

Report to GAVI Secretariat

Lessons Learned from GAVI Phase 1 and design of Phase 2: Findings of the Country Consultation Process

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Abbreviations & Acronyms

AD	Auto-disable
ARIVA	D'Appui au Renforcement de l'Indépendance Vaccinale en Afrique
APR	Annual Progress Report
BMGF	Bill & Melinda Gates Foundation
CC	Country Consultation
CCP	Country Consultation Process
DMS	Directors of Medical Services
DTP3	Diphtheria, Tetanus and Pertussis vaccine – 3 rd dose
DTwP	Whole cell DTP vaccine
DQA	Data Quality Audit
EPI	Expanded Programme on Immunisation
FSP	Financial Sustainability Plan
GAVI	Global Alliance for Vaccines and Immunisation
GIVS	Global Immunisation and Vaccination Strategy
GNI	Gross National Income
HepB	Hepatitis B
Hib	Haemophilus influenza b
ICC	Inter Agency Coordination Committee
IFFIm	International Financing Facility for Immunisation
IRC	Independent Review Committee
ISS	Immunisation Services Support
INS	Injection Safety
JRF	Joint Reporting Form
LLS	Lessons Learned Survey
MDGs	Millennium Development Goals
MoH	Ministry of Health
MYP	Multi-Year Plan
NVS	New Vaccines Support
RWG	Regional Working Group
SWAp	Sector Wide Approach
UNICEF	United Nations Children's Fund
VF	Vaccine Fund
WB	World Bank
WHO	World Health Organisation
YF	Yellow Fever

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Executive Summary

Lessons learned

- Overall GAVI support was viewed positively by countries, it has helped to raise awareness and support for the immunisation programme and led to an increase in coverage for a significant number of countries.
- The Data Quality Audit (DQA) was reported as a useful process tool that was having a catalytic effect on information management. Similarly, the Financial Sustainability Plan (FSP) was positively received as a useful process, which should be integrated at an earlier stage in country planning processes.
- The predominant concern from many countries is that five years is too short a period to introduce and transfer responsibility for funding new vaccines and attain global targets including GIVS and MDGs.
- Injection safety support (INS) in Phase 1 is overwhelmingly considered a positive experience which has proved a catalyst at country level but concerns were raised over long term sustainability.
- The incentive benefits of a performance-based mechanism for GAVI systems support were appreciated by countries, however understanding of the precise nature of the ISS investment and reward mechanism were fairly limited.

Recommendations

- Respondents recommended that the eligibility criterion for ISS support (DTP3 < 80%) should not continue for future systems support, so that all countries could apply for support.
- A strong message from the country consultation meeting in Geneva and echoed in country visits was that GAVI should focus on encouraging manufacturers to reduce vaccine prices.
- The countries visited welcomed the idea of bridge funding to continue support for combination vaccines, but would need to see the financial consequences before deciding whether to take on a bridge funding commitment (which includes increasing levels of co-financing from the country level).
- Possible new vaccines to be considered for Phase 2 support include Japanese encephalitis, rubella, meningococcal meningitis (A & C) & the malaria vaccine when it is available on the vaccine market. The Gambia and Guyana requested the pneumococcus and rotavirus vaccines respectively.
- A significant number of countries requested support for the safe disposal of used auto-disabled syringes and other injection safety equipment to continue.
- There was consensus that immunisation should remain the focus of GAVI systems support in phase 2, with support to address system constraints particularly at the service delivery level. There was not full consensus on how far support should be used outside the immunisation system.

Key Findings

1. The Global Alliance for Vaccines and Immunisation (GAVI), established in 2000, has been operational for five years. It has committed over \$1.2 billion over this period and disbursed over \$480 million of funds to 71 of the 75 countries considered eligible for financial support. Funds are drawn from the Vaccine Fund (VF).
2. This period of five years is now being considered as 'Phase 1'. 'Phase 2' is conceived as a further period of support from 2006-2015 which will draw on new donations/pledges to the VF which may include additional funding from an International Financing Facility for Immunisation (IFFIm).
3. As GAVI moves from one phase to the next it has commenced a Country Consultation (CC) Process that invites all eligible countries to provide comments from their experience of Phase 1 in order that planning for Phase 2 takes account of their experience and views. The consultation process commenced in March 2005, has six components and continues into June 2005.
4. This report is a summary of the findings from the CC process. It incorporates comments returned to GAVI after an earlier draft of the report was circulated to all eligible countries in June.
5. The CC process considers three areas: GAVI Processes; New Vaccines & Technology (including New Vaccines Support, NVS, and Injection Safety, INS); and Systems Support (including Immunisation Systems Support, ISS). This report follows these themes in its layout, presenting areas of consensus and divergence in the feedback on Phase 1 and then summarising issues for Phase 2.
6. *GAVI Processes:*
 - To improve the efficiency of the application process, it was proposed during the consultation process, that applications and reports to GAVI should in future require the signatures of only four key stakeholders, including the government, rather than all members of the Inter Agency Coordination Committee (ICC). ICC minutes where the report/application was discussed would be provided as supporting evidence.
 - Most respondents indicated an increased understanding of the application requirements and GAVI processes in the years since the initial launch. However there was a call for greater recognition of individual country characteristics which may not always fit a standardised model or templates, and for GAVI to increase flexibility.
 - Reduced duplication in reporting requirements was proposed, by merging GAVI Annual Progress Reports with the Joint Reporting Form.
 - Country representatives would welcome greater dialogue with the Independent Review Committee (IRC) should questions relating to a country application/report arise.
 - The Data Quality Audit (DQA) was reported as a useful process tool that was having a catalytic effect on information management. Similarly, the Financial Sustainability Plan (FSP) was positively received as a useful process, which should be integrated at an earlier stage in country planning processes.
 - There is an ongoing need for coordination among agencies providing support and continued support to develop country capacity.

7. *New Vaccines and Technology:*

- The predominant concern from many countries is that five years is too short a period to introduce and transfer responsibility for funding new vaccines.
- Awareness of the cost issue was greater once countries had prepared an FSP or where they had a SWAp.
- In the Geneva CC meeting and from country visits it was recognised that the financing concerns partly reflect the changing behaviour of international donors, challenging the assumption that GAVI can act as a 'lever' for increased donor support for immunisation at country level
- Combination vaccines cause a significant increase in immunisation costs at the national level, raising fears over sustainability after GAVI support ends.
- Many respondents suggested that GAVI consider a timescale of 10 years in Phase 2 and there was a clear request for additional support to help sustain the use of pentavalent vaccine where it has already been introduced.
- The countries visited welcomed the idea of bridge funding to continue support for combination vaccines, but expressed concern over the high cost of the vaccine at the end of the bridge period. The financial consequences would need to be carefully considered before deciding whether to take on increasing levels of co-financing from the country (a condition of the bridge financing).
- A strong message from the Geneva meeting and echoed in country visits was GAVI should focus on encouraging manufacturers to reduce vaccine prices.
- Injection safety support (INS) in Phase 1 was overwhelmingly considered a positive experience which proved a catalyst at country level. However some countries questioned whether three years of support was enough to sustain improvements in injection safety.
- The unfinished agenda for injection safety is to deal with safe disposal of syringes, recognising this is much broader than just for immunisation.

8. *Systems Support:*

- The majority of respondents supported the flexibility of ISS funds, and felt that it was important to continue this principle in phase 2. A smaller group expressed concerns and felt that guidance on use of funds would be helpful, e.g. to use most at district level and below, as well as clearer accountability.
- The incentive benefits of a performance-based mechanism for GAVI systems support were appreciated by countries, however understanding of the precise nature of the ISS investment and reward mechanism were fairly limited.
- The use of a single indicator (DTP3) was welcomed by many countries as being a simple mechanism for measuring performance. However some EPI managers would prefer multiple indicators to give a fairer representation of the overall EPI Programme, and would welcome process indicators.
- There was support for increasing the period of systems strengthening support from 5 to 10 years (or longer), as there is still limited capacity to attain the Global Immunisation and Vaccination Strategy (GIVS) targets and meet the Millennium Development Goals (MDGs) by 2015 in many GAVI countries.
- Additional support was proposed for maintaining coverage rates and providing services for 'hard to reach' population groups.
- There was consensus that immunisation services should remain the focus of GAVI systems support in phase 2, with support to address system constraints particularly at the service delivery level. There was not full consensus on how far support should be used outside the immunisation system.
- Respondents (mostly, but not all those approaching the upper eligibility limit) recommended that the cut off criteria for ISS support (DTP3 > 80%) should not continue for future systems support, so all countries can apply for support.

1 Background and Introduction

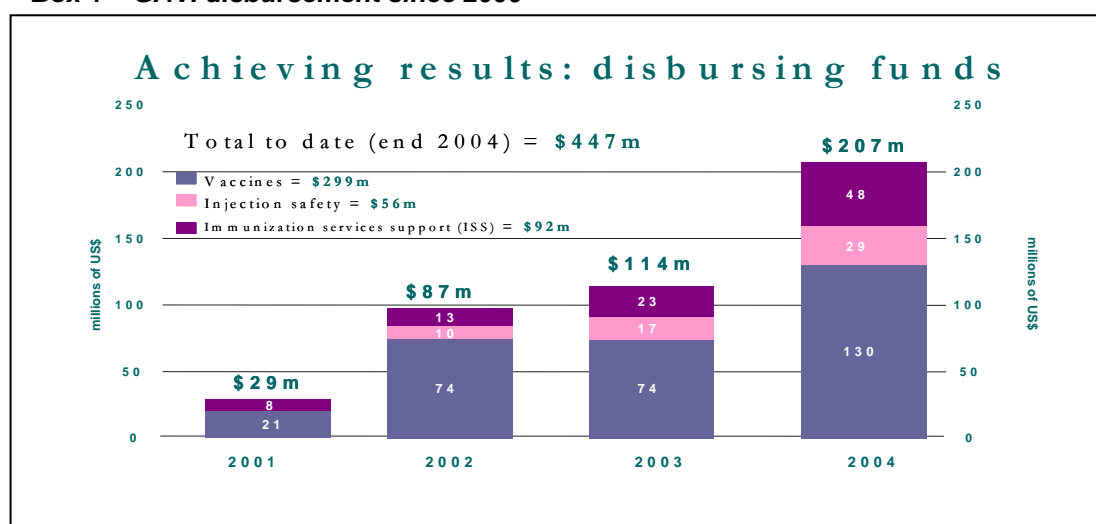
The Global Alliance for Vaccines and Immunisation (GAVI) was publicly launched at Davos in 2000. Its mission statement is:

"To save children's lives and protect people's health through the widespread use of vaccines."

It is an alliance of governments, organisations and institutions from both the public and private sectors. Partners in this alliance include, amongst others, the World Health Organisation (WHO), the United Nation's Children's Fund (UNICEF), the World Bank (WB), the Bill & Melinda Gates Foundation (BMGF), developed and developing countries, NGOs and vaccine manufacturers. Each of the partners is committed to the vision of improving children's lives through the improved use of vaccines and in working collaboratively to do so.

The organisational structure of GAVI is deliberately lean, to 'add value' rather than replicate existing work by members. The Secretariat in Geneva works in support of the Board, facilitating the interaction between alliance members and managing the processes for country support. An Independent Review Committee (IRC) advises the Board on country applications, financial plans and progress reports.

Box 1 – GAVI disbursement since 2000



Source: GAVI presentation, 14th May, 2005, Geneva.

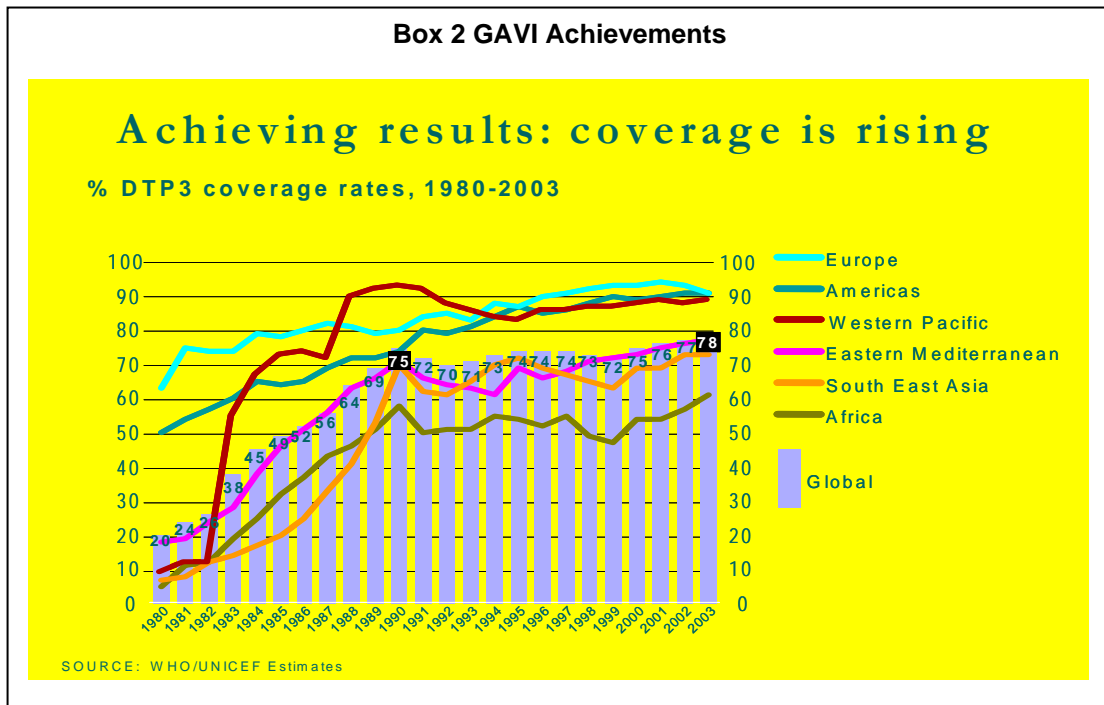
In its first five years of operation, GAVI has rapidly demonstrated its ability to establish procedures, funding mechanisms and advocacy programmes that support its mission statement.

From a standing start GAVI has committed over \$1.2 billion of financial support to eligible countries (countries with Gross National Income (GNI) below \$1000 per capita). By the end of 2004 GAVI had disbursed \$447m. This funding is drawn from its partner organisation, The Vaccine Fund (VF).

75 countries are deemed eligible for GAVI/VF support of which current funding is directed to 71 countries (see Annex 1). These 71 have successfully submitted applications for support in one of three main areas:

1. Immunisation Services Support (ISS) – financial support intended to enable increased coverage of immunisation services
2. Injection Safety (INS) – supplies of syringes and safe disposal boxes
3. New Vaccines Support (NVS) – usually in the form of vaccine supplies

After five years, much has been achieved and most commentators recognise that GAVI has been a major catalyst in raising awareness and supporting countries to improve their preventive health programming. These five years are now being considered as ‘Phase 1’ of GAVI support. ‘Phase 2’ is conceived as a further period of support from 2006-2015 which will draw on new donations/pledges to the VF which may include additional funding from an International Financing Facility for Immunisation (IFFIm).



As GAVI proceeds from its first phase to the next, the Executive Secretary of GAVI, Dr. Julian Lob-Levyt, is overseeing a process of reflection to ensure that the organisation is strategically and operationally equipped to tackle the challenges ahead. One aspect of this reflection is a Country Consultation (CC) Process which commenced in March 2005.

The CC process is a multi-dimensional consultation process and has included:

1. Country Consultation Meeting in Geneva (12-14 May 2005)
2. Country Visits (May – June 2005)
3. Telephone survey
4. Online survey
5. A study conducted by the D'Appui au Renforcement de l'Indépendance Vaccinale en Afrique (ARIVA) programme for West & Central Africa
6. A report compiled by a group of countries of the European Region together with members of the Regional Working Group, entitled “Recommendations on the GAVI / VF support to the countries of the European Region”

The principal objective in each of the above elements was to extend opportunities to personnel from all GAVI eligible countries to provide feedback, opinions and commentary on their experiences of working with and alongside GAVI in phase 1 and provide suggestions for the design of phase 2. This is to ensure that Phase 2 builds on the achievements of Phase 1 and has active country participation in its design.

56 of the 71 current countries benefiting from GAVI/VF support have participated in one or more of the above consultation processes. This report summarises the opinions and suggestions of the country representatives, each of whom has been actively involved in Phase 1 at some point since 2000.

The respondents include:

- Ministers of Health,
- Directors of Medical Services (DMS),
- Managers of the Expanded Programme on Immunisation (EPI)
- Professionals and advisers involved in immunisation programmes
- Regional Working Group members

Corresponding to the themes of enquiry established by the GAVI Secretariat and utilised in the consultation processes above, the report is presented in three sections:

1. GAVI Processes
2. New Vaccines and Technology: including New Vaccines Support (NVS) and Injection Safety (INS)
3. Systems Support: including Immunisation Systems Support (ISS)

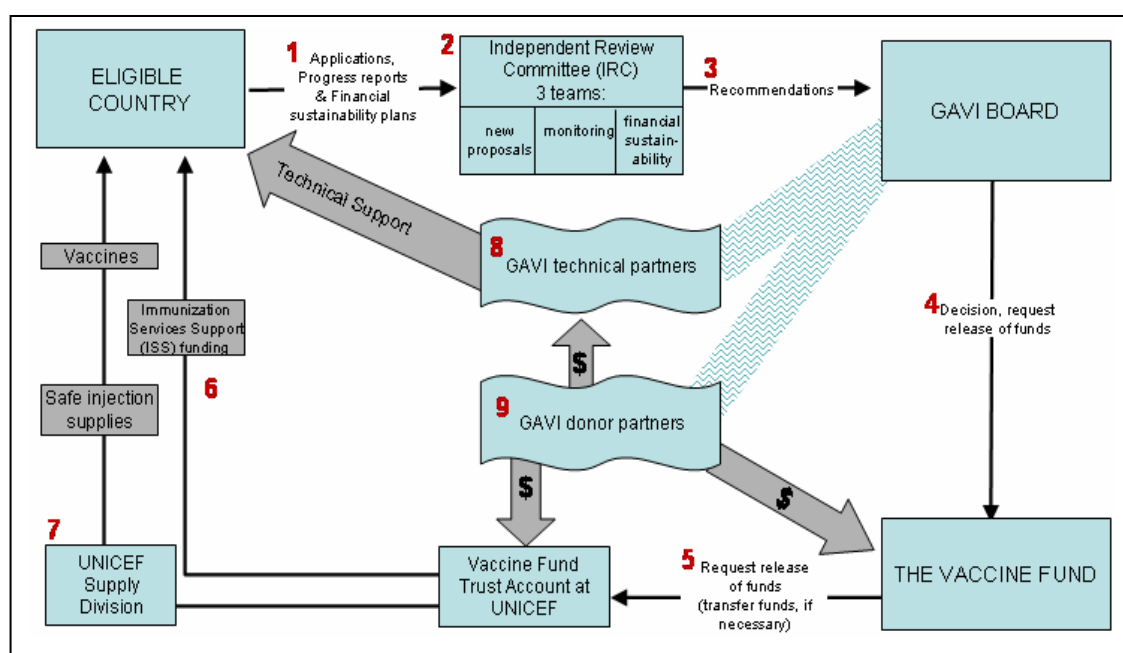
Where data was available comparisons were made between sub-categories of eligible countries, e.g. a regional grouping. These are reported where there were significant differences between groupings, but in general there were not strong regional differences.

Apart from the country visits (where the country reports have been approved by the country representatives consulted), comments are not attributed to individuals or their country in keeping with the confidentiality commitment to survey respondents. We are indebted to all of those who gave their time to contribute to this study.

2 GAVI Processes

The eligibility, application and monitoring processes have been at the core of GAVI and the Vaccine Fund's support to countries since 2000. With a lean staffing structure in the Secretariat the functionality and strength of the processes are essential elements of past and future success. The core principle is that GAVI responds to a bottom-up national application process (detailed as Step 1 in Box 3 below). Applications are initially presented alongside a Multi-Year Plan (MYP) that covers organisational, management, human resources, institutional strengthening and financing issues related to improving immunisation services.

Box 3 – GAVI Application & Country Support Process



Source: GAVI website.

At each step of the application and monitoring processes GAVI requests countries to fulfil a number of obligations and complete a number of forms. These are designed to relate, as much as possible, to existing country systems and best management practices. They include the review and approval of applications by a functioning Inter Agency Coordination Committee (ICC) and the presentation of Annual Progress Reports (APR). Each process is perceived as a necessary step for GAVI and its Secretariat to maintain standardisation, governance and accountability and to ensure coordination of efforts in immunisation.

The validity of these processes and their usefulness was reviewed in the consultation exercise, with country respondents asked to provide their feedback on the range of procedures, guidelines and rules implemented by GAVI/VF. The following section outlines the key findings.

2.1 Experiences/lessons learned from Phase 1

The overall findings on GAVI processes have been consistent throughout the various elements of the consultation process. Where discordant views have been presented they are most often related to country-specific incidences/examples and often of a unique or unusual character. The most consistent findings are presented below:

Eligibility Criteria

Eligibility is limited to those countries with GNI <\$1000 per capita to ensure that it is the poorest countries of the world who benefit from GAVI support. This is one of the principles of GAVI's initial programming. At the Geneva country consultation meeting this principle was explored and a suggestion put forward that there could be greater flexibility on this (to extend eligibility above the \$1000 level), particularly in situations when countries rise above that level, but are still experiencing economic hardship and/or catastrophic events. Opinion varied on the level of flexibility required, and so a more detailed review was proposed. However, suggestions were also made (during the country visits) for extra support for very poor countries (<\$500 per capita).

Application Process

The application process and the application forms that have to be submitted to GAVI generally produced a positive response with some responses that the process had been of great value to debate, discussion and awareness-raising within countries. However, among the many experiences represented in the consultation process, there were some examples where difficulties had been encountered or where the standard approach did not quite fit with the country circumstance.

"[GAVI] try to apply the same system for all countries, but difficult and populated countries should have special consideration"

Country respondent – online survey

The difficulties included getting accurate population figures and (in several cases) establishing the commitment and signatures of partners on the Inter Agency Coordination Committee (ICC). Other difficulties related to the application forms and guidance either being in English where country respondents were not proficient in English or being poorly translated; and not fitting with country planning processes. However, unlike some previous studies, there was less explicit feedback that the application process was a major burden, with high opportunity costs, or being a process of "jumping through hoops" (Brugha et al, 2002; Heaton & Keith, 2002).

Members of Regional Working Groups (RWG) recalled that the initial roll-out of processes and the subsequent scale-up, both in pace and evolving content, had led to some early confusion amongst RWG members and country level practitioners, occasionally resulting in tensions between personnel (GAVI, 2005a). This was echoed by several countries who reported similar confusion with changing forms or a considerable investment in time to complete the process. However, country respondents who had applied more recently and utilised the accumulated experience within RWG, WHO/UNICEF country offices or other forms of bilateral support tended to report positive experiences and were complementary of external assistance. This trend suggests an increased understanding of the application requirements and GAVI processes in the years since the initial launch and the 2001/2 studies, as well as confirmation of the evolving maturity in GAVI-country interactions.

The ICC

The establishment and continuous functioning of an ICC is one of the GAVI requirements for countries to access support and the ICC must sign the initial application and subsequent progress reports. The majority of respondents thought the ICC was appropriate and helpful, but opinions varied on ICC capacity and effectiveness (ARIVA 2005, p.4; GAVI 2005a, p.9).

The role and effectiveness of the ICC was criticised by many respondents, and in some cases a weak ICC was reported to have contributed to the breakdown of policy dialogue, and failure of partner buy-in to the concept of sustainability at country level. Major reform of these ICCs was recommended by some partners to ensure a more active involvement of policy makers (including Ministry of Finance and Planning).

Countries which are developing (or have) a sector-wide approach (SWAp) to health had particular issues around the ICC, where it was often perceived as a parallel body distancing itself from health programming and wider discussions (Brugha et al, 2002, p.436). Two aspects in particular were highlighted in the online and telephone survey returns:

- an implicit reaction from SWAp countries, and
- a divergence in opinion on whether the ICC primarily fulfilled a coordinating role or a technical advisory and planning role

The implicit reaction we noted among many respondents from SWAp countries was the poor/irregular member attendance at ICC meetings and difficulties in collecting signatures from ICC members for minutes, reports and applications. Whilst this was also reported in some countries without a SWAp the percentage was considerably less. This suggests that there is greater concern among SWAp countries on the overall efficiency of the ICC. However, more than one country reported an initiative that would, in due course, integrate the ICC with the existing SWAp mechanism.

A clear division of opinion on the value of the ICC was apparent between professional EPI staff and senior civil servants who are also responsible for wider health programming. EPI professionals were broadly appreciative of the ICC but would have liked more technical focus, saying that technical discussions were often rushed or were more effective if delegated to a sub-group, whilst those at a planning level (or more senior Ministry of Health level) were more likely to report that the ICC had proved an effective coordinating forum.

The IRC

The independent nature of the Independent Review Committee (IRC), convened to review applications and progress reports (step 2 in Box 3 above), was considered appropriate; however it was also perceived as being remote and / or unfair when dealing with country applications. These perceptions were highlighted from varying strands of the CC process including one-third of respondents on the online survey, representatives in the country consultation meeting and individuals interviewed during country visits. The experiences related suggested that a lack of dialogue and absence of country-specific knowledge in the IRC disadvantaged both the country and the IRC. Examples provided often related to a country-specific requirement that did not fit readily within the application forms.

“Our applications should not be treated like examinations where you fail or pass; plans can be improved and countries are to be encouraged to do that with the suggestions from the IRC”

Country respondent – online survey

Monitoring & Reporting

The Monitoring & Reporting processes raised considerable discussion in most fora. A consistent opinion was that GAVI’s Annual Progress Report (APR) and the Joint

Reporting Form (JRF) for WHO & UNICEF would be best consolidated to reduce duplication. The revised version of the APR (February 2005) was considered to be a major improvement.

A recurring theme from the telephone and online surveys questioned the assumption that all countries would have functioning health information systems able to generate the data required in GAVI/VF forms. Many countries presented examples where their management information systems were decentralised, often inconsistent and rarely available electronically.

“The information form and the information requirements need to be considered from a developing country perspective and not just a developed country one. Data is fragmented, it takes a lot of time to collect and then it’s inconsistent. I can appreciate why HQ [GAVI] would require this but on the ground it is a very different situation and not homogeneous”.

Country respondent – telephone survey

In terms of overall programme management, reports from one country were that notable progress had been made in social mobilisation, coverage, injection safety and waste management practices, however there were still significant weaknesses in overall EPI programme planning and budgeting and reconciliation of GAVI funding activity streams with non GAVI funded EPI activities. This was a finding repeated across a number of the countries visited as part of the country consultation exercise.

DQA

The Data Quality Audit process (DQA) is conducted in year two in countries receiving ISS (52 countries as at Jan 2005) as a means to verify reporting systems as well as to identify areas of the immunisation monitoring and reporting systems that require improvement. It was reported as an excellent process tool across most of the respondent groups and the strands of the consultation, however some felt that the timing of the DQA exercise was not appropriate, and had negative implications in terms of results. Some also felt the DQA objectives were not clear from the start.

Many respondents commented that the DQA process was having a catalytic effect on reporting systems in country. However, there were concerns in some countries about the rigorous nature of the process, especially where data information systems were not in place to effectively collect data, or where rural areas could not be reached.

“The DQA provided an opportunity to assess and improve the health information system, highlighting issues and challenges”

Country respondent – telephone survey

FSPs

Development of a Financial Sustainability Plan (FSP) during the second year of GAVI/VF support is a requirement for all countries. Many respondents in the CC process found the FSP process as valuable as the outcome:

“This work was very useful and we were not doing it in the past. We were totally dependent on the Government and obtained support from the donors only when they offered. Now we are really planning for the future. We have now a plan to follow.”

Country respondent – online survey

However, some respondents at the country consultation meeting expressed concerns about the FSP template itself including questions on the definition of sustainability used by GAVI, and the role of external consultants in providing support (some respondents wanted a more capacity-building type approach and some wanted more practical help from consultants to “get on with the job”). Direct criticisms included that the FSP was not grounded, realistic or related to country specific needs and processes and that actual implementation of the FSP is a real concern for countries. The time-frame of 10 years was also felt by many to be unhelpful. A shorter horizon of 3-5 years to fit in with national planning cycles was felt to be much more useful.

A number of respondents questioned in the country visits agreed with the principle of merging the FSP with the Comprehensive Multi-Year Plan for immunisation, however certain partners queried the usefulness of a separate plan for immunisation when the main planning instrument for the health sector (and indeed the country) is the MTEF.

Communication and Support

The role of the RWG, a forum for regional representatives of alliance partners, was generally perceived as helpful by country respondents. Subject to the geographical location of the respondent there were varying positions on how supportive the RWG had been, but for the majority of countries, the RWG had played a supportive role in preparation and review of applications, and particular requirements such as the FSP.

The process of communication between the Secretariat, countries, country partners including UNICEF, WHO and RWG is generally functioning well. However conditions in some individual countries, including postal and IT infrastructure and internal communication systems within Ministries, led to suggestions for improvements, although not all of these are within GAVI’s mandate or responsibilities.

At the country consultation meeting in Geneva it was noted that communications only directed to Ministers of Health may delay dissemination to operational levels and that it is preferable that letters come in parallel to the immunisation manager, and translated into the working language of the country, not just in English (with careful translation of technical content and nuance).

A significant percentage of respondents, over a third, had experienced delays with funding transfers, which was not helped by the absence of communication on when international transfers were made. It was recommended in Eritrea that GAVI should become increasingly predictable in terms of the amount and timing of funds released, and become more synchronised with individual government planning and budgeting processes where possible, to increase efficiency and speed in the utilisation of funds.

2.2 Issues for Phase 2

Eligibility Criteria

At the country consultation meeting in Geneva there was some support for GAVI to consider support to countries in the region with per capita GNI greater than \$1000 in particular conditions. Alternative indicators were discussed including: proportion of population below poverty line; debt burden; and severe sub-national economic disparities. It was also suggested that if a country experienced a severe economic crisis then the Alliance partners should look into a rapid response to provide support to enable the country to sustain immunisation. Whilst participants in the Geneva CC

meeting proposed this for consideration in Phase 2, very few respondents in other strands of the consultation process shared these thoughts.

Application Process

Recommendations for the application process focused on incorporating country knowledge and country specific technical amendments to formulae. Examples included that there may be more accurate projections of immunization target populations than census data; and use of the country's projections for wastage rates. In respect to the IRC process, countries proposed a process of dialogue so that country representatives were able to interact with the IRC on technical points.

"The process is as important as the documents. It makes people ask questions and answer them. It opens transparency".

Country respondent – telephone survey

On the requirement for signing of application forms by the ICC, a proposition was put forward at the consultation meeting and endorsed by Ministers in the plenary session that applications could be signed off by four key stakeholders, including government. The ICC minutes where the application was discussed would be provided as supplementary evidence. The same approach could be extended to the monitoring and reporting process.

Some countries requested that GAVI consider a move away from the use of GAVI-specific application forms and make a greater use of existing sector plans and budget documents which have been approved in-country – for example in Tanzania, through the SWAp policy dialogue structures, to promote ownership and avoid verticalisation. In Kenya too, respondents endorsed the proposal for a fully costed MYP to be an input into the application process, however they stressed the need for GAVI to keep the process simple, making full use of existing documents and wherever possible attaching documents to the application rather than generating new text.

The ICC

In the vast majority of countries, increasing the involvement of higher level policy makers and enhanced interaction with the main-stream policy processes were seen as essential to ensure success of the ICC. In countries with SWAp mechanisms in place, it was often requested that the ICC and SWAp groups merge (or at least have greater dialogue), and GAVI needs to support countries in working out how to do this best.

In terms of improving the effectiveness of the ICC, other suggestions included:

- Technical sub-committees to support ICCs with wider-than-EPI mandates
- Membership of ICCs to be limited to committed partners
- Technical updates should be provided by EPI team
- Targets and progress made in EPI should be discussed

Monitoring & Reporting

Recommendations for monitoring and reporting were most often associated with the ICC. The responses demonstrate the need to consider the individual country context rather than assuming each suggestion could be equally appropriate in all countries. Emerging themes were the need for improved coordination of reporting requirements and continuing support to develop internal capacity. In fact, one country requested support to help strengthen the performance management of the GAVI contract.

The DQA procedure was also well received, however GAVI were asked to consider a proposal that national sector monitoring frameworks and data quality assessment procedures be the basis of monitoring progress of GAVI support by one country.

FSP

A number of recommendations emerged through the consultation process including:

- ❑ Continuing need for in-country capacity building / guidance
- ❑ Use of national / regional institutes to support FSP (suggestion from SE Asia)
- ❑ FSP works best if integrated in in-country planning / budgeting process, with sub-national input, and updated annually
- ❑ FSPs to determine in-country priorities, and to improve functioning of ICCs
- ❑ Countries need to create their own FSP objectives
- ❑ Need for a mandate to implement
- ❑ Need ongoing partner support, not a one-off process

Communication and Support

Two main recommendations emerged from the consultation process on communications from GAVI:

- ❑ Correspondence between the Secretariat and the country should include copies to EPI programme manager and partners
- ❑ Translation of correspondence should be undertaken by GAVI before sending
- ❑ The Vaccine Fund/GAVI should notify the country programme management and partners as and when financial transfers are initiated so that they can expect receipt of funds.

It was also suggested that the RWGs could play a stronger role in improving exchange of experiences between programme managers. This included the RWG coordinating meetings to deal with specific issues (e.g. health systems barriers, waste disposal). Countries recognised that resources are required to assure technical assistance by RWG partners.

3 New Vaccines and Technology

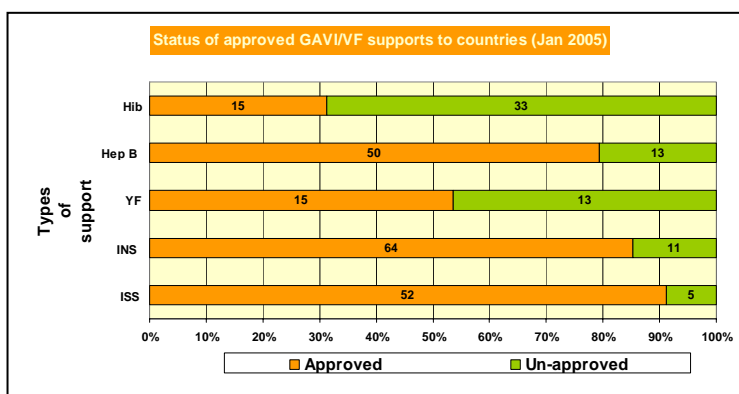
A core element of GAVI programming is support to the introduction of new vaccines and technology. To date this has included support on injection safety (INS) and the following vaccines: Hepatitis B (HepB), *Haemophilus influenzae b* (Hib), Yellow Fever (YF) and whole-cell DTP based combination vaccines (DTP-HepB; and pentavalent DTP-HepB+Hib). The introduction of these new and underutilised vaccines should have a positive impact in decreasing the burden of disease (calculated by WHO as over 1 million deaths in 2002 for the above three vaccine-preventable diseases ¹).

Most of the 75 eligible countries have benefited from one or more forms of GAVI/VF new vaccine and technology support.

50 of these have been approved for funding of the HepB vaccine, of which 25 are using the combination vaccine rather than a monovalent.

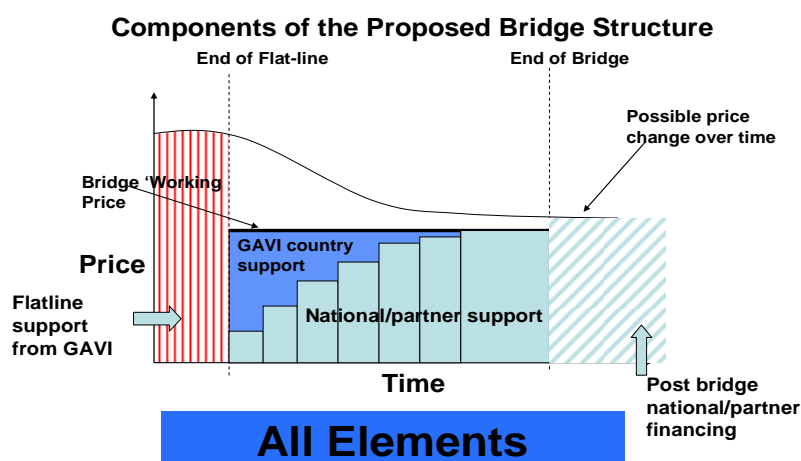
15 countries have received approval for Hib.

Box 4 – GAVI/VF support in new vaccines & technology



Source: Dr. Mercy Ahun, GAVI presentation, Geneva, May 2005.

During the country visits, GAVI discussed with the ‘early adopter’ countries (those whose support for new vaccines is expiring in 2005 or 2006) a variety of options for how GAVI can help countries with adoption of these new (and expensive) vaccines over a longer period. This has been described as the ‘bridge financing’ proposal, and is based on a few key principles, shown in brief in the diagram below.



¹ WHO estimates, January 2005. HepB – 600,000; Hib – 386,000; YF-30,000
http://www.vaccinealliance.org/General_Information/Immunization_informa/Diseases_Vaccines/vaccine_preventable_deaths.php

The first principle of the ‘bridge financing’ proposal is that GAVI country support will continue “as is” until the end of 2007 for countries with support ending in 2005 and 2006 (called the ‘flat-line’). The second principle is that from 2008, GAVI will commit to subsidising the price of the vaccines to an agreed level. This level will be based on what GAVI predicts the mature price of the vaccine will be in the future. The third essential component of the bridge financing support is that all countries commit to co-financing a proportion of the subsidised price (either from government funds only, or from a combination of government and country-level donors). This can be a fixed percentage over all years of the GAVI support, or a sliding percentage up to 100% by a certain time (say 2015).

The decision to support the new vaccines in GAVI-funded countries for an extended period of time was taken when it became clear that a number of the underlying assumptions of the GAVI model were not in fact valid. These include the assumption that vaccine prices will decline over the 5 year period of GAVI support. In fact, prices for combination vaccines have increased over the period. GAVI also predicted that a 2-3 year period would be sufficient to mobilize new resources for vaccines, and that governments and partners would be able to significantly increase their allocations to immunization. Neither of these new sources of resources have materialised.

The objective of the bridge financing proposal is therefore to improve public health by assisting the 26 countries that adopted combination vaccines sustain the gains achieved through their expanded, enhanced immunization programmes. In particular, GAVI hopes to:

- Support countries on the path towards Financial Sustainability
- Stimulate downward pressure on vaccine prices
- Sustain public health impact of new vaccines as prioritized by countries
- Support evidence-based priority setting/better decision-making (C/E, equity); for pentavalent countries, use information provided through Hib Initiative
- Support integrated planning and budgeting (incl. MTEFs, revised PRSPs)

This proposal was discussed in detail with all of the countries visited as part of the GAVI consultation process, and in principle with those countries (and Regional Working Group representatives) attending the country consultation meeting in May, however the bridge financing proposal itself was not a subject in the telephone or online surveys (although feedback on the NVS and INS support and concerns for the future were discussed).

The overwhelming majority of countries (64 out of 71 approved applications) have implemented INS support, resulting in the supply of nearly one billion auto-disable syringes (as of December 2004) through UNICEF supply division. Of the 15 countries where INS has already completed its three-year support cycle it is reported that 14 have been able to secure funding for continuing the initiative.

With this scale of support the country consultations were able to elicit considerable feedback from country respondents on two key enquiry themes:

- The five-year duration and scope of NVS and how GAVI could improve support in the future
- The three-year duration and scope of INS

The main findings of the consultations are presented below.

3.1 Experiences/lessons learned from Phase 1

NVS

Country respondents at the consultation meeting in Geneva reported that GAVI Phase 1 has had clear benefits with: increased awareness of and reduced mortality from disease burden of Hib, Hep B, and Yellow Fever; encouraged improvement in surveillance, vaccine management and supervision; stimulated expansion of cold chain capacity; and renewed interest in and prestige of immunisation services. This message was echoed in other strands of the consultation, but mitigated by concerns on the sustainability of some of the new vaccines that have been added.

The predominant concern from many countries was that they would find it difficult to maintain the achievements of phase 1 if GAVI support ends at the end of five years. The vast majority of countries felt that five years was too short a period to introduce new vaccines and technologies and expect countries and their partners to take over the funding of relatively expensive products.

“Five years support for countries was useful but short considering that the cost of vaccines is more than the entire health budget. This raises concern of sustainability. My fear is that if not extended [it] may result in some if not all countries reverting back to the traditional vaccines. GAVI should continue support to countries and cheaper sources of the vaccines be found”

Country respondent – online survey

“The duration of the support should be linked with the economic status of the country and ability to cover the cost of the vaccine at the end of the GAVI support”

Country respondent – online survey

“The EPI Programme in xxx is not mature enough for GAVI to withdraw support. Long term funding needs to be entrenched, as only then will donors and Government be persuaded to become more committed, after which GAVI can withdraw. With new vaccines, the funding gap remains too large to bridge, thus GAVI must continue support until Government and donors can catch up, and the wider Public Health programme can incorporate it”.

Country respondent – telephone survey

In some of the countries visited, reports were also made of GAVI support displacing traditional funds for immunisation services, sometimes because the GAVI funds were placed off-budget and so out of view of SWAp partners (who were therefore unaware of sustainability issues), and sometimes because it was felt that since GAVI was supporting the new vaccines, injection safety, system strengthening etc., donors (and government as well in some cases) could spend their funds more usefully elsewhere.

The issues highlighted above are indicative of the concerns raised, which extended to the unit cost of the vaccines and the capacity of countries to be responsible for additional costs at the end of the period. There were suggestions that the funding for pentavalent would be difficult even after 10 years of support, and a response from one country interview predicted this would be the case for “15-20 years at present prices”. A number of countries reported that the offer of free vaccines from GAVI had been very difficult to resist, and they only considered the financial implications at a later stage. It was not clear if there had been an adequate discussion of alternatives, such as the potential benefits and costs of monovalent preparations with countries.

Awareness of the cost issue was greater once countries had prepared an FSP or where they had a SWAp, with over 50% of country respondents with a SWAp and/or FSP reporting issues with costs. Some of these countries also mentioned the need

for an in-country review of sustainability/affordability before the introduction of more new vaccines. Only 10% of non-SWAp countries that have not yet prepared an FSP made similar comments. The increased awareness of costs in countries with more advanced financial management systems suggests that the FSP is fulfilling its primary purposes² but has not resolved the questions over financial sustainability.

In the Geneva meeting and during country visits it was recognised that some of the financing concerns reflect the changing behaviour of donors. In countries where a SWAp or direct budget support approach is in operation or where key donors have made large-scale commitments to GAVI/IF for immunisation, there are real concerns that no further donor funding will be made available and earmarked for immunisation at country level. This resulted in a challenge to the assumption that GAVI acts as a 'lever' for increased donor support for immunisation at country level. These concerns have previously been articulated in FSP documents submitted to the IRC³.

There was also concern on the unit prices of new vaccines. In those countries which had taken advantage of GAVI's NVS support to introduce combination vaccines there was awareness of the rising unit costs of combination vaccines and the significant increase in immunisation costs at the national level (for example, data from one of the countries interviewed showed a three-fold increase in costs⁴).

The fact that the world market prices for new as well as traditional vaccines have not yet reduced with increased demand, as once anticipated, is creating a lack of confidence within countries about future prices. This is making the transition to long term financing more difficult for a number of countries responding to the consultation and confirms the findings of GAVI's 2004 report on financial sustainability:

"A major concern however is the doubling and sometimes quadrupling of the costs of the programme following the introduction of new vaccines. The high cost of the vaccine is a threat to the sustainability of the programme following the end of GAVI support". (GAVI, 2004, p.5)

Some countries reported that committing to a longer term programme (as proposed by the bridge financing) is difficult. Although there may be a willingness to maintain increasing co-payments, given a situation of scarce resources (and cash budgets in some countries), many respondents reported that they cannot be sure whether they will be able to afford the new vaccines so far in advance. Many countries may find that their only option will be to accept the bridge resources and continue for as long as possible, but possibly revert to previous presentations if prices do not fall.

Other country comments related to criteria, new vaccines and awards. Current GAVI eligibility criteria for new vaccines (DTP3- coverage >50%) were generally endorsed, but some low coverage countries (< 50%) expressed an interest in applying for NVS support. Approximately one-half of SEARO countries encouraged support for new vaccines taking account of regional disease burden beyond Yellow Fever, particularly Japanese Encephalitis. There was a suggestion that where there is tight control of health budgets, supply of commodities 'in kind' is less disruptive to budgeting.

In addition, countries reported that high level engagement is essential to ensure the success of new initiatives requiring policy decisions such as the GAVI interventions.

² GAVI describes the FSP as guidelines and tools that help decision makers with a stake in the immunization programme and the analysts who assist them to understand current cost and financing patterns; project forward both future costs and prospects for financing; and define and initiate implementation of a strategy for mobilizing resources, reducing unnecessary costs, and making the flow of funding more reliable.

³ Ghana's November 2003 FSP as an example (pp.33-37)

⁴ Country visit – Malawi.

INS

Injection safety support in Phase 1 was overwhelmingly considered a positive experience which has proved a catalyst for further work in many countries. Auto-disable (AD) syringes were welcomed and many countries reported improved injection practices at points of service and new procedures, policies and legislation being adopted as a result of the support. INS has also proved a mechanism for reviewing wider issues from which the following two themes emerged:

- ❑ disposal and waste management practices
- ❑ human resource training and development

Positive comments from respondents (and comments about training) included:

“Injection safety funds were very useful, made the health workers change to practice injection safety practices and districts managed to get permanent incinerators. The issue of disposing at the lower level needs to be worked upon”.

“Some of the health workers who were trained are no longer there so retraining is important.”

Country respondent – online survey

The introduction of AD syringes has resulted in a requirement to review waste management practices and incineration capacities from a wider health and environmental perspective in many countries, although the safe disposal of a greater number of safety boxes has also been a significant logistical consideration for many countries. However, this has provided incentives to tackle medical waste management at the sector level. The concerns raised largely reflected the added costs of incineration, both capital costs for new facilities and future recurrent costs, and the requirement to extend this to peripheral levels of service delivery.

The other theme to emerge was the necessity to consider safety at the broader level of health services and not solely within EPI. Several respondents made reference to ‘syringe culture’ and/or preferences for medical treatment by injection, and injecting drug users and a requirement to extend safe injection practice into these areas. The consequent training requirement is therefore greater than anticipated and also has to take account of staff turnover; repeat courses were therefore essential to maintain the improvements that have been initiated.

As a result of the wider issues many country respondents felt that that the three-year duration of support was relatively short to guarantee the sustainability of the initiative, and there were some specific requests to continue injection safety support through into phase 2.

3.2 Issues for Phase 2

A key concern moving towards Phase 2, reported in a number of the country visits, is the immunisation programme finding it increasingly difficult to leverage resources from traditional bilateral partners who also contribute to GAVI at the global level. GAVI needs to address this with partners at a headquarters / global and country level.

NVS

The most consistent message from all components of the consultation process is that 5 years is too short for introducing new expensive vaccines and guaranteeing the financial sustainability of these after GAVI funding has ceased. Many respondents

suggested that GAVI commit to a timescale of a minimum of 10 years for Phase 2. There was also a clear request for additional support to help sustain the use of pentavalent vaccine where it has already been introduced, and for GAVI to consider supporting the introduction of other vaccines in some countries, including Japanese Encephalitis in Asia, Rubella in Bhutan, Rotavirus in Guyana and the pneumococcus and meningococcal (A & C) vaccine in The Gambia and Ghana respectively.

The bridge funding concept was welcomed in the country visits although the finer details of the level and type of co-financing needs more consideration before countries can commit (particularly to continuing the use of the pentavalent vaccine).

Some countries have tried to develop plans for taking over the new vaccines in cooperation with partners, and some have already started paying a share of the costs (for example, Guyana and Ghana), however other countries are very concerned that they will not reach the required levels of funding even in 10 years. Many countries also reported that governments find it very difficult to commit so far in advance (to the end of the proposed bridge funding component). All countries need to know the principles that GAVI is proposing to adopt so that they can incorporate the additional (much-needed) resources from flat-line and step-wise bridge funding into their own financing plans.

At this initial stage of consultation, most countries visited reported that they would prefer a step-wise approach to the co-financing of new vaccines, however a few countries said that a fixed amount over their 3 year MTEF cycle would be easier to programme for and therefore to meet. It is therefore essential for the EPI team to work more closely with the MTEF team in country, to ensure realistic options for co-financing are developed and sources of funding identified. GAVI (and GAVI partners working at country level) need to consider their role in supporting countries to do this.

During the visits to countries, a number of countries reported that a 'memorandum of understanding / record of discussion' would be sufficient to form the basis of the bridge agreement (to be signed by the MoH, MoF, GAVI, the Permanent Secretary and witnessed by key partners in immunisation). Eritrea also suggested this approach, however they also recommended that a contingency plan be included.

A strong message from the consultation meeting in Geneva and echoed in country visits was that GAVI should focus on measures and advocacy that will encourage manufacturers to reduce vaccine prices. There was disappointment that both tetravalent and pentavalent vaccines had risen in price since 2000.

A recommendation from the CC meeting was that countries should explore adding a budget line for vaccines and supplies into their national budgets, to adequately show the government commitment to co-financing immunisation in future. Countries should also work to increase local partnerships supporting immunization programmes, including donors, NGOs and commercial sector. However there are major concerns regarding the level of co-financing possible, especially in the poorest countries.

Another issue which was not discussed at length, but which needs to be considered before countries commit to bridge funding, is what GAVI will do if countries default.

INS

The main themes for consideration are the period of support for INS and the unfinished agenda of dealing with safe disposal of syringes, recognising this is much broader than just immunisation.

4 Systems Support

In Phase 1 GAVI offered eligible countries support to strengthen their health and immunization systems through Immunization Services Support (ISS). The original term of ISS funding was 5 years. The first batch of countries are reaching the end of this support in 2006, however the Board decided in December 2004⁵ to extend ISS to an additional year of funding for this first group of countries.

The amount of ISS each country was allocated depended on its plans to increase immunization coverage, and on how far it had actually achieved the planned improvements in coverage. This performance related funding arrangement provides \$20 per additional child immunized compared to the year before. Countries have been able to allocate ISS funds as they choose in order to achieve improved immunization coverage, reporting how the funds have been used as part of the Annual Progress Report to GAVI.

The Chee et al report of 2004 - *Evaluation of GAVI Immunisation Services Support Funding* - showed that country managers greatly appreciated the flexibility in the funding arrangement and that for the most part countries mainly spent their funds on logistics, transport, training, surveillance, cold-chain and supplies. Some countries succeeded in increasing coverage, enabling them to be eligible for new vaccine support (which they had not been before) while others enjoyed less success and reported no increased coverage.

Similar messages have come out of the CCP, with commentary suggesting that ISS funding:

“... illustrated that with appropriate financing, key sector output targets can be met and can eliminate access to services as a problem with services taken to the people”
Country visit report

In advance of Phase 2 there is a consensus that GAVI should continue strengthening the capacity of country health systems to deliver immunization services and sustain high coverage in future: thus assisting countries to achieve the Global Immunisation and Vaccination Strategy (GIVS) targets, as well as the Millennium Development Goals (MDGs).

This aspect of the CCP was therefore to help define how the systems support should be provided in phase 2; what the support should cover; who it should be provided to; and the mechanism for providing it. The key points that have been raised in discussions with countries and partners have been:

- If future support should address immunization specific system constraints only
- Flexibility versus earmarked supported based on country barriers and plans
- The nature of future performance based funding scheme and monitoring
- The basis for allocation (including weighting in favour of poorer countries?)
- Whether / how to stratify countries e.g. countries in crisis etc
- Length of time limited support (5-10 yrs?)
- How to align with country planning processes, GIVS/MYP, sector plans etc

The findings are summarised below.

⁵ http://www.vaccinealliance.org/Board/Board_Reports/14brd_index.php

4.1 Experiences/lessons learned from Phase 1

Time period

There was overwhelming support for increasing the period of support from 5 years to 10 years (or longer), as the capacity to attain the GIVS targets and meet the MDGs by 2015 are still very low in many GAVI supported countries. Ministers of Health at the CCM responded positively to the proposal by Julian Lob-Levyt that GAVI support should be of a longer term in future.

Eligibility

Eligibility for ISS is currently only those countries whose percentage coverage for the third shot of the combined Diphtheria, Tetanus and Pertussis vaccine (DTP3) is less than 80% of the target population. The country visits and survey responses indicated that several countries with DTP3 coverage near or above 80% felt that this criterion should be reconsidered so they would not be excluded from systems support in future. Respondents proposed that extra support should be available for maintaining coverage rates and providing services for 'hard to reach' population groups.

"It is more difficult to increase coverage when you are in the 80% level than to increase from 40% to 60%. The reward for those in the 80% level should be higher. In EPI you begin from a clean sheet every year and it is more difficult to maintain a high coverage - it is not automatic that once you attain 80% in a particular year you will increase coverage to over 80%. At that level one needs to adopt some 'business unusual' methods"

Country respondent - online survey

These responses came from AFRO, SEARO and EURO countries suggesting it is not just the lowest-income countries or one geographical area that are hopeful of further innovative systems support mechanisms from GAVI in Phase 2. This call was supported at the both Geneva meetings, as well as in a report prepared by a number of countries in the EURO region which shows the difference between the 80% DTP3 coverage criteria adopted by GAVI and the MDG and GIVS targets of 90% coverage in all children in all countries by 2010 (95% coverage in the European Region).

This report also points out that the indicator currently used measures coverage in the first year of life only, whereas vaccination continues in the European Region after this stage, and so the performance of the national immunisation programme is not fully reflected. They therefore recommend using measles vaccination in the second year as well. They also feel that a relatively small investment into immunisation programmes in the European Region would result in a greater impact than in some other regions, and so they would like this to be taken into account by GAVI in considering Phase 2 options.

Flexibility

The majority of respondents supported the flexibility of ISS funds, and felt that it was important to continue this principle in phase 2. The Honourable Minister for Health in Tanzania was reported to be "very highly pleased" with this component, and other responses from the consultation include the following:

"Flexible nature of ISS funds enabled them to be used in critical system support areas that are locally determined, such as funding for 'last mile' activities needed to complete chain of service delivery, but usually under-funded such as mobilization activities, and outreach support"

Country visit report

Respondents in Madagascar also favoured maintaining the flexibility in use of system support funds, however felt that some guidance to help countries identify the health system wide strategies which are known to have a positive impact on immunisation coverage would be useful. Some were also concerned about how to demonstrate a causal impact between funding health system activities and coverage rates.

Many of the respondents were keen to link the use of funds to the activities defined in country EPI plans (i.e. the comprehensive costed Multi-Year Plan) or sector plans more closely, but to have no earmarking of support by GAVI for particular areas. However, others wanted more structure and guidance from GAVI in helping to plan their activities, possibly with some focus on specific areas, for example spending a larger proportion at a district level. Some respondents were interested in having greater accountability (with audit) of the use of flexible funds.

Those requesting a slightly less flexible approach came from every WHO region, and were largely due to concerns that funds could be sidetracked into other projects, or 'diluted' by those with priorities outside the immunisation programme. It was notable that the majority of those respondents who expressed concerns came from countries with mid to high levels of reported corrupt practices.

Some countries found difficulties with the fact that GAVI ISS funds were received as cash, and so had to be managed 'off-budget'. Kenya for example, reported that the off-budget nature of the ISS support had posed substantial problems in subsequent years and presented significant challenges to long-term sustainability and monitoring.

There was not a clear message from countries on whether the systems support funds should be allowed to be used for recurrent funding or not. A few countries felt that it should not (and should definitely not be used for salary costs, as this is the MoH responsibility), however a number also felt that it should be allowed, especially where human resources are the biggest constraint to improving immunisation coverage, particularly in remote areas (i.e. Guyana). However, when asked, most countries reported using the funds for strengthening immunisation specific services only.

Funding

There was overall support for increasing the amount of the reward payment, as the \$20 payment for each additional child vaccinated was considered by many to be insufficient to fully immunise the hardest to reach children in many countries.

RWG members feel GAVI has a continuing role in ensuring financial sustainability at country level and to help countries reprioritise immunization within the health sector.

Country respondents across the board asked country level partners to harmonise and provide more predictable and long term funding. They also encouraged GAVI to accept responsibility at a global level to consolidate efforts by partners and other Global Health Partnerships to work on high level advocacy as an on-going and urgent priority as well as continuing work on reducing costs of vaccines.

Performance & Monitoring

The incentive benefits of a performance-based mechanism for GAVI systems support were generally appreciated by countries, however understanding of the precise nature of the ISS investment and reward mechanism were fairly limited. Most respondents felt that future funding should continue to be performance based, but there was no consensus on how this should work. The RWG representatives felt that systems strengthening support should include a greater focus on accountability, and comprise both fixed payment and performance-based reward elements.

"[ISS performance payment] is a big motivation – not just the financial prize but the moral prize as well of being rewarded for good work".

Country respondent – telephone survey

"The one-off payment was quite helpful. We used it for HepB surveillance, Measles and Rubella surveillance, Hib surveillance and Media communications/education. So the money has been reinvested into further improvements"

Country respondent – telephone survey

The use of a single indicator (DPT3) was welcomed by many countries (particularly by Directors of Medical Services and those at a higher level in the health system) as being a simple, easy-to-use mechanism for measuring performance; however others felt that multiple indicators would give a fairer representation of the overall EPI Programme – for instance over 50% of EPI Managers wanted other child survival related indicators to be included alongside DPT3, for example measles and neonatal tetanus, to relate to the emphasis on MDGs.

Many countries were positive about the possibility of using process indicators for assessing performance, and felt very strongly that reporting requirements for GAVI should be aligned with existing monitoring and reporting mechanisms (including those in SWAps) wherever possible. Equally, the application requirements should be kept to a minimum, and integrated with national planning cycles as much as possible.

Countries felt that aligning the GAVI systems support to the GIVS / MYP and planning process was important, and that in all monitoring issues, shifting some of the accountability to district levels was important to make it meaningful. A number of respondents also felt that GAVI should consider using (or linking to) existing national monitoring frameworks and indicators wherever possible.

Some respondents remarked that failing to meet the targets set for the first two years of ISS support, resulted in a lack of reward payments in the final years, and felt this was not appropriate for countries that really were endeavouring to vaccinate more children. In addition, other factors (such as the falling birth cohort in Guyana) could adversely affect the performance rating (and therefore funding) in some countries. Respondents therefore asked for greater consideration of country conditions.

The concern over cessation of GAVI ISS support was raised by a number of RWG representatives and those countries which had either not met their targets, or been unable to continue improvements. Since this reflects the direct link between reward funds and continuing increases in numbers vaccinated, it suggests that there is not full acceptance of the validity of the performance funding approach in ISS.

4.2 Issues for Phase 2

Most respondents felt that GAVI should continue providing some support to systems strengthening in phase 2, and welcomed the proposed systems support initiative. Most believed that immunisation should remain the focus of GAVI in phase 2, with support to address system constraints, particularly at the service delivery level necessary if countries are to achieve the GIVS and MDG targets. There was no agreement however on how far to extend support outside the immunisation system. Many of the Ministers at the Geneva Country Consultation meeting reported that providing support to systems (wider than immunisation) would be extremely useful (particularly linking in with the work of other Global Health Partnerships), whilst warning that GAVI should not "spread itself too thinly" and so concentrate its efforts.

During the country visits, a wide range of views on the scope of future health systems support were voiced. It may well therefore be necessary for GAVI to adopt a different approach in different situations. Responsibility for the monitoring and allocation of funds may well also need to be considered on a country-by-country basis depending on a number of factors, including if there is a SWAp, the strength of the ICC etc.

There was general agreement across respondents that hard to reach areas could usefully be a focus of systems support in the future and some countries asked that a specific factor for remoteness be included in the allocation formulae for distributing systems support funds (i.e. % rural population with no access to existing facilities).

Countries also requested that GAVI liaise with other global initiatives to avoid overlap and encourage consistency of approach, as other partnerships are also developing support for health systems (particularly the Global Fund Against TB, HIV/AIDS and Malaria). In Eritrea, they also suggested that countries should be asked to indicate in their applications how they would ensure coordination with other global partnerships.

RWGs called for clear and timely communication on all new support to enable countries to fully prepare.

Time Period

The clearest message from the consultation process (stated above) is that countries welcome longer-term funding.

Eligibility

Respondents recommended that the eligibility criteria of ISS support (DTP3 < 80%) should be ended and support offered to all countries. Gains made in the past needed to be maintained and accessing the hard to reach groups in the final 20% is often even more time consuming and expensive, thus necessitating greater support. In these areas, EPI services are often provided in an even more integrated way, and so using GAVI funds to address the wider health system (in remote in particular) was seen as a real advantage in those countries with disperse populations.

Design of systems support

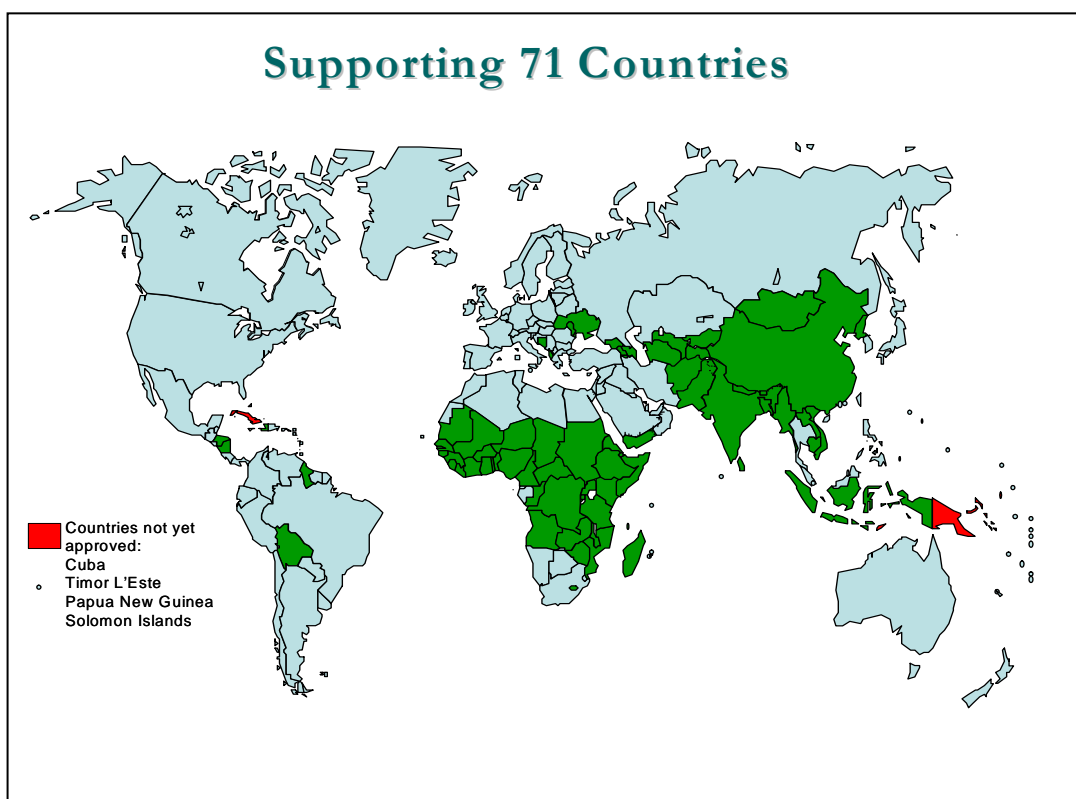
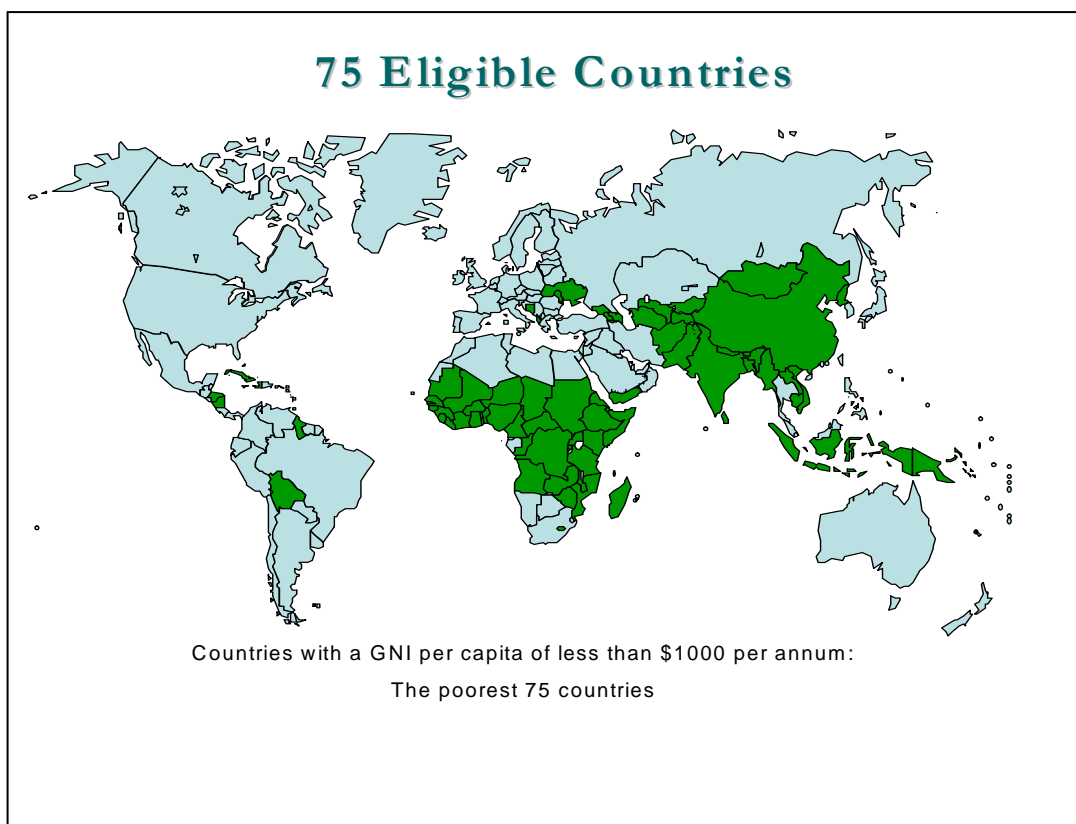
Participants at the CC meeting in Geneva were informed of the draft phase 2 funding principles by Julian Lob-Levyt. These principles have clear implications for the type and level of systems support provided by GAVI to eligible countries in phase 2. No objections were raised to these principles (summarised below) during the meeting:

- Focused on performance, outcomes and review (MDGs)
- Nationally-defined priorities; non-earmarked
- Promote equity
- Innovative
- Catalytic and time-limited (but not short term)
- Financially sustainable
- Near-term R&D
- Coherent with GAVI partners' mandates

An additional suggestion, not necessarily under the systems support component, but raised during the country consultation in Eritrea, was that GAVI introduce a separate account to provide additional funds to countries in unique or difficult circumstances. Requests would focus on special needs, and awards would be competitive, reviewed independently and acknowledge previous programme performance. GAVI should consider this request, and report back on whether it will be debated further or not.

Annexes

4.3 Annex 1: Eligible Countries



4.4 Annex 2: Overview of country participation & involvement in the consultation process



Participation by CC Process strand

Eligible Countries	EPI Manager Online Survey	EPI Manager Telephone Survey	Director of Medical Services Telephone Interview	Country Visit from GAVI	ARIVA Survey / Visit	Country Meeting 13/14 May
Afghanistan	X					
Albania	X		X			
Angola	X					
Armenia						X
Azerbaijan						
Bangladesh						X
Benin					X	X
Bhutan	X					X
Bolivia	X					
Bosnia & Herzegovina			X			
Burkina Faso						X
Burundi	X					X
Cambodia	X					X
Cameroon						X
Central African Republic			X			
Chad					X	
China						
Comoros						X
Congo, Democratic Republic						X
Congo, Rep						
Cote d'Ivoire						
Cuba						
Djibouti	X					
Eritrea	X			X		
Ethiopia	X					X
Gambia				X	X	
Georgia						X
Ghana	X			X		
Guinea						
Guinea-Bissau						
Guyana				X		
Haiti						X
Honduras	X		X			
India	X					
Indonesia						
Kenya				X		
Korea, DPR						
Kyrgyz Republic						
Lao PDR	X					
Lesotho		X				
Liberia						
Madagascar				X		
Malawi	X			X		
Mali					X	X
Mauritania						
Moldova		X	X			
Mongolia	X					
Mozambique				X		
Myanmar			X			
Nepal	X					X
Nicaragua	X		X			
Niger						
Nigeria						
Pakistan	X		X			X
Papua New Guinea	X					
Rwanda	X			X		
Sao Tome						
Senegal					X	X
Sierra Leone	X					
Solomon Islands						
Somalia	X					
Sri Lanka	X					
Sudan	X					
Tajikistan						x
Tanzania	X			X		
Timor Leste						
Togo					X	
Turkmenistan		X				
Uganda				X		
Ukraine						
Uzbekistan		X				
Viet Nam	X					
Yemen	X		X			X
Zambia	X		X			X
Zimbabwe		X				

4.5 Annex 3: References

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