

Ministry of Foreign Affairs – Department for Migration, Stabilisation and Fragility (MNS)

Meeting in the Council for Development Policy on 26.10.2023

Agenda Item No. 3

1. Overall purpose: *For discussion and recommendation to the Minister*

2. Title: Organisation Strategy for GAVI 2023-2026

3. Amount: DKK 100 million 2023-2026

4. Presentation for Programme Committee: 12.09.2023

5. Previous Danish support presented to UPR: No

Danish Organisation Strategy 2023-2026 for Gavi, the Vaccine Alliance (GAVI)

Introduction:

GAVI's key results:

1. Introduce and scale-up coverage of high-impact vaccines for disease prevention
2. Strengthen health systems to increase equity in immunisation
3. Improve sustainability of immunisation programmes
4. Ensure healthy markets for vaccines and related products

Justification for support:

Gavi's mandate and work is highly relevant for key Danish priorities and interests on global health – sustainable development through immunization and promotion of healthy populations and communities. By improving health through immunization Gavi's work supports the Danish goals on stronger pandemic prevention and response through stronger health systems.

- Gavi meets the requirements of an effective multilateral organisation and is considered fit for purpose. The organisation works together with national governments, private sector and civil society to leverage each stakeholder's comparative advantage to fund immunisation and to shape the vaccine market.
- Gavi demonstrates transparency and accountability in its operations, and its compliance with fiduciary and social requirements and safeguards is strong.

From 2000 to 2021, Gavi's programmes helped vaccinate more than 1 million children. Gavi currently operates in 57 countries, covering approximately 50 percent of the global birth cohort. 19 countries have transitioned out of Gavi-support.

How we will ensure results and monitor progress:

- Monitoring of progress within prioritised areas will be done through annual reports, participation in Gavi briefings and meetings.
- Denmark will seek to influence Gavi through participation in the Nordic+ Constituency represented in the executive board.

Risk and challenges:

- Competing priorities and lack of capacity and capability among partner countries
- Insufficient demand and vaccine hesitancy
- Investments in health system strengthening does not materially improve programmatic outcomes
- Global supply shortage of vaccines
- Insufficient donor support
- Misuse of funds and fraud

| | | | | | | |
|-----------------------------|-------------------------|------|------|------|------|-------|
| File No. | 2023-28069 | | | | | |
| Responsible Unit | MNS | | | | | |
| | <i>Mill. DKK</i> | 2023 | 2024 | 2025 | 2026 | total |
| Commitment | 25 | 25 | 25 | 25 | 100 | |
| Projected Disb. | 25 | 25 | 25 | 25 | 100 | |
| Duration of strategy | 2023-2026 | | | | | |
| Finance Act code. | § 06.36.03.17 | | | | | |
| Desk officer | Marie My Warborg Larsen | | | | | |
| Financial officer | Antonio Ugaz-Simonsen | | | | | |

SDGs relevant for Programme

| | | | | | |
|--|---|---|--|--|---|
|  No Poverty |  No Hunger |  Good Health, Wellbeing |  Quality Education |  Gender Equality |  Clean Water, Sanitation |
|  Affordable Clean Energy |  Decent Jobs, Econ. Growth |  Industry, Innovation, Infrastructure |  Reduced Inequalities |  Sustainable Cities, Communities |  Responsible Consumption & Production |
|  Climate Action |  Life below Water |  Life on Land |  Peace & Justice, strong Inst. |  Partnerships for Goals | |

Budget

Annual budget 2022 from Gavi's externally audited consolidated financial statements:

Total: 2,054 mio. USD

Danish involvement in governance structure

Denmark is a member of the Nordic+ Constituency

Strat. objectives

To save lives and protect people's health by increasing equitable and sustainable use of vaccines

Priority results

1. Health security, pandemic preparedness and health system strengthening
2. Addressing the effects of climate change on health
3. Equity, access and gender equality

Core information

Established: 2000

Headquarters: Geneva

Board member: Eighteen members are representative board members and nine members are unaffiliated/independent board members

Reach: Gavi currently operates in 57 countries



MINISTRY OF FOREIGN AFFAIRS
OF DENMARK

Organisation Strategy

Gavi | 2023-2026

DRAFT

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1. Objective

This organisation strategy (OS) for the cooperation between Denmark and Gavi, the Vaccine Alliance (Gavi) forms the basis for the Danish support to Gavi and is the foundation for Denmark's partnership and dialogue with Gavi. It sets out Danish priorities for Gavi's performance within the overall framework established by Gavi's own strategy 2020-2025 (cf. annex 1). This strategy covers the period 2023-2026.

Evidence shows that immunisation programmes are one of the most successful and cost-effective public health interventions. Immunised communities are healthier and better educated, their household economics are bolstered, and the next generation will grow up and be more productive members of societies.

The overall objective of Denmark's engagement with Gavi is – in line with Denmark's strategy for development cooperation – to support pandemic preparedness and response as well as the vaccine agenda and the efforts to build more resilient healthcare systems and ensure vaccine sharing. This is in line with Gavi's overall vision expressed in their current strategy "*Leaving no one behind with immunisation*" with the mission to "*save lives and protect people's health by increasing equitable and sustainable use of vaccines*".

The OS is anchored in Denmark's overall commitment to the SDGs. It is furthermore anchored in the Danish Strategy for Development Cooperation 2021-2025, "The World We Share", which includes a focus on health: *A healthy physical and mental life is essential for enabling people to unlock their life opportunities, for example through participation in the labour force. Access to basic healthcare services is important for preventing disease and for helping people in urgent need. This access has become even more imperative during the COVID-19 pandemic, which has exacerbated the pressure on already weak health systems and reduced the life opportunities of millions of people – particularly vulnerable and marginalised groups.* [One of five preconditions for a good life, p.17]. Danish development cooperation is rooted in a human rights-based approach and the principles of 'leaving no one behind', non-discrimination, participation, transparency, and accountability across the development cycle.

With its global reach and focus on strengthening national health systems in low-income countries, Gavi is a key partner in Denmark's efforts to contribute to better access to healthcare. Gavi's partnership model and strategic priorities to strengthen health systems and ensure healthy markets for vaccines and related products are aligned with Denmark's partnership approach, which brings together government, private partners, and civil society organisations as well as innovative instruments to make development assistance more sustainable and effective.

This strategy builds on 'the organisation strategy for Denmark's Support to Gavi 2018-2022' and identifies key strategic priorities for the partnership and dialogue between the Danish Ministry of Foreign Affairs (MFA) and Gavi. It outlines specific goals and results that Denmark will pursue in cooperation with Gavi and like-minded partners. The OS will cover four years (2023-2026) in order for the next OS to be aligned with Gavi's next strategic plan which will be developed in 2025.

2. The organisation

Background: Gavi is an international alliance established in 2000 to improve access to and affordability of new and underused vaccines for children living in the poorest countries in the world. The backdrop of establishing Gavi was a stalling in the progress in international immunisation in the late 1990s. The Gavi partnership model is designed to leverage financial resources and technical expertise to shape a healthy market mechanism and make vaccines more affordable, available and the supply more reliable. By increasing equitable uptake and coverage of vaccines in lower-income countries, the partnership delivers on the mission to save children's lives and protect people's health.

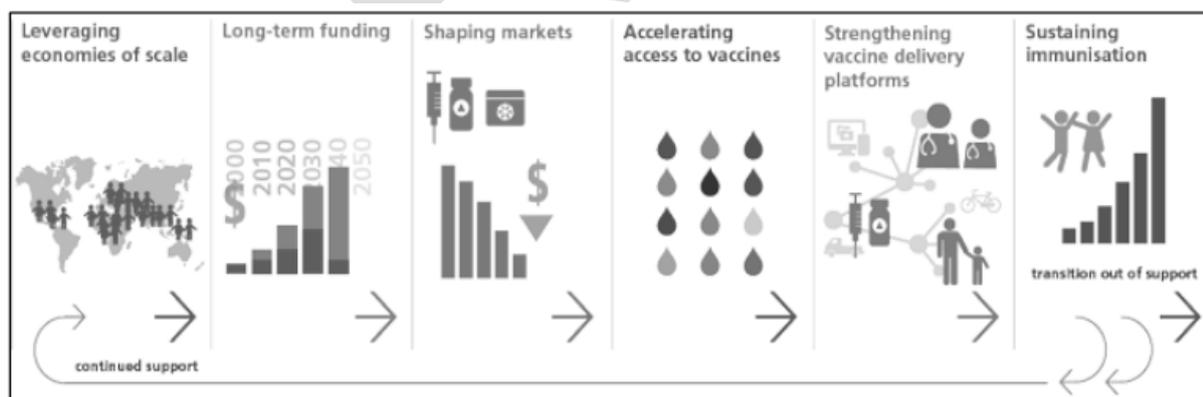
Denmark is one of the six original donors in the alliance. Other partners include civil society organisations, developing country governments, developing country pharmaceutical industry, industrialised country pharmaceutical industry and research and technical institutes.

Vision and mission: In June 2019, the Gavi Board approved a new five-year strategy with the vision of 'Leaving no one behind with immunisation' and a mission to save lives and protect people's health by increasing equitable and sustainable use of vaccines.

From 2000 to 2021, Gavi's programmes helped vaccinate more than 1 million children. Gavi currently operates in 57 countries, covering approximately 50% of the global birth cohort (see annex 2 for list of Gavi country list). 19 countries have transitioned out of Gavi support.

Fundamental for the Gavi business model is that support includes an exit strategy for implementing countries to take over their national immunisation programmes. Countries receiving support have to co-finance programmes and work towards sustainable national budget allocation for national immunisation programmes. The business model and the theory of change is illustrated below in figure 2.1

FIGURE 1: THE GAVI BUSINESS MODEL AND THEORY OF CHANGE



Gavi strategy 2020-2025

Gavi's current strategy Phase V is supported by four goals:

Goal 1 – the vaccine goal, to be achieved through three strategic objectives: (1) strengthening countries' prioritisation of vaccines; (2) support countries to introduce and scale up coverage of vaccines for

prevention of endemic and epidemic diseases; and (3) enhance outbreak response through availability and strategic allocation of vaccine stockpiles.

Goal 2 – the equity goal, to be achieved by: (1) helping countries extend immunisation services to zero-dose children, defined as children who failed to receive any routine vaccination, and under-immunised by building stronger primary health care platforms; (2) supporting countries to ensure that immunisation services harness innovation and are well-managed and sustainable; and (3) work with countries and communities to build resilient demand and to address gender-related barriers to immunisation.

Goal 3 – the sustainability goal, to be achieved by: (1) strengthening political and social commitment to immunisation; (2) promoting domestic public resources for immunisation and primary health care to improve allocative efficiency; and (3) preparing and engaging self-financing countries to maintain/increase performance.

Goal 4 – the health markets goal, to be achieved by: (1) ensuring sustainable, healthy market dynamics for vaccines and immunisation-related products at affordable prices; (2) incentivising innovation for the development of suitable vaccines, and (3) scaling up innovation in immunisation-related products.

In the light of the impact of the COVID-19-pandemic on global health in general and the set-back in routine-vaccination in particular, the Gavi strategy 2021-2025 was updated with the Board's adoption of the Gavi 5.1 strategy. Gavi 5.1 builds on the lessons of the pandemic and acknowledge new challenges in global health security posed by the increasing number of outbreaks and their profound societal, economic, and technological impact of the environment in which Gavi operates. The 5.1 strategy will serve as a bridge to Gavi 6.0 (for the period 2026-2030) by reflecting the changing context of recent years.

2.1 Management

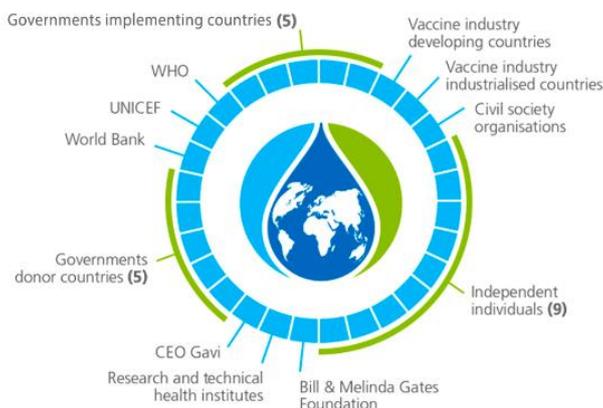
Gavi is a Swiss foundation with international institution status in Switzerland. The Gavi secretariat is based in Gavi's headquarters in Geneva, with support from an office in Washington DC. The secretariat is led by the chief executive officer.

The Gavi secretariat is responsible and accountable for the day-to-day operations of the Gavi alliance as they are set forth in the operations procedures determined by the Board. Main responsibilities include mobilisation of resources to fund programmes; coordination of programme approvals and disbursements; policy development and strategic initiative implementation; monitoring and evaluation; legal and financial management; and administration for the Gavi Board.

2.2 Governance and accountability

Gavi is governed by a Board, which is the highest decision-making body of the alliance. The Board is comprised of 18 "representative seats", 9 seats for independent or "unaffiliated" individuals and one seat for the Gavi Chief executive officer. Donor countries have five seats, shared in constituencies. Denmark has re-joined the Nordic+ Constituency in August 2023, and will follow the work of Gavi through this forum.

FIGURE 2: GAVI BOARD COMPOSITION



The Gavi Board is responsible for strategic direction and policy-making. Key tasks of the board include; adopting strategies and procedures necessary for the administration and management of Gavi, overseeing the operation of the vaccine alliance; and monitoring programme implementation.

An independent internal audit function (named “Audit and Investigations”) was established in 2009 to evaluate and strengthen risk management, internal control, and governance. The work of Audit and Investigations covers the secretariat as well as programmes and activities of Gavi’s in-country programmes, including grant recipients. The accountability framework of Gavi comprises of the following:

1. *Internal audit*, responsible for evaluating and improving the effectiveness of the organisation’s risk management, control, and governance processes.
2. *Programme audit*, evaluating programmes in-country to assess whether Gavi support, including cash, vaccines and related supplies, has been used as intended. Audits take into account both financial and programmatic aspects.
3. *Investigations and counter-fraud*, responsible for making evidence-based investigations of possible misuse or other misconduct with Gavi and Gavi-supported programmes in-country.
4. *Whistleblower (confidential) reporting*, receiving reports from internal and external sources on potential misuse or misconduct of Gavi resources.

2.3 Financial resources

The budget for Gavi’s 5.0 strategy, 2021-2025 is 9,4bn USD. The majority of financial resources is budgeted for vaccine programmes (56%) and investments in immunisation systems and enabling infrastructure (36%). The Gavi Secretariat will continue to coordinate the Alliance, support the Board, manage the Alliance’s resources and monitor and evaluate progress with annual overheads staying at less than 3%. The overview of expected expenditures is presented below in figure 3 and 4. The budget is presented and updated during each board meeting.

FIGURE 3: OVERVIEW OF EXPECTED GAVI EXPENDITURE, 2021–2025

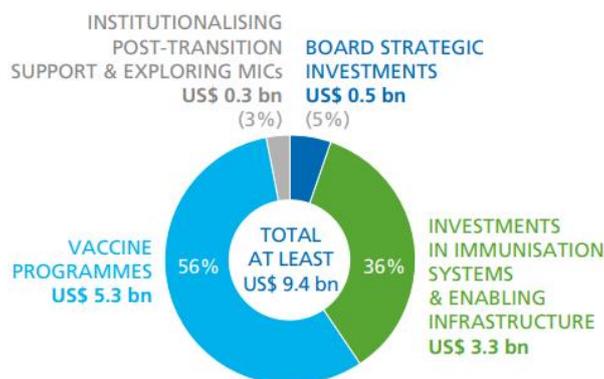


FIGURE 4: EXPECTED EXPENDITURE TO MEET COUNTRY DEMAND, 2021–2025

| 2016–2020 | Cash flow basis, US\$ million | 2021–2025 | | | |
|--------------------|---|---------------------|---------------|---------------------|------------------------|
| Total US\$ million | Programme | Existing programmes | Future demand | Total US\$ millions | % of total expenditure |
| | Vaccines | | | | |
| 2,402 | Pneumococcal | 1,141 | 163 | 1,304 | 13.9% |
| 544 | Pentavalent | 348 | 0 | 348 | 3.7% |
| 668 | Rotavirus | 497 | 60 | 558 | 6.0% |
| 206 | HPV | 159 | 358 | 516 | 5.5% |
| 263 | Yellow fever | 58 | 366 | 424 | 4.5% |
| 376 | Measles and rubella | 22 | 271 | 294 | 3.1% |
| 41 | Typhoid | 0 | 302 | 302 | 3.2% |
| 20 | Ebola | 0 | 150 | 150 | 1.6% |
| 77 | CEPI | 0 | 0 | 0 | 0.0% |
| 133 | Cholera | 0 | 32 | 32 | 0.3% |
| 169 | Meningitis A | 32 | 83 | 115 | 1.2% |
| 9 | Japanese encephalitis | 2 | 8 | 9 | 0.1% |
| 39 | Other | 55 | 0 | 55 | 0.6% |
| 46 | VIS vaccines | 0 | 360 | 360 | 3.8% |
| 495 | IPV / polio | 800 | 0 | 800 | 8.6% |
| 5,488 | Vaccine programmes | 3,114 | 2,153 | 5,267 | 56.3% |
| 0 | Institutionalising post-transition support & exploring MICs | 281 | 281 | 5,267 | 3.0% |
| 2,161 | Cash grant support | 53 | 1,678 | 1,731 | 18.5% |
| 951 | Partners' Engagement Framework | 913 | - | 913 | 9.8% |
| 613 | Operating expenses | 659 | - | 659 | 7.0% |
| 3,725 | Investments in immunisation systems and enabling infrastructure | 1,625 | 1,678 | 3,302 | 35.3% |
| 9,123 | Total Board approved programmes and expenses | 4,739 | 4,112 | 8,851 | 94.7% |
| ** | Board strategic investments | - | - | 500 | 5.3% |
| 9,213 | Total Board approved programmes and expenses and strategic investments | - | - | 9,351 | 100.0% |

\$9.4 bn

At the last replenishment conference in 2020, hosted by UK in London, world leaders pledged USD 8.8 billion for Gavi's 5.0 strategy, 2021-2025. Gavi's total annual income in 2022 was DKK 13,984 million

(USD 2,055 million). Table 1 presents a breakdown of the revenue by source during the current strategy period¹. This only includes core Gavi programmes and not COVAX.

TABLE 1: GAVI INCOME BY SOURCE, IN MILLIONS USD

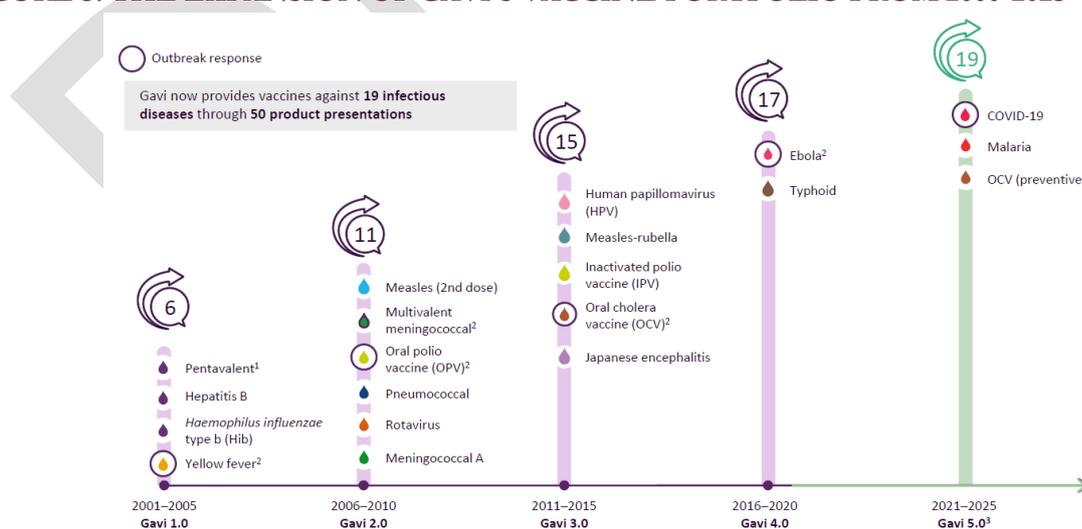
| Year | 2021 | 2022 |
|---------------------------------------|--------------|-------------------|
| Governments and private donors | 1,116 | 1,160 |
| IFFIm proceeds | 434 | 634 |
| Investment income, etc | 89 | (53) ² |
| Total | 1,639 | 1,741 |

Major donors include United States, United Kingdom, Norway, Germany, Canada, Sweden and the Netherlands. In total, government contributions constitute approximately three quarters of the total funding to Gavi. The rest consists of private contributions from foundations (e.g. the Bill & Melinda Gates Foundation).

3. Lessons learnt, key strategic challenges and opportunities

Since its inception in 2000, Gavi has contributed to the immunisation of 1 billion children and supported countries in averting more than 16-17 million deaths. From 2000-2017 vaccination programmes have contributed to a 70% reduction in vaccine-preventable child deaths and a 50% reduction in under-5 mortality rate in the countries, where Gavi operates. When the alliance was founded, it supported vaccines against three diseases. Today, Gavi supports vaccines against 19 diseases, cf. figure 3 below on the expansion of the Gavi vaccine portfolio from 2000 till today.

FIGURE 3: THE EXPANSION OF GAVI'S VACCINE PORTFOLIO FROM 2000-2023



¹ The figures in table 1 are from Gavi's externally audited consolidated financial statements, which are prepared in conformity with accounting principles generally accepted in the United States. Governments' and private donors' contributions are reported as revenues in the year in which payments are received or unconditional promises are made. So depending on when a grant agreement is signed, the level of contributions in the grant agreement and/ or when payment is received – this affects the timing in which the amount can be recognised as revenue.

² Negative interest on money in the bank, placements of IFFIm contributions.

In the current strategy period 130 million children have been immunised, which indicates that Gavi is on track to deliver the 2025 target of immunising an additional 300 million children, preventing 7-8 million deaths. A study of immunisation programmes in low- and middle-income countries from 2020 found that the programmes provide a high “return on investment” in terms of the economic costs of diseases that are prevented and the values of lives that would have been lost³.

Gender equality, human rights and democracy were focus areas in Denmark’s organisation strategy 2018-2022. During this period Gavi revised their Gender Policy (June 2020) and has established new gender-responsive funding systems as part of this strategy. With the gender policy Gavi has committed to increasing immunisation coverage by supporting countries to overcome gender related barriers to accessing immunisation services and promoting equity of access for all genders to immunisation and related health services that respond to their different needs. Furthermore, Gavi has implemented capacity-building initiatives on addressing gender issues in immunisation programming and gender has been mainstreamed into all Gavi guidelines and grant applications in the current strategic period (2021-2025). However, inequalities in immunisation programmes persist. While there is no significant difference in immunisation coverage rates for girls and boys, the status of women in a society impacts their ability to access health services and therefore also her children’s likelihood of being immunised regardless of their sex. The challenges are numerous: women’s lack of household financial resources to pay for indirect cost, limited education and health literacy, as well as security and mobility issues. For all children to have access to vaccines, gender barriers need to be addressed. Women and girls’ lack of access to health services is also a challenge in relation to cervical cancer. Every year 266,000 women die from cervical cancer, 80% of the cases are in developing countries. If the current trend continues, cervical cancer deaths can outpace maternal mortality. It is estimated that HPV-vaccines can prevent up to 90% of all cervical cancer cases, which means that today, women die from cervical cancer that is preventable. Gavi recognises in its ‘2023 Mid-Term Review Report’ that there is a need for more government gender expertise and increased in-country gender technical support to enable the translation of applications into strong programming. Gavi also sees gaps and further works with countries to address the significant gender imbalance in leadership positions in immunisation and increase women’s representation at decision-making levels⁴.

In the previous phase Denmark has had a key interest in Gavi’s work with civil society. In Gavi’s progress report of the strategy 2016-2020 Gavi found a lack of progress on civil society engagement with no change from 2018-2020 (24%) and significantly below the 2020 target of 43%⁵. In response to this, Gavi worked with the Civil Society Organisation (CSO) Steering Committee to develop a new approach to CSO and community engagement for the Gavi strategy 5.0 (2021-2025). The new CSO and Community Engagement framework has resulted in the majority of countries applying for new support involves at least 10% of funding to CSOs⁶. Civil society has a unique reach, knowledge and influence at the community level and is already playing an essential role in the architecture of immunisation, from

³ [Immunization Programs Yield High “Return On Investment,” Saving Hundreds of Billions of Dollars | Johns Hopkins | Bloomberg School of Public Health \(jhu.edu\)](#)

⁴ [MTR23_Report_FULL_eng.pdf \(gavi.org\)](#)

⁵ [Gavi-Progress-Report-2020.pdf](#)

⁶ [MTR23_Report_FULL_eng.pdf \(gavi.org\)](#)

advocacy to service provision. With the prioritisation of funds for civil society, Gavi moves much closer to those communities and children, who were previously out of reach. One example of such a partnership in action is in Uganda and Kenya. Gavi has worked with the organisation 'Living Goods' to equip community health workers with digital immunisation records. This has contributed to boosting childhood vaccination coverage in supported communities by 36% in Uganda and 69% in Kenya since 2019, while reducing the number of zero-dose children.

The last funding period was profoundly affected by the COVID-19 pandemic - both within the MFA and for Gavi. In April 2020 Gavi established COVAX, a platform that supports the research, development and manufacturing of a wide range of COVID-19 vaccine candidates, and negotiates their pricing. The purpose was to ensure that middle- and lower-income countries that cannot fully afford to pay for COVID-19 vaccines themselves get equal access to COVID-19 vaccines. The pandemic itself and the focus on COVID-19 vaccines has disrupted health systems and Gavi's work with routine immunisation. The pandemic demonstrated the importance of a flexible Alliance. Gavi can build on the lessons from COVAX to retain and enhance the required capabilities to help drive a global response to the next pandemic. The key challenge for Gavi now is to integrate COVAX into Gavi's core business, while continuing to support countries to prioritise high-risk populations and integrate COVID-19 vaccination into their health systems.

Denmark was not part of a constituency in the last funding period. This was found to be very challenging in terms of Denmark's ability to influence and follow Gavi's work. Therefore, it was decided that Denmark should re-enter a constituency in order to ensure that Danish priority areas are included in the board meetings. The Nordic+ constituency is found to be a good fit for Denmark and Danish priorities are aligned with the priorities of the constituency. This is elaborated in section 5 of this OS 'Danish approach to engagement with the organisation'.

3.1 Challenges

Despite significant progress overall and in the Gavi 2020-2025 strategic period, challenges and risks remain in terms of meeting the strategic goals. The pandemic magnified global inequalities in access to vaccines and other countermeasures and took a disproportionate toll on the most vulnerable countries and communities.

The COVID-19 pandemic demonstrated that countries with strong health systems - including strong immunisation programmes - and swift access to countermeasures and vaccines were best placed to respond to the pandemic. Moving forward there is a need to learn from the pandemic and integrate experiences and lessons-learned in a stronger and more robust global health security infrastructure. There is a need to define Gavi's role in the global architecture for pandemic preparedness, prevention and response. Furthermore, Gavi's country-programmes has an important role to play in building stronger health system capacity to prepare, prevent and respond to disease outbreaks with pandemic potential.

Coming out of the pandemic, the world is facing multiple crises. Increasing debts and rising inflation has left countries with fiscal constraints. The impact of climate change, rising levels of conflict and insecurity, including food insecurity, and health systems that are strained after the pandemic all amount to a

challenging environment for the Alliance, partners, and not least implementing countries and communities.

Climate change causes vector-borne diseases carried by mosquitos, such as malaria, yellow fever, and dengue to spread to new areas and regions. At the same time, extreme weather caused by climate change damages local health infrastructure and disrupts health delivery services. Increasing climate change in connection with urbanisation also increases the risk of the emergence of new diseases capable of spreading from wild animals to humans.

The World Health Organisation (WHO) has estimated that the number of un- or under-vaccinated children grew from 17 million in 2019 to 25 million in 2021. At the same time, outbreaks of vaccine-preventable diseases have increased. In 2022, Gavi supported 40 campaigns in response to outbreaks - a 75% increase compared to 2021. This upwards trend is continuing in 2023. In terms of extending the power of increased immunisation there is a need to resume the targeted focus on reaching zero-dose children to prevent further backsliding of immunisation and recover from set-backs during the pandemic. Delays to key vaccine rollouts, e.g. HPV vaccine, as countries have been forced to prioritise during the pandemic, also needs attention.

The Gavi business model is based on partner countries taking increased ownership of their immunisation programmes by contributing more domestic resources over time. Six countries are expected to transition out of Gavi support from 2020-2025, falling short of the goal of 10 countries. Also, countries are expected to fall USD 200 million short of the USD 3.6 billion target for self-financing and co-financing by 2025. At the same time, newer vaccines with increased prices and higher than expected prices for existing programmes are challenging the sustainability of Gavi's co-financing model. Recognising these issues, the Gavi Board has updated the transition policy. As an alliance, Gavi will work closely with transitioning countries to establish the strong political commitment necessary to lay the foundation for sustainable national immunisation programmes.

3.2 The relevance and effectiveness of Gavi in relation to the international development and humanitarian agenda

Immunisation is a global public good and remains one of the most effective ways to save lives. Gavi's response to the COVID-19 pandemic demonstrated the power of vaccinations, but it also served as a reminder that no one is safe until everyone is safe. The Gavi mandate to save lives and protect against future disease outbreaks, epidemics, and pandemics remains important to secure progress on achieving the SDGs, in particular poverty reduction (SDG 1), good and health and well-being (SDG 3), equality in education (SDG 4), decent work and economic growth (SDG 8), peace and strong institutions (SDG 16), and partnerships for goals (SDG 17).

Strong health systems and better public health support long-term stability, create jobs and contribute to reduced inequality. Vaccinations build resilience to mitigate disasters in humanitarian settings, whether from conflict, instability, climate change or natural disasters, and have a positive impact on the health and well-being of communities. Gavi adopted a Fragility, Emergency and Refugees Policy (FER policy) in 2017 with the aim of: 1) articulating criteria for identifying a subset of Gavi countries that are affected

by fragility, as per international standards; 2) providing guidance on adapting certain Gavi policies to tailor them to the local context; and 3) detailing flexibilities that can be extended in the case of an emergency and for Gavi countries hosting refugees. An evaluation of the FER policy in 2021 concluded that the FER policy is robust enough to allow flexibility in Gavi policies and operations in countries facing fragility, emergencies, or refugee situations. The policy would benefit from a revised application mechanism enabling prompt decision-making where immediate action is required.

4. Priority areas

The overall mission of Gavi to promote sustainable development through immunisation and promotion of healthy populations and communities is in line with the Danish priorities for global health. Denmark's priorities are defined in the Danish development strategy "The World We Share" and in the How-to note for Social sectors and social Safety nets. The objectives in "The World We Share" is to contribute to the fulfilment of the SDGs. The main goal is to support access to healthcare services in fragile countries and regions, with particular focus on marginalised groups, women, children and young people. Based mainly on SDG 3 Denmark's priorities in global health include strengthening local, regional and global health and health security, including pandemic prevention, preparedness and response, stronger health systems, and access to primary care. Denmark's priorities in global health also recognise the effect of climate change. Pressure on nature and population growth has a negative effect on public health. Therefore, the integration of climate mitigation and adaptation in global health initiatives is crucial. Gavi's focus on gender equality and empowerment of women is in line with the Danish priority for gender equality as a crosscutting issue in Danish development cooperation.

The OS priority areas and results to be achieved are based on the link between Denmark's strategic priorities for sustainable global development, Gavi's strategic priorities and the challenge and opportunities described in section 3.1 above.

Health security, pandemic preparedness and health system strengthening

Strong institutions, robust health systems and resilient supply chains are critical for health globally, regionally and locally and for countries to be able to develop and maintain immunisation programmes. This includes technical capacity to administer and deliver vaccines, operational capacity to plan and execute programmes and an open dialogue on priorities and needs to designing and operating well-functioning health systems. Denmark is committed to take part in efforts to strengthen health security and pandemic preparedness at the local, national and global level alongside likeminded and multilateral partners. Likewise, Gavi's goal is to explore new ways to partner with others to build resilience at country level and contribute to the overall global pandemic prevention. This includes addressing the inadequate manufacturing capacity and lack of diversification of supply chains.

Denmark will continue to support Gavi's promotion of health system strengthening and the integration of lessons learned from the pandemic to build stronger and more robust country capacity to address disease outbreaks and prevent pandemics. Denmark will also support Gavi's work on contributing to a higher level of global health security by building stronger production capacity and more resilient supply chains to ensure equal and timely access to vaccines and other countermeasures.

Addressing the effects of climate change on health

Climate change is creating conditions for preventable diseases to spread, and climate emergencies damage local infrastructure and disrupt essential health services. Furthermore, climate change exacerbates the risk of antimicrobial-resistant bacteria (AMR) by spreading resistant bacteria to new areas and creating conditions for development of new resistant bacteria and fungi. Six of Gavi's vaccines protect against AMR diseases by reducing transmission of sensitive and resistant strains and preventing people from catching hard-to-treat infections. Vaccines also contribute to the battle against AMR by reducing the unnecessary antibiotic use. Furthermore, climate change is creating the conditions for vaccine-preventable diseases to spread. Mosquitos that cause malaria, yellow fever and dengue are thriving and spreading to new regions, and climate disasters are increasing the risk of waterborne diseases, including diarrhoea caused by rotavirus, typhoid and cholera. Gavi is helping countries adapt to the impacts of climate change by rolling out vaccines that protect against many of these diseases and Gavi's newly launched malaria programme is a key response to a disease encouraged by climate change.

Globally, the health sector is responsible for around 5% of the total greenhouse gas emissions. Gavi – together with partners, including UNICEF, is focused on mitigating emissions related to immunisation programmes. This is for example done by introducing sustainable energy solutions in the cold chain or leveraging new and more energy-efficient technology in delivering vaccines, e.g. the use of drones to reach remote areas instead of using trucks and vans. Since many health facilities in Gavi implementing countries lack access to reliable electricity, there has been a particular focus on scaling up climate-friendly solar-powered refrigeration technologies, which account for 60% of all units installed to date.

Denmark will support Gavi initiatives to address the effects of climate change and climate emergencies on health and health systems in its mission. Denmark will work to ensure that the updated Gavi strategy for 2026-2030 includes ambitious goals on addressing climate change and its effects on Gavi's core mission and programme. This includes goals on how to further mitigate emissions related to immunisation programmes, including e.g. more sustainable waste management.

Equity, Access and Gender Equality

Equity, equal access to health services, and gender equality are values underpinning the Danish development strategy on global health. The Danish approach emphasises a human rights based approach to development as the basis for the development of sustainable and equal societies. Denmark places strong emphasis on gender equality and the rights of women and girls, including sexual and reproductive health and rights. This includes access to vaccines such as HPV. The revitalisation of the HPV vaccination programme is based on a tailored approach for reaching women and young girls. In June 2020, a revised gender policy was approved by the Gavi Board, which includes initiatives to encourage and advocate for women's and girls' full and equal participation in decision-making related to health programmes and wellbeing. Furthermore, Gavi has established a new gender-responsive funding system as part of the overall gender policy.

Denmark will closely follow Gavi's work with development and strengthening of the gender policy and the ability to identify and address actual gender barriers for accessing immunisation. Denmark will furthermore work to ensure that the newly established gender-responsive funding system is implemented and evaluated to ensure the overall effectiveness of the programme.

5. Danish approach to engagement with the organisation

Gavi is an international alliance between multiple private partners (including the funding partners; WHO, World Bank, Unicef and Bill & Melinda Gates Foundation), donor governments, partner countries and civil society organisations. Denmark's ability to influence the strategy and operating model of Gavi will be through its participation in the Nordic+ Constituency. Each constituency has a seat at the Board. The Nordic+ currently comprises of Norway, Sweden, Finland, Switzerland, and Denmark with Norway representing the constituency on the Board until the end of 2023. The Nordic+ Constituency is consensus driven and positions are developed in collaboration prior to the two annual board meetings. The Danish priorities are in line with the priorities of the Nordic+ Constituency. As part of Nordic+, Denmark has increased cooperation with other donor countries both internally in the group and with countries in other constituencies, especially within the EU where coordination is high.

In 2023, Gavi has conducted a Mid Term Review (MTR) to serve as a basis for discussion for the development of the next strategic framework 2026-2030. Denmark will actively seek to influence the development of Gavi's strategy 6.0 for the period 2026-2030 by emphasising the priority areas from this OS in collaboration with the Nordic+ Constituency. The influence of the constituency is relatively high as it is a homogeneous group that is able to leverage each other strengths to influence the overall strategic direction and decision making.

To monitor performance and progress of Gavi strategy 2020-2025 there is specific goals and objectives for each strategic goal. The results are based on Gavi's results framework and progress monitoring systems. The secretariat monitors progress based on Gavi's indicators, and reports to the Board on the progress. A MTR of this organisation strategy will be conducted in 2025, which will inform the need for potential adjustments and be the basis for a dialogue with Gavi on progress and the continued partnership.

The financial oversight will be done through the annual financial reporting, and the board meetings, where the Gavi budget is presented and updated. Gavi undergoes external audit annually and the current external auditor is Deloitte. The Audit and Investigations activity is established by the Board. Its activities are defined by the Board as part of their oversight role, as set out in Audit and Investigation's Terms of Reference which are reviewed and approved by the Board. To ensure independence, Audit and Investigations reports to the Gavi CEO and the Gavi Board. The Audit and Finance Committee provides Board-level oversight of the Audit and Investigations function in Gavi including its objectives, organisational reporting lines, and plans and operating budget, to ensure that these are appropriate and sufficient to enable Audit and Investigations to satisfy its mission.

Gavi is assessed as fitting well into the portfolio of Denmark's partners. UNICEF, WHO and the World Bank all have a permanent seat on the Gavi board, and there is a high degree of collaboration. Gavi relies

on country-based systems and works with partners with widespread field presence to deliver its programmes. On the ground Ministries of Health take the lead in close collaboration with WHO regional and country offices, which provide expert recommendations on vaccine use and assessment of new vaccines. Even though Gavi provides the funding for vaccine purchases, it is UNICEF's supply department that makes the purchases. The World Bank gives strategic advice on capital market dynamics and plays a key role in innovative financing. Denmark will explore potential synergies between current (Tanzania and Kenya) and future health programmes and Gavi's work.

6. Budget

Denmark has since 2000 contributed a total of DKK 310 million in core contributions to Gavi, which includes an extraordinary contribution of DKK 10 million to support preparation for the launch of the human papilloma virus (HPV) vaccine. The Danish core contribution is spent on Gavi programmes only, none of it on investments. In addition to the core contribution to Gavi, Denmark contributed an extraordinary DKK 190 million in 2021-2022 to the Gavi COVAX Advance Market Commitment (COVAX AMC), a financial mechanism within COVAX that supports low- and middle-income countries to COVID-19-vaccines through procurement, and support to delivery and logistics related to COVID-19 vaccines.

TABLE 2: DENMARK'S PLANNED CONTRIBUTION TO SUPPORT TO GAVI 2023-2026 IN MILLION DK, SUBJECT TO ANNUAL PARLIMENTARY APPROVAL

| 2023 | 2024 | 2025 | 2026 |
|------|------|------|------|
| 25 | 25 | 25 | 25 |

7. Risks and assumptions

The Gavi Alliance recognises that risks must be taken into consideration and managed carefully. To manage risks, the Gavi Board has adopted a risk policy in 2014. A yearly report provides an update on risk management across the alliance, including an analysis of trends affecting Gavi's risk profile and changes in top risks compared to previous years.

While not an immediate health emergency, the COVID-19 pandemic continuously influences the environment in which Gavi operates, with a significant impact on the risks facing the Alliance.

Competing priorities and lack of capacity and capability. The Alliance is based on collaboration and involvement of partner countries. However, many partner countries continue to have insufficient capacity and capabilities to develop, maintain, restore, and strengthen immunisation programmes. For countries that have transitioned out of Gavi-supported programmes there is a risk that they fail to sustain progress. Of the 19 countries that have transitioned out of Gavi support as of 2022, 13 have not yet introduced at least one of pneumococcal conjugate vaccine (PCV), rotavirus vaccine, or HPV vaccine. Competing priorities in a time of multiple crisis is the reality for Governments in implementing countries around the world. This makes continued commitment and capacity to collaboration an area of attention. To further mitigate this risk, the Gavi Board agreed that it will be essential to continue to strongly advocate to protect domestic financing for health and immunisation, as well as to ensure global health agencies collaborate

further to unlock efficiencies in health spending at country level. Gavi proactively engages in a dialogue with countries to assess the risk of countries not paying their co-financing, supports engagement with Ministries of Finance and partners, and advocates for alternative sources of funding through close collaboration with the World Bank.

Insufficient demand and vaccine hesitancy. High levels of demand are critical to reach every child and every community and to achieve high levels of vaccine uptake. Demand can be affected by vaccine hesitancy, due to immunisation not being actively prioritised by parents and caretakers, and by lack of data on zero-dose/under-immunised children. Vaccine confidence depends on trust on the safety and efficiency of vaccines and the systems and health workers delivering them. The experience of roll-out of COVID-19 vaccines have in some countries and communities led to increased vaccine hesitancy, which needs to be actively addressed as a drop in demand for vaccines would negatively affect Gavi's ability to achieve its overall mission. To manage this risk, Gavi developed a demand generation framework which has built vaccine confidence and trust as a central component.

Health systems strengthening. During the current Gavi strategy 2020-2025, Gavi is expected to invest approximately 2 billion USD in the strengthening health systems in partner countries to reach zero-dose children, improve cold-chain equipment, and other optimisation platforms, including digital platforms. There is a risk that the investments in health system strengthening does not materially improve programmatic outcomes due to systematic and programmatic bottlenecks, such as gaps in workforce, design of the overall health system, grants and programmes duplicate other programmes, or if grants are not big enough to have a significant impact. To further mitigate this risk, Gavi will continue to make concerted efforts to work with countries to accelerate the different planning processes, ensuring that new grants which align to the Alliance's 5.0 goals are approved and begin implementation as soon as possible.

Global supply of vaccines. Gavi tries to mitigate supply shortages by its market-shaping strategy to help build and support a healthy global vaccine market. The strategy enables manufacturers to produce vaccines in quantities, and at prices, that are sustainable for lower-income countries. However, some markets continue to be of low health, due to lack of supplier diversity as well as limited capacity for manufacturing expansion. Sustained supply security continues to be dependent on factors and assumptions outside the scope and influence of Gavi, such as global production capacity, (lack) of supplier diversity, and lack of introduction of new technologies, that may influence manufacturers capacity. A stronger global diversification of supply chains and vaccine manufacturer will help secure global supplies.

Continued donor support. The continued support from donors is crucial to sustain Gavi's programmes and keep up with a growing birth-cohort. Global economic setbacks and uncertainty, a changing geopolitical environment, and competing priorities in development (such as climate change, migration, security, education) as well as a general domestic strain on resources in most countries, poses a risk to continued donor support. Reduced donor support and access to financing, will undermine achievements and risk further backsliding leading to increased risk of a re-emergence of COVID-19 as well as the risk of new pandemics caused by vaccine-preventable diseases. To manage this risk, Gavi continues to

diversify its donor base to ensure a broad based support. The Secretariat invests significant efforts in engaging a variety of donors and ensuring their needs are met.

Misuse of funds and fraud. The risk of deliberate misuse of Gavi support and Gavi funds remains high in time of economic uncertainty, low morale after years struggling with the pandemic, and financial pressure. At the same time, countries and implementing partners were under pressure to spend faster to deliver progress during the immediate health emergency setting aside some of the usual processes for procurement, oversight and assurance. Gavi acknowledges that during the duration of a health emergency, risks may increasingly materialise despite efforts to mitigate them. In case of actual misuse, however, Gavi will always require reimbursement as a condition for continued support. It is the responsibility of the internal auditor, under the supervision of the Board, to conduct investigations and counter-fraud, which conducts an evidence-based examination of possible misuse and other misconduct within Gavi, in Gavi-supported programmes in countries, or which otherwise impact upon the organisation. During the last phase of Danish engagement with Gavi (2018-2022) there has been two c-cases. Gavi have shown that their mechanisms for detecting and prosecuting corruption cases are effective. In both c-cases, Denmark has been informed of the possible suspicion of misuse of funds and continuously kept informed of developments. All funds have been repaid to Gavi.

8. Annex

Annex 1 Gavi 5.0 Measurement Framework (2021-2025)

Annex 2 Summary of 5.0 country allocations for Gavi-eligible countries

Annex 3 Gavi risk Policy (2014)

LEAVING
NO ONE
BEHIND WITH
IMMUNISATION



Gavi 5.0 Measurement Framework (2021-2025)

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OVERVIEW

INTRODUCTION

The Gavi 5.0 Measurement Framework (“Measurement Framework”) is the primary mechanism for routine monitoring and reporting on performance of Gavi’s 2021–2025 strategy (“Gavi 5.0”). It was developed iteratively by the Gavi Secretariat, in consultation with partners and technical experts across the Alliance.

The Measurement Framework is a component of Gavi’s Learning System—the overarching approach to generating and using evidence to strengthen delivery of Gavi strategies, policies, and programming. This document details the rationale, structure, and components of the Measurement Framework.

BACKGROUND

The Gavi Board approved the [2021–2025 strategy](#) (“Gavi 5.0 strategy”) in June 2019. The Measurement Framework has been designed to measure progress towards achieving Gavi’s mission, strategy goals and objectives stipulated in the 2021–2025 Strategy.

Gavi, the Vaccine Alliance: 2021–2025 Strategy

| Vision | | Gavi The Vaccine Alliance | | Leaving no one behind with immunisation | | SUSTAINABLE DEVELOPMENT GOALS | | |
|--------------|--|------------------------------|--|--|---|-------------------------------|--|--|
| Mission 2025 | To save lives and protect people’s health by increasing equitable and sustainable use of vaccines | Mission indicators | <ul style="list-style-type: none"> • Under-five child mortality reduction -10% • Future deaths averted 7–8m • Future DALYs averted 320–380m | <ul style="list-style-type: none"> • Reduction in zero-dose children (equity indicator) -25% • Unique children immunised 300m • Economic benefits unlocked US\$80–100bn | | | | |
| Principles | <ul style="list-style-type: none"> • Missed communities, first priority: Prioritise children missing out on vaccination, including among migrants, displaced and other vulnerable populations • Gender-focussed: Identify and address gender-related barriers to promote immunisation equity • Country-led, sustainable: Bolster country leadership to sustainably deliver and finance immunisation • Community-owned: Ensure community trust and confidence in vaccines by engaging communities in planning, implementation and oversight of immunisation • Differentiated: Target and tailor support to national and subnational needs, including fragile contexts | | | | | | | |
| Goals | 1 INTRODUCE AND SCALE UP VACCINES | | 2 STRENGTHEN HEALTH SYSTEMS TO INCREASE EQUITY IN IMMUNISATION | | 3 IMPROVE SUSTAINABILITY OF IMMUNISATION PROGRAMMES | | 4 ENSURE HEALTHY MARKETS FOR VACCINES AND RELATED PRODUCTS | |
| Objectives | <ul style="list-style-type: none"> A Strengthen countries’ prioritisation of vaccines appropriate to their context B Support countries to introduce and scale up coverage of vaccines for prevention of endemic and epidemic diseases C Enhance outbreak response through availability and strategic allocation of vaccine stockpiles | | <ul style="list-style-type: none"> A Help countries extend immunisation services to regularly reach under-immunised and zero-dose children to build a stronger primary health care platform B Support countries to ensure immunisation services are well-managed, sustainable, harness innovation and meet the needs of all caregiver C Work with countries and communities to build resilient demand, and to identify and address gender-related barriers to immunisation | | <ul style="list-style-type: none"> A Strengthen national and subnational political and social commitment to immunisation B Promote domestic public resources for immunisation and primary health care to improve allocative efficiency C Prepare and engage self-financing countries to maintain or increase performance | | <ul style="list-style-type: none"> A Ensure sustainable, healthy market dynamics for vaccines and immunisation-related products at affordable prices B Incentivise innovation for the development of suitable vaccines C Scale up innovative immunisation-related products | |
| Enablers | <ul style="list-style-type: none"> • Secure long-term predictable funding for Gavi programmes • Ensure global political commitment for immunisation, prevention and primary health care • Use evidence, evaluations and improved data for policies, programmes and accountability • Leverage the private sector, including through innovative finance mechanisms and partnerships | | | | | | | |

Figure 1: Gavi 2021–2025 Strategy One-Pager

THEORY OF CHANGE

Gavi's highest level ambitions are stipulated in its vision ("Leaving no one behind with immunisation") and mission ("Save lives and protect people's health by increasing equitable and sustainable use of vaccines"). The vision and mission represent the impact level results that Gavi will contribute to. Gavi's investments and programming will be operationalized to achieve four main strategy goals (long-term outcomes): 1) Introduce and scale up vaccines, 2) Strengthen health systems to increase equity in immunisation, 3) Improve sustainability of immunisation programmes, and 4) Ensure healthy markets for vaccines and related products. Gavi will apply the following key levers to generate requisite outputs and short-to-medium term outcomes that will contribute to achievement of the strategy goals: a) vaccine support, b) cash grants, c) technical assistance, and d) advocacy. The Gavi 2021-2025 strategy theory of change is illustrated in figure 2 below.

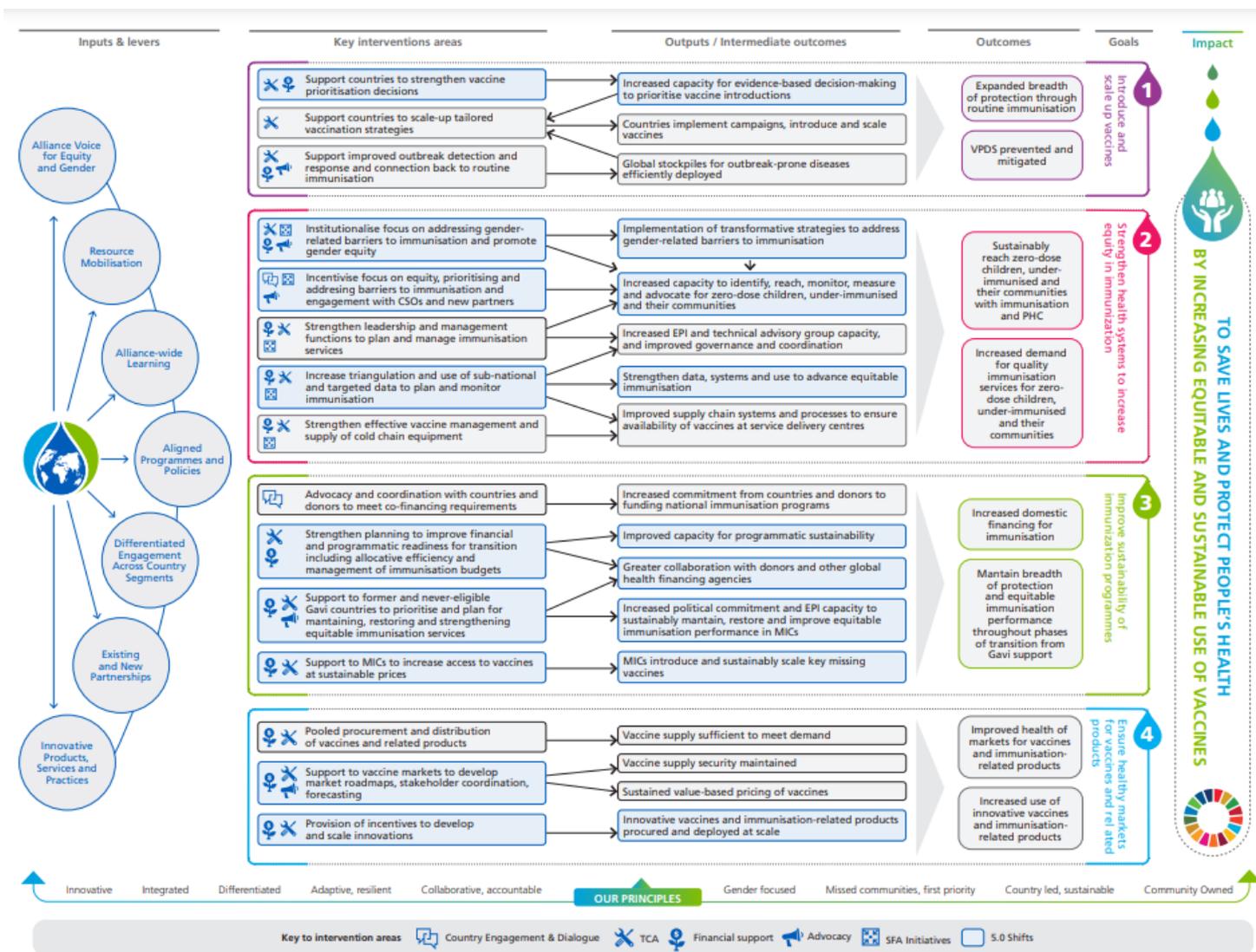


Figure 2: Gavi 5.0 Theory of Change

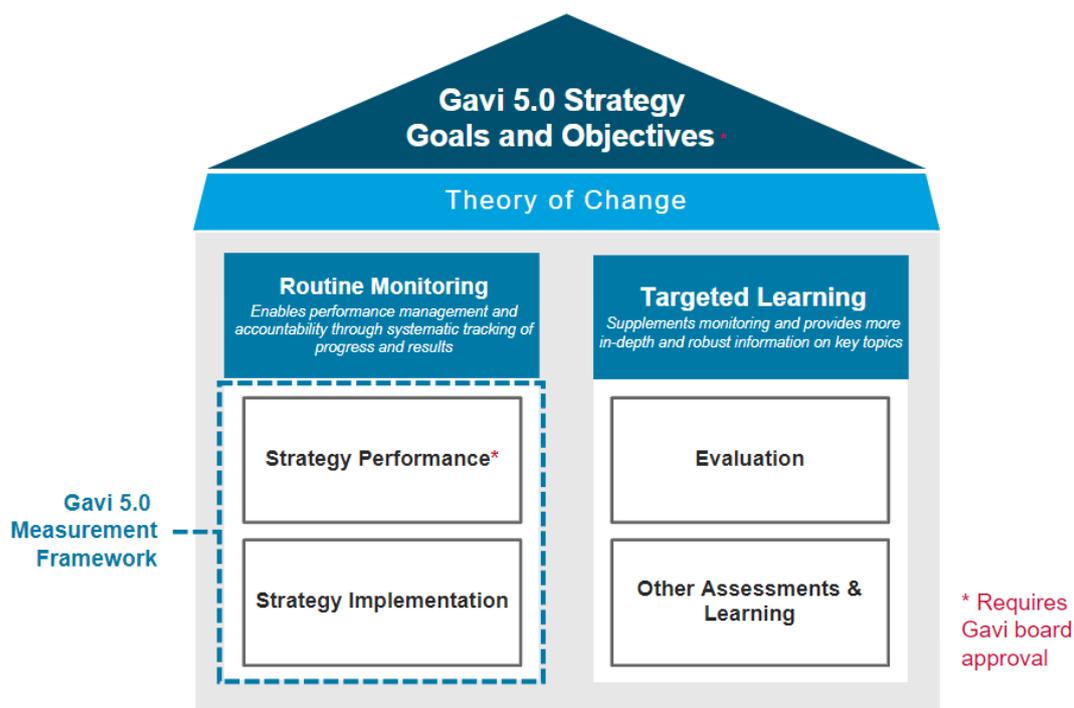
Using the ToC to underpin routine performance management facilitates the selection of indicators that are directly linked to the strategy goals and, due to their location along causal pathways, will indicate not only whether the Alliance is on or off-track to meet its objectives, allowing for more real-time course correction. An important part of the ToC approach is the identification of key assumptions about our operating context and risks to the achievement of our objectives—both of which will be routinely monitored.

PERFORMANCE MONITORING

Key shifts from Gavi 4.0 to Gavi 5.0 necessitated new ways of approaching performance monitoring of Gavi's strategy. The Measurement Framework reflects these shifts and builds on the lessons learned from performance monitoring of the 2016-2020 strategy. The major improvement is the use of the theory of change (ToC) to clearly articulate the Gavi 5.0 strategy in a way that strengthens our ability to monitor and evaluate it. Key performance indicators included in the Measurement Framework have been selected to measure results along and across the causal pathways of the strategy theory of change (from monitoring implementation of inputs and processes to delivery of outputs and achievement of immunisation outcomes).

The Measurement Framework has been structured to monitor and measure performance of Gavi 5.0 at two levels:

- 1) Strategy performance;
- 2) Strategy implementation.



Strategy Performance Monitoring

Strategy performance monitoring focuses on measuring progress towards achievement of the strategy objectives and goals (i.e., the outputs, outcomes, and impact), with shared accountability across the Alliance and reporting to the Gavi Board. Strategy performance indicators measure the production of deliverables and achievement of key results downstream in the causal pathways of the Gavi 5.0 theory of change. Strategy performance indicators, and their associated baselines and targets, have been approved by the Gavi Board (see figure 3). Several Mission indicator targets are included as commitments in the [Gavi 2021-2025 Investment Opportunity](#). The strategy performance indicators, baselines and targets approved by the Gavi Board are summarized in Annex A.

Note:

The Gavi Board approved elements of the 5.0 measurement framework across meetings held in 2020 and 2021. For some decisions, the Board approved proposals as part its consent agenda based on the recommendation of the Programme and Policy Committee (PPC). Board documents related to this process, which contain the rationale for the choice of indicators include: [July 2020 Board paper](#), [December 2020 Board paper](#), [June 2021 Board Consent Agenda](#), [November 2021 Board Consent Agenda](#).

| Mission | M.1 Under-five mortality rate (SDG 3.2.1)^o M.2 Future deaths averted[*] M.3 Future DALYs averted^o | | M.4 Reduction in zero-dose children (Equity indicator)^{**} M.5 Unique children immunized^o M.6 Economic benefits unlocked^o | |
|----------------------|---|---|--|---|
| Goals | INTRODUCE AND SCALE UP VACCINES | STRENGTHEN HEALTH SYSTEMS TO INCREASE EQUITY IN IMMUNISATION | IMPROVE SUSTAINABILITY OF IMMUNISATION PROGRAMMES | ENSURE HEALTHY MARKETS FOR VACCINES AND RELATED PRODUCTS |
| Strategy performance | S1.1 Breadth of protection[*] S1.2 SDG 3.b.1 (DTP3, MCV2, PCV3, HPV coverage) ^{**} S1.3 Rate of scale up of new vaccines ^o S1.4 Vaccine introductions [*] S1.5 Country prioritisation of vaccines [*] S1.6 Preventive campaign reach (measles)^o S1.7 Timely outbreak detection and response^{**} | S2.1 Geographic equity DTP3 coverage^{**} S2.2 DTP drop-out^{**} S2.3 MCV1 coverage^o S2.4 Number of immunisation sessions ^o S2.5 Stock availability at facility level ^{**} S2.6 EPI management capacity [*] S2.7 Percentage of countries implementing tailored plans to overcome demand barriers ^{**} S2.8 Percentage of countries addressing gender-related barriers with Gavi support ^o | S3.1 Co-financing fulfillment[*] S3.2 Preventing backsliding in routine immunisation coverage in Gavi-transitioned countries^o S3.3 New vaccine introductions in former- and never-Gavi eligible countries^o | S4.1 Number of markets exhibiting acceptable supply dynamics^{**} S4.2 Number of innovative products within the pipeline with commercial-scale manufacturers^o S4.3 Number of vaccine and immunisation-related products with improved characteristics procured^o |

Alignment with Global IA2030 M&E indicators

** full alignment (8)

* alignment with differences due to Gavi context (6)

! not aligned (0)

^o not included in IA2030 (12)

Figure 3: Gavi 5.0 Strategy Performance Indicators

Strategy Implementation Monitoring

Strategy implementation monitoring focuses on measuring progress in the provision of key inputs by Gavi, and implementation of programming necessary to produce key deliverables and achieve outputs and short-to-medium term outcomes. While there are different operational monitoring activities within Gavi, a small set of strategy implementation indicators are selected to supplement and help interpret the strategy performance indicators as part of regular reporting to the Board. These strategy implementation indicators on progress (SIIPs) facilitate monitoring operational and programme implementation aspects of Gavi 5.0 and serve as intermediary signals to monitor whether the Alliance is on track to achieving the strategy objectives or the likelihood of top risks materialising. These indicators are not approved by the Board.

REPORTING

Gavi 5.0 strategy performance indicators will be used to measure the progress Gavi is making towards achieving the strategy's mission and goals. They measure progress at an aggregated level, across Gavi's portfolio of countries and programming. Strategy performance indicator data will be used to understand trends in specific programmatic areas or portfolio of countries, and to determine progress towards achieving the Board-approved target of planned achievement by 2025. Interpretation of the strategy performance indicators will be facilitated by reporting on the SIIPs, which provide more operational information and are "on the results chain" to the Board-approved strategy performance indicators. Results will be reported annually to the Gavi Board and the public via the Strategy Programmes and Partnerships updates to the Board and Annual Progress Report, respectively¹. In addition, results will be reported via customised reports to fulfill donor requirements.

ROLES AND RESPONSIBILITIES

The Measurement and Strategic Information sub-team within the Measurement, Evaluation and Learning team is the custodian of the Gavi 5.0 Measurement Framework. Key responsibilities include:

- 1.** Coordinate design of the measurement framework for a given strategy period. This includes coordinating selection of key performance indicators to measure strategy performance, establishing targets for each indicator and attaining Board approval of proposed indicators and targets.
- 2.** Support the Gavi Resource Mobilisation team to develop donor logframes that are consistent with the measurement framework.
- 3.** Compute indicator results and ensuring new data are available for reporting to the Gavi Board and relevant stakeholders as per agreed schedule.
- 4.** Support interpretation of indicator results and conduct further analysis to unpack additional insights.
- 5.** Ascertain quality and accuracy of reported data and interpretation.
- 6.** Coordinate updates and reporting of strategy implementation indicators, in collaboration with business owners and the Strategy team.

¹ New data for strategy performance indicators are available at different time points over the course of a calendar year. Some indicators are updated in Q1 and Q2 of a given calendar year, others are available only in Q3 and Q4. Reporting to the Gavi Board will occur in two tranches, June and November/December of a given calendar year. Reporting to the public and donors will occur in Q3 of a given calendar year.

Annex A: Summary of Baselines² and Targets for Gavi 5.0 Strategy Performance Indicators

| ID | Indicator name | Baseline | 2025 target |
|--|--|--------------------------|-------------------------|
| MISSION INDICATORS | | | |
| M.1 | Under-five mortality | 58 per 1,000 | -10% |
| M.2 | Future deaths averted | - | 7-8m |
| M.3 | Future DALYs averted | - | 320-380m |
| M.4 | Reduction in zero-dose | 9.7m | -25% |
| M.5 | Unique children immunised | - | 300m |
| M.6 | Economic benefits unlocked | - | US\$80-100b |
| STRATEGY GOAL 1: INTRODUCE AND SCALE UP VACCINES | | | |
| S1.1 | Breadth of protection | 47% ³ | +16pp |
| S1.2 | SDG3.b.1 | | |
| | DTP3 | 81% | +4pp |
| | MCV2 | 58% | +13pp |
| | PCV3 | 53% | +23pp |
| | HPV2 | 8% | +17pp |
| S1.3 | Rate of scale up of new vaccines | | |
| | PCV3 | n/a | 90% |
| | Rotac | | |
| | MCV2 | | |
| | YF | | |
| S1.4 | Vaccine introductions | - | 82 |
| S1.5 | Country prioritisation ⁴ | - | - |
| S1.6 | Preventative campaign reach (measles) | - | 50% |
| S1.7 | Timely outbreak detection and response | 25% | +50% |
| STRATEGY GOAL 2: STRENGTHEN HEALTH SYSTEMS AND EQUITY IN IMMUNISATION⁵ | | | |
| S2.1 | Geographic equity of DTP3 coverage | 67% | +7pp |
| S2.2 | DTP drop-out | 7% | -1pp |
| S2.3 | MCV1 coverage | 80% | +4pp |
| S2.4 | Number of immunisation sessions | n/a | n/a |
| S2.5 | Stock availability at facility level | n/a | n/a |
| S2.6 | EPI management capacity | n/a | n/a |
| S2.7 | Plans to overcome demand barriers | n/a | n/a |
| S2.8 | Gender-related barriers | n/a | n/a |
| STRATEGY GOAL 3: IMPROVE SUSTAINABILITY OF IMMUNISATION PROGRAMMES | | | |
| S3.1 | Co-financing fulfillment | 100% | 100% |
| S3.2 | Preventing backsliding in Gavi-transitioned countries | 8 countries ⁶ | No decline ⁷ |
| S3.3 | New vaccine introductions in former- and never-Gavi eligible countries | n/a | n/a |
| STRATEGY GOAL 4: ENSURE HEALTHY MARKETS FOR VACCINES AND RELATED PRODUCTS | | | |
| S4.1 | Healthy market dynamics | - | 10 |
| S4.2 | Incentivise innovations | - | 8 |
| S4.3 | Scale-up innovations | - | 9 |

² Baseline values as of Board approval in December 2021 unless otherwise noted. Baselines may be updated as more data become available and revised estimates for indicators are published. For coverage indicators, the baseline values are for year 2019 (pre-COVID19 pandemic).

³ Baseline as of July 2022, based on 5.0 definition for breadth of protection.

⁴ Indicator held in abeyance pending future implementation of the Vaccine Investment Strategy.

⁵ The Gavi Board approved (December 2020) to the proposal that no targets be set for indicators S2.4 to S2.8. They will be monitored for directionality as the Alliance establishes and strengthens systems to consistently collect quality data.

⁶ Baseline for 2021 set as of July 2022.

⁷ No numeric value for 2025 target, which is framed as the proportion of Gavi-transitioned countries at least sustaining performance.

MISSION INDICATORS



M.1

Under-five mortality rate

The under-five mortality rate measures the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates for that period. This indicator is expressed as the number of deaths among children under-five in a given year, per 1000 live births.



2025 Target

-10% reduction

| | |
|-------------------------|--|
| Strategic objective | NA |
| Level of reporting | Mission |
| Numerator | Number of deaths among children aged 0-4 years (0-59 months of age) |
| Denominator | Number of live births |
| Data type | Average probability |
| Level of disaggregation | Gavi-eligible countries |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation Team – Corporate Performance Monitoring and Measurement |
| Rationale for use | <p>The under-five mortality rate is a leading indicator of child health and overall human development. It is indicative of government commitment to health. By increasing access to immunisation and enabling equal access to new and underused vaccines, Gavi support is contributing to the reduction in under-five deaths from vaccine-preventable diseases.</p> <p>The use of this indicator as part of Gavi's strategy reflects Gavi's commitment to contributing to global and country health goals and is in alignment with Sustainable Development Goal (SDG) 3 target on child mortality: All countries to reduce under-five mortality to at least as low as 25 deaths per 1,000 live births by 2030.</p> |
| Method of measurement | <p>This indicator is calculated as a population-weighted average of estimated under-five mortality rates from the UN Inter-agency Group for Child Mortality Estimates (IGME) for Gavi-eligible countries in the 2021-2025 strategy period.</p> <p>Generating accurate estimates of under-five mortality poses a considerable challenge because of limitations in data availability and quality. The IGME was established in 2004 to enhance country capacity to produce timely and properly assessed estimates of child mortality. This is led by UNICEF and WHO and includes the World Bank and United Nations Population Division.</p> |



2025 Target

-10% reduction

M.1

Under-five mortality rate

The under-five mortality rate measures the probability of a child born in a specific year or period dying before reaching the age of five, if subject to age-specific mortality rates for that period. This indicator is expressed as the number of deaths among children under-five in a given year, per 1000 live births.

| | |
|-----------------------------|--|
| | <p>The estimation process takes vital registration systems as the preferred source of data on child mortality because they collect information as events occur and cover the entire population. However, many developing countries lack vital registration systems that accurately record all births and deaths. Therefore, household surveys, such as the Multiple Indicator Cluster Surveys (MICs) and Demographic and Health Surveys (DHS), are the primary source of data on child mortality in developing countries. The IGME seeks to compile all available national-level data on child mortality, including data from vital registration systems, population censuses, household surveys and sample registration systems. A hierarchical Bayesian regression is used to estimate the trend in under-five mortality from the available data sources; this estimation process includes the projection of mortality rates for years without available data.</p> |
| Analysis and interpretation | <p>This indicator is expressed as the number of deaths among children under-five in a given year, per 1000 live births. Formally, this is not a rate (i.e., the number of deaths divided by the number of individuals at risk during a certain time period), but a probability of death derived from a life table.</p> <p>The reduction in under-5 mortality is a mission indicator and reflects one of Gavi's aspirations for the 2021-2025 strategic period. Tracking progress annually across Gavi-eligible countries provides a measure of the ultimate impact of Gavi activities, recognizing that Gavi's contributions toward averting these under-five deaths are intertwined with many other investments and actions—most importantly those made by countries themselves.</p> |
| Strengths and limitations | <p>A strength of including the under-five mortality rate as part of the Gavi strategy is that this is a key impact indicator used globally for multiple purposes, including the Sustainable Development Goals (SDGs). This indicator is also calculated using publicly available data, requiring no additional reporting burden from countries.</p> <p>A limitation of this indicator is that many other factors beyond the influence of Gavi affect a country's under-five mortality rate—including poverty, conflict, nutrition and many other factors. Therefore, a contribution perspective is essential. An additional limitation relates to extensive challenges in measurement. Due to the lack of consistent and high-quality data across countries, the values for this indicator come from an estimation process that involves imputation for years without primary data on child mortality rates (particularly for recent years) and have large accompanying uncertainty. This indicator may be slow in responding to policy changes, both because it is at the end of a long results chain and because it relies on data from household surveys which reflect child mortality from earlier time periods.</p> |
| Data source | <p>Child mortality estimates from IGME and estimates of live births from the United Nations, Department of Social and Economic Affairs, Population Division.</p> |



2025 Target

7-8m

M.2

Number of future deaths averted with Gavi support

Number of future deaths averted as a result of Gavi-supported vaccinations

| | |
|-------------------------|--|
| Strategic objective | NA |
| Level of reporting | Mission |
| Numerator | NA |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | None |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation Team – Corporate Performance Monitoring and Measurement |
| Rationale for use | This indicator estimates the impact of Gavi-supported vaccinations in terms of averting future deaths from vaccine-preventable diseases. Mortality reduction is one of the ultimate impacts of Gavi support and is therefore important to estimate on a periodic basis. |
| Method of measurement | <p>Future deaths averted are estimated by the Vaccine Impact Modeling Consortium (VIMC), an external consortium of disease modelers coordinated by a Secretariat based at Imperial College London. The VIMC Secretariat coordinates the work of 18 academic research groups with each group estimating the impact of a specific vaccine based on a counterfactual in which no vaccines are administered. The estimate for each disease is calculated as the average of two or three separate models (depending on the disease) to account for uncertainty in estimated impact due to model differences. Future deaths averted are estimated over the lifetime of those receiving vaccinations in a given year, to reflect the long-term benefits of vaccination, which is particularly relevant for HepB and HPV vaccination given the morbidity and mortality benefits occur in adulthood. Overall deaths averted is then reported as the aggregate across disease areas. Methods are described further in Li et al 2019 and on the VIMC website.</p> <p>In order to assess the long-term impact of Gavi support in countries which may not have otherwise funded vaccine programmes, the numbers reported against this indicator reflect both where Gavi has provided direct support (i.e. active funding for vaccine programmes in a given year), as well as catalytic support (i.e. in the five-year period immediately following a country's transition out of Gavi support).</p> <p>Most of the pathogens in Gavi-supported vaccines are included in the calculation, as follows: hepatitis B, Haemophilus influenzae type-b, pneumococcal, rotavirus, yellow fever (campaign and routine), meningitis A (campaign and routine), Japanese Encephalitis (campaign and routine), human papillomavirus, measles second dose, measles-rubella campaigns, rubella routine. Typhoid, preventive cholera, diphtheria, tetanus and pertussis (through Gavi-supported DTP boosters) will be added for Gavi 5.0). While Gavi supports Inactivated Polio Vaccine (IPV) estimates of future averted from IPV are not incorporated due to the difficulty of assessing the counterfactual of no vaccination given most countries are polio-free.</p> |



2025 Target

7-8m

M.2

Number of future deaths averted with Gavi support

Number of future deaths averted as a result of Gavi-supported vaccinations

| | |
|---------------------------------------|--|
| Analysis and interpretation | <p>Future deaths averted is a mission indicator and reflects one of Gavi's aspirations for the 2021-2025 strategic period. Tracking progress annually against the target of 7-8 million deaths averted with Gavi support between 2021 and 2025, provides a measure of the ultimate impact of Gavi support and allows for an assessment of whether the Alliance is on track to achieve our target. For communication purposes, this indicator is sometimes referred to as "lives saved".</p> <p>As described in its M&E framework and Strategy, Gavi adopts a contribution perspective when estimating impact—recognizing that reported impact estimates do not reflect exclusive attribution to Gavi, but a broader impact at country level to which Gavi is one of many contributors, in support of countries and alongside other development partners.</p> |
| Strengths and limitations | <p>The strength of this indicator is that it provides an estimate of the ultimate impact of Gavi-supported vaccines on vaccine preventable mortality.</p> <p>The primary limitation is substantial measurement error, which is difficult to quantify. Model-based estimates of impact rely on several assumptions that are difficult to test. To some extent, the uncertainty is mitigated by the use of two to three different models per disease to account for uncertainty due to model differences.</p> <p>A second limitation is that the indicator estimates impact of Gavi-supported vaccination against a simple alternative scenario of no vaccination rather than a more complex scenario that seeks to determine which countries may have introduced which vaccines in the absence of Gavi support; this may lead to an overestimation of Gavi-related impact.</p> <p>Lastly, since the aim of this indicator is to track all deaths averted through Gavi-supported vaccination, it counts deaths that would have happened in the following year as well as decades into the future. From a communication perspective, the inclusion of the latter can be challenging to explain.</p> |
| Data source | <p>Publicly available, peer-reviewed disease models are used to estimate future deaths averted, as described further in: Li, Xiang., et al, 2019". The disease models use WHO/ UNICEF estimates of immunisation coverage (WUENIC) for coverage and estimates of population size from the United Nations Population Division.</p> |
| Further information and related links | <p>Li, X. et al. 2019. Estimating the health impact of vaccination against 10 pathogens in 98 low- and middle-income countries from 2000 to 2030. medRxiv 19004358; doi: https://doi.org/10.1101/19004358</p> <p>VIMC website: https://www.vaccineimpact.org/resources/</p> |

M.3

Number of future disability-adjusted life years (DALYs) averted with Gavi support



2025 Target

320-380m

Number of future disability-adjusted life years (DALYs) averted as a result of vaccination with Gavi-supported vaccines

| | |
|-------------------------|---|
| Strategic objective | NA |
| Level of reporting | Mission |
| Numerator | NA |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | None |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation Team – Corporate Performance Monitoring and Measurement |
| Rationale for use | <p>This indicator measures the impact of Gavi-supported vaccines on morbidity, and mortality.</p> <p>Reduction in overall disease burden from vaccine-preventable diseases is one of the ultimate impact measures of Gavi support and is therefore important to estimate on a periodic basis. The use of DALYs comes from recognition that focusing exclusively on deaths averted overlooks important morbidity-related impact achieved as a result of reduction in morbidity. This helps supplement the tracking of future deaths averted.</p> |
| Method of measurement | <p>DALYs measure the number of healthy life years lost due to disability or premature death. DALYs are calculated as the sum of the years of life (YLL) lost due to premature mortality and the number of years lost due to disability (YLD) amongst people living with a health condition. Years lost from premature mortality are estimated using a standard expectation of the age of death. Years lost due to disability are estimated by weighting the number of years lived with a disability by a disability weight which reflect the severity of the condition and its impact on functional capacity.</p> <p>Future DALYs averted are estimated by the Vaccine Impact Modeling Consortium (VIMC), an external consortium of disease modelers coordinated by a Secretariat based at Imperial College London. The VIMC Secretariat coordinates the work of 18 academic research groups with each group estimating the impact of a specific vaccine based on a counterfactual in which no vaccines are administered. The estimate for each disease is calculated as the average of two or three separate models (depending on the disease) to account for uncertainty in estimated impact due to model differences. Future DALYs averted are estimated over the lifetime of those receiving vaccinations in a given year, to reflect the long-term benefits of vaccination, which is particularly relevant for HepB and HPV vaccination given the morbidity and mortality benefits occur in adulthood. Overall DALYs averted is then reported as the aggregate across disease areas. Methods are described further in Li et al 2019 and on the VIMC website.</p> <p>In order to assess the long-term impact of Gavi support in countries which may not have otherwise funded vaccine programmes, the numbers reported against this indicator reflect both where Gavi has provided direct support (i.e. active funding for vaccine programmes in a given year), as well as catalytic support (i.e. in the five-year period immediately following a country's transition out of Gavi support).</p> |

M.3**Number of future disability-adjusted life years (DALYs) averted with Gavi support****2025 Target****320-380m**

Number of future disability-adjusted life years (DALYs) averted as a result of vaccination with Gavi-supported vaccines

Analysis and interpretation

Most of the pathogens in Gavi-supported vaccines are included in the calculation, as follows: hepatitis B, Haemophilus influenzae type-b (Hib), pneumococcal, rotavirus, yellow fever (campaign and routine), meningitis A (campaign and routine), Japanese Encephalitis (campaign and routine), human papillomavirus, measles second dose, measles-rubella campaigns, rubella routine. Typhoid, preventive cholera, diphtheria, tetanus and pertussis (through Gavi-supported DTP boosters) will be added for Gavi 5.0). While Gavi supports Inactivated Polio Vaccine (IPV) estimates of future averted from IPV are not incorporated due to the difficulty of assessing the counterfactual of no vaccination given most countries are polio-free.

Future DALYs averted is a mission indicator and reflects one of Gavi's aspirations for the 2021-2025 strategic period. Tracking progress on DALYs annually against the 2021-2025 target (TBD) provides a measure of the ultimate impact of Gavi support and allows for an assessment of whether or not we are on track to achieve our target.

As described in its M&E framework and strategy, Gavi adopts a contribution perspective when estimating impact—recognizing that impact numbers reported do not reflect exclusive attribution to Gavi, but a broader impact at country level to which Gavi is one of many contributors, in support of countries and alongside other development partners.

Strengths and limitations

The strength of this indicator is that it broadens the estimated impact of Gavi-supported vaccines to morbidity/disability, alongside mortality reduction. Many vaccine-preventable diseases and their sequelae have a significant impact on non-fatal health outcomes that are captured in DALYs.

The primary limitation is substantial measurement error, which is difficult to quantify. Model-based estimates of impact rely on several assumptions that are difficult to test. To some extent, the uncertainty is mitigated by the use of two to three different models per disease to account for uncertainty due to model differences. Further, computing this indicator requires an additional step to estimate years lived with disability (YLDs), in addition to the uncertainty around disability weight estimates.

A second limitation is the indicator estimates impact of Gavi-supported vaccination against a simple alternative scenario of no vaccination rather than a more complex scenario that seeks to determine which countries may have introduced which vaccines in the absence of Gavi support; this may lead to an overestimation of Gavi-related impact.

Since the aim of this indicator is to track all DALYs averted through Gavi-supported vaccination, it counts DALYs that would have happened in the immediate future as well as decades into the future. From the communication perspective, the inclusion of the latter can be challenging to explain.

Data source

Publicly available, peer-reviewed disease models are used to estimate future DALYs averted, as described further in Li, Xiang., et al, 2019. The disease models use WHO/UNICEF estimates of immunisation coverage (WUENIC) for coverage and estimates population size from the United Nations Population Division.

Further information and related links

Li, X. et al. 2019. Estimating the health impact of vaccination against 10 pathogens in 98 low- and middle-income countries from 2000 to 2030. medRxiv 19004358; doi: <https://doi.org/10.1101/19004358>
VIMC website: <https://www.vaccineimpact.org/resources/>

M.4

Reduction in the number of zero-dose children



2025 Target

-25%

This indicator tracks the reduction in the number of zero-dose children in Gavi-eligible countries relative to the number at baseline. Zero-dose children are infants who have not received the first dose of DTP-containing vaccine (DTP1) by the end of their first year of life.

| | |
|-----------------------------|--|
| Strategic objective | NA |
| Level of reporting | Mission |
| Numerator | NA |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | None |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation Team – Corporate Performance Monitoring and Measurement |
| Rationale for use | The indicator serves as an equity measure, giving an indication of the reach of routine immunisation services to missed communities. The focus on zero-dose is meant to serve as a starting point for addressing inequities in immunisation coverage, with an emphasis on regularly reaching children who are being missed by routine immunisation. |
| Method of measurement | The indicator is computed as the total number zero-dose children in Gavi-eligible countries in the reporting year minus the total number of zero-dose children at baseline in those countries. The number of zero-dose children in a given year is computed as the total number of surviving infants minus the number of surviving infants who received the first dose of DTP containing vaccine, as estimated from WUENIC immunisation coverage estimates and UNPD population estimates. |
| Analysis and interpretation | The reduction in the number of zero-dose children is a mission indicator and reflects Gavi’s overall vision for the 2021-2025 strategic period to ‘leave no one behind with immunisation’. Tracking its progress on annually against the 2021-2025 target (TBD) provides a measure of the outcome of the different strategies and targeted investments specifically aiming to strengthen routine immunisation to extend routine immunisation services to regularly reach missed communities. |
| Strengths and limitations | The primary strength of this indicator is that it is simple to understand and communicate. It is also calculated using publicly available data, requiring no additional reporting burden from countries. The primary limitation is underlying uncertainty in available coverage and population estimates. The quality of the coverage and population estimates are constrained by the quality and availability of underlying data sources, which have gaps for many countries. In addition, because it looks at a reduction the number of zero-dose, in the context of population growth, it does not clearly demonstrate the need to reach additional children not only to increase reach but also to maintain existing coverage. |
| Data source | Vaccine coverage: WHO/UNICEF estimates of national immunisation coverage. Population estimates: United Nations, Department of Social and Economic Affairs, Population Division. World population Prospects. |

M.5**Unique children immunised through routine immunisation with Gavi support****2025 Target****300m**

This indicator tracks the number of children immunised with the last recommended dose of at least one vaccine delivered through routine systems with Gavi support

| | |
|-----------------------------|--|
| Strategic objective | NA |
| Level of reporting | Mission |
| Numerator | NA |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | None |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation Team – Corporate Performance Monitoring and Measurement |
| Rationale for use | This indicator demonstrates the reach of Gavi-supported vaccines through routine immunisation systems. |
| Method of measurement | <p>This indicator refers to the total number of children reached with the last recommended dose of at least one Gavi-supported vaccine delivered through routine systems, corrected on a country-by-country basis so that children receiving multiple vaccines are not double-counted. Campaigns and supplementary immunisation activities are not included.</p> <p>On a country-by-country basis, the Gavi-supported vaccine delivered through the routine system with the highest level of coverage at national level is selected. In the majority of countries, this is pentavalent vaccine, but theoretically other Gavi-supported vaccines could have higher coverage at national level, or Gavi may not support pentavalent vaccine in a country. Coverage is translated into an estimate of the number of children reached with that vaccine by multiplying the fraction of the target cohort reached, per the WHO/UNICEF estimates of national immunisation coverage, by a target population estimate (for the vaccines included in this indicator, this is the estimate of surviving infants from the United Nations Population Division for the corresponding country and year). The numbers reported against this indicator reflect both where Gavi has provided direct support (i.e. active funding for vaccine programmes in a given year), as well as catalytic support (i.e. in the five-year period immediately following a country's transition out of Gavi support).</p> |
| Analysis and interpretation | The number of unique children immunised with Gavi support is a mission indicator and reflects one of Gavi's aspirations for the 2021-2025 strategic period. Tracking progress annually against the target of 300 million children immunised between 2021 and 2025 with Gavi support provides a measure of the number of children reached with Gavi support and allows for an assessment of whether or not we are on track to achieve our target. |
| Strengths and limitations | The strength of this indicator is that it directly estimates the number of children reached with Gavi-supported vaccines using publicly available data, requiring no additional reporting burden from countries. |

M.5

Unique children immunised through routine immunisation with Gavi support



2025 Target

300m

This indicator tracks the number of children immunised with the last recommended dose of at least one vaccine delivered through routine systems with Gavi support

The primary limitation of this indicator is underlying uncertainty in available coverage and population estimates. The quality of the coverage and population estimates are constrained by the quality and availability of underlying data sources, which have gaps for many countries. In addition, many other factors in a country influence the number of children reached with routine immunisation coverage.

Another limitation is that the indicator does not provide us with an indication of how many Gavi-supported vaccines each child reached received, nor whether the distribution of coverage is equitable. Coverage and equity dimensions are, however, captured by other indicators in the measurement framework.

Data source

Vaccine coverage: WHO/UNICEF estimates of national immunisation coverage.
Population estimates: United Nations, Department of Social and Economic Affairs, Population Division. World population Prospects.

M.6

Economic benefits generated through Gavi-supported immunisations



2025 Target

US\$80-100b

This indicator measures the value of averting short and long-term economic costs associated with the diseases that Gavi-supported vaccines protect against.

| | |
|-------------------------|---|
| Strategic objective | NA |
| Level of reporting | Mission |
| Numerator | NA |
| Denominator | NA |
| Data type | Number (US dollars) |
| Level of disaggregation | None |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation Team – Corporate Performance Monitoring and Measurement |
| Rationale for use | This indicator measures the impact of Gavi-supported vaccines beyond health benefits to include the direct and indirect economic benefits of averting illness, death and long-term disability. |
| Method of measurement | <p>Estimates of economic benefits generated by Gavi-supported immunisations are computed by an external academic institution, the Decade of Vaccine Economics (DOVE) research group, housed at the International Vaccine Access Center (IVAC) at Johns Hopkins University. DOVE-cost of illness (DOVE-COI) models serve as the primary method for estimating economic benefits. The models calculate the value of averting short and long-term costs associated with the diseases that Gavi-supported vaccines protect against, using as inputs the estimates of cases and deaths averted from the Vaccine Impact Modeling Consortium (VIMC). The short and long-term costs measured by the COI models include: (1) acute treatment costs associated with a specified illness; (2) transportation costs associated with a specified illness; (3) caretaker wages lost because of a child’s illness; (4) productivity losses that occur due to premature death; and (5) productivity losses due to disability. The detailed methodology outlined in Sim et al. (2019) and on the Immunisation Economics website.</p> <p>Gavi adopts a contribution perspective when estimating impact—recognizing that impact numbers reported do not reflect exclusive attribution to Gavi, but a broader impact at country level to which Gavi is one of many contributors, in support of countries and alongside other development partners.</p> <p>In order to assess the long-term impact of Gavi support in countries which may not have otherwise funded vaccine programmes, the numbers reported against this indicator reflect both where Gavi has provided direct support (i.e. active funding for vaccine programmes in a given year), as well as catalytic support (i.e. in the five-year period immediately following a country’s transition out of Gavi support).</p> <p>Most of the pathogens in Gavi-supported vaccines are included in the calculation, as follows: hepatitis B, Haemophilus influenzae type-b (Hib), pneumococcal, rotavirus, yellow fever (campaign and routine), meningitis A (campaign and routine), Japanese Encephalitis (campaign and routine), human papillomavirus, measles second dose, measles-rubella campaigns, rubella routine. Typhoid, preventive cholera, diphtheria, tetanus and pertussis (through Gavi-supported DTP boosters) will be added for Gavi 5.0). While Gavi supports Inactivated Polio Vaccine (IPV) estimates of economic benefits from IPV are not incorporated due to the difficulty of assessing the counterfactual of no vaccination given most countries are polio-free.</p> |

M.6

Economic benefits generated through Gavi-supported immunisations

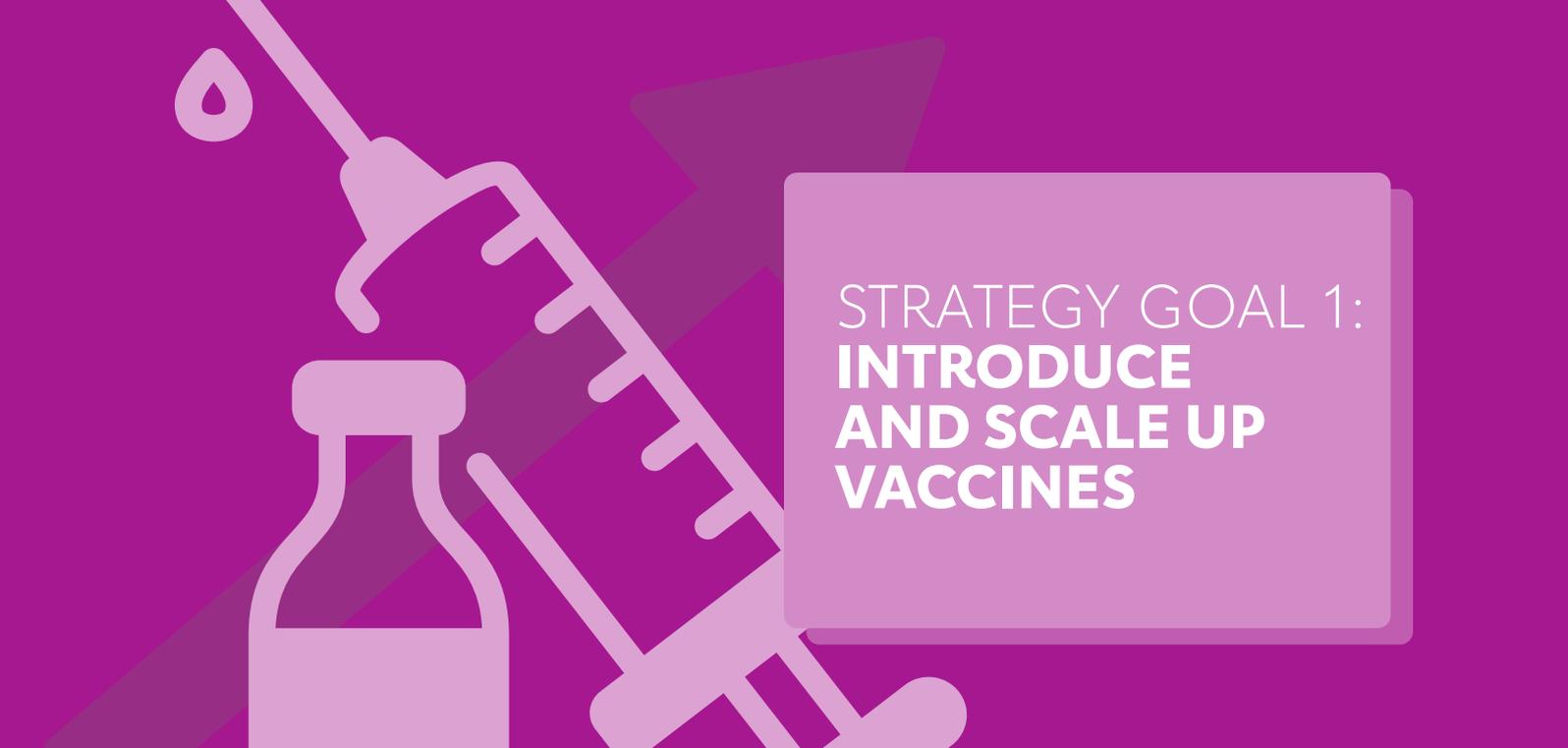


2025 Target

US\$80-100b

This indicator measures the value of averting short and long-term economic costs associated with the diseases that Gavi-supported vaccines protect against.

| | |
|---------------------------------------|--|
| Analysis and interpretation | Economic benefits generated through Gavi-supported vaccinations is a mission indicator and reflects one of Gavi's aspirations for the 2021-2025 strategic period. Tracking progress annually against the target of 80-100 billion US dollars between 2021 and 2025 with Gavi support provides a measure of the ultimate impact of Gavi support and allows for an assessment of whether or not we are on track to achieve our target. |
| Strengths and limitations | The strength of this indicator is that it captures the impact of Gavi-supported vaccines beyond just health and includes the economic benefits that accrue as a result of averted direct and indirect costs of illness, disability and deaths. The primary limitation of this indicator is that there is substantial measurement error, which is difficult to quantify. Model-based estimates of impact rely on a number of assumptions that are difficult to test and are sensitive to methodological assumptions about morbidity estimates, life expectancies, and disability weights. |
| Data source | The DOVE ROI model as outlined in Sim et al. 2019. Additionally, the DOVE-ROI models use health impact estimates from the VIMC. Li, Xiang., et al, 2019. |
| Further information and related links | Sim, Y. et al. 2019 "Return on Investment from Immunisation Programs Against 10 Pathogens in 94 Low- and Middle-Income Countries from 2011-2030" Immunisation Economics website at http://immunizationeconomics.org/dove-roi Li, X. et al. 2019. Estimating the health impact of vaccination against 10 pathogens in 98 low- and middle-income countries from 2000 to 2030. medRxiv 19004358; doi: https://doi.org/10.1101/19004358 VIMC website: https://www.vaccineimpact.org/resources/ |



STRATEGY GOAL 1: INTRODUCE AND SCALE UP VACCINES

S1.1 Breadth of protection

Average vaccination coverage across all Gavi-supported vaccines in Gavi-supported countries

| | |
|-------------------------|--|
| Strategic objective | SG 1 – Introduce and scale up vaccines |
| Level of reporting | Strategy |
| Numerator | Sum of children vaccinated with the last recommended dose of Gavi-supported routine vaccinations in Gavi-supported countries |
| Denominator | Sum of target populations of each vaccine in Gavi-supported countries |
| Data type | Percent |
| Level of disaggregation | None |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation – Corporate Performance Monitoring and Measurement |
| Rationale for use | Breadth of protection is a summary measure of prioritized vaccine introductions, rate of scale up of newly introduced vaccines, and vaccine coverage. It measures the extent to which Gavi-supported countries have been introduced and scaled up routine coverage of Gavi-supported vaccines. |
| Method of measurement | <p>This indicator is the population-weighted average coverage of Gavi-supported vaccines. It is computed as the sum of children vaccinated with the last recommended dose of Gavi-supported routine vaccinations in Gavi-supported countries divided by the sum of the number of children eligible to receive each of those vaccines in those countries. Target populations are specific to individual vaccines (e.g. surviving infants, two-year-olds, and adolescents). Campaign delivery is not included.</p> <p>The following vaccines are included: pentavalent, pneumococcal, rotavirus, measles-containing vaccine second dose, rubella, inactivated polio vaccine (IPV) second dose, human papilloma virus (HPV), yellow fever, Japanese encephalitis (JE), and meningitis type A. (Men A).</p> <p>JE, Men A and yellow fever are regional vaccines that are specific to endemic countries, and in some cases, to subnational regions within those countries. The denominator for breadth of protection is adjusted accordingly, taking into account only the relevant target populations.</p> |

| | |
|-----------------------------|---|
| Analysis and interpretation | Breadth of protection reflects the effectiveness of the Alliance’s support to countries to introduce Gavi-recommended Gavi vaccines and scale up routine coverage. Tracking progress annually against the 2021 - 2025 target provides an indication of the progress countries are making to introduce and scale-up vaccines. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - Indicator provides a single composite measure of average coverage with all Gavi-supported vaccines and thus provides a portfolio-level view of the effectiveness of the Alliance’s investments to support countries introduce and scale up Gavi-supported vaccines. It is closely related to the measurement of a “fully immunised child”, but provides a more sensitive measure that reflects progress on each vaccine. - Publicly available data is used, imposing no additional reporting burden on countries. <p>Limitations:</p> <ul style="list-style-type: none"> - Lack of available WHO/UNICEF estimates at present for some vaccines in the portfolio (e.g. HPV). For some vaccines, namely JE and Men A, data on coverage is available through the Joint Reporting Forum (JRF), but these data are subject to some measurement error - Indicator does not track co-coverage of multiple vaccines at the unit of the individual (i.e., it does not reflect how many children have individually received each recommended vaccine). |
| Data source | <p>Vaccine coverage: WHO/UNICEF estimates of national immunisation coverage, WHO Joint Reporting Forum (JRF) for JE and Men A .</p> <p>Population estimates: United Nations, Department of Social and Economic Affairs, Population Division. World population Prospects.</p> |

S1.2**Vaccine coverage [SDG indicator 3.b.1]**

The target population for given vaccine is defined based on recommended age for administration. The primary vaccination series of most vaccines are administered in the first two years of life.

| | |
|-------------------------|--|
| Strategic objective | SG 1 – Introduce and scale up vaccines |
| Level of reporting | Strategy |
| Indicator definition | <p>Coverage of DTP containing vaccine (3rd dose): Percentage of surviving infants who received 3 doses of diphtheria-tetanus toxoid-pertussis containing vaccine in a given year.</p> <p>Coverage of Measles containing vaccine (2nd dose): Percentage of children ages 12-23 months who received two dose of measles containing vaccine according to nationally recommended schedule through routine immunisation services in a given year.</p> <p>Coverage of Pneumococcal conjugate vaccine (last dose in the schedule): Percentage of surviving infants who received the nationally recommended doses of pneumococcal conjugate vaccine in a given year.</p> <p>Coverage of HPV vaccine (last dose in the schedule): Percentage of 15 years old girls received the recommended doses of HPV vaccine.</p> |
| Numerator | NA |
| Denominator | NA |
| Data type | Percent |
| Level of disaggregation | By vaccine |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation – Corporate Performance Monitoring and Measurement |
| Rationale for use | <p>This indicator aims to measure access to vaccines, including the newly available or underutilized vaccines, at the national level.</p> <p>Enables Gavi to demonstrate alignment to the Sustainable Development Goals agenda.</p> |
| Method of measurement | <p>This indicator is measured using annually updated WHO/UNICEF estimates of coverage for DTP3, PCV3, MCV2 and HPV2 vaccines. The vaccine-specific coverage estimates are reported separately (it is not a composite).</p> <p>The overall coverage estimates for Gavi-supported countries are based on the population-weighted average of the coverage estimates from each of the countries, using the target populations for each vaccine as the weight.</p> |

S1.2**Vaccine coverage [SDG indicator 3.b.1]**

The target population for given vaccine is defined based on recommended age for administration. The primary vaccination series of most vaccines are administered in the first two years of life.

| | |
|-----------------------------|---|
| Analysis and interpretation | <p>The coverage estimates will provide insights into the state of immunisation programmes across Gavi-supported countries and inform the following interpretations:</p> <p>Coverage of DTP containing vaccine: measure the overall system strength to deliver infant vaccination</p> <p>Coverage of Measles containing vaccine: ability to deliver vaccines beyond first year of life through routine immunisation services.</p> <p>Coverage of Pneumococcal conjugate vaccine: adaptation of new vaccines for children</p> <p>Coverage of HPV vaccine: life course vaccination</p> |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none">- Indicator directly measures coverage of routine immunisation services- Publicly available data is used, imposing no additional reporting burden on countries.- Coverage of the selected vaccines reflect the ability of immunisation programmes to deliver vaccines over the life course and to adapt new vaccines.- Coverage for other WHO recommended vaccines are also available and can be provided. <p>Limitations:</p> <ul style="list-style-type: none">- Indicator comprises 4 independent vaccine coverage estimates (one for each individual vaccine). This presents a challenge to succinct interpretability. However, there is strategic and programmatic value in having visibility of how effectively coverage of new and under-used vaccines is scaling up. |
| Data source | <p>Vaccine coverage: WHO/UNICEF estimates of national immunisation coverage.</p> <p>Population estimates: United Nations, Department of Social and Economic Affairs, Population Division. World population Prospects.</p> |

S1.3**Rate of scale up of new vaccines**

Coverage of routine vaccines (PCV3, Rotac, MCV2 and yellow fever) relative to benchmark vaccine within reference time frame for new introductions.

| | |
|-----------------------------|---|
| Strategic objective | SG 1 – Introduce and scale up vaccines |
| Level of reporting | Strategy |
| Numerator | Number of children vaccinated with individual vaccines in countries with mature introductions (2 years for rotavirus and PCV3; and 3 years for MCV2 and yellow fever) |
| Denominator | Number of children vaccinated with the reference vaccine (DTP3 or MCV1) in countries with scaled-up introductions of the new routine vaccine |
| Data type | Percent |
| Level of disaggregation | By vaccine |
| Frequency of reporting | Annual |
| Responsible team | Vaccine Implementation |
| Rationale for use | <p>This metric evaluates whether new introductions are achieving high coverage within a reasonable timeframe as measured by WUENIC data.</p> <p>“Mature introduction” – Internal analyses suggest that it takes, on average, two years post-introduction (three years for MCV2 and yellow fever) for a new routine vaccine to achieve coverage similar (at least 90%) to that of the existing routine vaccine following a similar immunisation schedule.</p> |
| Method of measurement | <p>This indicator is computed as the number of children vaccinated with the 4 new routine vaccines (PCV3, Rota, MCV2, YF) in countries with scaled-up routine introductions (2 years for Rota & PCV3 and 3 years for MCV2 & YF) divided by number of children vaccinated with the corresponding benchmark vaccine in countries with scaled-up introductions of new vaccine.</p> <p>For the purposes of calculating this indicator, the “year of launch” is defined differently based on which month the vaccine was launched:</p> <ul style="list-style-type: none"> - If a vaccine was launched within January to September of a given year, the year of launch is the same as recorded in the Vaccine Launches Database; - If a vaccine was launched within October to December of a given year, the year of launch is one year later than that recorded in the Vaccine Launches Database. <p>Notes:</p> <ul style="list-style-type: none"> - WUENIC coverage for the new vaccine is taken two years (for PCV3 and Rota) or three years (for MCV2 and yellow fever) after the assigned year of launch - WUENIC coverage for the reference vaccine is taken two years (for DTP3) and three years (for MCV1) after the assigned year of launch. |
| Analysis and interpretation | Evaluate whether new introductions are achieving high coverage within a reasonable timeframe. |

S1.3**Rate of scale up of new vaccines**

Coverage of routine vaccines (PCV3, Rotac, MCV2 and yellow fever) relative to benchmark vaccine within reference time frame for new introductions.

Strengths and limitations

Strengths:

- The indicator provides insight into the time taken for newly introduced vaccines to achieve strong coverage, allowing Gavi to examine where new vaccine introductions are falling behind or exceeding expectations.

Limitations:

This indicator comprises 4 independent vaccine coverage estimates (one for each individual vaccine). This presents a challenge to succinct interpretability. However, there is strategic and programmatic value in having visibility of how effectively coverage of newly introduced vaccines is scaling up.

Data source

Vaccine coverage: WHO/UNICEF estimates of national immunisation coverage.

Population estimates: United Nations, Department of Social and Economic Affairs, Population Division. World population Prospects.

Vaccine introductions: Gavi vaccine launches database (internal).

| | |
|-----------------------------|--|
| Strategic objective | SG 1 – Introduce and scale up vaccines |
| Level of reporting | Strategy |
| Numerator | NA |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | By vaccine |
| Frequency of reporting | Semi-annual |
| Responsible team | Vaccine Implementation |
| Rationale for use | Monitor incremental change in numbers of countries introducing under-used vaccines into the routine immunisation schedule, with Gavi support. |
| Method of measurement | Count of the number of vaccine introductions is obtained from the Vaccine Launch Database. |
| Analysis and interpretation | Vaccine introductions are a core driver of Gavi’s achievement of strategy goal 1 (introduce and scale up vaccines). Indicator results will inform on the effectiveness of the Alliance’s support to countries to introduce under-used vaccines into the routine immunisation system. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - Indicator allows for real-time monitoring and reporting of Gavi-supported vaccine introductions. <p>Limitations:</p> <ul style="list-style-type: none"> - Indicator only measures the first phase of phased introductions and thus does not fully reflect programmatic efforts at country level in the phased scale-up of certain vaccines. |
| Data source | Gavi vaccine launch database (internal) |

S1.5

Country prioritisation of vaccines

Percentage of vaccine applications that demonstrate use of evidence to support prioritisation of vaccines appropriate to their context.

| | |
|-----------------------------|--|
| Strategic objective | SG 1 – Introduce and scale up vaccines |
| Level of reporting | Strategy |
| Numerator | Number of applications for new vaccine support (NVS) reviewed by the Independent Review Committee (IRC) in a given year that demonstrate use of evidence to support prioritisation of vaccines |
| Denominator | Number of NVS applications reviewed by the IRC in a given calendar year |
| Data type | Percent |
| Level of disaggregation | None |
| Frequency of reporting | Semi-annual |
| Responsible team | Vaccine Implementation |
| Rationale for use | This indicator will evaluate the extent to which countries use robust evidence to inform prioritisation of their vaccine programmes. |
| Method of measurement | This indicator is computed as the sum of the number of NVS applications reviewed by the IRC and determined to sufficiently demonstrate prioritisation divided by the total number of NVS applications reviewed by the IRC in a given calendar year. Country NVS applications will be assessed based on pre-determined criteria by the Gavi Secretariat as part of the pre-screening process and by the IRC as part of the review. |
| Analysis and interpretation | Strengthening the abilities of countries to use robust evidence to inform prioritisation of new vaccine programmes is a strategic objective of the 2021-2025 strategy. Use of context-appropriate evidence is a critical criterion for judging quality of NVS applications. A quality NVS application reflects the effectiveness of the collective support the Alliance provides to Gavi-supported countries to enable them to generate and use evidence manage their vaccine programmes. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - Indicator provides insight on the shared accountability of the Alliance to support countries make evidence-based decisions regarding vaccine introductions and prioritisation of vaccines in relation to other health programmes as per each country's programmatic, epidemiologic and fiscal context. - Directly monitoring quality of NVS applications will enable strategic discussions at the PPC and Board on the key bottlenecks and required actions by the Alliance to support countries manage trade-offs required to prioritise vaccine programmes. <p>Limitations:</p> <ul style="list-style-type: none"> - Criteria to determine the robustness of the evidence and how effectively it has been used to inform decisions outlined in the application will require both objective and subjective factors. - The indicator does not capture an evidence-based decision to forego an application for Gavi support. |
| Data source | Gavi Independent Review Committee reports |

| | |
|-----------------------------|--|
| Strategic objective | SG 1 – Introduce and scale up vaccines |
| Level of reporting | Strategy |
| Numerator | Number of under 5 children previously unvaccinated against measles who are vaccinated during Gavi-supported planned preventative MCV campaigns |
| Denominator | Number of under 5 children previously unvaccinated against measles targeted by a Gavi-supported planned preventative MCV campaign |
| Data type | Percent |
| Level of disaggregation | None |
| Frequency of reporting | Semi-annual |
| Responsible team | Vaccine implementation |
| Rationale for use | This indicator will measure the reach and quality of Gavi-supported MCV campaigns. |
| Method of measurement | <p>For a given year, the percentage of under 5 children previously unvaccinated against measles who receive an MCV dose for each of the Gavi-supported campaigns in that year will be counted towards the indicator.</p> <p>As part of their post campaign coverage survey reports, which are a requirement for all Gavi-supported campaigns, countries will be reporting on the required data points.</p> |
| Analysis and interpretation | Preventive campaigns are most effective and efficient if they reach unprotected individuals to close immunity gaps. Results will indicate the extent to which Gavi-supported preventative MCV campaigns are enabling countries to progress towards achieving herd immunity for measles. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - Indicator will directly quantify the percentage of under 5 children previously unvaccinated against measles reached by Gavi-supported preventative MCV campaigns—a key determinant of the quality of an MCV campaign. <p>Limitations:</p> <ul style="list-style-type: none"> - Though a requirement, not all countries implementing Gavi-supported MCV campaigns conduct post campaign coverage surveys (PCCS). This may lead to gaps in data for this indicator. However, the Gavi Secretariat is exploring mechanisms to improve compliance to PCCS requirements. |
| Data source | World Health Organization MCV post campaign coverage survey reports |

| | |
|-----------------------------|---|
| Strategic objective | SG 1 – Introduce and scale up vaccines |
| Level of reporting | Strategy |
| Numerator | Number of outbreaks detected and responded to in a timely manner |
| Denominator | Number of outbreaks for which there is an outbreak response vaccination campaign |
| Data type | Percent |
| Level of disaggregation | By disease (measles, meningococcus, yellow fever, cholera and ebola), by institution (MR&I, ICG, GPEI, WHO) |
| Frequency of reporting | Annual |
| Responsible team | Vaccine implementation |
| Rationale for use | Monitors timeliness of responses to vaccine-preventable disease (VPD) outbreaks for diseases for which there are established outbreak global response mechanisms. Disaggregation by steps in the process, from detection to application to review to shipment to campaign initiation, allows for understanding bottlenecks. |
| Method of measurement | This indicator is computed as the sum of VPD outbreaks detected and campaign responses initiated within a specified number of days divided by the number of outbreaks for which there was an outbreak response vaccination campaign. Time from onset of outbreak to implementation of vaccination campaign will be determined for each programme area (measles, meningococcus, yellow fever, cholera and ebola) through the IA2030 M&E Framework. |
| Analysis and interpretation | This indicator measures the efficiency of global outbreak response mechanisms in responding to vaccine preventable disease (VPD) outbreaks in Gavi supported countries. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - Indicator may be disaggregated by key steps in outbreak response, across multiple diseases. This will enable the Alliance to systematically identify specific bottlenecks and identify solutions. <p>Limitations:</p> <ul style="list-style-type: none"> - Indicator combines measurement of outbreak processes and procedures of multiple independent institutions. As a result, the aggregated result may present challenges with regards interpretability. However, disaggregated results will provide actionable insights regarding outbreak response mechanisms for specific vaccines and institutions. |
| Data source | Routine reports from ICG, MRI, GPEI, WHO, national immunisation and diseases surveillance programmes. Information would need to be systematically collected from national immunisation disease surveillance programs. |

STRATEGY GOAL 2: STRENGTHEN HEALTH SYSTEMS AND EQUITY IN IMMUNISATION

S2.1

Geographic equity (DTP3 coverage)

Average unweighted DTP3 coverage in the 20% of districts with the lowest coverage in each country

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|-----------------------------|--|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | The sum of the average coverage of the 20% of districts with the lowest coverage in each country |
| Denominator | The total number of Gavi supported countries with reporting in a given year |
| Data type | Percent |
| Level of disaggregation | NA |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation – Corporate Performance Monitoring and Measurement |
| Rationale for use | |
| Method of measurement | Analysis of district-level coverage reported by WHO member states through the WHO/ UNICEF Joint Reporting Form. For each country in each year, districts are rank ordered by their DTP3 coverage levels. The 20% of districts with the lowest coverage levels are then selected and average coverage of these districts is computed for each country. Then, an unweighted average is computed across all countries with reporting. |
| Analysis and interpretation | As this indicator focuses on performance among the lowest coverage districts, it is a measure of how well Gavi supported countries are able to increase coverage in areas with the weakest immunisation services. This indicator is most responsive to prioritization strategies that emphasize targeting of districts based on the percentage of children who are underimmunised, as opposed to the number of underimmunised children, since it focuses on the districts with the lowest coverage levels. |

S2.1**Geographic equity
(DTP3 coverage)**

Average unweighted DTP3 coverage in the 20% of districts with the lowest coverage in each country

Strengths and limitations

Strengths:

- Computed directly from country reported data.

Limitations:

- The quality of subnational administrative data on immunisation coverage is poor in many Gavi supported countries and therefore the interpretation of trends in this indicator can be challenging.
- Not all Gavi supported countries have consistently reported subnational administrative data on immunization coverage.

Data source

WHO Joint Reporting Form

Further information and related links

1. IA2030 M&E framework (url TBD)

| | |
|-----------------------------|---|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | Difference between coverage of DTP containing vaccine (1st dose) and coverage of DTP containing vaccine (3rd dose) |
| Denominator | Coverage of DTP containing vaccine (1st dose) |
| Data type | Percent |
| Level of disaggregation | NA |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation |
| Rationale for use | |
| Method of measurement | The overall estimate for Gavi-supported countries is calculated as the target population-weighted average of first dose pentavalent coverage and drop-out from first to third dose of DTP containing vaccine. The formula for calculating drop-out is $[(DTP1-DTP3)/DTP1] * 100$. |
| Analysis and interpretation | DTP1-DTP3 drop out measures the same delivery systems multiple times, thereby providing into whether there are factors that hinder caregivers to continue utilising a delivery system. Dropout rates show the ability of the system to reach children with the third dose in a series. In strong systems, children have enough contacts with the system at appropriate times to ensure high coverage with three doses of DTP-containing vaccine. Weaker systems may have the ability to reach a child with the first dose in the series, but not the third dose. |
| Strengths and limitations | Strengths: <ul style="list-style-type: none"> - Data on DTP drop out, in complement to DTP1 coverage, provides a concrete basis for understanding shifts in access, demand and service delivery over time. First dose coverage provides information on access, while drop-out from first to third dose provides information on demand and service delivery. Limitations: <ul style="list-style-type: none"> - DTP drop out provides is a non-specific signal: further explorations are needed to understand the drivers of drop-out from first to third dose of DTP containing vaccine. |
| Data source | Vaccine coverage: WHO/UNICEF estimates of national immunisation coverage. Population estimates: United Nations, Department of Social and Economic Affairs, Population Division. World population Prospects. |

| | |
|-----------------------------|---|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | Number of children under one year of age who have received at least one dose of measles containing vaccine through routine immunisation in a given year |
| Denominator | Number of surviving infants (children before age of 12 months) |
| Data type | Percent |
| Level of disaggregation | NA |
| Frequency of reporting | Annual |
| Responsible team | Monitoring and Evaluation |
| Rationale for use | This indicator aims to measure access to measles containing vaccines through routine immunisation. |
| Method of measurement | This indicator is measured using annually updated WHO/UNICEF estimates of coverage for Measles containing vaccine (1st dose). The overall coverage estimate for Gavi-supported countries is based on the population-weighted average of the coverage estimates from each of the countries, using the number of surviving infants as the weight. |
| Analysis and interpretation | Coverage of first dose of MCV highlights the importance of reaching children at the final routine immunisation touchpoint in the first year of life. It will enable tracking progress towards increasing routine coverage of MCV. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - Indicator is that it directly measures the reach of routine immunisation services, and thus provides information on the level of coverage achieved by the routine immunisation platform. <p>Limitations:</p> <ul style="list-style-type: none"> - The primary limitation of this indicator is underlying uncertainty in available coverage estimates. The quality of the WHO/UNICEF estimates is constrained by the quality and availability of underlying data sources, which have gaps for many countries. |
| Data source | Vaccine coverage: WHO/UNICEF estimates of national immunisation coverage. Population estimates: United Nations, Department of Social and Economic Affairs, Population Division. World population Prospects. |

S2.4

Immunisation sessions conducted

Number of immunisation sessions conducted in Gavi countries, in the reporting year.
 Immunisation sessions conducted reflects the aggregation of immunisation sessions performed
 This indicator will be measured through country administrative data systems. Additional work is needed to understand if and how sessions that may be uncounted by those data systems, e.g., sessions provided by Civil Society Organizations in some contexts, can be measured.
 Immunisation sessions should include both outreach and fixed sessions. This indicator is an aggregation of the results across all Gavi-supported countries.

| | |
|-----------------------------|---|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | NA |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | Mode of service delivery (fixed, outreach) |
| Frequency of reporting | Annual |
| Responsible team | Health Systems and Immunisation Strengthening |
| Rationale for use | Increasing immunisation sessions is a key desired output of HSS investments, and an intermediate result in the causal pathway to increasing vaccine coverage. |
| Method of measurement | Data will be collected through aggregation of district level operational data collected through regular Admin systems and reported at district level through JRF. |
| Analysis and interpretation | Immunisation sessions are a key operational output of an immunisation system and are needed in order to reach children with life-saving vaccines. In general terms, and in most Gavi supported countries the higher the number of sessions (due to an increase in number of health facilities offering immunisation, or in outreach efforts or even in frequency of fixed sessions) the better the country capacity to reach zero dose children. However, some exceptions apply, especially in some subnational areas where the redeployment of services or demand-related interventions or the implementation of extended hours may increase the number of children immunized with same or less sessions. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - Indicator will measure the Alliance’s ability to increase service availability—a key ingredient to increasing coverage and equitable reach of vaccines. <p>Limitations:</p> <ul style="list-style-type: none"> - Successfully conducting an immunisation session reflects the culmination of multiple programmatic elements of the immunisation system (i.e. support for vaccines, vaccinators and vaccines). This indicator will not provide details to ascertain the specific drivers of the reported results. - Gavi will not be the only contributor to immunisation session performance as other funding sources support health facilities activities. |
| Data source | WHO Joint Reporting Form (anticipated) |

S2.5

Stock availability at facility levels

Average over all reporting countries of the percentage of health facilities that reported no stock-outs for the full year for DTPcv and MCV

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|---------------------------------------|--|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | Total number of health facilities with no stock-outs of DTPcv, or MCV, vaccines in a given year |
| Denominator | Total number of health facilities (public and private) providing immunisation service with EPI provided vaccines and with a system in place to measure and report vaccine availability |
| Data type | Percent |
| Level of disaggregation | NA |
| Frequency of reporting | Annual |
| Responsible team | Health Systems and Immunisation Strengthening |
| Rationale for use | This indicator will measure the capacity of countries to forecast and distribute vaccines to health facilities making them available when needed to reach zero dose children. |
| Method of measurement | <p>Gavi supported countries will monitor and collect facility-level data on DTPcv and MCV full stock availability over a year using existing information system (e.g. LMIS, HMIS, DHIS2, wVSSM or other available information management platforms).</p> <p>The JRF questionnaire will ask countries to report on the percentage of health facilities without full stock availability of DTPcv and MCV separately. The data will be used to compute the average proportion of health facilities that reported no stock-outs for the full year for the two vaccines.</p> |
| Analysis and interpretation | This indicator is highly sensitive to stockouts at health facility level. If a health facility has a stock out of DTPcv or MCV for just one day in the year, the health facility will be considered to not have full stock availability of that vaccine for the year. For this reason and taking into consideration the capacity of most country systems, the baseline will most likely be low. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - This indicator provides a good understanding of country capacity to forecast and distribute vaccines through routine systems and is a good proxy for availability of vaccines at lower levels, which is a key component of EPI systems and the results chain to reach zero dose children. - The use of a tracer vaccines (DTPcv and MCV) makes this indicator comparable across all Gavi-supported countries, as it standardises definitions across all countries. In addition, these antigens are less prone to global supply shortages, being more representative of the capacity of health systems to forecast and distribute vaccines. <p>Limitations:</p> <ul style="list-style-type: none"> - Indicator will not measure or provide insights of stockouts of other antigens. |
| Data source | WHO Joint Reporting Form |
| Further information and related links | <ol style="list-style-type: none"> 1. http://www.technet-21.org/iscstrengthening/index.php/en/resources/indicator-reference-sheets#full-stock-availability 2. IA2030 M&E framework |

S2.6**EPI management capacity**

Average of country composite score for programme management and coordination of EPI programmes in Gavi-supported countries

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|---------------------------------------|--|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | Sum of EPI management capacity composite scores for each Gavi57 country |
| Denominator | Count Gavi-supported countries (Gavi57) |
| Data type | Number |
| Level of disaggregation | By status of LMC investment in country (Yes, No) |
| Frequency of reporting | Annual |
| Responsible team | Health Systems and Immunisation Strengthening |
| Rationale for use | The indicator tracks two areas defined as the key fields of engagement under the Leadership, Management and Coordination Strategic Focus Area: EPI management capacity and functionality of Inter-agency coordinating mechanisms. Strengthened institutional capacity for programme management and monitoring is on the critical pathway to programmatic and financial sustainability. It is a strategic enabler of Gavi’s overall 2021–2025 strategy. |
| Method of measurement | Data will be collected through an annual assessment of the following areas of a country’s capacity to effectively manage the EPI programme and functionality of the Inter-agency coordinating mechanisms. The assessment will be based on an annual survey completed by key stakeholders across the Gavi Alliance. Survey respondents will include representatives from the Gavi Secretariat, technical partners (global and country level) and Gavi-supported countries. |
| Analysis and interpretation | This indicator will enable monitoring of the effectiveness of Gavi investments to strengthen management capacities of country EPI programmes and determining the level of maturity of EPI programmes—both for a specific country and across the portfolio of Gavi-supported countries. Clear identification of strengths and weaknesses in country management capacity will inform better targeting of Gavi investments (e.g. technical assistance) to support countries effectively implement EPI. |
| Strengths and limitations | The strength of this indicator is that it begins to address issues of country capacity to implement effective EPI programmes in two areas through objective measurement. The primary limitation is that there is risk of respondent assessments introducing bias to the overall results. This is mitigated, as best as possible through the questionnaire design and ensuring that respondents are representative of all key stakeholders in the Alliance. In addition, findings from the survey will be validated in consultation with members of the Alliance Working Group on institutional capacity, as well as with findings from the Programme Capacity Assessments, which are conducted by independent parties. |
| Data source | Gavi institutional capacity assessment tool |
| Further information and related links | Information about the Programme Capacity Assessment: http://www.gavi.org/library/gavi-documents/guidelines-and-forms/frequently-asked-questions-about-the-joint-appraisal/ |

S2.7

Percentage of countries implementing tailored plans to overcome demand barriers

Percentage of countries with tailored plans implemented to overcome vaccine demand-related barriers in high risk communities

Demand-related barriers are defined as social and behavioural determinants (including social processes, knowledge, and motivation), and environmental or practical factors (including access to quality services, and experience of care), that prevent individuals from seeking and supporting vaccination.

High risk communities are defined as populations identified as vulnerable to un/under-immunisation, falling below coverage targets, high drop-out rates and high numbers of never vaccinated. These communities will benefit from assessment of social and behavioural barriers.

| | |
|-----------------------------|---|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | Number of countries that have implemented tailored plans to overcome vaccine demand-related barriers in high risk communities in the previous year |
| Denominator | Number of Gavi-supported countries |
| Data type | Percent |
| Level of disaggregation | NA |
| Frequency of reporting | Annual |
| Responsible team | Health Systems and Immunisation Strengthening |
| Rationale for use | Indicator provides insights into root causes of success or failure for vaccination; helps to drive actions. |
| Method of measurement | The operational definition and method of measurement is pending finalization of the IA2030 M&E framework. One option under consideration is to measure this via a checklist of demand-oriented interventions that illustrate whether or not a country has implemented strategies to address under-vaccination |
| Analysis and interpretation | As countries and partners are sensitized about the impact and relevance of demand side interventions to immunisation, and prioritise it in their strategic and operational plans, we expect to see an increase in number of countries implementing tailored plans to address reasons for under-vaccination and to overcome demand-related barriers to immunisation. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - This indicator allows, to some extent, tracking of country commitment to systematically address demand related barriers to immunisation. and what countries are doing to strengthen services and generate demand. The indicator drives action to effect change. <p>Limitations:</p> <ul style="list-style-type: none"> - This indicator is process-oriented and does not allow monitoring of programmatic results from implementing the tailored plans. of implementation. Programmatic results of investments in strengthening demand for immunisation will be monitored through indicators developed by the WHO Behavioural and social drivers of childhood vaccination working group. |
| Data source | WHO Joint Reporting Form |

S2.8**Percentage of countries addressing gender-related barriers to immunization with Gavi support**

This is a composite indicator that will monitor two components: (1) have countries conducted an analysis to identify gender related barriers to immunisation linked to subnational mapping to identify zero-dose and missed communities (2) are countries implementing actions to address gender-related barriers to immunisation as part of their annual workplan based on this analysis. To be considered successful, countries would need to fulfil both criteria. The indicator is defined in terms of the proportion of Gavi supported countries that meet these criteria.

| | |
|-----------------------------|---|
| Strategic objective | SG 2 – Strengthen health systems to increase equity in immunisation |
| Level of reporting | Strategy |
| Numerator | Countries implementing actions to address gender-related barriers to immunisation as part of their annual workplan based on previous analysis of gender related barriers linked to subnational mapping to identify zero-dose and missed communities. |
| Denominator | Gavi-supported countries with active HSS grants in a given year |
| Data type | Percent |
| Level of disaggregation | NA |
| Frequency of reporting | Annual |
| Responsible team | Health Systems and Immunisation Strengthening |
| Rationale for use | This indicator measures the countries capacity to understand, recognize and address gender related barriers to immunization with Gavi support |
| Method of measurement | <p>This indicator will be monitored on an annual basis by analysis of documents presented in the HSS application and annual joint appraisals (JA/MSD) since the starting year of the HSS grant and compared with the workplan of the previous year.</p> <p>An analysis of gender related barriers to immunisation should include any of the following components: women and girl’s access to resources (financial, information or otherwise) to immunize their children; decision making power on vaccination; mobility to get immunization services; time limitation outside work or household chores to bring child to be immunized; community participation and engagement on immunization. Also, adequacy of services to men and women, including men engagement on immunisation, health workforce imbalance or inadequacy in EPI management and service delivery and other gender analysis disaggregated by sex of caregiver or health workforce. This analysis will need to be performed at subnational level and linked with mapping to identify zero-dose and missed communities for it to be compliant.</p> <p>Gender interventions will be tagged in the annual workplan by the Secretariat according to the gender programming guidance. Those interventions may be either gender sensitive or gender transformative and both will be considered as compliant.</p> |
| Analysis and interpretation | <p>As countries and partners are sensitized about the impact of gender-related barriers to immunisation, and the capacity to understand, recognize and address those barriers increases, we expect to see an increase in number of countries including interventions addressing those barriers based on gender analysis.</p> <p>However, the objective is not to silo gender in the workplan, but that gender thinking is incorporated across interventions—a gender tag will facilitate identifying gender-targeted interventions in the workplan.</p> |

S2.8

Percentage of countries addressing gender-related barriers to immunization with Gavi support

This is a composite indicator that will monitor two components: (1) have countries conducted an analysis to identify gender related barriers to immunisation linked to subnational mapping to identify zero-dose and missed communities (2) are countries implementing actions to address gender-related barriers to immunisation as part of their annual workplan based on this analysis. To be considered successful, countries would need to fulfil both criteria. The indicator is defined in terms of the proportion of Gavi supported countries that meet these criteria.

Strengths and limitations

Strengths:

- This indicator will enable Gavi to track if countries conduct analyses to understand gender-related barriers to immunisation and use those analyses to prioritise interventions to address them. It is a proxy for the output and outcome components of the gender theory of change (capacity building, evidence and analysis and prioritization).
- This indicator will facilitate harmonised monitoring of interventions addressing gender-related barriers across all Gavi-supported countries without being prescriptive on specific interventions.

Limitations:

- A gender tag in Gavi workplans will likely be biased by some degree of subjectivity. Gavi's gender programming guidance shall mitigate this by providing a clear list of interventions that may be considered as addressing gender related barriers.
- An analysis of application materials and regular country reports will need to be performed on an yearly basis to ensure there are relevant analysis informing the prioritization of those interventions.
- A learning agenda to measure gender barriers to immunisation and progress on addressing them will look for more outcome oriented-indicators.

Data source

Gavi Health Systems and Immunisation Strengthening annual financial reports.



STRATEGY GOAL 3: IMPROVE SUSTAINABILITY OF IMMUNISATION PROGRAMMES

S3.1

**Co-financing
fulfilment**

Percentage of countries with a co-financing obligation to Gavi that meet their co-financing commitments

Strategic objective

SG 3 – Improve sustainability of immunisation programmes

Level of reporting

Strategy

Numerator

Number of countries with co-financing obligations to Gavi that complete co-financing payments by 31 December of the year in question (or by the end of their fiscal year, if agreed so with Gavi), or that clear default within the 12 months following the due date of the obligation

Denominator

Number of countries with a co-financing obligation to Gavi

Data type

Percent

Level of disaggregation

By co-financing category and timeliness of payment (i.e., proportion paying by December 31 of the year in question or fiscal year and proportion clearing default within the following twelve-month period)

Frequency of reporting

Annual

Responsible team

Immunisation Financing and Sustainability

Rationale for use

The fulfilment of co-financing commitments is a measure of country commitment to financing vaccines. Co-financing serves as a mechanism to support countries on a path toward greater sustainability.

Method of measurement

The numerator is the number of countries that either make their co-financing payments by the end of the year in question (or fiscal year, if agreed so with Gavi), or that clear default within the following twelve months (per the Gavi policy). A country is considered to be in default if it does not make its co-financing payment by December 31 of each year (or by the end of their fiscal year, if agreed so with Gavi).

The denominator is all countries with a co-financing commitment to Gavi, per the Board-approved co-financing policy.

| | |
|-----------------------------|---|
| Analysis and interpretation | <p>This indicator will monitor the commitment of Gavi-supported countries to financing vaccines as they progress towards phasing out of Gavi support. The ability to co-finance, in complement to increasing GNI, reflects a country's financial readiness to transition.</p> <p>Co-financing of vaccines is one of the ways in which Gavi-supported countries contribute to their immunisation costs.</p> |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - This indicator directly measures country fulfilment of co-financing commitments. Including in the numerator any countries that clear default within 12 months allows to differentiate countries with protracted challenges from those who may experience just transient delays in payments. <p>Limitations:</p> <ul style="list-style-type: none"> - This indicator is not a comprehensive measure of sustainable national financing of all vaccines. Sustainability of national immunisation programmes requires more than investment in Gavi-supported vaccines. |
| Data source | <p>UNICEF Supply Division, PAHO Revolving Fund and Gavi Secretariat records (for self-procuring countries). Each agency records receipt of country vaccine payments, against the deadline for payment submission.</p> |

| | |
|-----------------------------|--|
| Strategic objective | SG 3 – Improve sustainability of immunisation programmes |
| Level of reporting | Strategy |
| Numerator | N/A |
| Denominator | N/A |
| Data type | Number |
| Level of disaggregation | N/A |
| Frequency of reporting | Annual |
| Responsible team | Immunisation Financing & Sustainability |
| Rationale for use | The indicator measures the sustainability of immunisation systems in former-Gavi countries, as demonstrated through the capacity to maintain or increase DTP3 coverage following transition from Gavi support. The indicator reflects the objectives of Gavi’s new approach to engaging with middle-income countries (the “MICs Approach”), as well as Gavi transition more broadly. |
| Method of measurement | <p>Former-Gavi countries include those defined by the Board as part of the MICs Approach in December 2020 (N=17).</p> <p>Taking the most-recent two-year period, the indicator captures countries in which coverage was held constant or increased in at least one year compared to coverage in 2019. With this, the indicator results represent countries that maintained or increased coverage over both years, as well as those that experienced a decline in coverage in the first year but recovered at least to 2019 levels in the following year.</p> <p>The countries that remain experienced a sustained reduction in coverage in the most-recent two-year period, signalling a less-sustainable immunisation system. To ensure that the indicator is responsive to meaningful changes:</p> <ol style="list-style-type: none"> 1. Reductions in coverage are defined with a margin of 1 percentage point (i.e., coverage is considered “maintained” if the reduction bringing coverage below baseline is no greater than 1 percentage point). 2. A distinction is made for countries sustaining coverage above 95%, whereby they will be considered to have “maintained” coverage so long as they sustain coverage at or above 95%. |
| Analysis and interpretation | Results will reflect the impact of the MICs Approach over the strategic period and provide insight into the state of immunisation system sustainability in former-Gavi countries. Countries experiencing reductions in immunisation coverage will be identified and the contributing factors, both internal and external to the immunisation system, will be investigated. |

Strengths and limitations

Strengths:

- The indicator measures trends in coverage, captures meaningful changes, and directly reflects three facets of immunisation system sustainability:
 - (i) capacity to maintain or increase coverage over time
 - (ii) capacity to recover following a temporary shock
 - (iii) capacity to sustain coverage at or above 95%. The indicator utilises a publicly-available data source, imposing no additional reporting burden on countries.

Limitations:

- The primary limitation is underlying uncertainty in coverage estimates. The quality of coverage estimates is constrained by the quality and availability of underlying data sources, which have gaps for many countries.

The measurement method does not capture single-year declines in coverage, as it seeks to observe the capacity of the immunisation system to recover following such declines. The measurement method will also conceal fluctuations in coverage (i.e. increases followed by decreases) that occur above baseline. However, any such changes in coverage will be measured and acted upon as part of the monitoring plan for the MICs Approach.

Data source

WHO/UNICEF estimates of national immunisation coverage

S3.3

New vaccine introductions in former- and never-Gavi eligible countries

Number of new vaccine introductions (PCV, rotavirus, HPV) in former- and never-Gavi countries eligible under the MICs Approach

| | |
|-----------------------------|---|
| Strategic objective | SG 3 – Improve sustainability of immunisation programmes |
| Level of reporting | Strategy |
| Numerator | N/A |
| Denominator | N/A |
| Data type | Number |
| Level of disaggregation | By vaccine |
| Frequency of reporting | Annual |
| Responsible team | Middle Income Country's Approach |
| Rationale for use | Monitor change in number of middle-income countries eligible under the MICs Approach introducing PCV, rotavirus and HPV vaccines into their routine immunisation schedules. |
| Method of measurement | Count of the number of new vaccine introductions, specifically PCV, rotavirus and HPV vaccines |
| Analysis and interpretation | New vaccine introductions are a core driver of Gavi's achievement through the MICs Approach. Indicator results will inform on the effectiveness of the Alliance's support to countries to introduce PCV, rotavirus and HPV vaccines into their national immunisation programmes. |
| Strengths and limitations | <p>Strengths:</p> <ul style="list-style-type: none"> - The indicator allows for real-time monitoring and reporting of vaccine introductions supported through the MICs Approach <p>Limitations:</p> <ul style="list-style-type: none"> - The indicator only measures the first phase of phased introduction and thus does not fully reflect programmatic efforts at country level in the phased scale-up of certain vaccines, nor does it measure the extent to which equitable coverage is achieved. However, these elements will be captured through the monitoring plan for the MICs Approach. |
| Data source | Gavi vaccine launch database (internal) |



STRATEGY GOAL 4: ENSURE HEALTHY MARKETS FOR VACCINES AND RELATED PRODUCTS

S4.1

Healthy Market Dynamics

Number of markets exhibiting sufficient levels of healthy market dynamics

| | |
|-------------------------|--|
| Strategic objective | SG4 – Ensure sustainable, healthy market dynamics for vaccines and immunisation-related products at affordable prices |
| Level of reporting | Strategy |
| Numerator | Number of Gavi-supported vaccine and CCE markets assessed to have sufficient healthy market dynamics |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | By individual vaccine and CCE market |
| Frequency of reporting | Annual |
| Responsible team | Market Shaping |
| Rationale for use | <p>Since 2016, Gavi’s market shaping objectives have shifted towards a holistic approach defined by the Healthy Markets Framework (HMF). Under the HMF approach, a fundamental attribute of a healthy market is having sufficient supply security to ensure sufficient and uninterrupted supplies of appropriate vaccines to countries. As markets continues to evolve, additional market attributes such as innovations and competition may contribute towards the achievement of sustainable and appropriate pricing. In contrast with a singular focus on price or innovation, this holistic approach better aligns with Gavi’s strategic goals to 1) introduce and scale up vaccines and to 2) improve sustainability of immunisation programmes.</p> <p>The HMF approach gives a holistic view of markets, where market healthy level is determined by the following factors:</p> <ul style="list-style-type: none"> - Level of supply to meet demand - Level of supply security to mitigate supply risks - Level of long-term competition - Overall programmatic cost and effectiveness due to product characteristics and price per dose - Development of vaccines with improved characteristics that address programmatic needs |

Method of measurement

Semi-quantitative assessment of individual market health, conducted by core Alliance partners (i.e., UNICEF, BMGF, WHO).

Based on assessments of individual Healthy Markets Framework attributes and a holistic overview of each market's programmatic context, markets will be assessed based on the following categories:

| | |
|---|--|
| Insufficient and requires further intervention | Severe supply security challenges and risks exist No improvement is expected without Alliance intervention |
| Insufficient with conditions for improvement | Severe supply security challenges and risks exist Improvements possible but requiring further monitoring and lead time to materialise |
| Sufficient with risks | Limited supply security challenges with unacceptable risks of backsliding Interventions are required to mitigate risks |
| Sufficient and sustainable | Limited supply security challenges with acceptable risks Monitoring required to ensure risks to not increase |

Analysis and interpretation

Impact of analysis:

- Identification of low HMD drivers is needed to identify appropriate interventions to address challenges and mitigate risks
- HMF analysis provides context for changes in supply availability and price trends, and thus guidance on whether the changes are acceptable or require interventions to address

Analysis takes into consideration a multitude of factors required for access to near-term vaccine supplies as well as conditions for long-term sustainable HMD to facilitate long-term country programmes.

Strengths and limitations

Strengths:

- Gives a more holistic view of markets, with considerations of long-term market evolution and risk mitigation
- Has enough flexibility to accommodate the specific needs of different market contexts

Limitations:

- Flexibility comes with added subjectivity that may pose challenges in reaching assessment alignment

Data source

Vaccine procurement data: UNICEF SD MoU reports

Market intelligence data: Gavi MS roadshows, Alliance partner industry engagements

| | |
|-------------------------|---|
| Strategic objective | SG4 – Incentivise innovation for the development of suitable vaccines |
| Level of reporting | Strategy |
| Numerator | Number of innovative products within the pipeline of commercial-scale manufacturers |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | By individual products |
| Frequency of reporting | Annual |
| Responsible team | Market Shaping |
| Rationale for use | <p>One of the key objectives of Gavi’s market shaping work is to ensure the availability of quality and suitable vaccines products for countries. As the health of markets improve over time with increased supply security, an increasing focus will be placed on product innovations that can better address countries’ programmatic challenges.</p> <p>Uptake of innovative products, including those included in the Vaccine Innovations Prioritisation Strategy (VIPs), by commercial manufacturers is intended to measure and demonstrate effectiveness of Gavi’s interventions in increasing market attractiveness for manufacturers to invest in the commercialisation and production of new innovations (Strategic Objective 4B).</p> <p>Gavi’s supply and procurement roadmaps for individual vaccine markets outline key challenges that countries face and potential innovations that may have a critical impact in improving coverage and equity. Tools for incentivizing the development of such innovations are considered and used in alignment with roadmap targets.</p> <p>Additionally, during the 2016-2020 period, the Vaccine Innovations Prioritisation Strategy (VIPs) was launched to prioritise innovations in vaccine delivery attributes to provide greater clarity to manufacturers and immunisation partners to make investment decisions. Through an Alliance-wide collaboration effort, VIPs analysed 24 vaccine product innovations through thorough evaluation process centered on country needs. The evaluations will result in the prioritisation of 3-4 vaccine product innovations paired with specific antigens. Depending on Gavi 5.0 mandate and resources, the Alliance will consider how to support the prioritised innovations beyond prioritisation and signaling.</p> |
| Method of measurement | Count of “products” as individual assets, i.e., two independent pipeline vaccine candidates for the same antigen or innovation will be counted as a progress of two. Indicator progresses when any Gavi-supported innovations partner with a commercial-scale manufacturer that is committing to take a product to market. |

Analysis and
interpretation

VIPS-prioritised innovations are expected to be in early phased of product development during the 5.0 period and products may not enter the market until after 2025. In order to assess the impact of Gavi's incentivisation tools, commercial-scale manufacturers committing to taking a product to market may be the most effective proxy for market attractiveness.

Strengths and limitations

By counting individual vaccine candidate instead of general categories of innovations or products, the indicator will be able to track an estimated magnitude of impact of Gavi's incentivization for innovations.

Strengths:

- Allows assessment of whether sufficient incentives are in place for manufacturers to invest in product development.

Limitations:

- Does not track further progress once a pipeline programme is initiated by a commercial-scale manufacturer.
- Difficult to quantify causation that may be attributed to Gavi interventions.

Data source

Market intelligence data: Gavi MS roadshows, Alliance partner industry engagements
VIPS: TBD, pending Board decision on VIPS phase 2

| | |
|-----------------------------|---|
| Strategic objective | SG4 – Scale up innovative immunisation-related products |
| Level of reporting | Strategy |
| Indicator definition | Number of vaccines and immunisation-related products with improved characteristics procured by Gavi as compared to the baseline year |
| Numerator | Number of vaccine and immunisation-related products with improved characteristics procured between 2021 and 2025 |
| Denominator | NA |
| Data type | Number |
| Level of disaggregation | Vaccines, CCE, other immunisation-related products |
| Frequency of reporting | Annual |
| Responsible team | Market Shaping |
| Rationale for use | One of the Gavi Alliance’s key priorities for the 2021-2025 period is to scale-up innovations. As manufacturers successfully bring innovative products to market, tracking whether these products are procured through UNICEF gives an indication of whether countries are adopting products with improved characteristics for use. |
| Method of measurement | <p>The procurement process entails an assessment of these trade-offs. If the procurement process determines that the trade-off is worthwhile and the new products is procured, it will be counted towards this indicator.</p> <p>For vaccines, the criteria against which new products can be assessed include the following:</p> <ul style="list-style-type: none"> - Programmatic suitability of vaccine candidates for WHO prequalification (also known as “PSPQ”). - Vaccine presentation and Packaging Advisory Group (VPPAG) Generic preferred product profile (gPPP). - In some instances, improved characteristics will refer to characteristics not explicitly included in PSPQ or gPPP. In these cases, SAGE recommendations, WHO Position Papers and other objectives reference documents will be used to determine whether the new vaccine meets the definition for “improved characteristics” (e.g., reduction in number of doses required, or addition of serotypes) <p>For other immunisation products, the criteria against which new products can be assessed and sources include the following:</p> <ol style="list-style-type: none"> 1. WHO Performance, Quality and Safety (PQS) Specifications / Standards 2. PQS Target Product Profiles or “TPPs” 3. Any additional Gavi CCE platform-eligible criteria not reflected in PQS Specifications / Standards and TPPs. 4. Assessment for other immunisation products is less straightforward, given the emerging nature of markets for such products. |
| Analysis and interpretation | One of the Gavi Alliance’s key priorities for the 2021-2025 period is to scale-up innovations. As manufacturers successfully bring innovative products to market, tracking whether these products are procured through UNICEF gives an indication of whether countries are adopting products with improved characteristics for use. |

Strengths and limitations

Strengths:

- Directly tracks the number of innovations in vaccines and immunisation products of immediate relevance to the Alliance and its overall strategy.
- Assesses how successful the Alliance is in translating pipeline products into meaningful and improved products with market demand.

Limitations:

- The primary limitation lies in the lack of objective benchmark for what constitutes “improved characteristics” for all products.

Data source

Gavi-UNICEF Supply Division Memorandum of Understanding reports and key performance indicators.

Summary of 5.0 country allocations for Gavi-eligible countries

Country allocations in Gavi 5.0 (2021-2025) include Health Systems Strengthening (HSS), Equity Accelerator Funding (EAF), Cold Chain Equipment Optimisation Platform (CCEOP) support, and Targeted Country Assistance (TCA). Gavi uses the Board-approved allocation formula to calculate 5-year ceilings for every country's allocation¹. This allocation formula accounts for four equally weighted parameters – the number of zero-dose children (children not receiving a first dose of DTP-containing vaccine), the number of under-immunized children (children not receiving a third dose of DTP-containing vaccine), the birth cohort and GNI per capita – as a proxy for countries' target population, health system strength, equity gaps and ability to pay. Each ceiling, described and listed below, represents the maximum amount of funding a country is eligible to receive over a five-year period.

Countries can apply to receive these ceilings as part of an integrated planning process during Gavi's 5.0 strategic period (2021-2025). Details of how to apply to these country ceilings and other streams of support are described [here](#).

Health Systems Strengthening (HSS) ceilings can be accessed when countries apply for a new 5-year HSS grant during their Full Portfolio Planning (FPP) process in the 5.0 period. Any approved amounts which fall beyond the current Gavi strategic period (2021 – 2025) are considered indicative, and subject to the availability of resources and Board approval of a new HSS envelope for Gavi's next strategic period. In some cases, only a portion of a country's ceiling is approved through the end of the current Gavi strategic period (2021-2025). Additional HSS under the Fragility, Emergency and Refugee (FER) policy is available in specific contexts and assessed case-by-case (not included below).

Equity Accelerator Funding (EAF) ceilings will be made available to countries to accelerate efforts to reach zero-dose children and missed communities sustainably. The EAF is only available for use within Gavi's current strategic period (2021-2025). Eligible countries² can apply for the EAF during the Full Portfolio Planning (FPP) or make a standalone application.

Cold Chain Equipment Optimisation Platform (CCEOP) ceilings can be accessed when countries apply for their new CCEOP grant within the 5.0 period (2021-2025). Countries are requested to note that any approved amounts which fall beyond the current Gavi strategic period (2021 – 2025) are considered indicative. A corresponding country joint investment will be required from countries based on their transition status at the time of a country's application.

Targeted Country Assistance (TCA): Countries can plan TCA funding through the end of the Gavi 5.0 strategic period (2021-2025). Countries are encouraged to reserve a portion of funds for flexibility within their TCA ceiling in case of unforeseen needs during the strategic period. Additional TCA under the Fragility, Emergency and Refugee (FER) policy is available in specific contexts and assessed case-by-case.

¹ Some countries' HSS and TCA ceilings have been manually adjusted, where they faced a particularly large change between grant cycles, to smoothen the transition from previous ceilings.

² Countries with special Board-approved strategies (Nigeria, India, Papua New Guinea) are not eligible to apply for EAF; and will require individually tailored approaches within currently approved funds.

Summary of 5.0 country ceilings & approval cap for ongoing grants or those starting within Gavi 5.0 (2021-2025)

| Country | HSS 5.0 Ceiling ³ : For next FPP in 5.0 | HSS Core Approval Cap ⁴ 2021-2025 | Equity Accelerator Fund (EAF) Ceiling 2021-2025 | CCE Ceiling: Gavi JI For next FPP in 5.0 | PEF TCA Ceiling 2021-2025 |
|--------------------------|--|--|---|--|---------------------------|
| Afghanistan | 46,051,882 | 39,323,663 | 17,747,501 | 7,260,232 | 14,721,200 |
| Bangladesh | 20,428,303 | 37,575,090 | 7,871,943 | 3,220,590 | 5,520,520 |
| Benin | 11,056,523 | 9,174,318 | 4,260,997 | 1,743,097 | 4,665,931 |
| Burkina Faso | 15,247,768 | 14,276,276 | 5,886,261 | 2,403,861 | 6,308,713 |
| Burundi | 22,250,275 | 18,819,857 | 3,863,616 | 1,576,620 | 3,745,814 |
| Cambodia | 13,223,184 | 11,033,194 | 1,906,513 | 779,811 | 3,597,520 |
| Cameroun | 25,306,203 | 19,237,057 | 9,739,725 | 3,989,607 | 5,427,656 |
| Central African Republic | 8,282,079 | 7,373,405 | 2,914,598 | 1,192,515 | 14,721,200 |
| Chad | 29,452,898 | 18,364,409 | 11,345,133 | 4,643,347 | 14,732,229 |
| Comoros | 3,000,000 | 3,000,000 | 1,000,000 | 472,960 | 3,812,144 |
| Congo | 3,574,555 | 7,972,943 | 1,375,544 | 563,540 | 5,076,254 |
| DR Congo | 155,024,179 | 101,554,131 | 59,730,647 | 24,440,076 | 25,000,000 |
| Côte d'Ivoire | 10,389,764 | 10,026,368 | 4,001,236 | 1,637,981 | 5,729,177 |
| Djibouti | 3,000,000 | 3,000,000 | 1,000,000 | 472,960 | 4,665,931 |
| Eritrea | 7,500,000 | 6,282,750 | 1,000,000 | 472,960 | 3,419,524 |
| Ethiopia | 114,644,142 | 99,947,139 | 44,180,347 | 18,074,029 | 25,000,000 |
| Gambia | 3,000,000 | 4,500,000 | 1,000,000 | 472,960 | 3,078,773 |
| Ghana | 7,213,909 | 9,912,157 | 2,778,809 | 1,137,297 | 3,456,054 |
| Guinea | 26,164,181 | 21,241,307 | 7,997,101 | 3,274,201 | 5,366,194 |
| Guinea-Bissau | 3,000,000 | 3,000,000 | 1,000,000 | 472,960 | 4,817,733 |
| Haiti | 10,552,785 | 8,280,825 | 4,065,366 | 1,663,682 | 14,624,729 |
| Kenya | 14,740,590 | 20,764,167 | 5,678,000 | 2,323,903 | 6,175,217 |
| DPR Korea | 8,756,337 | 11,356,337 | 2,583,574 | | 3,419,524 |
| Kyrgyzstan | 3,000,000 | 3,000,000 | 1,000,000 | | 4,150,608 |
| Lao PDR | 976,000 | 1,576,000 | 1,728,563 | 153,870 | 5,799,661 |
| Lesotho | 3,000,000 | 3,000,000 | 1,000,000 | 472,960 | 3,400,706 |
| Liberia | 9,226,755 | 11,441,234 | 1,679,830 | 686,345 | 3,592,756 |
| Madagascar | 26,594,953 | 24,830,532 | 10,257,829 | 4,192,783 | 6,572,840 |
| Malawi | 31,216,733 | 25,570,191 | 5,190,082 | 2,117,830 | 5,337,676 |
| Mali | 22,691,812 | 20,904,640 | 8,746,480 | 3,577,439 | 12,814,298 |
| Mauritania | 3,000,000 | 3,000,574 | 1,117,038 | 472,960 | 3,681,269 |
| Mozambique | 31,250,799 | 31,250,799 | 10,515,600 | 4,294,411 | 7,669,960 |
| Myanmar | 14,345,527 | 17,935,978 | 5,529,571 | 2,261,620 | 5,860,059 |
| Nepal | 26,401,850 | 24,872,352 | 3,590,741 | 1,466,759 | 4,730,056 |
| Niger | 28,510,399 | 28,875,652 | 11,002,734 | 4,494,759 | 14,721,200 |
| Nigeria | 126,000,000 | 126,000,000 | - | | 26,208,676 |
| Pakistan | 118,697,088 | 114,957,670 | 45,686,028 | 18,712,989 | 25,000,000 |
| Papua New Guinea | 40,000,000 | 40,000,000 | - | | 14,721,200 |
| Rwanda | 6,093,067 | 6,853,492 | 2,354,021 | 960,592 | 3,440,002 |
| Sao Tome and Principe | - | 762,037 | 500,000 | | 1,746,304 |
| Senegal | 7,139,078 | 6,531,273 | 2,753,593 | 1,125,499 | 3,970,010 |
| Sierra Leone | 10,313,692 | 7,793,875 | 2,042,077 | 833,574 | 5,535,024 |
| Solomon Islands | 600,000 | 1,320,000 | 1,000,000 | 94,592 | 3,307,459 |
| Somalia | 34,622,122 | 26,406,593 | 13,334,053 | 5,458,292 | 13,321,811 |
| South Sudan | 19,880,000 | 19,532,728 | 7,827,835 | 3,204,302 | 14,678,271 |
| Sudan | 13,999,611 | 19,299,611 | 5,520,929 | 2,258,524 | 12,189,107 |
| Syrian Arab Republic | 22,000,000 | 22,000,000 | - | | 9,872,956 |
| Northwest of Syria | 11,000,000 | - | - | | 3,290,985 |
| Tajikistan | 3,867,580 | 3,924,129 | 1,493,284 | 609,737 | 3,443,986 |
| Tanzania | 40,730,960 | 31,615,684 | 15,707,813 | 6,421,371 | 6,356,910 |
| Togo | 6,499,356 | 6,137,023 | 2,507,392 | 1,024,645 | 4,665,931 |
| Uganda | 32,973,851 | 35,945,910 | 11,405,683 | 4,655,140 | 6,390,918 |
| Yemen | 19,230,564 | 19,230,564 | 10,626,207 | 4,345,812 | 11,221,373 |
| Zambia | 9,213,352 | 8,105,280 | 3,550,434 | 1,452,515 | 5,571,207 |
| Zimbabwe | 9,583,707 | 9,786,303 | 2,377,019 | 972,313 | 4,127,084 |

Note: HSS Ceilings for India, Nigeria & Papua New Guinea were not calculated using the allocation formula as they have special Board-approved strategies. For further enquiry, kindly contact the Gavi Senior Country Manager for your country.

³ Ceilings: maximum amount a country can approve during their next 5-year HSS grant cycle, if FPP is to begin in Gavi 5.0 (2021-2025)

⁴ Approval cap: maximum amount a country can access in approvals for disbursement during Gavi 5.0 (2021-2025)

| | | |
|---|------------------|------------|
|  | | |
| Gavi Risk Policy | Version No.: 1.0 | Page 1 / 4 |

DOCUMENT ADMINISTRATION

| VERSION NUMBER | APPROVAL PROCESS | DATE |
|----------------|--|-------------------------------------|
| 1.0 | Reviewed and recommended by: Gavi Programme & Policy Committee | 10 November 2014 |
| | Reviewed and approved by: Gavi, the Vaccine Alliance Board | 11 December 2014 |
| | | Effective from: 1 January 2015 |
| | | Review: at the request of the Board |
| | | |
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Gavi Risk Policy

1. Goal and scope of the policy

- 1.1. The purpose of the Gavi Risk Policy is to
 - 1.1.1. create a consistent risk language and a shared understanding of risk concepts
 - 1.1.2. promote a culture of risk awareness, which encourages careful assessment of risks and benefits involved with Gavi operations and decision-making
 - 1.1.3. provide high level guidance on risk management
 - 1.1.4. guide strategic and operational decision-making within the Alliance
- 1.2. The risk policy forms the overarching framework for Gavi's risk management approach, which is embedded across the Secretariat in various structures and processes for risk monitoring, reporting and mitigation.

2. Principles

- 2.1. **Risk is integrally linked to ambition:** Gavi recognises that objectives can only be achieved by taking calculated and carefully managed risks. Some high-impact opportunities may require taking greater risks. Sometimes the greatest risk is inaction.
- 2.2. **Risk is everyone's responsibility:** risk management is an integral part of Gavi operations. Everyone working towards the Gavi mission is expected to pro-actively identify, assess, and manage risks.
- 2.3. **Gavi encourages a culture of learning:** Gavi aims to nurture a culture that encourages staff and stakeholders to be risk-aware in delivering on Gavi's mission, while also recognising and accepting that success will not always be achieved. It ensures that processes are in place to learn from both positive and negative results.

3. Roles and responsibilities

- 3.1 The **Gavi Board** provides leadership on risk management and is ultimately responsible for:
 - 3.1.1 Determining Gavi's risk philosophy, including risk appetite;
 - 3.1.2 Validating that the Secretariat has established effective risk management processes;
 - 3.1.3 Being appraised of the most significant risks and whether Alliance partners are responding appropriately;
 - 3.1.4 Reviewing Gavi's portfolio of risks and ensuring that these risks are within Gavi's risk appetite.
- 3.2 The **Gavi Secretariat** is responsible for leading discussions with partners to translate risk appetite, as endorsed by the Board, into appropriate strategies and processes. In addition it promotes a risk-aware culture, implements risk management processes, and communicates risks to the Gavi Board in a timely fashion. Secretariat staff members are

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|  | | |
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responsible for identifying, assessing, and managing risks in their daily work and for escalating risk management to appropriate levels when needed.

3.3 The Alliance model leverages the strengths of the **Alliance partners** through shared responsibility and mutual accountability for risks. Each Gavi partner is responsible for managing risks involved with Gavi activities and alerting the Secretariat in a timely manner to risks that may affect the Gavi mission, including risks to the responsible use of Gavi resources in countries and to the effective implementation and sustainability of Gavi programmes.

3.4 **Implementing countries** are responsible for delivering programmatic results with the vaccines and funds provided, and for meeting co-financing requirements. They have primary responsibility for managing risks to the results being pursued with Gavi-funded programmes and for reporting risks encountered in the implementation of these programmes in a timely manner.

4. Strategic directions

4.1. **Risk:** the probability of an event that could negatively affect the achievement of objectives if it were to occur.

4.2. **Opportunity:** the probability of a (positive) event that could bring benefits if it were to occur.

4.3. **Inherent risk:** risk prior to the application of mitigation efforts or controls.

4.4. **Residual risk:** risk remaining after relevant controls or reasonable mitigation efforts have been applied.

4.5. **Risk management:** the process of identifying, assessing and prioritising risk followed by the application of resources to treat the risk:

4.5.1. **Risk treatment:** to avoid, accept, mitigate or transfer the risk in order to minimise the probability and/or the impact of adverse events and to maximise the realisation of benefits.

4.5.2. **Risk mitigation:** a reduction in the probability and/or impact of a risk, also called risk reduction. Risk mitigation will reduce the risk, but rarely eliminates it completely.

4.6. **Risk appetite** is the amount of risk, on a broad level, that an organisation is willing to accept in pursuit of objectives. It reflects the risk philosophy of the organisation and is at the heart of its business model; it guides strategy development and related investments in risk mitigation processes. A defined risk appetite statement helps to align people and processes in pursuing organisational goals within acceptable ranges of risk.

4.7. **Risk tolerance** is the specific, maximum amount of risk that an organisation is willing to accept in relation to a specific outcome. While risk appetite is broad, risk tolerance is specific and operational.

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Risk categories

- 4.8. The following **risk categories** can be distinguished in relation to Gavi operations and objectives. The list is not exhaustive and the categories are not mutually exclusive; in practice, some risks will fit more than one category.
- 4.9. The following categories highlight the *source* of the risk:
- 4.9.1. **Operational** risks are related to inadequate or failed internal processes, people and systems.
- 4.9.2. **Financial** risks are related to the management and control of Gavi resources.
- 4.9.3. **Fiduciary** risks are related to funds not being used for the intended purposes, not being used to achieve value for money, and/or not being properly accounted for. The realisation of fiduciary risk can be due to a variety of factors, including lack of capacity, competency or knowledge; bureaucratic inefficiency; and/or corruption.
- 4.9.4. **Governance and stakeholder relationship** risks are related to the management of decision-making structures of the Alliance and operational relationships between Gavi partners.
- 4.9.5. **Programmatic** risks are related to the implementation of Gavi programs at country level. The following sub-categories can be distinguished for programmatic risks at the country level:
- a) Social, political and environmental
 - b) Financing and sustainability
 - c) Fiduciary
 - d) Technical and institutional capacity including programme governance
- 4.10. Risks across all categories can also be described according to the potential *effect* of the risk:
- 4.10.1. **Strategic** risks threaten the achievement of Gavi's strategic objectives.
- 4.10.2. **Reputational** risks threaten Gavi's reputation.
- 5. Effective date and review of the policy**
- 5.1. This policy comes into effect 1 January 2015.
- 5.2. The risk appetite statement (annex 1) is to be reviewed every two years.
- 5.3. The risk policy is to be updated in accordance with changes in objectives or major alterations in the business model, as requested by the Gavi Board.