# REFERENCE

The purpose of this report is to present an update on the main themes and findings emerging to date of GAVI's second evaluation. It is tabled as reference.

# GAVI Second Evaluation: First Update on Emerging Themes

To help inform the strategy discussion, the enclosed report contains an update on the main themes and findings emerging from GAVI's second evaluation. CEPA LLP in association with Applied Strategies authored the enclosed report. It is tabled to help inform the strategy discussion.

# GAVI SECOND EVALUATION

## FIRST UPDATE ON EMERGING THEMES

16 March 2010

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# 1. INTRODUCTION

## 1.1. Background and purpose

This is the second deliverable on the assignment, following the submission of the Inception Report on 5 February 2010. The purpose of the deliverable is to present an update on the main themes/ findings emerging in the evaluation to date. We understand that this paper will be used by the Secretariat to inform the discussions at the upcoming GAVI Board retreat on GAVI's strategy 2011-15, rather than being presented as such to the Board. A second update on emerging evaluation themes will be provided by CEPA on 3 May 2010.

## 1.2. Methodology

The emerging themes/ early findings presented in this report are based on the following:

- Desk based review of relevant GAVI and external documents;
- Analysis of GAVI data and broader immunisation/ health metrics; and
- Consultations with GAVI Secretariat (including the Executive team) and a few other stakeholders including GAVI Board members (both current and past), ex-GAVI employees, previous GAVI program evaluators, advisory groups and task team members, vaccine suppliers, GAVI partners, and other Global Health Partnerships.

We continue to undertake further desk-based analysis and other planned consultations for the evaluation.[1] An evaluation e-survey[2] and an EPI manager questionnaire (focused on program performance) have also been finalised and are being administered this month. Five country field visits are planned for early April to early May. The emerging themes presented here therefore do not benefit from these additional sources of evidence or triangulation of findings.[3]

We also recognise the importance of bringing together the relatively disparate components of our analysis under each Strategic Goal into an overall judgement about GAVI's achievement and value add in that Goal and for the overall assessment of the Alliance. However, we are not yet in a position to do this.

Given this, **the emerging themes set out below match broadly the components of analysis (set out in the Inception Report) that we have conducted to date. <u>They should be treated as preliminary and subject to change.</u>**

To keep the report short, we do not repeat the contents of the Inception Report on evaluation methodology, limitations, etc. These will be covered in the final report. Nor do we dwell on the evaluation process issues and progress, which are a subject of our monthly progress reports.

[1] At the time of submission of this paper, we have only covered only some of the proposed consultations. A list of consultations completed to date are in Annex 1. The full list of planned consultations is in our Inception Report.

[2] The e-survey has been delayed due to conflicting timelines with the GAVI strategy survey.

[3] Please refer to CEPA's Inception Report and Proposal for details on the various sources of evidence to be examined for this evaluation, as well as our detailed methodology.

### 1.3. Structure of the document

Section 2 presents the emerging themes by strategic goal, drawing on the evaluation framework outlined in the Inception Report. Section 3 summarises the emerging themes across the goals – please note that these are not overall conclusions on GAVI results or value add, but rather a summary of themes/ findings analysed to date.

The paper is supported by the following annexes:

- Annex 1 sets out the list of consultations carried out so far.
- Annex 2 presents the list of evaluation questions by goal, as per the Inception Report.
- Annex 3 sets out our current thinking on the typology for assessing HSS value add.

## 2. EMERGING THEMES BY STRATEGIC GOAL

This section presents the main emerging themes by strategic goal, based on our evaluation work thus far. Based on the data collected by/ provided to us to date and the sources of evidence examined, we have advanced our assessment of some evaluation questions more than others.[4] Therefore, we do not present below the outcomes on each evaluation question, but only the main themes that have arisen in our analysis so far, by goal. These are by no means definitive or exhaustive, and will be taken forward as we progress our analysis.

### 2.1. SG1 – Health systems strengthening

The ongoing analysis of SG1 programs seems to suggest that INS has achieved some clear results and has demonstrated some value-add, the ISS rewards based approach and performance are more ambivalent, and the CSO program is constrained by some fundamental strategic and operational issues. The jury is still out on the HSS results, which is likely to be very country specific and difficult to measure/ attribute to GAVI. That said, the emerging theme is that 'de-bottlenecking' health system constraints is key to achieving immunisation outcomes – whether delivered through GAVI or in a more integrated manner with other HSS donors.

#### 2.1.1. The INS program is generally viewed as successful with some evidence of GAVI value add, particularly in terms of sustained safety policies

This evaluation reviews the 58 Phase I INS countries and particularly examines the 13 Phase II countries. Based on consultation feedback, and ongoing analysis of the self-reported JRF and country APR data,[5] the following are the key emerging themes (although difficult to attribute to GAVI):

- Both Phase I and II countries have done well on uptake of AD syringes, with nearly 100% of districts supplied with adequate safety syringes and large reductions in reported use of non-AD disposable syringes. A similar analysis by the WHO compares post-

[4] Annex 2 sets out the evaluation questions by goal as presented in the Inception Report.

[5] We analysed eight key INS questions/ indicators from the JRF (reflecting countries' safety policies, work plan and approach, and their uptake of AD syringes) and the APR data on INS financial sustainability. There are a number of caveats to the completeness, reliability, and interpretation of this data, which will be set out in the evaluation report.

support JRF results with pre-support Injection Safety Assessment Reports (completed by 42 of the 71 INS countries). It confirms that uptake of AD syringes (for immunisation and therapeutic use) and safety boxes increased sharply, and safety box shortages fell.

- Analysis of the APRs of Phase I and II countries that completed INS funding by 2006 suggests sustained financing of safety kit after support ended. All countries for which we were able to gather data reported continued usage of safety equipment, with the majority (58%) reporting only government funding. 23% reported total reliance on donor support, and the remaining 20% a mix of government and donor funding.
- Majority of the INS countries, especially the Phase II countries, improved substantially on budgeting for purchase of safety equipment for routine immunisation.
- For Phase I countries, there was a large improvement in planning and policymaking for injection safety, waste management and disposal, though the JRF data suggests that the Phase II countries have not been as successful on these counts.
- A comparison of the above JRF indicators between the INS countries (post-support) and GAVI ineligible middle income countries seems to suggest that INS countries are reported to have done better, particularly for the indicators reflecting safety policies, work plans for injection safety, waste management and disposal, and AD syringe use for routine immunisations. This limited comparison suggests high GAVI value-add on INS.

### 2.1.2. Whilst the HSS program health outcomes/ impact are difficult to measure, it has positively influenced donor health aid architecture at global and country levels

As also noted in the HSS evaluation, the early days of HSS implementation,[6] its insignificant size compared to the total health spend in country, and weak country performance reporting, make it difficult to track any health system impacts and attribute to GAVI funding. Further, GAVI's support is predominantly for downstream HSS activities (e.g. health workforce, infrastructure facilities) that cannot be readily related to immunisation coverage outcomes.

Results notwithstanding, initial feedback suggests that the HSS window has positively influenced donors' approach to health systems at global and country levels (as presented in Table 2.1 below, and to be further analysed using the HSS value-add typology described in Annex 3).

*Table 2.1: Initial findings on GAVI HSS*

<table>
<tr><th>Country level</th><th>Global level</th></tr>
<tr><td colspan="2">• Raised the profile of immunisation as a core part of the donor and government HSS agenda.</td></tr>
<tr><td>• Improved coordination among key HSS actors at country level. Linked immunisation and health system issues and stakeholders.</td><td rowspan="2">• A key partner in the common financing platform, despite its much smaller HSS window compared to Global Fund and the World Bank.</td></tr>
<tr><td>• High HSS demand generated by the country-driven and flexible approach focussed on key health systems bottlenecks in countries – GAVI funding is viewed as catalytic.</td></tr>
</table>

[6] The first round of GAVI HSS approved countries confirmed receipt of funding in April 2007.

Although there is broad agreement that HSS investments are vital for immunisation outcomes (and realisation of MDG4), there are mixed views on whether GAVI is necessarily the right agency with the appropriate delivery structures to implement the HSS program. Several consultees expressed the view that the fiduciary risks associated with large cash-based programs like HSS are significantly different to/ greater than the NVS program, and GAVI's systems need to be take account of this (for example, through its recent introduction of TAP/ FMA policies).

### 2.1.3. There are mixed views on the performance based approach of the ISS program

The initial feedback is that the ISS results- and rewards-based approach is innovative, and provides lessons for designing other performance based health initiatives. Nonetheless, GAVI's performance in this area is tempered by possibly unrealistic expectations of data quality and country capacity for monitoring and reporting (notwithstanding some reported issues of data misuse and fraud, which we do not propose to comment on as part of our evaluation).[7] It is agreed that GAVI's introduction of data quality audits and surveys addresses the data reliability issue.

Initial EPI manager survey responses suggest that several countries depend on ISS grants to target/ extend routine immunisation coverage to the unreached, as no other donor supports this – implying GAVI value-add. However, there seems to be mixed views on the appropriateness of the ISS reward criteria, and several EPI managers responded that the incentives need to be shared (by central governments) with the District level to increase coverage.

### 2.1.4. The poor uptake of the CSO support (particularly Type A) has been attributed to design and implementation issues

Although the CSO program pilot was approved by the GAVI Board for a two year window of 2007-09, its uptake (particularly Type A) has been rather slow, resulting in the Board extending the program into 2010.[8] Some emerging issues are:[9]

- Questions have been raised regarding the clarity of CSO program objectives (increased immunisation coverage/ improving HSS delivery/ others?), and whether it should at all be a stand-alone program (or integrated with HSS). The validity of the pilot country eligibility criteria and allocation of Type A commitment to all GAVI countries (rather than a prioritised or pilot approach) are also questioned.
- Small grant sizes of $10,000 to $100,000 for Type A support, combined with cumbersome application forms and approval/ disbursement processes, have discouraged countries (already constrained by human capacity) from applying.

[7] For example, Lancet - Editorial (2009): "Who runs global health?", Lancet Vol 373 June 20, 2009; reported that GAVI's ISS has encouraged over-reporting of vaccination success by recipient countries

[8] As of December 2009, 66% of committed Type B support had been approved, of which about 72% had been disbursed. By February 2010, 92% of committed Type B support has been approved. In contrast, only 10% of Type A committed support has been approved/ disbursed.

[9] Some of these issues were also highlighted in the Type A Support Review by Eliot Putnam, and presented by the Secretariat to the Program and Policy Committee for approval in re-designing aspects of the support.

- The inability of GAVI to provide direct funding to CSOs (but rather through governments/ partners) has reduced program effectiveness, although some EPI managers believe that channelling CSO funding through government is better suited to increase CSO engagement/ coordination in public health and immunisation programs.
- Delays in approval and disbursement of CSO funds have meant that it is too early to measure outputs or outcomes, and none of the CSO countries have yet reported results in the latest 2008 APRs.

Overall feedback suggests that although GAVI has been instrumental in recognising the role of CSOs in immunisation and related health services, its results and value-add to date is limited in light of the above design and implementation constraints. The Global Fund and Stop TB Challenge Facility for Civil Society (CFCS) provide useful lessons on funding CSOs directly, proposal review processes and CSO requirements, and reporting and monitoring.

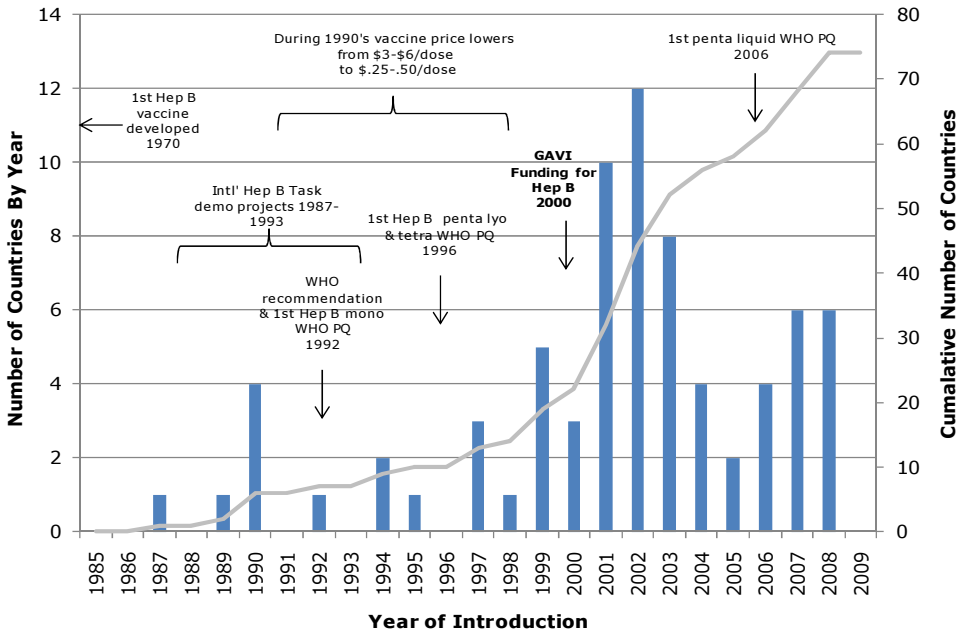
## 2.2. SG2 – Vaccine supply/ security

The introduction of underused vaccines by GAVI countries has been accelerated since GAVI's support. It is more difficult to attribute time to achieve peak coverage for new vaccines to GAVI funding, given the number of potential explanatory factors. With respect to anticipated fall in vaccine prices, the evidence varies by vaccine. The number of pre-qualified vaccine suppliers has increased over time, the attribution of which to GAVI is being examined.

### 2.2.1. GAVI has had an impact on the acceleration of introduction and use of Hepatitis B, Hib, and Yellow Fever vaccines

GAVI country introduction rates have increased since GAVI began providing funding for the three underused vaccines (see, for example, Figure 2.1 for Hepatitis B introduction). High income countries introduced these vaccines earlier than both middle and low income countries. The rate of acceleration of introduction for low-income countries increased after 2000.

*Figure 2.1: Hepatitis B introduction in GAVI-eligible countries*



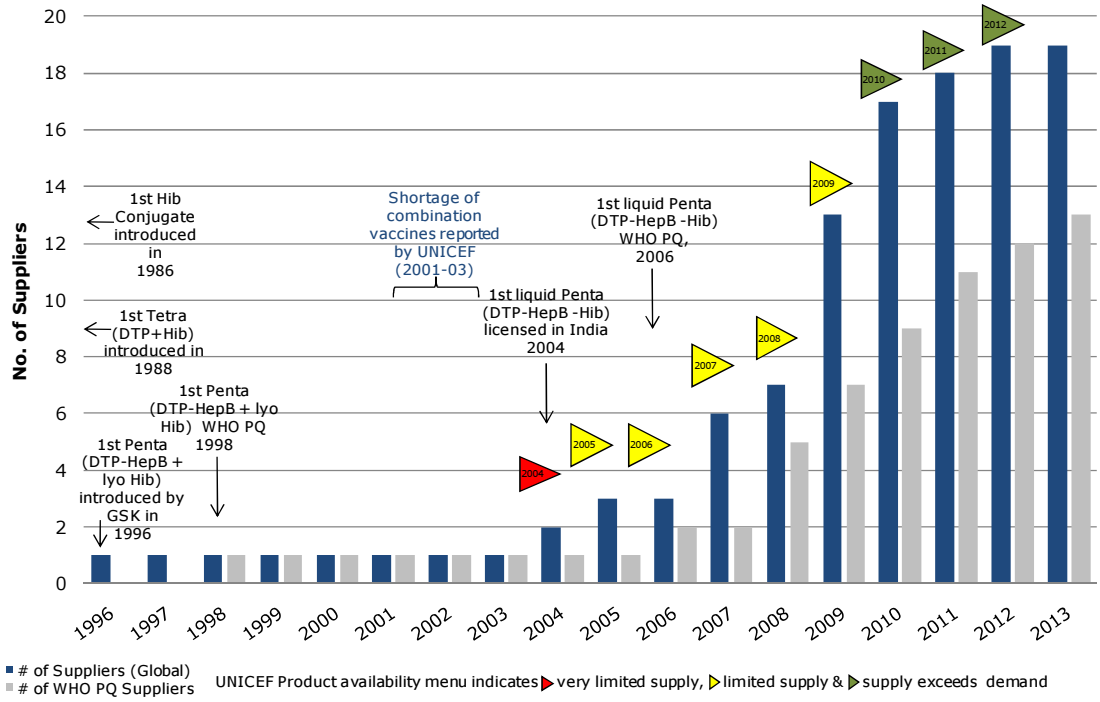

### 2.2.2. There is no clear trend with regards to country time-to-achieve-peak-coverage after introduction of a new vaccine

- It takes the majority of countries less than one year to achieve peak coverage when a "switch" occurs. We define a "switch" as introduction of a vaccine that replaces an existing vaccine, e.g., switching from DTP to Hep B tetravalent.
- There is no trend in the time to achieve peak coverage when comparing countries that introduced before and after the start of GAVI, or by comparing across country size or GAVI financing tier.
- It is difficult to determine the causes behind time to achieve peak coverage because so many factors (e.g., country size, infrastructure, phased vs. immediate introduction, health systems funding, vaccine supply, etc.) can impact the result. Because of this, it is very difficult to isolate GAVI's impact on this variable.

### 2.2.3. Overall, an increasing number of suppliers have entered the GAVI-supplied vaccine market and have been WHO pre-qualified

Literature reviews and qualitative interview data are being gathered to determine whether the entry of any of these suppliers can be attributed to GAVI (see Figure 2.2 for an example of pentavalent supply over time).

*Figure 2.2: Pentavalent vaccine timeline and supply situation*




### 2.2.4. Vaccine price changes over the ten years of GAVI's existence have varied by vaccine

- At GAVI's inception, there was an assumption that increasing the volume of vaccines purchased would lead to a drop in vaccine prices.[10] While price declined over time for certain vaccines, this occurred predominantly when a new, more desirable vaccine was introduced in the market. For example, GAVI tetravalent prices went up slightly before steeply dropping in 2007, the first year that liquid pentavalent was supplied to GAVI markets.
- During the evaluation timeframe, the price of pentavalent vaccine did not decrease substantially; we should note that this evaluation does not cover 2010 and therefore does not reflect projected decreases in pentavalent prices beginning in 2010.
- With regards to affordability to countries, with 2008 co-financing requirements, GAVI-qualifying countries were paying between 3-8% of the UNICEF weighted price per dose for pentavalent vaccines.
- Using the financing tiers, adding pentavalent and yellow fever vaccines more than doubles the cost of vaccinating one infant for intermediate and least poor countries.

Feedback from the industry suggests that the main driver of price reduction for GAVI vaccines will be greater competition arising from increased market entry of new suppliers (including emerging market suppliers), and that this takes time. We also understand that the UNICEF

[10] GAVI Secretariat, (2005), "14th GAVI Board Meeting, Abuja, Nigeria, 4-5 December 2004: Summary Report", pg. 3 found at http://www.gavialliance.org/resources/14brd_ExSum.pdf, Accessed January 10, 2010.

procurement principles emphasise security more than price (recognising the trade-offs involved). We shall explore these points including the extent to which the Alliance could have reasonably been expected to do better in relation to vaccine price reductions.

### 2.3. SG3 – Increased, predictable and sustainable immunisation financing

The analysis to date suggests that GAVI has played an important role in increasing the level and predictability of global financial resources for immunisation, also through its value added role in supporting the implementation of the innovative financing mechanisms of IFFIm and AMC. Financial sustainability at the national level however remains a concern.

#### 2.3.1. GAVI has achieved clear results in increasing overall immunisation funding levels; however further work is required to explore additionality – particularly in terms of GAVI effect on funding for multilaterals

Total immunisation funding has doubled from around $0.5bn in 2003 to almost $1bn in 2007.[11] Of this, GAVI's share has grown from 20% in 2003 to 35% in 2007, with the increase in its funding over the period representing a compound growth rate of 27.5%. However this increase in GAVI (and total immunisation) funding needs to be viewed in light of the increase in global donor funding for health overall. Over the period 2003-07, immunisation funding grew at a slower rate than total development assistance for health (DAH)[12], implying that other health sectors (for example, reproductive health) have grown faster. Total DAH was nearly $22bn in 2007, i.e. total immunisation funding represented only 4% of DAH in 2007.

Donor health budgets (including the US, UK, and Norway) show that as they prioritise health in their total ODA, they also increase their funding to GAVI. For example, the Norway government's DAH as a percentage of its total ODA increased from 6.4% in 2000 to 14.4% in 2007, with a concomitant increase in funding to GAVI at 0.7% in 2001[13] and 2.3% in 2007 (as a percentage of its ODA).

Initial donor feedback suggests that they view GAVI as a focused immunisation agency providing a measurable return on donor investments, and as an agile and flexible mechanism to achieve development results (compared to traditional channels). The donors stated that they would not have channelled the same amount of money for immunisation in the absence of GAVI. In terms of attribution to GAVI, however, we note that the Gates Foundation has played a critical role in 'crowding-in' other donor investments into GAVI.

However, an important issue is whether funding to GAVI is truly additional, or has displaced funding from other channels, including multilaterals. Discussions with WHO and UNICEF suggest that they have found it increasingly difficult to source funding for their immunisation activities that are not GAVI-related. In order to assess this, we have requested detailed information on both immunisation expenditure and funding sources for immunisation from both WHO and UNICEF.

[11] Note that we have access to consolidated data on immunisation funding for 2003-07 only.

[12] Including bilateral government ODA as well as assistance from private foundations and NGOs.

[13] Norway did not fund GAVI in 1999-2000.

### 2.3.2. GAVI has received longer term funding commitments from donors (and hence greater predictability), however there are some issues relating to sustainability of global funding

An analysis of direct donor funding to GAVI reveals the following:[14]

- Unlike bilateral donors whose budgets are approved on an annual basis by their Parliaments[15], GAVI, similar to some other GHPs and multilaterals, has access to longer term funding. The percentage of GAVI donors to date at least one agreement of three years or more is 53% and the total number of agreements that span greater than three years is 16%.
- Total donor contributions to GAVI have been relatively more volatile than total DAH and health ODA (which might be expected, given funding to GAVI is a narrower category). In addition, comparison with the Global Fund reveals that yearly fluctuations in total donor contributions for GAVI have been higher. However, it is important to note that this volatility does not imply a negative result – as apart from 2002-04 and 2006, the volatility in funding to GAVI results from increases in total donor funding.

We note that GAVI has played an important role in supporting / facilitating IFFIm – which is rightly regarded as 'ground breaking' and innovative financing in terms of achieving longer-term commitments. However, the impact on GAVI and its programs is slightly perverse in terms of predictability – since (by definition) it has created 'lumpiness' in GAVI disbursement.

An issue that we hope to consider as part of our consultations is whether donor liabilities in relation to the IFFIm bonds will have an impact on future funding for immunisation (or other donor assistance to health).

Another dimension of sustainability of global funding is the number of contributing donors – in comparison with the Global Fund and GPEI,[16] GAVI has fewer donors, with a median contribution of $9.7m per year vis-a-vis $2.5m for Global Fund and $1.5m for GPEI. Also, in terms of composition of donors, while both Global Fund and GPEI are dependent on the G8 donors for majority of their funding, the role of the Gates Foundation in GAVI (38% of its total funding) is far more important. The range of other bilateral and private philanthropy donors for these other GHPs is also higher than that for GAVI. This may not necessarily imply weaker sustainability of GAVI funding, but we do note the potential risk of a few large contributions driving the base of funding, especially in periods of financial crunch.

### 2.3.3. Financial sustainability at national level remains a concern

The area of national financial sustainability requires further work. However, it is clear that the introduction of the pentavalent in most GAVI countries in Phase II (as opposed to the

[14] Note that this is in reference to direct contributions to GAVI and does not include IFFIm.

[15] Some bilateral donors have longer periods for indicative spending plans, although these do not guarantee the availability of funds.

[16] Global Polio Eradication Initiative

tetravalent in Phase I) has increased concerns of financial sustainability.[17] Also, GAVI's support for new vaccines in Phase II puts additional pressure on countries, given their higher prices.

There is a general view that GAVI was innovative in Phase I in its active consideration (through the work of the Financing Task Force) of issues relating to financial sustainability. In part, this reflected an overly optimistic view of what could be achieved with price.

Innovation appears to have continued in Phase II with the introduction of GAVI's co-financing approach. GAVI is one of the few GHPs to implement this approach (for example, the Global Fund approaches country sustainability by requiring governments to pay a minimum percentage of the disease intervention). However, further consideration is required on the incentive effects of current co-financing and eligibility policies compared with Phase I.

### 2.3.4. GAVI has been instrumental in the design and implementation of innovative financing mechanisms such as IFFIm and AMC

Initial consultations suggest that GAVI has facilitated the design and implementation of the innovative mechanisms of IFFIm and AMC:

- It is important to recognise that a large part of the impetus for IFFIm came from the UK Government. In this context, it was the characteristics of immunisation (i.e. as a health investment that offers measurable and high returns to upfront investment, and is not as constrained as other health investments by capacity). Notwithstanding this, it is clear through our initial consultations that GAVI (and particularly in the form of the GAVI Fund) has played an important role in terms of its flexibility and ability to innovate in terms of institutional and financial structures. Indeed it is not unreasonable to conclude (i) that such an innovative financial structure would not have succeeded had it relied on the existing multilateral financing architecture; or failing that (ii) that GAVI's role in IFFIm had a catalytic effect in terms of bringing the multilaterals to the table earlier on other innovative financing mechanisms – notably AMCs.
- GAVI has played a unique role in facilitating the AMC - its flexibility, 'entrepreneurial' nature, and transparency to audit/ measure results were key contributing factors (in contrast to what the multilateral systems and procedures might have allowed). Also, the ability and willingness of the GAVI Board to take risks and be proactive in implementation of new financing mechanisms has been valued. For example, the GAVI Board passed the establishment of the AMC Independent Advisory Committee through its by-laws, for oversight of AMC operations (given that it is a virtual entity with GAVI providing Secretariat services).

## 2.4. SG4 – Added value of GAVI as a global health PPP

As we indicated in our Proposal (and subsequent Inception Report), the analysis that we are undertaking in relation to GAVI's added value as a partnership relies to a significant degree on interview based evidence. Given that these are not yet complete, what follows largely reflects

[17] In addition to the cost of the vaccines there are significant implications in terms of the required volume of cold storage for both pentavelent and rota and pneumo

consultation feedback so far, desk review and analysis, and CEPA judgement. As already noted in the introduction to this paper, the themes are largely organised around the areas of analysis that we are conducting. At this stage, they do not seek to bring together conclusions at either the SG-level or at GAVI's level as a whole.

### 2.4.1. GAVI is right to see its 'lean structure' as an important contributor to its value add, but this will be eroded if recent increases in operating (and Work Plan) costs combined with a reduction in disbursements continue

An important aspect of GAVI's 'USP' in Phase I and Phase II has been its claim to have a 'lean' structure that maximises the amount of resources that it passes on to countries (subject to appropriate fiduciary standards). As part of our evaluation, we have conducted a high-level review of GAVI's overhead costs, by benchmarking various measures of 'donor cost efficiency' against comparator organisations. These measures are based on those used in Easterly and Pfutze (2008)[18] – which provides a series of existing comparators. In undertaking the analysis, we have considered what we refer to as both 'narrow' and 'wide' measures of operating costs – where the 'wide' measures includes estimates of Work Plan expenditure as part of operating costs. This analysis is still underway and subject to change.[19] However, initial points to note are:

- During Phase I, GAVI's operating cost as a proportion of disbursements increased from a very low base. By the beginning of Phase II (2005) operating cost indicators for GAVI (on both a narrow and wide basis) were:
    - broadly comparable with the Global Fund;
    - comparable with the average bilateral donor (although there quite a broad range);
    - slightly lower than our estimates of Gates Foundation; and
    - significantly lower than the average multilateral (note the analysis excludes WHO given its specific technical mandate).
- This appears to have remained broadly the case during Phase II – with operating costs rising in line with disbursements through to 2007. However, in 2008, with disbursements falling back from the 2007 high of around $0.8bn and Secretariat and Work Plan costs increasing both narrow and wide operating cost indicators have increased (worsened) dramatically.

It is important to emphasise that low overheads are not necessarily a measure of aid effectiveness. But, given that GAVI's views itself as being lean it is important for us to place the organisation for these specific indicators vis-a-vis a small number of comparators.

Our analysis to date suggests that it is right for GAVI to claim to have been a relatively lean entity in terms of overhead / operating costs. This remains the case compared with the average multilateral (based on Easterly and Pfutze). However:

[18] Where does the money go? Best and Worst Practices in Foreign Aid (2008), Global Economy and Development Working Paper 21, William Easterly and Tobias Pfutze

[19] We have some specific questions that we need to discuss with GAVI colleagues before being able to finalise this analysis.

- it is interesting to note that GAVI is only comparable (as opposed to 'better' than) to the Global Fund (on both narrow and broad measures)– which is arguably the closest comparator; and
- the claim to be 'lean' will be eroded if trends in operating costs and disbursements (in 2008 particularly) continue.

### 2.4.2. Our initial understanding is that TAP policy and process have been implemented well and that they do not compare unfavourably with the policies /process put in place by comparator organisations

Our evaluation work to review two key corporate policies / procedures has started with the Transparency and Accountability Policy (TAP). We have conducted and initial desk review comparison of GAVI's policies with comparator organisations (Global Fund, DFID, World Bank and UNDP). We are in the process of considering each against criteria based on GAVI's TAP principles. However, our judgement at this stage is significantly influenced by our interview with Secretariat staff.

### 2.4.3. GAVI's contribution to promoting awareness and importance of immunisation – particularly at the national level – has been significant. However, more work is required to understand whether this is the result of specific advocacy actions or is largely a by-product of GAVI's program and financing activities

This is the area within the SG4 evaluation where that least work has been done. The emerging theme is therefore based on initial interview evidence and CEPA's desk review of GAVI documents. It is therefore particularly subject to change.

### 2.4.4. The GAVI Work Plan and Budget is at the heart of the Alliance. But, in retrospect the time taken to resolve ongoing issues with the process and material has not supported the effectiveness of the Partnership

Whilst the Work Plan and Budget has been integral to GAVI's achievements, it is clear that it has also been a source of significant tension within the Alliance since its inception. Perhaps more than other aspects of GAVI, it goes to the heart of what the Alliance really means, what its value add is, and how the Technical Partners should be accountable to it.

Given its importance, the Work Plan and Budget needs to be seen in the context of the development of GAVI – i.e. the evolution of more formalised governance structures, processes, and an expanded Secretariat. There are clearly different views about the advantages and disadvantages of these changes – and particularly in terms of the relationship between the Technical Partners and the Alliance. We will return to this issue in more detail in our evaluation report.

Based on this review, as well as preliminary interview evidence, our initial views about the Work Plan and Budget process are as follows.

- Although subject of considerable tension, the Work Plan is actually an indication of real partnership – since it attempts to define explicitly the obligations that the Technical

Partners have to the Alliance and vice versa. In its earlier form, it was described as being "the collective effort of partners" and the "critical coordinating role" required for outcome optimisation.[20] It is interesting to contrast this with the Global Fund, where the engagement of the Multilateral Technical Partners particularly is much less clear[21].

- Prior to the 2008 Work Plan and Budget, the process typically appears to have been protracted and difficult; and Board approval has often been provided despite recurrent concerns about the structure and content of the material.
- Since 2008, the process and material appear to have improved very significantly. However, concerns remain particularly about:
    - how to define GAVI related activity as against the Technical Partner normative mandates – and this was reflected in the Work Plan Validation Process.
    - defining work plan activities specifically against the achievement of GAVI's objectives and monitor them at an appropriate level.

  With the benefit of hindsight, the time taken to resolve issues with both the process and the structure of materials appears (in CEPA's view) to not have supported the effectiveness of the Partnership. In part, this can be explained by the difficulties of producing and managing financial data for such a complex entity (or group of entities). But it is also appears to reflect a relative failure to tackle this difficult, but nonetheless important issue.

## 3. SUMMARY OF EMERGING THEMES

This final section brings together the preliminary themes and findings that we have presented in the previous section. The summary presented in Table 3.1 below seeks to consolidate the emerging evidence from our analysis thus far on areas that GAVI appears to have demonstrated relatively better or weaker performance (these are subject to change as we progress the evaluation work, and are not to be treated as conclusions on GAVI results and value add). Evaluation questions or components of review that are in very early stages of analysis and therefore have no clear emerging theme are not included in the table below.

[20] GAVI Consolidated Work Plan 2003-04

[21] As noted in the recent Global Fund evaluation, this reduces the extent to which the Partnership is a reality.

*Table 3.1: Emerging and preliminary themes on GAVI's performance*

| Strategic Goal | Emerging themes on positive results/ value add | Emerging themes on weaker results/ value add |
|---|---|---|
| SG1: Health systems strengthening | • INS program shows initial evidence of improving uptake of safety equipment, sustained financing of safety kit after INS support ended, and improved safety planning and policies for Phase I INS countries. Initial comparison of JRF safety indicators of GAVI eligible and ineligible middle income countries suggests GAVI value add.<br>• HSS program suggests some value add in terms of positively influencing donor health aid architecture at global and country levels, and increasing the profile of immunisation within HSS.<br>• ISS focus on increasing coverage to unreached is valued, given lack of other donors in this space (although impact – to be examined - is subject to data quality/ reliability issues). | • HSS program health outcomes/ impact are early and difficult to measure and attribute to GAVI.<br>• CSO program has some fundamental design and implementation issues, resulting in poor uptake. Results are too early to measure. |
| SG2: Vaccine support | • Country introduction and use of Hep B, Hib, and Yellow Fever vaccines have increased since GAVI provided funding.<br>• Increased market entry of new pre-qualified suppliers (including emerging market suppliers) for GAVI vaccines – attribution to GAVI to be examined. | • No clear trend or attribution to GAVI possible on country time to achieve peak coverage after introduction of a new vaccine.<br>• Vaccine price reductions achieved vary by vaccine, but generally, have not been as large as initially anticipated by GAVI. |
| SG3: Financing | • GAVI has clearly increased overall levels and predictability (through longer term commitments) of immunisation funding - although additionality of funding needs to be examined.<br>• GAVI has facilitated and enabled the design and implementation of innovative financing mechanisms such as IFFIm and AMC. | • Some emerging issues related to sustainability of global immunisation funding, as well as financial sustainability at country level. |
| SG4: Added value as a global PPP | • GAVI's lean and cost efficient structure (using various benchmark metrics vs. comparators) is a value add; however continuing recent trends in operating costs and disbursements might reverse this. | • GAVI's work planning and budgeting process and structure of materials appear to have not supported the effectiveness of the Alliance (although representative of the Partnership). |

## ANNEX 1: CONSULTATIONS TO DATE

*Table A1: Evaluation consultees*

| Name, designation | Organisation |
|---|---|
| **GAVI Secretariat** | |
| Julian Lob-Levyt | CEO |
| Helen Evans | Deputy CEO |
| Nina Scwalbe | MD, Policy and Performance |
| Mercy Ahun | MD, Program Delivery |
| Joelle Tanguy | MD, External Relation |
| Tony Dutson | Acting Chief Financial and Investment Officer |
| Timothy Nielander | Acting MD, Corporate Services |
| Carole Presern | Special Projects (HSS) |
| **Board members (current and past)** | |
| Saad Houry, Deputy Executive Director | UNICEF |
| Dagfinn Høybråten | Unaffiliated member |
| Sigrun Mogedal (ex) | Norway |
| **Advisory groups and task teams** | |
| Logan Brenzel, co-chair, Immunisation, Financing and Sustainability Group; Senior Health Specialist, Human Development Network | World Bank |
| Wendy J. Graham, co-chair, Data task team; Professor of Obstetric Epidemiology | University of Aberdeen, UK |
| **Donor Organisations** | |
| Gavin McGillivray, HOD; Jeffrey Tudor (innovative financing); Abigail Robinson; Julia Watson (Senior health adviser) | DFID |
| **Ex-GAVI members** | |
| Marc Hofstetter, Deputy Executive Director | Centre for Humanitarian Dialogue |
| Lisa Jacobs, ex-Head Governance, GAVI | |

*Table A2: Data & Information consultees*

| Name, designation | Organisation |
|---|---|
| **GAVI Secretariat** | |
| Gian Gandhi, Policy and Performance team | GAVI |
| Santiago Cornejo, Program delivery team (Americas and Lusophone Africa countries) | GAVI |
| Ulf Herzer, Finance | GAVI |
| Ranjana Kumar Program delivery (SEARO) | GAVI |

| Name, designation | Organisation |
|---|---|
| Peter Hansen, M&E head | GAVI |
| Nilgun Aydogan, CSO program head | GAVI |
| Essengue Elouma Marthe Sylvie, Program delivery (French speaking countries in West Africa) | GAVI |
| Steve Bloom, Director of operations | GAVI |
| Sarah Papineau, Program Funding Director | GAVI |
| Geoff Adlide, Director, Advocacy and Communication | GAVI |
| Talinn Yazmaciyan, Finance | GAVI |
| Craig Burgess, Program delivery (HSS, CSO) | GAVI |
| Jon Pearman, AVI manager | GAVI |
| Pooja Mall, Coordination of Work Plan for 2008, 2009, 2010 | GAVI |
| Jorn Heldrup, Program delivery (African countries) | GAVI |
| Mikella Hurley, TAP | GAVI |
| Tania Cernuschi, AMC manager | GAVI |
| Raj Kumar, Country responsible officer (Anglophone African countries) | GAVI |
| **Other GHPs** | |
| Martin Taylor; Rifat Atun | Global Fund |
| Birgit Poniatowski | GAIN |
| Phyllidia Travis | IHP |
| **Academic experts** | |
| Stephen Lim, Assistant Professor | Institute for Health Metrics and Evaluation |
| **Previous evaluators** | |
| Javier Martinez, Lead specialist in aid effectiveness; Team leader, GAVI HSS Evaluation | HLSP |
| Wendy Abramson, HSS Tracking Study | JSI |
| Beth Plowman, HSS Tracking Study | JSI |
| Eliot Putnam, CSO Type A Evaluation | Independent consultant |
| Anne Lafond, CSO M&E Study | JSI |
| **Suppliers** | |
| Dr. GV. J. A. Harshavardhan, Director RVDP | Bharat (penta, pneumo, rota) |
| Sai D.Prasad, Vice President, Business Development | Bharat (penta, pneumo, rota) |
| Yves Leurquin | Berna Biotech (all liquid penta) |

| Name, designation | Organisation |
|---|---|
| Joan Benson | Merck (rota) |
| Stephen Faust | Merck (rota) |
| Edmund Bresnahan | Merck (rota) |
| Jaco Smit | Sanofi-Pasteur (penta, men AC, yellow fever) |
| Navita Khanna | Panacea Biotech (penta) |
| **ADIPs** | |
| Robin Biellik | Rotavirus Vaccine Program |
| Evan Simpson | Rotavirus Vaccine Program |
| MarcLaForce | Meningitis Vaccine Project |
| Angeline Nanni | PneumoADIP |
| **GAVI Partners** | |
| Jean Marie Okwo Bele, Director | WHO |
| Lidija Kamara, Finance and planning, WHO coordinator for GAVI | WHO |
| Thomas Cherian, Coordinator for EPI | WHO |
| Gillian Mayers, New vaccines team | WHO |
| Miloud Kaddar, Financing, vaccine procurement, immunisation and health systems | WHO |
| Patrick Kadama | WHO |
| Casey Downey | WHO |
| Selma Khamassi | WHO |
| Claudio Politi | WHO |
| Ann Ottoson | UNICEF |

## ANNEX 2: LIST OF EVALUATION QUESTIONS BY GOAL

*Table A2.1: Evaluation Questions*

| |
|---|
| **SG1: health systems strengthening** |
| 1. What have been the results and value add of GAVI's INS program at country and global level? |
| 2. What have been the results of GAVI's HSS program at global and country level? |
| 3. What has been the value add of GAVI's HSS program compared to alternate HSS financing channels? |
| 4. What have been the results and value add of GAVI's ISS program? |
| 5. What have been the results and value add of GAVI's CSO program? |
| **SG2: vaccine support** |
| 1. To what extent has GAVI accelerated the uptake of underused and new vaccines by partner countries? |
| 2. To what extent have countries introducing underused and new vaccines been able to take them to scale quickly, i.e. achieve full scale coverage? |
| 3. To what extent has GAVI improved the stability of global and country level vaccine supply? |
| 4. To what extent has GAVI made vaccines and related technologies more affordable? |
| 5. To what extent has GAVI contributed to the advancement of the evidence base required for countries to address the policy decision related to introduction of new vaccines? |
| 6. To what extent has GAVI developed and used vaccine demand forecasts that are accurate and timely? |
| **SG3: immunisation financing** |
| 1. To what extent has GAVI increased the level of global financial resources from donors for immunisation activities? |
| 2. To what extent has GAVI increased the predictability and sustainability of global financial resources from donors for immunisation activities? |
| 3. To what extent has GAVI promoted and increased the sustainability of immunisation funding at the national level? |
| 4. To what extent is the existence of innovative financing mechanisms (such as IFFIm and AMCs) dependent on the existence of GAVI in its current structure and form? |
| **SG4: GAVI's added value as a global PPP** |
| 1. Has the distinctive organisational structure contributed to the efficiency, effectiveness and impact of GAVI? If so how? |
| 2. To what extent has GAVI increased awareness of, interest in, and commitment to immunisation and child health? |
| 3. Has the GAVI focus on collaboration with a wide range of private and public stakeholders contributed to its effectiveness and impact? |

## ANNEX 3: ASSESSMENT OF HSS VALUE-ADD

The inception report sets the main focus of evaluating HSS value-add as *'to assess the relative strengths and weaknesses of GAVI's approach to health systems support compared to alternate approaches'.*

HSS performance can be measured both at country level (based on outcome of the specific activities of GAVI and other donors), and at global level (based on judgements on the effectiveness of GAVI's support vis-a-vis other organisations). The value-add assessment will differ depending on whether country or global aspects are studied.

*Country level assessment*

*Comparison variables*

Actual outcomes of GAVI HSS can only be studied in exceptional cases, since the program has been underway for a short time and results are early to track/ attribute. For this reason, we focus on *process and output indicators* alongside any *normative and outcome indicators.*

Potential HSS process and output indicators at country level are:

- General strategy to HSS development (what can be covered, eligible and non-eligible partners, role of CSO and private sector, etc.)
- Financial resources (overall and average per grant)
- Process of initiation of country work (application), including level of donor control of process.
- Process of analysis and approval of applications (including country vulnerability analysis, and application approval criteria and timing)
- Transfer/ disbursement of resources
- Support for HSS implementation in country
- Focus activities supported by HSS grant (and whether at national/ sub-national level)
- Monitoring and evaluation (including methods for correction of implementation imperfections), including fiduciary risk management
- Additionality of support and sustainability

Potential normative and outcome indicators are:

- Paris and Accra principles (particular emphasis will be laid on "catalytic" because of its importance in the GAVI strategy to support with relative small sums)
- GAVI HSS principles
- Any initial measure of HSS outcomes and catalytic effects (to extent possible given early days of implementation)

In addition to comparing GAVI's HSS support to other HSS donors along the above indicators/ criteria, we propose to juxtapose our country value-add analysis with a study of country

contextual factors that we believe are critical to understand and measure HSS performance. Inevitably, the effects of general HSS interventions of global organisations will vary because of such contextual factors.

Alternate HSS approaches at country level could fundamentally be of vertical (disease focussed) or horizontal (system wide, cross cutting) character. Additionally, the approach could be "mixed" (sometimes described as diagonal). GAVI has been involved in HSS in all three categories.

The three country contextual factors we propose to examine are:

- *Architectural context in country:* As mentioned, the choice of HSS actors to study as alternatives to GAVI will depend on the country (rather than pre-selected). For example, country A may be supported by GAVI, Global Fund, and World Bank; whilst country B may only be supported by GAVI. Also, some countries may have a health sector wide integrated approach/ SWAP, and others may not. We therefore need to study different HSS actors both as elements in the total HSS aid architecture in the case study countries as well as individual organisations whose approaches to HSS vary in a number of aspects (e.g. their strategy and focus for HSS activities).
- *Governance quality:* Another contextual variable is the capacity of the country to plan and implement HSS interventions. Specific governance capacity indicators for the health sector that can be used across countries do not exist at the moment. It can be assumed that governance indicators derived from studies of general governance quality across the board also reflects on health sector governance. It is suggested that the World Bank governance index and its individual components be used for this purpose.
- *General development level*: The final contextual variable to consider is general development level. It is proposed the GDP/capita be used as an indicator.

The use of these three contextual factors creates a three dimensional typology of countries. It could be made infinitely more complex – population sizes could be added as could also general government structure (federal versus central). But number of countries and time/budget set strict limits to the analytical design.

*Country selection*

Five countries have been selected for field studies, which would form the basis for the HSS value add evaluation at country level. This limits the possibility of causal inference from the analysis. To compensate, additional material from the earlier studies (HLSP et al) needs to be re-analysed in an identical analytical design, to the extent possible and already available readily for analysis in the proposed typology.[22] The use of additional earlier country studies will particularly serve the purpose of a corrective for uncontrolled random variation on contextual variables and target variables in results from the field studies. Any country level feedback from the e-survey and consultations will also be collated.

[22] For avoidance of doubt, it is not proposed to collect country level evidence beyond the five field visit countries. Any readily available material from previous GAVI studies hat is still relevant and conducive for analysis as per the proposed HSS value add typology will be utilised, as additional possible evidence.

*Study methodology in countries*

A study guide paper shall be developed to specify the kind of data and qualitative information that needs to be sought from the field study countries and the desk study work on earlier HSS studies.

In field study countries, the assessment needs to include both efforts to actually judge the quality of performance of all comparators and the judgement passed on them in these respects from *local "jurors"* – government representatives, professional organisations in country, UN reps, non-aligned international experts with specific knowledge of the country, etc. Where possible, the approach of the "jury" might be that of "focus group discussions" leading to – perhaps – a common understanding of the performance of the various HSS comparator organisations.

The jurors also need to be asked to assess the comparators based on the principles from the declaration of Paris and Accra principles laid down in the OECD analytical framework for development aid, and the GAVI HSS principles.

*Global assessment*

Four global actors in HSS are suggested to be studied:

- GAVI
- GFATM
- World Bank
- USAID

The following issues need to be focused in the global studies:

- Overhead costs (or types thereof) associated with the HSS strategy implementation (assuming this is available/ measurable amongst the comparator organisations' multiple programs)
- Underlying development strategies behind organisational choice of HSS business models
- Efficiency of structural design of global organisations
- Contribution from each of the actors to policy development of a global HSS strategy

The modus operandi will be that of desk analysis of existing studies that can be combined with telephone interviews with leadership and management (of the four chosen organisations).