EURO HEALTH GROUP

Evaluation of Gavi's Initial Response to COVID-19

Final report
Volume II (Annexes)

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Annexes

This document is Vol. II of a final evaluation report produced by EHG on *Gavi's Initial Response to COVID-19.* The evaluation explores 21 Evaluation Questions (EQs), as set out in Annex 3. The evaluation report Vol. I is structured to maximize accessibility and use by our primary audience (Gavi staff) and secondary audience (Gavi Alliance partners), not by Evaluation Question; a mapping of EQs to report sections is provided in Annex 4 below. As such, and as requested by Gavi, Vol I. includes a 5-page executive summary, and a short report with key findings, conclusions and recommendations, which should be read in conjunction with Vol II. The Annexes in Vol II. provide supporting evidence and more detail on key findings.

1 Description of flexibilities available under R&P and M&R&S

We summarize below the flexibilities that Gavi introduced to respond to COVID-19, under the Respond and Protect (R&P) and Maintain Restore & Strengthen (M&R&S) initiatives.

Table 1: Flexibilities available under Respond and Protect (R&P)

Flexibility	Description
Reallocation of HSS (10%)	Countries were able to reprogramme current support. Up to $200m in total available across all countries (in transition and post-transition countries) with HSS grants in place.
Reallocation of PEF/TCA	All countries could apply for NCE and / or reallocation (same as reprogramming)
Eligibility freeze	To 'freeze' country eligibility in 2021 so that countries remain in their current (2020) phase. This addresses the inherent multi-year time lag in the underlying Gross National Income (GNI) data used to determine a country's eligibility and specific phase and the anticipated negative GDP growth because of COVID-19 pandemic. Related to eligibility freeze, other operational and programmatic flexibilities were introduced such as expired exceptional acceptance of mandatory country documents.
Co-financing waiver	Available on a case-by-case basis where there are specific indications of challenges in the fulfilment of 2020 obligations. This waiver would ensure that co-financing obligations do not hamper countries' efforts to tackle the pandemic.
Reallocation of post-transition support (using remaining HSS balances)	Transitioning/ transitioned countries with remaining HSS balances should be allowed to reallocate for COVID-19 as other countries. In addition, select Gavi-supported countries have access to Post-Transition Support.
Reprogramming of underspent VIG/Ops grants	We have not yet seen a written description of this flexibility. Our understanding is that all countries were able to transfer savings from other cash grants to HSIS reallocation for COVID-19 response.
Transition grant flexibility (extension and/or reallocation)	Flexibility to reallocate existing transition grants to support the Covid-19 response.

Table 2: Flexibilities available under Maintain Restore & Strengthen (M&R&S)

Flexibility	Description
HSS (25%)	Countries were able to reprogramme current support, or access up to 25% of the country's next HSS allocation ceiling.
Additional PEF/TCA	Additional TCA available until end of 2020 to enlist the support of local partners such as CSOs, faith-based organisations, humanitarian actors that bring the voices of marginalized communities to the table.
Additional vaccines	Not included in published M&R&S guidance, but Global KIs suggest this was a flexibility on offer.

2 Terms of reference

The following Terms of Reference (ToR) is taken from Gavi's request for proposals, and formed the basis for EHG's proposal and evaluation design.

1. Introduction

Gavi Alliance ("Gavi"), invites qualified bidders (herein after called "Bidder" or "Bidders") to submit offers, consisting of a technical and a financial offer, together with any supporting documents (herein after called the "Proposal" or "Proposals") for the provision of the requirements defined in this RFP document. In order to prepare a responsive Proposal, Bidders must carefully review and understand the contents of this covering letter, parts 1-6 of this RFP and the following key dates:

Procurement Activity	Responsible Party	Due Date
RFP Issue Date	Gavi	24 August 2021
Intent to Participate due	Bidder	07 September 2021
Final date for submitting Questions	Bidder	07 September 2021
Gavi Response to Questions	Gavi	14 September 2021
Bid submission deadline (CET)	Bidder	05 10 2021 24:00 (CET)
Shortlisted Meetings	Gavi/Bidder	18 October 2021
Estimated Contract Award Date	Gavi	25/10/2021
Estimated Contract Start Date	Gavi	15 November 2021

The proposed timeline set out above indicates the process Gavi intends to follow. If there are any changes to this time plan, Gavi will notify all Bidders of this in writing.

2. Gavi's Requirements

2.1 Background

Gavi Mission

To save children's lives and protect people's health by increasing access to immunisation in poor countries.

Gavi, the Vaccine Alliance is a public-private partnership that helps vaccinate half the world's children against some of the world's deadliest diseases. The Vaccine Alliance brings together developing country and donor governments, the World Health Organization, UNICEF, the World Bank, the vaccine industry, technical agencies, civil society, the Bill & Melinda Gates Foundation and other private sector partners. Since its inception in 2000, Gavi has helped immunise a whole generation – over 822 million children – and prevented more than 14 million deaths, helping to halve child mortality in 73 developing countries. Gavi also plays a key role in improving global health security by supporting health systems as well as funding global stockpiles for Ebola, cholera, meningitis and yellow fever vaccines. After two decades of progress, Gavi is now focused on protecting the next generation and reaching the unvaccinated children still being left behind, employing innovative finance and the latest technology – from drones to biometrics – to save millions more lives, prevent outbreaks before they can spread and help countries on the road to self-sufficiency.

Learn more at www.gavi.org .

Gavi Project

As the novel coronavirus (COVID-19) pandemic unfolded around the world, Gavi, the Vaccine Alliance initiated a rapid response aimed at supporting countries to safeguard and strengthen immunization programs. The focus of Gavi's support aimed at mitigating the immediate effects of COVID-19 on routine immunization, building and strengthening immunization services that sustainably reach children and communities who are missed by immunization and other critical health services exacerbated in the context of COVID-19 pandemic. The response was grounded in Gavi's 2021-2025 vision of "Leaving no one behind with immunisation" with equity as the organizing principle of the Alliance's work.

Gavi's initial (immediate and interim) response to COVID-19 pandemic fell in two buckets:

1. Respond and Protect:

In March 2020, the Gavi Board meeting agreed to allow flexibilities up to US$ 200 million of its funding for health systems to help countries respond to the acute phase COVID-19 pandemic. This included reallocating and reprograming up to 10% of existing Health System and Immunisation Strengthening (HSIS) grants, Partners' Engagement Framework (PEF), Targeted Country Assistance (TCA) and post transition support for response to the pandemic.
Other potential flexibilities approved at the March 2020 Board meeting included:

- Co-financing waivers: Gavi would allow waivers on a case-by-case basis where there are specific indications of challenges in the fulfilment of 2020 obligations. This waiver would ensure that co-financing obligations do not hamper countries' efforts to tackle the pandemic.

- Eligibility freezes: Another key flexibility was to 'freeze' country eligibility in 2021 so that countries remain in their current (2020) phase. This addresses the inherent multi-year time lag in the underlying Gross National Income (GNI) data used to determine a country's eligibility and specific phase and the anticipated negative GDP growth because of COVID-19 pandemic. Without this 'freeze' Gavi would be using 2019 GNI data, from before the onset of the pandemic, to determine 2021 eligibility.

  Related to this, other operational and programmatic flexibilities were introduced such as exceptional acceptance of mandatory country documents, e.g., countries whose comprehensive multi-year plans (cMYPs) were expiring in 2020 could still submit these cMYPs for various Gavi processes and applications while they worked on the new cMYPs.

This support also covered the immediate funding to health systems aimed at enabling countries to protect health care workers, perform vital surveillance and training, and purchase diagnostic tests. The specific areas of support under Respond and Protect included, but was not limited to[1]:

- Hygiene and infection control training for health workers
- Infection control supplies
- Surveillance activities and laboratory testing materials
- Risk and behavioural communication
- Community, civil society and/or media engagement
- Coordination and oversight

[1] https://www.gavi.org/sites/default/files/board/minutes/2020/19-march/04-Gavis-Engagement-on-COVID-19.pdf

Gavi introduced a fast-track application process and committed to review and approve all applications within five days of receipt[2].

2. Maintain, Restore, and Strengthen (M&R&S):

Gavi further extended its support beyond the immediate response to help countries maintain immunisation services during the pandemic and recover more quickly. Gavi support to Maintain, Restore and Strengthen routine immunization in countries aimed to help countries adapt and restart immunisation services; rebuild community trust and catch up those who have been missed both before and during the pandemic, while also investing in strengthening immunisation systems to be more resilient and responsive to the communities they serve. The guidance on use of Gavi support to Maintain, Restore and Strengthen immunization in the context of COVID-19 describes how Gavi support can be used for 12-18 months following the publication of these guidelines (October 2020).

The priority activities for Gavi support under M&R&S include: adapting services to deliver immunisation safely; monitoring and data management; catching up missed children, including those missed prior to the pandemic, primarily through routine immunisation; planning for increased integration across vaccines and with other Primary Health Care (PHC) interventions; addressing demand-side barriers, including caregiver trust; and introducing innovative approaches.

The specific efforts, include but are not limited to:

- HSIS flexibilities: No upper limit on reprogramming as long as there is a demonstrated need to do so and the funds are used for immunisation-specific activities in line with Gavi's existing guidance. In exceptional circumstances, where there were insufficient funds to be reprogrammed within a country's existing HSS grant, countries could access up to 25% of their next HSS allocation ceiling.

- Additional Targeted Country Assistance (TCA): Additional short-term catalytic TCA funding was made available to local partners in Gavi eligible countries through the PEF modality. This unique support was particularly prioritized for local partners in countries with clearly identified Technical Assistance (TA) needs aimed at strengthening community engagement to prevent backsliding of immunization and to support implementation of HSS support and respectively reprogrammed activities. This was made available until the end of 2020 to enlist the support of local partners such as CSOs, faith-based organizations, humanitarian actors to support implementation of activities to Maintain, Restore and Strengthen equitable immunisation by targeting marginalized communities.
    - Core Partners can reallocate or reprogramme their TCA support to address the needs of maintaining, restoring, and strengthening routine immunisation and should consider M&R&S needs when planning for new TCA for 2021.

All country requests would be subject to prior approval from the Secretariat and would be contingent on[3]:

- Conformity with WHO guidance on maintaining essential health services for the COVID-19 context and National Preparedness and Response Plans.

- Confirmation that funding is not available from other funding sources for the proposed activities (including inclusion of requested Gavi support into the country's resource mapping where feasible).

[3] https://www.gavi.org/sites/default/files/support/Gavi-Guidance-immunisation-during-COVID-19.pdf

- Robustness of proposed activities and accompanying budget, and alignment with agreed areas of support highlighted above.

Reporting and monitoring achievement for Maintain, Restore and Strengthen immunisation related activities occurred through the Grant Performance Framework (GPF) via the online Gavi Country Portal. The GPF guidelines describe the relevant metrics related to both vaccine and Health System and Immunisation Strengthening (HSIS) grants within the scope of reprogramming and/or new application in response to the flexibilities under Gavi's initial response to COVID-19.

The Gavi Secretariat is keen to ensure the successes, challenges and lessons learnt from Gavi's initial response to the COVID-19 pandemic are independently evaluated, both from a learning and an accountability perspective. The evaluation is intended to assess the design, implementation, and results and to describe the main successes, challenges and lessons learnt from Gavi's initial response to COVID-19.

2.2 Scope of Work

This evaluation will cover Gavi's initial response to COVID-19 under Respond and Protect and the design and roll out of M&R&S. The evaluation will examine M&R&S implementation since release of the guidance in October 2020. The evaluation is not intended to address any questions related to the COVAX Facility and COVAX AMC – these are being pursued through a separate evaluation.

The main objectives of this evaluation are:

- To assess the design, implementation process, efficiency and effectiveness of Respond and Protect (i.e. reprograming up to 10% of existing HSIS grants, PEF, TCA, post transition support, co-financing waiver, and eligibility freezes);

- To assess the design, implementation process, efficiency and effectiveness of M&R&S in terms of maintaining, restoring, and strengthening immunization services at country level;

- To describe the main successes, challenges and lessons learnt from Respond and Protect and M&R&S;

- To the extent possible, assess how effectively countries executed the flexibilities funds and how Gavi, the Vaccine Alliance mitigated risk.

The evaluation findings and recommendations are intended to inform ongoing programmatic initiatives to Maintain, Restore and Strengthen routine immunisation and inform the future direction of Gavi's response to epidemic/pandemic situations. The findings will also provide critical evidence to inform Gavi's mid-term evaluation to be completed by early 2023.

The primary audiences for this evaluation are the Gavi Board, Gavi Secretariat, Alliance partners and countries.

2.2 Evaluation questions:

Design and Planning:

1. To what extent did the design and planning of Gavi's Respond and Protect and Maintain, Restore and Strengthen:
    a) Lead to an initial response that was appropriate and fit for purpose?
    b) Adapt to changing context and needs as the epidemic progressed?

c) Fulfil the premise of flexibility to allow rapidly adapting programmatic, administrative, or financial processes to support Gavi countries in the context of the COVID-19 pandemic?
d) Align, complement, and link with Gavi policies and programmatic interventions (related to emergency preparedness and strategies to reach both newly and persistently missed communities) in a coherent manner and reflect country priorities?
e) Clearly articulate the rationale for exemptions/ exceptions granted to Gavi countries?
f) Demonstrate effective coordination and collaboration between Gavi Alliance Partners?
g) Clearly articulate the roles, responsibilities and coordinating mechanisms of Gavi Secretariat teams, Alliance partners and other agencies?
h) Align to Gavi's 5.0 strategic goals?

Implementation:

2. To what extent was Respond and Protect and M&R&S implemented as planned? Particular attention should be given to the following:
    a) How well, particularly in terms of timeliness and addressing priority needs, did the Gavi Secretariat respond in supporting countries to Respond and Protect, Maintain, Restore and Strengthen Routine Immunisation / ease disruption?
    b) To what extent was Gavi's Respond and Protect and M&R&S well communicated and understood by Gavi countries and Gavi partners?
    c) Whether/how quickly the streamlined processes and structures were in place to enable the response?
    d) What were the key challenges in implementing Respond and Protect and M&R&S and how were these addressed?
    e) How, and to what extent, did Gavi partners help address Gavi's challenges in regard to implementing the overall response?
    f) To what extent were Gavi's flexibilities accessible to all eligible countries and what was the experience of countries when accessing Gavi's flexibilities?
    g) To what extent, and how, did the Alliance coordinate its initial response to COVID-19 at the global and country levels including sharing of core information and data across partners, support to countries and communication with partners outside the Alliance?
    h) To what extent were the proposed activities in country requests targeted towards vulnerable children and communities who are missed by immunisation and other critical health services?

Results:

3. To what extent did Gavi's Respond and Protect and M&R&S achieve the intended objectives? Particular attention should be given to the following:
    a) To what extent did Gavi's immediate flexibilities (Respond and Protect) facilitate countries to institute appropriate measures to effectively respond to COVID-19 pandemic?
    b) To what extent did Gavi's response achieve the goals of Respond and Protect and Maintain, Restore and Strengthen?
    c) To what extent were the assumptions behind Gavi's Respond and Protect and M&R&S response to COVID-19 appropriate?
    d) To what extent were there a Theory of change and M&E framework in place to track results?

Lessons Learnt:

4. What are the key lessons learnt from the initial Gavi Alliance COVID-19 response?
    a) What lessons can be drawn to inform Gavi 5.0 operationalization, including for remaining responsive to the changing COVID-19 context and longer-term programming?
    b) What lessons can be drawn, both successes and challenges, from Gavi's Respond and Protect and M&R&S to inform future pandemic response?

c) What lessons can be drawn to inform Gavi's future engagement with partners and partnership coordination & support models to inform effective partner-led response in countries with other ad-hoc crises?

Bidders may refine and propose additional evaluation questions as part of their proposals, with justification.

2.3 Methodology

In order to respond to the above questions and provide useful, credible findings and recommendations, bidders are expected to employ a range of evaluation methods and to pursue innovation where appropriate.

A theory-based evaluation design is proposed. A theory of change should be developed to describe Gavi's initial response to COVID-19, and the underlying assumptions for this approach. Performance against the Theory of Change will be assessed, and the causal pathways and assumptions will be tested through a thorough document review; Key Informant Interviews (KIIs) within the Secretariat, Alliance, and the wider global health community; case studies, and/or other approaches as deemed necessary.

If case studies are used, a mix of countries with different size of COVID-19 infections or mortality should be considered to gather sufficient country perspectives. Further, a robust approach to analytic generalisation through theory, or alternative approach, is expected. Where case studies are proposed, bidders are encouraged to provide separate budgets for them.

In developing the lessons learnt, the evaluators would also seek to triangulate lessons learnt by the Gavi Secretariat with those learnt by the other Alliance partners and potentially other comparable actors (e.g, the Global Fund etc).

The evaluation design should be informed by the current context and the potential challenges this presents and should mitigate against identified risks/barriers to delivery.

2.4 Deliverables

The following deliverables shall be produced through the completing these tasks:

- Draft inception phase report including approach and methods, interview guides, a communication and learning plan for the evaluation, and a draft Theory of Change.
- Final Inception phase report with an executive summary as well as a finalized communication and learning plan, and a Theory of Change for the evaluation (word doc).
- Preliminary findings (slide deck and relevant annexes).
- Draft report 1 including executive summary (word doc).
- Revised draft report 1 including executive summary (format TBC).
- PowerPoint slide deck summarising the First Draft report, including draft recommendations.
- Facilitate recommendation cocreation meeting or learning workshop (TBD).
- Draft report 2 including executive summary (word doc).
- Draft final report (TBD).
- Final Report, with finalized Executive Summary and slide deck summarizing the Final Report.
- Draft Policy Brief summarising the main findings, lessons learnt and final recommendations.
- Final Policy Brief summarising the main findings, lessons learnt and final recommendations.

2.5 Key Dates

The following key dates apply:

Milestone/Deliverables	Due date	Assumptions
Bi-weekly update calls (including meeting minutes)	Bi-weekly throughout the evaluation	
Monthly Progress reports (Format TBD)	Monthly throughout the evaluation	
Milestone 1:		
Deliverable 1: Draft inception phase report including approach and methods, interview guides, a communication and learning plan for the evaluation, and a draft Theory of Change	03rd January 2022	To be reviewed by the Secretariat, Steering Committee and EAC
Deliverable 2: Steering Committee T/C engagement (with slide deck presentation)	w/c 17th January 2022 (TBC)	
Deliverable 3: Final inception phase report with an Executive Summary (format TBC) as well as finalized evaluation theory of change (word document)	07th February 2022	
Milestone 2:		
Deliverable 1: Preliminary findings (slide deck and relevant Annexes)	01st April 2022	
Deliverable 2: Draft Report 1 (word doc)	31st May 2022	To be reviewed by Secretariat
Deliverable 3: Revised Draft 1	28th June 2022	To be reviewed by Secretariat and Steering Committee
Deliverable 4: PowerPoint slide deck summarising the Revised Draft report, including draft recommendations	05th July 2022	Pre read for the Cocreation meeting
Deliverable 5: Facilitate recommendation cocreation meeting	w/c 11th July 2022 (TBC)	
Deliverable 6: Draft 2, with an Executive Summary (format TBC)	25th July 2022	To be reviewed by Secretariat and QA by EAC
Deliverable 6: Draft final	9th September 2022	To be reviewed by Secretariat
Deliverable 7: Final Report, with an Executive summary (word doc) and slide deck summarizing the Final Report	30th September 2022	Reviewed by Secretariat and assessed by EAC
Milestone 3:		
Deliverable 1: Draft Policy Brief summarising the main findings, lessons learnt and final recommendations	30th September 2022	Reviewed by Secretariat
Deliverable 2: Final Policy Brief summarising the main findings, lessons learnt and final recommendations	21st October 2022	
Deliverable 2: Presentations of Final Report at Gavi Secretariat (including slides)	21st October 2022	

2.6 Duration of the Work

The scope of work is expected to be finalised over the period from November 2021 to October 2022.

2.7 Location of the Work

The scope of work shall be performed at the Bidder's registered office, at Gavi offices or such other location as may be agreed to by Gavi and the successful applicant.

2.6 Work Context

The tasks shall be performed for The Evaluation and Learning Unit under the supervision of Gilbert Asiimwe, Programme Officer, and in collaboration with relevant internal and external stakeholders.

3 Evaluation matrix with evaluation questions

The table below provides the framework for exploring 21 Evaluation Questions (EQ) at the heart of our evaluation design. It includes information on methods for data collection and analysis, and data sources for each EQ.

Table 3: Evaluation questions for workstream 1

WS1 Right Design: To what extent was the design and planning of Gavi's Respond and Protect and Maintain, Restore and Strengthen interventions fit for purpose?						
Criteria	**Evaluation questions**	**Approach**	**Analytical methods**	**Data collection**	**Judgement criteria**	**Data sources (docs / KI category)**
Relevance	**EQ1** To what extent was the design and planning of flexibilities under R&P and M&R&S appropriate and fit for purpose in terms of providing sufficient flexibility to allow for timely repurposing of investments while staying true to the overriding objectives of Gavi?	TBE	• Thematic analysis (coding/ structured qualitative analysis of documents and interviews) • Contribution analysis • VfM analysis	• Global KIIs • Case studies • Doc review	• Evidence that interventions were in line with needs identified by key stakeholders (Gavi partners inc. WHO) • Evidence that flexibilities were available at the right time, equitably accessible to all countries in need, aligned with outstanding resource requirements etc. • Evidence of total resources invested by Gavi compared to other donors/global figures (broken down by region/country) • Evidence that flexibilities/funding filled key resource gaps not addressed by other sources • Evidence that quantity of resources made available was appropriate (in terms of amounts and in terms of reallocation away from other activities)	• Board reports • PPC reports • CEO reports • Funding flexibilities guidance and design documents • MSD reports • Quarterly CP reports • Quarterly monitoring reports • WHO guidance documents • WHO Partners platform global and in-country leads • WHO COVID-19 Strategic Preparedness and Response Plan – 2020 and 2021 editions • National COVID-19 response plans for case study countries KIIs: • Gavi secretariat (SCMs, Regional and Managing Directors, M&R&S TWG, Country finance, IF&S (Immunisation Financing & Sustainability), NITAG (National Immunisation TAG), FD&R (Funding Design and Review) team), HSIS Director, HSIS technical staff • Global & regional stakeholders (WHO, UNICEF, GF) • Country-level stakeholders (EPI managers, CSOs)
	EQ2 How and to what extent were interventions designed to support adaptation of programmatic, administrative, and/or financial processes as needed in the changing context of the COVID-19 pandemic?				• Evidence that programmatic, administrative and financial processes behind interventions were designed to be flexible (e.g., overall processes clearly outlined; risks and proposed mitigations to processes clearly outlined etc.) • Evidence of clear guidance on types of flexibilities included in R&P and M&R&S,	• Funding flexibilities internal guidance and design documents, SOPs etc. KIIs: • Gavi secretariat (Regional and Managing Directors, M&R&S TWG, IF&S (Immunisation Financing & Sustainability), NITAG (National Immunisation TAG), FD&R (Funding Design and Review) team), HSIS Director, HSIS technical staff

WS1 Right Design: To what extent was the design and planning of Gavi's Respond and Protect and Maintain, Restore and Strengthen interventions fit for purpose?						
Criteria	**Evaluation questions**	**Approach**	**Analytical methods**	**Data collection**	**Judgement criteria**	**Data sources (docs / KI category)**
	EQ3 How and to what extent was the rationale for exemptions/exception granted to Gavi countries clearly articulated? How and to what extent was the rationale for exemptions clearly articulated?				with documented rationale for exceptions	
	EQ4 To what extent were the allocation/mix of activities supported under R&P and M&R&S flexibilities (at country and aggregate level) strategically focused? (i.e., aligned with priority needs for mitigating COVID-19 impact)				• Evidence of alignment of activities supported with needs identified by WHO at global level (categorised against WHO COVID 19 preparedness and response plan 9 pillars and/or 143 recommended actions "drawn from the most up to date guidance created by international experts") • Evidence of alignment with Country COVID-19 response plans • Evidence of alignment of activities with Gavi's comparative advantages	• Board reports • PPC reports • CEO reports • MSD reports • Quarterly CP reports • Quarterly monitoring reports • WHO guidance documents • WHO Partners platform global and in-country leads • WHO COVID-19 Strategic Preparedness and Response Plan - 2020 and 2021 • National C-19 response plans for case study countries KIIs: • Gavi secretariat (SCMs, Regional and Managing Directors, M&R&S TWG, Country finance, NITAG (National Immunisation TAG), FD&R (Funding Design and Review) team), HSIS Director, HSIS technical staff • Global & regional stakeholders (WHO, UNICEF, GF) • Country-level stakeholders (EPI managers, CSOs)
Coherence	**EQ5** How and to what extent were interventions and the activities they supported designed to align, complement, and link with Gavi policies, programmatic interventions, 5.0 Goals (including emergency preparedness and strategies to reach both newly and persistently missed			• Global KIIs • Case studies • Doc review	• Evidence of alignment with Gavi policy/program documents • Evidence of alignment R&P and MR&S with 5.0 goals • Evidence of alignment with Gavi gender policy and other GESI considerations • Evidence of consideration (in design of R&P and MR&S) of UN Secretary general's directive: "A disability-inclusive response to covid 19" and/or	• Board papers • PPC papers • Gavi Policy and Strategy documents (inc. Gender Policy, 5.0 strategy) • R&P and MR&S guidance documents KIIs: • Gavi secretariat (SCMs, M&R&S TWG, IF&S, HSIS Director/Senior Management. Steering Committee) • Global & regional stakeholders (WHO, UNICEF, GF) • Country-level stakeholders (EPI managers)

WS1 Right Design: To what extent was the design and planning of Gavi's Respond and Protect and Maintain, Restore and Strengthen interventions fit for purpose?						
Criteria	**Evaluation questions**	**Approach**	**Analytical methods**	**Data collection**	**Judgement criteria**	**Data sources (docs / KI category)**
	communities) and Gavi's comparative advantages?				consideration/involvement with covid 19 gender working group	
	EQ6 How and to what extent were interventions designed to contribute to a coherent, coordinated response by Gavi Alliance Partners?			• Global KIIs • Case studies • Doc review	• Evidence of well-planned and clearly articulated (written) roles, responsibilities and coordinating mechanisms across teams, partners and other agencies • Evidence that R&P and M&R&S were informed by/joined up with the WHO Partners Forum, and integrated into a costed Covid 19 preparedness plan	• Board papers • PPC papers • Minutes from partner meetings/forums • Coordination mechanism SOPs, TORs etc. KIIs: • Gavi secretariat (Regional and Managing Directors, MR&S TWG, Country finance, HSIS Director, HSIS technical staff • Global & regional stakeholders (WHO, UNICEF, GF)

Table 4: Evaluation questions for workstream 2

	WS2 Right Ways: How well has Gavi's initial response to COVID-19 been implemented?					
Criteria	**Evaluation questions**	**Approach**	**Analytical methods**	**Data collection**	**Judgement criteria**	**Data sources (docs / KI category)**
Timeliness/ Efficiency	**EQ7** To what extent were Gavi's flexibilities (inc. exemptions) accessible to all eligible countries, and what was the experience of countries when accessing Gavi's flexibilities? How did it compare to accessing funds from various sources? (I.e., amounts $ accessed, ease of access, timeliness of access (securing approvals, funds transfer), reporting requirements?		• Thematic analysis • VfM analysis (Efficiency) • Cross-case analysis	• Global KIIs • Case studies • Doc review	• Evidence on types of COVID-19 support (including exemptions) accessed by respective Gavi countries through R&P and M&R&S • Evidence of time it took Gavi to respond to countries' requests (noting 5-day target) • Evidence of time taken to disburse funds to countries • Evidence of time taken to set up any governance/ management processes and structures • Evidence of degree of alignment of processes and structures, staffing levels with industry benchmark standards (VFM efficiency) • Evidence of Gavi having applied its risk mitigation approach4 for R&P and M&R&S	• Board reports March 2020 onwards & PPC reports May 2020 onwards • MR&S Review Oct 2021 • Pulse surveys and country reports • CP tracker • COVID19 Situation reports • MSD reports • Country Programmes (CP) Quarterly reports • Risk and Assurance Reports 2020 and 2021 • CP Grant Operation Manual KIIs: • Gavi Sec. MR&S: Country Support (SCMs, RHs), FD&R, PEF, HSIS. • Gavi Sec. R&P – CS and HSIS teams • Country case studies: SCMs (implementing partners – MoH IPs, CSOs), technical and financing partners at country levels • Global level: Gavi partners (WHO, UNICEF, WB, other donors)

[4] As outlined in Gavi's risk management approach Risk management (gavi.org)

	WS2 Right Ways: How well has Gavi's initial response to COVID-19 been implemented?					
Criteria	**Evaluation questions**	**Approach**	**Analytical methods**	**Data collection**	**Judgement criteria**	**Data sources (docs / KI category)**
	EQ8 How well, particularly in terms of timeliness and addressing priority needs, did the Gavi Secretariat respond in supporting countries to R&P, M&R&S, Routine Immunisation/ ease disruption? To what extent/how quickly were the streamlined processes and structures in place to enable the response? **EQ9** To what extent did the allocation of Gavi spending under the two components reflect a strategic focus on spending in support of a coherent response to COVID-19, with a view to ensuring the economy, efficiency and effectiveness? **EQ10** Were any unintended consequences (positive and/or negative) experienced (e.g., by implementers in countries, by Gavi Secretariat, by Gavi partners) because of Gavi's R&P and/or M&R&S response?				• Evidence that Gavi's response was well communicated and understood by Gavi countries and Gavi partners. • Degree of efficiency of decision-making processes (e.g., number of steps, approvals involved) (against industry standards) (VfM efficiency) • Evidence of response being changed to meet evolving needs as the epidemic progressed (responsiveness and adaptation to needs) • Evidence of countries using Gavi funds to fill real gaps and needs (VfM efficiency)	
Coordination	**EQ11** How did coordination with country and global partners	Process Evaluation	• Thematic analysis • Cross-case analysis	• Global KIIs • Case studies	• Availability and clarity of guidance documentation shared with countries, Alliance partners and non-partners	• PPC and Board reports (e.g., May 2020 PPC report on UNICEF collaboration) • QMS reports (Jan and June 2021) • Data from WHO Partners Platform

	WS2 Right Ways: How well has Gavi's initial response to COVID-19 been implemented?					
Criteria	**Evaluation questions**	**Approach**	**Analytical methods**	**Data collection**	**Judgement criteria**	**Data sources (docs / KI category)**
	materialise in practice,[5] and how effective did this prove to be?		•	• Doc review	• Evidence of coordination mechanism/platforms being adapted or set up and/or used at global and country levels • Evidence of data being shared with different partners • Evidence that coordination mechanisms evolved to changing needs	• KIIs: • Regional heads and SCMs • UNICEF, WHO, WB global focal points for Gavi • Country level UNICEF, WHO, WB, other donors and CSO reps in countries selected for case studies • WHO Partners Platform leads
Challenges	**EQ12** What were the key challenges experienced in implementing R&P, and M&R&S, and how were these addressed?	Process Evaluation	• Thematic analysis • Cross-case analysis	• Global KIIs • Case studies • Doc review	• Evidence of documentation of challenges and discussion around how to overcome them. • Evidence of partners' engagement in discussion and/or response to challenges arisen.	• QMS reports Jan and June 2021 • CP Quarterly reports (have specific section on challenges and risks KIIs • Gavi Sec. MR&S: Vaccine Implementation (co-lead) + CP- HSIS, PF, CS) + CMM + PEF + FD&R/PPE)? • Gavi Sec. R&P: CS + CMM + PEF + Cross cutting project team • Country case studies: SCMs (implementing partners – MoH IPs, CSOs), technical and financing partners at country levels • Global level: Gavi partners (WHO, UNICEF, WB, other donors)
GESI	**EQ13** To what extent was the implementation/delivery of interventions responsive to GESI considerations?	Process Evaluation	• Thematic analysis • Cross-case analysis • VfM analysis (Equity) •	• Global KIIs • Case studies • Doc review	• Evidence to show countries have used funds in alignment with GESI guidance shared with countries • Evidence that flexibilities and exemptions available/given were transparently/equitably offered/given • Extent to which the proposed activities in country requests targeted vulnerable children and communities who are missed by immunisation and other critical health services	• EHG analysis of activities supported with flexibilities • QMR reports share efforts to reach missed children, reach vulnerable pops • M&R&S review 2021 notes country innovation examples to reach ZD • Innovations catalogue (Aug 2020) pre-dates M&R&S and features section d on reaching missed communities – have any of these examples been used by countries? KIIs: • Regional Heads, SCMs in countries selected for country case studies, plus country implementers.

[5] Global partners would include, UNICEF, WHO, and other donors supporting a COVID response like WB, DFID etc and country partners would include e.g., MoH IP teams, UNICEF, CSOs supporting implementation efforts

Table 5: Evaluation questions for workstream 3 ***WS3 Right Results: To what extent Gavi initial response to COVID-19 has contributed to the right results?***						
Criteria	***Evaluation questions***	***Approach***	***Analytical methods***	***Data collection***	**Judgement criteria**	**Data sources (docs / KI category)**
M&E framework	**EQ14** To what extent was there a Theory of Change and M&E framework in place to track results? Were these fit for purpose?	TBE	• Thematic analysis • Contribution Analysis • Cross-case analysis • VfM analysis (Effectiveness, Equity) •	• Global KIIs • Case studies • Doc review	• Presence of a ToC including assumptions, shared and validated with main stakeholders involved, linked to the M&E framework • Shared understanding of what appropriate to track to measure success / progress • Presence / use of an M&E framework with SMART indicators, able to pick up on relevant dimensions	• COVID-19 Monitoring & Learning Overview • Grant Performance framework • Country Programmes Quarterly reports • Quarterly monitoring meetings with SCM if documented? • COVID-19 Impact and COVAX delivery tracking parameters • Monthly Situation reports • MSD reports • Implementation Monitoring Review (IMR) weekly reports • COVID-19 Country Readiness and Delivery (CRD) KIIs • Gavi (data/M&E teams, SCMs, IFS team, Country Programmes)
Effectiveness	**EQ15** To what extent did Gavi's immediate flexibilities (under Respond and Protect) plausibly contributed to countries being able to carry out critical COVID-19 interventions (in line with WHO guidance and country requirements) in a timely fashion? **EQ16** To what extent did Gavi's response through M&R&S plausibly contribute to countries being able to adapt RI activities to the COVID-19 context to design new/ innovative ways of reaching vulnerable populations? **EQ17** To what extent were the assumptions behind Gavi's Respond and Protect and M&R&S response to COVID-19 valid?	TBE	• Thematic analysis • Contribution Analysis • Cross-case analysis • VfM analysis (Cost effectiveness)	• Global KIIs • Case studies • Doc review	• Effectiveness of measures put in place by countries to respond to COVID-19 thanks to Gavi flexibilities under R&P • Evidence of various flexibilities helping countries overcoming / tackling additional challenges (including financial) posed by COVID-19 and related PH measures to RI and resuming / catching up on RI • Evidence against main assumptions – main assumption being perhaps that it was inevitable that 'millions of people in Gavi- supported countries will miss out on immunisation due to COVID-19' (strategy & implications) – risking resurgence of VPD and outbreaks (Alliance update) • Cost/ management overhead in Gavi to implement R&P and MR&S (important to compare this against the "benefit" that these flexibilities provided)	• Monthly Situation reports • Coverage data-WHO-UNICEF vaccination coverage estimates (WUENIC and DHIS) • UNICEF Global Dashboard (on stocks) • WHO pulse survey on continuity of essential health services during the COVID-19 and immunisation dashboards? • RI demand trend data (Continuous PREMISE Demand Survey) • Vaccine Preventable Death (VPD) outbreaks • KIIs with Gavi (data/M&E teams, SCMs, Country Support.); WHO, UNICEF, country stakeholders (Covid response, EPI, ICC/NITAG, MOH. Incl. DPs)

GESI	**EQ18** To what extent the results of Gavi's initial response to COVID-19 are equitably distributed?	TBE	• Thematic analysis • Cross-case analysis • VfM analysis (Equity)	• Global KIIs • Case studies • Doc review	• What difference R&P measures made for different genders and other groups. • Disaggregated coverage results (by region and other relevant characteristics if data is available (incl. on zero dose children and children from marginalised communities) in Gavi countries (current vs pre COVID-19) • Extent to which Gavi has supported countries achieving equitable results / narrowing any growing inequalities in relations to RI due to COVID-19	See above KIIs • Gavi (data/M&E teams, SCMs, Head of Country Programmes); WHO, UNICEF, country stakeholders (Covid response, EPI, ICC/NITAG, MOH.. incl. DPs)

Table 6: Evaluation questions for workstream 4

WS4 Lessons learnt: What are the key lessons learned from the initial Gavi Alliance COVID-19 response?							
		Evaluation questions	***Approach***	***Analytical methods***	***Data collection***	**Judgement criteria**	**Data sources (docs / KI category)**
Criteria	**Lessons**	**EQ19** What lessons can Gavi learn that would benefit operationalisation of Gavi 5.0 including how to remain responsive to the changing COVID-19 context and for longer-term programming? **EQ20** What lessons can Gavi learn from Gavi's Respond and Protect and M&R&S that could inform Gavi's response to future pandemics? **EQ21** What lessons can Gavi learn from Gavi's partnership approach during its COVID-19 response that could inform a more effective partner-led response in countries experiencing other crises (including engagement with partners and partnership coordination & support models)	Builds on other WS approaches; mapping EQs from WS 1 to 3 against these EQs and seeing where data gaps are likely to be (I.e., new Qs to add to KIIs); using co-creation workshop to identify lessons learnt by Gavi	• Thematic analysis – gap analysis against relevant models, if not already being used by other WS leads • Builds on and synthesises findings from other workstreams; ideally involve Gavi Evaluation Team in lesson identification/ validation • Presenting as a set of lesson headlines (with illustrative stories) that cover the three areas of interest in the EQs: Keeping Gavi 5.0 on track; Responding to future pandemics; Working effectively with partners in countries experiencing crises. • Use Davies' advice on identifying Lessons Learnt Link Davies	• Global KIIs • Case studies • Doc review • Comparator study • Co-creation workshop	4.1 - Extent to which Gavi's approach to adapting Gavi 5.0 follows good practice in adaptive programming; relevance of lessons learnt to 12 objectives of Gavi 5.0; 4.2 - Extent to which Gavi's response to Covid-19 follows good practice in pandemic preparedness; relevance of lessons learnt to categories of risk in Risk Appetite. 4.3 - Extent to which Gavi's partnership approach enables public health emergency preparedness; relevance of lessons to Gavi's partnership priorities	Docs - Internal reviews of learning/AARs, reports to the Board; Alliance members' reviews; findings from WS 1 and 2 primarily, and comparator studies; co-creation workshop.

4 Mapping evaluation questions onto report sections

We have structured the report to maximise accessibility and use by our primary audience (Gavi staff) and secondary audience (Alliance partners), not by Evaluation Question; a mapping of EQs to report sections is provided below.

Table 7: Mapping of EQs in report sections

Evaluation question	Vol I.	Vol. II
	Where addressed	
Workstream 1: What flexibilities were offered and why?		
EQ1 To what extent was the design and planning of flexibilities under R&P and M&R&S appropriate and fit for purpose (in terms of accessibility, timeliness, meeting resource needs etc)?	**4.1.1 4.1.2 4.1.3**	**Annex 9.2, 9.4**
EQ2 How and to what extent were interventions designed to support adaptation of programmatic, administrative, and/or financial processes as needed in the changing context of the COVID-19 pandemic?	**4.1.1 4.3.1**	**Annex 9.2**
EQ3 How and to what extent was the rationale for flexibilities including any exemptions/exception granted to Gavi countries clearly articulated?	**4.1.1 4.3.1**	**Annex 9.2**
EQ4 To what extent were the allocation/mix of activities supported under R&P and M&R&S flexibilities (at country and aggregate level) strategically focused (i.e., aligned with priority needs for mitigating COVID-19 impact on RI)?	**4.2.3**	**Annex 9.3**
EQ5 How and to what extent were interventions and the activities they supported designed to align, complement, and link with Gavi policies, programmatic interventions, 5.0 Goals (including emergency preparedness and strategies to reach both newly and persistently missed communities) and Gavi's comparative advantages?	**4.1.2 4.1.3**	**Annex 9.1, 9.4**
EQ6 How and to what extent were interventions designed to contribute to a coherent, coordinated response by Gavi Alliance Partners?	**4.1.3 4.2.7.2**	**Annex 12**
Workstream 2: How well were these implemented?		
EQ7 To what extent were Gavi's flexibilities (inc. exemptions) accessible to all eligible countries, and what was the experience of countries when accessing Gavi's flexibilities? How did it compare to accessing funds from various sources (i.e., amounts $ accessed, ease of access, timeliness of access (securing approvals, funds transfer), reporting requirements)?	**4.2.1 4.2.2 4.2.3 4.2.4 4.2.5 4.2.6 4.2.8.1 4.2.9 4.3.4**	**Annex 10, Annex 14**
EQ8 How timely and appropriate were Gavi processes and structures put in place to manage R&P and M&R&S??	**4.2.7 4.2.8.2**	**Annex 10**
EQ9 What was Gavi R&P and M&R&S funding spent on and what evidence is there of this expenditure met priority needs and was spent with economy and efficiency in mind?	**1. What was R&P and MRS spent on? See 4.2 of Vol I and more detail in the charts in section 10 of Vol II 2. Did the expenditure meet priority needs? 4.1.3 of Vol I and in Vol II: 11.17 on uptake and 11.18 absorption (uptake**	

Evaluation question	Vol I.	Vol. II
	and absorption are proxies for whether it met country needs/had utility) 3. Was spent with economy and efficiency in mind? Vol I 4.2.7 (approvals/disbursement i.e., use of funds in timely and efficient/VfM manner) and 11.20 and 11.21 in Vol II	
EQ10 Were any unintended consequences (positive and/or negative) experienced (e.g., by implementers in countries, by Gavi Secretariat, by Gavi partners) because of Gavi's R&P and/or M&R&S response?	**Box 13 4.3.4**	
EQ11 How did coordination with country and global partners materialise in practice, and how effective did this prove to be?	**4.1.3 Box 8**	**Annex 12**
EQ12 What were the key challenges experienced in implementing R&P and M&R&S, and how were these addressed?	**4.2.9**	
EQ13 To what extent was the implementation/delivery of interventions responsive to GESI considerations?	**4.2.9.6**	**Annex 13.8**
Workstream 3: With what results?		
EQ14 To what extent was there a Theory of change and M&E framework in place to track results? Were these fit for purpose?	**4.3.1**	
EQ15 To what extent did Gavi's immediate flexibilities (under R&P) plausibly contribute to countries being able to carry out critical COVID-19 interventions (in line with WHO guidance and country requirements) in a timely fashion?	**4.3.2 4.3.4**	**Annex 13.3 and 13.7**
EQ16 To what extent did Gavi's response through M&R&S plausibly contribute to countries being able to adapt RI activities to the COVID-19 context and to design new/ innovative and/or more efficient ways of reaching vulnerable populations?	**4.3.2 4.3.4**	**Annex 13.4 and 13.5 and 13.7**
EQ17 To what extent were the assumptions behind Gavi's R&P and M&R&S response to COVID-19 valid?	**4.3.4**	**Annex 13.6**
EQ18 To what extent the results of Gavi's initial response to COVID-19 are equitably distributed?	**4.3.3**	**Annex 13.8**
Workstream 4: What lessons can Gavi learn?	**Section 6**	
EQ19 What lessons can Gavi learn that would benefit operationalisation of Gavi 5.0 including how to remain responsive to the changing COVID-19 context and for longer-term programming?	**Section 6**	
EQ20 What lessons can Gavi learn from Gavi's R&P and M&R&S that could inform Gavi's response to future pandemics?	**Section 6**	
EQ21 What lessons can Gavi learn from Gavi's partnership approach during its COVID-19 response that could inform a more effective partner-led response in countries experiencing other crises (including engagement with partners and partnership coordination & support models)?	**Section 6**	

5 Evaluation Methodology & limitations

Annex 5 provides a summary of the evaluation methodology and any limitations and biases that are important to bear in mind when interpreting findings; a full description is included in the Inception report of 11 March 2022 Vol. I, Section 3. Annex 5 also includes a summary of the theory of action that has been explored through the evaluation process (Annex 5.1), information on who conducted the evaluation (Annex 5.2), and a Use and Influence Plan (Annex 5.3).

Purpose, objectives and scope

The evaluation is of high strategic importance to the Gavi Board, given both the nature and specific challenges presented by COVID-19 and the need to assemble a robust evidence base as a key foundation for the Mid-Term Evaluation (MTE) of Gavi 5.0 that was planned for and started in late 2022. The evaluation has both a **summative component**, looking at Gavi's initial response to COVID-19 under **Respond and Protect** (March to November 2020) and a **formative component**, focusing on the design and roll out of **M&R&S** which started in October 2020 with interventions ongoing up to March 2022.[6] As such, the main objectives of this evaluation are:

- To assess the design, implementation process, efficiency and effectiveness of R&P;
- To assess the design, implementation process, efficiency and effectiveness of M&R&S in terms of maintaining, restoring, and strengthening immunisation services at country level;
- To describe the main successes, challenges and lessons learnt from R&P and M&R&S;
- To the extent possible, assess how effectively countries executed the flexibilities funds and how Gavi mitigated risk.

In addressing these objectives, we primarily looked at the extent to which R&P enabled countries to implement their intended interventions to respond to COVID-19, and M&R&S enabled countries to mitigate COVID-19's impact on RI. We did not look at the flexibilities' impact on COVID-19 or COVID-19 vaccine readiness, which is being assessed through a separate ongoing COVID-19 Vaccines Global Access (COVAX) evaluation.

The evaluation methodology was broadly implemented as proposed in the evaluation inception report, summarised below, with no significant departures from the TOR. Minor departures were made in relation to VfM: focusing on efficiency, effectiveness and equity (not on economy) following advice from the evaluation steering committee; exploration of a theory of action instead of a theory of change. We also made minor changes to the comparator study to emphasise the light-touch nature of the exercise and the learning focus (looking at how equivalent organisations have tackled similar challenges to those faced by Gavi). And finally, we introduced an additional short online survey of Gavi SCMs, to fill gaps in our understanding of uptake of R&P and M&R&S. Deadlines for deliverables also shifted, in agreement with Gavi's EvLU.

Evaluation questions

Our design is focused on exploring a range of evaluation questions (EQs) as per the ToR in the request for proposal (RfP), as set out in Annex 2. The EQs reflect three broad areas of enquiry around which we have organised our evaluation approach:

1) What flexibilities were offered and why?
2) How were these implemented?
3) With what results?[7]

[6] Based on M&R&S releasing guidelines in October 2020, with Gavi support in this area listed as available for 12-18 months from this date

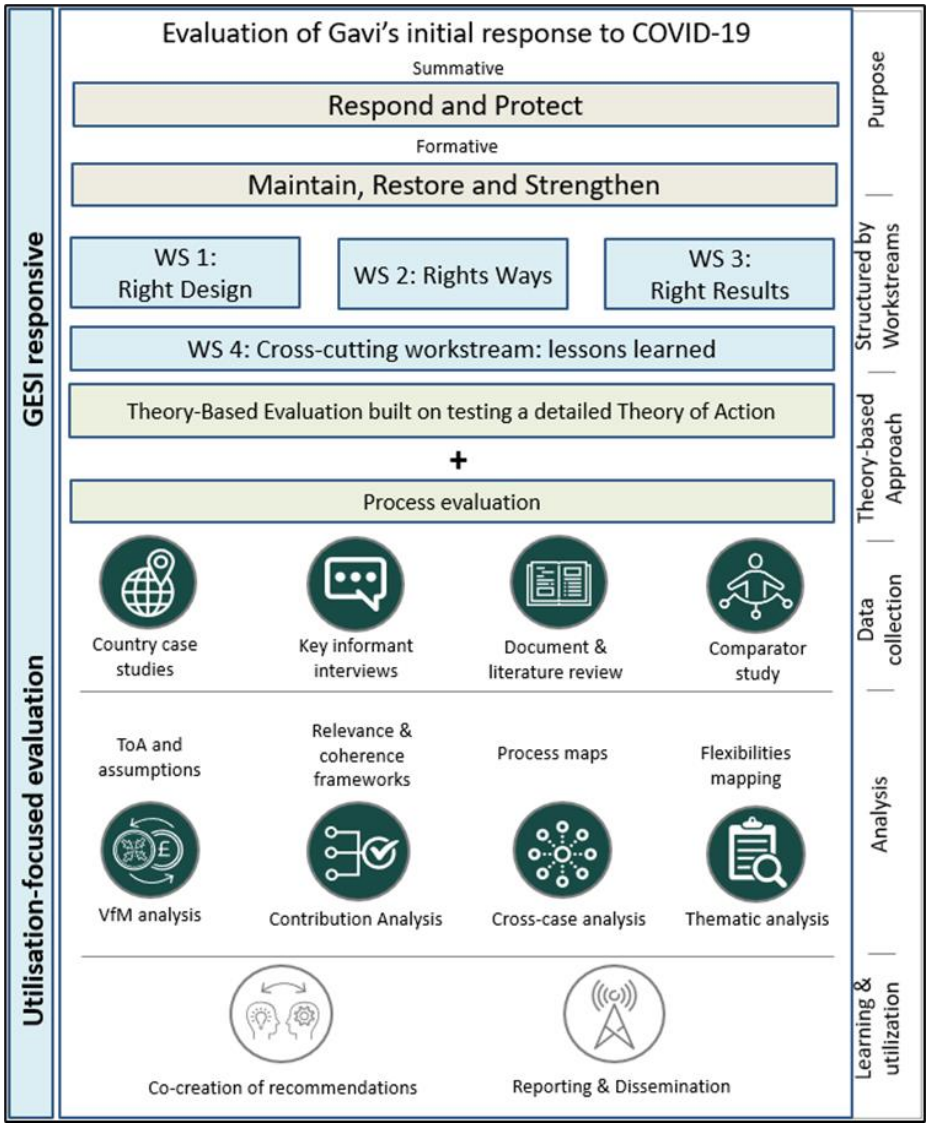
[7] For R&P 'results' are defined in terms of enabling countries to take intended actions to respond to COVID-19; for M&R&S results are defined in terms of mitigating the impact of COVID-19 on RI.

Evaluation approach and methodology

Our overall evaluation design is theory-based (see Annex 5.1) and utilisation focused (see Annex 5.3). We employed a mixed methods approach using a variety of data collection and analytical methods. As requested in the RfP, and following guidance from Gavi Evaluation Unit, our design utilised a Theory of Action (ToA)[8] for both R&P and for M&R&S and is grounded in contribution analysis to deliver the required analytical products to inform and guide Gavi on its ongoing programmatic initiatives to maintain, restore and strengthen RI.

We used four workstreams (WSs), focusing on 1) right design, 2) right ways, 3) right results, and 4) cross cutting lessons learnt, as a way of ensuring that all EQs were covered in a systematic and efficient manner, that the right evidence was collected, and appropriate analytical methods were deployed to address the EQs.

Figure 1: Evaluation design



Methods and related data collection tools have been developed during the inception phase in consultation with Gavi to ensure the final methodology adequately captured all aspects needed to answer the EQs and fulfilled Gavi's information needs, while remaining lean and feasible. Data

[8] A ToA "explains how programmes or other interventions are constructed to activate their theory of change". Funnell, Sue, 2011. Purposeful programme theory: effective use of theories of change and logic models. pp31.

collection tools have been collaboratively developed by and peer-reviewed among WS leads and QA-ed firstly by the TL and then by EHG. Tight timelines meant that we could not fully pilot our approach before rolling it out to other countries/ KIs but we did take stock progressively and tweaked tools if need be in order to achieve the best possible results in the short time available. Further detail on EHG QA processes to ensure quality at all stages is available in the Inception Report.

We undertook at **structured document** review of global-level documents and various external secondary data sources, both to ensure the strongest possible evidence base for our findings, and to ensure that KIIs and interactions with Gavi staff are optimized and as efficient as possible. Documents, KII- and focus group discussion (FGD) notes were thematically coded and analysed against a pre-established coding frame.

We relied on a range of **key informant interviews** (KIIs), and in particular on the implementation of **eight structured case studies**[9] to generate an in-depth understanding of how and why the flexibilities were offered and taken up, and to what effect, including to understand key contextual factors and inform lessons learnt. Our proposed list of case study countries was chosen based on an explicit set of criteria, and on an assessment of feasibility – informed through conversations with Gavi's three regional directors of country programmes.

Box 1: Sampling

Case study countries were selected in consultation with Gavi, informed by the following criteria: regional coverage, trend in RI coverage, number of children missing vaccinations, uptake of R&P/M&R&S (based on understanding developed during inception phase), Gavi country category, impact of COVID-19.

An initial proposal of eight countries was made to Gavi by the evaluation team based on these criteria. Gavi reviewed, taking into view operational considerations – such as other ongoing evaluations or audits. Through this process, final case study selection was significantly informed by Gavi.

We conducted 190 **KIIs with Gavi stakeholders (Secretariat and Board), global, regional and country partners including those conducted in case study countries and in a light-touch learning exercise to look at how equivalent organisations have tackled similar challenges to those faced by Gavi.**[10] KIIs were conducted using a semi- structured KI guide based around the evaluation questions and four workstreams. It was not possible to pre-test tools due to the sequencing of country case studies, but experience from the first case study (Mozambique) was used to inform revision and application of KI guides and other data collection tools.[11]

All interviews were conducted on a voluntary basis, with informed consent. Confidentiality was maintained through a unique identifier coding system for each key informant. Key points from the interview were noted in summary, and audio recordings of interviews were made with permission. All interview notes and audio recordings were stored on a project specific Microsoft SharePoint owned by EHG, and will be deleted by the Project Officer after the evaluation has concluded. As far as possible, global KIIs were **timed to enable us to discuss emerging hypotheses from document review and country case studies** – so that our enquiry was targeted, and used key informants' time efficiently.

[9] Kenya, Mozambique, Niger, Nigeria, Pakistan, Sudan, Togo, Uganda

[10] This was described as a comparator study in the inception report. In discussion with Gavi it was agreed to describe the exercise differently, to emphasise the learning focus and value in terms of contextualising Gavi challenges. Given availability of KIIs and documentation, a more formal process was not realistic at this time.

[11] Experience in Mozambique – which was implemented ahead of other case studies, but not sufficiently far to consider a 'pilot' as such – was fed back to the team during weekly team calls. These provided an opportunity to highlight what was working/not working with tools and KI questions, and to identify modifications required to both tools and questions in other case studies.

We undertook **cross-country analysis and synthesis** at two points in the evaluation: 1) to feed into preliminary findings; 2) after all global data collection and country case studies had been completed. Each round of synthesis incorporated a process of desk-based review of available evidence (from documents, KII- and case study notes), plus a cross-team analysis workshop in which workstream- and theme-leads presented findings for peer review by the rest of the evaluation team. We used the EQs and evaluation criteria (see Annex 3) as an overall framework. Raw data from all sources was coded against a coding tree based on the Evaluation matrix and against different elements of the overarching ToA using qualitative analysis software (*Dedoose*). Then, workstream leads analysed excerpts to identify patterns across countries and explore how and why these exist.

Triangulation in our analysis happened at multiple levels:

- Data (drawing on multiple sources of information from implementing partners) and from KIIs and country level case studies;
- Respondent types (for example, between Gavi internal stakeholders, Alliance partners and different categories of country level stakeholders);
- Workstream leads presented emerging trends and findings to the rest of the team during a virtual analysis workshop in order to further triangulate findings among all members that were involved in data collection;
- In our reporting, we used a strength of evidence rating (see below) for findings under each workstream in order to orient the reader to the strength of each finding based on the level of triangulation that was possible.

Assessing the **strength of evidence** requires considering the underlying "quality" of the evidence as well as the triangulation/ "quantity" of evidence. We applied the robustness rating shown in the table below for our findings:

Table 8: Robustness rating for main findings

Rating	Assessment of the findings by strength of evidence
Strong (1)	• Evidence comprises multiple data sources, both internal (e.g., Gavi Secretariat and Board) and external (good triangulation from at least two difference sources, e.g., document review and KIIs or multiple KIIs of different stakeholder categories), which are generally of good quality.
Moderate (2)	• Evidence comprises multiple data sources (good triangulation) of lesser quality, or the finding is supported by fewer data sources (limited triangulation, e.g., only documents of KIIs of one stakeholder category) of decent quality.
Limited (3)	• Evidence comprises few data sources across limited stakeholder groups (limited triangulation) and is perception-based, or generally based on data sources that are viewed as being of lesser quality.
Poor (4)	Evidence comprises very limited evidence (single source) or incomplete or unreliable evidence. Additional evidence should be sought.

Ethical considerations

As set out in the inception report, our aim is to provide credible and useful evidence to strengthen accountability for development of results and contribute to learning processes. To that end, we will adhere to the professional, ethical and quality standards highlighted in the below table.

PROFESSIONAL & ETHICAL STANDARDS	
Objectivity	The team will undertake the evaluation objectively. All efforts will be taken to avoid and dismiss any preconceptions so as not to bias the assessment process or final analysis
Confidentiality	The team will commit to complete confidentiality during and after the evaluation process. Any information or data provided in confidence will be kept as such. KIIs will be confidential, information from KIs will not be quoted/presented in a way that is

	traceable to the exact individual. We will delete all Gavi docs from our laptops/systems once the evaluation is over and will not disseminate any findings from the evaluation without Gavi's consent.
Open Communications	The team will commit to maintaining open and frequent communications with the evaluation management team at Gavi. Specifically, any issues that come up during the evaluation that may affect timing or outcome of the reporting will be communicated to Gavi in a timely manner.
Integrity	The team will commit to complete integrity of the evaluation process in line with EHG business integrity systems. Should there be any actual or perceived conflict of interest, it will be brought immediately to attention of Gavi.
Thoroughness	The team will commit to obtaining sufficient information needed to make professional judgments.
Incorporate Feedback	The team will allow sufficient time for the Secretariat to review all draft documents, consider the implications and provide any feedback. From the feedback and questions received, the team will incorporate all valid changes and clarifications requested

Limitations and biases

- **Access to data has been a challenge throughout the evaluation and significant data was received very late in the process despite substantial early efforts to obtain this**. There is no centralised monitoring system, and Gavi staff have had limited bandwidth to engage to help fill gaps in our understanding. There were significant delays in start-up of case studies, and challenge accessing key data. The net effect is that we cannot be completely sure that we are presenting a fully comprehensive picture of Gavi's efforts and experience from these.
- **Recall bias and disentangling COVID-19 flexibilities from COVAX**. We asked all KIs to recall events that took place up to two and more years ago, and during which time similar interventions (e.g., COVAX) have been implemented which were outside the scope of the evaluation. We sought to clarify the boundaries round our evaluation and probe where we identified risk that respondents were referring to interventions outside our scope, but recall cannot be completely reliable. Where possible, we have triangulated evidence through documentation or perspectives from different stakeholder categories.
- **Inability to generalise from eight case studies**. As noted in the inception report, we did not seek to generalise from our case studies. However, the profile of our country sample is Africa-heavy, which may limit applicability of lessons to other regions.
- **Lack of data at output and outcome level beyond WUENIC, and limited Gavi contribution at this level.** Also noted in the inception report, WUENIC data and proxy measures are the best available (albeit imperfect) sources for tracking progress. But evidence on Gavi's contribution at this level is weak.

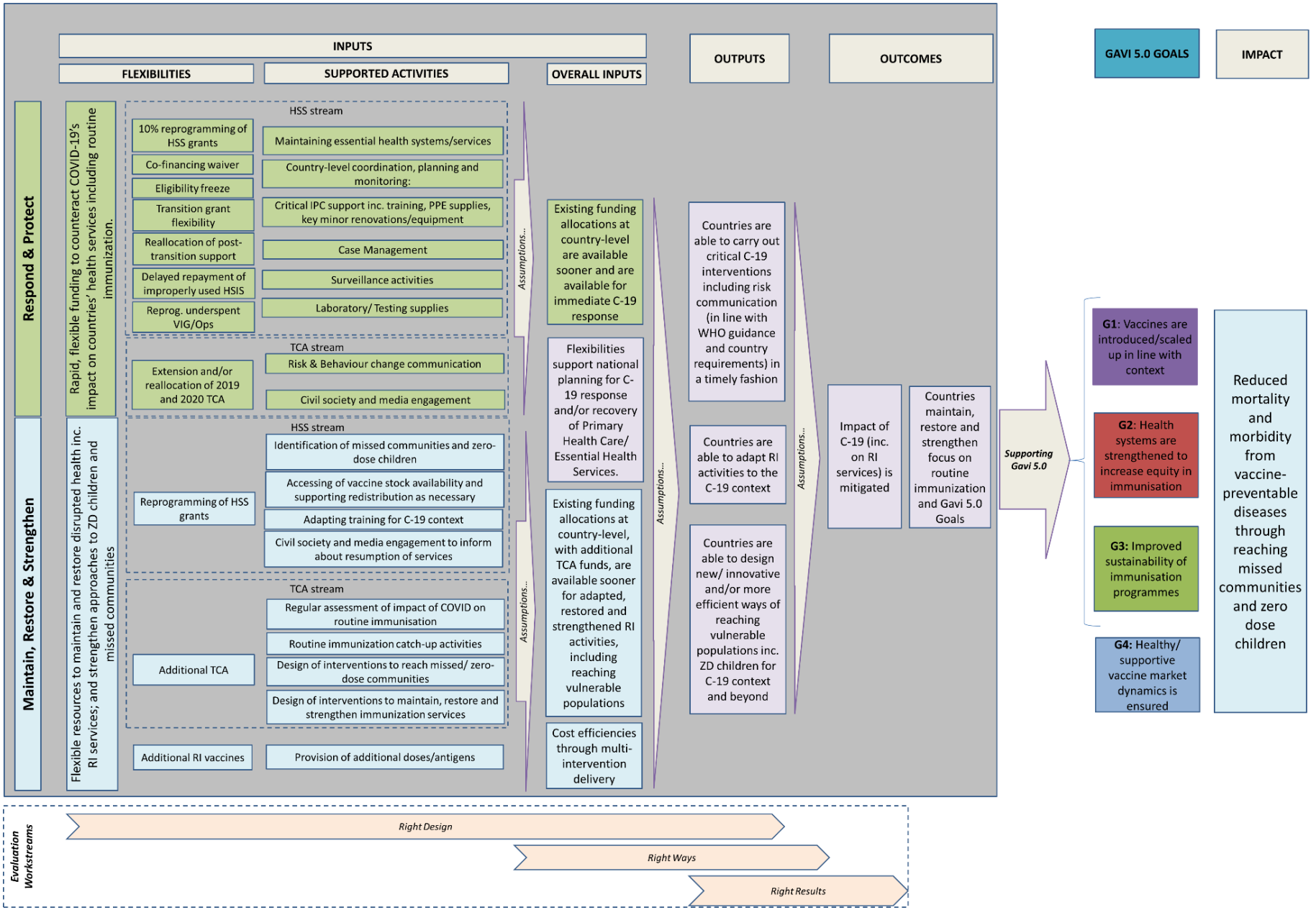
Learning and dissemination

Given the context within which the evaluation is being conducted, our commitment to the principle of **utilisation-focused evaluation**[12] is particularly important. We undertook to maximize the usefulness of and buy-in to evaluation findings, conclusions and recommendations. Further information on our how we have and will continue to do so is set out in Annex 5.3 below.

[12] Patton, 2013. Available at: https://wmich.edu/sites/default/files/attachments/u350/2014/UFE_checklist_2013.pdf

5.1 Theory based evaluation

The Theory of Action for Gavi's COVID-19 flexibilities focuses on the inputs and outputs and the assumptions between these levels of change, as Gavi's contribution to longer-term change through its COVID-19 flexibilities is explicitly understood to be very small. The figure and narrative below reflect this emphasis, with more detailed discussion around input and output level. The ToA proposed during the Inception Phase has been amended slightly in the figure below to reflect our findings that both R&P and M&R&S inputs contributed to all three outputs.


INPUTS
FLEXIBILITIES
SUPPORTED ACTIVITIES
OVERALL INPUTS
OUTPUTS
OUTCOMES
GAVI 5.0 GOALS
IMPACT
Respond & Protect
Rapid, flexible funding to counteract COVID-19's impact on countries' health services including routine immunization.
HSS stream
10% reprogramming of HSS grants
Co-financing waiver
Eligibility freeze
Transition grant flexibility
Reallocation of post-transition support
Delayed repayment of improperly used HSIS
Reprog. underspent VIG/Ops
Maintaining essential health systems/services
Country-level coordination, planning and monitoring:
Critical IPC support inc. training, PPE supplies, key minor renovations/equipment
Case Management
Surveillance activities
Laboratory/ Testing supplies
TCA stream
Extension and/or reallocation of 2019 and 2020 TCA
Risk & Behaviour change communication
Civil society and media engagement
Assumptions...
Existing funding allocations at country-level are available sooner and are available for immediate C-19 response
Flexibilities support national planning for C-19 response and/or recovery of Primary Health Care/ Essential Health Services.
Maintain, Restore & Strengthen
Flexible resources to maintain and restore disrupted health inc. RI services; and strengthen approaches to ZD children and missed communities
HSS stream
Reprogramming of HSS grants
Identification of missed communities and zero-dose children
Accessing of vaccine stock availability and supporting redistribution as necessary
Adapting training for C-19 context
Civil society and media engagement to inform about resumption of services
TCA stream
Additional TCA
Regular assessment of impact of COVID on routine immunisation
Routine immunization catch-up activities
Design of interventions to reach missed/ zero-dose communities
Design of interventions to maintain, restore and strengthen immunization services
Additional RI vaccines
Provision of additional doses/antigens
Assumptions...
Existing funding allocations at country-level, with additional TCA funds, are available sooner for adapted, restored and strengthened RI activities, including reaching vulnerable populations
Cost efficiencies through multi-intervention delivery
Assumptions...
Countries are able to carry out critical C-19 interventions including risk communication (in line with WHO guidance and country requirements) in a timely fashion
Countries are able to adapt RI activities to the C-19 context
Countries are able to design new/ innovative and/or more efficient ways of reaching vulnerable populations inc. ZD children for C-19 context and beyond
Assumptions...
Impact of C-19 (inc. on RI services) is mitigated
Countries maintain, restore and strengthen focus on routine immunization and Gavi 5.0 Goals
Supporting Gavi 5.0
G1: Vaccines are introduced/scaled up in line with context
G2: Health systems are strengthened to increase equity in immunisation
G3: Improved sustainability of immunisation programmes
G4: Healthy/ supportive vaccine market dynamics is ensured
Reduced mortality and morbidity from vaccine-preventable diseases through reaching missed communities and zero dose children
Evaluation Workstreams
Right Design
Right Ways
Right Results

Rationale – the problems Gavi's COVID-19 flexibilities were seeking to address
At the beginning of the COVID-19 pandemic and as it progressed, Gavi identified several problems that they wanted to help address, namely:

1. **Need to respond to COVID-19: Countries did not have the immediate resources required to respond to acute disruption of health services.** Thus, previously planned RI activities were (or were considered likely to be) substantially delayed or otherwise impacted by C-19.
2. **Need to maintain and restore RI: Services were disrupted (e.g., supply chain challenges, misinformation, fear within communities re. vaccines, fear among health workers needing to know how to continue work safely etc) and countries needed help to maintain and restore them.** This implied a need for longer-term support in recognition that COVID-19 challenges would likely continue to present challenges to service delivery for some time ahead and impact on progress towards Gavi 5.0.
3. **Need to strengthen RI: Countries also needed support to strengthen approaches to reaching zero dose children and missed communities. The COVID-19 situation presented an opportunity to identify more of these children and communities (e.g., via digital systems used during COVID-19 that could be leveraged for wider RI).** This was an existing gap (in reducing mortality and morbidity from VPDs) and is the ultimate impact sought from Gavi 5.0, and impact of COVID-19 meant even greater focus was needed on these populations.

Gavi's COVID-19 flexibilities were designed to respond to these needs and contribute to the results identified below.

Impact:
The impact of Gavi's COVID-19 flexibilities is to **"contribute to reduced mortality and morbidity from vaccine preventable diseases through reaching missed communities and zero dose children"**. This impact is aligned with the Gavi 5.0 Strategy mission statement, which is "to save lives and protect people's health by increasing equitable and sustainable use of vaccines", with a particular emphasis on the equity component.

Gavi 5.0 Goals:
Contributing to this overall impact are the four Goals from the Gavi 5.0 Strategy:

- Goal 1: Vaccines are introduced/scaled up in line with context
- Goal 2: Health systems are strengthened to increase equity in immunisation
- Goal 3: Improved sustainability of immunisation programmes
- Goal 4: Healthy/ supportive vaccine market dynamics is ensured

While all these goals provide important contributions to the overall impact, Gavi's COVID-19 flexibilities have been designed to focus on the first three of these goals.

Due to the focus on inputs and outputs within the TOA, the assumptions between Gavi 5.0 goals and impact were not reviewed or outlined in full, but Gavi 5.0 outlines a number of key enablers, which can be reframed as assumptions. These are: existence of long-term predictable funding for Gavi programmes; ongoing global political commitment for immunisation, prevention and primary health care; existence and use of evidence, evaluations and improved data for Gavi policies, programmes and accountability; and an ability to leverage the private sector including via innovative finance mechanisms and partnerships.

Outcomes:
The long-term outcome of Gavi's COVID-19 flexibilities, which is intended to support the first three Gavi 5.0 goals is that **countries maintain, restore and strengthen the focus on RI and Gavi 5.0 goals**,

and leading directly into this is the intermediate outcome that the **impact of COVID-19 (including on RI services) is mitigated**. Again, assumptions between these two outcome levels were not thoroughly reviewed due to the emphasis at input and output level, but a critical assumption would be that other emergencies do not affect countries' ability to refocus on RI and Gavi 5.0.

Gavi's COVID-19 flexibilities are intended to have some level of contribution towards these outcomes. However, implicit within the TOA's focus on input and output level is the acknowledgement that measuring both the extent to which these outcomes have been achieved, and Gavi's level of contribution will be hard, if not impossible, within a complex and rapidly changing donor landscape and likely lack of necessary data.

Outputs:
The outputs contributing to the above outcomes are:

1. Countries are able to carry out critical COVID-19 interventions including risk communication (in line with WHO guidance and country requirements) in a timely fashion;
2. Countries are able to adapt RI activities to the COVID-19 context;
3. Countries are able to design new/innovative and/or more efficient ways of reaching vulnerable populations inc. ZD children for COVID-19 context and beyond.

In the original TOA developed during the inception phase of the evaluation, it was expected that Output 1 was supported exclusively or mainly by R&P flexibilities, and that Outputs 2 and 3 would be supported exclusively or mainly by M&R&S flexibilities. However, during the course of the evaluation it has become clear that the design of the flexibilities in fact allowed for countries to use R&P flexibilities to support all three outputs. In line with this, the TOA has been adjusted to reflect the fact that all three outputs cut across both R&P and M&R&S flexibilities with a pathway to the intended outcome.

While Gavi's COVID-19 flexibilities are expected to provide a greater degree of contribution towards output level, and for the degree of contribution to be possible to measure in a qualitative sense, Gavi's contribution is still set within the context of busy stakeholder landscape, especially regarding the general COVID-19 response (Output 1), and thus contribution towards this output in particular can be realistically anticipated to be smaller than towards Outputs 2 and 3, which are more focussed on Gavi's core mandate.

Inputs:
The overall inputs to the outputs outlined above are as follows, with R&P and M&R&S intended to support specific outputs as outlined in parenthesis:

1. existing funding allocations at country-level are available sooner and are available for immediate COVID-19 response (R&P);
2. flexibilities support national planning for COVID-19 response and/or recovery of Primary Health Care/ Essential Health Services (R&P and M&R&S);
3. existing funding allocations at country-level, with additional TCA funds, are available sooner for adapted, restored and strengthened RI activities, including reaching vulnerable populations (M&R&S);
4. cost efficiencies through multi-intervention delivery (M&R&S).

A clear attribution is expected between the actual flexibilities and these inputs, with each flexibility supporting one or more of these inputs.

Flexibilities and supported activities:
The individual flexibilities under R&P and M&R&S were designed to support a range of activities. R&P flexibilities were intended to support a range of activities aligned with WHO's COVID-19 response pillars. Gavi outlined a list of specific types of support under these broader categories in R&P application guidance, with certain types of activities, such as larger capital purchases, discouraged. M&R&S flexibilities were intended to support activities more explicitly focussed on addressing the impact of COVID-19 on RI.

Critical Assumptions:
The table below summarises the list of assumptions identified during the inception phase of the evaluation and presents a preliminary list of those assumptions to be researched during the evaluation.

Table 9: Summary list of assumptions

Flexibilities - Inputs		Inputs - Outputs	Outputs - Outcomes
Specific	**Over-arching**		
• Country GNI data for 2019 would have made some countries ineligible for co-financing without the freeze • Countries choose to use funds available through flexibility for COVID-19 response rather than other needs (health-related or otherwise) • • Countries are unable to use original funding for original purposes/ within original timelines due to COVID-19 and thus reprogramming is considered appropriate • Extension periods are appropriate for different country contexts (e.g., different COVID-19 timelines) • Activities supported are seen as distinct from "business as usual" and thus flexibility seen as useful/ appropriate • Critical gaps can be addressed by reprogrammed existing funds (rather than additional funds), or additional funding needs are addressed by other partners • Additional funding is sufficient to support additional/ adapted/ innovative activities and outputs (i.e., cost increase of regular TCA activities has not significantly increased (due to COVID-19 or otherwise) • There is adequate in-country capacity to design and implement multi-intervention campaigns	• There is need for additional COVID-19 response funds (i.e., countries do not have sufficient funds domestically/from other partners) • There is a need for reprogrammed/ additional (TCA only) RI funds (i.e., due to diversion of funds away from RI or due to increased costs of providing RI in context of COVID-19) • Reprogrammed/ additional (TCA only) Gavi funds fill key funding gaps from other DPs • Coordination mechanisms e.g., WHO pooling mechanism for partner funds work effectively • Types of activities supported by flexibilities are appropriate • Activities remain relevant during period flexibility is offered • Processes for applying for flexibilities are not overly burdensome • Flexibilities allow timely release of sufficient funding to countries • More appropriate, flexible and/or timely funding is not available from other sources • Flexibilities are appropriate for and equitable across different country contexts • Country level COVID-19 preparedness and response plans are developed/in existence	• There is consensus among partners/ stakeholders about priority interventions and which of these Gavi should support (versus other partners) • Countries use funds as intended, aligned with WHO guidance (training, PPE, surveillance etc) • There is adequate partner co-ordination to manage and mitigate key implementation risks around supported activities (including, for example, risks related to in-country HR capacity, other non-financial resources/ capacity/ quality; supply chain bottlenecks/ delays; impact of C-19 misinformation etc.) • COVID-19, other disease outbreaks and/or other national/ international emergencies do not further interrupt health systems and provision of RI • CSO partners are able to absorb increased focus/ have capacity to take on additional activities/ responsibilities • COVID-19 innovations are appropriate and effective for longer term (non-COVID-19) context	• Activities funded are and continue to be effective in mitigating COVID-19 to a level that allows RI/ health services provision to resume/ continue • There is sufficient alignment between interventions and existing Gavi policies and Goals inc. 5.0

5.2 Who carried out the evaluation; roles and responsibilities

Table 10: Key evaluation team members: names, position and roles

Core Team		
Member/ position	**Expertise**	**General roles and responsibilities**
Tim Shorten (TL/ WS4 Lead) – PH theory-based evaluation specialist	Tim Shorten is an evaluation specialist with 20 years of experience in international development primarily focused on M&E, impact and accountability. He is an established TL and DTL with experience in coordinating high-profile, multi-stakeholder, multi-country evaluations. He has led and played key roles in high profile evaluations including for DFID, the UK Department of Health and Social Care, Public Health England, UNICEF, WHO, the Hewlett Foundation, the Bill & Melinda Gates Foundation, CHAI and UNITAID. His areas of technical focus and experience include Aid Effectiveness, Global Health Security, HIV and AIDS, Sexual Reproductive and Health and Rights (with a keen interest in Adolescent SRH) and Health Systems. He is experienced in development and implementation of international and national level policy. Tim has a proven track record of developing and implementing high quality theory-based, mixed-methods evaluation designs and methodologies, including in a particular emphasis on utilization-focused and developmental evaluation approaches.	Tim serves as the TL, leading the drafting of all deliverables and client engagement on technical matters. He has overall responsibility for ensuring project objectives are met, EHG QA procedures are followed, and the client's requirements are satisfied/ exceeded in terms of all deliverables. He also leads on the Lessons Learnt workstream (WS4) with the support of the learning advisor, as well as on overall analysis and synthesis.
Giada Tu Thanh (DTL/WS3 Lead) - PH evaluation and gender inclusion specialist	Giada has 12 years of experience working in international development, consulting and Monitoring, Evaluation and Learning (MEL) across 18 different countries. In the last six years, Giada has led, designed, and conducted MEL projects commissioned by Gavi, The Global Fund, BMGF, UNICEF, WHO, DFID, the UK Department of Health and Social Care (DHSC), Public Health England (PHE) and the EU. She is a recognized expert in contribution analysis, ToC development, gender-sensitive and transformative approaches, utilisation-focussed evaluation (including co-creation of recommendation processes) and project management. Her areas of technical focus and experience include Global Health Security, antimicrobial resistance (AMR), Sexual and Reproductive Health (SRH), vaccines, advocacy, strategy, organisational and development effectiveness.	Giada serves as DTL, providing technical advice across the whole evaluation and all deliverables. She assists the TL with team management and client relations. She also leads on WS3 (Right results). Giada will also ensure that GESI aspects are integrated into all workstreams and be responsible for GESI specific EQs. She supports development of all deliverables and has conducted one country case study.
Ruth Sherratt (WS1 Lead) - PH strategy design and implementation specialist	Ruth has over 15 years' experience in health, education & international development. She has extensive experience in the design of programme theories of change and strategy, as well as management, implementation, and evaluation of programmes. Her areas of experience include global health security (including two recent theory-based evaluations of multi-country programmes focussed on response to outbreaks including COVID-19), health systems, TB, HIV, community health, and maternal and child health programmes. She brings experience with UK and US governments, UN, EU, World Bank, and other donor projects.	Ruth leads WS1 (Right design). She has conducted one country case study, partaken in document review, stakeholder consultations and analysis under Workstream 1 and across all workstreams.
Helen Merati (WK2 Lead) - PH implementation and stakeholder engagement specialist	Helen is an international health development professional with 17 years' experience working with and for international consulting organisations, philanthropic organizations, NGOs, and the UK NHS. Her core areas and experience include M&E, project design and implementation, stakeholder engagement, leading and coordinating teams. Core skills include monitoring, evaluation, learning - developing M&E frameworks, ToC, indicators, results frameworks and learning systems. She is highly experienced with participatory evaluation techniques, quantitative & qualitative data management and analysis, training, facilitation, and stakeholder engagement and coordination. Her areas of technical focus include HIV, Sexual	Helen leads WS2 (Right way). She has conducted one country case study and partaken in document review, stakeholder consultations and analysis under WS2 and across all workstreams.

Core Team		
Member/ position	**Expertise**	**General roles and responsibilities**
	and Reproductive Health and Rights, MNCH. Helen gained an in-depth understanding of the challenges facing country EPI teams in the planning and implementation of cMYPs during a rapid review of these in 2017. Most recently she has been working on the Gavi COVAX Evaluability Assessment and Evaluation Design.	
Cheri Grace (VfM Expert) - PH supply chain and VfM specialist	Cheri has over 30 years of experience in a variety of work settings - pharmaceutical industry; corporate finance; grassroots development; academic research, and 20 years in global health management consulting. She has worked in over 20 aid recipient countries managing and/or evaluating programmes. Her areas of technical focus include health systems strengthening, evaluation, health economics, value for money, policy analysis and strategy advice, market dynamics, and product development. As Evaluation Lead of ASCEND, FCDO's £200 million Neglected tropical Disease commitment covering 24 countries, Cheri evaluated how the programme implemented its Covid-flex response including "Covid-flex" funding to mitigate COVID impact as well as ultimately adapting approaches to the core business of delivery of Mass Drug Administration of NTD drugs (via community-based campaigns similar to immunisation campaigns). Cheri is also on the Expert Advisory Group of the ongoing COVAX evaluation and on the Steering Committee of the recently completed Pneumococcal AMC end-line evaluation.	Cheri has conducted two country case studies and partaken in document review and stakeholder consultations. She has furthermore provided expert advice on VfM across the four workstreams with particular attention to questions 1.5, 2.3, 2.4, 2.10-2.13, 3.1, 3.2, 3.5.
Sjoerd Postma (Comparator Study) – Health systems strengthening and UHC specialist	Sjoerd is a PH services management specialist focusing on health service delivery, health services management, health systems development as well as health sector development and reform with a particular emphasis on Primary Health Care. He has over 30 years' experience (of which 20 years in leadership positions) in international health sector development. His core areas of technical focus include health services and programme management - planning and implementation, budgeting and financing, logistic management, health infrastructure development, private sector development, and M&E. Specific health technical skills relate in general to Primary Health Care, integrated service delivery and Universal Health Coverage.	Sjoerd is main responsible for conducting the comparator study in addition to conducting two country case studies and contribution to overall analysis.
Cheryl Brown (Learning advisor) – Research communication specialist	Cheryl is a specialist in promoting utilisation of evidence and learning among funders and implementers of development programmes. She has 18 years' experience working in research communication, evaluation and learning roles for research institutes, donor agencies, NGOs, research portals and networks. Cheryl has a particular interest in supporting remote participation in learning and adaptive programming processes. She has considerable experience in designing and facilitating virtual, hybrid and face-to-face workshops and meetings that are sensitive to the barriers to knowledge-sharing and learning and is able to turn evaluation and research reports into plain English insights and practical suggestions for increasing impact.	Cheryl supports adaptive management of the evaluation by finding creative and practical ways to capture and share learning, including supporting the TL/DTL on the design and implementation of internal and external learning events including the analysis workshop, co-creation for recommendations, ToC development, etc.
Support team		
Michele Gross (Project Director) – PH evaluation and HSS specialist	As the CEO of EHG Michele has led and co-led evaluations of programmes and rolled out planning, monitoring, and reporting systems, as well as setting up and overseeing large teams. Michele is currently the Project Director for a UNFPA maternal child health trust fund evaluation and a UNAIDS prevention for key population evaluation. Both of these have teams of 10+ people and involve development of ToCs, contribution analysis, country case studies, cross case analysis and synthesis. She also currently serves as Project Director on two pieces of COVID-19 research commissioned by WHO and Euro Health Foundation.	Michele is the day-to-day manager for the assignment. She supports Tim and Giada in managing the delivery of the various workstreams and deliverables. Together with the TL/DTL, she acts as the reviewer of all workstreams.

Core Team		
Member/ position	**Expertise**	**General roles and responsibilities**
Ted Freeman - QA Manager/Technical Support	Ted has over 30 years of experience designing and leading large scale, multi-disciplinary evaluations including theory-based evaluation using contribution analysis as an overall analytic approach. He is adept at working with senior government officials and development partners including UNFPA, UNICEF, WFP, WHO, Danida, Sida, etc. He recently served as TL for an early lessons and evaluability assessment of the Secretary General's COVID-19 Response and Recovery Multi-Partner Trust Fund (MPTF) for the Office of the Deputy SG and the SG Designate for COVID-19.	Ted provides strategic advice through the duration of the review, bringing his global COVID-19 evaluability experience. He will assure the robustness of the methodologies used and the quality of all outputs/ deliverables.
Lene Andersen, Cedric Huntzinger - Research Assistants	Lene Klosterskov Andersen has a background in Public Health and nursing and extensive PH research experience. Lene serves as project coordinator/research assistant managing implementation of projects from EHG HQ as well as the qualitative thematic organisation and analysis of data for document reviews and case studies. Cedric Huntzinger has a background as a journalist. He has served as research assistant in a number of social- and health related research and evaluation projects	Together they have provided research support to the core team including for document review and analysis. This includes supporting primary data collection and inputting into the development of all deliverables as requested by the TL/DTL.

5.3 Use and influence plan

A communications plan for how and when the evaluation team will engage stakeholders with this evaluation was submitted as an annex to the Inception Report, and an updated version is included below.

From our regular contact with the Gavi Secretariat and monitoring Board and Committee documents, the evaluation team is keenly aware that Gavi is going through an intense period of learning and reprioritising as a consequence of COVID-19. This will continue beyond the end of our evaluation and has several implications on our plans for engaging stakeholders with learning from the evaluation:

A) Evaluation outputs need to be **easy to repurpose** by the Gavi Secretariat after EHG completes this contract. New guidance is due soon from Gavi for those producing evaluation reports and early discussions around it emphasise the need for outputs that can 'travel'.

EHG response: slides will be created that can be used individually and as we move from first to final draft report, we will refine the content of this report in line with the advice due to be issued by Gavi in August.

B) EHG's plan for encouraging utilisation of the evaluation findings needs to be **live and maintained in collaboration** with the Gavi Secretariat so it can respond to the dynamic needs for learning about responding to COVID-19 and future pandemic preparedness.

EHG response: Our Learning Advisor and Jessica Gergen, Gavi's MEL and communications consultant, will continue to meet regularly, using a 'COVID-19 Evaluation Communications Opportunities' online whiteboard to enable sharing of advice, comments and ideas between these calls. September and October will be a critical period for this and EHG will endeavour to be able to respond to opportunities to contribute learning directly into internal or Gavi-hosted discussions.

C) Dissemination needs to **complement other evaluations** such as COVAX and the forthcoming mid-term evaluation of Gavi 5.0.

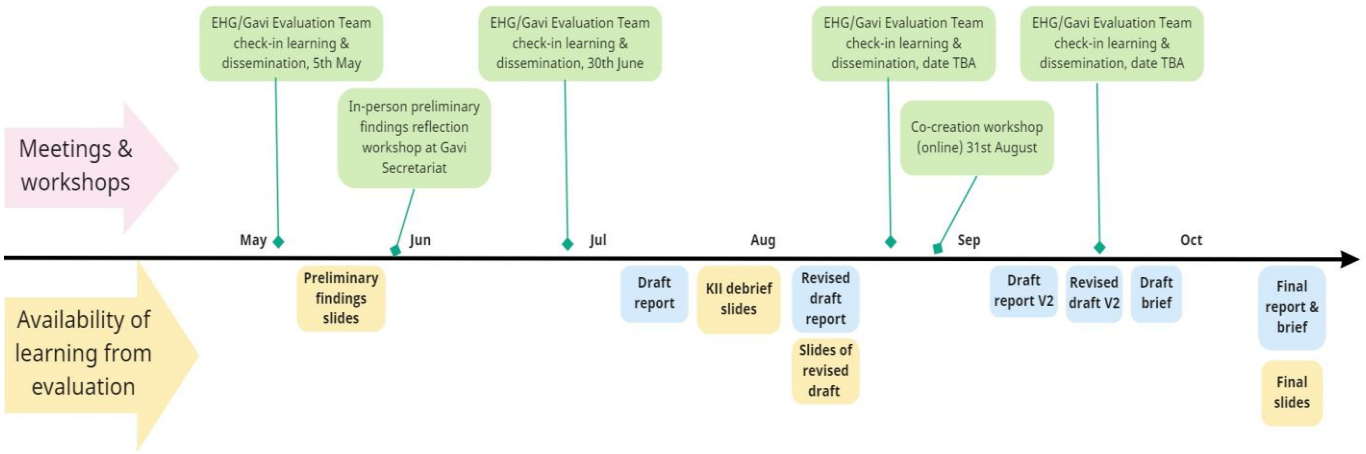
EHG response: The composition of our evaluation team means we have close links already with the COVAX evaluation and the forthcoming evaluation of the Operationalisation of Gavi's Strategy through Gavi's policies, programmatic guidance and use of funding levers.

(updated) Communications plan: how/when we will engage stakeholders in the evaluation

Stakeholder mapping
As part of our KII preparations, we drew up a list of potential key informants who would need to be included within our communications plan. The Gavi Evaluation and Learning Office also provided a preliminary analysis of the evaluation stakeholders, which we used as a starting point for exploring key stakeholders' capacity to engage with the evaluation (as contributors of data and intended users) and how our initial proposals for communications might be adapted and improved.

Identifying communications channels
Our background reading of Gavi documentation and follow-up discussions on the stakeholder mapping with the Gavi EVLU helped us to identify an initial set of internal communications channels within Gavi that would be appropriate for inclusion in our strategy. We have created an online calendar of communication opportunities; dates and periods in the coming months when lessons learnt from the evaluation are likely to be of particular use to key stakeholders. This calendar is available to the Gavi evaluation team who are helping us to keep it updated. Figure 2 below illustrates some key points from this calendar:

Figure 2: Online communications calendar for Gavi and EHG evaluation teams



The table below summarises how we have engaged with the evaluation stakeholders to date and our intentions going forward. We identified six categories of stakeholder based on their likely interest in the evaluation and our purpose for communicating with them. The table shows the demands the evaluation has already and will continue to place on the stakeholders and this has influenced how we propose to engage with them on learning from it.

Table 11: EHG evaluation team engagement with evaluation stakeholders

Stakeholder Category	Gavi Eval Unit	Gavi Country Programmes	Gavi Theme Leaders	Gavi Board & PPC	Alliance Core Partners	External audiences
RFP for evaluation	Y			Y		
Selection & contracting	Y			Y		
Inception consultation	Y		Y	Y		
Reviewing inception report	Y		Y		Y	Y
TOC workshop	Y	Y	Y		Y	
Data collection	Y	Y	Y	Y	Y	
Reviewing draft preliminary findings	Y	Y	Y		Y	Y
Reviewing draft report	Y	Y	Y	Y		Y
Co-creation workshop	Y	Y	Y	Y	Y	
Reviewing 2nd draft report	Y	Y	Y	Y		Y
Reviewing final report	Y	Y	Y	Y		Y
Reviewing draft policy brief	Y	Y	Y	Y		Y

We are providing three levels of communications to support learning from the evaluation that respond to these differences in capacity and necessity to engage:

- **Distribution** – making the evaluation findings available to stakeholders who need to know about the evaluation for accountability purposes and where it is good practice to do so, e.g., circulating a report or policy brief by email, sending relevant findings to key informants.
- **Personalisation** – sharing deliverables by email with stakeholders who have limited capacity to engage with the evaluation but for whom the learning is likely to be highly relevant. An appropriate approach here would be to send a report by email with a covering note that includes key findings that are particularly relevant to the recipient and telling them where to go to in the attachment for more on these areas. Ideally, this email would be sent by someone that the recipient trusts, to increase the likelihood of it being read and acted upon. If none of our evaluation team members are already in contact with the recipient, then this may mean asking the Gavi Evaluation Office to send the email on our behalf.
- **Interaction** – for stakeholders with interest and capacity in engaging with the evaluation at a deeper level, we will offer live presentations of evaluation findings and recommendations e.g., a webinar on a specific topic, and provide opportunities to participate in discussions that help identify lessons learnt by Gavi and explore the implications this has for Gavi 5.0 and the wider organisation. Within this category we expect there to be different levels of capacity to engage but it will be important to extend the invitation to participate to all members of this category and make recordings and notes available if they are unable to attend
- **Co-creation workshop** – scheduled for 31 August: this online workshop was a critical opportunity to engage key stakeholders with the lessons and conclusions from the evaluation report and aided the evaluation team in producing useful recommendations in the final report. The appetite for learning from this evaluation has proven to be greater than anticipated so a wide cross-section of stakeholders were invited to participate in the workshop which was by EHG and used group work to explore the lessons learnt.

The following table summarises which of these approaches we anticipate taking for the stakeholder groups and examples of how this will be delivered. Our mapping of these approaches against stakeholder groups signals the level of engagement we think it is reasonable to expect but does not exclude wider participation if stakeholders are able to make the time for it.

Table 12: Possible approaches for interaction with different stakeholder groups

Stakeholder Group	Communications approach
Gavi Evaluation Office	Interaction - Regular engagement at each stage of the evaluation including reflection workshops on preliminary findings and co-creation of lessons learnt.
Gavi Country Programmes	Personalisation – Dissemination of country level findings through a debriefing in country and sharing of a brief PPT presentation via email to those who have been interviewed.
Gavi Theme Leaders	Personalisation – Dissemination of reports and policy brief with covering email signposting most relevant content; where feasible, additional products tailored to their interests e.g., lightning talk at COVAX monthly forum.
Gavi Board & PPC	Interaction – Making all products available to them by email; using opportunities to share findings in person (or virtually) e.g., webinar.
Alliance Core Partners	Personalisation - Dissemination of reports and policy brief with covering email signposting most relevant content; where feasible, additional products tailored to their interests e.g., Knowledge Exchange Talk.
External audiences	Distribution – dissemination of relevant products e.g., via Zero-Dose Community of Practice.

6 Case study summaries

We undertook data collection in eight case study countries, selected as described in Annex 5 above. Case study countries included: Kenya, Mozambique, Niger, Nigeria, Pakistan, Sudan, Togo and Uganda. We present below a summary of key findings for each of the case studies, with a timeline for each country showing how the COVID-19 unfolded and Gavi's response. (See also separate submissions of the eight country study notes for higher quality graphs).

6.1 Kenya

Background

- Since the identification of COVID-19 on 12 March 2020 up to date (mid-July 2022), there have been 335 929 infections and 45,668 coronavirus-related deaths (JHU, 2022). Only 17.35% of the eligible population has been fully vaccinated.
- The country saw a slight drop in its measles and DTP vaccination coverages but has rebounded to 2019 levels by 2021.

Flexibilities accessed:

- Kenya accessed one flexibility under R&P: Reprogramming of HSS grant funds directed towards a) capacity development of HWs on Covid case management, prevention, and surveillance, b) national coordination of the response, including ensuring the continuation of RI and other essential PHC services, c) the procurement of PPE for frontline HWs, and d) development of IEC and risk communication for HWs; only 20% of IT support requested was granted to allow connectivity of staff working from home. The total granted amounted to US% 1.56m and was only about 68% of what was available. The funding was considered minor by in-country stakeholders as many other donors provided substantially more for most of the WHO response pillars.

Findings

Right Design – applying the R&P flexibilities was seen as relevant, streamlined, and helpful in filling initial gaps in the COVID-19 response.

- The "National 2019 Novel Coronavirus Contingency (readiness and early response) Plan" was in line with the WHO technical guidance and appeared adequate to the country's context for technical and programmatic contents, including its monitoring framework.
- The proposed GAVI request and award addressed four pillars of the plan: Coordination, risk communication, IPC, and case management.
- Significantly, the capacity development of HW in case management, prevention, and surveillance, as well as the provision of PPE, was instrumental in the continuation of PHC services (A fifth WHO pillar), including immunization services, and in line with an additional rapid response plan and working group to maintain essential services. It also diminished the fear among the population that it was unsafe to go to health facilities.
- There was never an application for **M&R&S.**

Right Ways – timeliness and efficiency of R&P flexibilities were seen as generally good; however, the delivery of the goods was delayed.

- Gavi approved Kenya's request for R&P support for US$1.56m within a month by mid-April. As UNICEF in-country already held the funding, funds were immediately disbursed for the activities while the PPE request was routed through UNICEF's supply division. UNICEF SD has however clarified that Kenya was not included in the recipients of supplies purchased with the Gavi

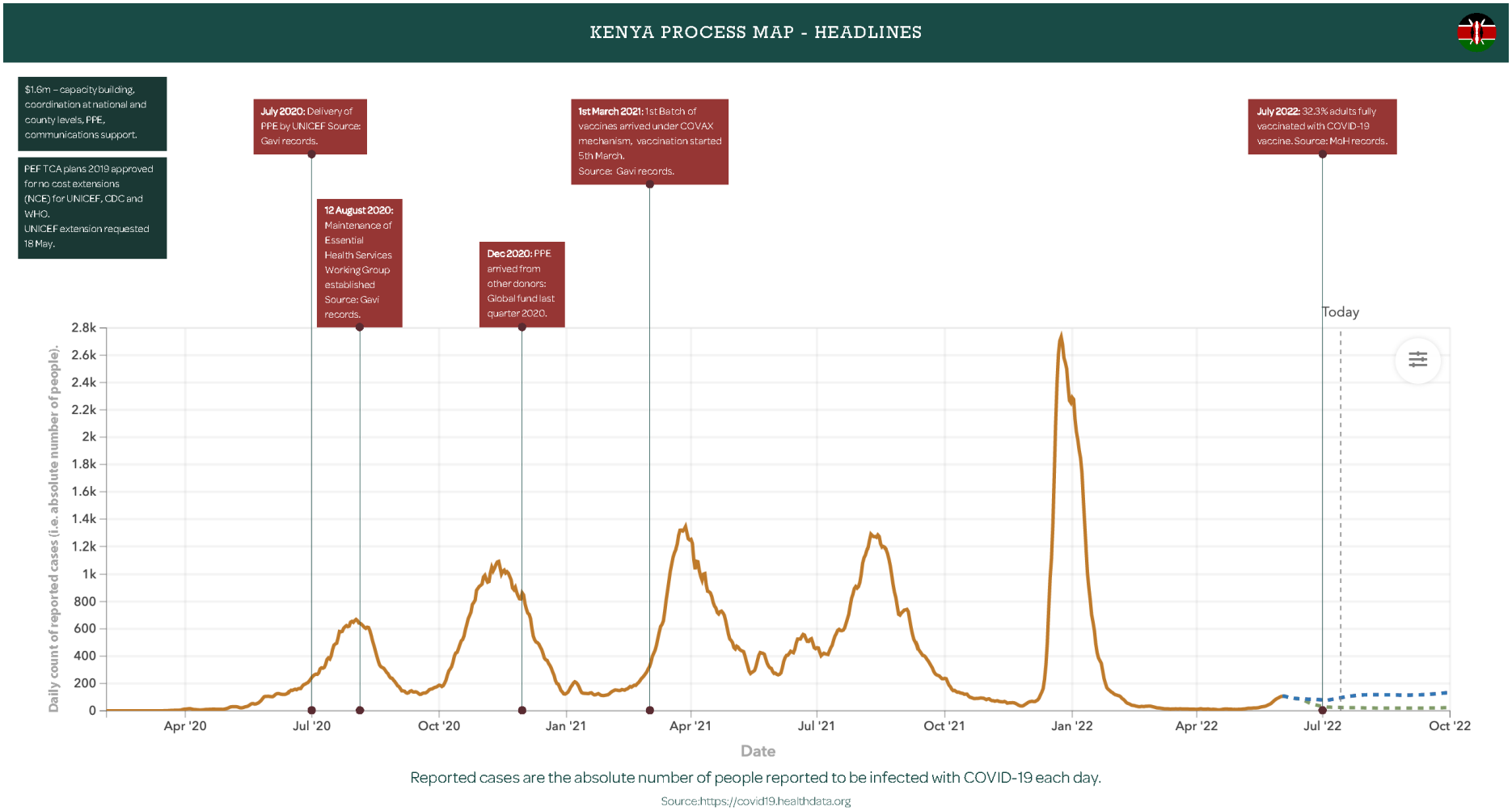
special arrangement funds; the evaluation team was not able to resolve the discrepancy between reported data between country KIIs and UNICEF SD.
- Due to global shortages, UNICEF did not deliver the goods immediately (unclear when they arrived among all other supplies requested by other donors through the UNICEF supply division. It is, however, clear that other donors also brought PPE, and there was sufficient protective gear available from the third wave onwards.
- National stakeholders reported that due to the individual agendas of most donors, the response was not well coordinated in the beginning.

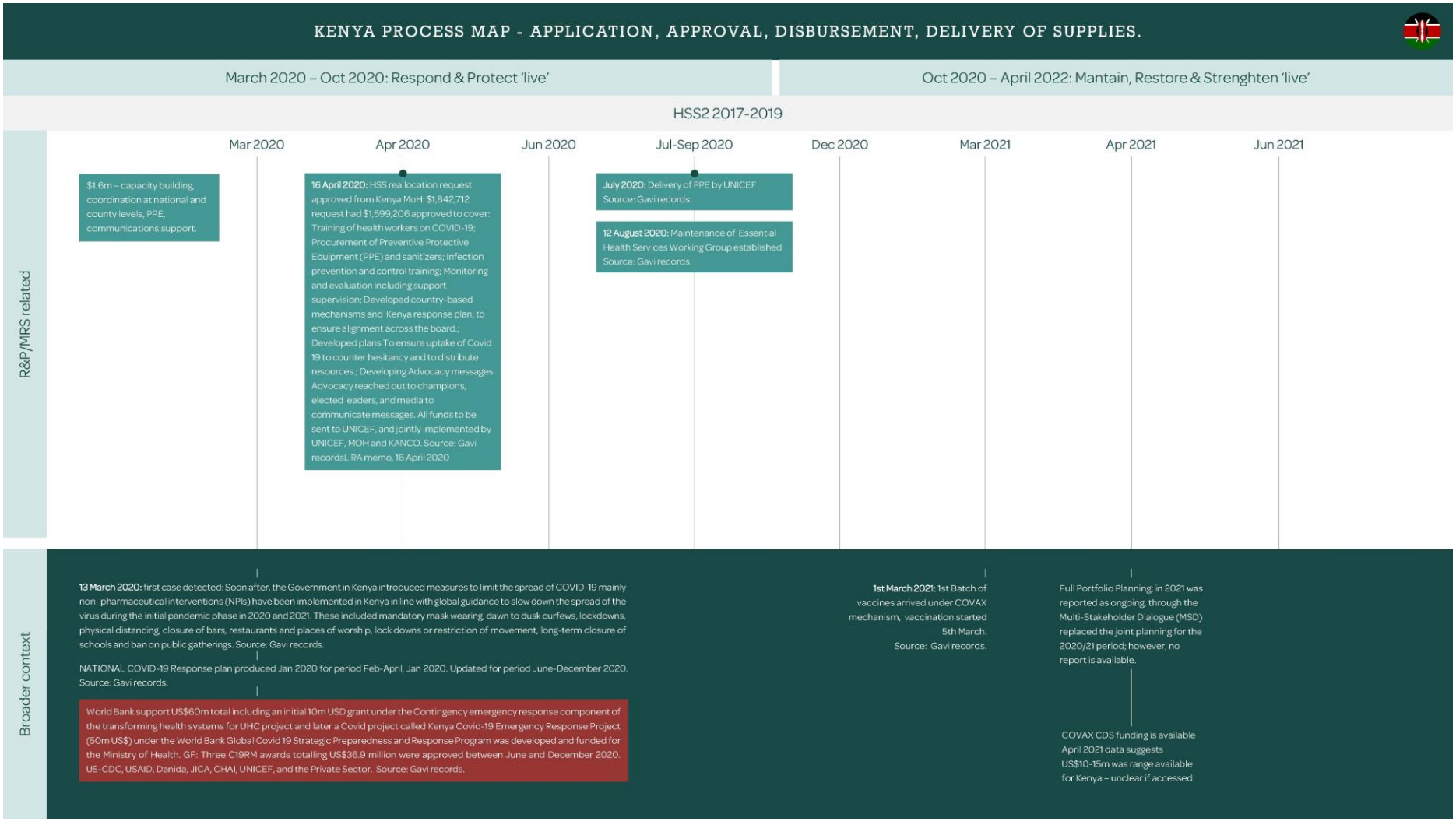
Right Results – the immediate offer for support was timely, but its size and late arrival became insignificant in the overall response to COVID-19. It did not necessarily affect RI.

- A generally considered insignificant amount (0.6% of what was required and 2% of what was pledged by other donors) was made available from the HSS reallocation for the response activities, half of which was for PPE that arrived late. By that time, other donors had provided the necessary PPE. It was reported that at the beginning of the pandemic, there was limited coordination and thus duplication of requests and provisions.
- The initial training and IEC development ensured the continuation of services after a short interruption.
- Public health measures like masks, lockdowns, and other non-pharmaceutical interventions were effective before the vaccines came.
- The continuous sharing of the SITREPS data helped inform decision-making, and a national task force was in place to determine the successive waves. Still, modelling was not very reliable due to the changing virus.
- UNICEF leveraged its global supply chain management experience and expertise to secure COVID-19 emergency supplies, which helped to ensure adequate supplies of health and nutrition commodities. In addition to the encountered logistics challenges, the COVID-19 pandemic has revealed severe issues in the PPE ecosystem characterized by acute shortages, steep price shocks, and large gaps in access.
- The earlier COVID-19 response was not very targeted towards issues of equity and social inclusion as there was no deliberate effort on this, but later on, vulnerable groups were targeted.
- Key unintended (secondary) consequence due to the initial response and mainly the non-pharmaceutical interventions was a steep rise in Kenya of gender-based violence and sexual assault, primarily prevalent in urban settings. This also included an increase in teenage pregnancies due to the school lockdowns.
- Also, mental health became a big issue. The Government set up a mental health commission to understand this further, and the Ministry of Health has since developed an elaborate mental health strategy.

Lessons

- There is a need for close monitoring and engagement with the EPI program and other partners in the country in times of crisis.
- There is a need to improve coordination and mutual accountability of the response efforts by Gavi partners to avoid duplication of efforts and maximize support provided.


KENYA PROCESS MAP - HEADLINES
$1.6m – capacity building, coordination at national and county levels, PPE, communications support.
PEF TCA plans 2019 approved for no cost extensions (NCE) for UNICEF, CDC and WHO.
UNICEF extension requested 18 May.
July 2020: Delivery of PPE by UNICEF Source: Gavi records.
12 August 2020: Maintenance of Essential Health Services Working Group established Source: Gavi records.
Dec 2020: PPE arrived from other donors: Global fund last quarter 2020.
1st March 2021: 1st Batch of vaccines arrived under COVAX mechanism, vaccination started 5th March. Source: Gavi records.
July 2022: 32.3% adults fully vaccinated with COVID-19 vaccine. Source: MoH records.
Today
Daily count of reported cases (i.e. absolute number of people).
2.8k
2.6k
2.4k
2.2k
2k
1.8k
1.6k
1.4k
1.2k
1k
800
600
400
200
0
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


KENYA PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Oct 2020: Respond & Protect 'live'
Oct 2020 – April 2022: Mantain, Restore & Strenghten 'live'
HSS2 2017-2019
Mar 2020
Apr 2020
Jun 2020
Jul-Sep 2020
Dec 2020
Mar 2021
Apr 2021
Jun 2021
R&P/MRS related
$1.6m – capacity building, coordination at national and county levels, PPE, communications support.
16 April 2020: HSS reallocation request approved from Kenya MoH: $1,842,712 request had $1,599,206 approved to cover: Training of health workers on COVID-19; Procurement of Preventive Protective Equipment (PPE) and sanitizers; Infection prevention and control training; Monitoring and evaluation including support supervision; Developed country-based mechanisms and Kenya response plan, to ensure alignment across the board.; Developed plans To ensure uptake of Covid 19 to counter hesitancy and to distribute resources.; Developing Advocacy messages Advocacy reached out to champions, elected leaders, and media to communicate messages. All funds to be sent to UNICEF, and jointly implemented by UNICEF, MOH and KANCO. Source: Gavi recordsL RA memo, 16 April 2020
July 2020: Delivery of PPE by UNICEF Source: Gavi records.
12 August 2020: Maintenance of Essential Health Services Working Group established Source: Gavi records.
Broader context
13 March 2020: first case detected: Soon after, the Government in Kenya introduced measures to limit the spread of COVID-19 mainly non- pharmaceutical interventions (NPIs) have been implemented in Kenya in line with global guidance to slow down the spread of the virus during the initial pandemic phase in 2020 and 2021. These included mandatory mask wearing, dawn to dusk curfews, lockdowns, physical distancing, closure of bars, restaurants and places of worship, lock downs or restriction of movement, long-term closure of schools and ban on public gatherings. Source: Gavi records.
NATIONAL COVID-19 Response plan produced Jan 2020 for period Feb-April, Jan 2020. Updated for period June-December 2020. Source: Gavi records.
World Bank support US$60m total including an initial 10m USD grant under the Contingency emergency response component of the transforming health systems for UHC project and later a Covid project called Kenya Covid-19 Emergency Response Project (50m US$) under the World Bank Global Covid 19 Strategic Preparedness and Response Program was developed and funded for the Ministry of Health. GF: Three C19RM awards totalling US$36.9 million were approved between June and December 2020. US-CDC, USAID, Danida, JICA, CHAI, UNICEF, and the Private Sector. Source: Gavi records.
1st March 2021: 1st Batch of vaccines arrived under COVAX mechanism, vaccination started 5th March. Source: Gavi records.
Full Portfolio Planning; in 2021 was reported as ongoing, through the Multi-Stakeholder Dialogue (MSD) replaced the joint planning for the 2020/21 period; however, no report is available.
COVAX CDS funding is available April 2021 data suggests US$10-15m was range available for Kenya – unclear if accessed.

6.2 Mozambique

Background

- Since identification of COVID-19 on 22 March 2020 up to 13 May 2022, there have been 225,470 infections and 2,201 coronavirus-related deaths (WHO, 2022)
- When comparing routine vaccination from 2018-2021 differences of low coverage were observed in March 2020 and March 2021 and from October to December 2020. From September until December 2021, the country experienced stockouts of DPT and IPV vaccines at the central warehouse.[13]
- The presidential decree announced on 30 March 2020 was misinterpreted, with the slogan "stay home" taken as a literal order to not leave their homes - people stopped seeking services and vaccination coverage dropped.[14] The provision of basic health services was also negatively impacted (e.g. antenatal services, outpatient consultations, at risk child consultations and immunization services witnessed reduced demand, particularly at the beginning of the pandemic).

Flexibilities accessed:

- Mozambique accessed one key flexibilities under R&P: Reprogramming of HSS grant funds directed towards procurement of PPE and communication campaigns. Additionally, Mozambique undertook a routine reprogramming of the HSS grant in 2021 channelling funding to further support communication efforts and the work of mobile brigades to catch up on lost routine vaccinations.

Findings

Right Design – overall R&P flexibilities were seen as very relevant, streamlined and helpful in filling initial gaps in the COVID-19 response

- The engagement of Gavi partners and others in the design and implementation of the COVID-19 preparedness and response plan was considered relevant to the results achieved with respect to the COVID-19 response.
- The national response plan for preparedness and response to COVID-19 and the proposed activity plan for the reallocation of 10% of HSS funds (March 2020) and reprogrammed (bridge) HSS funds (March 2021) were conceptualized and prepared with extensive involvement of Gavi partners and other MoH cooperation partners.
- The needs, for PPE and information campaigns, were in line with the COVID-19 country plan however PPE being on a smaller scale than other donors and certainly not enough to fill the needs of the country. The campaigns were far reaching and timely according to key stakeholders, despite their delay in implementation.
- However, M&R&S guidance was never shared with the country as it was deemed unnecessary due the additional routine reprogramming of HSS funding (March 2021) that would otherwise have not been utilized prior to grant completion.

Right Ways – timeliness and efficiency of R&P flexibilities were seen as generally good however delays in execution of funding channelled to the MoH were evident

- Gavi was one of the prominent key partners expressing the willingness to support the country for the response to COVID-19 in the years 2020/21 through reallocation of 10% HSS funding ($2.98mill) in addition to routinely reprogrammed (bridge) HSS funding ($714,000).

[13] Vaccine Readiness and Recovery Plan in the context of COVID-19
Contributing to maintaining the protection of children against vaccine-preventable diseases, Final Draft V2.0 (27 June 2020); Extracts from the MoH DHIS (provided by the EPI Manager)
[14] Based on key informant interviews and extracts from the MoH DHIS (provided by the EPI Manager)

- Compared to the usual procedures and requirements for accessing Gavi funds, the reallocation of 10% of funds and reprogramming of available funds, followed simplified and more flexible processes.
- Although Gavi was not directly involved in any national coordination meetings for the response to COVID-19, key Gavi partners supporting the EPI program participated in the national coordination meetings and were active in various technical working groups (sub-groups) of the coordination committee.
- On the level of execution of the 10% of reallocated HSS as of December 2020, only 3% had been spent, as of December 2021 73% had been spent, and as of end March 2022 91% had been spent.
- Areas most affected by COVID-19, and with low immunization coverage, were prioritized for the recovery of lost to follow up and unvaccinated children through the intensification of mobile brigades which was supported through routine (bridge) reprogramming undertaken in 2021.

Right Results – the response to COVID-19 was timely and well-coordinated by Government with Gavi contributing however on a relatively small scale in relation to other funders and with a limited focus on RI

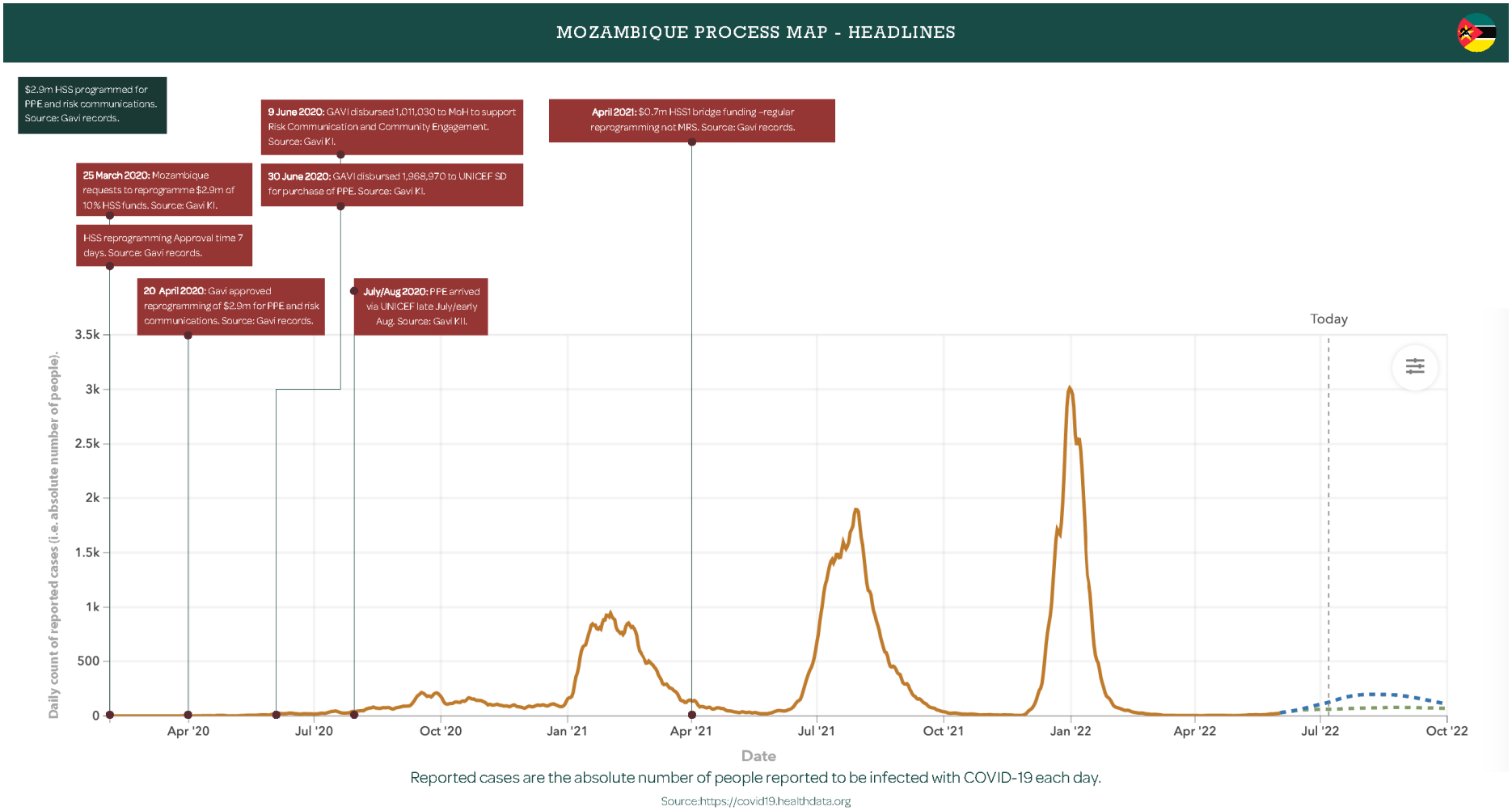
- There is widespread recognition of the readiness with which Gavi expressed its willingness to support some of the key gaps identified by the government to be able to implement its plan (notably acquisition of PPE to frontline health providers and relevant funding on risk communication and community engagement interventions).
- Gavi's timely commitment to respond to COVID-19 was considered to have catalysed the response of the other partners who promised initial funding but delayed in actual commitment and disbursement.
- Gavi funding contributed to the acquisition of PPE thereby narrowing the availability gap for frontline health providers, albeit the contribution was relatively small in comparison to others. In addition, it was not possible to track disbursement of the equipment and therefore not possible to concretely say that PPE support routine immunization efforts.
- Bridge funding (routine reprogramming) contributed to catalyse provincial and district level supervision activities in the field of vaccination against COVID-19; provision of subsidies to vaccination teams and funding of awareness-raising spots on COVID-19 in the first phase of vaccination.

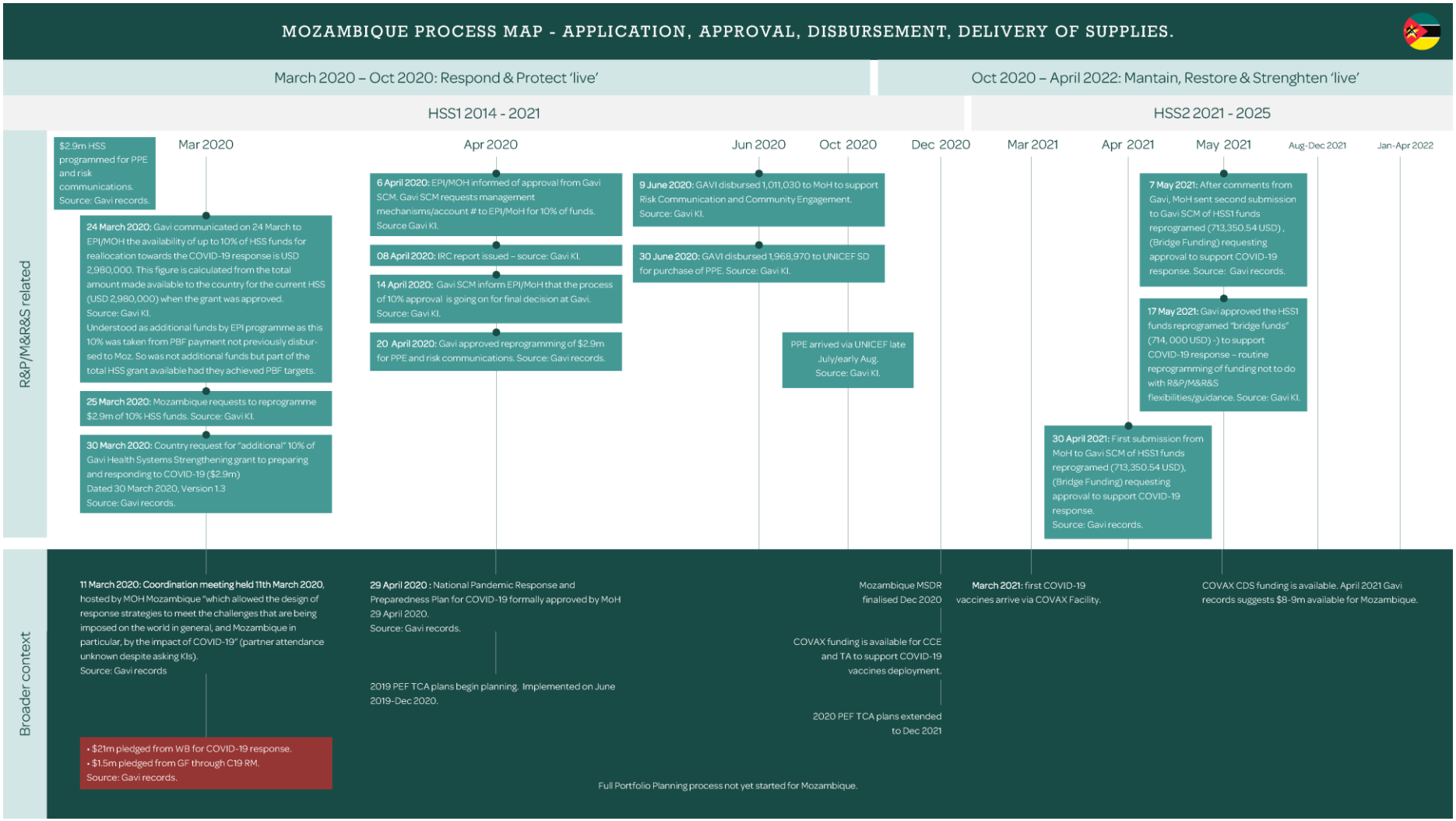
Lessons

- Teamwork and better coordination to jointly respond to COVID-19 was seen as a critical aspect that contributed to the achievement of the observed results along with the commitment of government leaders to the national response.
- Periodic assessments of the impact of COVID-19 on the provision of services were essential to detect the unintended consequences of the response and the impact of COVID-19 and to course correct and more accurately plan for interventions/needs.[15]

[15] Periodic assessments, on a monthly basis, were conducted by the EPI technical working group. During these assessments issues of service provision challenges for both the users and providers were discussed along with mitigating actions. An example of this course correction included working on the mobilization and recovery plan including a reorientation towards intensification of the mobile brigades. Based on an analysis conducted to identify and prioritise the districts that were most affected and with zero dose children, funds were made available to increase the activities of the mobile brigades and many "lost" children were vaccinated.
It was also reported by key informants that an assessment of the impact of COVID-19 on health and immunization services was done in 2020. The results showed that people were not going to health facilities and were afraid as the messages disseminated encouraged people to focus on staying home to prevent COVID-19. Messages encouraging people to continue with routine vaccination and other primary health activities were later adapted and made available through media channels.

- The challenge of exhaustive planning was notorious, even with the support of the partners. Budget planning was done according to the funds pledged by each of the partners based on the ceiling presented/available rather than needs.
- The need to improve coordination and mutual accountability by Gavi partners is recognized to avoid duplication of efforts and maximize support provided.


MOZAMBIQUE PROCESS MAP - HEADLINES
$2.9m HSS programmed for PPE and risk communications. Source: Gavi records.
25 March 2020: Mozambique requests to reprogramme $2.9m of 10% HSS funds. Source: Gavi KI.
HSS reprogramming Approval time 7 days. Source: Gavi records.
20 April 2020: Gavi approved reprogramming of $2.9m for PPE and risk communications. Source: Gavi records.
9 June 2020: GAVI disbursed 1,011,030 to MoH to support Risk Communication and Community Engagement. Source: Gavi KI.
30 June 2020: GAVI disbursed 1,968,970 to UNICEF SD for purchase of PPE. Source: Gavi KI.
July/Aug 2020: PPE arrived via UNICEF late July/early Aug. Source: Gavi KII.
April 2021: $0.7m HSS1 bridge funding –regular reprogramming not MRS. Source: Gavi records.
Today
Daily count of reported cases (i.e. absolute number of people).
3.5k
3k
2.5k
2k
1.5k
1k
500
0
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


MOZAMBIQUE PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Oct 2020: Respond & Protect 'live'
Oct 2020 – April 2022: Mantain, Restore & Strenghten 'live'
HSS1 2014 - 2021
HSS2 2021 - 2025
R&P/M&R&S related
Broader context
Mar 2020
Apr 2020
Jun 2020
Oct 2020
Dec 2020
Mar 2021
Apr 2021
May 2021
Aug-Dec 2021
Jan-Apr 2022
$2.9m HSS programmed for PPE and risk communications. Source: Gavi records.
24 March 2020: Gavi communicated on 24 March to EPI/MOH the availability of up to 10% of HSS funds for reallocation towards the COVID-19 response is USD 2,980,000. This figure is calculated from the total amount made available to the country for the current HSS (USD 2,980,000) when the grant was approved. Source: Gavi KI. Understood as additional funds by EPI programme as this 10% was taken from PBF payment not previously disbursed to Moz. So was not additional funds but part of the total HSS grant available had they achieved PBF targets.
25 March 2020: Mozambique requests to reprogramme $2.9m of 10% HSS funds. Source: Gavi KI.
30 March 2020: Country request for "additional" 10% of Gavi Health Systems Strengthening grant to preparing and responding to COVID-19 ($2.9m) Dated 30 March 2020, Version 1.3 Source: Gavi records.
6 April 2020: EPI/MOH informed of approval from Gavi SCM. Gavi SCM requests management mechanisms/account # to EPI/MoH for 10% of funds. Source Gavi KI.
08 April 2020: IRC report issued – source: Gavi KI.
14 April 2020: Gavi SCM inform EPI/MoH that the process of 10% approval is going on for final decision at Gavi. Source: Gavi KI.
20 April 2020: Gavi approved reprogramming of $2.9m for PPE and risk communications. Source: Gavi records.
9 June 2020: GAVI disbursed 1,011,030 to MoH to support Risk Communication and Community Engagement. Source: Gavi KI.
30 June 2020: GAVI disbursed 1,968,970 to UNICEF SD for purchase of PPE. Source: Gavi KI.
PPE arrived via UNICEF late July/early Aug. Source: Gavi KI.
7 May 2021: After comments from Gavi, MoH sent second submission to Gavi SCM of HSS1 funds reprogramed (713,350.54 USD) , (Bridge Funding) requesting approval to support COVID-19 response. Source: Gavi records.
17 May 2021: Gavi approved the HSS1 funds reprogramed "bridge funds" (714, 000 USD) -) to support COVID-19 response – routine reprogramming of funding not to do with R&P/M&R&S flexibilities/guidance. Source: Gavi KI.
30 April 2021: First submission from MoH to Gavi SCM of HSS1 funds reprogramed (713,350.54 USD), (Bridge Funding) requesting approval to support COVID-19 response. Source: Gavi records.
11 March 2020: Coordination meeting held 11th March 2020, hosted by MOH Mozambique "which allowed the design of response strategies to meet the challenges that are being imposed on the world in general, and Mozambique in particular, by the impact of COVID-19" (partner attendance unknown despite asking KIs). Source: Gavi records
• $21m pledged from WB for COVID-19 response.
• $1.5m pledged from GF through C19 RM.
Source: Gavi records.
29 April 2020 : National Pandemic Response and Preparedness Plan for COVID-19 formally approved by MoH 29 April 2020. Source: Gavi records.
2019 PEF TCA plans begin planning. Implemented on June 2019-Dec 2020.
Mozambique MSDR finalised Dec 2020
COVAX funding is available for CCE and TA to support COVID-19 vaccines deployment.
2020 PEF TCA plans extended to Dec 2021
March 2021: first COVID-19 vaccines arrive via COVAX Facility.
COVAX CDS funding is available. April 2021 Gavi records suggests $8-9m available for Mozambique.
Full Portfolio Planning process not yet started for Mozambique.

6.3 Niger

Background

- **Niger recorded its first case of COVID-19 on 19 March 2020.** Since then, the country has experienced three waves of COVID-19. A state of health emergency was declared in March. Lockdown was implemented, including closing Niamey airport, followed by schools and universities. By May 6, Niger had 770 confirmed cases, 561 recoveries and 38 deaths. At the beginning of the pandemic, with government measures and fear of the disease, there was a drop in attendance at health facilities.

Right design

- Gavi's flexibilities were relevant in terms of being able (in theory) to respond to the national needs outlined in the National COVID-19 Response, and in terms of being available rapidly (in theory). They were designed to be available speedily, using existing funds already in the country. The design of flexibilities was coherent and aligned with other partners supporting the national response to COVID-19, framed by WHO Pillars. KIs suggested the design could have been more responsive to Niger's needs had the funds been fully fungible and able to be used according to evolving needs.

Right ways

- Gavi approved three flexibilities in Niger:
- **R&P reprograming**: In collaboration with Alliance partners WHO and UNICEF, Niger chose not to access the $4.7m available in R&P 10% HSS ceiling for fear of needing these funds for RI2. Instead, Niger identified unspent funds from six earlier vaccine grants and requested to reprogramme US$ 653 000, of which US$ 592 000 was approved. Approved funds were to cover IPC, strengthened surveillance for COVID-19, strengthen 8 regional and 72 district level epidemic management committees, and to produce materials for and fund risk communication and community engagement activity. $85k did not get approved. This was requested to carry out risk communication at community levels. Gavi deemed the high proportion of per diem costs for outreach workers too high and too much of a fiduciary risk. In terms of IPC supplies the AR memo noted intention to procure via the UNICEF SD special arrangement, however KIs confirmed this did not happen. KIs noted that the GoN decided instead to procure PPE via the National Procurement body ONPPC as the procedure for this would have been quicker and easier than procuring via UNICEF. In practice, however, we understand (from another KI) that all PPE procured, by the GoN and WB arrived in October/November 2020. It is unclear whether the GoN used Gavi funds to procure PPE.
- **R&P PEF TCA:** Niger requested and had approved a no-cost extension (NCE) of the 2019 PEF TCA plans for CDC Foundation, UNICEF and WHO. KIs commented that NCE are regular practice in Niger due to the length of time it takes for annual planning. By the time annual plans are agreed it is too late in the year to allow for full implementation.
- **M&R&S reprogramming:** A request was recently approved for a no-cost extension and budget reprogramming of Niger's HSS3 grant until end of 2023. Secretariat staff confirmed that among other changes, three activities (of an overall budget of USD 1 040 486) focusing on ZD Reach, were added to the initial budget. The evaluation team were not able to triangulate this information with written documentation.

Right results

- It is not possible to say anything concrete in this area. One focus group suggested that approx. one third of reprogramming funds had been used in practice. It was not possible for the

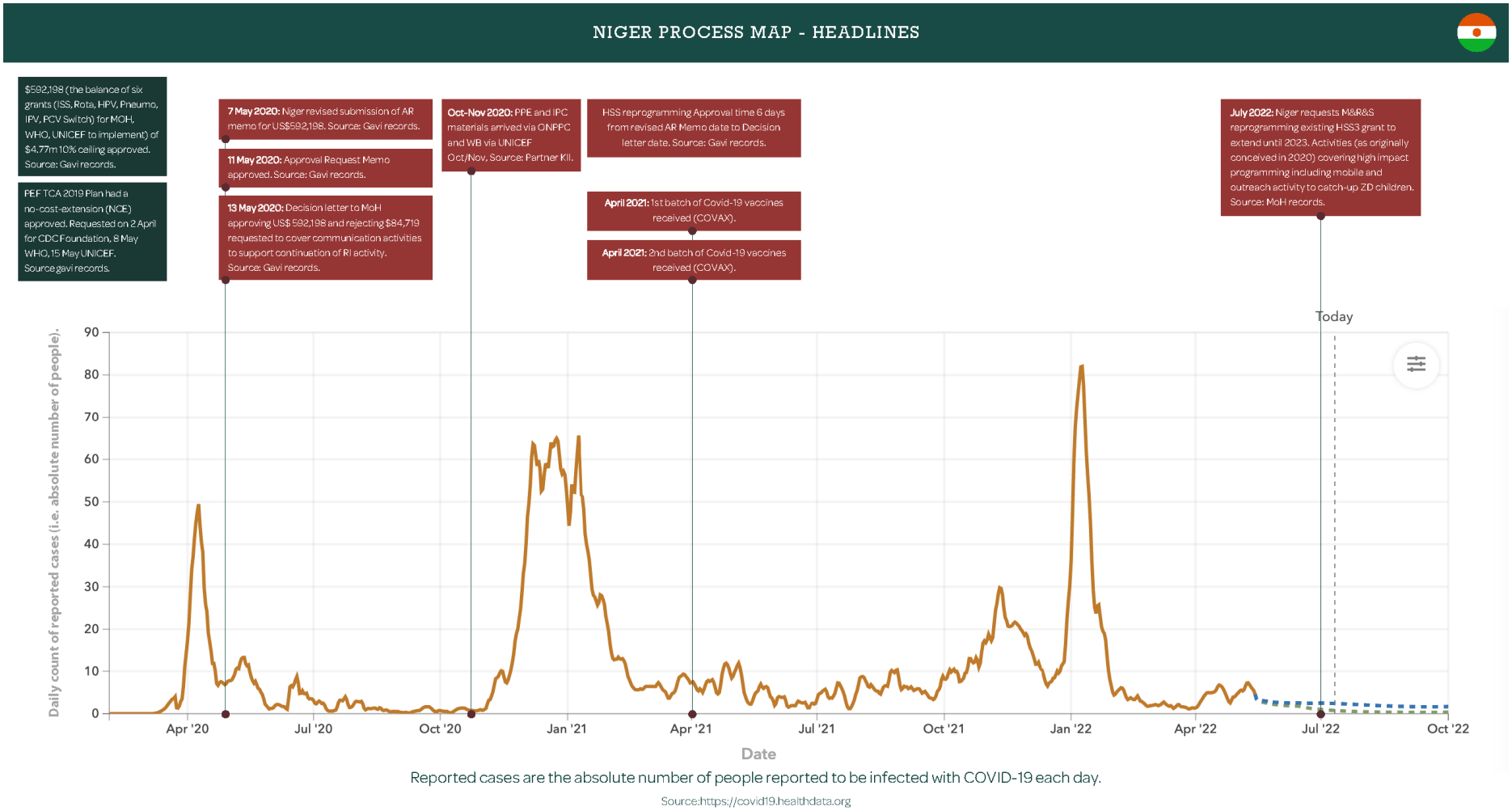
evaluation team to verify this through any evidence of amount of funds spent in X or Y activity areas.[16]

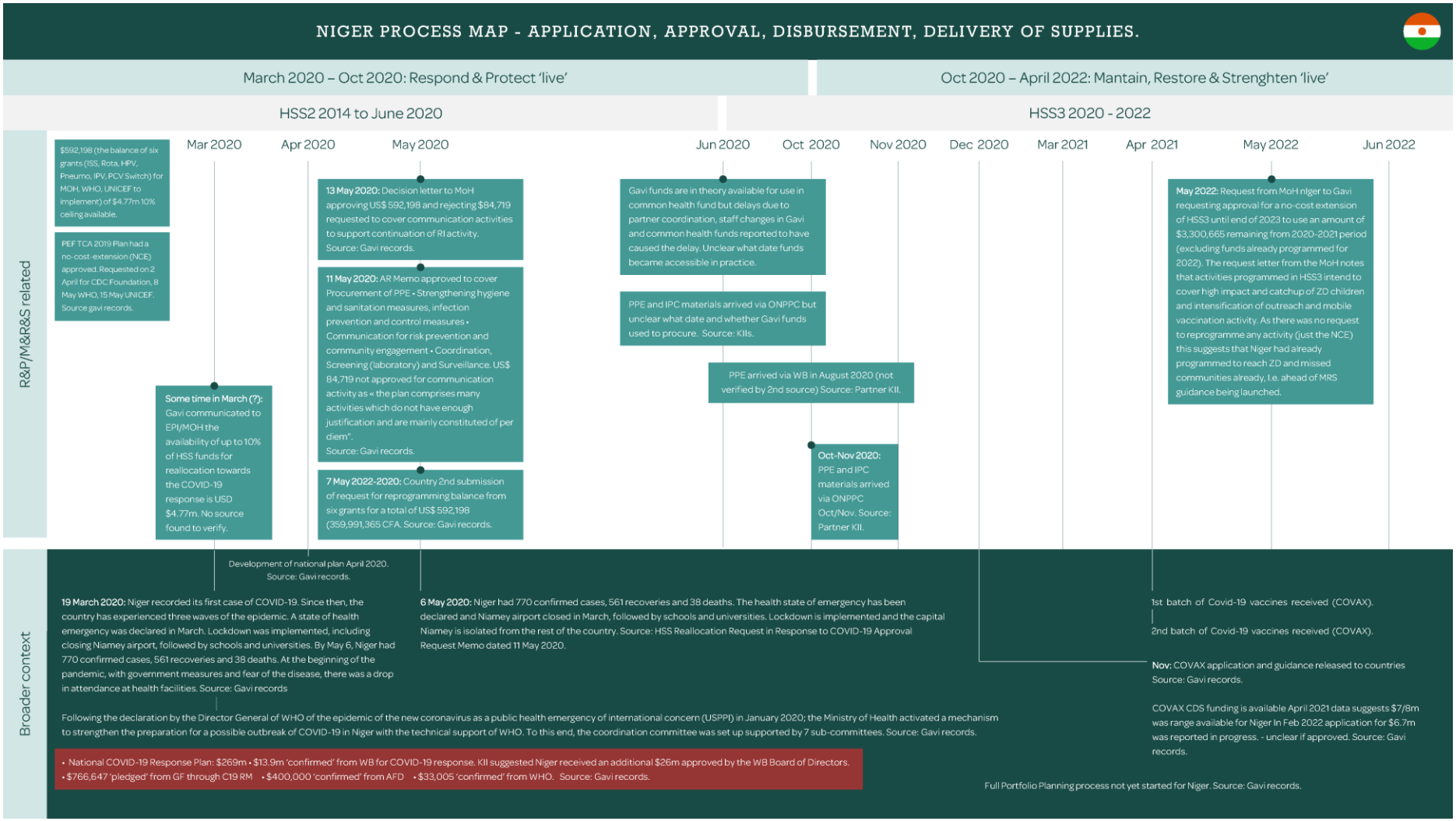
- Several KIs noted that Gavi's funds had been useful in supporting the strengthening of epidemic management committees, and that embedded consultants (funded via regular pre-COVID-19 PEF TCA plans) were helping the MoH to identify additional donor resources to cover the implementation of ZD and missed communities' strategies.

Lessons

- **For Gavi:** There is a need to have more fungibility/flexibility in the use of flexibilities' funding in crisis situations - to allow the country to use them as they see fit, as needs evolve.
- **More broadly:** The use of existing mechanisms for coordination in a crisis in the country such as the one health committee proved helpful and was noted by most KIIs as having helped Niger respond and coordinate its national COVID-19 response quickly.

[16] Not limited to the scope of this evaluation, one key informant noted that the lack of data was a particular challenge in Niger, and despite the GoN having attempted to track and document what different partners had spent on COVID-19 response, partners were reluctant and / or not able to share this information


NIGER PROCESS MAP - HEADLINES
$592,198 (the balance of six grants (ISS, Rota, HPV, Pneumo, IPV, PCV Switch) for MOH, WHO, UNICEF to implement) of $4.77m 10% ceiling approved. Source: Gavi records.
PEF TCA 2019 Plan had a no-cost-extension (NCE) approved. Requested on 2 April for CDC Foundation, 8 May WHO, 15 May UNICEF. Source gavi records.
7 May 2020: Niger revised submission of AR memo for US$592,198. Source: Gavi records.
11 May 2020: Approval Request Memo approved. Source: Gavi records.
13 May 2020: Decision letter to MoH approving US$ 592,198 and rejecting $84,719 requested to cover communication activities to support continuation of RI activity. Source: Gavi records.
Oct-Nov 2020: PPE and IPC materials arrived via ONPPC and WB via UNICEF Oct/Nov, Source: Partner KII.
HSS reprogramming Approval time 6 days from revised AR Memo date to Decision letter date. Source: Gavi records.
April 2021: 1st batch of Covid-19 vaccines received (COVAX).
April 2021: 2nd batch of Covid-19 vaccines received (COVAX).
July 2022: Niger requests M&R&S reprogramming existing HSS3 grant to extend until 2023. Activities (as originally conceived in 2020) covering high impact programming including mobile and outreach activity to catch-up ZD children. Source: MoH records.
Today
Daily count of reported cases (i.e. absolute number of people).
0
10
20
30
40
50
60
70
80
90
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


NIGER PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Oct 2020: Respond & Protect 'live'
Oct 2020 – April 2022: Mantain, Restore & Strenghten 'live'
HSS2 2014 to June 2020
HSS3 2020 - 2022
R&P/M&R&S related
Mar 2020
Apr 2020
May 2020
Jun 2020
Oct 2020
Nov 2020
Dec 2020
Mar 2021
Apr 2021
May 2022
Jun 2022
$592,198 (the balance of six grants (ISS, Rota, HPV, Pneumo, IPV, PCV Switch) for MOH, WHO, UNICEF to implement) of $4.77m 10% ceiling available.
PEF TCA 2019 Plan had a no-cost-extension (NCE) approved. Requested on 2 April for CDC Foundation, 8 May WHO, 15 May UNICEF. Source gavi records.
Some time in March (?): Gavi communicated to EPI/MOH the availability of up to 10% of HSS funds for reallocation towards the COVID-19 response is USD $4.77m. No source found to verify.
13 May 2020: Decision letter to MoH approving US$ 592,198 and rejecting $84,719 requested to cover communication activities to support continuation of RI activity. Source: Gavi records.
11 May 2020: AR Memo approved to cover Procurement of PPE • Strengthening hygiene and sanitation measures, infection prevention and control measures • Communication for risk prevention and community engagement • Coordination, Screening (laboratory) and Surveillance. US$ 84,719 not approved for communication activity as « the plan comprises many activities which do not have enough justification and are mainly constituted of per diem". Source: Gavi records.
7 May 2022-2020: Country 2nd submission of request for reprogramming balance from six grants for a total of US$ 592,198 (359,991,365 CFA. Source: Gavi records.
Gavi funds are in theory available for use in common health fund but delays due to partner coordination, staff changes in Gavi and common health funds reported to have caused the delay. Unclear what date funds became accessible in practice.
PPE and IPC materials arrived via ONPPC but unclear what date and whether Gavi funds used to procure. Source: KIIs.
PPE arrived via WB in August 2020 (not verified by 2nd source) Source: Partner KII.
Oct-Nov 2020: PPE and IPC materials arrived via ONPPC Oct/Nov. Source: Partner KII.
May 2022: Request from MoH nIger to Gavi requesting approval for a no-cost extension of HSS3 until end of 2023 to use an amount of $3,300,665 remaining from 2020-2021 period (excluding funds already programmed for 2022). The request letter from the MoH notes that activities programmed in HSS3 intend to cover high impact and catchup of ZD children and intensification of outreach and mobile vaccination activity. As there was no request to reprogramme any activity (just the NCE) this suggests that Niger had already programmed to reach ZD and missed communities already, I.e. ahead of MRS guidance being launched.
Broader context
Development of national plan April 2020. Source: Gavi records.
19 March 2020: Niger recorded its first case of COVID-19. Since then, the country has experienced three waves of the epidemic. A state of health emergency was declared in March. Lockdown was implemented, including closing Niamey airport, followed by schools and universities. By May 6, Niger had 770 confirmed cases, 561 recoveries and 38 deaths. At the beginning of the pandemic, with government measures and fear of the disease, there was a drop in attendance at health facilities. Source: Gavi records
6 May 2020: Niger had 770 confirmed cases, 561 recoveries and 38 deaths. The health state of emergency has been declared and Niamey airport closed in March, followed by schools and universities. Lockdown is implemented and the capital Niamey is isolated from the rest of the country. Source: HSS Reallocation Request in Response to COVID-19 Approval Request Memo dated 11 May 2020.
1st batch of Covid-19 vaccines received (COVAX).
2nd batch of Covid-19 vaccines received (COVAX).
Nov: COVAX application and guidance released to countries Source: Gavi records.
COVAX CDS funding is available April 2021 data suggests $7/8m was range available for Niger In Feb 2022 application for $6.7m was reported in progress. - unclear if approved. Source: Gavi records.
Following the declaration by the Director General of WHO of the epidemic of the new coronavirus as a public health emergency of international concern (USPPI) in January 2020; the Ministry of Health activated a mechanism to strengthen the preparation for a possible outbreak of COVID-19 in Niger with the technical support of WHO. To this end, the coordination committee was set up supported by 7 sub-committees. Source: Gavi records.
• National COVID-19 Response Plan: $269m • $13.9m 'confirmed' from WB for COVID-19 response. KII suggested Niger received an additional $26m approved by the WB Board of Directors.
• $766,647 'pledged' from GF through C19 RM • $400,000 'confirmed' from AFD • $33,005 'confirmed' from WHO. Source: Gavi records.
Full Portfolio Planning process not yet started for Niger. Source: Gavi records.

6.4 Nigeria

Background

- Nigeria is a federal republic comprising 36 states and a Federal Capital Territory, with a total population estimated at 200 million and a birth cohort of 7.3 million children.[17] About 70% of people live in poverty. In addition, Nigeria has an extremely high burden of communicable diseases with a considerable incidence of vaccine-preventable diseases (VPDs) among children under 5. The country is classified as a lower-middle-income country due to the many social and economic challenges facing the nation
- The COVID-19 pandemic strained the health system in Nigeria, just like many other countries across the world and this caused marked disruptions to routine immunisation service delivery, particularly during the early phases of the pandemic (March – July 2020).[18] However, NICS/MICS 2021 data shows the country maintained the gains made previously (e.g., 70% DTP1/57% DTP3)

Findings

Right Design

- GAVI flexibilities (financial resources) were deployed to fill gaps which were useful to implement activities aimed at tackling the disruptions caused by the pandemic; funding went towards improving coordination among various partners responding to the pandemic, technical capacity support to the Presidential Taskforce for COVID-19 (PTF); PPE procurement, ICT strengthening in support of virtual meetings, HCW training, support to identifying under vaccinated children. The assumptions behind the need for these resources were that other donors' funds would take longer to materialise and that there were immediate gaps which Gavi could fill, especially related to targeting community level and frontline health workers. Several development partners (NGOs, donors, private sector and CSOs) provided different support to complement the efforts of the Government of Nigeria to tackle the COVID-19 pandemic, however there was – as anticipated – a problem with timely release of funds from various partners. Gavi HSS resources reprogrammed essentially came at a zero-opportunity cost/loss to the EPI programme because the ~12 million came from a budget line initially allocated for the CCEOP joint investment, which the government decided to instead fund itself with resources under a World Bank loan. In addition, there were many activities that were put on hold during COVID and this resulted in core and expanded partners having budget lines that could be redirected to immediate covid response efforts and longer term RI recovery needs.
- Nigeria is a special Gavi case, with many flexibilities other countries do not have. For this reason, some KIIs were of the view that the flexibilities were not very impactful for Nigeria relative to what could be accomplished anyway. The Nigeria country team shared the Respond and Protect (R&P) guidance in early April and received two applications from Nigerian agencies for R&P HSS reallocation. There was initial confusion about which of the Government agencies between the NPHCDA and the NCDC should apply to GAVI for the support; GAVI replied that there should be harmonization of both applications and coordination among both Government agencies to put forward only one application for the country. According to KIs, other aspects of the flexibilities were not as clearly communicated as the R&P HSS reallocation potential: the subsequent change in PPE eligibility later in 2020; the different approaches/delineation among the different flexibilities; and co-financing eligibility.
- The support provided by GAVI through its flexibilities (reprogramming of HSS funds) was aligned with the National COVID-19 response plan developed by the Government of Nigeria and with WHO guidelines on COVID19 response. Assurance was provided during the application stage

[17] UNICEF, Immunization Regional Snapshot 2019, West and Central Africa, 2019, https://data.unicef.org/wp-content/uploads/2020/04/1-Immunization-Profile-WCAR-2019.pdf

[18] UNICEF, Tracking the situation of children during COVID-19, May 2021 Situation of children during COVID-19

that Gavi resources would be complementary the support committed by other development partners (World Bank, USCDC). Reallocated funds also strengthened systems towards both MRS and Zero dose Gavi 5.0 objectives.

Right Ways

- The (Presidential Taskforce on COVID-19) PTF provided the right leadership, oversight and guidance of the various implementation efforts in line with the WHO technical guidance/strategies while adapting these technical resources to the local country context. Gavi's communication of the flexibilities and its responses to country queries were prompt. Technical capacity support to the PTF (via Syndani) was funded by Gavi and this supported a quickened response from the Nigerian side. Nonetheless, some delays were experienced from the countryside, due to initial confusion about which agency should apply (NCDC or NPHCDA), the time taken to co-ordinate the applications of these agencies and time taken respond to queries raised when the application was incomplete or lacking clarity. Government was also a bit slow to sign off on sending funds to UNICEF for procurement, and KI perceptions were that UNICEF SD was also slow to send cost estimates. Although Gavi's part was played very efficiently by promptly approving the flexibilities, the result was not satisfactory, as PPE was received extremely late and some of the items were comparatively overpriced. There were also issues with the ability to track which goods had been procured with Gavi funds.
- There are several dashboards which collect data on covid-committed funds; they show some inconsistencies but roughly we can conclude that most of the funding came from the Federal Government of Nigeria (FGoN) and that Gavi's $12.24 m was substantial relative to other donors. Besides IPC procurement and operational support to PIRIs, GAVI also funded TA to the PTF and (mentioned above) and the Clinton Health Access Initiative (CHAI) to provide technical support to the Presidential Task Force on COVID-19 (PTF) to better improve coordination efforts among development partners and the private sector to prevent duplication of efforts. Other dashboards existed to collect data on funds committed to covid, none are complete, and they do not track actual disbursements. Despite the mechanisms to ensure co-ordination, there were some hiccups when it came to core partners being cut out of communication with extended partners.
- Extra attention was given to reaching underserved and vulnerable groups through tailored service delivery and social communication.

Right Results

- M&E: The initial proposal submitted to Gavi had a theory of change but there is no siloed M&E framework for the flexibilities.
- The COVID-19 pandemic strained the health system in Nigeria and led to disruptions to routine immunisation service delivery particularly during the early phase of the pandemic (March – July 2022) in 2020.19 As a result, access to routine immunisation services such as measles, polio and pertussis were affected.
- RI coverage dipped again when covid vaccination was introduced.
- Several strategies and interventions were put into place to try and recover RI gains. Although different versions of these initiatives had been piloted at a smaller scale, Gavi's support during the pandemic (since it provided dedicated funding for HCWs to visit remote areas) provided an opportunity to intensify and pilot these initiatives in new ways. Studies are ongoing to analyse the additional benefit and cost of these initiatives, to determine if they are efficient and should be continued.

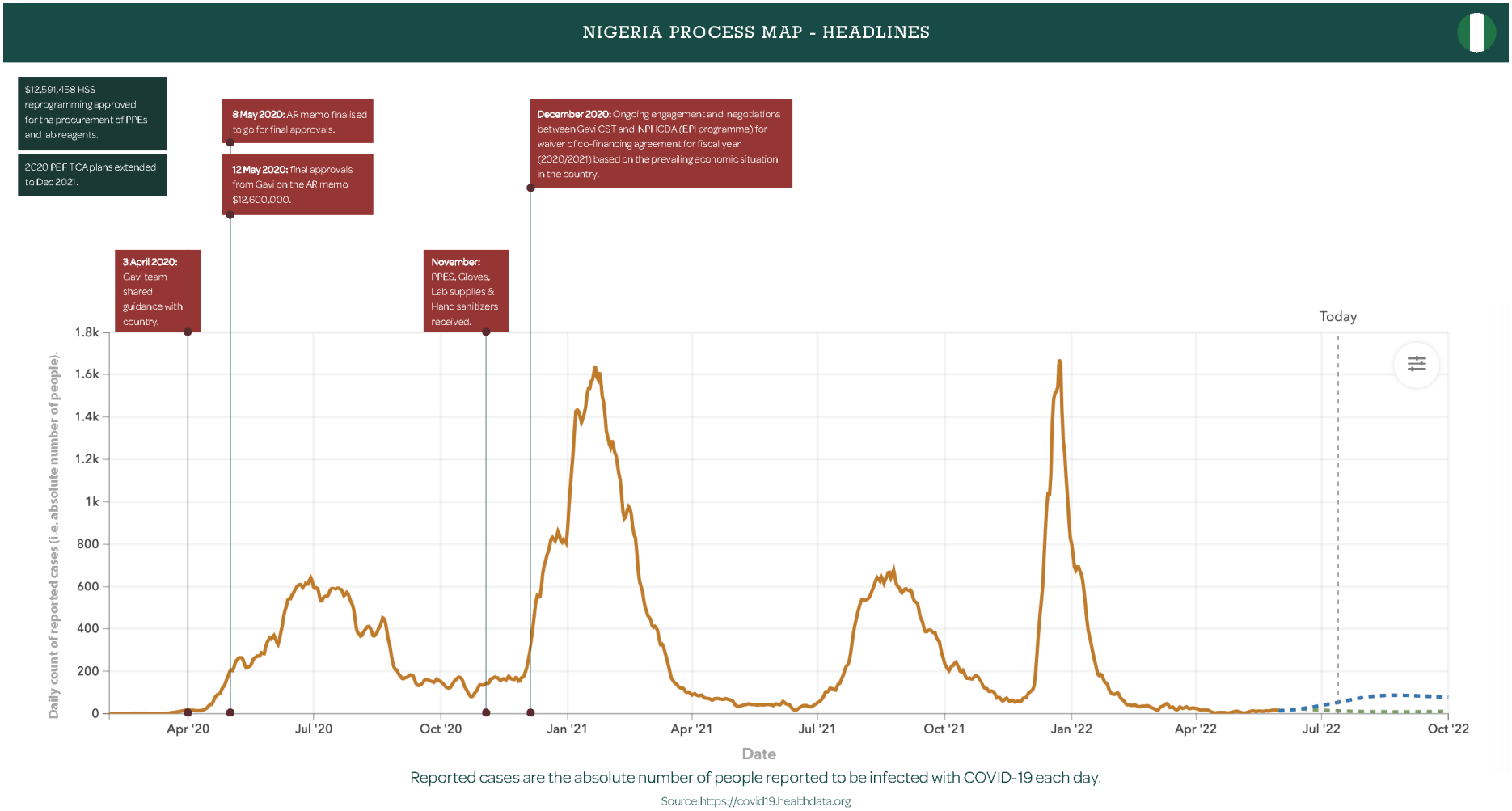
[19] UNICEF, Tracking the situation of children during COVID-19, May 2021 Situation of children during COVID-19 and (Figure 10, source: CHAI PSI-COVID)

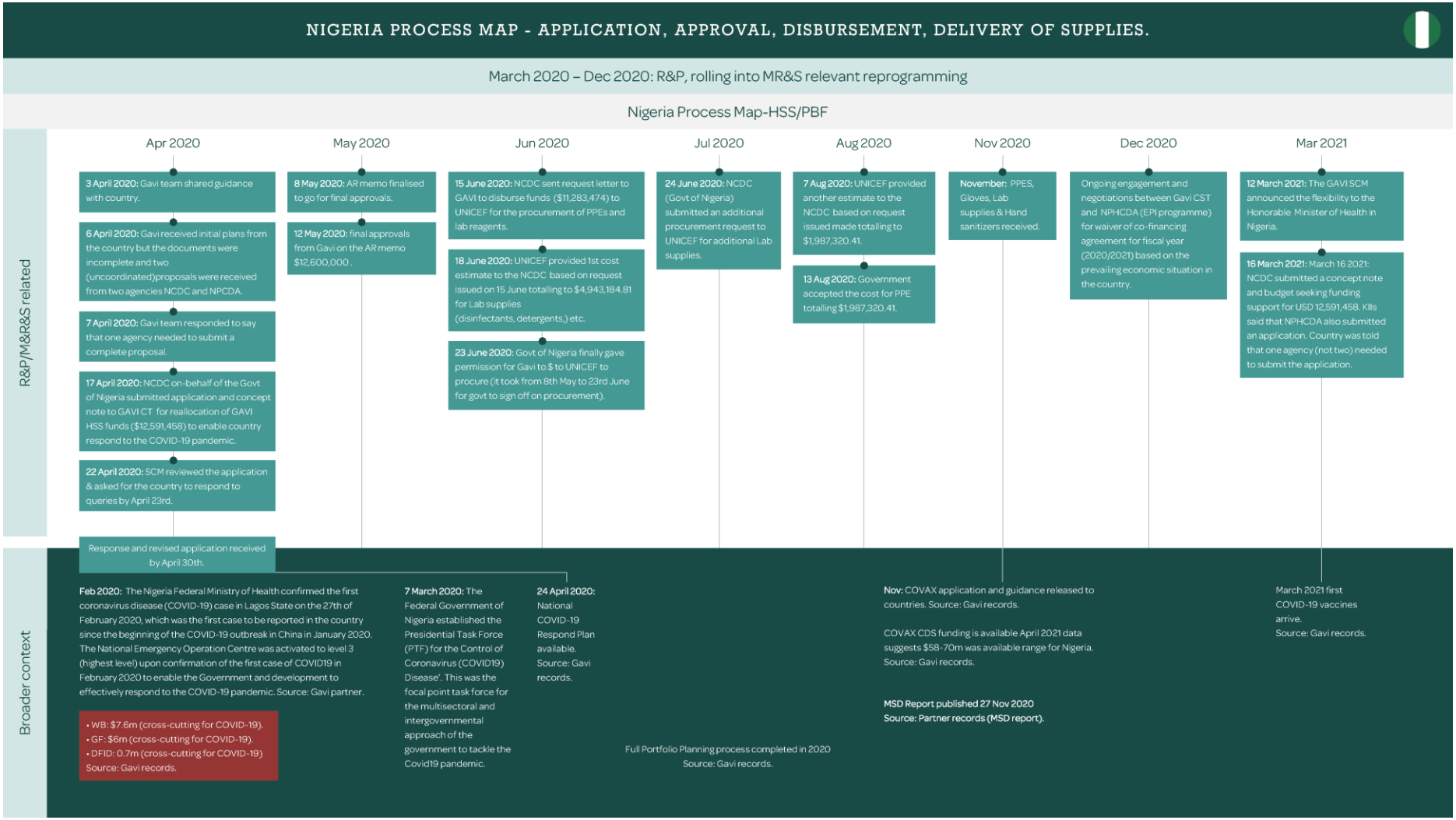
- Despite the pandemic, Nigeria has increased national DTP3 coverage to 56% in 2021, up from 33% in 2016 and has consistently met co-financing obligations.20 However, sub-optimal progress has been made across other accountability framework indicators such as the proportion of states that reached expected coverage rates for DTP3, IPV, and MCV.21

Lessons

- There are incentives operating to compel Gavi to do something different/extra in the face of a global pandemic shock. Gavi took the position of making the entire 10% HSS budget available at the start; alternatively, Gavi could have released some of the flexibility at the start and then, once more was known, released further flexibilities. But this might have been criticised for adding transaction costs. Some KIs are of the view that funding that went to PPE was lost to the Nigerian EPI programme. *"Anyone can fund PPE; getting to lost children is unique to Gavi"*
- The pandemic in Nigeria brought lessons about preparedness – in health and governance systems, logistics and supply chain, and the need for drawing on locally supplied and/or procured PPEs.

[20] Change from 2016 Multiple Indicator Cluster Surveys/National Immunization Coverage Survey (MICS/NICS) to the preliminary NICS/MICS 2021 data (as reported in Gavi's Report to the Programme and Policy Committee, 18-19May2022)
[21] Gavi's Report to the Programme and Policy Committee, 18-19May2022


NIGERIA PROCESS MAP - HEADLINES
$12,591,458 HSS reprogramming approved for the procurement of PPEs and lab reagents.
2020 PEF TCA plans extended to Dec 2021.
8 May 2020: AR memo finalised to go for final approvals.
12 May 2020: final approvals from Gavi on the AR memo $12,600,000.
December 2020: Ongoing engagement and negotiations between Gavi CST and NPHCDA (EPI programme) for waiver of co-financing agreement for fiscal year (2020/2021) based on the prevailing economic situation in the country.
3 April 2020: Gavi team shared guidance with country.
November: PPES, Gloves, Lab supplies & Hand sanitizers received.
Today
Daily count of reported cases (i.e. absolute number of people).
1.8k
1.6k
1.4k
1.2k
1k
800
600
400
200
0
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


NIGERIA PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Dec 2020: R&P, rolling into MR&S relevant reprogramming
Nigeria Process Map-HSS/PBF
R&P/M&R&S related
Apr 2020
May 2020
Jun 2020
Jul 2020
Aug 2020
Nov 2020
Dec 2020
Mar 2021
3 April 2020: Gavi team shared guidance with country.
6 April 2020: Gavi received initial plans from the country but the documents were incomplete and two (uncoordinated)proposals were received from two agencies NCDC and NPCDA.
7 April 2020: Gavi team responded to say that one agency needed to submit a complete proposal.
17 April 2020: NCDC on-behalf of the Govt of Nigeria submitted application and concept note to GAVI CT for reallocation of GAVI HSS funds ($12,591,458) to enable country respond to the COVID-19 pandemic.
22 April 2020: SCM reviewed the application & asked for the country to respond to queries by April 23rd.
Response and revised application received by April 30th.
8 May 2020: AR memo finalised to go for final approvals.
12 May 2020: final approvals from Gavi on the AR memo $12,600,000 .
15 June 2020: NCDC sent request letter to GAVI to disburse funds ($11,283,474) to UNICEF for the procurement of PPEs and lab reagents.
18 June 2020: UNICEF provided 1st cost estimate to the NCDC based on request issued on 15 June totalling to $4,943,184.81 for Lab supplies (disinfectants, detergents,) etc.
23 June 2020: Govt of Nigeria finally gave permission for Gavi to $ to UNICEF to procure (it took from 8th May to 23rd June for govt to sign off on procurement).
24 June 2020: NCDC (Govt of Nigeria) submitted an additional procurement request to UNICEF for additional Lab supplies.
7 Aug 2020: UNICEF provided another estimate to the NCDC based on request issued made totalling to $1,987,320.41.
13 Aug 2020: Government accepted the cost for PPE totalling $1,987,320.41.
November: PPES, Gloves, Lab supplies & Hand sanitizers received.
Ongoing engagement and negotiations between Gavi CST and NPHCDA (EPI programme) for waiver of co-financing agreement for fiscal year (2020/2021) based on the prevailing economic situation in the country.
12 March 2021: The GAVI SCM announced the flexibility to the Honorable Minister of Health in Nigeria.
16 March 2021: March 16 2021: NCDC submitted a concept note and budget seeking funding support for USD 12,591,458. KIIs said that NPHCDA also submitted an application. Country was told that one agency (not two) needed to submit the application.
Broader context
Feb 2020: The Nigeria Federal Ministry of Health confirmed the first coronavirus disease (COVID-19) case in Lagos State on the 27th of February 2020, which was the first case to be reported in the country since the beginning of the COVID-19 outbreak in China in January 2020. The National Emergency Operation Centre was activated to level 3 (highest level) upon confirmation of the first case of COVID19 in February 2020 to enable the Government and development to effectively respond to the COVID-19 pandemic. Source: Gavi partner.
• WB: $7.6m (cross-cutting for COVID-19).
• GF: $6m (cross-cutting for COVID-19).
• DFID: 0.7m (cross-cutting for COVID-19)
Source: Gavi records.
7 March 2020: The Federal Government of Nigeria established the Presidential Task Force (PTF) for the Control of Coronavirus (COVID19) Disease'. This was the focal point task force for the multisectoral and intergovernmental approach of the government to tackle the Covid19 pandemic.
24 April 2020: National COVID-19 Respond Plan available. Source: Gavi records.
Full Portfolio Planning process completed in 2020
Source: Gavi records.
Nov: COVAX application and guidance released to countries. Source: Gavi records.
COVAX CDS funding is available April 2021 data suggests $58-70m was available range for Nigeria. Source: Gavi records.
MSD Report published 27 Nov 2020
Source: Partner records (MSD report).
March 2021 first COVID-19 vaccines arrive.
Source: Gavi records.

6.5 Pakistan

Background

- Pakistan is the fifth-most populous country in the world, with a population of around 230 million people in 2022. Administratively, Pakistan has four provinces – Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Balochistan and three federating areas of Gilgit Baltistan (GB), Azad Jammu and Kashmir (AJK) and Islamabad Capital Territory (ICT).
- Gavi Health Systems Strengthening support to Pakistan have been managed through the World Bank (WB) Multi-donor Trust Fund- National Immunisation Support Project (NISP), by WHO/UNICEF, and since 2018, contracting direct to extended partners. HSS largest sum through WB NISP (100m), smaller amounts to UNICEF (6m), WHO (14m), IRD (1.6) Acasus (1.2) Civil Society Human and Institutional Development Programme (CHIP)(.5). Other Gavi grants relate to VIG (measles, TCV, IPV2, PCV, MR) and PBF. Additionally, funds have been channelled through expanded partners such as John Snow International (JSI), JHPEIGO and PHC Global to provide technical assistance in different areas.
- Pakistan reported its first COVID-19 case on February 26, 2020, and as of January 18, 2022, there are 1,338,993 confirmed cases with 29,037 reported deaths. The ongoing pandemic has had a considerable impact on Pakistan's health delivery system especially RI services.
- In such challenging situation, Gavi offered the opportunity to reallocate or reprogramme the existing HSS (and/or use the option to programme the country's PBF award) to respond to immediate needs presented by the COVID-19 pandemic and restore routine immunisation. This support was executed with a participatory and effective coordination between the government and expanded partners.

Right Design

- It has not been possible to establish what funds were used under R&P, nor is it clear whether Pakistan accessed any MR&S flexibilities. This appears to be partly due to incomplete record keeping and partly due to lack of clarity in the conceptualisation and definition of what constitutes R&P and MR&S.
- Funding PPE procurement was relevant to the needs in the country once services started to reopen as of quarter 2 of 2020. However, even though memos to agree using the UNICEF special arrangement were approved as of May 8 2020, the first six months of PPE procurement came from sources other than Gavi.
- The flexibilities offered a few speed advantages, but Pakistan could have done the same thing if R&P and MR&S had not existed as initiatives.
- The options available to Pakistan in terms of flexibilities were communicated in a discretionary manner to Pakistan stakeholders.
- It is clear that the allocation/mix of activities supported through HSS and PBF reprogramming were strategically focused (aligned with priority needs for mitigating Covid-19 impact on RI).
- The operational activities funded through HSS reprogramming and the PBF (see Annex 3 for activity and budget breakdown) are directly focused on 5.0 Goals of reaching newly and persistently missed communities, in alignment with Gavi's comparative advantage.
- The portion of funding reprogrammed for PPE purchase was, in theory, aligned with 5.0 Goals (HCWs needed them to restart services) and with comparative advantage of the Gavi Alliance (the idea that UNICEF could offer superior VfM to alternatives) however, the theoretical advantages did not play out in practice, with PPE being overpriced and arriving late.
- Coherence was assured through each partner contributing towards an agreed 3-phase, costed restore and maintain plan; this plan met priority needs and is aligned with both MR&S and zero dose objectives.

Right Ways

- Under covid, pre-established mechanisms for EPI coordination were superseded by new mechanisms and strong government leadership and finance contributions, although the coordination and communication were not without hiccups.
- Other donors' contributions towards operational costs of the covid response were relatively limited in Pakistan although substantial when it comes to funding covid vaccination costs.
- KIIs were very complimentary re: Gavi's flexibility and responsiveness and there is evidence of effective partner working between Gavi, technical partners and the EPI programme to retain commitments to RI objectives.
- Procurement through UNICEF SD was not timely, and prices were very high. With hindsight, Gavi funding of PPE procurement via UNICEF SD may not have been the best use of Gavi resources.
- Ensuring RI coverage to vulnerable and missed populations was central to the strategies already in Pakistan's HSS plans since 2018; these efforts were able to be intensified with the support of the PBF and reprogrammed HSS funds.
- Several positive innovations arose out of the effort to restore RI after covid.
- A version of Pakistan's co-financing waiver request was accepted; that is, rather than treating it as a straight waiver of vaccine costs, the funds were released to UNICEF to establish a financial buffer to guard against provinces paying late in the future. Communications on that flexibility were unclear and the process was lengthy.

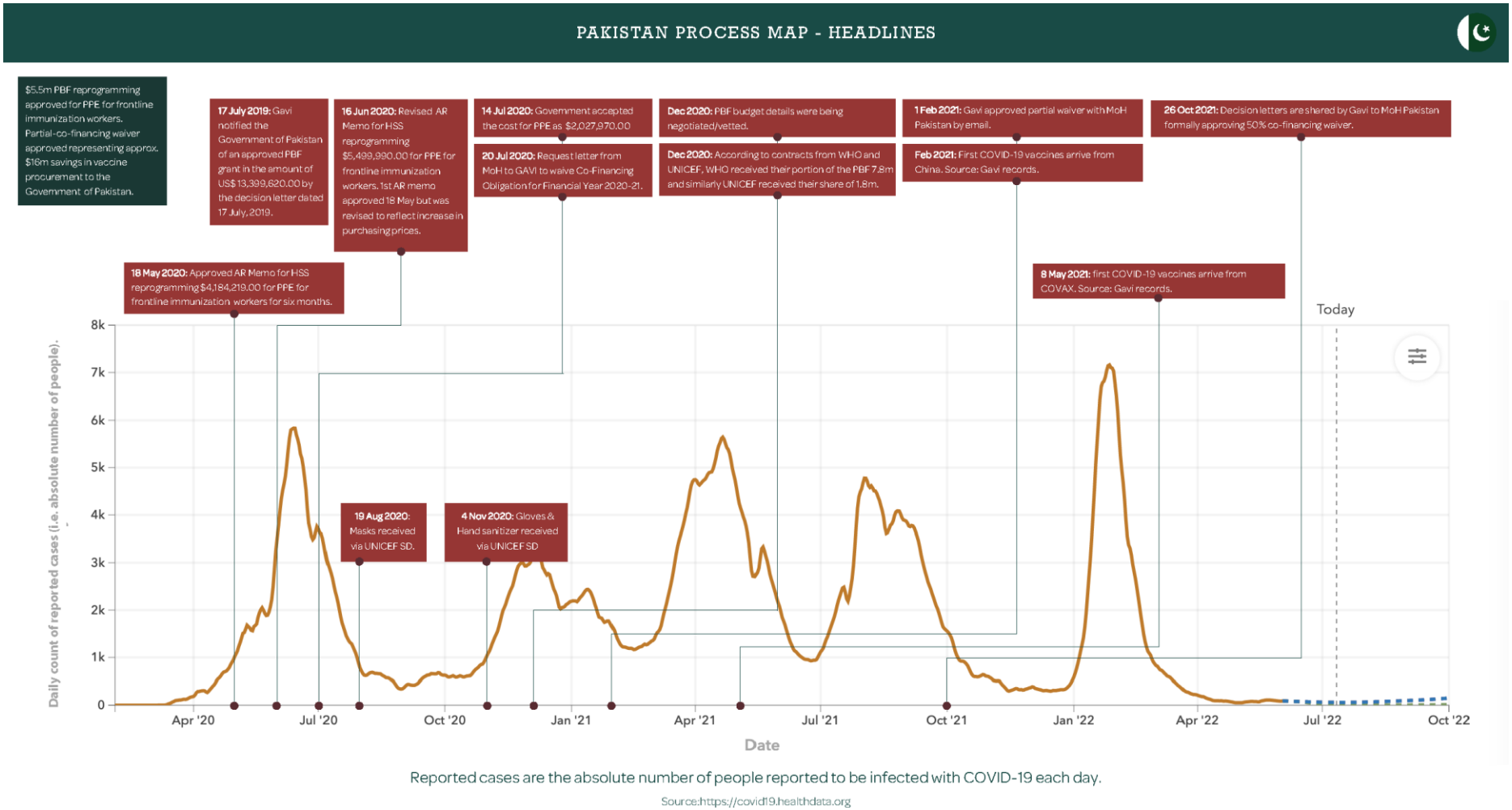
Right Results

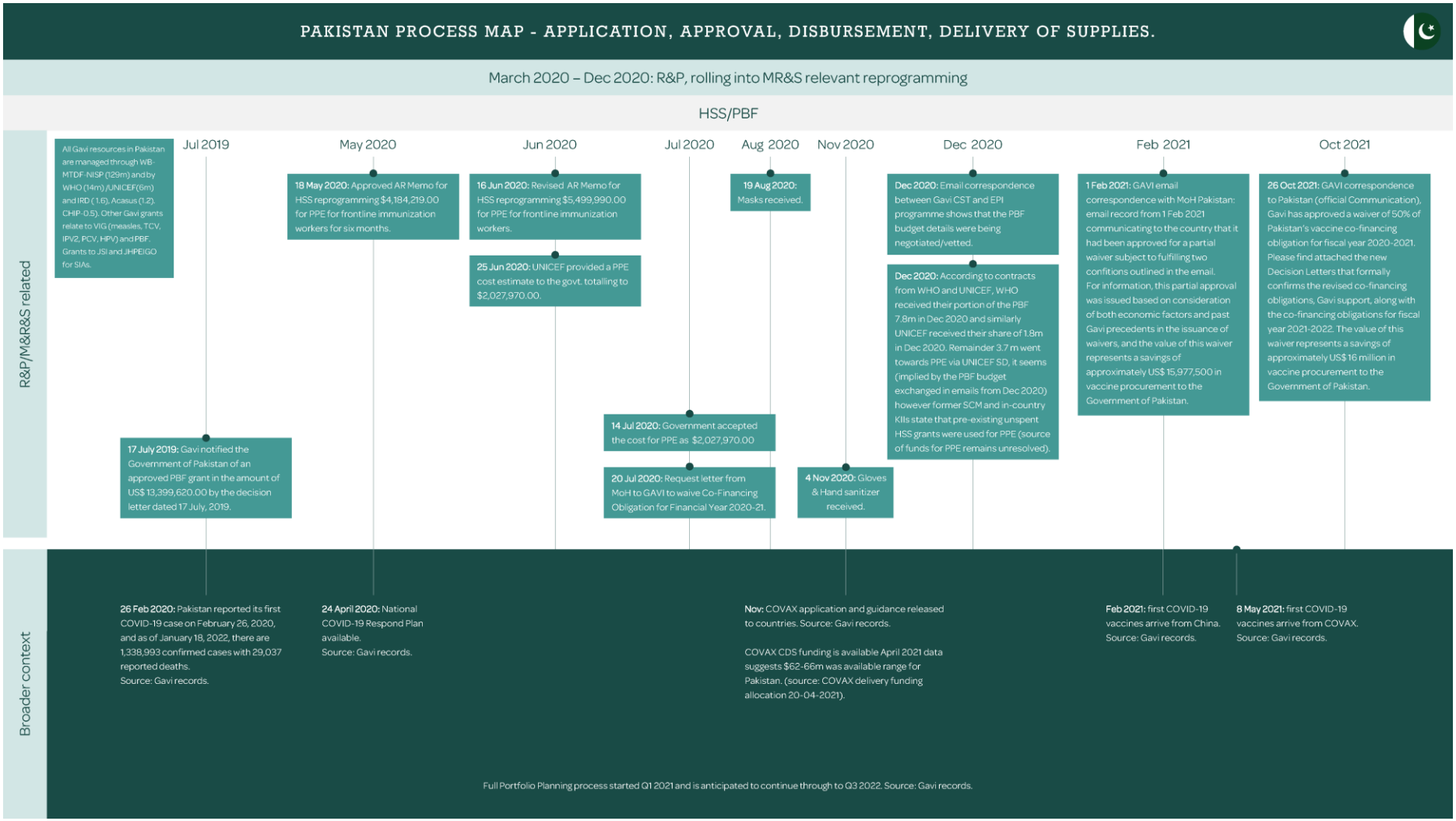
- Government, donors – including Gavi - and the Chinese government enabled a strong response to carrying out critical COVID-19 interventions, nonetheless the number of cases was not well controlled in the beginning.
- There was no Theory of Change and no dedicated M&E for this effort. The interventions put into place to restore and strengthen RI were already aligned with existing grant M&E.
- Pakistan has been successful in restoring and even increasing RI coverage.
- The EOAs were essential not only to restoring RI to missed children but to actually increasing coverage of zero dose children as well.
- Other factors contributed to Pakistan's success, e.g. high level political & military leadership, as well as management and data systems enabling emphasis on covid & RI.
- Gavi's contribution to restoring and maintaining RI was through working as a team with partners to ensure effective use of the EPI budget for best practice interventions, to finance EOAs, and pre-pandemic support to data and supply systems were also key to an effective response.
- Other Gavi supported areas (e.g. introduction of new vaccines and campaigns) were affected by the pandemic, but are now back on track.

Lessons

- There may be incentives working against the willingness to reprogramme existing/approved but as yet unspent funds
- It is likely that Pakistan could have achieved RI recovery without any new initiatives.
- Healthcare HR may be insufficient to deal with the pandemic as well as routine services.
- UNICEF procurement of non-specialist goods such as PPE may not offer best VfM.
- During a pandemic, changing GAVI-SCMs or initiating major new changes to INGO contracting mechanisms is not very helpful.

- New microplanning and service delivery models have been implemented during C-19 to reach under vaccinated and ZD children; lessons need to be captured from these.


PAKISTAN PROCESS MAP - HEADLINES
$5.5m PBF reprogramming approved for PPE for frontline immunization workers. Partial-co-financing waiver approved representing approx. $16m savings in vaccine procurement to the Government of Pakistan.
17 July 2019: Gavi notified the Government of Pakistan of an approved PBF grant in the amount of US$ 13,399,620.00 by the decision letter dated 17 July, 2019.
16 Jun 2020: Revised AR Memo for HSS reprogramming $5,499,990.00 for PPE for frontline immunization workers. 1st AR memo approved 18 May but was revised to reflect increase in purchasing prices.
14 Jul 2020: Government accepted the cost for PPE as $2,027,970.00
20 Jul 2020: Request letter from MoH to GAVI to waive Co-Financing Obligation for Financial Year 2020-21.
Dec 2020: PBF budget details were being negotiated/vetted.
Dec 2020: According to contracts from WHO and UNICEF, WHO received their portion of the PBF 7.8m and similarly UNICEF received their share of 1.8m.
1 Feb 2021: Gavi approved partial waiver with MoH Pakistan by email.
Feb 2021: First COVID-19 vaccines arrive from China. Source: Gavi records.
26 Oct 2021: Decision letters are shared by Gavi to MoH Pakistan formally approving 50% co-financing waiver.
18 May 2020: Approved AR Memo for HSS reprogramming $4,184,219.00 for PPE for frontline immunization workers for six months.
8 May 2021: first COVID-19 vaccines arrive from COVAX. Source: Gavi records.
Today
19 Aug 2020: Masks received via UNICEF SD.
4 Nov 2020: Gloves & Hand sanitizer received via UNICEF SD
Daily count of reported cases (i.e. absolute number of people).
8k
7k
6k
5k
4k
3k
2k
1k
0
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


PAKISTAN PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Dec 2020: R&P, rolling into MR&S relevant reprogramming
HSS/PBF
R&P/M&R&S related
Broader context
Jul 2019
May 2020
Jun 2020
Jul 2020
Aug 2020
Nov 2020
Dec 2020
Feb 2021
Oct 2021
All Gavi resources in Pakistan are managed through WB-MTDF-NISP (129m) and by WHO (14m) /UNICEF(6m) and IRD (1.6), Acasus (1.2), CHIP-0.5). Other Gavi grants relate to VIG (measles, TCV, IPV2, PCV, HPV) and PBF. Grants to JSI and JHPEIGO for SIAs.
17 July 2019: Gavi notified the Government of Pakistan of an approved PBF grant in the amount of US$ 13,399,620.00 by the decision letter dated 17 July, 2019.
18 May 2020: Approved AR Memo for HSS reprogramming $4,184,219.00 for PPE for frontline immunization workers for six months.
16 Jun 2020: Revised AR Memo for HSS reprogramming $5,499,990.00 for PPE for frontline immunization workers.
25 Jun 2020: UNICEF provided a PPE cost estimate to the govt. totalling to $2,027,970.00.
14 Jul 2020: Government accepted the cost for PPE as $2,027,970.00
20 Jul 2020: Request letter from MoH to GAVI to waive Co-Financing Obligation for Financial Year 2020-21.
19 Aug 2020: Masks received.
4 Nov 2020: Gloves & Hand sanitizer received.
Dec 2020: Email correspondence between Gavi CST and EPI programme shows that the PBF budget details were being negotiated/vetted.
Dec 2020: According to contracts from WHO and UNICEF, WHO received their portion of the PBF 7.8m in Dec 2020 and similarly UNICEF received their share of 1.8m in Dec 2020. Remainder 3.7 m went towards PPE via UNICEF SD, it seems (implied by the PBF budget exchanged in emails from Dec 2020) however former SCM and in-country KIIs state that pre-existing unspent HSS grants were used for PPE (source of funds for PPE remains unresolved).
1 Feb 2021: GAVI email correspondence with MoH Pakistan: email record from 1 Feb 2021 communicating to the country that it had been approved for a partial waiver subject to fulfilling two confitions outlined in the email. For information, this partial approval was issued based on consideration of both economic factors and past Gavi precedents in the issuance of waivers, and the value of this waiver represents a savings of approximately US$ 15,977,500 in vaccine procurement to the Government of Pakistan.
26 Oct 2021: GAVI correspondence to Pakistan (official Communication), Gavi has approved a waiver of 50% of Pakistan's vaccine co-financing obligation for fiscal year 2020-2021. Please find attached the new Decision Letters that formally confirms the revised co-financing obligations, Gavi support, along with the co-financing obligations for fiscal year 2021-2022. The value of this waiver represents a savings of approximately US$ 16 million in vaccine procurement to the Government of Pakistan.
26 Feb 2020: Pakistan reported its first COVID-19 case on February 26, 2020, and as of January 18, 2022, there are 1,338,993 confirmed cases with 29,037 reported deaths.
Source: Gavi records.
24 April 2020: National COVID-19 Respond Plan available.
Source: Gavi records.
Nov: COVAX application and guidance released to countries. Source: Gavi records.
COVAX CDS funding is available April 2021 data suggests $62-66m was available range for Pakistan. (source: COVAX delivery funding allocation 20-04-2021).
Feb 2021: first COVID-19 vaccines arrive from China. Source: Gavi records.
8 May 2021: first COVID-19 vaccines arrive from COVAX. Source: Gavi records.
Full Portfolio Planning process started Q1 2021 and is anticipated to continue through to Q3 2022. Source: Gavi records.

6.6 Sudan

Background

- Since the identification of COVID-19 on 13 March 2020 up to date (mid-July 2022), there have been 62,745 infections and 4,592 coronavirus-related deaths (JHU, 2022). Only 10.35% of the eligible population has been fully vaccinated.
- Despite catch-up campaigns, the country saw a 10% drop in both its measles and DTP vaccination coverages, from which it has not yet recovered.
- The epidemic concentrated most in and around the central regions, with Khartoum State at the epicentre.
- Despite an initial euphoria about transitioning to a democratic government, the country has been plagued by continued socio-economic and humanitarian crises, which may have had an additional effect on routine immunization.

Flexibilities accessed:

- Sudan accessed two key flexibilities under R&P:
  a) **Reprogramming of HSS grant funds directed towards the procurement of PPE using only about 39 % of what was available. The funding was considered small by in-country stakeholders and arrived after the second wave when most PPE needs were already fulfilled.**
  b) **A full waiver of co-financing with partial replenishment, but no details could be established; this could also have been in response to the prevailing dire socio-economic situation in the country, with high inflation, lack of foreign currency, and price hikes.**

Findings

Right Design – applying the R&P flexibilities was seen as relevant, streamlined, and helpful in filling initial gaps in the COVID-19 response.

- The national response plan for preparedness and response to COVID-19 and the proposed activity plan for a portion of the 10% of HSS funds were conceptualized and prepared by the FMoH/EPI program with extensive involvement of the Gavi consultant and other FMoH cooperation partners.
- The provision of PPE allowed for PHC services, including immunization services, to continue. It also diminished the fear among the population that it was unsafe to go to health facilities.
- There was never an application for **M&R&S.**

Right Ways – timeliness and efficiency of R&P flexibilities were seen as generally good; however, delays in the delivery of the goods made the support ineffective.

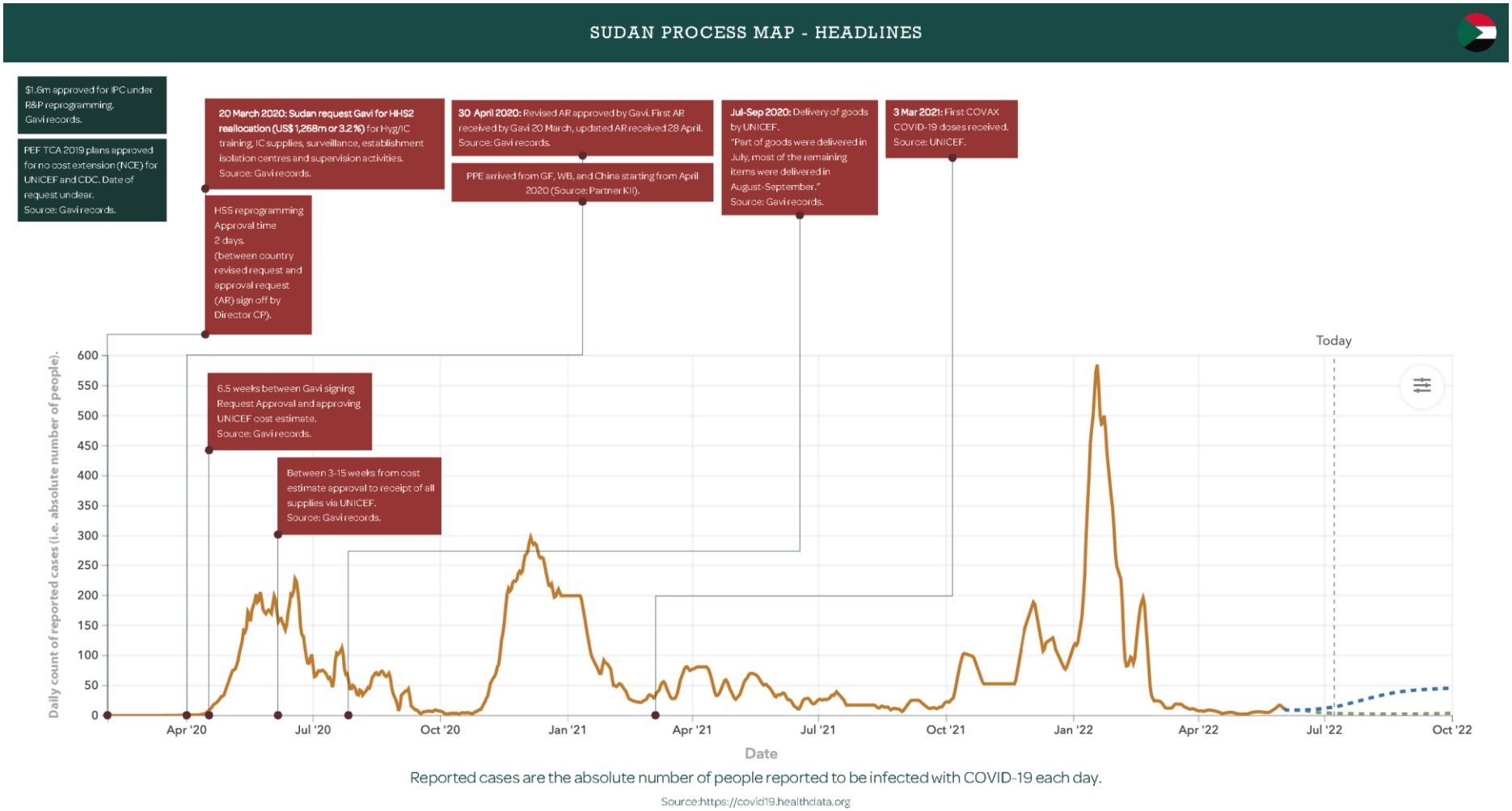
- Gavi approved Sudan's request for PPE for US$1.56m within a month. The request was routed through UNICEF's supply division by mid-June 2020.
- Due to global shortages, UNICEF did not deliver the goods until July-August, with even some in September. By that time, the second, though small, wave had passed, and most PPE needs were foreseen for.
- Due to GAVIs financial procedures and subsequent delays as people were concentrating on COVID responses, the Gavi Budget for RI activities (HSS2) was not allocated to FMoH in 2020. As a result, for the whole of 2020, the FMoH did not receive Gavi support for RI, which was channelled through WHO. As this budget was critical to running the essential RI activities, and the situation was very critical, even without the effects of the COVID-19 pandemic, this aggravated the effective and efficient implementation of RI.

Right Results – the immediate offer for support was timely, but its size and late arrival became insignificant in the overall response to COVID-19. It did not mitigate the decrease in RI.

- The almost insignificant amount (less than 1% of what was pledged by other donors) made available from the HSS reallocation for the procurement of PPE even arrived 4-6 months after Gavi approved it. By that time, other donors had provided the necessary PPE. The latter suggests that there was a duplication of requests and provisions.
- Regarding the non-release of funding for RI during 2020, it was found that emerging needs were discussed and responded to. Still, the procedures and processes were slow, resulting in unnecessary delay, especially when the funds were needed promptly.

Lessons

- There is a need for close monitoring and engagement with the EPI program in the country in times of crisis. With the remote management of the COVID and normal grant operations in a state of lockdown, opportunities were lost to monitor the country's situation closely and respond to emerging needs, including some minor outbreaks.
- There is a need to improve coordination and mutual accountability of the response efforts by Gavi partners to avoid duplication of efforts and maximize support provided.


SUDAN PROCESS MAP - HEADLINES
$1.6m approved for IPC under R&P reprogramming. Gavi records.
PEF TCA 2019 plans approved for no cost extension (NCE) for UNICEF and CDC. Date of request unclear. Source: Gavi records.
20 March 2020: Sudan request Gavi for HHS2 reallocation (US$ 1,268m or 3.2 %) for Hyg/IC training, IC supplies, surveillance, establishment isolation centres and supervision activities. Source: Gavi records.
HSS reprogramming Approval time 2 days. (between country revised request and approval request (AR) sign off by Director CP).
30 April 2020: Revised AR approved by Gavi. First AR received by Gavi 20 March, updated AR received 28 April. Source: Gavi records.
PPE arrived from GF, WB, and China starting from April 2020 (Source: Partner KII).
Jul-Sep 2020: Delivery of goods by UNICEF. "Part of goods were delivered in July, most of the remaining items were delivered in August-September." Source: Gavi records.
3 Mar 2021: First COVAX COVID-19 doses received. Source: UNICEF.
6.5 weeks between Gavi signing Request Approval and approving UNICEF cost estimate. Source: Gavi records.
Between 3-15 weeks from cost estimate approval to receipt of all supplies via UNICEF. Source: Gavi records.
Today
Daily count of reported cases (i.e. absolute number of people).
0
50
100
150
200
250
300
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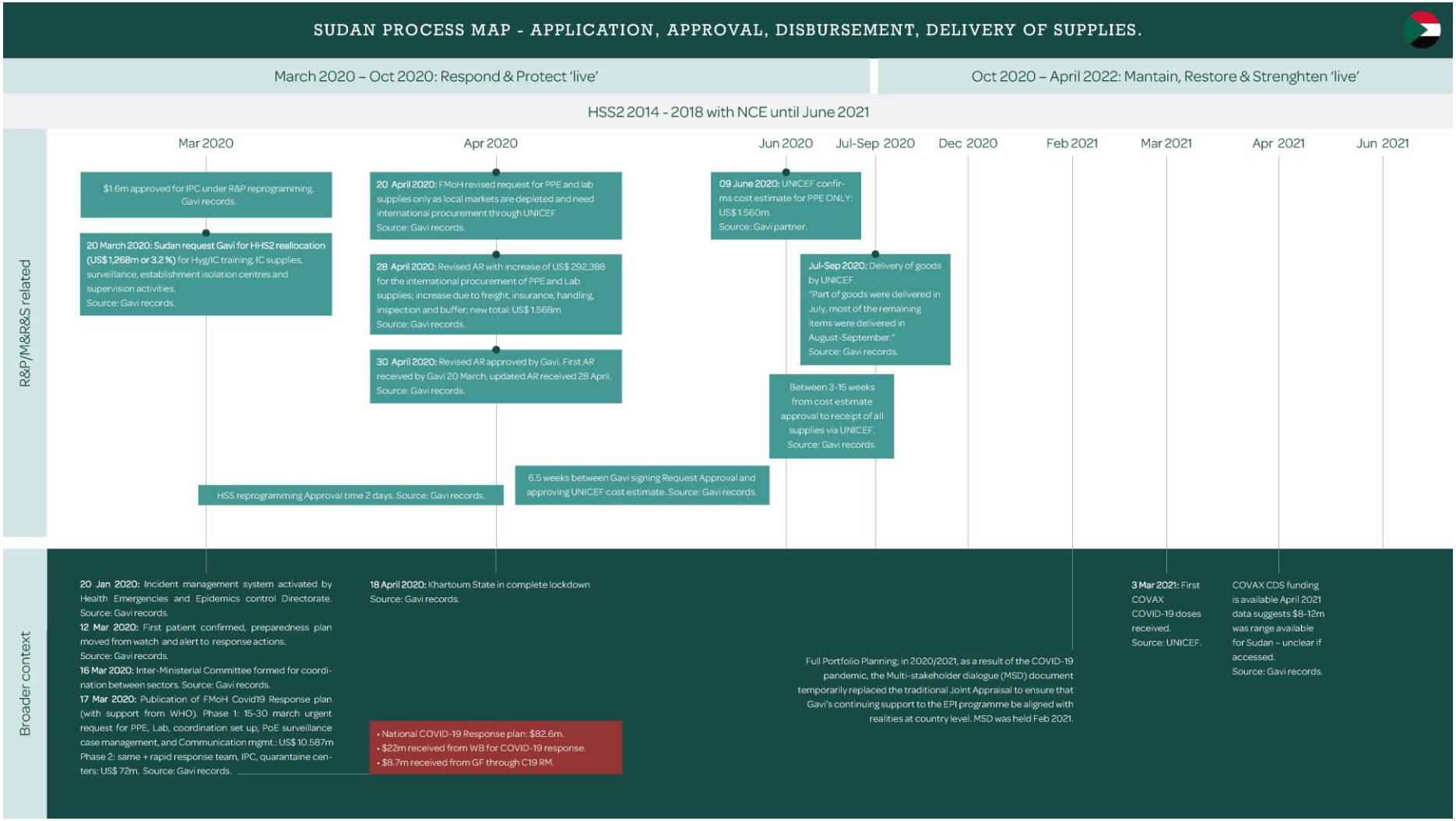
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


SUDAN PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Oct 2020: Respond & Protect 'live'
Oct 2020 – April 2022: Mantain, Restore & Strenghten 'live'
HSS2 2014 - 2018 with NCE until June 2021
Mar 2020
Apr 2020
Jun 2020
Jul-Sep 2020
Dec 2020
Feb 2021
Mar 2021
Apr 2021
Jun 2021
R&P/M&R&S related
$1.6m approved for IPC under R&P reprogramming. Gavi records.
20 March 2020: Sudan request Gavi for HHS2 reallocation (US$ 1,268m or 3.2 %) for Hyg/IC training, IC supplies, surveillance, establishment isolation centres and supervision activities. Source: Gavi records.
20 April 2020: FMoH revised request for PPE and lab supplies only as local markets are depleted and need international procurement through UNICEF Source: Gavi records.
28 April 2020: Revised AR with increase of US$ 292,388 for the international procurement of PPE and Lab supplies; increase due to freight, insurance, handling, inspection and buffer; new total: US$ 1.568m Source: Gavi records.
30 April 2020: Revised AR approved by Gavi. First AR received by Gavi 20 March, updated AR received 28 April. Source: Gavi records.
09 June 2020: UNICEF confirms cost estimate for PPE ONLY: US$ 1.560m. Source: Gavi partner.
Jul-Sep 2020: Delivery of goods by UNICEF. "Part of goods were delivered in July, most of the remaining items were delivered in August-September." Source: Gavi records.
Between 3-15 weeks from cost estimate approval to receipt of all supplies via UNICEF. Source: Gavi records.
HSS reprogramming Approval time 2 days. Source: Gavi records.
6.5 weeks between Gavi signing Request Approval and approving UNICEF cost estimate. Source: Gavi records.
Broader context
20 Jan 2020: Incident management system activated by Health Emergencies and Epidemics control Directorate. Source: Gavi records.
12 Mar 2020: First patient confirmed, preparedness plan moved from watch and alert to response actions. Source: Gavi records.
16 Mar 2020: Inter-Ministerial Committee formed for coordination between sectors. Source: Gavi records.
17 Mar 2020: Publication of FMoH Covid19 Response plan (with support from WHO). Phase 1: 15-30 march urgent request for PPE, Lab, coordination set up, PoE surveillance case management, and Communication mgmt.: US$ 10.587m Phase 2: same + rapid response team, IPC, quarantaine centers: US$ 72m. Source: Gavi records.
18 April 2020: Khartoum State in complete lockdown Source: Gavi records.
• National COVID-19 Response plan: $82.6m.
• $22m received from WB for COVID-19 response.
• $8.7m received from GF through C19 RM.
Full Portfolio Planning; in 2020/2021, as a result of the COVID-19 pandemic, the Multi-stakeholder dialogue (MSD) document temporarily replaced the traditional Joint Appraisal to ensure that Gavi's continuing support to the EPI programme be aligned with realities at country level. MSD was held Feb 2021.
3 Mar 2021: First COVAX COVID-19 doses received. Source: UNICEF.
COVAX CDS funding is available April 2021 data suggests $8-12m was range available for Sudan – unclear if accessed. Source: Gavi records.

6.7 Togo

Background

- For Gavi, Togo is a core priority country in the West Africa Region.
- From 2001 and 2023, Gavi has committed $75,534,917 for cash, HSS, vaccine, cold chain and other support related to immunisation in Togo.
- DPT3 coverage pre-pandemic (2019) was at 84% up from 50% in 2001 according to WUENIC data.
- By 30 June 2022, Togo had reported 37,403 cases and only 275 covid related deaths.

Findings

Right Design

- Gavi's support under the R&P and M&R&S flexibilities have responded to Togo's need to address several challenges in order to cope with COVID-19 and its effect on RI, in particular the need to strengthen case detection, the low availability of test kits, reagents and laboratory equipment in all regions, as well as the decline in the use of health services, and the difficulties in carrying out planned health activities, including routine vaccination.
- Gavi´s support to Togo under the flexibilities was found to be in line with the country COVID-19 response plan, its National Health Development Plan, WHO guidelines and Gavi 5.0.

Right Ways

- Togo benefited from: a TCA reallocation of $103 299 approved for WHO activities to be converted to support COVID-19 response (approved in July 2020); $129 000 PBF funds reprogrammed for test kits and swabs (arrived in Aug 2020); $ 574 260 existing HSS funds reprogrammes under M&R&S to support the first vaccine acceleration campaigns through the recruitment of specialists (approved in April 2021); reallocation of $250 340 HSS funds for two open automatic extractors to rapidly confirm cases of COVID-19 (arrived only in Apr 2022).
- Guidelines on support available were clearly communicated by Gavi to Ministry of Health and its partners, which has helped to speed up the application and approval processes.
- UNICEF's global procurement mechanism has expedited the delivery of the test kits (arrived in 4 months) as opposed to the open extractors (arrived in 1.5 years). The delay in delivery of these laboratory equipment is believed to be due to disruptions in the global supply chain.
- Gavi organised of a virtual multi-stakeholder dialogue in October 2020. Through UNICEF and WHO, Gavi has supported with coordination and development of strategic documents.
- Coordination among partners was however found to be relatively weak.
- A map of these areas of vaccine hesitancy was drawn up with Gavi PBF support by CSOs.
- An analysis of the performance of the health districts was carried out with Gavi support and made it possible to identify the districts with poor performance.

Right Results

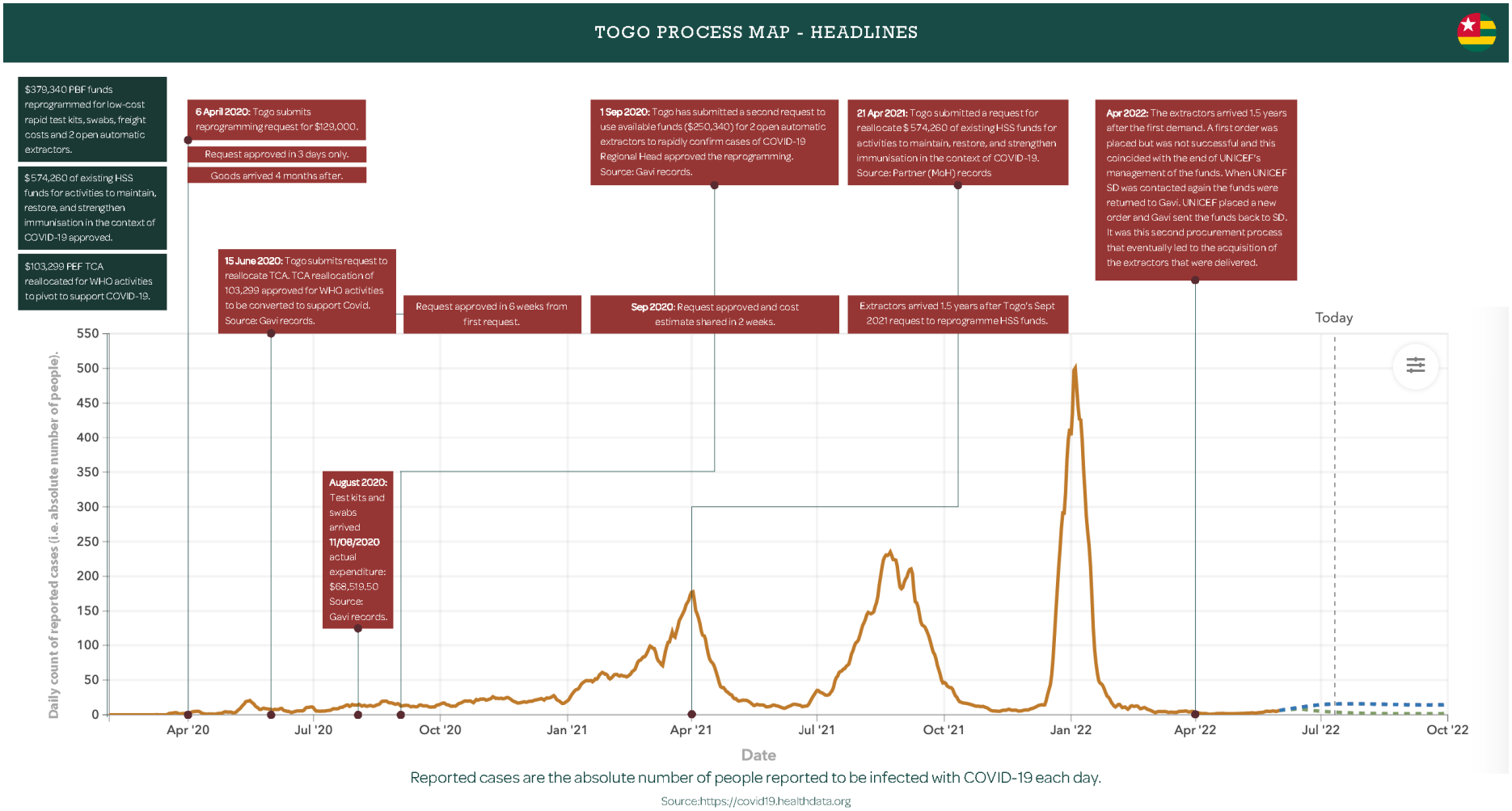
- Recent WUENIC data show that COVID-19 has likely negatively impacted immunisation services through the decrease in vaccine coverage in 2020 and 2021 (DTP3 coverage was – 2 and – 1 per cent points respectively compared to 2019 and this is also confirmed by an increase in reported measles cases in 2020 and 2021 compared to 2019.
- Gavi convened regular meetings with the MoH and other relevant stakeholders involved to take stock of the situation and review progress. Gavi also supported through its core partners in country the implementation of the inter-action review after 20 months of intervention5.
- Outputs in our ToA were generally achieved in Togo. Gavi´s contribution to drivers behind the achievement of output 1 was rated as limited, while contribution to drivers behind output 2 was

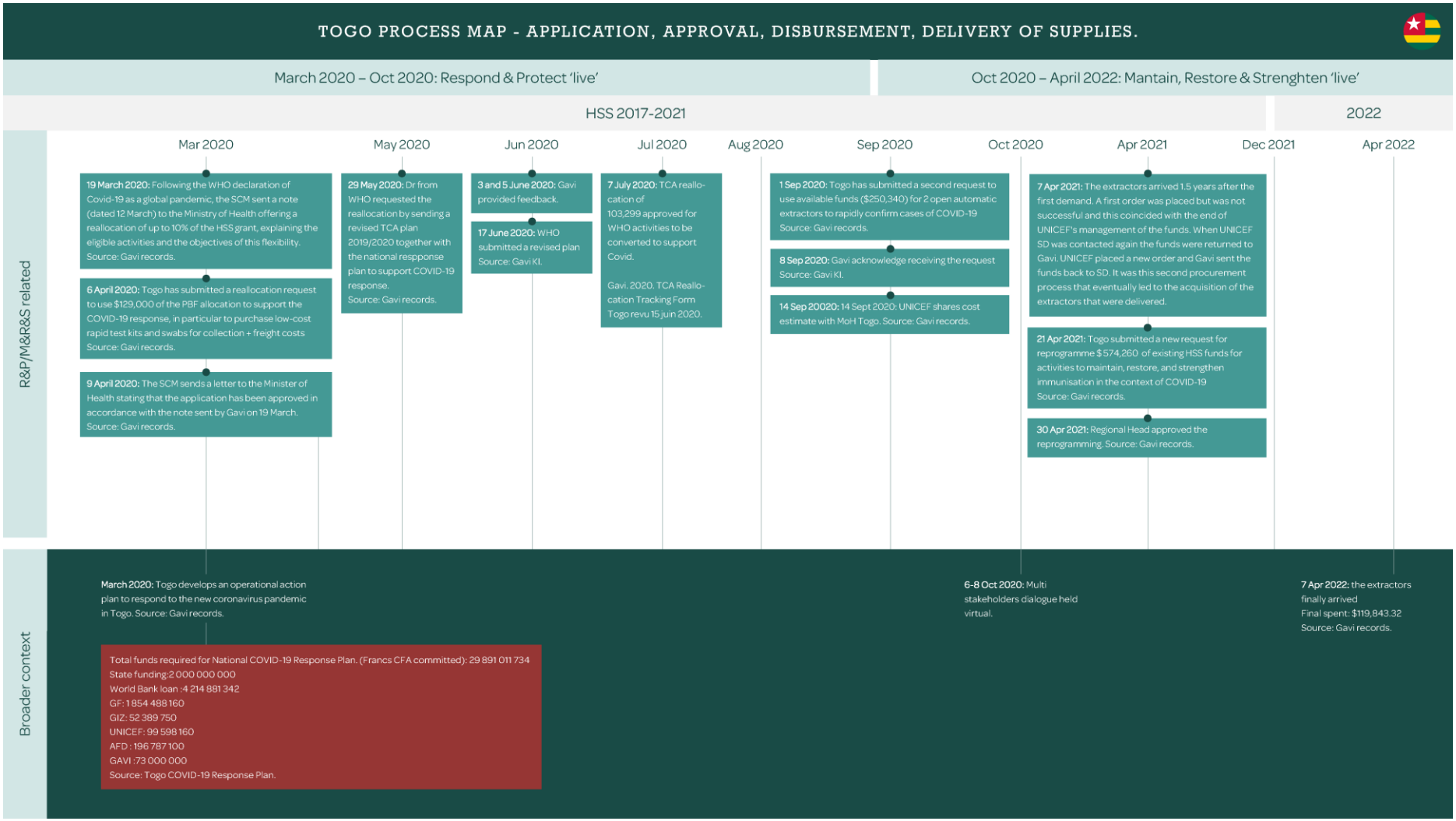
rated as important. Gavi contributed to the implementation of innovative vaccine acceleration strategies to catch up missed children, in synergies with other partners.

- ToA assumptions generally held or at least partially held.

Lessons

- Intensified communication strategies and community engagement by civil society are effective strategies for supporting improved immunisation coverage.
- Strengthening logistics is a necessity to further increase immunisation coverage.


TOGO PROCESS MAP - HEADLINES
$379,340 PBF funds reprogrammed for low-cost rapid test kits, swabs, freight costs and 2 open automatic extractors.
$574,260 of existing HSS funds for activities to maintain, restore, and strengthen immunisation in the context of COVID-19 approved.
$103,299 PEF TCA reallocated for WHO activities to pivot to support COVID-19.
6 April 2020: Togo submits reprogramming request for $129,000.
Request approved in 3 days only.
Goods arrived 4 months after.
15 June 2020: Togo submits request to reallocate TCA. TCA reallocation of 103,299 approved for WHO activities to be converted to support Covid. Source: Gavi records.
Request approved in 6 weeks from first request.
August 2020: Test kits and swabs arrived 11/08/2020 actual expenditure: $68,519.50 Source: Gavi records.
1 Sep 2020: Togo has submitted a second request to use available funds ($250,340) for 2 open automatic extractors to rapidly confirm cases of COVID-19 Regional Head approved the reprogramming. Source: Gavi records.
Sep 2020: Request approved and cost estimate shared in 2 weeks.
21 Apr 2021: Togo submitted a request for reallocate $ 574,260 of existing HSS funds for activities to maintain, restore, and strengthen immunisation in the context of COVID-19. Source: Partner (MoH) records
Extractors arrived 1.5 years after Togo's Sept 2021 request to reprogramme HSS funds.
Apr 2022: The extractors arrived 1.5 years after the first demand. A first order was placed but was not successful and this coincided with the end of UNICEF's management of the funds. When UNICEF SD was contacted again the funds were returned to Gavi. UNICEF placed a new order and Gavi sent the funds back to SD. It was this second procurement process that eventually led to the acquisition of the extractors that were delivered.
Today
Daily count of reported cases (i.e. absolute number of people).
550
500
450
400
350
300
250
200
150
100
50
0
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


TOGO PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Oct 2020: Respond & Protect 'live'
Oct 2020 – April 2022: Mantain, Restore & Strenghten 'live'
HSS 2017-2021
2022
Mar 2020
May 2020
Jun 2020
Jul 2020
Aug 2020
Sep 2020
Oct 2020
Apr 2021
Dec 2021
Apr 2022
R&P/M&R&S related
19 March 2020: Following the WHO declaration of Covid-19 as a global pandemic, the SCM sent a note (dated 12 March) to the Ministry of Health offering a reallocation of up to 10% of the HSS grant, explaining the eligible activities and the objectives of this flexibility. Source: Gavi records.
6 April 2020: Togo has submitted a reallocation request to use $129,000 of the PBF allocation to support the COVID-19 response, in particular to purchase low-cost rapid test kits and swabs for collection + freight costs Source: Gavi records.
9 April 2020: The SCM sends a letter to the Minister of Health stating that the application has been approved in accordance with the note sent by Gavi on 19 March. Source: Gavi records.
29 May 2020: Dr from WHO requested the reallocation by sending a revised TCA plan 2019/2020 together with the national respponse plan to support COVID-19 response. Source: Gavi records.
3 and 5 June 2020: Gavi provided feedback.
17 June 2020: WHO submitted a revised plan Source: Gavi KI.
7 July 2020: TCA reallo-cation of 103,299 approved for WHO activities to be converted to support Covid.
Gavi. 2020. TCA Reallo-cation Tracking Form Togo revu 15 juin 2020.
1 Sep 2020: Togo has submitted a second request to use available funds ($250,340) for 2 open automatic extractors to rapidly confirm cases of COVID-19 Source: Gavi records.
8 Sep 2020: Gavi acknowledge receiving the request Source: Gavi KI.
14 Sep 20020: 14 Sept 2020: UNICEF shares cost estimate with MoH Togo. Source: Gavi records.
7 Apr 2021: The extractors arrived 1.5 years after the first demand. A first order was placed but was not successful and this coincided with the end of UNICEF's management of the funds. When UNICEF SD was contacted again the funds were returned to Gavi. UNICEF placed a new order and Gavi sent the funds back to SD. It was this second procurement process that eventually led to the acquisition of the extractors that were delivered.
21 Apr 2021: Togo submitted a new request for reprogramme $ 574,260 of existing HSS funds for activities to maintain, restore, and strengthen immunisation in the context of COVID-19 Source: Gavi records.
30 Apr 2021: Regional Head approved the reprogramming. Source: Gavi records.
Broader context
March 2020: Togo develops an operational action plan to respond to the new coronavirus pandemic in Togo. Source: Gavi records.
Total funds required for National COVID-19 Response Plan. (Francs CFA committed): 29 891 011 734
State funding:2 000 000 000
World Bank loan :4 214 881 342
GF: 1 854 488 160
GIZ: 52 389 750
UNICEF: 99 598 160
AFD : 196 787 100
GAVI :73 000 000
Source: Togo COVID-19 Response Plan.
6-8 Oct 2020: Multi stakeholders dialogue held virtual.
7 Apr 2022: the extractors finally arrived
Final spent: $119,843.32
Source: Gavi records.

6.8 Uganda

Background

Uganda is a developing country of about 40.9 million people as of 2021 with a high (20.3%) poverty rate and a growth rate of 3.7% rate with more than half of the population aged below 18 years. The country's government allocation on health is 7.2%, with a per capita health expenditure of UGX 57,715 (about US$ 16) as of 2020. With the prevailing double disease burden of CDs and NCDs, premature deaths from, among others, VPDs remain high in the country. Immunization is a priority intervention within Uganda's minimum health care package largely funded by the Gavi.

From the onset of the COVID-19 pandemic, Uganda aimed to minimize the number of new infections from institution of stringent control measures, creating coordination mechanisms and contextualizing the COVID-19 Preparedness and Response Plan underpinned by the WHO COVID-19 response pillars which was partially financed through domestic resources and development partners. However, access to immunisation services such as DPT1, DPT3, measles, HPV and Td coverage for pregnant women were significantly impacted during this period. And just like any other economy globally, Uganda suffered a severe contraction in economic activity and subsequent impacts on livelihoods during the pandemic.

Flexibilities accessed:

- **Uganda accessed two key flexibilities, both under R&P:** Reprogramming of HSS grant funds and unused Ops grants worth a total of $3.12m, directed towards procurement of C-19 test kits; and several NCEs of 2019 and 2020 TCA funds for WHO, US CDC, PATH and AFENET.

Right design

- **R&P flexibilities were seen as very relevant**: They were **available at critical time** when Uganda was seeking to prevent case numbers from over-whelming the health system by ramping up PPE and testing capacity; and **were seen as filling key resource gaps in the C-19 response plan**
- **MR&S flexibilities were not accessed:** Informants were unaware of MR&S flexibilities, possibly due to the SCM not communicating them. We were unable to verify this with the relevant SCM.
- **Several stakeholders felt in retrospect that Gavi should have more explicitly supported RI activities, and that this may have reduced C-19's impact on RI.**
- **Some stakeholders felt that the design of Gavi support should have been even more flexible given the evolving, unpredictable nature of the pandemic.** Instead, further reprogramming was required as the context changed, placing further burden on both Gavi and MoH/EPI staff.

Right ways

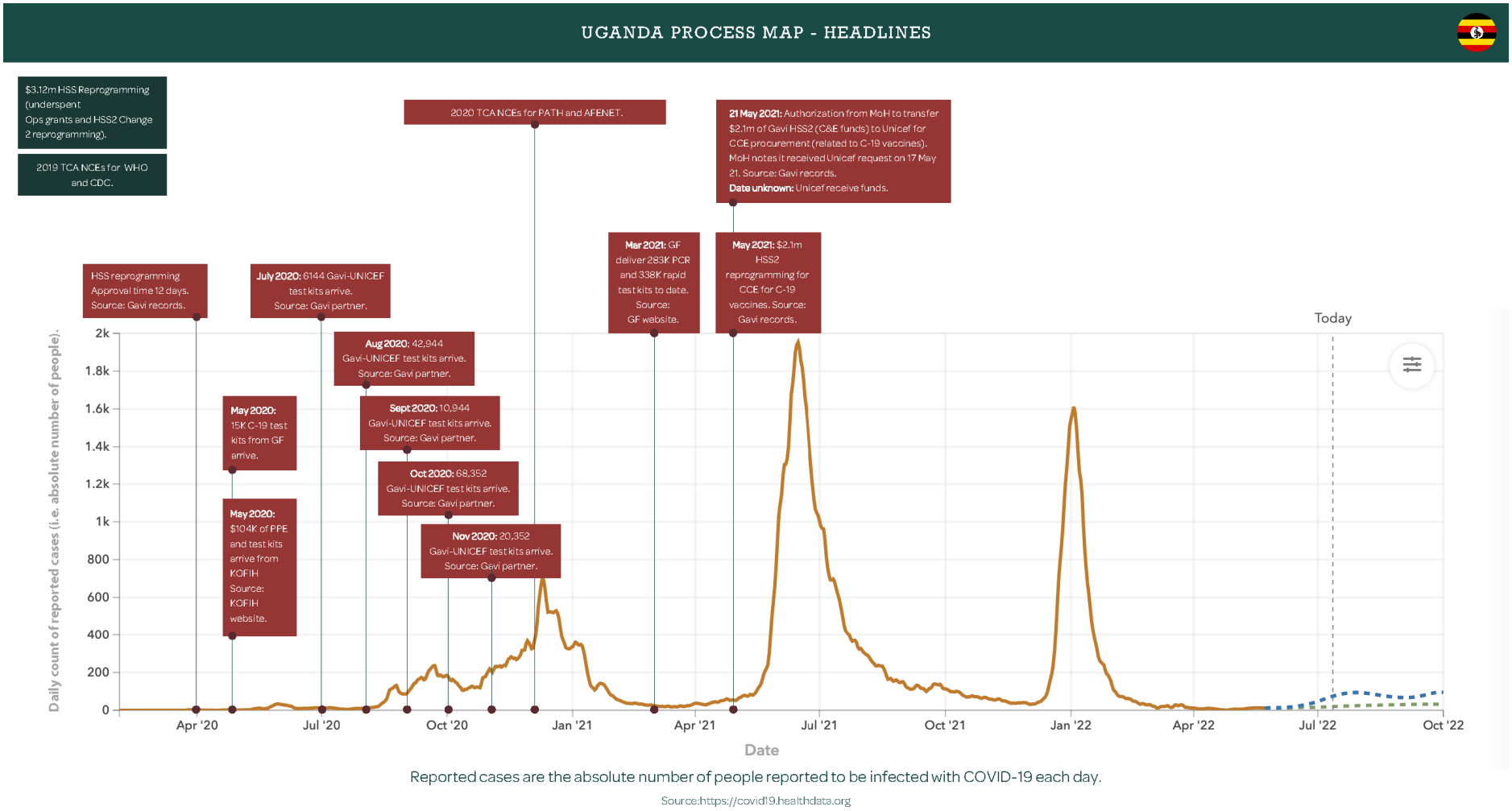
- **Timeliness and efficiency of R&P flexibilities was seen as generally good:** In-country stakeholders felt the 12-day approval was very fast and appreciated the simplified application. Timelines for receipt of test kits compared well with that obtained from other sources.
- **While the test kits were seen as the key need in the initial stages of the pandemic, other needs emerged later which Uganda struggled to resource:** A need for HCW surge capacity, especially once C-19 vaccines arrived, was seen as an unmet need in efforts to restore RI.
- **Gavi flexibilities were not used to explicitly integrate or address GESI concerns,** however testing was directed in accordance with surveillance protocols, regardless of gender, social status etc.

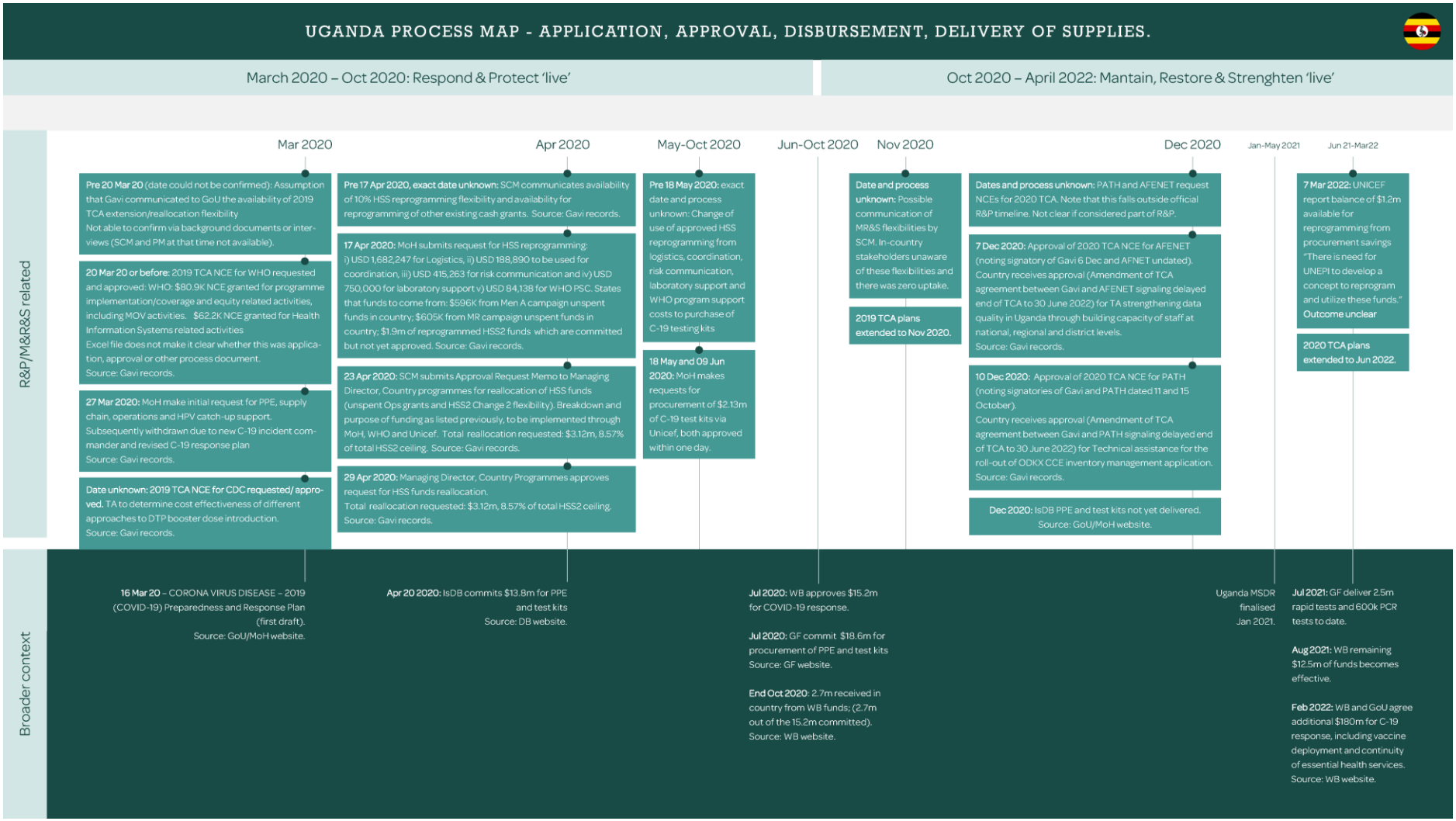
Right results

- **Uganda was able to carry out critical C-19 response activities, and Gavi flexibilities provided limited contribution:** A key driver of this was the strong response across all response pillars, and Gavi-funded test kits provided limited contribution to the Laboratory response pillar.
- **Uganda successfully adapted RI to the C-19 context, and Gavi flexibilities provided some contribution:** A key driver was the fact that HCWs had the necessary resources to restart RI safely. Gavi-funded test kits supported this, and a NCE for WHO TCA also supported Missed Opportunities for Vaccination (MOV) activities relevant to this.
- **Uganda was partially able to design new/innovative approaches to reaching vulnerable communities with RI, and TCA NCEs provided some contribution:** WHO TCA supported activities around MOV, and PATH TCA supported identification of under-performing areas and solutions.

Lessons

- **For Gavi:** There is a need to have more fungibility/flexibility in the use of flexibilities' funding in crisis situations - to allow the country to use them as they see fit, as needs evolve. Where it is known/likely that multiple partners will be funding an emergency response, focus on RI from the start in line with Gavi's core mandate and to protect RI.
- **More broadly**: Strong country coordination is key, and all partners need to work through and support these mechanisms and not set up parallel systems.


UGANDA PROCESS MAP - HEADLINES
$3.12m HSS Reprogramming (underspent Ops grants and HSS2 Change 2 reprogramming).
2019 TCA NCEs for WHO and CDC.
2020 TCA NCEs for PATH and AFENET.
21 May 2021: Authorization from MoH to transfer $2.1m of Gavi HSS2 (C&E funds) to Unicef for CCE procurement (related to C-19 vaccines). MoH notes it received Unicef request on 17 May 21. Source: Gavi records.
Date unknown: Unicef receive funds.
Mar 2021: GF deliver 283K PCR and 338K rapid test kits to date. Source: GF website.
May 2021: $2.1m HSS2 reprogramming for CCE for C-19 vaccines. Source: Gavi records.
HSS reprogramming Approval time 12 days. Source: Gavi records.
July 2020: 6144 Gavi-UNICEF test kits arrive. Source: Gavi partner.
Aug 2020: 42,944 Gavi-UNICEF test kits arrive. Source: Gavi partner.
May 2020: 15K C-19 test kits from GF arrive.
Sept 2020: 10,944 Gavi-UNICEF test kits arrive. Source: Gavi partner.
May 2020: $104K of PPE and test kits arrive from KOFIH Source: KOFIH website.
Oct 2020: 68,352 Gavi-UNICEF test kits arrive. Source: Gavi partner.
Nov 2020: 20,352 Gavi-UNICEF test kits arrive. Source: Gavi partner.
Today
Daily count of reported cases (i.e. absolute number of people).
2k
1.8k
1.6k
1.4k
1.2k
1k
800
600
400
200
0
Apr '20
Jul '20
Oct '20
Jan '21
Apr '21
Jul '21
Oct '21
Jan '22
Apr '22
Jul '22
Oct '22
Date
Reported cases are the absolute number of people reported to be infected with COVID-19 each day.
Source:https://covid19.healthdata.org


UGANDA PROCESS MAP - APPLICATION, APPROVAL, DISBURSEMENT, DELIVERY OF SUPPLIES.
March 2020 – Oct 2020: Respond & Protect 'live'
Oct 2020 – April 2022: Mantain, Restore & Strenghten 'live'
R&P/M&R&S related
Broader context
Mar 2020
Apr 2020
May-Oct 2020
Jun-Oct 2020
Nov 2020
Dec 2020
Jan-May 2021
Jun 21-Mar22
Pre 20 Mar 20 (date could not be confirmed): Assumption that Gavi communicated to GoU the availability of 2019 TCA extension/reallocation flexibility
Not able to confirm via background documents or interviews (SCM and PM at that time not available).
20 Mar 20 or before: 2019 TCA NCE for WHO requested and approved: WHO: $80.9K NCE granted for programme implementation/coverage and equity related activities, including MOV activities. $62.2K NCE granted for Health Information Systems related activities
Excel file does not make it clear whether this was application, approval or other process document.
Source: Gavi records.
27 Mar 2020: MoH make initial request for PPE, supply chain, operations and HPV catch-up support.
Subsequently withdrawn due to new C-19 incident commander and revised C-19 response plan
Source: Gavi records.
Date unknown: 2019 TCA NCE for CDC requested/ approved. TA to determine cost effectiveness of different approaches to DTP booster dose introduction.
Source: Gavi records.
Pre 17 Apr 2020, exact date unknown: SCM communicates availability of 10% HSS reprogramming flexibility and availability for reprogramming of other existing cash grants. Source: Gavi records.
17 Apr 2020: MoH submits request for HSS reprogramming: i) USD 1,682,247 for Logistics, ii) USD 188,890 to be used for coordination, iii) USD 415,263 for risk communication and iv) USD 750,000 for laboratory support v) USD 84,138 for WHO PSC. States that funds to come from: $596K from Men A campaign unspent funds in country; $605K from MR campaign unspent funds in country; $1.9m of reprogrammed HSS2 funds which are committed but not yet approved. Source: Gavi records.
23 Apr 2020: SCM submits Approval Request Memo to Managing Director, Country programmes for reallocation of HSS funds (unspent Ops grants and HSS2 Change 2 flexibility). Breakdown and purpose of funding as listed previously, to be implemented through MoH, WHO and Unicef. Total reallocation requested: $3.12m, 8.57% of total HSS2 ceiling. Source: Gavi records.
29 Apr 2020: Managing Director, Country Programmes approves request for HSS funds reallocation.
Total reallocation requested: $3.12m, 8.57% of total HSS2 ceiling.
Source: Gavi records.
Pre 18 May 2020: exact date and process unknown: Change of use of approved HSS reprogramming from logistics, coordination, risk communication, laboratory support and WHO program support costs to purchase of C-19 testing kits
18 May and 09 Jun 2020: MoH makes requests for procurement of $2.13m of C-19 test kits via Unicef, both approved within one day.
Date and process unknown: Possible communication of MR&S flexibilities by SCM. In-country stakeholders unaware of these flexibilities and there was zero uptake.
2019 TCA plans extended to Nov 2020.
Dates and process unknown: PATH and AFENET request NCEs for 2020 TCA. Note that this falls outside official R&P timeline. Not clear if considered part of R&P.
7 Dec 2020: Approval of 2020 TCA NCE for AFENET (noting signatory of Gavi 6 Dec and AFNET undated). Country receives approval (Amendment of TCA agreement between Gavi and AFENET signaling delayed end of TCA to 30 June 2022) for TA strengthening data quality in Uganda through building capacity of staff at national, regional and district levels.
Source: Gavi records.
10 Dec 2020: Approval of 2020 TCA NCE for PATH (noting signatories of Gavi and PATH dated 11 and 15 October).
Country receives approval (Amendment of TCA agreement between Gavi and PATH signaling delayed end of TCA to 30 June 2022) for Technical assistance for the roll-out of ODKX CCE inventory management application.
Source: Gavi records.
Dec 2020: IsDB PPE and test kits not yet delivered.
Source: GoU/MoH website.
7 Mar 2022: UNICEF report balance of $1.2m available for reprogramming from procurement savings "There is need for UNEPI to develop a concept to reprogram and utilize these funds." Outcome unclear
2020 TCA plans extended to Jun 2022.
16 Mar 20 – CORONA VIRUS DISEASE – 2019 (COVID-19) Preparedness and Response Plan (first draft).
Source: GoU/MoH website.
Apr 20 2020: IsDB commits $13.8m for PPE and test kits
Source: DB website.
Jul 2020: WB approves $15.2m for COVID-19 response.
Jul 2020: GF commit $18.6m for procurement of PPE and test kits
Source: GF website.
End Oct 2020: 2.7m received in country from WB funds; (2.7m out of the 15.2m committed).
Source: WB website.
Uganda MSDR finalised Jan 2021.
Jul 2021: GF deliver 2.5m rapid tests and 600k PCR tests to date.
Aug 2021: WB remaining $12.5m of funds becomes effective.
Feb 2022: WB and GoU agree additional $180m for C-19 response, including vaccine deployment and continuity of essential health services.
Source: WB website.

7 Bibliography

Listed below are documents used in the evaluation. In summary we systematically reviewed 408 documents:

- 214 Gavi global documents, received from Gavi evaluation office and KIs, including policies from Gavi website www.gavi.org;
- 15 global documents received from external partners and organisations: and
- 179 specific country documents

A further, 225 documents were received from the above sources and reviewed for relevance to the evaluation but not coded.

Source	Document title	Year
GAVI documents		
Board 2020/21	Gavi's Engagement on COVID-19	2020
	COVID-19 Gavi immediate and interim response	2020
	COVID-19 Tracking Parameters	2021
	COVID-19 Vaccine Development Access and Delivery	2020
	Gavi 5.0 An overview of key issues	2021
	Minutes of Board meeting 11 May 2020	2020
	Minutes of Board meeting 19 March 2020	2020
	Minutes of Board meeting 30 July 2020	2020
	Recalibrating Gavi 5.0 in light of Covid-19 and successful replenishment	2020
	Strategy and implications of COVID-19	2020
	Strategy Programmes and Partnerships, June 2021	2021
CEO's Updates	CEO's Report Film and Presentation	2020
	CEO's Report June 2020	2020
	CEO's Report December 2020	2020
	CEO's Report June 2021	2021
	CEO's Report September 2021	2021
	Update on Replenishment March 2020	2020
	Update on Replenishment May 2020	2020
Board June 2022	Report of the Chief Executive Officer to the Board 22-23 June 2022	2022
	Financial update including forecast	2022
	Gavi's potential role in pandemic preparedness response	2022
	Strategy, Programmes and Partnerships; Progress, Risks and Challenges	2022
	COVAX - Key Strategic Issues	2022
	Annex B, Supporting Considerations for a future COVAX-Supported Paediatrics Programme and Risks and Trade-offs	2022
	"*Gavi board responds to an uncertain world: fragile and conflict settings, future pandemics and the ongoing fight against COVID-19*" post Board article	2022
	Fragility, Emergencies and Displaced Populations Policy	2022
	Covid-19 Situational Report 6	2020
	Covid-19 Situational Report 7	2020
	Covid-19 Situational Report 8	2020

Situational Reports March – November 2020	Covid-19 Situational Report 9	2020
	Covid-19 Situational Report 10	2020
	Covid-19 Situational Report 11	2020
	Covid-19 Situational Report 12	2020
	Covid-19 Situational Report 13	2020
	Covid-19 Situational Report 14	2020
	Covid-19 Situational Report 15	2020
	Covid-19 Situational Report 16	2020
	Covid-19 Situational Report 17	2020
	Covid-19 Situational Report 18	2020
Annex 1 to situational reports (reprogramming information)	Annex 1-COVID-19 Situation Report #6	2020
	Annex 1-COVID-19 Situation Report#7	2020
	Annex 1-COVID-19 Situation Report#8	2020
	Annex 1-COVID-19 Situation Report #9	2020
	Annex 1-COVID-19 Situation Report #10	2020
	Annex 1-COVID-19 Situation Report #11	2020
	Annex 1-COVID-19 Situation Report #12	2020
	Annex 1-COVID-19 Situation Report #13	2020
	Annex 1-COVID-19 Situation Report #14	2020
	Annex 1-COVID-19 Situation Report #15	2020
	Annex 1-COVID-19 Situation Report #16	2020
	Annex 1-COVID-19 Situation Report #17	2020
	Annex 1-COVID-19 Situation Report #18	2020
	Annex 1-COVID-19 update	2020
Reports to the Programme and Policy Committee (PPC)	Accelerating efforts to reach zero-dose children and missed communities in 5.0	2020
	COVID-19 Pandemic Response: An Alliance update	2020
	COVID-19 Pandemic Vaccine Development Access Delivery	2020
	COVID-19 Tracking Parameters	2021
	Draft Learning Priorities	2020
	Gavi 5.0 – Middle Income Countries (MICs) approach and COVID-19	2020
	PPC meeting minutes 28-29 October 2020	2020
	Risk Implication and Mitigation	2020
	Risk Implication and Mitigation_ Annex A	2020
	Strategy Programmes and Partnerships and recalibration of Gavi 5.0	2020
	Strategy progress challenges and risks and implications of COVID-19.pdf	2020
	Update on Risk Management	2020
Annexes to reports to PPC meeting May 2022	Annex A - COVAX Reporting Framework	2022
	Annex B - Update on the Humanitarian Buffer	2022
	Annex C - Phase II allocation	2022
	Annex D - Interim Approach to Paediatric Support	2022
	Annex E - Supporting Considerations for a Future COVAX-Supported Paediatrics. Programme and Risks and Trade-offs	2022
	COVAX_Key Strategic Issues	2022
	Gavi's Engagement in Pandemic Preparedness and Response	2022

	Annex A - Lessons learnt from Gavi 4.0	2022
	Appendix 3 - Co-financing and fiscal space for health in Gavi-eligible countries	2022
	Appendix 4 - Further details on the economic impact of COVID	2022
	Appendix 5 - Implementation of exceptional COVID-19 co-financing waivers	2022
	PPC May 2022 - 03 - Strategy Programmes and Partnerships	2022
Communication	Q&A on COVID-19 Country Programmes Response (internal document)	---
	Talking points and Q&A on M&R&S activities and associated funding in the context of COVID-19 (internal document)	9/2020
	Gavi, the Vaccine Alliance response to COVID-19 – Template COVID-19 Country Correspondence and Guidance	2019
	Combining COVID-19 and routine vaccination: Nigeria implements a "whole family" approach	2021
Country programme	Evolution of COVID-19 core team (internal document)	--
	Country Support and Core team - countries overview (internal document)	--
	M&R&S data – Countries MRS exemplars	--
	Internal Guidance on use of HSIS, PBF, PTE and PEF TCA Response to Covid-19	2020
Funding flexibilities	C&E Costing	--
	COVID-19 Maintain and Restore_Update on preliminary thinking	--
	HSS Flexibilities design for Maintain & Restore	--
	Internal Guidance on use of HSIS, PBF, PTE and PEF TCA Response to Covid-19	--
	Key updates on internal guidance and news on COVID-19 from the Alliance & UN	2020
	Maintain & Restore HSS process Flexibilities	--
	Maintain Restore and Strengthen Update to DCEO	2020
	M&R&S Review	2021
	PEF Targeted Country Assistance (TCA). Guidance for 2020 Planning of Short-Term Catalytic TCA for Maintaining, Restoring and Strengthening Immunization Services in Light of COVID-19 (WHO, UNICEF, Gavi, CDC, WB)	--
	Proposed Programmatic and Monitoring Considerations_Covid-19	2020
	Guidance Co-financing approach under COVID-19	2020
	Guidance Co-financing approach under COVID-19	2021
Monitoring	COVID-19 Monitoring and Learning Overview	
	COVID-19 Impact & COVAX Delivery Tracking Parameters – Public Version	2021
	COVID-19 dashboard	2022
Multi Stakeholder Dialogues (MSDs)	Burundi MSD	2020
	Cambodia MSD	2020
	Congo Republic MSD	2020
	Cote d'Ivoire MSD	2020
	Ethiopia MSD	2020
	Kyrgyzstan MSD	2020
	Lao MSD	2020
	Liberia MSD	2020
	Malawi MSD	2020
	Mozambique MSD	2020
	Nicaragua MSD	2020

	Nigeria MSD	2020
	PNG MSD	2020
	Sierra Leone MSD	2020
	Somalia MSD	2020
	Sudan MSD	2020
	Tajikistan MSD	2020
	Tanzania MSD	2020
	Togo MSD	2020
	Uganda MSD	2020
	Uzbekistan MSD	2020
	Yemen MSD	2020
	Zambia MSD	2020
	Zimbabwe MSD	2020
Quarterly Country Programme reports	CP Quarterly Report August - November 2020	2020
	CP Quarterly Report December 2020- March 2021	2021
	CP Quarterly Report April - June 2021	2021
	CP Quarterly Report July - September 2021	2021
Quarterly Monitoring Reviews (QMR)	January 2021 QMR Presentation Slide Deck	2021
	June 2021 QMR Presentation Slide Deck	2021
Governance	Evaluation Advisory Committee terms-of-reference	2020
	Gavi Evaluation Policy (latest revision November 2021)	2021
Grant Performance	List of core Indicators, GPF	2022
	GPF data update	2022
	Grant Performance Frameworks (website explanation to GFP)	(live)
COVAX	First National Hackathon on COVID-19 vaccinations – Initial findings and discussions with Gavi – Ivory Cost	2022
	Abridged Routine Immunisation and Covid-19 Vaccine Delivery Dashboard Jan 2022	2022
	2022 Audit and Finance Committee: approved audit plan	2021
Digital Health	Gavi Digital Health Information Strategy (DHIS) – country segmentation	2022
	Gavi DHIS COVID-19 Innovations Briefing Document, final review	2022
R&P	PPE: Gavi to UNICEF confirmation letter on PPE procurement; letter signed by Gavi CEO	2020
	PPE Gavi HSS Reporting 2020.05.31	2020
	PPE Gavi HSS Reporting 2020.06.22	2020
	PPE HSS Reporting 2020.06.30 updated	2020
	PPE Gavi HSS Reporting 2020.07.31	2020
	PPE Gavi HSS Reporting 2020.08.31	2020
	PPE Gavi HSS Reporting 2020.09.30	2020
	PPE Status of PPE 24092020	2020
	PPE UNICEF PPE Prices, June2020	2020
	COVID-19 Programmatic risks and mitigation strategies	2020
	DRAFT memo programmatic risks and mitigation 02042020	
Risk	Gavi programmatic risks and mitigation strategies	
	COVID-19 Programmatic risks and mitigation strategies	2020
	DRAFT memo programmatic risks and mitigation 02042020	2020
	Top programmatic risks and mitigation strategies (presentation)	2020
	Tracking Available Funds for Transfer to SD – 06042020	2020

	Time spent on COVID response; time-tracker on time spent to manage Covid response	2020
	Approval Summary Table-COVID-19 - Excel file with financial info on approvals	2020
	Targeted Country Assistance Reallocation Guidance in the context of COVID 19 pandemic	2020
MRS	MRS Review	2021
	MRS tracker (Excel on RI disruption)	2021
	Narrative for MRS monitoring considerations (reporting of MRS through GPF)	2020
	M&R Guidance Overview July9; PPT presentation M&R guidance + zero-dose guidance overview	2020
	Reaching missed communities in light of COVID	2020
	Short term needs M and R; Identifying immediate additional support needs to maintain immunisation services	2020
	M&R Country mapping, validated Immediate Needs	2020
	mini workshop; timeline on M&R/ S/ reach zero dose today -> 2025	2020
	Gavi's support for equity and reaching missed communities in light of Covid-19 - Maintain and restore	2020
	Narrative monitoring MRS reallocations; using GPF to monitor MRS	2020
Other | various		
	Premise Global project: lessons learned and next steps	2021
	WHO Pulse surveys	2022
	75th Gavi World Health Assembly High Level Messages presentation	2022
	Cold Chain Investments	--
	HSIS COVID tracker (COVID response plan, support by Gavi, support by World Bank and The Global Fund)	2022
	Gavi PEF TCA 2022-2025 Guidance	2022
	Gavi Programme Funding Guidelines release 2 draft v 23.05.2022	2022
	Gavi 5.1 C19 vaccine programme & life course approach	2022
	Gavi Guidance to Address Gender-Related Barriers to Maintain, Restore and Strengthen Immunisation in the Context of COVID-19	2021
	Maintaining, Restoring & Strengthening immunisation. Gavi innovation catalogue	2020
	Use of Gavi Support to Maintain, Restore and Strengthen Immunisation in the Context of COVID-19	2020
	A quick guide to inform understanding of gender-related barriers to immunisation: learning from research	2017
CONFIDENTIAL	Administrative data from some countries – reviewed for triangulation but not quoted in this report	2022
	Preparing for the next pandemic (Learnings from COVAX ....)	2022
	Reference guide_COVAX Organigram_April 2022	2022
	Gavi organisational chart January 2022	2022
	Access to next HSS grant for MR&S (note to Ex. Office)	2021
	COVAX Rollout_Sudan-MA_Inception and pre-rollout	2022
	Gavi Monitoring Agents Nigeria_2nd Roll Out Assessment Report_highlights	2022
	COVAX Rollout Uganda-MA_Inception Report- Feb 2022	2022
	COVAX pre-roll out monitoring report_KPMG Cluster summary_Somalia_Sudan_South Sudan	2022

	"June 2022/ Zero-dose country analysis" one report from each of our 8 countries	2022
Most important policies sourced from Gavi website	Gavi application process guidelines	
	Summary Gavi 5.0 country allocation	
	Gavi support guidelines	
	Co-financing policy	
	Transparency and accountability policy	
	Fragility, emergencies and displaced populations policy	
	Gender policy	
	Health system and immunisation strengthening support framework	
	Risk policy	
	Guidance for Gavi Grant Performance Frameworks – 2019	
	Responding to COVID-19	
	COVID-19: Gavi steps up response to pandemic	
	Targeted country assistance	
	The Zero Dose child explained	

DOCUMENTS FROM EXTERNAL PARTNERS AND ORGANISATIONS		
Center for Global Development	COVID-19 Vaccine Rollout in historical perspective – Working paper	2022
COVID-19 Evaluation Coalition	COVID-19 Early Lessons and Emerging Evidence Presentation May 2021	2021
COVID-19 Evaluation Coalition	COVID-19 Early Synthesis Report June 2021	2021
COVID-19 Evaluation Coalition	Draft Strategic Evaluation questions	2020
COVID-19 Evaluation Coalition	Guidance Communications Toolkit	2021
COVID-19 Evaluation Coalition	How are the COVID-19 response and Recovery efforts being evaluated?	2021
COVID-19 Evaluation Coalition	Joint Bilateral COVID-19 Evaluation Planning Session	2021
LSHTM CMMID C-19 working group	Routine childhood immunisation during the COVID-19 pandemic in Africa: A benefit–risk analysis of health benefits versus excess risk of SARS-CoV-2 infection	2020
MSF	Key considerations for Gavi's new global financing mechanism (a critical view on COVAX)	2020
The Global Fund	Audit of COVID-19 Response Mechanism Global Fund	2021
The Global Fund	Audit of the COVID-19 Response Mechanism 2022_Global Fund	2022
The Global Fund	Audit Report Continuity and Oversight of Country Programs during the Covid-19 Pandemic	
UNICEF	Learning Focused Evaluation Implementation Plan	2020
WHO	VPD campaigns covid disruptions 20220502 Update	2022
WHO	WHO Guiding Principles for Immunization Activities during Covid-19 Pandemic	2020

CASE STUDY COUNTRY DOCUMENTS		
KENYA		
	Coordination mechanisms for COVID-19 in the WHO Regional office for Africa	
AMREF	Amref June-December 2021 report	2022
AMREF	Seizing the moment, Global action to end the COVID-19 crisis and prevent the next pandemic	2022
AMREF	The impact of the COVID-19 pandemic and response on reproductive, maternal, child and adolescent health service provision in Kenya, Uganda and Zambia.	--
BMC Health Services Research	Coordination mechanisms for COVID-19 in the WHO Regional office for Africa	2022
BMGF	BMGF press statement 15-Apr-20 additional funding to countries	2020
Gavi	Country dashboard – information incl. 2021	2021
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, TGO-HSS-2-PBF-COVID-19	2020
Joint Learning Network (JLN)	Kenya country core group webinar	2020
JLN	Kilifi County COVID-19 Experience	2020
JLN	Utilization of community health services during COVID pandemic; presentation by Dr Salim Husein, Head, Dept. PHC	2020
(JLN)	Coordinating the National Pandemic in Kenya	--
Kenya Health Federation (KHF)	Coordinating private sector efforts and complementing MoH efforts on the COVID-19 health response	2020
KHF	Engaging private health sector during COVID-19 vaccinations	2020
MoH	Coordinating private sector efforts and complementing MoH efforts on the COVID-19 health response	2020
MoH	COVID-19 Pandemic: Kenyas's experience	2020
MoH	DPG and Global Health partners' response to C-19 in Kenya Apr/20	2020
MoH	DPG and Global Health partners' response to C-19 in Kenya Jul/20	2020
MoH	DPG and Global Health partners' response to C-19 in Kenya Oct/20	2020
MoH	EIR REPORT DRAFT - National vaccines and immunization programme - assessment of electronic immunization records	2020
MoH	Guidance on PS role in deployment of C-19 vaccines	2021
MoH	Kenya COVID-19 Response Enhancement Plan	2020
MoH	Maintaining Essential Health Services (MEHS) presentation to DPHK June 25th	2020
MoH	MEHS WG and SWGs August 2020 minutes	2020
MoH	National 2019 Novel Coronavirus Contingency Readiness and Early Response Plan – February -April-2020	2020
MoH	Stakeholder Engagement Plan SEP KENYA COVID-19 EMERGENCY-RESPONSE-PROJECT-P1738201	2020
The Global Fund	GF-OIG-22-005 Kenya Audit Board version	2022
World Bank	Kenya COVID-19 emergency response project – PAD3832	2020
MOZAMBIQUE		
Gavi	Country dashboard – information incl. 2021	2021
Gavi	GAVI HSS funds reprogramming for COVID19 initial approval	2020
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, MOZ-HSS-1-COVID-19	2020

Gavi	Narrativa PPR 27062020_Preliminar	2020
Gavi	Proposal for HSS support 2020 - Mozambique	2020
Gavi	Reallocation request_ 3 2020	2020
Gavi	Reallocation request_ 6 2020	2020
Gavi	REVISED-Appendix 6_MOZ_Country-Request-Budget 2020-04-03	2020
Gavi	Targeted country assistance plan Mozambique 2020	2020
Gavi	TCA-Plan-Mozambique_2021	2021
MoH	Comprehensive multi-year plan (cMYP) 2022 – 2024	2020
MoH	Final Plano de Preparacao e Resposta COVID-19 --2020-3_31	2020
MoH	Intra Action Review Covid19-Mozambique Final 20201221	2020
MoH	MoH responses to email on Budgetary request for COVID_20 7 20	2020
MoH	PH emergency response Skills Development Plan_ draft of June 1st 2021	2021
MoH	Plano Nacional de reposta a pandemia do COVID-19 2021_OFICIAL	2021
MoH	Plano operacional COVID 19 Grupo de Comunicacao 14.04.20-2	2020
MoH	Resposta ao COVID-19 AA1408 29 Abril VFinalissima	2020
NIGER		
	La situation de la rougeole demeure encore inquiétante au Niger	2021
BBC	L'arrêt des programmes de vaccination met la vie des enfants en danger - BBC News Afrique	2021
Gavi	2021-TCA-Plan-Niger	2020
Gavi	Country dashboard – information incl. 2021	2021
Gavi	Gavi Guidance immunization during COVID-19	2020
Gavi	Gavi Zero-dose Funding Guidelines	2021
Gavi	Gavi_Guidance-to-address-gender-barriers-in-MRS-immunisation	2020
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, NER-HSIS-COVID-19	2020
Gavi	Narratif_Plan Covid-19_Niger	2020
Gavi	NER-HSIS-COVID-19	2020
Gavi	Niger_COVID_Lettre d'Approbation_13 Mai 2020	2020
MoH	Niger-COVID-19-Response-Plan-April-2020	2020
MoH	Targeted-country-assistance-plan-Niger-2020	2020
MSF	Niger _ augmentation exponentielle des cas de rougeole	2021
MSF Australila	Niger - Fighting measles through vaccination	2021
Niameyinfo	Quand la Covid-19 impacte le suivi des vaccinations de routine -	2022
Pan-African Medical Journal	Impact de la pandémie de la COVID-19 sur l'utilisation des services de santé dans la ville de Niamey: une analyse dans 17 formations sanitaires de janvier à juin 2020	2021
UNICEF	Niger 2021 Country Annual Report	2022
WHO	Bulletin mensuel OMS Niger (FEVRIER2021)	2021
WHO	Bulletin spécial OMS Niger Semaine africaine de la vaccination	2021
WHO	Maintenir les services de santé essentiels : orientations de mise en œuvre dans le cadre de la COVID-19	2020
WHO	Niger 4 mois réponse COVID-19	2020
WHO	Plan de preparation reponse_Pandemie COVID-19_Bureau OMS Niger (VF)_0	2020
WHO	Résumé Rapport OMS Niger 2020	2021

WHO	Revue Intra Action (RIA) de la réponse à la pandémie de la Covid-19 au Niger	2020
World Bank	Niger COVID-19 Emergency response project PAD3865	2020
World Bank	WB & l'UNICEF acheminent des fournitures essentielles pour la réponse du Niger à la COVID-19	--
NIGERIA		
CHAI	RI Trend Post COVID 19	2020
Gavi	200424_COVID-19 HSS Reallocation Approval Letter	2020
Gavi	Country dashboard – information incl. 2021	2021
Gavi	End-Term Review Partner Donor Report Template	2020
Gavi	Gavi letter of support	2020
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, NGA-HSS-2-COVID-19	2020
Gavi	NGA-HSS-2-COVID-19; HSIS reallocation request approval mem	2020
MoH	COVID 19 Workplan Proposal Narrative	2020
MoH	Covid-19 Outbreak-Incident Action Plan (IAP) Signed (NCDC)	2020
MoH	Lab Forecast_21052020_Gavi	2929
MoH	Letter of acceptance; Acceptance of cost estimate 1.9 mill by NCDC	2020
MoH	Letter of request to Gavi	2020
MoH	National PPE Needs updated 13-5-20	2020
MoH	Request to disburse Gavi COVID-19 funds to UNICEF	2020
MoH	Strengthening Nigeria's Response to COVID-19 with Gavi support	2020
NERICC	NERICC Update on Zero dose Strategy and Work Plan	2020
UNICEF	CE Local procurement Gavi HSS-signed	2020
UNICEF	CE Nigeria-Covid-GAVI-HSS	2020
PAKISTAN		
Gavi	Country dashboard – information incl. 2021	2021
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, PAK-HSS-2-COVID-19-Revised	2020
Gavi	Grant Agreement - Agreement on implementation of Gavi financed programme Jan21-Dec22	2020
Gavi	Full Portfolio Planning mission to Pakistan	2022
Gavi	Pakistan Decision Letters 2020-2021	2020
Gavi	Pakistan Request for Gavi Co-Financing Waiver - Partial Waiver Approved	2021
Gavi	Pakistan fact sheet	2022
Gavi	Full Portfolio Planning mission to Pakistan Feb-March 2022	2022
MoH	Letter Gavi for co-financing; letter from MoH/EPI to Gavi to waiver co-financing for 2020/21	2020
MoH	National Vision 2016-2025, Pakistan vision to address challenges of Reproductive, MNCAH and Nutrition	--
MoH	National Development & Vaccination Plan (NDVP) for COVID-19 vaccines	2022
World Bank	Pakistan COVID-19 Emergency Response Project WB PAD 3826	2020
SUDAN		

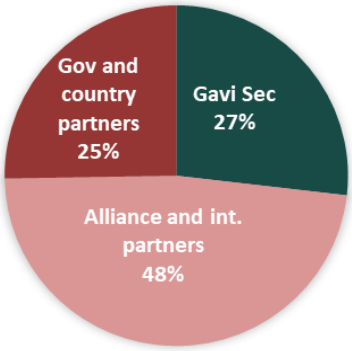
Gavi	Country dashboard – information incl. 2021	2021
Gavi	Gavi-HSS-COVID supplies-signed Gavi CEO-MOU GAVI-UNICEF	2020
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, SDN-HSS-2-COVID-19	2020
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, SDN-HSS-2-COVID-19-Amendment	2020
Gavi	SDN Amendment AR memo COVID-19 2nd reallocation request	2020
Gavi	SDN MOH on 1st request and Approval of Covid-19 signed 200422	2022
Gavi	SDN-HSS-2-COVID-19 - 1st reallocation request and signed 080422	2020
Gavi	SDN-HSS-2-COVID-19-Amendment 2nd allocation signed - 300420	2020
Global Health Development	Review of the immunization position; Review of the immunization position in UHC related policies in Sudan_Final working draft	2020
MoH	Authorization letter to release funds for procurement	2020
MoH	Ensuring continuity of PHC services and essential services	2020
MoH	National COVID-19 Preparedness and Response Plan; response plan 1 May - 31 December 2021 from FMOH	2021
MoH	SDN - FMoH Covid19 Response Plan - 170320	2020
MoH	Sudan Synthesis Report Phase II April 2022	2022
MoH	المنح والتبرعات لصالح وزارة الصحة الاتحادية Final Report copy - TRSP&ZK chosen	2020
MoH	المنح والتبرعات لصالح وزارة الصحة الاتحادية في الفترة من مارس - يونيو 2020edited - TRSP&ZK chosen	2020
UNICEF	CE 10022287 SUDAN Gavi HSS – Cost estimate for supplies from UNICEF for Gavi funds	2020
TOGO		
Gavi	Communication Gavi_COVID-19_Mars 2020	2020
Gavi	Country dashboard – information incl. 2021	2021
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, TGO-HSS-2-PBF-COVID-19	2020
Gavi	Lettre_Evaluation Réponse Initiale C19	2022
Gavi	Lettre_Ministre_demande Gavi COVID19	2020
Gavi	TGO AR Memo for HSS Reprogramming Request MRS; approval letter	2021
Gavi	TGO-2021.09 (CDS) (COVID-19 vaccine delivery support)	202 1
Gavi	TGO-COVID19-EOS-CCE (cold chain equipment support)	2021
Gavi	Togo COVAX TA Plan	2020
Gavi	Togo COVID Budgeting Concept Template filled (HSIS reallocation)	--
Gavi	Togo TCA Reallocation Tracking Form	2020
MoH	BORDEREAU_LTA N071-37678782_20220520 – (receipt for equip)	2020
MoH	Demande flexibilité GAVI COVID 19_Extracteurs	2020
MoH	Lettre_Ministre_demande COVID-19 à la Directrice de Prgm GAVI	2020
MoH	PEV-routine-Togo- 2019 VF	2019
MoH	PEV-routine-Togo- janvier … Décembre 2020 VF	2020
MoH	Plan d'Action de Lutte Contre la Pandémie de la COVID-19 au Togo Secteur de la Sante	2021
MoH	Plan d'Action Opérationnel de Riposte Contre La Pandemie Du Nouveau Coronavirus Au Togo	2020
MoH	Plan National de déploiement et de accination contre la COVID-19 Togo revise	2022

MoH	pnds-togo-2017-2022-version-definitive	
MoH	PPAC_PEV Togo - 2016-2022 version 31 dec 2020 def VF	2020
MoH	Rapport Final Revue Externe PEV Togo 2019, Supported by WHO, Gavi, UNICEF	2019
MoH	RIA de la response sanitaire a la COVID-19 au Togo	2021
MoH	SMT_Togo_2019 VF	2020
MoH	SMT_Togo_Decembre_2020 VF	2020
MoH	Togo Justifcation appui GAVI_COVID-19_01 09 2020	2020
UNICEF	CE 10024040 Rev. 1 – Togo (quote for equipment)	2020
World Bank	Togo COVID-19 Emergency Response and System Prep PAD3861	2020
UGANDA		
CHAI	CHAI Bilateral Meeting_ CHAI Ug-GAVI Mission Update	2022
FTS	FTS Uganda Intersectoral COVID-19 Response Plan 2020	2022
Gavi	Country dashboard – information incl. 2021	2021
Gavi	Exhibit A1 Signed Gavi-Shifo	2021
Gavi	final SHIFO Amendment Agreement 2021 Nov signed	2021
Gavi	Gavi programme audit report	2021
Gavi	HSS Reallocation Request in Response to COVID-19, approval request memo, UGA-HSS-2-COVID-19	2020
Gavi	NCE AFENET and Gavi for DIT Uganda	2021
GAVI	PATH ODKX-CCE Exhibit A-39 Amendment No.1_PATH_cosigned	2021
Gavi	UGA-COVID19-CDS DL	2021
Gavi	UGA-COVID19-CDS-CDS-AR memo	2021
Gavi	UGA-COVID19-CDS-CDS-AR table	2021
Gavi	UGA-HSS2-COVID-19: HSIS Reallocation Request in Response to COVID-19	2020
Gavi	Uganda Programme Audit Notification letter	2021
Gavi	UGANDA WHO NCE	
GoU	Uganda Government COVID-19 Interventions Report	2020
MoH	20210706_CDS Early Access Funding Request-submitted	2021
MoH	CE AUTHORISAION	2021
MOH	FMA Quarterly Report-Summary	2022
MoH	GAVI Confirmation letter-$3.554m	2021
MoH	MOH Introduction Meeting GAVI 2022 Mission program overview	2022
MoH	UGA COVID-19 Response UNEPI Revised Request to Gavi	2020
MoH	Uganda Concept Paper on EPI Health Systems Support to the COVID-19 Outbreak response - 17th April 2020	2020
MoH	UNEPI Update to UNITAG 02_06_22	2022
MoH	UNEPI Workplan 2022 and Audit Response GAVI presentation	2022
PATH	Gavi mission 2022_PATH_JA	2022
PATH	Zero Dose Children Proposal_PATH-UNEPI	2022
UNICEF	CE 10024230 Uganda CCEOP and Services	2021
UNICEF	Real-Time Assessment UNICEF's Ongoing Response to COVID-19 Uganda	2021
UNICEF	UNICEF - Gavi Bilateral meeting 04 April 2022-FINAL	2022
WHO	WHO DHTs Overview _Presentation to Gavi	2022

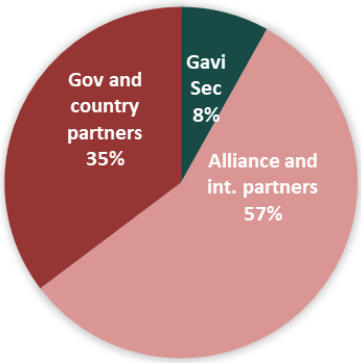
8 Key informants interviewed

In total, the evaluation team interviewed 190 KIIs, including those gathered through eight country case studies. An approximate allocation of KIIs to three key categories is included below, including for KIIs conducted at global- and country- levels.

Overall split of KIIs to three key categories



Split for country KIIs



Split for global KIIs

Name	Position	Organisation
Global key informants		
Nimma Abbaszadeh	Senior Program Officer, Health Funds and Partnerships	Bill & Melinda Gates Foundation
Sue Graves	Deputy Director, Health Funds and Partnerships	Bill & Melinda Gates Foundation
Anuradha Gupta	Deputy CEO	Gavi
Colin Paterson	Consultant, Evaluation & Learning	Gavi
Homero Hernandez	India Senior Country Manager	Gavi
Marthe Essengue Elouma	Regional Head, West and Central Africa	Gavi
Mkhululi Moyo	Manager, Evidence, Learning & Communications	Gavi
Pascal Bijleveld	Chief Executive Officer	Atscale
Stephen Sosler	Head Vaccine Programme	Gavi
Tarek Elshimi	Gambia Senior Country Manager	Gavi
Tito Rwamushaija	Ethiopia Senior Country Manager	Gavi
Alex De Jonquieres	Director, HSIS	Gavi
Amy LaTrielle	Director, Fragile & Conflict Countries	Gavi
Anna Standertskjold	Programme Manager Afghanistan and Syria	Gavi
Assietou Diouf	Managing Director, Finance & Operations	Gavi
Caitlin Leonard	Programme Manager, CS	Gavi
Clarissa Van Heerden	Senior Manager, Risk	Gavi
Colette Selman	Director, Core Countries	Gavi
Dan Hogan	Head, Measurement & Strategic Information	Gavi
Dave Cagen	Senior Manager, PST	Gavi
Deepali Patel	Former Head, Policy, Gavi	

Emmanuel Bor	Head, IF&S	Gavi
Friederike Teutsch	Senior Manager, Funding Design and Communication	Gavi
Gurleen Hans	Head, Portfolio Finance Management	Gavi
Heidi Reynolds	Senior Specialist, Evaluation & Learning	Gavi
Hope Johnson	Director, Measurement, Evaluation & Learning	Gavi
Johannes Ahrendts	Director, Strategy, Funding, & Performance	Gavi
Josh Lorin	Programme Officer, Measurement & Strategic Information	Gavi
Katja Schemionek	Senior Manager, Country Health Systems, Health Systems & Immunisation Strengthening	Gavi
Lindsey Cole	Head, Funding Design and Review (FD&R)	Gavi
Manjari Shankar	Manager, Programme Support Team	Gavi
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Gemma Orta-Martinez *	SD arrangements UNICEF	UNICEF Supply Division
Krista Hund	Financing waivers UNICEF	UNICEF Supply Division
Peter Leth *	SD arrangements UNICEF	UNICEF Supply Division
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Country key informants		
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Samora Otieno, Dr	Basic Services Team leader and Health Adviser, Foreign, Commonwealth and Development Office (FCDO)	British High Commission Kenya
Abhijeet Anand, Dr.	Immunization focal person	CDC
Justin Williams	Communications and partnerships	CDC
Anthony Ngatia	Director vaccines/ digital health	CHAI
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Evelyne Wesangula, Dr.	Head of Patient Safety and Health Workers Safety Division	Ministry of health
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NIGER		

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Madam DEZAN Mariama	Head of Advocacy and Social Mobilization Division, Directorate of Immunizations (Focus group discussion *4 ppl)	Ministry of Health
Rachid Souley	Monitoring and Evaluation Officer at the Directorate of Immunizations (Focus group discussion *4 ppl)	Ministry of Health
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ANKOUA Aboubacar	Associate expert for ROASSN (Focus group discussion *6ppl)	ROASSN
Djermakoye Idé	National Coordinator/ National grouping of NGOs and Associations of the health sector of Niger (ROASSN) (Focus group discussion *6ppl)	ROASSN
Harouna Balkissa	Accounting assistant (Focus group discussion *6ppl)	ROASSN
Ibrahim Abdoul Nasser	Monitoring and Evaluation Officer (Focus group discussion *6ppl)	ROASSN
Idé Haoua	Responsible of Training and information (Focus group discussion *6ppl)	ROASSN
Somalia Mahamadou	General Secretary of NGO ROASSN (Focus group discussion *6ppl)	ROASSN
Amadou Haroun	Immunization team member (Focus group discussion *4ppl)	UNICEF
Jean Claude Mubalama, Dr	Chief of health (Focus group discussion *4ppl)	UNICEF
Kone Moriba, Dr	Immunisation manager (Focus group discussion *4ppl)	UNICEF
Yessoh Bogui Theodule	Immunization specialist (Focus group discussion *4ppl)	UNICEF
Blanche Anya, Dr	Country representative (Focus group discussion *4ppl)	WHO
Kaya Mutenda, Dr	Immunization Program Coordinator (Focus group discussion *4ppl)	WHO
Kimba Moussa Harouna	National consultant (Focus group discussion *4ppl)	WHO
Oumarou Batouré, Dr	Responsible for routine immunisation (Focus group discussion *4ppl)	WHO
Cedric Ndizeye	Senior Health Specialist	World Bank

NIGERIA		
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Omotayo Giwa	Programme manager	CHAI
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Sidney Sampson	Principal, Sydani Initiative for International Development (management consultants)	Sydani Initiative
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Soofia Yunus, Dr	Deputy National Programme Manager EPI	Ministry of Health
Chengetanai Mangoro	Procurement Services Manager (covering Pakistan)	UNICEF
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Khawaja Aftab Ahmed, Dr	HSS Specialist UNICEF	UNICEF
Naeem Asghar, Dr	(former) Immunisation Coordination Officer	UNICEF
Yasmin Calloub	Team Lead Immunisation	UNICEF
Nida Taqi, Dr	WHO Country Immunization Team	WHO
Shahnawaz Jaskani	Data Analyst Country Immunization Team	WHO
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Osama Mere, Dr	Team Leader for EPI (former)	WHO EMRO

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TOGO		
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Marin Kokou Wotogbé, Dr	Secretary General	Ministry of Health
Mawunyo ZIGAN, DR		Ministry of Health
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Tcha Gnao Agoro	Member	Poscvi
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UGANDA		
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Driwale Alfred, Dr	EPI Manager	Ministry of health
Richard Mugahi, Dr	Assistant Commissioner Child Health	Ministry of health
Sabrina Kitaka, Dr	Deputy Chair NITAG	NITAG
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Atnafu Getachew Asfaw	Health Manager	UNICEF
Atnafu Getachew Asfaw	Health Manager	UNICEF
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Jon Blasco	UNICEF Supply Manager	UNICEF
Patrick Banura	Immunization Officer	UNICEF
Christina Mugasha	USAID MCH Program Manager	USAID
Annet Kisakye, Dr	EPI Covid 19 focal officer	WHO
Rogers Akiyo	Senior Country Officer, Health	World Bank

*Individuals marked with *provided information to the evaluation but not as part of a formal interview with audio recording and informed consent. However, information from interactions with these individuals made a material contribution to the evidence on which our findings are based.

9 Supporting evidence (figures and charts) for WS1: right design

In this annex we present supporting evidence for the findings under workstream 1, which looks at the relevance and coherence of Gavi's R&P and M&R&S initiatives ('right design'). Findings are presented in section 3.1 of Vol I.

9.1 Mapping COVID-19 flexibilities onto the FER

The following table maps the flexibilities offered under R&P and M&R&S onto flexibilities that were available under the FER policy.

	C-19 Flexibilities	FER Policy Flexibilities
R&P	**10% HSS reallocation**	Included but without specific threshold
	TCA extension	Not included
	TCA reallocation	
	Eligibility freezes	
	Co-financing waiver	Included
	Reallocation of post-transition support	Included in general terms under HSIS flexibility
	Reprogramming of underspent VIG/Ops grants	Included implicitly as VIG/Ops are HSIS funds
	Transition grant flexibility (extension and/or reallocation)	Not included
MR&S	HSS 25% ceiling	Included but without specific threshold
	Operational costs for adapted RI strategies	Included
	Additional TCA for CSOs	Included
	Additional RI vaccines	Included
N/A	Not included	Direct vaccine support and operational costs to CSOs
		Advocacy for CSO procurement of vaccines

9.2 Summary of Gavi's COVID-19 response in relation to identified needs; Gavi goals, policies and ways of working

The following table maps the flexibilities offered under R&P and M&R&S against the needs that Gavi identified to show the extent to which flexibilities met these needs.

Identified need	Relevant flexibilities	Alignment with Gavi goals/ policies/ operations	Related design considerations	
Need for rapid access to resources to respond to emerging pandemic threat in the context of the economic impact of C-19 on domestic resources	All R&P flexibilities	**Aligned:** • FER policy • Transparency and Accountability Policy **Not aligned:** • HSIS Framework/ sustainability objectives • Organisational risk appetite (in particular with reference to co-financing waivers) • Gavi 5.0 Goal 3: Improved sustainability of immunisation programmes • Gender/GESI-related policies	• **All R&P flexibilities were designed to address the need for rapid resources** as they released funds already in-country for COVID-19 response. • **Co-financing waivers and eligibility freezes addressed the economic impact of COVID-19** on domestic budgets by temporarily reducing/eliminating requirement for countries to allocate budget for co-financing obligations • **Transparency and accountability processes** were adjusted but still existed, e.g. SCMs used as flexibility "gate-keepers"; use of in-country financial monitoring agents; special arrangement with UNICEF SD to ensure accountability of PPE procurement[22] • **Lack of alignment with usual sustainability focus was mitigated by**: offering flexibilities for a limited period; requiring alignment with WHO COVID-19 response pillars/gaps in country response plans; clear eligibility criteria which ruled out particularly unsustainable support, e.g. purchase of vehicles • **Co-financing waiver risks were mitigated by:** Offering waivers on a discretionary basis via SCMs; positioning Gavi as a donor of last resort; requiring approval at CEO, complemented through advocacy effort up to senior management level. • While R&P flexibilities were not explicitly aligned with gender/GESI policies, **flexibilities could be used to focus on reaching vulnerable communities**	Addressed need for rapid access by being sensitive to country transaction costs, with simplified application and sign-off process, use of GPF to avoid parallel reporting processes
A need to address the disruption to RI services that had resulted due to lockdowns and fear of infection, especially among HCWs A need to strengthen approaches to reaching ZD children and missed communities	**R&P:** Indirectly via HSS reprogramming support for PPE and testing for HCWs **MR&S:** All flexibilities	**Aligned:** • FER policy (partial) • Gender/GESI-related policies • Organisational risk appetite (especially risks required to strengthen health systems and increase equity) • Gavi 5.0 G2: Health systems are strengthened to increase equity in immunisation • Gavi 5.0 G3: Improved sustainability of RI programmes	• **R&P reprogramming/reallocation designed to address fear of infection and disruption to RI services** by supporting activities such as procurement of PPE (especially for HCW) and risk communications • **MR&S flexibilities designed to address disruption to RI services** by only supporting activities explicitly focussed on this, rather than more general COVID-19 response (i.e. no longer supporting PPE) • **MR&S flexibilities addressed need to strengthen approaches to reach ZD children and missed communities** by offering additional TCA funding to support innovative solutions to reach ZD children and additional RI vaccine doses and/or new antigens allow for multi-intervention delivery of vaccines	

[22] Update on risk management, Report to the PPC, 6 May 2020

9.3 WHO-pillars R&P flexibilities supported

The following table shows how case study countries used R&P flexibilities for activities set out in WHO COVID-19 guidance, as well as a summary of alignment with Gavi policies and Gavi's comparative advantage.

WHO COVID-19 COUNTRY READINESS AND RESPONSE PILLARS	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
1: Country level coordination, planning & monitoring	R&P: National and sub-national coordination	N/A	N/A	R&P: Coordination and oversight		N/A	R&P: 2019 TCA NCE supported TA for management	N/ASP
2: Risk communication and community engagement	R&P: Communication support inc. media advocacy	R&P: Communication on COVID-19 via radio, community leaders, relays etc.	R&P and MR&S: Communication on C-19 via radio, community leaders, relays etc.	R&P: Communication inc. media advocacy with CSO support	R&P: Contribution mentioned – details unclear	N/A	R&P: 2019 TCA NCE supported HCW communication training	N/A
3: Surveillance, rapid response teams, and case investigation	N/A	N/A	R&P: Supervision of isolation sites; rumour surveillance	R&P: Support for surveillance activities	R&P: Contribution mentioned – details unclear	N/A		N/A
4: Points of entry	N/A	N/A	R&P: Training on PPE use			N/A		N/A
5: National laboratories	N/A	N/A	R&P: Supply of test kits	R&P: C-19 test kits and reagents	R&P: Details unclear	N/A	R&P: C-19 test kits & other equipment	R&P: C-19 test kits
6: Infection prevention & control	R&P: PPE & IPC training	R&P: PPE	R&P: PPE	R&P: PPE and IPC training	R&P: PPE	R&P: PPE	R&P: 2019 TCA NCE supports IPC TA	N/A
7: Case management	R&P: Capacity building of HCWs on case management	N/A	N/A	N/A	R&P: Details unclear	N/A		N/A
8: Operational support and logistics	N/A	N/A	R&P: Transporting test kits & other consumables	N/A		N/A	R&P: 2019 TCA NCE supported data management	N/A
9: Maintaining essential health services and systems	Support for Pillars 1,2,6, and 7 ensure maintaining of	N/A	R&P and MR&S: Provision of RI vaccine storage; RI campaigns; RI and data systems	R&P: Development of guidelines on	R&P: Payment of incentive to vaccinators		R&P: 2020 TCA NCEs for WHO to strengthen RI equity & coverage	R&P: 2019 and 2020 TCA NCEs for WHO, PATH and Afenet

	essential services, incl. immunization			delivery of RI in COvID-19 context				
Alignment with Gavi policies	No alignment	Some alignment with gender-related policies and MR&S innovation catalogue	Some alignment with gender-related policies, MR&S innovation catalogue	Some alignment with gender-related policies and MR&S innovation catalogue	Some alignment with gender-related policies and MR&S innovation catalogue	No alignment	Some alignment with gender-related policies and MR&S innovation catalogue	Some alignment with gender-related policies and MR&S innovation catalogue
Alignment with Gavi comparative advantage	Some alignment to ensure immunization would continue	Some alignment with misinformation C. A	Some alignment with misinformation C. A	No alignment	No alignment	No alignment	No alignment	No alignment

9.4 Alignment of Gavi C-19 response with perceived comparative advantage

Perceived comparative advantage	Evidence on alignment of C-19 flexibilities
Partnership model[23]	Some Gavi staff felt that Gavi had somewhat capitalised on its partnership model, but that at the same time limitations in this had been exposed, with the potential value of bringing on more partners had been highlighted
Provision of catalytic financing[24]	While some R&P funding flexibilities did have a speed advantage in that they released funds already in country, there is no evidence that they were catalytic.
CSO partner network with expertise in reaching missed communities and ZD children	Gavi did seek to leverage existing CSO relationships via M&R&S TCA flexibilities, which focused on the importance of working with CSOs to identify ZD and missed communities. However as previously mentioned and discussed in full in Section 3.2, poor uptake meant that this comparative advantage was not leveraged.
Strengthening health systems (for vaccines specifically)[25,26] including support to cold-chain infrastructure[27]	Cold chain support was taken forward as part of COVID-19 vaccine roll-out. Extended outreach activities and other service delivery innovations have been supported with funding from Gavi.
Vaccine and health technology procurement	UNICEF, a key Gavi partner, has established offices and relationships with EPI teams and is the world's largest procurer of vaccines. UNICEF is also faster and has better VfM than some governments with inefficient procurement or finance release systems. Alliance expectations (as set out in the documents explaining the rationale for the "special arrangement") were that channelling PPE procurement through UNICEF would avoid delays in supply, and thus leverage UNICEF's comparative advantage in this area. However, stakeholder expectations were not uniformly realised in practice as described in Annex 10.25.
Combating disease/vaccine misinformation[28]	Within case study countries, there were some examples where flexibilities had been used to address C-19 and vaccine misinformation through the WHO risk communication pillar, but there were no other clear examples of activities being in alignment with Gavi's comparative advantage. There were also some examples of Gavi partners supporting the risk communication and essential services WHO pillars through CSO networks, but no examples were found of other organisations supporting activities which Gavi would have had a clear comparative advantage to support.

[23] See Gavi, The Vaccine Alliance: Doubling Down on Coverage, Partnerships, and Transition Incentives for the Next Phase - World | ReliefWeb

[24] P31, Ibid

[25] P12, "Break COVID now: The Gavi COVAX AMC Investment Opportunity" (Gavi, 2022) – available from Break COVID now - the GAVI COVAX AMC investment opportunity.pdf (reliefweb.int)

[26] Also referenced here default (parliament.uk) ("DFID supplementary submission Funding for vaccines, treatments and tests research: COVID and GAVI")

[27] COVID-19 Pandemic Response_An Alliance update.pdf, COVID-19 Gavi immediate and interim response

[28] Mentioned here Gavi@20: What's Next for Global Immunization Efforts | Center For Global Development (cgdev.org)

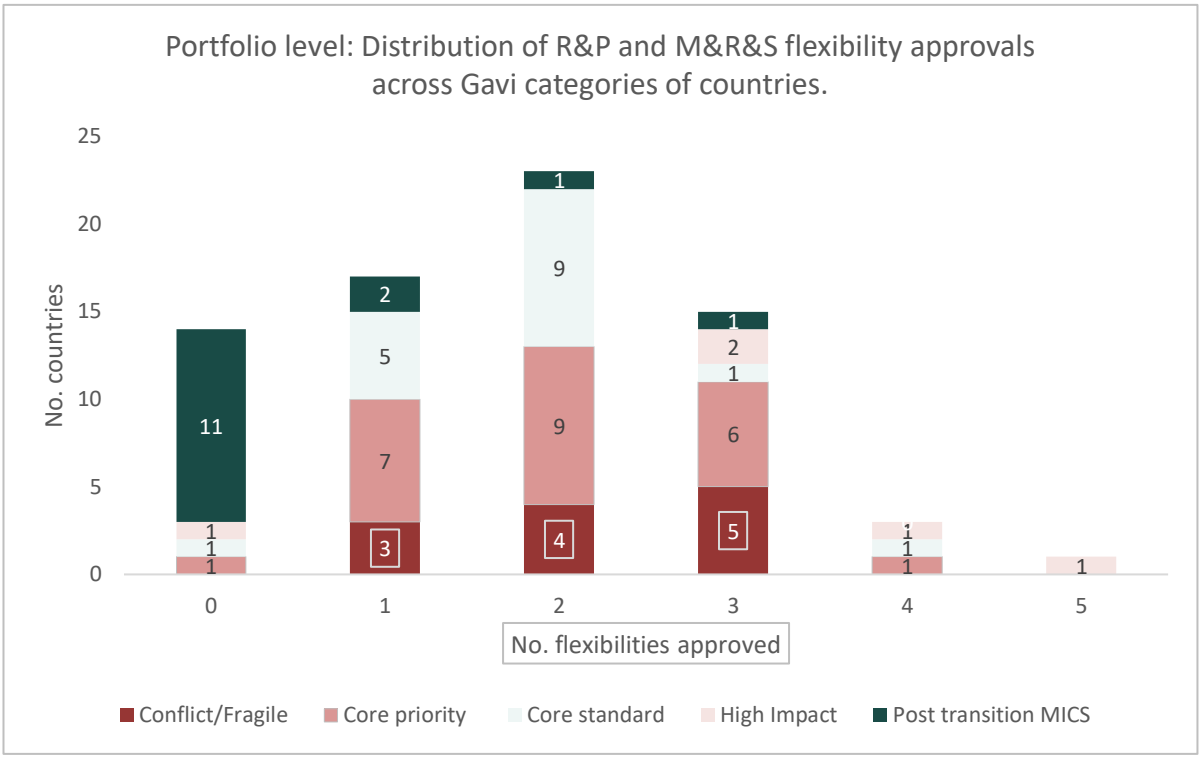
10 Supporting evidence (figures and charts) for WS2: Right Ways

This Annex provides a visual presentation of the types of flexibilities accessed by countries at the portfolio level and in the evaluation's case study countries. Annex 10.1 below provides an overview of the uptake of GAVI's COVID-19 response's main flexibilities uptake across 73 eligible countries.

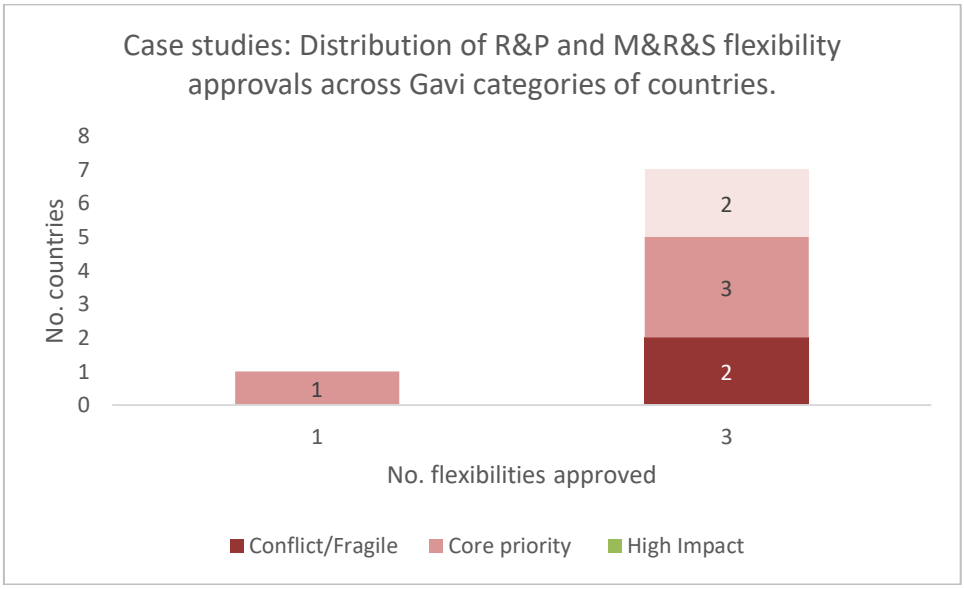
10.1 Overview of flexibilities uptake by countries

		R&P						MRS		
Country type (Gavi 5.0 classification)	**Country**	Reprog. 10% HSS	TCA Reallocation	TCA NCE	Co-financing 2019	Co-financing 2020	Eligibility Freeze	Reprog. existing HSS	Rep. next HSS <25%	Additional TCA CSOs
Conflict/fragile	Papua NG									
Conflict/fragile	Haiti									
Conflict/fragile	Central African Republic									
Conflict/fragile	Yemen									
Conflict/fragile	Chad									
Conflict/fragile	Mali									
Conflict/fragile	Somalia									
Conflict/fragile	South Sudan									
Conflict/fragile	Sudan									
Conflict/fragile	Afghanistan									
Conflict/fragile	Niger									
Conflict/fragile	Syria									
Core - priority	Guinea-Bissau									
Core - priority	Solomon Island									
Core - priority	Djibouti									
Core - priority	Togo									
Core - priority	Lao PDR									
Core - priority	Benin									
Core - priority	Congo									
Core - priority	Zambia									
Core - priority	Cote d'Ivoire									
Core - priority	Burkina Faso									
Core - priority	Sierra Leone									
Core - priority	Madagascar									
Core - priority	Kenya									
Core - priority	Cameroon									
Core - priority	Mozambique									
Core - priority	Guinea									
Core - priority	Uganda									
Core - priority	Tanzania									
Core - priority	Nepal									
Core - priority	Malawi									
Core - priority	Bangladesh									
Core - priority	Myanmar									
Core - priority	Ghana									
Core - priority	Angola									
Core - standard	Mauritania									
Core - standard	Senegal									
Core - standard	Burundi									
Core - standard	Lesotho									
Core - standard	Comoros									
Core - standard	Sao Tome & Principe									
Core - standard	Gambia									
Core - standard	Kyrgyz Rep									
Core - standard	Rwanda									
Core - standard	Tajikistan									
Core - standard	Eritrea									
Core - standard	Zimbabwe									
Core - standard	Liberia									
Core - standard	Cambodia									
Core - standard	DPRK									
Core - standard	Timor-Leste									
Core - standard	Uzbekistan									
High impact	Ethiopia									
High impact	DRC									
High impact	India									
High impact	Pakistan									
High impact	Nigeria									
Post-transition MICS	Indonesia									
Post-transition MICS	Armenia									
Post-transition MICS	Azerbaijan									
Post-transition MICS	Bolivia									
Post-transition MICS	Cuba									
Post-transition MICS	Georgia									
Post-transition MICS	Guyana									
Post-transition MICS	Kiribati									
Post-transition MICS	Moldova									
Post-transition MICS	Nicaragua									
Post-transition MICS	Vietnam									
Post-transition MICS	Bhutan									
Post-transition MICS	Honduras									
Post-transition MICS	Mongolia									
Post-transition MICS	Sri Lanka									

Analysis of the above mapping table at the portfolio level reveals that 59 out of the 73 countries (81%) had at least one type of flexibility approved, and only 14 countries had no flexibility approved. 11 of these are currently classified as post-transition MICS countries.



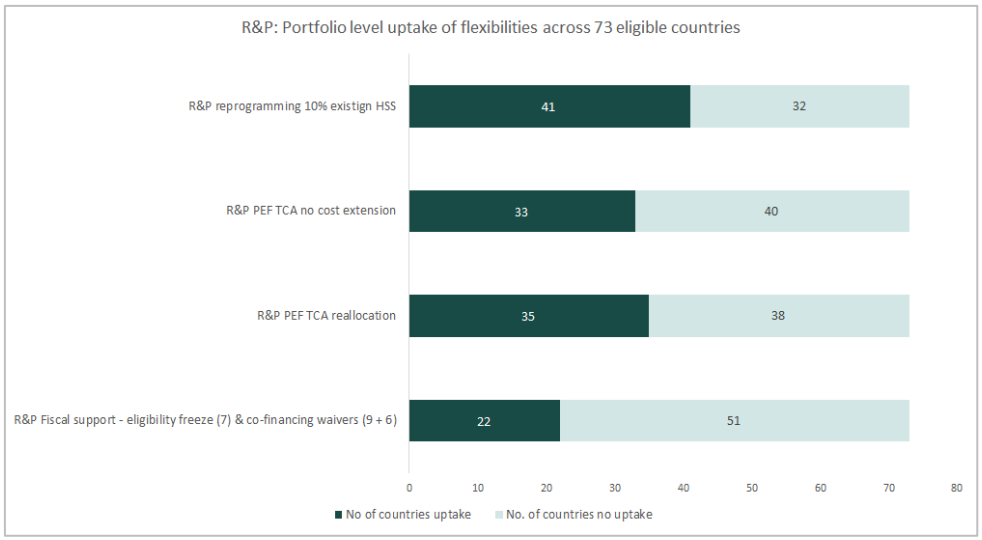
Across the country case studies, 7 out of 8 of the countries had 3 types of flexibilities approved. Only Mozambique requested just one (HSS reprogramming) flexibility.



10.2 Portfolio level overview of uptake by type of flexibility

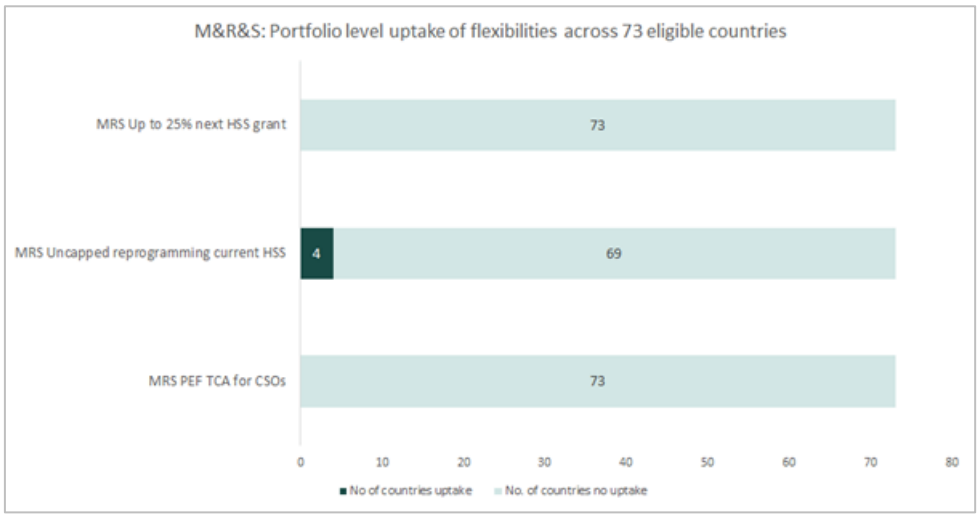
Portfolio level overview of type of **R&P** flexibility accessed:

- 56% of 73 countries had reprogramming of grants approved
- 48% had TCA reallocation approved
- 45% had TCA no cost extension approved
- 30% had economic support (eligibility freeze or co-financing waiver) approved

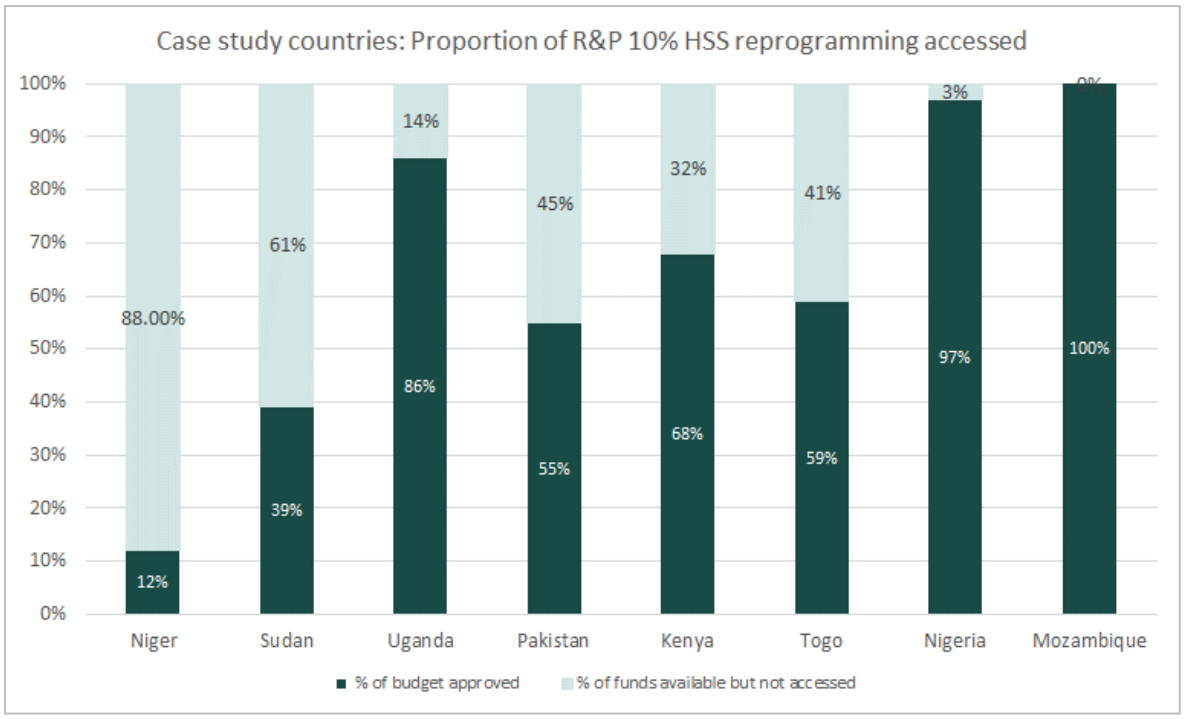


Portfolio level overview of type of **M&R&S** flexibility accessed:

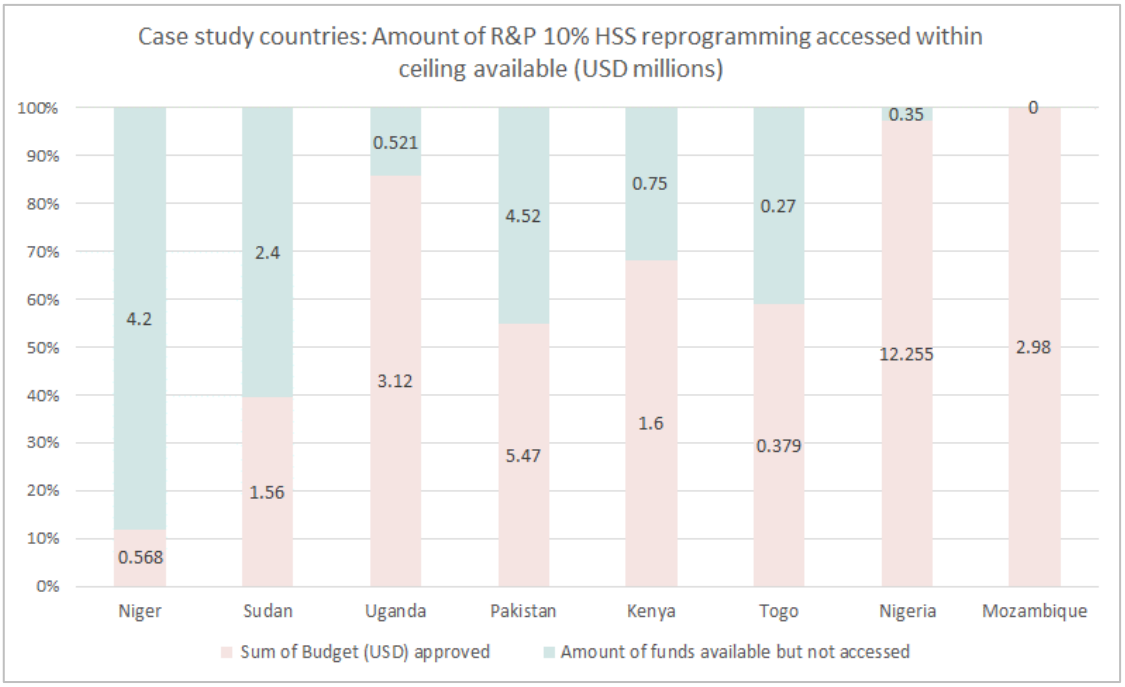
- No countries accessed up to 25% of the next HSS grant
- 4 out of 73 countries (5%) had reprogramming approved
- No countries accessed additional PEF TCA for CSOs



10.3 Percentage of R&P 10% reprogramming ceilings approved in case study countries



10.4 Amount of R&P 10% reprogramming ceiling funds approved in case study countries



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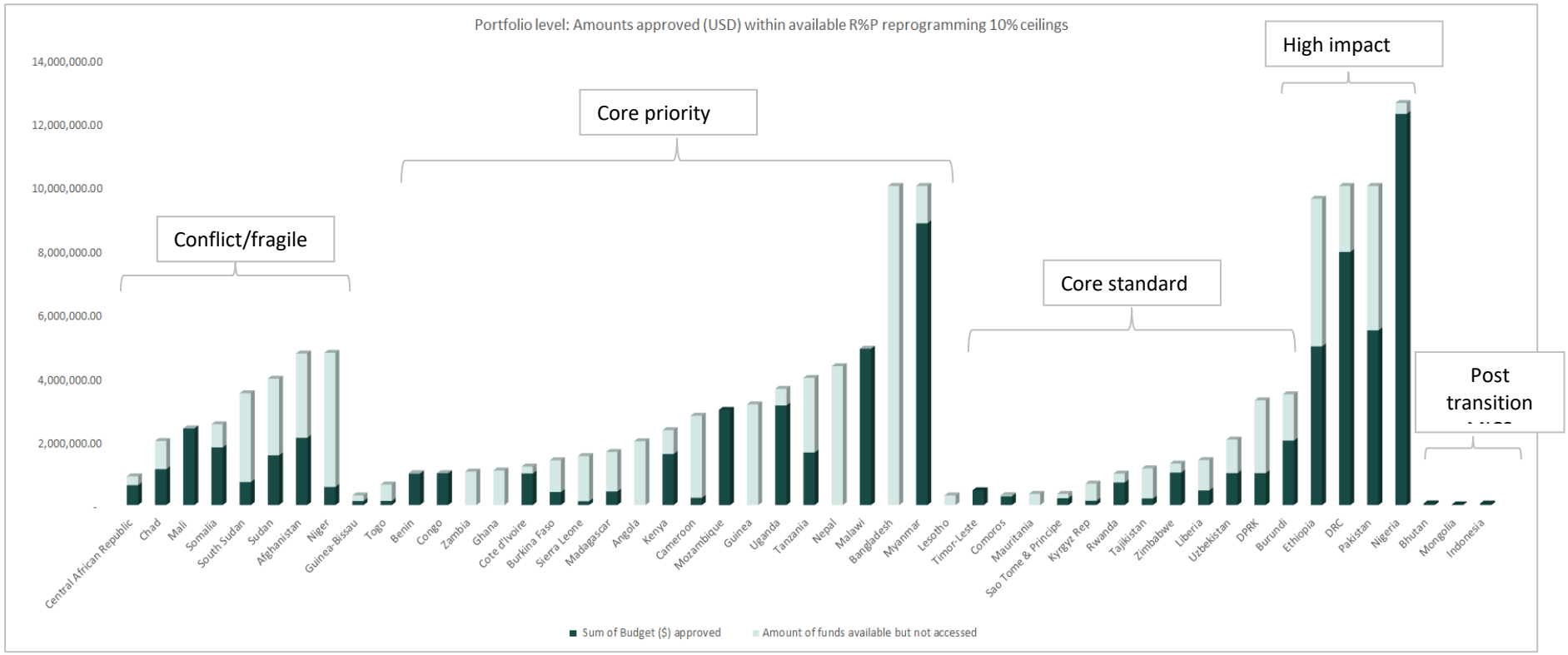
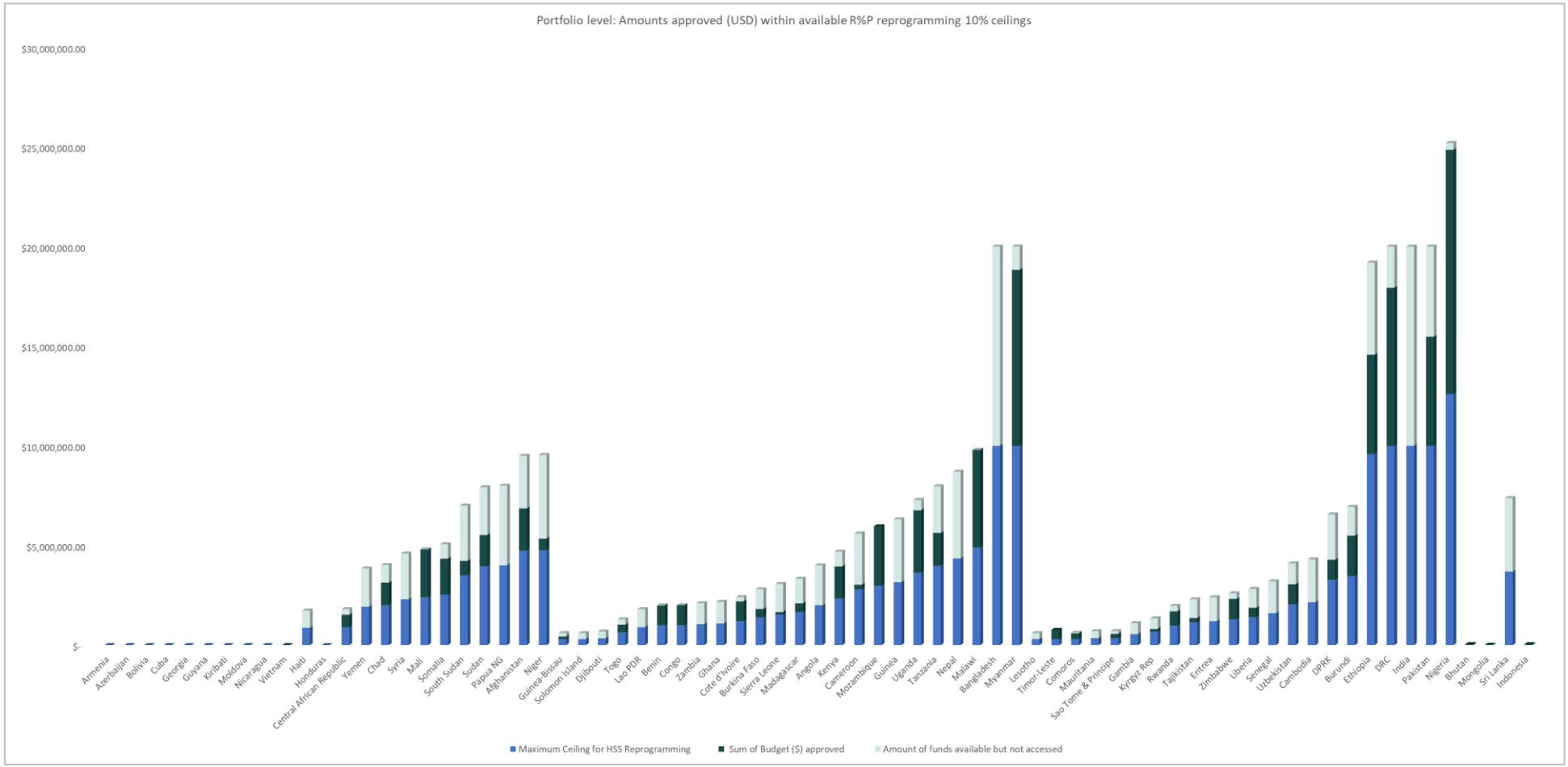
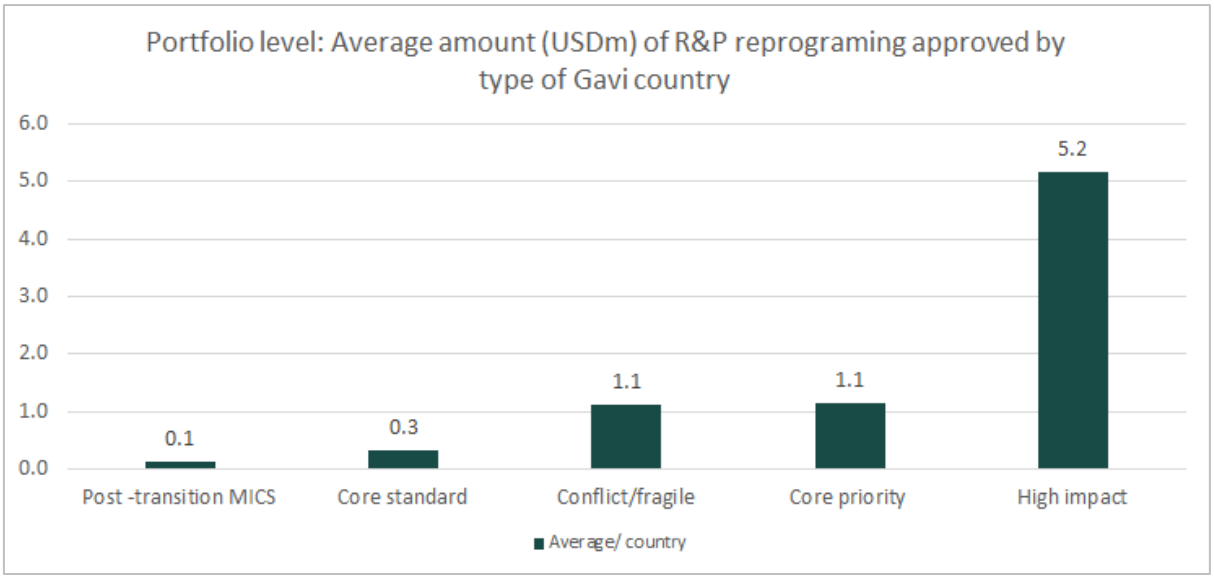
10.5 Portfolio level amounts approved across 41 countries within R&P 10% ceilings available, by type of Gavi countries (5.0 classification)



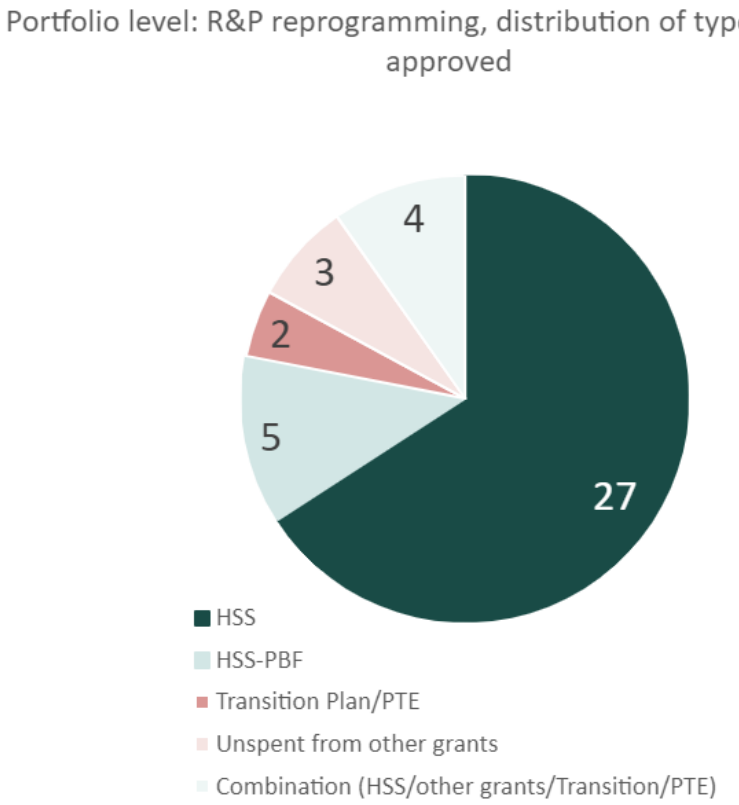
10.6 Portfolio level amounts approved within R&P 10% ceilings available, across the 73 eligible countries



10.7 Portfolio level average amounts approved by type of Gavi country (5.0 classifications)



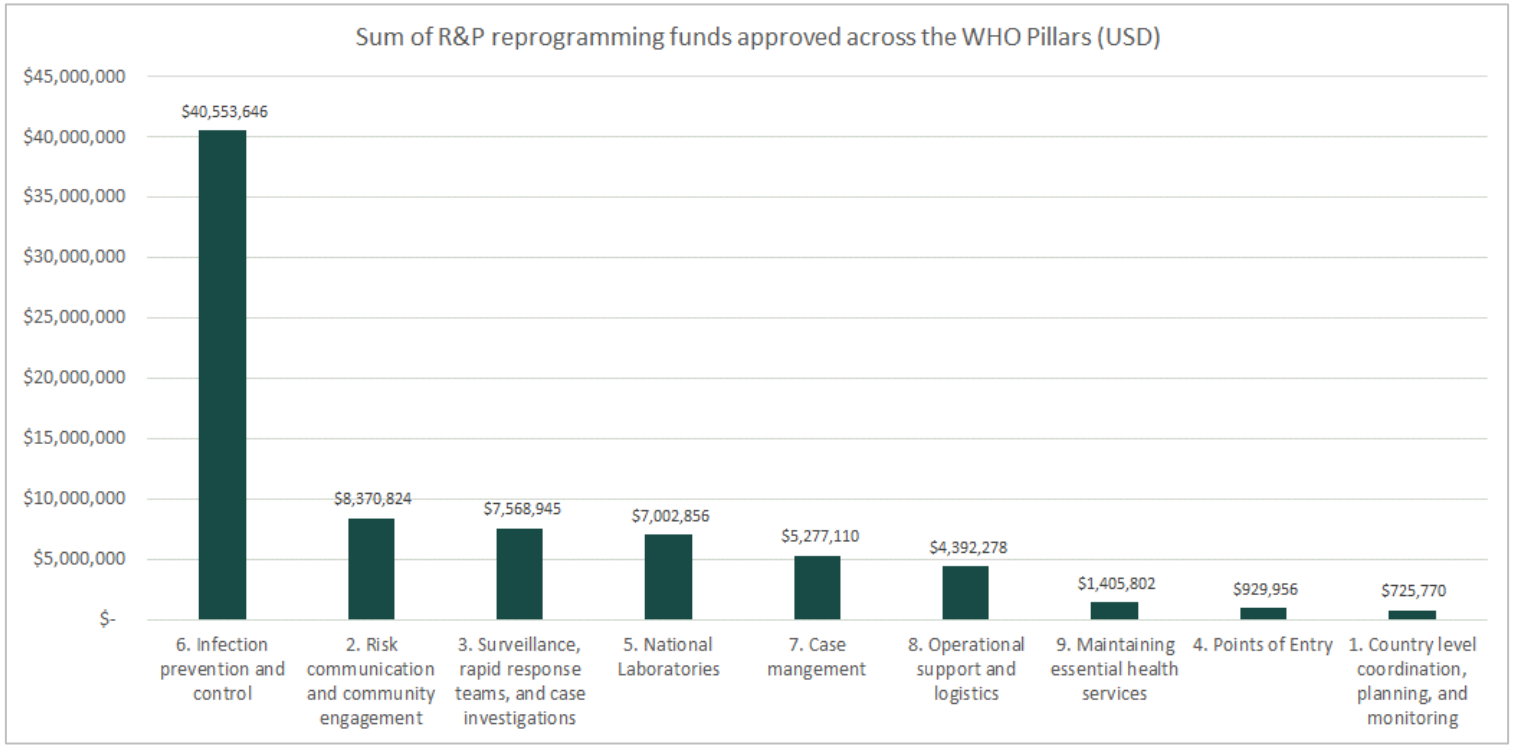
10.8 Portfolio level types of grants reprogrammed across 41 countries



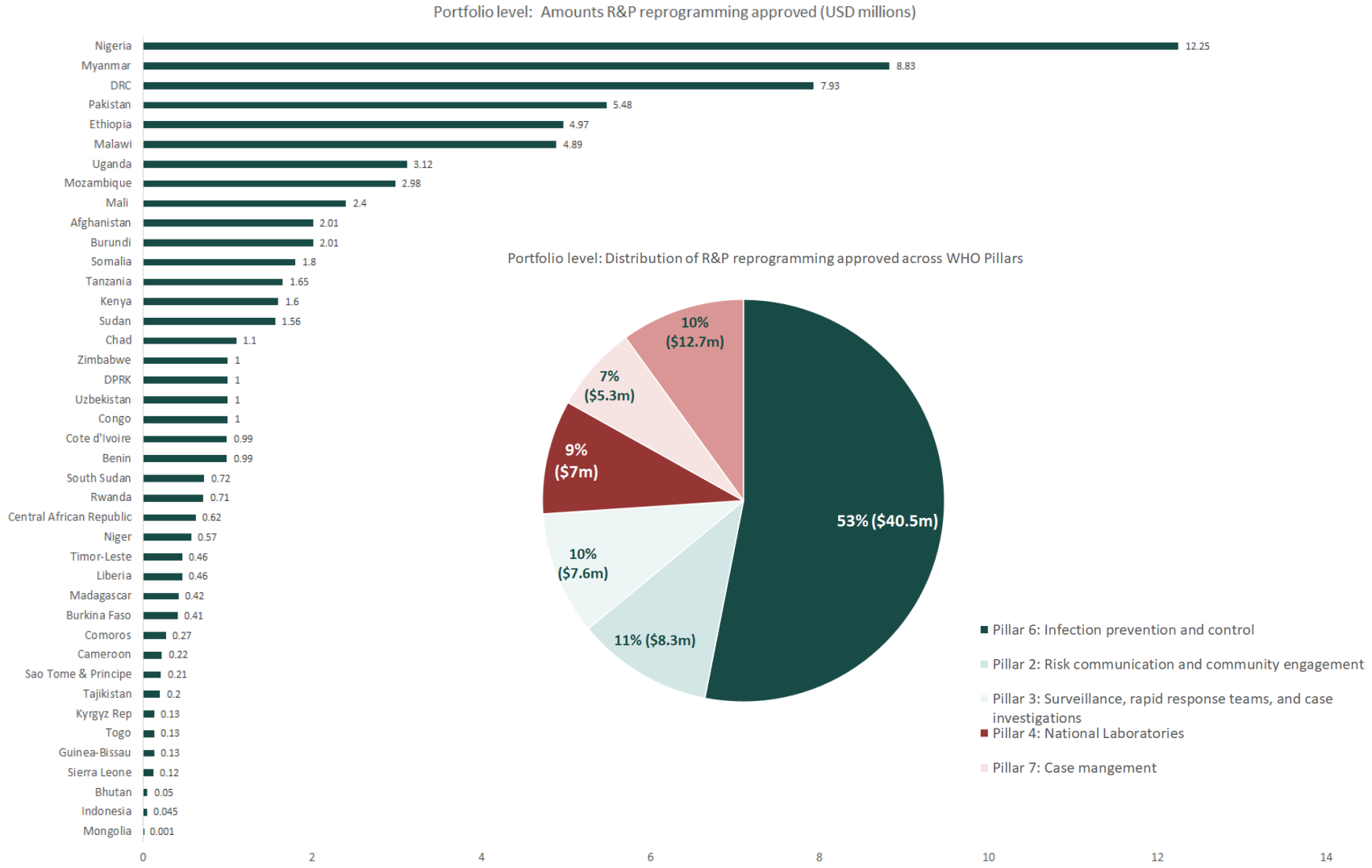
10.9 Portfolio level R&P amounts approved by WHO Pillars

R&P reprogramming amounts (USD) approved by WHO Pillars. Of the $76.9 million reprogrammed:

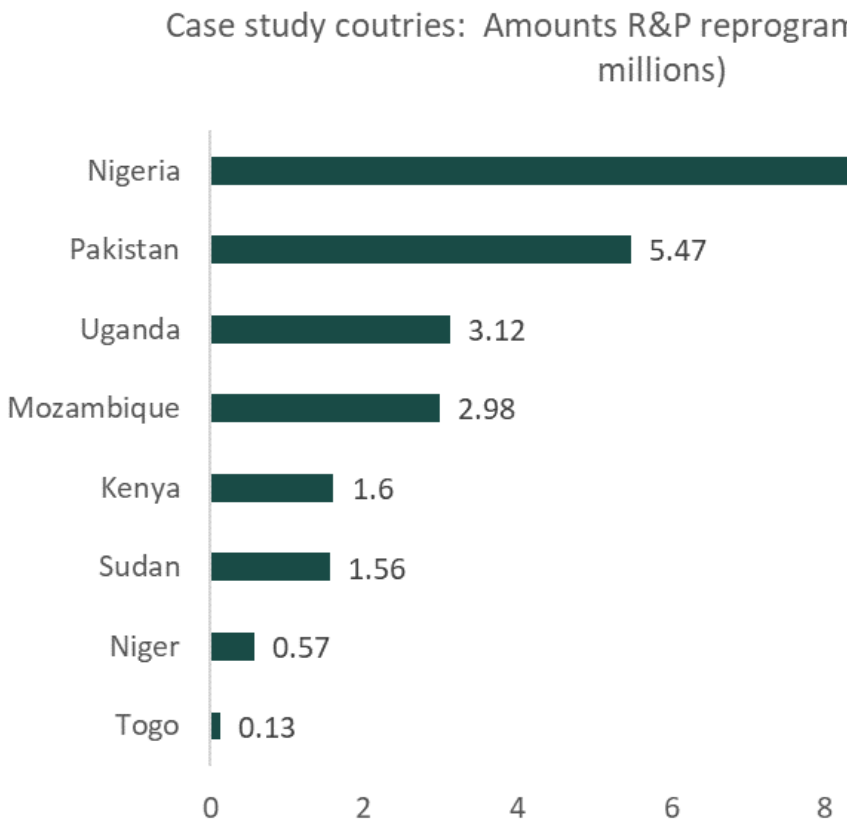
- 53% reprogrammed funds were intended for IPC
- 11% risk communication and community engagement
- 10% surveillance, rapid response teams, and case investigations
- 9% national laboratories strengthening
- The remaining 17% were approved for case management, operational support and logistics, points of entry and country level coordination, planning and monitoring

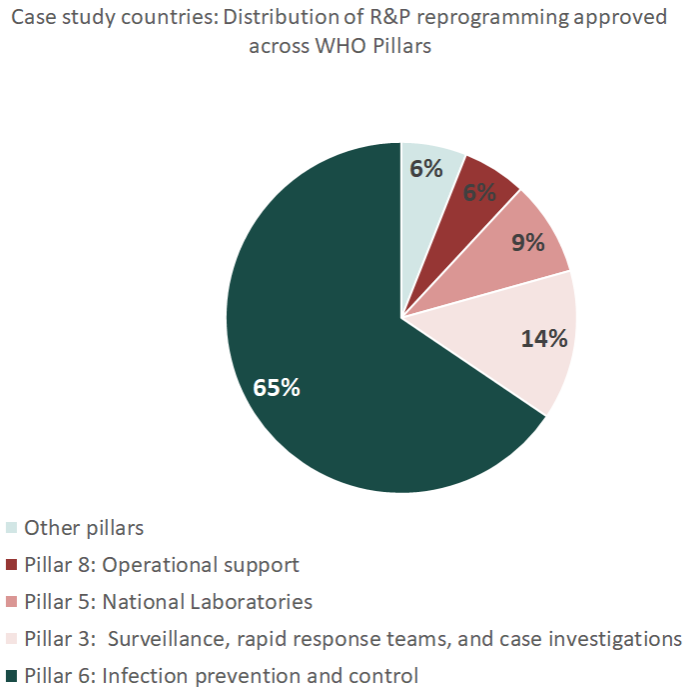


10.10 Portfolio level R&P reprogramming amounts and distribution by WHO Pillars



10.11 Case study level R&P reprogramming amounts and distribution by WHO Pillars

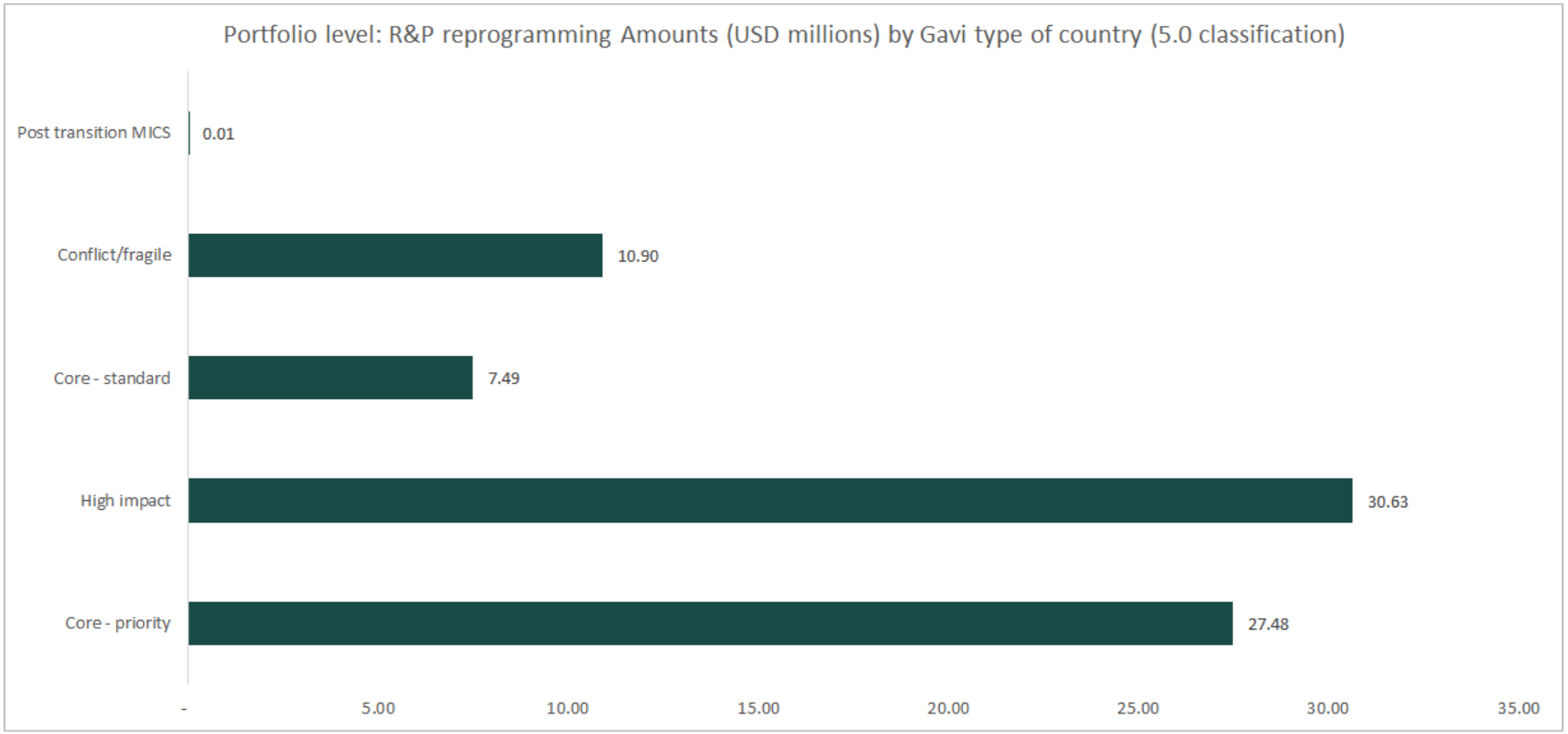




10.12 Portfolio level R&P reprogramming amounts by Gavi country type (5.0 classification)

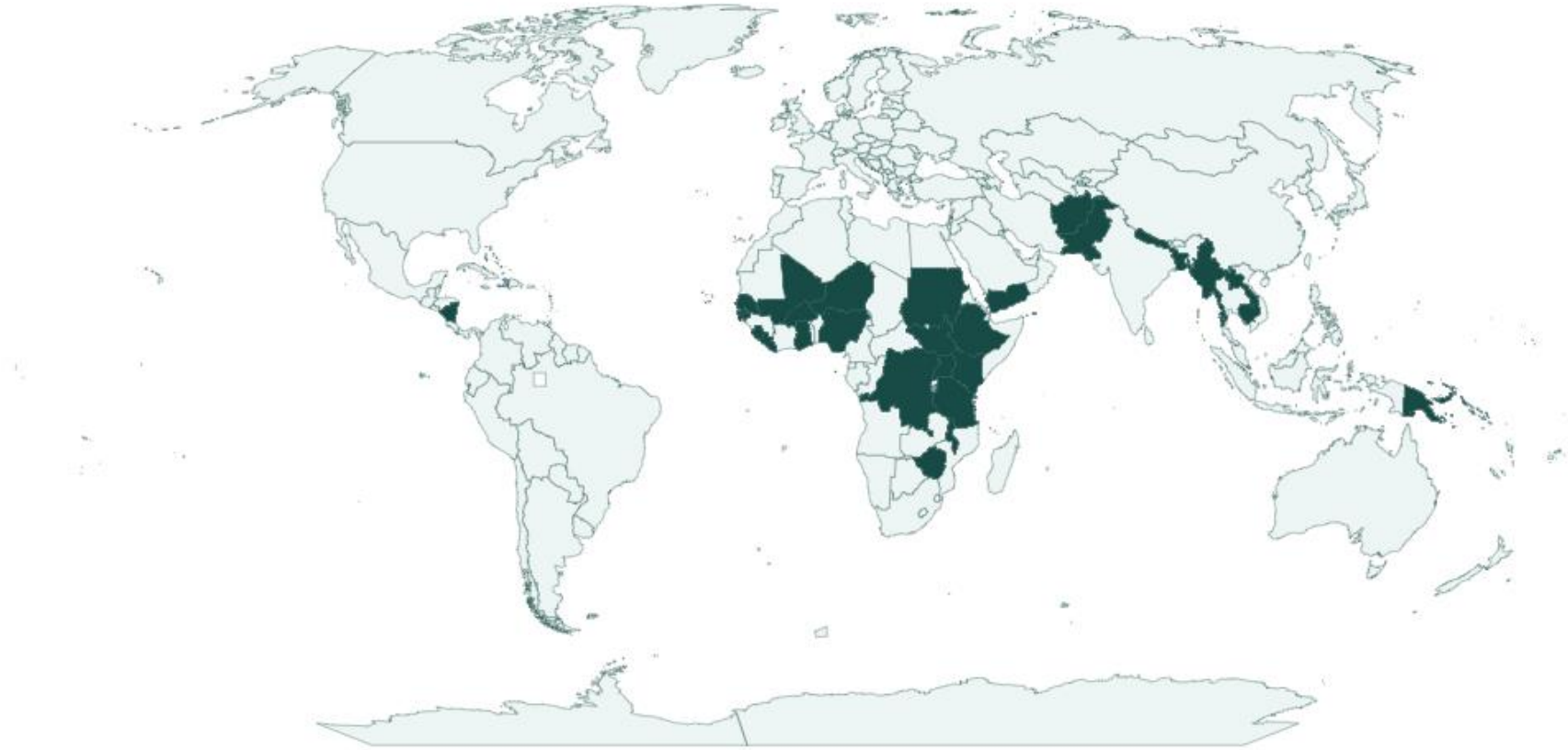
Distribution by Gavi types of countries

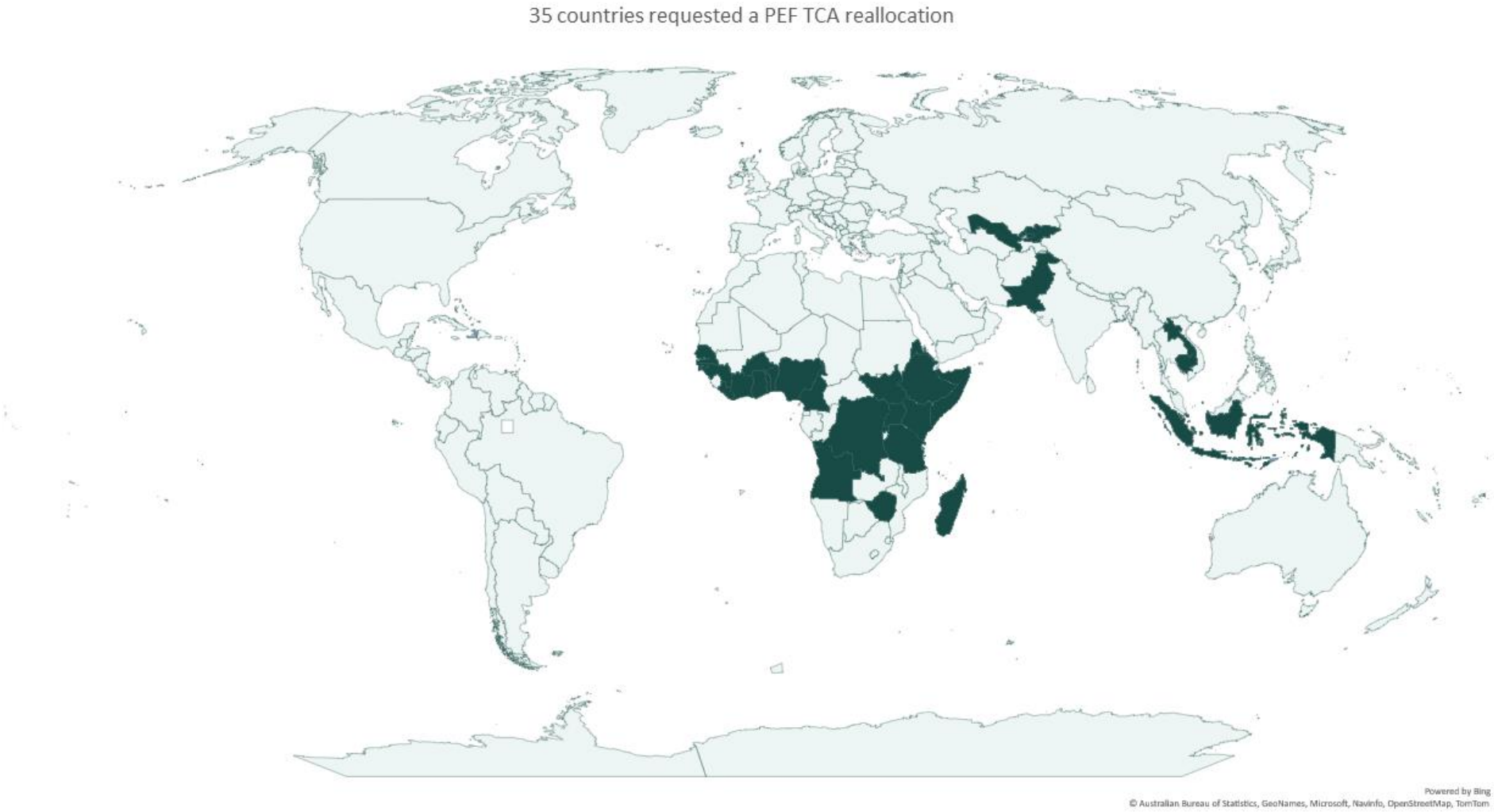
- 76% of funding reprogrammed was in high impact (40%) and core priority countries (36%)
- 14% in conflict/fragile countries
- 10% in core-standard
- Under 1% for post-transition MICs



10.13 Portfolio level PEF TCA No Cost Extensions and PEF TCA Reallocations

33 countries requested a PEF TCA no cost extension (NCE)




35 countries requested a PEF TCA reallocation
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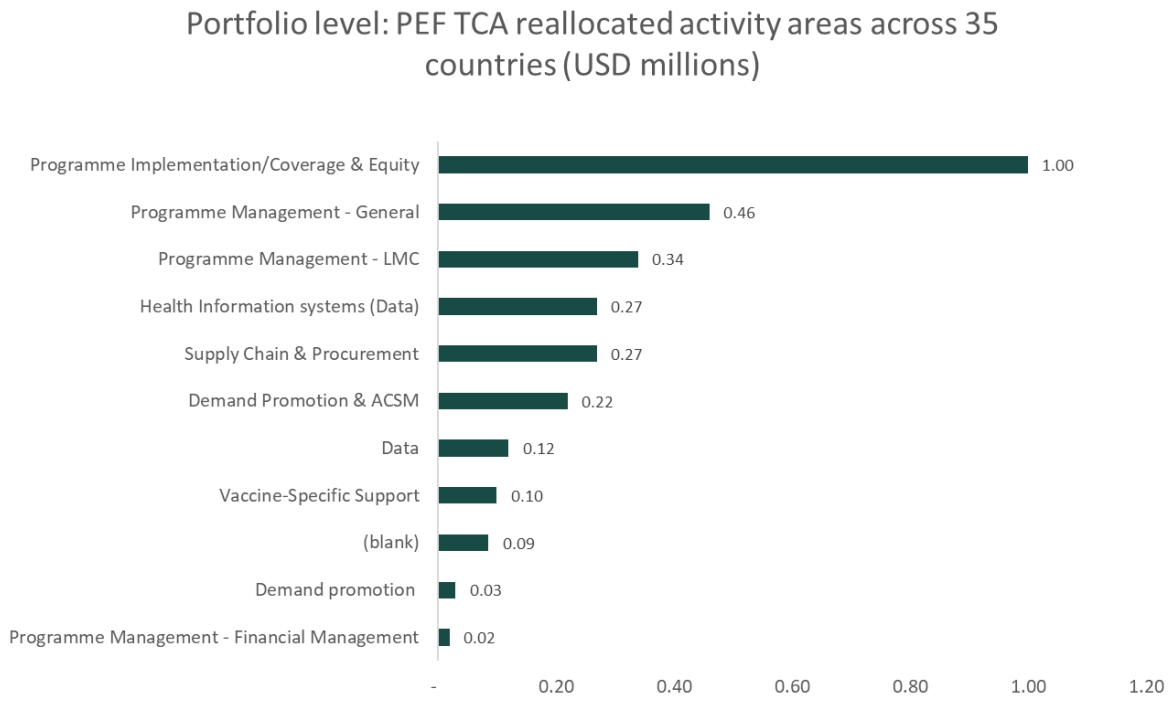
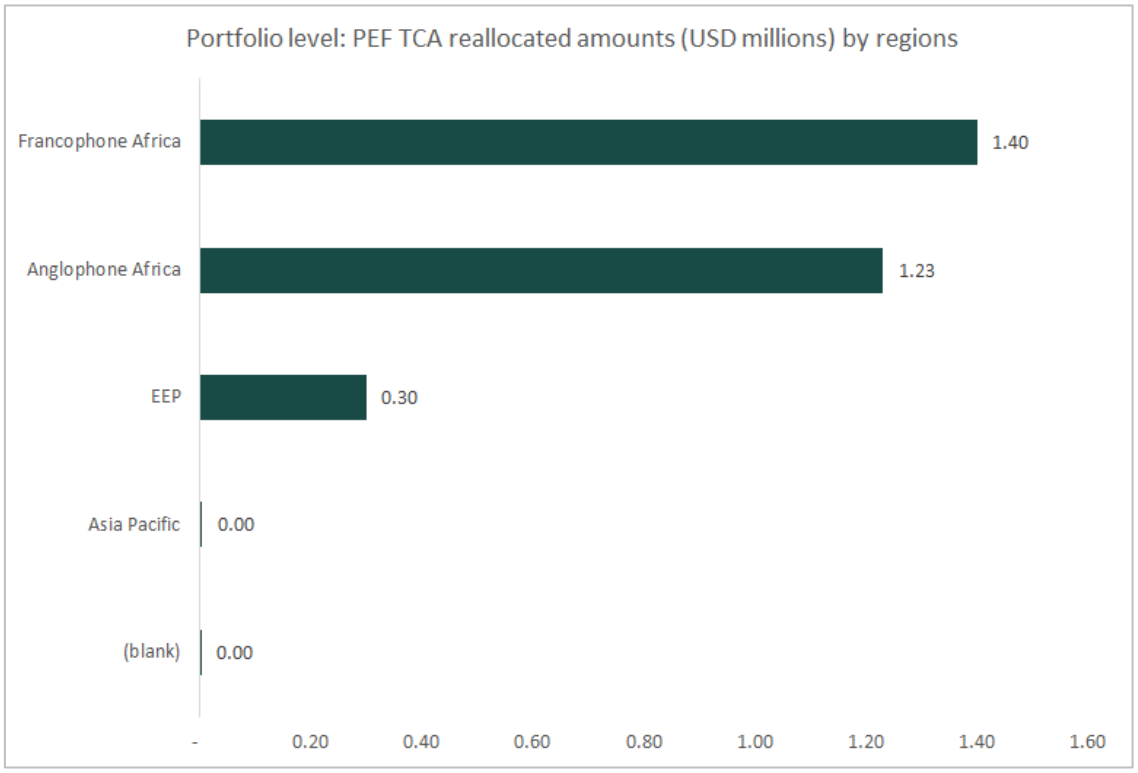
10.14 Portfolio level PEF TCA reallocated amounts by activity areas

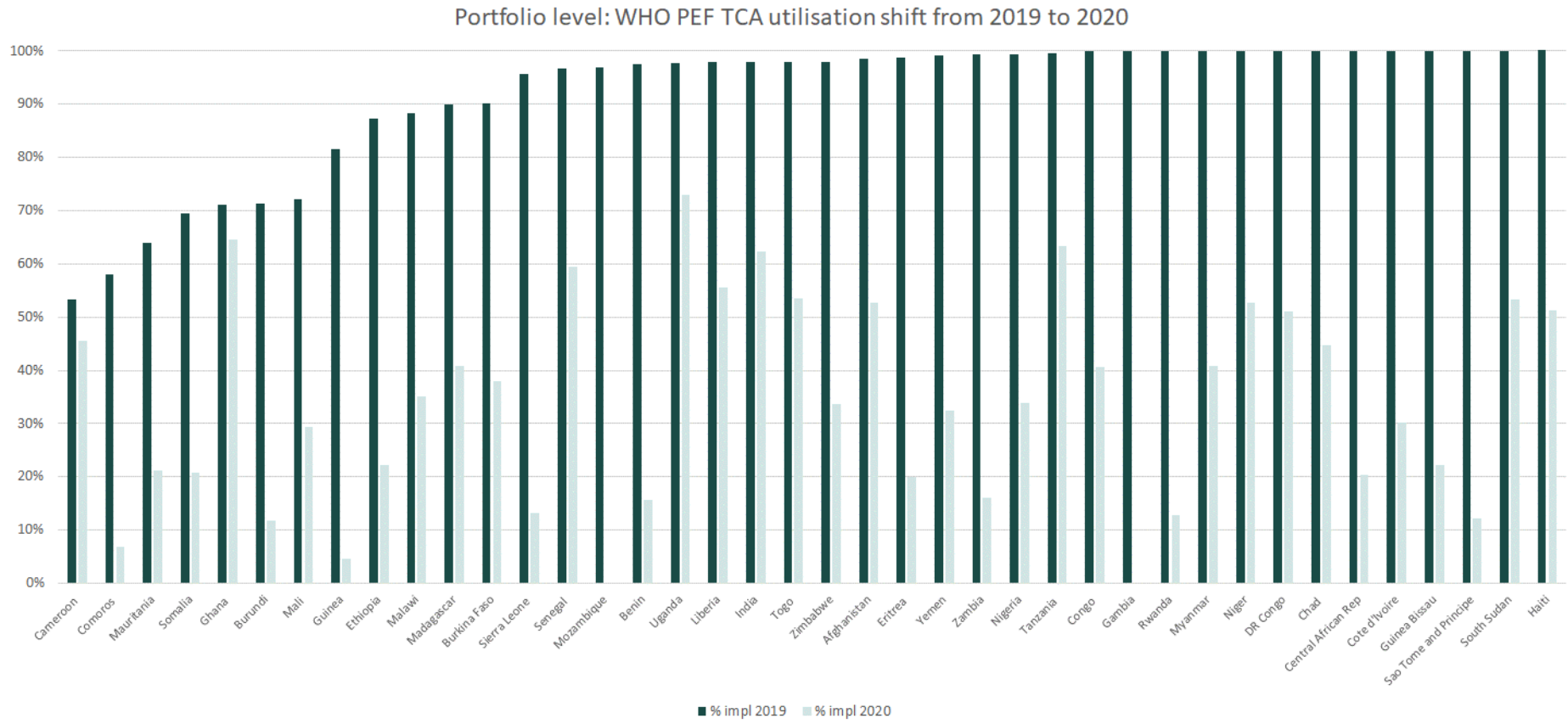
Data available is incomplete on PEF TCA extension/ reallocation. The tracker available for this flexibility does not include complete data on what activities were in place pre- and post-reallocation. Therefore, it is not possible to comment on how this flexibility may have allowed countries to pivot activities. However, we can see that approx. One million US$ of activities that feature in the reallocated programme areas was tagged as *programme implementation/ coverage and equity* and a further 1 million tagged to *programme management functions*. It is not possible to ascertain whether this same mix of programme areas was targeted before reallocation due to data gaps in the tracker made available to the evaluation team.



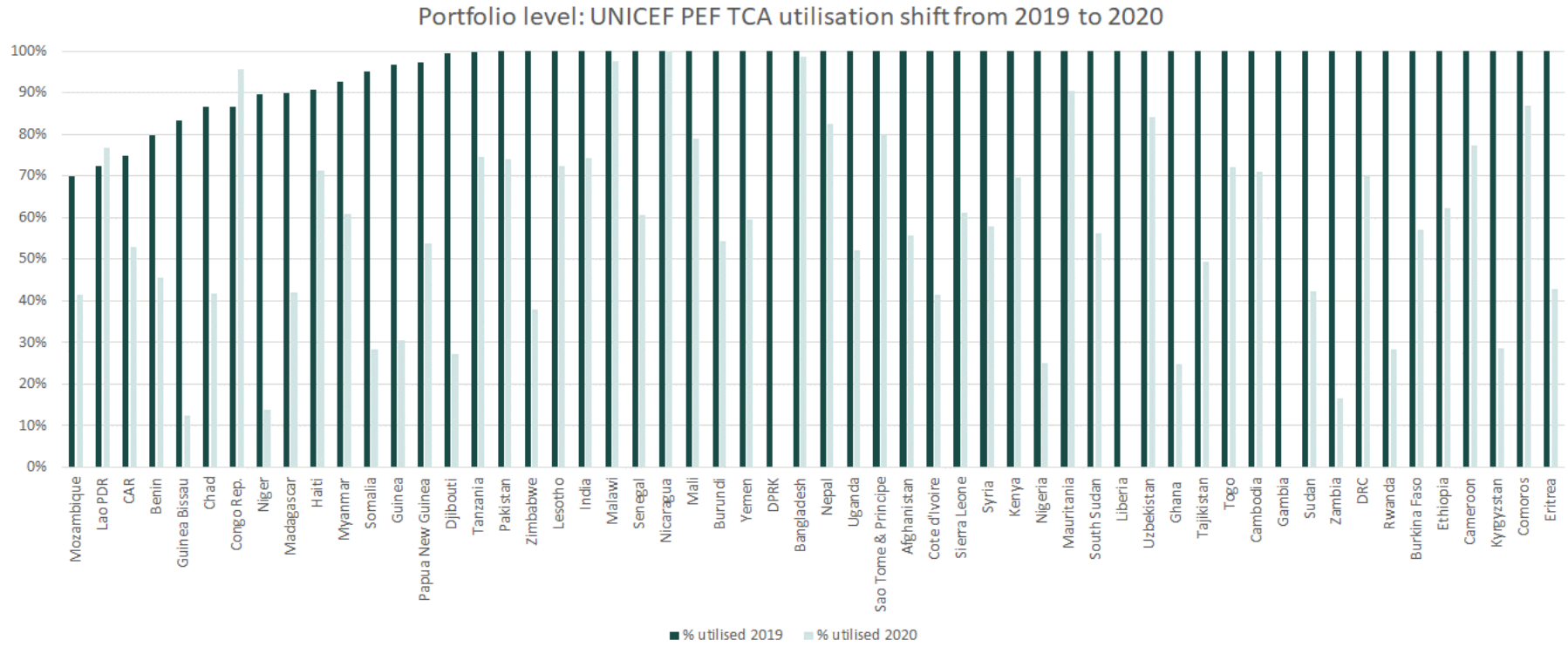
10.15 Portfolio level PEF TCA reallocated amounts by regions



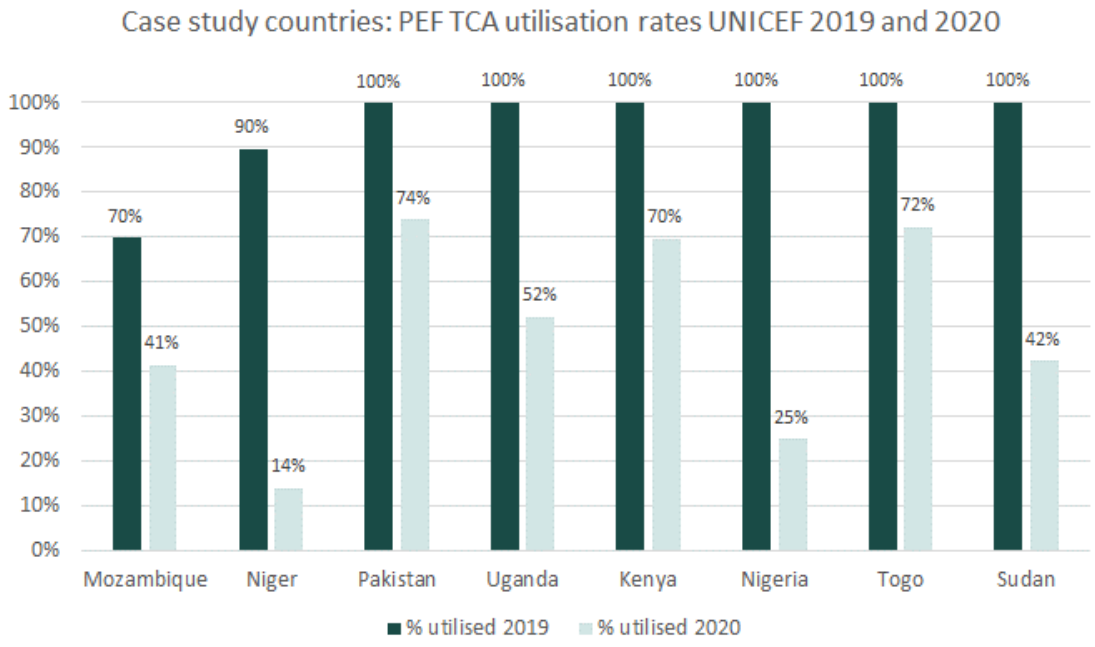
10.16 Portfolio level PEF TCA utilisation shift 2019-2020: WHO

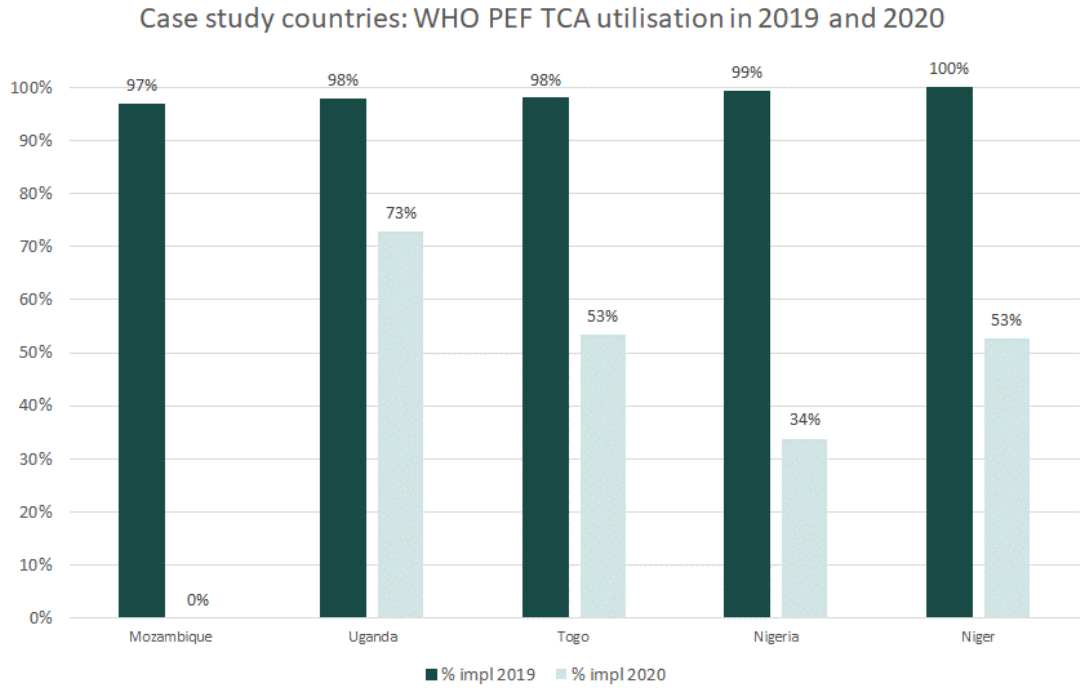


10.17 Portfolio level PEF TCA utilisation shift 2019-2020: UNICEF

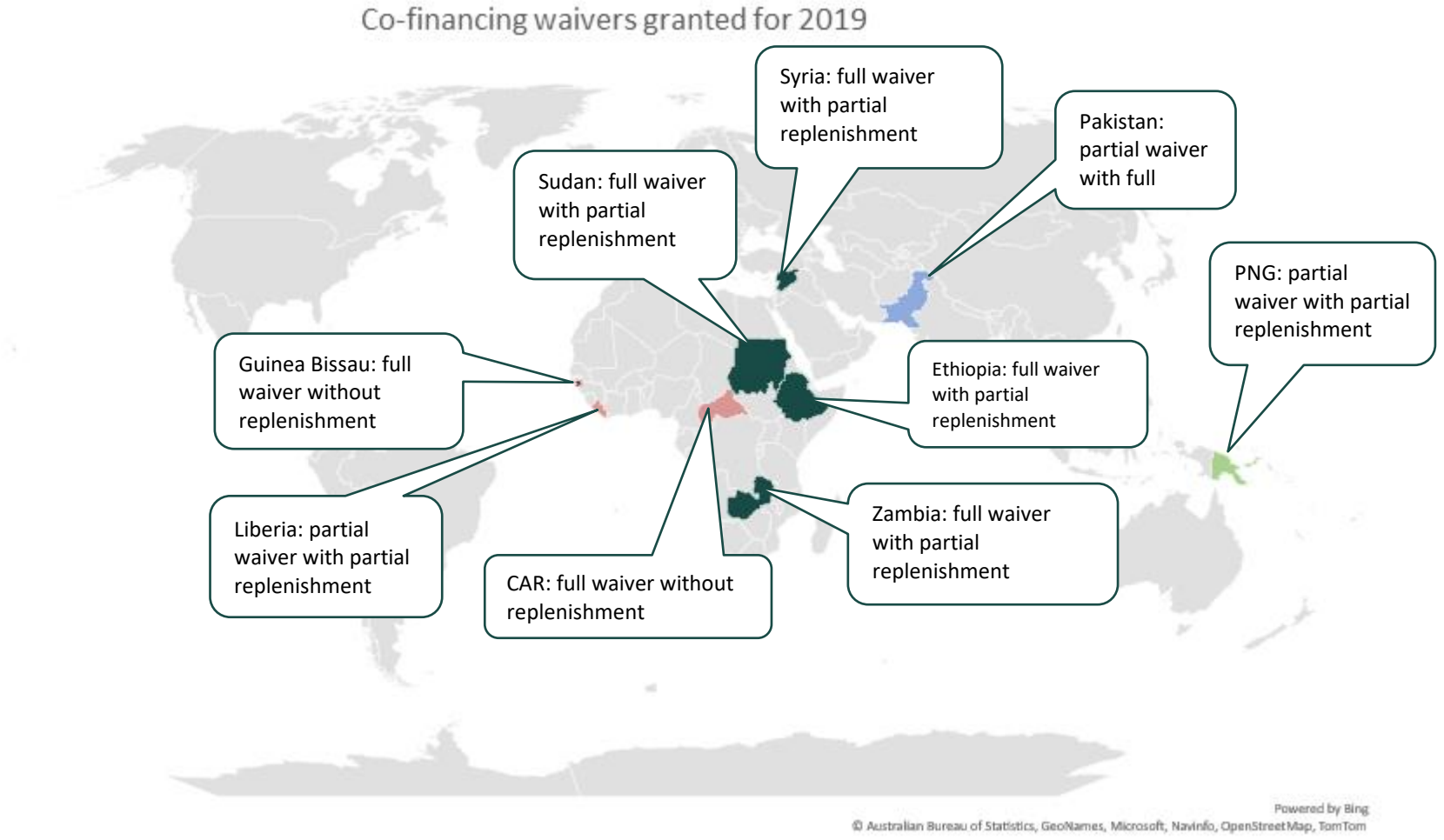


10.18 Case study countries PEF TCA WHO and UNICEF Utilisation rates 2019 and 2020





10.19 Cofinancing waivers approved for 2019 payments



10.20 Risk management

Annex 1 of Gavi's report to the PPC for its meeting on 6 May 2020 documents the key Alliance-facing risks anticipated through implementing its COVID-19 response, designed to respond to country needs. The Table below summarises the evaluation's evidence of Gavi having applied its mitigation measures as intended.

Table 13: Evidence of Gavi having applied its risk mitigation approach for its COVID-19 response (R&P and M&R&S)

Risk	Evidence of Gavi having applied its mitigation approaches
There is a risk that if many countries are granted flexibilities, this could make the exceptions in the Fragility, Emergencies, Refugees (FER) policy common across the portfolio and thereby limit implementation of Gavi's standard policies. *To mitigate this, the* ***Secretariat will develop a clear approach to determine when and how flexibilities are granted*** *and new HSIS funding applications will be subject to external review to ensure that the requested flexibilities are justified and proportionate.* *The* ***Secretariat will systematically track all flexibilities*** *and* ***develop a clear approach to transition countries*** *to updated 'standard' policies post-COVID.*	The evaluation found strong evidence of clear approaches having been put in place and documented[29] to determine when and how flexibilities would be granted. However, guidance is not explicit on how these flexibilities complement, align with and/ or duplicate those in the then FER policy. A mapping of areas of overlap between FER policy and R&P and M&R&S is found in Section 3.1 and Annex 9.1. Related to *clarity of R&P and M&R&S approaches*, a major design feature for implementation/ roll out of all flexibilities was discretionary decision-making authority for SCMs. This allowed the SCMs/country teams to decide whether and when they would offer one, all, or no flexibilities to countries. This intentionally differentiated approach was designed to be flexible and responsive to country needs, based on SCMs' informed assessments. It has not been possible for the evaluation team to determine the implications of this at the portfolio level, i.e., whether it resulted in countries accessing the support they needed at the right times. The evaluation team found strong evidence to suggest that the mitigation approach to *systematically track all flexibilities* was not applied, either for operational tracking (what was approved and how funding was used) nor for performance tracking (indicators that allow visibility on results being achieved whether at output or outcome levels). The evaluation found efforts having been made toward operational tracking, but efforts resulted in fragmented, incomplete, and inconsistent operational trackers, tracking some and not all flexibilities with no apparent data quality control. There is ample evidence available to confirm that the Alliance recognizes this challenge and is taking steps towards addressing it. For example, through the development of systematic slide decks for regular reporting (COVID-19 parameters), the COVID-19 delivery dashboard, and more recently the Management Performance and Monitoring stream of work that several Secretariat key informants referred to. The evaluation team did not find evidence as to whether the approach to transition countries has been updated.
There is also a risk that the Alliance will have to make decisions on adjusting support to countries rapidly and with inadequate	The evaluation team found evidence of the Secretariat regularly reporting on the degree of fiscal challenge in countries[30], using co-financing payments status as a proxy indicator. Limited evidence was found of Gavi having monitored the financial impact

[29] Through the various internal and external facing guidance documents referenced in the main report
[30] In internal slide decks such as COVID-19 tracking parameters

information, which could result in suboptimal allocation of resources or fiduciary risk.
To mitigate this risk, ***the Secretariat will continue to monitor the financial impact of the flexibilities granted*** *and* ***report to the Audit and Finance Committee (AFC)****, Programme and Policy Committee (PPC) and Board.*

of the flexibilities granted. For example, in the report to the PPC referred to as 'Appendix 5 - Implementation of exceptional COVID-19 co-financing waivers' dated Oct 2021 there is evidence of Gavi tracking the GNI per capita growth:
"*Whilst GNI per capita growth was not a criterion in the granting of waivers, looking at the latest GNI per capita data it is interesting to note that although many countries with a slowdown in growth of GNI per capita did not request a waiver, the average GNI per capita growth of countries who did ask for a waiver was at -5.2%, compared to an average of -0.4% for countries that did not receive a waiver. This does not reflect a cause-and-effect relationship between GNI per capita and the request and granting of a waiver, but it does indicate that countries who received a waiver also happened to be facing a more challenging economic situation".*

The decision to set up the special arrangement with UNICEF SD is reported to have been directly influenced by Gavi's desire to reduce fiduciary risk in countries at a time of supply chain crisis and lack of visibility on country-level procurement options:

"Emergency reprogramming of HSS funding (to help countries respond to the COVID-19 pandemic and keep immunisation programmes going) used a fast-tracked application and review process, but a risk lens was applied with lower risk personal protective equipment being the largest area of funding, procured by UNICEF Supply Division."[31]

Two KIIs with different Secretariat members also confirmed that specific flexibilities were in place to support fiduciary risk. These included the ability to offer a 3-6 months' delay for countries needing to have completed external audits, and a more relaxed approach to reporting on activities. The delay on audits was noted not to have been offered proactively. Rather the management group, and FM team engaged with a subset of countries to understand what challenges they were facing with the upcoming Financial Management pressures and audit.

Fiduciary risk was not highlighted in any of the eight case study countries evaluated through KIIs and document review. However, given the limited access to information the evaluation team had, it would not have been possible to explore fiduciary risk robustly.

The evaluation team saw only one report to the PPC regarding risk management related to the COVID-19 response. The evaluation team have not accessed any reports to the AFC. No evidence was found of risk reporting to the board on the COVID-19 response.

The Secretariat's cautious approach to risk was noted by several key informants.[32] Recognising the tension between the need for speed in an emergency context, alongside ensuring a minimum of necessary checks and balances are followed. Several Secretariat

[31] Update on risk management, Report to the PPC, 6 May 2020
[32] Within the Gavi Secretariat and Alliance partners

	and partner KIs suggest Gavi's inability to tolerate higher levels of risk (by function of both its organisational culture and its operational systems) may have hindered Gavi's ability to be more responsive and provide timely[33] support to country needs during the COVID-19 response. One KI noted that the level of risk appetite within Gavi relates to its business model in that it manages public funds: "We are accountable to donors and populations of donor countries." (Gavi Secretariat). Several KIIs with the Secretariat and Alliance partners also confirmed that Gavi systems were not sufficiently agile to enable rapid contracting with expanded partners, especially when setting up new contracts with new partners.
There is a risk that the additional flexibilities will result in accelerated expenditure from Gavi's health system and immunisation strengthening (HSIS) and Partners' Engagement Framework (PEF) envelopes over the next 1-2 years. While this will help countries to respond to the pandemic, it would also mean that additional funding would be required to ensure countries continue to have access to adequate support in the latter years of Gavi 5.0. *To mitigate this risk,* ***the Secretariat will continue to monitor the financial impact of the flexibilities granted and report to the Audit and Finance Committee (AFC), Programme and Policy Committee (PPC) and Board.***	Analysis of PEF TCA utilisation rates among WHO and UNICEF for 2020, comparing to 2019, suggests PEF TCA expenditure for 2020 (no data available to the evaluation team for 2021) was significantly lower. Due to lockdown, reduced international travel possible to carry out TA assignments, reduced bandwidth of Alliance partners in countries to manage and deliver TA, WHO's utilisation rate went from 80% in 2019 to 22% in 2020, and UNICEF's went from 97% to 55%[34].
There is a risk that Gavi's support is inadequate to mitigate the impact of COVID-19 on countries' immunisation programmes and this could result in a resurgence of vaccine preventable disease (VPD) outbreaks and mortality. *To mitigate this risk,* ***the Alliance will engage closely with other development partners to ensure a coordinated approach*** *to help countries maintain and restore immunisation programmes as part of a primary health care (PHC) response. The* ***Alliance will continue to monitor the performance of immunisation programmes*** *and* ***report to the Board if further interventions are needed***	The evaluation found evidence[35] of collaboration and coordination during R&P and M&R&S development, e.g., during R&P on the establishment of the UNICEF SD Special Arrangement, and for M&R&S the development of its guidelines supported by WHO and UNICEF. There are several other examples of coordination provided in Annex 12.
There is a risk that the Secretariat and Alliance partners may have inadequate capacity to manage the COVID-19 response, while also maintaining existing programmes and preparing for implementation of Gavi 5.0.	Gavi's (combined with Alliance and other development partners) support has not been adequate to mitigate the full impact on immunisation programmes and prevent VPDs, evidenced through the emergence of VPDs. Several countries are experiencing backsliding with RI and VPDs. Gavi (like other partners) has

[33] KII with the Secretariat and a CSO triangulated to confirm contracting severe delays reported to have led to the need to update the programmatic approach originally designed, given extent of delay.
[34] Tracker: TCA Utilisation 4.0 (Jan21)
[35] Multiple KIIs with Secretariat staff and partners

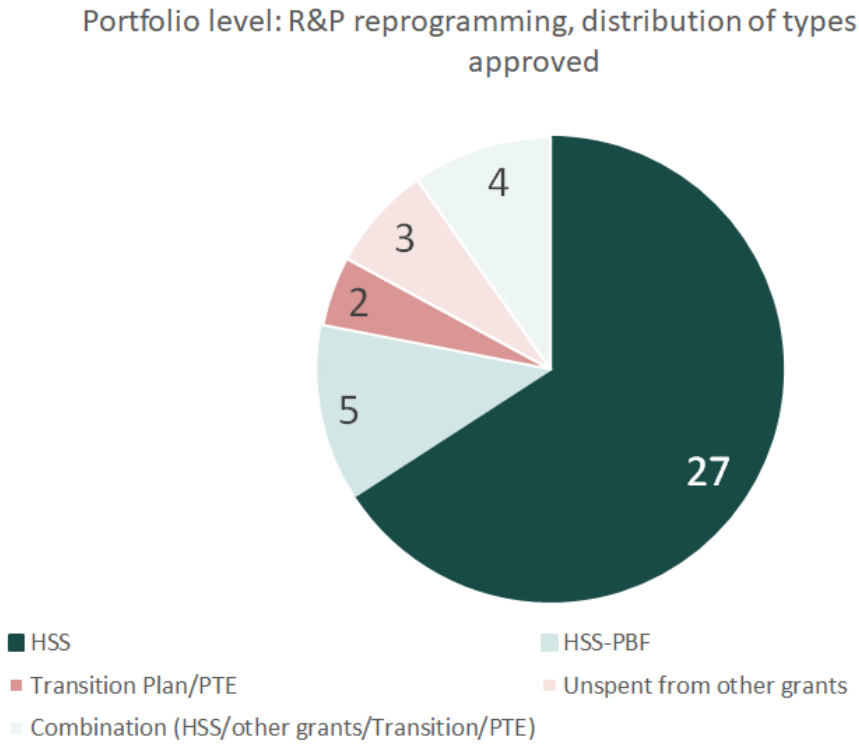
To mitigate this risk, the Alliance ***will seek to coordinate support for COVID-19 recovery*** *with implementation of Gavi 5.0,* ***and will closely monitor whether existing resources are adequate or surge capacity*** *is required.*	actively monitored these[36] outbreaks during the COVID-19 response, but the lack of access to good quality data from countries has hampered robust analysis. Investing in data systems and capacity has been noted by several Secretariat and partner KIs as a weakness through the COVID-19 response and as an investment need ahead of future pandemics. The evaluation team did not find evidence of monitoring whether existing resources were adequate or whether surge capacity was required.

10.21 Analysis on uptake of 10% HSS R&P in case study countries

This section aims to provide an overview of why the case study countries that did not ask for more of the R&P 10% funds available, chose not to. And why those that chose to access much more, did so.

The evaluation team found approved budget information for 41 countries. Internal Gavi reports suggest that Angola, Georgia and Kiribati also had Transition grants/PTE approved, however the evaluation team did not find any budget information on these countries.

The figure below shows that most countries that reprogrammed under R&P opted to reprogramme HSS grants (66%), 12% opted to reprogramme PBF allocations within HSS grants, 9% opted to use a combination of HSS, other grants/ Transition and/ or PTE, and 7% opted to use remaining funds from other grants. Bhutan and Mongolia were the only two countries for which financial data was found that used the Transition/Post Transition Engagement flexibility alone (i.e., without combining reprogramming of HSS or other grant funds).



Headlines: The two main factors explaining why uptake was not higher for R&P reprogramming among case study countries included:

[36] Evidence through COVID-19 Parameters slide decks, for example and the COVID-19 delivery dashboard menu

- **fear of not having sufficient funds to cover immunisation and HSS activities as programmed in grants**. However, analysis of uptake approvals across the portfolio demonstrates that 66% of countries that had reprogramming approved, opted to reprogramme HSS grants rather than unspent funds from other grants. This may reflect the fact they did not have PBF allocations available, and/ or unspent funds available to reprogramme from other grants, but it is not possible for the evaluation team to tell with available data.
- **the availability of other, more significant pots of funding from other donors available in a timeframe that suited their needs.**

The low level of uptake **in Niger** is explained in the Approval Request (AR) by the country's reluctance to use funds destined for HSS for RI. Niger opted to use the remaining unspent funds from 6 earlier vaccine grants rather than 'lose' any of their HSS3 grant funds.

For Sudan and Kenya, the key reasons appear to be related to the availability of other, more significant pots of funding from other donors available in a timeframe that suited their needs. The GAVI amounts available were modest in comparison to others. Also, the GAVI money offered was a reprogramming from existing HSS funds, while other donors were offering new money in most cases.

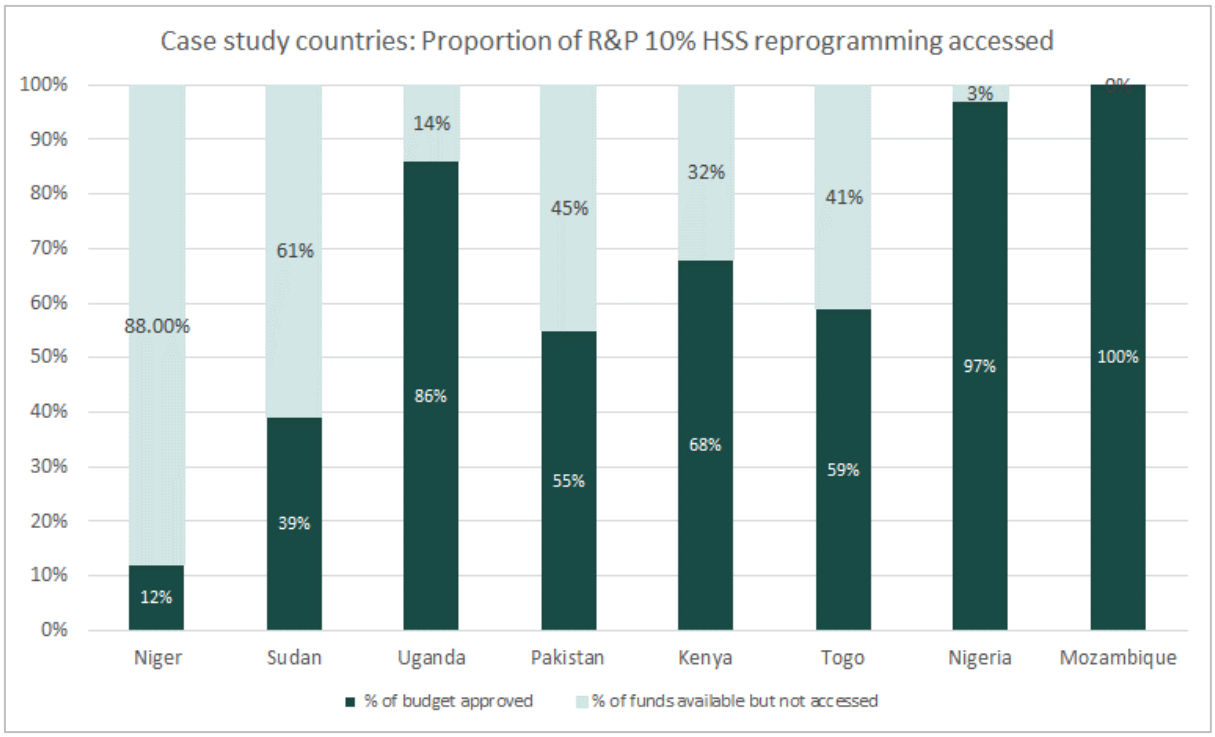
In Nigeria and Pakistan, HSS reprogramming was more significant, likely a result of the opportunity cost of "losing" funds from the EPI programme not being so apparent, as in both cases, funds came from resource pools which had not yet been programmed towards HSS and the EPI programme as well as PEF TCA funds for activities that could not go forward in the near term and would therefore be underutilized.

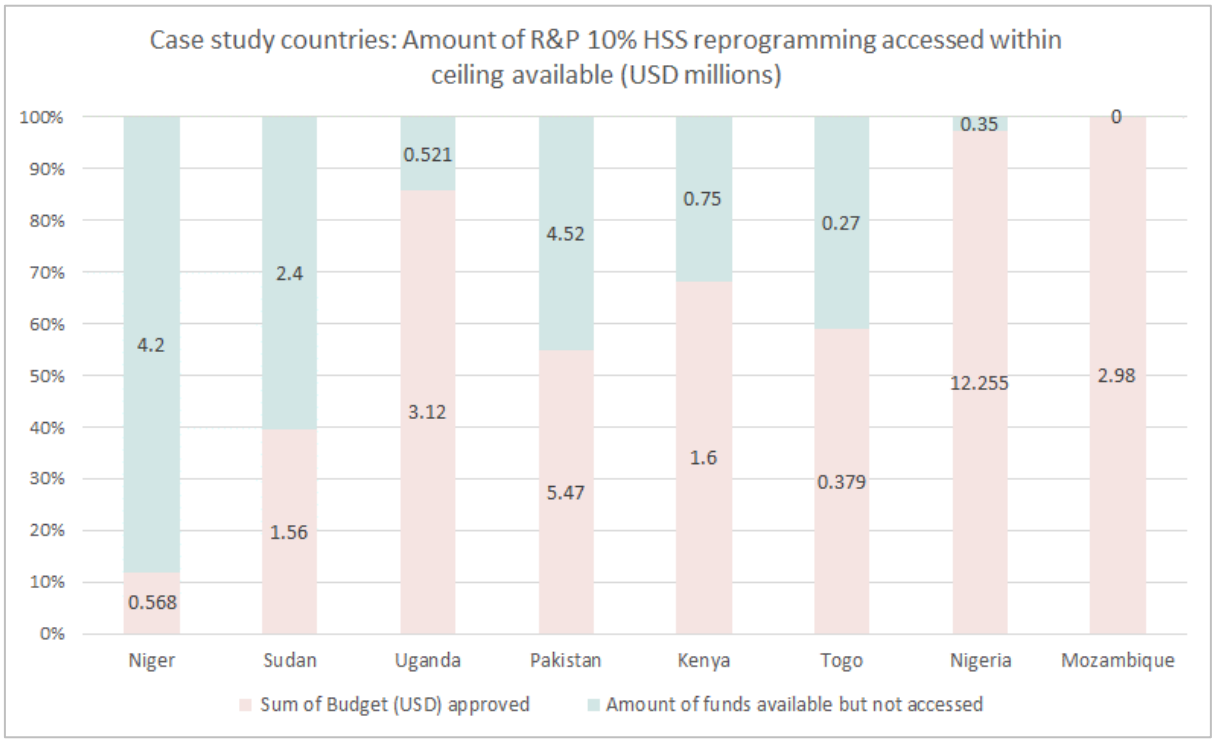
In Pakistan, the government decided to use their (at the time unprogrammed) PBF award as well as PEF TCA funds for activities for which utilisation would be problematic due to lockdowns affecting EPI NVI campaigns amongst other things.

In Nigeria, the CST and government had just (prior to COVID-19) concluded an agreement that the government instead of Gavi would take over the cost of the CCEOP investment, using World Bank loan funds. This agreement came about due to the Nigerian government wanting a specific CCEOP provider that Gavi did not support. This freed up $23 million of resource to go into HSS, which would have otherwise gone to CCEOP, and half of these funds were those used for PPE (primarily).

In Mozambique: The uptake and rapid reprogramming of 10% of the HSS funding under the R&P mechanism was in part attributable to the sense that the funding was seen by stakeholders as "additional" to the existing grant. The actual 10% had yet to be disbursed to the country as it was PBF funding, and the country was in a position where existing grant funding was potentially not going to be expended prior to grant closure. Therefore, instead of traditional reprogramming of existing grant funding, this was seen as "additional" or a "bonus" and a chance to respond quickly to the COVID-19 pandemic without diverting funding from existing or planned activities. The support of the SCM to assist in the development of the application for the 10% HSS R&P and to push the process within the Secretariat was also seen as contributing to the uptake of the reprogrammed funding.

In Uganda: No KIs explicitly addressed why Uganda chose to reprogramme a relatively high proportion of HSS-related funds available. However, a large proportion of their reprogrammed funding was unused Ops grants, which they had previously been planning to reprogramme towards HPV campaigns. As schools were closed (and stayed closed for a very long time in Uganda) KIs referred to the fact that it was not feasible to use the unspent Ops grant money for HPV anymore, so using it for COVID-19 testing supplies, identified as a key need in their national COVID-19 Response Plan made sense.


Case study countries: Proportion of R&P 10% HSS reprogramming accessed
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88.00%
12%
61%
39%
14%
86%
45%
55%
32%
68%
41%
59%
3%
97%
0%
100%
Niger
Sudan
Uganda
Pakistan
Kenya
Togo
Nigeria
Mozambique
% of budget approved
% of funds available but not accessed


Case study countries: Amount of R&P 10% HSS reprogramming accessed within ceiling available (USD millions)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
4.2
0.568
2.4
1.56
0.521
3.12
4.52
5.47
0.75
1.6
0.27
0.379
0.35
12.255
0
2.98
Niger
Sudan
Uganda
Pakistan
Kenya
Togo
Nigeria
Mozambique
Sum of Budget (USD) approved
Amount of funds available but not accessed

10.22 Absorption

Being able to provide clarity on absorption is a challenge, given that there is no centralized tracker within Gavi that monitors absorption rates, combined with challenges at country levels in tracking use of COVID-19 response funds.

In four countries, it is possible to see that R&P reprogramming funds absorption was as follows:

- Uganda: 68% by November 2020
- Mozambique: 3% by Dec 2020, 73% by Dec 2021, and 91% at March 2022.
- Togo: 18% by Aug 2020
- Pakistan: 36% by Aug 2020

In the remaining four countries, it is not possible to say with any degree of confidence how much funding has been used (Niger, Kenya, Nigeria, Sudan) and by when.

Absorption challenges uncovered related to use of national systems (Mozambique), delays in administration of funds within the pooled health fund (Niger), as well as being impacted by disbursement timelines (often with delays) as noted in Annex 10.24.

Country	Absorption info.
Kenya	GAVI approved $1.8 million in reprogramming under R&P, for procurement of PPE via UNICEF, as well as IPC training, coordination support at national and country levels, and communications. We have not been able to obtain data from UNICEF on the extent to which these funds were used.
Mozambique	$2.9m was approved under R&P for PPE and risk communications. MoH finance data indicates that most of this was spent in 2021. As of December 2020, only 3% had been spent; by December 2021, 73% had been spent, and at the end of March 2022, 91% had been spent. These data suggest that initially (June to December 2020) and even afterward there were challenges in spending the money allocated by Gavi for an initial response to COVID-19. These challenges were reported to be associated with the procedures for registering funds in the E-SISTAF (government electronic systems for transactions) and processing activities at MISAU's internal level, which had to go through several stages or units until execution.
Sudan	$1.56m was approved for reprogramming in Sudan, for PPE and lab supplies. Records reviewed suggest all these funds were used for PPE (based on the UNICEF Cost Estimate). PPE supplies were reported to have arrived between August and September. It was not possible to ascertain how much of the funds were eventually used of the total available.
Niger	Niger had $592,000 approved under R&P for PPE, strengthening IPC measures, risk communications, coordination, and strengthening of laboratories. It was not possible to access data on how the funds were used in practice. One focus group discussion suggested that approximately 30% of reprogrammed funds had been used in practice (approximately $200,000). However, it was not possible to verify or triangulate this with other sources. One KI noted that an attempt had been made (by the pooled health fund) to track the different donor commitments for the COVID-19 response. A template was apparently circulated among partners, who were reported to be unable to complete it, due to a) the complexity of disentangling how funds had been used according to different cost categories, and b) bandwidth challenges.
Nigeria	$12.6m was approved to cover PPEs and lab reagents. Cost estimates from UNICEF for $1.2m and $5m were approved by the government in May and then August 2020. Supplies are reported to have arrived by November 2020. However, it has not been possible to understand whether supplies that arrived in November absorbed the full $6.2m approved in Cost Estimates, nor the extent to which the remaining $6.4m approved funds were used. According to KIIs, none of the fund trackers (government, CHAI, CACOVID) were complete and there is no single accurate source of funds

	committed to or used under the covid response. No KIIs were aware of the WHO "partners platform" tool which tracks covid response funding needs and funder commitments. Through PEF TCA, GAVI funded the Clinton Health Access Initiative (CHAI) to provide technical support to the Presidential Task Force on COVID-19 (PTF) to better improve coordination efforts among development partners and the private sector to prevent duplication of efforts. CHAI designed a dashboard (real-time-visibility tool and donor investment tracker) to track and harmonize all donated resources (financial and in-kind) provided by other donors (development partners, NGOs, private sector etc) to strengthen donor coordination and engagement for the pandemic response and prevent duplication of efforts. Beside the CHAI dashboard, CACOVID collected data on private donations, the government also collected data, which was summarized in the HSS reallocation request in response to the COVID-19 approval Request Memo, but this was very early on in the response and documented committed funds, not funds that were actually programmed.
Uganda	$3.12m were approved for reprogramming to cover COVID-19 test kits. Partial data was available to show the timing and spend related to COVID-19 test kits procured via UNICEF with Gavi funds. A total of $2.13m (68% of $3.12m approved under R&P reprogramming) had been used to procure test kits by November. 4% of test kits arrived in July, a further 29% in August, 7% in September, 45% in October and 14% in November. It is unclear when and how the remaining $0.99m was used.
Togo	A total of $379,340 was approved in R&P reprogramming in Togo in two separate requests ($129k for test-kits and swabs and $250k for 2 open automatic extractors). KIs confirmed the first amount approved of $129,000 was used to buy approximately 5,000 test kits which arrived in August 2020. Actual expenditure for these was reported at $68,519 (53% of the $129k). Records also show that the extractors were purchased and arrived 1.5 years after the first order had been placed. Under M&R&S, in April 2021 Togo requested to reprogramme $574,260 of existing HSS funds for MR&S. Data on use of these funds was not available.
Pakistan	A total of $5.5m was approved under R&P reprogramming. It has not been possible to establish with confidence the extent to which these funds were used. This appears to be due to incomplete record keeping. Funding for PPE procurement was approved under R&P and was relevant to the needs in the country once services started to reopen as of quarter 2 of 2020. Records reviewed indicate that the $2 million (approximately 36% of $5.5 million approved) approved by the MoH in UNICEF's Cost Estimate was drawn down to purchase masks that arrived in August, and gloves and hand sanitiser received in November. *"… even though Approval Memos to agree using the UNICEF special arrangement were approved as of May 8 2020, the first six months of PPE procurement came from sources other than Gavi."*

10.23 Table of tracking databases

The EHG team identified the following 27 different databases that had been used by Gavi during the past 2 years to track implementation of R&P and M&R&S. This list is not necessarily comprehensive – Gavi staff noted that a separate internal exercise (albeit not specific to R&P and M&R&S) had identified more than 60 such trackers.

#	Date of tracker	Relevant to R&P or MRS or both	Name of tracker / excel sheet	Content
1	27 March 2020	R&P	COVID 19 country ceilings	Country HSS 10% ceilings for 73 countries. Indicates whether countries had expressed interest/ formal request received. Includes primary channel for current HSS funding (MoH/UNICEF etc) Includes whether procurement via partners/ gov/ UNICEF (partial data) under current HSS modality
2	6 April 2020	R&P	Tracking available funds for transfer to SD 06042020 'CP tracker'	Covers 75 countries. includes actual and predictive tabs including columns: • Ceiling available for reallocation • Total approved for reallocation % for **16 countries** • Approved funding for PPE ($+%) • Approved funding to procure laboratory diagnostic equipment (USD) ($+%)
3	24 April 2020	R&P	COVID-19 Approval budgets 24-04-2020	Includes summary of budgets approved for reprogramming **for 21 countries** – by WHO pillars, Gavi programmatic categories, cost category and HSS grant activity classification
4	30 April 2020	Both	COVID-19 fora	Summarises all the coordination mechanisms/ forum: • Forum COVID objectives • Forum convener • Gavi lead • Gavi FP • Gavi other participants, • Other participants, • Priority level for Gavi, • Gavi objectives • Gavi workstream, • Meeting frequency, • Upcoming milestones, Type (broader alliance/core alliance)

5	13 May 2020	R&P	HSIS_COVID tracker_13-05-2020 (1)	• Includes reprogramming budgets approved for **36 countries.** • Shows breakdown of budgets per cost category (Gavi) and WHO pillars
6	Undated – but data aligns with Sit Rep 18 dated 24 Sept 2020	R&P	Approval summary table COVID-19	**Total approved reprogramming support for 39 countries ($76.6m)** • Total HSS ceilings for 38 countries • Main components of reprogrammed support (narrative) • National response budgets ($) • Gavi share of national response budget % • Gavi's share as a % of partner contributions • Other agency contributions ($) **PTE reallocation support** Only Timor-Leste identifiable as PTE in this sheet ($336k) – so sits under reprogramming flexibility. **Total PEF TCA approved – reallocation and NCEs** • $3.6m approved across 21 countries plus $115k for University of Oslo. • NCE across 32 countries
7	15 May 2020		2020-05-15 Campaign Tracker	Tracks various campaigns (OCV, IPV, MMR etc) across 80 countries. Seems to be tracking delays, postponement and reasons.
8	9 June 2020	Both	Copy of COVID HSS tracker Updated for Finance - 9 June 2020	Shows UNICEF procurement figs/ countries for vaccines.
9	10 June 2020	MRS	RC-RC mapping (Red Cross and Red Cresent)	Covers 58 eligible countries plus Indonesia
10	28 June 2020 (28062020)	Both	Country mapping_V_ Validated_ Immediate_ Needs	Mapping of Gavi 73 eligible countries immunisation, and capacity (using various proxy indicators of health system and political economy), assessment of needs appears to be based on SCM discussion with countries. Assesses likelihood of countries needing to request 'additional HSS needs' and additional needs for ops/catch-ups' in future.
11	8 July 2020	Both	COVID-19 Phase 2 operationalisation action tracker	Action tracker for MRS phase with target dates
12	16 July 2020	Both	Time spent on COVID response	Summary FRE for CP and core team mid-March to mid-July 2020

				• COVID-19 response Level of effort (LOE) by thematic area - CP COVID CORE TEAM since March 2020 • COVID-19 response Level of effort (LOE) by thematic area - PROGRAMME FINANCE COVID-19 response Level of effort (LOE) by thematic area - HSIS
13	15 Sept 2020	MRS	MRS funds 25% ceiling	**For 50 countries, shows:** • Current core HSS ceiling • Option A 25% new ceiling *(total up to $279, 514.5m out of $1.36b HSS grants ceiling total))* • Ongoing grant no. • Endorsed, approved, disbursed amounts (and %ages per "July 2020 Financial file" • End year of ongoing grant • Comments – e.g., delayed implementation
14	30 Sept 2020	Both	COVID Response: Procurement on behalf of countries leveraging existing Gavi HSS funding	Includes summary of PPE and ICE equipment procurement status in HSS grants
15	13 Nov 2020	MRS	MSD tracking sheet	For 73 countries Includes MSD dates, format of meeting, type of meeting, no. ZD children.
16	Undated	Both?	Tracker MRS applications	**Across 69 countries** • HR data on which HSIS FP is leading on which countries, plus WUENIC data 2016, 2017 • Across 57 countries: "HSIS Focal Point engagement plan - serves as guidance to lead informed discussion on a) sequencing of FPP and EAP and b) opportunities for strategic investments towards 0 dose and 5.0 objectives " (largely incomplete) **Across 61 countries:** ZD identification includes: • Whether Gavi 57 country • Whether socialising EAF in progress • Comments **M&R&S tracker includes:** • MDS date (year)

				• M&R&S tracker tab that includes whether reprogramming requested (seems R&P as well as MRS – across 28 countries) • Capturing 'innovative catch-up' activities • Whether request submitted to IRC • $ amount requested for reprogramming
17	Undated	Both	Costing for additional HSS for restarting and adapting RI services	**Across 74 countries** • Projects low, medium and high covid scenarios • "The results of this analysis show that the cost of delivering immunization through outreach could increase by 19-138% depending on the way outreach strategies will be adapted. "
18	Undated	Both	PEF COVID Reallocation tracker	**2019 TCA extension tracker (33 countries)** • Date of request • TCA year • Partner • Approved by MOH/Gavi • Activities and new milestones • Amount being reprogrammed (v ltd data – suggesting most NCE only) • Original TCA plan activities, milestones, budgets approved **PEF TCA reallocation tracker (35 countries)** • TCA year • Partner • Approved by MOH/Gavi • New programmatic areas • Activities and new milestones • Amount being reprogrammed • Original TCA plan activities, milestones and new dates • Savings reallocated $ and narrative justification
19	Undated		Cold chain investments	Covers 57 Gavi countries plus 31 non Gavi countries. Tracks amounts and activities for early CDS and CDS needs based grants. Includes WB and Japan and Vodafone investments.
20	31 Jan 2021	Both	TCA Utilisation 4.0	**Covers 59 countries** • Gavi PEF 2020 Technical Country Assistance (TCA) Tier 1, 2 and 3 budget implementation – shows ANNUAL UTILISATION by countries (initial versus utilised) **between 2016 and 2020**, by WHO and UNICEF • Notes 4.0 tiers and 5.0 tiers

21	Undated	Both	Gavi %	For 20 countries summarises Gavi % contribution to National COVID-19Response plan, compared to WB and GF support
22	Undated	Both	GPF data	
23	Undated	Both	FPP tracker	Tracker of FPP processes
24	Undated	Both	Innovation tracker	Sheet includes a mix of global and country-specific innovative activities. Includes: Innovation area, purpose, partner, stage of discussion, funding status.
25	Undated	R&P	Copy of COVID-19 Approval Budgets_MASTER	**Covers 35 countries.** Includes: • reallocation budgets • Equipment Procurement Funds (PPE, diagnostics, and medical equipment) • Funds with recipient (yes, no partial), Funds confirmed to UNICEF
26	undated	Both	COVID-19 programmatic risks and mitigation strategies	Risk plan – unclear if kept up to date, how often updated etc
27	undated	Both	COVID-19_Approval Budgets_zzMASTER - Editable	Full tracker of approved R&P reprogramming – $76.3m across 38 countries

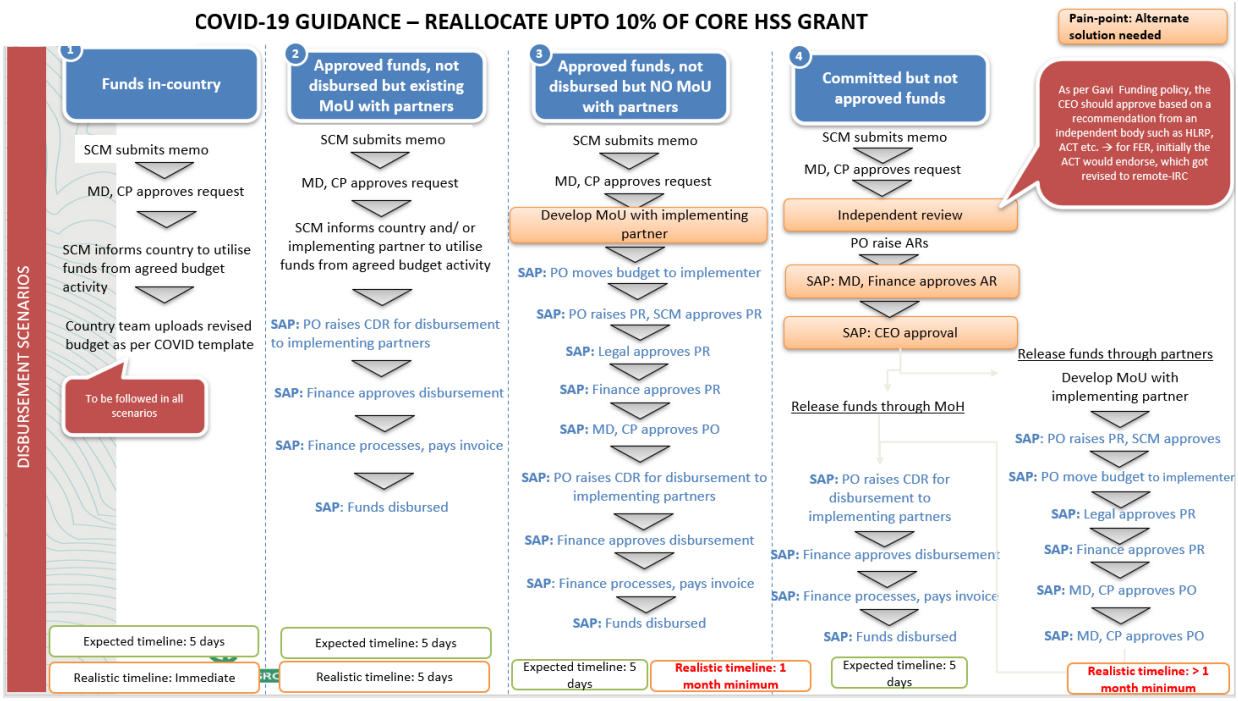
10.24 Application approval and disbursement processes and timeframes (implementation)

Setting internal approval process of five days to approve reprogramming memos and five days for disbursement appears to have focused Secretariat staff minds, with one SCM noting they had met the approval timeline target and another noting that this target existed. It is clear from KIIs and guidance documents that timeliness was of utmost importance for Gavi.[37]

Approval was confirmed with a management 'decision' letter from Secretariat, signed off by the Director of Country Programmes. Application templates and approval processes were intentionally streamlined, and Secretariat staff and countries appreciated this.[38]

The attempt to streamline processes was mostly commended by Secretariat staff close to operations at the time, noting and appreciating lighter-touch, faster application and approval processes. The UNICEF Special arrangement was cited by several key informants as a specific, positive example of a process being set up with speed of procurement as the target.

The example process map below illustrates the extent to which the team had to grapple with adapting existing business processes and documenting decision-making processes for new and streamlined approval and disbursement approaches to respond to the emergency context of COVID-19.



[37] Guidance on use of HSIS, PBF, PTE and PEF TCA_Response to Covid-19, 3 KIIs Gavi Secretariat

[38] 4 KIs Gavi Secretariat, 2 country case studies

Gavi's efforts to streamline approval and disbursement processes have been recognized by some KIs, notably country-level stakeholders.

"It was very quick, normally Gavi's requests go through a specific form and are assessed independently. But in this case, the evaluation had already been done in the sense that this support can be released without following that whole process, which normally ends up taking 2-3 months when we're dealing with Gavi." (Mozambique case study)

One Secretariat key informant noted the Secretariat could have benefited from more flexibility (though heightened risk) in their procurement/contracting approach with expanded partners especially. The same key informant also suggested it would have been appropriate to reduce the signing authority levels to free-up the CEO and DCEO during this time:

"From the top there is language that you need to be fast, and we can be flexible but when it comes to signing, all sorts of questions are asked. This is a function of leadership and nothing else at this point in time. There is a lack of willingness to truly let go from higher level so ability to move fast is lacking." (Gavi Secretariat staff)

Approval and Disbursement times in the case study countries

Approval times: Gavi set an internal target for country teams to respond to approve R&P reprogramming requests from countries within five days[39]. It is unclear in Gavi internal guidance, however, whether the 5-day target begins from the country's first or ultimate request following iterations. And whether the target ends when the Gavi AR Memo is internally signed off by the Director of Country Programmes, or whether it ends on the date Decision letters were sent. Approval times were explored by reviewing any documentation shared with the evaluation team from country teams, plus Approval Request Memos available in the evaluation SharePoint folder. In some instances, email correspondence was available to confirm when countries requested reprogramming and when Gavi responded, in other cases not. In some instances, dated Decision Letters were available, in other cases not. The below analysis draws on information gathered and presented in case study process maps.

Headlines from analysis of the case study country process maps:

In six out of eight case study countries where data was identified, approval times vary from 2 to 21 days, depending on how the approval time is defined. Regardless of which definition is taken as the target end date, these are fast turnaround times.

In four out of eight case study countries requests for reprogramming were updated – in Sudan to reflect changes in costing, in Niger to reflect a new activity requested, in Mozambique it is unclear why a 2nd version was submitted. In Uganda a 2nd version was submitted due to a change in incident commander and change in the COVID-19 Response Plan. Iterations and the speed with which they were carried out suggest very active/responsive communications between countries and SCMs at the time.

[39] Q&A on COVID-19 Country Programmes Response, undated

Summary of approval times across individual case study countries:

Country	Approval times
Kenya	**Unclear approval time.** Unclear when Kenya MoH submitted its reprogramming request. 16 April HSS Approval request Memo was internally approved by Gavi. Unclear when Decision letter sent.
Mozambique	**12 days informal approval from first request, formal approval from updated request to formal approval was 21 days.** Mozambique submitted their request for reprogramming 25 March. Updated version sent 30 March. On 6 April, Gavi informally approved by SCM. On 20 April formal approval sent to Mozambique.
Niger	**6 days approval time from updated ARM** Unclear when Niger submitted first request for reprogramming. Updated (version 2) Approval Request Memo is dated 7 May. On 13 May Decision letter sent approving request.
Nigeria:	**12 days approval time from confirmed request to internal Gavi approval. Unclear when Decision letter sent.** April 30: NCDC on-behalf of the Govt of Nigeria submitted application and concept note to Gavi. May 12: final approvals from Gavi on the AR memo.
Pakistan:	**Unclear approval time.** Unclear when Pakistan request for reprogramming was received. Approval Request Memo (ARM) approved 18 May, but Decision letter dated 17 July.
Togo: R&P:	**R&P 1st request: 3 days approval time**. Togo submitted request to reprogramme 6 April 2020. On 9 April Decision letter send to MoH approving funds. **R&P 2nd request: Unclear approval time.** 1 September 2020 Togo submitted new request to use available funds to purchase two automatic extractors. Cost estimate from UNICEF shared with Togo 8 September 2020.
Togo M&R&S	**9 days for internal Gavi approval time**. There was no decision letter sent as this was a reallocation of already approved funds**.** Togo submitted request 21 April 2021. Gavi approved it 30 April.
Sudan	**10-day internal Gavi approval from first request, 2 days internal approval from revised request. Unclear when Decision letter sent**. On 20 March Sudan submitted first request for reprogramming. **On** 20 April revised request. On 30 April Gavi signed Approval Request Memo.
Uganda	**12 days approval time from request to internal Gavi approval**. **Unclear when decision letter sent.** On 17 April Uganda submits request for reprogramming. On 29 April Gavi approves reprogramming Approval Request Memo.

Disbursement

Gavi set an internal target for country teams to disburse funds to countries within 5 days[40]. It is unclear in Gavi internal guidance, however, where the 5-day target begins and ends, i.e., does it end when funds arrive in government/ partner accounts at a central or country level, or when Gavi has given the approval for funds to be used (e.g., if funds already in country), or when funds become accessible for use in those accounts.

The process of disbursement generally appeared to involve several key steps:

1. Gavi giving the approval for funds to be used. These funds may have been one or some of the following:
    a. funds already in country (Uganda, Kenya, Sudan, Nigeria, Togo);
    b. requiring disbursement of 'new' (PBF) funds to WHO/UNICEF or government accounts (Mozambique, Pakistan);
    c. authorizing a transfer of funds from one national account to another (Niger).

[40] Q&A on COVID-19 Country Programmes Response, undated

2. Funds were then used by government, and/ or partners.
3. *When procurement was required*: Once Gavi had given approval of funds to be used, UNICEF (or other procurement agencies in countries) developed cost estimates that were sent for approval to governments.
4. Governments reviewed/approved cost estimates and then (in the case of the UNICEF SD special arrangement) asked Gavi to disburse funds to UNICEF.
5. Funds were disbursed by Gavi to WHO, and/ or UNICEF, and/ or government accounts accordingly.

Headlines from analysis of the case study country process maps:

- **It was not possible, in any of the case study countries, to access accurate data to get clarity on disbursement timelines.** One KI (Gavi Sec) noted that getting information on disbursement and financial information more generally from countries is always a challenge.
- **The time from approval of reprogramming request to disbursement ranged from 1.5 (Sudan) to 5 months (Pakistan –** NB this relates to PBF contracts received by UNICEF and WHO in December 2020).
- Uganda, Kenya and Sudan (all using funds available in country) and Mozambique (PBF funds that had to be transferred) have the fastest disbursement times between 1.5 and 3 months.
- It was not possible to establish where the bottlenecks in the process were at country level in most case studies.
- Approving cost estimates between governments and UNICEF incurred delays in the case of Nigeria, Pakistan and potentially other countries.

Summary of disbursement timelines (based on analysis of country process maps):

Country	Disbursement times
Kenya	**Disbursement time 2-3 months**. **Using funds already in country** to procure PPE, comms, capacity building support. The approval request for reprogramming was approved on 16 April 2020. Following this, PPE was delivered through UNICEF in July. PPE arrived from the GF later, in the last quarter of 2020.
Mozambique	**Disbursement times 2-3 months.** **Using PBF funds requiring actual disbursement**. MoH received approval of the request to reprogramme from Gavi on 6 April. Gavi disbursed $1 million to WHO to support risk communication and community engagement on 9 June (**approximately 2 months' disbursement time**), and $2 million to UNICEF for the purchase of PPE 30 June (**almost 3 months' disbursement time**). The delay was attributed in part to the delay from MoH to make a special emergency bank account available for the Gavi transfer, rather than using the routine channels used between Gavi and MoH. Despite the delay, there is consensus among key informants that the process of making these funds available was faster than usual.
Niger	**Unclear disbursement time**. **Using funds already in country** but which needed transferring from one national account to the pooled health fund account. On 13 May Gavi issued Decision letter to MoH. Unclear when funds became available in the pooled fund account. KIs reported delays in being able to access reprogrammed funds in the pooled health fund due to lack of coordination and communication challenges between partners using the pooled fund. PPE funded by WB (via UNICEF) and MoH (via national procurement body) arrived October/November. Unclear if MoH PPE used Gavi funds as intended in approval request or own or other donor funds.
Nigeria:	**Unclear when disbursed funds arrived with UNICEF** **Using funds through UNICEF SD special arrangement**. May 12 Gavi approves request to reprogramme. 15 June GoN sends request to Gavi to disburse funds to UNICEF for PPE and laboratory reagents. 18 June UNICEF shares cost estimate with GoN. Noting that it

	took from 8 May (when GoN finalised its request to reprogramme memo) to 23 June (almost 7 weeks) for GoN to sign off on procurement. Further request to procure additional laboratory supplies went from GoN to UNICEF 24 July. August 13 (approximately 3 weeks later) GoN approved UNICEF's new cost estimate. PPE and supplies were received in November 2020 (6 months from original reprogramming approval).
Pakistan:	**Approximately 5 months disbursement time.** **Using PBF funds that required disbursement to both WHO and UNICEF.** 16 June approval request approved for purchase of PPE. 14 July (**1 month later)** cost estimate approved by Government. UNICEF and WHO received PBF contracts/funds in December 2020**.**
Togo: R&P:	**R&P 1st request: Unclear when disbursement took place.** Funds were sent from Gavi to the PMU account. **Using PBF funds requiring new disbursement to UNICEF** to purchase test kits and swabs and freight costs**.** 6 April Gavi approves first request to reprogramme. Records show that test kits arrived in August, 4 months later. **R&P 2nd separate request: Unclear when disbursement took place to UNICEF.** **Using available funds in country, to UNICEF**. 1 Sept 2020 Togo submits new request to use available funds to purchase two automatic extractors. Request approved sometime between 1 and 14 September. 14 September cost estimate from UNICEF is shared with MoH. This first order apparently coincided with the end of UNICEF's management of the funds. When UNICEF SD was contacted again, the funds were returned to Gavi. UNICEF placed a new order and Gavi sent the funds back to UNICEF SD. This second procurement process eventually led to the acquisition of the extractors that were delivered to the country **1.5 years** after the original request**.**
Togo M&R&S	**M&R&S: 1st Request: Unclear disbursement time.** **Using funds available in country**. 21 April 2021 Togo requests reprogramming. Approved by Gavi 30 April, 9 days later. Disbursement unclear. Approval Request Memo notes a new PMU being set up (shared with TGF) suggesting funds would be transferred there but unclear.
Sudan	**Unclear disbursement time.** **Using funds already in country** to procure PPE. Request to reprogramme approved 30 April. On 9 June UNICEF confirms cost-estimate. Sometime between July and September, PPE arrived in country *"Part of goods were delivered in July, most of the remaining items were delivered in August-September*[41]*.* Time between approval of request to reprogramme and cost estimate confirmation[42] approximately 1.5 months.
Uganda	**Disbursement time must have been in 2-3 months for first set of supplies and up to 7 months for the last supplies.** **Using funds already in country.** 8 May and 9 Jun 2020: MoH requested procurement of COVID-19 test kits worth $2.13 million through UNICEF, both approved within one day. The first test kits arrived in July (4% of the total order), a further 29% in August, 7% in September, 45% in October and 14% in November. The time-laps between 8 May and July means disbursement time must have been in 2-3 months for first set of supplies and up to 7 months for the last supplies received in November).

[41] PPE and supplies mapping timeline

[42] Used as a proxy for disbursement

10.25 UNICEF SD Special Arrangement

The Gavi secretariat's working assumption was that establishing a special arrangement with UNICEF for supply of PPE and IPC would lead to efficiencies in procurement in terms of price, timeliness etc and help manage risk associated with alternative contracting options. Observations based on emerging evidence suggest that the secretariat assumptions were not completely upheld. This annex provides supporting evidence and additional information to unpack this finding.

In order to avoid the usual process whereby countries are required to make advance payment to UNICEF SD for procurement, UNICEF SD and Gavi agreed that Gavi would transfer US$ 40 million of "frontloaded" funds (the "HSS deposit") to enable UNICEF SD to enter into special contracting transactions for COVID supplies such as advance purchasing, firm commitments, pre-payments to suppliers and other special terms. This was intended to enable UNICEF SD to i) secure availability of COVID supplies to Gavi countries prior to receipt of country-specific orders since at the time, there was a global shortage of PPE, ICC and COVID tests due to a surge in demand and disruption to supply chains and ii) to procure COVID supplies for Gavi countries with their HSS funds.

As noted previously, the largest single category of HSS reprogramming expenditure went towards COVID infection control and PPE purchase, 80% of which went to six countries. It is therefore necessary to evaluate how/whether the flexibilities Gavi put in place (including the flexibility to reprogramme HSS funds to buy COVID supplies via the special arrangement with UNICEF SD) contributed to intended outputs and outcomes,[43] i.e., did cost effective quality PPE arrive in time to support the COVID response and RI recovery?

This section breaks down findings into two sections – 1) What were the expectations and assumptions; and 2) What did the evaluation find in terms of prices, timeliness and quality?

Expectations and assumptions

Although the UNICEF SD-Gavi special arrangement contract did not specify procurement timeframes or prices, several documents make clear that the arrangement was based on speed and efficiency expectations:

- A report to PPC (26-27 May 2020) notes that: "There are reports of countries facing difficulties in procuring critical products to respond to the pandemic due to supply disruptions, increased demand, bidding wars, confiscations, and political tensions. To help address this, the Secretariat has set up a pre-financing mechanism with UNICEF to accelerate countries' access to PPE and diagnostics procured with Gavi support." The underlying assumptions were that because Gavi could quickly pivot funds towards PPE and leverage its relationship with UNICEF-SD, that the result would be quick access to PPE by countries.
- UNICEF-SD was also making some assumptions about its ability to supply quickly; the UNICEF website says (of the rationale for the special arrangement): "We need to get ahead of demand and use our relationships with the private sector to ensure supplies are available when needed…. Following the agreement, UNICEF will procure PPE, diagnostic tests and other supplies to improve both the quantities and timing of supply availability to meet incoming requests from countries."
- The reprogramming memo for Nigeria shows similar expectations and assumptions, that other donors' funds would take longer to materialise and that there were immediate gaps which Gavi could fill, especially related to targeting community level and frontline health workers. The AR memo stated that support was urgently needed, and there would be a need to ensure the goods will be

[43] Outcome of "Mitigating the impact of C-19, including on RI services…" Driven by outputs of i) "Countries able to carry out critical C-19 interventions including risk communication in a timely fashion" ii) "Countries able to adapt RI activities to the C-19 context" and iii) "Countries able to design new/innovative and/or more efficient ways of reaching vulnerable pops"

delivered as soon as possible given the evolving pandemic situation and major impact on PHC and RI services. "NCDC has a major challenge with concrete contributions in that there are commitments made by some donors, but the actual support is delayed. We need to work with UNICEF SD to ensure timely procurement and delivery of PPE, lab reagents and test kits." ..."Once approved, the activities proposed by the country will increase capacity to rapidly scale-up testing, surveillance, contact tracing, infection prevention and risk communication, especially at community level. …The support includes provision of PPEs to 25% of PHCs to ensure that frontline health workers are equipped to continue immunisation and other PHC services."

What did the evaluation find: prices, timeliness and quality

With regard to prices, there were significant changes in prices in Pakistan between the UNICEF SD catalogue prices used for the May 2020 cost estimate and those used for the final cost estimate in June. For example, the unit price of a face mask went from USD 11 cents to 50 cents for latex gloves from USD 6 cents to 40 cents. Several KIs concluded that the Gavi special arrangement with UNICEF SD was not effective for the purpose of procuring quickly and economically. "This was a challenge baked into the mechanism – not Pakistan specific." As for local procurement, KIIs state "we were strongly discouraged from this, the idea being that it would be better VfM if going through UNICEF SD."[44] In Sudan, the initial amount to be directed for UNICEF procurement was US$ 1.26m; this was subsequently increased by US$292,388 to US$1,560,519 due to increased costs related to freight, insurance, inspection, handling fees, and other logistic arrangements (The final SoA for CE 10022287 shows expenditure for Sudan under these funds was $998k). In Nigeria, prices quoted for liquid gels/disinfectants were also reported to be too high and the government preferred local procurement.

There were problems with timely receipt of PPE in Nigeria, Pakistan, and Sudan. In Togo, receipt of COVID tests was delayed by 4 months and extractors by 1.5 years. The Memo titled "UNICEF Supply Division price indications for PPE supplies (as of 24 June 2020)" states "Availability from UNICEF Warehouse in Copenhagen or Shanghai, for most of the supplies, is starting from August when initial shipments can commence." By this time, most countries had restarted PHC and RI recovery and had already received PPE from other sources. In Nigeria, PPE did not arrive until November; "we were able to leverage other organizations like the private sector who were able to bring in their commodities much faster to support the country despite the global shortage and scarcity of these interventions. For instance, we got supplies from the BUA Group and Dangote foundation much faster. Also, some supplies (Lab regents and PPEs like face masks and gloves) came into the country from the Africa CDC through the support provided by China - Jack Ma Foundation to African countries." (KII) Lab reagents were also near to expiry, and the government had difficulty using them quickly enough: "Most of the PPEs procured with GAVI funds through UNICEF arrived extremely late in the country towards the end of the 2nd wave of COVID-19, to the extent that some of the commodities like the Lab reagents were already expiring with short-dated shelf lives, so we had to ramp up the utilization rate of the commodities to prevent expiration of the supplies and to quickly distribute the supplies to various labs across the country and made some donations to the private laboratories to step up the utilization rates" (KII) In Pakistan, RI services restarted in May, but Gavi funded UNICEF SD procured masks arrived in August while gloves and sanitiser arrived in November. PPEs to support earlier recovery efforts came from existing stock in country, from Pakistan government funds (including the government's loan component of the World bank managed HSS NISP funds), from the Chinese government, from INGOs procuring locally as well as from some limited procurement using WHO emergency funds and USAID funds. In Sudan, PPE arrived from GF, WB, and China starting from April 2020, while UNICEF SD supplies came between July - October

[44] Initially, local procurement was encouraged, but after some time UNICEF globally made the decision to centralize PPE procurement through SD to protect the significant investment (over $400m) that had been made to stockpile PPEs early in the pandemic, as well as for quality assurance purposes. This was put in effect on 7 April 2021. (UNICEF SD KII)

2020. By the time final consignments were received in October, other donors had largely met the need for PPE, including for PHC workers that were not initially prioritized. "GAVI was very supportive and resilient in approving the fund in a short period however release was a little bit delayed and the process of procurement, shipping, and delivery was very delayed and certainly not timely"

Internal Gavi documents from July 2020 acknowledge concerns about Gavi-eligible countries having access to reliable supply of and competitively-priced and suitable quality PPE, and consequently, a working group was proposed to explore mapping the full extent of the sourcing capabilities in Gavi eligible countries as well as looking at opportunities to stimulate regional and local production of PPE in developing and emerging markets to address the concern of disruption to global supply chains had a negative impact on the health response. (Source: Problem Statement & Working Group Terms of Reference stimulating Local Production of PPE in Gavi-eligible countries Date: July 2020) However, this idea fell by the wayside essentially, due to questions around mandate, Secretariat capacity issues and eventual movement in the market. (KIIs)

Several contextual factors are important to note:

- In the early phase of the global pandemic, the situation regarding critical supplies of PPEs was well-known. A confluence of events, notably including a concentration of PPE manufacturing and supply in China and lock-down of the Asia region disrupted global supply chains and worked to drive up demand and costs worldwide. The response that UNICEF SD took to serious constraints in PPE was to lead a joint-PPE tender (with other UN agencies). This served as a mechanism to negotiate PPE pricing and to update pricing in line with market development.
- UNICEF SD reports that in 2020, UNICEF procured US$470 million worth of Personal protective equipment, whereas the Gavi/UNICEF special arrangement is a small amount (US $*40 million*) front-loaded with HSS funding for use in Gavi countries.

It is possible that the experiences identified in our case study countries are anomalies; other countries may have benefitted more from timely and cost competitive COVID supplies procured via UNICEF SD. However, the experiences in Nigeria and Pakistan in particular lead us to conclude that for some countries and some products, the utility of reprogramming EPI funds towards global COVID supply procurement may be questioned, from the perspective of realizing the intended outputs, since the very intent of this was to provide immediate support whilst countries waited for more significant funds to be allocated and disbursed by the global community for the COVID response.

11 Approach to analysis of the efficiency of Gavi's COVID-19 flexibilities

As explained in our inception report, the focus of the value for money (VfM) analysis is on allocative and technical efficiency as well as equity. Rather than conducting a distinct VfM analysis, we have woven VfM-relevant questions within the work packages:

Allocative efficiency is approached at a strategic level: which countries and regions accessed the flexibilities and funds (EQ1), what activities were eligible to be funded and towards which activities (in aggregate) the funds were allocated (EQ4) and the degree to which this was aligned with priority country needs filling gaps not filled by other donors (EQ6). We look at allocative efficiency at the portfolio level – distribution/take-up of the flexibilities across countries and by cost category/activity type – as well as the distribution of activities/goods funded within countries by geography/ population group and by cost category/activity type.

Technical efficiency is covered under WS2, with EQ8 focusing on the timeliness and efficiency of the overall process of accessing the funds, and EQ9 on the operational effectiveness of that spend. We focus on technical efficiency from two angles: a) internal to Gavi Secretariat processes and b) processes external to Gavi Secretariat, influenced by the Gavi partnership system overall driving towards the ToC outputs.

Equity parameters are the focus of EQ13 and covered within WS3 – how/whether activities supported prioritized vulnerable populations.

Ultimately under WS3, evaluating VfM requires assessing the plausibility that the R&P and M&R&S responses contributed towards the outcome objectives of mitigating COVID-19 impact and restoring and strengthening RI services ("right results") – our approach to answering this is through contribution analysis.

12 Gavi role in coordination mechanisms, including with Alliance partners

Analysis of findings across the EQs reaffirms the importance of effective partnership working and coordination in emergency contexts. Gavi's model and therefore effectiveness relies on a range of partnerships at all levels. We describe below how Gavi has worked with internal and external partners towards a coordinated response:

Working within the Alliance model

- As set out in the table below, Gavi's model is built on the comparative strengths of Alliance core and expanded partners to deliver effective partnerships, focused on delivering routine immunisation in the context of health system strengthening efforts. Existing partnerships have been built to support this, albeit with recognition that these can be strengthened (e.g., with CSOs).
- R&P and M&R&S were designed with this division of labour in mind – Gavi funding, WHO providing TA and country coordination, UNICEF focus on health product procurement, delivery and GESI (section 4.1.3).
- In broad terms this worked as expected: Gavi leveraged Alliance funding (4.1.3), drew on WHO guidance (4.1.3), drew on UNICEF procurement expertise and experience (4.1.3), benefitted from WHO support to coordination at country and regional level (4.1.3).
- But with some limitations: M&R&S guidance was delayed (4.2.2.2), surfacing tensions around WHO/Gavi Secretariat role in production of technical guidance (4.2.9.4); the implementation of special arrangements for procurement experienced some challenges as detailed in Annex 10.25; challenges with reliable, timely data (section 4.3.4, albeit broadly held, not specific to alliance) and questions which the evaluation has not been able to explore about the extent to which the Alliance is leveraging UNICEF efforts on real-time assessment.
- Shifting roles under COVID-19 response (ACT, HS accelerator, COVAX facility) have disrupted existing roles and responsibilities and need to be kept under review as GHS architecture is firmed up going forward.

Theme	Description of Alliance role	Relevant findings (abridged)	Evidence of leveraging Alliance roles; any emerging issues	Vol I section #
Funding	Gavi Secretariat manages funding, and some Alliance partners contribute substantial funds (e.g., BMGF and WB).[45,46]	Gavi had no additional funding and positioned itself as a donor of last resort	Collaboration with TGF, WB and IMF on funding, e.g., with WB/ IMF to support co-financing waivers	4.1.3
Technical assistance	WHO[47] and UNICEF[48] provide technical assistance at country, regional and global levels to support effective design and implementation of EPI/ Routine immunisation in pursuit of Gavi's goals.	Gavi support was aligned with WHO technical guidance Much of Gavi TCA went to WHO and UNICEF	WHO provided guidance, albeit with some issues around timing and some tensions around Gavi's role in production of technical guidance. Gavi used Q&A to signpost	4.1.3 4.2.3

[45] The Bill & Melinda Gates Foundation (gavi.org)
[46] The World Bank Group (gavi.org)
[47] The World Health Organization (gavi.org)
[48] UNICEF (gavi.org)

Theme	Description of Alliance role	Relevant findings (abridged)	Evidence of leveraging Alliance roles; any emerging issues	Vol I section #
			resources from Alliance partners. Some questions about whether current model allows Gavi to hold WHO and UNICEF accountable for performance under TCA when WHO and UNICEF sit on the Gavi board.	
Coordination	WHO works closely with national health authorities and their partner organisations in identifying national health priorities, formulating policy and supporting immunisation and health system development. At regional level, WHO and UNICEF usually lead regional working groups to coordinate support for country programmes working through a core group of partners.	Coordination in emergency context is critical, esp. with new entrants. Needs to happen at all levels. Coordination at global level worked well, but appears not to have been leveraged to check duplication (done at country-level instead).	WHO supported coordination (e.g., through C-19 NCC) and Gavi was an active participant. Evidence of regional-level coordination, some of which was led by the Alliance (e.g., by WHO AFRO) in which Gavi actively participated. Shifting roles under COVID-19 response (ACT, HS accelerator, COVAX facility) have disrupted existing roles and responsibilities and need to be kept under review as GHS architecture is firmed up going forward.	4.2.3
Country support		No explicit findings as such, however all case study countries had COVID-19 response plans	Evidence of WHO and UNICEF being key TA partners for Gavi. Supporting e.g., production of COVID-19 response plans, risk communication plans/ guidelines, TA for surveillance, rapid response teams, logistics/ procurement	4.2.3
Procurement	At global and country level UNICEF provides technical assistance and	Supply of PPE was key contribution under R&P, including through	UNICEF SD leadership in line with Alliance division of labour.	4.2.2.1 4.2.2.2

Theme	Description of Alliance role	Relevant findings (abridged)	Evidence of leveraging Alliance roles; any emerging issues	Vol I section #
	management support to ensure a reliable supply of quality and affordable vaccines and health technologies and assess governments vaccine/technology needs.	UNICEF SD, although with some concerns.		
Community engagement/ focus on vulnerable groups	At country level UNICEF helps countries analyse and overcome obstacles to improving immunisation coverage and equity.	CSO engagement through PEF-TCA but additional funds not taken up, and use of TCA not easy to track. Stronger focus on GESI within M&R&S than in R&P.	Some evidence (e.g., Pakistan) that TCA funds to UNICEF focused on vulnerable groups and community engagement.	4.2.3 4.2.9.6
Data/ local intelligence	Not mentioned explicitly on Gavi website but highlighted as important function that Alliance partners play from Gavi secretariat perspective.	Lack of reliable data at portfolio level and challenges in getting access to real-time data for RI. Admin data is made available confidentially in some WHO regions but not used due to data quality/ interpretation challenges.	WHO provides RI and surveillance data. Gavi keeps in close contact with WHO on this. Challenges in availability of reliable, timely data experienced by all. UNICEF has RTA monitoring systems. Not clear whether Gavi is leveraging lessons from this experience. SCMs worked closely with UNICEF COs to understand issues around vaccine stock levels etc. but limited by SCM bandwidth.	4.3.1
Pandemic Preparedness and response		Gavi and other orgs were ill prepared for COVID-19. Importance of PPR plan for future readiness.	Any Gavi plan would need to set clear, agreed expectations for roles of Alliance partners and Gavi secretariat.	6, lesson 1

Coordination more broadly

There is evidence of Gavi playing a role at both central and country levels. We summarize our understanding of Gavi's efforts from document review and KIIs.

Central level

Gavi was an active participant in a range of coordination mechanisms, including regular Alliance partner calls, with near daily communication with WHO and UNICEF, as well as with the World Bank task team leaders or in-country teams. These were used to sharing understanding of the impact on RI in particular, discussing mitigation and how Alliance resources could be used to support. The

Secretariat used regular Regional Working Group calls, to discuss the evolving situation in each region and in Gavi countries, reviewing broader risks and impact, and capturing key developments in Gavi countries in the region. Secretariat staff also reported being in regular dialogue with its Global Fund counterparts and, where relevant, GFF focal points, in order to coordinate response and funding. However, it was noted that Gavi could strengthen collaboration with non-Alliance partners.

Some concerns were raised about the efficiency and proliferation of these mechanisms. Secretariat staff noted that there were too many meetings/ fora, and the need for a more strategic approach to identifying key opportunities. "*No one was questioning any time a new mechanism was created fear of missing out (FOMO). They might say something and even if the agenda was not very relevant they still had to show up to the same meeting. Where can we align and streamline? Some of them with 20-30 high level people and even if it´s needed need to take stock and see if the ask is actually reasonable"*

Country level

Generally good level of inclusion of Gavi in national working groups/ coordination groups for immunisation, and during COVID-19 the national COVID-19 response groups.

For example Mozambique: "*There was a mechanism for local partners to update Gavi on the challenges faced by Gavi, but internally there were no such mechanisms for monitoring the implementation of funds applied by partners. There should be such a monitoring forum within the country"* and Pakistan from an EP: *"But there was strong coordination at the national level with Gavi."* However, some concerns were raised about how coordination was done in ways that did not strengthen country ownership (Pakistan, Uganda), and the need to strengthen working with CSOs.

A number of challenges were identified with coordination, including:

- Understanding what other donors were contributing
- Accountability lines between Gavi and some TCA partners
- More fragmentation and more complexity in RI space
- Coordination across sectors, outside traditional EPI teams

13 Supporting evidence (figures and charts) for WS3: Right Results

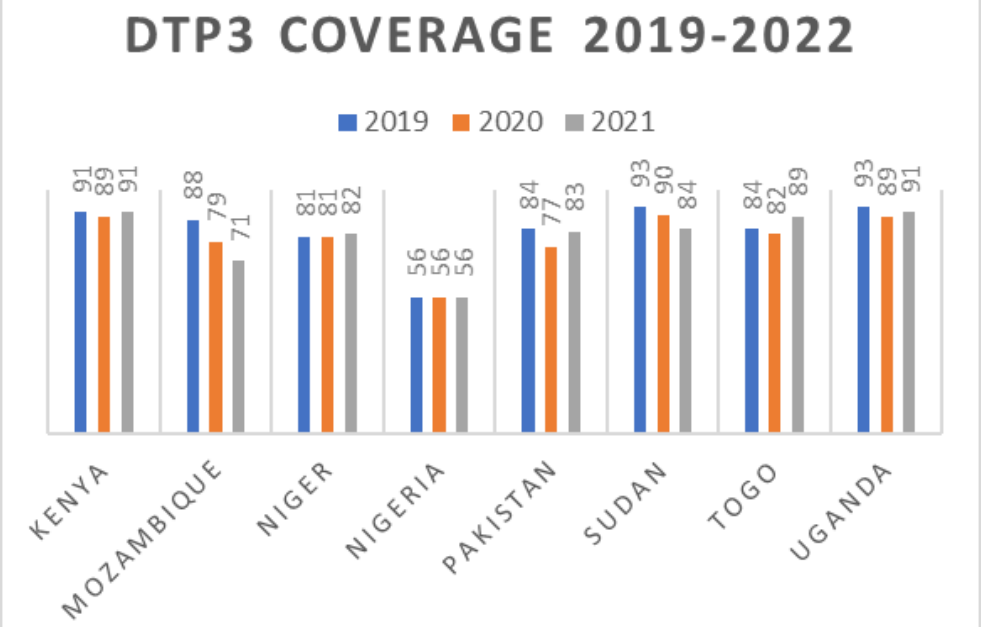
This Annex provides supporting evidence across case study countries for the findings presented in section 4.3 of Vol I. We present data on impact of COVID-19 in our case study countries (annex 13.1), a summary of select WUENIC data across the period 2019-21 in our case study countries (annex 13.2), cross country summaries on Gavi's contribution to key outputs (annexes 13.3-13.5), and a summary of whether key underpinning assumptions have held in our case study countries (annex 13.6). Finally, we bring together our data against the ToA in Annex 13.7.

13.1 Impact of COVID-19 on RI in our case study countries

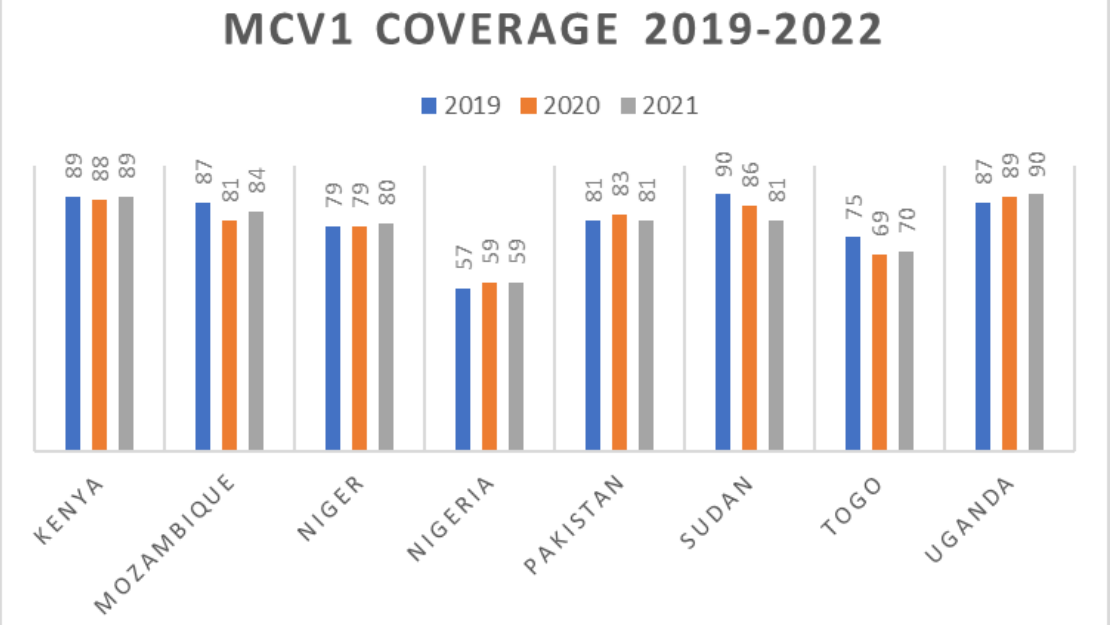
	Kenya		Mozambique		Niger		Nigeria		Pakistan		Sudan		Togo		Uganda	
	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
Deaths - cumulative tot per 100000[49]	743		48		81		105		1065		633		187		596	
Cases - cumulative tot per 100000[50]	38,191		40,438		2,337		8,502		4,723		8,469		19,391		20,668	
New deaths[51]	1,667	3,709	165	1,831	101	173	1,278	1,776	10,047	28,921	1,561	3,337	68	180	304	3,297
New cases[52]	96,251	195,986	18,485	184,219	3,208	4,157	86,576	154,937	477,240	817,621	25,500	21,325	3,611	26,552	35,220	107,451
DTP3 coverage (cf. 2019)[53]	Minus 2 % points	Back to 2019 %	Minus 9 % points	Minus 27%	Stable	Plus 1%	Stable	Back to 2019 %	Minus 7 % points	Minus 1%	Minus 3 % points	Minus 9%	Minus 2 % points	Minus 1 %	Minus 4 % points	Minus 2%
Measles coverage (cf. 2019)[54]	Minus 1 % points	Back to 2019 %	Minus 6 % points	Minus 3 % points	Stable	Plus 1%	Plus 2 % points	Plus 2 % points	Plus 2 % points	Back to 2019 % (so -2 cf. 2020)	Minus 4 % points	Minus 9%	Minus 6 % points	Minus 5%	Plus 2 % points	Plus 3 % points
Measles cases (difference cf 2019)[55]	+158	-173	+363	+556	-7567	-1050	-19217	-17445	+681	+8333	-3154	n/a	+22	+13	-606	-314
Impact on non-RI health expenditure??																

[49] https://covid19.who.int/data
[50] https://covid19.who.int/data
[51] https://covid19.who.int/data
[52] https://covid19.who.int/data
[53] https://immunizationdata.who.int/pages/coverage/dtp.html
[54] https://immunizationdata.who.int/pages/coverage/mcv.html
[55] https://immunizationdata.who.int/pages/incidence/MEASLES.html?CODE=Global&YEAR=

13.2 WUENIC analysis



COUNTRY	YEAR	DTP3 COVERAGE	Difference with baseline	Trend
Kenya	2021	91	0	Back to 2019 level
	2020	89	-2	Backsliding
	2019	91	-	
Mozambique	2021	61	-27	Further backsliding
	2020	79	-9	Backsliding
	2019	88	-	
Niger	2021	82	1	Plus 1 pp coverage
	2020	81	0	Maintained coverage
	2019	81	-	
Nigeria	2021	56	0	Maintained coverage
	2020	56	0	Maintained coverage
	2019	56	-	
Pakistan	2021	83	-1	Almost back to 2019 level but still 1pp under
	2020	77	-7	Backsliding
	2019	84	-	
Sudan	2021	84	-9	Further backsliding
	2020	90	-3	Backsliding
	2019	93	-	
Togo	2021	83	-1	Almost back to 2019 level but still 1pp under
	2020	82	-2	Backsliding
	2019	84	-	
Uganda	2021	91	-2	Recovering but still 2pp under
	2020	89	-4	Backsliding
	2019	93	-	



COUNTRY	YEAR	MCV1 COVERAGE	Difference with baseline	Trend
Kenya	2021	89	0	Maintained coverage
	2020	88	-1	Backsliding
	2019	89	-	
Mozambique	2021	84	-3	Further backsliding
	2020	81	-6	Backsliding
	2019	87	-	
Niger	2021	80	1	Increased coverage
	2020	79	0	Increased coverage
	2019	79	-	
Nigeria	2021	59	2	Increased coverage
	2020	59	2	Increased coverage
	2019	57	-	
Pakistan	2021	81	0	Maintained coverage
	2020	83	2	Increased coverage
	2019	81	-	
Sudan	2021	81	-9	Further backsliding
	2020	86	-4	Backsliding
	2019	90	-	
Togo	2021	70	-5	Further backsliding
	2020	69	-6	Backsliding
	2019	75	-	
Uganda	2021	90	3	Increased coverage
	2020	89	2	Increased coverage
	2019	87	-	

13.3 Summary of contribution of Gavi´s flexibilities to output 1

Output 1 Countries are able to carry out critical C-19 interventions including risk communication (in line with WHO guidance and country requirements) in a timely fashion

	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Extent to which output materialised	**Partial**	**Yes**	**Partial**	**Yes**	**Yes**	**Partial**	**Yes**	**Yes**
Key drivers	Strong coordination between national and sub-national levels; availability of funding for commodities; deployment of community health volunteers	Experience in managing emergencies; Strong political will; awareness raising for SBC; availability of PPE; emergency response plan aligned with the WHO pillars	Strong coordination; Intersectionality; technical and financial support	Right leadership, oversight and guidance; financial and in-kind support by partners	Govt political will, human and financial RM; RCCE; PPE, SOPs & FHW training	Technical and financial support by partners; presence of a robust EPI programme	Availability of diagnostic equipment; Existence of trained health human resource; risk comms and community engagement; tech support in IPC	Experience in managing outbreaks; strong political will and coordination; provision of guidance; supplies; human resources
Gavi's flex contribution	**Limited** -support for governance, PPE and development of IEC material for health workers. Other donor funding was more substantial	**Limited** – only 3% of budget for communication has been used (by Dec 2020); eventually 90% was used by March 2022. Gavi did not contribute to the first 2 drivers above	**Limited** – mainly support to strengthening inter-ministerial committees. PPE that had been planned to be procured with Gavi funds via UNICEF did not take place. $143k of reprogrammed Gavi funds were intended for use for communications activity but we saw no evidence of use.	**Some** - Gavi played a facilitating role, training of FHWs,-,PPE arrived only in Q3/4 '20	**Some** - Gavi funded RI-related SOPs, training and risk comms	**None** – PPE arrived late, funding was small and potentially duplicative	**Limited** – mainly through making 5000 screening tests and 6000 swabs available (arrived in Aug 2020) and WHO TA reallocated for IPC and other response activities. The two extractors arrived very late (in April 2022, i.e.. 1.5 years after approval). Contribution by other partners was more substantial.	**Limited** - supported GoU's Surveillance and Laboratory pillar via test kits. Gavi did not contribute to the first 2 drivers above

			Absorption was low (1 KI noted approx. 30% absorbed, not verifiable).					
Other partners' contribution	WB US$10m for response (ICU and lab support) TGF 3 C19RM grants: US$37m Mainly PPE US CDC for lab and surveillance, test kits WHO/CHAI/PATH TA JICA 19mKSH for test kits USAID reprogrammed from existing health grants	Main financial contributions in order were: World Bank, BID, USAID/CDC, TGF, EU (via UNICEF), Gavi..; WHO, World Bank, Village Reach and ThinkWell supported the development of the COVID-19 response plan	WHO: coordination of Technical and Financing Partners; training of 3 MAPI technical committee members and 35 regional focal points; training of 350 community relays	Donations (financial and non-financial) provided by all Development partners and private sector	The World Bank support through NISP was instrumental in earliest procurement of PPEs and essential equipment; PPEs also came from INGOs, existing stock and China	Substantial other donor funding for long-term health sector resilience	World Bank REDISSE II project (US$ 9 million) Global Fund: 25,000 Xpert Xpress SARS-CoV-2 tests	Multiple, all the following vital: UNICEF supported all pillars WHO supported all pillars TGF supported all pillars WB supported most GoU pillars CHAI supported multiple pillars USG supported multiple pillars

13.4 Summary of contribution of Gavi´s flexibilities to output 2

Output 2 Countries are able to adapt RI activities to the COVID-19 context

	Kenya	**Mozambique**	**Niger**	**Nigeria**	**Pakistan**	**Sudan**	**Togo**	**Uganda**
Extent to which output materialised	**Yes**	**Yes**	**Partial**	**Yes**	**Yes**	**Partial**	**Yes**	**Yes**
Key drivers	Solid EPI programme; media dealt effectively with mis-information; availability of PPE	Awareness for SBCC; necessary resources available for mobile brigades	Compliance with barrier measures; training of FHWs; Awareness for SBCC	Development of strategic plans; Mapping of LGAs with high ZD; Micro Planning and coordination meetings	Govt political will, human and financial RM; RCCE; and reopening of services enabled by PPE, SOPs & FHW training	PPE was in place; resources for campaigns to be held; robust EPI program	Availability of financial resources for the organisation of catch-up immunisation and for the implementation of an urban immunization	HCWs had the necessary resources to restart RI safely

							strategy; Mobilisation of civil society, CHWs and community relays	
Gavi's flex contribution	**Limited** - Gavi provided (limited) funding for coordination, capacity development for case management, prevention and surveillance, PPE for frontline health workers and support for IEC material development and risk communication	**Some** - Additional media campaigns, deployment of mobile brigades at an accelerated pace	**None** - $143,000 of reprogrammed Gavi funds were intended for use for communications activity but we saw no evidence of use.	**Important** - training and orientation of FHWs; support RI intensification planning; GVI granted no cost extensions for WHO and UNICEF to support RI intensification planning in underserved communities	Important - funded RI-related SOPs, training and risk comms Resilient cold chain capacity facilitated the response (especially valuable with MR campaigns and covid vaccination being rolled out in close temporal proximity) Gavi's previous investments – immunisation registers helped identify the children not reached during lockdowns and enable strategies re: how to reach them	**Limited** - The PPE supplies arrived late. Other Gavi funding through WHO was not released for a year due to internal processes. Emergency campaign funding was released faster	**Important** - reallocate $574,260 of existing HSS funds for support the first vaccine acceleration campaigns in late 2021; Recruitment of consultants for the extension of the urban immunisation strategy	**Some** - test kit procurement; supported coverage and equity related activities, including MOV activities.
Other partners' contribution	WB US$10m for response (ICU and lab support) TGF 3 C19RM grants: US$37m Mainly PPE US CDC for lab and surveillance, test kits WHO/CHAI/PATH TA JICA 19mKSH for test kits. USAID reprogrammed from existing health grants	Continued support of WHO, UNCIEF, Village Reach, ACASUS and WB to develop and disseminate appropriate messages. Continued support and contributions by multiple other partners to oversee procurement and supply management including purchasing of PPE, test kits etc.. WB was main contributor	WB: PPE (arrived in Oct/Nov 2020) WHO: training of community relays, awareness raising UNICEF: awareness raising	The Govt of Nigeria and other immunization partners allocated resources and TA for the restoration and maintenance of RI & PHC services	USAID support in Sindh and KP was also useful in selected districts. The WB support through NISP was instrumental in earliest procurement of PPEs and essential equipment. Initial PPE also came from INGOs, existing stock, Chinese govt and govt funded sourcing	UNICEF, USAID, GF and ISD delivered PPE faster than GAVI and allowed for PHC to run		Availability of (Gavi/COVAX) and prioritisation of (GoU) C19 vaccines to HCWs. Important contributions by multiple other partners to PPE, test kits etc. WB and TGF main contributors.

13.5 Summary of contribution of Gavi´s flexibilities to output 3

Output 3 Countries are able to design new/ innovative and/or more efficient ways of reaching vulnerable populations inc. ZD children for COVID-19 context and beyond

	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Extent to which output materialised	**No**	**No**	**Partial**	**Yes**	**Yes**	**No**	**Partial**	**Partial**
Key drivers	n/a	n/a	Availability of TA; PPE and child focus	Training of FHW and community volunteers; availability of PPE and other IPC materials	Govt political will; good data on missed children; Gender/service barrier analysis; Bottom-up microplanning; Resilient cold chain capacity	n/a	Good follow-up data thanks to village monitoring; technical support for development of vaccine acceleration strategies; good communication and community engagement	Availability of FHWs and required logistical support; Effective community outreach
Gavi's flex contribution	n/a	n/a	**Limited -** tech support of the Gavi consultant (funded through TCA via JSI/ Expertise France) providing useful permanent capacity to MoH; coordination and advocacy with partners for the mobilisation of more resources	**Important** - Gavi financed TA to enable RI integration into polio campaigns, primary care services (IMOP) and latterly integrate RI into covid vaccination campaigns. (PSI-COVID)	**Important** - Intensified outreach (EOA)s to get to unreached pockets, + birth dose initiative, urban health initiative and various NGO innovations such as those which were MIS and GIS related – all principally funded by Gavi and the Pak govt. Gavi also expedited MoUs with new	n/a	**Some** - Gavi support to UNICEF for the development of communication strategies (C4D) and community engagement by civil society; Gavi supported performance analysis of health districts the development of a map of these areas of vaccine hesitancy	**Some** - supported ongoing RI programme implementation/coverage and equity related activities, including MOV activities.

					expanded partners and though previous support			
Other partners' contribution	UNICEF supports the EPI program	n/a	UNICEF routine vaccine monitoring dashboard and support to prevention pillar; ECHO project; AFD: through the ISANCO project	The Govt of Nigeria and other immunization partners allocated resources and TA for the restoration and maintenance of RI & PHC services	Data triangulation by other partners to identify hot spots; expanded partners to reach refugees and unregistered pops; Pak govt political will, human and financial resource mobilisation	n/a	??	USAID providing important support at sub-national level as part of Regional Health Integration to Enhance Services project in each region

13.6 Assumption mapping (selection)

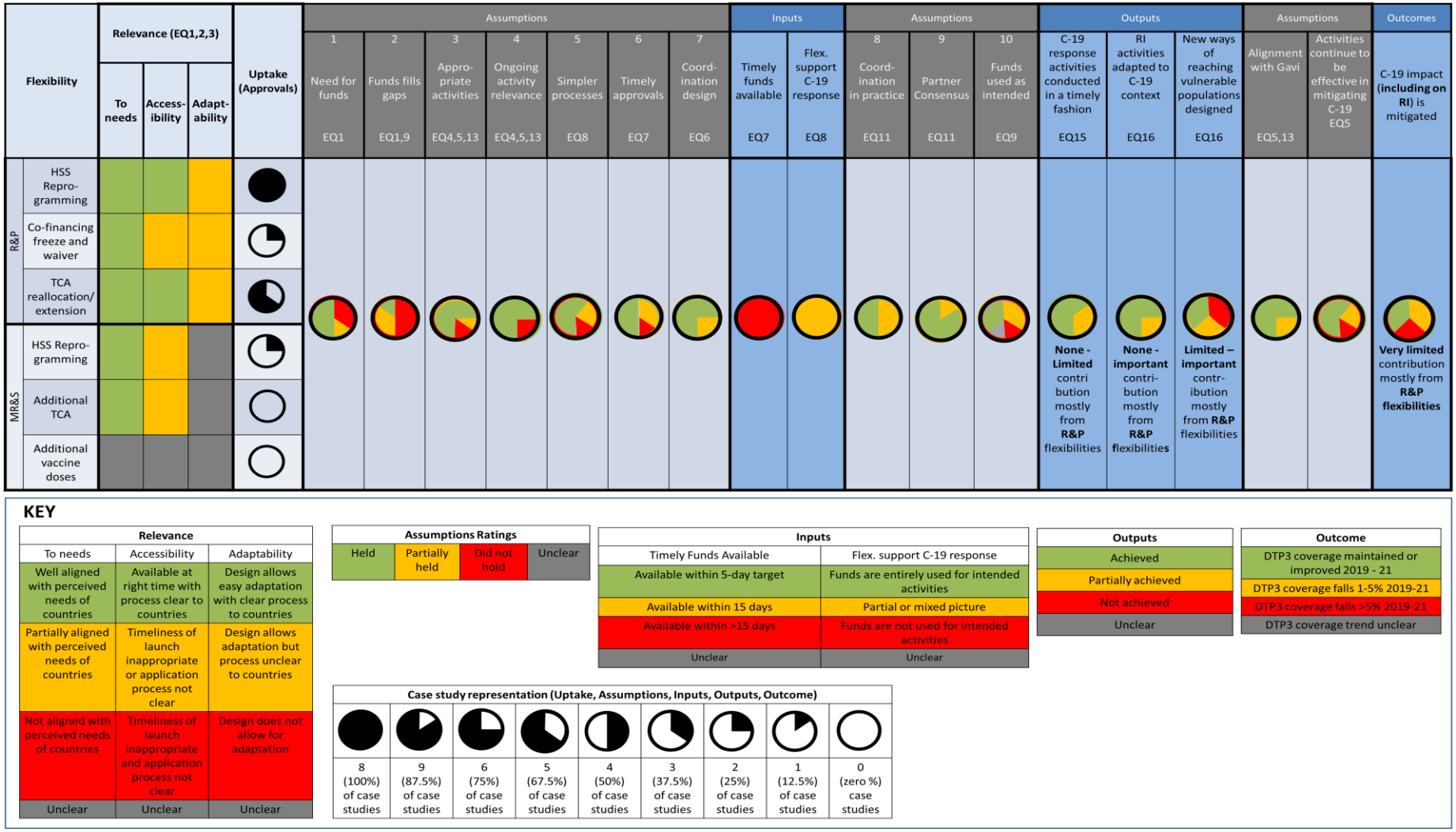
		Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Funding	There is need for additional COVID-19 response funds								
	More appropriate, flexible and/or timely funding is not available from other sources								
Alignment and relevance	Types of activities supported by flexibilities are appropriate								
	Activities remain relevant during period flexibility is offered								
	Alignment between interventions and existing Gavi policies and Goals inc. 5.0								
Coordination	Coordination mechanisms work effectively								
	Consensus among partners/ stakeholders about priority interventions and which of these Gavi should support								
	There is adequate partner coordination to manage and mitigate key implementation risks around supported activities								
Efficiency	Processes for applying for flexibilities are not overly burdensome								
	Flexibilities allow timely release of sufficient funding to countries								
	Countries use funds as intended, aligned with WHO guidance								
Effectiveness	Activities funded are and continue to be effective in mitigating COVID-19								

Our analysis suggests:

- **Assumptions about additional funding/resources being needed completely held only in a minority of cases**. According to our assumption mapping, the need for additional COVID-19 response funds, for example, was not present in at least three out of eight cases. Moreover, the assumption that more appropriate/flexible and/or timely funding were not available from other sources, such as the World Bank and other international or bilateral donors, seem to have completely held in only one case study country (Togo).
- **Assumptions about alignment with Gavi policies and relevance to country needs were those that completely held in most cases**. In at least six of the eight countries, types of activities supported by R&P and M&R&S flexibilities were found to be appropriate and activities remained relevant during the period these flexibilities were offered. Sufficient alignment between interventions and existing Gavi policies and goals held or partially held in all cases but one (Sudan).
- **Assumptions about coordination between different partners completely held in most cases.** Coordination mechanisms were found to be effective in at least four out of eight cases. Adequate partner coordination and consensus among partners/stakeholders among priority interventions was present to some degree in all cases.
- **Assumptions about efficiency completely held in most cases**. While no countries reported processes for applying for R&P and M&R&S as overly burdensome (completely held in all cases but one where it partially held) and all countries used funds as intended, aligned with WHO guidance (six held, two partially held), the assumption about timely release of sufficient funding to the country completely held in only three out of eight cases.
- **Assumptions about effectiveness completely held in most cases**. Activities funded were found to be effective in mitigating COVID-19 to a level that allowed RI/ health services provision to resume/ continue in five out of eight cases (Mozambique, Nigeria, Pakistan, Togo, Uganda).

13.7 Summarizing findings against the Theory of Action

The figure below provides an overview of evidence against the TOA. An overview of key takeaways is provided overleaf.



Key take-aways:

- Flexibilities with the greatest degree of relevance were those with the highest uptake whereas those with lower relevance had limited or no uptake.
- M&R&S flexibilities had very low uptake: This is reflected in their lack of contribution to outputs and outcome.
- Inputs were not achieved as anticipated, which can be attributed to key assumptions failing
    - Timely funds (defined by the 5-day target)
        - the fact that the 5-day target was not met can be attributed to assumptions around simpler processes (Assumption 5) and/or timely approvals (Assumption 6) not holding in seven out of eight countries. The fact that even in Pakistan, this input was not achieved implies that there may have been other underlying assumptions that did not hold.
    - Flexibilities support COVID-19 response
        - the fact that this picture was mixed in all countries can be attributed to the fact that in all countries Assumptions 1, 2, 3, 4 and/or 7 did not always hold.
- Output achievement was mixed, with some achievement despite inputs not being achieved as anticipated:
    - This indicates that while flexibility funding was not as timely as intended, they still supported outputs to some extent.
    - Gavi flexibility contribution to Output 1 (C-19 response activities conducted in a timely fashion) was very low, but this was anticipated to some extent due to the broad and busy stakeholder context within which Gavi was working.
    - Gavi flexibility contribution to Outputs 2 and 3 was variable across countries, and was from R&P flexibilities, rather than M&R&S flexibilities as originally intended in the design of each flexibility stream. Given that R&P flexibilities were not explicitly targeted at these outputs, it is not surprising that the contribution here is variable in line with how each country decided to use the R&P flexibilities accessed.
- Outcome was limited, and Gavi contribution very limited, which was anticipated given the broad stakeholder context.

13.8 Summary of GESI considerations

In agreement with Gavi, GESI considerations have been incorporated into the main report throughout. However, as also agreed, we include below the specific GESI section that was included in previous versions of the evaluation report:

This section covers issues related to GESI that emerged across WS1, 2 and 3. In particular: i) issues related to R&P and M&R&S design and related guidance; ii) the extent to which GESI considerations informed implementation of R&P and M&R&S interventions and iii) impact of R&P and M&R&S on different genders and groups. More detail is provided in Annex 13.8, Vol. II; and some comparison with the World Bank and Global Fund's GESI approach is included in Annex 14, Vol. II.

Headline finding	**Strength of evidence rating**
GESI concerns did not explicitly feature in R&P design and guidance, while it featured strongly in M&R&S design and guidance.	Strong
There are some good examples of GESI concerns informing M&R&S funded interventions but involvement of CSOs and communities could have been stronger. Overall, GESI is often misunderstood, with emphasis being put on MNCH and absence of discrimination and gender transformative approaches examples within M&R&S are scant.	Moderate
R&P impact on GESI has probably been limited. There are however some clear positive examples of M&R&S interventions increasing GESI (with a focus on geographic equity).	Moderate

13.8.1 GESI in R&P and M&R&S design and guidance

Gavi´s revised Gender Policy[56] states that Gavi-funded interventions should: 1) identify and address underlying gender-related barriers faced by caregivers, adolescents and health workers; 2) overcome differences in immunisation coverage between girls and boys; 3) encourage and advocate for women's and girls' full and equal participation in decision-making related to health programmes and wellbeing. The policy also states that gender-transformative approaches will be needed.[57]

GESI concerns did not explicitly feature in R&P design and guidance. The evaluation team reviewed all available guidance and design documents and found that GESI considerations such as, for example, geographic equity, gender related and other barriers to health-seeking and access or the option to procure different sizes of PPEs when applicable, did not feature strongly in the R&P design or production of related guidance. We found one internal document designed to help Gavi country teams review requests for reallocation of HSS grants for COVID-19 response, which mentioned the need to contract gender expertise and translate or adapt materials and language used for different literacy levels, gender sensitivity and to avoid social stigma; this was an encouraged expense under the ´Risk communication and public engagement'[58] area of work.

By contrast, GESI concerns featured strongly in M&R&S design and guidance. According to several documents, equity was at the core of M&R&S design,[59] the assumption being that 'marginalized communities, especially those with large numbers of ZD and under-immunised children, will be most impacted by the pandemic and are at greatest risk of VPDs.' This appears to be borne out by available data. The guidance also noted that they must be a priority in the response.[60] The need for understanding the gender dimension of the pandemic and to tackle gender related barriers in the

[56] Gavi. 2020. Gavi Alliance Gender Policy V.3.0.
[57] Ibid.
[58] Gavi. 2020. COVID-19 Programmatic Considerations
[59] Strategy and implications of COVID-19.pdf
[60] COVID-19 Pandemic Response_An Alliance update.pdf

response was also explicit in available guidance documents.[61,62,63] In particular, a dedicated note was published titled 'Guidance to Address Gender-Related Barriers to Maintain, Restore and Strengthen Immunisation in the Context of COVID-19'.

13.8.2 GESI in implementation practice

There are some good examples of GESI concerns informing M&R&S funded interventions but involvement of CSOs and communities could have been stronger. Evidence from case studies, shows that epidemiological profiles were used to inform the targeting of M&R&S supported activities in a number of cases (e.g., in Kenya, Mozambique,[64] Niger, Pakistan, Sudan and Togo). Enhanced outreach activities have also been carried out to counterbalance barriers based on geography, gender and other factors. In Mozambique, geographic areas most affected by COVID-19, and with low immunisation coverage, were prioritized for the recovery of lost to follow up and unvaccinated children through the intensification of mobile brigades which was supported through routine reprogramming undertaken in 2021. In Nigeria, over 71% of total unimmunised children were located in 145 local government areas (LGAs) across 29 States; the fact that these 145 LGAs were prioritized by the government and partners for the intensification of RI shows strategic focus, in line with GAVI's 5.0 strategy of improving vaccine equity. In Pakistan, the reduction in immunisation uptake was over 50% in slum areas and places dependent on outreach for service delivery. Enhanced outreach activities started at the beginning of June in the most impacted districts, and tailored services were provided and adapted to the needs of under-vaccinated and ZD geographies and communities. Changes in service delivery models to meet their needs included, for example, extending opening hours to evenings and weekends and use of mobile vans.

We were also able to observe examples of integration of RI with other services (e.g., intensified outreach, integrated with nutrition and MCH services, to recover dropouts was carried out in 66 of the 87 Pandemic Preparedness & Response (PPR) priority districts in Nigeria) and of enhanced working with CSOs (e.g., in DRC, Zimbabwe, Malawi and Pakistan), where female CSO mobilizers were used to make house to house visits and extend advocacy regarding immunisation to all children, especially girls). Several stakeholders, however, pointed out that involvement of CSOs and communities in particular could have been stronger, especially in view of the new CSO strategy. We also observed few examples of GESI concerns informing R&P activities, beyond targeting of the most affected areas (e.g., in Togo).

Overall, GESI is often understood as equalling MNCH and absence of discrimination, while gender transformative approaches examples within M&R&S are scant. As corroborated by evidence from the case studies, GESI questions and issues often seem to be understood in terms of 'non-discrimination' or caring for ´mother and children´. More transformative approaches such as for example targeting of fathers to ensure that the burden of getting children immunised does not fall disproportionally on women seem to have been absent.

13.8.3 Impact of R&P and M&R&S on different genders and groups

R&P impact on increasing GESI has probably been limited. Evidence showing the impact of R&P on different genders and groups is fairly limited. Precise data on use and allocation of materials and equipment procured with R&P funds, for example, is scarce. Indications from case studies, however, suggest that impact on increasing GESI has probably been limited.

There are, however, some clear positive examples of M&R&S interventions increasing GESI (with a focus on geographic equity). Examples from case study countries, such as for example

[61] Use of Gavi support to MRS in the context of C-19.pdf
[62] Reaching missed communities in light of COVID_v3.docx
[63] Gavi_Guidance-to-address-gender-barriers-in-MRS-immunisation_ENG.pdf
[64] Using R&P funding and regular bridge funding as opposed to funding obtained through an M&R&R 'official' application

Mozambique[65] and Pakistan, show activities funded by Gavi´s flexibilities likely having a positive impact on GESI (with a focus on geographic equity rather than gender equality) through reaching out to otherwise missed children.

[65] Using R&P funding and regular bridge funding as opposed to funding obtained through an M&R&R 'official' application.

14 Summary of learning from World Bank and The Global Fund experience

We summarise below findings from a high-level exercise to understand how the World Bank and Global Fund (as equivalent, comparable organisations to Gavi) have encountered and tackled similar challenges to those faced by Gavi in its response to COVID-19. These are presented to contextualise Gavi's experience and maximise learning for future action.

Areas of enquiry	GAVI	World Bank (WB)	Global Fund (TGF)
Workstream 1: Right Design, Relevance and Coherence of response			
Total funding available	US$ 200 million for HSS Others unclear	US$ 12 billion	US$ 5 billion
Funding approved: 2020	- HSS reprogramming flexibilities: US$ 76.9 million - Co-financing flexibilities: US$ 28 million	- Fasttrack funding: US$ 1.9 billion	- Reprogramming flexibilities US$ 232 million - C19RM V1.0: US$ 759m - Emergency funding: US$ 46 million
Funding approved: 2021	- M&R&S flexibilities or normal reprogramming? - Support to 41 countries	- From April 2020 through June 2021, $8.4 billion (includes 1,9 above) was committed for 153 operations under the MPA and reprioritized $3.1 billion from the portfolio - to support over 100 countries	- C19RM V2.0: US$ 3.34billion - eventual support to 131 countries
Funding mechanisms	- Reprogramming	- Restructuring existing grants - Use of emergency components in existing grants - Catastrophic deferred drawdown options - New funding IDA/IFC	- Reprogramming savings/portfolio optimisation - New Funding (US government) - Emergency Funding - V 1.0 Emergency mode with little consideration for context, just emergency - V2.0 more emphasis on mitigation of impact on diseases and HSS to prepare for/respond to epi/ pandemics
Funding for preparedness and response activities	- Coordination, planning, and monitoring 1% - Risk communication and community engagement 11%	- Coordination, planning, and monitoring - Risk communication and community engagement	- Coordination, planning, and monitoring 4% - Risk communication and community engagement 6%

Areas of enquiry	GAVI	World Bank (WB)	Global Fund (TGF)
	- Surveillance 10% - Points of entry 5% - Laboratories and diagnostics 9% - Case management 7% - Infection prevention and control 53% - Operational support and logistics 6% - Essential health services and systems/mitigating impact on RI 2%	- Surveillance - Laboratories and diagnostics - Case management - Infection prevention and control - Operational support and logistics - Essential health services and systems/mitigating impact on PHC	- Surveillance 4% - Laboratories and diagnostics 23% - Case management 15% - Infection prevention and control 14% - Operational support and logistics 10% - Essential health services and systems/mitigating impact on ATM 24%
Workstream 2: Right Ways; looking at timeliness, efficiency, coordination of responding to application requests			
Organizational structures	- No specific taskforce as such, but specific team created from existing resources (as described in section 34.2.2.2) - Support coordinated through SCMs	- All global health office staff assigned to work on COVID response, together with Task managers, supported with expert consultants (ICU, oxygen) at global and country level - Establishment of an emergency operating centre - Establishment of functional groups (along pillar lines)	- Initially secretariat staff (mainly GM/A2F) reassigned to special C19 task force, working with FPMs - Later: full functioning C19RM secretariat with additional staff 100, half permanent/other consultants, and still members of TAP, GMD, Risk management - Establishment of functional groups (along pillar lines, but also risk management)
Application review	- SCM and individual experts review	- Task manager and functional group review	- FPM and functional group review; coordinated by C-Tag
Application approval	- SCM prepared reallocation memo after individuals reviewed and cleared it; approval by senior leadership	- Use of established MPAs,[66] initially for COVID response, later for vaccine procurement, allowed for fast-track approval (2 applications initially for Board approval) thereafter all approved by (regional) VP - the Executive Director granted approval of specific waivers and exceptions required to enable the	- C19 investment committee approved based on C-Tag recommendations; chaired by head risk management, including heads of finance, legal, GMD and diseases. - CCMs provided little input into C19 FRs - Approvals <10 days

[66] Multiphase Programmatic Approach (MPA) allows countries to structure a long, large, or complex engagement as a set of smaller linked operations (or phases), under one program.

Areas of enquiry	GAVI	World Bank (WB)	Global Fund (TGF)
		rapid preparation and implementation of country operations processed under this rapid response facility - Approvals within 10 days	
Procurement of PPE **All three agencies witnessed delays in PPE arrival**	- at country level initially but local shortages led them to use UNICEF supply division for most countries, same experience as TGF - Tracking of PPE from UNICEF supply division	- Given the emergency of the situation, procurement was frontloaded to the maximum extent possible according to the availability of medical supplies during the first year of project implementation. - no pool system as countries 'own' the funding - facilitated on behalf of countries with global suppliers - Supplies not tracked	- 60% of C19RM funding was for commodities - V1.0: limited PPM and countries to buy themselves; risk was high ('*several ministers have lost their jobs'*) - V2.0: PPM through UNICEF supply division - PSM unit tracked supplies and deliveries
Monitoring of the epidemic	- No systematic monitoring system in place for either R&P or M&R&S; GPF monitoring was used as a proxy - Waiting for annual data from WUENIC, while local EPI programme data was available if only requested for.	- Country office (provide weekly updates) - Grant quarterly performance reports - (GFF did phone surveys with in-country stakeholders)	- LFAs in country provided bi-weekly updates on the pandemic and ATM disruptions, supply chain and office operations; from end of 2020, became monthly - Quarterly 'sentinel' surveillance system of key ATM indicators in 15 health facilities in 38 HI/HB countries (proven to be similar like regular reports of all facilities) - Normal PUDRs, though submission delays accepted - Also, a waiver for PR to respond monthly on short list of indicators rather than waiting for six monthly LFA/PUDR report - Management executive committee monitored the trends (TB missing cases, HIV prevention, bed net

Areas of enquiry	GAVI	World Bank (WB)	Global Fund (TGF)
			distribution were major concerns); TB had similar symptoms as COVID-19; malaria shared fever symptom with COVID - COVID module integrated in DHIS2 - Successful M&E systems now integrated in normal grant reviews
	- Heads of agencies (WB, GF, WHO, GAVI, FIND, later as part of the ACT-A partnership, and others) met initially weekly to review the global pandemic; no monitoring of duplication. Even at country level, there was no formalized coordination between WB TMs, GF FPMs and GAVI SCMs		
GESI	- No specific GESI considerations in the R&P guidance.	- The overarching MPA guidelines ensure that gender considerations are checked in each of the application. - Senior management reiterated in 2020-21 also that the emphasis of support should be for the poorer populations	- KVP communities and other civil society groups were involved in the C19RM grant designs in most countries. However, several factors such as short timelines, focus of emergency commodity supplies and lack of clear guidelines on eligible activities, reduced their level of participation and the resources allocated for CSS/CRG
Workstream 3: right results; did the response contribute to the right results			
	GAVI's limited input was intended mainly to procure PPE to ensure the safety of health workers and thus ensure the continuation of health services, including immunisation services. However, due to delayed delivery, some of the PPE gaps were already filled by other partners. Secondly, due to non-pharmaceutical interventions, such as lockdowns and travel restrictions, and the focus of EPI staff towards COVID vaccination, routine immunization suffered, as witnessed in the recent WUENIC report 2022. M&R&S funding	- Uptake of the non-commoditized parts of the SPRPs for the countries has been patchy, as government have internal processes to accept and approve loans - The fact that the country is in charge of the funding has led to frustration by other agencies when they had to lock-in their procurement offers and did not know what government would buy from the WB funding (longer decision-making processes).	Despite quick approval, only 55% of C19RM V1.0 spend by Mid 2021 - V2.0 overall integrated into the standard grants

Areas of enquiry	GAVI	World Bank (WB)	Global Fund (TGF)
	was hardly taken up, and normal reprogramming processes refocused GAVI's support to restoring routine immunization services, catch-up campaigns, and addressing zero-dose and remote community strategies as per GAVI 5.0.		

15 Overview of findings, conclusions and recommendations

The following table underlines the link between evidence, conclusions and recommendations.

Table 14: Overview of findings, linking to conclusions and recommendations

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
	WS1			
Relevance	R&P and M&R&S flexibilities were not substantially different from those offered through the existing policies, with the exception of eligibility freezes and funds being eligible to cover PPE. Adaptations were focused on streamlining internal processes to enhance speed and reduce transaction costs and on allowing existing Gavi funds to be used for a wider range of activities, including the general COVID-19 response.		Ultimately, neither Gavi nor its counterparts were well-prepared to respond to a pandemic of this nature, hence the need to develop R&P and M&R&S to protect RI. In the October 2022 PPC papers, Gavi underlines the need to 'quickly mobilize in a worst-case scenario',[i] To this end, Gavi can learn lessons from its initial COVID-19 response in terms of strengthening strategic planning, articulating priorities to support decision making in emergency contexts, and ensuring sufficient capacity at country and Secretariat level.	**Gavi Secretariat should ensure a strategy(ies) are in place for Gavi's role in PPR, which incorporate lessons from COVID-19 and COVAX.** Complement strategy(ies) for Gavi's role in PPR with implementation plans which set out key decision criteria (e.g., on trigger points, conditions in which Gavi will fund outside its CA), roles and responsibilities etc. to ensure Gavi is able to quickly mobilize. This should facilitate upfront discussion with stakeholders to avoid having to address this in the moment of an emergency. Gavi Secretariat should also work with the Board
	GESI considerations did not explicitly feature in the R&P design and guidance, however, they featured more strongly in the M&R&S design and guidance.	There was a clear and compelling rationale for Gavi's initial COVID-19 response: in terms of enabling countries flexible use of existing Gavi funds to support a timely pandemic response. Whilst this entailed going beyond it's core business[67] (albeit with intended purpose to protect frontline vaccinators and therefore RI) it is hard to imagine a scenario where Gavi did nothing to respond,		
	Gavi's rationale for the introduction of R&P and M&R&S was clear and aligned broadly with the perceived key needs. The design of the flexibilities offered under R&P and M&R&S sought to balance these needs against the risks to Gavi's business model and ways of working.			
	R&P flexibilities were used to support activities that were in strong alignment with countries' COVID-19 response plans, and, thus, were well-aligned with the WHO's COVID-19 response pillars.			

[67] Gavi's core business is defined in key documents such as Application Process Guidelines and Programme Funding Guidelines. These set out the types of Gavi support (vaccine support, health system strengthening support, equity accelerator funding, cold chain equipment optimisation platform, and Partner's Engagement Framework – Targeted Country Assistance) and the parameters for this support (service delivery; human resources for health; supply chain; health information systems and monitoring and learning; vaccine preventable disease surveillance; demand generation and community engagement; governance, policy, strategic planning and programme management, health financing). R&P & M&R&S went beyond core business through allowing greater flexibilities in use of Gavi funding – eg for PPE and IPC, and modifications to internal processes to ensure timely access to existing funds. See Annex 9.1 for more detail.

[67] Or indeed that low M&R&S uptake led to drops in RI coverage – which appear to have been due to lockdowns and other contextual factors such as COVAX scale-up.

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
	Generally, from multiple interviews with the Gavi Secretariat and partners, there is a sense that Gavi's tendency to be risk-averse resulted in the design of both R&P and M&R&S being overly focussed on minimising risk, at the expense of the need to maximize responsiveness, adaptability and innovation.	given the potential impact on its strategic goals. Gavi Secretariat staff felt that Gavi did not go further in developing more innovative measures to protect RI because its prevailing culture (in terms of attitude to risk and focus on protecting previous gains) and systems (in terms of decision making and prioritisation,[68] partnership, staff resources) presented obstacles that could not easily be overcome within available time and resources. As noted in conclusion 7, it was also not clear how significant the risk was to RI.	Balancing risk and innovation is challenging, but the concept of 'no regrets' (i.e. the option to take greater risk with acceptance of greater uncertainty on delivery of results) offers a way of exploring, between the Secretariat and Board, and within the Secretariat, risk-appetite in different scenarios if supported with relevant, effective monitoring systems. Use of the 'no regrets' concept for COVAX could offer lessons for future work on RI.	and other governance structures to ensure that there is an aligned understanding of the operational implications of 'no regrets' and this is communicated to all Gavi Secretariat staff and Board members.
Coherence	Gavi's R&P reprogramming was perceived (as intended) to fill key resource gaps, which may not have otherwise been filled in an appropriate timeframe, even though the reprogrammed funds were comparatively small.		Gavi has an important comparative advantage in supporting and advocating for RI,[69] and clear experience in having supported RI-related aspects of PPR (e.g. in terms of responding to outbreaks). It is not clear however that it was a good use of limited Secretariat resources to broaden the remit of targeted RI programming funds to support countries in financing	
	The launch of Gavi's R&P flexibilities was seen as highly relevant in terms of timeliness; however, M&R&S experienced delays, which impacted the timeliness of the offer.			
	Overall, there was a sense that, with the information available at the time, R&P's support for the general COVID-19 response was appropriate, but that, especially with the information now available on the long-term impact on RI,	Whilst some Gavi stakeholders felt that Gavi could have given stronger priority to its core mandate (RI) instead of diverting		

[68] In terms of the consultative, consensus-based style of decision-making within Gavi, and lack of clear signalling on what could be dropped in face of overburden for staff.
[69] See conclusion 1 footnote for description of Gavi's core business.

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
	Gavi should have been focused more explicitly on RI from the start.	to focus on the immediate COVID-19 response, **this was not always practically feasible given country-level constraints to respond to COVID-19 and RI in parallel**.	their broader pandemic response efforts (albeit with intended purpose to protect frontline vaccinators and therefore RI); although Gavi did this for good reason - because other funding sources were expected to take time to reach countries.	
	WS2			
Efficiency	Overall, 81% of the countries eligible to apply for flexibilities (59 of 73) had at least one flexibility approved. Seventeen countries had one flexibility approved, 23 countries had two approved and 15 had three approved. Three countries had four flexibilities approved, and one country (Ethiopia) had five flexibilities approved. Only 14 countries had no flexibilities approved. Eleven of these are currently classified as post-transition, middle-income countries. More countries had flexibilities approved under R&P (58 of 73) than under M&R&S (4 of 73), and there is a high degree of variation in the extent to which countries accessed the funds available through reprogramming (ranging from 8 to 100% and a mean of 39%).	We can conclude, in terms of the primary objective of enabling countries to make quick decisions on reprogramming existing funds, that the R&P flexibilities were a qualified success. It is too early to conclude whether M&R&S will achieve its goals, given a) limited data availability; b) that its implementation is ongoing as it continues to provide a useful framing for Gavi's efforts to refocus on routine immunisation after the initial pandemic response; and c) that evaluation was not tasked to provide a summative judgement on M&R&S.	Experience from R&P and M&R&S suggest Gavi can provide timely access to flexible funding and may therefore have a comparative advantage in this regard, provided that internal processes are efficient and downstream issues (related to disbursement and absorption) are managed to ensure performance in terms of delivery.	
	It has not been possible to identify any reliable data at a portfolio-level that demonstrates how much of the R&P and M&R&S funds were used (absorption), which makes it difficult to assess what the use resulted in and, therefore, what value was added through R&P and M&R&S. However,	Adapting existing Gavi systems was insufficient to ensure uptake of M&R&S and protect RI. Due to a range of factors, including	Addressed through the M&E conclusions	Addressed through the M&E recommendations

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
	in four of the eight case study countries we did find data on the R&P absorption levels (between 3% and 68%, in 2020). It is not possible to provide definitive figures as to the uptake of the M&R&S flexibility. This is due, in part, to the lack of a centralized tracker and a centralized/agreed filing system. No evidence was found to suggest that Gavi intended to track information related to the approvals, use and results related to the M&R&S flexibilities. Within Gavi, R&P enabled a quickening of internal processes, albeit varied in terms of timing, with 5 of 8 case studies approvals happening in less than two weeks. Disbursement delays under R&P limited or slowed absorption and, in several countries, delayed the arrival of PPE.	limited incentives to apply, uptake of M&R&S was low and RI coverage was subsequently seen to have dropped. Available evidence does not allow us to comment on causality i.e., that increasing M&R&S uptake would have mitigated impacts on RI (although that was its goal).[70] However, experience suggests that better incentives to apply, better communication and roll-out of M&R&S and strengthening EPI team capacity could have increased uptake. We also recognize that M&R&S was one part of Gavi's overall COVID-19 response alongside e.g., COVAX, advocacy efforts. Notwithstanding these data challenges, uptake appears to have been low, especially for M&R&S. Initially this was considered acceptable given understanding of COVID-19 impact on RI coverage, but with the publication of WUENIC data in 2022 (which saw the biggest falls in RI coverage for 30 years) the low uptake of M&R&S could be interpreted as a missed opportunity		

[70] Or indeed that low M&R&S uptake led to drops in RI coverage – which appear to have been due to lockdowns and other contextual factors such as COVAX scale-up.

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
	The Gavi Secretariat's working assumption was that establishing a special arrangement with UNICEF for supply of PPE and IPC would lead to efficiencies in procurement in terms of price, timeliness etc and help manage risk associated with alternative contracting options. Observations based on emerging evidence suggest that the Secretariat assumptions were not completely upheld.			
Coordination & partnership	Factors that enabled the uptake of R&P and M&R&S include the following: responsiveness to country needs, fast access to flexible funds and reduced transaction costs for countries.		Based on the country case studies, experience suggests that making additional resources available to countries could help make the investment of time in accessing funds seem worthwhile. This in turn could help countries to maintain focus on RI as well as respond to new threats. From experience with the initial COVID-19 response alone, it is not clear to what extent this would have led to different outcomes in these exceptional circumstances. Based on the experience of Gavi's initial response to COVID-19,[71] efforts to respond to pandemics and maintain RI depend on country capacity (EPI teams). Responding effectively to emergency situations requires partnerships are in place in addition to those required during "normal times". Partnerships	**Board and Gavi Alliance should work with other partners to guarantee a strategy is in place to ensure fast access to additional, flexible funding to support emergency responses from Gavi funding and other sources**. Recognising that access to existing resources was a barrier in some cases, Gavi Secretariat should ensure, including through the recently launched EVOLVE initiative, that countries' access to Gavi funding is not constrained. This should be done through addressing e.g., downstream bottlenecks to disbursement and absorption (such as availability of other donor funds). **Board and Gavi Alliance should review and agree options to ensure adequate capacity can be put in place quickly, when**

[71] which prioritized increased flexibilities for limited funding and not Gavi's full response to pandemics

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
			need to be in place in advance of need, as there are contractual and systems-related issues that can prove time consuming to address.	**needed, to engage in context-specific dialogues with country partners and to respond efficiently to country needs.** Gavi secretariat should ensure SCMs, and EPI teams are adequately resourced to engage with COVID-19 and RI concurrently. **Gavi secretariat should review and ensure a partnership strategy, which identifies the strategic partnerships that are needed (e.g., with private sector or emergency and humanitarian organisations) to provide effective, efficient pandemic preparedness and response.** Gavi secretariat to work with partners identified in the strategy to ensure that partnerships can be activated when needed to enable a rapid Gavi response to emergency or other context-specific needs
	Factors that constrained the uptake of R&P and M&R&S include the following: less need for R&P and M&R&S flexibilities than expected (as COVID-19 had less impact on RI than feared, at least initially, and there was less need for Gavi resources due to inputs from other donors); limited benefit for countries in applying for R&P and M&R&S; timing; and competing priorities.	Low uptake appears to have been linked more to lack of operating capacity in Gavi and country EPI teams than to concerns about the relevance of the flexibilities offered under R&P and M&R&S;		

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
	There are some good examples of GESI considerations informing the M&R&S-funded interventions, but the involvement of CSOs and communities could have been stronger. Overall, GESI is often misunderstood, generally being taken to mean MNCH and the absence of discrimination. As such, the implementation of more transformative approaches was absent.	and, whilst comparable organisations experienced similar challenges, the need for surge capacity (both within the Secretariat and at country-level) is highlighted as a key lesson.[ii]		
	WS3			
M&E	There was no bespoke ToC or M&E framework in place to track the results of R&P and M&R&S interventions. Learning questions and monitoring activities were set out to gather an understanding of COVID-19 impact on RI and the effectiveness of Gavi's initial response. These were only partially implemented. The GPF was chosen as a monitoring framework, despite its inherent limitations. This, and other factors constrained Gavi's ability to monitor performance and the contribution of the initiatives to the results. The chosen approach, while sensible in the context of an unprecedented crisis, limited opportunities for learning and course-correction.	Gavi had limited availability of data on uptake and performance of R&P and M&R&S as a result of its justifiable decisions to reduce transaction costs for countries to allow them to focus on the emergency response. Lack of data in turn prevented Gavi from both systematically reflecting on the appropriateness of its offer and from learning lessons about what worked. Gavi also suffered from lack of timely access to strategic data (in terms of external systems to track effectiveness) which could have helped to respond sooner to the double dip of RI coverage.		**Board and Gavi Alliance should ensure there is a) clear agreement on a minimum set of evidence to enable strategic decision-making in pandemic response (e.g., on RI coverage and performance of interventions); and b) a strategy for how to achieve this including at the level of the Alliance and country partners.** Gavi Secretariat and Alliance should ensure they a) have monitoring systems in place to make available timely data on implementation performance of Gavi support and b) strengthen country information systems (data collection, analysis and sharing) to improve availability of data on relevant RI indicators (see section 8 for details).
Effectiveness	The initiatives implemented under R&P and M&R&S have made some contribution to countries' ability to carry out timely and critical COVID-19 interventions in two of our eight cases, whereas the contribution seems to have been limited in another five cases, and negligible in one.			

	Findings	Conclusions = RI focused	Lessons = PPR focused	Recommendations (strategic)
	The contribution of R&P and M&R&S to countries being able to adapt RI to COVID-19 was rated as important in three out of eight cases, while their contribution to countries' implementation of innovative approaches was rated as important in two out of eight cases.		**Additional, timely funds are key to effective pandemic response because they enable countries to maintain focus on RI as well as responding to new threats**	
	R&P impact on GESI has probably been limited. There are, however, some clear positive examples of M&R&S interventions increasing GESI in relation to geographic equity.		**Efforts to respond to pandemics and maintain RI depend on country capacity (EPI teams) , availability of additional resources and Gavi technical support and advocacy**	
	The assumptions in our ToA about alignment/relevance, efficiency, coordination and effectiveness were maintained in the majority of cases. However, other assumptions about funding and resources were maintained in fewer cases. The assumption regarding the need for additional COVID-19 response funds did not always materialize as expected, as funding seems to have been available from other sources in the majority of the case study countries.	Addressed through other conclusions	Addressed through other lessons	

16 Cross case analysis

Annex	Flexibility	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Region		E&S Africa	E&S Africa	W Africa	W Africa	S Asia	E&S Africa	W Africa	E&S Africa
Type		Priority	Priority	FCAS	HI	HI	FCAS	Priority	Priority
10.11	WHO pillars and R&P flexibilities								
	Uptake of R&P								
10.1 10.4 10.3 10.21 10.22	10% reprogramme HSS: Y/N, amount and % of available accessed, drivers, absorption and drivers	X (1.6M, 68%)	X (2.98M, 100%) Absorption: 3% by Dec 2020, 73% by Dec 2021, and 91% at March 2022.	X (0.568M, 12%)	X (12.255M, 97%)	X (5.47M, 55%) Absorption: 36% by Aug 2020	X (1.56M, 39%)	X (0.379M, 59%) Absorption: 18% by Aug 2020	X (3.1M, 86%) Absorption: 68% (Nov 2020)
	TCA reallocation:	X			X	X		X	X
10.18	TCA NCE (utilisation rates in 2020 UNICEF and WHO)	X UNICEF: 70% WHO: ??	UNICEF: 41% WHO: 0%	X UNICEF: 14% WHO: 53%	X UNICEF: 25% WHO: 34%	X UNICEF: 74% WHO: ??	X UNICEF: 42% WHO: ??	UNICEF: 72% WHO: 53%	X UNICEF: 52% WHO: 73%
10.19	Co-financing 2019					X Partial waiver with full replenishment	X Full waiver partial replenishment		
	Co-financing 2020								
	Eligibility freeze								
	Uptake of M&R&S								
	Reprogramme existing HSS			X				X	
	Reprogramme future HSS 25%								
	Additional TCA CSOs								

Annex	Flexibility	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Region		E&S Africa	E&S Africa	W Africa	W Africa	S Asia	E&S Africa	W Africa	E&S Africa
Type		Priority	Priority	FCAS	HI	HI	FCAS	Priority	Priority
10.24	Approval timelines	Unclear	12 days informal approval from first request, formal approval from updated request to formal approval was 21 days	6 days approval time from updated ARM	12 days approval time from confirmed request to internal Gavi approval. Unclear when Decision letter sent.	Unclear	10 day internal Gavi approval from first request, 2 days internal approval from revised request	R&P: 3 days approval time MRS: 9 days	12 days approval time from request to internal Gavi approval.
10.24	Disbursement record	**2-3** months using funds already in country	**2-3** months. Using PBF funds requiring actual disbursement	**Unclear** disbursement time. Using funds already in country	**Unclear** when disbursed funds arrived with UNICEF Using funds through UNICEF SD special arrangement	Approx. **5 months** Using PBF funds that required disbursement to both WHO and UNICEF	**Unclear** disbursement time. Using funds already in country	R&P 1st request: **Unclear** when disbursement took place. Using PBF funds requiring new disbursement to UNICEF R&P 2nd request: **Unclear** when disbursement took place to UNICEF. Using available funds in country, to UNICEF	**2-3** months for first set of supplies and up to 7 months for the last supplies. Using funds already in country
13.1 13.2	RI trends (DTP3)	2020: -2% 2021: back to 2019%	2020: -9% 2021: -27%	2020: stable 2021: +1%	2020: stable 2021: back to 2019%	2020: -7% 2021: -1%	2020: -3% 2021: -9%	2020: -2% 2021: -1%	2020: -4% 2021: -2%
13.3	Contribution to output 1	**Limited** - support for governance,	**Limited** – only 3% of budget for	**Limited** – mainly support to strengthening	**Some** - Gavi played a facilitating	**Some** - Gavi funded RI-related SOPs,;	**None** – PPE arrived late, funding was	**Limited** – mainly through	**Limited** - supported GoU's Surveillance and Laboratory pillar via test

Annex	Flexibility	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Region		E&S Africa	E&S Africa	W Africa	W Africa	S Asia	E&S Africa	W Africa	E&S Africa
Type		Priority	Priority	FCAS	HI	HI	FCAS	Priority	Priority
		PPE and development of IEC material for health workers. Other donor funding was more substantial	communication has been used (by Dec 2020); eventually 90% was used by March 2022. Gavi did not contribute to the first 2 drivers above	inter-ministerial committees. PPE that had been planned to be procured with Gavi funds via UNICEF did not take place. $143k of reprogrammed Gavi funds were intended for use for communications activity but we saw no evidence of use. Absorption was low (1 KI noted approx. 30% absorbed, not verifiable).	role, training of FHWs,-, PPE arrived only in Q3/4 '20	training and risk comms	small and potentially duplicative	making 5000 screening tests and 6000 swabs available (arrived in Aug 2020) and WHO TA reallocated for IPC and other response activities. The two extractors arrived very late (in April 2022, ie. 1.5 years after approval). Contribution by other partners was more substantial.	kits. Gavi did not contribute to the first 2 drivers above
13.4	Contribution to output 2	**Limited** - Gavi provided (limited) funding for coordination, capacity development for case management, prevention and surveillance, PPE for frontline health workers and support for IEC	**Some** - Additional media campaigns, deployment of mobile brigades at an accelerated pace	**None** - $143k of reprogrammed Gavi funds were intended for use for communications activity but we saw no evidence of use.	**Important** - training and orientation of FHWs; support RI intensification planning; Gavi granted no cost extensions for WHO and UNICEF to support RI intensification planning in	Important - funded RI-related SOPs, training and risk comms Resilient cold chain capacity facilitated the response (especially valuable with MR campaigns and covid vaccination	**Limited** - The PPE supplies arrived late. Other Gavi funding through WHO was not released for a year due to internal processes. Emergency campaign funding was	**Important** - reallocate $ 574,260 of existing HSS funds for support the first vaccine acceleration campaigns in late 2021; Recruitment of consultants for the extension of the urban	**Some** - test kit procurement; supported coverage and equity related activities, including MOV activities.

Annex	Flexibility	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Region		E&S Africa	E&S Africa	W Africa	W Africa	S Asia	E&S Africa	W Africa	E&S Africa
Type		Priority	Priority	FCAS	HI	HI	FCAS	Priority	Priority
		material development and risk communication			underserved communities	being rolled out in close temporal proximity) Gavis previous investments – immunization registers helped identify the children not reached during lockdowns and enable strategies re: how to reach them	released faster	immunisation strategy	
13.5	Contribution to output 3	n/a	n/a	**Limited -** tech support of the Gavi consultant (funded through TCA via JSI/Expertise France) providing useful permanent capacity to MoH; coordination and advocacy with partners for the mobilisation of more resources	**Important** - Gavi financed TA to enable RI integration into polio campaigns, primary care services (IMOP) and latterly integrate RI into covid vaccination campaigns. (PSI-COVID)	**Important** - Intensified outreach (EOA)s to get to unreached pockets, + birth dose initiative, urban health initiative and various NGO innovations such as MIS and GIS related – all principally funded by Gavi	n/a	**Some** - Gavi support to UNICEF for the development of communication strategies (C4D) and community engagement by civil society; Gavi supported performance analysis of health districts the development of a map of these areas of	**Some** - supported ongoing RI programme implementation/coverage and equity related activities, including MOV activities.

Annex	Flexibility	Kenya	Mozambique	Niger	Nigeria	Pakistan	Sudan	Togo	Uganda
Region		E&S Africa	E&S Africa	W Africa	W Africa	S Asia	E&S Africa	W Africa	E&S Africa
Type		Priority	Priority	FCAS	HI	HI	FCAS	Priority	Priority
						and the Pak govt. Gavi also expedited MoUs with new expanded partners and though previous support		vaccine hesitancy	
	Assumptions[72]	2.09	2.75	2.42	2.67	2.58	1.67	2.83	2.58

[i] Gavi's role in a future COVID-19 vaccine programme, Agenda Item 04. Report to the PPC 31 October – 1 November 2022.

[ii] 'Audit of the COVID-19 Response Mechanism 2021' March 2022; Annex 14, Vol.II.

[72] Score shown is an average score across 12 assumptions – where 3 was scored for an assumption that held, 2 for partially held, and 1 for not held.