# Vaccine Access Investment Monitoring Report

## Description

Australia's COVID-19 vaccine support for Indo-Pacific countries is summarised below.

| Program | Period | Funding |
|---|---|---|
| Regional Vaccine Access and Health Security Initiative (VAHSI) | FY20-21 to FY22-23 | 523.2m |
| Quad Vaccine Partnership (Southeast Asia only) | FY21-22 | 100m |
| COVAX Advance Market Commitment[1] | FY 2020-21 & FY 2021-22 | 215m |
| Bilateral funding contributed to VAHSI delivery support agreements (Vietnam, Laos) | FY20-21 to FY21-22 | 8.18m Vietnam<br>1m Laos |

This report covers VAHSI activities from 1 January to 31 December 2021 and bilateral and Quad funds programmed in 2021 (from July at the earliest). Bilaterally funded activities are rolled in with VAHSI unless otherwise specified. Australia's contribution to vaccine doses supplied through COVAX Advance Market Commitment (AMC) in 2021 is also reported.

2021 was characterised by intense global demand for COVID-19 vaccines, uncertainty regarding the regulatory approval of vaccine types and severe supply constraints. Accessing vaccines was a high priority for our regional partners. In 2022, vaccine supply exceeds demand, and there is a greater donor focus on 'the last mile' – strengthening national delivery support systems to increase the reach of vaccine coverage and strengthen immunisation systems for future pandemics.

VAHSI is a 3-year initiative designed to support equitable and inclusive access to COVID-19 vaccines tailored to need and supported by access to Australian technical expertise. It is implemented in the Pacific - Fiji, Kiribati, Nauru, PNG, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu and Timor-Leste (TL), and Southeast Asia (SEA) - Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand and Vietnam. s 33(a)(iii)

VAHSI aims to support comprehensive coverage in the Pacific and Timor-Leste while contributing to vaccine needs in Southeast Asia.[2]

Australia's COVID-19 vaccine access support comprises three components:

1. **Vaccine access:** delivery of doses from Australia's supply and through a regional vaccine procurement partnership with UNICEF. Between August 2020 and June 2021, Australia also contributed $130m to COVAX AMC.
2. **Delivery support:** assistance for partner countries to roll out their COVID-19 vaccination programs in response to their needs and priorities, including technical advice and end-to-end

[1] COVAX AMC is a global initiative to provide equitable access to COVID-19 vaccines in 92 low and middle-income countries.

[2] VAHSI Strategic Investment Framework Pg3.

support (such as facilitating regulatory and policy systems, vaccination surge capacity, public communication campaigns, and providing cold chain and other logistics capacity). Activities are delivered by managing contractors, multilaterals (WHO, UNICEF, WB), TGA, NCIRS and NGOs.

3. **Regional health security architecture**: VAHSI is contributing funding to the ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED $21m) to establish a health security architecture for Southeast Asia to prepare for and respond to future pandemics. Activities are expected to commence in 2022.

The VAHSI Performance Assessment Framework (PAF) is annexed to this IMR. In November 2021, the Aid Governance Board (AGB) decided that Quad outcomes and bilateral activities that funded VAHSI delivery support would be covered by the VAHSI PAF. The VAHSI PAF includes three End of Program Outcomes (EOPOs), with six intermediate outcomes (IOs).

## Effectiveness

**Rating: 5 - Good**

VAHSI (and Quad) have been effective investments during the reporting period and are on-track to achieve (fully or partially) the IOs and EOPOs.

**EOPO1: Partner governments expand COVID-19 vaccine coverage**

By 31 December 2021, across the Pacific and TL (10 countries), 68% to 2.5% of the total population had completed their primary course of COVID-19 vaccination. DFAT assessed 5 countries on track, 3 with less than adequate coverage and 2 off track.[3]

In SEA (8 countries), 24% to 82% of total population completed their primary course of COVID-19 vaccination in 2021. DFAT assessed 4 countries on track (50%) and 4 with less than adequate coverage.

**IO1** DFAT **engaged actively with countries to meet their vaccine needs**. No targets were set for 2021, given the high level of uncertainty and rapidly changing supply and demand. DFAT aimed to supply 19m doses (13m Australian shared doses and 6m through our UNICEF partnership). By December we had donated 15.1m doses: 12.8m from our supplies and 2.3 million through UNICEF. UNICEF procured shipments were delayed, thus we reached 19m by early February 2022.

In the Pacific and TL, we were the largest bilateral donor of vaccines, providing 2.5m doses from our own supply – approx. 47% of total doses donated. We offered countries up to 15m doses which allowed their planning with guarantee of supply.

Australia was the 8th largest vaccine donor to SEA in 2021, having donated 12.6m doses to 5 countries - approx. 1.6% of total doses donated. 10.3m were from our own supply, and 2.3m via UNICEF procurement. Our vaccine donations to SEA mainly occurred in late 2021, consistent with Government direction that prioritised supply to the Pacific and Timor-Leste.

Australia contributed approx. 0.92% of total donor funds to COVAX AMC's vaccine procurement and distribution. It distributed 832.3m doses globally, including 184.3m doses to VAHSI partner countries.

[3] Regional Vaccine Access Update Placemat, 5.1.22

**IO2** Australia supported COVID-19 vaccination **policy and regulatory oversight** and strengthened **pharmacovigilance** (11 countries) through NCIRS and WHO; and n**ational vaccine planning** and **immunisation guidelines** including **priority and at-risk groups** through NCRIS and UNICEF (9 countries).

With TGA, we supported **timely regulatory approval** of COVID-19 vaccines – however, only 5 of 14 countries initially identified by TGA sought support.

**IO3** Australia supported partner health authorities to strengthen **accessible and safe national vaccine delivery** through:

- **Support for domestic vaccine delivery systems –** surge capacity, vaccination management, logistics and stock management, vaccination data systems and mobile clinics.
- **Provision** of equipment and consumables to support rapid rollout of vaccine campaigns – included 6,700 pieces of equipment – cold storage equipment, warehouse equipment, vehicles, computers, and tablets, and 18 million consumables (syringes, PPE etc.)
- **Strengthened capacity for vaccine delivery, regulatory and communications -** improved skills were used to strengthen national vaccine campaigns. A total of 141,000 people: 132,000 in SEA and 9,000 in the Pacific/TL were trained.

**EOPO2 Target populations access vaccination in accordance with national planning priorities**

**IO4** - VAHSI supported communication strategies to **address vaccine hesitancy and misinformation**, and **community engagement**. Overall, Australia funded vaccine messaging in 11 partner countries that:

- reached 312m people (one-directional) through television, social media and other media. Reach varied across countries. Data on changed behaviours is not yet available.
- engaged 543,000 people (bi-directional) through targeted community forums, social media exchanges, with some evidence of increased uptake.
- enabled 1m people to use community feedback mechanisms.

**EOPO3 Australian support for the COVID-19 vaccination program is valued.**

Australia contribution to partner governments' vaccination efforts was highly valued. Partner governments at senior levels acknowledged this support in public and private discussions. Partners acknowledged Australia's responsiveness to their evolving needs.

**IO5** - Australia was influential in support for vaccine access - engaging at **national, regional** and **global** levels. As GAVI Board Vice-Chair, Australia advocated successfully COVAX AMC vaccine dose allocations to be broadened so as not to disadvantage Pacific countries. Australia worked with NZ, US, Japan, France, Gavi, UNICEF and WHO to maximise Pacific vaccine access and delivery support.

**IO6** – Posts and CHS communicated effectively through social and traditional media to give prominence to Australia's vaccine access support.

## Efficiency

**Rating: 4 - Adequate**

Australia's vaccine access initiatives were designed to meet an urgent need in our region for vaccines and delivery support. DFAT has navigated a complex and fast-changing situation: vaccine supply, demand and epidemiological factors, and coordination with a broad range of partners. Our response has had a high profile within Government, with ministers closely involved in program decisions.

**Budget Management**

There are **complex arrangements to manage the budget**. CHS coordinates the overall budget while country teams manage country delivery support budgets. Southeast Asia Maritime Division (SMD) oversees the Quad contribution. Ministerial approval was required for a range of programming decisions. While it helped mitigate risk and meant existing relationships in-country could be leveraged, the split of financial delegation, spending and program management coupled with challenges forecasting costs led to heavy contracting and program management loads at Posts and some delays programming funds. Despite constraints, CHS staff fed back that the **system generally works well.**

By 31 December 2021, we had expended 64.1% (~$384.8m) of the total VAHSI and Quad allocations, including $276.1m to UNICEF for procurement over the program's life. This excluded departmental funding of $23.2m allocated over 2020-23.

Country-level budget commitments were agreed upon early in the program's development and announced publicly. Amending these given difficulties programming funds (for example, in PNG, where we encountered implementing partner capacity constraints, or in Myanmar, where broader policy settings constrain our engagement) has been difficult.

**Delivery modality**

CHS provides overall management, including managing global (UNICEF), regional (UNICEF Pacific) and domestic contracts - TGA, NCIRS and contracts for vaccine delivery logistics. Posts manage in-country partnerships, with CHS, SMD and Office of the Pacific (OTP) support. In liaison with CHS, geographic divisions and partner governments, Posts **selected partners** that best met each country's context and needs. Several Posts noted the value of the AETAP partners' (NCIRS, TGA) and CHS in-house **technical expertise**. This model drew on the range of skills and relationships across DFAT and Australian agencies.

DFAT manages the delivery of vaccines from Australia's supply through contractual arrangements with Palladium. This was an intentional and appropriate decision, given the profile and priority of Australia's vaccine supply efforts, the premium placed on responsiveness to partner countries' needs, and the need to engage at the highest levels with the Department of Health and Vaccine Taskforce. Government decisions directed our approach.

Direct management of requests and delivery of vaccines and consumables required significant work and coordination for DFAT staff in Canberra and at Post. CHS engaged logistics expertise and had systems in place by the end of 2021 for efficient deliveries. CHS established weekly meetings to recommend vaccine allocations to the Minister, efficiently manage geopolitical competition for vaccines and reduce delays.

**Partner alignment**

A fundamental principle in the design of individual VAHSI and Quad country activities was alignment with **partner government national vaccine plans**. Australia made offers of doses to the region and responded to partner requests as they were received. Global supply constraints led to delays in dose provision, particularly to partners in SEA.

DFAT coordinated its vaccine dose-sharing plans, policy and regulatory advice and delivery support with other donors in an increasingly crowded space and, where possible, sought to deliver through existing actors (e.g., UNICEF) or leverage in-country partnerships. In countries with no health sector

engagement/footprint, this approach helped expedite efforts to re-establish Australia in the sector and ensure alignment.

Australia chairs a delivery support working group in the Quad Vaccine Partnership and convenes a regular coordination mechanism with the US, Japan, NZ, Gavi, UNICEF, and WHO on dose deliveries to the Pacific.

**Monitoring, evaluation and learning (MEL)**

The design of the MEL system reflects the investment value and complexity. The program logic, PAF, partner MEL systems, and reporting are connected at the country level through tailored MEL frameworks.

Performance reporting for 2021 has been resource-intensive and impacted by delays in partner reporting. Feedback suggests the MEL system could be streamlined, and in 2022 CHS will work on refining the VAHSI MEL systems.

## Gender Equality

(3,921 /4,000 Characters)

| | |
|---|---|
| **Overall** | 3 - Less than adequate |
| Analysis of gender equality gaps and opportunities substantially informs the investment | 3 - Less than adequate |
| Risks to gender equality are identified and appropriately managed | 3 - Less than adequate |
| The investment is making progress as expected in effectively implementing strategies to promote gender equality and women's empowerment | 3 - Less than adequate |
| The M&E system collects sex-disaggregated data and includes indicators to measure gender equality outcomes | 3 - Less than adequate |
| There is sufficient expertise and budget allocation to achieve gender equality related outputs of the investment | 4 - Adequate |
| As a result of the investment, partners increasingly treat gender equality as a priority through their policies and processes | 3 - Less than adequate |

The VAHSI design recognised that COVID-19 has **amplified gender inequalities** and profoundly impacted women and girls. Failure to consider and address gender inequality impacts vaccine uptake and access. The VAHSI SIF conducted a literature review to inform a gender analysis of vaccine access which included an analysis of gender barriers and norms of vaccination programs. Our approach to gender equality recognised risks such as the potential for inequitable vaccine access, that vaccine services are not seen as safe for all, and that women face barriers to access vaccines and appropriate information.

We developed a **GEDSI strategy** to guide implementing staff and partners. The GEDSI Strategy focuses on inclusive recovery, facilitating meaningful participation and ensuring no one is left behind. The GEDSI Strategy was finalised in January 2022, by which point many activities had already commenced. While a few partner proposals were reviewed to assess strategies to promote gender equality, most were not. In 2022, projects have been reviewed.

Posts engaged strategically and practically with **implementing partners (NGOs, bilateral programs, UNICEF, WHO)** to support and strengthen their work to advance gender equity, access and inclusion. In contrast, we engaged on gender equality issues with only a few partner governments. There is **little sex-disaggregated training and recruitment data** available. Where data is available, most health workers trained were female (e.g., in Fiji - 81% female).

DFAT supported partners to strengthen gender equality as follows:

- National vaccine authorities (4 countries) received and used technical guidance to assess, authorise and provide public information on vaccination for **pregnant and lactating women.** Communication advice designed to counter vaccine misinformation on the impact of vaccines on fertility was also provided. E.g., in Thailand, vaccination of pregnant women had increased by 60% post-campaign.
- Communication campaigns were developed and delivered by UNICEF and other partners through social media, radio, TV etc. Social media analytics in Vietnam demonstrated that while only 41% of those reached with messages were female, **58% of people engaged in vaccination awareness campaigns were female**. Vietnam was one of few countries that provided sex-disaggregated data for those engaged in communication campaigns via the Vietnam UNICEF Country Office.
- VAHSI through partners (WHO, Beyond Essential Systems), strengthened partner government systems to collect real-time vaccine data, including **sex-disaggregated data** (Fiji, Timor-Leste, Samoa, Tonga, Laos). While available data demonstrated equal access between women and men, data is insufficient to determine access of specific groups, e.g. LGBTQ+, young women planning a pregnancy.
- Community events and house-to-house visits were **designed to support increased vaccination of women** (e.g., in Timor-Leste, Vietnam, PNG, Fiji). This approach enabled women who found it difficult to leave home to access information and vaccines.
- Health workers/volunteers organised women-only meetings to address vaccine misinformation (e.g., in PNG, Fiji, and TL)**.**

Implementing partners recruited **female health workers/volunteers** to support women's vaccination, with volunteers primarily being women in some countries (e.g., Fiji, 65% female). However, while volunteers have benefitted from additional skills and recognition for their role, they also faced challenges (frustrated public, long hours, risk of COVID-19). Partners are identifying ways to mitigate these challenges.

The VAHSI PAF and country MELFs **indicators measure key gender outcomes** – related to policy, delivery, and training. Indicators include sex-disaggregated data where applicable. CHS reviewed some partners' MELFs and reports and provided feedback to strengthen monitoring of gender equality – particularly the need to improve reporting of gender outcomes and provide sex-disaggregated data.

VAHSI draws on expertise to support gender equality and women's empowerment. CHS country focal points, with the Gender Adviser and MEL team, provide partners with feedback on reporting.

Few partner proposals included information on how they would promote and report on gender equality. Only 50% of partners had information on how women benefitted or provided sex-disaggregated data in their 2021 reports. CHS will continue to work with partners to strengthen strategies and report progress toward gender equality. Our opportunity to influence has been limited as VAHSI is delivered through other agencies.

## Disability

| | |
|---|---|
| **Overall** | 3 - Less than adequate |
| The investment actively involves people with disabilities and disabled persons' organisations in planning, implementation and monitoring and evaluation | 3 - Less than adequate |
| The investment identifies and addresses barriers to inclusion and opportunities for participation for people with disabilities to enable them to benefit equally from the aid investment | 3 - Less than adequate |

The VAHSI design and the VAHSI GEDSI strategy highlighted the barriers people with disabilities face in accessing health services, including immunisation programs, and the disproportionate impact of the pandemic on people with disabilities. The strategy outlined our approach to addressing critical barriers to access to enable meaningful participation and inclusive and equitable vaccine access. Our opportunity to influence greater disability inclusion has been dependent on engagement by partner governments, which implement vaccine campaigns.

In part due to the rapid nature of the process, organisations for persons with disabilities (OPD) were not engaged in the VAHSI design. However, a qualitative study was commissioned early in implementation to understand barriers and enablers to accessing COVID-19 vaccination for people with disabilities and inform programming. This study took place in Timor-Leste, Fiji and PNG, with OPDs leading the data collection and informing the recommendations.

While the study was delayed, some primary data was gathered in the three countries during the reporting period. Critical barriers identified included physical barriers to travel to and access vaccine sites, inaccessible vaccine information, and misinformation (linked to broader attitudes shared in the community and beliefs related to disability/underlying health conditions contributing to vaccine hesitancy). While the study reported additional informational gaps and challenges experienced by people with intellectual disability and psychosocial disability, there are no findings on the experience of others who experience intersectional marginalisation, including women and girls with disabilities.

Early findings additionally identified strategies and enablers to addressing barriers, including engaging with OPDs to improve access to vaccine clinics or provide alternatives such as home visits or vaccination at OPD offices; improving accessibility of vaccine communication materials; engaging OPDs to provide vaccine information and address misconceptions; and including OPDs in vaccine coordination groups. The study will be shared with partners to support improved engagement with people with disabilities.

**There has been limited engagement with OPDs by VAHSI partners.** Fiji, Timor-Leste, Vanuatu, and Vietnam used DFAT funding to engage with OPDs to address barriers and enable access to vaccination.

- In Timor-Leste, **OPD representatives were engaged as members of the Health Coordination Committee**, the COVID-19 vaccination coordination body. They advised strategies to increase access to and provide information about COVID-19 vaccines.
- In Fiji, Timor-Leste, Vanuatu and Vietnam, **OPDs have been actively engaged in disseminating vaccine information to members**, including providing information to address misconceptions.
- In Fiji, Tuvalu, Timor-Leste, Vietnam, and Cambodia, partners utilised home visits and facilitated access to vaccination sites to **provide information on COVID-19 and the COVID-19 vaccination.**
- In Vietnam and Fiji, **OPDs supported sign language interpretation** for TV spots and press conferences.

Partners in other countries, including Malaysia and PNG, integrated disability inclusion approaches **into vaccine micro-planning** (sub-national planning).

**Limited data has been collected on coverage rates for people with disabilities** (noting that the integration of disability data into health systems and COVID-19 vaccination programs is a global challenge)**.** Through VAHSI funding (UNICEF), the Government collected information through its existing people with disabilities database. This data-informed the MOH. This data indicated that by November 2021, only 53% of registered people with disabilities had been fully vaccinated (36% were female), compared to 85% of the wider population (in December). In Tonga, the MOH was interested in collecting disability data; however, systems to classify disability status were not established.

For example, in TL, engagement with OPDs improved vaccine access. It has not, however, been a consistent approach across all VAHSI partner countries, with only approximately 30% of countries making targeted efforts to integrate disability-inclusive approaches. CHS will provide feedback to partners, were possible, on reporting, encourage engagement with OPDs where applicable, advise on the integration of disability inclusion strategies that address barriers for diverse groups of people with disabilities, and share examples of disability inclusion with posts and partners to support disability inclusion efforts further.

## Risk and safeguards

**Rating: 5 –Good**

Australia's vaccine access investments operate in a dynamic, complex and high-risk environment. The inherent risk rating is high to very high for a range of reasons, including the:

- Size of the investment
- Reactive yet protracted nature of the response
- Variable implementation environments
- New COVID-19 variants and outbreaks
- Large shifts in global vaccine supply and demand
- Risk that Australian vaccines may cause severe adverse events following immunisation (AEFIs)
- Legal recourse that may be pursued from the Commonwealth.

**Risk mitigation measures** were developed to support VAHSI implementation as the global and regional operating context has evolved. Australia’s contribution to the Quad was later included in

these existing processes. Risk is regularly discussed, and opportunities to identify and escalate risks and treatments are built into program management and governance.

A dedicated **Risk and Safeguards Advisor** developed the VAHSI Risk Framework and management process, supported teams on risk management, and reviewed risk treatments and controls for adequacy.

The Advisor established and chaired a **risk reference group** with GHD, SMD and OTP members. Meetings were held monthly from August 2021, with variable levels of engagement. Members addressed emerging issues and risks and reviewed relevant treatments, controls and ratings.

As an example of risk management, through consultation, operational guidance on incident management and handling was prepared and communicated to internal stakeholders.

In 2021, GHD provided regular reporting to the Aid Governance Board (AGB), including the VAHSI/Quad risk dashboard (which captures risks with a residual risk rating of High/Very High) and weekly dose-sharing updates to the relevant Deputy Secretaries and the then Minister's office.

The Daily VAX management meeting enabled GHD and geographic divisions to discuss emerging issues, including coordinating dose allocations to manage supply and demand challenges and sharing information on outbreaks or suspected AEFIs. DFAT established a liaison position with the Department of Health's vaccine taskforce, helping to manage the complexities associated with providing Australian vaccines.

**Fraud risk** considerations are detailed in the investment-level risk register.

**Safeguards** are managed primarily through implementing partners. DFAT monitors this as part of risk management. Information from and engagement with partners could be strengthened.

**Vaccine access and delivery support activities:**

VAHSI and the Quad are implemented by **experienced partners** with a deep understanding of country contexts and the capacity to deploy well-tested risk management systems. However, delivery support partner reporting has been variable, including risk management and safeguards.

A risk matrix detailing the investment's **logistics activities** to support the delivery of bilaterally shared vaccines and associated consumables sits under the investment-level matrix. It is maintained to support risk management and programming.

Despite proactive risk management, both VAHSI and the Quad carry significant risk. Selected risks to the achievement of EOPOs are detailed below.

**Vaccine hesitancy:**

Vaccine uptake was generally strong across the region, with **vaccine hesitancy** pockets influencing coverage. Chronic health system weakness, low health-seeking behaviour, and widespread misinformation contributed to low vaccine uptake in Papua New Guinea, with only 2.5% of the population having completed the primary course (31 December 2021).

Additional to our existing work to mitigate vaccine hesitancy, including investment in vaccine communications and coordination with other donors, we will work with partner governments, NGOs and others to identify further strategies.

**Liability for damages:**

DFAT engaged proactively with the Department of Health, internal and external legal counsel and partner governments to manage legal risks to the Commonwealth associated with doses Australia shares from our supply. Successive approaches adopted over 2021 reduced this legal risk. An AEFI strategy was developed, and work to establish a No-Fault Compensation Scheme for bilaterally shared doses progressed.

**Forward view:**

Given the urgency to respond to the pandemic, VAHSI was designed at speed as a targeted and temporary measure. Aside from the inherent risks already covered, COVID-19 responses have also impacted routine immunisation programs and health services. As the response to the pandemic matures and VAHSI's activities continue into the second year, it would be prudent to ensure any gains to health systems through VAHSI-funded activities can be leveraged.

## Other (Social Inclusion)

Additional to our activities to promote gender equality and disability inclusion, VAHSI used a social inclusion lens that recognises other factors that will affect vaccine acceptance and uptake, such as ethnicity, age and socioeconomic status. Project activities supported vaccine access for **groups at risk of exclusion or inequitable vaccine access across at least 8 countries** - Fiji, PNG, Timor-Leste, Indonesia, Malaysia, Philippines, Laos, Cambodia and Vietnam.

In these countries, partners designed appropriate strategies to **address misinformation and promote the importance of COVID-19 vaccination to at-risk groups**. Materials were designed to reflect the needs of these groups, and materials, video spots etc., were produced in Indigenous and minority languages to communicate with those in remote communities or at-risk groups effectively.

- In Timor-Leste, social media videos were developed covering eight **Indigenous languages** - the whole video was watched 14,000 times.
- In PNG, VAHSI-funded NGOs **engaged with youth experiencing or at risk of homelessness** to provide information and access vaccine support.
- In Fiji, Thailand, Cambodia, Vietnam and Malaysia – vaccine messages were developed in various languages and dialects with a focus on **Indigenous communities and migrant workers.**
- In Laos, VAHSI partners focused on training to reach at-risk groups, with **18% of health workers trained from ethnic Lao groups** to maximise trust in vaccination services.

Additionally, VAHSI convened an informal internal reference group with representatives across GHD, geographic divisions, Gender Equality Branch (GEB) and Disability Inclusion Section (DIS). The group met twice during the reporting period to provide a critical review of progress and make linkages with other investments. GEDSI was included in the VAHSI Steering Committee agenda for the two meetings during this reporting period.

Our progress on GEDSI has been limited. As VAHSI is delivered through other agencies, including multilateral organisations, and vaccination campaigns are managed by partner governments, our opportunity to influence has been limited to the focus that partner governments and our partners such as UNICEF, WHO and World Bank place on GEDSI. While analysis has not been completed to confirm this, reporting would indicate that progress has been more substantial where strong

bilateral relationships already existed and bilateral programs or partner governments had already made gains on inclusion. Analysis may provide us with further insights and lessons on how to support inclusive health emergency preparedness and response efforts.

## Management response

1. The **GHD Strategy Communications and Effectiveness Section**, supported by the MEL team and the Technical Advisory Hub, to commission a practical research paper on lessons learned from efforts to support COVID-19 vaccine access as they relate to addressing other health security challenges, to be completed by 30 August.

   In order to support the identification of options for programming that can help partner governments to increase vaccine coverage while strengthening health systems, and with reference to other efforts already underway or completed (including the SHS's review of the impact of COVID-19 on routine immunisation coverage in the Pacific), and the CHS-coordinated immunisation 'deep dive', it should:

   a. Consolidate available information on the effect of COVID-19 response on wider health delivery in partner countries, including for infectious disease management and routine immunisation.

   b. Specifically address countries in the Pacific (and Timor-Leste) with less-developed health systems and slower COVID-19 vaccine uptake (e.g., Papua New Guinea, Solomon Islands).

   c. Identify and describe where VAHSI delivery support activities have contributed to the strengthening of health systems and workforce capacity and identify remaining gaps.

2. VAHSI management team to develop and consider **options for remaining VAHSI support**. This should be done as soon as possible, be informed by our partners' current priorities, and be integrated with work to advance broader regional and global health priorities.

   a. **Division Head, GHD**, to consider the scope to reallocate uncommitted VAHSI delivery support funds between countries and regions and to multilateral organisations supporting the Indo-Pacific with vaccine access and pandemic preparedness, and the parameters and process for doing so.

   b. Program managers programming delivery support for the final year of VAHSI to consult closely with **GHD Strategy, Communications and Effectiveness Section** to ensure this lays the groundwork for concurrent development of policy and programming for health security.

3. The **GHD MEL Team** is to refine the **system for VAHSI performance reporting,** integrating learning from the 2021 reporting process. Changes will be implemented in the process of six-monthly progress reporting, which is due in December 2022. The MEL team will:

   a. By August 2022, prepare **guidance about how partner reporting** should meet DFAT's reporting requirements as set in the M&E standards and agreements. This will also address reporting on gender, disability, safeguards and risk.

   b. By August 2022, revise the VAHSI **performance assessment framework** to reflect current activity and operating context.

c. By September 2022, revise country **Monitoring, Evaluation and Learning Frameworks** (MELFs) to ensure they are appropriate for the scope of activity.

d. By September 2022, revise the template, content and process for **country progress reporting** on vaccine access.

e. By December 2022, have scoped and developed draft terms of reference for an independent **end of program evaluation** of VAHSI, which will be undertaken in the 2023 calendar year.

4. The GHD GEDSI adviser to work with CHS staff, posts and partners and recommend how to strengthen ongoing analysis of **gender, disability and social inclusion gaps and barriers**, and to address associated **safeguards and risks**. By September 2022, the Adviser will develop a plan and identify resourcing to support partners to identify and implement activities that address these.

5. The GHD **Enabling Section** to review how implementation of the **Australian Expert Technical Assistance Program** for Regional COVID-19 Vaccine Access (AETAP) should be refined following recommendations from the (current) evaluation of the TGA Regulatory Strengthening Program / Regulatory Support and Safety Monitoring, and in the context of transition towards providing wider health systems support.

6. The GHD MEL team to work with CHS staff, the Health Advisory Hub and posts to consider and recommend options to support partners' use of **data on vaccination reach and hesitancy, including** to better **identify at-risk groups** yet to complete a full vaccine course, and to engage them through targeted **risk communication and community engagement** activities.

7. Yangon Post will continue to engage closely with like-minded **partners and UN agencies in Myanmar** to explore and find feasible avenues to support effective and equitable COVID-19 vaccine access, consistent with Australian policy settings.

Australian Government | INDO-PACIFIC CENTRE FOR HEALTH SECURITY

# Regional COVID-19 Vaccine Access and Health Security initiative
# Performance Assessment Framework: V13: Revised 2022/23

| # | Indicators[1] |
|---|---|
| **Overarching VAHSI objective:** To confirm Australia as a valued partner to countries in the Pacific and Southeast Asia by supporting their safe and effective vaccine rollouts so that their economies can reopen, contributing to economic recovery, national wellbeing and regional stability. | |
| **Overarching VAHSI end of investment outcome:** Australia has helped targeted partner countries maximise immunisation coverage to prevent disease and allow a safe return to a development trajectory needed for economic and social recovery. | |
| **COVID-19 VACCINES** | |
| **End of program outcome 1: Partner governments expand COVID-19 vaccine and routine immunisation coverage in a safe and timely manner[2]** | |
| 1 | Total number and proportion of population in partner countries that have completed a primary vaccination course[3] for COVID-19 from all sources of support (by target population[4], sex, age, disability and vulnerable groups[5] where data allow) - see also EOPO 2 and IO 4 |
| 2 | Number and proportion of the total population that have received a COVID-19 vaccine booster (3rd dose) from all sources of support |
| 3 | Total number and proportion of population in partner countries that have completed a primary vaccination course[6] for COVID-19 with Australian support (by target population, sex, age, disability and vulnerable groups where data allow) *(P4R indicator)* |
| 4 | Rate of childhood immunisation coverage in children aged 12-23 months (by measles (MCV1); DPT3) for each country[7] |
| 5 | Number of approved[8] COVID-19 vaccine doses delivered to partner countries with Australian support (by country, type of vaccine and procurement[9] mechanism/channel[10]) - see also IO 1 & output 1. |
| **Intermediate outcome 1: Australia contributes to partner governments' procurement of approved vaccine doses** | |
| | See indicator 6. |
| **DELIVERY SUPPORT** | |
| **End of program outcome 1: Partner governments expand COVID-19 and routine immunisation coverage in a safe and timely manner** | |
| **Intermediate outcome 3: Partner health authorities administer effective systems that enable accessible and safe national delivery of vaccines[11].** | |
| 7 | Evidence of improvements to vaccine distribution networks[12] (availability, capacity, functional status), including use of energy efficient and sustainable practices (by COVID-19; routine immunisation) |
| 8 | Evidence of improvements to COVID-19 and routine immunisation detection through laboratory test capacity and quality assurance in partner countries supported by Australia |
| 9 | Evidence of improvements to water, sanitation and hygiene (WASH) and waste management in health facilities that are administering COVID-19 vaccinations. |
| | **Output 1: Dose Procurement; Supply of Equipment and Consumables** |
| - | See indicator 6. |
| 10 | Number of pieces of additional equipment[13] to support immunisation response, provided to partner governments with Australian support (by COVID-19; routine immunisation; by type of equipment) |
| 11 | Number of consumables[14] to support the COVID-19/routine immunisation response provided to partner governments with Australian support (by type of consumable) |
| **End of program outcome 2: Target populations access vaccination in accordance with national vaccine planning priorities** | |
| - | See indicator 1 and 6 for COVID-19; Indicator 4 for routine immunisation. |
| 12 | Evidence that partner countries have administered COVID-19 vaccines /routine immunisation to target populations (qualitative data). |
| **Intermediate outcome 4: Partner countries implement an effective and inclusive vaccine (COVID-19/routine immunisation) social mobilisation and engagement strategy** | |
| **Output S. Community engagement** | |
| **Output 3: Preparedness assistance – cold chains, tracking and surveillance systems** | |

| | |
|---|---|
| 13 | Evidence that in selected countries implemented effective communication through social mobilisation and engagement strategies is reaching intended populations incl. focus populations for both COVID-19 & routine immunisation (women/parents/carers, high-risk groups, people with disabilities and vulnerable groups) |
| 14 | Evidence that selected partner countries have developed a national social mobilisation and engagement strategy/demand plan and information awareness program[15], include focus populations: high-risk groups, women, people with disabilities and vulnerable groups. |
| 15 | Evidence that selected partner countries have improved COVID-19 vaccine/routine immunisation deployment planning documents and systems[16], developed with support from Australia |
| **HEALTH ADVICE** | |
| **End of program outcome 1: Partner governments expand COVID-19 vaccine & routine immunisation coverage in a safe and timely manner** | |
| **Intermediate outcome 2: Partner governments introduce or strengthen policy and regulatory oversight of their COVID-19 vaccination and routine immunisation programs.** | |
| 16 | Evidence that improved national policy and regulatory oversight of vaccination programs is being implemented and maintained in partner countries where Australian technical assistance has been requested |
| ↳ | **Output 2: Policy and regulatory support** |
| 17 | Number of pre-market assessments in partner countries supported by Australia (by country and type) |
| 18 | Number of partner country immunisation planning documents into which Australian partners have provided technical advice and review (immunisation campaign type) |
| **Intermediate outcome 3: Partner health authorities administer effective systems that enable accessible and safe national delivery of vaccines.** | |
| 19 | Evidence of improved Adverse Events Following Immunisation (AEFI) identification and reporting for COVID-19 vaccination and routine immunisation in partner countries supported by Australia, including sex and comorbidity disaggregated AEFI reporting where data allow |
| **Intermediate outcome 3: Partner health authorities administer effective systems that enable accessible and safe national delivery of vaccines.** | |
| 20 | Evidence that partner country health information systems for immunisation (COVID-19/routine immunisation) recording and disease surveillance, which include sex, disability and vulnerable group data where possible, that Australia has supported |
| 21 | Evidence of how training has been applied in practice |
| ↳ | **Output 8: Workforce** |
| 22 | Number of participants who have completed training events (by country, by sex, people with disabilities, category of training (e.g. regulation), training type[17] |
| **POLICY ENGAGEMENT** | |
| **Intermediate outcome 5: Australia engages influentially for, and leverages investments in, COVID-19 vaccination programs.** **Output 6. Policy dialogue & partnerships** | |
| 23 | Evidence that Australia has engaged influentially and leveraged[18] partnerships and collaborations to strengthen financial and technical support for national COVID-19 and routine immunisation programs |
| 24 | Evidence of promotion of gender equality, disability and social inclusion (GEDSI) through policy dialogue and programming in partner countries by Australia and implementing partners |
| 25 | Evidence of Australia's policy influence and strengthening of relationships with partner governments and regional networks |
| **COMMUNICATION** | |
| **End of program outcome 3: Australian support to COVID-19 vaccination programs is valued by the region** **Output 7. Events/actions promoting Australian identity** | |
| 26 | Evidence that Australia's support, including leveraging technical and financial resources for national COVID-19 and routine immunisation programs is valued by partner governments |
| 27 | Evidence that Australia's implementing partners engage and coordinate with partner governments and other actors in delivering VAHSI |

## ENDNOTES

[1] Where indicators require 'evidence of' this includes both qualitative and quantitative evidence.
[2] VAHSI with Post will collate data for indicators 1-6; and will contribute to indicators 23-27, where relevant to the country program. For the remaining indicators, data (qual & quant) will be sourced through partners, where relevant the country.
[3] Completion of a primary course is defined as two doses. While it is recognised that J&J is a single dose, in most countries, two doses is the primary course.
[4] *Target population* refers to groups prioritised for COVID-19 vaccine delivery/routine immunisations as indicated in key national vaccination planning documents.
[5] The impact of the virus is being disproportionately borne by the poor[5] and those socio-demographic groups that place them in vulnerable situations[5]. In the PAF, these populations are referred to collectively as vulnerable groups in alignment with World Health Organization (WHO) guidance[5]. Vulnerable groups may include older persons, women who are at the heart of care and response efforts, persons with disabilities, indigent workers with limited opportunities to self-isolate, indigenous peoples, LGBTI+ populations, those without access to safe water and sanitation, refugees, migrants, and the displaced. Target populations may or may not include vulnerable groups.
[6] See endnote 2 above.
[7] Regional and country vaccination rates are available from UNICEF - https://data.unicef.org/topic/child-health/immunization/
[8] *Approved* refers to products that are registered by regulatory authorities (e.g. US Food and Drug Administration, Therapeutic Goods Administration, European Medicines Agency and/or other stringent or national regulatory authorities) and/or are approved for use by partner governments (noting that some governments do not have their own national regulatory authority and in that case would rely on the data of a stringent regulatory authority to approve use) and/or approved for WHO Emergency Use Listing.
[9] *Procurement* means the acquisition of goods and services, in this case the acquisition of COVID-19 vaccines, https://www.who.int/about/accountability/procurement. Procurement includes Australian stocks provided to partner countries.
[10] Channels or mechanisms are VAHSI/UNICEF procured; COVAX AMC procured; shared from Australian domestic stocks.
[11] *Delivery of vaccines* includes cold chain capacity, transport, waste management, infection prevention control measures, PPE and SOPs for delivery.
[12] *Distribution networks* include cold chain, storage and transport systems.
[13] *Additional equipment* refers to new or improved equipment introduced to and used in partner countries in response to COVID-19/routine vaccination. Examples include vehicles, incinerators, ventilators, oxygen equipment, laboratory equipment, testing machines and cartridges, and data collection tablets etc.
[14] *Consumables* includes syringes, needles, sharps containers, personal protective equipment (PPE) etc. It excludes swabs, cotton balls, plastic spots, tissues, hypo paper tape or wipes.
[15] The social mobilisation and engagement strategy/demand plan and information awareness program includes advocacy, communications, social mobilisation, risk and safety communications (including how complaints may be lodged), community engagement and training (VIRAT/VRAF 2.0).
[16] *Deployment planning documents and systems* include national and sub-national deployment plans and surveillance systems.
[17] *Training type* may include training courses with or without formal qualifications, workshops, mentoring, placements, study tours, peer learning or train the trainer
[18] *Leverage* could include Australia facilitating or joining partnerships or collaborations, and that these combine technical or financial support for COVID-19 and routine immunisation programs