

FOR INFORMATION**Country programme update 2009**

This paper provides a country programme update based on performance for 2009 and highlights programmatic achievements and challenges.

The Board is requested to note:

- 1) Programmatic achievements and challenges.
- 2) Priorities for 2011.

Country programme update 2009**Executive Summary**

This paper provides a country programme update based on performance for 2009¹ and highlights programmatic achievements and challenges. (Some 2010 data is included in this report to address issues raised by the Programme and Policy Committee in October 2010).

Countries have made *progress in new vaccine introduction* in 2009:

- 19 countries introduced pentavalent, 2 countries introduced pneumococcus and 2 countries introduced rotavirus.
- GAVI eligible countries reached an average DTP3 (WHO/UNICEF estimates) coverage of 73% in 2009 compared to a global average of 82%.
- 16 countries qualified for ISS rewards based on DTP3 performance in 2009, compared to 32 countries in 2006.
- Overall 38 countries reported on progress of HSS funded activities in 2009. 24 countries were recommended for continuing support by the IRC while 6 countries provided insufficient information; 8 countries were not due to receive any further funding.

In 2009 the number of countries required to co-finance increased from 32 to 49. 44 countries had paid by the end of 2009. The remaining 5 countries completed full payment by October 2010.

¹ It is not possible to bring the Country Program Update to the board earlier than the November/December Board meeting each year because the annual Country Progress Reports are received from mid-May to August, based on the financial planning cycles of countries. In addition the WHO UNICEF DTP3 coverage estimates used to assess country performance are provided by August each year. The reports are subsequently analysed by the Independent Review Monitoring Committee. It would be difficult to prepare a rigorous consolidated by July each year.

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Current challenges and risks include:

- The rate of increase of DTP3 coverage has slowed in the last five years (2005 – 2009).
- Most unimmunised children are in GAVI eligible countries, with around half these children being in India and Nigeria whose WHO/UNICEF DTP3 coverage ratios at 2009 are 66% and 42% respectively.
- Increasing complexity of GAVI policies and therefore requirements for country support.

Effectiveness of GAVI support for civil society has been mixed. GAVI will develop a longer-term strategy that articulates how it will support the engagement of CSOs in national health policy dialogue. This strategy needs to ensure consistency with other policies such as the Health System Funding Platform.

The introduction of the Transparency and Accountability Policy has been well received by all GAVI partners. There are however instances where implementation of FMAs has resulted in delays in implementation resulting in loss of momentum. GAVI is continually monitoring impact and effectiveness of the TAP policy. An evaluation is planned for 2011.

The *priorities for the future* are to:

- Address the implications of moving from a one size-fits-all to a more differentiated approach. A matrix of country eligibility for GAVI support windows for 2011 will be available on the GAVI website by December 2010.
- Improve and streamline communication with countries on GAVI policies and process for all GAVI support, with a particular focus on the following group of countries: low performing, graduating and those introducing new vaccines.
- Use of improved tools for efficient programme management including strengthened monitoring & evaluation and data analysis.

FOR INFORMATION**1. Background**

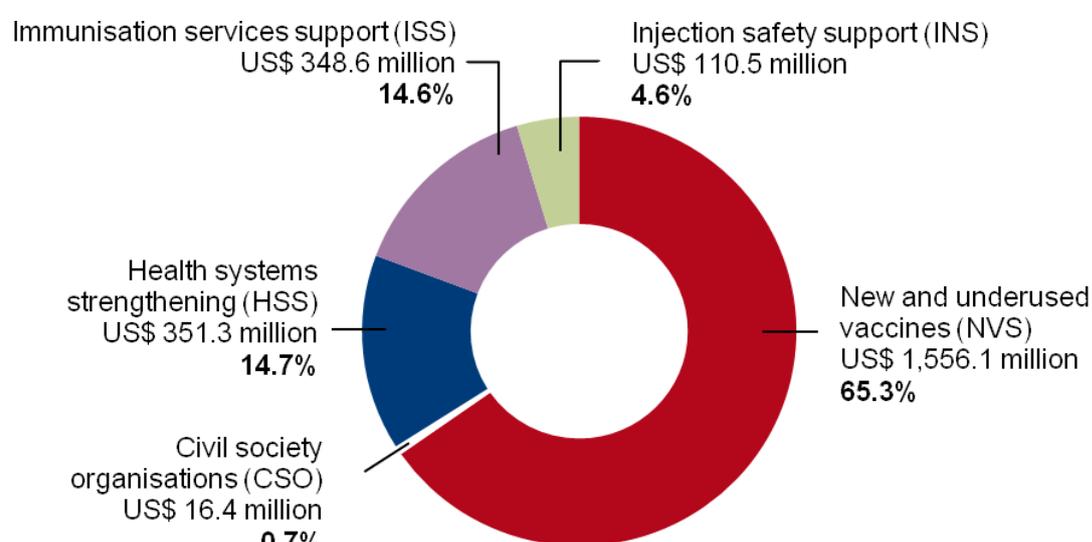
1.1 This paper provides a country programme update based on performance for 2009 and highlights programmatic achievements and challenges. (Some 2010 data is included in this report to address issues raised by the Programme and Policy Committee in October 2010.) It should be noted that the GAVI Board decided to defer approval of the recommendations of the Independent Review Committee for new country proposals at the end of 2009 pending further clarification of the financial situation and the development of a mechanism to prioritise. While this did not impact on 2009 performance, it is expected to have a significant impact in 2010.

1.2 This paper is based on:

- Data from the country Annual Progress Reports submitted in May 2010 (on 2009 performance);
- WHO/UNICEF 2009 DTP3 coverage estimates;
- Programme uptake information and disbursement data (available as at 31st August 2010); and
- Transparency and Accountability Policy implementation activities to date.

1.3 Figure 1a illustrates the relative size of approvals for GAVI's five support windows for the period 2000 – 2009. The approved support to New and Underused Vaccines (NVS) represents approximately 65.3% of the approved funds. Health Systems Strengthening (HSS) and Immunisation Services Support (ISS) constitute approximately 14.7% and 14.6% of the committed funds respectively. Injection Safety Support (INS) and Civil Society support (CSO) represent approximately 4.6% and 1% respectively.

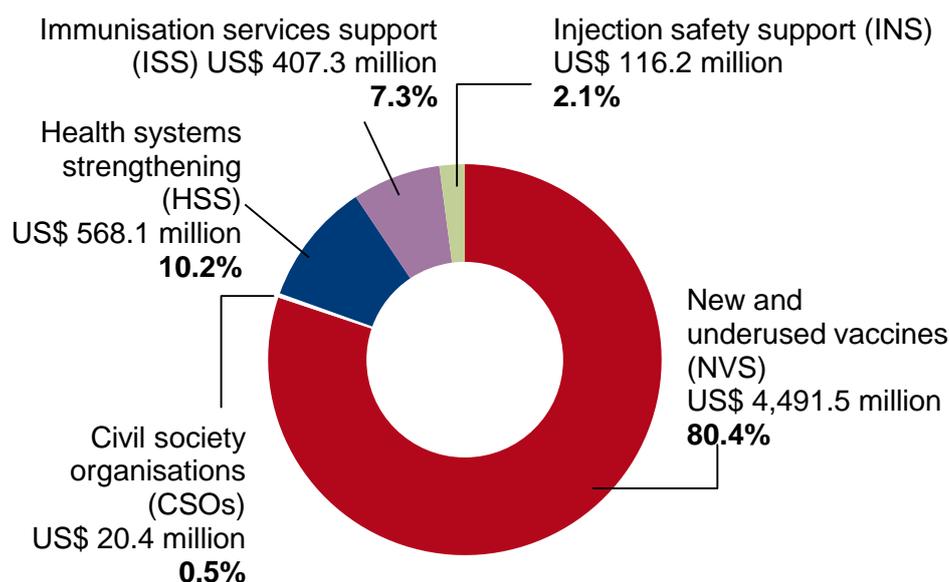
Figure 1a. Close to US\$ 2.4 billion approved to countries for 2000-2009 programmes



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1.4 Figure 1b illustrates the relative size of the commitments up to 2015 for GAVI's five support windows. The committed support to New and Underused Vaccines (NVS) represents approximately 80.4% of the committed funds. Health Systems Strengthening (HSS) and Immunisation Services Support (ISS) constitute approximately 10.2% and 7.3% of the committed funds respectively. Injection Safety Support (INS) and Civil Society Support (CSO) represent approximately 2% and 1% respectively.

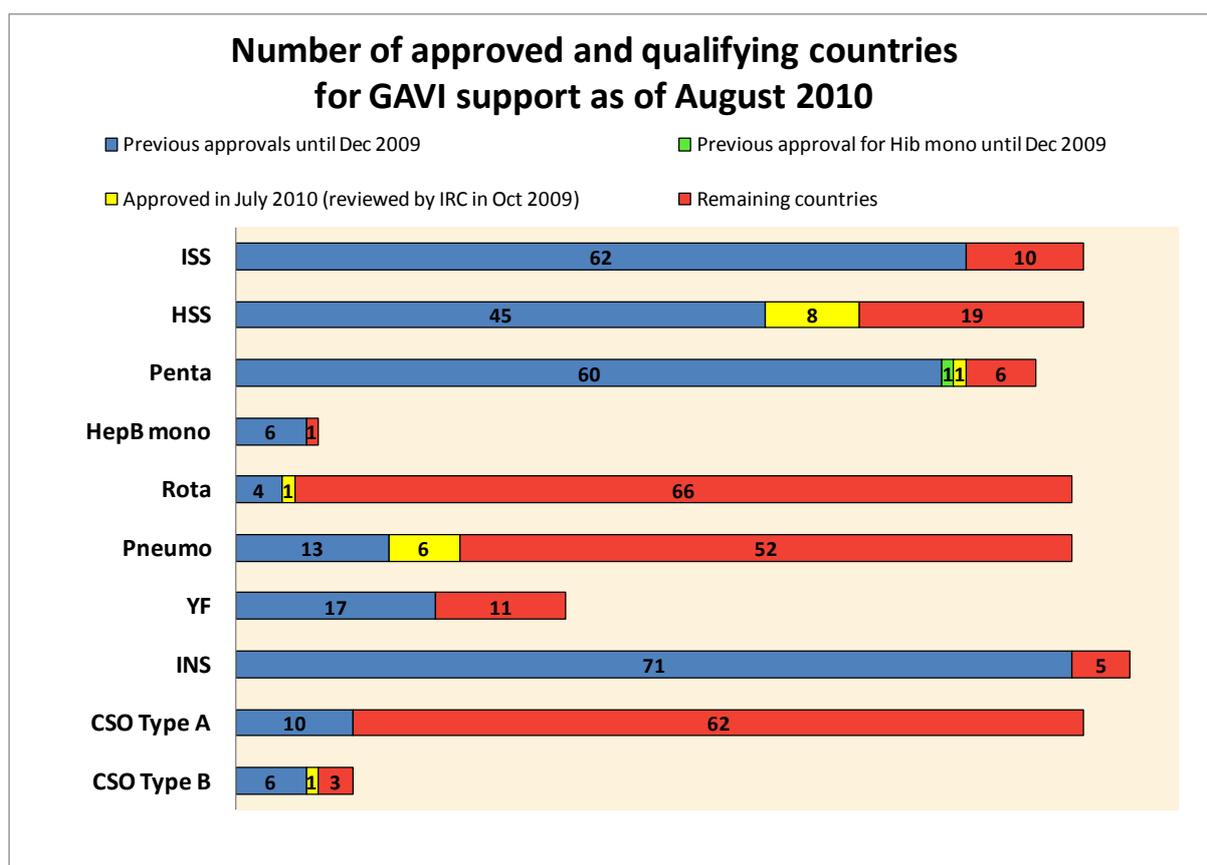
Figure 1b. Close to USD 5.6 billion committed to countries up to 2015 as of 31 July 2010



2. Country programme approvals

2.1 This section summarises the latest information on country programme approvals. Figure 2 summarises the number of countries that were approved for each window of support until December 2009. The figure also includes the countries that were approved for funding by the Executive Committee in July 2010 from the October 2009 round of proposals. Three IRC recommendations for vaccine approvals (2 for rotavirus and 1 for pneumococcus vaccines) were deferred due to funding constraints.

2.2 Pneumococcal vaccine is now the third most prevalent vaccine in terms of country approvals with 19 countries having been approved for introduction. Another important milestone is the fact that 5 countries have been approved for rotavirus introduction including Sudan, the first country outside the Americas.

FOR INFORMATION**Figure 2. Number of approved and qualifying countries for GAVI support****3. Uptake of new vaccines in 2009****Achievements**

3.1 This section summarises the latest information on country programme uptake. Countries have made significant progress in introducing pentavalent (DTP-Hep B+Hib) vaccines with GAVI support.

3.2 Out of the 61 countries approved for pentavalent 59 have introduced the vaccine; 19 countries introduced penta vaccine in 2009, the highest number ever to introduce the vaccine in a single year. (Afghanistan, Armenia, Bangladesh, Bhutan, Cameroun, Congo, Comoros, Cote d'Ivoire, DRC, Kyrgyz Rep, Lao PDR, Mauritania, Moldova, Mozambique, Nepal, Pakistan, Sao Tome, Tanzania and Uzbekistan.)

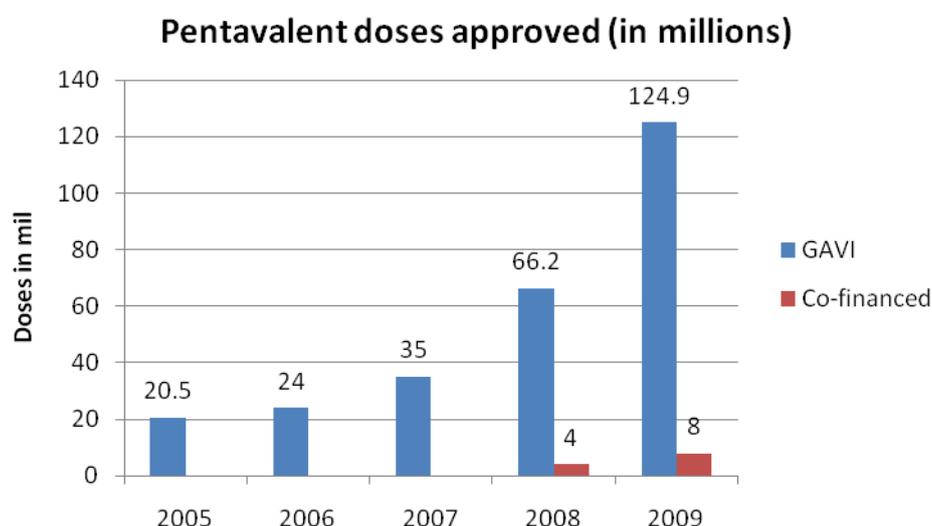
3.3 Two countries, (The Gambia and Rwanda), successfully introduced the pneumococcal vaccine in 2009.

3.4 Two countries, (Honduras and Nicaragua), successfully introduced rotavirus vaccine in 2009.

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3.5 A total of nearly 125 million doses of pentavalent vaccine were approved for supply in 2009. This represents a 100% increase compared to the number of doses supplied in 2008 (Table 1. below).

Figure 3. Pentavalent doses approved (in millions)



Challenges

3.6 Six countries have not received approval for pentavalent vaccine use. Four (DPRK, Indonesia, Myanmar and Timor-Leste) have never applied. Nigeria's application was declined by the IRC and Haiti's coverage is below 50%, the required level for new vaccine introduction.

3.7 Two countries (Bhutan and Sri Lanka) reported significant adverse events following immunisation (AEFIs) after the introduction of pentavalent vaccine. Although WHO-supported investigations showed no demonstrable link between administration of the vaccine and the adverse events in both cases, these events have raised concerns and media attention in neighbouring countries. While the vaccine was temporarily suspended by both countries, Sri Lanka has since reintroduced the vaccine and Bhutan plans to resume in 2011. The draft Business Plan targets strengthening of vaccine safety committees in 30 countries by 2015.

3.8 Inadequate supplies have slowed down the uptake of pneumococcal and rotavirus vaccines by countries: only 2 countries out of the 13 approved for Pneumo were able to introduce the vaccine in 2009. (This was done through a donation programme.) Both the 10 and 13 valent pneumo vaccines have now been pre qualified by WHO and role-out is expected from 2011.

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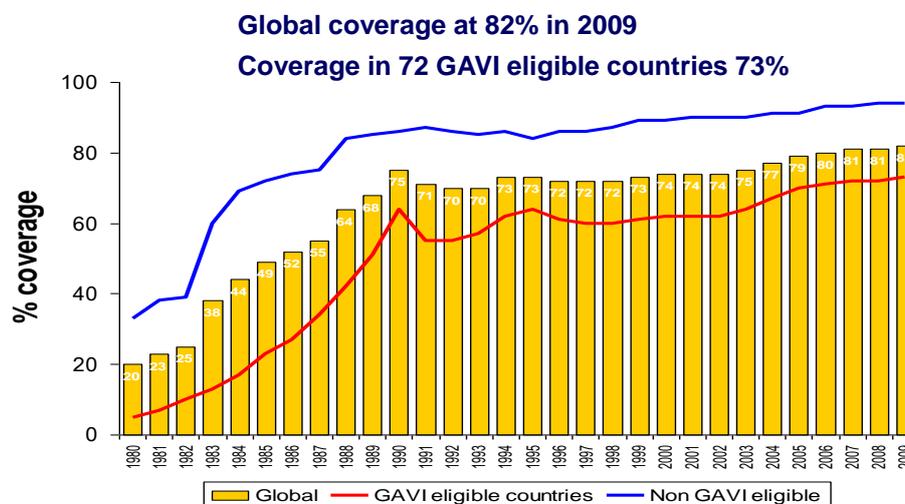
4. Basic immunisation coverage

Achievements

4.1 GAVI eligible countries reached an average of 73% DTP3 coverage in 2009, compared to global coverage of 82% (Figure 4). However coverage in GAVI countries still shows an upward trend.

Figure 4. Trends of DTP3 Coverage in GAVI and non-GAVI countries 1980-2009

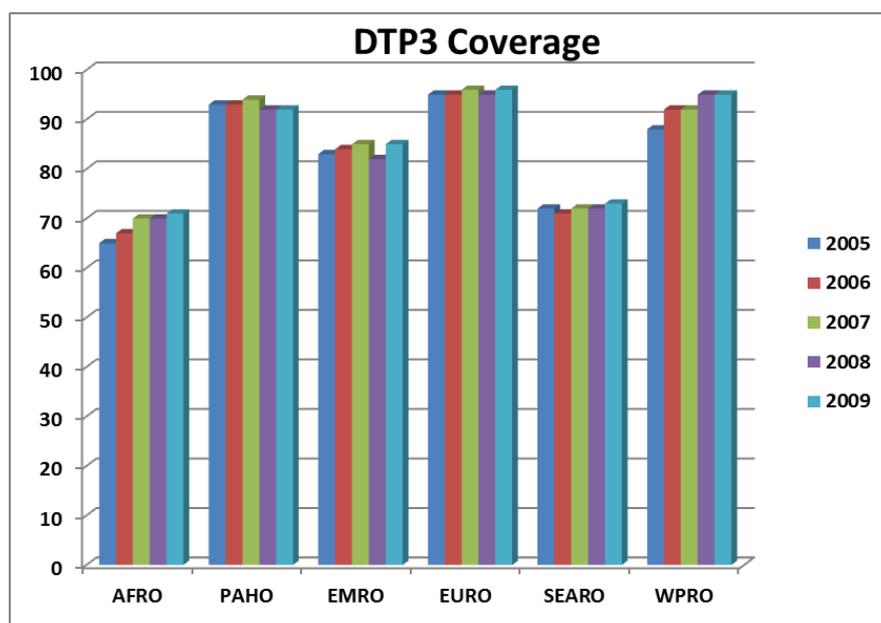
**Global, GAVI and non GAVI eligible countries
Immunization 1980-2009, DTP3 coverage**



Source: WHO/UNICEF coverage estimates 1980-2009, July 2010 Date of slide: 22 July 2010



4.2 The performance of geographical regions (based on WHO defined regions) varied; the most impressive achievement was made in the Western Pacific region (WPRO) where coverage increased from an average of 88% to 95%. Coverage in the American (PAHO) and European (EURO) regions although high, remained flat in 2009. The African region increased from 65% to 71% DTP3 coverage in 2009, bringing it nearer to SEARO region coverage rate (Figure 5).

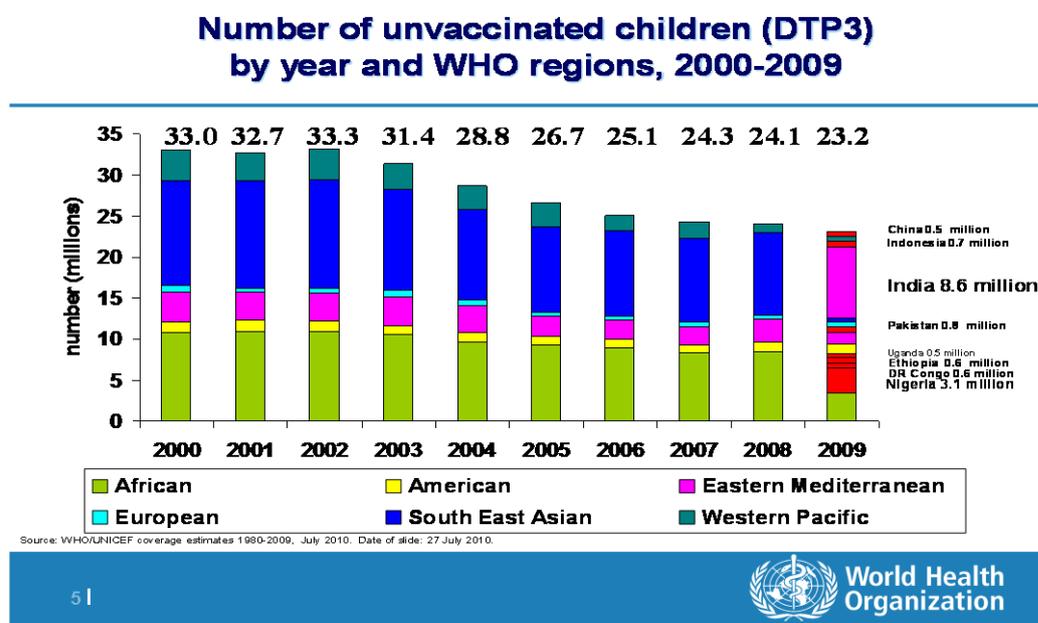
FOR INFORMATION**Figure 5. Regional DTP3 Coverage (2005 – 2009)**

4.3 Fifty-eight countries achieved DTP3 coverage of at least 70%, the new filter that will be required by the Board for approving support for new vaccine introduction from 2011.

4.4 The number of unimmunised children globally has decreased by 15%, from 26.7 million in 2005 to 23.2 million in 2009 (Figure 6).

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Figure 6. Number of unvaccinated children by WHO Regions, DTP3 by year and WHO Regions, 2000 – 2009



Challenges

4.5 Average DTP3 (Penta) coverage has slowed to an annual increase of 1% between 2005 and 2009 compared to an annual average increase of 3% between 2002 and 2005. Increased efforts are needed to maintain high coverage. The draft new GAVI Business Plan targets a Penta 3 coverage increase to 81% by 2015.

4.6 Most of the unimmunised children (86%) come from GAVI eligible countries. An estimated 50% of the 23.2 million unimmunised children come from India and Nigeria. Coverage improvement in these two GAVI eligible countries with large birth cohorts is critical to GAVI's mission.

4.7 Fourteen countries (Guinea Bissau, Yemen, India, Uganda, Mauritania, Liberia, Haiti, Lao, Guinea, CAR, Papua New Guinea, Nigeria, Somalia and Chad) will not be able to apply for new vaccine support (as opposed to cash-based programmes) in the next round because their latest WHO/UNICEF DTP3 coverage estimates fall below the new filter of 70% (Figure 7).

4.8 Reasons for low coverage in these 14 countries include:

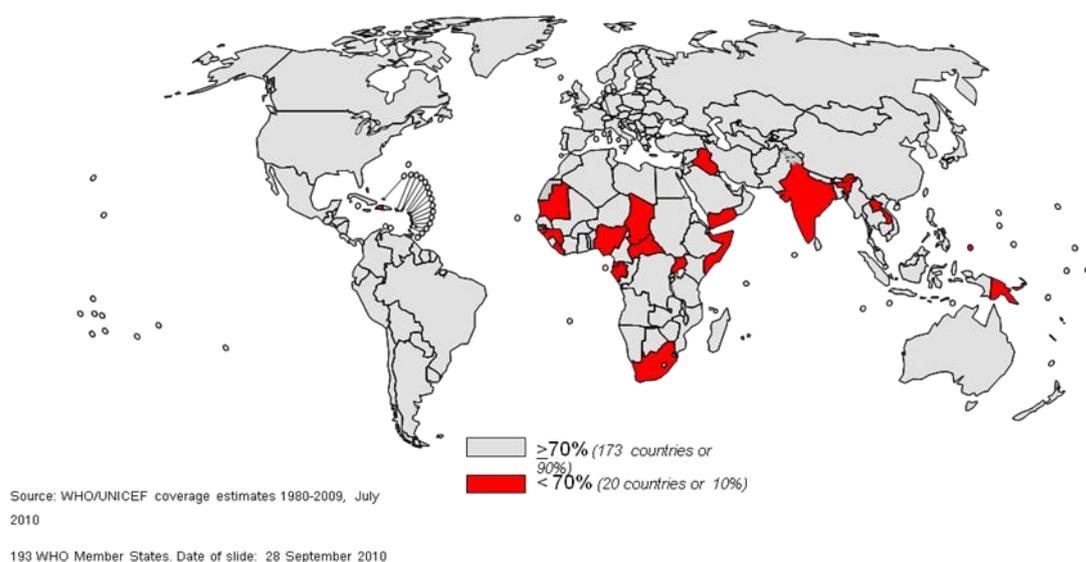
- **Political insecurity:** Chad, CAR and Somalia.
- **Human resources:** Some countries with low performance also have weak capacity of human resources. This problem is acute in Guinea, Guinea Bissau, Liberia and Mauritania.
- **Governance related;** Lack of coordination among stakeholder and low capacity and incentives for coordination within governments affect service delivery.

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- **Data quality.** Weak health management information systems undermine data quality.
- Additional issues related to India and Nigeria are:
 - Decentralised administrative system with marked inequities in the poorest regions.
 - Un-interrupted transmission of polio.

4.9 A new window of support, Incentives for routine immunisation strengthening (IRIS) will be brought to the Board in November 2010. The programme's core objective is to raise coverage in countries that have DTP3 of below 70 percent.

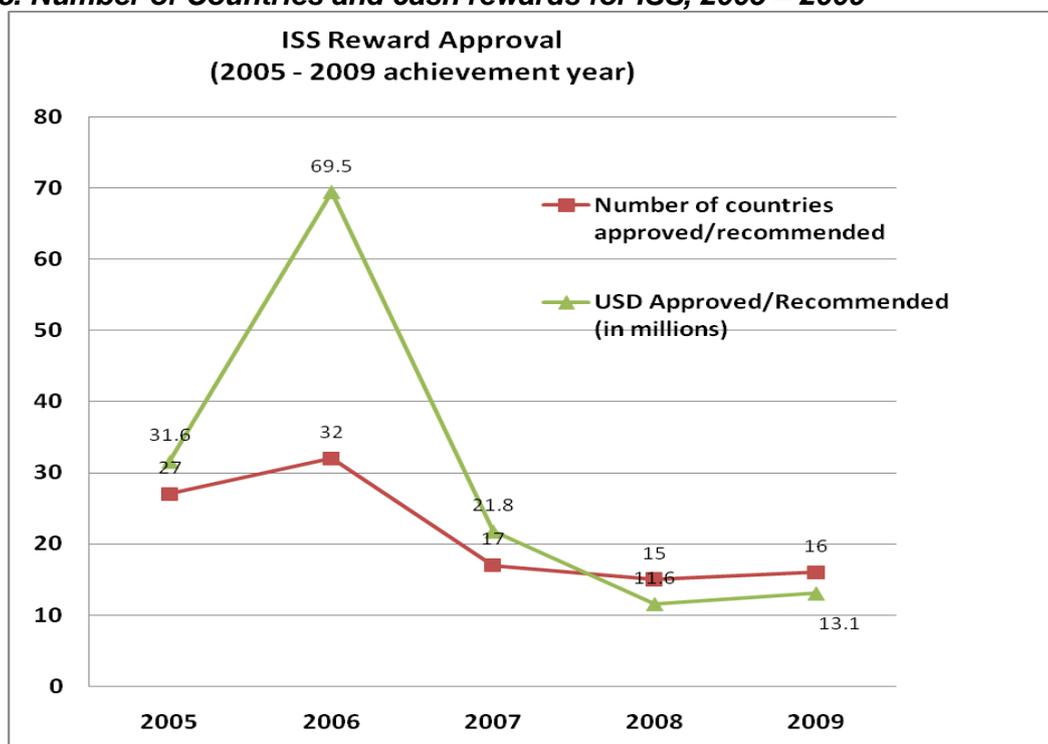
Figure 7. Countries with less than 70% DTP3 coverage, 2009



FOR INFORMATION**5. Immunisation services support (ISS)****Achievements**

5.1 Sixteen countries qualified for ISS rewards based on performance in 2009. The peak seen in rewards (Figure 8) in 2006 is due to countries with large birth cohorts including Ethiopia, Nigeria and Pakistan exceeding their targets for the year.

Figure 8. Number of Countries and cash rewards for ISS, 2005 – 2009

**Challenges**

5.2 The number of countries receiving rewards and the average numbers of additional children vaccinated per year has decreased since 2006. This is to be expected with increasing immunisation coverage. The focus moving forward will be on low performing countries (some of which are very large countries) in order to increase the number of fully immunised children by 30 million in 2015, (target from draft business plan).

5.3 Data Quality - In 2008, 12 countries (Bangladesh, CAR, Chad, Guinea, Indonesia, Mali, Nepal, Nigeria, Pakistan, Rwanda, Sierra Leone and Tajikistan) were suspended for ISS rewards until discrepancies between administrative data and WHO/UNICEF coverage estimates could be assessed. The Secretariat and partners reviewed each country on a case-by-case basis and lifted the suspension, based on this review, for 6 of the 12 countries (Bangladesh, Nepal, Pakistan, Rwanda, Sierra Leone, and Tajikistan). Five out of the remaining six (CAR, Chad, Guinea, Mali and Nigeria) are proposed countries for the new IRIS window.

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6. Health systems strengthening (HSS) support

Follow up of recommendations of the HSS evaluation and tracking study

6.1 The recommendations have been divided into the 3 categories outlined below.

- *Weak monitoring* was a recurrent theme in the Evaluation and Tracking Study. The Secretariat is working on specific guidance to strengthen country indicators and M&E implementation plans through the development of the Health Systems Funding Platform. For existing support, a “traffic light” system is in development to direct efforts and technical support to countries with low implementation rates.
- *Management issues – risk, procurement, financial oversight.* The Evaluation and Tracking Study commented on the need to manage financial and programmatic risk. Institutionalised Financial Management Assessments and the implementation of the new TAP policy and increased use of pooled/joint financing arrangements (including reporting and audit) through the development of the HSFP mean that financial risk is being managed more pro-actively. Programmatic risk is dealt with through a more targeted technical support to countries with weak performance and the improved application and monitoring arrangements developed through the HSFP. Also see section 9.
- *Technical support and capacity building.* The relevance and quality of technical support provided in relation to GAVI HSS support are reported to be variable. The support is relatively strong on proposal design and pre-review stages, but weaker on start-up and implementation stages of the program. To a large extent GAVI has depended on WHO staff to provide this support. The development of a more demand-driven and flexible provision of TA support has started. For existing HSS programmes the secretariat is intensifying collaboration with the Alliance partners to ensure high quality technical support is provided to countries where institutional capacity to implement programmes and report on progress is weakest. Other options to provide technical assistance are being explored, including the possibility of outsourcing.

Achievements

6.2 Thirty eight countries reported on progress of activities carried out in 2009 to the IRC. In total 24 countries were recommended for continuing support by the IRC, while 6 countries provided insufficient information; the remaining 8 countries were not due for any further funding due to various reasons such as low utilisation rate, conclusion of HSS funding or late disbursement of previous tranche of funds. A number of countries reported on progress in terms of timely implementation of activities as well as tracked progress on output and outcome. Among these are:

Vietnam - the country reports high level of implementation and almost all activities are accomplished according to plan. The support has resulted in 79 training courses for Village Health Workers and 36 training courses on EPI practice for Community Health Workers. The retention programme has resulted in an impressive increase in

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retention for Village Health Workers, especially in the mountainous and difficult-to-reach areas.

After three years of HSS funding, Vietnam surpassed the majority of targets for 2009 based on chosen indicators. Vietnam reported a 36.5-point increase in births assisted by a skilled birth attendant from a baseline figure of 60% in 2007 to 96.5% in 2009 and a 19.5% increase in the contraceptive prevalence rate. DTP3 coverage also increased by 12.8% and is currently 97.9%. Vietnam also saw a 1.5% decrease in the malnutrition rate of children under five.

Cambodia - HSS support to Cambodia between 2007 and 2009 was focused on improving child and maternal health in ten districts selected on the basis of low coverage and no NGO presence. Before HSS support, only one of the ten districts had achieved a DTP3 coverage rate above 80% and in 2009 nine districts were reported to have high DTP3 coverage contributing to a national increase of 35 districts improving coverage. Although there was a 17% increase in DTP-Hep B3 coverage in HSS districts, the target of 90% set was not met due to the difficulty of improving coverage in remote areas.

Cambodia exceeded its targets for the percentage of pregnant women who have two antenatal care visits from a trained health professional which doubled nationally and increased by 26% in HSS districts. The percentage of immunisation provided at the fixed site increased by 28% in HSS districts and has overtaken national figures for fixed immunisation sites. Every health centre in the ten districts has received training, compared to 78% of health centres nationally.

Afghanistan - has made an impressive progress in a short period of time and reports a high level of financial resource absorption and programme implementation. Outputs of the support include an increasing number of health facilities being staffed with female health workers, and an in-service training programme for doctors, nurses, and midwives up and running since February 2009.

Between 2007 and 2009 Afghanistan reported an increase in national DTP3 coverage of 6%; however, security was stated as a key challenge to health service delivery. The under five-mortality rate decreased from 191/1000 live births to 161/1000 live births. Other successes included an increase in national measles coverage to 76% and an increase of 13% in the percentage of deliveries attended by a skilled birth attendant. Monitoring visits to provinces also increased.

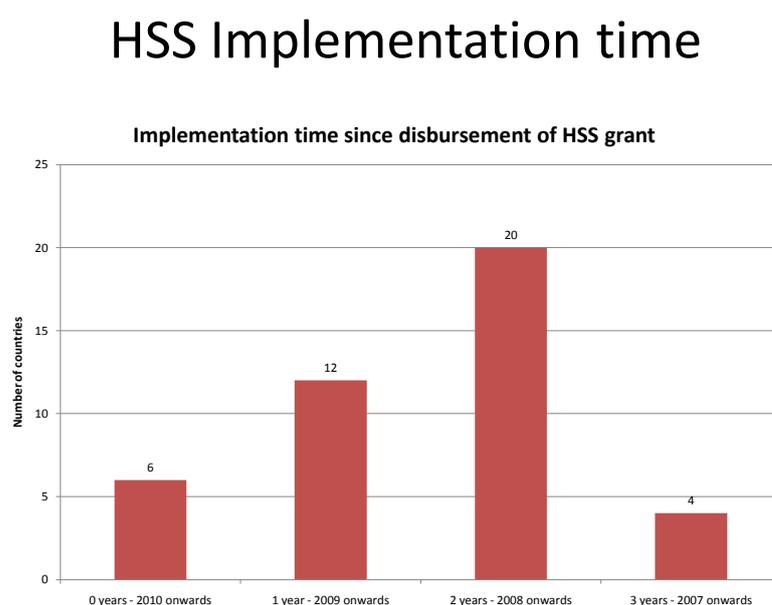
Rwanda - reported an increase in births attended by a skilled birth attendant of 20% between 2007 and 2009 and by 2009 reported a 5% increase in the number of districts with functioning cold chain facilities.

Kyrgyzstan - HSS support has played an important role in capacity building of primary health care providers, improved supervision of performance, and outreach to remote populations. HSS funds have also been used to initiate a new approach to provide motivation/incentives.

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6.3 The number of countries implementing HSS support at the end of 2009 is 36. However only 24 countries have been implementing HSS support for more than 2 years. Further analysis of these 24 countries with HSS for more than 2 years of funding shows that 63% of the countries are on track with implementation of HSS, and that in a majority of cases outcome and impact indicators indicate that countries are making progress.

Figure 9 HSS implementation time²



Commitments and disbursement data

6.4 By the end of 2009, US\$ 294.7 million have been disbursed from GAVI for HSS support and US\$ 149.4 million had been reported as expenditures³. The average grant utilisation rate across all countries is estimated to be 43%. Based on this information the level of unspent funds remaining at the end of 2009 amounted to a total of US\$ 145.3 million.

Challenges

6.5 Countries demonstrated low levels of implementation during the first year of support and different levels of absorption of funds. The average grant utilisation rate for 2009 was 65%, however there were some countries with very low budget execution (<15%). Key reasons for delayed implementation and low utilisation of grants are inability to manage funds in a timely manner, and lack of readiness to start implementing planned HSS activities. For newly approved countries, FMAs

² CAR, Congo DRC, Georgia, Ghana, Honduras, Kenya, Madagascar, Malawi, Nepal, Nicaragua, Sri Lanka, South Sudan, Afghanistan, Cameroun, Rwanda, Vietnam, Yemen, Zambia Kyrgyzstan, Bhutan, Burundi, Cambodia, Ethiopia, Liberia

³ Based on what has been reported in Table 11 in the APR

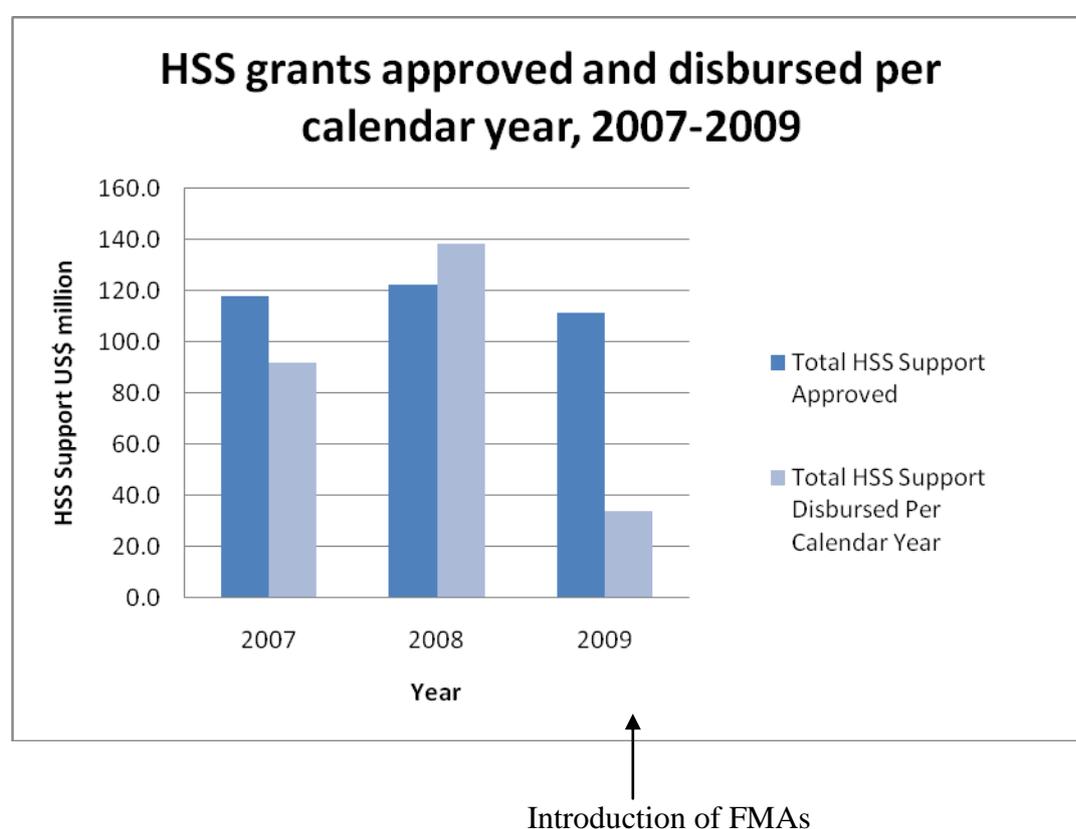
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have been revised to include an assessment of country readiness before funds disbursement.

6.6 Delayed disbursements from GAVI is also a challenge, in some cases, the delay can be as long as one year. It has a direct impact on countries' ability to implement GAVI HSS support, resulting in significant reprogramming of activities (e.g. Burundi, DRC, Ghana and Senegal) or requests for no cost extensions in other countries (e.g. Indonesia, Vietnam). Delays in disbursements were largely due to efforts to improve financial management and the institution of FMAs before funds could be disbursed (Figure 10). See also Section 9.

6.7 In several countries, administrative bottlenecks delayed the implementation of GAVI HSS supported activities, after the funds had arrived in the country. In some cases currency fluctuations and depreciations of local currencies eroded the financial resources available for the implementation of GAVI HSS supported activities.

Figure 10. Total HSS support approved and disbursed 2007-2010



6.8 Recommendations from the HSS Tracking Study (TS) and Evaluation carried out in 2009 have been crucial in redesigning HSS support and have been incorporated into the new draft GAVI Business Plan as well as informed the development of the new Health systems funding platform.

6.9 A rating system for more accurate and precise assessment of weaknesses in reporting and implementation of HSS support is in development; it will assist the

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Secretariat and the Alliance Partners in providing timely and high quality technical assistance according to needs in countries.

7. Civil society organisations (CSO) support

7.1 The objective of GAVI CSO Type A support is to strengthen the coordination and representation of CSOs at country and regional levels. The uptake of Type A CSO support has been largely poor due the small size of the cash grants which are channelled through governments, low capacity of some country level CSOs and a cumbersome application process. The redesign of the support is in process. Options are being examined to ensure a cost-effective approach, possible management outsourcing and direct transfers to CSOs.

7.2 The objective of CSO Type B funding is to support implementation of GAVI HSS support and the comprehensive multi-year plan (cMYP) for immunisation.

7.3 Ten countries are eligible with for Type B support under the pilot, and eight applications were received by end 2009. Seven countries have been approved for support, and five of these countries have received their funding and initiated the implementation.

7.4 Some examples from countries currently being supported:

Afghanistan: The activities include establishment of community midwifery schools and a public/private partner model where private practitioners are providing immunisations and basic reproductive and child health services in return for incentives.

Congo DR: The activities are mainly aimed at improving immunisation activities with the involvement of CSOs. The type B support has also enabled the Government to establish a consortium to strengthen CSO capacity.

Indonesia: Activities conducted include development of national guidelines in community empowerment, monitoring and evaluation, health education training, and development of IEC materials.

7.5 The reports points to safety issues for those CSOs working in conflict areas, and delayed implementation of activities due to delayed fund disbursements.

Challenges

7.6 Consultation is continuing with the CSO Constituency and other partners to finalise the redesign of Type A support. Discussion is underway to agree on a process to release the balance of \$500,000 remaining from the original Board approval of \$1.2 million. GAVI needs to determine with partners how to access an amount of \$6 million notionally allocated by the (then) GAVI Fund in 2008, but not approved for expenditure. The CSO Constituency is keen to allocate these funds as quickly as possible. However obtaining Board approval requires that a sound

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business case is developed that demonstrates earlier shortcomings have been addressed.

7.7 At the same time it is estimated that all Type B activities (up to \$22 million) will have concluded by mid 2012. It is reasonable to expect that some countries will have made good progress and will seek to continue to a new phase of implementation. Partners want to anticipate the completion of these activities and ensure that there is a clear succession strategy in place for GAVI funding support. This would avoid a funding gap and loss of momentum.

7.8 GAVI needs to develop a longer-term strategy that articulates how it will support the engagement of CSOs in national level health policy dialogue including health system strengthening and service delivery. This strategy needs to ensure consistency and when appropriate integration with other GAVI policies and programmes such as HSFP and IHP. The strategy would also be informed by a formal evaluation of GAVI support for CSOs. Timing for the evaluation is not yet decided. Early internal conceptual work has begun on developing a longer-term strategy prior to establishing a more formal workplan involving collaboration with the CSO Constituency Group.

8. Vaccine co-financing

8.1 Implementation of the policy began in 2008. The GAVI Secretariat, with assistance from Alliance partners, through the Immunization and Financing Sustainability (IF&S) task team⁴, has been responsible for monitoring the implementation of the policy. The co-financing policy is under review. A revised policy will be presented for discussion and decision at the next Board meeting.

Achievements

8.2 In 2008, a total of 32 countries co-financed GAVI supported vaccines. Of these countries 26 co-financed on a mandatory basis and six voluntarily, with a combined total country co-financing amount of just over US\$ 20 million.

8.3 In 2009 the number of countries required to co-finance increased to 49 countries. Of these, 44 countries have fulfilled their co-financing requirement for 2009 and an additional 3 countries co-financed on a voluntarily basis for a total amount of just over US\$ 33 million. By the end of 2009, 5 countries were in default. All five have now completed payments for 2009.

⁴ Terms of reference for the Immunization Financing & Sustainability (IF&S) Task Team are attached at Annex 2.

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9. Financial Management

Achievements

9.1 The Board approved Transparency and Accountability Policy (TAP) took effect in January 2009. The central objective of TAP is to improve GAVI's knowledge of fiduciary risks posed by public financial management systems in a country's health sector towards GAVI's cash-based programmes (HSS and ISS) and, through FMAs and strengthened monitoring, enable the partner government and GAVI Secretariat to pre-emptively respond to those risks.

9.2 Countries are now required to provide additional information on the financial management of GAVI cash support in applications and annual progress reports. Compliance with enhanced financial monitoring and reporting requirements is now a requirement for GAVI support.

9.3 GAVI has substantially enhanced its monitoring function by introducing new requirements for financial statements and audits and has seen a large increase in the number of countries presenting financial statements and audit reports along with their APR submissions. The pre-screening of this information for IRCs, by the TAP team, has been essential and acknowledged as such by successive IRCs.

9.4 The following progress in implementing TAP is also noted:

- **Integration of TAP into Programme Delivery Department (PD) operations:** The TAP team is now fully embedded into PD operations and workflows. Procedures manuals, APR reporting templates and guidelines have been updated accordingly;
- **TAP response to cases of alleged and actual misuse of funds:** The TAP team, along with the Country Responsible Officers, has been able to respond to allegations of, or confirmed, misuse of funds in several countries.
- **Financial management assessments (FMAs):** the FMA is a tool that allows GAVI to gather information on countries' public financial management systems, with particular emphasis on the health sector, in order to evaluate the potential risks for management of GAVI funds. As at the end of October 2010, the TAP team had undertaken FMAs in 27 countries. The table in **Annex 1.1** summarises the current status for each of the first wave of FMAs.
- **Risk profiling:** A central component of the TAP early warning system has been the development of a risk profile for all GAVI eligible countries.
- **Strengthening links with other partners:** The TAP team has been developing links with the World Bank and GFATM financial management teams to facilitate information sharing and coordination. The Health Systems Funding Platform (HSFP) provides an opportunity for the TAP team to formalise linkages further with GFATM and the World Bank.

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- **Development of a Protocol on misuse of funds:** The Secretariat has developed a 'Protocol' on how to deal with actual or suspected cases of funds misuse. The Protocol includes arrangements for handling such information and who should be notified, actions to be taken by the Executive Team and the CEO/DCEO, what follow up steps should be taken, and by whom, and whether a country visit by Secretariat staff is required.

Impact of Financial Management Assessments

9.5 The October 2010 meeting of the Policy and Programme Committee has requested up-to-date analysis of the impact of FMAs. The introduction of TAP has been well-received by all GAVI partners. There have been instances, real and perceived, where implementation of FMAs has resulted in delays to implementation process resulting in loss of momentum. GAVI is continually monitoring impact and effectiveness of the TAP policy. While it is essential to ensure accountability and transparency, this also has to be balanced with program continuity and effectiveness.

9.6 FMAs have been undertaken in 27 countries and are at various stages of completion. The GAVI Secretariat now has approximately 18 months first-hand experience of this element of TAP implementation (from the date of the first FMA in March 2009 until October 2010). An analysis of these first 27 FMAs reveals that 19 of the 27 studies undertaken to date will be completed within, or around, the estimated 6-8 months timeframe. Four are delayed for country specific reasons and a further 4 are delayed because of either actual or suspected misuse of funds. The TAP team aim to undertake measures to further reduce the targeted 6-8 months timeframe. The analysis of FMA and actions for continual improvement are outlined in **Annex 1**.

10. Country Communication

10.1 Effective communication with and from countries continued to be a challenge in 2009 for the GAVI Alliance. In part this challenge involves greater clarification about the respective roles of the Secretariat vis-à-vis the roles of the GAVI Alliance Partners at the country level, and to what extent they are in a position to provide up-to-date information to the countries and feedback country information to the GAVI Alliance Secretariat in Geneva. Targeted resourcing for improved communications is necessary.

11. Priorities for the future

11.1 Average immunisation coverage in GAVI eligible countries has increased approximately 3% from 70% in 2005 to 73% in 2009. For 2011, the focus will be to support all countries in improving and maintaining a high DTP3 coverage through better utilisation of the GAVI HSS, civil society and ISS support.

11.2 Special areas of focus are:

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11.2.1 Roll out of new policies: The Alliance is moving from a one-size-fits-all towards a more differentiated approach to supporting countries. While this in line with received feedback from partners and evaluation reports, it has implications for the GAVI business model which traditionally has used the light touch approach. Work with the 16 graduating countries, 14 low performing countries with expected new vaccine introduction acceleration and a move towards a joint country based review approach will stretch current human resource capacity. Secretariat staff responsible for supporting countries work across all areas of GAVI engagement including roll out of the health systems platform, country co-financing and monitoring of meningitis and yellow fever investment cases. This has stretched available human resources. We need to review what is achievable with the available resource capacity.

As country status changes and GAVI policies are refined, it is important to be clear about which countries have access to which support windows (in the process identifying if any country no longer meets the requirements for any GAVI support). A matrix of country eligibility against GAVI funding programs for 2011 is being reviewed. The matrix will also track implementation status of country programs currently under implementation. This process requires careful review of country APRs as well as country visit reports to ensure all information is as accurate as possible. The matrix will be available on the GAVI website by December 2010.

11.2.2 Country Communication: Improve and streamline communication with countries on GAVI policies and processes for all GAVI support, with a particular focus on low performing countries (DTP3 < 70; cash utilisation rate < 50%), countries introducing pneumo and rotavirus vaccines and those who will graduate from GAVI support in 2015. The Secretariat will work closely with developing country Board members, other country representatives and implementing partners (WHO, UNICEF, World Bank, Global Fund) to continue to maintain and improve our country focus and effectively communicate new GAVI policies and procedures to countries. This will include receiving input and feedback on implementation issues through country visits, regional meetings, update letters and other communication materials. Timely feedback and alerts from in-country partners on status of implementation of country programmes is critical. The recruitment of new staff to improve country communications has been proposed. New policies in particular need to be communicated clearly to ensure countries have a thorough understanding before they apply for support. This includes policies on eligibility, co-financing, prioritization, and the health systems funding platform. Sound routine communications is the cornerstone of effective relations with GAVI partners.

11.2.3 Use of improved tools: The secretariat will work with GAVI Alliance partners to develop and use information and monitoring tools to improve programme efficiency. This includes financial management assessments, monitoring co-financing monitoring and the joint assessment for national strategies for the health systems funding platform. New tools expected to be introduced in 2011 include strengthened monitoring & evaluation and data analysis, harmonised and aligned approach to reviews and timely disbursement of funds effective vaccine management

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assessments; vaccine stock monitoring; and improved forecasting for the timeline of new vaccine introduction, especially in large countries.

FOR INFORMATION**Annex 1****Countries under close scrutiny by the GAVI Secretariat
Impact of Transparency and Accountability Policy**

Financial Management Assessments (FMAs) have been undertaken in 27 countries and are at various stages of completion. The GAVI Secretariat now has approximately 18 months, (from the date of the first FMA in March 2009 until now) first-hand experience of this element of TAP implementation. An analysis of these first 27 FMAs reveals the following:

1. For 7 countries where the FMA has been completed (including Southern Sudan, Senegal, Eritrea, Cuba, Pakistan, Cameroon and Mongolia), completion of the FMA took between 6-8 months;
2. For a further 12 countries where the FMA is nearing completion (including Burundi, Malawi, Indonesia, Burkina Faso, CAR, Chad, Yemen, Tajikistan, Gambia, Lao, Somalia and Mauritania) it is expected (barring any unexpected findings or delays in Gambia, Lao, Somalia and Mauritania) that the average time taken to complete these will also be between just over 6 months;
3. In 4 countries (Bangladesh, Nigeria, Azerbaijan and Myanmar) the time between announcing the FMA (when the clock starts) and signing an Aide Memoire (when the clock stops) has been between 10 and 14 months mainly due to unique country-specific factors such as political issues (Bangladesh's election and Myanmar's unique status) or extremely bureaucratic civil services (Nigeria's inability to agree on a management arrangement and Azerbaijan's inefficiencies in processing a straightforward Aide Memoire). Delays in implementation either pre-date the FMA and/or are completely outside GAVI's control; and,
4. In a further 4 countries the FMA has uncovered major accounting and control weakness which increase the risk of misuse of funds (CIV and Mali), evidence of GAVI funds in jeopardy due to a bank insolvency (DRC) and, in a final case, has been delayed due to the delayed replenishment of misused funds (Uganda).

In summary, 19 of the 27 FMAs undertaken to date are expected to be completed within, or around, the estimated 6-8 months timeframe, 4 are delayed for country specific reasons and a further 4 are delayed because of either actual or suspected misuse of funds.

The TAP team aim to further reduce the targeted 6-8 months timeframe by undertaking the following actions:

- **Increasing awareness of TAP amongst countries and partners:** Strengthening the understanding of TAP and its requirements is essential to further implementation and refinement of the policy. Only through outreach to, and communications with, partners and countries can TAP be further developed and refined. The TAP team aims to decrease, where possible, the time required for completion of FMAs through, amongst other measures, improving the understanding, at country level, of GAVI standards in financial management,

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assisting in revisions of APR formats and guidelines and being proactive in development of the joint HSS platform.

- **Improvements in the management of the TAP workload:** The TAP team strives to manage the unpredictable nature of this type of work through a combination of the following factors:
 - further consolidation of the TAP team and processes within PD (including continued use of existing CRO lines of communication with countries);
 - improved 'intelligence' gathering from partners on fiduciary issues at country level and the health sector in particular;
 - the possibility of earlier involvement of TAP in the design of funding mechanisms to lighten FMA workload later in the process (this is linked to the joint work with GFATM and the World Bank on the HSS platform);
 - identification and use of local and regional consultants for future FMAs;
 - better coordination of FMA visits with other planned GAVI/partner visits;
 - consistent and clearer communications with countries on new GAVI financial reporting and audit requirements through improved guidelines and templates; and,
 - strengthening of the TAP team through the selection and appointment of a francophone PFM specialist.

FOR INFORMATION**ANNEX 1.1 - Summary status of FMAs**

	Country	Completion of in-country visit	Finalisation of FMA report*	Signature of Aide-Mémoire **	Disbursement of funds	Comments
1	Southern Sudan	March 2009	Yes	Sept 2009	Yes	Completed
2	Senegal	April 2009	Yes	Oct 2009	Yes	Completed
3	Eritrea	May 2009	Yes	Nov 2009	Yes	Completed
4	Bangladesh	May 2009	Yes	Jul 2010	Yes	Completed
5	Uganda	June 2009	No	No	No	Replenishment issue resolved. Design of new mechanism can begin.
6	Nigeria	Aug 2009	Yes	No	No	Delays due to in-country reasons.
7	DRC	Aug 2009	Yes	Final adjustments	No	Revised AM sent with additional reporting requirements. Included.
8	Cuba	Aug 2009	N/a	Final adjustments	No	All support thru PAHO; AM in draft with SC.
9	Pakistan	Oct 2009	Yes	Jul 2010	Yes	Completed
10	Azerbaijan	Oct 2009	Yes	Final adjustments	No	CRO following up on banking details for Aide Memoire.
11	Cameroon	Dec 2009	Yes	Final adjustments	No	AM signed by DCEO and sent to country
12	Mongolia	Jan 2010	Yes	Jul 2010	Yes	Completed
13	Myanmar	Jan 2010	Yes	Draft sent to country	No	Finalising the AM with WHO-M and MoH Myanmar.
14	Burundi	March 2010	Yes	Final adjustments	No	AM signed by DCEO and sent to country
15	Malawi	May 2010	Yes	No	No	FMA report finalised and Aide Memoire being drafted.
16	Indonesia	June 2010	Yes	No	No	FMA report finalised and Aide Memoire being drafted.
17	Burkina Faso	June 2010	Yes	No	No	FMA report finalised and Aide Memoire being drafted.
18	RCA	June/July 2010	No	No	No	Draft report received from consultant and will be sent to country.
19	Mali	June/July 2010	No	No	No	FMA highlighted need for further investigation/ audit.
20	Chad	July/Aug 2010	No	No	No	Draft FMA report sent to country.
21	Yemen	July/Aug 2010	No			Draft report being reviewed.
22	Tajikistan	Aug 2010	No			Draft report being reviewed.
23	Cote d'Ivoire	Sept 2010				FMA in-country visit started w/c 6th September

- = FMA still in progress
 = Aide Memoire almost complete and ready for signing
 = AM signed & disbursements proceeding

* = FMA findings and recommendations agreed by country and partners.

** = Date of receipt of signed AM

FOR INFORMATION**Annex 2****Terms of Reference of the Immunization Financing & Sustainability (IF&S) Task Team
August 31st, 2009****Background:**

The support of the GAVI Alliance to the poorest countries of the world to strengthen and expand their immunization programs is expected to contribute substantially towards attainment of MDG4 (child health). In GAVI Phase 1, support to countries for new and underused vaccines was provided free to countries for an initial period. In order to assist countries to move toward greater financial sustainability of their national programs, a new policy of country co-financing has been developed for Phase 2. Transition to this new policy requires more evidenced-based decision-making and better planning and budgeting at country level to ensure timely and adequate financing. This transition requires additional GAVI Alliance partner effort at both country and global levels. For this reason, the Immunization Financing & Sustainability Task Team was formed.

Mandate:

The Task Team is mandated by the GAVI Secretariat as an advisory body to ensure that the GAVI Alliance is on the best path regarding vaccine co-financing and immunization program financial sustainability, and to oversee the implementation of Strategic Goal (Outcome) 3.1 '*Increase the predictability and sustainability of long-term financing for national immunisation programmes*' in the GAVI Work Plan. The duration of the group will be initially for up to the duration of the Work Plan (31/12/2010). The Group mandate will be revised during the development of the next Strategic Phase (2011-2015).

Responsibilities:

The group will be responsible for advising on policy and operational issues stemming from GAVI co-financing policy. Specifically, the group will:

- Oversee implementation of output 3.1 (activities within sub-outputs 3.1.1 through 3.1.4) in the 2009/10 GAVI Work Plan;
- Monitor and report on GAVI Work Plan activities both on a narrative and financial basis. Although, Partners will report on activities in this area as part of their overall reporting to the Secretariat, the task team will consolidate a report for 3.1
- Advise on the potential re-allocation of funds across activities;
- Identify issues related to the implementation of the co-financing policy and bring them to the GAVI Secretariat as needed basis;
- Delegate implementation of certain activities in the Work Plan to sub-groups on an as needed basis;
- Provide support to the GAVI Secretariat in review, revision, and dissemination of the relevant sections of the New Vaccine Introduction Guidelines and forms and Annual Progress Report; and,
- Steer technical and analytical activities for the revision of the co-financing policy.

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Deliverables:

The Task Team will monitor the deliverables of the Work Plan. In addition to the deliverables stated in the Work Plan for each partner, the specific deliverables for the task team are:

- Quarterly monitoring reports on co-financing
- Mid-year and end of year reports on the implementation of the Work Plan
- Two face to face meetings per year (Reports)
- Inputs and recommendations provided to Board papers and updates regarding co-financing
- Summary reports of work conducted on default countries

Membership

The core group of the Task Team will be composed by:

- 2 members from WHO;
- 2 members from The World Bank;
- 1 member from UNICEF;
- 1 member from UNICEF SD;
- 3 members from the GAVI Secretariat;
- 1 member from PAHO;
- 1 member from and the Bill and Melinda Gates Foundation;
- 1 rotating member from a Regional Working Group.

In addition, the group will involve other experts in specific discussions and face to face meetings, such as representatives from countries, AVI, universities, NGOs, bilaterals and other organizations, and this will be done on an as needed basis.

Leadership:

The GAVI Secretariat

Modus Operandi:

The group will aim to have face-to-face meetings twice yearly, with teleconference or video-conference meetings of the entire group, as needed. Face-to-face meetings will be used for major decision-making and reviews/evaluations of progress with implementation of activities for output 3.1 of the GAVI workplan.

In addition, sub-groups composed of IF&S Task Team members and other experts as needed, will be formed to address specific issues in a time limited manner. For instance, the need for subgroups dealing with managerial issues arising from implementation of co-financing, monitoring/evaluation issues, and setting co-payment levels have already been identified.

Reporting:

Under the new governance structure the IF&S Task Team will report to the Deputy Chief Executive Officer of the GAVI Secretariat.