, MMR2</td>
<td></td>
</tr>
<tr>
<td># PEF positions funded</td>
<td>2016</td>
<td>14</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Risk category</th>
<th>Highest</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Vaccine introductions</th>
<th>Gavi commitments vs disbursements (all time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduced: Penta, IPV, PCV, Rota</td>
<td>Type: Cash</td>
</tr>
<tr>
<td>Expected: HPV, YF, MenA, MMR1, MMR2</td>
<td>Commissions: $307m</td>
</tr>
</tbody>
</table>

Top 3 Areas for Gavi Engagement

1. **Coverage**
   - WUENC DTP3 coverage has increased between 2011 and 2014 - to a level of 86% in 2015. However, 2012 coverage survey was 65% and 2016 DHS survey for DTP3 coverage is far lower (53%) and there is currently a high risk that coverage decreases due to political unrest in the country (a nationwide state of emergency has been in place since October 2016) as well as food supply issues.
   - measles campaigns have already taken place in 10 regions. Somali region had a delayed start due to low readiness and the current drought which has delayed implementation.

2. ** Equity**
   - Key barriers to equity are socio-economic (39 and 34 percentage point difference in DTP3 coverage in wealth and maternal education in 2016, respectively), related to education (there is a drop in Penta3 coverage by 33.7% between those with high and this with no/low education level) and related to geography.
   - There are significant regional disparities with persistently low coverage in pastoral areas of Somali, Afar, and Gambella (a 2015/16 annual Health Sector performance report showed full immunisation coverage of 100% in Addis Ababa while Gambella had the lowest coverage of 55.2%). Of concern is that regions with large population are poorly performing (8bn the last DHS (Amhara 63.8%).

3. **Demand**
   - Key barriers to demand are geographic (with lowest demand in areas where access to health facilities is difficult).
   - To address some of the demand barriers, the government has taken actions e.g. engaging community and religious leaders, equipping community social mobilisation committees with necessary information on vaccination programmes, strengthening engagement of CSOs, developing and implementing the Routine Immunisation Improvement Plan as a strategy for improving access and creating demand for routine immunisation, and implementing a Health Development Army (HDA) to create awareness and demand for healthcare at community level.

Data Quality

- Data quality is a major issue in the country, as evidenced by the large discrepancy between admin and survey data (27 percentage point discrepancy between administrative and survey data in 2016).
- The government has undertaken efforts to improve the situation (for example through the creation of a single platform for data (data repository), annual data quality audits, service availability and readiness assessments, and the 2017 decision to adopt DHIS2 as the platform for data collection.)

Financing & Sustainability

- Ethiopia has historically fulfilled its co-financing requirements on time (with the exception of a small amount of the country's 2014 obligations that was paid late due to a confusion over the co-financing requirements).
- However, nearly half of the health sector support is donor funded which is not sustainable given that Ethiopia is projected to be a lower-middle income country by 2025.
- Political will is high at the national level. However, due to the decentralised nature of the country, there is a need to work with the sub-national level to advocate for the prioritisation of health and immunisation.

Financial Management & Fiduciary Risk

- An audit has been finalised in Feb 2017. It covered the period 1 January 2013 to 31 December 2015. An amount of USD 378,011 was questioned by the audit, related to inadequate management of budgets to ensure that grants are only used for Gavi approved activities. There are also recurring delays regarding invoice submission and payments - showing weak capacity and inadequate supervision.
- All cash grants (HSS, VIGs and operational costs) are channelled through the government. However, the HSS grant is managed through a pooled funding mechanism; other partners channelling funds through the pooled fund include: the UK; Spain; Netherlands;
- National EPI team is currently not adequately staffed - WHO is currently filling some key positions through secondes.
- ICC does exist - it meets regularly and includes all relevant stakeholders (CSO, WHO, UNICEF DFID, BMGF, etc.)

Programmatic & Institutional Capacity (LMC)

- The HSS grant is managed through a pooled funding mechanism called the Sustainable Development Goal Performance Fund (SDG PF). Gavi monitors the performance of the pooled fund through quarterly updates.
- Historically, around 80% of the pooled fund have been used for the procurement of health commodities

HSS grant

- There is a shortage of skilled human resources, and high turnover of skilled health workers due to low salaries in the public sector.
- The government has deployed 38,000 health extension workers (HEWs) to the community level to deliver preventive and promotive services, including immunisation.

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**Ethiopia Country Summary Sheet**

**Tier 1 country**

**Co-financing**

- The government has targeted, through the Pooled Fund mechanism, pastoral areas to reach more of the 'hard to reach' populations - e.g. through improving service delivery

**Supply chain**

- A large share of the Pooled Fund (~80%) is targeting procurement of health equipment and commodities.

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**Annex F: Country Summary Sheets**
Indonesia:

Context: Indonesia has transitioned from Gavi support for pentavalent vaccine in 2016. It will receive catalytic support for the introduction of MR and JE (in 2017) as well as for an HPV demonstration project (mid-2017 to mid-2019). The government has requested continued support for the introduction of new vaccines beyond Gavi transition, indicating that mobilising funds for the introduction is challenging, while continuation of funding for already introduced vaccines can be ensured.

HSS implementation, ongoing since 2008, has suffered from poor coordination and management and a very slow rate of implementation. Since implementation has now improved, the country has been granted a no-cost extension for the HSS grant until July 2017. In addition, a two-year plan to sustain the benefits of Gavi support, as Indonesia transitions from Gavi, and advancing the agenda on reaching the unreached, is currently under development using the unspent cash balances from Gavi vaccine and cash support. Partner technical assistance, in some cases financially supported by Gavi, has been instrumental in supporting the EPI programme management to date and will be critical for ensuring the sustainability of investments. Global and regional benchmarks indicate that Indonesia’s expenditure on health is very low, currently at 3.1% of its GDP. As Indonesia has transitioned from Gavi financing, it will be necessary to remove certain institutional constraints in order to improve coverage rates and expand immunisation services. Sustaining technical capacities in the MoH, including in such areas as planning, budgeting, surveillance and communication will also be important to sustain immunisation outcomes.

Issues: Equity remains of concern: While there is almost no difference in immunisation coverage by sex, a big gap exists in coverage between wealth quintiles (85% versus 52% between highest and lowest) and there is also wide geographical variation between provinces, with several, such as Papua (35%) and West Sulawesi (58%) being far from their targets. Hard to reach areas are in remote, sparsely populated eastern provinces and in urban slums. Data quality also remains a major issue in the country, as evidenced by the large discrepancy between admin and survey data regarding population estimates.

Next steps: Coverage & equity remains one of the key areas of focus for Gavi engagement, notably through the CESAP (Coverage, Equity and Sustainability Action Plan), aiming to reach the fifth child. As Indonesia has transitioned out of Gavi support, financing and sustainability is the other main area for engagement, with Gavi ensuring that the country has the capacity to finance new vaccine introductions after its transition. In addition, cold chain is a focus with Gavi currently supporting a cold chain inventory in 15 provinces, including assessment, guidelines and trainings for private health providers.
Indonesia
Country Summary Sheet
Tier 1 country

Gavi funding | Ongoing
---|---
Co-financing group
Fully self-financing
Vaccine introductions
Fragility status | Not fragile
Risk category | Relatively high

| Indicator | Year | Value | Gavi 68 rank |
|---|---|---|---|---|
| # under-immunised (DTP3) | 2015 | 39m | 4 |
| % GPF targets achieved | 2015 | 70% | 11 |
| # PEF positions funded | 2016 | 2 | 27 |

Gavi commitments vs disbursements (all time)

<table>
<thead>
<tr>
<th>Type</th>
<th>Commitments</th>
<th>Disbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$63m</td>
<td>$58m</td>
</tr>
<tr>
<td>Vaccine</td>
<td>$113m</td>
<td>$74m</td>
</tr>
</tbody>
</table>

Top 3 Areas for Gavi Engagement

1. Coverage & equity - ensuring that the immunisation programme reaches the 5th child, through, amongst other CESAP (Coverage, Equity and Sustainability Action Plan) which targets action to districts with high number of unimmunised/partially immunised children, particularly at sub-national level. Gavi is currently supporting cold chain inventory in 15 provinces, including assessment, guidelines and trainings for private health providers. Gavi also supports the review of Immunisation regulations.

2. Financing of new vaccine introductions - notably through enhancing the technical capacity of national officers; improving data and surveillance capacity; advocating for immunisation to national stakeholders / decision-makers; and contributing to relevant studies.

3. Health Workforce - Each puskesmas (health centre) has its own EPI coordinator. There is however a high turnover, with limited training opportunities and often low capacity.

<table>
<thead>
<tr>
<th>Area</th>
<th>Status &amp; Trend</th>
<th>Key information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td></td>
<td>• Coverage for DTP3, measles and polio has remained stagnant for many years. DTP3 coverage is lower than 80% in Papua and &lt;50% in West Sulawesi.</td>
</tr>
<tr>
<td>Equity</td>
<td></td>
<td>• There are large inequities in wealth and mother’s education, with 33 and 55 percentage point differences in DTP3 coverage in 2011, respectively.</td>
</tr>
<tr>
<td>Demand</td>
<td></td>
<td>• Trend in demands are hard to assess as it highly depends on provinces</td>
</tr>
<tr>
<td>Supply Chain</td>
<td></td>
<td>• Although being at good levels overall (The National Vaccine Store scored a perfect 100%), there are still some gaps in supply chain at sub-national level</td>
</tr>
<tr>
<td>Data Quality</td>
<td></td>
<td>• Data quality remains a major issue in the country, as evidenced by the large discrepancy between admin and survey data.</td>
</tr>
<tr>
<td>Financing &amp; Sustainability</td>
<td></td>
<td>• Although recent improvements on monitoring and reporting for HSS, there has historically been poor understanding of results achieved with HSS support.</td>
</tr>
<tr>
<td>Financial Management &amp; Fiduciary Risk</td>
<td></td>
<td>• HSS fund utilisation is low due to the bureaucratic system - it takes a lot of time to get approvals. In 2015 only 30% of the HSS fund was used.</td>
</tr>
<tr>
<td>Programmatic &amp; Institutional Capacity (LMC)</td>
<td></td>
<td>• The national leadership and management capacity is strong. The EPI team is well resourced and has the capabilities required to manage the EPI programme</td>
</tr>
<tr>
<td>HSS grant</td>
<td></td>
<td>• The country currently has seven grants on-going, mainly focused on MR, HPV, JE, IPV and the CESAP.</td>
</tr>
<tr>
<td>Health Workforce</td>
<td></td>
<td>• The coverage in Papua, Banten, Maluku, West Sulawesi is generally low</td>
</tr>
</tbody>
</table>

Annex F: Country Summary Sheets
Kenya:

**Context:** Kenya’s health sector has been negatively impacted by devolution which has resulted in that all of the 47 counties have significant autonomy regarding their health programmes. Health is one of the most decentralised government functions, with all operational aspects of EPI being decentralised to the county level, and only key policy functions remaining at national level. Kenya is just starting a new HSS grant, the previous one having ended in 2012. However, elections will take place in August this year, and it is likely that immunisation related activities will slow down in the run up and aftermath to the elections. Kenya is also prone to natural disasters that can impact immunisation outcomes in the counties - for example the current drought affects a large share of counties.

**Challenges:** Kenya is one of the countries within the Gavi portfolio where fiduciary risk is particularly high - with significant misuse of funds as per 2015 audit ($1.6m). Equity also remains another key challenge, with numerous remote areas and nomadic populations that are hard to reach, and major urban slums. Progress on equity has stagnated in the past few years due to the devolution (counties are frequently not prioritising the provision of immunisation). Supply chain is also a major concern, with poor management of vaccines and record keeping.

**Next steps:** As a result of the fiduciary risk in the country, Gavi has channelled support only through partners in the past years, and strongly encourages procurement in HSS proposal to be undertaken through partners, with additional assurance than normal (coming at an increased cost to Gavi). Kenya will start a new HSS grant this year, the last one having been closed in 2012. This grant will help addressing coverage and equity issues posed since the devolution. Gavi will also focus on strengthening data quality which has significantly decreased since devolution.
**Kenya**

**Country Summary Sheet**

**Tier 1 country**

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### Gavi Co-financing Group

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Value</th>
<th>Gavi 68 rank</th>
</tr>
</thead>
<tbody>
<tr>
<td># under-immunised (DTP3)</td>
<td>2015</td>
<td>2m</td>
<td>21</td>
</tr>
<tr>
<td>% GPF targets achieved</td>
<td>2015</td>
<td>11%</td>
<td>65</td>
</tr>
<tr>
<td># PEF positions achieved</td>
<td>2015</td>
<td>4</td>
<td>15</td>
</tr>
</tbody>
</table>

### Vaccine Introductions

- Introduced: Penta, IPV, PCV, Rota, YF, MR
- Expected: HPV, MenA

### Gavi Commitments vs Disbursements (all time)

<table>
<thead>
<tr>
<th>Type</th>
<th>Commitments</th>
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<tr>
<td>Vaccine</td>
<td>$398m</td>
<td>$394m</td>
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</tbody>
</table>

---

### Key Information

**Coverage**

- **Latest EVA** assessment in 2014 showed an aggregate score of 56%.
- The main challenges are poor management of vaccines and lack of record keeping (e.g. history of unaccounted doses of PCV identified through Gavi audit).
- Country has been approved for CCEOP - due to start in 2017.
- Gavi is facilitating a private sector partnership with DHL to support with developing a VAN (vaccine analytics network) to provide more visibility over vaccine supply chain.

**Equity**

- Key barriers to equity are mainly geographic with remote arid/semit arid areas and nomadic populations - making it difficult to reach populations. There is also a high number of unimmunised children in urban slum areas, notably in Nairobi.
- Wealth and maternal education inequities remain a challenge, with 9 and 16 percentage point differences in DTP3 coverage in 2014.
- Since devolution, counties have full autonomy over their health (and immunisation) programmes and immunisation budgets; they vary in their commitment to prioritising immunisation in their budgets.

**Data Quality**

- Data quality is one of the key issues in the country - DTP3 administrative estimates (81%) are lower than survey data (90%), which is highly atypical and likely a result of an overestimation of the denominator.
- Data quality has decreased in the past years following devolution, with data not being well captured at county level, frequently due to vaccine registers not being available, and lack of trained staff.

### Health Systems Strengthening - start of a new HSS grant to help address coverage and equity issues and the challenges posed by devolution.

- The country has just started a new grant - the last grant has ended in 2012.
- Coverage for DTP3 is high (89% in 2015 according to WUENIC - however, it has stagnated / decreased in the past few years (according to admin / JRF data respectively) since devolution in 2013 (commitment and prioritisation of EPI varies widely across the 47 counties).
- MR campaign took place in May 2016 with 96% coverage.

### Financial Management & Fiduciary Risk

- There was a misuse of funds of approximately $1.6m as per 2015 audit, although the mis-used funds have been fully reimbursed.
- Fiduciary risk remains inherently high in Kenya, notably as the country structures are still nascent, and particularly during an election year.
- Gavi has decided to route funds through UNICEF with enhanced safeguards for at least the next year and, whilst this reduces the residual risk for Gavi in the shorter term, we leave the rating as high risk due to the longer term preference for routing funds through the MoH when the necessary safeguards are in place. Funds are also being channelled directly from Gavi to the CSO partner on the HSS project, KANCO, a PR for Global Fund, with fiduciary oversight from an in-country monitoring agent.

### Financial Management & Fiduciary Risk

- Programmatic & Institutional Capacity (LMC)
- The country has just started a new grant - the last grant has ended in 2012.
- Health worker resourcing tends to be weak due to poor quality of training and irregular payment of salaries.
- Frequent strikes (for example, by doctors striked for 3 continuous months between Nov 2016 and Mar 2017) can paralyse the health system, including immunisation delivery.

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**Annex F: Country Summary Sheets**
**Nigeria**

*Country Narrative is in Annex D to the Alliance update on Country Programmes*

### Country General Information

<table>
<thead>
<tr>
<th>Gavi funding</th>
<th>Co-financing group</th>
<th>Vaccine introductions</th>
<th>Fragility status</th>
<th>Gavi commitments vs disbursements (all time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Year</td>
<td>Value</td>
<td>Gavi 68 rank</td>
<td>introduced</td>
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<tr>
<td># under-immunised (DTP3)</td>
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<td>2.9m</td>
<td>2</td>
<td>Penta, IPV</td>
</tr>
<tr>
<td>% GFP targets achieved</td>
<td>2015</td>
<td>63%</td>
<td>17</td>
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</tr>
<tr>
<td># GPE positions funded</td>
<td>2016</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

**Fiduciary risk** - Following the discovery of mis-use of funds by a 2014 & 2015 audit, 30 recommendations have been developed to decrease fiduciary risk, including e.g. embedding a fiduciary agent and a coordination unit in the NPHCDA.

**CEF** - Work closely with the country and partners on the country’s application under the CEF, which will likely include an application for HSS2, CCE OP, MBD, HPV national and transition grant.

**Data and Demand** - as part of next HSS2 grant a major focus will be placed on data improvement and demand creation.

### Area | Status & Trend | Key information
---|---|---
**Coverage** | ![Up](image) | • Coverage remains low but has seen a modest increase over the past years (from 46% in 2012 to 56% in 2015 as per WUENIC data). This is mainly due to the fact that supply for almost all vaccines has improved after supply shortages in 2011/12 and Gavi support helped to increase service delivery.
• There is a wide variation between the administrative data and WUENIC estimates/CE5.
• Country faces disease outbreaks every year (in particular with respect to measles, Meningitis C & W-in 2017), polio resurfaced in 2016. A follow-up measles SIA in 2017 has been planned.
• Polio campaigns over the years have diverted attention from other routine activities and many health workers prefer to work frequent.
• Government, relying on its admin data, is only gradually acknowledging that there is an issue.
• Data quality is a major issue in the country, as evidenced by the large discrepancy between admin and survey (48 percentage point difference between admin and survey data in 2014).
• Upcoming 2017 coverage survey will assist future planning and investments at national level, including in the area of data improvement.
• Political will: A new Executive Director has joined NPHCDA in January 2017. The new ED visited the Gavi Secretariat in March to share his vision and ambition for the next two years: to re-position NPHCDA so it can fully deliver on its mandate.
• The sustainability of routine immunization is not assured - for example, the country pays only 25% of the cost of vaccines itself; moreover, the federal government has reduced the 2017 health budget.
• Financial & Sustainability
• The 2015 audit revealed misuse of funds on a large scale as well as weaknesses in the country’s financial management systems.
• As a result of the audit, HSS funding was effectively suspended, and campaign funds are channelled only through partners.
• 30 recommendations have been developed to decrease fiduciary risk, including e.g. embedding a fiduciary agent and a coordination unit in the NPHCDA.
• The EPI team has strong technical capacity but lacks managerial capabilities, yet these tend to be underutilised in a system that has been marred with corruption. In addition, the capacity tends to be concentrated at the central level.
• ICC is not fulfilling its role as a strategic oversight body.
• There is inadequate human resources for RI. As states are not always able to pay the salaries of health workers strikes are frequent.
• Polo campaigns over the years have diverted attention from other routine activities and many health workers prefer to work during campaigns, where per diems are guaranteed.
• There is poor reach of immunization programmes, particularly in the northern states and areas affected by conflict.
• There is a wide variation between the administrative data and WUENIC estimates/CE5.
• The government, relying on its admin data, is only gradually acknowledging that there is an issue.
• Data quality is a major issue in the country, as evidenced by the large discrepancy between admin and survey (48 percentage point difference between admin and survey data in 2014).
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• Country faces disease outbreaks every year (in particular with respect to measles, Meningitis C & W-in 2017), polio resurfaced in 2016. A follow-up measles SIA in 2017 has been planned.
• Supply chain has improved at national level with a new vaccine management system (VAN) put in place to have increased visibility on stocks.
• However, supply chain is still very weak at the subnational level.
• Latest EVM assessment in 2014 showed an aggregate score of 60%
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• However, supply chain is still very weak at the subnational level.
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Pakistan:

*Country Narrative is in Annex D to the Alliance update on Country Programmes*

**Country General Information**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Value</th>
<th>Gavi 68 rank</th>
<th>Vaccine introductions</th>
<th>Fragility status</th>
<th>Risk category</th>
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<tbody>
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<td>1.4m</td>
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<td>Introduced</td>
<td>Fragile</td>
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<td>% GPF targets achieved</td>
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<td>Pentax, IPV, PCV, Rota</td>
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<td>2016</td>
<td>17</td>
<td>1</td>
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<td></td>
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**Gavi funding vs disbursements (all time)**

<table>
<thead>
<tr>
<th>Type</th>
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<th>Disbursements</th>
</tr>
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<td>Vaccine</td>
<td>$916m</td>
<td>$806m</td>
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**Top 3 Areas for Gavi Engagement**

1. Coverage - Gavi's HSS-2 funding, through the National Immunisation Support Project, incentivises increases in immunisation coverage and provides tailored support to sub-national immunisation projects to achieve these outcomes. Gavi has high equity within and between provinces. Gavi Alliance and partners provided technical assistance to Provincial programmes in cold chain and demand generation and is piloting new approaches in urban slums.

2. Supply chain - Insufficient supply chain was a key gap to improving the coverage of service delivery and is a strong focus of new support (CCIEOP), technical assistance (funded positions through UNICEF) and a new project to redesign the supply chain system.

3. Preparatory transition - Pakistan has an NIP, the NIP Advisory Board and the national immunisation task force. The NIP Advisory Board meets regularly, the National Advisory Committee on Immunisation Policy (NACIP) needs to be further strengthened. The provinces have an ICC and the ICC meets regularly. There is a large impact on the coverage gap. The NIP Advisory Board meets regularly, the NIP meets regularly, the PACIP needs to be further strengthened. There is a large impact on the coverage gap. The NIP Advisory Board meets regularly, the NIP meets regularly, the PACIP needs to be further strengthened. There is a large impact on the coverage gap.

**Country Summary Sheet**

**Pakistan**

**Tier 1 country**

**Country General Information**

- **Health Workforce**
  - There are ongoing initiatives to engage 'Lady Health Workers' in Routine Immunisation (programme started in 2015). Polio uses vaccinators which otherwise work on Routine Immunisation in campaigns, affecting their availability for RI.
  - There are demand issues in Pakistan caused by numerous factors - notably the lack of knowledge of vaccines benefits and a lack of confidence into the system (lack in consistency and availability of government services).
  - For polio campaigns, vaccinators travel from house to house which raises the expectation that vaccinators will also come to a household for routine vaccination.

- **Programmatic & Institutional Capacity (LMC)**
  - WUENIC data shows stagnating coverage rates (72% in 2015), although some improvements are expected to be shown in an upcoming district-level coverage survey, funded by Gavi. A coverage increase in the largest Province, Punjab (50% of the population), was confirmed via an independent survey in 2016.
  - There are still outbreaks of diphtheria and measles reported in older cohorts of children that need to be monitored in the upcoming years.

- **Fiduciary Risk**
  - There are severe key barriers to achieving equity in immunisation coverage, including geographic and social barriers, which vary in their impact by regions of the country.
  - Health and maternal education inequalities remain a challenge, with 58 and 19 pct. point differences in DTP3 coverage in 2012.
  - Throughout Pakistan, there are differences between rural and urban coverage with low coverage found in urban slum areas.
  - Gavi, with partners, is developing an urban slum strategy for immunisation and targeting service improvements in Pakistan’s largest slum, Karachi.

- **Equity**
  - There is a 29 percentage point difference between administrative and survey, according to the latest survey data available (DHS completed in 2013).
  - Pakistan has defaulted in previous years (2015) due to issues in the government procurement system.

- **Demand**
  - There are several major steps have improved the co-financing arrangement in the last year. (1) The operationalisation of NISP has secured funding for immunisation in budgets until 2020 for vaccines and services. (2) The cabinet has allowed the Ministry to forgo co-financing.

- **Supply Chain**
  - EVM in 2014 showed a score of 61% - Pakistan has an aging cold chain equipment, insufficient number of equipment to improve service availability and reach of services and is currently inefficiently designed with vaccines arriving through one port of entry.

- **Data Quality**
  - EVM in 2014 showed a score of 61% - Pakistan has an aging cold chain equipment, insufficient number of equipment to improve service availability and reach of services and is currently inefficiently designed with vaccines arriving through one port of entry.

- **Financing & Sustainability**
  - Pakistan has a history of defaulting in previous years (2015) due to issues in the government procurement system.
  - While the ICC meets regularly, the oversight function of the ICC needs to be further strengthened. Punjab has drastically improved coverage in the last two years by setting up an accountability system under the chief Minister and by integrating polio and Routine programmes.

- **Financial Management & Fiduciary Risk**
  - There are still outbreaks of diphtheria and measles reported in older cohorts of children that need to be monitored in the upcoming years.

- **Programmatic & Institutional Capacity (LMC)**
  - Devolution required a change in the type of engagement from all partners as provincial governments took over responsibility for health in their provinces.
  - As a result, the current HSS grant is channelled through a Multi Donor Trust Fund managed by the World Bank, which enables disbursements directly to the provincial governments.

- **Health Workforce**
  - There are ongoing initiatives to engage 'Lady Health Workers' in Routine Immunisation (programme started in 2015). Polio uses vaccinators which otherwise work on Routine Immunisation in campaigns, affecting their availability for RI.
Uganda:

**Context:** Coverage has increased from 2006 to 2011 but has been stagnating since. The country has until recently been focused on introducing new vaccines (e.g. HPV, IPV) but is now focussing more on strengthening routine immunisation and coverage/equity. Uganda benefits from strong political support for immunisation, with the government stating its willingness to take on more responsibility for immunisation financing (aiming to create an immunisation fund at national level). However in practice, government expenditure as a proportion of the growing overall immunisation programme is falling despite good overall economic conditions, raising potential sustainability issues.

**Challenges:** There remain equity issues Uganda, with remote rural, island and mountainous communities lacking access to health facilities. Some ethnic, religious and marginalised/poor groups also have relatively little access, including in the capital (Kampala). Fiduciary risks remain high, with a history of miss-use of GAVI funds – funds were frozen between 2006 and 2013 and increased controls and monitoring/supervision are in place with most of the funds for high risk activities such as procurement (channelled through partners). Health workforce remains a major issue in the country with high vacancy rates (up to 35%) and absenteeism (up to 50%). Supply chain is also a key challenge due to lack of predictable funding flows from central to district and to health facility level, disrupting vaccine distribution from district stores to lower health facilities.

**Next steps:** Gavi is increasing risk management measures, including by putting in place a new Fiduciary Management Agent and a range of pre-conditions for strengthened systems before HSS2 can start. The new HSS2 and CCEOP (likely to start in July) will address some of the key issues identified above, for example in supply chain. The upcoming JA will be used to focus on solutions to the country’s equity and coverage issues and on improving microplanning in 37 key districts (out of 118) with the highest levels of inequities. Gavi will also increase capacity in the EPI team and is supporting better decision making on immunisation in MoH by reviewing existing governance structures and technical groups and by establishing a revitalised ICC by the end of 2017. Gavi will work with wider partners such as World Bank, DFID and USAID to look at how wider Health System programmes (e.g. on HRH and Government health budgeting) can improve immunisation outcomes, particularly at the district level.
## Country General Information

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Value</th>
<th>Gavi 68 rank</th>
</tr>
</thead>
<tbody>
<tr>
<td># under-immunised (DTP3)</td>
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<td>3m</td>
<td>8</td>
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<tr>
<td>% GPF targets achieved</td>
<td>2015</td>
<td>48%</td>
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<tr>
<td># PEF positions funded</td>
<td>2016</td>
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<table>
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<table>
<thead>
<tr>
<th>Vaccine introductions</th>
<th>Expected introduction</th>
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<tbody>
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<td>HPV, IPV, Penta, PCV</td>
<td>Rota, Meva, YF, MCV2, MR1</td>
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</table>

<table>
<thead>
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## Gavi Commitments vs Disbursements (all time)

<table>
<thead>
<tr>
<th>Type</th>
<th>Commitments</th>
<th>Disbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$33m</td>
<td>$33m</td>
</tr>
<tr>
<td>Vaccine</td>
<td>$39m</td>
<td>$273m</td>
</tr>
</tbody>
</table>

## Top 3 Areas for Gavi Engagement

1. **Coverage**
   - Coverage for DTP3 has historically been growing but is now stagnating (79% as per WUENIC data in 2015). Uganda has introduced several new vaccines lately, and the country has focused on introductions and campaigns rather than strengthening immunisation in hard to reach areas
   - HPV campaign has taken place in 2015; MenA campaign in January 2017. Rota campaign is currently on hold due to global supply (it will potentially be done by the end of 2017). The country is currently applying for HPV multi cohort campaign

2. **Equity**
   - Some geographical inequities exist: Urban poor, migrants, ethnic minorities, some religious groups (esp. Muslims), those in new settlements, fishing communities, refugees, remote rural, island and mountainous communities, and those having to travel far for immunisation and/or having to pay transport costs ($3) are least likely to be immunised.
   - Wealth and maternal education remain less challenging with 0 and 3 percentage point difference in DTP3 coverage in 2015, respectively.

3. **Demand**
   - A key barrier to demand is the weak health education. There are generally low levels of awareness in young men and women (e.g. on HPV prevention) and gender disparities exist (e.g. in access to education).
   - Though remaining at low levels, demand has increased in the past years

## Key Information

### Coverage
- Latest EVM (79% in 2014) shows supply chain has improved considerably at the national level - however, at district and health facility level little improvements have been seen with numerous 'last mile' issues
- A key challenge is the lack of predictable funding flows from the central to district and to health facility level, resulting for example in disruptions of vaccine distributions from district stores to lower health facilities
- CCEOP has been approved (will start in July)

### Equity
- Data quality is an issue in the country (10 percentage points difference between admin and survey in 2015) - particularly at district/health facility levels and in determining accurate population/birth data (e.g. for coverage calculations). A Data Quality Self Assessment was carried out in 2013 and found on average districts met only 63% (health facilities 58%) of the required criteria well below the required target of 80%
- Data quality is getting more attention however - with web based and SMS based systems having been trialled in districts and PEF funded efforts by CDC to establish District Information Teams across the country to increase Data quality

### Demand
- Political will: The government has indicated that it is willing to become more independent in terms of ownership and financing for immunisation - the government is in the process of creating an immunisation fund at national level. However, in practice revenue from consistent growth in Uganda is not being invested in health and Uganda mainly relies on donor funding
- The country has defaulted in 2015 but has paid its obligations in 2016; on time payment is expected for 2017

### Supply Chain
- Data quality is an issue in the country (10 percentage points difference between admin and survey in 2015) - particularly at district/health facility levels and in determining accurate population/birth data (e.g. for coverage calculations). A Data Quality Self Assessment was carried out in 2013 and found on average districts met only 63% (health facilities 58%) of the required criteria well below the required target of 80%
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### Data Quality
- Political will: The government has indicated that it is willing to become more independent in terms of ownership and financing for immunisation - the government is in the process of creating an immunisation fund at national level. However, in practice revenue from consistent growth in Uganda is not being invested in health and Uganda mainly relies on donor funding
- The country has defaulted in 2015 but has paid its obligations in 2016; on time payment is expected for 2017

### Financing & Sustainability
- As a result, a large share of funds is channelled through UNICEF (e.g. procurement) and WHO (e.g. MenA campaign)
- Since 2013 a Fiduciary Agent (FA) has been in place to oversee the HSS2 grants. Following a PCA in 2016 the role of the FA has been reinforced.
- Until the effectiveness of the FA is demonstrated fiduciary risk remains high

### Financial Management & Fiduciary Risk
- The EPI team faces a staffing shortage in the light of new demands on the EPI system resulting from more vaccines being added to the programme. The managerial capabilities of the national EPI team has improved due to an embedded managerial support by Gates-funded CHAI staff. However, performance management practices remain to be strengthened at the interface between the national EPI team and the districts
- The ICC is currently not providing adequate oversight, however, the wider health sector coordination is working well

### Programmatic & Institutional Capacity (LMC)
- The HSS-1 will end in June. It is mainly focused on construction of staff houses and district medical facilities. The grant has historically underperformed due to procurement and financial management issues however new leadership in M4H has brought it back on track.
- Overall HSS1 fund utilisation remains low, following stop-start programme - we plan to decommit unutilised funds at the grants closure in June
- HSS2 and CCEOP will start in July

### Health Workforce
- Health worker vacancy rates (up to 30%) and absenteeism (up to 50%) is high in some districts - a key driver being the lack of regular payment of salaries