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Baseline Assessment Report

Evaluation of the technical assistance provided through the Gavi Partners' Engagement Framework

July 2017

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Acronyms and abbreviations

AFC	Audit and Finance Committee
APR	Annual Progress Report
AMP	Agence de Medecin Preventative
APR	Annual Percentage Rate of Change
AVI-TAC	The Accelerated Vaccine Introduction Technical Assistance Consortium
BMFG	Bill & Melinda Gates Foundation
BP	Business Plan
CCE	Cold Chain Equipment
CCEOP	Cold Chain Equipment Platform
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CRS	Catholic Relief Services
CSO	Civil Society Organisations
DAC	OECD Glossary Development Co-Operation Directorate
DTP	Vaccine against diphtheria, pertussis, and tetanus
DFID	Department for International Development
DRC	Democratic Republic of Congo
EAC	Evaluation Advisory Committee
EPI	Expanded Program on Immunization
EURO/EMRO/PAHO	European Region/ Eastern Mediterranean Region/ Pan-American Region
FAQ	Frequently Asked Questions
FTE	Full-time Equivalent
HLRP	High Level Review Panel
HPV	Human papillomavirus
HSCC	Health-Sector Coordinating Committee
HSS	Health System Strengthening
HQ	Headquarters
ICC	Interagency Country Committee
JA	Joint Appraisal
JHU	Johns Hopkins University
JSI	John Snow, Inc.
KPI	Key Performance Indicator
LMC	Leadership, Management, and Coordination

MoH	Ministry of Health
MR	Measles-rubella
NGO	Non-governmental Organization
NITAG	National Immunization Technical Advisory Groups
OECD	Organisation for Economic Cooperation and Development
OFID	OPEC Fund for International Development
OPEC	Organisation of the Petroleum Exporting Countries
OPV	Oral poliovirus vaccines
PATH	Program for Appropriate Technologies for Health
PEF	Partners' Engagement Framework
PEF MT	PEF Management Team
PPC	Programme and Policy Committee
REPAOC	Network of West and Central African NGO National Platforms
RFI	Request for Information
RFP	Request for Proposal
SFA	Strategic Focus Area
SFP	Strategy, Funding and Performance team
SCC	Sector Coordinating Committee
SCM	Senior Country Manager
SOW	Statement of Work
STTA	Short Term Technical Assistance
TA	Technical Assistance
TCA	Targeted Country Assistance
TOC	Theory of Change
TOR	Terms of Reference
UNICEF	United Nations Children's Emergency Fund
VITAC	Vaccine Implementation Technical Assistance Consortium
WB	World Bank
WHO	World Health Organization

Definition of Key Terms

Core Partners	Organizations that receive Foundational Support under the Partners Engagement Framework (UNICEF, WHO, CDC, World Bank, and CSO Consortium). Core Partners, are also funded under PEF to delivery TCA.[1]
Expanded Partners	Organizations, beyond the Core Partners (WHO, UNICEF, CDC, World Bank, CSO Consortium) funded by Gavi to deliver PEF-TCA in accordance with the Expanded Partner principles[2]. Includes, but not limited to, the following:* • ACASUS • AEDES • PATH • JSI • JHU • UNFPA • One23 Partnership • Village Reach ** this list is reflective of Expanded Partners in Tier 1 & 2 countries only*
Partners	For the purpose of this report we use the term 'Partner' to refer to organizations funded under PEF to provide targeted country assistance to national immunization programs. Unless otherwise specified "Partners" is used broadly to refer to both Core and Expanded partners. In this document the term "Partner" does not include Ministries of Health (MOHs) or Expanded Programs for Immunization (EPIs).
Programmatic Areas	Programmatic areas are terms that are used throughout Gavi literature, guidance, and reporting tools to classify technical assistance activities performed by partners. However, there is no formal definition for each term. This has led to confusion about how activities should been categorized as well as what the overarching goals are in relation to the programmatic area.
Technical Assistance	The "transfer, adaptation, mobilization and utilization of services, skills, knowledge and technology. It includes both short- and long-term personnel from both national and foreign sources, plus training, support equipment, consultancies, study visits, seminars, and various forms of linkage [to improve the capacity of the immunization program]" (definition adapted from DAC)
Transparency	The extent to which key aspects of the TCA (including but not limited to planning, development of the TA plan, approval of TA activities, award of partners, delivery of TA, and progress on activities and expected outcomes)

[1] This is an operational definition within the context of PEF, however it does not reflect the definition of Core Partners from the perspectives of broader Gavi Alliance governance

[2] As much as possible, technical assistance is embedded within the EPI team; Activities are clearly focused on transfer of skills, with a goal towards achieving sustainability; At least 70% of fees (i.e. HR staff costs) must be on country-level staff (i.e. non-HQ/regional staff); Expenses (i.e. non-fees) are not to exceed 25% of contract; There must be clearly defined semi-annual milestones that will be reported against in the Partner Portal

	are clearly documented, disseminated, and understood by all key stakeholders.
Accountability	**Accountability** is the shared responsibility and answerability of the TA recipient, TA provider, and the TA funder (Gavi Secretariat) for the quality and effectiveness of technical assistance. The PEF Functions document provides further clarity on what each stakeholder is accountable for*: ◦ **TA providers** are accountable for providing support in an integrated and holistic manner; systematically tracking progress; proactively identifying and addressing bottlenecks; and monitoring and reporting on progress ◦ **TA recipients** are accountable for the achievement of expected outputs and outcomes ◦ The **Gavi Secretariat** is accountable for ensuring performance across key constituents of the Alliance through performance management at different levels (PEF performance management, Secretariat performance management, Country grant performance management)*
Country ownership	The full engagement and leadership of the national immunization programme in identifying, prioritizing, coordinating, participating in, monitoring and evaluating technical assistance activities

Evaluation Team

This baseline assessment was conducted by an Evaluation Team led by Deloitte Consulting, in partnership with country-based evaluators in four case study countries.

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Executive Summary

The Evaluation of Technical Assistance Provided through Gavi Partners' Engagement Framework is a prospective evaluation of Gavi's support to Partners to provide Targeted Country Assistance (TCA) in the twenty Gavi Tier 1 and 2 countries.

As Gavi's overall strategy and goals have evolved across several strategy periods, the role of Partners has remained the same – to support operationalization of the strategic plans at the country and global levels through technical assistance. This evaluation seeks to understand the degree to which the PEF-TCA achieves improvements around transparency, accountability, and country ownership of the technical assistance, when compared to the prior strategy period, as well as over the course of the 4 year evaluation period. Additionally, key achievements of the TCA will be tracked and evaluated.

The four primary objectives of the evaluation are to:

- Understand the extent to which the new TCA planning and delivery model has incorporated the principles of country ownership, transparency, and accountability
- Assess in what ways the new model has shaped the delivery of TA and improved its effectiveness and efficiency
- Examine the contributions of the TCA to the larger national immunisation programme
- Identify the internal and external factors that affect TCA delivery and outcomes

The prospective evaluation will measure progress in TCA planning and implementation across three assessment phases between 2016 and 2020: a baseline assessment, mid-term assessment, and end-line assessment. This report presents findings from the baseline assessment conducted between September 2016 and May 2017.

Baseline Assessment Methods

The baseline assessment focuses on the planning and delivery of the 2016 TCA cycle, with planning beginning in 2015, as this was the first full year of PEF-TCA. The findings from this baseline assessment will serve as the baseline for the prospective assessment. The baseline assessment employed a mixed-methods approach, with varying levels of emphasis across Tier 1 and 2 countries. Additional data collection and analysis was conducted in four case study countries (Afghanistan, DRC, Ethiopia, and Nigeria).

- ***Interviews (****Scope: Tier 1 stakeholders, Gavi Secretariat, regional/global level Partners)*
  We completed semi-structured interviews with 95 stakeholders from the Tier 1 countries, 23 stakeholders from the Gavi Secretariat, and 12 regional and global level stakeholders. Interviewees were identified by the Gavi Secretariat, Alliance Partners, and through recommendations from stakeholders in the Case study countries.

- ***360º Online Survey:*** (Scope: Tier 1 and Tier 2 Countries & Gavi Secretariat)
  An online survey was developed to capture perspectives on TCA planning and delivery from a wider pool of respondents, including those from Tier 2 countries. An initial pilot test of the

survey was conducted in the four case study countries in January 2017. The full survey (revised version[3]) was launched in March 2017 for all countries, excluding those from case study countries who had already responded.

- ***Desk Reviews/Document Reviews: (****Scope: Tier 1 and Tier 2 Countries, with a focus on Tier 1 Countries & Gavi Secretariat)*
  We systematically reviewed 80 documents to obtain objective information to inform the context of the TCA processes at the Gavi Secretariat and county levels. These documents were used to ground the evaluation in the TCA planning and delivery process used by Gavi, as well as to better understand the varying ways this process has been implemented in priority countries.

- ***Observations:*** *(Scope: 4 Case Study Countries)*
  Together with our in-country partners, we conducted observations of the Joint Appraisal meetings and other relevant TCA planning or review meetings in the four case study countries.

Findings

TCA Planning. The first Joint Appraisal, the country-level platform for TCA planning, was conducted in 2015 to inform the design of the 2016 TCA activities. Being the first year, there was notable confusion across EPI teams and Partners on the expectations and requirements for the JA and subsequent development of the TCA Plan. Lessons learned from this first round were used to modify the guidance for the 2016 JAs, which were positively received by country-based stakeholders. In general, the JAs are seen as a key strength of the PEF-TCA process. They have been commended for bringing visibility on the different Partners supported by Gavi to provide technical assistance to the EPI. Furthermore, both EPI teams and in-country Partners appreciate the level of engagement and leadership in identifying TA needs and defining the corresponding TA activities through joint development of the TCA Plan (a marked improvement from prior years where TA activities were determined at Partners' regional or headquarters offices).

Several factors were identified that limit full transparency and ownership around the TCA Planning process.

1. The timing of the JA does not always align with relevant national-level processes, hindering its ability to be integrated into national processes and owned by the EPI teams.
2. Lack of engagement of key stakeholders, including some Core Partners (World Bank, CDC), as well as subnational level immunization officers or TA providers, limits transparency on the full breadth and scope of TCA activities

[3] Following the pilot test of the survey, the questionnaire was revised to minimize the number of questions and further specify the focus of the questions. For example, the revised questionnaire narrowed the list of TCA quality attributes asked about from 11 to 7. Questions about the effectiveness of the JA in identifying the EPI technical needs were further specified to ask about identifying needs in each programmatic area.

3. Stakeholders agree that the TCA planning process does, for the most part, take into account and reflect the needs of the immunization program. However, the structure of the TCA Plan, which is categorized into 7 programmatic areas defined by Gavi, does not correspond with countries' comprehensive multiyear plans (cMYPs), which are structured using the Immunization System Components. This mismatch in how TA needs and activities are framed creates confusion.

TCA Delivery. One of the primary changes in the TCA model when compared to prior strategies is the allocation of increased funds to Partners at the country-level instead of the headquarters or regional levels. This has allowed Partner country office teams to take more ownership of the hiring process for provision of TCA and subsequently increase the number and availability of Partner staff directly supporting TCA efforts on the ground. However, in some cases, TCA funds only partially cover Partner staff salaries. The implication of this is that Partner staff are commonly not fully dedicated to supporting the TCA efforts (or even broader immunization efforts in some cases) which results in not being able to fully address the needs of EPI.

Even with the increased Partner staffing on the ground, interviewees noted that activities supported under TCA are "business-as-usual". This is perhaps reflective of the sentiment that most TA efforts are primarily focused on implementation support with little emphasis on capacity building or introduction of innovative approaches. Due to lots of competing priorities, and shortage of staff, TCA activities tend to be interwoven with the day-to-day functioning of the EPI programs and offer continuous support. This is the case both at the Central level (within the MOH) as well as the subnational level. In general, there is more concern about the quality of TA provided at the subnational level. At the same time, interviewees stressed the need for more TA at the subnational level as that is where there are more prominent and systemic resource gaps.

The major challenges encountered in TCA delivery in 2016 were funding disbursement delays which the delayed hiring and the start of planned activities; insufficient funding; and competition for EPI team's time created by the high volume of TCA activities across multiple partners.

With respect to quality of TCA delivery, the expertise of TCA providers and relevance of TCA activities for immunization program needs were the most highly scored quality attributes. On the other hand, timeliness and flexibility were the weakest attributes of TCA.

Coordination. At a high level, stakeholders agree that the PEF-TCA has brought about more structure to facilitate greater coordination and collaboration across TCA providers, mainly through the Joint Appraisals. However, there are still some major gaps in the level of transparency, communication, coordination, and collaboration, both at the country level as well as at the level of the Gavi Secretariat. At the country level, coordination tends to be strong between the EPI, UNICEF, and WHO but not across the remaining partners. Expanded Partners seem to be operating in the periphery in most countries.

At the Gavi Secretariat level, there are gaps in communication across different teams (e.g. the SCMs and the Vaccine Implementation Team), which create misunderstanding or confusion with regards to expectations for specific Partners on the ground.

Milestone reporting - EPI interviewees particularly noted the benefit of the milestone reporting process for articulating what Partners are supposed to be doing and serving as a platform for holding them accountable. However, they consistently noted their lack of awareness on what Partners are actually reporting. From another perspective, the SCMs also appreciate the milestone reporting, but noted the lack of recourse for poor performance on the milestones.

While Partners have been diligent about reporting on the milestones, the quality of the milestones is questionable, both in the way the milestones are defined as well as in how they are reported.

Contribution of TCA to programmatic areas: On average, across all programmatic areas, Partners' TCA contributions were rated to have contributed moderately to the EPIs progress towards its goals across all the programmatic areas (mean scores between 4 and 7 (out of 10)). EPI respondents noted the highest contribution within HSS (mean score=6.63), Financing (mean score=6.1), and LMC (mean score=6.62). Interestingly, these are the same programmatic areas that stakeholders had indicated during interviews as ones that they are not very familiar with. On the other hand, the two programmatic areas that have the lowest mean score for Partners' contribution - Supply chain (mean score 4.46) and Data (mean score=4.93) - are programmatic areas that are well understood and in which Partners have a large number of activities.

Transparency. PEF-TCA has brought about improved transparency around the planning and delivery of technical assistance. Now, both EPI teams and Partner have much greater clarity on others who are supporting the immunization efforts through Gavi-funded TCA as well as a better understanding of the activities they support. However, there remain some challenges with transparency, mostly around the activities of Partners that do not have much country-presence or do not work directly with the EPI program (CDC and World Bank).

Accountability. The TCA milestone reporting process has established a solid platform for holding Partners accountable for the milestones they set for themselves. It is not clear, however, whether the intention is for Partners to be accountable to the Gavi Secretariat/Alliance or to the EPI programs that they are supporting. While there is progress towards improved accountability, the Gavi Secretariat should critically consider what this means within the PEF-TCA framework and how the milestone reports will or should inform action at the Secretariat level as well as at the country level.

Country ownership. The JA has brought the TA planning process down to the country level and facilitated a country-driven approach to defining TA needs and activities. However, the EPI teams are not always empowered to select the Partners they want to support different activities; the terms of agreement with TA providers are still managed by the Gavi Secretariat; even the selection of Expanded Partners is managed at the Secretariat level often with very minimal input from the EPI teams; milestone reports are submitted to the Gavi Secretariat and not the EPI teams.

1. Introduction

Gavi, the Vaccine Alliance has identified technical assistance (TA) provided to national immunization programs as a catalyzing force to bolster implementation of Gavi grants and accelerate improvements in immunization coverage and equity in a sustainable manner. In 2016, Gavi adopted a new strategy of supporting technical assistance under the Partners' Engagement Framework (PEF). Through this framework, Gavi provides three categories of funding to its Partners to support technical assistance, dedicating about 51% of the PEF funding directly to country-level support through Targeted Country Assistance (TCA). This is a major shift from prior strategies where the vast majority of TA funding was allocated to Partners at the global or regional levels[4]. With this increased country-level funding, it is expected that Partners will be able to hire more staff in-country and engage more closely with the national immunization program to deliver TA that is relevant, effective, efficient, and contributes to sustainable capacity building of the immunization program.

This evaluation seeks to understand how the transition from the Business Plan to the PEF-TCA strategy has affected the planning and delivery of TA by Gavi's partners, and assess the degree to which the new approach has achieved improvements around transparency, accountability, and country ownership of the technical assistance. Additionally, key achievements of the TCA funds will be tracked and evaluated. The evaluation is a prospective study, which will measure progress in the TCA across three assessment phases between 2016 and 2020: a baseline assessment, mid-term assessment, and end-line assessment. This report presents findings from the baseline assessment conducted between September 2016 and May 2017.

1.1. Overview of the Evaluation Approach

The focus of this five-year evaluation is to assess the TCA component of the Partners' Engagement Framework in Tier 1 and Tier 2 countries. Under this purview, the evaluation has four main objectives:

Objective 1: Understand the extent to which the new TCA planning and delivery model has incorporated the principles of country ownership, transparency, and accountability

Objective 2: Assess in what ways the new model has shaped the delivery of TA and improved its effectiveness and efficiency

Objective 3: Examine the contributions of the TCA to the larger national immunisation programme

Objective 4: Identify the internal and external factors that affect TCA delivery and outcomes

Evaluation Questions

In order to attain the aforementioned objectives, the evaluation is structured into evaluation questions centered on three domains. As a baseline assessment, this report focuses on Domains 1 and 2. The Outcome Assessment is not included in the baseline assessment, but will

[4] Partners' Engagement Framework (PEF) & Alliance Accountability Framework. Presentation for the Board Meeting by Anuradha Gupta. 22-23 June 2016. Geneva.

be included in the mid-term and end line assessments. Annex 2: Overview of Evaluation Methods provides a more comprehensive evaluation of what is included in which phase of the evaluation.

Domain 1: TCA Planning Assessment - How effective and efficient is the TCA Planning Process?
Domain 2: TCA Delivery Assessment - Which TA models are most effective and efficient, and why?
Domain 3: TCA Outcome Assessment - To what extent does TCA contribute to improvements in the national immunization programme?[5]

1.2. Baseline Evaluation Methods

The overall evaluation method was developed through an intensive inception phase, and continually refined over the course of the evaluation baseline period, incorporating guidance from the Steering Committee. An overview of the evaluation method, including key changes made from what was proposed in the inception report, is provided in Annex 3. 2.

The baseline assessment focuses on the planning and delivery of the 2016 TCA cycle, with planning beginning in 2015, as this was the first full year of PEF-TCA. As such, this document highlights the key insights from the 2016 TCA process to contribute to ongoing learning. These same findings will serve as the baseline for the prospective assessment. Where we have quantified specific findings, these will serve as key indicators that will be used to measure change over time in the next two phases. These key indicators are denoted throughout the report by the following icon:

Domain 1: TCA Planning Assessment Key Indicators

Evaluation Question 1: How effective and efficient is the TCA planning process?

	Evaluation Focus	Key Indicators & Baseline Analysis
1.1	To what extent is the TCA planning process implemented as intended?	○ Key Indicator: Top 3 suggested improvements to the JA. ○ Baseline finding: **1. Broaden stakeholder engagement, 2. Increase use of evidence to inform TA needs, 3. Use Partner performance data to inform TA activities**
1.2	To what extent is the TCA planning process fit-for-purpose and responsive to country-expressed needs?	○ Portion of Survey respondents saying that the needs identified in the JA aligned to the country needs "to a great extent" ○ Baseline finding: **47% Averaged across Programmatic Areas.** ○ The areas with the highest percentage of respondents reporting alignment to a great extent ○ Baseline finding: **Supply Chain followed by Coverage & Equity, and then Vaccine Sub-groups.**
1.3	To what extent does the TCA planning process promote country ownership of the TCA?	○ Level of Engagement of the EPI Survey Respondents in the Joint Appraisal Process ○ Baseline finding: **64% Very Engaged at Baseline** ○ Average TCA Planning Ownership Score ○ Baseline finding: **7.1 for Tier 1 & Tier 2 Countries**
1.4	How transparent is the TCA planning process?	○ The most common suggestion for improvement of the Joint Appraisal was **increasing the breadth of stakeholders (including subnational) at Baseline.** ○ **Average TCA Planning Transparency Score: 5.6 for Tier 1 & Tier 2 Countries**
1.5	How efficient is the TCA planning process?	○ Alignment with National Planning Processes ○ Baseline finding: In 2016 (Baseline), only **35%** of Joint Appraisals occurred within 3 months of the country's fiscal year end.

[5] This domain is included here to provide the reader with the overall objectives of the 5-year evaluation. It is not included in the Baseline Assessment.

Data Collection Methods

The evaluation uses a mixed methods approach, with varying levels of emphasis across Tier 1 and 2 countries. These tiers are determined by Gavi, who takes a differentiated approach by prioritizing 20 countries based on severity of immunization challenges and fragility and/or high inequity. The 10 Tier-1 countries[6] will benefit from focused attention and dedicated resources above and beyond what will be provided for other countries. These are countries with the highest burden of under immunized children. The 10 Tier-2 countries[7] are those that face challenges of internal conflict and/or high inequity. Additionally, four case study countries (Afghanistan, DRC, Ethiopia, and Nigeria) were selected among Tier 1 countries for more in-depth analysis.

Interviews (*Scope: Tier 1 stakeholders, Gavi Secretariat, regional/global level Partners)*

We completed semi-structured interviews with 95 stakeholders from the Tier 1 countries, 23 stakeholders from the Gavi Secretariat, and 12 regional and global level stakeholders. Interviewees were identified by the Gavi Secretariat, Alliance Partners, and through recommendations from stakeholders in the Case study countries. Annex 6 provides a list of stakeholders who participated in the interviews.

360º Online Survey: (Scope: Tier 1 and Tier 2 Countries & Gavi Secretariat)

An online survey was developed to capture perspectives on TCA planning and delivery from a wider pool of respondents, including those from Tier 2 countries. An initial pilot test of the survey was conducted in the four case study countries in January 2017.

The full survey (revised version[8]) was launched in March 2017 for all countries, excluding those from case study countries who had already responded. Whenever possible, the results of the pilot survey are analyzed together with results from the full survey. However, this was not always possible as some of the survey questions had changed across the two versions. Table 1 provides a snapshot of the response rate for the survey. The survey questionnaire are provided in Annex 5 and further details of the full survey results are provided in Annex 9.

Table 1.1: Response Rates of Pilot and Full Surveys

FULL + PILOT SURVEYS	Targeted	Completed 100% - include in all survey Q analysis		Completed at least50-90% (include in analysis of questions through TA characteristics only)		Completed at least 20-50% (include in analysis of TCA planning questions only)	
		n	%	n	%	n	%
EPI	100	29	29%	38	38%	43	43%
Core Partner	142	76	54%	79	56%	83	58%
Expanded Partner	14	11	79%	11	79%	11	79%
SCMs	24	15	63%	16	67%	16	67%
TOTAL RESPONSE RATE	**280**	**131**	**47%**	**144**	**51%**	**153**	**55%**

[6] Afghanistan, Chad, DR Congo, Ethiopia, India, Indonesia, Kenya, Nigeria, Pakistan, Uganda

[7] Central African Republic, Haiti, Madagascar, Mozambique, Myanmar, Niger, Papua New Guinea, Somalia, South Sudan, Yemen

[8] Following the pilot test of the survey, the questionnaire was revised to minimize the number of questions and further specify the focus of the questions. For example, the revised questionnaire narrowed the list of TCA quality attributes asked about from 11 to 7. Questions about the effectiveness of the JA in identifying the EPI technical needs were further specified to ask about identifying needs in each programmatic area.

Desk Reviews/Document Reviews: (*Scope: Tier 1 and Tier 2 Countries, with a focus on Tier 1 Countries & Gavi Secretariat)*

The evaluation team closely reviewed 80 documents to obtain objective information to inform the context of the TCA processes at the Gavi Secretariat and county levels. Annex 7 lists the documents that were reviewed. These documents were used to ground the evaluation in the TCA planning and delivery process used by Gavi, as well as to better understand the varying ways this process has been implemented in priority countries. Documents were also used to triangulate and validate key findings.

Observations: *(Scope: 4 Case Study Countries)*

Together with our in-country partners, we conducted observations of the Joint Appraisal meetings or other relevant TCA planning or review meetings in the four case study countries. The countries included Afghanistan, Nigeria, the Democratic Republic of Congo, and Ethiopia.

Analysis

Data from the different data collection methods were first analyzed individually, by data source, then triangulated with data from different sources. Throughout this report, we have indicated the data sources from which our key findings are drawn to indicate the strength of the evidence supporting the findings. Table 1.1 below explains our notation for relaying the strength of evidence for each key finding.

Table 1.2. Strength of evidence rating system

Rating	Description
I S D 	I – Interview Data (Tier 1 countries only) S – Survey Data (Tier 1 & 2 countries) D – Document Reviews (Tier 1 & 2 countries) O – Observations (4 focus countries only)
	Green – The data source is reliable, it reflects views from majority of respondents, and captures an emerging view. Yellow – The data source is less reliable, it may not reflect views from most respondents, or captures differing views. Grey – The data source is not reliable, and/or it does not support the finding.
Examples:	
	Finding is based on survey data, interview data, AND objective data from relevant documents (may also be supported by observations). Survey data are of generally good quality (high response/completion rate) and reflect input from the majority of respondents. Interview findings reflect emerging views from an observationally/ practically significant number of interviewees

	Finding is supported by 4 data sources (including survey data, interview data, and document review, observations) but interview and survey data do not reflect views from the majority of respondents
	Finding is supported by two data sources (survey data and document review) which are reliable and reflect emerging views from the majority of respondents
**	Finding is limited only to the 4 case study countries

1.3. Limitations

This assessment was limited by several procedural and program-related factors:

Program-related limitations:

- ***Weakly defined program components.***[9] Some critical aspects of the TCA structure and processes remain poorly defined, presenting a challenge for crafting reliable methods to measure and evaluate those program components. For example, we found no standard definition for TCA, nor is there standard guidance provided by Gavi for understanding the different programmatic areas.

  Similarly, there are no agreed upon standards for some of the principles of the PEF-TCA: transparency, accountability, and country ownership. Measuring these concepts, in the absence of an established and agreed upon framework has been greatly challenging and limits the robustness of any attempts at quantifying these concepts, comparing across partners or countries, and identifying change across time.

- ***Limited awareness of key Partners' role within the PEF TCA Framework.*** There was limited awareness and understanding of the role of CDC and the World Bank within the PEF-TCA framework across most country-level stakeholders as well as among some SCMs. While stakeholders were aware that CDC and the World Bank are Gavi-funded TCA Partners, there was no further understanding of the activities they supported, or how they engaged with government counterparts. This greatly limits the interpretation of the survey results about the quality and contribution of the TCA provided by these Partners.

- ***Limited generalizability across countries.*** Gavi works with countries which vary considerably across factors that cannot be controlled in this evaluation, including differing governance structures and levels of fragility. Therefore, it is difficult to generalize based on findings in any one particular country as they may not be appropriate for other contexts.

[9] In the 2017- 2018 planning guidance, Gavi provided definitions for these components. However, this guidance is not included in the baseline assessment.

Methods-related limitations:

- ***Limited scope of evaluation of TCA provision at Central Level.*** Given the large number of countries included in the evaluation (20 countries) and number of Partners engaged at each country (2-6 organizations) and the number of stakeholders engaged at the central level, this evaluation did not have the resources necessary to evaluate in depth the TCA that is provided at the sub-national level. While perspectives of the sub-national level were collected through interviews and surveys, the respondents were largely those working at the central level. Only in the case study countries, were sub-national level stakeholders particularly targeted for interviews or surveys. Even in these cases, the scope of the evaluation was necessarily limited and therefore limited the insights gathered regarding the effectiveness, relevance, or efficiency of TCA provided sub-nationally.

- ***Sampling Bias of the Interview and Survey.*** Any sampling methodology to identify stakeholders and prospective respondents to a survey or interviews imposes a tradeoff between practicality, cost-effectiveness and the potential for bias in the results. The only feasible sampling strategy in this case was to request a list of relevant stakeholders from the Gavi Secretariat and key stakeholders in the Partner organizations. In the Case Study countries, where more interviews took place, it was possible to add an additional "snowball" strategy to request interview respondents to identify others that should be included in the evaluation. The result of this top-down sampling approach was that the evaluation included many national level stakeholders, but did not capture many perspectives of those working at the sub-national level.

  Additionally, since the respondent list came from the Partner organizations, there was a level of nuance regarding the stakeholders within their organization that was not captured and is not reflected in this evaluation. For instance, the evaluation did not systematically target or differentiate TA providers that were embedded within the EPI. These providers that may act on a day-to-day basis if they were members of the EPI are not differentiated from those others in their organization that work from within the Partner organization itself.

- ***Low Survey Response Rate of EPI Stakeholders.*** Unfortunately, the evaluation experienced a relatively lower response rate from stakeholders in the EPI (43%) than those from the Gavi Secretariat (67%) and Partners (60%). Therefore, the survey findings do not adequately reflect viewpoints from the national immunization programs. Likewise, though we had a 55% response rate overall, the number of respondents is sparsely spread across the 20 Tier 1 and 2 countries, curtailing the feasibility of meaningful country comparisons. For Partner-specific TCA delivery questions, the number of respondents for each Partner is also quite limited, especially for CDC, the World Bank, and Expanded Partners. Therefore, it is not possible to draw conclusive insights on the delivery of TCA by these Partners. All data presented here on the delivery of TCA by these Partners is merely a raw reflection of the survey responses, and should not be used to draw any conclusions.

- ***Reliance on subjective data (individual perspectives), which we have controlled for to some degree with data triangulation, but not always possible to do so.*** Much of the data captured through this evaluation were perspectives of stakeholders through surveys and interviews. Whenever individuals' perspectives are used to evaluate programs, there is a degree of subjectivity and bias on account of the partiality of those perspectives. This evaluation sought to control for this by using a triangulation methodology, where multiple data sources and types were consulted to validate key findings. However, this was not always possible. Therefore, the evaluation uses a strength of evidence notation (see Table 1) to delineate what type of data source(s) was used and the strength of that source or those sources.

- ***Potential issues with recall among respondents.*** This baseline evaluation covered the 2015 planning sessions as well as 2016 implementation. The timing of the data collection was necessarily well after those activities took place. There is, therefore, a possibility that recall among participants was reduced, potentially hindering the reliability or relevance of these perspectives.

- ***Poor Comparability between Partners.*** TCA funds support Core Partners and Expanded Partner. However, even with this delineation, there are structural differences in regards to how Gavi interacts with these Partners that greatly reduces their comparability. Core Partners are defined by Gavi Leadership as those Partners that receive foundational funds, meaning UNICEF, WHO, the CDC, the World Bank and Community Support Organizations (CSOs). However, while UNICEF and WHO largely plan, receive funding, and provide technical assistance in a similar manner, the World Bank and the CDC have different agreements with the Secretariat and subsequently different processes related to planning and delivery of TCA. For instance, the World Bank and CDC do not have the same level of in country presence as UNICEF and WHO, which impacts how they plan and execute their work. Additionally, World Bank has a multi-year agreement with the Secretariat, while the other Core Partners have one year funding and review cycles.

2. Findings - Technical Assistance under the Business Plan

As Gavi's overall strategy and goals have evolved across several strategy periods, the role of Partners has remained the same – to support operationalization of the strategic plans at the country and global levels. In prior strategic periods, this support was not consistently referred to specifically as "technical support" or "technical assistance". Partners' support was defined through a set of activities outlined in annual work plans (for the 2007-2010 strategy period) or through a set of deliverables closely aligned with the strategic goals and objectives of the 2011-2015 strategic plan. In large part, Partners' support for Gavi's strategic plans has been an expansion of their ongoing, core organization-specific immunization efforts both at the country and global levels.

We have taken a closer look only at the last strategy period (2011-2015) to serve as a point of comparison for the technical assistance framework under the current strategy period (2016-2020). We conducted a detailed document review to understand the strengths and weaknesses of TA under the BP. We also sought input from key stakeholders during our in-depth interviews to understand their perspective on the key changes between these two frameworks. Given prior assessment of technical support under prior Strategy periods, we did not focus greatly on this component. ***Our findings are aligned with those that have been documented in prior evaluations of Gavi's technical support.***[10]

[10] McKinsey and Company. Strengthening technical support-Gavi Alliance.

Box 2.1: Overview of Key Finding on TA under the Business Plan

- ***Key Finding.*** The BP allowed for a high degree of flexibility in spending
- ***Key Finding.*** The HQ-based structure of the BP facilitated efficiency with funding disbursement and delivery
- ***Key Finding.*** There was a clearly articulated link between the TA activities and the higher level Gavi goals
- ***Key Finding.*** The BP funding structure lacked transparency at the national and subnational levels.
- ***Key Finding.*** The BP was a top-down approach, lacking country-level engagement in defining TA needs
- ***Key Finding.*** Poorly structured performance monitoring processes led to weak accountability in the BP
- ***Key Finding.*** Coordination and communication across Partners, Gavi Secretariat, and EPI was weak under the BP

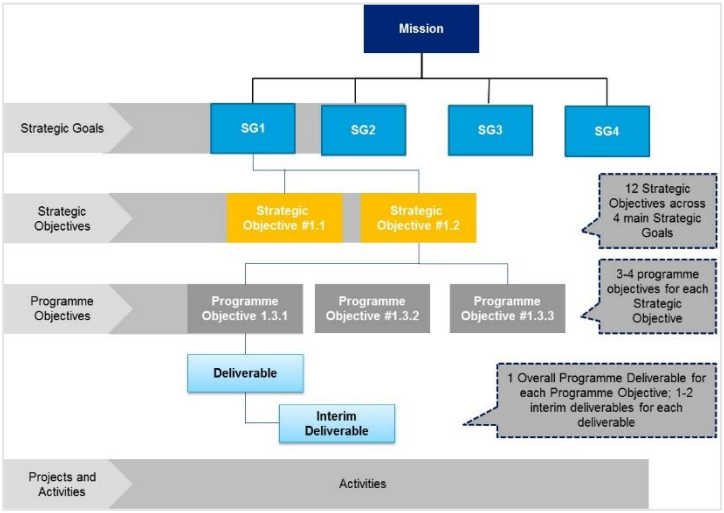
2.1. Technical Assistance under the Business Plan

The Business Plan (BP) was formulated in 2010 to support the operationalization of the four goals and associated strategic objectives of the 2011-2015 Strategy.[11] The BP aimed to ensure a strong logical link between the strategic goals and program activities and therefore specified 26 programmatic objectives, each linked with performance targets and program-level deliverables, including deliverables to be achieved by the end of the strategy period (Figure 2.1). These programmatic objectives and activities were developed collaboratively between Alliance stakeholders and Partners, followed by a review from the Gavi Secretariat.[12]

Implementing Partners then specified their own quarterly deliverables for programmatic objectives that aligned with their technical strengths. These deliverables were reviewed, discussed, and endorsed by the Gavi Secretariat. Partner-specific quarterly deliverables were aligned with and contributed to the overall programmatic deliverables and were set at the global level, with reference to specific countries only in limited cases. As these deliverables were set at the organizational level, it allowed Partners to shift resources to different countries, based on emerging needs and in some cases, requests from countries.

Figure 2.1. Overview of the Business Plan[10]

[11] Gavi Alliance Board Meeting 30 November – 1 December 2010
[12] Gavi Alliance Board Meeting 30 November – 1 December 2010
[13] Gavi Alliance Board Meeting Minutes (June 2010)



Over time, the BP started to specify focus countries for the programmatic objectives and activities and also differentiated Partners' roles and responsibilities, in cases where more than one Partner was supporting a given country. The 2013-2014 BP was built with more focus on country needs as well as country-based activities and deliverables.

The BP performance management plan required implementing partners to report on specific key performance indicators (KPIs) on a quarterly basis; the reports were then reviewed against the agreed-upon deliverables. Senior management from the Secretariat as well as Partner organizations were engaged to discuss program objectives for which progress was insufficient or areas where Partners were facing specific bottlenecks or constraints.

2.2. Implementing Partners under the BP

The primary Implementing Partners under the BP were WHO and UNICEF, with WHO receiving notably more Gavi funds than UNICEF. A non-Alliance partner, The Accelerated Vaccine Introduction Technical Assistance Consortium (AVI-TAC) was awarded a contract of $51.3 million between 2009 and 2015 to accelerate demand for vaccines in Gavi countries. It was not until 2014 that the World Bank and CDC were funded by Gavi to support technical assistance under the BP framework. The World Bank started engaging in the BP to assist Gavi-supported countries for graduation, financial sustainability and support for Health System Strengthening (HSS). CDC supported vaccine introductions (OPV and HPV), data quality, and surveillance and vaccine safety. Other partners (non-exhaustive) included Catholic Relief Services (CRS), VITAC (in-country advocacy), JSI/AMP vaccine introductions), and PATH (support innovation development agenda).[14]

2.3. Strengths of TA under BP

Technical assistance under the BP model had several strengths that should be acknowledged.

***Finding:* The BP allowed for a high degree of flexibility in spending**

In the BP structure, TA planning and delivery was decided by the partner organizations at the HQ and regional level. This allowed a holistic view of the funding portfolio from a global lens. Some interview respondents felt that this left key decisions to the "experts," while others felt the global and regional stakeholders were uninformed of the specific needs of each unique country.

[14] 2015 Business Plan and Budget. Report to the Board (December 2014)

The BP allowed Partners a great deal of flexibility and discretion in how these funds were spent. While still accountable to the agreed-upon deliverables, this flexibility allowed Partners to modify the activities implemented to achieve those deliverables or where those activities were implemented, to better respond to emerging or changing needs and priorities. Some TA Partners at the global level felt that allowing Partners more discretion in spending Gavi funds led to a greater outcomes. This flexibility allowed for funds to be easily re-allocated to other countries or activities, as the needs arose. This was regarded as an important benefit, especially for supporting new vaccine applications and introductions. Others commented on the necessity and benefits of such a flexible funding structure to "glue" projects together between the country, regional, and HQ levels. The downside of the flexibility in spending was the lack of transparency (discussed in more detail below).

***Finding:* The HQ-based structure of the BP facilitated efficiency with funding disbursement and delivery**

Under the BP structure, Gavi funding went directly to the Partners' headquarter office. This structure was designed for efficiency, to minimize overhead and transaction costs. Most of the funds were expended at the HQ level, with only small proportion of funds being directed to the regional or country offices. As these funding release decisions were made at the HQ level and did not involve input or approval from other stakeholders, use of funds and therefore delivery of activities, was quite streamlined and efficient.

***Finding*: There was a clearly articulated link between the TA activities and the higher level Gavi goals**

The cascading flow of strategic goals > objectives > activities > deliverables presented a clear linkage of how Partners' activities supported and contributed to Gavi's overall strategic goals and objectives, providing a solid framework to define the value of Partners' efforts.

2.4. Weaknesses of the BP

There are several weakness in the BP model, which have already been identified in prior reviews and Gavi documents, including challenges around country ownership, transparency, and accountability. The sentiments that we heard in our interviews echo what has already been documented in these previous evaluations by McKinsey, the Gavi Full Country Evaluation team, and others.

***Finding*: The BP funding structure lacked transparency at the national and subnational levels.**

Though the BP afforded a lot of flexibility to Partners' HQ offices, Partners' regional and country based teams frequently cited a lack of transparency on what was being funded with the BP funds, how much was being funded, and even why certain activities were being supported over others. Even more so than the Partner country counterparts, EPI teams and SCMs lacked much visibility on the activities supported with Gavi –BP funds for Partners. SCMs cited frustration with their exclusion from decisions regarding support for countries within their portfolio. There was an overall lack of awareness of what the BP was and how it functioned. Many interview respondents had not previously heard of BP and were not aware of how it worked until the new system of PEF/TCA was described to them, and the first JA was introduced.

"In regional offices, we had zero visibility what was going to the country, and the countries themselves had zero visibility of what was coming from Gavi or not."
- Partner (Regional level)

"Senior Country Managers at Gavi were absolutely kept in the dark... technical assistance, at country level was more or less a black box."
- SCM

<u>Finding</u>: The BP was a top-down approach, lacking country-level engagement in defining TA needs

TA planning and delivery directly reflected the funding structure in the BP system. TA planning was driven at a global (HQ) or regional level, and focused on meeting the milestones pre-defined at HQ contributing to Gavi's strategic objectives. BP TA delivery and planning was piece-meal and project based, similar to small contracts of other development or large donor organizations. The type of TA under BP leaned more towards short term consultancies and short term technical assistance (STTA) in the form of workshops and trainings for capacity building, rather than long term support efforts.

"Normally we contacted the country offices to see if they were willing to work on these things and asked them to put this into the EPI national plan. And then if we got positive feedback, we would put it into the BP."
-- Core Partner (HQ)

"*We were told 'you are on the priority list so you will receive money to do …..' and we just said 'oh, thank you"* -- Core Partner (Country-level)

The primary TA providers under BP, UNICEF and WHO, designed TA activities primarily at the HQ level, based on their technical expertise. Where there were country-specific activities planned, they would engage the country-level counterpart who may then engage with the EPI manager to notify them of the planned activity. In some cases, the EPI manager was engaged only to provide feedback on the proposed dates of TA delivery, without input on the type or scope of TA to be provided. Partners reported attempts of trying to be as country-specific as possible but also reported complaints of HQ stakeholders who approved the budgets not fully understanding the country-context and country needs.

The BP did not include a high level of detail regarding what was to be done in each country, which country stakeholders feel is necessary as the challenges faced by each country are unique. By excluding EPI programs from participating in evaluating and identifying their needs, and planning and requesting TA, some stakeholders remarked that the system created a culture

of country-partner dependency on Gavi-funded support rather than capacity building to transcend the need for that support.

***Finding:* Poorly structured performance monitoring processes led to weak accountability in the BP**

A general lack of accountability was cited among stakeholders as a key problem borne out of the lack of transparency. With a lack of understanding of which Partners were funding which activities or positions, and a lack of clear lines of reporting, there was a general inability to effectively monitor results and hold stakeholders accountable to milestones and deliverables. Performance reporting itself was also cited as a weakness in the BP. Partners sent quarterly progress reports but the SCMs had no context to effectively review the reports. Because BP strategic priorities, objectives, and deliverables were not very specific to the needs of each country, reporting was often paraphrasing or verbatim repeating the objective or deliverable to "check the box" without providing a clear context of the process, results, outcomes, challenges, or impact.

***Finding:* Coordination and communication across Partners, Gavi Secretariat, and EPI was weak under the BP**

A general lack of communication and coordination was cited between Partners, Gavi, and EPI stakeholders. Within the BP, stakeholders acknowledged that although Partners delivered TA, the nature of disparate, uncoordinated projects without transparency among Partners did not reflect Gavi's potential to be a true partnership or alliance. The SCMs were minimally involved, and only occasionally consulted in specific country-related questions.

3. Shifting Gears – Partners' Engagement Framework

Towards the end of the 2011-15 strategy period, the Alliance identified the need and opportunity to use more bottom-up, country-driven and country-focused approaches for planning TA. In 2016, the Gavi Alliance adopted a new strategy of supporting TA under the Partners' Engagement Framework (PEF). PEF seeks to overcome the structural weaknesses of the BP by focusing on four key pillars: country focus, differentiation[15], transparency, and accountability. Under PEF, funding to partners for technical assistance is divided into three categories:

- **Foundational Support:** Longer term, predictable funding to maintain Core Partner activities at the global/regional levels which are critical to sustaining and further improving immunisation-related outcomes;
- **Targeted Country Assistance (TCA):** Time-limited resources provided to Partners (Core and Expanded) for the provision of targeted country assistance (TCA) to address identified needs in all eligible countries (Gavi countries that have not transitioned/ fully self-financed), with more resources dedicated to the priority countries.
- **Special Investments in Strategic Focus Areas (SFAs):** Gavi partners jointly develop medium- to long-term approaches in programmatic areas that have been identified as critical for 2016-20 period and where the Alliance needs to go beyond business as usual. To date, these include Supply Chain; Data; Leadership, Management and Coordination; Demand Promotion; Political Will and Sustainability. All these areas underscore the key strategic focus for 2016-20 on coverage and equity, and financial and programmatic sustainability.

Under this new framework, in 2016 Gavi allocated about 51% of PEF funding directly to Partners in country through the TCA mechanism, whereas previously the vast majority of TA funding was allocated to Partners at the global or regional levels.[16] The design of PEF reflects material changes in the way that TA needs are identified and how corresponding TCA activities are developed; the process for selecting and awarding TCA providers; the allocation of TCA funding to country versus regional/global level activities; the types and models of TCA that are supported; and the monitoring and reporting requirements for TCA providers and recipients. As such, the principles of *country-ownership*, *accountability*, and *transparency* are key drivers of this new process and simultaneously, tracked as outcomes expected as a result of this new approach. In the absence of standardized Gavi definitions for these terms, the Evaluation Team conducted a literature review to identify commonly accepted definitions for these terms and the dimensions that encompass the full breadth of each concept. Definitions were tailored to apply to the specific PEF context, as noted in Box 3.1, to facilitate a common understanding of these concepts.

[15] "Differentiation" is a strategy of the PEF that categorizes and prioritizes countries into three tiers of funding, based on the scale and severity of challenges in immunization, with Tier 1 countries receiving the most investments. This pillar of PEF is an important tenet of the PEF and determines the range for the total TCA funding envelop for each country.

[16] Partners' Engagement Framework (PEF) & Alliance Accountability Framework. Presentation for the Board Meeting by Anuradha Gupta. 22-23 June 2016. Geneva.

Box 3.1. Definition of key terms for Technical Assistance:

- **Transparency** is measured by the extent to which key aspects of the TCA (including but not limited to planning, development of the TA plan, approval of TA activities, award of partners, delivery of TA, and progress on activities and expected outcomes) are clearly documented, disseminated, and understood by all key stakeholders.
- **Accountability** is the shared responsibility and answerability of the TA recipient, TA provider, and the TA funder (Gavi Secretariat) for the quality and effectiveness of technical assistance. The PEF Functions document provides further clarity on what each stakeholder is accountable for*:
  - **TA providers** are accountable for providing support in an integrated and holistic manner; systematically tracking progress; proactively identifying and addressing bottlenecks; and monitoring and reporting on progress
  - **TA recipients** are accountable for the achievement of expected outputs and outcomes
  - The **Gavi Secretariat** is accountable for ensuring performance across key constituents of the Alliance through performance management at different levels (PEF performance management, Secretariat performance management, Country grant performance management)*
- **Country-ownership** is characterized by the full engagement and leadership of the national immunization programme in identifying, prioritizing, coordinating, participating in, monitoring and evaluating technical assistance activities

3.1. What is Technical Assistance?

Technical assistance is a much discussed and debated topic in the development aid space. Where available, definitions for “technical assistance” or “technical support” are often intentionally vague to cover a broad and diverse range of activities, including training, mentoring, research, collection or analysis of data, developing and disseminating tools or guidelines, or drafting policies, among other things.[17] While some TA activities are directly related to capacity building (e.g. training, mentoring), others are more advisory in nature, or provide direct implementation or management support (sometimes in a gap-filling capacity).[18]

Technical assistance typically uses an outside ‘expert’ to supplement existing teams or fill in for gaps in the team.[19] Experts can be hired from within the country or be expatriates (from the regional or global levels); they may be residential or non-residential. Once in country, the experts may sit within the donor (the hiring agency) offices or they may be embedded directly

17 West, G., Clapp, SP, Averill, EMD, & Cates, WJ. (2012). Defining and assessing evidence for the effectiveness of technical assistance in furthering global health. Global Public Health. 7 (9). 915-930.
18 Land, T. Joint Evaluation Study of Provision of Technical Assistance Personnel – What can we learn from promising experiences. A Synthesis Report. European Centre for Development Policy Management. September 2007. Available from: www.ecdpm.org/dp78.
19 Action Aid International. Real Aid: Making Technical Assistance Work. Available from: http://www.actionaid.org/sites/files/actionaid/real_aid_2.pdf

within the recipient program teams. TA can also be a one-time activity, delivered over a short-term period, or span over a period of several years.[20,21]

Within the Gavi context, **we were not able to obtain a specific definition for TCA from different Gavi Secretariat and Alliance stakeholders**. Following document reviews, we retrieved the following description for TCA from the June 2015 Gavi Board Paper[22]: "assistance provided by partners to countries to support successful implementation of the Gavi grants and overcome the bottlenecks within their immunization programmes….All partners would be expected to provide support to countries in ways that ensure transfer of skills to in-country staff and engage local or regional assistance providers – including CSOs – to promote sustainability and long term capacity building."

This high level description of TCA offers a high level view of the purpose of the TCA and highlights some critical aspects of TCA, namely it should:

- support successful implementation of Gavi grants
- address bottlenecks of the immunization program
- ensure transfer of skills to country staff
- engage local/regional TA providers
- promote capacity building and sustainability.

However, the description of TCA does not provide any clear parameters for what qualifies as "assistance" or "support" or the methods by which the TCA should be provided. A review of the literature on the topic revealed various elements of the structure of TA that must be understood in order to assess it comprehensively, as described in Box 3.2.

20 Action Aid International. Real Aid: Making Technical Assistance Work. Available from: http://www.actionaid.org/sites/files/actionaid/real_aid_2.pdf
21 West, G., Clapp, SP, Averill, EMD, & Cates, WJ. (2012). Defining and assessing evidence for the effectiveness of technical assistance in furthering global health. Global Public Health. 7 (9). 915-930.
22 Gavi, the Vaccine Alliance, "A New Gavi Engagement Framework for Implementing the 2016-202 Strategy. Gavi Board June 2015

Box 3.2. Definition of key terms for Technical Assistance:

Technical Assistance (TA): *The "transfer, adaptation, mobilization and utilization of services, skills, knowledge and technology. It includes both short- and long-term personnel from both national and foreign sources, plus training, support equipment, consultancies, study visits, seminars, and various forms of linkage [to improve the capacity of the immunization program]" (definition adapted from DAC)*

TA Functions: A typology of the nature of TA activities and the roles of TA providers, classified as:

- *Capacity development* – Activity for which the primary objective is to assist individuals or programs to develop specific capabilities or enhance performance (e.g. cold chain technical training on maintenance and repair of CCE)
- *Advisory* – Expert advice or consultation for a specific programmatic area (e.g. to assist in program design or to contribute to the investment and sustainability plan)
- *Gap-filling/implementation* – Provision of personnel to help an organization carry out its work in lieu of its own staff (e.g. Conduct outbreak investigation; conduct equity assessment)*

(Adapted from the *Land: Joint Evaluation Study of Provision of Technical Assistance Personnel)*

TA model – The way in which TA is provided, as a combination of its duration (short vs long term), its level of proximity to the recipient program (embedded or remote), and its function (capacity development, advisory, implementation, management support)

It should also be noted that the PEF-TCA guidance materials shared with countries do not provide any definition or guidance for what constitutes technical assistance. The lack of a specific definition of TCA may be intentional to allow flexibility and tailoring for country-specific needs. However, **the result is that there are varying, and often inconsistent views on what TCA is or what it should be, which has implications for the scope of activities supported**, as will be discussed in Section 5 below.

Below are the four common perception on what TCA is or what it should include, as expressed by interviewees:

Implementation Support: The large proportion of EPI stakeholders (and some partners) that we interviewed view technical assistance as being human resource support for the EPI to fill a personnel or expertise gap. It is essentially viewed as a mechanism to support day-to-day tasks of the EPI and "get the job done". While in theory, it should be directed at addressing a specific problem, it is more often the case that it is broad in nature and fills in any gaps within the EPI team.

Capacity Building: In some cases, but not all, stakeholders noted that technical assistance includes any effort that is focused on building the knowledge or skills of the EPI team and subsequently improving the capacity of the EPI to fully implement the necessary support with limited external support.

Advisory support: A limited number of stakeholders explained that the role of technical assistance is to provide high-level strategic advice for developing national strategy plans or to facilitate the planning for introducing new vaccines, etc. Such support may encompass the actual development of the strategic/technical plans or may simply provide input for these products. However, once plans are developed, the implementation of those plans is the

responsibility of the EPI. Stakeholders also indicated that this type of support should be introducing the EPI to new ways of thinking or introducing innovative processes, methods, or tools to help "do things better" (as opposed to the day-to-day status quo support).

Program Support: Though not a commonly shared viewpoint, it is worth noting that some stakeholders, particularly from the EPI viewed the TCA specifically as a resource to support specific activities or resources for the EPI that may not have been budgeted for under the HSS or cMYP. There is an underlying tension in this perspective as the connotation is that TCA funds should not be used to support Partner staff salaries, but instead support EPI programmatic activities. This view may be confounded by the fact that in some countries Gavi HSS funds for procurement of both vaccine and non-vaccine items (such as cars, motorcycles, generators, etc) are given to Partners, primarily UNICEF, in cases where government procurement systems are not well equipped to manage such large procurements in a timely manner.

"The government thinks often that we are here to take the money that GAVI has to give them" - - Core Partner

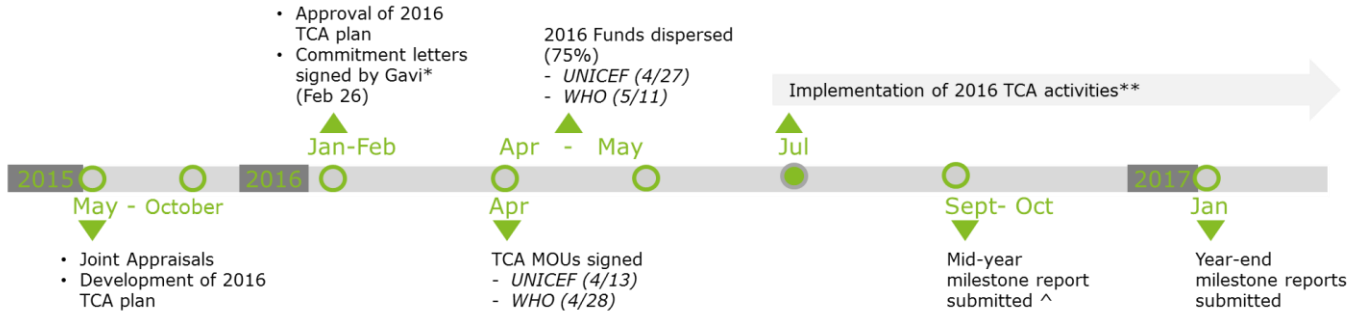
These views are not mutually exclusive. There is certainly a little of all of these elements across most TA efforts. However, most stakeholders emphasized either the implementation support or capacity building aspects of TA. And some acknowledged that while the ultimate goal of TA is to build capacity, in practice it takes on more of an implementation support role. Of course the purpose of TA and the form it takes will be determined by the needs of the program. However, **this foundational question of where the focus of TA is - *"getting things done"* and/or building capacity of the EPI so they can take full ownership of "getting things done" - is central to defining the TCA activities to be funded, how those TCA activities are delivered, and ultimately to determining the success of TCA efforts.**

4. Findings - TCA Planning Assessment

4.1. 2016 TCA Cycle

2016 marks the first year of implementing the full cycle of the new PEF-TCA approach. The first round of Joint Appraisals conducted between June and November, 2015 informed the planning for the 2016 TCA activities, as defined in the 2016 PEF TCA Spreadsheet (TCA Plan). The Gavi Secretariat approved the TCA Plans by Feb, 2016. Due to the anticipated delay in releasing funds, Gavi provided letters of commitment to Partners in April notifying them of the committed funding level and the 2-year funding commitment to support TCA staff salaries. Gavi then started releasing funds to Partners in June, 2016 (Figure 4.1). The letters of commitment from Gavi were intended to support Partners in starting the implementing of TCA, including hiring new staff. However, the majority of stakeholders we interviewed noted that they did not begin implementing on the 2016 TCA Plan until July 2016. As per the reporting requirements, partners submitted their mid-year milestone report on a rolling basis, prior to convening the JA and their end-year report on 30 November 2016. We will be referring to this cycle as we discuss the different aspects of the TCA planning and delivery, as several of our conclusions and key findings are rooted in this cycle.

Figure 4.1. Overview of the 2016 TCA Cycle[23,24]



* *The Gavi Secretariat signed and shared funding commitment letters to allow Partner to begin recruitment prior to actual disbursement of funds*

** *Due to the delayed start of 2016 TCA activities, Partners were allowed to use 2016 funds through June 2017*

^ *The guidance for submission of mid-year milestone reports is that they should be submitted prior to the JA in each country, and by Oct 30th at the latest*

4.2. Implementation of the 2016 TCA Planning Process

The TCA planning process is a country-based annual review cycle whose two main functions, according to Gavi circulated guidelines, are to report progress from ongoing TCA activities, and to facilitate the development of a proposal for the next year's funding cycle. Post Joint Appraisal meetings support the identification of the technical assistance provider or Partner who will perform those activities, as well as milestones the Partner will be used to report on progress and

[23] GAVI PEF Management Team Update. Sep 27 2016, Geneva, Switzerland
[24] GAVI PEF Management Team Update. Feb 1-2 2017, Geneva, Switzerland

outcomes from stemming from those activities. These activities are intended to be based on the identification and validation of key issues facing the national immunization program, and should reflect the priorities of the country. Joint Appraisal reports are then submitted to a High Level Review Panel (HLRP), who makes funding recommendations to the PEF management team for the subsequent year.[25]

The planning process is a significant departure from that under the Business Plan, where planning of activities was largely done at regional or global levels between the Gavi Secretariat and Partners. From interviews and reviews of the countries' JA reports, it is clear that while the JA Process has been largely implemented successfully across the priority countries, its implementation varies widely. This section explores the key themes that emerged around the JA implementation processes, perceived relevance of the JAs, and areas for improving the JA moving forward.

Box 4.1: Summary of Key Findings from the TCA Planning Assessment

- ***Key Finding:* There may be misalignment of the JA with other national planning/reporting processes.** *The majority of Joint Appraisals occur between June and September, which is not in line with most countries' fiscal year, which usually ends in December.*
- ***Key Finding:* Overall, there is a sense that the TCA activities defined during the TCA planning process reflect the needs of the immunization program.** *However, there is still some lack of clarity around how the activities of some partners (e.g. World Bank, CDC) are determined. This lack of clarity reduces the transparency among partners and the level of country ownership.*
- ***Key Finding:* The Joint Appraisal planning process has been rolled out successfully and has gathered support from key stakeholders**. *While the Joint Appraisal process is highly complex and resource intensive, it has gathered significant support. 57% of respondents felt that the Joint Appraisal was an appropriate platform to identify TA needs.*
- ***Key Finding*: There is confusion over long term support for human resources.** *Despite guidance provided by the Secretariat, there remains a lack of clarity on the TCA funding commitment for Partner staff in country. Though Gavi guidance specifies that it will support staff salaries for a 2-year period, this is not well understand at the country level, resulting in hiring challenges.*
- ***Key Finding:* The TCA planning process does not reflect specific agreements with some Partners** and therefore minimizes the transparency around these Partners' activities**.** *Several Partners, such as the World Bank, CDC and some Expanded Partners, have parallel planning and contracting processes. While they are engaged in the Joint Appraisal process, it does not determine what activities they are involved in.*
- ***Key Finding:* While transparency has increased among stakeholders, in some instances, this expectation of transparency has resulted in tension between the Core Partners and the Ministry of Health.** *The expectation of more transparency, when not met, has contributed to tension between the EPI and specific Partners. Similarly, the lack of clarity on the role of primarily Expanded Partners has contributed to a sense of competition. .*

Joint Appraisal Design Principles

To support the establishment and implementation of the JA process, the Gavi Secretariat developed guidance documents, which were shared with the SCMs, Partners and EPI teams. These guidelines outline the expectations and give examples of key elements of the JA process,

[25] 2016 Joint Appraisal Planning Guidance

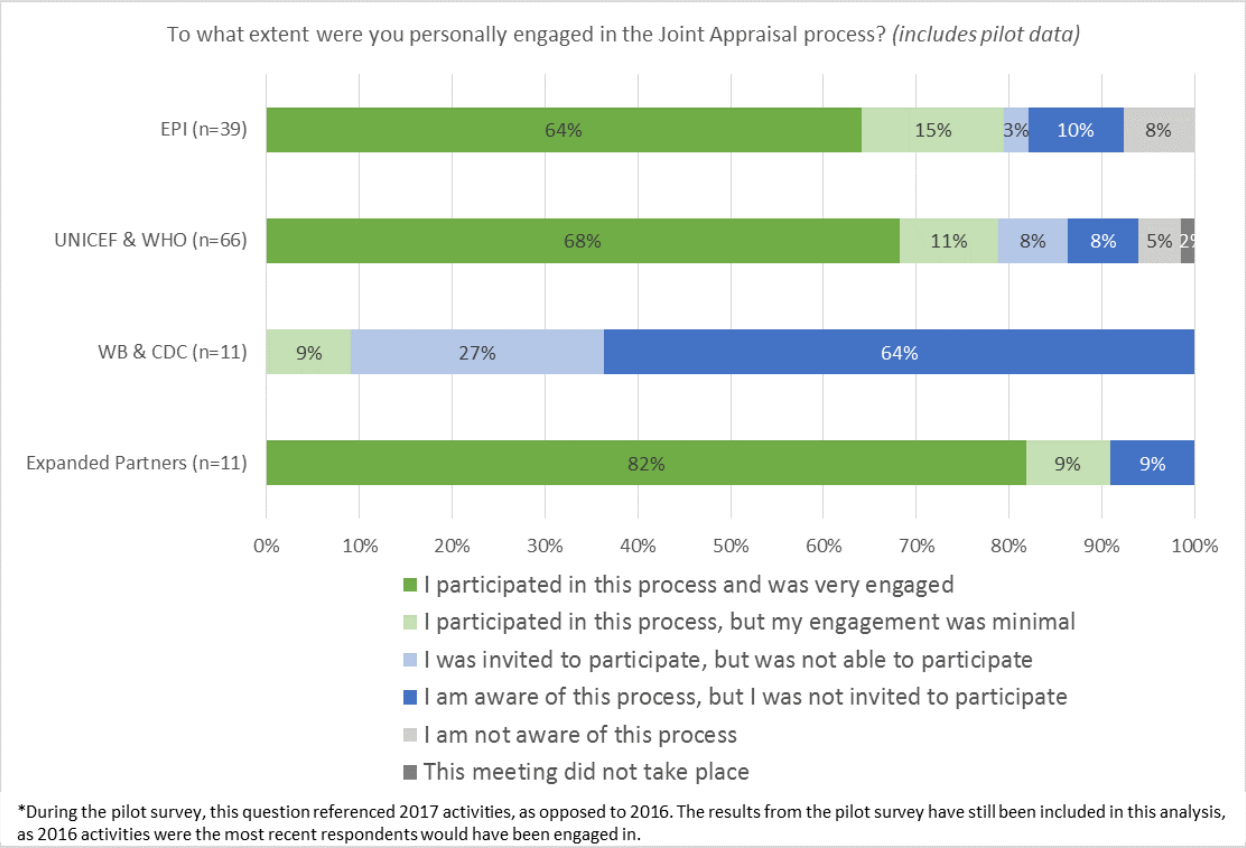
but also give considerable flexibility for countries to adapt the process to fit their particular context.

The JA guidance lays out 8 design principles that highlight the key features that Gavi considers important for a successful JA.[26] We have used these principles as the framework with which to assess how well the 2016 JAs (to design the 2017 TCA) conformed or diverged from Gavi's guidelines.

1. Design Principle 1: Be co-convened by the Ministry of Health (MOH) and Gavi Secretariat

Description of the JA process provided in the JA reports vary in specificity and breadth, with several reports leaving the section blank (e.g. Chad, DRC, 2016); however, there were no reports contradicting the idea that the JA was led and/or managed by the Ministry of Health (MOH) and the Gavi Secretariat. In a few instances where it was reported that the JA was led by the MOH (e.g. Afghanistan in 2016) without mention of the Gavi Secretariat; however, it is evident from the descriptions that the Secretariat was highly involved. Interviews also suggest that Joint Appraisals were convened by the Ministry of Health in most instances, and attended by the SCMs.

Figure 4.1. Stakeholder engagement in the Joint Appraisals



*During the pilot survey, this question referenced 2017 activities, as opposed to 2016. The results from the pilot survey have still been included in this analysis, as 2016 activities were the most recent respondents would have been engaged in.

[26] 2015 and 2016 Joint Appraisal Planning Guidance

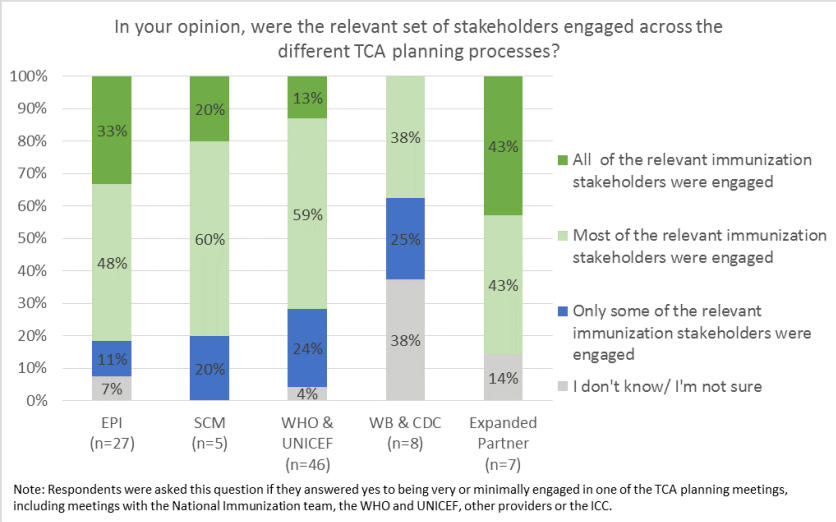
Survey responses also suggest a moderate level of engagement from the EPI, as 79% of EPI stakeholders reported to be engaged in some capacity with the JA, with 64% reporting being very engaged. Interview findings further corroborate this observation that in general, only some members of the EPI team (primarily the EPI manager, and team members working on supply chain, data) engage in the JA. Interestingly, 8% of EPI respondents and 5% of WHO and UNICEF respondents indicated that they are not aware of the JA.

However, there are instances that suggest that having a formal role may not signify the expected level of leadership during the process. In one instance, it was reported that while the EPI team members opened the JA meeting, they would often leave the discussion. In several countries it was often reported that it was Partners who often take the lead in developing the draft JA report ahead of the meeting and also lead the JA discussions.

2. Design Principle 2: Be inclusive of relevant national and international stakeholders

Survey respondents and interviews concurred that the JA process was inclusive of most, if not all, relevant stakeholders. As evidenced in Figure 4.2 the majority of EPI Representatives (81%), SCMs (80%), and Expanded Partners (86%) responded that either all or most of the relevant immunization stakeholders were engaged in the TCA planning process.

Figure 4.2: Engagement of relevant stakeholders in the Joint Appraisal



The anomaly in the results were respondents from the WB & CDC, where only 38% of respondents felt that the relevant set of stakeholders were engaged. This may be due to the fact that the CDC and the World Bank, are also reported to be less engaged with the JA themselves. This is attributed to the fact that they do not have the same level of staff continually on the ground in the countries where they work compared to other Core Partners, such as UNICEF and WHO.

This is confirmed through the survey, where the majority of CDC and World Bank stakeholders mentioned that they were aware of the Joint Appraisal, but either not invited to participate or not able to participate (91%) (Figure 4.2).

While the JAs were relatively highly representative among stakeholders at the national level, a common theme from interviews, document reviews, and review of open ended survey questions was the inadequacy of sub-national representation at these meetings. Some countries attempt to integrate understanding of sub-national issues through field visits, such as Kenya where the

JA included trips to three counties (Kajiado, Kitui and Nairobi) and Pakistan where the JA included visits to four regions (Karachi, Peshawar, Lahore and Islamabad), many did not have such direct interaction with the sub-national health system as a part of the Joint Appraisal process. This may be more or less of an issue given the level of decentralization in the particular country; however, the sub-national stakeholder should be involved regardless.

Other stakeholders that were identified as relevant for the JA process, but not present include: World Bank and CDC, other health financing oriented donors, other immunization actors (e.g. CHAI, Gates Foundation, USAID), and representation of other relevant ministries and departments in the country (e.g ministry of finance, the health information management team; health commodities supply programs, etc).

3. Design Principle 3: Enable unbiased, evidence-based discussions

Most JA reports did provide evidence to frame the immunization challenges. However, in response to suggestions for improving the JA, survey respondents frequently highlighted the need for more data-driven decision making during the JA, and the need for performance data on Partners' activities to inform planning (Table 4.).

Interview findings supported the view that TCA performance data is largely missing from the conversation. TCA milestone reports and other Partner performance data are not shared with the EPI program or across Partners, limiting the use of performance data to guide TCA planning discussion or direct Partner activities.[27] This may undermine having evidence-based decisions regarding what activities to continue to discontinue.

4. Design Principle 4: Build on existing country processes and results of other reviews

The Gavi guidance is for JAs to coincide with other country meetings and processes; however, it is unclear at this point how many of them actually coincide with larger meetings. Most JAs happen between June and August, even though the fiscal year for most of these countries end in December. There are a few examples where the JA did closely follow other processes: In Myanmar, the JA was reported to have taken only 90 minutes as it built off discussions during meetings for the HSS grant application. In Mozambique, the JA was planned to follow the larger EPI review. Stakeholders in Nigeria communicated that the JA does not follow a larger meeting, but expressed it may be more efficient if it did.

5. Design Principle 5: Be conducted in-country at a suitable time as determined by the country

Gavi Guidelines recommend that the JA meeting take place in country, so as to include as many stakeholders as possible. In reality, this is not always possible due to the political or security environments of several of Gavi priority countries. For instance, due to security reasons the JA for Afghanistan took place in Cairo in 2015. In Yemen, the 2016 consultative meeting took place in Amman, Jordan. However, these examples are the exception, as the majority of meetings do take place in country.

[27] Some process changes have occurred in the latter half of 2016 that are not reflected in the baseline, including EPI access to the Partner Portal.

***Key Finding:* There may be misalignment of the JA with other national planning/reporting processes**

Eleven of the 20 Tier 1 and 2 countries have fiscal years that align with the calendar year, yet, the vast majority of JAs occur between June and September.[28] In fact, only 35% of JAs occurred within 3 months of the country's fiscal year end in 2016.[29] Only Afghanistan had their JA outside of the June–September timeframe in 2016, which did align to their fiscal year end of December 20th according to the JA report

Key indicator

35% % of Joint Appraisals that occurred within 3 months of the country's fiscal year end

The guidance is not consistent with encouraging alternate timings so that it aligns to the country's own processes. For instance, it suggests that the JA can be reviewed at a number of three HLRP meeting dates; however, the 2016 guidance mentions, "Each year in August/September, all countries will be informed of their co-financing obligations for the following year." If these decisions for funding are only made once throughout the year and are not timey to the JA, there may be little incentive to do the JA earlier. Indeed, the determination of co-financing obligations may be critical in finalizing the plans for the subsequent year.

"'JA timing [is in] July, but should be a bit earlier - in April so can align better with MOH work planning cycle." – Core Partner

Additionally, funding for the activities planned through the JA process is disbursed to countries in March each year, regardless of when they complete the JA.

Surveys conducted after the 2015 Joint Appraisals and reporting in the "Feedback on joint appraisals in 2015" report identify that the JA is "Resource intensive and time-consuming" and "Duplicative with APR in 2015 and in some cases with EPI reviews". However, the fact that the timing of Joint Appraisals did not materially change from 2015 to 2016 and feedback from interviews suggest that no improvement was achieved between the 2015 and 2016 JAs in this domain. Interviews echo that the timing is the most challenging aspect of the JA.

Better alignment may alleviate the concerns of duplicity and allow for streamlined processes, relieving some of the burden of coordinating and facilitating the discussions. Another concern aired during interviews considered the alignment of the Gavi reporting cycle, stating that the timelines of receiving funds and reporting progress was not adequately aligned so that some activities were reported artificially as delayed. As a Core Partner said, "So, the support that we got in 2016….. we reported that in November 2016... So, we reported [as of end of] October. So in this five month period, we [received] funds, we helped plan activities, but our final report was submitted. So as a result of this, some of our activities which were on time, were shown as delayed."

[28] Joint Appraisals 2016 – Frequently Asked Questions (February 2016).
[29] Deloitte Analysis using JA Reports

6. **<u>Design Principle 6:</u> Identify actionable recommendations**

<u>Key Finding.</u> Survey responses indicate that the JA and planning process is largely successful in identifying the countries' immunization TA needs and activities, in line with Gavi programmatic areas (Figure The two programmatic areas that are not seen to be addressed as well through the planning process are around Advocacy and Leadership, Management, and Coordination. This may be due to the fact that these two programmatic areas only constitute a minority of Gavi TCA funding. It may also be due to ongoing SFAs that are focused on these topics and have separate processes.

Key indicator

47% % of respondents who indicate that needs identified in the JA align to the country needs "to a great extent".

7. **<u>Design Principle 7:</u> Have the process, findings and recommendations documented in a report that is endorsed by the ICC or HSCC.**

A review of the JA Reports for Tier 1 countries indicate that the recommendations were indeed endorsed by the ICC or HSCC. Of course, each country had varying levels of specificity around what this process was in the particular context. This varied from the Nigerian example, where the process was documented at length, to Kenya, where the confirmation simply stated, "The Joint appraisal draft was circulated to Child Health ICC members followed by an ICC meeting that endorsed the Joint Appraisal Report." Among Tier 2 countries, Haiti, Somalia, and Yemen did not indicate if an endorsement process had taken place as the sections were blank.

71% of EPI stakeholders and 64% of UNICEF or WHO stakeholders did report having been involved with soliciting the approval of the ICC.

8. **<u>Design Principle 8:</u> Be supported through intensive engagement by the Secretariat in-person**

This design principle was introduced into the 2016 guidance, and did not appear in the original documentation. This introduction ostensibly derived from feedback from the first JA process, where there was a suggestion that the countries and Gavi should present at the Joint Appraisal and orient all members to the purpose of the mission.

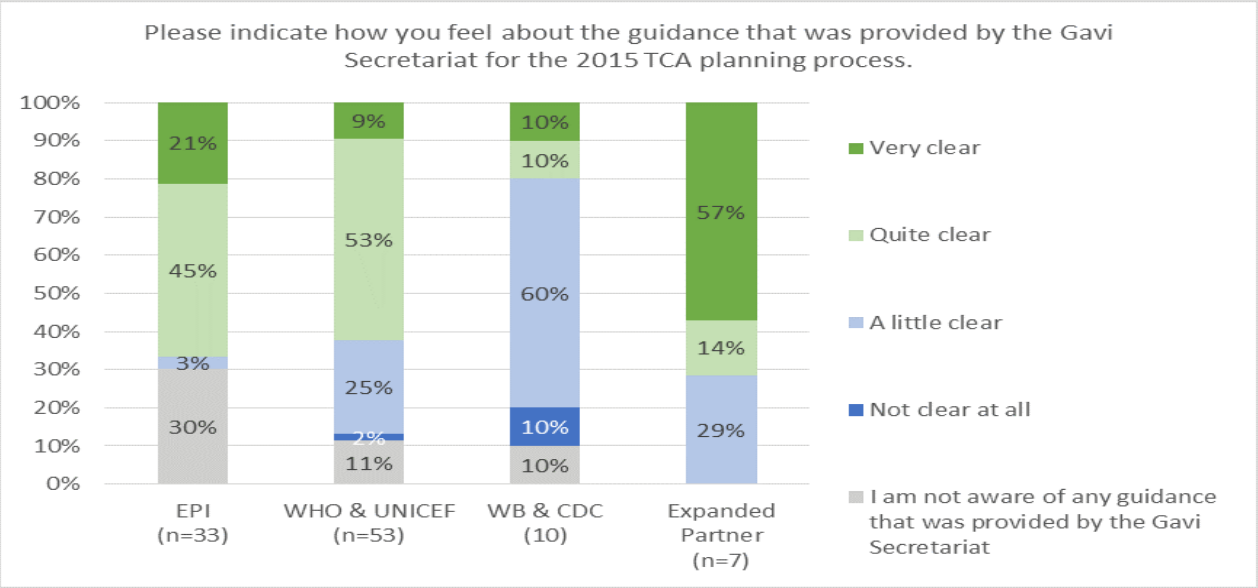
All information from the JA Reports and interviews suggest that when a JA occurred in person, the Gavi SCM participated in person. In cases where the Joint Appraisal did not happen in person, as was the case in Afghanistan in 2016 for security reasons, the SCM participated remotely.

Post-JA Review Process

Following the JA, key Partners and EPI team members are expected to coordinate and meet to finalize the JA report and to discuss which activities should be performed by which Partner in the coming year. Interviews revealed a large variance among countries in regards to how these processes were undertaken. Generally, however, it entailed some degree of review by soliciting comments electronically to the report document as well as meetings with the Gavi SCM and meetings with TA providers. After the JA report is finalized, it is anticipated that it is then shared, with the expectation of soliciting approval, from an ICC, as discussed above.

According to surveys, nearly 64% of EPI stakeholders reported meeting with the Gavi Secretariat after the JA, while only 36% reported having participated in meeting with TA providers.

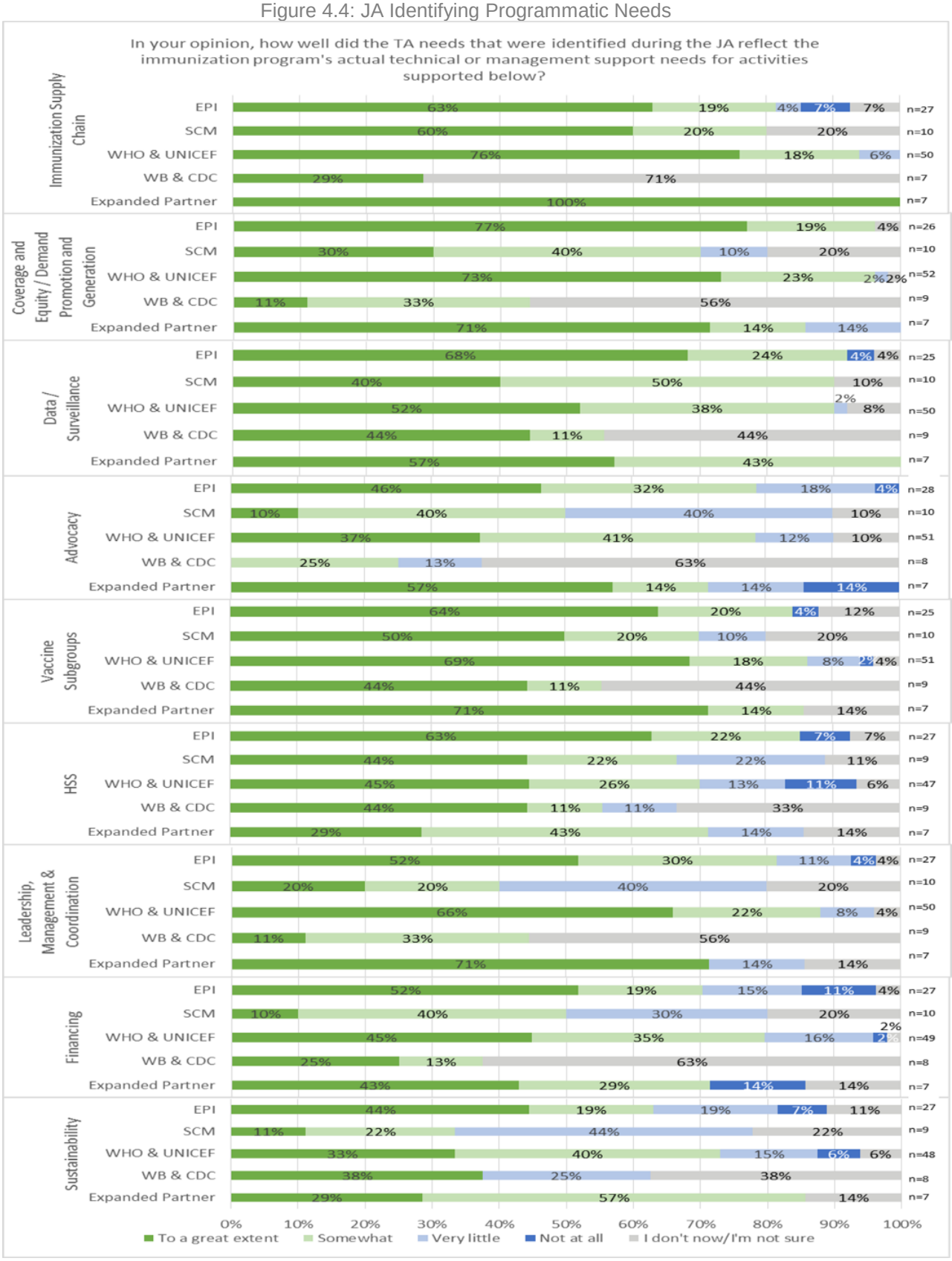
Figure 4.3: TCA Planning Guidance

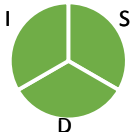


Perceptions about guidance provided

Overall, the survey suggested that the guidance received by the Gavi Secretariat was clear, though there may be room for improvement as 30% of EPI and 11% of Core Partner respondents were not aware of guidance given by Gavi at all, and 3% of EPI, 33% of Core Partner, and 29% of Expanded Partners felt that the guidance was either “A little clear”, or “Not clear at all”.

Figure 4.4: JA Identifying Programmatic Needs





Key Finding: The Joint Appraisal planning process has been rolled out successfully and has gathered support from key stakeholders

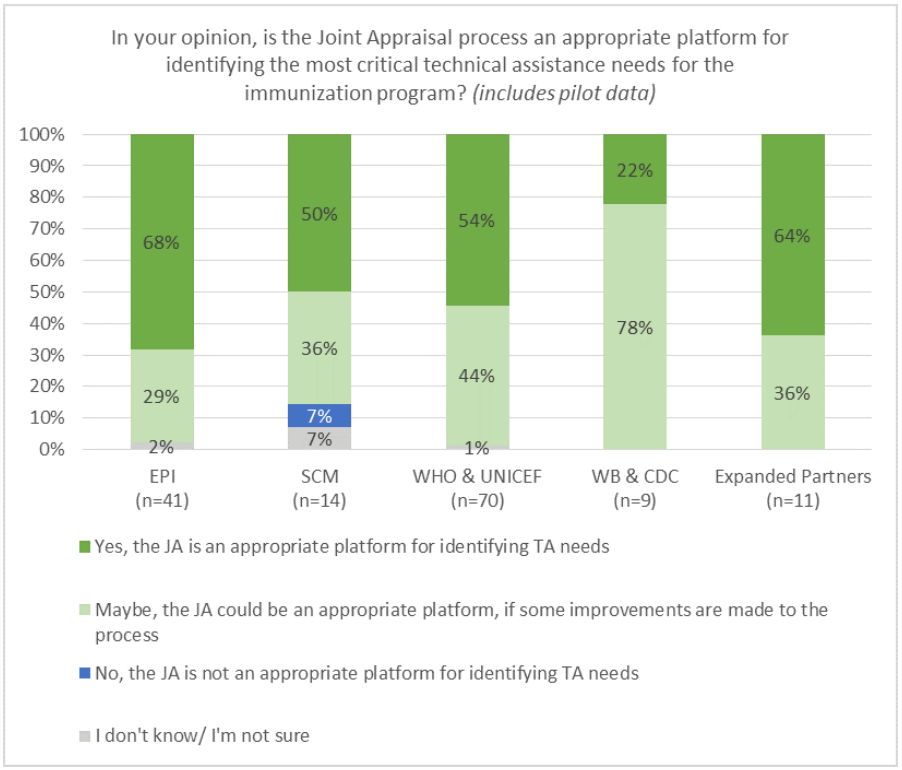
The planning process is an inclusive, though intensive, process. From interviews, surveys, and document reviews, it is clear that there is a high level of support among stakeholders for this process. The key benefits of the planning process was reported to be increased transparency among Partners and the Country, increased participation among all stakeholders in defining the Country's needs, and an increased role of the EPI to align technical assistances activities to needs. Being such an intensive process, there was some initial resistance, and there is considerable learning involved in order to make the process run smoothly.

"Everyone was originally against it, then they participated in it and decided it was a great process"– Gavi Secretariat Regional Head

"[The] JA process is very powerful in driving change, quite good to have that point where based on what country has reported we can see how Gavi investment fits in wider investment and objectives.

JA brings all the pieces together and creates transparency and understanding around the gaps"– Gavi Regional Head

Figure 4.5: JA Appropriateness for Identifying TA Needs



Overall, the vast majority of survey respondents feel that the JA is an appropriate platform to identify the most critical TA needs (Figure 4.5).

However, there are also areas of improvement for the Joint Appraisal process. Survey responses highlighted some of the emergent themes about how the Joint Appraisal process may be improved. The top themes include increasing the level of stakeholder participation, increasing the data-driven review approach, and conducting evaluations and performance reviews of programs to inform planning (Table 4.1).

Key indicator

Top 3 suggested improvements to the JA:

- *Broaden stakeholder engagement*
- *Increase use of evidence to inform TA needs*
- *Use Partner performance data to inform TA activities*

Table 4.1: Most Comment Suggestions for JA Improvement

	Broaden and increase the level of stakeholder participation and engagement	Take an evaluative, data-driven approach to inform and review the program during or before the JA	To conduct evaluations and performance reviews of the programs and country needs to inform the JA and planning process	Need for enhanced coordination between partners	The JA should be integrated into existing planning processes inside and outside of GAVI	Need to widen the scope of the JA beyond immunization	During the JA, have an increased focus on planning	Need to see enhanced engagement/involvement of governments
Response rate:	**14**	**10**	**8**	**5**	**4**	**4**	**3**	**3**

Key Finding: There is confusion over long term support for human resources.

One theme that emerged from stakeholder interviews, was the perception that Gavi does not commit to 2 year funding cycles for human resources, and therefore the negative perception that the one year planning cycle has on attracting and retaining quality staff. In countries such as Nigeria and India, interviewees reported that the yearly cycle impeded their ability to offer multi-year contracts to staff who are hired with Gavi TCA funds. Without a multi-year commitment to these positions, it was anecdotally conveyed that staff became less effective as they began looking for new positions the closer they came to that year end. While there is guidance provided in the 2016 PEF Guidance suggesting that Partners can commit to two year contracts for staff members, it was not included in the 2015 or 2016 JA guidance. The Gavi Secretariat also noted that this guidance was specified in the commitment letters to WHO and UNICEF. However, there remains a lack of clarity on this issue at the country level.

4.3. Transparency and Ownership of the TCA Process

Transparency

Increased transparency is one of the major aims of the JA process. The most common response regarding participants' views of the JA process was the increase in transparency that it provides for all stakeholders around which Partners are working on immunization within the country, and what activities they are supporting with TCA funds. Interviewees also highlighted that as a benefit of this transparent approach, there was an increased pressure to rationalize and prioritize Partner activities.

However, stakeholders did also identify two specific areas where the JA may be improved. Firstly, it is clear that while transparency has increased overall, this transparency has not increased to the same degree around all Partners. Additionally, this transparency may have some unintended consequences, including tension or competition among Partners, and Gavi may provide guidance to reduce these negative effects.

"The first thing is that they tend to create competition among the support of agencies, which is not what it should be. It should be collaboration. So to some extent, the model that is being promoted has got this negative consequence that suddenly you find yourself arguing against another agent when in fact both of them have got validity in equal manner. So that's what the first problem with the model." – Core Partner

***Key Finding:* The TCA planning process does not reflect specific agreements with some Partners and therefore minimizes the transparency around these Partners' activities**

The TCA planning process has changed how WHO and UNICEF propose, plan and fund activities; however, this process is not the same for other Partners who have different agreements with the Gavi Secretariat, such as the CDC and the World Bank, as well as Expanded Partners.

While it is self-reported that these organizations work with their country counterparts to determine the need for the activities, interviews and observations suggest that this level of engagement may be insufficient if the goal is to truly put the country in the center of the decision making process of what activities Gavi Partners should undertake. For instance, through observing the Ethiopian Joint Appraisal in September of 2016, stakeholders highlighted that they did not know what their CDC counterparts were doing in the country.

"I think the joint appraisal helps with bringing everyone together to decide on how do we prioritize […]. Instead of prioritizing six thousand things we prioritize top three, top five so it requires rigor on the partners' side but really helping to guide the country" – Core Partner

The fact that these organizations have different contractual planning and implementation policies may undermine the goals of the PEF more generally, and the Gavi Secretariat should have a clear plan for either integrating these organizations more thoroughly into the JA |?process, or being clear with all stakeholders how their participation is determined. Since their overall budget is relatively small in relation to the total funds given to Gavi Partners, it may be considered more efficient to

maintain separate agreement; however, there may be negative consequences to transparency and country ownership.

Key Finding: While transparency has increased among stakeholders, in some instances, this expectation of transparency has resulted in tension between Partners and the Ministry of Health

As an unintended consequence, instances of increased tension and/or competition between the Partners and the Ministry of Health surrounding the Joint Appraisal process has been reported in Ethiopia, Kenya and Chad. The expectation of more transparency, when not met, has contributed to tension between the EPI and specific Partners. For example, during the JA in Ethiopia, the EPI team publicly noted that they did not have any visibility into CDC's immunization activities, even though CDC was written into the 2016 TCA Plan and also present at the JA. Similarly, the lack of clarity on the role of primarily Expanded Partners has contributed to a sense of competition. For the most part, Expanded Partners were brought into the 2016 TCA framework outside of the established JA/TCA planning processes. Given these separate processes and different levels of visibility at the country level, there is a sentiment among both Core Partners and the EPI managers that Expanded Partners are being imposed onto the EPI program and that they are given resources that could otherwise have been awarded to the MOH or to Core Partners. On one hand, increased competition may result in more effective and efficient funding allocation. However, due to the high level of collaboration necessary between all Partners, the competition should not be at the detriment of the working relationships between Partners. The tension currently reported may be merely the result of growing pains under the new model; however, Gavi may consider suggesting strategies for these situations.

Ownership

Increasing Country Ownership of the Gavi-funded technical assistance is another overarching goal of the PEF. However, it is less clear how successfully this goal has been attained from country to country.

Two-thirds of interview respondents did report an increasingly strong role of the Ministry of Health within the TCA planning process, which suggests that ownership may be improving. However, there were reports that this role could be further strengthened and improved upon. In some countries, such as Indonesia, Kenya, and Nigeria, the Ministry of Health either did not provide leadership for the Joint Appraisal, or did not fully engage in the process. Some key examples of Ministries not taking ownership included poor management of the process and the inaccessibility of TA performance data to drive EPI decisions and discussions. The lack of visibility of the Ministry of Health into the Gavi reports may undermine the Ministry's ability to take full country ownership

> "One is if the Minister of Health had a stronger role in the whole process, but until now we have a lot of time constraints so it is folded into the joint appraisal submission […] Sometimes it is rushed and takes shortcuts, relying on existing analysis or continuing business as usual, things already being done at country level. Definitely room for improvement." – Gavi SCM

Another indication of ownership in the TCA planning process is if the TA needs identified in the JA are largely seen to be aligned to the actual needs in the country. This does seem to be the case, as the survey found that the needs identified during the JA did align to the actual needs of the country, as discussed above (Figure .4).

Transparency and Ownership Scores

In an effort to measure changes across time in the areas of Transparancy and Ownership, we developed an analytical model that captures relative levels of these concepts in Gavi priority countries based on an objective analysis of survey data. Survey responses were seperated by country, converted to a numerical score, averaged within stakeholder groups, and aggregated through a weighted average up to the concept level. Concept scores were then normalized out of ten (See Annex 10 for more details).

It is important to point out that the model is limited, and should be interpreted in a limited fashion. The model has not gone through a community-driven process to confirm what a particular numerical level may mean. It should not be considered a scientific measure of these concepts, but rather an objective diagnostic tool to capture variation among countries as well as to objectively track change over time. While this tool may not have exernal validity, the application of the same measures across time is still useful to see how things have changed and to diagnose those changes.

While each country does have a "score", due to the limitations of the measure and the high sensitivities around reporting on levels for each country, instead countries have been aggregated to provide a "snapshot" of where these countries currently fall (Table 4.2). A bar was set, based upon concept of what a relatively high level in these domains should be, and countries are either reported to be meeting that bar or not. This sets a baseline so that changes can be tracked and measured in the Midterm and Endline evaluations. It will also serve a diagnostic tool so that exceptional changes will be evaluated and highlighted as cases in the future.

Table. 4.2. Transparency and Ownership Scores for TCA Planning

		Tier 1 Countries		Tier 2 Countries	
		Not Meeting	Meeting	Not Meeting	Meeting
TCA Planning	Transparency	5	3	6	2
	Ownership	4	4	4	4

Note: Only 16 countries (8 in Tier 1 and 8 in Tier 2) had sufficient responses to be included in this analysis.

In regards to TCA planning, Tier 2 and Tier 1 countries scored similiary. The driver of the Transparancy piece of the TCA planning scores was involvement of stakeholders in the TCA planning process, from the Joint Appraisal to Post JA-planning meetings. Ownership was driven by the extend respondents felt that the Joint Appraisal identified the real needs of the country along programmatic lines.

Tier 1 Country scores ranged from 1.8 to 8.5 for Transparency of TCA Planning and 4.8 to 9.4 for Ownership. Tier 2 Countries scores ranged from 2.7 to 7.7, and from 5.6 to 9.3 for Transparency and Ownership, respectively.

4.4. 2016 TCA Plan

Review of the 2016 TCA Plan outlining the funded activities for 2016 demonstrates the types of activities that each Partner engaged in and the respective funding shares for those activities. Of the $36M allocated for Tier 1 and Tier 2 support, WHO and UNICEF activities constituted 74%, with each organization receiving $13.4M. A higher proportion of these funds went to activities in Tier 1 countries over Tier 2 countries, with 59% of WHO funds being directed to Tier 1 country activities, and 64% of those of UNICEF.

Table 4.3: 2016 TCA Activities and Funding by Partner

	WHO	UNICEF*	World Bank	CDC	Expanded Partners
Demand Promotion	-	19 Activities	-	-	4 Activities (A & C) (22% of funding)
Data	20 Activities (20% of funding)	7 Activities	4 Activities (36% of funding)	12 Activities (65% of funding)	-
Financing/ Sustainability	7 Activities (2% of funding)	3 Activities	3 Activities (48% of funding)	1 Activity (2% of funding)	-
Supply Chain	15 Activities (4% of funding)	30 Activities	-	-	2 Activities*

Vaccine Sub-Groups	19 Activities (25% of funding)	1 Activity	-	-	3 Activities*
HSS	16 Activities (6% of funding)	2 Activities	2 Activities (16% of funding)	-	14 Activities*
Coverage & Equity	20 Activities (43% of funding)	30 Activities	-	4 Activities (22% of funding)	1 Activity*
Leadership, Management & Coordination	1 Activity*	8 Activities	-	3 Activities (11% of funding)	1 Activity*
Total Funding	**$13.4M USD (37% of Total)**	**$13.4M USD (37% of Total)**	**$1.5M USD (4% of Total)**	**$2.6M USD (7% of Total)**	**$5.1M USD (14% of Total)**

** unreported funding percentage*

WHO

WHO received $13.4M USD in 2016 for activities in Tier 1 and Tier 2 countries, which was 37% of all TCA funds provided to Tier 1 and 2 countries from Gavi.

WHO was funded primarily for activities within the Coverage & Equity programmatic area, as with 41% of their funding for Tier 1 and 45% of their funding for Tier 2 countries were dedicated to activities. WHO spent a slightly higher proportion on Vaccine Sub-groups in Tier 1 (31% of funding) over Tier 2 countries (20% of funding). The third area of relatively high funding allocations was in the area of Data, which constituted 20% of WHO funds in both Tier 1 and Tier 2 countries. WHO had considerably fewer funds for activities in HSS (3% of Tier 1 and 9% of Tier 2), Supply Chain (3% of Tier 1 and 5% of Tier 2) and Financing/Sustainability (2% in both Tier 1 and Tier 2). WHO was only funded for one activity in the domain of Leadership, Management and Coordination.

The programmatic breakdown does align to the activities for which WHO is expected to have a comparative advantage. When asked in semi-structured interviews, the most common areas of expertise noted were around Data and Coverage & Equity. This is also reflective of WHO's share of the overall number of activities that were funded in these programmatic area. WHO undertakes 37% of all activities considered Coverage and Equity and 47% of those considered to be Data activities (see Table 4.3). Interestingly, WHO also leads a large percentage of activities under Financing & Sustainability (50%), HSS (52%), and Vaccine Sub-Groups (83%), yet they did not arise as sources of comparative advantage for WHO. This may be due to the fact that many fewer activities are funded in these programmatic areas, and the funding allotments are lower, and so may not present as comparative advantages.

Other sources of comparative advantage that do not immediately map to programmatic areas include developing Norms, Standards and Guidelines, and convening stakeholders.

The intent of the planning process that informs which activities each partner will be funded to undertake is to make the activities more aligned with country priorities. A review of the Joint Appraisals, which stipulate TA needs, with the activities in the TCA Spreadsheet, provide some insight into whether the activities the WHO is funded for addresses a specified need identified

through the consultative process. Generally, for the four case study countries reviewed, the WHO led activities presented on the TCA Spreadsheet do align with needs that were highlighted in the Joint Appraisal Report. However, this alignment is not necessarily direct, as many of the needs identified in the Joint Appraisal were broad (E.g. “Capacity building/mentoring” in the case of Ethiopia) or some of the activities in the spreadsheet were broad (e.g. “Support monitoring and evaluation” in Ethiopia). Additionally, in many cases, WHO presented the word-for-word need from the Joint Appraisal and repurposed it as the TCA activity. This may be useful when the activity is relatively specific and concrete, such as “Assessment in gaps of health workers”, which will be incorporated into the HSS2 plan in Afghanistan. However, often it does not specify, which leads to questions of accuracy and accountability along those activities. For instance, the previous example of “Capacity building/mentoring” in Ethiopia, which had no outcome or milestone suggested.

In terms of how these activities are carried out with the funds, the funding allocated to the WHO largely funds salaries, with 61% of all funding going to 57.15 positions with an average cost per position being $144,520. 11% of WHO funds go to Staff Travel, 11% goes to Consulting Fees and Travel, 7% is used for Workshops, 3% goes to an “Other” category and the remainder is made up by the recovery rates for overhead (an average of 7%).

UNICEF

UNICEF received $13.4M in 2016 for activities in Tier 1 and Tier 2 countries, constituting 34% of all TCA funding for Tier 1 and 2 countries. 64% of these funds were dedicated to Tier 1 countries, with the remaining 36% funding activities in Tier 2 countries.

“Each organization has its specialty, because they have some global mandate which they have over time have grown to know how to achieve.

UNICEF’s global mandate is about logistics and social mobilization.” – Ministry of Health

UNICEF does not report funding by activity and associated programmatic area on the TCA spreadsheet, and therefore this does not lend itself to nearly as rich analysis. The level of analysis is limited to the number of activities within each programmatic area and understanding the alignment between the funded activity types and UNICEF’s comparative advantage.

According to the TCA spreadsheet, UNICEF engaged disproportionally to other partners in the areas of Demand Promotion, where UNICEF was funding for 100% of activities under this domain, Supply Chain (67% of all activities), Leadership, Management and Coordination (62% of recorded activities), and Coverage & Equity (56% of activities).

These activities align to what stakeholders report as UNICEF’s comparative advantages. The most commonly associated comparative advantages, in order of most to least reported, were Supply Chain, Cold Chain, Demand Generation & Communications.

As for alignment of the planned activities to the needs specified in the Joint Appraisal reports, UNICEF’s activities are largely aligned with the requests stemming from the JA. As expected, there are many activities that appear on the TCA spreadsheet are more specific than the needs highlighted; however, they satisfactorily drive toward to the same goals. However, there were a

few activities, specifically regarding support of CSOs, which do not neatly align to any need identified.

The majority of funding that UNICEF receives for activities goes to salaries, with 50% of all funds dedicated to salaries for 81.1 positions, resulting in an average cost per position of $82,792 per position. The difference between the WHO and UNICEF's average salary cost ($82,792 vs. $144,520) may be due to the type of activities that the separate organizations do or the level of staff that each organization recruits; however, this is not apparent from TCA planning documentation. Interviews in Afghanistan identified this disparity and noted the negative perception around it.

After salaries, UNICEF dedicates the highest percentage of funding to Consulting Fees & Travel (17%). Workshops & Trainings contributes to 10% of UNICEF's budget and another 10% falls under the "Other" Category. Only 6% of UNICEF's budget is dedicated to Staff Travel. Like WHO, UNICEF also captures a recovery rate of an average of 8%.

World Bank

The World Bank funding allocations work somewhat differently than for WHO and UNICEF. While the funds for UNICEF and WHO come from a determined funding envelope, the World Bank and the CDC are provided a budget that is outside of the specific countries' set resources. Gavi's agreement with the World Bank is part of the Bank's broader Multi-donor Trust Fund. Given the Bank's broader focus on health systems (not just immunization), and different operational processes at the country level, its mode of engagement in the TCA processes is notably different from that of WHO and UNICEF.

As noted above, the World Bank is not always present during the country JAs. Instead, interviews with key stakeholders from the World Bank revealed that World Bank Team Leaders identify opportunities to overcome immunization bottlenecks and consult with the EPI team to identify interest in the World Bank's approach. Then, those Team Leaders work with the Gavi SCM to develop a proposal, which is then funded by Gavi. These projects may be funded annually, but increasingly there are multi-year engagements.

In 2016, the World Bank received $1.5M, which constituted only 4% of all funds distributed for TCA for Tier 1 and Tier 2 countries. Of this, 87% of the funds went to supporting 6 Tier 1 countries (DRC, Ethiopia, Kenya, Nigeria, Pakistan, and Uganda). The remaining funds supported Myanmar among Tier 2 countries.

These funds primarily supported the Financing and Sustainability programmatic area, as the World Bank undertook 21% of those activities; however these were only in Nigeria, Kenya and Myanmar. These activities did constitute 40% of the World Bank's total funding portfolio. The World Bank led 9% of all Data related activities, focused on activities in Ethiopia, Kenya, Uganda and the DRC. This also made up 40% of the World Bank's budget. Lastly, the World Bank worked on a few HSS related activities (6% of total), in Pakistan, Nigeria and the DRC, which made up the final 20% of the World Bank's funding.

This aligns with interview responses, who identified financial management as the World Bank's key comparative advantage.

In 2016, the World Bank did not use the TCA Plan to specify their TCA activities[30]. Instead, their activities were specified in the Trust Fund Agreement using a different structure (not aligned with the programmatic areas used in the TCA Plan) and so alignment between those activities and the Joint Appraisal needs was not possible. This separate World Bank Plan agreement did not report on the TCA-specific funding split between Staff Salaries, Staff Travel, Consulting Fees & Travel, and Workshops & Trainings nor did it specify the overhead recovery fees for the Bank. Similarly, TCA-specific milestones were not specified in the Trust Fund Agreement. However, the World Bank does define its milestones in discussions with the Secretariat.

CDC

The planning and funding of the CDC's TCA activities is managed similarly to the World Bank as the funding is not directly resultant from the TCA planning process, but set aside separately for CDC activities. These funds do not affect those available to UNICEF and WHO.

World Bank & CDC

The World Bank and CDC have different operating models and different modes of engagement with the PEF-TCA processes.

World Bank. Gavi funding for World Bank TCA activities is channeled through the Bank's multi donor trust fund. As such, the specific details of the Bank's TCA-related activities and budget are documented in that larger document and not the TCA Plan. At the country level, the Bank engages primarily with the Ministry of Finance or with broader HSS efforts, and rarely with the EPI teams. The Bank has health staff in country only in a few countries. Typically, immunization efforts (including TCA efforts) are supported by the Task Team leaders based out of DC. The World Bank does not have a regional structure like that of WHO or UNICEF.

CDC. While CDC has offices in some countries, it does not have immunization staff within those offices. Instead, CDC uses a multilateral engagement model, where it places its immunization staff within partner organizations. For Immunization-specific activities, CDC primarily seconds staff to WHO, including at the HQ, regional, and country levels. In countries where CDC does not have immunization staff seconded to the WHO country office, team members from HQ support the TCA activities. Like the World Bank, CDC does not have a regional structure.

[30] The planning process has been updated in 2017. The 2017 TCA spreadsheet includes the World Bank's activities.

The CDC was allotted $2.6M for 2016 TCA activities in Tier 1 and 2 countries. The CDC was funded primarily for work in Tier 1 countries, with 84% of their overall funds dedicated to activities in India, Ethiopia, Kenya, Uganda, Nigeria, the DRC and Chad, but no activities in the Tier 1 countries of Pakistan, Indonesia, or Afghanistan. The CDC did allocate 16% of the funding for activities in the Tier 2 countries of Myanmar, South Sudan and Haiti.

"[The CDC] has been a key partner for data improvement area. They're working with district to ensure data is of high quality - so [they] work at lowest point of data collection to see if they are sending us the right data"– Core Partner

As for programmatic support, the CDC's activities were split between Data, where 28% of activities were led by the CDC, Leadership, Management & Coordination, where the CDC engaged in 24% of all activities, and Coverage & Equity and Financing & Sustainability, where the CDC was funded to undertake 7% of all activities in each respective programmatic area.

The programmatic areas echo responses around the CDC's comparative advantage. Respondents identified Data Quality and Surveillance as the CDC's core advantages.

Analysis of activity alignment between the TCA Spreadsheet and JA needs suggest that the activities led by the CDC do contribute to the country priorities and goals.

39% of CDC funding is used for Workshops & Trainings, a rate considerably higher than the WHO (7%) or UNICEF (10%). Consulting Fees & Travel constitutes 24% of CDC funding, with only 8% and 18% going to Staff Salaries and Staff Travel, respectively. The final 10% falls under the "Other" category.

Expanded Partners

The review and funding for Expanded Partners is conducted on a rolling basis (outside of the TCA Planning process aligned with the JA). Therefore, the version of the 2016 TCA Plan that we reviewed for this evaluation included only the Expanded Partners that had been awarded as of January 2017. The 2016 TCA Spreadsheet indicates that Gavi allocated $5.1M to Expanded Partner organizations for Tier 1 and Tier 2 countries at that point in time, or 14% of the overall spending. In order of funding allocations from high to low, these partners include the Catholic Relief Services (CRS, 34%), John Snow, Inc. (JSI, 23%), Johns Hopkins University (JHU, 14%), PATH (12%), Network of West and Central African NGO National Platforms (REPAOC, 10%), and an additional 6% set aside for a TBD partner.

CRS was funded to work in seven Tier 1 countries (India, Pakistan, Ethiopia, Kenya, Uganda, Nigeria, and Chad), and three Tier 2 countries (South Sudan, Madagascar, and Haiti). The funding was equal between countries and was devoted to the same set of activities in each countries, all focused on supporting CSOs and enabling coordination within the country.

According to the TCA Spreadsheet, JSI only worked in three Tier 2 countries (South Sudan, Madagascar, and Niger). JSI's budget is shared equally between the three identified countries, according to the spreadsheet. The activities attributed to JSI include those of HSS support, Coverage & Equity, as well as Supply Chain activities. Though not reflected in the version of the

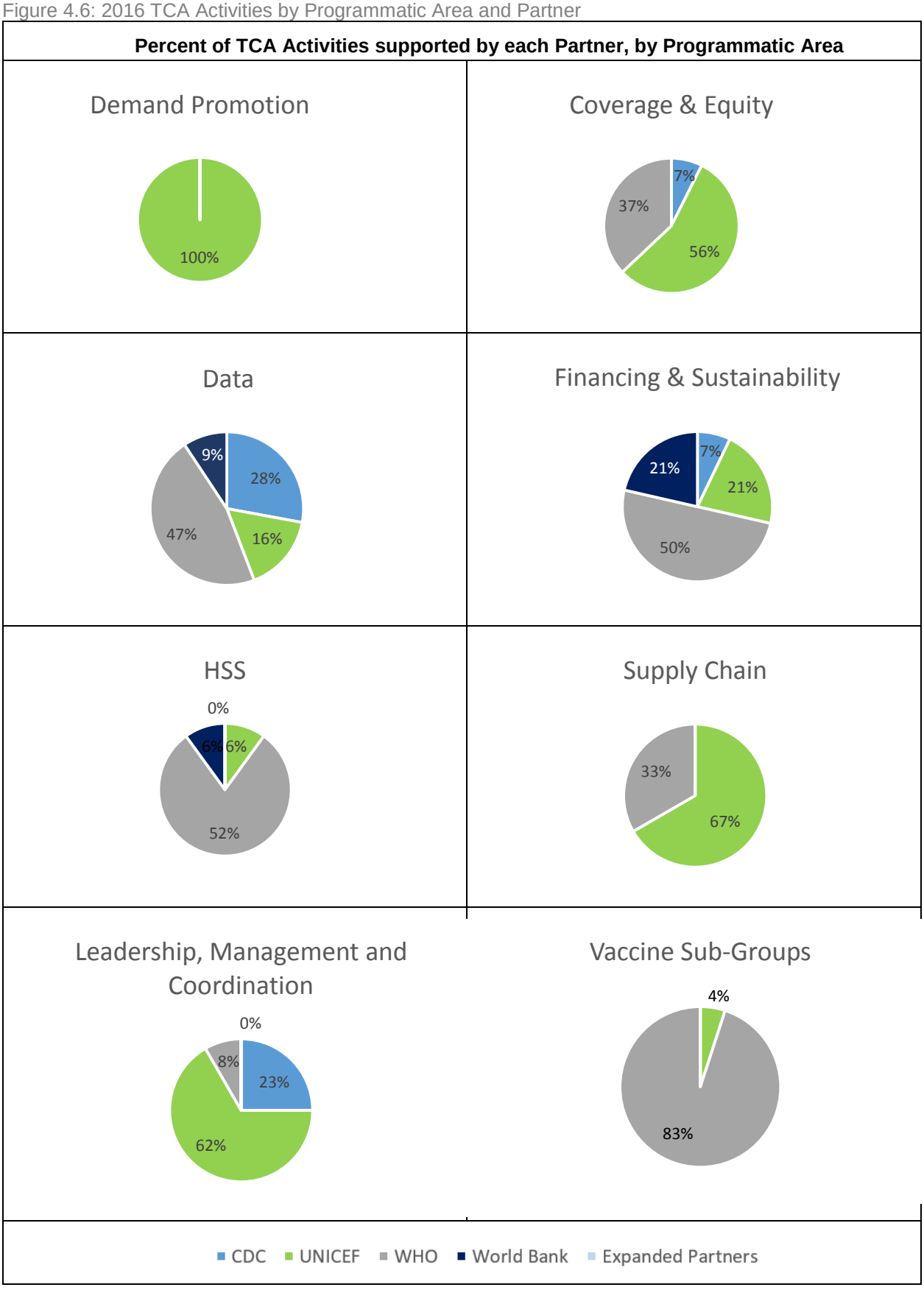
TCA Plan that we reviewed, we were informed that JSI is also funded to support TCA activities in India.

JHU also works with a subsection of Tier 1 countries. 71% of their budget is for activities in Nigeria, while 29% is dedicated to work in Pakistan. Both activities are reported to be in the area of Advocacy & Communications.

PATH's funding supports work in Ethiopia (40%), Kenya (10%), Uganda (10%), the DRC (30%), and one Tier 2 country, Niger (10%). Path's work in Ethiopia and the DRC were in the programmatic area of Advocacy & Communication, while in the Kenya, Uganda, and Niger was in the area of Vaccine Sub-groups.

REPAOC supports the DRC, Niger, and Central African Republic in the area of HSS with equal funding for each country.

Figure 4.6: 2016 TCA Activities by Programmatic Area and Partner



4.5. Changes from the BP

Key changes from the BP to the TCA, include a higher degree of country focus and ownership, increased transparency, and accountability. There was a notable transition from the "top down" global approach to the "bottom up" country approach, as under the PEF, TA planning and requests are driven by countries rather than donor or partner headquarters. TA is requested and approved through a holistic country package approach, rather than disparate and uncoordinated projects. Through this new process, described below, specific activities and Partners have a clearer mechanism to increase reporting, communication, and coordination between partners. This also puts more responsibility on the EPI stakeholders in-country to request and define the type of TA provided by Partners.

Other key changes include the actual funding structure, where Gavi funding is directly allocated to Partners at the country level, rather than funding allocated to global or regional partners through the BP.

4.6. Reflection on TCA Planning Assessment Evaluation Questions

Reflections on TCA Planning Evaluation Questions for Baseline Assessment
1.1 To what extent is the TCA planning process implemented as intended?

Overall, the Joint Appraisal Process has been implemented in the Tier 1 and Tier 2 countries and has achieved widespread support
• While the first year's (2015) JA has been reported to be a "learning process", the 2016 planning process was largely reported as an improvement, as ministries, partners and stakeholders better understand how the planning process functions
• There were high levels of participation of Core Partners, Expanded Partners, MoH and Gavi SCMs.
• Key themes that emerged from discussions around the TCA planning process included:
  ○ Increased representation and participation among stakeholder groups, though with less representation from subnational stakeholders
  ○ Increased transparency between Partners and Country Counterparts regarding TA needs and current partner activities
  ○ Increased pressure to prioritize and rationalize Partner activities
• However, the implementation has not been smooth for all cases and many challenges still exist

1.2 To what extent is the TCA planning process fit-for-purpose and responsive to country-expressed needs?
• The process was reported to be very effective in identifying TA needs and no survey respondents suggested there should be an alternative process in place of the current JA process • Both interviewees and survey respondents suggested that effectiveness would be improved if the Joint Appraisal process was timed to coincide with other EPI or health-wide planning processes already ongoing in the country • The timing of the reporting requirements to Gavi are also misaligned to the country reporting cycles, potentially creating duplication of efforts

1.3 To what extent does the TCA planning process promote country ownership of the TCA?

- 2/3 of interview respondents reported an increasingly strong role of the Ministry of Health within the TCA Planning Process
- Across Partners, EPI and SCMs, the TA needs identified in the JA are largely seen to be aligned to the actual needs in the country
- However, in some countries, such as Ethiopia, Indonesia, Kenya, and Nigeria, the Ministry of Health either did not provide leadership for the Joint Appraisal, or did not fully engage in the process
    - Some key examples of Ministries not taking ownership included poor management of the process and the inaccessibility of TA performance data to drive EPI decisions and discussions
- The lack of visibility of the Ministry of Health into the Gavi reports may undermine the Ministry's ability to take full country ownership

1.4 How transparent is the TCA planning process?

- The most common improvement stemming from Joint Appraisal process reported through interviews was *increased transparency*
- Areas of increased transparency included:
    - What the perceived challenges in the immunization space are within the Country
    - What Partners (WHO, UNICEF, & Expanded Partners) were working on immunization within the Country
    - What activities Partners were engaging in with TCA funds
- Some areas are not viewed as transparent to the Partners or EPI, including:
    - The presence of WB and the CDC within the Country under Gavi or their activities funded through the TCA
    - The budgets for activities under the Core & Expanded Partners

Additionally, Country Counterparts indicated that they do not have access to the reports that Partners send to Gavi, and that access to those reports would increase transparency

1.5 How efficient is the TCA planning process?

- Timing of the Planning Process
    - The TCA planning process does not always align to other country planning processes, which hinders full participation
- Lack of understanding for process to reprogram funds
    - TCA is considered to be inflexible, and there is a lack of understanding of the process for Partners to reprogram funds as needs change within the year
- Clarity of Guidance
    - Overall, the guidance is considered timely and helpful
    - Several iterations of guidance had resulted in confusion as to how to facilitate the TCA planning process
- Planning not based on Performance

Limited performance data is reported to the EPI program, limiting its ability to guide conversations or direct Partner activities based on performance

4.7. Summary of Key Findings and Recommendations for TCA Planning

Below are the key findings and recommendations to continue building on the achievements of the TCA Planning process under PEF.

Level of Priority	Recommendations
Continue doing	❖ ***Key Finding:*** ***The Joint Appraisal planning process has been rolled out successfully and has gathered support from key stakeholders.*** While the Joint Appraisal process is highly complex and resource intensive, it has gathered significant support. 57% of respondents felt that the Joint Appraisal was an appropriate platform to identify TA needs. ➢ ***Recommendation 1. The Gavi Secretariat should continue the Joint Appraisal platform for joint immunization program review and TCA planning, with some enhancements as recommended below***
Study further and take action as needed	❖ ***Key Finding:*** ***The TCA Planning Process does not reflect or align with specific agreements with each Partner*****.** Several Partners, such as the World Bank, CDC and some Expanded Partners, have parallel planning and contracting processes. While they may be engaged in the Joint Appraisal process, it does not determine what activities they are involved in. ➢ ***Recommendation 2: The Gavi Secretariat should better communicate with all TCA stakeholders (SCMs, Partners, and EPI Teams) the different agreements in place with specific Partners such as World Bank and CDC, and the implications of these agreements for the TCA planning processes.*** Many stakeholder reported a poor understanding of how Gavi funds certain Partners, such as the World Bank and the CDC, largely due to their separate planning processes. While this may be most efficient for these Partners who do not have a local immunization presence in all countries, it sends a mixed-message regarding expectations for these Partners to act and be treated the same as others, such as WHO and UNICEF. It is possible that this lack of awareness is due to guidance that does not clearly articulate the different expectations of each Partner, leading country stakeholders to expect a level of coordination and communication from the World Bank or the CDC that is not reflective of their operations in country. This can be unfair to the EPIs, who have unreasonable expectations, as well as unfair to these Partners, who cannot fulfill them. It is also possible that TCA is not the most appropriate mechanism for these Partners' activities. While there should be country coordination, this should be happening regardless in the national level immunization meetings with all donors. Interviews revealed that some Expanded Partners, who have ongoing contracts much like the World Bank and the CDC, may be migrating over to the fully TCA planning and funding mechanism, and that should relieve some of the transparency challenges. However, some, such as the

	World Bank and CDC, may never migrate over to strictly align to the same funding mechanisms as other Partners, and Gavi should acknowledge this, either through clearer communication regarding how their activities are planned and funded, or by clearly separating these funding mechanisms. ❖ ***Key Finding:*** ***While transparency has increased among stakeholders, in some instances, this transparency has resulted in tension between the Partners and the Ministry of Health.*** The expectation of more transparency, when not met, has contributed to tension between the EPI and specific Partners. Similarly, the lack of clarity on the role of primarily Expanded Partners has contributed to a sense of competition. ➢ ***Recommendation 3:*** The Gavi Secretariat, through the SCM, should facilitate greater communication between all Partners and the EPI teams to build greater awareness and transparency on the roles of each Partner and how they fit into the TCA framework. Similarly, the SCMS as well as Partners, should clarify to the EPI and to other Partners, any unique agreements between the Gavi Secretariat and their organization to minimize confusion and tension on any different modes of engagement in the TCA process.
Act Now	❖ ***Key Finding:*** ***There is confusion over long-term support for human resources.*** While Gavi documents do specify that Gavi will commit to funding TCA staff for a 2-year period, the prevailing perception at the country level is that Partners can only commit to a 1-year contract for new staff hired with TCA funds. This understanding has resulted in hiring challenges for Partners. ➢ ***Recommendation 4:*** ***Gavi should be clearer about the ability to commit to multiple-year activities, to allow Partners to invest in human resources.*** Interviews suggest that the one year planning cycle has made attracting and retaining key staff difficult, contracts are customarily given in 2-year increments. UNICEF did report offering 2-year contracts regardless of the uncertainty whether the activities would be funded, however, Gavi may consider increasing clarity about the support of Partners investing in human resources and the fact that while the planning cycle is yearly, that Gavi is committed to supporting the Alliance member throughout the five year period. It may be a matter of assuaging concerns regarding staffing, and how each year's planning cycle fits into the strategic period, rather than changing the funding period itself. ❖ ***Key Finding:*** ***There may be misalignment of the JA with other national planning/reporting processes.*** The majority of Joint Appraisals occur between June and September, which is not in line with most countries' fiscal year, which usually ends in December. • ***Recommendation 5:*** ***There should be clear and strong guidance from Gavi that the Joint Appraisal should closely follow national planning processes, whenever possible.*** While Gavi guidance does stipulate that the JA process should follow, and build, on other national planning processes, and should occur within three

months of the end of the fiscal year, that guidance may not be sufficiently clear given the precedent set for the Joint Appraisals to happen during the summer. It is also unclear whether it is practical as well. While there are three dates set for the meeting of the HLRP to meet and review funding proposals, if the actual funds do not come until March of the next year, this may reduce the practicality of the guidance. This means, that if a JA occurred in February, they may not have received the funds from the previous year, and may be planning over a year in advance. This would not meet the goals or intention of the Joint Appraisal planning process. Gavi should consider making TCA funding decisions and disbursements on a rolling basis, if possible, to increase the flexibility over timing of the Joint Appraisal, and decreasing the time between funding decision and disbursement so that the plans that are made are still relevant and executed quickly.

- ***Key Finding:* Overall, there is a sense that the TCA activities defined during the TCA planning process reflect the needs of the immunization program. However, there is still some lack of clarity around how the activities of some partners (e.g. World Bank, CDC) are determined.** This lack of clarity reduces the transparency among partners and the level of country ownership.

  - ***Recommendation 6*: Gavi may consider aligning the "Programmatic Areas" to the Health Systems Building Blocks used in cMYPs.**
    Interviews and document reviews reveal considerable confusion surrounding the definitions and usage of Gavi's programmatic area. In fact, there is significant overlapping between the programmatic areas and the Immunization System Components that are used in the Comprehensive Multi-Year Plans.[31] It would be feasible for Gavi to utilize the same terminology used in the cMYPs in order to reduce confusion stemming from these terms. One may consider the following mapping:

Gavi Programmatic Areas	Immunization System Components
Leadership, Management & Coordination	Leadership & Governance: Programme Management
HSS	Health Workforce: Human Resource Management
Finance, Sustainability	Finance: Costing & Finance
Vaccine Sub-groups, Cold Chain	Medical Products & Technology: Vaccines, Cold Chain, a
Coverage & Equity	Service Delivery: Immunization Services
Data	Information: Surveillance & Reporting
Demand Generation, Advocacy & Communications	Community: Demand Generation & Communications

[31] WHO-UNICEF Guidelines for cMYP for Immunization – Update September 2013

5. Findings - TCA Delivery Assessment

Our assessment for Domain 2 focuses on the delivery of TCA activities specified in the 2016 TCA spreadsheet. We examined the scope of 2016 TCA activities, the different models of TCA delivery, challenges related to TCA implementation, management and coordination mechanisms, monitoring and reporting processes, and external factors that impact the successful delivery of TCA.

Our observations and key findings are drawn from the in-depth stakeholder interviews (*I*), the online survey (*S*), and document reviews (*D*). Where available, data from multiple sources have been triangulated to present comprehensive and corroborated evidence on a given topic. We have indicated the strength of the evidence supporting our conclusions using the criteria specified in Table 1.1 in the Methods section of this report.

Box 5.1: Overview of Key Findings from the TCA Delivery Assessment

- ***Key Finding:*** The PEF-TCA has been received very positively by all stakeholders.
- ***Key Finding:*** Partners have adapted well to the new processes and reporting requirements under the PEF-TCA.
- ***Key Finding:*** TCA has increased the number of Partner staff in country-dedicated to immunization activities. However, not all of the FTE positions are net new personnel.
- ***Key Finding:*** The ability to use TCA funds to support Partner staff salaries is a key value add for Partner organizations who are facing increasing challenges in securing other sources of immunization funds
- ***Key Finding:*** Embedded support is effective for supporting immediate deliverables and achieving short term objectives. However, it does not provide a sustainable approach for improving capacity.
- ***Key Finding:*** Though the aim of the TCA is to build capacity, this goal is not clearly communicated with all stakeholders. Consequently, across the different TA delivery models, there is little evidence to indicate that there is an intentional and purposeful approach to foster the transfer of knowledge and skills and build capacity. Moreover, there is not a shared understanding or vision for what "improved capacity" looks like for EPIs.
- ***Key Finding:*** The lack of guidance around the programmatic areas has resulted in: (1) Lack of a common thread across activities within a programmatic area; (2) overlap in activities across different programmatic areas that may inadvertently lead to duplication of efforts; and (3) widespread confusion about some programmatic areas across partners, EPI team members, and HQ-level Gavi Alliance representatives, alike.
- ***Key Finding:*** The "continuous" nature of the TCA activities presents challenges for defining discrete milestones for a six to twelve month period. Moreover, the interweaving of TCA activities with day-to-day functioning of the EPI program obscures what milestones can be attributed to TCA efforts versus broader EPI activities, thereby undermining the accountability processes.
- ***Key Finding:*** While the volume of partners' TA activities has increased due to TCA funding, there has not been a notable change in the type of activities supported, when compared to Partners' prior support for the EPIs.
- ***Key Finding:*** TCA efforts tend to be concentrated at the central level, both in the planning and delivery processes. Given that the HR capacity gaps are generally more prominent and systemic at the sub-national levels, stakeholders agree that TCA should be more focused on support for sub-national levels.
- ***Key Finding:*** Across all the Partners, the quality attributes rated most positively by EPI respondents were expertise of TCA providers and the relevance of TCA activities for addressing the implementation challenges/bottlenecks of the immunization program. On the contrary, reporting on TCA progress, timeliness, and flexibility of TCA providers have the poorest quality ratings.

Overall, our findings indicate that ***the PEF-TCA has been received very positively by all stakeholders,*** and has been noted as an improvement from prior processes around Gavi-supported technical assisstance. The most significant improvement brought about by the PEF-TCA has been the engagement of the EPI and in-country Partners in defining the TCA activities and the increased transparency around the activities of key Partners such as UNICEF and WHO.

Partners have adapted well to the new processes and reporting requirements under the PEF-TCA. There has been a high level of engagement between UNICEF, WHO, and the EPI with regards to TCA planning and implementation. Milestone reporting has also been successfully completed across most Partners. However, there are some systemic challenges in the engagement of the remaining partners, as is detailed below.

There are several program elements that are continuing to evolve and shift as the Gavi Secretariat refines its requirements. Where relevant, we have made a note of these changes that have taken effect during the course of the baseline assessment, specifying how they impact the current or subsequent phases of the evaluation.

5.1. TCA Staffing

One of the primary changes in the TCA model when compared to the BP is the allocation of increased funds to Partners at the country-level instead of the headquarters or regional levels. This has allowed Partner country office teams to take more ownership of the hiring process for provision of TCA and subsequently increase the availability of Partner staff directly supporting TCA efforts. This increase in partner capacity at the country level has also allowed for more variation in the way in which TCA is delivered, shifting away from a training or short term TA model to an emphasis on embedded and ongoing TA support models.

Increase in Partner Staffing

<u>Finding.</u> TCA has increased the number of Partner staff in country-dedicated to immunization activities. However, not all of the FTE positions are net new personnel.

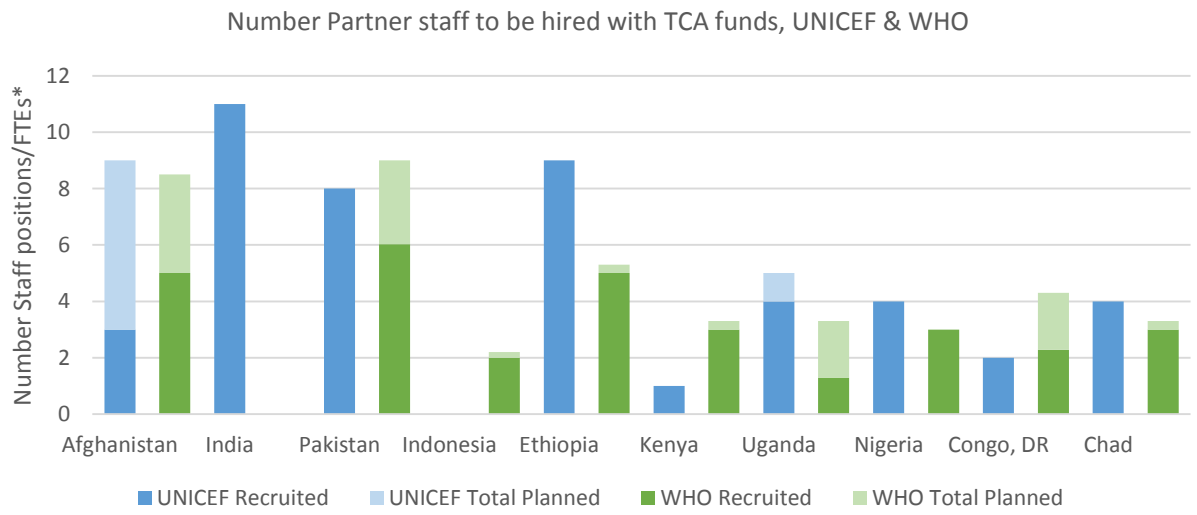
TCA funds have primarily helped UNICEF and WHO retain and expand their country-based immunization staff; or commit more staff time for immunization activities over other health activities. Due to other Partners' different operating models and different engagement with Gavi, there are no data available to indicate whether TCA has increased the in-country presence of staff from CDC, World Bank, Path, JSI, and other Expanded Partners. These Partners do not maintain long-term immunization-specific teams in country and therefore are not required to report to Gavi on their staffing processes.

In the 2016 TCA Plan, UNICEF and WHO specified the number of staff positions they plan to fill to support TCA efforts and reported on the progress of recruitment in November 2016 (Figure 5.1). WHO specified their staffing plan using staff Full Time Equivalents (FTEs). On the other hand, UNICEF specified the number of positions to be funded by Gavi TCA funds, even if not fully supported with TCA funds.[32] The Partner staffing plans vary greatly from country to country, ranging from 11 staff positions in India to only 2-4 UNICEF and WHO staff combined in several of the Tier 2 countries. In general, the number of Partner staff hired across the Tier 1 countries is double that of Partner staff in the Tier 2 countries.

WHO's staffing plan includes the use of TCA funds to cover regional and global level staff time. Of the 37 WHO FTE positions planned for the Tier 1 countries, 80% are positions within the National Program Office (NPO), while only 45% of the positions in the Tier 2 countries are within the NPO. Such a distinction is not obvious for the UNICEF staffing plan.[33]

"One area where [we] have benefited is that previously 2 out of our 4 team members were being funded by GPEI. Now we are planning to use GAVI PEF to fund their salaries at 100%. - - Core Partner

Figure 5.1. Number of UNICEF and WHO staff hired with TCA funds (Tier 1 countries)



** UNICEF's staffing figures refer to number of positions supported by TCA funds, even if not 100% funded by TCA funds*

WHO's staffing figures refer to # FTEs

[32] UNICEF's staffing plan specifies number of posts to be supported by Gavi Funding. For example, if UNICEF plans to use TCA funds to support 50% respectively of two staff members' salary, this is counted as 2 positions (not 1 FTE).
[33] 2016 PEF Staffing Plan – Document received from Gavi Secretariat M&E Team

Despite the fact that the Gavi Secretariat provided letters of commitment to UNICEF and WHO (Headquarters level) in April to facilitate the hiring process, Country Offices did not begin the recruitment of staff to support TCA until late in 2016, citing the delay in TCA funding release as the reason for this delayed timeline. Both UNICEF and WHO interviewees also noted the organizational administrative processes that further delayed the hiring process. In some cases, interviewees from the Country Offices noted that they used their own core funds to hire staff, while waiting for Gavi funds in order to avoid major delays to their planned activities. Nevertheless, Reports submitted to Gavi in November indicate that the majority of FTE/staff positions have been filled in both the Tier 1 and 2 countries, with a total of 76 WHO or UNICEF FTEs/staff positions filled in Tier 1 countries, and 38.5 FTEs/staff in Tier 2 countries.

Partial funding. In some cases, TCA funds only partially cover Partner staff salaries both at the national and subnational levels.[34] Partners use their core funding or funding from other sources to support the full salaries. The implication of this is that Partner staff are commonly not fully dedicated to supporting the TCA efforts (or even broader immunization efforts in some cases) which results in not being able to fully address the needs of EPI. A common challenge often raised was the insufficient staffing to allow comprehensive support to the EPI. Our survey findings indicate that on average, Partners dedicate about 40% of their time to supporting TCA activities (Figure 5.3), with variation across partners. Only 10% of respondents indicate they support TCA 75-100% of their time (figure 5.2). The percent of time that partners spend supporting other TA to the immunization program (beyond TCA) is comparable to the time spent on TCA.

"…We had this conversation with WHO and UNICEF about staff qualifications and needs, but the recruitment was not based on need. I received terms of preference and job descriptions but when it came to appointment they just renewed those already in the position. They didn't take the opportunity to restructure and get new blood, those that can really bring what is needed to positions." - - SCM

Consistent with other observations, a notably larger proportion of respondents from CDC, World Bank, and Expanded Partners indicated working on TCA for 25% or less of their time. At the same time, two Expanded Partner respondents did indicate they support TCA at 100% effort.

We acknowledge here that there may be a selection bias in the Partners invited to complete the survey, skewing towards senior staff that by default would be engaged in multiple initiatives and not solely focused on TCA.

Support for existing staff salaries. We heard several indications that TCA funds are used to secure more immunization-specific time from existing Partner staff. In other cases, TCA funds have been used to renew contracts for existing Partner Staff. Several stakeholders emphasized the critical role of staff members funded by the Global Polio Eradication Initiative (GPEI) for broader immunization operation efforts beyond polio. With the scale down of GPEI, stakeholders (primarily from WHO) across different countries indicated that moving forward (starting in 2017), they plan to use the TCA funds to support the transition of polio staff to

[34] Following submission of the draft of this report, we have learned that there are some contradictory viewpoints from Gavi Secretariat and Alliance Stakeholders at the Headquarters level on whether TCA funds fully or only partially cover in-country staff salaries. Our assessment did not include a detailed budget analysis to determine the overall percent of staff salaries that TCA funds cover. However, interview findings suggest that TCA funds do not always cover full salaries.

support routine immunization so as to cover the anticipated staffing gap that may be caused by the decreasing GPEI funds.

There are certainly new staff that have been hired, however there is no systematic data available to differentiate between net new staff and existing staff who are now dedicating more time to support Gavi TCA.

Figure 5.2. Percent time Partners dedicate to TCA activities

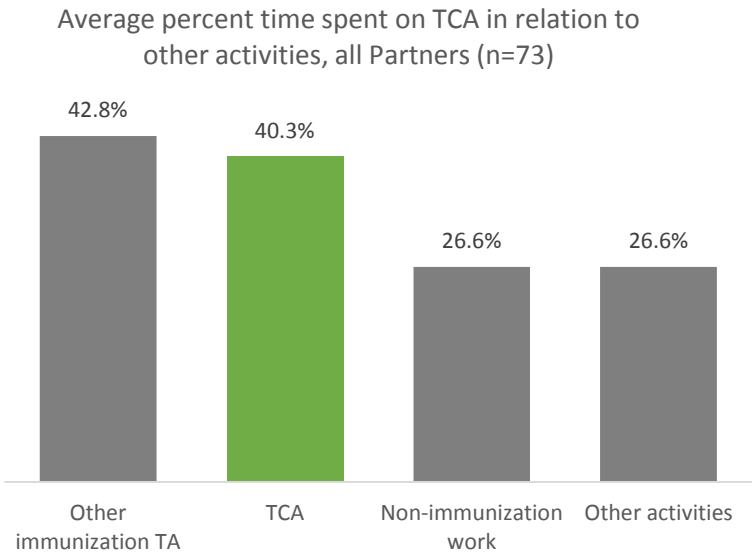
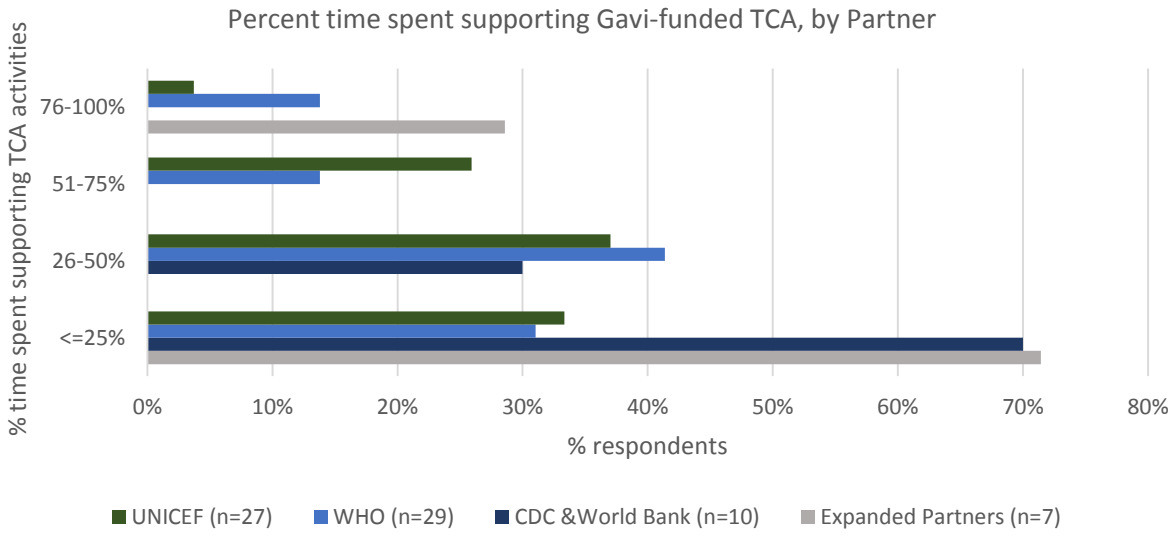


Figure 5,3. Percent time Partners dedicate to TCA activities, by Partner



Subnational-level technical assistants. In addition to the FTE hired at the Central level, UNICEF and WHO, also hire technical assistants to support immunization activities at the

subnational levels. While staff at the Central level tend to have longer contracts (2 years) subnational level technical assistants are hired typically on shorter-term contracts and are therefore not included in the FTE recruitment reports. We have not found systematic data on the numbers of subnational-level technical assistants supported through TCA funds. For example, the TCA Plan for Ethiopia indicates a total of 14 UNICEF and WHO staff to be funded to support TCA in 2016 (at the Central level). UNICEF and WHO interviewees noted that they use TCA funds to partially cover salaries for a total of 35 zonal technical assistants that were hired to support the regional and zonal health bureaus with routine immunization, reporting, and local training. These zonal technical assistants are not reflected in the staffing update reports submitted to Gavi.

Finding. The ability to use TCA funds to support Partner staff salaries is a key value add for Partner organizations who are facing increasing challenges in securing other sources of immunization funds. About 50-60% of TCA funds in Tier 1 and 2 countries support Partner staff salaries. As such, there is widely-held view or acknowledgement that TCA funds are primarily used to provide human resource support for Partner country offices. Most stakeholders are supportive of this model of support and point to the necessity of a robust Partner team in country to provide the requisite support to the EPI. TCA funding is appreciated by UNICEF and WHO in-country staff for the niche role it fills as it is becoming increasingly difficult for Partners to obtain immunization-specific funding from other sources. A common concern raised by WHO and UNICEF stakeholders is the reluctance of other donors to fund immunization efforts as they are already contributing to the Gavi fund.

EPI stakeholders, likewise, note the critical role of the technical assistance they receive in helping them ensure steady progress with their immunization efforts (discussed further in subsequent sections). At the same time, we did also sense an undertone of skepticism on why such funds are awarded to Partner organizations and not directly the EPI teams.

> "I recommend highly to continue this mechanism if GAVI wishes to maintain long term EPI specific high level experts in country offices. Donor funding for salaries of staffs on immunization at country and global level is in a very sober situation. Potential donors shy away as they have contributed already to the GAVI pool, also most donors now don't fund program specific funds but for health systems strengthening" - - Core Partner

5.2. TCA Delivery Models

Under the BP, the majority of technical support was provided either through a training or workshop, or during a short-term technical assistance (STTA) visit from a HQ or regional level Partner staff to the country. Under PEF-TCA, we have identified 6 primary TCA models, as illustrated in Figure 5.4, which are reflective of TA delivery models used by other development

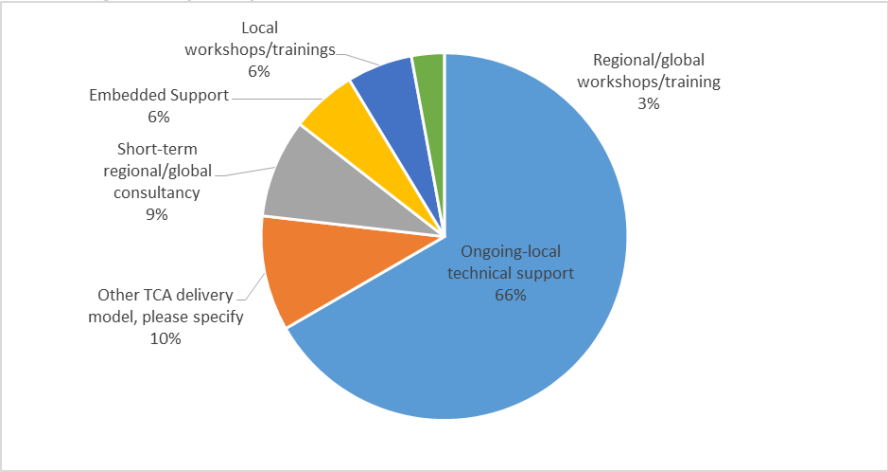
programs.[35] While these 6 models are by no means exhaustive of all the different TA models, they reflect the approaches most commonly described by Partners, EPI teams, and SCMs alike in the Tier 1 countries. For example, we understand from anecdotal information that there are some examples of TA providers working with academic institutions to improve pre-service training, but we did not find any supporting evidence for this in the Tier 1 countries from interviews, document reviews, or the survey responses.

[35] *Land, T. Joint Evaluation Study of Provision of Technical Assistance Personnel – What can we learn from promising experiences. A Synthesis Report. European Centre for Development Policy Management. September 2007. Available from: www.ecdpm.org/dp78.*

Figure 5.4. TA Delivery models

We do not have systematic data on the number of staff supporting each TA delivery model. Our survey results indicate that the majority of TA providers (66%) are providing ongoing local technical support from their country office (figure 5.5), with only 6% providing embedded support. We suspect that this does not reflect the actual proportion as there is a sampling bias in the survey approach. TA providers embedded within the EPI were not always identified as Partner staff or were incorrectly identified as MOH staff, and were therefore not invited to complete the Partner version of the survey.

Figure 5.5. Percent of TA providers using the different TA delivery models as the primary method for delivering TCA (n=62)



During the interviews, Partner and EPI stakeholders frequently described the embedded model of TA delivery and the benefits as well as challenges with such a model. In the case study countries, stakeholders quantified the number of Partner staff that are embedded directly within the EPI team and supporting implementation of the immunization program as part of the EPI team.

From our interview data, and validated by further HQ-level stakeholder consultations, we conclude that there is commonly a wide mix of TA delivery models used within a country and even by one TA implementing organization or provider, as the TA model used is necessarily dependent on a variety of factors such as:

- **Capacity and programmatic maturity** of the immunization program and the health system as a whole – In countries that are lacking a full or fully dedicated EPI team, or where the EPI program is lacking resources to support implementation, stakeholders highlighted the critical role of the embedded support model to ensure timely and quality implementation of key immunization activities. Whereas, in more mature programs, more remote, ad hoc support was seen as sufficient.
- **Urgency of the TA need or the scope of the TA activity** – As TA providers themselves are frequently pulled on to support other health efforts set as priorities by their organizations, they may not always be immediate available to support urgent TA requests or TA activities that are broad and long-term in nature.
- **Competing priorities** – Emerging public health threats such as an outbreak or epidemic can divert Partner Organizations' focus, as well as the EPI team's focus, onto other health issues. Partners aim to continue supporting immunization efforts in such circumstances by bringing in or hiring external consultants for a short term to dedicate their attention to the TCA tasks at hand.
- **The technical expertise and/or availability of the Partner staff in country** – for some specialized activities (e.g. EVM assessment, financial planning, etc), in-country partner staff do not always have the necessary expertise. In these cases, the country team may choose to bring in short-term consultants, either from the local talent pool, local institution, or from their regional or HQ offices.
- **Preference of the EPI team** for type of support to be provided – in some cases, EPI teams have expressed a strong preference for having a partner staff embedded within their team. Other times, the EPI refuses this model even when offered by Partners. As one EPI manager explained: "UNICEF/WHO are very interested in hiring more staff to embed. EPI is not as interested in hiring more embedded staff".

There is by no means a one-size fits all approach. The relative effectiveness of the different models needs to be assessed within the country-specific contexts. It is helpful to understand the relative tradeoffs of each delivery model, especially with how it contributes to the long-term success and sustainability of the TCA approach. Table 5.1 illustrates the perceived advantages and disadvantages of each TA model. (Source: Interviews)

Table 5.1. Advantages and disadvantages of TA models

	Advantages	Disadvantages
Embedded Support	• Dedicated full time to supporting the EPI activities facilitates completion of key activities • Close proximity with the EPI team offers more opportunity for knowledge transfer • Provides easy access to EPI team for immediate support • Builds an understanding of how the government works and how best to move things forward	• Focuses on day-to-day implementation support vs. advisory support • Can foster a dependency and undermine capacity of the MOH • TA provider is isolated from their Partner Office and not able to take advantage of Partners' knowledge bank • TA provider gets pulled into other EPI/MOH activities beyond those they were hired to do • Constrained working conditions may impede productivity (e.g. power outages, lack of connectivity)
Ongoing Local Technical Support	• Provides ample reach back into larger Partner organizational expertise/ knowledge bank • Allows for a broader view on activities vs focus on direct implementation • Increases HR capacity of partners	• Partner staff are not fully dedicated to supporting the EPI – are sometimes pulled into other health tasks or Organizational priorities
Short-term consultancy (local & regional/global)	• [Local consultancy] Can serve to build capacity of other country-level institutions • [Regional/global] offers broader/global view of technical areas beyond what the country may be familiar with, which provides rich insights • For partner, allows expertise to be deployed across several countries	• Completion of task is sometimes done with little engagement with the EPI • Sometimes lacks accountability with no report out upon completion of task • [Regional/global] Can sometimes lack knowledge of the local context, limiting the utility of recommendation or deliverables
Workshops/ trainings (local & regional/global)	• Opportunity for direct skills building, if use appropriate adult learning approaches • Focus on specific topic supports skill/knowledge building	• "Per diem patronage"- participants are motivated to attend for the per diem, but not to take in the new knowledge or skills • Skills don't always translate into capacity improvement for the EPI due to staff turnover

A Closer look at the Embedded Model

It is important to take a closer look at the embedded support model, as this is the one model where there are very disparate views. Firstly, it is worth noting that where appropriate, the PEF-TCA framework does encourage the embedded model: "Where relevant, these staff will be embedded in the Ministry of Health to ensure day-to-day, hands-on support and capacity building".[36] Partners and EPI stakeholders also commonly perceive that this is Gavi's preferred model, as it is sometimes explicitly encouraged by the SCMs.

"Once you are at the [Partner] office you can't provide day to day technical assistance, and we're pushing for that [embedded support]" - - SCM

"I know that Gavi wants that we embed staff in the Ministry." - - Core Partner

Though we do not have systematic data on how many TA providers are embedded in the EPIs across all the Tier 1 countries, the anecdotal evidence from the interviews suggests that this is common practice for UNICEF and WHO, and some Expanded Partners.

"Country is demanding embedded staff rather than someone being added to UNICEF teams. This dynamic is growing which is good" - - SCM

Key Finding. Embedded support is effective for supporting immediate deliverables and achieving short term objectives. However, it does not provide a sustainable approach for improving capacity.

Support for the Embedded Model:

Implementation support. Embedded support is regarded as a "stop-gap" measure to support the EPI in implementing day-to-day tasks as the EPI does not have its own staff, particularly in countries with limited programmatic capacity. However, the embedded model is used even in countries such as Nigeria, and Indonesia, which are scheduled to soon graduate from Gavi support (thereby implying relatively more mature immunization programs).

"MOH wants that person to be theirs, report to them, accountable to them, this model results in the support being more administrative" - - Core Partner

This implementation support is seen as critical to completing key tasks and achieve performance targets. Embedded TA allows for task-sharing across the EPI and Partner teams. In most cases, Partner staff embedded within the EPI are regarded as an integral part of the EPI team, taking direction from the EPI managers and providing support where needed, even if not directly related to the activities outlined in the TCA Plan.

"And now UNICEF has two officers who sit with us with the Ministry. We supervise them, we give them what to do, they report to us, and we're working." - - EPI team member

The close proximity between the TA provider and the EPI team is seen to facilitate deeper engagement on tasks, providing increased potential for knowledge and skills transfer. From the Partners' perspective, having their team members embedded within the EPI also

[36] Partners' Engagement Framework (PEF) & Alliance Accountability Framework. Presentation for the Board Meeting by Anuradha Gupta. 22-23 June 2016. Geneva, p3.

provides greater insight on the operations and decisions making processes of the Ministry which can help advance specific tasks.

"Embedded TA providers do routine tasks. For example, WHO TA embedded in EPI – as long as he's based at the EPI, there isn't anything that he does not support. He participates in the weekly planning just like the rest of the team. You can say that he is ours. When someone is sitting right there next to us, that's the way that they can help support, even with minor things… It is helpful to have the TA right there. We can ask for review of or comment on technical documents, proposals, even help with computer issues, etc." - - EPI team member

Concerns about the Embedded Model:

While the embedded support model of TA delivery allows for greater flexibility and engagement in the scope of activities supported by TA Providers, stakeholders almost ubiquitously voiced concern with this specific model of technical support, mainly the following:

- **The embedded support model displaces the MOH staff.** With the embedded support model taking on the role of implementation support, it effectively transfers the responsibility for some specific tasks from the EPI team to the TA provider. This happens by default where TA providers fill in a human resource gap that negates the need to fill that position with a government employee. Or it can also happen as a result of MOH staff abdicating their responsibilities to the TA provider as they perceive that the TA provider is there to do that job and paid well to do so. As one Core Partner explained it, "when they see technical assistants, they say to themselves 'This person must have a lot of money', so they no longer do the work that they are supposed to do and leave it to the technical assistant."

"The problem is that instead of building the capacity in country, the TA is just replacing the national staff and doing the job in their place, it's not really their place" - - SCM

"There are certain things we have already assigned people to do and we just see someone come and take it over. And sometimes they just advise and show you what to do but there are instances that they did the two." - - EPI stakeholder

- **Embedded support is focused on implementation support which does not promote knowledge transfer or capacity building.** While in theory, implementation support can promote on-the-job learning, stakeholders commonly noted that the pressure to meet timelines and deliverable milestones, and competing priorities does not facilitate an effective platform for knowledge or skills transfer.
- **The discrepancy in salaries can demoralize MOH staff.** The placement of well-compensated TA staff within government health bureaus (both at the central and subnational levels) sometimes creates tension that can be more detrimental than productive. Low government salaries are one of the root causes of the systemic challenges of human resources for health. Juxtaposing Partner staff, who are better compensated while typically doing similar work as the MOH staff, can (and does) cause discontent among MOH staff. Some stakeholders also noted that in some cases, the TA providers were themselves previously MOH employees, highlighting the fact that organizations are sometimes competing with the MOH for the limited pool of qualified experts.

Other TA Models

Although stakeholders voiced concern about the embedded model, the concern about the focus of technical assistance on implementation support is not unique to the embedded model. Even where TA providers are based out of their local country office, or even in cases where short-term consultants are brought in, the perception is that the support provided is often times focused on "getting things done" and not on building capacity or introducing new and improved processes.

"But because Gavi has targets and deliverables and you yourself have targets, then you end up doing the work because if you don't do it, no one else will do it." - Expanded partner

"I think they do challenge a little bit on the critical thinking, but often it's, honestly, so much to do in [country]. There is so much on their agenda that they're just actually helping get things done" - Gavi Secretariat

Survey responses indicate a general preference for the *ongoing-local technical support model*, where TA providers provide ongoing support while based out of their local country offices (Figure 5.6). This model is viewed as generally more effective for supporting both individual-level and program-level capacity gains. Though other models of TCA delivery were not frequently viewed as particularly effective, about 12% of respondents who selected "other" indicated that a combination of different models is often necessary and the most effective.

There are some notable differences in the perceptions by different stakeholders as noted in Figure 5.6. EPI and SCM respondents selected embedded support as the more effective model for both individual-level and program-level support. On the other hand, Core Partners pointed to the ongoing local support model as being more effective for both instances. Expanded partners seem to view embedded support as more effective for individual-level capacity growth, but the ongoing local support model as being more effective for program-level capacity development (figures 5.7-5.8)

Figure 5.6. Perception on relative effectiveness of different TCA delivery models

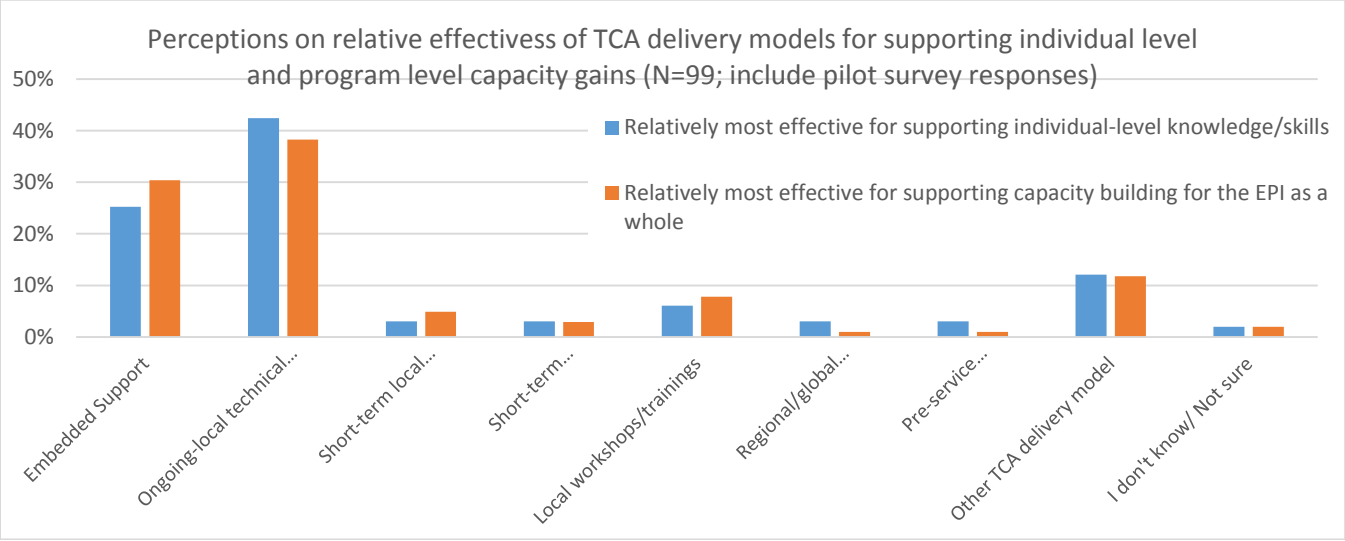


Figure 5.7. Perception on relative effectiveness of TCA delivery models on individual level knowledge/skills

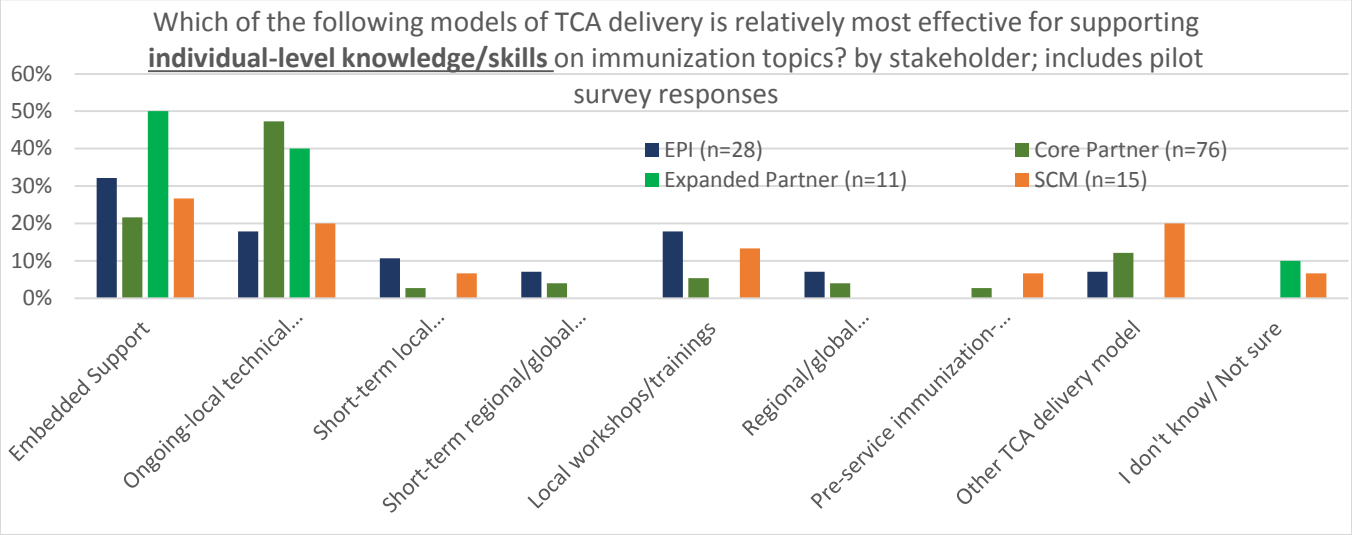
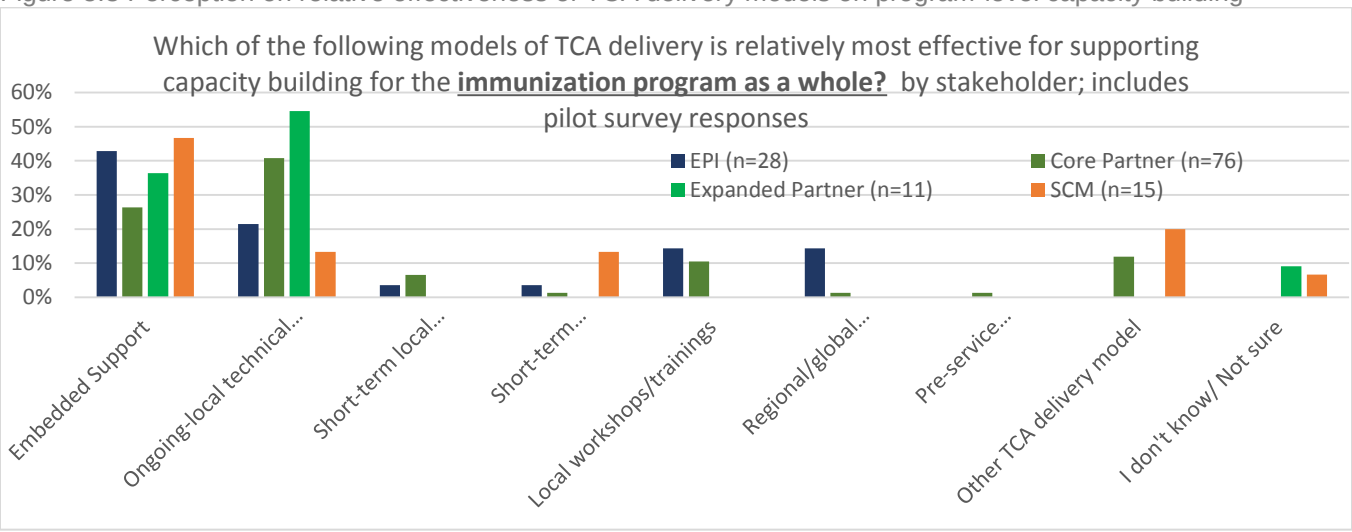


Figure 5.8 Perception on relative effectiveness of TCA delivery models on program-level capacity building



***FINDING:* Though the aim of the TCA is to build capacity, this goal is not clearly communicated with all stakeholders. Consequently, across the different TA delivery models, there is little evidence to indicate that there is an intentional and purposeful approach to foster the transfer of knowledge and skills and build capacity. Moreover, there is not a shared understanding or vision for what "improved capacity" looks like for EPIs.** The implicit assumption underlying TA efforts is that there is a capacity gap that is impeding successful completion of programmatic activities and achieving targets and goals. This capacity gap may be that the EPI program is lacking sufficient personnel or it may be that the personnel do not have the requisite technical knowledge and skills. We have not seen any articulation of the specific capacity gaps that TCA is aiming to fill.

Personnel gap. The TCA is currently used to fill in vacant positions or provide supplementary HR support to the EPI. It does not ultimately address the root cause of the personnel gap, nor

the human resource issue itself. Root causes for the personnel gap may include lack of local institutions that provide training programs on specific technical areas such as cold chain management or surveillance. Another root cause is the lack of sufficient budget for EPIs to increase their team size to address the voluminous amount of work they are tasked with.

If these are the capacity gaps that TCA is intended to address, alternate approaches may need to be provided to better target the root cause.

Skills/knowledge gap. There is no specification of what knowledge or skills are needed and who specifically within the EPI team needs these skills. While this may very well be understood implicitly by those on the ground, the lack of explicit mention of such objectives within the TCA plan casts doubt on whether this is an inherent component of the TCA efforts.

It was noted by a couple of stakeholders that the key challenge to the skills/knowledge gap is that recruitment of civil servants in most countries is political, resulting in a more administratively-oriented team lacking in technical expertise.

5.3. Scope of TCA Activities

The 2016 TCA spreadsheet includes an expansive list of 259 sets of TCA activities[37], organized into 9 programmatic areas and divided across 13 implementing Partners across both Tier 1 and Tier 2 countries. In most countries, there is more than one Partner supporting activities within the same programmatic area. In some of these cases, the types of activities supported by different Partners in the same programmatic area are quite similar or complementary, whereas in others, the activities specified are quite varied and disparate, especially within the Vaccine Subgroups, HSS, and LMC programmatic areas.

<u>Key Finding:</u> The lack of guidance around the programmatic areas has resulted in: (1) Lack of a common thread across activities within a programmatic area; (2) overlap in activities across different programmatic areas that may inadvertently lead to duplication of efforts; and (3) widespread confusion about some programmatic areas across partners, EPI team members, and HQ-level Gavi

[37] The TCA spreadsheet lists sets of activities organized into programmatic areas. In some cases Partners have listed multiple activities within one programmatic area, while in other cases, only one activity is listed for a given programmatic areas. There are also instances where partners have specified 2 or more sets of activities for the same programmatic area.

Alliance representatives, alike. There is a broad mix of activities under each programmatic area, with activities not always clearly related to each other. As was specified in the TCA Planning section, the Gavi Secretariat did not provide standard definitions, descriptions, or guidelines for the types of activities that are to be supported under each programmatic area.[38] This is intentional so as not to be too prescriptive and allow EPI teams and Partners flexibility to define the activities most relevant to the country-specific challenges and needs. However, this lack of direction has resulted in a very long and often disjointed list of activities within and across the different programmatic areas, particularly LMC, HSS, and Vaccine Subgroups. In most cases, there is no clear alignment of some of these activities with the related PEF Functions[39] or with the national level priorities in related technical areas. Table 5.2 below illustrates a sampling of the disparate list of activities specified under these programmatic areas in the 2016 TCA Plan.

Process Note:

We faced quite a bit of challenge in understanding the programmatic areas:

1. We were not able to obtain specific definitions or descriptions for the programmatic areas to inform the design of our data collection tools. Instead, we proposed definitions for these programmatic areas, based on a careful review of the TCA activities, PEF Functions, and overall understanding of Gavi's priorities. These definitions were reviewed, revised, and validated by the Secretariat SFP team.
2. When reviewed by the Alliance representatives on the TCA Steering Committee, there was disagreement on some of the proposed descriptions as well as the programmatic areas themselves.

There is quite a bit of overlap in the types of activities supported under HSS and LMC. For example, support for HSS grant application or monitoring are listed under both programmatic areas, as are activities related to updating or implementing the EPI integration plan.

Although the activities under the Vaccine sub-groups programmatic area are a bit more streamlined around planning for, preparing application for, implementing, and evaluating introduction of new vaccines (such as PCV, Rotavirus, OPV/IPV, Men A, HPV, etc.) or otherwise supporting supplementary immunization activities (such as Measles SIAs). However, there is still a lack of clarity and confusion on what the purpose of this programmatic area is. As one country-level Core Partner explained: "Vaccine sub-groups? It's difficult to know what this means. Sometimes if we don't have a place to put an activity, we just put it under Vaccine sub-group." Similarly, this programmatic area was questioned profusely by stakeholders at the HQ level who repeatedly noted that they were not aware of what this programmatic area is or suggested that this programmatic area should be focused only on new and underused vaccine introductions.

Although there were not a lot of concerns voiced around the *Financing* and *Sustainability* programmatic areas (likely due to the limited scope of these activities), a review of the TCA spreadsheet indicates quite a bit of overlap in the activities specified under these programmatic areas as well.

[38] The 2018 TCA guidance documents have been updated to include descriptions of the programmatic areas and an illustrative sample of type of activities to be included under each programmatic area.
[39] The guidance and template for the 2018 TCA Plan has been revised to allow for the TCA activity to be linked to the PEF Functions.

Table 5.3. Sample of TCA activities by programmatic area, from 2016 TCA Spreadsheet

Programmatic Area	Examples of TCA activities
HSS	• Budget classification, tracking and reporting; Federal and provincial governments to develop and approve an immunization risk mitigation policy framework agreement • Analysis of the supply systems; cost-benefit analysis and roadmap with solutions • Appraisal of EPI staff through HR department • Facilitate CSO and MOH coordination for immunization service delivery and promotion in marginalized communities, including urban slums • Updating and Implementation of EPI/PEI integration plan • Strengthen HR capacity at federal and provincial level by developing a strategic HR plan - including staff supported by partners • HSS program support to facilitate development of proposal, and align this to Country HSS priorities • Evaluation of the implementation of NHSP 2010-2015 TA for coordinating support and responses in the health sector • TA for coordinating support and responses in the health sector • HSS proposal development and implementation plan Improvement to work conditions, TA to analyze needs, develop construction/rehabilitation plans and evaluate their costs • Improvement to work conditions, TA to analyse needs, develop construction/rehabilitation plans and evaluate their costs • WHO RO HSS participation to the joint appraisal
LMC	• Formulate and implement strategies to improve the EPI data quality and develop dashboard; Support external EPI review • Support development and roll out of communication strategies for IPV and rotavirus vaccine introduction and tOPV bOPV switch as part of polio end game strategy to ensure high community acceptance and coverage • Monitor and support Measles SIA preparation and implementation activities • Support improved ICC oversight, partner expansion and functioning • Conduct trainings for all cadres involved in immunisation at state and LGA level. • Support GAVI Graduation process • Support cMYP revision • Support the MOH to update health worker capacity in all aspects EPI planning, implementation and monitoring
Vaccine Sub-Groups	• Comprehensive EPI review : Review current status of implementation of the EPI program, • Monitoring of EVM IP implementation • Provide technical support to improve SIA quality and use opportunities to improve RI: • Coordinate post-Measles SIA coverage Survey • Technical support for planning and training for introduction of MenA into routine immunization and HPV demo • Support for updating strategic documents and reports, National EPI policy • Support for coordination, reinvigorate, strengthen ICC

Support for Gavi Processes

Stakeholders often complained about the time-consuming nature of key Gavi processes, including preparation of Gavi grant applications and reports, as well as preparing for and attending meetings with different technical teams that visit from Geneva (similar finding was noted by the Full Country Evaluation team[26].) The intense requirements of such efforts takes time away from core immunization tasks and adds burden to the EPI teams. As such, EPI stakeholders commonly noted that one key contribution of Partners is their support for Gavi-specific processes such as preparation of Gavi proposals and reports. When asked for key TA accomplishments, the successful submission of Gavi grant applications was frequently cited as a key accomplishment: "Without TA, HSS application and the CCEOP grant may never have seen the light of day or would not have been successful. [The EPI] has one program manager and 2 additional staff - they are running everything from admin to technical. For the HSS application, it is so intensive it needs people that are technically competent but also putting their time to that process".-".-" - - Core Partner

Nature of TCA Activities

"The technical assistance is not a circumscribed activity that we see ourselves doing. But it's a constant presence, constant support presence in the program." - - Core Partner

Finding. The "continuous" nature of the TCA activities presents challenges for defining discrete milestones for a six to twelve month period. Moreover, the interweaving of TCA activities with day-to-day functioning of the EPI program obscures what milestones can be attributed to TCA efforts versus broader EPI activities, thereby undermining the accountability processes.

TCA activities are "ongoing", "continuous", and are interwoven into the broader scope of Partner activities as well as within ongoing EPI operations.[40] TCA activities are a mix of ongoing administrative/programmatic support to the EPI, and discrete technical support for specialized efforts, often with blurry lines between these types of activities. In many cases TA providers have a big role across the full lifecycle of any given immunization effort. For example, support for a coverage survey can span from the initial advisory level support of developing the survey plan and methodology, and perhaps the development of the survey tools; then the TA providers conduct the training for using the tools and conducting the survey; in some cases, TA providers themselves may be engaged in data collection or at least supervise data collection; then lead or oversee data analysis and report writing, as well as development of the plan for how to address the findings from the survey.

"It's actually much more interwoven than one normally would think of as technical assistance. It's actually much less discrete as the separate entity. And that's something that now that we've come to have seen." - - Core Partner

[40] The guidance and template for the 2018 TCA Plan have been revised to request Partners to specify the duration of each proposed TCA activity.

Depending on the country context, the level of engagement of the EPI team in these processes varies greatly. While in some cases, such efforts are inarguably owned and lead by the EPI team with the Partners serving only as support, in other cases, such cases are very much driven by the Partners themselves.

Example: Ongoing communication support in Indonesia: carving out the role for Partner support and Ministry work

In Indonesia, UNICEF is supporting the roll out of the EPI Communications Strategy. It is conducting training for all regional staff on the communications plan and rolling out the plan in 11 provinces – UNICEF "participated in most of the activities in the 11 provinces". The Ministry of Health is leading the role out in the remaining 23 provinces using their own Gavi funds. This support started in 2013 and continued through 2016.

Continuation of existing Partner support

"TCA is about framing the support – we've been doing these things" - - Core Partner

<u>Key Finding.</u> While the volume of partners' TA activities has increased due to TCA funding, there has not been a notable change in the *type* of activities supported, when compared to Partners' prior support for the EPIs.

It is important to highlight here that in the case of UNICEF and WHO, the TCA is an extension of their core mission-related activities. UNICEF and WHO have been working with the national immunization programs for decades, providing ongoing support across multiple technical areas. Overall, 42% of respondents from Partner organizations indicated that they have been providing TA to the EPI in the country where they currently work between 1-4 years, while about 19% have been providing such support for only less than a year. In alignment with the data on staff recruitment, a higher proportion of respondents from UNICEF have a shorter tenure as TA providers, when compared with respondents from WHO (31% vs 6%, respectively, having provided TA for less than 1 year).

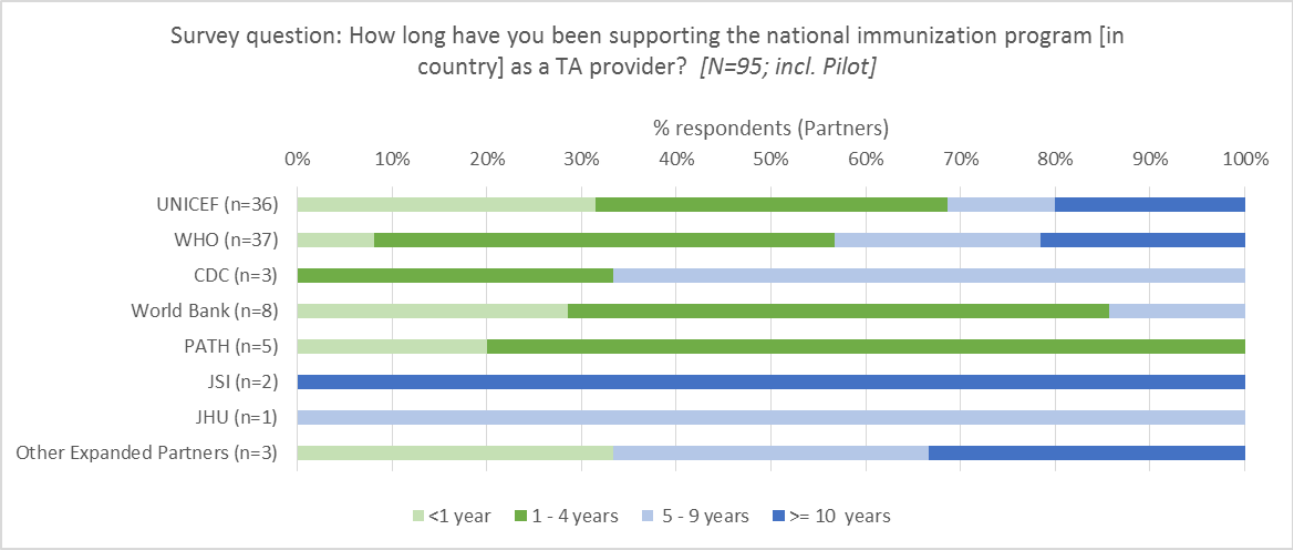
"We have been doing the same thing for the last 4-5 years. The only change is that we are looking more at equity and where there are gaps" - - Core Partner

"Partners are doing what they've always been doing, the one additional thing is payment of allowances of officers to closely look at Gavi related activities [HSS grant]" - - EPI stakeholder

Partners and EPI representatives alike noted how partners have been "doing the same thing" for a long time. The TCA funding allows Partners to hire or retain more immunization-focused staff, which in turn allows for continued and increased support for the EPI. The only differences noted in Partners' current support efforts being either the focus on equity, the link to HSS activities, or support to Gavi-specific processes.

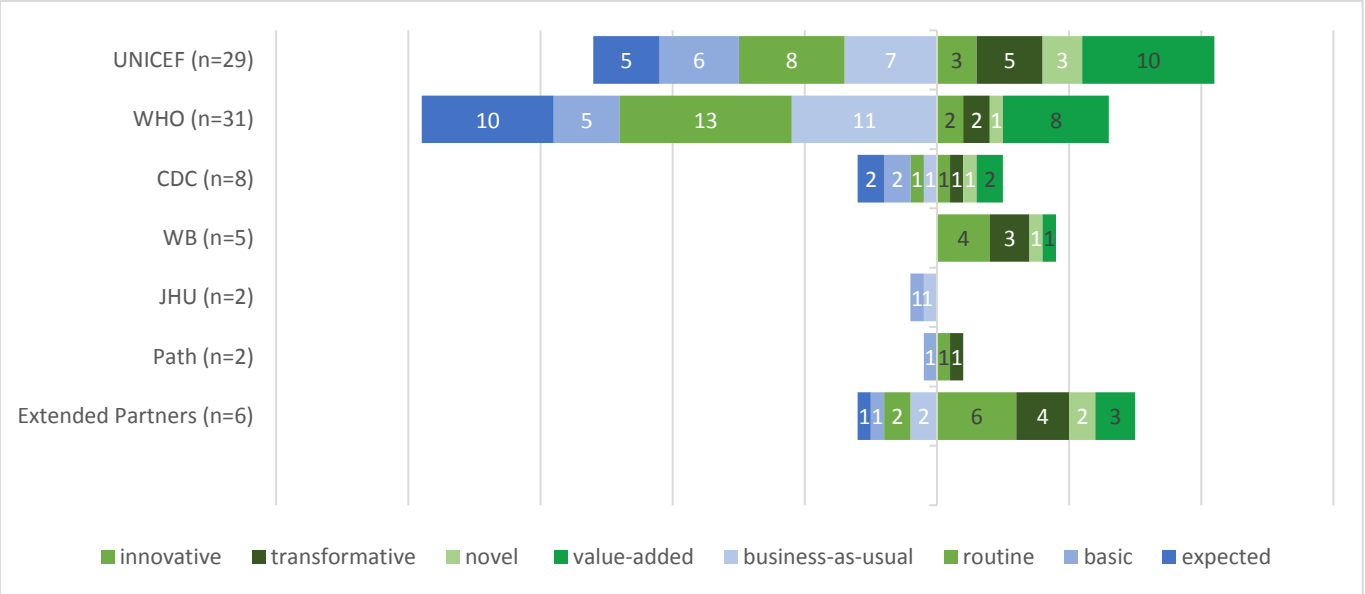
"They have been supporting country for several years, they're just continuing to do what they've always done with some limited funding from Gavi" - - Gavi Secretariat

Figure 5.9. Duration of respondents' TA provision in country, by Partner



Though, not explicitly stated by interviewees, there is a sense that the TCA is "business-as-usual" with Partners continuing with the same or similar activities that they had previously been supporting either under the BP or through other funding mechanisms. When asked to select the words that they would associate with the TCA provided by each organization, EPI stakeholders and SCMs selected words signifying the *routine* or *business-as-usual* nature of TCA more frequently than words associated with *innovation* and *value-added* services (figure 5.10). The few respondents that are familiar with the Bank's activities tend to view them as being *innovative* and *transformative*. Perhaps because the World Bank is a relatively new partner for the EPIs, there is no historical precedence through which to view its support as being *routine* as is the case for WHO and UNICEF.

Figure 5.10. Frequency of words used to describe TCA, by partner



Furthermore, UNICEF and WHO, and to a lesser extent some of the other TCA providers, also receive some of the Gavi HSS grant funds to support specific aspects of the grant (e.g. funds for procuring the vaccines are usually directed to UNICEF; funds for surveillance related activities may sometimes be granted to WHO). For example, in DRC, a UNICEF stakeholder explained that they receive HSS funds: "Actually I can say that we received funding as much as USD 40 million. This means that UNICEF is accountable for the implementation of the supply chain of the EPI in DRC in terms of financing GAVI HSS 2. I can say that the activities were really put in place by 70%. There weren't too many challenges and that is thanks to the follow-up of our technical assistance." Because of this history and conflation of interrelated efforts across different funding sources, it is sometimes difficult to precisely specify which activities are TCA and what is part of UNICEF's or WHO's ongoing country-level immunization support.

"… I think these are things that UNICEF does on their own. So it sort of I mean sometimes there is a case of overlap also between the two for the Government - what the UNICEF office does [as] their own work [and as part of TCA]. It's more like they do something with their own money and then they sort of at the same time develop some sort of policy and strategy around those things which is on the Government." - - SCM

Subnational level TA

"… the level of impact for any program is the provincial, and peripheral level. And that's the weak link. The provincial level today is a weak link. That is where we need to consolidate, and that is where we need more technical assistance. Do not limit yourself too much to technical assistance at the national level because often the impact is not what you want." - - Expanded Partner, DRC

Key Finding. TCA efforts tend to be concentrated at the central level, both in the planning and delivery processes. Given that the HR capacity gaps are generally more prominent and systemic at the sub-national levels, stakeholders agree that TCA should be more focused on support for sub-national levels. It is evident that the large majority of the ground work for immunization efforts take place at the subnational level. Moreover, it is often at this level where there is paucity of well-trained human resources. It is not very clear how much of the TCA efforts are committed to support at the subnational level - neither the TCA plan nor the milestones systematically specify at what level the TA support is provided. However there is widespread consensus across all stakeholders that the TCA efforts are skewed to the central level, where there is typically higher capacity and higher competence.

Process Note:

One limitation of our evaluation is the lack of systematic inquiry on the subnational level TCA activities. While we have compiled some limited information on this topic from case study countries where we conducted a handful of interviews with sub-national level stakeholders, we did not have notable representation from subnational level stakeholders to offer their viewpoints on the TCA.

Across all the Tier 1 countries, EPI staff and Partners alike noted the necessity of more focus on technical assistance at the district or provincial levels, as "this is where the work gets done".

In most countries, WHO and UNICEF have used TCA funds to support salaries for subnational level technical assistants who are stationed within either the provincial health offices or within the WHO/UNICEF sub-national offices. Technical assistants at the provincial, district, or zonal levels work with the respective health authorities to support routing immunization or special immunization campaigns primarily through supportive supervision, training, and data management and reporting.

In the four case study countries, this subnational Partner support mechanism is not new. As such, TCA funds cover only partial salaries for the subnational technical assistants, and therefore these TA providers are not fully committed to supporting immunization activities.

"The presence of WHO in all regions, though all are not immunization TAs, is the strength of WHO. Their regional presence helps to assist the RI program, communicate immunization data, work on data quality assurance, and provide trainings." - - EPI

Provision of TA closer to the point of immunization service provision has been credited with some key process improvements such as:

- more complete and more timely reporting of immunization data
- continuity in activities in the face of high turnover of subnational level government health staff

Though this support is deemed critical and essential, many stakeholders also voiced concerns about TA at the subnational level, mainly:

- **There is not sufficient TA provided at the subnational level.** In most countries, TCA is concentrated at the Central level, providing support to the EPI team within the MOH. Such support does also include training or supervisory visits to the subnational levels. Stakeholders across the Tier 1 countries did specify that there are technical assistance providers at the subnational level as well. However, there is agreement that there is need for more of a focus on TA at the sub-national level. This is due to the absence of fully-dedicated immunization TA providers at relevant sub-national levels. In most cases, subnational level technical assistants are supporting various health functions, not just immunization. For example, it was noted in a number of countries that WHO assigned more surveillance officers than immunization staff at the sub-national level.
- **The quality of TA at the subnational level is subpar compared to the TA provided at the central level.** Though not common across all Tier 1 countries, stakeholders in some countries did point out that TA at the subnational level tends to be of lower quality than that provided at the Central level, often due to the TA providers' level of expertise or specific knowledge of the EPI program. On the other hand, the capacity to absorb the TA is also lower at the sub-national level as health programs often do not have the necessary resources to implement the recommendations from the TA providers.

- **Subnational levels are not engaged in the planning process.** Subnational level stakeholders are often missing from the JA discussions. It is not clear to what extent the Partners country offices engage with their colleagues at the provincial or district levels to plan out the TCA activities and align with the most pressing needs and realities on the ground.
- **Sustainability is of more concern at the subnational level.** Stakeholders frequently noted that when the TA provider leaves "things fall apart". This is indicative of the lack of expertise at the local offices to fully absorb the contribution of the technical assistant or maintain the activities once the TA providers leaves. This also calls into question the extent to which TA providers are working to build capacity of local health officers.

  The lack of resources was also noted as a key factor impeding sustainability of efforts at the subnational levels. TA providers often come with their own resources (e.g. laptops, internet connectivity, access to vehicles, etc), which the local health officers are often lacking. When the TA provider leaves, s/he takes their resources with them, potentially disrupting key activities.

"When they are here, things are quite simple, but when the colleagues leave things get harder, which means we don't have the same skills. This is where we are fighting, so that we can improve things" - - EPI

"We should ensure the sustainability of the activities. Because what we notice, is that when the technical assistance arrives, [they] had all the resources, the work progresses, but when the technical assistance leaves, everything falls down. So, we have to consider that we should have a technical assistance but also the financial resources, so that the program can continue normally in the provinces and maintain the achievements of this technical assistance." - EPI

5.4. Challenges in TCA Delivery

Being the first year of TCA implementation, there were several process-related challenges that impeded progress and some outstanding systemic issues that should be addressed moving forward.

- **Funding disbursement delays.** The most frequently cited challenge is the delay in TCA funding disbursement to countries, and then to the subnational level. As noted earlier, though Gavi sent commitment letters to WHO and UNCIEF headquarters offices in April, 2016 TCA funds were not disbursed until May-June of 2016 for Core Partners, but even later for Expanded Partners, with funds released to different organizations at different times. This delayed the recruitment and hiring of TA providers, a process which was further lengthened due to Partners' internal organizational processes. These delays impacted Partners' ability to achieve the 6-month milestones set for November 2016. More importantly, the different timelines with which the funds were released undermined the coordination efforts across Partners to implement on complementing activities. This was clearly exemplified in the DRC: "[There is a] two-speed disbursement in the project … and we are not served according to the same schedule. There are those who receive the funds on time and also start activities [on time]. This does not promote good

coordination and good implementation of activities. We can educate people to get vaccinated, when they arrive things are not yet developed because the funding has not arrived at the [subnational] level…It makes the strategy used inefficient and that's what I [mean] by double speed. It is a lack of coordination in relation to the disbursement of funds."

- **Insufficient funding.** In addition to the delayed funding, Partners also noted that the TCA funding is oftentimes insufficient. As noted above, the majority of TCA funds are used to partially support Partner staff salaries. While it seems that TCA funds are supplemented with core Partner budgets to cover staff salaries, the inability to pay for staff who are fully dedicated to immunization was raised as an obstacle by several WHO and UNICEF stakeholders. As noted in Figures 5.3 above, about 30% of Partners who responded to the survey indicated that they work on other non-immunization health activities for more than 25% of their time. The concern with the funding level is especially pertinent when thinking about the TA needs at the subnational level.

  There is the vision that PEF funding is to serve as a catalytic force to encourage commitment of support from other donors and domestic funding. However, a common frustration echoed by partners across the Tier 1 countries was that **other donors are less inclined to fund immunization-specific efforts as they are already contributing to the Gavi Fund.** Therefore, Partners find it difficult to supplement the limited Gavi TCA funding with other funding to support a full immunization-specific team.

- **The high volume of TCA activities creates competition.** The long list of TCA activities, in addition to being ambitious and unrealistic, is seen as creating competition on two levels:
  1. **Fund utilization.** The guidance from Gavi is that any TCA funds that are not utilized by Partners by a specified date are to be returned to the Gavi Secretariat. Partners view this as a penalty and sense pressure to utilize the funds. This inadvertently leads to competition between Partners to be the ones to provide as much TCA as possible to fully utilize their funds. It also contributes to the provision of TCA that may not necessarily be needed at that time, even if it was originally identified in the TCA plan.
  2. **Competition for the EPI team's time.** Partners have to engage with their EPI counterparts to complete their assigned tasks and ensure they utilize their funds. In most countries, the EPI teams are comprised of only a handful of individuals. Yet there are multiple TA providers from multiple organizations going to these same individuals with multiple requests and in essence competing for the EPI team's time. As one SCM described it: "I think sometimes I feel that it's the same horse that everybody is riding. We have only the program managers, the immunization EPI program managers that we're interacting with. But there is a huge agenda on the plate. And the capacity is very limited."

5.5. Quality of TCA Delivery

The quality of TCA delivery was measured on 7 attributes (Box 5.2) which have been identified in the literature as being key characteristics that drive the effectiveness of TA.[41,42] These characteristics were also discussed and vetted with the TCA Evaluation Steering Committee and the PEF Strategy, Funding, and Performance (SFP) team. Survey respondents were asked to rate the TCA provided by each Partner against the 7 attributes, using a 4-point scale.[43] Partners were also asked to rate their own TCA efforts on these characteristics. As over 90% of Partners consistently rated themselves positively on each characteristic, we excluded Partners' self-assessment from the analysis so as not to skew the data. Instead, we looked more closely at how the EPI members and the SCMs assess the quality of the TCA provided. EPI respondents were asked only about the characteristics of the TCA provided by Partners that they have worked closely with. Similarly, SCMs were asked only about the Partners providing TCA within the country that the SCM oversees (Figure 5.11). The percent of EPI and SCM respondents that rate each characteristic positively serve as the key TCA quality indicators.

Box 5.2. Quality Attributes and indicators:

- **Clarity of objectives:** % of EPI/SCM respondents who rate TCA objectives as quite clear or very clear
- **Relevance of TCA activities:** % of EPI/SCM respondents who rate TCA activities to be quite relevant or very relevant
- **Timeliness of delivery:** % of EPI/SCM respondents who rate TCA activities as being usually or always delivered in a timely manner
- **Flexibility of TCA providers:** % of EPI/SCM respondents who rate TCA providers to be quite or very flexible
- **Frequency of reporting:** % of EPI/SCM respondents who rate TCA providers as providing usual or frequent reporting on TCA activities
- **Expertise of TCA providers:** % of EPI/SCM respondents who rate TCA providers as having moderate/high level of expertise
- **Extent of skills/knowledge transfer:** % of EPI/SCM respondents who rate TCA providers as having supported knowledge/skills transfer to some/great extent

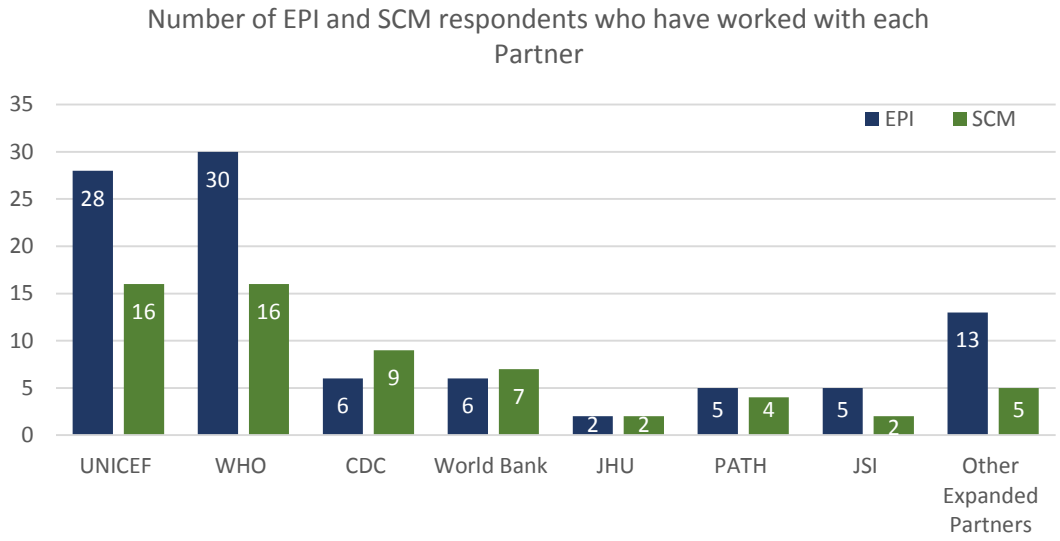
Given that few EPI team members work directly with TCA providers from the World Bank or CDC, the number of respondents for these Partners is very low, greatly limiting the interpretation of any results specific to these Partners. Similarly, since the number of EPI respondents working with an individual Expanded Partner organization is very low, responses for all Expanded Partners have been analyzed jointly. ***Any observations noted for CDC, the World Bank, and Expanded Partners are merely raw reflections of the survey responses, but should not be used to draw any conclusions***.

[41] West, G., Clapp, SP, Averill, EMD, & Cates, WJ. (2012). Defining and assessing evidence for the effectiveness of technical assistance in furthering global health. Global Public Health. 7 (9). 915-930.

[42] International Monetary Fund Independent Evaluation Office. Evaluation of the Technical Assistance Provided by the International Monetary Fund. January 2015. Available from: http://www.imf.org/external/np/ieo/2005/ta/eng/013105.htm

[43] For example: 4-point scale for measuring clarity of objectives: Objectives were: very clear, quite clear, a little clear, not clear at all.

Figure 5.11. Number of EPI and SCM respondents who have worked with each Partner



***Finding*: Across all the Partners, the quality attributes rated most positively by EPI respondents were expertise of TCA providers and the relevance of TCA activities for addressing the implementation challenges/bottlenecks of the immunization program. On the contrary, reporting on TCA progress, timeliness, and flexibility of TCA providers have the poorest quality ratings.**

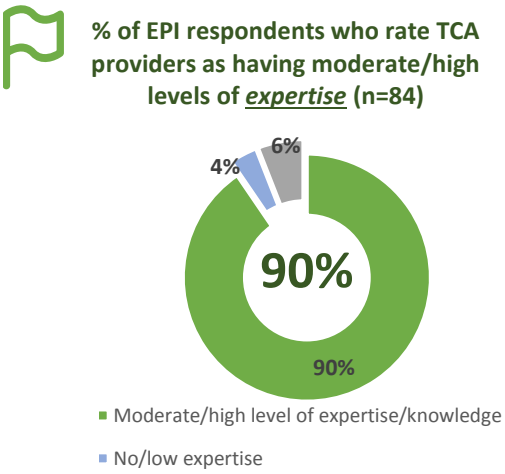
Interestingly, there is a very notable difference in quality ratings between EPI and SCM respondents (Table 5.4). SCMs rated relevance and clarity of TCA objectives most positively across all Partners, but tended to view timeliness, flexibility and extent of skills transfer less favorably. About 10-30% of SCMs specified "I don't know/Not sure" for one or more of these quality attributes, making the overall SCM ratings relatively low. There is also notable variability in the quality ratings across the different Partners, though *these observations should be interpreted very cautiously due to the low number of respondents particularly for CDC and World Bank.*

Table 5.4 Percent of EPI and SCM respondents who rate characteristics positively[44]

	UNICEF		WHO		CDC		World Bank		Expanded Partners		ALL	
	EPI (n=28)	SCM (n=16)	EPI (n=30)	SCM (n=16)	EPI (n=6)	SCM (n=9)	EPI (n=6)	SCM (n=7)	EPI (n=14)	SCM (n=13)	EPI (n=84)	SCM (n=61)
Clarity of Objectives	82%	88%	70%	69%	67%	33%	67%	29%	64%	62%	73%	62%
Relevance	86%	81%	87%	75%	83%	56%	83%	29%	71%	85%	83%	70%
Timeliness	68%	50%	53%	25%	83%	22%	50%	14%	57%	54%	61%	36%
Flexibility	64%	44%	40%	31%	50%	11%	50%	0%	50%	38%	51%	30%
Reporting	71%	56%	63%	56%	67%	22%	67%	14%	57%	54%	65%	46%
Expertise	96%	69%	90%	63%	83%	56%	83%	43%	86%	69%	90%	62%
Skills Transfer*	71%	31%	70%	23%	100%	14%	100%	20%	60%	40%	72%	27%

[44] Table only displays % of respondents who rated characteristics as e.g. "quite clear" or "very clear"; "quite relevant" or "very relevant", etc.

Expertise: ***Respondents are satisfied with the level of TCA providers' knowledge and expertise***



EPI respondents relayed satisfaction with TCA providers' expertise or knowledge of country-specific immunization context. More than 80% of EPI respondents rated this characteristic positively across all Partners, with slightly lower ratings for CDC and World Bank TA providers. SCMs rated this attribute more moderately, with only about 62% of SCM respondents noting that TCA providers have high or moderate level of expertise or knowledge. About a third of SCM respondents did not answer or indicated lack of certainty on the expertise of TA Providers, particularly those from CDC and World Bank, reflective of SCMs' lack of familiarity with TCA providers from these agencies (see Annex 9, for further details).

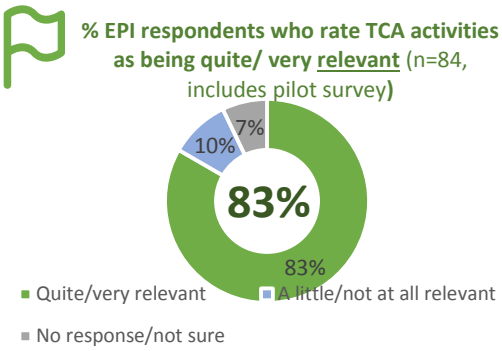
TCA providers' response to background questions indicate that they are highly trained (37% have MDs, 31% have MPH, 20% have other Master's degree, and 9% have a PhD or other doctoral degree) and have extensive experience in the immunization field (71% have 10 or more years of experience in this field).

Our interview findings identified concerns with the qualifications of the TCA providers at the subnational level. We do not believe that these findings are incongruous. Given the structure of the survey (see process note), it can be assumed that this survey indicator reflects views about the TCA providers at the national level (vs. sub-national level), as well as short-term consultants hired locally or internationally. Therefore, we conclude that while there is high satisfaction with the level of expertise of TCA providers at the national level, this same caliber is not met consistently at subnational levels.

Process Note:

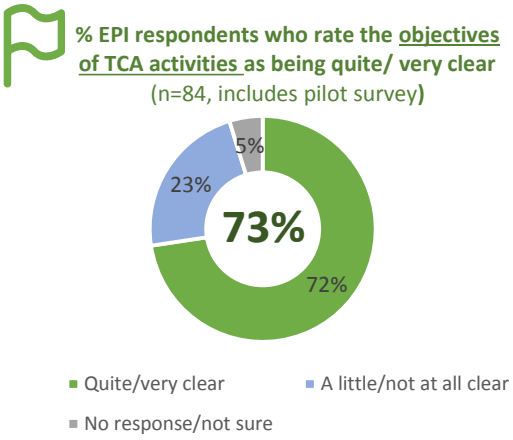
The survey question specifically asked about the level of expertise/knowledge of short-term technical assistance providers from each organization. On the contrary, the majority of Partners that responded indicated that they provide ongoing (long-term) support at the central level. The survey did not ask respondents to differentiate between TCA providers at the central vs sub-national level. Similarly, TCA providers at the sub-national level were not invited to complete the survey.

Relevance: ***Respondents view the TCA activities to be relevant for addressing the implementation challenges/bottlenecks of the immunization program.***



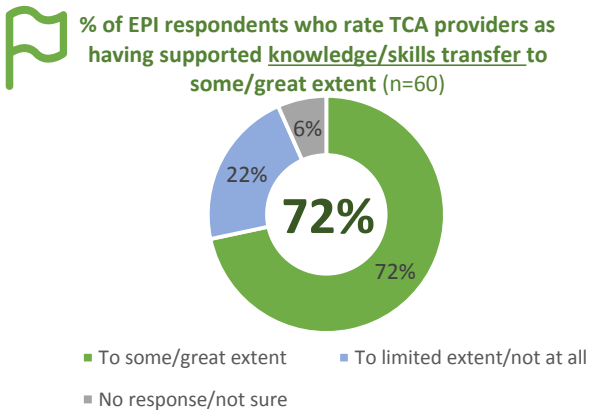
Relevance, along with TCA providers' expertise, was the highest rated characteristic, particularly for the activities supported by all four Core Partners (including among SCMs). For UNICEF and WHO in particular, this speaks to the success of the JA process through which these Partners engaged closely with the EPIs to define the TCA activities, maximizing alignment with the needs of the EPI. Even though interview findings frequently highlighted the absence of the World Bank from the JA and lack of awareness of the Bank's activities, EPI respondents rated the Bank's TCA efforts as being quite relevant for their immunization program. As the engagement of other Expanded Partners in the JA process varies from country to country, it is expected that their activities may not be viewed quite as relevant.

Clarity of Objectives: ***There is wide variability in the clarity of the objectives of the TCA activities supported by different Partners.***



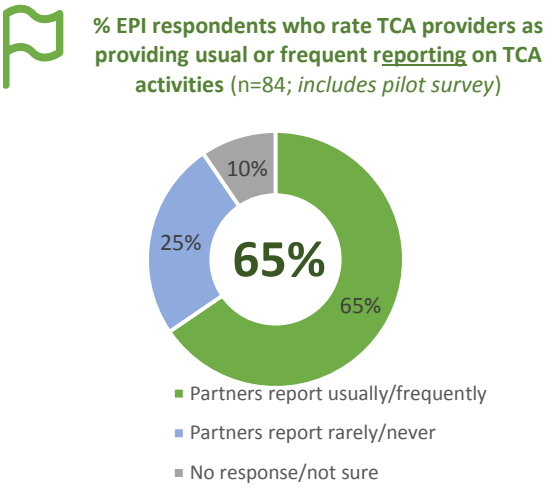
An integral aspect of transparency is the shared understanding of what is being done and why it is being done. TA providers specify the intended milestones and longer term expected outcomes within the TCA Plan. Interview findings suggest that these milestones, outputs, and outcomes are not fully reflective of the overall intent or objectives of the activities conducted. However, the survey findings indicate that the majority of EPI and SCMs view the objectives to be quite clear or very clear. SCMs indicated less clarity of objectives for CDC and World Ba with only about one third or less of SCM respondents indicating clarity of objectives of the TCA activities supported by these Partners (see Annex 9, for further details). About 29% and 15% of SCM respondents either did not answer or specified they were unsure about this particular characteristic for the TCA provided by the World Bank and Expanded Partners, respectively. This in itself is indicative of the limited awareness that EPI teams and SCMs have about the activities of these Partners and is reflective of the unique arrangements that some Partners have with Gavi. For example, PATH's activities for HPV were developed at the global level without country-specific objectives. Similarly, as the World Bank does not work directly with the EPI in most countries, there is limited awareness of its activities as well as the objectives of those activities.

Knowledge/Skills Transfer: **The extent of knowledge/skills transfer via TCA efforts is perceived to be relatively low.**



The level of skills transfer is the characteristic where there is the greatest divergence in EPI and SCM perspectives. Somewhat contrary to the findings from the interviews, about 75% of EPI respondents indicated that the TCA activities support transfer of knowledge or skills to a moderate or great extent. Partners also consistently noted that they provide TCA in a way that supports knowledge/skills transfer (to some or to a great extent). Only about one quarter of SCM respondents agreed with this viewpoint, with the majority of SCMs (54%) indicating they did not know or were not sure of this aspect of Partners TCA efforts. There were some variations in the ratings across partners, ranging from 60% of EPI respondents rating the TCA supported by Expanded Partners as providing moderate/high levels of skills transfer to 100% of EPI respondents providing this rating for TCA provided by CDC and World Bank. However, as these data do not include data from the pilot survey, the total number of respondents for this question is lower than for the other characteristics, and offers lower power to make cross-partner comparisons.

Reporting. **While reporting on TCA-specific efforts during country-level meetings varies by Partner, it is more a direct function of country processes rather than Partner characteristics.**

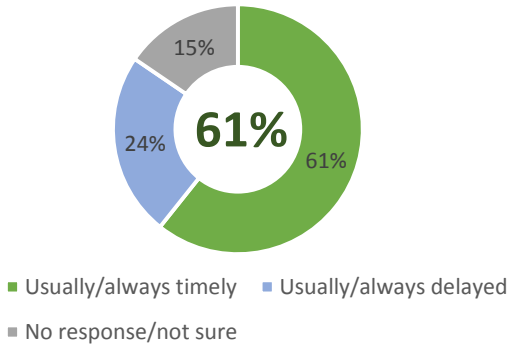


Overall, 65% of EPI respondents and only 46% of SCM respondents indicated that Partners usually provided updates on the status of TCA activities in about 50% or more of relevant country-level meetings. In open-ended questions as well as during the interviews, it was frequently noted that Partners do typically provide updates on TCA during established national EPI review meetings, ICC meetings, or regular immunization technical working group meetings. Given these country-level fora for reporting, Partners that are in country usually participate in these meetings and provide updates on their activities. However, those that are not in country miss these opportunities. Interestingly, WHO was rated as having slightly lower frequency of reporting than other Core Partners. Interestingly, SCM respondents indicated in open-ended responses that reporting on

TCA only happens when the SCM is visiting in country, or in response to a Gavi request (i.e. the milestone reports).

Timeliness: **Delay in implementation was a main challenge in 2016.**

% EPI respondents who rate TCA activities as being usually/always provided in a timely manner (n=84, includes pilot survey)

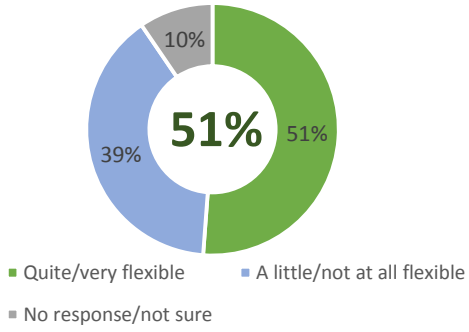


The relatively low rating for timeliness is consistent with interview findings and is likely reflective of the funding delays and organizational bureaucratic processes that were frequently noted as challenges by respondents from UNICEF and WHO. In response to open-ended questions, respondents clarified further that the delayed start in the TCA activities sometimes results in planned activities not being implemented or in rushed implementation.

Beyond delays in funding disbursement from Gavi, respondents cited other factors that impeded timely delivery such as competing public health priorities (e.g. measles outbreak or polio activities in Nigeria); other programmatic elements not being in place (e.g. vaccines supplies not available); or security concerns.

Flexibility: **While TCA is regarded as offering limited flexibility, there are anecdotal examples of the use of TCA funds to address emerging priorities.**

% EPI respondents who rate TCA activities as quite or very flexible (n=84, includes pilot survey)



Flexibility was the lowest rated quality of TCA. EPI and SCMs were asked to rate each Partner organization on the degree of flexibility to meet changing priorities/needs of the immunization program. With the exception of UNICEF, 50% or less of EPI representatives and SCMs rated TCA provider organizations to be only a little flexible, if at all (see Annex 9, for further details). In open-ended responses respondents indicated that the limited number of Partner staff can be an impediment to changing course, as needed, during the course of implementation.

EPI and SCM respondents did also point out that limits on flexibility are due to the TCA structure more so than a reflection of Partner organizations themselves. Partners were asked to rate the flexibility of the Gavi TCA structure in allowing them to adapt TCA activities. A little over a third of Partners indicated that the TCA structure is either "a little flexible" (36%) or "quite flexible" (37%). Though the TCA Guidance document provides guidance on reprogramming of TCA funds, the common understanding among Partners in country is that once the TCA Plan has been approved and funded, there is little room to adapt or shift resources around as Partners are held accountable to the milestones that they have set. At the same time, several respondents did also indicate that they do in fact adapt their activities as needed, with approval from the SCM.

"We used the funds to support priorities that emerged during the year" - - Core Partner

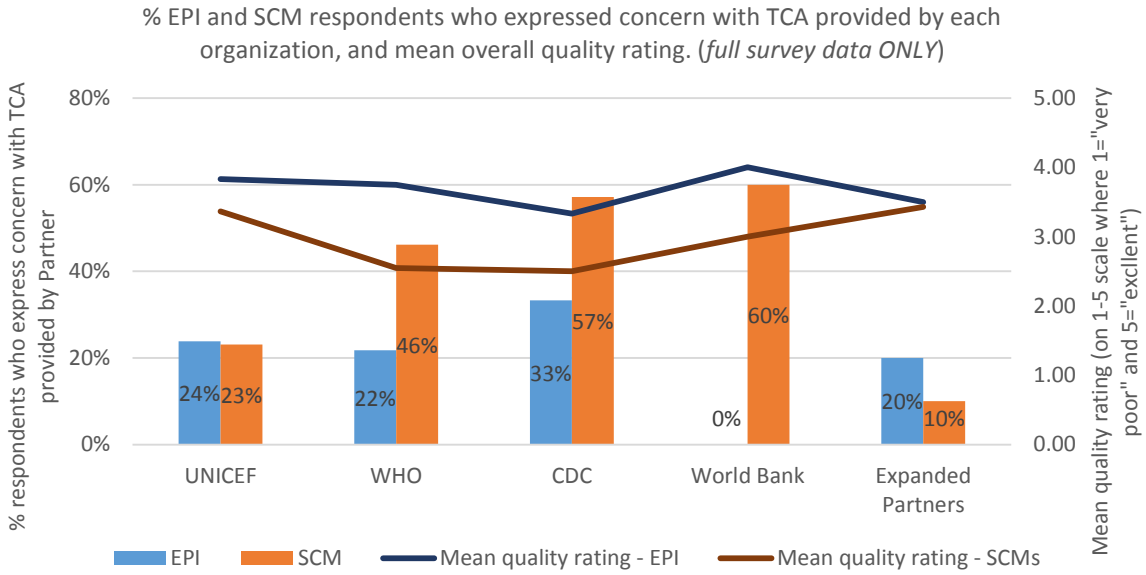
"We are constantly adapting our activities and support to the government" - - Core Partner

The somewhat discrepant perspectives on this topic reflect a lack of understanding of Gavi's guidelines and expectations on how TCA activities can be reprogramed to accommodate changing priorities. Guidance for reprogramming of funds would also need to account for how such changes should be coordinated across different Partners to maximize coordination, as the lack of transparency on some Partners' activities was raised as one challenge in adapting activities after completion of the JA. Flexibility is particularly critical in conflict-prone areas where unrest can affect the EPI's and Partners' ability to conduct immunization activities as planned.

Concerns and overall quality rating

The survey asked EPI and SCM respondents whether they had any concerns with the TCA activities supported by each Partner. *As these questions were asked only on the full survey, the number of respondents is quite low for each Partner and does not provide enough data points to draw conclusive insights.* In general, a higher proportion of EPI and SCM respondents noted concerns for CDC (50%). While EPI respondents did not express any concern with the World Bank, a high proportion of SCM respondents did so. In both cases, the cited concern is the limited country presence and limited visibility on the activities of these two agencies. However, despite the concerns noted and other findings regarding the lack of awareness of the Bank's activities, the overall quality rating for the World Bank was relatively high compared to all other Partners.

Figure 5.12.Level of concern about TCA and overall quality rating



n=	UNICEF	WHO	CDC	World Bank	Expanded Partners
EPI	18	20	3	3	8
SCMs	11	11	7	5	7

Though only less than 40% of EPI and SCM respondents indicated any concern with the TCA provided by other organizations (beyond CDC and World Bank), it is worth noting that the specific concerns they did have were most commonly related to technical or program-specific issues, such as "weaknesses in supporting logistics", or "inability to deliver requested items".

6. Findings - TCA Coordination

At a high level, stakeholders agree that the PEF-TCA has brought about more structure to facilitate greater coordination and collaboration across TCA providers, mainly through the Joint Appraisals. Most importantly, when compared with the BP, all the key players now have much better awareness of which organizations are providing TCA to the EPI and a general understanding of the types of activities they are supporting. In fact, this was a key perceived advantage of the TCA. Not so much that it is bringing added support or changing the support provided by Partners, but that it has now brought more visibility and transparency to the immunization TA landscape in country. This improved transparency allows for improved coordination. However, there are still some major gaps in the level of transparency, communication, coordination, and collaboration. In addition to some of the outstanding gaps observed at the country-level, there are important coordination impediments at the global and Gavi Secretariat levels that have downstream implications.

Box 6.1: Overview of Key Finding o Coordination and monitoring of TCA

- ***Key Finding.*** Coordination of TCA efforts is strong between UNICEF and WHO, but not across remaining Partners.
- ***Key Finding:*** The strong Partner coordination mechanism, facilitated by the EPI in DRC, is exemplary.
- ***Key Finding***. The TCA milestone reporting process has laid the foundation for improved accountability at the county level (when compared to the BP). However, there are some process-related and quality challenges of the milestone reporting process that limit its utility.

We identified 3 levels at which there are outstanding weaknesses in coordination.

1. Coordination across implementers at the country level, including the EPI and all in-country Partners
2. Coordination across the different administrative levels of partner organizations and Gavi Secretariat
3. Coordination across different teams within the Gavi Secretariat

6.1. Coordination across implementers at the country level, including the EPI and all Partners

Key Finding. Coordination of TCA efforts is strong between UNICEF and WHO, but not across remaining Partners.

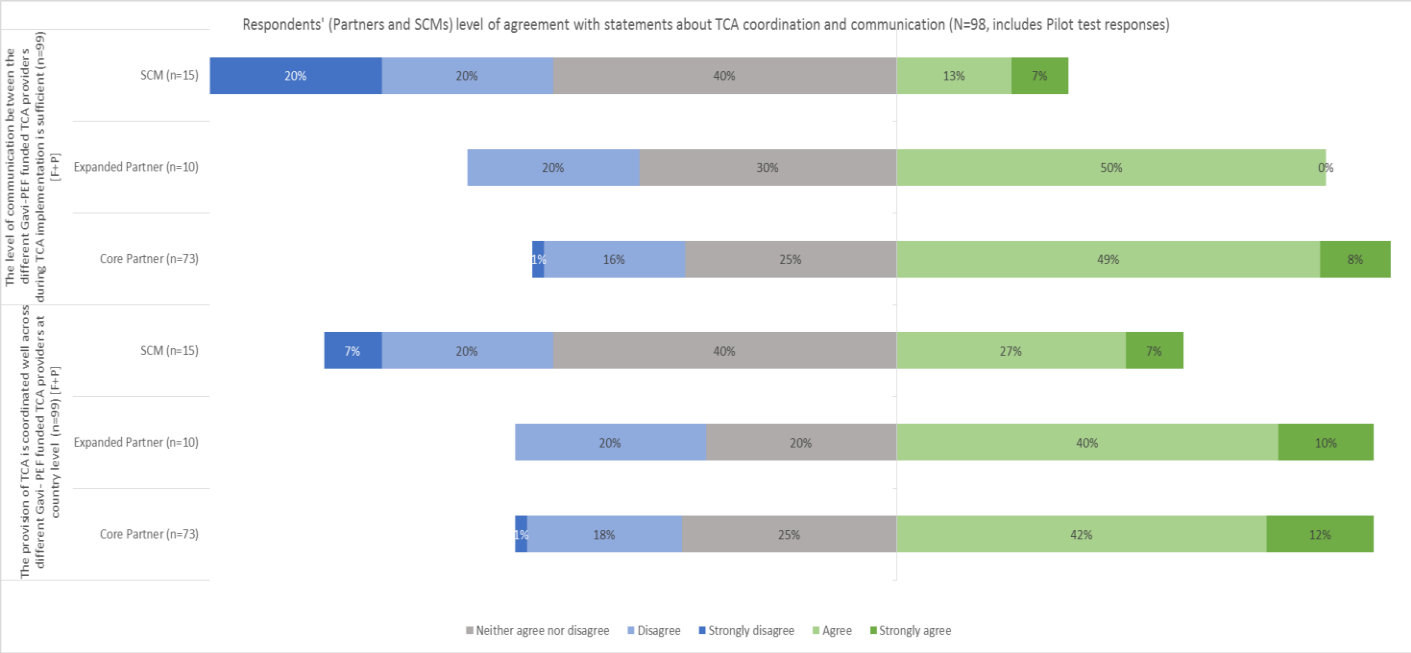
During interviews, UNICEF and WHO stakeholders consistently noted that they work very closely together on all of their TCA and broader immunization efforts. Even where their TCA activities are similar within the same programmatic area, they noted that their efforts are complementary and not redundant, most often purposefully dividing up their efforts geographically. However, this level of coordination is not evident among the other TCA providers. Other Partners were quick to share that they do not have much visibility on what other TCA providers are doing, let alone coordinate with them. This is consistently true in the case of World Bank and CDC, where other TCA partners as well as the EPI teams noted that they know that the World Bank and CDC are TCA Partners, but they "haven't seen them". Expanded Partners also seem to be on the periphery in most countries, but there is some awareness of their general roles and responsibilities, though coordination may be weak.

> "Where do we overlap? It is the coverage and equity. But even that area, we've divided. We said okay, we are thinking of supporting the country to reach at least maybe 60% of the districts. WHO cover 30%, UNICEF cover another 30%. But by the end of the day we're all going to implement the same activity "– Core Partner

Overall, only about half of the survey respondents agreed or strongly agreed that there is good communication and coordination across TCA providers, with no notable difference in the perceptions of Core vs Expanded Partners. Interestingly, SCMs were more likely than Partners to disagree that the levels of communication and coordination across partners are sufficient (Figure 6.1). There were no notable differences in the perceptions of coordination across different Partners.

In response to suggestions for improving TCA, survey respondents commonly highlighted the need for better communication and coordination, both across Partners as well as between Partners and the Secretariat.

Figure 6.1. Partners' and SCMs' perspectives about TCA coordination and coordination



Coordination Mechanisms. Not all countries have established formal Partner coordination mechanisms. DRC is a rare example where the EPI convenes weekly calls with all Partners to discuss and coordinate activities. In other countries, the only established mechanisms to bring Partners together are the EPI reviews, the JA, and some other existing national-level meetings, at which technical assistance may be one agenda item. However, we did not find evidence of regular, ongoing communication between the EPI and all TCA providers at the country level.

The EPIs in Nigeria and Ethiopia are trying to use resource mapping as a way to identify key Partners, their contributions, and where they are working. However, stakeholders noted the sensitivities and politics of such an effort. Expanded Partners shared the view that Core Partners embedded within the EPI are driving the agenda and discouraging such an effort in order to retain their influence on the EPI.

The lack of coordination results in role confusion and redundancy of efforts (and therefore inefficiency). More importantly, poor coordination has direct implications for the delivery of immunization services. For example, in Ethiopia and DRC stakeholders cited examples of how Partners working on communication and demand generation activities worked with communities to encourage them to get their children vaccinated, but when they come looking for vaccines, services are not available, creating a setback for all immunization efforts. As one Expanded Partner noted "we are creating the demand, but the system is not there".

Though not a commonly held viewpoint, a proposed solution to avoid this misalignment is to structure TCA so that one Partner is offering comprehensive services – i.e. demand generation, cold chain, data, etc – within select geographic areas.

"When you stimulate demand, you identify unvaccinated children, and by bringing them back to services, vaccines are not available, that is a problem. It happens that there is a break in vaccine, or vaccines are not available in a given area, and so on. It is a huge problem. In terms of credibility and everything we are doing on the ground. So we should already make sure that the services are available "– Expanded Partner

6.2. Coordination across the different administrative levels of partner organizations and Gavi Secretariat

The PEF-TCA has changed the dynamic between Partners' global, regional offices and the country offices. Whereas under the BP, the global offices (and in some cases the regional levels), had more insight on the Gavi processes and decisions, that dynamic seems to be reversed now. It is now the countries that have the more direct communication with the Gavi Secretariat. While this has been a tremendous advantage for the country offices, it has in some cases resulted in the lack of consistent communication from Gavi Secretariat to the Partner country and regional offices.

"And I think that that's really an area that I thought it needs some streamlining to ensure that both the regional and the headquarter level of each of the agencies involved within the Gavi alliance partnership, and especially the targeted country assistance…that they're engaged and they are well informed so that we do not have a situation where part of each of the agency has more information than another one." - - Core Partner

"So we need to understand how these senior country managers are linking up with the regional officers or how regional officers are linking up with senior country managers of Gavi. If the SCMs are working with the countries only without having actually linked up with the regional office or regional office not having a clue of what's going on at the country level, then I think we won't meet the desired spirit of our work." - - Core Partner, Regional level

This is mostly exemplified by the regional offices who express their lack of understanding of the role of the SCM, and similarly, by the SCMs who question the role of the Partners' regional office within the PEF-TCA structure. With the shift in focus of the PEF-TCA from the global and regional levels to the country level, the role of the regional levels has become more obscure, especially for the SCMs. Many of the in-country UNICEF and WHO stakeholders noted that their regional offices are often engaged in the TCA planning process and approve the TCA plan before it is submitted to Gavi. To varying degrees across different countries, the regional offices also provide some level of oversight via regular conference calls to discuss status of activities. However, the main gap

seems to be in the lines of communication between the Gavi Secretariat and the Partner regional offices, which may be due to the lack of clearly defined roles for the regional offices within PEF-TCA.

6.3. Coordination across different teams within Gavi Secretariat

A number of the process challenges we encountered during the evaluation stemmed from the apparent inconsistency in the awareness and knowledge of the various details of the TCA process across stakeholders within the Gavi Secretariat and the Alliance partnership. In many instances it was obvious that critical aspects of the process were not being communicated well across the different players. The lack of shared understanding of the programmatic areas is one example of this. Similarly, there were several questions raised by Alliance partner representatives on what the terms "Core" and "Expanded" partners referred to, despite these being common references used within the Gavi Secretariat-issued materials related to PEF-TCA. These inconsistencies in understanding are no doubt shaped by the ever-dynamic nature of the PEF-TCA modifications. However, it also speaks to the lack of streamlined communication between the Gavi Secretariat and key stakeholders within the Alliance.

Communication between technical teams and SCMs. As with Partners on the ground, SCMs also lamented about their lack of visibility on CDC and World Bank TCA activities. Most SCMs seem unaware of the details of the unique agreements that both CDC and the World Bank have with the Secretariat. As they are not aware, they are not able to communicate well with the EPI teams to clarify why the CDC and World Bank are not as visible as the other Partners.

Similarly, partners such as PATH, and JSI are supporting a wide range of activities, some with TCA-specific funds and others with larger Gavi grant funds. For example, PATH has a multi-country grant to support the planning for and roll out of the HPV vaccine. This grant is managed by the Vaccine Implementation Team at the Gavi Secretariat, which is separate from the Country Management team under which the SCMs sit[45]. As such, SCMs are not always privy to the discussions between PATH and the technical team, creating misunderstandings and confusion on the ground.

The lack of coordination across SCMs and Gavi Secretariat technical teams is also manifest in the lack of consistent messaging about technical issues or recommendations. Some partners voiced the concern that some SCMs come from backgrounds that are not necessarily health-related (e.g. economists), yet still engage with EPI managers and TCA providers on technical health issues, which can discredit the recommendations presented by Gavi.

[45] There are currently discussions to put in place a system to coordinate better across the SFP, Country Management, and Vaccine Implementation teams.

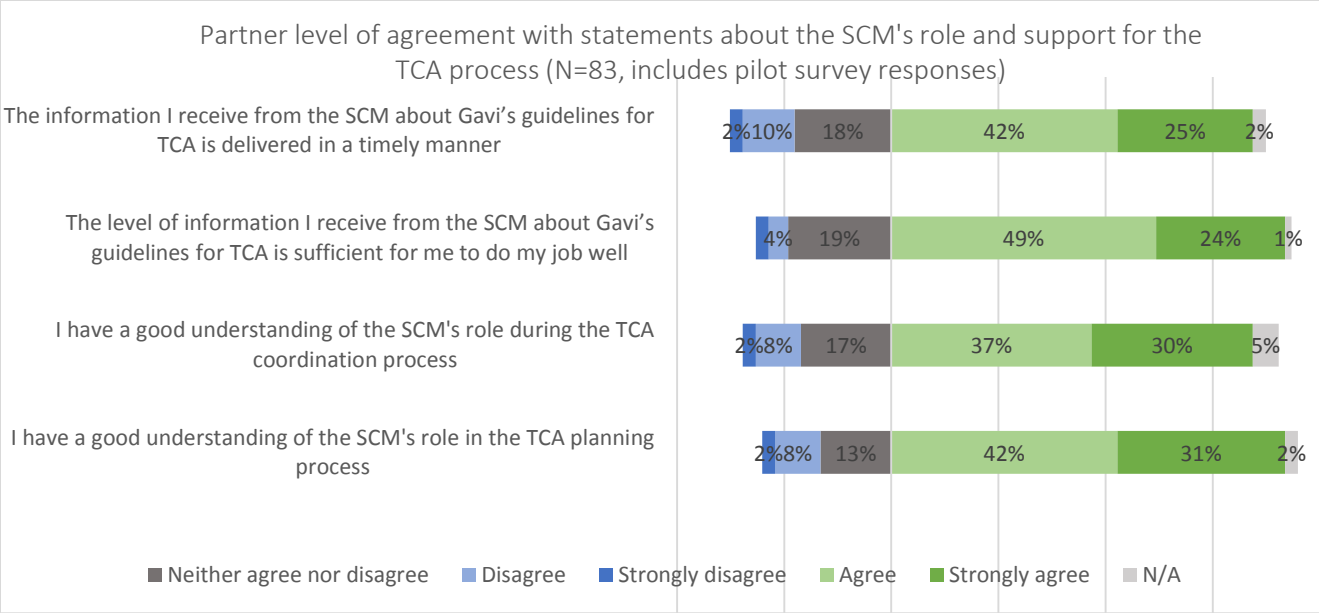
6.4. The role of the Gavi Secretariat

The PEF TCA places the Senior Country Managers in a critical role to shepherd the process at the country-level. Twelve of the 16 SCMs who completed the survey agreed or strongly agreed that they have a good understanding of their role as the SCM. Primarily, SCMs most frequently noted their role as being to facilitate the TA needs identification process through the JA, to monitor TCA implementation, and to provide guidance to all stakeholders on the PEF processes. A handful indicated their role in strengthening the government's ownership of the TCA process. Interestingly only 2 SCMs specified coordination as being their core responsibility.

During the 5-month evaluation data collection period, we were informed of at least 4 Tier 1 countries in which the SCM assignments were changing.

The majority of Partners indicated that they have a good understanding of the role of the SCM and feel that they are receiving sufficient and timely guidance from the SCMs. (Figure 6.2). There is no notable difference in the perceptions between Core and Expanded partners.

Figure 6.2. Partners' perspective on the role of the SCM



Challenges. Though the high turnover in SCMs was noted as a challenge by in-country Partners and EPI teams, in general stakeholders noted a positive working relationship with the SCMs. The turnover does of course create challenges as the SCMs are having to learn the country context anew with each new SCM.

CDC and World Bank stakeholders more often complained that the SCMs do not seem to have a good understanding of their organizations' strengths and therefore what they bring to the TCA.

Though not widely shared, there are some concerns from Partners that they are expected to report to the SCMs, causing some confusion on the reporting hierarchy. This was voiced at the country level as well at the headquarters level for a Core Partner.

> "What has often happened is that we often talk about one GAVI but there is GAVI Alliance and GAVI Headquarters. GAVI Headquarters is not represented in the countries but there are members of the alliance such as WHO and UNICEF who are in the countries and represent GAVI's interests. About coordination in the countries, I believe that when GAVI headquarters sends messages to WHO and UNICEF offices, they coordinate with the health department of UNICEF at the country level to represent GAVI's interests. GAVI should represent itself in the country as GAVI headquarters." - - Core Partner

Lack of in-country presence of the Gavi Secretariat. The PEF model intentionally puts the emphasis on country-level processes. The Gavi Secretariat structure is Headquarters-based, relying on Alliance members, primarily UNICEF and WHO, to serve as Gavi representatives on the ground. Several UNICEF and WHO stakeholders acknowledged this responsibility - as one stakeholder described it: "since Gavi is not represented in country WHO takes the role seriously for making sure that these [HSS] funds are used carefully so that they are not misappropriated." However, this dual role of the Partners – serving as Gavi Alliance members and "overseers" of Gavi funds, while at the same time being recipients of Gavi funds themselves, has created some confusion. Perhaps because of this confusion, several stakeholders including both EPI team members as well as Partners on the ground suggested that having the SCMs based in country would be beneficial. The current structure of SCMs visiting their assigned country 3-5 times a year is not viewed as being sufficient to promote full functioning of the TCA and facilitating the relationships between Partners and the EPI teams.

7. Findings - Milestone Reporting

"The one thing that PEF has done at least for the Ministry is bring visibility on what partners are doing. And they are asking for more. [They ask] what did they say they would do and what did they tell you they did?" - - SCM

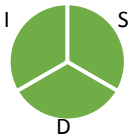
A key change of PEF-TCA when compared to the technical assistance process under BP is that PEF requires Partners to set milestones for their activities at the country-level and then report on them on a semi-annual basis. Under the BP, reporting was done at a global level only, not differentiating achievements by country. With this new process, Partners set their milestones after the JA process in consultation with the EPI team, and then provide a status update on those milestones during the reporting periods specified by the Gavi Secretariat. This reporting process is designed to hold Partners accountable, both to the Secretariat as well as the EPI teams for effective use of the TCA funds awarded to them.

"Very odd that Gavi is in a position where they are giving money but have no leverage" - - Gavi Secretariat

EPI interviewees particularly noted the marked improvement in this approach, compared to prior years. Many reiterated how the JA process itself and the joint process for defining the TCA activities *AND* milestones has shed much needed visibility on what partners are supposed to be doing. EPI teams also appreciate that there is a process by which Gavi monitors Partners' implementation of planned activities, yet consistently noted their lack of awareness on what Partners are actually reporting. Partners similarly appreciate the need and value of the reporting process, but did express that it is yet another reporting requirement which they are still learning about: "I approve this new framework. It is true that we are still unfamiliar with it, but the positive points are starting to show up." - - Core Partner.

Box 7.1: Overview of Key Finding on Milestone Reporting

- ***Key Finding.*** The TCA milestone reporting process has laid the foundation for improved accountability at the county level (when compared to the BP). However, there are some process-related and quality challenges of the milestone reporting process that limit its utility.



<u>Key Finding.</u> The TCA milestone reporting process has laid the foundation for improved accountability at the county level (when compared to the BP). However, there are some process-related and quality challenges of the milestone reporting process that limit its utility.

Process-level shortcomings

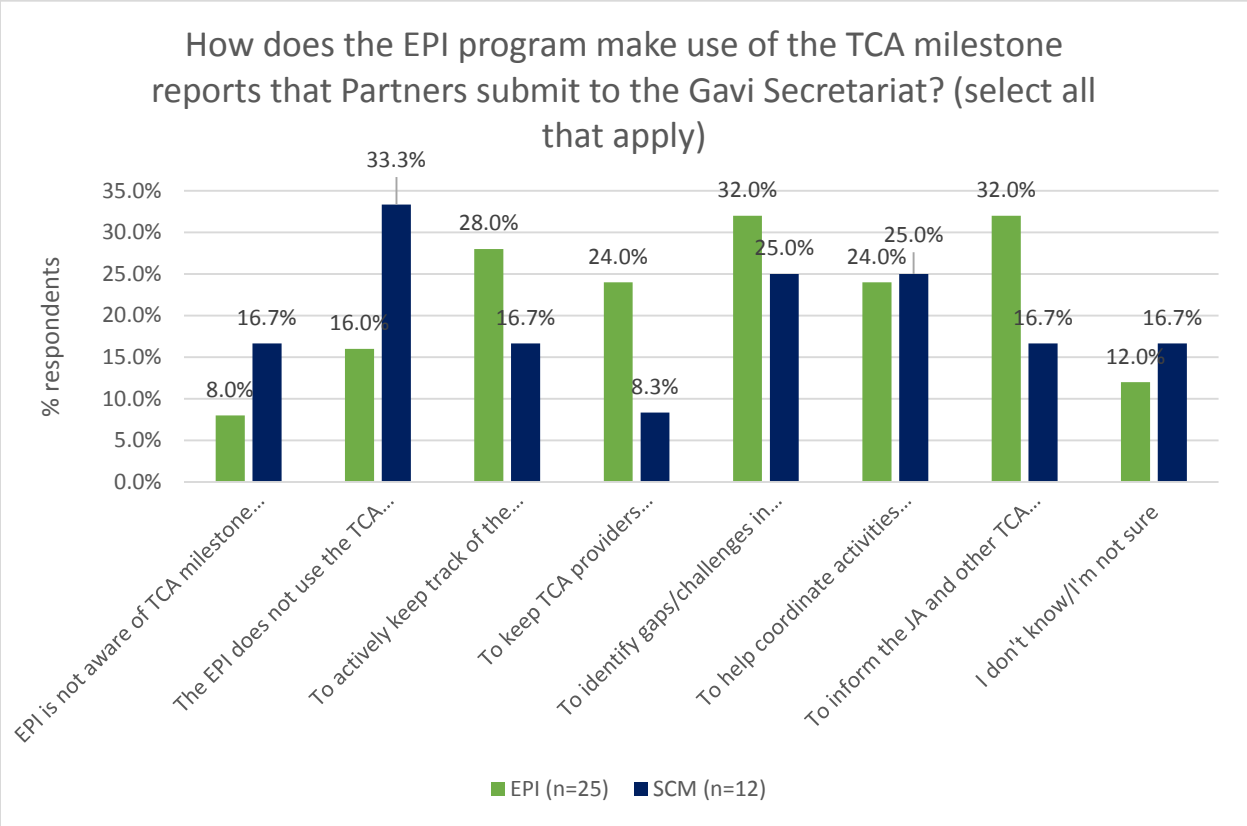
Milestone reporting was not required of all partners in the 2016 TCA. Only UNICEF, WHO, and CDC were required to set and report on milestones for the 2016 TCA, introducing different levels of accountability for different Partners. Due to the different contracting mechanisms with the World Bank and Expanded Partners, this requirement was not included. Though the World Bank is not required to report on milestones, they did submit updates on their 2016 activities to the Secretariat. Similarly Expanded Partners, though they did not report on milestones did submit deliverables to the Secretariat. We have learned that all Partners, with the exception of the World Bank will be required to report on milestones for 2017.

There is not a well-defined follow up mechanism for the Gavi Secretariat to validate and take any needed action on lagging milestones. Several SCMs as well as EPI stakeholders noted that it is not clear how the Gavi Secretariat uses the milestone reports beyond reporting to the Gavi Alliance. There is no recourse that SCMs or EPIs have to truly hold Partners accountable to achieve the defined milestones. As one SCM expressed: "It's always been a trick to know what we are going to do if they [Partners] haven't done what they are supposed to do. There could be all kinds of reasons for that, [maybe], they didn't have enough capacity, or maybe it's on the government side to do things, or maybe there were problems in hiring some consultants. There are all kinds of problems that they run into and to me it's not clear "So what we do with that?"

The milestone reporting process is geared more to holding Partners accountable to the Gavi Secretariat/Alliance and not so much to the national immunization programs.[46] While the Gavi Secretariat does encourage Partners to review and discuss the milestones with the EPI teams before submission, many EPI stakeholders raised concerns that they had not seen the milestone reports. When asked to indicate how (if at all) EPI teams use the TCA milestone reports submitted to the Gavi Secretariat, 8% of EPI respondents noted they were not aware of the milestone reports and 16% indicated they did not use the report for any particular purpose. Only less than one third of EPI respondents indicated that they make use of the reports for any purpose. Interestingly, when asked this same question, SCMs were much more likely to indicate less use of the milestone reports by the EPI teams (figure 7.1).

[46] The milestone reporting process and platform have been updated in 2017 to provide reviewer rights to the EPI Manager, with the intention to facilitate more transparency around the milestones reported by Partners.

Figure 7.1. Use of TCA milestone reports by the EPI program



Quality shortcomings

Poorly defined milestones present challenges for reporting. Likely because of the ongoing non-discreet nature of most TCA activities, the majority of milestones are defined quite broadly.

> *Sample milestones*: "Improved logistics and cold chain management"; "Improved data monitoring system established"

Such milestones are very broad and redundant of the TCA activity itself, without specification of what improvement is expected, what exactly will be achieved by the end of the mid/end-year reporting period. A status report for such milestones (these particular milestones are both marked as "completed") is hard to interpret and does not provide any actionable information.

Milestones do not differentiate what is to be achieved by the Partner vs the EPI team. As described above, the efforts of Partners and the EPI are often intricately intertwined. One depends on the other to progress on many tasks. However, from an accountability perspective, it is important to clarify what specifically Partners will be responsible for producing, as well as the downstream changes those products/efforts will contribute to at the level of the EPI.

> *Sample milestone:* "*At least 30% of activities in the EVM improvement plan are initiated*" –

While this is a relatively specific and measurable milestone, it is not clear that this task is entirely under the purview of the Partner as implementation of such activities is likely undertaken by EPI staff at the subnational levels.

The level of accuracy of the reported milestones is questionable. Given the nature of the TCA activities, the often vague milestones and the non-nuanced reporting status (completed/minor delays/major delays[47]), the reported status of the milestones does not always sufficiently reflect what has/has not been done on the ground. While a total of 59% of year-end milestones were reported as "completed", a closer look at the notes provided by the reporters, raises questions what this status truly reflects. For example table 7.1 presents a sample of milestones for which the explanatory notes provided are incongruous with the reported status of "completed", either indicating that the activities is yet to be completed, or that it is being implemented by another Partner.

Table 7.1. Illustrative subset of "completed" milestones with incongruous explanations.

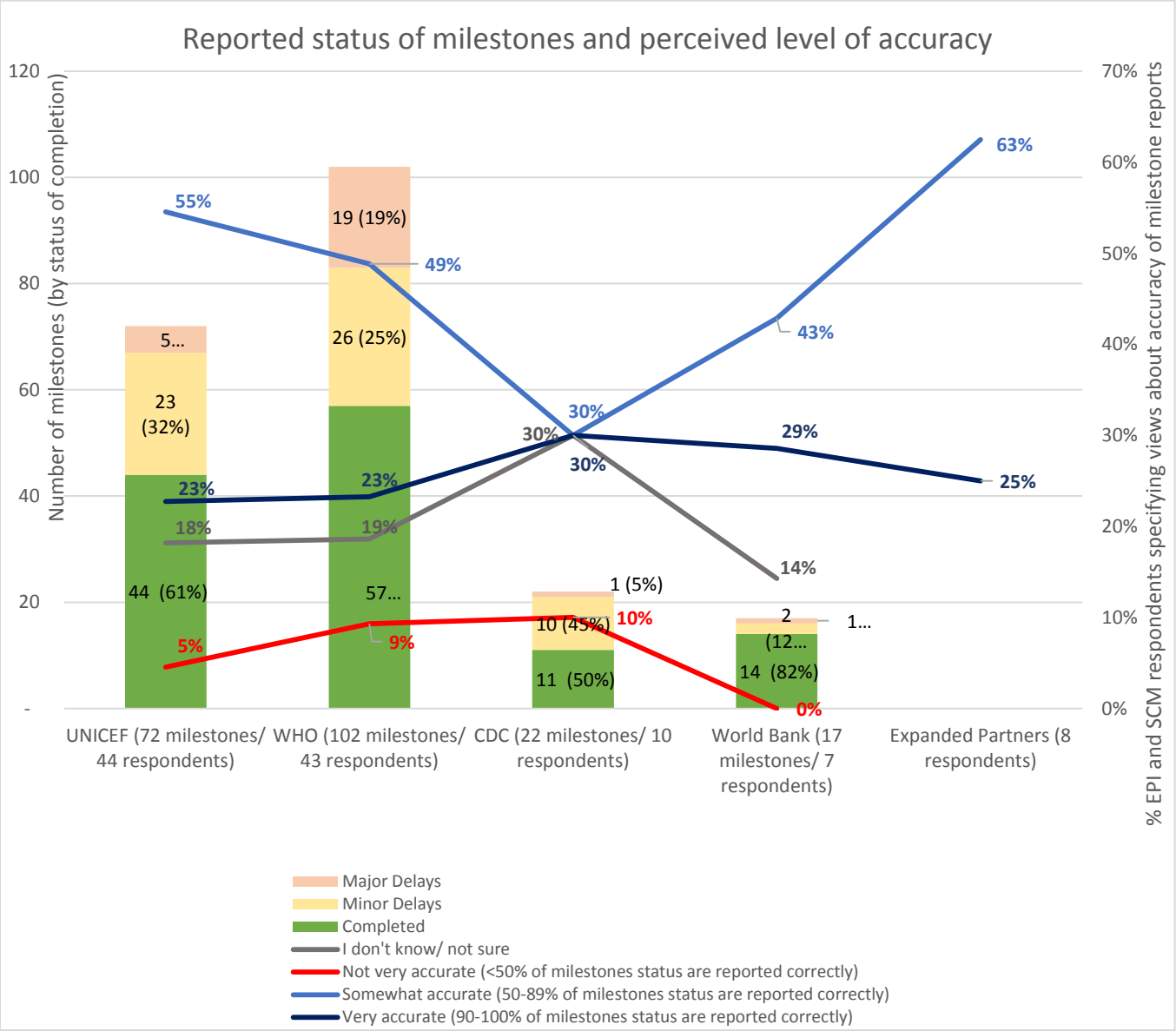
Milestone	Status	Notes
EVM assessment completed	Completed	EVMA was completed in May 2015
EVM practices fully operationalized at all levels	Completed	Activity to completed by Q1 2017
HPV costing completed	Completed	Country not conducting HPV demo project. No further engagement for GID.
Number of solar refrigerators installed in the FOSA/Districts (*translated)*	Completed	Installation of solar refrigerators is underway in the health districts. The number of technician teams has increased to 24 with the formation of district teams. Each team currently has a (tool) installation kit. (*translated)*
Plan for improving birth registration rates using the immunization program developed	Completed	Preparations underway
Support to establish national committee for AEFI monitoring	Completed	No separate committee will be established. ICC will play the role instead.
Training of health workers involved with immunization and birth registration	Completed	Training plan developed
Vaccine management and stock data regularly updated	Completed	This TA is provided by UNICEF

When asked about the level of accuracy of the milestone reports, 50% of EPI and SCM survey respondents indicated that the milestone reports are only "somewhat accurate" (50-89% of milestone status are reported correctly). SCMs in particular noted the lack of processes to allow follow up and validation of the milestone reports, further weakening the confidence in the accuracy of the reports.

"There is no guidance that partners have to submit evidence for milestones. When I asked [Partner] to see the communication plan they developed, the Partner did not provide the document. It is not even clear if the national programme sees the deliverable". - - SCM

[47] The 2017 milestone report template has been updated to include options to report status of activities as "On-track" or "reprogrammed"

Figure 7.2. Milestone status and perceived accuracy



Other TCA reporting mechanisms

Despite the lack of EPI's visibility on the TCA milestone reporting processes, there are other monitoring mechanisms that either the Partners are using or that the EPI has instituted. For example, WHO regional offices often convene monthly calls with country offices to review progress and any challenges or needs in the TCA implementation process. In some countries, the EPI as well as some other TCA providers are invited to join these regional calls.

In countries like Uganda and DRC, the EPI convenes regular meetings with all key Partners to review and discuss progress on key activities. For example, in Uganda, a Core Partner explained that during monthly meetings convened by the EPI, Partners "review overall annual work plan, and key activities are laid out in a Gantt chart. We review this in the monthly meetings and discuss what we are supposed to do and what we've been able to achieve. We've made tremendous progress in accountability, transparency."

However, in most countries, stakeholders specified that there is not a regular platform, outside of the JA meetings, for Partner to report on and discuss progress on TCA activities. In few cases, it was reported that such discussions do sometimes occur during Gavi Secretariat missions to the country.

8. Findings - Contribution of TCA to progress in each programmatic area

In efforts to assess the contribution of each Partners' TCA efforts to the EPI, we asked all survey respondents to rate *to what degree TCA provided by each organization (or their own organization in the case of Partners) has contributed to helping the national immunization program advance towards achieving its goals in each programmatic area* (on a scale of 1-10, where 1 signifies no contribution and 10 signifies that the TCA was crucial to the progress made in that programmatic area). Respondents were asked to rate only the Partners that they have worked with or that provide TCA in the country that each SCM oversees.

As with the TCA quality ratings, Partners' self-rating of their contribution was typically higher than the rating provided by EPI and SCM respondents. These ratings are therefore analyzed separately. On average, across all programmatic areas, Partners' TCA contributions were rated to have contributed moderately to the EPIs progress towards its goals (mean scores between 4 and 7). EPI respondents noted the highest contribution within HSS (mean score=6.63), Financing (mean score=6.1), and LMC (mean score=6.62). Interestingly, these are the same programmatic areas that stakeholders had indicated during interviews as ones that they are not very familiar with. On the other hand, the two programmatic areas that have the lowest mean score for Partners' contribution - Supply chain (mean score 4.46) and Data (mean score=4.93) - are programmatic areas that are well understood and in which Partners have a large number of activities.

Table 8.1. Description of the TCA programmatic areas

Programmatic Area	Description
Supply chain	Activities related to strengthening one of the five fundamentals of the immuzation supply chain (i) capacity and supply chain leadership, (ii) using data to manage supply chains, (iii) cold chain equipment management, (iv) effective vaccine management and supply chain strengthening strategies and (v) optimizing the the supply chain distribution.
Coverage and equity, Demand promotion and generation	Activities related to targeted efforts to increase the number of children immunized with all routine vaccines, with special focus on groups identified as having lower access/coverage; includes coverage surveys, equity assessments, micro-planning for RED or REC strategies, and social mobilisation Promote and sustain public demand for quality immunization services through interventions informed by evidence on social determinants, supporting the integration of interventions into national plans, and building national capacity to design, implement and monitor interventions
Data/surveillance	Activities to support immunization data collection, management, analysis and overall data quality improvement, as well as support for the planning and implementation of regular surveys and surveillance activiites, as per established guidelines.
Advocacy	Advocacy activities with stakeholders to develop and/or update policies, raise awareness and support of immunization efforts.
Vaccine subgroups	Activities related to planning for, preparing application for, implementing, and evaluating of introduction of new vaccines (such as PCV, Rotavirus, OPV/IPV, Men A, HPV, etc.) or otherwise supporting supplementary immunization activities (such as Measles SIAs)
Financing	Activities related to securing, analyzing, planning for overall expenditure and financing for immunization from all sources, where relevant.
HSS	Activities in support of the implementation of the Gavi HSS grant or (re)application for the Gavi HSS grant. Including but not limited to: updating and Implementation of EPI/PEI integration plan; Procurement; Redefine policy and procedures and guidelines; Faciliate CSO and MOH coordination for immunization service delivery and promotion.
Leadership, management, and coordination	Activities in support of strengthening the capacity of national level leadership, management, oversight, and coordination (including Interagency Coordinating Committees (ICC) and Health Sector Coordinating Committees); this may include, for example, support of strategic and operational planning (e.g. cMYP, operational plans), monitoring of implementation and follow-up of those plans; support for enhancement of performance management practices of the EPI; activities to strengthen the functionality of ICCs (e.g. support for 'ICC secretariat', coaching of ICC members on their role); support of donor/Gavi reporting and donor/Gavi missions
Sustainability	Activities in support of financial sustainability planning, development of Gavi graduation plan, and other efforts to support successful transition and the continued funding of the immunization program

There are noteworthy variations in the mean scores across the different partners for each programmatic area, described in detail below. *There were only between one to five EPI or SCMs who provided ratings for the contribution of CDC, World Bank, and Expanded Partners' TCA contributions. These ratings are displayed below, but are not discussed in detail as the low number of respondents does not provide reliable insights.* ***Results for these Partners should not be used to draw any conclusions about the contribution of these Partners.***

Supply Chain

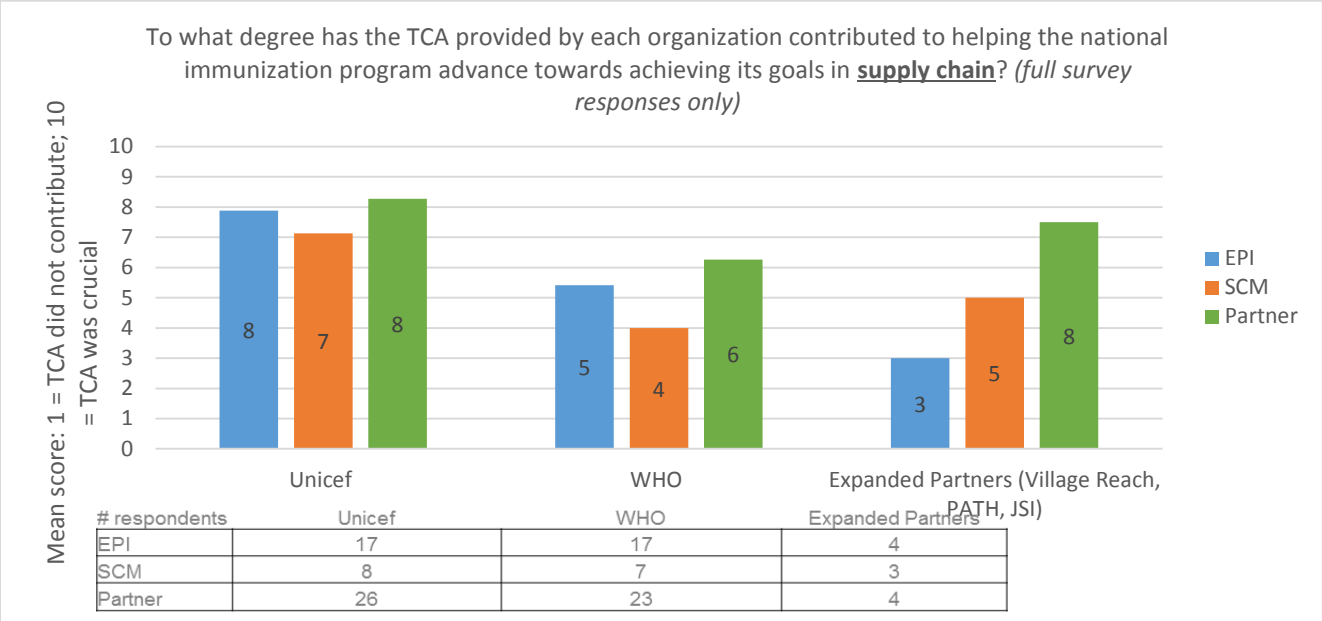
Key indicator

4.46 *Mean score of Partners' TCA contribution to helping national immunization program advance towards achieving Supply Chain programmatic goals (EPI score only)*

The 2016 TCA plan lists UNICEF, WHO, and Village Reach as TCA providers for Supply Chain related activities, supporting a total of 50 activities. Supply chain/cold chain was consistently identified as a key strength or *comparative advantage of UNICEF*. Congruently, UNICEF's contribution to this programmatic area was scored at 8 by EPI respondents, indicating significant contribution towards the EPI's progress in this programmatic area. The close alignment of UNICEF stakeholders' self-rating (mean score of 8.3) with EPI and SCMs' ratings also supports the alignment of perspectives of UNICEFs perceived strengths and perceived contributions. Though only two EPI/SCM respondents provided a rating for Village Reach, this Expanded Partner's contribution to Supply chain/ Cold Chain goals was also viewed as being quite strong with a mean score of 7.

Though WHO was not identified as having particular strengths in supply chain/ cold chain, it is funded to support this programmatic area across 15 countries. Its activities in this programmatic area range from establishing standards for an effective system for the safe disposal of Bio-Medical waste under Universal Immunization Programme, to strengthening vaccines/cold chain management activities, updating cold chain inventory and supporting temperature monitoring, redesigning the supply chain system, to conducting EVM assessments and developing EVM improvement plans. The majority of these activities are the same or similar to those provided by UNICEF, but may be supported within different geographies of the same country. The relatively low mean score given to WHO by EPI and SCM respondents indicates that WHO's contributions have not been as effective as that of UNICEF and Village Reach in this programmatic area.

Figure 8.1. Contribution of TCA to Supply Chain Programmatic Area



# respondents	Unicef	WHO	Expanded Partners
EPI	17	17	4
SCM	8	7	3
Partner	26	23	4

Though this programmatic area was not specified in the TCA Plan for PATH and JSI, it was noted during interviews that these Expanded Partners do support the immunization Cold Chain. It should be noted that several EPI interviewees identified CHAI (not funded under Gavi TCA) as a critical partner for driving progress in supply chain/ cold chain efforts. For example, CHAI and JSI are not Gavi-funded Partners in Ethiopia, but are funded by USAID to support the cold chain information system and have been praised for their support to the EPI's efforts, even more so than Core Partners' support.

Coverage and Equity/ Demand Promotion and Generation

This programmatic area was divided into three separate programmatic areas (1-Coverage and Equity; 2-Demand Promotion and Generation; 3-Communication) in the 2016 TCA plan, but it was recommended by the Gavi Secretariat SPF team that these activities be analyzed together as they are complementary. Given the large scope of these activities, this programmatic area consists of 75 sets of TCA activities supported by UNICEF, WHO, CDC. In addition, though not specified in the TCA Plan, survey respondents identified PATH, JSI, Acasus, and REPAOC as also supporting this programmatic area.

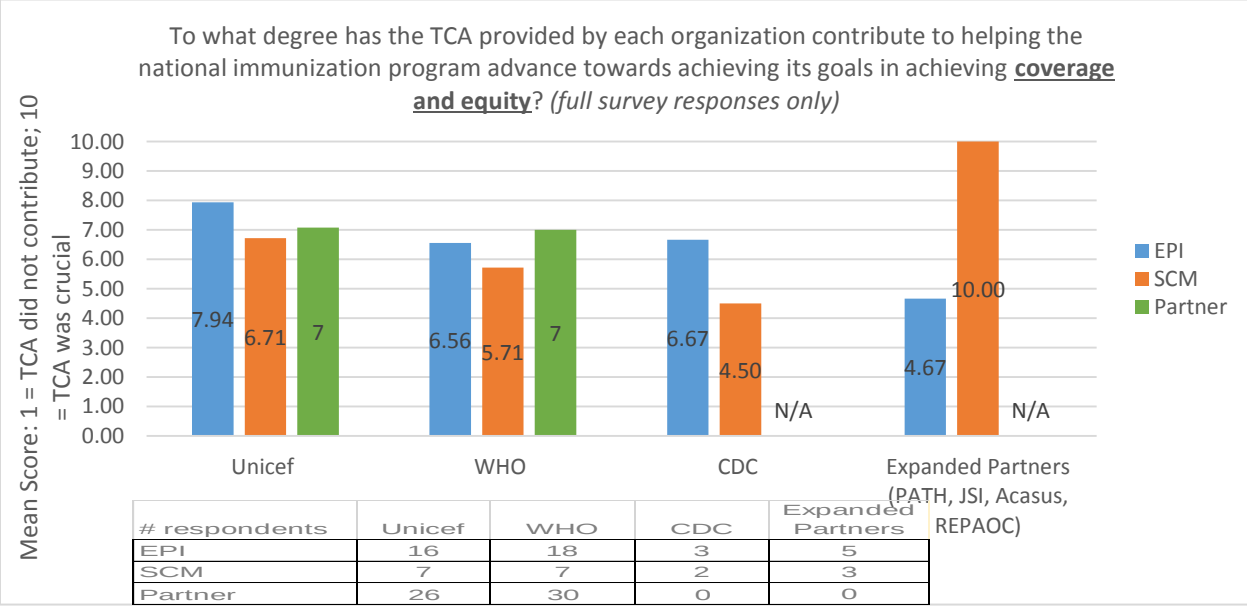
Key indicator

5.86 *Mean score of Partners' TCA contribution to helping national immunization program advance towards achieving Coverage Equity/Demand promotion and generation programmatic goals (EPI score only)*

With the exception of PATH and Acasus, Partners' contribution to this programmatic area is relatively comparable with mean scores (per EPI rating) between 5 and 7.8, indicating moderate level of contribution to progress in this programmatic area. The average scores for PATH and Acasus (as scored by both EPI and SCM respondents) were outliers on either end of the range, contributing to the large differences in EPI and SCM scoring for Expanded Partners. As with other cases, these findings should be interpreted with caution given the small number of respondents for these organizations.

TCA activities in this programmatic area span a broad range of activities such as conducting equity assessments and developing equity strategies, developing and implementing communication plans, including social mobilization; supporting micro planning; supportive supervision for routine immunization (RI) and training of health workers. *Demand generation/social mobilization was noted as a comparative advantage of UNICEF. PATH was also recognized by several stakeholders for its strength in community mobilization and communication, and JSI for its strength in reaching remote populations.* However, key components of this programmatic area – conducting equity assessments, developing micro plans, and supporting routine immunization – were not aligned with the strengths of any one organization. Commonly, these tasks are shared between UNICEF and WHO. CDC's activities in this technical area are focused on Measles supplementary immunization activities (SIAs) as well as strengthening RI.

Figure 8.2. Contribution of TCA to Coverage and Equity Programmatic Area



# respondents	Unicef	WHO	CDC	Expanded Partners
EPI	16	18	3	5
SCM	7	7	2	3
Partner	26	30	0	0

A critical Partner in this programmatic area are the CSOs as they are typically the key partners on the ground at the community level working with health officers to identify and reach the unvaccinated in remote areas. As the funding for CSO had not yet been released at the time of data collection for this evaluation, CSOs were not included in this assessment.

Key shift in understanding of Equity. In spite of the relatively modest survey ratings on TCA contributions to this programmatic area, interviewees frequently raised the progress made in the conversation about equity as a key achievement of the TCA efforts. The focus of the Gavi 2016-2020 strategic plan on improved coverage and equity builds on prior efforts to improve reach to underserved and marginalized populations. In many countries, both Partner and EPI stakeholder noted a key shift in the conversation of equity. For example, in both DRC and Ethiopia, stakeholders noted that prior conversations about equity focused on gender equity. However, with current Partners' support under TCA, EPI teams' understanding of equity has broadened to encompass hard to reach populations (such as pastoralists in Ethiopia) or remote geographic areas. Equity assessments have been conducted across most Tier 1 countries, and results have been used to inform microplanning and immunization delivery.

> "This means that the evaluation process of equity only started this year and it was not evident in the beginning that it would be accepted by the Ministry. But we pushed forward that this approach be used and slowly we explained over and over again to the Ministry through our TA. Actually it was well acquired at their level and for the 2017 operational plan of action of the EPI. For me, that is really an achievement." - - Core Partner

> "We talked about equity for a long time but I can say that it started this year in the DRC starting with the evaluation of equity in July. Previously the country was stubborn in regards to it because for them equity is related to gender whereas there is no gender with vaccines… We explained little by little and our staff really helped to bring the concept and explain by going beyond gender. Even in the PEV plan of action, this analysis of equity was used even before implementation [of RI] just to show you that we have influenced the EPI."- - Core Partner

Data/ Surveillance

Partners' contribution to supporting Data/ Surveillance efforts was rated relatively low, with a mean score of 4.93. This programmatic area is supported by all four Core Partners as well as Village Reach with a total of 44 sets of activities across the Tier 1 and 2 countries. TCA activities in this programmatic area include, but are not limited to: conducting data quality assessments; developing and implementing data quality improvement plans; preparing for and conducting coverage surveys; strengthening surveillance for vaccine-preventable diseases (e.g. measles, rotavirus, IBDs); strengthening the M&E system; and integrating birth registration and immunization data systems.

Key indicator

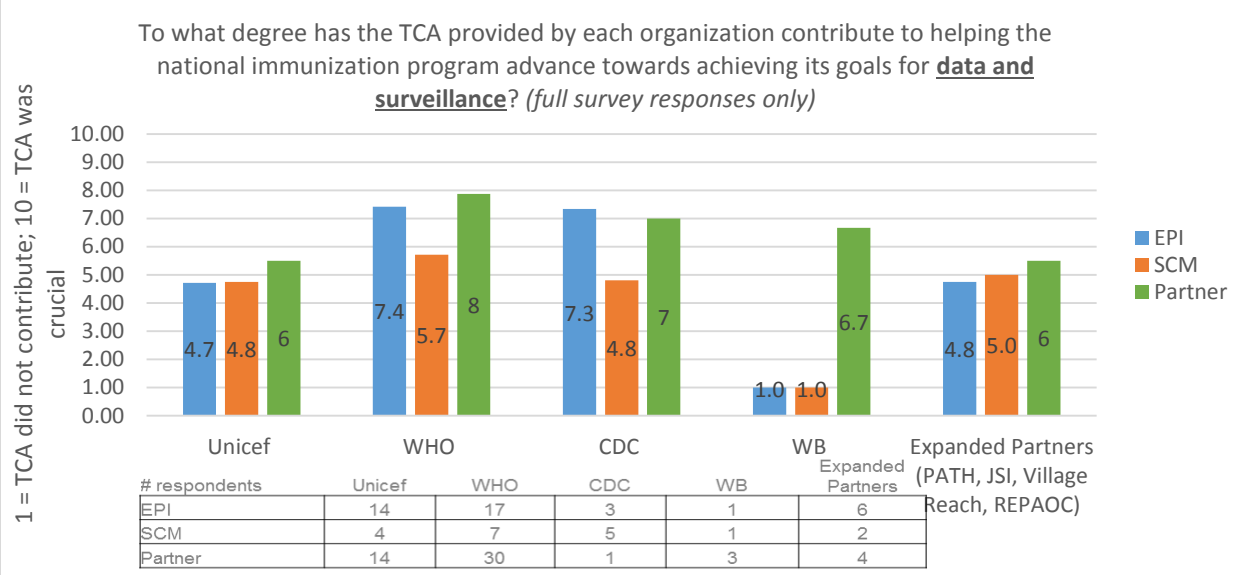
4.93 *Mean score of Partners' TCA contribution to helping national immunization program advance towards achieving* ***Data/Surveillance*** *programmatic goals*

Both *WHO and CDC were identified as having comparative advantage in data and surveillance* (for CDC) and their contribution to this programmatic area is rated similarly (EPI rated mean score of 7.3 for CDC and 7.4 for WHO). UNICEF's contribution was rated lower, reflecting that data/ surveillance is not a key strength for UNICEF. Similarly, the World Bank's efforts in this area were not viewed very favorable (though reflecting only two respondents' viewpoints).

In almost all Tier 1 countries, interviewees highlighted data as being a key challenge/ bottleneck for the EPI. Critical data on vulnerable populations/population sizes; immunization rates; vaccine wastage are often not available, dated, incomplete, or unreliable. For example, in both

Nigeria and Ethiopia, there are large discrepancies between administrative data on immunization coverage and data from coverage surveys conducted by Partners. Likewise, high coverage rates reported by the EPI are often contradicted by disease outbreaks in areas with reported high coverage rates. Despite these key data challenges, TA needs identified in the JA reports do not always cover this issue.

Figure 8.3. Contribution of TCA to Data Programmatic Area



# respondents	Unicef	WHO	CDC	WB	Expanded Partners
EPI	14	17	3	1	6
SCM	4	7	5	1	2
Partner	14	30	1	3	4

Interviewees often commented that the data quality issues need to be addressed at the very root, which is often at the point of data collection/data entry – i.e. the health workers at the community level, who have a much broader mandate beyond immunization and are not within the direct supervision of the EPI manager. For example, during the JA in Ethiopia, participants discussed that immunization data quality needs to be tackled within the broader health information system. However, it was not clear the extent to which TCA efforts were engaging other relevant stakeholders from the larger HIS efforts.

Vaccine Subgroups

EPI, Partner and even Gavi Secretariat and Alliance (at HQ level) stakeholders noted uncertainty about what this programmatic area encompasses or what is expected to be supported under this. As noted in Section 5.3 above, there are a broad range of sometimes disparate activities supported under this programmatic area. For the most part, support for introduction of new vaccines or supplementary immunization activities is included here. The 2016 TCA Plan specified only UNICEF and WHO as the Partners supporting this programmatic area. However, there are several other Partners supporting related activities. For example, CDC is a key partner supporting planning and roll out of Measles immunization efforts, PATH is a key Partner

Key indicator

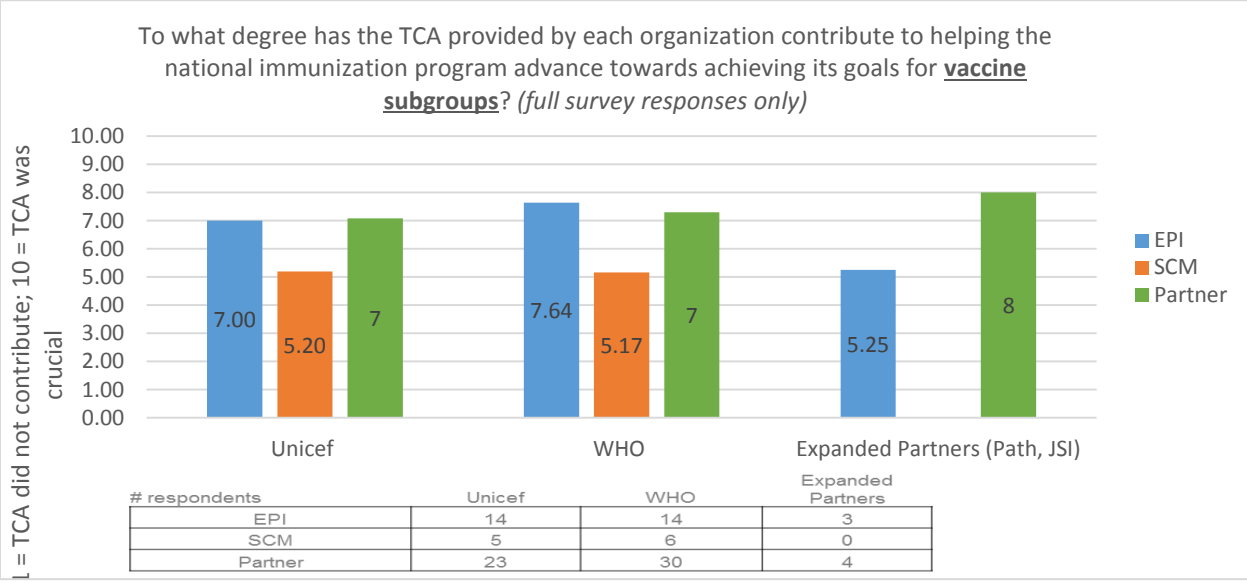
6.29 *Mean score of Partners' TCA contribution to helping national immunization program advance towards achieving Vaccine Subgroups programmatic goals (EPI score only)*

"In the area of new vaccine, we can say we have achieved a lot in terms of introduction and supporting and preparing the country in the introduction of IPV, PCV and also the development of proposal on Rota and Human Papilloma virus that was submitted to Gavi." - - Core Partner

supporting introduction of HPV vaccine, however, these activities are noted under the coverage and equity programmatic area or not associated with a programmatic area at all (in the case of PATH). EPI and SCM respondents did not provide a rating for CDC in this Programmatic area, but did do so for PATH as well as JSI, though it is not clear from the TCA spreadsheet what support JSI is providing to this programmatic area.

Survey responses which indicated a moderate level of Partners' contribution to this programmatic area, with the exception of PATH which received a lower score (based on only 1 respondent response). On the contrary, during the interviews, the introduction of new vaccines or submission of the new vaccines grant were frequently raised as examples of key achievements or successes of the TCA.

Figure 8.4. Contribution of TCA to Vaccine Subgroups Programmatic Area



# respondents	Unicef	WHO	Expanded Partners
EPI	14	14	3
SCM	5	6	0
Partner	23	30	4

Advocacy

The 2016 TCA Plan specifies only one Expanded Partner, JHU, as receiving TCA funds to support advocacy efforts. JHU's TCA activities are limited to only two countries: Nigeria and Pakistan and focused on strengthening advocacy for immunization financing and raising political will for RI. JHU's contribution to this programmatic area is rated as being moderate, though only based on 2 respondents.

While not funded specifically for Advocacy-related efforts, WHO and UNICEF partners who were interviewed commonly noted that "closed door diplomacy" with senior MOH leadership is a critical aspect of their support for the EPI. EPI team members also acknowledged that Partners are commonly able to leverage their broader organizational reputation and relationships with various parts the MOH to facilitate important discussions with key stakeholders outside the EPI.

"I have a very important role in my opinion. This role, along with my colleague from the WHO, is an advocacy role... that allows me to dialog in a constructive dialogue with the highest authorities in [country]…for example, the public health minister. Thanks to this contact with him, along with my colleague in the WHO, we can convey key messages that allow activating

levers that we hope will improve the efficacy and efficiency of the expanded immunization service." - - Core Partner

Health System Strengthening (HSS)

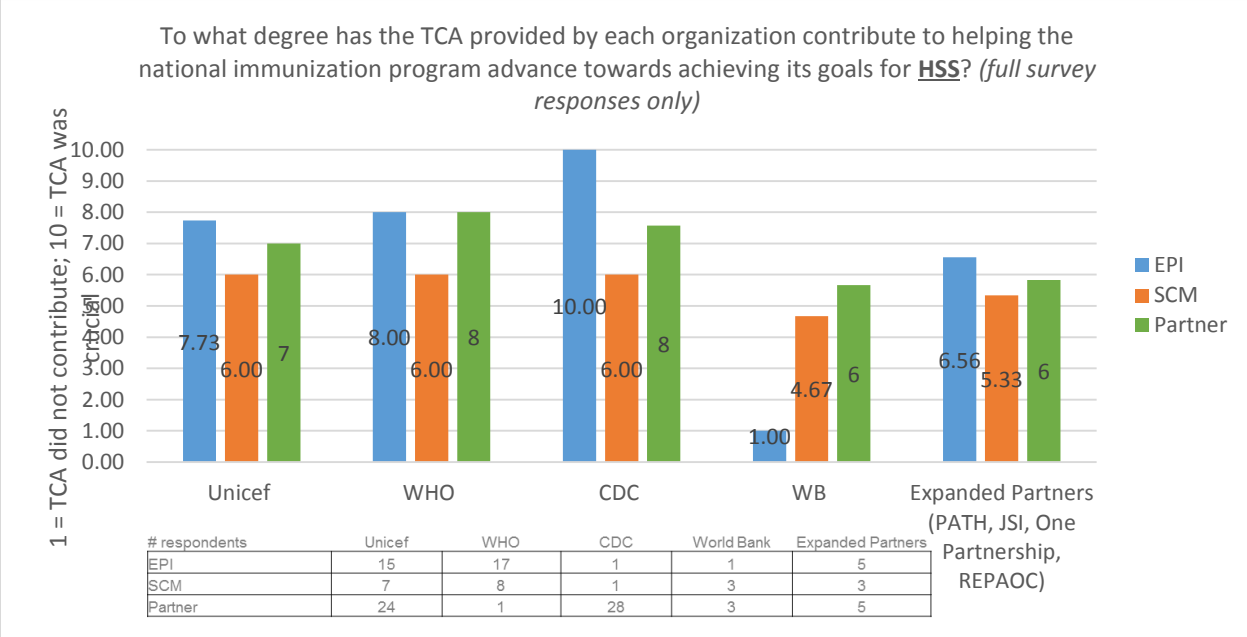
Key indicator

6.63 *Mean score of Partners' TCA contribution to helping national immunization program advance towards achieving HSS programmatic goals (EPI Scoring only)*

While the 2016 TCA Plan specifies only UNICEF, WHO, and the World Bank as the partners supporting a total of 14 sets of activities in this programmatic area, survey respondents indicated other Partners' contribution this area. As with Vaccine Sub-groups, this programmatic area was found to be unclear for stakeholders. However, Partners' contribution to this area was marked relatively more favorably when compared to contributions to other programmatic areas. One explanation for this may be that a key activity often noted under this programmatic area is support for development of Gavi grant applications, including the HSS grant application. The successful submission of this and other Gavi grants was commonly highlighted as a key achievement of TCA efforts.

"Without TA, HSS application may never have seen the light of day or would not have been successful. For the HSS application, it is so intensive it needs people that are technically competent but also putting their time to that process." - - Core Partner

Figure 8.5. Contribution of TCA to HSS Programmatic Area



# respondents	Unicef	WHO	CDC	World Bank	Expanded Partners
EPI	15	17	1	1	5
SCM	7	8	1	3	3
Partner	24	1	28	3	5

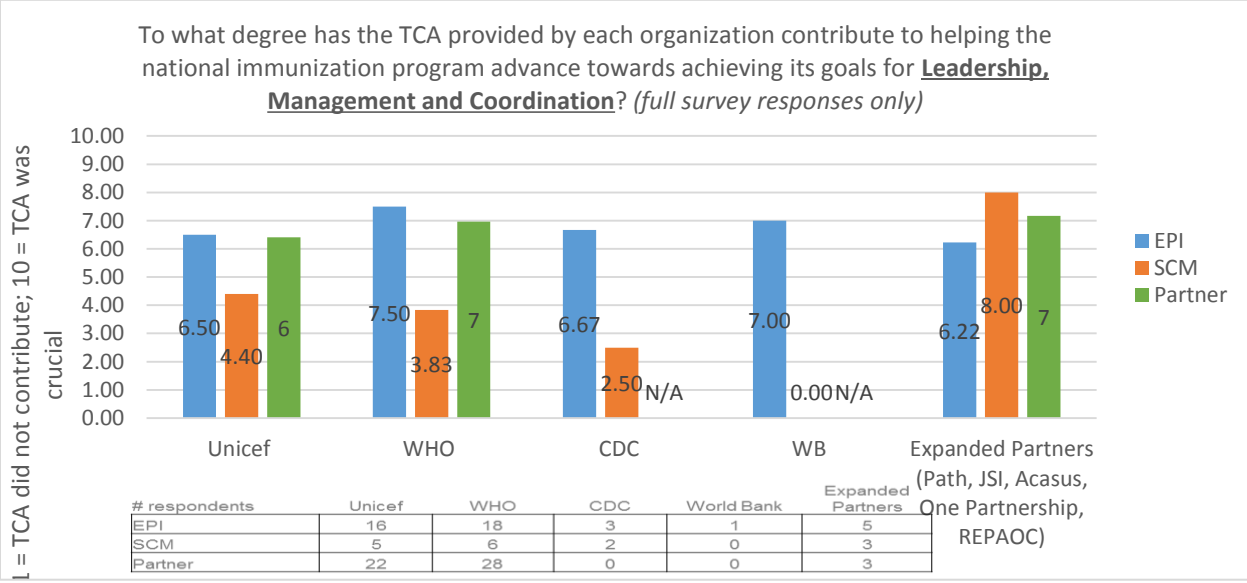
Leadership, Management, and Coordination (LMC)

Key indicator

6.62 *Mean score of Partners' TCA contribution to helping national immunization program advance towards achieving LMC programmatic goals (EPI Score only)*

While still a modest rating, the mean score for Partners contribution towards LMC goals was higher than scores for other programmatic areas. This is once again a programmatic area with a broad and somewhat incongruous set of activities, supported by UNICEF, WHO, and CDC (per the TCA spreadsheet). Yet, EPI and SCM respondents also indicated that this programmatic area is supported by most other Partners, though we do not have details on the nature of their support. Interview findings do not provide much insights to provide further clarity on what may contribute to the relatively more positive ratings for TCA efforts in this programmatic area.

Figure 8.6. Contribution of TCA to LMC Programmatic Area

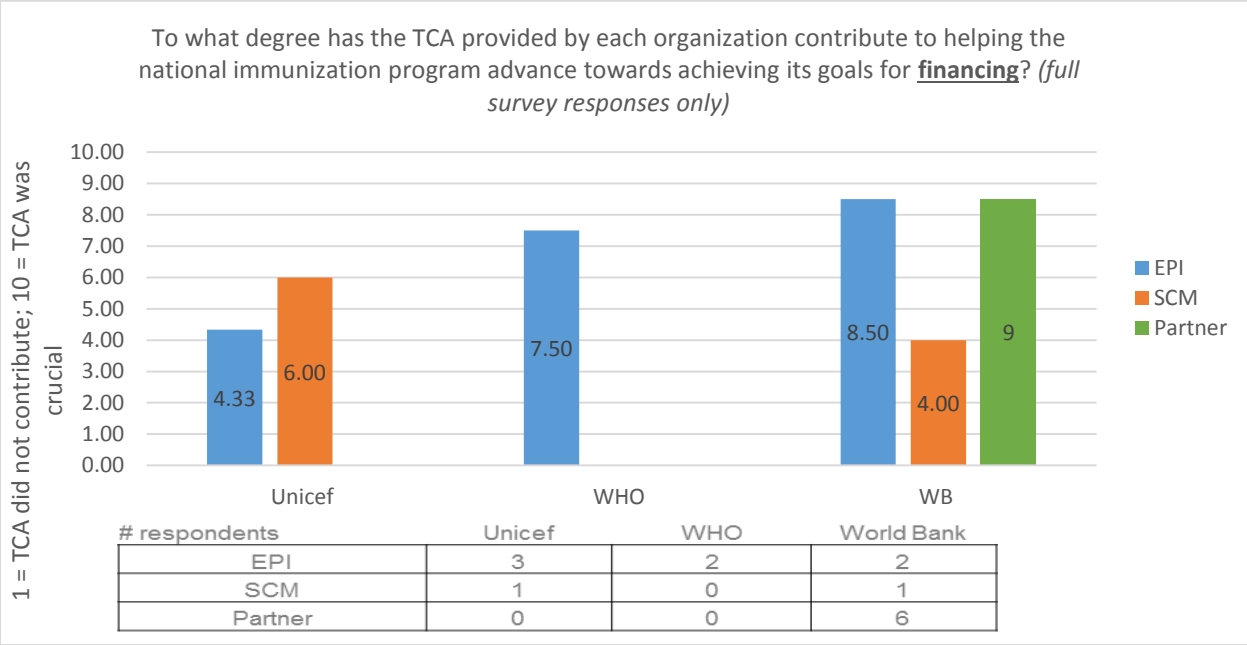


Financing and Sustainability

Financing and Sustainability are both relatively small programmatic areas with only 6 and 9 sets of TCA activities, respectively. Though these programmatic areas are related, they are supported by different set of Partners. The 2016 TCA Plan lists UNICEF and the World Bank as TCA providers for Financing, while WHO, CDC, and Village Reach are funded to support Sustainability. Survey responses identified other Partners as supporting the Sustainability activities as well.

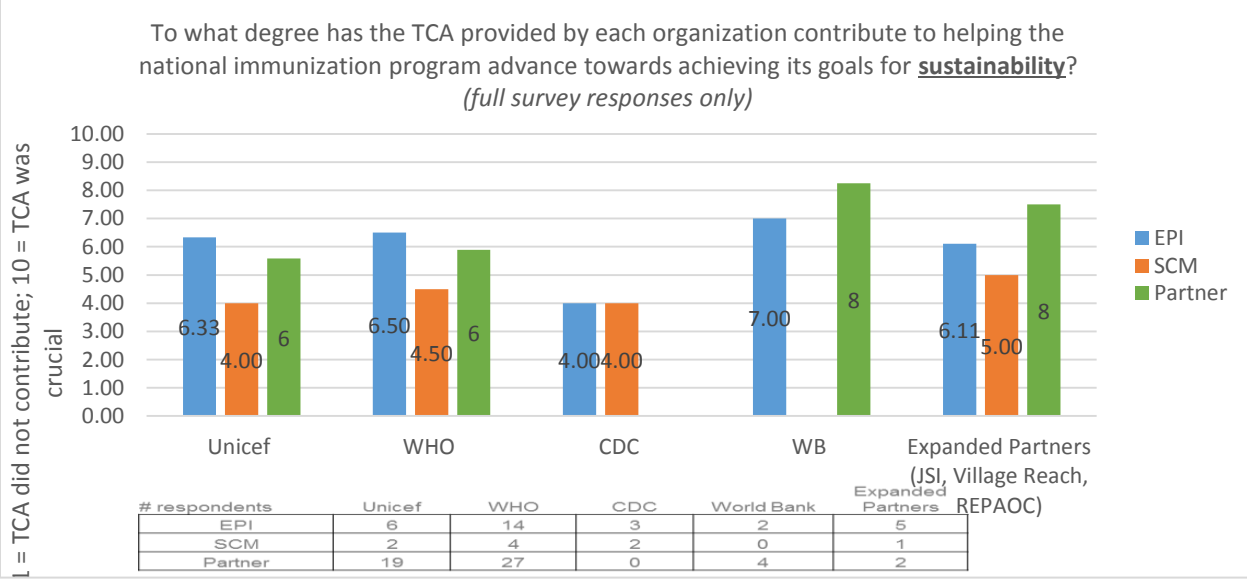
The World Bank has the comparative advantage in financing. Despite this comparative advantage, the contribution of WHO to this programmatic area was rated higher than that of the Bank's (even though WHO does not have any activities listed in this programmatic area in the TCA Plan). This likely reflects, once again, the reality that the EPI teams as well as the SCMs are not very familiar with the Bank's activities, as the Bank tends to work more closely with the Ministry of Finance or the health system as a whole instead of just with the immunization program.

Figure 8.7. Contribution of TCA to Financing Programmatic Area



# respondents	Unicef	WHO	World Bank
EPI	3	2	2
SCM	1	0	1
Partner	0	0	6

Figure 8.8. Contribution of TCA to Sustainability Programmatic Area



# respondents	Unicef	WHO	CDC	World Bank	Expanded Partners
EPI	6	14	3	2	5
SCM	2	4	2	0	1
Partner	19	27	0	4	2

Reflection on measuring capacity gains:

In the absence of objective measures of capacity, the mean ratings from these questions provide proxy indicators to assess the level to which TCA is supporting the progress of the EPI program across different programmatic areas. While these indicators do provide a cursory view of the contribution of TCA, they have three key limitations:

1. The indicators reflect subjective measure of Partners' contributions
2. The indicators are measuring Partners' TCA contributions in supporting the EPIs *programmatic goals*, and not necessarily contribution to building the EPI's *capacity* in the different programmatic areas.

3. The programmatic areas do not always align with the technical structure of national immunization plans. Therefore, the premise that TCA should be contributing to achieving goals in each programmatic area is not entirely accurate.

The distinction between the points raised in bullet 2 above was highlighted by one Core Partner's assertion: "I can say without any fear [that the] EPI has been expanding. It started with the 6 vaccines, now we're talking about 12 vaccines. Program structure in terms of the MOH has not changed. [They] still have a program manager plus 2 medical officers and 2 cold chain officers. This structure was created 20 years ago - still same structure to oversee program that has tripled. Without TA from providers, we can comfortably say, the program would not be able to grow as much." This TA provider's views encapsulates what was shared frequently by other stakeholders during interviews. In essence, TA support has been a vital aspect of the EPI program, particularly in the introduction of new vaccines, establishing and improving cold chain systems. However, most of the gains in these areas have been a result of the TA providers having taken on the implementation tasks for these areas.

9. Reflection on key findings

9.1. Reflection on transparency, accountability, and country-ownership

Transparency

Transparency. As was noted in Section 4 of this report, PEF-TCA has brought about improved transparency around the planning and delivery of technical assistance. Now, both EPI teams and Partner have much greater clarity others who are supporting the immunization efforts through Gavi-funded TCA as well as a better understanding of the activities they support. Much of this transparency is brought about by the JA that has established an effective platform for joint planning. However, there remain some challenges with transparency, mostly around the activities of Partners that do not have much country-presence or do not work directly with the EPI program (CDC and World Bank). As 2016 was the first year where Expanded Partners were brought to the table together with UNICEF and WHO, Core Partners expressed that they are still not clear on what the role of Core Partners is.

Accountability. The TCA milestone reporting process has established a solid platform for holding Partners accountable for the milestones they set for themselves. It is not clear, however, whether the intention is for Partners to be accountable to the Gavi Secretariat/Alliance or to the EPI programs that they are supporting. The 2016 reporting process favored accountability to Gavi as it does not offer much insight for EPI teams on what Partners are reporting. The question also remains, what recourse is available in cases where performance is not as expected? It is not clear to EPI team nor to SCMs if Gavi has any recourse to take with Partners with poor performance or if this is even feasible given the structure of the Alliance. Therefore, while there is progress towards improved accountability, the Gavi Secretariat should critically consider what this means within the PEF-TCA framework and how the milestone reports will or should inform action at the Secretariat level as well as at the country level.

Country ownership. This construct is particularly difficult to interpret for the PEF-TCA context. No doubt the JA has brought the TA planning process down to the country level and facilitated a country-drive approach to defining TA needs and activities. However, the EPI teams are not always empowered to select the Partners they want to support different activities; the terms of agreement with TA providers are still managed by the Gavi Secretariat; even the selection of Expanded Partners is managed at the Secretariat level often with very minimal input from the EPI teams; milestone reports are submitted to the Gavi Secretariat and not the EPI teams. Under this structure, it is not clear what Gavi's vision is for country ownership of the TCA process.

Transparency, Accountability, and Ownership Scores

Similar to the quantification of these constructs for the TCA Planning process, we have developed an analytical model to captures relative levels of these concepts in Gavi priority countries based on survey data (See Annex 10 for more details on the scoring method).

Using this analytical model, we computed the following scores for transparency, accountability, and ownership. A bar was set, based upon concept of what a relatively high level in those

domains should be, and countries are either reported to be meeting that bar or not. This bar was set as a numeric measure that can be used in the future to report in the mid-term and endline on where all of the countries land. The majority of comparability; however, will not be based on this 'artificial bar', but will be rather based on the actual countries scores across time.

This sets a baseline so that changes can be tracked and measured in the Midterm and Endline evaluations. It will also serve a diagnostic tool so that exceptional changes will be evaluated and highlighted as cases in the future.

Table 9.1 Transparency, Accountability, Ownership Scores for TCA Delivery

		Tier 1 Countries		Tier 2 Countries	
		Not Meeting	Meeting	Not Meeting	Meeting
TCA Delivery	Transparency	8	0	6	2
	Accountability	7	1	4	4
	Ownership	0	8	6	2

Note: Only 16 countries (8 in Tier 1 and 8 in Tier 2) had sufficient responses to be included in this analysis.

The number of countries meeting the bar for Transparancy and Accountability of TA delivery is quite low in both Tier 1 and 2 countries, though this may be a reflection on the model. Witness changes on these measures in the midterm and endline will be more informative than looking at a constructed measure alone.

Additionally, the limited level of countries that passed the bar regarding transparancy of delivery was largely due to the lack of positive responses to four questions regarding the understanding of the SCM and EPI of the types of TCA activities supported by Core and Expanded Gavi-PEF funded TA providers, and the level of coordination and communication among those partners.

The high level of countries "passing the bar" regarding TCA delivery ownership is largely due to the fact that there was only one question mapped to this concept, which regarding the ability for the country to use or absorb the TCA provided by Gavi Partners. This was rated highly among all Tier 1 countries. However, as stated above, the construct of "ownership" needs to be carefully re-assessed for what it truly means within the PEF-TCA context.

9.2. Key changes in TA delivery between BP and PEF-TCA

There have been some notable changes in the delivery of technical assistance under PEF-TCA when compared to the BP, as briefly summarized below.

TA under BP		2016 PEF TCA
• Focus on workshop/training approach to build country capacity	→	• More diversity in the TA models used, with emphasis on the embedded and ongoing TA support models
• Limited visibility on scope of TA activities at the country level	→	• Much improved visibility of TCA activities at the country level, particularly those of UNICEF and WHO. Still weak in transparency around activities of WB/CDC and Expanded partners
• Accountability based on process deliverables at global level	→	• TA monitoring processes in place at the country level. Some variability across countries in scope and oversite of TCA monitoring. • TCA milestone reporting is in place, but not viewed as being helpful for EPI teams
• No evidence of coordination at the country level	→	• Beyond the JA, Partners' increased and ongoing country presence allows for more regular communication and coordination with the EPI as well as with other Partners. However, the extent to which this is happening varies greatly.
• Strong lead role of global and regional level Partners	→	• There is a fairly even distribution of responsibility for different parts of the TCA process across the EPI team, in-country partners, and SCMs, with reduced engagement of regional level Partner stakeholders.

9.3. Reflection on Domain 2 Evaluation Questions

Reflections on Evaluation Questions for Baseline Assessment

2.1. To what extent is there clarity on the objectives and scope of the TA activities?

There are varying degrees of clarity on the objectives of TCA activities supported by different Partners, with lower clarity around activities supported by WHO, CDC, and Path.

- Overall, the majority (68%) of EPI and SCM respondents to the online survey perceive the objectives of the TCA to be *quite* or *very clear.*
- However, only 47% and 46% of these respondents view the objectives of the TCA supported by CDC and World Bank, respectively, to be clear. This observation is reflective of the lingering challenge of transparency on the TCA activities of these Core Partners. Similarly, only 33% of these respondents indicated clarity of the objectives of activities supported by PATH.
- The lack of specificity in the activities, outcomes, and milestones defined in the TCA plan, combined with the varying processes in place to engage with different partners that do not always involve the EPI teams, contributes to the lack of clarity on the full portfolio of TCA activities per country

2.2. What are the different ways in which TA is delivered across different partners (and by country)?

During both interviews and survey responses, Partners indicated that they use a combination of different TA delivery methods, based on the specific needs and context of the national immunization program.

- 66% Survey responses indicate that the vast majority (66%) of Partners that responded provide TCA through the *ongoing-local support model*, where they sit at their local country office and support the EPI, on an ongoing basis.
- Less than 10% each provide support through the other models we identified: short-term regional or global consultancy (9%); embedded support (6%); local workshops/trainings (6%), regional/global workshops/training (3%); and 10% other (specifying that they use a combination of different methods).
- We suspect that our survey does not accurately reflect the proportion of TCA providers using the embedded model, as TCA providers were sometimes misclassified as being MOH stakeholders in our sample list.
- These findings reflect TA provision at the Central level. Interview findings suggest that subnational level TA is also provided using a combination of both the embedded model as well as the ongoing-local support model.

2.3. To what extent is TA implemented as intended?

In spite of the reported delays, TCA activities have mostly been implemented as planned. Though not entirely an accurate report, about 60% of milestones have been marked as completed, indicating that activities are at least on the right track. In general, Partners have a good understanding of their responsibilities and are well into the implementation process.

2.4. What is the capacity of TA providers to deliver quality TA?

TCA providers are perceived as having the technical expertise and knowledge of country-specific immunization knowledge to deliver quality TCA. However, they are viewed to be spread thin across a very expansive portfolio of TCA activities, which can impeded their ability to offer quality TCA.

TA provider (at the Central level) are highly trained, with 37% of TA providers that responded to the survey indicating they have a MD, 31% have a MPH, 20% have other Master's degree, and 9% have a PhD or other doctoral degree.

There are concerns about the level of expertise of providers hired to support TCA at the subnational level, often considered not to have comparable expertise to TCA providers at the Central level.

2.5. How well do the TA management, coordination and monitoring processes work?

At baseline, TA management, coordination, and monitoring are implemented at different levels, with room for improvement across all three processes.

- For the most part, TA management, including funding decisions, drafting and signing of Terms of Reference with TA Partners, provision of guidance on how to engage in the TCA process, etc are all implemented by the Gavi Secretariat (the SFP team, and the SCMs).
- TCA coordination is happening to varying degrees at the country level, led in some cases by the EPI. There is notable improvement from coordination of efforts during the BP. However, coordination has been consistently raised as an area of weakness in the TCA process, with Partners and EPI stakeholder alike raising concerns that there remain questions about what some Partners are supporting within the TCA framework, making it hard to coordinate efforts.
- Monitoring of TCA activities was led by the Gavi Secretariat through the review of milestone reports submitted by some Partners. Until early 2017, the milestones submitted to the Gavi Secretariat were not consistently shared with the EPI teams, impeding the extent to which they were able to use TCA status reports to inform TCA planning decisions.

  * DRC is an example of a country that has assumed ownership of the TCA coordination and monitoring process through convening weekly conference calls with all TCA providers to discuss updates, challenges, emerging needs.

2.6. *To what extent have ownership, accountability, and transparency increased?*

When compared to the delivery of technical assistance under the BP, there has been great improvement in transparency, and some notable progress towards improved accountability and ownership. Given the retrospective nature of the assessment of the BP, these comparisons are based on qualitative insights only.

- **Transparency:** The JA and the joint planning process have brought much greater transparency around UNICEF and WHO's TCA activities and has increased awareness of the other key Partners who support TCA. However, there remains a lack of transparency on the activities or mode of engagement of Partners such as CDC and World Bank, as well as some Expanded Partners.
- **Accountability:** When compared to the BP, PEF-TCA provides a much clearer structure of accountability through the milestone planning and reporting process. As milestones are collectively defined, EPI teams have more informed expectations on what is to be accomplished/delivered by each TCA provider. However, a major shortcoming of the 2016 mid-year milestone reporting process was that Partners' milestone reports were not shared with the EPI teams. This has been rectified for the year-end milestone reports. There is no evidence to indicate that the Partners are being held accountable to the EPIs rather than to the Gavi Secretariat.
- **Country ownership:** The PEF-TCA has brought about great strides in the engagement of EPI stakeholders not just in the planning phase, but also in the delivery phase. Through the embedded support or the ongoing-local support TA delivery models, TCA providers are now more engaged with the EPI teams, enhancing the EPI's ownership of the TA process and products. However, our findings also suggest that due to various factors such as competing

priorities or perceptions of the role of TA providers, the EPI teams are not always able to take full ownership of the TCA delivery process.

2.7. *To what extent does TA improve individual-level technical/managerial competencies?*

The baseline assessment was not able to systematically address this evaluation question as we were not able to find expected competencies for immunization program staff and did not deem it feasible to develop and validate such competencies during the baseline period.

2.8. *To what extent does TA improve organization-level technical/managerial/operational capacity?*

The survey results indicate that Partners TCA efforts have contributed to a moderate extent to EPI goals across the different programmatic areas. Though these responses serve as initial indicators, a clearer understanding of the desired capacity change is needed in order to effectively measure improvements in organizational capacity (see Recommendation 6 below).

2.9. *What factors influence the effectiveness of TA?*

The effectiveness of TA needs to be weighed with respect to the intended goal of TA as well as the timeframe for the desired goal. For example, if the goal of TA is to ensure improved immunization coverage/equity for the current year, specific models of TA delivery may be considered more effective than others. However, if TA is intended to build capacity and ensure sustainability in the long run, other factors need to be considered.

In general, the following factors are important determinants of the success of TA efforts:

- The way in which TA is delivered – e.g. implementation support vs advisory support
- The maturity of the EPI program
- The level at which the TA is provided in relation to where the need is (Central level vs subnational level)
- Agreement on the objectives of the TA
- Full engagement of counterparts from the EPI team in the planning of and receipt of TA

9.4. Summary of Key Findings and Recommendations for TCA Delivery

Below is a summary of our key findings and recommendations to continue building on the achievements of the PEF-TCA.

Level of Priority	Recommendations
Continue doing	❖ ***Finding.*** ***The PEF-TCA has been received very positively by all stakeholders.*** The most significant improvement brought about by the PEF-TCA has been the engagement of the EPI and in-country Partners in defining the TCA activities and the increased transparency around the activities of key Partners such as UNICEF and WHO. ➢ **Recommendation 1.** The Gavi Secretariat should continue the Joint Appraisal platform for joint immunization program review and TCA planning, with some enhancements as recommended below (an in Section 3 above). ❖ ***Finding.*** ***Partners have adapted well to the new processes and reporting requirements under the PEF-TCA.*** There has been a high level of engagement between UNICEF, WHO, and the EPI with regards to TCA planning and implementation. Milestone reporting has also been successfully completed across most Partners. ➢ **Recommendation 2.** Partners should continue building and refining on the processes established in this first year of the PEF-TCA. ❖ ***Finding.*** ***There are some examples of strong Partner coordination mechanism, facilitated by the EPI.*** For example, the DRC has monthly and weekly Partner meetings to jointly discuss updates on Partners' immunization activities, promoting strong coordination and collaboration. ➢ **Recommendation 3.** The SCMs should work with countries with strong coordination mechanisms to facilitate experience-sharing with other countries.
Study further and take action as needed	***Related Findings.*** ❖ ***The ability to use TCA funds to support Partner staff salaries is a key value add for Partner organizations who are facing increasing challenges in securing other sources of immunization funds.*** ❖ ***TCA has increased the number of Partner staff in country-dedicated to activities. However, not all of the FTE positions are net new personnel. It is clear that Partners rely on Gavi funds to partially support their country-based immunization teams. However, the majority of Partner staff support TCA for less than 50% of their time.*** ❖ ***TCA efforts tend to be concentrated at the central level, both in the planning and delivery processes. Given that the HR capacity gaps are generally more prominent and systemic at the sub-national levels, stakeholders agree that TCA should be more focused on support for sub-national levels.***

- **Recommendation 4** – The Gavi Secretariat should consider a more streamlined approach to supporting Partner country-based staff. A more detailed investigation on the percent allocation of TCA funds to different staff salaries in comparison to the percent staff time dedicated to supporting TCA may be helpful in determining the efficiency of this approach of supporting in-country partner staff.
  Such an investigation should also assess Partner teams' allocation of funding to Central level vs sub-national level staff as well as the relative time allocation of central level Partner staff to TCA activities at the national versus subnational levels.

- **Recommendation 5** – During the TCA Planning process, Partners and EPI teams should specify whether the specified TCA activities will be implemented primarily at the central or subnational levels. Such specification during the planning phase may help to bring more attention to the needs at the subnational level and target activities accordingly.

Related Findings.

- ***The embedded support model of TA delivery has been praised for its effectiveness in supporting immediate deliverables and achieving short term objectives. However, it does not provide a sustainable approach for improving capacity.***
- ***Though the aim of the TCA is to build capacity, this goal is not clearly communicated with all stakeholders. Across all the different TA delivery models, there is little evidence to indicate that there is an intentional and purposeful approach to foster the transfer of knowledge and skills and build capacity. Moreover, there is not a shared understanding or vision for what "improved capacity" looks like for EPIs.***

Recommendation 6 – If the aim of the TCA is indeed to transfer knowledge/skill and thereby build capacity of the EPI program, the design of the TA activities should be founded on a clearly articulated understanding of the knowledge/skills gaps as well as capacity gaps of the EPI team. While there are some existing tools to assess capacity for some of the programmatic areas (e.g. EVM assessment for cold/supply chain; DQAs for data quality), other programmatic areas do not have clearly specified standards or goals and related measurement tools. Gavi should consider working with its Partners (including EPI teams) to define the gold standard for each programmatic area and the progressive stages to get to that gold standard. This can then serve as a framework to guide the TCA efforts, so that it is clear what "capacity gains" TA Providers are helping the EPI move towards. The existing Program Capacity Assessment tool could serve as a potential platform upon which to build additional modules to assess capacity of other program components.

Additionally, the TA delivery model (e.g. embedded support, training, mentoring, etc) should be selected strategically to best serve the current capacity level of the EPI and most effectively achieve the desired capacity gains. For example, the use of the embedded support approach to TA should be minimized for more "mature" EPI programs.

	Related Findings. ❖ ***The "continuous" nature of the TCA activities presents challenges for defining discrete milestones for a six to twelve month period. Moreover, the interweaving of TCA activities with day-to-day functioning of the EPI program obscures what milestones can be attributed to TCA efforts versus broader EPI activities, thereby undermining the accountability processes.*** ❖ **The TCA milestone reporting process has laid the foundation for improved accountability at the county level (when compared to the BP). However, there are some process-related and quality challenges of the milestone reporting process that limit its utility.** ➢ **Recommendation 7** – Gavi should consider redefining the milestones as "deliverables" or "outputs" to clearly articulate what will be produced/achieved by each Partner within the reporting period. In addition, the deliverables should be clearly linked to the immunization challenges as well as national immunization program goals/objectives they are working towards, and the desired capacity gains for each programmatic area. Such a deliverable-based reporting system will serve to better differentiate the Partners' contributions from that of the EPI team, while at the same time clarifying how Partners' efforts fit into the larger national goals The status update options should also be broadened to allow greater specificity in the reporting – e.g. include options for Partners to indicate that deliverables are "in progress", or "deliverable no longer needed".
Act Now	❖ ***Finding: The lack of guidance from Gavi around the programmatic areas has resulted in: (1) Lack of a common thread across activities within a programmatic area; (2) overlap in activities across different programmatic areas that may inadvertently lead to duplication of efforts; and (3) widespread confusion about some programmatic areas across partners, EPI team members, and HQ-level Gavi Alliance representatives, alike.*** ➢ **Recommendation 8** – The Gavi Secretariat should provide more guidance on the overall purpose or vision for each programmatic area, especially as these programmatic areas do not always reflect how national programs structure their activities. Nor do these programmatic areas align well with the PEF Functions. One possible option to minimize confusion and also promote greater alignment with national efforts is to align the Gavi PEF programmatic areas and functions with the immunization system components specified in the WHO-UNICEF Guidelines for Comprehensive Multi-Year Planning for Immunization. ❖ Finding. ***While the volume of partners' TA activities has increased due to TCA funding, there has not been a notable change in the type of activities supported, when compared to Partners' prior support for the EPIs.*** One of the aims of the PEF-TCA is to promote innovative approaches to tackling program challenges instead of "business-as-usual" approaches. **Recommendation 9** – While the gap-filling/ implementation support is still necessary in most countries, a certain portion of TCA funding per country can be set aside for the introduction of new systems/new approaches

through a more consultative TA model (vs implementation support), particularly in countries with more capacity.

- ***Finding: Across all the Partners, the quality attributes rated most positively were expertise of TCA providers and the relevance of TCA activities for addressing the implementation challenges/bottlenecks of the immunization program. On the contrary, flexibility of TCA providers and timeliness have the poorest quality ratings.*** Though EPI respondents had positive views about the extent of skills transfer, interviewees shared more nuanced views on this issue, suggesting the need for more intentional approaches for skills transfer.

  - **Recommendation 10** – It is expected that the funding disbursement from Gavi will be timelier moving forward. Similarly, now that Partners have adjusted their internal processes to align with the PEF-TCA, it is expected that some of the bureaucratic delays will be minimized, improving the overall timeliness of TA delivery.

    With respect to flexibility, the Gavi Secretariat should clearly communicate the guidance on the extent to which Partner can redefine TCA activities following completion and approval of the TCA plan to accommodate emerging priorities. The recommended process for doing this should also be specified and clearly communicated to minimize potential redundancy across Partners.

    The TA needs identification discussions should include explicit discussions of the knowledge/skills gaps within the EPI team (at the Central and subnational levels). TA activities should be carefully designed to address the knowledge/skills building needs. Even when the embedded support or ongoing support models are used, there should be an intentional approach to facilitating knowledge/skills transfer.

- **Finding. Coordination of TCA efforts is strong between UNICEF and WHO, but not across remaining Partners.** One of the challenges has been the continued lack of clarity on the activities of CDC, WB, and Expanded Partners as well as the lack of in-country presence of these Partners.
  - **Recommendation 11** – A critical aspect for improving coordination will be to establish a common understanding of how each Partner is engaged with the Gavi Secretariat, and, what, if any, the special agreements are so that stakeholders do not have unrealistic expectations for Partners. The SCM is well positioned to facilitate these conversations in country and should be empowered to work with the EPI teams to establish processes for effective collaboration that will take into consideration the constraints of each Partner. This should of course be led by the EPI team, but the SCM can play a key role in this process, especially at the beginning.