Gavi
The Vaccine Alliance

ZAMBIA

Findings from the 2015 Gavi Full Country Evaluations

icddr,b

UNIVERSIDADE EDUARDO MONDLANE

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HEALTH ALLIANCE INTERNATIONAL

IDRC

PATH

This report presents findings in Zambia from the 2015 Gavi Full Country Evaluations (FCE). It was prepared by the Institute for Health Metrics and Evaluation (IHME) at the University of Washington (UW) in collaboration with members of the FCE Team: the University of Zambia (UNZA), Zambia; icddr,b in Bangladesh; University of Eduardo Mondlane (UEM), Mozambique; Health Alliance International (HAI), Mozambique; Manhiça Health Research Centre (CISM); the Infectious Diseases Research Collaboration (IDRC), Uganda; and PATH in the United States.

This work is intended to inform evidence-based improvements for immunization delivery in FCE countries, and more broadly in low-income countries, with a focus on Gavi funding. This publication reflects content from the 2015 Annual Report, available for download at IHME's and Gavi's websites. The contents of this publication may not be reproduced in whole or in part without permission from the Gavi Full Country Evaluations Team.

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TIMELINE of major immunization events

We present an overview of major immunization events in-country, indicating any relevant delays in implementation (Figure 1).

Figure 1: Overview of major immunization events in Zambia

		PLANNED	ACTUAL
2014	JAN		
	FEB		
	MAR		
	APR		
	MAY	Expression of Interest (EOI) submitted to Gavi	✓
		EOI submitted to Gavi	✓
		EOI submitted to Gavi	✓
		EOI submitted to Gavi	✓
	JUNE		
	JULY		
	AUG		
	SEP	Application IPV Vaccine Introduction Grant (VIG) submitted	✓
		First application for HSS grant submitted to Gavi	Postponed
	OCT		
	NOV		
	DEC		
2015	JAN		
	FEB		
	MAR		
	APR		
	MAY		
	JUNE		
	JULY		
	AUG		
	SEP	Application for MR introduction submitted	✓
		Application for HSS grant resubmitted to Gavi	✓
	OCT		
	NOV	Planned introduction for IPV	New date not yet set
	DEC		

Support streams evaluated in 2015

- Health Systems Strengthening (HSS)
- Human papillomavirus vaccine (HPV)
- Inactivated polio vaccine (IPV)
- Measles-rubella (MR) vaccine
- Other
- ✓ Implemented as planned/no delay
- Delay

2015 evaluation activities

Assessment of progress, successes, and challenges

- Collected and reviewed documents relevant to Gavi funding, operational plans and budgets, guidelines, studies, program review reports, and datasets.
- Attended and observed key meetings and workshops at the national level.
- Conducted fact-checking interviews.

Key informant interviews (KII)

- Conducted 15 interviews with government, government partners, Gavi partners, and non-governmental organizations (NGO).
- Conducted 23 interviews at the global level with the Gavi Secretariat, Vaccine Alliance partners, and others.

Analysis of partnership

- Conducted 11 partnership surveys around HSS application with WHO, PATH, CHAZ, CHU, DPI, Ministry of Health (MOH), and the Centre for Infectious Disease Research in Zambia (CIDRZ).

Resource tracking

- Analyzed financial resources for immunization through review of National Health Accounts (NHA) and KIIs with various organizations known to support immunization in Zambia.

Household survey

- Collected household survey data for 1,010 households.
- Collected dried blood spot (DBS) samples from 955 children.

Analysis of administrative data on vaccine coverage

- Compiled and analyzed all available household survey and census data sources.

Small area analysis

- Complied and analyzed all available household survey and census data sources.
- Estimated national, divisional, district, and subdistrict-level vaccination coverage and under-5 mortality.

Inequality analysis

- Compiled and analyzed all available survey data sources with information on household wealth and vaccination coverage.

Health Management Information System (HMIS) analysis

- Analyzed HMIS data.

ANALYSIS of major challenges and successes

Each finding is accompanied by a ranking that reflects the robustness of evidence. The four-point ranking scale is summarized below:

Ranking	Rationale
A	The finding is supported by multiple data sources (good triangulation) which are generally of good quality. Where fewer data sources exist, the supporting evidence is more factual than subjective.
B	The finding is supported by multiple data sources (good triangulation) of lesser quality, or the finding is supported by fewer data sources (limited triangulation) of good quality but perhaps more perception-based than factual.
C	The finding is supported by few data sources (limited triangulation) and is perception-based, or generally based on data that are viewed as being of lesser quality.
D	The finding is supported by very limited evidence (single source) or by incomplete or unreliable evidence. In the context of this prospective evaluation, findings with this ranking may be preliminary or emerging, with active and ongoing data collection to follow up.

PNEUMOCOCCAL CONJUGATE AND ROTAVIRUS vaccines

Pneumococcal conjugate vaccine (PCV) and rotavirus vaccines were introduced into the routine immunization schedule in 2013. Following introduction, there have been no activities specific to the improved routinization of the two vaccines.

FINDING 1

Our previous analysis of facility data in Zambia suggested that both PCV and rotavirus vaccine introductions were launched nationwide and were becoming increasingly routinized nationwide. Based on HMIS data available to us (up to Q3, 2015) delivery of PCV and rotavirus vaccine had stabilized over time but delivery was below that of pentavalent vaccine, particularly for rotavirus vaccine.

Ranking: C

PCV and rotavirus vaccine delivery stabilized over 2014 and into 2015, but is still low.

- Delivery remained lower for these vaccines than for existing vaccines in the system (Figure 2 and Figure 3), particularly for rotavirus vaccine, though there are indications of improvement for both vaccines in the latter part of 2015.

Figure 2: Ratio of PCV to pentavalent doses reported to be delivered from HMIS in Zambia

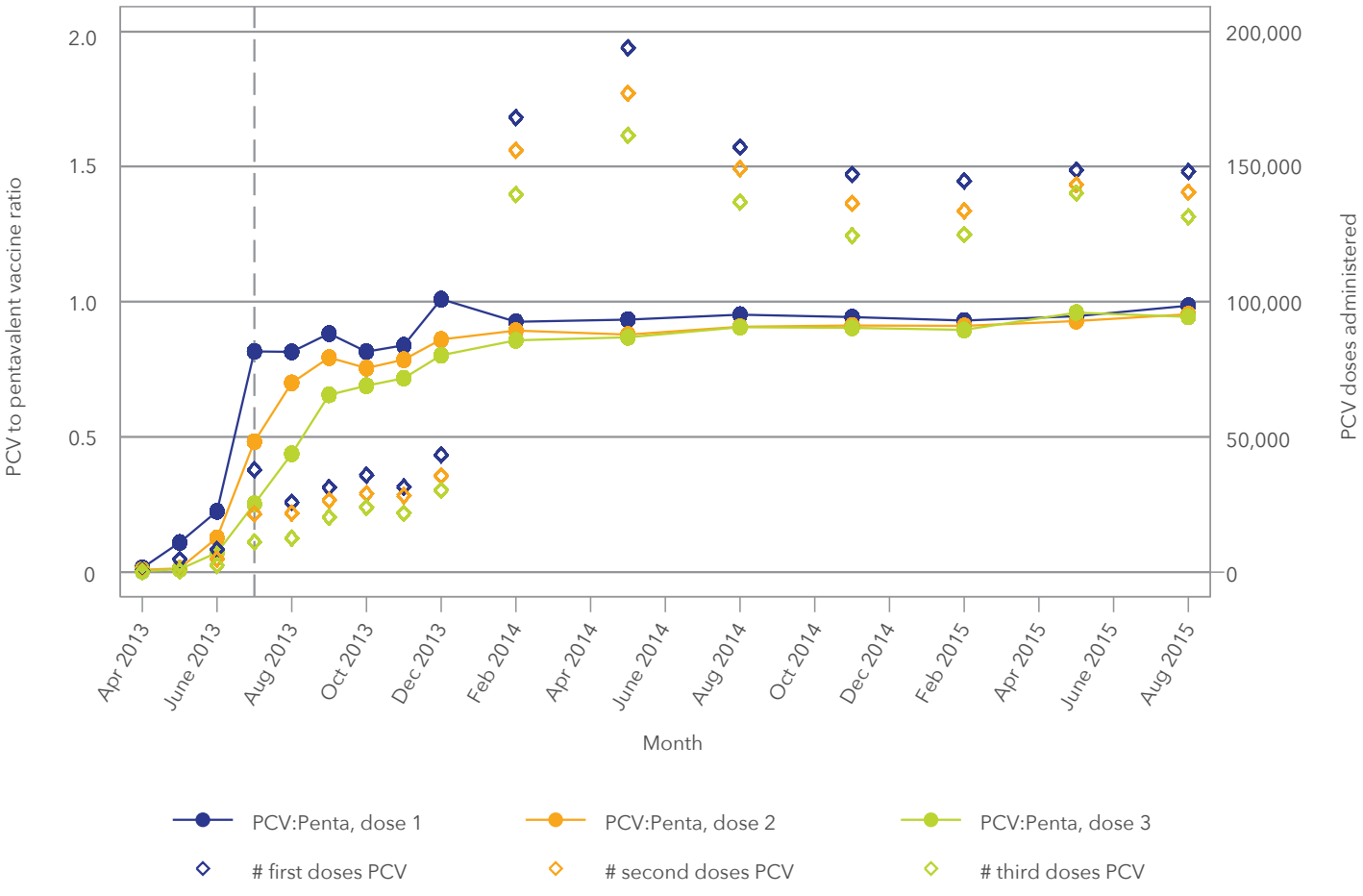
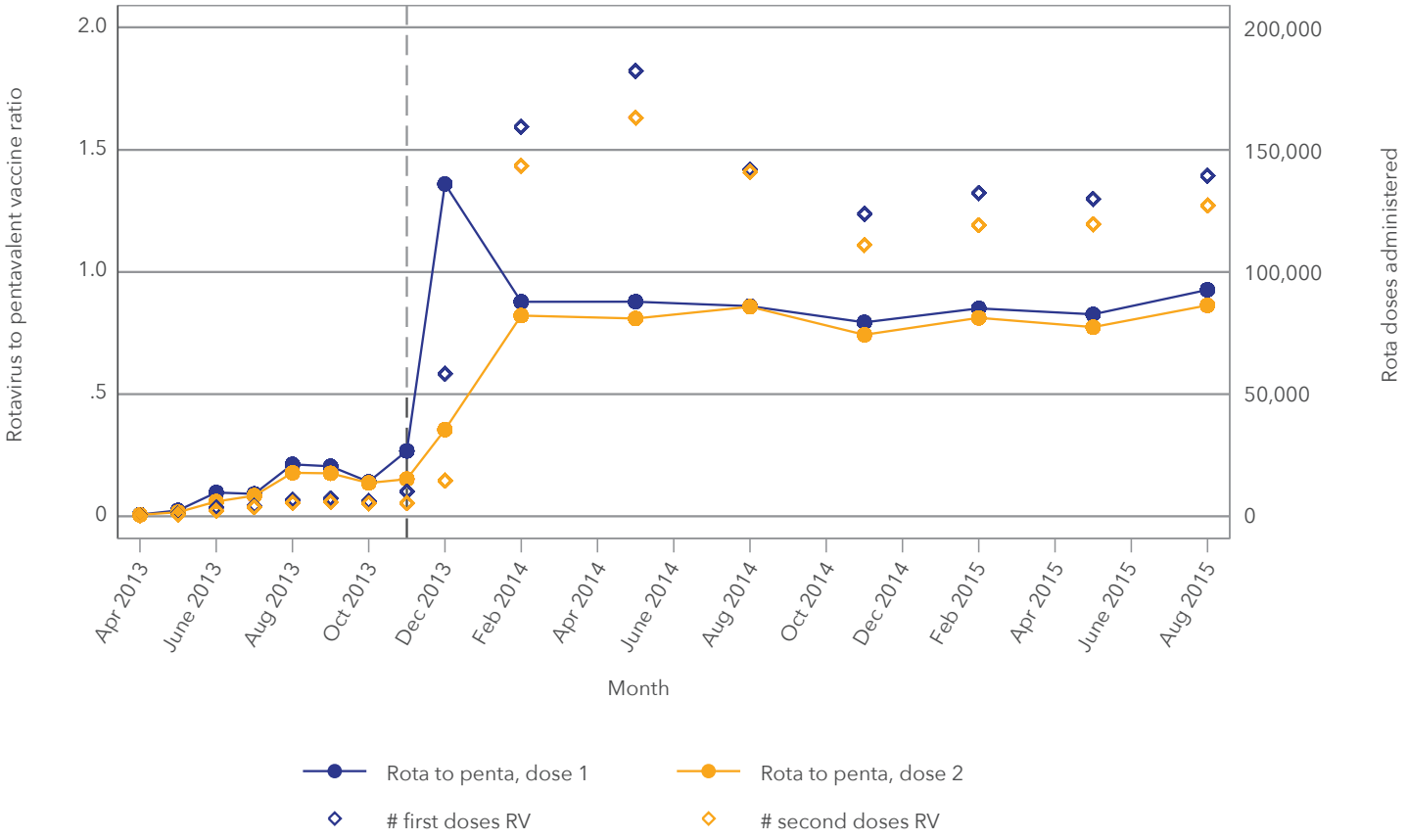


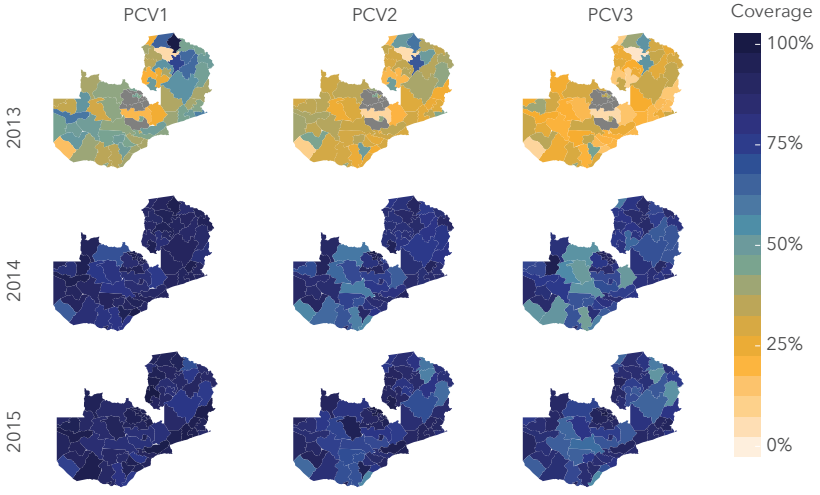
Figure 3: Ratio of rotavirus vaccine to pentavalent doses reported to be delivered from HMIS in Zambia



Low routinization is attributable to several factors

- **Logistical challenges.** While there have been no national-level stock-outs, it was confirmed that logistical challenges in getting vaccines from national to district level have caused stock-outs of PCV and rotavirus vaccine in some districts.
- **Underestimation of vaccine stocks.** PCV and rota supplies by UNICEF are based on an anticipated 60% coverage in year one and about 80%-90% in year two, which has not since been updated and could also contribute to stock-outs at the district level
- **Challenges acquiring accurate population figures from Central Statistical Office (CSO).** Vaccine suppliers (UNICEF) based their provision of vaccine stocks on these figures, which are inaccurate.

Figure 4: Estimated coverage of PCV by dose and district in Zambia

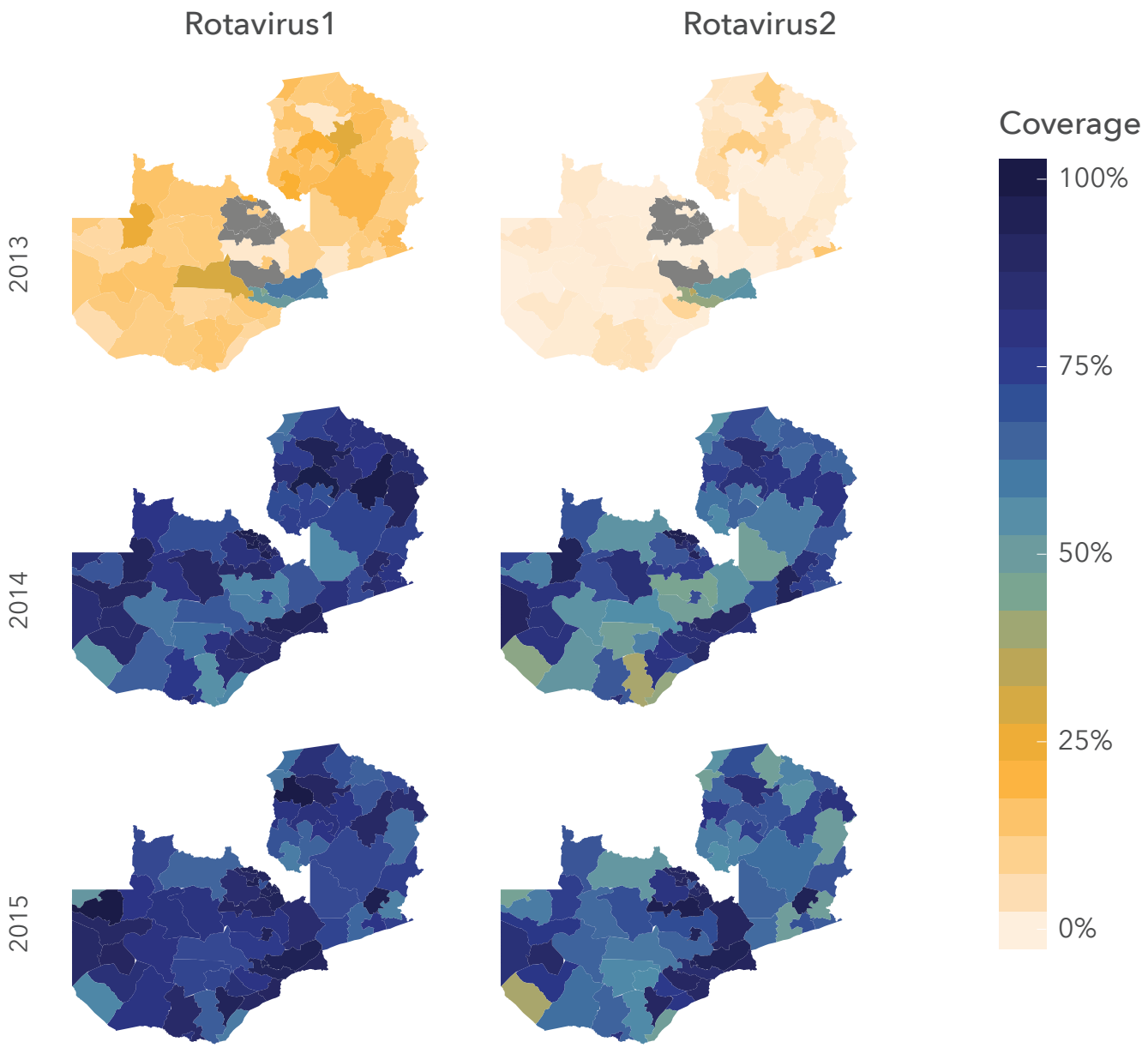


Grey shaded areas indicate districts where data were not reported to HMIS.

Though routinization has progressed, inequities persist.

- The combination of less-than-full routinization of PCV and rotavirus vaccine, and existing system bottlenecks highlight inequalities in new vaccine delivery (Figure 4 and Figure 5).

Figure 5: Estimated coverage of rotavirus vaccine by dose and district in Zambia



Grey shaded areas indicate districts where data were not reported to HMIS.

RECOMMENDATIONS

1. Improvements in the timeliness and quality of HMIS data are required to better monitor routinization of new and existing vaccines in Zambia.

2. Closer monitoring of vaccine supply between health facilities and the district level as well between the national, province, and district levels is required to avoid stock-outs.

INACTIVATED POLIOVIRUS vaccine

Zambia's inactivated poliovirus vaccine (IPV) application was approved by Gavi in February 2015. Introduction was initially planned for late 2015, but due to a global vaccine supply shortage, the delivery of vaccine is expected to occur sometime in 2016 rather than at the end of 2015.

FINDING 1

The introduction of IPV in Zambia has mainly been driven by a global agenda, with less participation by country stakeholders leading to delayed funding and subsequently implementation of preparatory activities for the launch. Coupled with global supply issues this has resulted in a postponement of the launch until 2016.

Ranking: A

Global political pressures and application incentives strongly encourage countries to apply for IPV introduction.

- The World Health Assembly, with the Strategic Advisory Group of Experts on immunization (SAGE), pushed for global polio eradication. Gavi reinforced this by waiving the co-financing requirements for IPV.

Many in-country stakeholders perceived that the global push for IPV introduction was more influential than domestic priorities in driving the decision to adopt IPV; this affected implementation.

- The Ministry of Health (MOH) did not allocate sufficient funds in the vaccine budget line to cover the anticipated introduction of IPV in the national budget.
- The Ministry of Community Development, Mother and Child Health (MCD-MCH) had to justify to the Ministry of Finance (MOF) through the MOH that IPV was a priority for the EPI in order for funds to be allocated to IPV introduction. There have since been MOF delays in releasing the IPV introduction funds.

The global push for IPV introduction also reduced the involvement of local stakeholders in the decision, which then affected local buy-in.

- There have also been competing EPI priorities for all parties and untimely and inconsistent stakeholder engagement by the MCDMCH on IPV.

RECOMMENDATIONS

1. When globally driven initiatives, such as polio eradication, are not aligned with the most pressing country priorities, support from local partners and government is more difficult to attract. In such situations, Gavi and global alliance partners should therefore play a more active role in facilitating the provision of support required to introduce a new vaccine such as IPV.

2. Even in cases of globally driven initiatives, government should ensure that the decision-making and application processes are participatory so that stakeholders are brought on board early in the process. This will help to promote efficient planning and implementation of vaccine introductions.

HUMAN PAPILLOMAVIRUS vaccine

In 2013 Zambia launched an HPV demonstration project to generate lessons to inform the national rollout and meet introduction requirements for Gavi support for national introduction. The demonstration was not a Gavi-supported project but was funded by a number of other organizations.

The demonstration project was conducted in three of four districts in Lusaka province: Lusaka, Kafue, and Chongwe. The school-based campaign was the main delivery model, targeting school girls in grade four (i.e., ages 9 to 13 years). Concurrent with the school-based model, a facility-based model was used on a limited based to reach eligible girls (age 10) who were not in school.

At the end of the demonstration, a post-introduction evaluation (PIE) and a cost analysis desk review were conducted.

FINDING 1

Suboptimal implementation due to leadership and coordination challenges, as well as problems with social mobilization for the HPV demonstration project, resulted in lower-than-expected coverage rates in both rounds.

The demonstration project yielded lower-than-expected coverage.

- Target coverage for the HPV vaccine demonstration was 70%. Based on administrative data, coverage was 59% for the first year and 58% for the second year.

Low coverage was driven by leadership and coordination challenges:

- **Political support.** The demonstration project had strong political will, especially from the former first lady. Her departure contributed to lowered political will.
- **Unclear government ownership.** Stakeholders reported being unclear of whether the HPV vaccination program should reside with the CHU or with another entity of Ministry of Health, since HPV vaccination targets a different population than routine immunization for children.
- **Coordination challenges between MCDMCH and Ministry of Education (MOE).** Implementation of the school-based delivery was hindered by underestimation of the target population from education authorities and by the weak involvement of the District Education Board Secretary's offices (DEBS) in the planning process of the HPV demonstration at the district level. Ultimately the lack of coordination resulted in many schools and eligible children missing vaccination opportunities.

Low coverage was driven by problems with social mobilization for the demonstration.

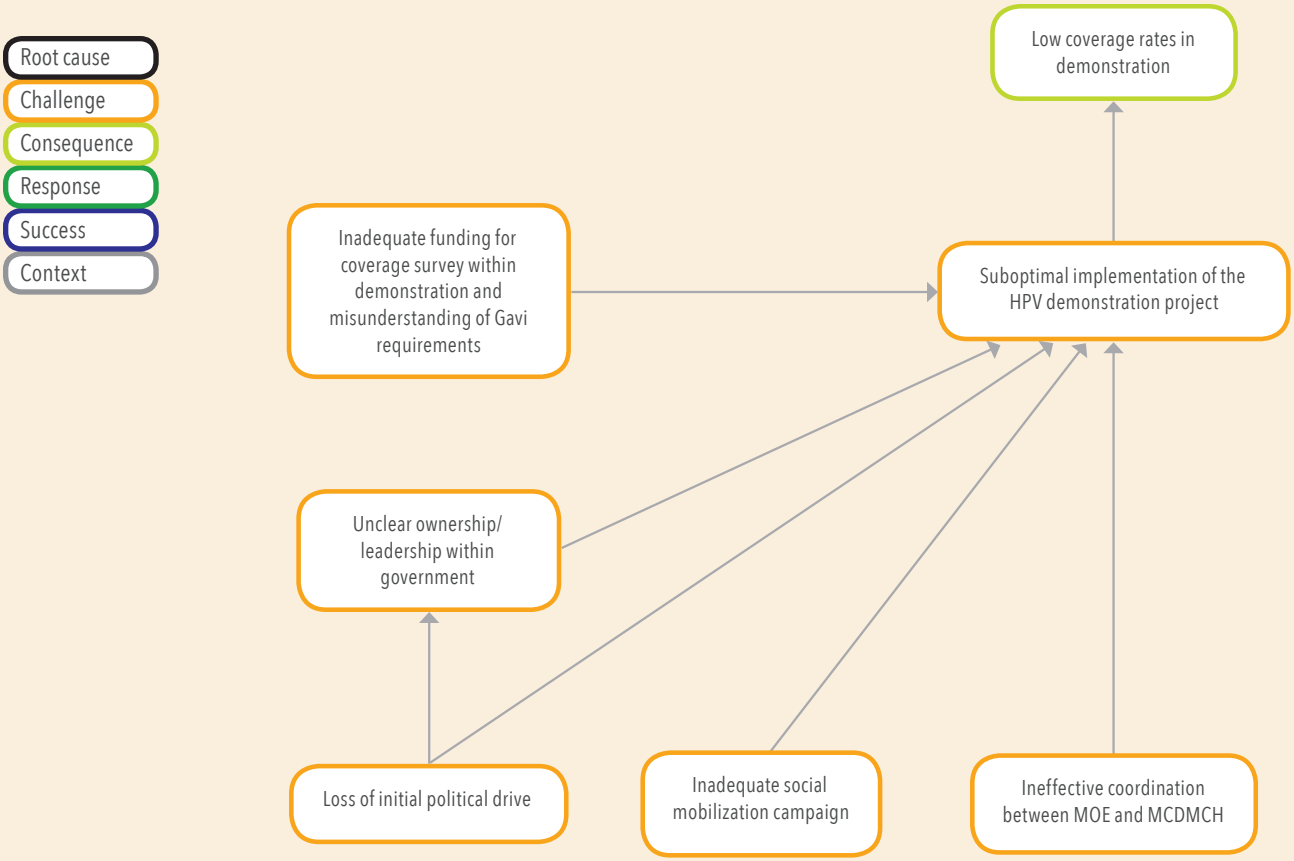
- The difficulty of targeting an older age group was exacerbated by cultural and religious misconceptions associated with the HPV vaccine, which were not sufficiently addressed in the social mobilization campaign.

Inadequate funding for the coverage survey contributed to suboptimal implementation of the HPV vaccine demonstration.

- An objective of the HPV demonstration was to meet Gavi requirements to apply for support for national HPV introduction. Gavi requirements for introduction included an HPV coverage survey.
- While the coverage survey is a required deliverable for Gavi-funded demonstration projects, it is not a requirement for national introduction.
- The lack of consistency between requirements for a Gavi-funded demonstration project (which did not apply to Zambia) and Gavi's requirements for national introduction were unclear to country stakeholders.
- As a result, the ministry understood a coverage survey to be a requirement to apply for national introduction and sought to identify funds.

Root cause analysis diagram for suboptimal HPV implementation

Ranking: B



RECOMMENDATION

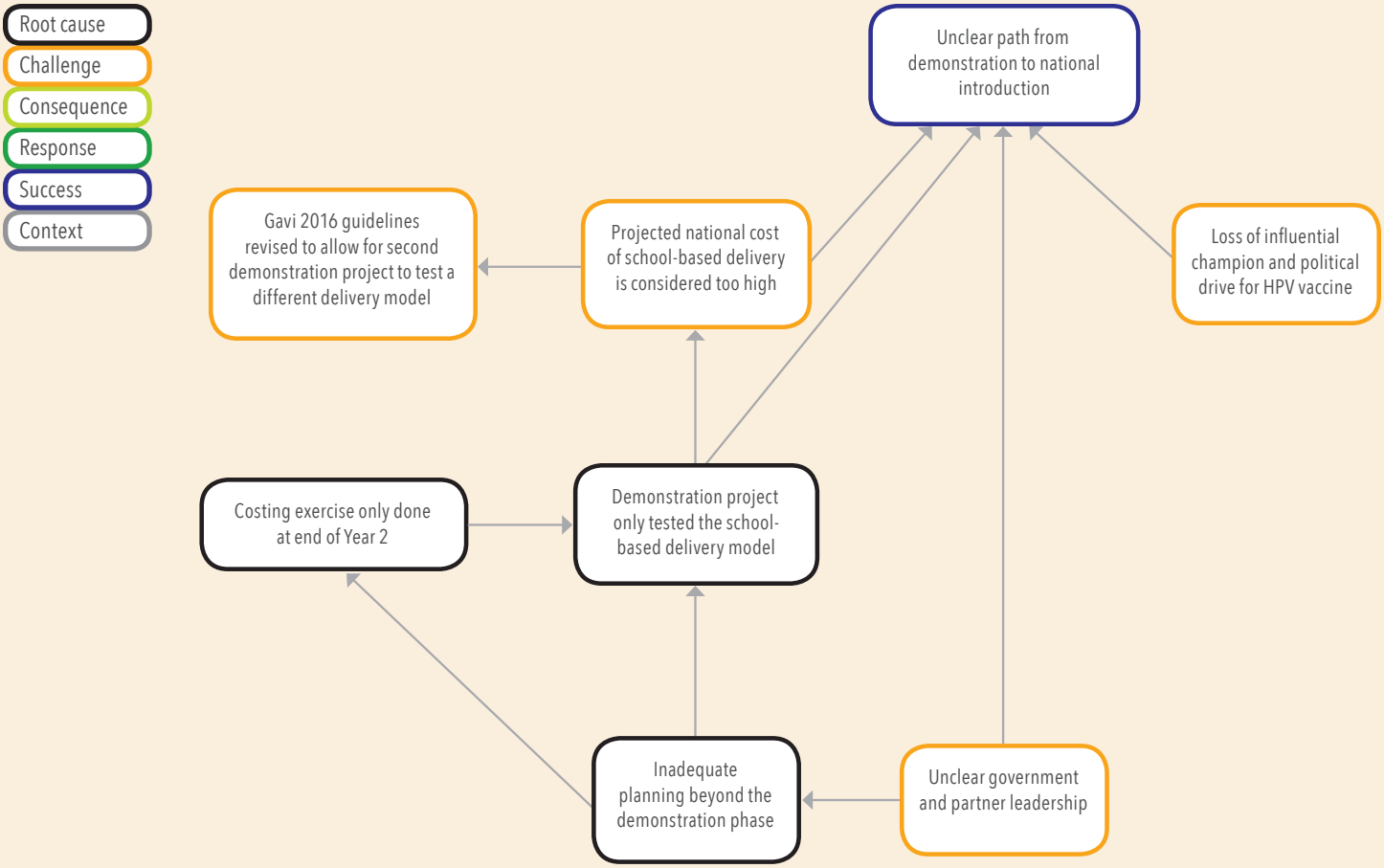
Gavi should clearly indicate differences in requirements for HPV vaccine demonstration projects and HPV vaccine national introduction for countries, particularly those undertaking demonstration projects supported by other funders.

FINDING 2

Testing only a single, school-based model, which was found to be financially unsustainable for national introduction following the demonstration project, has resulted in an unclear path toward national introduction of the HPV vaccine in Zambia. How the demonstration project informed national introduction needs was further limited by the costing analysis becoming available only at the end of the second year of the demonstration project.

Root cause analysis for unclear path from demonstration project to national introduction

Ranking: B



RECOMMENDATIONS

1. Demonstration projects should be designed to test different implementation models, thus allowing for a comparison of the relative merits of different models.

2. An important feature of demonstration projects, regardless of the source of support, is to learn and refine implementation over their duration. Ensuring that implementation is comprehensively reviewed in terms of financial sustainability, acceptability, and feasibility at the end of year one will allow adjustments to be made in year two to maximize the potential of demonstration projects to inform national scale-up.

3. Government and stakeholders need to focus on three main issues for readiness for HPV introduction: commitment of funding from government and partners for the chosen delivery model before commencement of activities; clear leadership and coordination roles; and clarity on which model will be used.

HEALTH SYSTEM strengthening

Zambia's HSS application was endorsed by the Inter-Agency Coordinating Committee (ICC) in early January 2015, prior to its submission later that month. The HSS proposal has evolved through several iterations since then:

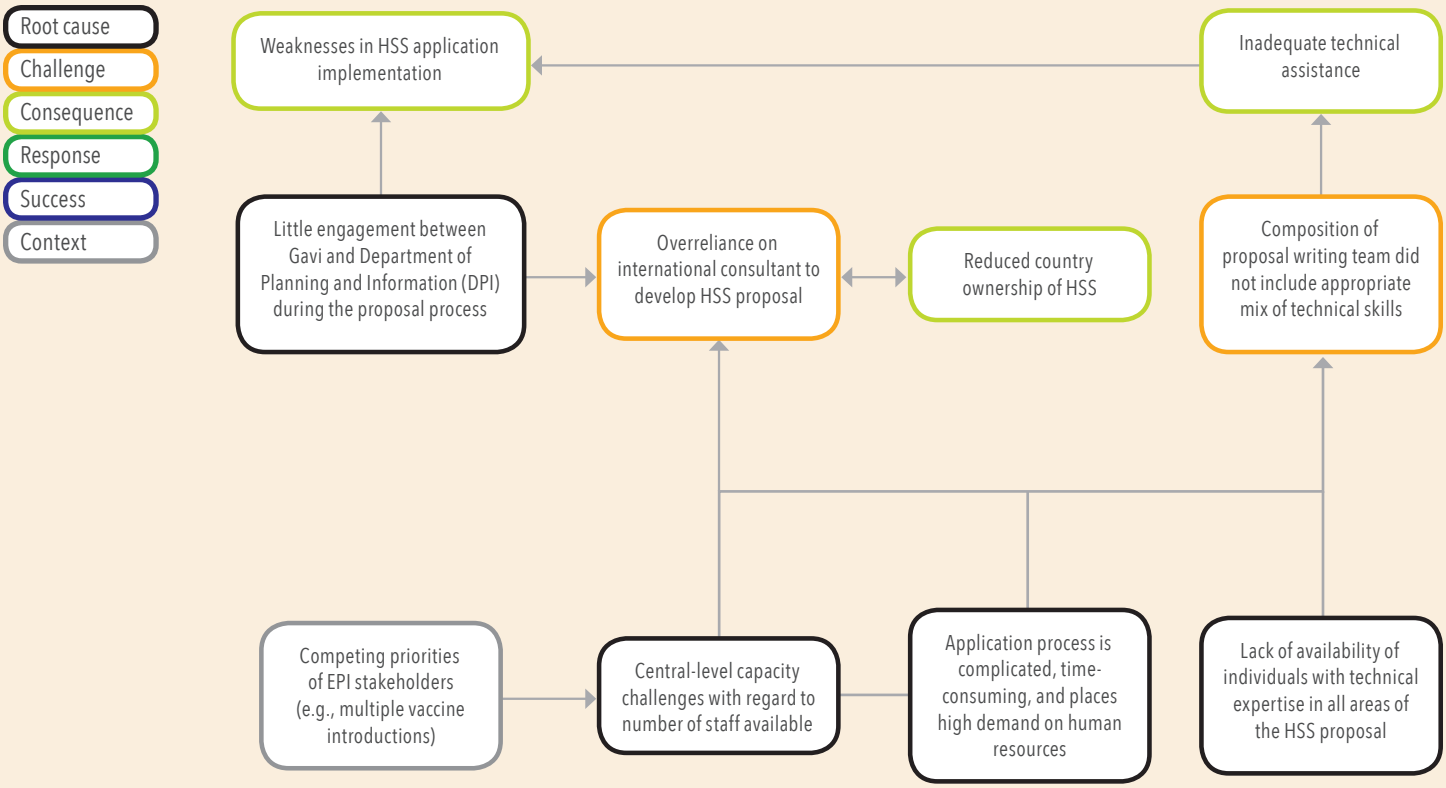
- In March, the Gavi Independent Review Committee (IRC) recommended resubmission of the HSS proposal due to (1) unclear alignment with the existing national health plans; (2) a weak M&E framework; (3) an inadequately described performance-based financing (PBF) plan; (4) unclear target district selection criteria; and (5) lack of clarity on division between national- and district-level expenditures.
- Revisions were made during weeklong meetings in July 2015 with stakeholders, including the application process's newly involved HSS focal person for the Department of Planning and Information (DPI). The revised proposal was endorsed by the ICC in September of 2015 and submitted to Gavi shortly thereafter.
- WHO pre-review prescribed additional proposal strengthening, and after meetings the country submitted the proposal again in October 2015. The country was awaiting IRC feedback at the time of reporting.

FINDING 1

The HSS application process was complicated, time-consuming, and strained existing capacity. There was overreliance on technical assistance provided mainly by short-term, external consultants during the writing process, which in turn limited country stakeholder participation and affected the quality of the proposal.

Root cause analysis for overreliance on international consultants to develop HSS proposal

Ranking: A



FINDING 2

The composition of the proposal development team did not include sufficient technical skills, contributing to weaknesses in some of the technical aspects of the proposal such as the M&E and PBF framework.

Ranking: A

The M&E capacity on the proposal team was inadequate during the January proposal submission and September resubmission.

- Although there was no representation from MoH in the initial application, the FCE team MCD-MCH requested for support from MoH-Directorate of Policy and Planning, However, inviting the MoH to attend HSS proposal writing meetings did not equate to specifically requesting assistance with M&E and budgeting.

- In the first phase of proposal development, there was no MOH representation. During the resubmission phase, the MOH sent an officer previously involved in the HSS proposal, but there was still no representation of the MOH M&E unit. The M&E capacity remained unchanged on resubmission, despite the emphasis placed on the M&E framework by the IRC recommendations.

FCE review, and WHO pre-review of resubmission as well as the IRC, showed that the M&E components have potential weak points, possibly stemming from the lack of additional capacity in M&E during the process.

- The M&E framework seems to be focused more on process indicators than outcome indicators.

- The proposal's M&E description lacked clear justification for the dedicated M&E budget.

- The HSS proposal focuses more on training rather than comprehensive improvement to the entire M&E system such as Information and Communications Technology (ICT) infrastructure and systems.

There was limited support from the World Bank PBF project for the PBF section of the proposal.

- The PBF section of the proposal is based the on the World Bank PBF project; however, the FCE observed that there was limited support to the proposal writing process from the World Bank PBF project.

- Designing a PBF component for the HSS required significant expertise and experience, which was not adequately available among the core proposal writing team.

RECOMMENDATIONS

1. Gavi should consider ways to simplify the HSS application process considering strained country capacity. Simplification should include (but is not limited to) a shorter proposal (comprised of fewer component parts) and greater clarity on the levels of detail required in each section. Gavi's efforts to provide guidance on the types of interventions most likely to contribute to increased coverage and equity are a useful step toward simplifying the overall design process but do not address the broader complexities of the application process.

2. The country and partners should identify TA needs and engage appropriate TA providers in a timely manner.

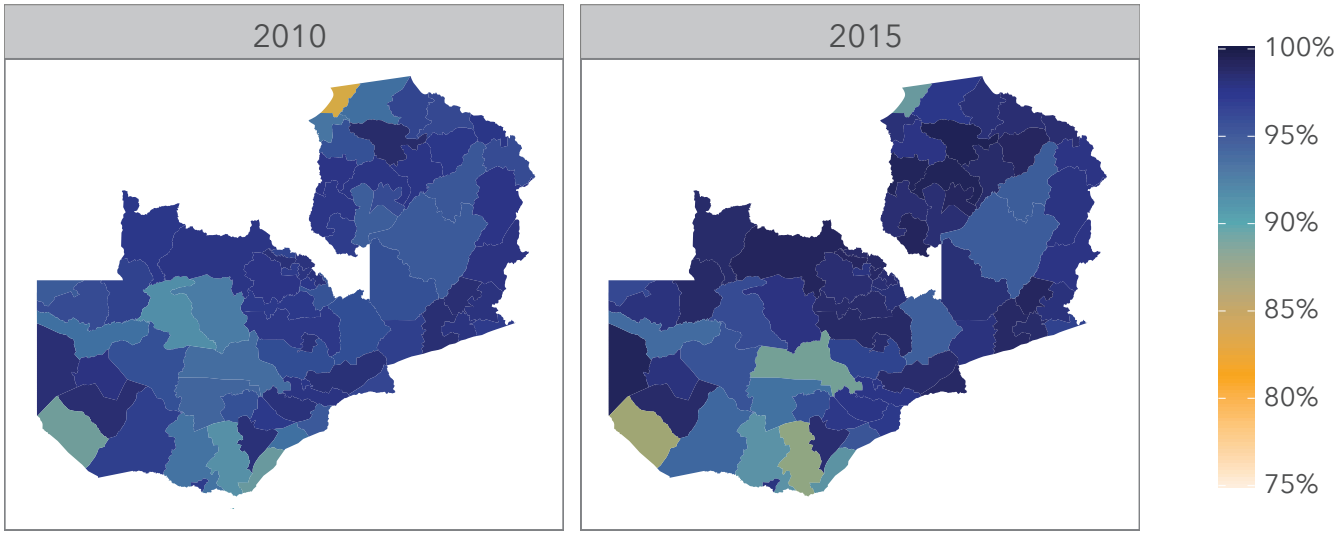
3. Gavi SCM should play a greater role in guiding the HSS proposal development process and supporting in-country TA providers.

FINDING 3

Although Gavi HSS has not been active in Zambia, significant increases in coverage of some vaccines have been observed in most districts in the country over the last five years. Understanding the drivers of these improvements will help to guide future immunization system strengthening investments. Furthermore, despite improvements, notable geographic inequality persists, and low-coverage districts should be targets of system-strengthening investments.

Ranking: B

Figure 6: Pentavalent three-dose coverage in Zambia, 2010 and 2015[1]



Despite the absence of a Gavi HSS grant in recent years (following the suspension of cash support), data suggest that Zambia made notable improvements in vaccine coverage, though inequities remain (Figure 6).

- There are significant improvements in vaccine coverage, particularly in provinces such as North-western and Luapula, between 2010 and 2015. This progress followed a period of decline in vaccine coverage in many areas that began in the mid-to-late 1990s.
- Geographic inequality in vaccine coverage persists, with a number of districts having coverage as low as 64%.

The FCE identified potential drivers of trends in subnational coverage:

- **Expansion of cold chain.** Significant cold-chain investments were made by partners including the Japan International Cooperation Agency (JICA), Centre for Infectious Disease Research in Zambia (CIDRZ), Canadian International Development Agency (CIDA), and WHO. Provincial cold-chain capacity was expanded in 2013, and expansions were extended to provincial and district cold chain in 2013 to 2014.
- **Performance-based funding.** With support from the World Bank, Zambia implemented a pilot PBF project at the district level between 2011 and 2014 that incentivized EPI outputs and aimed to improved immunization coverage.
- **Heightened policy focus on EPI.** This focus likely resulted from a ministerial realignment, with MCDMCH assuming maternal and child health programs in 2012. The realignment gave the CHU, and resultantly the EPI, elevated visibility under MCDMCH.

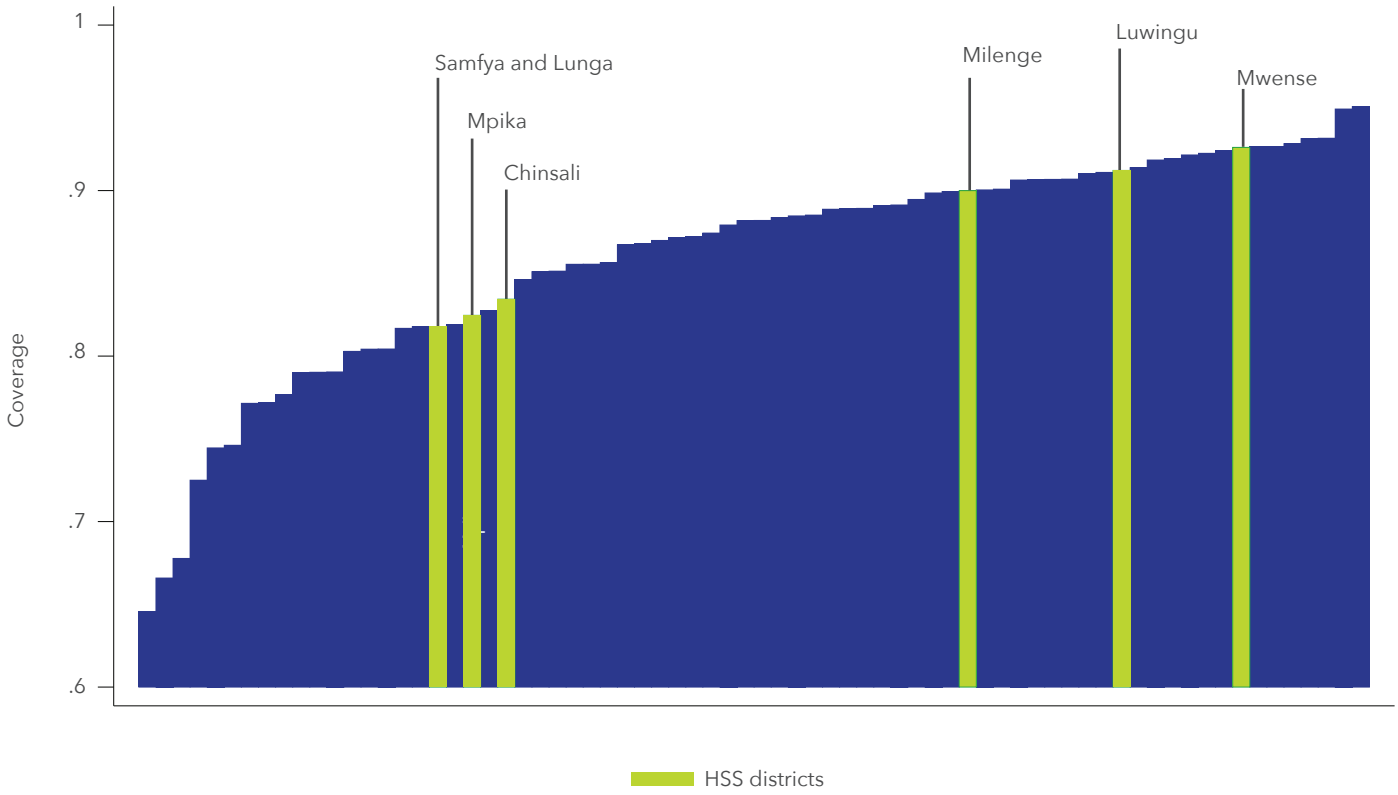
[1]These estimates incorporate the FCE's latest round of subnational estimates, data from a Gavi FCE survey conducted in 2015, and the recently released data from 2013-2014 Demographic and Health Survey.

- **Increased awareness of immunization at community level.** This is partly driven by the introduction of a number of new vaccines in the recent past, including PCV, rotavirus vaccine, and measles second dose, although it should be noted that the improvements in coverage largely predated the new vaccine introductions.

Low-coverage districts should be targets of system-strengthening investments. However, the seven districts selected for HSS support do not represent districts with the lowest vaccine coverage (Figure 7).

- Some districts were excluded because information suggested those districts were targeted for support for by other (i.e., non-Gavi) immunization and health system development partners in coming years. Other districts were excluded because of access concerns and poor performance with regard to other immunization indicators.
- Finally, there was a deliberate intention to have all the selected districts in one geographical region.
- Consequently, low-immunization coverage districts were left out on account of having support from other donors or being in good-performing regions.

Figure 7: Three-dose pentavalent vaccine coverage for all districts in Zambia, 2014



RECOMMENDATIONS

1. A comprehensive understanding of drivers of improvements in vaccine coverage observed over the last five years in Zambia will help to better target HSS investments.
2. Enhanced investments should be considered for districts with the lowest vaccine coverage (< 80% pentavalent three-dose coverage) in Zambia.

MEASLES-RUBELLA vaccine

Zambia's Gavi application to introduce measles-rubella (MR) vaccine proposes a campaign-based approach targeting 9-month- to 14-year-olds, followed by a national introduction in routine immunization services. The proposed MR campaign caters to a 2015 missed measles follow-up campaign.

Zambia submitted two separate proposals to Gavi: one for the campaign-based approach and the second for the national introduction. The MR national introduction and campaign plans and budgets were developed at an EPI Technical Working Group (TWG) in August 2015 with WHO, PATH, UNCIEF, MCDMCH, Zambia Medicines Regulatory Authority (ZAMRA), and CIDRZ, as well as a consultant from WHO's Inter-country Support Team (IST). Both MR proposals were discussed at the ICC meeting in September 2015. The MR campaign proposal and the introduction of MR into the routinized immunization proposal were endorsed by ICC members for submission to Gavi.

CROSS-STREAM analysis

FINANCIAL SUSTAINABILITY OF EPI IN ZAMBIA

FINDING 1

Zambia currently depends heavily on Gavi for funding immunization, particularly for new vaccines that have recently been introduced. As a transition country, the country's co-financing requirements will increase 15% annually for pentavalent, PCV, and rotavirus vaccine. We have noted a number of instances where there have been challenges in financing recent immunization activities. These cases raise concerns about Zambia's preparedness to transition off Gavi support.

Ranking: A

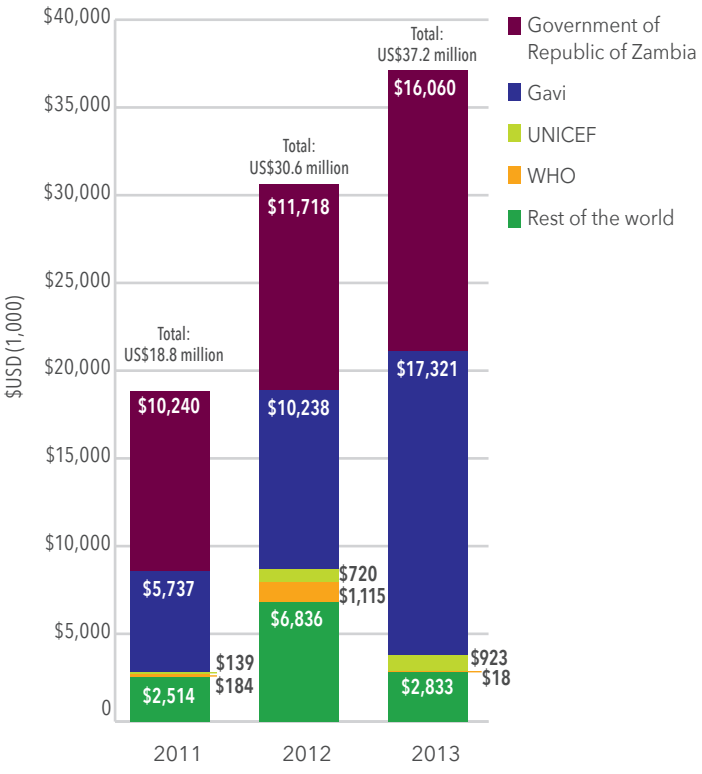
Expenditure on EPI is consistently increasing.

- Gavi FCE resource tracking indicates a 64% increase between 2011 and 2012 and a 27% increase between 2012 and 2013 (Figure 8).
- An increased number of vaccines and a growing population necessitate this increased expenditure.

Gavi and the government dominate EPI funding, which raises questions of sustainability.

- EPI funding is dominated by Zambia's government and Gavi, whose joint contribution makes up more than 80% of total funding.

Figure 8: Sources of funding for EPI between 2011 and 2013 in thousands of US dollars



- The proportion of Gavi funding has consistently increased, rising from 30% in 2011 to 33% in 2012 and 47% in 2013.
- There is a limited number of stakeholders on whom the government can rely in the absence of Gavi support.

Zambia's co-financing policy shifting raises questions about the government's ability to meet requirements.

- Zambia's contribution according to Gavi's co-financing policy will increase by 15% each year.
- Financing IPV preparatory activities and the HPV vaccine national introduction based on the tested school-based delivery model was a challenge.
- As Zambia moves toward graduation from Gavi support, the relatively limited diversity and proportional contribution of other donors for immunization may mean that donors are unlikely to fill the funding gap that would be left by Gavi.
- The dependence on external financing raises questions of financial sustainability in post-transition years.

Noted investments are required in key immunization system areas.

- There have been significant investments in cold chain, supported by donors, to allow for cold-chain expansion for new vaccines and to improve vaccine coverage. Consistent support over time is needed to maintain this.

TECHNICAL ASSISTANCE

Technical assistance (TA) to the EPI program has received increasing attention in Zambia, particularly as it relates to funding streams such as HSS, which demands much TA. WHO and UNICEF are the main Gavi partners tasked with providing TA to EPI in Zambia. This TA is provided either directly from their staff members with the required technical expertise or through hiring of consultants.

FINDING 2

With an increasing number of new vaccine introductions, programmatic capacity is strained in Zambia, which has led to reliance on technical assistance and support from partners. Technical assistance (TA) has not always been optimally provided due to a range of reasons, including limited capacity-building as part of TA provision, a restricted pool of TA providers that does not leverage local providers, and limitations in funding.

Capacity building is not yet a major focus of TA, particularly in the HSS application process.

- This may perpetuate the need for TA in the same areas, rather than build country capacity to manage these areas of need in the future.

There is a limited pool of identified TA providers; this stems from a largely untapped local capacity to provide TA outside of the usual EPI partners.

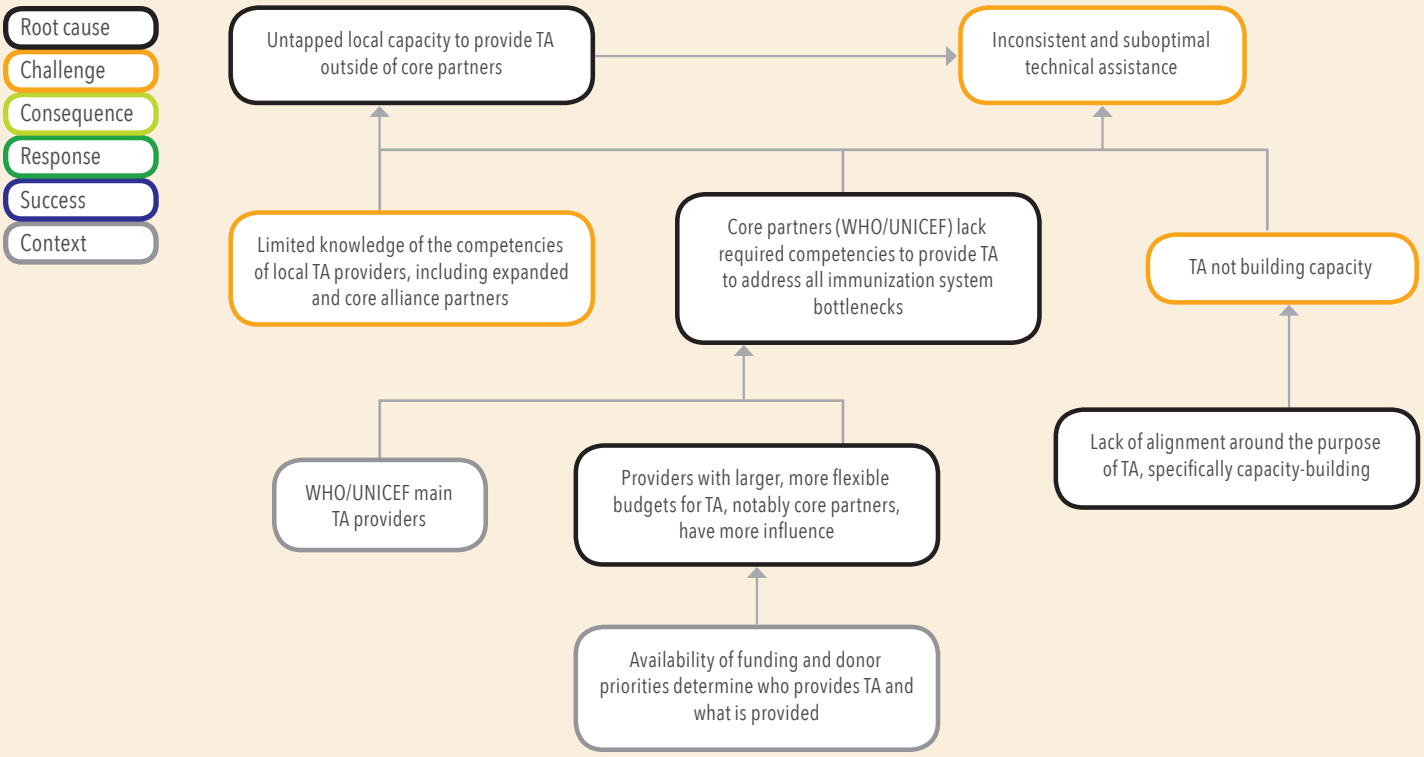
- Local stakeholder capacity is not well-mapped to identified TA providers. This is particularly important given Gavi's emphasis on the role of expanded partners in the PEF.
- Resorting to regional consultants hired through WHO and UNICEF may diminish the opportunities for local consultants to provide TA, which could have consequences for country ownership and sustainability.
- The full country report from the 2015 FCE Annual Report provides details on the network analysis of TA provision in Zambia.

Funding strongly determines who among the EPI partners provides TA and in what form.

- For example, WHO and UNICEF funding spans all funding streams, allowing these providers to offer TA in more areas than expanded partners.

Root cause analysis diagram for suboptimal TA

Ranking: B



INTER-AGENCY COORDINATING COMMITTEE

Established in 1999 and chaired by the Minister of the MCDMCH, ICC membership draws from agencies, partners, and key MCDMCH policy and technical staff. There were four ICC meetings in 2015, which accomplished final endorsements for HSS and MR proposals. The ICC has been discussing the implementation of HPV and IPV as well as finalization of the Joint Annual Review.

FINDING 3

The function of ICC is unclear to some stakeholders, leading to inadequate guidance and oversight over immunization activities in Zambia, which could potentially undermine the country's achievements with regard to the effectiveness of Expanded Programme on Immunizations (EPIs) and their sustainability.

Ranking: B

The ICC's role has expanded beyond its initial scope and there is a mismatch of expectations between Gavi and stakeholders about the role of the ICC.

- **Expansion of scope to maternal, newborn, and child health (MNCH) activities.** Though initially formed to advise on the immunization program, its role has expanded to focus on broader MNCH activities. One key informant reported:

  Having interacted with Gavi at global level and also at country level, it is clear that Gavi expectations of the countries' ICC are very high. Country realities are less ideal. ICC is not only for the EPI in the country and deals with other matters. Gavi still expects a lot from ICC, but ICC has changed from the original composition. (KII)

- **Expansion of role to reviewing and endorsing proposals.** The ICC Terms of Reference (TOR) constitute the ICC as an advisory body to support government in resource and partner mobilization for MNCH. In the absence of the more technical regulator, the ICC also plays the role of endorsing EPI-related activities like new vaccine introductions, program strengthening activities, mobilization of resources, advocacy, and monitoring and evaluation.

The expanded scope of work for the ICC could result in the ICC providing inadequate guidance and oversight, ultimately undermining the sustainability and effectiveness of EPI work.

- The ICC lacks the technical capacity to fulfill this expanded role, which leads to perceptions of inadequate performance.

- The ICC's dual function as a policy and technical body contributes to mismatched expectations of its role, which are further exacerbated by inconsistent meeting attendance by partners and a lack of critical feedback on key documents during meetings.

RECOMMENDATIONS

1. Government needs to develop a feasible transition plan with consultation with stakeholders, including MoF.

2. Mapping local technical capacity, and expansion in the pool of providers of TA, should be prioritized in order to optimize use of available resources and minimize dependence on external TA.

3. Providers of TA should provide clear statements indicating how assistance provided will contribute to building capacity.

4. Gavi and partners should ensure orientation of Gavi requirements for local TA providers in areas where they are expected to provide support to countries.

5. There is need to clarify the role of the ICC on EPI in terms of its policy versus technical input.