# Independent Review Committee (IRC)
# Report and Recommendations
# November 2003

Table of Contents

# PART 1: Proposal for an Expanded Independent Review Committee (IRC)

## Introduction

The GAVI Board decided, during its June 2002 meeting in Paris, to separate the review of proposals and progress reports in order to avoid potential conflicts of interest. Consequently, the IRC was split into two teams: the Proposal Review Team and the Monitoring Review Team. The established mandate of the Independent Monitoring Team has been endorsed by the GAVI Board.

Financial Sustainability Plans (FSPs) are a requirement under the support offered by the Global Alliance for Vaccines and Immunizations (GAVI). Countries receiving support from GAVI are required to submit FSPs during the second year of support. In 2002, twelve FSPs were submitted and reviewed by the Independent Monitoring Committee. Twenty two countries are expected to submit FSPs for review in 2004, thirty in 2005 and 4 in 2006.

Experience from the 2002 review has indicated that emphasis should be placed on relevance and feasibility of the strategies identified within the FSP for improving prospects for financial sustainability. As a result, there is interest to form a third team under the IRC to review FSPs. The new team members would have more expertise and experience with financial management systems and national planning and budgetary processes in developing countries.

The IRC will therefore have three teams:

- Proposal Review Team
- Monitoring Team
- FSP Review Team

No changes are proposed for the role of the Proposal Review Team. Each team will be accountable to the GAVI Board.

## Revised terms of reference for the IRC Monitoring Team

The Monitoring Team of the IRC has conducted three review sessions to date. Based on the reviews, the Monitoring Team has requested to revise its mandate by incorporating more defined Terms of Reference. The Board has introduced some changes to the GAVI entities, (July 2003 GAVI Board report). For example, the ITF (Implementation Task Force), which was fully involved in GAVI monitoring activities, will be dissolved in December 2003. In addition, policies have changed, such as the cancellation of the mid term review. Taking the above modifications into consideration, the Board is requested to approve the updated mandate and modus operandi of the Monitoring Team found below.

### The mandate of the IRC monitoring team is to:

1- Review global analyses conducted independently, or by partners, and inform the Board on progress towards the GAVI strategic objectives and milestones that relate to support provided by the Vaccine fund.
2- Make recommendations regarding continuation of annual requests for new vaccines and safety supplies, according to GAVI Board policies, as spelled out in the proposal guidelines and procurement policy (see Annex I). In particular, the IMC should assess changes in targets, wastage rate, and proportion of GAVI support and baseline data.

3- Make recommendations regarding amount of share allocations to countries (based on DQA findings and achievements) according to GAVI Board policies, as spelled out in the proposal guidelines.
4- Report to the GAVI Board specific issues and problems reported by countries in their progress reports. Based on major issues recognized, suggest specific global analyses, evaluations or actions to be performed by the GAVI entities.
5- Report to the GAVI Board any relevant findings through the review process.
6- Provide technical advice and coordination of monitoring or evaluation activities suggested by GAVI entities and partners.
7- Make recommendations on improvement of the monitoring process and possible changes to introduce in relation to GAVI policies.

**The modus operandi of the IRC monitoring team is to:**

1- The IRC monitoring team will carry out its mandate primarily through the review of country annual reports (the committee should compare country-approved plans with activities reported in the progress reports; special attention should be given to coverage achievements), DQA reports, and if necessary other relevant documentation such as WHO/UNICEF JRFs

2- The IRC monitoring team will formulate its recommendations, which will then be forwarded to the GAVI Board for its decision.

3- The committee may recommend conducting specific studies in order to assess activities, tools, and impact of GAVI. A calendar for those studies is to be suggested by the committee. For some particular studies, the committee might be requested to contribute defining objectives, methodology, reviewing results and making recommendations to the Board in terms of possible changes to GAVI policies or operations.

4- Upon conclusion of the review, the IRC monitoring team is expected to provide, to the GAVI Secretariat, the following reports: a) IMC comments by country b) recommendations for improving the monitoring process c) a consolidated report on progress reports.

**5-** The IRC monitoring team may decide to constitute subgroups to follow up on some specific issues such as reviewing results of studies.

## Proposal for New FSP Review Team

### Required skills of team members

Chair – expertise in health financing with experience working on public health and immunization programs.

Members

1. Two to three individuals with extensive EPI Program experience
2. Three to five individuals with expertise and experience with national planning and budgetary processes & financial management systems in developing countries. Familiarity with immunization preferred.
3. One to three international staff with expertise in health financing, particularly experience with national planning & budgetary processes for health in developing countries ( regional institutions)

4. At least two individuals, one from groups 1 and 2 above should also be team members of the Independent Monitoring Committee. This will facilitate monitoring FSPs during review of Annual Progress reports

**Terms of Reference**

The overall mandate is to assess and review Financial Sustainability Plans to ensure an adequate and reliable diagnosis of program costs and future resource requirements, the current and future financing of the national program, and the magnitude and timing of the financing gap. In addition, a major emphasis of the review will be to ascertain how well the FSP strategies and plans are contextualized within the national health financing and NIP situation, and how realistic and feasible these plans will be to implement.

The Team in addition will review all subsequent major and minor revisions of the FSP. They will also conduct and submit pre-assessment of the FSP section of the Annual Progress Report for the Independent Monitoring Team.

**Specifically, the committee will:**

1. Determine whether the FSP provides an accurate and reliable picture of current costs and future resource requirements of the NIP (at all levels and for all strategies), the current and future financing of the program, and the magnitude and nature of the financing gap.

2. Indicate whether the FSP identifies the key strategies for improving the prospects for financial sustainability (including those which reduce cost, improve efficiency, mobilize additional resources and improve reliability of funding flows), and the extent to which these strategies are in line with the current financing of the health sector more broadly)

3. Ascertain the extent to which the FSP strategies and actions identified are relevant, feasible and well-contextualized within the country context

4. Ascertain both the involvement of the Ministry of Health, Ministry of Finance and program partners in discussions on implementation of the FSP (i.e. implementation of the strategies or actions to improve prospects for financial sustainability) and the extent to which they are prepared to take on the FSP as part of ongoing health planning and budgeting processes within the country.

**Products of the review:**

1. IRC comments by country, along the line of the four areas addressed above, (country specific details to be incorporated into response to countries

2. A consolidated report on FSPs which addresses trends and issues pertaining to the above four areas across countries

3. A set of recommendations to the GAVI Board and the GAVI/FTF summarizing:

    a. The main recommendations and findings from the country-level analysis regarding the adequacy and accuracy of the program diagnosis; the reliability and feasibility of strategies and plans; and the extent to which these plans are likely to be implemented, including the prospects for the results of the FSP to be integrated with national planning and

budgeting processes, such as annual budget cycle, PRSP reviews, MTEF/SEF/PER reviews and the like.

b. Suggestions for actions to be taken by:

- Countries (in general)
- GAVI partners at country, regional and international level

## Current and co-opted members of IRC Proposal and Monitoring Teams

### IRC Proposal Team Members

Mr. Oleg Benes (Serving since 2001)
Epidemiologist, National Centre of Preventive Medicine, Moldova
(not participating in decisions on Turkmenistan)

Dr Merceline Dahl-Regis (Serving since 2001)
Chief Medical Officer, Ministry of Health, Bahamas

Dr Peter Figueroa (Serving since 2002)
Chief Medical Officer, Jamaica

Dr Grace Murindwa (Serving since 2003)
Principal Health Planner, Ministry of Health, Uganda

Dr Stanislava Popova-Doytcheva (Serving since 2001)
Scientist, WHO STC
Bulgaria
(not participating in decisions on Turkmenistan)

Dr Jane Soepardi (Serving since 2002)
Chief Section, CDC & EH, Ministry of Health, Indonesia

Dr Mean Chhi Vun (Serving since 2003)
Deputy Director General of Health, Ministry of Health, Cambodia

***Co-opted Member:***

Mr Gordon Larsen (Co-opted member for this review)
Independent Consultant for EPI, UK

### IRC Monitoring Team Members

Mr Fred Binka (Serving since 2003)
Executive Director, Indepth – Network, Ghana

Ms Brenda Candries (Serving since 2002)
Health Economist, Belgium

Mr Supamit Chunsuttiwat (Serving since 2003)
Department of Disease Control, Ministry of Public Health, Thailand

Mr Chenjerai Victor Maziwisa (Serving since 2002)
Freelance Management Consultant, Zimbabwe

Dr Andrew Hall (Serving since 2003)
Professor of Epidemiology, London School of Hygiene, UK

Mr Mia Bilenge Constantin Miaka (Serving since 2002)
Ministry of Health, Congo DR

Ms Gradeline Minja (Serving since 2002)
Ministry of Health, Tanzania

Dr Liudmila Mosina (Serving since 2002)
Vaccine Program Specialist, CDC, Uzbekistan

Mr Ciro de Quadros (Serving since 2002)
Director of International Programs, Sabin Vaccine Institute, USA

Dr Jose Santos (Services not provided)
Director General, Secretaria de Salud, Mexico

Ms Sally Stevenson (Serving since 2003)
Health Economist, Australia

Mr Viroj Tangcharoensathien (Serving since 2003)
Ministry of Health, Thailand

Dr Jingjin Yu (Services not provided)
Ministry of Health, China

***Co-opted Members:***

Dr Basile Kollo (Serving since 2003)
Ministry of Health, Cameroun

Mr Alan Tait (Serving since 2003)
Consultant, University of Kent & Cantebury, UK

## Proposed members of IRC Financial Sustainability Plan Review team

| **Health economist / Health financing** | | | |
|---|---|---|---|
| **Name** | **Nominated by** | Sex / nationality | **Details** |
| **Tiberius Muhebwa** | FTF | M / Uganda | • Snr Health Economist<br>• UN Economic Commission consultant on ATM<br>• Consultant, Health system appraisal performance for Uganda |
| **Dr. Ann Levin** | FTF | F / USA | • Financing and costing studies expert<br>• Research, Health systems operation research<br>• Consultant, Bangladesh, 5yr immunization plan & GAVI Application |
| **Dr Marty Makinen** | FTF | M / USA | • Financing Specialist<br>• Chair, Subgroup developing indicators for FSP<br>• Consultant, FSP Training<br>• TA for FSPs, Ghana, Rwanda, Uganda |
| **Daniel Osei** | FTF | M / Ghana | • Head, Planning & Budget, MoH<br>• Member FSP Drafting Committee<br>• Member, Government Financial Management Computerisation Program. |
| **KENAISSI Cheriha Nadia** | FTF | F / Tunisia | • University professor<br>• Responsible of course in hospital management |
| **Beena Varghese** | FTF | **Bangladesh** | • Head, Health Economics Unit, ICCDR,B<br>• Research on Economics of child health interventions including new vaccines, Economic studies of poverty and health, especially urban health |
| **Alan Tait** | Tore Godal | **M / United Kingdom** | • Public Finance expert |
| **Public health / Immunization** | | | |
| **Name** | **Nominated by** | Sex / nationality | **Details** |
| **Clifford Wurie Kamara** | FTF | **M / Sierra Leone** | • Director, Planning & Information<br>• Established Unit responsible for national HIS<br>• Co-ordinator, Health Sector Reconstruction & Development Project<br>• Manager, WB supported Health & Pop. Project |
| **Maria Nakyanzi-Mugisha** | Tore Godal | **F / Rwanda** | • Director (Epidemiology)<br>• Bilingual (French & English) |
| **Maureen Law (Chair)** | FTF & Tore Godal | **F / Canadian** | • World Bank Consultant<br>• Director, Human development, WB, E. Asia & Pacific<br>• Chair, Executive Board, WHO |

## PART 2: New Funding Policies for Board Approval: Clarification of GAVI policies for New Vaccine Support

***[NOTE: This document was distributed by email to the Board by Tore Godal on 31 October, with requests for any disagreements to the recommendations to be sent to the Secretariat. As there were no disagreements received from Board members, the recommendations were adopted by implicit Board approval on BLANK October. The Board is now asked to give official Board approval.]***

This document outlines issues related to Vaccine Fund support for new vaccine introduction that required policy clarification, specifically in the case:

1. a country chooses to introduce new vaccines in a phased manner;
2. a country that receives new vaccines is approved for and introduces/switches to another antigen;
3. a country forecasts vaccines requirement.

### 1. Support for countries that opt for a phased vaccine introduction

GAVI support for new vaccines is calculated based on annual targets of infants to be immunized over a period of five years (60 months), starting from the month of introduction. The support is adjusted each year by the Independent Review Committee after review of country annual reports.

As currently applied, countries that chose a phased introduction (i.e. starting in a sub-set of the country with gradual expansion of activities) receive less vaccine than if they had opted for a nationwide coverage right from the start, since vaccine quantities are allocated according to the number of children to be immunized.

- Ten countries to date approved for NVS have adopted a phased introduction of Hepatitis B vaccine, and two countries for Yellow Fever vaccine. Table 1 shows for each country the amount of vaccine that is "unused" because of the phased-in introduction, assuming a five-year support and coverage targets equalling DTP3 (for HepB) and Measles (for YF vaccine).

**Table 1: Vaccine Fund support "unused" by countries due to a phase-in strategy**

| Country | Type of vaccine | Support approved (US$m) | Period of phase-in (yrs) | Support "missed" due to phase-in (US$m)* | Increment to current support |
|---|---|---|---|---|---|
| Bangladesh | HepB | 18.3 | 3 | 10.1 | 55% |
| Cambodia | DTP-HepB | 4.8 | 4 | 5.1 | 106% |
| Cote d'Ivoire | DTP-HepB | 6.5 | 2 | 1.3 | 20% |
| DR Congo | YF | 8.1 | 1 | 1.2 | 15% |
| Korea DPR | HepB | 2.6 | 1 | 0.3 | 11% |
| Lao PDR | DTP-HepB | 4.0 | 1 | 0.5 | 12% |
| Liberia | YF | 0.4 | 3 | 0.2 | 50% |
| Myanmar | HepB | 12.7 | 4 | 3.6 | 28% |
| Nepal | HepB | 4.5 | 2 | 0.5 | 11% |
| Pakistan | HepB | 25.8 | 2 | 7.4 | 28% |
| Sri Lanka | HepB | 2.2 | 4 | 1.0 | 45% |
| Viet Nam | HepB | 12.7 | 5 | 3.2 | 25% |
| *Total* | | *102.6* | | *34.4* | |

** Estimates based on 2003 vaccine prices*
*Source of data: GAVI Secretariat*

The total Vaccine Fund support not accessed by these countries is estimated to be US$ 34.4m, with half accounted by Bangladesh and Pakistan. This represents an additional 60m doses of monovalent HepB; 6.2m doses of DTP-HepB; and 2 million doses of YF vaccine.

***Issue for consideration:***

Should countries that chose to phase-in a new vaccine be allowed to retain NVS they "miss" as a result of the phase-in, and use this vaccine in later years?

- Arguments in favor of such a decision could be that countries should not be penalised for making programmatically valid choices (i.e. opting for a phased introduction in order to "pilot-and-adjust" prior to expansion, or to strengthen the immunization system as part of new vaccine introduction); that accessing full support is an issue of equity among countries; and that countries may have chosen differently if they had been made explicitly aware at the time of application of the implications of a phased introduction.

- Other than the additional costs this would incur to GAVI and the Vaccine Fund (estimated at $34.4m), arguments against making such a decision could be that countries should not be encouraged to delay the delivery of these vaccines; and that experience in several countries indicates that a phased strategy is not required to successfully introduce a new vaccine.

*Working Group recommendation:*

Countries that chose a phased introduction will be offered the opportunity to access the "unused" portion of vaccine in subsequent years (over a period of up to three years). If all countries that have phased in to-date request for this support, this would increase total country approval by $34.4m (2003 vaccine prices).

## 2. Support for introduction of additional antigens ("switching")

Vaccine Fund support for new and under-used vaccines is currently provided for a period of five years (with a maximum stretching up to eight years) on an "antigen" and not a "product" basis. As such, a country that has received HepB vaccine support for three years and has applied and been approved for Hib vaccine will receive five year support for Hib but will have only two years of remaining support for HepB vaccine

This policy is straightforward with regard to monovalent products. However application of the policy for countries that use combination vaccines carries additional challenges, in particular practical aspects of co-funding and procuring a combination product.

This policy clarification is important to help inform countries in their decision-making and to project Vaccine Fund expenditures.

To maintain the basic principle of equitable access to Vaccine Fund resources and to promote program sustainability, the following procedures are proposed:

- The duration of Vaccine Fund support will continue to be determined on an antigen basis, i.e. support will be provided for five years (60 months) from the time a new antigen is approved. Countries can chose to stretch support over a maximum period of eight years.

- The GAVI Secretariat will track Vaccine Fund support to countries by individual antigen. Countries that receive combination vaccines will be responsible to finance the "unfunded" portion of the product when Vaccine Fund support ends.

**Proposal**

- To manage co-funding of combination products in a practical way, Vaccine Fund support will be calculated and provided as a proportion of total vaccine quantity (doses) needed by the country for this particular product, relative to the price of the additional antigen towards the total product price. UNICEF SD weighted average prices will be used as the basis for calculation. In the case of pentavalent (DTP-HepB+Hib) vaccine, the Hib component of the pentavalent vaccine accounts for 67% of the total pentavalent vaccine price, when comparing the prices of DTP-HepB and DTP-HepB+Hib in 2004.

- A country that receives DTP-HepB/HepB vaccine support and is approved for Hib in pentavalent form, will receive the full quantity of pentavalent vaccine needs until HepB support ends.

- After that and for the remaining period of Hib support, the pentavalent vaccine will be co-funded with 67% of vaccine needs provided by GAVI/Vaccine Fund and 33% covered through other funding sources mobilised by the country.

Table 3 illustrates as a case example GAVI/Vaccine Fund support for countries that switch from tetravalent (DTP-HepB) or monovalent HepB vaccine to pentavalent (DTP-HepB+Hib) vaccine.

**Table 3: GAVI/VF and the country co-funding of the same product**

| | | | | |
|---|---|---|---|---|
| Period of HepB support (5yrs) | |  | | |
| Period of Hib support (5 yrs) | |  | | |
| Product provided | | DTP-HepB | DTP-HepB+Hib | |
| Funding source | GAVI / Vaccine Fund | 100% | 100% | 67% |
| | Other funding source | 0% | 0% | 33% |

*Working Group recommendation:*

*The Working Group supports this proposal.*

3. Guidelines for revised vaccine needs forecasting

General guidance for vaccine needs forecasting can be obtained from the WHO manual 'Procurement of vaccines for public-sector programmes – A reference manual. (WHO/V&B/02.29).

The basic formula to estimate vaccine needs described in this document is the following:

***Target Population x Expected Coverage x Number of Doses per Child x Estimated Wastage Factor***

In addition, a buffer stock of 25% of total is usually included for the first full ordering year. After the first year, historical utilization data should guide the calculation, taking into account the carry over of stock and expected changes in coverage.

A number of clarifications to this formula appear necessary for its applicability by national programme managers (usually annual forecast), in particular regarding:

a) target population with or without infant mortality;
b) for vaccines with a scheduled number of doses >1;
c) situations where the local wastage rate is not sufficiently known.

### *WHO principles*

1. Estimates should err on the side of overestimation rather than underestimation of vaccine needs since vaccine shortages or refusing vaccination to save stocks could reduce public confidence in immunization services. Efforts are needed to improve session planning in a way that maximizes efficient use of vaccines, prevents unnecessary demands and reduces drop-outs.

2. It is not possible to advocate a universally acceptable vaccine wastage level. Acceptable wastage levels depend on each programme, based on experience and analysis of local situations (importance of outreach, coverage level, national policies, vial size, …).

3. All WHO recommended strategies should be applied in order to reduce the wastage (eg. multi-dose vial policy, use of vaccine vial monitor, adjustment of vial size to the average size of the immunization session).

4. Wastage rate should be monitored in order to get realistic figures and allow for corrective actions where it is too high.

### WHO recommendations for refinements of the vaccine forecast formula:

1. **target population** is the total birth cohort. Rationale: infants who die before the age of 1 year may receive a number of vaccine doses and should therefore be accounted in the target population.

2. For multi-doses vaccines, the **expected coverage** is the coverage expected with the first dose. Rationale: taking subsequent doses would underestimate the total number of doses needed. It should be noted that with high coverage rates, the difference is minimal.

3. If actual **wastage** rate is not available, the following estimations can be used in the formula:
   for lyophilised vaccines:
   wastage rate for 10-20 dose vials: 50% (wastage factor: 2)
   wastage rate for 1-2 dose vials: 10% (wastage factor: 1.11)
   for liquid vaccines
   wastage rate for 10-20 dose vials: 25% (wastage factor: 1.33)
   wastage rate for 1-2 dose vials: 10% (wastage factor: 1.11)

The above estimates do not constitute recommended targets. Only utilization rates documented from national experience will provide an accurate basis for understanding the constraints and determining what an adequate wastage rate target should be.

4. Subsequent orders should be based on historical data (how many children were actually immunized) and should take into account the remaining vaccine balance in stock. Hence the calculation should be adjusted after completion of one full year of vaccine usage (can be split over one or two calendar years).

**Financial implications for GAVI/VF**

The revision of the formula for vaccines forecasting will result in the following financial implications

- The total funding for 2004-2009 of GAVI/VF supported countries will increase between 42 and 88 million dollars
- The total funding of 5 year GAVI/VF commitment would therefore increase from 1,027 to 1,069-1,115 million dollars.

As an example, Annex 1 documents the calculation of the requirement of vaccines and funds (applying the revised formula) in 9 countries with VF support for Pentavalent.

- UNICEF-SD has confirmed that the increased volume of vaccines (calculated with the revised formula) fits within the quantity forecasted to be procured for 2004-06.

**Operational implications**

1. The guidelines for submission of Proposals and of Progress report will be revised to forecast vaccines requirement using revised formula for targets of children and for vaccines wastage rate.
2. Countries will be requested to report annually on progress made on management of vaccines stock and of vaccines wastage.
3. Request of vaccines need for 2004 that will be submitted with Annual Progress Report in October 2003 will be adjusted by the Secretariat according to revised formula:
    a. DTP1 = DTP3 x factor of DTP1-DTP3 drop-out (most recent report by country)
    b. Revised maximum acceptable vaccines wastage rate

*Proposed Working Group Recommendations:*

- *To apply the revised formula to adjust the country request of vaccines for 2004*
- *To revise GAVI guidelines to use the revised formula for country forecast and request of vaccines*
- *For countries to use revised formula to forecast vaccines requirement for 2005.*

## Annex A: Application of the revised formula to forecast Pentavalent vaccines

| **Timeline of 5-year VF commitment to:** | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|
| Guyana (Pentavalent 1-dose vial) | ---------- | | | | | | | | | |
| Ghana, Kenya, Malawi, Rwanda, Uganda | | ---------- | | | | | | | | |
| Burundi, Zambia | | | ---------- | | | | | | | |
| Yemen | | | | ---------- | | | | | | |

**Currently approved forecast (September 2003)**

| ***(in million)*** | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2004-09 |
|---|---|---|---|---|---|---|---|
| **Total births** | 4.7 | 6.5 | 6.7 | 1.8 | 1.8 | 0.9 | 22.5 |
| **Children to be vaccinated with Penta** | 3.8 | 5.4 | 5.6 | 1.5 | 1.5 | 0.7 | 18.4 |
| **Number of Pentavalent doses** | 12.0 | 18.0 | 16.3 | 4.6 | 4.8 | 2.3 | 58.0 |
| **Total fund in US$** | 45.9 | 71.4 | 64.4 | 18.5 | 19.2 | 9.4 | 228.8 |

**Example scenario:**

a) Target of DTP1 in 2004; targets of DTP3 the following years
b) A fixed Vaccines Wastage rate of 10% all years.
c) The financial implication: a 12% increase of the currently approved GAVI commitment for 2004-09

**Forecast as per scenario 2**

| ***(in million)*** | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2004-09 |
|---|---|---|---|---|---|---|---|
| **Number of Pentavalent doses** | 14.7 | 19.9 | 18.5 | 4.9 | 5.0 | 2.4 | 65.5 |
| Increased number of doses | 2.8 | 1.9 | 2.3 | 0.3 | 0.3 | 0.1 | 7.6 |
| **Total fund in US$** | 56.4 | 78.8 | 73.2 | 19.5 | 20.3 | 10.0 | 258.2 |
| Increased fund in US$ | 10.5 | 7.5 | 8.8 | 1.0 | 1.1 | 0.5 | 29.4 |

## PART 3: Financial Implications of recommendations from IRC Proposal and Monitoring Team

During September and October, the Secretariat received 11 proposals for support from GAVI/VF and 48 Progress Reports to be reviewed by the Independent Review Committee.

The Independent Review Committee (IRC) was organized into two teams which worked independently: the Proposal Team that met from October 28 to November 1, 2003 to review proposals, and the Monitoring Team that met from October 27 to November 7, 2003 to review progress reports.

**Financial implications for 2004-05**

Proposal Review:

- The financial implications that result from the recommendations on country proposals are estimated to be US$ 4.8 million for 2004-2005

Monitoring Review:

- The financial implications that result from the recommendations on country reports requesting support for 2004 are estimated to be US $105,228,500 – US$ 9.1 million for Injection Safety Support (INS), US$ 68.8 million for New and Under-Used Vaccines Support (NVS) and US$ 27.3 million for Immunization Services Support (ISS).

Total:

- The total financial demand from these two reviews is of US$ 110 million.

**Five- year financial commitment**

- Last June, the estimated five-year financial commitment for all country approvals amounted to US$ 1,027 million.
- With the recommended approvals of these two reviews the total financial commitment for 5 years will move to US$ 1.1 billion.
- Countries have started contributing funds for procurement of vaccines, consequently transferring the equivalent GAVI/VF support to later years. One country contributed US$ 1.2 million for 2003 and 5 countries have committed a total of US$ 2.6 million for 2004.
- For a detailed calculation of estimated five-year commitments by country see Table 1.

## Table 1: Five year Financial Commitment (December 2003)

| # | Country | Type of support | Prior 5-year commitment as of June 2003 | Updated 5-year financial commitment |
|---|---|---|---|---|
| 1 | **Afghanistan** | ISS | 7,255,000 | 7,255,500 |
| | | NVS | | |
| | | INS | 1,452,500 | 1,619,000 |
| 2 | **Albania** | ISS | | |
| | | NVS | 507,500 | 452,000 |
| | | INS | 92,500 | 102,000 |
| 3 | **Angola** | ISS | 6,565,000 | 6,565,000 |
| | | NVS | | |
| | | INS | 1,377,000 | 1,525,000 |
| 4 | **Armenia** | ISS | 60,000 | 60,000 |
| | | NVS | 459,000 | 436,000 |
| | | INS | 55,000 | 56,000 |
| 5 | **Azerbaijan** | ISS | 266,000 | 487,500 |
| | | NVS | 761,500 | 775,500 |
| | | INS | 132,500 | 145,000 |
| 6 | **Bangladesh** | ISS | 26,935,000 | 26,935,500 |
| | | NVS | 17,553,500 | 16,536,500 |
| | | INS | 7,397,500 | 8,204,500 |
| 7 | **Benin** | ISS | | |
| | | NVS | 2,771,500 | 2,692,500 |
| | | INS | | |
| 8 | **Bhutan** | ISS | | |
| | | NVS | 519,000 | **539,500** |
| | | INS | 205,000 | 29,000 |
| 9 | **Bolivia** | ISS | | |
| | | NVS | | |
| | | INS | | **660,000** |
| 10 | **Bosnia & Herz** | ISS | | |
| | | NVS | 497,500 | 342,500 |
| | | INS | | |
| 11 | **Burkina Faso** | ISS | 4,410,000 | 4,410,500 |
| | | NVS | | |
| | | INS | 622,000 | **806,500** |
| 12 | **Burundi** | ISS | 2,662,000 | 2,662,500 |
| | | NVS | 17,908,500 | 17,196,500 |
| | | INS | 419,000 | 428,000 |
| 13 | **Cambodia** | ISS | 3,012,000 | 3,012,500 |
| | | NVS | 6,126,000 | **6,161,000** |
| | | INS | 668,000 | 667,500 |
| 14 | **Cameroon** | ISS | 5,556,000 | 5,557,000 |
| | | NVS | 4,019,000 | **8,483,000** |
| | | INS | 1,091,000 | 1,108,500 |
| 15 | **Central Afr Rep** | ISS | 1,837,000 | 1,837,000 |
| | | NVS | 679,000 | 730,000 |
| | | INS | 146,000 | 156,000 |
| 16 | **Chad** | ISS | 2,715,000 | 2,715,000 |
| | | NVS | 1,219,000 | 1,251,500 |
| | | INS | 374,000 | 421,500 |
| 17 | **China** | ISS | | |
| | | NVS | 22,753,500 | 22,753,500 |
| | | INS | 15,926,000 | 15,926,000 |
| 18 | **Comoros** | ISS | 165,000 | 173,500 |
| | | NVS | 255,000 | 256,500 |
| | | INS | 37,500 | 39,500 |
| 19 | **Congo DRC** | ISS | 31,299,000 | 31,298,500 |
| | | NVS | 11,407,500 | 11,694,000 |
| | | INS | 3,052,500 | 3,238,000 |
| 20 | **Congo Rep** | ISS | 1,534,500 | 1,534,500 |
| | | NVS | 872,500 | 896,500 |
| | | INS | 237,500 | 266,500 |

| # | Country | Type of support | Prior 5-year commitment as of June 2003 | Updated 5-year financial commitment |
|---|---|---|---|---|
| 21 | **Côte d'Ivoire** | ISS | 3,859,000 | 3,859,500 |
| | | NVS | 7,615,000 | 8,057,500 |
| | | INS | | |
| 22 | **Cuba** | ISS | | |
| | | NVS | | |
| | | INS | | |
| 23 | **Djibouti** | ISS | 271,000 | 271,000 |
| | | NVS | | |
| | | INS | 31,500 | 32,000 |
| 24 | **East Timor** | ISS | | |
| | | NVS | | |
| | | INS | | |
| 25 | **Eritrea** | ISS | 930,000 | 930,500 |
| | | NVS | 2,217,000 | 2,188,500 |
| | | INS | 129,500 | 147,000 |
| 26 | **Ethiopia** | ISS | 19,130,000 | 19,130,000 |
| | | NVS | | |
| | | INS | 3,017,500 | 3,074,500 |
| 27 | **Gambia** | ISS | 489,000 | 489,500 |
| | | NVS | 3,452,500 | **3,280,500** |
| | | INS | 107,500 | 109,000 |
| 28 | **Georgia** | ISS | 341,000 | 341,500 |
| | | NVS | 646,500 | 700,500 |
| | | INS | 57,000 | 60,000 |
| 29 | **Ghana** | ISS | 3,359,000 | 2,888,000 |
| | | NVS | 47,194,500 | 44,252,000 |
| | | INS | 741,000 | 824,500 |
| 30 | **Guinea** | ISS | 2,585,000 | 2,585,500 |
| | | NVS | 1,102,500 | 1,114,500 |
| | | INS | | 645,500 |
| 31 | **Guinea-Bissau** | ISS | 423,000 | 423,000 |
| | | NVS | | |
| | | INS | | |
| 32 | **Guyana** | ISS | | |
| | | NVS | 1,204,000 | 1,329,000 |
| | | INS | | |
| 33 | **Haiti** | ISS | 2,171,000 | **2,171,000** |
| | | NVS | | |
| | | INS | | **617,500** |
| 34 | **Honduras** | ISS | | |
| | | NVS | | |
| | | INS | 371,500 | 471,500 |
| 35 | **India*** ** | ISS | | |
| | | NVS | 4,224,000 | 4,224,000 |
| | | INS | | |
| 36 | **Indonesia** | ISS | 14,808,500 | 15,659,500 |
| | | NVS | 16,332,500 | 14,965,000 |
| | | INS | 8,859,000 | 9,475,500 |
| 37 | **Kenya** | ISS | 11,113,000 | 11,113,500 |
| | | NVS | 74,209,000 | 73,497,500 |
| | | INS | 1,059,500 | 1,143,500 |
| 38 | **Korea, DPR** | ISS | 3,315,000 | 3,315,500 |
| | | NVS | 2,651,000 | 2,695,000 |
| | | INS | 741,500 | 754,500 |
| 39 | **Kyrgyz Rep** | ISS | | |
| | | NVS | 1,228,500 | 1,197,000 |
| | | INS | 158,500 | 178,000 |
| 40 | **Lao PDR** | ISS | 2,251,000 | 2,251,500 |
| | | NVS | 4,128,500 | 3,494,500 |
| | | INS | 281,000 | 279,000 |

| # | Country | Type of support | Prior 5-year commitment | Updated 5-year financial commitment |
|---|---|---|---|---|
| 41 | **Lesotho** | ISS | 517,000 | 517,500 |
| | | NVS | 507,000 | 482,500 |
| | | INS | 109,500 | 110,500 |
| 42 | **Liberia** | ISS | 2,804,000 | 2,405,000 |
| | | NVS | 638,000 | 645,500 |
| | | INS | | |
| 43 | **Madagascar** | ISS | 4,277,000 | 4,277,500 |
| | | NVS | 13,495,000 | 13,917,000 |
| | | INS | | |
| 44 | **Malawi** | ISS | | |
| | | NVS | 31,412,500 | **32,586,000** |
| | | INS | | |
| 45 | **Mali** | ISS | 4,100,000 | 4,426,000 |
| | | NVS | 3,161,000 | **3,277,500** |
| | | INS | 736,000 | 780,500 |
| 46 | **Mauritania** | ISS | 1,062,000 | 1,062,000 |
| | | NVS | | |
| | | INS | 182,500 | 193,000 |
| 47 | **Moldova** | ISS | | |
| | | NVS | 481,000 | 451,500 |
| | | INS | | |
| 48 | **Mongolia** | ISS | | |
| | | NVS | | |
| | | INS | | |
| 49 | **Mozambique** | ISS | 3,291,000 | 3,291,000 |
| | | NVS | 15,056,000 | 15,975,500 |
| | | INS | 960,500 | 986,000 |
| 50 | **Myanmar** | ISS | 7,902,000 | 7,902,500 |
| | | NVS | 13,184,500 | 15,025,500 |
| | | INS | 1,358,500 | 1,343,000 |
| 51 | **Nepal** | ISS | 4,494,000 | 4,494,000 |
| | | NVS | 4,516,000 | **4,232,500** |
| | | INS | 1,279,000 | **1,317,500** |
| 52 | **Nicaragua** | ISS | | |
| | | NVS | | |
| | | INS | | |
| 53 | **Niger** | ISS | 5,027,000 | 5,027,000 |
| | | NVS | | |
| | | INS | | **1,128,000** |
| 54 | **Nigeria** | ISS | 53,020,000 | 53,020,000 |
| | | NVS | 27,100,000 | 28,257,000 |
| | | INS | | |
| 55 | **Pakistan** | ISS | 33,900,000 | 32,508,000 |
| | | NVS | 25,729,500 | 26,300,000 |
| | | INS | 9,044,500 | 9,521,500 |
| 56 | **Papua N G** | ISS | | |
| | | NVS | | |
| | | INS | | |
| 57 | **Rwanda** | ISS | 4,108,000 | 3,728,000 |
| | | NVS | 22,360,000 | 21,256,000 |
| | | INS | 382,000 | 406,000 |
| 58 | **São Tomé** | ISS | 67,000 | 65,500 |
| | | NVS | 169,500 | 266,500 |
| | | INS | 11,500 | 11,500 |
| 59 | **Senegal** | ISS | 3,983,000 | 3,983,500 |
| | | NVS | 18,436,000 | 19,624,000 |
| | | INS | 846,500 | 749,500 |
| 60 | **Sierra Leone** | ISS | 2,353,000 | 2,423,500 |
| | | NVS | 1,435,500 | 1,466,500 |
| | | INS | 306,000 | 312,500 |

| # | Country | Type of support | Prior 5-year commitment as of June 2003 | Updated 5-year financial commitment |
|---|---|---|---|---|
| 61 | **Solomon Isl** | ISS | | |
| | | NVS | | |
| | | INS | | |
| 62 | **Somalia** | ISS | 3,399,000 | 3,399,500 |
| | | NVS | | |
| | | INS | 326,500 | 349,000 |
| 63 | **Sri Lanka** | ISS | | |
| | | NVS | 2,481,500 | 2,456,000 |
| | | INS | 524,500 | 589,000 |
| 64 | **Sudan** | ISS | 8,969,000 | 8,968,500 |
| | | NVS | | 52,915,000 |
| | | INS | 1,897,000 | 1,828,000 |
| 65 | **Tajikistan** | ISS | 1,138,000 | **1,510,500** |
| | | NVS | 999,500 | **959,000** |
| | | INS | | 255,500 |
| 66 | **Tanzania** | ISS | 6,499,000 | 8,665,500 |
| | | NVS | 28,053,500 | 29,822,000 |
| | | INS | 1,406,000 | 1,510,000 |
| 67 | **Togo** | ISS | 1,945,000 | 1,945,500 |
| | | NVS | 1,011,000 | 1,035,500 |
| | | INS | 354,500 | 374,500 |
| 68 | **Turkmenistan** | ISS | | |
| | | NVS | 890,000 | 828,500 |
| | | INS | | **161,000** |
| 69 | **Ukraine** | ISS | | |
| | | NVS | 2,878,500 | 2,768,500 |
| | | INS | 683,500 | 747,500 |
| 70 | **Uganda** | ISS | 9,343,000 | 11,794,500 |
| | | NVS | 55,752,500 | 62,878,500 |
| | | INS | 1,315,500 | 1,338,000 |
| 71 | **Uzbekistan** | ISS | | |
| | | NVS | 3,934,500 | 3,926,000 |
| | | INS | 779,000 | 808,500 |
| 72 | **Viet Nam** | ISS | | |
| | | NVS | 12,461,000 | 11,650,000 |
| | | INS | 3,140,500 | 3,296,500 |
| 73 | **Yemen** | ISS | 4,342,000 | 4,342,000 |
| | | NVS | 44,004,500 | 44,019,500 |
| | | INS | 1,021,500 | 1,238,000 |
| 74 | **Zambia** | ISS | 2,959,000 | 2,959,500 |
| | | NVS | 33,288,500 | 30,265,000 |
| | | INS | 743,500 | 762,500 |
| 75 | **Zimbabwe** | ISS | 3,220,000 | 3,220,000 |
| | | NVS | | |
| | | INS | 1,198,000 | 1,319,000 |
| | **TOTAL** | ISS | 332,036,000 | 335,870,500 |
| | | NVS | 617,951,500 | 679,479,500 |
| | | INS | 77,447,000 | 84,647,000 |
| | | | **1,027,434,500** | **1,099,997,000** |

Figures in bold = subject to clarifications

## PART 4: Proposal Team Report, November 2003

## I. Procedure of the review

The proposal team of the Independent Review Committee (IRC) met in Geneva from 28th October to 1st November 2003 for the review of country proposals for GAVI/VF support.

As usual, each proposal was reviewed by three reviewers. The first reviewer takes a leading role. The Proposal Review Team plenary discusses and makes a final judgment on recommendations for each component of request. All proposals were decided on a consensus basis, no vote was used.

A strict observation of any conflict of interest among Team members for individual proposals was effected with members excusing themselves from the discussion of that proposal.

Eight Proposal Review Team members participated (See Annex A). During this round, the team welcomed Merceline as new Chairperson and Gordon as a new member.

## II. Outcome of the review

Eleven countries submitted proposals for this review, with a total of 13 requests for different types of support broken down as follows:

- Injection safety 7 requests
- New and under-used vaccines 6 requests
  - ✓ Introduction of hepB vaccines 4 requests
  - ✓ Introduction of Hib vaccines 2 requests

The proposal team's recommendations on the above proposals are summarized in Table 1 and in Annexes B-E. The Board is requested to review these recommendations.

**Table 1: Recommendations on reviewed proposals**

| | Country | Requests | | | | |
|---|---|---|---|---|---|---|
| | | ISS | INS | YF | HepB | Hib |
| 1 | Bolivia | | Clarification | | | |
| 2 | Burkina Faso | | | | Conditional | Conditional |
| 3 | Cameroon | | | | Clarification | |
| 4 | Guinea | | Approval | | | |
| 5 | Haiti | | Clarification | | | |
| 6 | Madagascar | | Re-submission | | | |
| 7 | Mauritania | | | | Conditional | |
| 8 | Niger | | Clarification | | | |
| 9 | Sudan | | | | Approval | Approval |
| 10 | Tajikistan | | Approval | | | |
| 11 | Turkmenistan | | Clarification | | | |

The financial implications for 2004-2005 that result from these recommendations on country proposals are estimated to be US$ 4,842,500 (Tables 2 and 3) and the financial commitment for a five-year period is estimated to be US$ 60,735,000 (Table 4).

**Table 2: Planned disbursements 2004 and 2005 for proposals recommended for approval (in US$)**

| Country | Immunization Services | | New and Under-used Vaccines (estimate) | | Injection Safety (estimate) | | Other support |
|---|---|---|---|---|---|---|---|
| | 1st investment | 2nd investment | 2004 | 2005 | 2004 | 2005 | 2004 |
| Guinea | | | | | 229,000 | 198,000 | |
| Sudan | | | 415,000 | 1,079,500 | | | 100,000 |
| Tajikistan | | | | | 93,500 | 79,000 | |
| Sub-total | | | 415,000 | 1,079,500 | 322,500 | 277,000 | 100,000 |
| **Total 2,194,000** | | | | | | | |

**Table 3: Planned disbursements 2004 and 2005 for proposals recommended for approval with clarifications (in US$)** *(figures subject to change pending receipt of clarifications)*

| Country | Immunization Services | | New and Under-used Vaccines (estimate) | | Injection Safety (estimate) | | Other Support |
|---|---|---|---|---|---|---|---|
| | 1st investment | 2nd investment | 2004 | 2005 | 2004 | 2005 | 2004 |
| Bolivia | | | | | 236,000 | 204,500 | |
| Cameroun | | | - | 979,500 | | | |
| Haiti | | | | | 222,500 | 191,000 | |
| Niger | | | | | 359,500 | 346,000 | |
| Turkmenistan | | | | | 59,500 | 50,000 | |
| Sub-total | | | | 979,500 | 877,500 | 791,500 | |
| **Total 2,648,500** | | | | | | | |

**Table 4: Commitment of VF support for 3 years of INS and 5 years of NVS (in US$)**

| | Country | 5 years New and Under-Used Vaccines Support | 3 years Injection Safety Support | Other Support | TOTAL |
|---|---|---|---|---|---|
| 1 | Bolivia | | 660,000 | | 660,000 |
| 2 | Cameroun | 4,352,500 | | | 4,352,500 |
| 3 | Guinea | | 645,500 | | 645,500 |
| 4 | Haiti | | 617,500 | | 617,500 |
| 5 | Niger | | 1,128,000 | | 1,128,000 |
| 6 | Sudan | 52,815,000 | | 100,000 | 52,915,000 |
| 7 | Tajikistan | | 255,500 | | 255,500 |
| 8 | Turkmenistan | | 161,000 | | 161,000 |
| | TOTAL | 57,167,500 | 3,467,500 | 100,000 | **60,735,000** |

## III. Analysis of the review outcome

The total approval rate is 66% (only approvals and approvals with clarifications, excluding conditional approvals)

Approval rate by request of supports:

- INS 86%
- HepB 50%
- Hib 50%

By the 10th review, the status of countries applying to GAVI/The VF has remained unchanged: overall 71 countries have applied to GAVI, out of which 69 countries have been approved for at least some components (Figure 1). There are four countries that have never approached GAVI for support: Papua New Guinea, Solomon Islands, Nicaragua and East Timor. We estimate the remaining requests for support in future applications:

| | |
|---|---|
| ISS | 5 |
| INS | 17 |
| YF | 13 |
| HepB | 16 |
| Hib | 37 |

## IV. Notes from the review

### A. INDIA's request

In January 2002, the Board has approved India's proposal to support the introduction of hepatitis B vaccination for one and an half year, with the agreement to receive a second proposal in 2003 for an additional three and an half year of GAVI/VF support.

In a letter of September 30, 2003, the Government of India requested to receive HepB vaccines in 2004 according to the expansion of the immunization plan that was still under elaboration and that will be submitted in the next review round for GAVI/VF support. The quantity requested was indicated in the Progress Report submitted for review on 30 September 2003.

The Proposal Review Team has noted in the Progress Report that the implementation of India's immunization program for hepatitis B is one year behind schedule. They have recorded a balance of vaccine in stock at the beginning of 2004 of 5.71 million doses.

The Proposal Review Team recommends that for 2004 India applies the 2003 immunization plan using vaccines already supplied by GAVI for the same number of targeted children proposed in the approved plan. The Proposal Review Team recommends that the GAVI Board encourage India to submit its application for the May 2004 review.

### B. Other notes

1. How efficient is the use of multi-year and vaccine-introduction plans to monitor the progress. Would it be reasonable to measure the status of their implementation? *(For Monitoring Team's decision)*

2. How to assess the functioning of the ICC? *Verify with the Monitoring Team how to stimulate the ICC to become more involved in monitoring the EPI and building technical capacity in the country.*

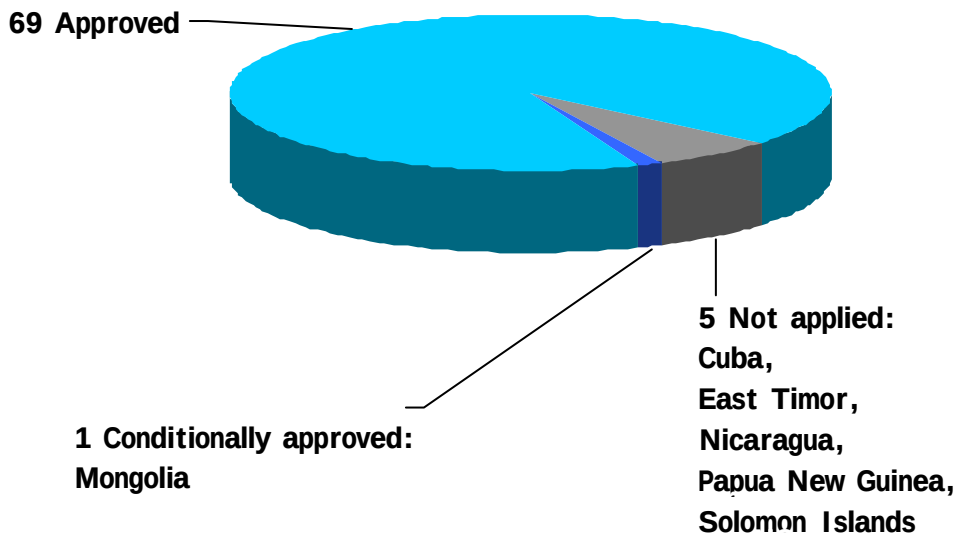
3. Technical Assistance to the countries should be organized assuring participation of local staff in order to build local capacity for development of GAVI/VF proposals. (*For WG to address)*

4. If a country has recently completed a vaccines coverage survey, its report should be submitted to the IRC together with documents for EPI assessment (*Secretariat for guidelines*).

5. Proposed dates for Spring Review are May 25 to June 3, 2004.

**Figure 1: Status of requests from eligible countries* after November 2003 review**

***75 eligible countries with GNI < US$1,000 / cap**



## Annex A: Participating IRC Proposal Team members

Mr. Oleg Benes (Serving since 2001)
Epidemiologist, National Centre of Preventive Medicine, Moldova
(not participating in decisions on Turkmenistan)

Dr Merceline Dahl-Regis (Serving since 2001)
Chief Medical Officer, Ministry of Health, Bahamas

Dr Peter Figueroa (Serving since 2002)
Chief Medical Officer, Jamaica

Mr Gordon Larsen (Co-opted member for this review)
Independent Consultant for EPI, UK

Dr Grace Murindwa (Serving since 2003)
Principal Health Planner, Ministry of Health, Uganda

Dr Stanislava Popova-Doytcheva (Serving since 2001)
Scientist, WHO STC
Bulgaria
(not participating in decisions on Turkmenistan)

Dr Jane Soepardi (Serving since 2002)
Chief Section, CDC & EH, Ministry of Health, Indonesia

Dr Mean Chhi Vun (Serving since 2003)
Deputy Director General of Health, Ministry of Health, Cambodia

## Annex B: Proposals recommended for approval

### GUINEA

- Injection Safety

### SUDAN

- New and under-used vaccines (HepB and Hib), limited to phases 1 and 2.

### TAJIKISTAN

- Injection Safety

## Annex C: Proposals recommended for approval with clarifications

### BOLIVIA

**Injection safety - supplies**

- Targets need to be reviewed and the quantities of injection safety supplies in Tables 6.1 and 6.5 recalculated.
- The ICC should provide written assurance that GAVI funds will not replace existing national or donor support for the EPI program.

### CAMEROON

**New and under-used vaccines (HepB)**

- Targets and indicators of activities of the vaccine introduction plan to be implemented.

### HAITI

**Injection safety – equivalent amount of funds**

- Provide more realistic targets in table 4 and tables 6-1 to 6.4.

### NIGER

**Injection safety – supplies**

- Baseline figures for 2002, the number of surviving infants, and targets for each antigen should be consistent with those of the Progress Report.

### TURKMENISTAN

**Injection safety – supplies**

- Baseline targets, numbers of surviving infants and target children for each antigen and for each year, 2003-2008 (Table 4)
- Details of budget required for each of the activities described in the National Plan of Action for Injection Safety.

## Annex D: Proposals recommended for conditional approval

### BURKINA FASO

### Introduction of new and under-used vaccine (HepB and Hib):

- Provide:
  - an updated inventory on the cold chain capacity and functioning at the central, intermediate and peripheral levels, with a detailed rehabilitation plan
  - A revised and detailed introduction plan for pentavalent vaccine that addresses: timelines, targets, quantifiable indicators for the phased introduction of pentavalent vaccine and revised coverage targets that are realistic

- The ICC should endorse a revised introduction plan that incorporates the recommendations of the 2003 EPI review and provide evidence of cold chain readiness for the introduction of new vaccine.

### MAURITANIA

### Introduction of monovalent 10-dose hepatitis B vaccine:

The previously imposed conditions were not fully met. Outstanding conditions are :

- In reference to the report of the April 2003 cold chain review provide a strategy to rehabilitate the cold chain at district and sub-district levels, including budgetary requirements, and give evidence of cold chain readiness to introduce the vaccine.

- Revise the timetable for vaccine introduction to include specific activities, tasks, timelines, indicators and targets.

- Revise table 4 of the proposal form considering the stated Infant Mortality Rate (IMR) and the estimated numbers of surviving infants. Revise also the figures for infants vaccinated in 2002 with BCG, OPV3 and DPT3 in consistency with those of the Joint Reporting Form..

- The number of HepB doses requested for the first year of support (2004) in table 8 contradicts the number stated in table 7.1. Re-constitution syringes are requested although these are not needed for HepB vaccine.

- Clarify whether the vaccine will be procured through UNICEF or by Government (as mentioned in connection with the previous submission).

## Annex E: Proposals recommended for Resubmission

### MADAGASCAR

### Injection Safety

# PART 5: Monitoring Team Report, November 2003

## Introduction

The Monitoring team of the Independent Review Committee (IRC) met in Geneva from 27 October to 7 November 2003, to review progress reports. Seven members of the Monitoring Team participated in the review (see annex B).

Forty-eight out of sixty-four countries submitted their 2002 progress report (5 inception reports, 23 first annual reports and 20 second annual reports).

This is the first time the Monitoring Team has made recommendations on rewards, which are based on countries' 2002 performance. Eight countries out of fifteen had both, good achievement in 2002 and a successful DQA. Therefore, these countries were eligible to receive rewards in 2002. Among those eight countries, 770,430 additional children have been vaccinated with DTP3 in comparison to the targets for 2001. As a result of this achievement, the countries will receive the total amount of US$ 14,873,000 (Tajikistan is still pending clarifications).

The Monitoring Team's recommendations for the progress reports are summarized in Annex C. The Board is requested to review those recommendations. For more details regarding the Monitoring Team's country specific comments, please refer to Annex I.

The Monitoring Team's executive summary, which contains both comments as well as policy issues raised during the review, is located in Annex A. The Board is requested to review the major policy issues identified by the Team. These are summarized in Annex D along with the comments from the Working Group teleconference of 20 November 2003.

The Board is also requested to consider the financial implications of the monitoring review of progress reports in October 2003, as outlined in Annex E. The total financial request to be approved by the board is: US$ 105,228,500.

- US$ 27,307,400 for the **Immunization Services Support** (see Annex F). The breakdown of financial implications is as follows:
    - Rewards: the total requested is US$ 14,873,000. The original commitment for those countries to receive rewards was:
      US$ 11,578,500, therefore increasing the request by an additional US$ 3,292,800.
    - Third Investment of Investment: the total requested is
      US$ 12,434,400 (no previously approved amounts)

- US$ 9,122,300 for the **Injection Safety Support** (see Annex G).

- US$ 68,798,800 for the **New Vaccines Support** (see Annex H). This figure was calculated by taking the needs for 2004 (US$ 92,798,500) and subtracting the previously approved amount (US$ 26,249,514).

## Annex A: Participating IRC Monitoring Team members

1. **Dr MOSINA Liudmila**
2. **Dr TANGCHAROENSATHIEN Viroj**
3. **BINKA Fred**
4. **STEVENSON Sally**
5. **QUADROS Ciro de**
6. **HALL Andrew J**
7. **Dr KOLLO Basile**

## ANNEX B: IRC Monitoring Team Summary Recommendations

| No | Country | Report | Support | Decision |
|---|---|---|---|---|
| 1 | **Afghanistan** | **AR** | ISS,INS | **Satisfactory** |
| 2 | **Albania** | **AR** | NVS,INS | **Satisfactory** |
| 3 | **Azerbaijan** | **AR** | ISS,NVS,INS | **Satisfactory subject to clarifications *** |
| 4 | **Bangladesh** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 5 | **Benin** | **AR** | NVS | **Satisfactory** |
| 6 | **Bhutan** | **IR** | NVS,INS | **Satisfactory subject to clarifications** |
| 7 | **Bosnia & Herz** | **IR** | NVS | **Satisfactory** |
| 8 | **Burkina Faso** | **AR** | ISS,INS | **Satisfactory subject to clarifications** |
| 9 | **Burundi** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 10 | **Cambodia** | **AR** | ISS,NVS,INS | **Satisfactory subject to clarifications** |
| 11 | **Cameroon** | **AR** | ISS.NVS,INS | **Satisfactory** |
| 12 | **CAR** | **IR** | ISS,NVS,INS | **Satisfactory** |
| 13 | **Congo DR** | **IR** | ISS,NVS,INS | **Satisfactory** |
| 14 | **Cote d'Ivoire** | **AR** | ISS,NVS | **Satisfactory** |
| 15 | **Eritrea** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 16 | **Gambia** | **AR** | ISS,NVS,INS | **Satisfactory subject to clarifications** |
| 17 | **Georgia** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 18 | **Ghana** | **AR** | ISS,NVS,INS | **Insufficient information *** |
| 19 | **Guyana** | **AR** | NVS | **Satisfactory** |
| 20 | **Haiti** | **AR** | ISS | **Satisfactory subject to clarifications** |
| 21 | **India** | **AR** | NVS | **Satisfactory** |
| 22 | **Indonesia** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 23 | **Kyrgyz rep** | **AR** | NVS,INS | **Satisfactory** |
| 24 | **Lao PDR** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 25 | **Lesotho** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 26 | **Madagascar** | **AR** | ISS,NVS | **Satisfactory** |
| 27 | **Malawi** | **AR** | NVS | **Satisfactory subject to clarifications** |
| 28 | **Mali** | **AR** | ISS,NVS,INS | **Satisfactory subject to clarifications** |
| 29 | **Moldova** | **AR** | NVS | **Satisfactory** |
| 30 | **Mozambique** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 31 | **Myanmar** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 32 | **Nepal** | **AR** | ISS,NVS,INS | **Satisfactory subject to clarifications** |
| 33 | **Niger** | **AR** | ISS | **Satisfactory** |
| 34 | **Pakistan** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 35 | **Rwanda** | **AR** | ISS,NVS,INS | **Satisfactory subject to clarifications** |
| 36 | **Sao Tome** | **AR** | ISS,NVS,INS | **Insufficient information** |
| 37 | **Senegal** | **AR** | ISS, NVS,INS | **Satisfactory** |
| 38 | **Sri Lanka** | **AR** | INS,NVS | **Satisfactory** |
| 39 | **Sudan** | **AR** | ISS,INS | **Satisfactory** |
| 40 | **Tajikistan** | **AR** | ISS,NVS | **Satisfactory subject to clarifications** |
| 41 | **Tanzania** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 42 | **Togo** | **IR** | ISS,NVS,INS | **Satisfactory** |
| 43 | **Turkmenistan** | **AR** | NVS | **Satisfactory** |
| 44 | **Uganda** | **AR** | ISS,NVS,INS | **Satisfactory** |
| 45 | **Vietnam** | **AR** | NVS,INS | **Insufficient information** |
| 46 | **Yemen** | **AR** | ISS,NVS,INS | **Insufficient information** |
| 47 | **Zambia** | **AR** | ISS;NVS,INS | **Satisfactory** |
| 48 | **Zimbabwe** | **AR** | ISS,INS | **Insufficient information *** |

*** Note from the Secretariat: clarifications have been provided and were found satisfactory**

## ANNEX C: Major policy recommendations of the IRC Monitoring Team

### *With responses from the GAVI Working Group*

1. **GAVI should consider postponing the expansion of the introduction of new vaccines in the India immunization program until a new proposal has been approved.**
   WG response: *India should be encouraged to integrate the introduction of new vaccines into its immunization plan and submit an application for expansion of introduction to other states.*

2. **When disbursements are delayed, GAVI should consider as baseline figures, those of the year prior to the first disbursement and rewards should be calculated accordingly.**
   WG response: *Further analysis is needed before any changes are instituted in determination of the baseline year.*

3. **GAVI should consider applying new criteria for countries in situations of conflict or disasters.**
   WG response: *Existing policy on countries in situations of conflict or natural disasters should be revisited by the Working Group. Additional policies need to be considered to address the issue of continuing GAVI/VF support to previously approved countries.*

4. **GAVI should establish rules regarding countries that did not provide clarifications and requested information from previous progress reviews.**
   WG response: *Guidelines will be submitted for Board consideration on how to manage this situation.*

5. **GAVI should consider changing the labelling of final monitoring review conclusions (satisfactory, satisfactory subject to clarifications, insufficient information).**
   WG response: *The Working Group accepts the proposal to replace the terms currently used by the Monitoring Team for final review conclusions.*

6. **GAVI should consider conducting coverage surveys in all countries at the end period of support to ascertain the validity of data.**

   WG response: *Coverage surveys will be conducted in selected countries based on agreed work plans. Efforts should be made to link up with the plans for other national survey activities such as UNICEF's MICs, DHS, etc.*

7. **GAVI should strengthen the monitoring review process with workshops to be attended by the IRC and EPI managers.**
   WG response: *The Working Group agreed that the quality of the progress reports submitted by countries should be improved and welcomed the initiative of the IRC Monitoring Team to propose a new mechanism. A multipronged approach should be explored. Components could include: Interaction between RWGs and the IRC, strengthening of partner agencies at country and regional levels and use of existing immunization meetings to improve reporting on GAVI issues could be explored. The independent role of the IRC must be maintained at all times.*

8. **GAVI Partners should support countries to strengthen epidemiological surveillance and establish mechanisms for better monitoring of vaccine stocks.**
   WG response: *The Working Group agreed that technical partners should support countries to strengthen surveillance and improve vaccine stock management.*

9. **GAVI should reinforce the role and effectiveness of ICC members at the country level in preparing and revising the progress reports.**
   WG response: *The current GAVI work plan addresses the issue of strengthening ICCs.*

10. **GAVI partners should work closely with countries to provide reliable estimates of population figures.**
    WG response: *The Working Group agreed that GAVI partners need to work further with countries on provision of reliable population data.*

## ANNEX D: TOTAL Financial Requests (in US$)

| Country | Immunization Services | Injection Safety | New Vaccines |
|---|---|---|---|
| **Afghanistan** | 1,039,000 | 30,500 | |
| **Albania** | | 2,000 | 31,500 |
| **Azerbaijan** | 260,500 | 10,500 | 123,500 |
| **Bangladesh** | 3,568,000 | 161,300 | 2,317,500 |
| **Benin** | | | 409,500 |
| **Bhutan** | | 700 | **16,500** |
| **Burkina Faso** | | **174,500** | |
| **Burundi** | 325,000 | 103,000 | 297,000 |
| **Cambodia** | 668,600 | **194,000** | 875,000 |
| **Cameroon** | | 47,200 | |
| **CAR** | | 7,600 | 59,600 |
| **Congo DR** | | 999,500 | 2,507,500 |
| **Cote d'Ivoire** | | | 1,850,500 |
| **Eritrea** | 78,600 | 3,700 | 319,500 |
| **Gambia** | 64,600 | 28,500 | **507,500** |
| **Georgia** | 34,000 | 2,000 | 117,000 |
| **Ghana** | 70,500 | 51,500 | 7,243,500 |
| **Guyana** | | | 124,500 |
| **Indonesia** | | 3,491,000 | 2,124,000 |
| **Kyrgyz rep** | | 4,100 | 167,000 |
| **Lao PDR** | 715,600 | 55,500 | |
| **Lesotho** | 74,800 | 30,500 | 59,500 |
| **Madagascar** | | | 2,664,000 |
| **Malawi** | | | **8,104,500** |
| **Mali** | 883,500 | 37,200 | **229,800** |
| **Moldova** | | | 23,500 |
| **Mozambique** | | 11,400 | 4,280,500 |
| **Myanmar** | 974,800 | 893,000 | 3,022,500 |
| **Nepal** | 705,000 | **486,000** | |
| **Niger** | 870,000 | | |
| **Pakistan** | 5,548,000 | 404,500 | 4,610,500 |
| **Rwanda** | 151,500 | 6,000 | **3,626,000** |
| **Sao Tome** | | | 1,900 |
| **Senegal** | 247,200 | 165,500 | 676,500 |
| **Sri Lanka** | | 27,000 | 92,500 |
| **Sudan** | 1,537,200 | 545,500 | |
| **Tajikistan** | **542,000** | | |
| **Tanzania** | 3,056,000 | 43,100 | 1,254,000 |
| **Turkmenistan** | | | 65,500 |
| **Uganda** | 4,361,000 | 413,000 | 19,393,000 |
| **Vietnam** | | **50,500** | 1,173,500 |
| **Yemen** | 567,000 | 450,500 | |
| **Zambia** | 328,000 | 170,500 | 430,000 |
| **Zimbabwe** | 637,000 | 21,000 | |
| **Total request** | **27,307,400** | **9,122,300** | **68,798,800** |
| | | **Grand Total** | 105,228,500 |

**NB: amounts in bold are pending clarifications**

## ANNEX E: Financial Requests Summary -- Immunization Services Support

| Country | Type of disbursement | Amount (US$) | Comments |
|---|---|---|---|
| **Azerbaijan** | First reward | 260,500 | Original commitment: $ 38,940 |
| **Ghana** | First reward | 70,500 | Original commitment: $ 542,400 |
| **Mali** | First reward | 883,500 | Original commitment: $ 557,120 |
| **Pakistan** | First reward | 5,548,000 | Original commitment: $ 6,940,000 |
| **Rwanda** | First reward | 151,500 | Original commitment: $ 531,780 |
| **Tanzania** | First reward | 3,056,000 | Original commitment: $ 889,640 |
| **Uganda** | First reward | 4,361,000 | Original commitment: $1,909,260 |
| *Tajikistan** | First reward | *542,000* | Original commitment: $169,360 |
| **Subtotal** | | **14,873,000** | |
| **Afghanistan** | third investment | 1,039,000 | |
| **Bangladesh** | third investment | 3,568,000 | |
| **Burundi** | third investment | 325,000 | |
| **Cambodia** | third investment | 668,600 | |
| **Eritrea** | third investment | 78,600 | |
| **Gambia** | third investment | 64,600 | |
| **Georgia** | third investment | 34,000 | |
| **Lao PDR** | third investment | 715,600 | |
| **Lesotho** | third investment | 74,800 | |
| **Myanmar** | third investment | 974,800 | |
| **Nepal** | third investment | 705,000 | |
| **Niger** | third investment | 870,000 | |
| **Senegal** | third investment | 247,200 | |
| **Sudan** | third investment | 1,537,200 | |
| **Yemen** | third investment | 567,000 | |
| **Zambia** | third investment | 328,000 | |
| **Zimbabwe** | third investment | 637,000 | |
| **Subtotal** | | **12,434,400** | |
| **Burkina Faso** | no rewards | 0 | Original commitment: $ 646,120 |
| **Cameroon** | no rewards | 0 | Original commitment: $ 873,340 |
| **Cote d'Ivoire** | no rewards | 0 | Original commitment: $ 447,220 |
| **Haiti** | no rewards | 0 | Original commitment: $ 84,000 |
| **Madagascar** | no rewards | 0 | Original commitment: $ 944,380 |
| **Mozambique** | no rewards | 0 | Original commitment: $ 549,320 |
| **Sao Tome** | no rewards | 0 | Original commitment: $ 2,200 |
| **CAR** | second investment | 0 | |
| **Congo DR** | second investment | 0 | |
| **Indonesia** | second investment | 0 | |
| **Togo** | second investment | 0 | |
| **Total** | | **27,307,400** | |

** pending clarifications*

## ANNEX F: Financial Request Summary -- Injection Safety Support

| Country | Needs for 2004 | Requested Amount |
|---|---|---|
| **Afghanistan** | 516,000 | 30,500 |
| **Albania** | 37,500 | 2,000 |
| **Azerbaijan** | 47,000 | 10,500 |
| **Bangladesh** | 2,910,000 | 161,300 |
| **Bhutan** | 9,000 | 700 |
| Burkina Faso* | 298,500 | *174,500* |
| **Cameroon** | 327,000 | 47,200 |
| **CAR** | 48,500 | 7,600 |
| **Eritrea** | 51,500 | 3,700 |
| **Georgia** | 21,500 | 2,000 |
| **Ghana** | 280,000 | 51,500 |
| **Kyrgyz rep** | 63,000 | 4,100 |
| **Mali** | 243,000 | 37,200 |
| **Mozambique** | 276,000 | 11,400 |
| **Pakistan** | 2,916,500 | 404,500 |
| **Rwanda** | 124,500 | 6,000 |
| **Sri Lanka** | 180,500 | 27,000 |
| **Tanzania** | 475,500 | 43,100 |
| **Zimbabwe** | 461,500 | 21,000 |
| Vietnam* | 1,023,000 | *50,500* |
| Sao Tome* | 3,000 | *0* |
| **Togo** | 118,000 | 0 |
| **Yemen** | 450,500 | 450,500 |
| **Gambia** | 28,500 | 28,500 |
| **Myanmar** | 893,000 | 893,000 |
| Nepal* | 486,000 | *486,000* |
| **Lao PDR** | 55,500 | 55,500 |
| **Lesotho** | 30,500 | 30,500 |
| **Burundi** | 103,000 | 103,000 |
| **Congo DR** | 999,500 | 999,500 |
| **Indonesia** | 3,491,000 | 3,491,000 |
| **Sudan** | 545,500 | 545,500 |
| **Senegal** | 165,500 | 165,500 |
| Cambodia* | 194,000 | *194,000* |
| **Uganda** | 413,000 | 413,000 |
| **Zambia** | 170,500 | 170,500 |
| **Total** | **18,457,000** | **9,122,300** |

** pending clarifications*

## ANNEX G: Financial Request Summary -- New Vaccines Support (in US$)

| Country | Previously approved | Needs for 2004 | Requested Amount |
|---|---|---|---|
| **Albania** | 15,500 | 47,000 | 31,500 |
| **Azerbaijan** | 23,500 | 147,000 | 123,500 |
| *Bhutan** | 67,192 | 83,500 | *16,500* |
| **Burundi** | 3,109,000 | 3,406,000 | 297,000 |
| **CAR** | 76,900 | 136,500 | 59,600 |
| **Congo DR** | 111,000 | 2,618,500 | 2,507,500 |
| **Cote d'Ivoire** | 45,500 | 1,896,000 | 1,850,500 |
| **Eritrea** | 30,500 | 350,000 | 319,500 |
| **Georgia** | 11,500 | 128,500 | 117,000 |
| **Ghana** | 153,500 | 7,397,000 | 7,243,500 |
| **Kyrgyz rep** | 72,996 | 239,500 | 167,000 |
| **Madagascar** | 78,000 | 2,742,000 | 2,664,000 |
| *Malawi** | 125,948 | 8,230,000 | *8,104,500* |
| *Mali** | 553,200 | 783,000 | *229,800* |
| **Moldova** | 13,000 | 36,500 | 23,500 |
| **Myanmar** | 207,000 | 3,229,500 | 3,022,500 |
| **Pakistan** | 1,549,500 | 6,160,000 | 4,610,500 |
| *Rwanda** | 134,500 | 3,760,500 | *3,626,000* |
| *Sao Tome** | 11,600 | 13,500 | *1,900* |
| **Senegal** | 4,164,000 | 4,840,500 | 676,500 |
| **Sri Lanka** | 379,000 | 471,500 | 92,500 |
| **Tanzania** | 5,044,000 | 6,298,000 | 1,254,000 |
| **Turkmenistan** | 27,000 | 92,500 | 65,500 |
| **Vietnam** | 755,500 | 1,929,000 | 1,173,500 |
| **Zambia** | 5,056,164 | 5,486,000 | 430,000 |
| **Togo** | 161,000 | 161,000 | 0 |
| **Cameroon** | 886,500 | 886,500 | 0 |
| **Bosnia & Herz** | 90,700 | 31,000 | |
| **Lao PDR** | 632,514 | 266,500 | |
| *Nepal** | 2,406,300 | 683,500 | |
| *Tajikistan** | 257,000 | 157,000 | |
| **Bangladesh** | | 2,317,500 | 2,317,500 |
| **Benin** | | 409,500 | 409,500 |
| **Cambodia** | | 875,000 | 875,000 |
| *Gambia** | | 507,500 | *507,500* |
| **Guyana** | | 124,500 | 124,500 |
| **Indonesia** | | 2,124,000 | 2,124,000 |
| **Lesotho** | | 59,500 | 59,500 |
| **Mozambique** | | 4,280,500 | 4,280,500 |
| **Uganda** | | 19,393,000 | 19,393,000 |
| **Total** | **26,249,514** | **92,798,500** | **68,798,800** |

** pending clarifications*

## ANNEX H: IRC Monitoring Team Executive Report

### Conclusions and Recommendations

### A. Introduction

The Monitoring Team of the Independent Review Committee (IRC) met in Geneva from 27 October to 7 November to review Inception and Annual Reports. The IRC reviewed 48 countries out of the 64 countries that were due to report at this time. Two signed reports were received too late to be reviewed, four submitted their reports without the appropriate signatures, and eleven countries did not submit a report.

The composition of the team included 7 members (their names and affiliations are attached).

### B. Summary of Conclusion and Recommendations

1. The IRC commends the Secretariat for following up on the recommendations made to improve the process. Of particular importance was the preparation of country work sheets with all the background information related to the each country. These include the dates that different kinds of support were approved, the dates of transfer of funds and of shipment of supplies, information from previous reviews on denominators and targets as well as DQA dates and results. The IRC also commends UNICEF for the pre-assessment of issues pertaining to supply of vaccines and injection safety materials.

2. The outcome of the review was as follows:

**Satisfactory Reports: 32 (66%)**

**Satisfactory subject to Clarifications: 11 (23%)**

**Insufficient Information: 5 (11%)**

*Consequences of the Outcomes:*

*Satisfactory: country will receive the support requested*

*Satisfactory subject to Clarifications: Countries will continue to receive support as previously approved. Secretariat follows up to obtain information requested.*

*Insufficient Information: The Committee could not reach a conclusion or decision for lack of information.*

With this review the committee has completed the review of the first year of activities of all countries that have received support from GAVI/VF.

3. This was the first time that the Committee considered the approval of rewards for those countries that surpassed their targets and had satisfactory DQAs. Sixteen of the 48 countries reviewed were eligible to receive rewards. Of these, seven surpassed their target and had satisfactory DQAs (Ghana, Mali, Pakistan, Rwanda, Sierra Leone, Tanzania and Uganda) for rewards totalling US$14,606,380.00.

Two countries, Azerbaijan and Tajikistan, surpassed targets and-or had satisfactory DQAs. However, delivery of the rewards will be delayed until clarification is given on the actual number of children under one year of age that have been vaccinated. It appears that the reported figure in the annual report includes children above this age group. These two countries will receive US $802,220.00 once clarifications are received. Countries reviewed that were eligible to receive rewards, but were not approved by the IRC, include those with poor achievement and/or unsuccessful DQA, such as Burkina Faso, Mozambique, Cote d'Ivoire, Cameroon, Sao Tome, Haiti and Madagascar.
It is to be noted that Mozambique, Burkina Faso and Cote d Ivoire had good performance evidenced by increased number of children being vaccinated compared to the 2001 target but failed to receive the reward due to an unsuccessful DQA.

The IRC Monitoring Committee notes that currently approved targets for many countries were those made in the original proposal. Therefore, it may be advisable for countries to review these in the light of current achievements.

It is important to note that in many instances considerable time elapses from approval to disbursement of ISS funds. The IRC recommends that the disbursement of funds be made when the country has had one year for utilization of the previous disbursement and that the baseline year for the rewards be related to the date of the first disbursement of ISS in the following manner: if first disbursement was made in the first half of a given year the baseline will be the previous year; if first disbursement was made in the second half of a given year the baseline will be the year of this disbursement.

Additionally, as indicated in the last report, the GAVI Board should define a policy that will not penalize those countries eligible to rewards that are in situations of conflict or natural disasters. The principle of such a policy should be that funds be directed to strengthen the national program and at the same time use caution to avoid a situation in which funds can not be properly used.

4. Total US $17,334 million USD of ISS funds were received by countries in 2002 (excluding balance brought forwards from 2001). A total of 28 countries provided complete expenditure data for analysis.

A total of 5,449 million USD was spent by 28 countries (spending rate of 31.43% (max 110.4% Nigeria, Min Bangladesh 0.1%). This may be due to arrival of funds at country level. Six countries had a spending rate below average (Bangladesh, Lao,

Niger, Cameroon, Sudan and Uganda) and seven countries had 100% spending rate (Mozambique, Burundi, Lesotho, Burkina Faso, Azerbaijan, Mali and Nigeria).

Of the total 5,449 million USD spent, training was the highest priority at 20%, IE&C and social mobilization at 13%, use for purchase/maintenance of cold chain equipment at 10%, transport at 9%, and purchase of vehicles at 7%. Epidemiological surveillance (1%), M&E and outreach got the least shares.

Slightly more than half of the funds were spent at district level, 27% at central and 21% by provincial level. However, this breakdown is rather arbitrary in a number of the countries analysed. Interpretation should be made cautiously, as the purchase of a vehicle at the central level can be used for district outreach clinics. A great variation in this proportion was observed among 27 countries analysed (Attachment 1).

5. Table 1 shows the total number of doses of new vaccines supplied to the countries during 2001 and 2002.

**Table 1: Doses of New Vaccines supplied to the 48 reviewed countries, 2001-2002.**

| Vaccine | Doses supplied |
|---|---|
| Hepatitis B* | 40,361,369 |
| Hib* | 8,597,939 |
| YF | 2,027,608 |

* Alone or in combination

Table 2 presents the number of children reported in JRF that have received new vaccines supplied by GAVI/VF.

**Table 2: Number of children vaccinated with new vaccines, JRF 2002**

| DPT/HepB/Hib | HepB* | | YF | |
|---|---|---|---|---|
| 2002 | 2001 | 2002 | 2001 | 2002 |
| 1,803,297<br><br>(6 countries) | 1,147,706<br><br>(14 countries) | 3,971,520<br><br>(19 countries) | 1,323,617<br><br>(9 countries) | 2,013,688<br><br>(11 countries) |
| | 3,799,471<br><br>(15 countries including Indonesia) | 9,472,764<br><br>(20 countries including Indonesia and Pakistan) | | |

- Include DTP-HepB
- 54,146 doses of DTP-Hib are not included in the Table.

Thirty nine out of the 48 countries reviewed presented requests for new vaccines for 2004.

Of these, 22 were approved for new vaccines as previously approved either in last year's report or by the proposal committee. Ten countries requested a decrease in targets, resulting in 2,105,221 less children to be vaccinated. Indonesia alone accounts for 1,362,833 of the children. Seven countries requested an increase in the targets resulting in 376,273 additional children to be vaccinated.

6. DPT3 coverage for 48 countries whose 2002 reports were reviewed during this review was analyzed as follows: there are two sources of information on 2002 coverage – one in the JRF and one in the Annual Report – these are not the same for several countries. The data is also dominated by 4 countries with very large populations (India, Indonesia, Pakistan & Bangladesh). Coverage is therefore reported in the
Table 3 below, shows figures with and without these large populations, and uses either JRF or AR figures.

**Table 3: Number of children vaccinated with DPT3, 2001-2002**

| Source of | 2001 | 2002 | Change between | Agreed | Difference from |
|---|---|---|---|---|---|

| information | | | 2001&2002 (%) | target | Target (%) |
|---|---|---|---|---|---|
| JRF, all countries | 48,278,673 | 43,634,952 | -4,643,721 (9.6% decline) | 43,146,583 | 488369 (1.1% above target) |
| AR, all countries | 38,852,021 | 39,752,816 | +900795 (2.3% increase) | 43,146,583 | -3,393,767 (7.9% below target) |
| JRF, without large poplns | 13,581,080 | 14,148,744 | +567,664 (4.2% increase) | 14,939,288 | -790544 (5.3% below target) |
| AR, without large poplns | 13,539,032 | 14,091,179 | +552,147 (4.1% increase | 14,939,288 | -848,109 (5.7% below target) |

- Includes data from all 48 countries reviewed

Using the JRF data 23/48 countries (48%) show a decline in numbers of children vaccinated with DPT3 from 2001 to 2002 (range –98 to –5,682,040). The other 25 countries increased the numbers (range +17 to +579,406).

7. The problem most often mentioned by countries was related to funding issues, from delay of disbursement from the Vaccine Fund to the country as well as bottlenecks for distribution of funds within the country. Other frequently mentioned problems include the delay in the introduction of vaccines, cold chain deficiencies and storage capacity as well as lack of incinerators, insufficient human resources and conflict situations. Country specific problems can be found in attachment 2.

**C. Major Issues**

The goal of monitoring is to ascertain if programs are functioning and performing well to reach their objectives and targets.

For this specific program, in which countries are pursuing objectives and targets supported by GAVI and the Vaccine fund, where resources and vaccines are being provided, and rewards will be given against outcomes, the monitoring process has to rely on two main aspects: evaluation of the processes (related to measurement of coverage) and the impact of the program in terms of disease outcome (epidemiological surveillance).

At present, the measurement of coverage is hampered by several problems, including identification of population denominators, and poor performing information systems with unreliable reporting.

Epidemiological surveillance has not yet been addressed at a level that may be strengthened to give the Alliance a true measure of impact for disease reduction.

At this juncture, the IRC Monitoring Committee is faced with several issues that will have to be addressed if it is to fulfil its mandate:

1. One major problem that the IRC faces continues to be the discrepancies between the targets presented in the annual and inception reports and those previously approved. Nearly all countries presented different denominators and targets in these reports. The discrepancies between data reported in the Annual Report and that reported in the JRF still persists. This has an impact on both the reward system and in the supply of vaccines. As stressed in the last IRC Report, the committee emphasizes the need for the GAVI partners in country (particularly WHO and UNICEF) to check the figures in the annual report before they sign it as members of the ICC. The Committee notices that 10 countries did not present the minutes of ICC meetings.

Unfortunately, the letter from the Heads of WHO and UNICEF stressing this fact to their country representatives was sent only in September, 2003, 7 months after the Committee's recommendation.

The IRC should not be responsible to decide on the denominators presented by the countries. This function should be a responsibility of agencies such as WHO and/or UNICEF or other UN Agency in discussions with the national authorities.

2. GAVI and the VF do provide funding to support immunization services in more than 64 countries around the world, without any conditionality linked to it. The only basic requirement for the disbursement of funds is the existence of a "functioning ICC". Prior to receiving money from the VF, different types of ICC or coordinating bodies were put in place by the various recipient countries, with different Terms of Reference in different settings.

   How to monitor the performance of these ICCs is a great challenge that the donor community and the partners will have to face in the near future, with problems such as vaccine supply shortage to difficulties in reaching marginalized groups and the need to improve deficient information systems. These obstacles should trigger action and support from the ICCs, in order for countries to be in a position to alleviate these constraints.

   The only tool available at present to assess the functioning of the ICCs is the minutes of their meetings attached to the progress reports. The attached minutes of ICC meetings presented in these annual reports can be summarized as follows:

   The main topics discussed by the ICCs were: approval of plan of action for 2003 and approval of the annual report for 2002. Only three countries out of 40 (6.6%) provided minutes that indicated discussion of the allocation of ISS funds received from the VF as requested in the annual report form.

   Table 4 shows the status of countries as they comply with the reporting on the minutes of their ICC meetings for the year 2002:

| COUNTRIES | **Minutes provided** | **ICC+ But No minutes** | **Nothing mentioned** |
|---|---|---|---|
| **N=40*** | **27(67.5%)** | **10(25%)** | **3(7.5%)** |

48 countries reviewed
*Countries with ISS and/or DQA

3 In the January, 2003 Report, this Committee emphasized that the final impact of the GAVI/VF will be in the reduction of vaccine preventable diseases targeted by the national immunization programs. It was then suggested that epidemiological surveillance for these diseases be considered a major component of the initiative.

   The priority given to this item in the 48 country reports does not give an indication that this issue has had priority in the period under review -1% of the ISS funds were reported to be used for this function.

4 The recommendation that the Working Group consider a policy with regard to the reward system when countries undergo conflict or natural disasters apparently has not been acted upon.

5. Many countries failed to provide clarifications or information that have been requested in previous reports. The IRC recommends that in such cases, in the future, the Secretariat continues the supply of vaccines or INS if country request is less than previously approved. If the quantities exceed previously approved, supply will be provided as previously approved unless full justification is provided with the request.

6. The IRC proposes to no longer use the previous decisions of Satisfactory, Satisfactory subject to clarifications or insufficient information – it will provide the Secretariat with recommendations for action.

7. For those countries that present a very high immunization coverage, depending on the situation in the country and other variables that may come to the attention of the IRC, the Committee may recommend that special surveys and additional surveillance data be presented to validate the numbers, even in the presence of an above threshold DQA. The GAVI Board may wish to consider, at the end of period of support, coverage surveys in all countries to ascertain the validity of the data.

   Furthermore, it is the impression of the IRC that that the present process of conducting DQA does not build capacity in the country, with no legacy left behind. However, the principle of independent assessment should be maintained and it is suggested that in country agencies such as, universities and research institutions should be involved with the DQA and DQS processes.

8. A major issue observed related to the information on stock that may be available at the country level at the end of each year. This stock has an important bearing on the request of vaccine for the subsequent year. Therefore, the IRC recommends that special attention be paid at the country level - WHO or UNICEF country advisors should give support - to the identify current stock before the request is presented.

9. The IRC Monitoring Committee understands that there will be another team of the IRC to deal with the Financial Sustainability Plans (FSPs). The mandate for the FSP review team is to review the FSPs. However, countries are required to report on financial sustainability within the AR. It has been assumed that financial sustainability issues are to be analysed by the FSP review team. FS information found in the progress report is not clearly part of the FSP team mandate.

   IRC reports for this session need to include comments by the IRC on the financial sustainability section. This is particularly important for countries who submitted information following the review of their FSP (e.g. Mali). The IRC recommends that the Secretariat indicate to the countries that information on their FS activities sent with the current report will be sent after the FS Team meeting.

   The impression is that there has been a positive response to demands for financial sustainability action and information. Development of Action Plans is encouraging but the limited analysis of the funding gap is a concern (see attachment 3).

   It will be important that meetings of this new group be synchronized with the meetings of the Monitoring Group, ideally just before the meeting of the latter.

D. The functioning of the IRC Monitoring and Evaluation Team:

Recommendations emanating from this Review

The IRC Monitoring Team remains disconcerted with the current monitoring process. Based in Geneva, and with no contact with the field, there is a gulf between its recommendations which can have a serious impact on the national immunization programs, and the Monitoring Team understanding of the realities in the country. As a consequence, the current format of IRC work is too remote from the field and the Committee is not able to perform a thorough evaluation of country programs. The implications of this include both the quality of the Team's decision-making and the credibility of its decisions.

As a result, after three meetings, the IRC Monitoring Team feels its contribution to the monitoring process of GAVI, and feedback to the countries has serious limitations and the potential for the its full potential to improve the GAVI process is not being realised. To overcome this, the IRC Monitoring Team believes it is imperative to close the gap between itself and the countries.

Although there is improvement in the annual reports of some countries, the majority of countries continue to fail to provide a report with adequate information for a true assessment of progress towards the objectives of the program. This may be a result of continuous lack of engagement of ICC and country advisors from WHO and UNICEF and lack of understanding of program managers in filling the format of the report.

Furthermore, the format now available does not give the opportunity for a true identification of problems and does not provide a work plan for the next period, with identification of activities aimed at solving problems and improving the program, with the identification of costs and responsibilities.

It is therefore suggested that the process for the monitoring and evaluation provides an opportunity to the IRC to dialogue with country managers for a more appropriate feeling of the real situation in each country and a better assessment of the program.

A methodology to address this issue could be the organization of sub-regional meetings with the national program managers, RWG members, selected ICC members, IRC members, the Secretariat and other key players.

Such a meeting would be a workshop in which program managers would be divided in small groups and their annual report on past activities and next year work plan would be analyzed and criticized by the participants in each group. This will require a proactive involvement by IRC members and active participations by WHO, UNICEF and members of the RWG.

This meeting is not to be a regular EPI Mangers Meeting as actually happening, but a workshop for review of reports and preparation of annual work plans.

Such meeting would also have the advantage of cross fertilization and capacity building, with managers learning from each other.

Country Annual Reports would be sent as usual to GAVI Secretariat, following the established guidelines. and after the preparation of background documentation, pre-assessment and other Secretariat functions, such as the background preparation for the IRC Monitoring Committee

members (background information for all sections -now scattered in various places - should be provided by the secretariat in a template for the IRC country report (see attachment 4).

Three meetings would be organized at sub-regional level for analysis and discussions between IRC Monitoring Committee members, Program Managers, RWG, ICC members and others.

The 68 countries would be divided in three groups for participation in these meetings which would take place in three different locations in the same week, with three-day duration. Three members of the IRC Monitoring Committee (considering a Committee with 9 members) would participate in each of these meetings to dialogue and discuss the reports and plans with the program managers, RWG and ICC members and others.

At the end of these meetings the country managers would review their reports and plans to be forwarded to GAVI Secretariat within four weeks of the ending of the meeting and the IRC Monitoring Committee members would meet in Geneva -3 to 4 days -for a final decision on the reports and plans.

**E.** The IRC Monitoring Committee is very pleased with the decision of the Board to have the next round of reviews July 2004, and hopes that the methodology suggested above is accepted**.**

***The IRC Monitoring Committee believes that such approach will greatly enhance the quality of the monitoring and in turn will also have a very positive impact in capacity building and active participation of the various actors involved in the technical cooperation aspects of this initiative***.

* *Attachments mentioned in this summary are available upon request through the GAVI Secretariat*

## ANNEX I: Country Specific Recommendations

| | | |
|---|---|---|
| 1 | **AFGHANISTAN** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS**: to receive INS support as originally approved in June 2003<br>**ISS:** to receive the third investment of investment |
| 2 | **ALBANIA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS**: to receive INS support as per originally approved in June 2003<br>**NVS**: to receive HepB vaccine as per request |
| 3 | **AZERBAIJAN** | **General Recommendation**<br>Satisfactory report subject to clarification<br><br>**Specific recommendations**<br>INS: **to receive INS support as per request**<br>**ISS:** the country to submit an estimate of the number of children aged less than one year who were vaccinated with DTP3 in 2002. The rewards for 2002 will be calculated accordingly<br>**NVS**: to provide the ratio of 10 and 20 doses vial, meanwhile HepB vaccine will be provided as per request for 2004 with the same ratio as in 2003<br>**From the secretariat: Clarifications have been provided and were found satisfactory** |
| 4 | **BANGLADESH** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per previously approved<br>ISS: **to receive the third investment of investment**<br>**NVS:** to receive HepB vaccine as per request |
| 5 | **BENIN** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>NVS**: to receive hepB and YF vaccines as per request** |
| 6 | **BHUTAN** | **General Recommendation:**<br>Satisfactory subject to clarification<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as originally approved<br>**NVS:** vaccine delivery will be postponed unless satisfactory clarifications are provided:<br>- Justification for the change in population figures and targets<br>- Situation of the current stock of DTP-HepB by the end of 2003 considering the<br>- delayed introduction and previous shipments |
| 7 | **BOSNIA HERZEGOVINA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**NVS:** to receive Hepb vaccine as per request |
| 8 | **BURKINA FASO** | **General Recommendation:**<br>Satisfactory subject to clarification<br><br>**Specific recommendations:**<br>**INS:** to receive AD syringes and safety boxes for measles and DTP as per request and for BCG and TT as per previously approved unless satisfactory clarifications are provided on the number of surviving infants and realistic targets (BCG and TT) for 2004 onwards<br>**ISS:** not to get rewards for 2002 because of unsuccessful DQA |

| | | |
|---|---|---|
| **9** | **BURUNDI** | **General Recommendation**<br>Satisfactory report<br><br>**Specific recommendations**<br><br>**INS**: to receive INS support as per request<br><br>**ISS:** to receive the third investment of investment<br><br>**NVS:** to receive DTP-Hib and HepB as per request |
| **10** | **CAMBODIA** | **General Recommendation:**<br>Satisfactory report subject to clarification<br><br>**Specific recommendations:**<br><br>**INS**: to receive INS support as per request except TT as per previously approved unless the country provide<br>- satisfactory clarifications on the increased TT target for 2004<br>- commitment from the new donor to provide AD syringes for TT and measles, and safety boxes for all antigens.<br>**ISS**: to receive the third investment of investment split in two payments as requested<br><br>**NVS**: to receive DTP-HepB as per request (less than previously approved) |
| **11** | **CAMEROON** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>**INS**: to receive INS support as per request for 2004<br>**ISS:** will not receive rewards due to unsuccessful DQA in 2002<br><br>**NVS:** to receive YF vaccine as per originally approved in June 2003 |
| **12** | **CAR** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>**INS:** to receive INS support as per request<br>**ISS**: to receive the second investment of investment<br>**NVS**: to receive YF vaccine as per request |
| **13** | **CONGO DR** | **General Recommendation**<br>Satisfactory report<br><br>**Specific recommendations**<br><br>**INS:** to receive INS support as per request<br><br>**ISS:** to receive the second investment of investment<br><br>**NVS:** to receive YF vaccine as per request |
| **14** | **COTE D'IVOIRE** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**ISS**: no rewards for 2002 because of unsuccessful DQA<br><br>**NVS:** to receive DTP-HepB as per originally approved |
| **15** | **ERITREA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>**INS:** to receive INS support as per request<br><br>**ISS**: to receive the third investment of investment<br><br>**NVS**: to receive DTP-HepB as per request for 2004 |
| **16** | **GAMBIA** | **General Recommendation:**<br>Satisfactory report subject to clarification<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per request<br>**ISS**: to receive the third investment of investment<br>**NVS:** to receive DTP-Hib as per request. This support will adjusted if the country wishes to revise its targets for DTP-Hib and HepB to be the same |

| | | |
|---|---|---|
| 17 | **GEORGIA** | **General Recommendation:**<br>satisfactory report<br><br>**Specific recommendations:**<br><br>**INS**: to receive INS support as per request for 2004<br>**ISS:** to receive the third investment of investment<br>**NVS:** to receive HepB vaccine as per request |
| 18 | **GHANA** | **General Recommendation:**<br>Insufficient information<br><br>**Specific recommendations:**<br><br>**INS:** the first shipment of injection safety materials will be provided based on previously approved targets. Subsequent shipments will NOT be sent unless clarifications are provided :<br>- a request must be provided, based on clarified targets.<br>**ISS:** to receive rewards for achievement in 2002<br>**NVS**: to receive the first shipment of DTP-hepB+Hib vaccine based on previously approved 2004 targets, subsequent shipments will not be sent unless clarifications are provided on<br>- Targets for 2003 – 2006, these should take into account previous achievements.<br>- A revised request for NVS must be submitted based on those targets.<br><br>**From the secretariat: Clarifications have been provided and were found satisfactory** |
| 19 | **GUYANA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>NVS**: to receive DTP-HepB + Hib as per request for** |
| 20 | **HAITI** | **General Recommendation:**<br>Satisfactory subject to clarifications<br><br>**Specific recommendations:**<br><br>ISS: **the country will not get rewards for 2002 because of unsuccessful DQA and low performance. The country is requested to provide the following clarification:**<br><br>- provide realistic targets for DTP3 for 2003 and onwards taking into account actual achievements |
| 21 | **INDIA** | **General Recommendation:**<br><br>Satisfactory report<br><br>**Specific recommendations:**<br>NVS: **to submit an application for further support in 2004** |
| 22 | **INDONESIA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as requested<br><br>ISS**: to receive the second investment of investment**<br><br>NVS: **to receive HepB Uniject** |
| 23 | **KYRGYZSTAN** | **General Recommendation**<br>Satisfactory report<br><br>**Specific recommendations**<br><br>INS: **to receive INS support as per request**<br>**NVS**: to receive HepB vaccine as per request |

| | | |
|---|---|---|
| **24** | **LAO PDR** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>**INS**: to receive INS support as per request for 2004<br>ISS: **to receive the third investment of investment**<br>**NVS:** to receive DTP-HepB as per request for 2004 |
| **25** | **LESOTHO** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>**INS**: to receive INS support as per request<br>ISS: **to receive the third investment of investment**<br>NVS**: to receive hepB vaccine as per request** |
| **26** | **MADAGASCAR** | **General Recommendation:**<br><br>Satisfactory report<br><br>**Specific recommendations:**<br>ISS**: not to receive rewards because of unsuccessful DQA and low performance in 2002**<br>NVS**: to receive DTP-HepB as per request** |
| **27** | **MALAWI** | **General Recommendation:**<br>Satisfactory report subject to clarification<br><br>**Specific recommendations:**<br><br>NVS: **to receive the first shipment of DTP-HepB+Hib vaccine as per previously approved,**<br>**further supply will be delayed until satisfactory clarifications are provided on**<br>- targets for children to be immunized and wastage targets for 2005 onwards<br>- stock of vaccine at the end of 2003 considering previous achievements |
| **28** | **MALI** | **General Recommendation:**<br>Satisfactory subject to clarification<br><br>**Specific recommendations:**<br><br>**INS**: to receive INS support as per request<br>**ISS:** to receive rewards for 2002 achievements<br>**NVS:**<br>- to receive hepB vaccine as previously approved unless satisfactory clarifications are provided for increased request for 2004<br>- to receive YF vaccine as per request |
| **29** | **MOLDOVA** | **General Recommendation**<br>Satisfactory report<br><br>**Specific recommendations**<br><br>**NVS:** to receive HepB vaccine as per request |
| **30** | **MOZAMBIQUE** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>**INS:** to receive INS support as requested<br>ISS**: not eligible for rewards because of unsuccessful DQA in 2002**<br>**NVS:** to receive DTP-HepB as per request for 2004 |
| **31** | **MYANMAR** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>**INS:** to receive INS support as per request<br>ISS: **to receive the third investment of investment**<br>NVS**: to receive hepB vaccine as per request** |

| | | |
|---|---|---|
| **32** | **NEPAL** | **General Recommendation:**<br>Satisfactory report subject to clarification<br><br>**Specific recommendations:**<br>**INS:** to receive as per previously approved unless satisfactory justification are provided on increased targets for 2004 and onwards<br><br>ISS: **to receive the third investment of investment**<br>**NVS**: : to receive HepB vaccine as per previously approved unless satisfactory clarifications are provided on increased targets |
| **33** | **NIGER** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br><br>ISS: **to receive the third investment of investment.** |
| **34** | **PAKISTAN** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per request<br>**ISS**: to receive rewards for 2002 achievement<br>NVS**: to receive HepB vaccine as per request** |
| **35** | **RWANDA** | **General Recommendation:**<br>Satisfactory report subject to clarification<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per request<br>**ISS:** to receive rewards for achievements in 2002<br>**NVS:** to receive the first shipment of DTP-HepB+Hib vaccines for 2004 as per<br>Request. Subsequent shipments will NOT be sent unless realistic targets are provided for 2004 onwards |
| **36** | **SAO TOME** | **General Recommendation**<br>Insufficient information<br><br>**Specific recommendations**<br>INS**: to receive a first shipment of INS support using the revised targets provided in table2 of the progress report, no further shipments will be sent unless a satisfactory request is provided**<br>**ISS**: no rewards due to low performance in 2002<br>**NVS**: to receive HepB vaccine as per request ,shipment of YF will be made according to measles target for 2004 unless satisfactory clarifications are provided on the revised request and the change in vial size |
| **37** | **SENEGAL** | **General Recommendation**:<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS**: as per request<br>ISS**: to receive the third investment of investment**<br>**NVS**: to receive DTP-Hib and HepB as per request |
| **38** | **SRI LANKA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per request<br>NVS**: to receive HepB vaccine as per request** |
| **39** | **SUDAN** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS**: to receive INS support as request<br>ISS: **to receive the third investment of investment** |

| | | |
|---|---|---|
| **40** | **TAJIKISTAN**<br>**.** | **General Recommendation:**<br>Satisfactory report subject to clarification<br><br>**Specific recommendations:**<br>**ISS:** the country to submit an estimate of the number of children aged less than one year who were vaccinated with DTP3 in 2002. The rewards for 2002 will be calculated accordingly<br>**NVS**: to receive HepB vaccine as previously approved unless satisfactory clarifications are provided on changes in targets for 2004 onwards |
| **41** | **TANZANIA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per request<br>**ISS**: to receive rewards for achievements in 2002<br>**NVS:** to receive DTP-HiB as per request for 2004 |
| **42** | **TOGO** | **General Recommendation**<br>Satisfactory report<br><br>**Specific recommendations**<br>INS: **to receive INS support as per request**<br>**ISS:** to receive the second investment of investment<br>**NVS:** to receive YF vaccine as per previous approval |
| **43** | **TURKMENISTAN** | **General Recommendation:**<br>Satisfactory report *<br><br>**NVS:** to receive hepB vaccine as per request however the country is urgently requested to inform of the number of 1 and 10 dose vials remaining in stock to permit the calculation of next shipments |
| **44** | **UGANDA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per request<br>ISS**: to receive rewards for achievements in 2002**<br>NVS: **to receive DTP- hepB-HiB as per request** |
| **45** | **VIETNAM** | **General Recommendation:**<br>Insufficient information<br><br>**Specific recommendations:**<br>**INS**: the INS support ( equivalent amount of cash) will be postponed until a satisfactory request using standard GAVI format is provided.<br><br>**NVS**: to receive INS support as per request |
| **46** | **YEMEN** | **General Recommendation:**<br>Insufficient information<br><br>**Specific recommendations:**<br>**INS**: to receive the third investment of investment<br><br>**ISS:** the country should provide new and realistic targets of infants to be vaccinated with DTP-HepB+Hib<br><br>**NVS**: to receive INS support as requested |
| **47** | **ZAMBIA** | **General Recommendation:**<br>Satisfactory report<br><br>**Specific recommendations:**<br>**INS:** to receive INS support as per request for 2004<br>**ISS:** to receive the third investment of investment<br>**NVS:** to receive DTP-HiB as per request |

| | | |
|---|---|---|
| **48** | **ZIMBABWE** | **General Recommendation:**<br>Insufficient information<br><br>**Specific recommendations:**<br>**INS:** to receive as per request<br>**ISS:** third investment to be available when satisfactory clarifications are provided on number of births, surviving infants and target infants for DTP3 vaccination<br><br>**From the secretariat: Clarifications have been provided and were found satisfactory** |