WHO-EM/EPI/293/E

Report on the

16th meeting of the Eastern Mediterranean Regional Working Group on the GAVI Alliance

Cairo, Egypt
6–7 September 2009

World Health Organization

Regional Office for the Eastern Mediterranean

WHO-EM/EPI/293/E

Report on the

16th meeting of the Eastern Mediterranean Regional Working Group on the GAVI Alliance

Cairo, Egypt
6–7 September 2009


World Health
Organization
Regional Office for the Eastern Mediterranean

Document WHO-EM/EPI/293/E/12.10/87

CONTENTS

.

1. INTRODUCTION

The 16th meeting of the WHO Eastern Mediterranean Regional Working Group on the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) was held in Cairo, Egypt, from 6 to 7 September 2009. The objectives of the meeting were to:

- review country progress in implementing the GAVI process (immunization services support [ISS], new vaccine introduction [NVI] and health system strengthening [HSS]) to reach goals
- identify weaknesses and gaps and recommended corrective measures
- agree on country-needed technical assistance to go ahead and adequately implement the GAVI process.

The meeting was attended by nationals representing immunization programmes and health system departments from Afghanistan, Djibouti, Pakistan, Somalia, northern Sudan, southern Sudan and Yemen–the GAVI support-receiving countries in the WHO Eastern Mediterranean Region. In addition the meeting was also participated by representatives from WHO headquarters, UNICEF Regional Office for the Middle East and North Africa, the WHO Regional Office for the Eastern Mediterranean and WHO and UNICEF country offices from some of the aforementioned countries. The programme and list of participants are given in Annexes 1 and 2.

The meeting was opened by Dr Nadia Teleb, Medical Officer, Vaccine-Preventable Diseases and Immunization, WHO Regional Office for the Eastern Mediterranean, on behalf of Dr Jaouad Mahjour, Director, Communicable Disease Control, and Dr Belgecem Sabri, Director Health Systems and Services Development, at the Regional Office.

In the lower-income countries in the Eastern Mediterranean Region, as in any other region, said Dr Teleb, financial constraints often impede the implementation of crucial health-related activities despite the best intentions of the respective governments. During the past few years of GAVI support, there had been remarkable achievements in the immunization programmes in almost all the countries receiving GAVI support in the Region. In 2008, the coverage with the third dose of DPT-containing vaccine increased in Afghanistan, Djibouti and northern Sudan compared to 2007. This coverage remained the same in Yemen and declined in Pakistan and Somalia.

All the countries in the Region eligible for GAVI support for new vaccine introduction had introduced hepatitis B and *Haemophilus influenzae* b (Hib) vaccines and were well on their way to introducing pneumococcal as well as rotavirus vaccines in the near future. Three out of the four countries receiving GAVI support which were required to co-finance the introduction of new vaccines have paid their share of the co-financing

scheme. Unfortunately, Pakistan had defaulted on its share, mainly because of procedural issues; however it is likely to come out of the default shortly.

There was increasing consensus among national health policy-makers and programme managers in the Eastern Mediterranean Region, especially in low-income countries, that health systems matter a great deal in achieving better health outcomes. Well functioning health systems were essential for the efficient and effective implementation of health programmes. By the end of 2005, GAVI had recognized that health system-related constraints also needed to be addressed. And in January 2008, the GAVI board decided that a share of GAVI resources would be devoted to investment in strengthening of health systems. This included addressing the issue of poorly motivated health workers, inadequate management skills and unpredictable financing in the periphery. Eligible countries in the Region were encouraged to use GAVI health system–strengthening funding to target the bottlenecks or barriers in health systems that impeded progress in improving the provision of and demand for immunization and other child and maternal health services. In all the eligible countries GAVI health system–strengthening support is complementary to and in coordination with the support of other development partners, and involves key stakeholders from civil society and representatives from marginalized groups (including hard-to-reach population groups) in joint efforts to strengthen the health system.

GAVI had adopted a transparency and accountability policy for cash-based support, which took effect as of 1 January 2009. The transparency and accountability policy outlined a set of minimum requirements for the financial management of GAVI health system–strengthening support. Funding should be used for objectives stated within a proposal and must be managed in a transparent manner. The Regional Office, in collaboration with concerned partners, was coordinating the provision of requested support to the policy requirements to achieve the objectives.

Dr Teleb acknowledged the coordinated efforts of all the partners in assisting the countries in strengthening their immunization programmes and health systems and strongly suggested that whenever international technical support was requested it must be linked with national capacity-building, so that the need for such support was gradually diminished and the country became more self-sustaining in technical issues.

2. BRIEFINGS

2.1 Update on accelerated vaccine introduction

Dr Susan Wang, WHO headquarters

For hepatitis B (hepB) and Hib, there was a 15-year delay between vaccine licensure in the developed world and vaccine introduction in developing countries.

WHO/UNICEF/GAVI changed the paradigm. Accelerated development and introduction plans provided focused support for vaccine introduction. In continuation of this effort, the accelerated vaccine introduction (AVI) project was formed in 2008. The AVI objectives are to assist all GAVI-eligible countries on making informed decisions regarding sustainable introduction of pneumococcal and rotavirus vaccines. By 2015, 42 pneumococcal and 44 rotavirus vaccines introductions in immunization programmes are targeted. AVI is organized into five interrelated work streams—ensure sufficient supply, generate informed country decisions, facilitate country introduction, secure financing and establish a platform for sustained use. Of the available pneumococcal vaccines, PCV7 (Prevnar, Wyeth) is WHO prequalified. PCV10 (Synflorix, GSK) has obtained marketing authorization from the European Medicines Evaluation Agency in April 2009; its WHO prequalification is pending. PCV13 (Wyeth) is to be submitted for prequalification in late 2009. Other products are possible in 2015 and beyond. Rotarix lyophilized (GSK) was prequalified in 2007, RotaTeq liquid (Merck) was prequalified in the last quarter of 2008 while Rotarix liquid (GSK) was prequalified the following quarter. Products are also expected from the Serum Institute of India, Bharat and Shanta in 2012 and beyond. By 2015 pneumococcal vaccine and rotavirus vaccine will make up 50% or more of GAVI's vaccine budget. The next steps include integration of vaccine implementation with other disease control strategies; assessing the Rotarix dosing schedule (2 doses or 3?); assessment of country-level cold-chain capacity for rotavirus and pneumococcal vaccines and corresponding capital purchases of cold-chain equipment; landscape assessment of country needs and initial planning for vaccines included in GAVI's Vaccine Investment Portfolio; HPV surveillance work; consulting work on human resources needs for India's Universal Immunization Programme; and supporting introduction in large countries.

2.2 Update on immunization and ISS-related activities in the Eastern Mediterranean Region

Dr Irtaza Ahmad Chaudhri, WHO Regional Office for the Eastern Mediterranean

Post-introduction evaluation (PIE) of pentavalent (DPT–HepB–Hib) vaccine was conducted in northern Sudan and Djibouti in 2009. WHO recommends PIE for countries which introduce a new vaccine. PIE focuses on the assessment of programmatic impact of introduction in areas of planning and introduction process, coverage and reporting, cold-chain and vaccine management, monitoring and supervision, training of health workers, waste management and injection safety, adverse events following immunization, advocacy, communication and acceptance by the community. The PIE is undertaken through desk reviews, discussions with stake holders and field visits to selected sites at different service delivery levels and vaccine storage facilities. PIE in northern Sudan was conducted in April 2009 by team of experts from the Sudanese Ministry of Health, WHO, and EPI in Afghanistan, Pakistan and Yemen. Northern Sudan introduced pentavalent (DPT–HepB–Hib), liquid 1-dose/vial vaccine in January 2008. The key recommendations for northern Sudan include: sustain the overall good performance attained using the

reaching every district (RED) approach, update denominator figures based on the finalized census, gradually establish a more fixed-site strategy and reduce mobile sites where possible, continue efforts to establish national immunization technical advisory groups (NITAG) for EPI and train health workers on interpersonal communications. Djibouti introduced pentavalent (DPT–HepB–Hib) vaccine, lyophilized 2-dose/vial vaccine in March 2007. PIE for Djibouti was conducted in May 2009 by a team of experts from the Djibouti Ministry of Health, WHO and the Centers for Disease Control and Prevention (Atlanta). The key recommendations for Djibouti were: a budget line for introduction of vaccines should be established, NITAG for EPI to be established, coordination among different units involved in EPI (EPI management, epidemiological surveillance and laboratory) to be improved and provision of refresher training to health workers.

Joint WHO/UNICEF/GAVI visits were conducted to Djibouti, southern Sudan, Somalia (in Nairobi) and Pakistan during January–August 2009 with the primary objective of having discussions with ministries of health and partners, on progress and issues related to GAVI support and suggestions for remedial actions including needs for technical assistance.

The comprehensive multi-year planning (cMYP) costing and financing tool was updated in February 2009 to version 2.2. The updated tool can be linked to the WHO Vaccine and Logistics Forecasting tool (EPI Log Forecasting Tool), has an option for calculation of co-financing and can considering target groups other than infants. Northern Sudan and Pakistan developed their cMYPs for next planning cycle in the third quarter of 2009. Yemen updated the same for its current duration for inclusion of rotavirus vaccine. Afghanistan plans to hold a workshop for developing the next cMYP in November 2009 in Kabul.

All countries applying for GAVI new and underused vaccine support (NVS) are required to co-finance GAVI-supported vaccines from the time of introduction. Four countries in the Eastern Mediterranean Region—Afghanistan, Pakistan, northern Sudan and Yemen—were required to co-finance the pentavalent vaccine in 2008. All except Pakistan made the required co-financing payment. Pakistan is therefore currently in default as per GAVI policy. Given the country’s commitment it is highly likely that it will come out of default shortly.

2.3 Update on global health systems support and civil society organizations

Dr Mounir Farag, WHO Regional Office for the Eastern Mediterranean

In all our eligible countries GAVI health systems support is complementary to and run in coordination with various development partners involving major key stakeholders from civil society organizations and representatives from marginalized groups (including hard-to-reach population groups) in joint efforts to strengthen the health system.

Well functioning health systems are essential for the efficient and effective implementation of priority health programmes. In addition, health systems should be accessible, equitable and be able to provide quality services to its users. Many countries in the Eastern Mediterranean Region are thus undertaking a wide range of organizational, management and financing reforms to improve the overall functioning of their health systems and to monitor their performance. The Regional Office conducts regular orientation sessions for WHO country representatives and country staff on health systems, including GAVI/HSS and Global Fund to fight AIDS, Tuberculosis and Malaria. Key partners such as UNICEF and the World Bank are coopted to support these meetings. Also the Regional Office now conducts regular health systems capacity-building courses for WHO and national staff. The Regional Office has a well institutionalized process for peer review of proposals.

One of the most important things to highlight is that the coordination and focal point for HSS is the same for different global health initiatives at WHO regional, country office and national ministry of health levels. This prevents fragmentation or duplication and maximizes the use of available resources, thereby reducing costs. In all joint missions and application development success was due to the same harmonized team at all levels for GAVI and Global Fund/HSS. A harmonized institutionalized collaborative spirit guided WHO's interactions with global health initiatives (GAVI, Global Fund and World Bank), based on experiences and lessons learned over the past three years of WHO–GAVI/HSS collaboration with civil society organizations and a year's WHO–Global Fund/HSS collaboration at country, regional and headquarters levels. The Regional Office achieved:

- regular GAVI joint missions according to the annual schedule set during the regional working group
- consultancy missions to countries to assist in the development of proposals and overcoming obstacles (such as the Regional Office's and deputy-executive of GAVI's mission to Afghanistan with the ministers of heath and finance and the vice-president)
- identifying HSS consultant for technical support
- establishing a regional working group HSS review for applications and annual progress report processes or other forms of peer review for draft proposals, to

ensure consistency with both GAVI and Global Fund requirements and WHO technical guidance

- sharing up-to-date GAVI and Global Fund information/guidelines received from the GAVI secretariat with country offices
- organizing GAVI and Global Fund parallel meetings during Regional Committee meetings and including GAVI and Global Fund related issues on the agenda of WHO Representatives meetings
- presenting best practices concerning GAVI and GF/HSS in particular on proposal development, integration and complementarities of global health initiatives
- Regional Office technical support
  - joint Regional Office and GF/HSS meeting
  - Global Fund and Global Fund/HSS Regional Office and countries' meeting (April)
  - technical support for application development: Somalia, southern Sudan, Afghanistan
- GAVI meeting with the GAVI (ISS and HSS)–eligible countries with ministers and their delegations in presence of the deputy-executive, GAVI secretariat
- Global Fund and GF/HSS meeting with eligible countries' ministers and their delegations.

Concerning GAVI/HSS support, it should be available for the duration of the national health sector plan (or country equivalent) or up until 31 December 2015, whichever is sooner. Countries whose GAVI/HSS support expires in 2009 may re-apply for GAVI HSS support in 2009. Any further applications for GAVI/HSS support after 2009 will depend upon the results of a mid-term evaluation taking place in 2009. If the National Health Sector plan expires in 2009, it is recommended to apply for GAVI/HSS support based on the subsequent plan (support of less than one year is not recommended for funding).

In 2009 the GAVI Alliance adopted a transparency and accountability policy for GAVI/HSS, which took effect as of 1 January 2009.The transparency and accountability policy outlines a set of minimum requirements for the financial management of GAVI/HSS support: funding to be used for objectives within proposal; funds must be managed in a transparent manner, and accurate and verifiable financial reports should be provided on a regular basis, as specified by individual funding arrangements; funds must be managed within accounts that meet national legal requirements for auditing, accounting and procurement; funds should be reflected in the national budget; funds should be additional to the government and partners allocation to the health sector.

The financial management assessment will focus on the following key areas: credibility of the budget; comprehensiveness and transparency of the budgeting process; policy-based budgeting; predictability and control in budget execution; accounting,

recording and reporting; and external scrutiny and audit. The findings of the financial management assessment will assist countries in identifying the best financing mechanism(s) to manage GAVI/HSS funds. Countries will be able to determine the timing of the financial management assessment, with the understanding that funds will not be transferred until the financial management assessment has been completed.

Implementation of GAVI/HSS supported activities will be monitored by GAVI through the annual progress report process. The report will provide information on progress in reaching targets set in the GAVI/HSS application form. The annual progress report will also provide financial management information on the use of GAVI/HSS funds. In countries where GAVI/HSS funds are channelled through joint financing mechanisms, the annual health sector report, including the annual joint financial report, should be attached to the GAVI annual progress report. The deadline for the submission is 15 May, all countries should submit an annual progress report, even if the GAVI/HSS support was received towards the end of the previous year.

2.4 Update on health system strengthening and civil society organizations

Dr Mounir Farag, WHO Regional Office for the Eastern Mediterranean

Situation of GAVI/HSS in Afghanistan, Pakistan, Sudan, Yemen

Country	Technical support	Total five year funds	Implemented	Approved
Afghanistan	WHO/EMRO +country office	34 100	First two years	Third year January 2010
Sudan	WHO/EMRO +country office	16 152	First year	Second year
Yemen	WHO/EMRO +country office	6 568	First two years	Third year
Pakistan	WHO/EMRO +country office	76 852 (only two years)	First year	Second year

Situation of GAVI/HSS in southern Sudan, Somalia and Djibouti

Country	Technical Support	Total five years fund	Approved	
Southern Sudan	WHO/EMRO +country office	13 953	September 2008	Waiting fund transfer
Somalia	WHO/EMRO +country office	11 561	Conditional June 2009	Submitted September 2009
Djibouti	WHO/EMRO NO EPI or HSS within country Second resubmission June 2009 rejected			

Civil society organizations: additional support to the GAVI/HSS window

To Afghanistan US$ 2426 was transferred through WHO (after a delay of more than one year) to let civil society organizations start implementation; to Pakistan US$ 4487 was transferred through UNICEF as per NHSCC advice to be under HSS, not in isolation; a mapping exercise costing between US$ 50 000 and US$ 100 000 for all countries is to be conducted at any time.

2.5 Update on GAVI policies

Dr Raj Kumar, GAVI secretariat

Key points highlighted.

- GAVI financial resources have diminished due to the international economic crisis. GAVI will have a fair idea of its resource envelop after the June 2010 board meeting.
- Countries will be provided with the funds/commodities for the GAVI support which is currently approved.
- GAVI basically supports poor countries.
- As of now, future vaccines (rubella, typhoid, human papilloma virus, Japanese encephelitis, etc.) will not be supported by GAVI due to financial constraints.
- self-procurement of pneumococcal vaccine will not be allowed because of an advance marketing commitment between GAVI and vaccine manufacturers.
- 10-dose vials of pentavalent vaccine, which needs less cold-chain volume, will be available next year. Afghanistan has already requested for conversion to 10-dose vials of pentavalent.
- GAVI will no longer accept applications for PCV7.

The current thinking on the revised eligibility criteria for GAVI is to continue its base on gross national income; however three possible scenarios are being considered:

status quo; gross national income less than US$ 1500; gross national income less than US$ 2000. The final decision in this respect will soon[1] be conveyed officially.

The rewards based on 2008 achievements will temporarily be withheld for the countries which have discrepancies between reported coverage and the WHO/UNICEF best estimate, till the time a mechanism for tackling these issues is agreed by the GAVI partners. The rewards based on 2008 performance for northern Sudan and Yemen, which have a disparity of 7% and 18% respectively in the reported and WHO/UNICEF best estimates, will thus be

Under the GAVI transparency and accountability policy, financial management assessments will be conducted in all GAVI support receiving countries. It will preferably be conducted first in countries which submitted new proposals and those with large volumes of GAVI support such as Pakistan and Nigeria.

A certified financial statement is mandatory for annual progress reports. For previous year transfers, audit reports are also required. All future applications for GAVI support will be submitted electronically.

3. COUNTRY UPDATES ON GAVI IMMUNIZATION SERVICES SUPPORT AND NEW VACCINE INTRODUCTION

3.1 Afghanistan

EPI Afghanistan received US$ 14.111 million under GAVI/ISS from 2004 to 2009. Out of this US$ 8.367 million has been used, and there is a balance of US$ 5.744 million. During 2008 (Afghan year 1387) the expenditures was on cold chain (43%), information, education and communication and social mobilization (14%), measles supplementary immunization activities (12%), training (11%), personnel (9%) and others (11%). DPT3 coverage increased from 83% in 2007 to 85% in 2008. The major activities carried out during 2008 were introduction of new vaccine (Hib) in the form of pentavalent (DPT–HepB–Hib) vaccine, immunization data quality self-assessment, national and regional EPI review workshops, integration of immunization services into health subcentres and mobile health teams, training of 120 new vaccinators and 800 EPI personnel, vaccine-preventable disease surveillance, measles genotyping, procurement of 10 walk-in cold rooms and other cold-chain equipment, construction of four buildings for EPI management teams, procurement of four vehicles and 10 sets of computers, and submission of application to GAVI for phase 2 ISS. A workshop for development of a

[1] The decision was conveyed in mid 2010 to the countries.

comprehensive multi-year plan for immunization will be held in November 2009. It is planned to introduce rotavirus vaccine from January 2011 and pneumococcal vaccine from January 2013. The key problems and challenges remain insecurity, weak participation of Basic Package of Health Services implementers in monitoring and supervision, low payments to health workers, shortage of transport, poor implementation of district microplans, and complicated procedures for accessioning the GAVI/ISS funds.

3.2 Djibouti

Out of total population of about 650 000, 15%–20% population is not stable. DPT3 coverage for 2008 was 89% while that for measles was 73%. A total of US$ 100 000 ISS funds were received from 2003 to 2007. These were used for equipment/cold chain (38%), transport (15%), personnel (14%), training (9%), supervision (9%), maintenance (8%) and social mobilization (7%). Cold-chain assessment was undertaken with the assistance of UNICEF. Primary health centres and regional vaccine stores in Djibouti are equipped with electrical refrigerators/freezers. Health posts in regions with little or no mains electricity are equipped with solar refrigerators. Djibouti applied for GAVI support for pneumococcal and rotavirus vaccine introduction in September 2009. According to GAVI, the application has not been received by the GAVI secretariat. Moreover the application was not supported by an appropriate comprehensive multi-year plan; even if received it could have not been put up by the GAVI secretariat for consideration by the GAVI independent review committee.

3.3 Pakistan

From 2002 to 2009 Pakistan was approved US$ 43.529 million under GAVI/ISS support. So far US$ 16.118 million has been disbursed to the country, with a balance of US$ 27.411 million outstanding. During 2008, a total of US$ 9.813 million from GAVI/ISS was available. Of this the total used was US$ 6.075 million, while US$ 3.738 million was carried over to 2009. The key areas of expenditure were personnel, procurement of vehicles and training. In December 2008 GAVI suspended disbursement of ISS funds on the basis of an article published in *The Lancet*. Later this suspension was lifted as per GAVI decision from all except seven countries, including Pakistan. As WHO has endorsed the reported DPT3 coverage, Pakistan's suspension has now been lifted. EPI has developed the PC1 document for 2009/10–2013/14 outlining the expenditure plan of US$ 25 million approved GAVI/ISS funds. The key areas under the PC1 are human resources, cold-chain capacity and operational expenses for outreach. EPI is still awaiting the transfer of US$ 1.811 million of GAVI new and underused vaccine grant as well as US$ 1.21 million requested from its second reward for supporting the immunization month in October 2009. The Pakistani government is committed to put in its share of co-financing of pentavalent vaccine. However as per agreement with GAVI the Pakistani government will procure its share of doses per Pakistani public procurement rules, by

September 2009 and will thus come out of default. The key problems in introduction of pentavalent vaccine were its non-registration in the country and thus delay in arrival as well as delay in training of the vaccinators because the GAVI new and underused vaccine grant was not available. Pakistan developed its comprehensive multi-year plan with Regional Office assistance in August 2009. The estimated cost per DPT3 per child for 2008 was estimated to be US$ 24.5. Pakistan applied to GAVI in the September 2009 round for a 2-dose pneumococcal vaccine to be introduced by January 2011 and plan to introduce rotavirus vaccine in 2013.

EPI Pakistan target figures are generally known to be over-projected. Federal EPI has initiated a process in consultation with the National Institute of Population Studies (NIPS) to produce a more rational target.

3.4 Northern Sudan

During 2008 northern Sudan received US$ 235 500 as GAVI/ISS funds, which was fully spent. In addition US$ 400 000 GAVI/HSS funds was used for EPI. The areas supported by this amount were: personnel (45%), transportation (40%), supervision (8%), cold-chain equipment (3%) and other (4%). The DPT3 coverage in 2008 was 92%; however there was a noticeable drop in coverage in 2009 primarily because of non-availability of GAVI funds. Sudan was eligible for US$ 1 794 500 as rewards for 2007, which has not been received yet. The remaining penta lump sum support (new and underused vaccine grant) of US$ 276 158, and the rewards for achievement of 2008 are still awaited. WHO, UNICEF and other partners are currently supporting a major part of the funding gap. A post-introduction evaluation for pentavalent vaccine was undertaken in April 2009. A national immunization technical advisory group was established in June 2009. The comprehensive multi-year plan was updated for 2010–2014. Estimated cost per DPT3 child increased from US$ 28 in 2008 to US$ 68 in 2011. Applications to GAVI were submitted in the September 2009 round for introduction of rotavirus vaccine in June 2010 and PCV10 vaccine in Jan 2011. Rotavirus surveillance network helped in making the decision to introduce rotavirus vaccine before PCV since the latter has limited local data. The new and underused vaccine grant for the introduction of both vaccines is crucial for good preparation and smooth introduction. The co-financing for 2009 of pentavalent vaccine will be finalized in October 2009. The application for yellow fever vaccine, to be introduced in some states, will be submitted in the near future. The main challenges are delay in transfer of GAVI/ISS funds, ensuring co-financing and reaching hard-to-reach populations, particularly in the war-affected areas. EPI Sudan aims to ensure sustainability of achievements, sustain a budget line for immunization in the national government budget and undertaking national immunization coverage survey. The HSS money for EPI is flexible and can be used according to the priority needs of EPI.

3.5 Southern Sudan

Southern Sudan received first tranche of GAVI/ISS amounting to US$ 1 019 125 in 2007. US$ 586 293 was used, starting in April 2008, while the balance of US$ 432 832 was carried over to 2009. The main areas of use of the funds were: cold-chain operations (25%), outreach and supervision (25%), training (17%), transportation (19%) and other (14%). The DPT3 coverage in 2008 was 26% with a drop-out rate of about 45%. EPI policy has been prepared with the support of partners and has been endorsed by the government of southern Sudan. Job descriptions for EPI staff have been prepared. Social mobilization focal points have been trained in eight out of 10 states. The main obstacles for accessible services are related to infrastructure and lack of trained human resources in addition to climatic conditions. As there is lack of guidance from GAVI regarding a financial flow system there is low use of budget. There is a high need for continuation of GAVI financial support and technical assistance from partners for in country capacity-building.

3.6 Somalia

The most recent tranche of GAVI/ISS funds amounting to US$ 229 987 is being released. The DPT3 coverage in 2008 is estimated to be around 30%. In the absence of a functioning government in the majority of the country, the health system, like other entities, is near collapse. The nongovernmental organizations are trying to provide the services but the coverage area of services provided by them is limited. The EPI structure is minimal, with little capacity. The strategy to boost immunization coverage is to increase the fixed sites to 220, implementation of the reach every district approach, mobile vaccinations in difficult to reach population and undertaking child health days. EPI activities use the poliomyelitis vaccination campaign structure. The child health days are undertaken every six months and last five days. The DPT1 coverage during the first round of child health days was 61% and 84% for measles. With the technical assistance of the Regional Office, a comprehensive multi-year plan has been developed for the period 2008–2010. In 2007 the main financier of the routine EPI services were UNICEF, WHO and about 38 nongovernmental organizations, including Somalia Red Cresent Society (SRCS), which contributed 39%, 20% and 32% of routine immunization costs, respectively. The remaining was covered by subnational governments in the north-east and north-west. Technical assistance is required to update the comprehensive multi-year plan, develop proposals for GAVI/ISS and document the achievements of the child health days.

3.7 Yemen

Routine immunization coverage for DPT3 during 2008 was 87%, with 34% of districts reaching 80% or above. The DPT3 coverage for the first half of 2009 was 86%.

About one-third of the immunizations provided are through outreach. The DPT3 coverage of 2009 is expected to reach at least the previous year's figure, since two immunization rounds are still left. Otherwise, a third round could be considered. The low use, of about 22%, of GAVI/ISS funds was mainly because of undertaking activities in 2007 and 2008 with planned budget from other resources, including from the World Bank, which left limited time. The main areas of GAVI/ISS funds use in 2009 will include training on mid-level management at all levels, refresher training of all vaccinators (about 3500), integrated supervision, purchase and installation of 13 new cold rooms, advocacy and social mobilization. The national immunization technical advisory group, which was established in 2008, was restructured according to WHO guidelines in July 2009. It is estimated that 43% of diarrhoeal diseases in Yemen are due to rotavirus. The current comprehensive multi-year plan was updated in August 2009 to incorporate rotavirus vaccine. The work on a new comprehensive multi-year plan for 2011–2015 will begin in the last quarter of 2009.Application for GAVI support for introduction of rotavirus vaccine from mid-2010 was submitted for consideration in the September 2009 round. The pneumococcal vaccine (PCV10), which is already approved by GAVI, will be introduced from the beginning of 2010. As planned, training of health workers, including training on surveillance of adverse effects following immunization, will be undertaken before introducing PCV. An introductory grant of US$ 257 000 for pneumococcal vaccine has been received. The pre introduction activities will be undertaken as planned. The government of Yemen is committed to pay its share of co-financing of all GAVI-supported vaccines. The co-financing share of pentavalent vaccine for 2009 will be paid by the government of Yemen before the end of 2009.

4. GENERAL POINTS DISCUSSED/AGREED

During the discussion the following major points were highlighted.

- The additional cold chain capacity available, if new formulation of vaccine requiring less storage space is introduced, should be considered to store vaccines like that against H1N1.
- Some countries are delaying introduction of pneumococcal vaccine based on available surveillance data. Surveillance data, which reflect a low isolation rate of pneumococcus, should be interrupted with caution to avoid underestimating the true burden of pneumococcal disease as a result of the difficulty of isolation of this organism. As per the recommendation of a WHO position paper on pneumococcal vaccine, countries with high infant and child mortality should consider introduction of pneumococcal vaccine a high priority. Therefore eligible countries are urged to consider earlier introduction of pneumococcal vaccine.
- Both types of rotavirus vaccines give comparable results with no significant difference in effectiveness.

- Though the single-dose vaccines have less wastage, the associated transport and cold-chain space requirements should be considered when planning introduction of single-dose vaccines.
- In view of the open vial policy, it is important to train health workers and monitor programmatic issues when using 2-dose vial PCV vaccine without a preservative.

5. RECOMMENDATIONS

5.1 General

1. Countries are requested to share draft annual progress reports with the core regional working group. The annual progress report for 2009 should be shared with the core regional working group by 10 April 2010. (Date for submission to the GAVI secretariat is 15 May 2010.)
2. Countries are also requested to consult with the regional working group in preparation of the new applications for GAVI support and prepare the applications and related documents in consultation with country-based partners (where applicable). These should preferably be shared with the core regional working group *at least one month* before the closing date for feedback.

5.2 Afghanistan

3. Should convene a workshop for development of the next comprehensive multi-year plan in November 2009.
4. Should ensure co-financing in order to continue receiving new vaccines, including future support for rotavirus and pneumococcal vaccines.

5.3 Dijibouti

5. Should work closely with the core regional working group for GAVI applications to avoid unfruitful efforts, because of not fulfilling the GAVI requirements.
6. Should get technical assistance for development of a comprehensive multi-year plan, establishment of laboratory-based surveillance and data management.

5.4 Pakistan

7. As Pakistan is currently considered to be in default regarding co-payment of its share for pentavalent vaccine under GAVI Co financing policy, it should provide evidence to the GAVI secretariat and core regional working group regarding procurement of the vaccine out of the government of Pakistan’s funds to be declared as out of default.

5.5 Sudan

8. Considering that there will be a decrease in GAVI/ISS funds in coming years (likelihood of fewer children to be reached and reported) should work extensively for alternate financing strategy. More reliance should be made on government funding.
9. Should consider use of HSS funds for immediate EPI operational needs to cover the shortage of funds.
10. Should resend the letter to GAVI secretariat for consideration to pay the balance amount of new vaccine grant for pentavalent vaccine introduction based on calculations of US$ 0.30 per child in the birth cohort in accordance with the updated GAVI policy for Introduction Grant for new vaccines introduction.

5.6 Southern Sudan

11. Should make all efforts to increase routine immunization coverage. Should consider alternate strategies such as acceleration campaigns besides routine immunization.
12. Should undertake operational research to tackle the increasing drop-out rate. Should request technical assistance if required.

5.7 Yemen

13. A comprehensive multi-year plan should be developed for 2011 onwards by the national team with assistance of the WHO EPI medical officer for Yemen.
14. In submitting applications to GAVI for support, Yemen must consider other funds from other sources if available for the same purpose to avoid duplication of resources which ultimately lead to underutilization of funds either of GAVI or other donors.

5.8 Somalia

15. Should document the achievements of the child immunization days with Regional Office support.
16. Should undertake operational research (as part of HSS) for increasing coverage.

5.9 GAVI secretariat

17. Should facilitate transfer of funds wherever pending, particularly new vaccine grant to Pakistan, rewards for 2007 to northern Sudan and HSS to Somalia.
18. Should provide new vaccine grants to countries in good time for use as per approved plans.

19. The GAVI financial management assessment missions should include WHO and UNICEF nominees from Regional and/or country offices (if within GAVI principles).
20. Should to provide clear directions regarding the calculation of ISS rewards i.e. reported versus WHO-UNICEF best estimates.
21. Should reconsider raising the ceiling of ISS rewards where a country has already achieved high coverage.
22. The regional working group should invite a GAVI financial representative to participate in next regional working group meeting to respond to an increasing number of questions regarding GAVI funds from the countries.

5.10 Key recommendations for HSS

23. Based on the new global orientation for one integrated HSS based on the national health plan preventing fragmentation or duplication and maximizing the use of available resources, countries should adopt this new approach and convey their needs for technical support and funds allocation to apply for such assistance.
24. Available funds should be reallocated to promote operational and health systems research.
25. Documentation of good practice and evidence-based health systems should be strengthened, scaling up primary health care service provision and encouraging periodic publication in the *Eastern Mediterranean health journal* and the health systems observatory web site.
26. Demonstrate how HSS makes a difference, focusing on the situation of hard-to-reach populations and building the capacity of lower-level health systems.
27. Countries have to communicate their need concerning financial management in line with the transparency and accountability policy and financial management assessment plan, so as not to delay next fund approval and transfer.
28. There should be better coordination with the Regional Office for the annual progress report on HSS and the civil society organization component to be sent on time (May) for review by the core group before final submission to the GAVI secretariat.
29. Countries having small amounts of allocated HSS funds (Djibouti) have to advocate through their ministries of health addressing GAVI and other global health initiative donors for additional HSS funds to ensure sustainability of technical support
30. Regional and intercountry HSS capacity-building workshops should be organized for country staff, WHO and partners.
31. HSS capacity-building workshops are oriented towards development and assessment of national health strategies (policies, strategic plans, health system management, health system performance). So countries have to communicate their needs to build the capacity of health system focal points at national and subnational levels.

32. Pakistan should report as soon as possible the situation for the second part of the US$ 6 million it plans to utilize through PC1 and when to plan for the new application for HSS development for the next 3 years.
33. Yemen should support the same recommendations as for the EPI.
34. Djibouti should use communication channels through the Regional Office. It has requested support for HSS resubmission using the US$ 50 000 and conducting fund-raising for sustainable HSS technical support.
35. Southern Sudan: GAVI/HSS preparation for implementation as funds will be released soon (there is currently no HSS technical officer in office).
36. Somalia should prepare for financial management assessment and funds to be channelled through WHO and UNICEF.

Annex 1

PROGRAMME

Sunday, 6 September 2009

09:30–10:00	Registration	
10:00–10:30	Opening Session:	
	• - Opening remarks	*Dr Nadia Teleb*
	• - Adoption of the Agenda	*WHO/EMRO*
	• - Introduction of the participants	

Session 1: Briefings

10:30–10:50	Update on the WHO work plan and AVI issues with regards to pneumococcal and rotavirus vaccines	*Dr Susan Wang WHO/HQ*
10:50–11:10	EMR update on immunization and ISS	*Dr Irtaza Chaudhri WHO/EMRO*
11:10–11:30	Discussions	
12:00–12:20	Update on Global HSS and CSO	*Dr Patrick Kadama WHO/HQ*
12:20–12:40	Regional update on HSS and CSO	*Dr Mounir Farag WHO/EMRO*
12:40–13:00	Discussions	
13:00–13:20	Update on GAVI policies	*Dr Raj Kumar GAVI Secretariat*
13:20–13:50	Discussion	

Session 2: Country updates

14:50–15:40	Yemen	*National EPI Manager/ National HSS Focal Person*
15:40–16:20	Pakistan	*National EPI Manager/ National HSS Focal Person*

Monday 7 September 2009

09:30–10:20	North Sudan	*National EPI Manager/National HSS Focal Person*
10:20–11:10	Southern Sudan	*National EPI Manager/National HSS Focal Person*
11:40–12:30	Afghanistan	*National EPI Manager/National HSS Focal Person*
12:30–13:20	Somalia	*National EPI Manager/National HSS Focal Person*
14:20–15:10	*Djibouti*	*National EPI Manager/National HSS Focal Person*

Session 3: Closing

15:10–16:00	Action points and wrap up	*WHO/EMRO*

Annex 2

LIST OF PARTICIPANTS

AFGHANISTAN
Dr Gula Khan Ayoub
Deputy National EPI Manager
Ministry of Public Health
Kabul
E-mail: gulakhanayoub@yahoo.com

Dr Najla Ahrari
Deputy National HSS Officer
Ministry of Public Health
Kabul
E-mail: najlaahrari@gmail.com

DJIBOUTI
Mr Ibrahim Barreh Adaweh
Director of Health Region
Ministry of Health
Djibouti
E-mail: Adaweh3@gmail.com

Mr Abdallah Ahmed Hade
National EPI Coordinator
Ministry of Health
Djibouti
E-mail: abdallahhade@yahoo.fr

PAKISTAN
Dr Altaf Hussain Bosan
National Programme Manager
Expanded Programme of Immunization
National Institute of Health
Islamabad
E-mail: altafbosan@gmail.com

SUDAN
Dr Mustafa Salih Mustafa
Assistant Under-Secretary for Planning, Policies and Research
Federal Ministry of Health
Khartoum
E-mail: mustafa.sm@fmoh.gov.sd

Dr Eltayeb Ahmed Elsayed
MCH National Director
Federal Ministry of Health
Khartoum
E-mail: eltayebelsayed@hotmail.com

Dr Amani Abdelmoneim Mahmoud
National GAVI Adviser
Federal Ministry of Health
Khartoum
E-mail: amanisara2000@yahoo.com

Dr Sara Hassan Mustafa
Director of Planning Unit
GAVI/HSS Coordinator
Federal Ministry of Health
Khartoum
E-mail: hsarra@gmail.com

Mr Kornelio Mawien
Deputy National EPI Manager
Ministry of Health/GOSS
Juba
E-mail: mawienus@yahoo.com

YEMEN
Dr Mohammed Ahmed Al Emad
Director of Child Health Department
Ministry of Health
Sana'a
E-mail: emad_epi@yahoo.com

Dr Essa Mohammed Essa
National EPI Manager
Ministry of Health
Sana'a
E-mail: eissa_mohd@yahoo.com

OTHER ORGANIZATIONS

GAVI Alliance
Dr Raj Kumar
Senior Programme Officer, Country Support
GAVI Alliance Secretariat
Geneva
SWITZERLAND

United Nations Children's Fund (UNICEF)
Dr Mahendra Sheth
Regional Health Adviser
UNICEF/MENARO
Amman
JORDAN
E-mail: msheth@unicef.org

Dr Moktar Omar Ahmed
Child Survival and Development Specialist
UNICEF Djibouti
Djibouti
DJIBOUTI
Email: mahmedomar@unicef.org

Dr Romanus Mkerenga
Chief, Health and Nutrition
UNICEF Southern Sudan
Juba
SUDAN
Email: rmkerenga@unicef.org

Mr Jones Itombra Okoro
Immunization Specialist
UNICEF Southern Sudan
Juba
SUDAN
Email: jokoro@unicef.org

WHO SECRETARIAT

Dr Nadia Teleb, Medical Officer, Vaccine Preventable Diseases and Immunization, WHO/EMRO
Dr Mounir Farag, Acting Regional Adviser, Health Management Support, WHO/EMRO
Dr Irtaza Ahmad Chaudhri, Technical Officer, Vaccine Preventable Diseases and Immunization, WHO/EMRO
Dr Abdallah Sid Ahmed, Technical Officer, Health Management Support, WHO/EMRO
Dr Nasrin Musa, Technical Officer, Vaccine Preventable Diseases and Immunization, WHO/EMRO
Dr Susan Wang, Medical Officer, IVB/EPI, WHO headquarters
Dr Patrick Kadama, Scientist, HSS/HDS, WHO headquarters
Dr Ashfaq Ahmed, Technical Officer, Health Systems Strengthening, WHO Afghanistan
Dr Abdul Shakoor Waciqi, National EPI Officer/GAVI Adviser, WHO Afghanistan
Dr Assegid Kebede, Technical Officer, Expanded Programme for Immunization, WHO Somalia
Dr Hamayun Rizwan, Medical Officer, Primary Health Care, WHO Somalia
Dr Ehsanullah Tarin, Medical Officer, Public Health Care, WHO Sudan
Dr Mohamed Osama Mere, Medical Officer, Expanded Programme for Immunization, WHO Yemen
Dr Osama Eisa Salama, Temporary Adviser, WHO/EMRO
Mr Mohamed Abdel Mohsen, Help Desk Assistant, WHO/EMRO
Mrs Zeinab Aboul Fadl, Senior Secretary, Division of Communicable Disease Control, WHO/EMRO
Ms Heidi Rizk, Secretary, Division of Communicable Disease Control, WHO/EMRO