



Report to the GAVI Alliance Board

4-5 December 2012

Subject:	New strategy for polio eradication: possible GAVI & IFFIm participation
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Agenda item:	13
Category:	For Decision
Strategic goal:	Affects all strategic goals

Section A Overview

1 Purpose of the report

- 1.1 This report presents a possible plan for closer collaboration with the Global Polio Eradication Initiative (GPEI) and other partners in the area of strengthening health systems to provide routine immunisation. This collaboration could span the introduction and implementation of inactivated polio vaccine (IPV), support services for these efforts and perhaps support the procurement and supply tools for oral poliovirus vaccine (OPV). GAVI's participation across these areas will be defined by identified overlaps and synergies between GAVI and GPEI programmes. (Note: A decision on IPV will be brought separately to the Board in 2013 through the Vaccine Investment Strategy.)
- 1.2 Should frontloading be required to support the GPEI fundraising effort and GAVI programmatic collaboration with GPEI, IFFIm is a mechanism well-suited to contribute to this. Expanding IFFIm to provide frontloaded, flexible and predictable financing to support GAVI's role in polio eradication could have advantages for donors who contribute to GPEI, GAVI and IFFIm.

2 Recommendations

- 2.1 The Secretariat recommends that the GAVI Alliance Board:

- **Approve** GAVI playing a complementary role to the Global Polio Eradication Initiative (GPEI) in the polio eradication effort, in line with GAVI's core mission to increase access to immunisation, and approve GAVI exploring the possible use of IFFIm as a funding structure for activities within GAVI's strategy and mission using existing structures, processes and procedures.

3 Executive Summary

- 3.1 Discussions at the GAVI June Board meeting suggested that the Secretariat look into the possible use of IFFIm as a modality to support GPEI.
- 3.2 The new 2014-2018 Polio Endgame Strategic Plan, currently being finalised by GPEI, will signal a fundamental shift toward prioritising routine immunisation strengthening as a strategy against polio. As part of this, the Polio Endgame Strategic Plan has specified the routine administration of at least one dose of IPV into routine immunisation programmes in countries using OPV. This recommendation was endorsed by WHO's Strategic Advisory Group of Experts on Immunization (SAGE) at its meeting of 6 November 2012.
- 3.3 This development has further highlighted the importance of exploring possible areas of collaboration between GAVI and GPEI.
- 3.4 The Secretariat brought the topic to the attention of the Executive Committee (EC), who then provided oversight to the process. On 11 October 2012, the Secretariat sought approval from the EC to fully explore the potential scope of GAVI-GPEI collaboration and within this to define a possible role for IFFIm as a funding tool, if there is significant unmet programme funding need and donor interest.
- 3.5 The EC decided that the Secretariat should consider the possibility of using the IFFIm mechanism to fund routine immunisation aspects of the Polio Endgame Strategic Plan on the conditions that (i) IFFIm funds are used for activities within GAVI's strategy and mission, (ii) there is sufficient interest among donors, (iii) it is technically and legally practicable, (iv) existing structures, processes and procedures are used and (v) GAVI-funded health system strengthening efforts and technical support continue to be channelled through GAVI's normal HSS mechanisms and the business plan.
- 3.6 The EC further agreed that any change to GAVI's vaccine portfolio should be part of the new Vaccine Investment Strategy and that none of GAVI's current resources should be used for this initiative.
- 3.7 As a response to GPEI's planning process and timing needs, the Secretariat has been participating in preliminary discussions with key polio eradication stakeholders to investigate modes of engagement with GPEI and IFFIm.
- 3.8 These discussions and the resulting Secretariat analysis have focused on (i) the recommended areas of "overlap" for programmatic cooperation and (ii) how programmes will be delivered in practice. Specific areas of potential overlap include (a) the introduction of IPV into routine immunisation, (b) enhancing routine immunisation coverage in underperforming countries (the three remaining countries where polio is endemic are key countries for GAVI where synergies between programs should be maximally pursued) and (c) planning, human resources, data and monitoring, and advocacy and communications. In addition, the Secretariat discussion and analysis has considered (i) the funding amount required to support programmatic

cooperation, (ii) the technical and legal practicalities of using IFFIm and (iii) resource mobilisation coordination.

- 3.9 Resource mobilisation efforts for polio eradication are proceeding rapidly. A formal decision is needed on whether IFFIm should be one of the mechanisms available for funding, and by extension, that GAVI should participate in this effort.

4 Risk implication and mitigation

- 4.1 Please see Section B, Part 6.

5 Financial implications: Business plan and budgets

- 5.1 Please see Section B, Parts 4 and 5.

Section B Content

1 Background

- 1.1 Recent developments

- 1.2 There is significant momentum around polio eradication. The number of polio cases is the lowest ever recorded, confined to the smallest geographic area ever recorded. The polio eradication challenge is led by GPEI.

- (a) At the Board's April 2012 retreat, it examined options and approaches that GAVI could take to build on its current strategy through 2020 and beyond. One of these options involved engaging in polio immunisation by supporting the introduction of IPV and, over time, possibly including it in hexavalent vaccine by switching from pentavalent where recommended and acceptable to recipient countries.
- (b) The UK's Department for International Development (DFID) and the Bill & Melinda Gates Foundation (BMGF) requested that GAVI consider the feasibility of leveraging IFFIm to contribute to the polio eradication effort.
- (c) Following consultations with polio eradication stakeholders and guidance from the EC, the Secretariat's discussions and analyses have sought to define more specifically (i) the recommended areas of "overlap" for programmatic cooperation, (ii) how programmes will be delivered in practice, (iii) the funding amount required to support programmatic cooperation, (iv) the technical and legal practicalities of using IFFIm, and (v) resource mobilisation coordination.
- (d) SAGE met on 6-8 November 2012. At that meeting, it recommended at least one dose of IPV in the context of the switch from trivalent OPV (tOPV) to bivalent OPV (bOPV).

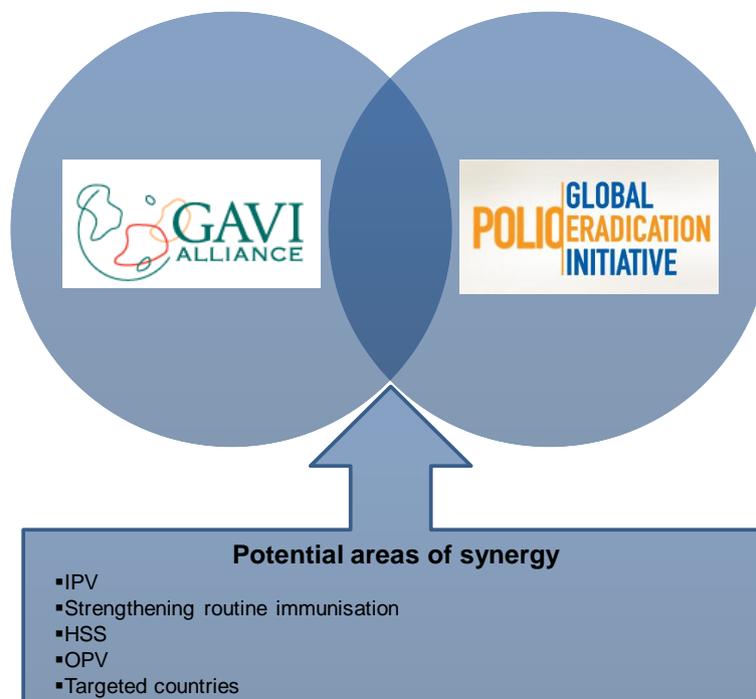
Draft GPEI Polio Endgame Strategic Plan

- 1.3 Under the mandate of the May 2012 World Health Assembly (WHA), GPEI is developing a comprehensive Polio Endgame Strategic Plan, as well as a projection of financial resources required between 2013 and 2018.
- 1.4 The current draft of the Polio Endgame Plan builds on some key assumptions, notably the possibility of stopping transmission of wild poliovirus in the next two years, thanks to an improvement in the quality of OPV campaigns in the three remaining endemic countries. The draft Polio Endgame Plan further assumes a switch from trivalent OPV (tOPV) to bivalent OPV (bOPV) and introduction of one dose of IPV together with DTP3 in 2015 (2016 at the latest). The switch will aim to improve responses to polio vaccines, increase safety by reducing vaccine-induced polio and stop transmission of vaccine-derived polio strains.
- 1.5 An important element of the draft Polio Endgame Plan is the strong emphasis on the importance of routine immunisation (i) to achieve the eradication and containment of all polioviruses and (ii) to secure the long-term gains of polio eradication by leveraging the capacity of the polio programme to bring life-saving interventions to hard-to-reach children. The importance of enhancing routine immunisation has been emphasised by the governments of the polio endemic countries, including at the last GAVI Board meeting by a Board member who is the Minister of Health of Afghanistan.
- 1.6 In particular, to boost coverage of routine polio immunisation, the polio programme is committed to work on traditional approaches (e.g., mobilising individuals and communities through information on the benefits of immunisation, and strengthening monitoring and surveillance systems) with other partners as well as new strategies (e.g., using GPEI staffing, microplans, seeking marginalised groups, and effective monitoring) to tackle inequities in key geographies (i.e., the recently endemic areas and re-established transmission areas).
- 1.7 The draft Polio Endgame Plan is intended to boost population immunity against polioviruses, thus substantially reducing the consequences of a subsequent circulating poliovirus, wild or vaccine-derived, and facilitating the containment of outbreaks.

Engagement with GPEI

1.8 GAVI is exploring how it can maximise collaboration in routine immunisation in a targeted fashion with GPEI and the implementing country. Subject to SAGE recommendations and a separate Board decision on IPV, GAVI’s programmatic role could include (i) IPV introduction in targeted countries at the appropriate time, (ii) support for routine immunisation and (iii) support for the potential use of OPV (participation would be the result of identifying overlaps and synergies between GAVI’s and GPEI’s programmes). The potential synergies between GAVI and GPEI are summarised in Figure 1. The programmatic aspects of GAVI’s engagement in polio eradication are covered in Section B Part 3.

Figure 1: Potential synergies between GAVI and GPEI



1.9 GPEI judges that one of the main risks to the Polio Endgame Plan is failure to strengthen routine immunisation. GAVI currently funds Health Systems Strengthening to assist countries to overcome or reduce health system constraints on immunisation service delivery. As a result, potential areas for better collaboration exist.

1.10 A decision to engage in polio eradication by collaborating with GPEI on routine immunisation would be an opportunity for GAVI to maintain its position as the global agency focused on immunisation. It also would bring additional resources to bear on some of the more challenging countries and increase the likelihood of increased routine coverage and the resulting health impact.

2 Consultations

Polio eradication stakeholders

- 2.1 The Secretariat has had discussions with polio eradication partners GPEI, DFID and BMGF around (i) challenges and opportunities associated with creating programmatic synergy between GAVI's routine immunisation programmes and polio eradication efforts, (ii) challenges and opportunities associated with simultaneous resource mobilisation for GAVI's routine immunisation programmes and for polio eradication and (iii) IFFIm structuring issues.
- 2.2 The CEO has also met and consulted with leadership at the Rotary International Foundation.

Donors

- 2.3 There are very early indications of some donor interest to utilise IFFIm as a financing facility for the polio endgame. This requires further assessment and corroboration.

IFFIm Board

- 2.4 The IFFIm Board has been kept informed on this topic, most recently at its board meeting on 25 October 2012, where the GAVI CEO presented on polio and IFFIm and on 14 November when it reviewed this paper. The IFFIm Board was supportive of GAVI's efforts and engagement, and it asked to be kept informed.

World Bank

- 2.5 The World Bank has been actively engaged with GAVI and polio eradication partners on the impact this could have for IFFIm, and it has provided input and guidance around IFFIm structuring and capital markets issues.

3 Areas of programmatic overlap between GAVI and GPEI

- 3.1 GAVI is providing significant support in the three remaining polio endemic countries – Afghanistan, Nigeria and Pakistan as well as India. In addition to supporting the introduction of new vaccines, an important component of GAVI support to countries is health and immunisation systems strengthening. The overall financial package of current or planned Health System Strengthening (HSS) support for these countries is >\$200 million (see Annex 1).
- 3.2 GAVI HSS support provides countries with flexible, reliable funding to address health system constraints on the delivery of immunisation and related maternal and child health services. In general, HSS support to countries has been primarily concentrated in the following areas:
- (a) Capacity building and training to strengthen programme management and supervision

- (b) Strengthening cold chain infrastructure and vaccine supply management
- (c) Improvement of immunisation data collection and management systems

GPEI and potential synergies

3.3 Key aspects of the GPEI Strategic Plan that provide potential opportunities for collaboration with GAVI's HSS programmes include: (a) strategic planning (b) advocacy, communication and social mobilisation (c) programme monitoring, and (d) disease surveillance. Each of these is described briefly below:

3.4 *Strategic planning*

Core to GPEI's focused support to conduct impactful mass immunisation campaigns is systematic and regular revision of local-level microplans. This exercise includes house-based visits to update lists of emerging communities and produce local level maps to orient vaccination teams and supervisors to ensure complete geographic and community coverage. The emphasis of polio campaigns on reaching every child has resulted in the development of innovative approaches to planning and implementation to tackle inequities and vaccinate the hardest to reach, most marginalised populations. Detailed and up-to-date polio microplans are readily available to health facility and district immunisation programme managers and should be periodically used to update routine immunisation plans including driving goals for implementation of these plans.

3.5 *Advocacy, communication and social mobilisation*

GPEI has developed comprehensive communication strategies including mass media, public advocacy to mobilise decision makers and administrative structures, community engagement and mobilisation, and in priority countries the establishment of local social mobilisation networks of men and women empowered to address local concerns related to polio and immunisation. The advocacy and communication approaches developed uniquely situate the programme to take on an expanded role for the promotion of routine immunisation services. Working to expand messaging to focus on strengthening routine immunization will have benefits for GPEI, the strengthening coverage of routine vaccines and the roll out of new GAVI vaccines.

3.6 *Programme monitoring:*

To assess the quality of eradication activities, GPEI has developed expertise and approaches to monitor performance through a mix of programme monitoring and survey methods (traditional coverage and lot quality assurance (LQA) methods). Moreover, regular feedback provides programme managers and decision makers with timely programmatic information for evidence-based decisions. The networks and skills sets of trained polio field monitors can be applied to monitoring the quality and safety of routine immunisation sessions. The cross-over capability of polio monitors to support routine immunisation monitoring is highlighted in the India case example.

3.7 *Epidemiologic surveillance*

GPEI effectively employs high quality, lab confirmed disease surveillance data to direct programmatic decisions and formulate policy. The AFP surveillance network and developed human resource expertise has been used in most polio-priority countries to support surveillance activities related to traditional vaccine preventable diseases (VPD), such as measles, yellow fever, diphtheria, pertussis and neo-natal tetanus. Although surveillance of diseases and syndromes related to newer vaccines (i.e., Hib, pneumococcal and rotavirus) require different methods, there is an opportunity to utilise existing laboratory structures, logistics and human resources to facilitate sentinel-site based invasive bacterial, pneumonia and rotavirus diseases surveillance.

Operational approaches

3.8 *Through years of concerted efforts, GPEI has established strong support networks focused on thematic areas that overlap with GAVI HSS support. These areas serve as potential convergence points between polio eradication resources and GAVI support for new vaccine introduction and immunisation system strengthening.*

3.9 *Geographic overlap*

GPEI maintains technical staff in more than 60 countries. The three remaining polio endemic countries, Afghanistan, Nigeria and Pakistan, as well as India, all have sub-national polio staff of approximately 2,156 people in aggregate¹. These four countries are also among the largest recipients of GAVI support for the introduction of new and underutilised vaccines and health system strengthening.

3.10 *Accountability structure*

The quality of GPEI programme implementation is influenced by different processes, functions and accountability frameworks. Micro planning, social mobilisation, performance monitoring and surveillance all benefit from defined standard operating procedures, training materials, monitoring indicators and reporting structures. To support these, monetary incentives are provided to government personnel and volunteers involved in the preparation, implementation and assessment of polio immunisation campaigns and active AFP case surveillance. To ensure concerted efforts from polio staff are coordinated with GAVI supported HSS activities, similar explicit terms of reference and performance monitoring of key strategic activities (e.g., monitoring of RI sessions, microplan convergence) will be required.

¹ Excludes additional surge capacity by GPEI in these countries, WHO local field monitors and staff at an international and national levels.

3.11 *Global advocacy and consensus building for greater integration between polio eradication and routine immunisation programmes*

Current donors to the GPEI have built-in strong incentives for country-level staff to prioritise polio campaigns over building routine immunisation systems. A meeting with the leadership of key players in Polio Eradication (WHO, UNICEF, BMGF, CDC) is required to align agency priorities, develop shared objectives and discuss whether new incentives are needed to integrate polio programmes with routine EPI. Clear high level imprimatur from these agencies is required before meaningful collaboration between polio and routine immunisation.

3.12 *Integrating a new set of incentives in current GAVI HSS support*

GAVI HSS funds could be used to promote integration. For example GAVI could also build on the introduction of Performance Based Funding (PBF) by incorporating performance indicators that would promote greater integration of between polio and routine programs. GAVI could link HSS performance funding to the proportion of routine immunisation sessions monitored by Polio staff, or to the proportion of routine vaccinations validated by Polio staff. This could be applied to all countries approved for new GAVI HSS/PBF support.

3.13 *Developing demonstration activities in selected countries*

Nigeria and Pakistan are polio endemic countries where GAVI has significant programmes and intensive engagement. In both countries, GAVI efforts to date have been on strengthening under-performing routine programmes. In addition, engagement at the subnational level (states & provincial level) will be critical for programmatic success. While there have been links with Polio programmes established, these are not strong. Examples of specific country initiatives include:

- (a) Nigeria - offering new funding on top of the recently re-programmed GAVI cash-support. Indicators that promote integration between Polio and EPI would be agreed (as proposed above for example) and significant additional funding offered to reward improvements.
- (b) Pakistan - Institutional uncertainties relating to devolution have exacerbated operational separation of Polio and routine programmes. GAVI has been part of donor efforts to urge the Government of Pakistan to co-locate institutional responsibility for EPI and Polio, though this is not resolved. GAVI has also been investigating opportunities for new partnerships on HSS in Pakistan and is currently considering co-financing with the World Bank. GAVI could seek to allocate funding within the project design that would promote integration – this could also include incentive funding elements.

The polio endemic countries are currently fully aligned with countries that would be recommended for a GAVI tailored approach (under the Country by Country policy to be submitted to the December 2012 Board). This would also facilitate the development of greater flexibility and innovation in developing GAVI programmes in these countries that can promote integration.

3.14 *Knowledge sharing and dissemination of good practices*

Quarterly or biannual meetings of partner agency leadership would provide an opportunity to maintain the profile of the integration objectives and to review progress of country initiatives.

Case study: India – Government leadership and partner collaboration is critical

3.15 With the recent unprecedented progress to achieve polio eradication, the landscape of immunisation in India has changed. The accumulated experience and technical support structures established for polio eradication – both at the national and sub-national levels – is recognised by the government of India and partner agencies to be a unique opportunity to provide strategic technical support to strengthen India's Universal Immunisation Programme (UIP).

3.16 A valuable lesson from polio eradication in India is the utility of timely and reliable evidence generated through high quality monitoring and laboratory supported surveillance networks. Understanding that India requires a variety of programmatic data to manage and strengthen the UIP, and take timely corrective action, WHO and UNICEF have been asked to re-tool their established surveillance and SMNet communication networks to respond to these needs.

3.17 An example of this is WHO's intensified support for routine immunisation session and community monitoring. WHO polio field staff (Surveillance Medical Officers and Field Monitors) in the high-risk polio states of Bihar, Jharkhand, Uttar Pradesh and West Bengal support routine immunisation session and community monitoring in large, underperforming states. WHO polio staff monitor on average 7,800 immunisation sessions each month and verify the vaccination status of more 60,000 children 0-23 months of age. At the request of state and district health officials, data collection, analysis and feedback of information to block, district and state officials for programme decision making has been streamlined. In addition, monthly District Task Force (DTF) meetings – originally established to review polio immunisation campaign preparation and performance – have evolved to become the main forum for routine immunisation data and information sharing with district officials.

The role of IPV within the polio eradication strategy

3.18 As part of the GPEI's Polio Endgame Strategic Plan, the use of at least one dose of IPV into routine immunisation programmes in countries using OPV is included. The plan includes estimates for funding the IPV vaccines of US\$ 274 million between 2014 and 2018. During the high level review undertaken for the Board retreat in April 2012, the Secretariat had estimated that GAVI's funding requirements for the period to 2020 could vary between US\$ 268 million and US\$ 1.2 billion. The factors that account for the difference in estimates between the GPEI plan and the initial GAVI estimate

include: countries,² funding sources,³ assumptions on uptake, price and the time period considered. Adjusting for the last two parameters, GAVI's estimated range for its funding requirement would likely tend toward the lower end of the estimate. These estimates will be reviewed during the Vaccine Investment Strategy review next year and be brought for consideration to the GAVI Programme and Policy Committee and Board.

- 3.19 Another complementary aspect of a closer GPEI and GAVI relationship could be the joint use of the procurement tools with UNICEF to maximise buying power through the pooling of demand for IPV and OPV vaccines and the joint use of innovative procurement mechanisms, if appropriate, even if funding sources differ.

4 Use of IFFIm

Why use IFFIm

- 4.1 IFFIm is well-placed as a funding mechanism to assist polio eradication. An eradication surge, and the rapid increase in routine immunisation coverage that is required, are a classic case of the public health value of frontloading that IFFIm can provide. This would facilitate eventual cost savings once countries are able to decrease investments in polio.

(a) IFFIm could efficiently facilitate the increased expenditure required over the next several years to help accomplish this global health challenge. IFFIm provides potential polio donors with the flexibility to meet the surge required today but spreading their contribution over a longer period. This benefit may be advantageous to some donors, particularly emerging countries or countries that are currently facing fiscal constraints.

(b) The Bill & Melinda Gates Foundation has indicated that it would consider channelling part of its contribution to polio eradication through IFFIm to unlock the value of frontloading and to encourage new donors to join.⁴ IFFIm for polio also has the potential to attract new donors to global immunisation funding.

- 4.2 Channelling more resources through IFFIm would have benefits for the instrument as a financing vehicle for global health. All other things being equal, IFFIm provides both scalable financing and operational returns. The IFFIm Board, GAVI Secretariat and the World Bank (in its capacity as IFFIm's treasury manager) recognise there are a number of potentially attractive features of using IFFIm to raise funds for polio eradication:

² The GPEI model comprises 112 countries that use IPV whereas there are 57 GAVI-eligible countries.

³ The GPEI estimates in the early years include all funding requirements and assume some level of country financing in the outer years. By contrast, GAVI applies country co-financing throughout.

⁴ BMGF does not have a credit rating, and this issue would need to be addressed before it can make a contribution to IFFIm.

- (a) More efficient operating costs: IFFIm's administrative costs are predominantly fixed. This would spread the same costs over a larger amount of funds raised for immunisation.
- (b) Enhancing IFFIm's credit: The initiative could potentially broaden IFFIm's donor base and in the process decrease or eliminate the credit linkage to IFFIm's largest donors placed by some ratings agencies. All other things being equal and subject to the composition of the broadened donor base, this could be seen as very positive by the ratings agencies.
- (c) Enhancing IFFIm's capital markets access, and therefore potentially its funding costs: All other things being equal, larger funding operations would give IFFIm access to more markets. As a result, it would have more funding options at its disposal and could potentially generate better funding costs.

Structuring approach

- 4.3 The overarching framework is to utilise the IFFIm's existing structure (including governance, funding both from donors and the capital markets, and IFFIm-approved programmes), processes and procedures. The introduction of IFFIm funding for the Polio vaccine will be on the reasonable judgement of GAVI and IFFIm that it does not overly compromise IFFIm's ability to continue to be used and raise additional funding for GAVI's existing vaccination-related activities. This is in line with guidance provided by the GAVI Executive Committee during its meeting on 11 October 2012.
- 4.4 In this context, structural enhancements to IFFIm may arise to bring potential major polio donors into IFFIm and to develop any potentially beneficial financial innovations.
- 4.5 A working group, comprising a small number of individuals from the Secretariat, GPEI, DFID, BMGF and the World Bank, has been established to jointly evaluate structural considerations of using IFFIm. The Secretariat has informed the IFFIm board of this development, and the IFFIm board has appointed a board member to serve as a focal point for the structuring working group. The purpose of the working group is to discuss and solve structuring issues at a technical level. It will provide recommendations and suggestions to the respective decision-making bodies of the IFFIm or GAVI boards.

5 Resource mobilisation

- 5.1 The GPEI estimate that US\$ 5.5 billion is needed between 2013 and end-2018, of which US\$ 4.5 billion is for the 2014-2018 endgame period (not including India's self-funded activities).
- 5.2 To achieve this, BMGF, UNICEF and GPEI envisage a vaccine moment in April 2013, with a focus on global immunisation efforts, an important element being the pledging of financial support for polio eradication. Discussions are underway with donors about this effort. The goal is to

generate sufficient commitments to fully meet funding needs through 2018. GPEI already has some commitments and firm prospects to help meet the polio eradication funding need. These, combined with current contributions, fall short of the funding requirement through 2018, hence the need for a focused resource mobilisation effort leading to the planned April 2013 vaccine summit.

- 5.3 A significant portion of this funding requirement is expected to apply to shared GAVI/GPEI programme objectives, where there is alignment with GAVI's support for new and underutilised vaccines and routine immunisation programmes.
- 5.4 In a first phase, a preliminary scan of GAVI's current donors' interest reveals a keen interest to support shared GAVI/GPEI activities. The use of any particular financing instrument to tackle the polio challenge has not yet been agreed upon. Early current donors' interest in IFFIm for polio related activities was tested taking into account the use of a wide range of instruments ranging from traditional instruments to IFFIm. While some initial indicative interest in IFFIm as a possible funding mechanism was signalled, this needs to be validated through more substantive discussions with donors. Furthermore, it is envisaged that in a second phase of resource mobilisation, once direct funding and immediate possibilities have been exhausted, IFFIm could be a solution to close any remaining gap.
- 5.5 A roadshow targeting more specifically new and emerging donors in Asia in February 2013 ahead of the April moment or summit will provide further information as to new donor interest to IFFIm as a possible solution. Leveraging IFFIm for the routine immunisation part of polio eradication would potentially enable GAVI to secure new IFFIm donors.
- 5.6 Further refined and targeted donors' interest testing in IFFIm will be pursued over the upcoming months once overall funding possibilities and the mix of instruments are confirmed.

6 Risks

- 6.1 There are several risks associated with a greater GAVI engagement in polio eradication.

Reputational risk

- 6.2 By engaging in polio immunisation, GAVI could be seen to share ownership in the programmatic successes and failures of polio eradication. Despite best efforts of GPEI partners and GAVI, due to geopolitical or other issues, eradication could fail despite "adequate" funding. On the other hand, increased collaboration directed to polio-affected countries should result in increased coverage and an improvement in routine immunisation, which GAVI has identified as key concerns.⁵

⁵ Consider, for example, that GAVI's current HSS allocation for Nigeria through end-2015 is US \$ 51 million. By contrast, the polio eradication effort envisages the expenditure of US \$ 184 million on HSS-related activities over the period, and there are roughly 300 individuals funded by WHO

Fragmentation of GAVI's focus

6.3 The polio eradication effort may involve activities that fall outside of GAVI's focus on its core vaccines and routine immunisation. The risk is that engagement with GPEI may divert GAVI's attention and resources away from its core mission.

Funding cannibalisation

6.4 To meet projected country demand for GAVI's core programmes in 2016-20, GAVI needs to mobilise at least US\$ 8.2 billion. Currently, 90% of this amount is unfunded. GAVI will begin consultations with donors in 2013. There is a concern that GAVI's funding for its existing programmes will be reduced or cannibalised should GAVI decide to include polio vaccine in its portfolio and thereby require a corresponding increase in funding. However, it could also be argued that this risk is relatively smaller if GAVI engages, on the timetable articulated by BMGF and GPEI, than if GAVI should choose not to engage.

Challenges in HSS implementation

6.5 Inherent in the broader HSS effort are obstacles facing in-country implementation. These will not, however, be unique to the polio eradication effort.

Tension between the polio eradication initiative and the current routine immunisation system

6.6 While coordination challenges may have been overcome at a global level, it could conceivably take time to settle similar issues at the country level. We envisage that a significant amount of work is required on the ground, including but not limited to human resource management, and there is a need to consider how and where GAVI would fit within this configuration.

Section C Implications

1 Impact on countries

1.1 See Section B above

2 Impact on GAVI stakeholders

2.1 See Section B above

3 Impact on Secretariat

3.1 See Section B above

in Nigeria who are working on polio immunisation and would by this proposed collaboration become heavily involved in routine immunisation.

4 Legal and governance implications

- 4.1 Should GAVI's involvement in the project be approved, the GAVI Board and relevant committees will be consulted as appropriate.
- 4.2 The intention is to use IFFIm as it is currently structured. Any additional feature or structuring aspect will go through the relevant management and governance processes within GAVI and IFFIm.
- 4.3 The Secretariat, in collaboration with IFFIm, will be required to put in place the necessary legal documentation to ensure that the project is consistent with existing structures, processes and procedures.

5 Consultation

- 5.1 See Section B, Part 2.2

6 Gender implications

- 6.1 Not applicable

Annex 1

GAVI support for Afghanistan

Type of support	Approvals 2001-2016 (US\$) (30 Sep 2012)	Commitments 2001-2016 (US\$) (30 Sep 2012)	Disbursements 2001-2012 (US\$) (30 Sep 2012)	% Disbursed (30 Sep 2012)	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Civil Society Organisation support (CSO)	\$3,590,500	\$3,590,500	\$3,906,400	109%															
Health System Strengthening (HSS)	\$40,875,522	\$52,299,607	\$29,950,346	73%															
Immunisation Services Support (ISS)	\$14,025,300	\$14,025,300	\$13,855,800	99%															
Injection Safety Support (INS)	\$1,676,500	\$1,676,500	\$1,676,500	100%															
Penta (NVS)	\$50,827,358	\$81,849,358	\$45,082,629	89%															
Tetra DTP-HepB (NVS)	\$9,903,633	\$9,903,633	\$9,903,633	100%															
Vaccine Introduction Grant	\$504,000	\$504,000	\$504,000	100%															
Total	\$121,402,813	\$163,848,898	\$104,879,308																

Red line on table indicates duration of support based on commitments.

Commitments: Multi-year programme budgets endorsed in principle by the GAVI Board. These become financial commitments upon approval each year for the following calendar year.

Approvals: Total Approved for funding (IRC Reviewed)

[Download data for commitments & disbursements in XLS format](#)

Afghanistan HSS support: US\$ 53 million, 2008 to present:

1. Improving access to and demand of quality maternal and child health care services.
2. Improving MOPH managerial and stewardship capacity at all levels.

GAVI support for Nigeria

Type of support	Approvals 2001-2016 (US\$) (30 Sep 2012)	Commitments 2001-2016 (US\$) (30 Sep 2012)	Disbursements 2001-2012 (US\$) (30 Sep 2012)	% Disbursed (30 Sep 2012)	2001	2002	2003	2004	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	
Health System Strengthening (HSS)	\$36,462,500	\$44,704,000	\$22,098,500	61%															
Immunisation Services Support (ISS)	\$47,324,000	\$47,324,000	\$30,637,000	65%															
Injection Safety Support (INS)	\$12,630,270	\$12,630,270	\$7,791,770	62%															
Meningitis A - campaign (NVS)	\$44,816,000	\$61,275,500	\$22,279,950	50%															
Operational Support	\$17,027,323	\$23,261,645	\$10,448,488	61%															
Penta (NVS)	\$21,514,500	\$124,736,000	\$16,915,311	79%															
Pneumo (NVS)	\$46,643,500	\$46,643,500																	
Vaccine Introduction Grant	\$10,013,974	\$10,013,974	\$100,000	1%															
Yellow Fever (NVS)	\$34,889,813	\$49,776,313	\$36,087,560	103%															
Total	\$271,321,881	\$420,365,203	\$146,358,580																

Red line on table indicates duration of support based on commitments.

Commitments: Multi-year programme budgets endorsed in principle by the GAVI Board. These become financial commitments upon approval each year for the following calendar year.

Approvals: Total Approved for funding (IRC Reviewed)

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Nigeria HSS support: US\$ 44.7 million, 2008 to 2010:

1. Improving access to quality vaccines and adequate storage.
2. Strengthening NHMIS to ensure data quality, data analysis and utilisation.
3. Building capacity of frontline health workers and EPI managers.

GAVI support for India

Type of support	Approvals	Commitments	Disbursements	% Disbursed (30 Sep 2012)	2002	2003	2005	2006	2007	2009	2011	2012
	2001-2016 (US\$) (30 Sep 2012)	2001-2016 (US\$) (30 Sep 2012)	2001-2012 (US\$) (30 Sep 2012)		2002	2003	2005	2006	2007	2009	2011	2012
HepB mono (NVS)	\$26,486,033	\$26,486,033	\$26,486,033	100%	■	■	■	■	■	■	■	■
Injection Safety Support (INS)	\$18,427,489	\$18,427,489	\$18,427,489	100%			■	■	■			
Penta (NVS)	\$165,000,000	\$165,000,000	\$38,178,105	23%							■	■
Vaccine Introduction Grant	\$415,523	\$415,523	\$415,523	100%	■				■			
Total	\$210,329,045	\$210,329,045	\$83,507,150									

■ Red line on table indicates duration of support based on commitments.

Commitments: Multi-year programme budgets endorsed in principle by the GAVI Board. These become financial commitments upon approval each year for the following calendar year.
Approvals: Total Approved for funding (IRC Reviewed)

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India planned HSS support: US\$ 80 million:

1. Improve the quality of vaccines delivered through improved vaccine intelligence on supply chain management and temperature control.
2. Support to strategic communications geared particularly on demand generation.
3. Support for evidence generation and consolidation of evidence for policy decisions related to adoption of new vaccines

GAVI support for Pakistan

Type of support	Approvals	Commitments	Disbursements	% Disbursed (30 Sep 2012)	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	2001-2016 (US\$) (30 Sep 2012)	2001-2016 (US\$) (30 Sep 2012)	2001-2012 (US\$) (30 Sep 2012)		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Civil Society Organisation support (CSO)	\$6,135,988	\$6,135,988	\$6,235,988	102%									■	■	■				
Health System Strengthening (HSS)	\$23,525,000	\$23,525,000	\$16,898,500	72%								■			■				
HepB mono (NVS)	\$24,953,324	\$24,953,324	\$24,953,324	100%	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Immunisation Services Support (ISS)	\$48,763,740	\$48,763,740	\$34,101,500	70%	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Injection Safety Support (INS)	\$7,405,082	\$7,405,082	\$7,405,082	100%		■	■	■	■	■									
Penta (NVS)	\$219,856,352	\$312,937,352	\$225,551,732	103%								■	■	■	■	■	■	■	■
Pneumo (NVS)	\$109,888,000	\$380,394,500	\$43,238,361	39%													■	■	■
Tetra DTP-HepB (NVS)	\$31,387,734	\$31,387,734	\$31,387,734	100%						■	■								
Vaccine Introduction Grant	\$6,750,500	\$6,750,500	\$3,694,000	55%	■							■		■					
Total	\$478,665,720	\$842,253,220	\$393,466,221																

■ Red line on table indicates duration of support based on commitments.

Commitments: Multi-year programme budgets endorsed in principle by the GAVI Board. These become financial commitments upon approval each year for the following calendar year.
Approvals: Total Approved for funding (IRC Reviewed)

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Pakistan HSS support: US\$ 23.5 million 2008 to present:

1. Improving integrated service delivery through strengthening human resource development, organizational management, leadership capacity, logistics, supplies and infrastructure.
2. Improve community and civic society organizations involvement in health system decision-making.

Annex 2

Abbreviations and Acronyms

Please find below definitions for the abbreviations and acronyms used in the paper.

bOPV	Bivalent oral poliovirus vaccine
cVDPV	Vaccine-associated paralytic poliomyelitis and vaccine derived poliovirus outbreaks
GPEI	Global Polio Eradication Initiative
HSS	Health Systems Strengthening
IFFIm	International Finance Facility for Immunisation
OPV	Oral poliovirus vaccine
OPV2	Oral poliovirus vaccine type 2
SAGE	WHO Strategic Advisory Group of Experts (on immunisation)
SIA	Supplemental immunisation activity
tOPV	Trivalent oral poliovirus vaccine
VAAP	Vaccine-associated paralytic poliomyelitis