Gavi PEF TCA Country Assessments

Meta Review

Prepared for: Gavi, the Vaccine Alliance

By: IOD PARC

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Table of Contents

Acronyms and Abbreviations

AEFI	Adverse Event Following Immunisation
CDC	Centres for Disease Control
CHAI	Clinton Health Access Initiative
CHAZ	Churches Health Association of Zambia
cMYP	Country Multi Year Plan
CSO	Civil Society Organisation
DQA	Data Quality Assessment
DRC	Democratic Republic of Congo
EPI	Expanded Programme on Immunization
EVM	Effective Vaccine Management
HPV	Human Papilloma Virus
HSS	Health System Strengthening
JA	Joint Appraisal
KAP	Knowledge, Attitudes and Practice
LMC	Leadership, Management and Coordination
MoH	Ministry of Health
MoU	Memorandum of Understanding
NVI	New Vaccine Introductions
NSIPPS	Nigeria Strategy on Immunization and Primary Health Care Systems Strengthening
PEF	Partners Engagement Framework
PNG	Papua New Guinea
RED/REC	Reach Every District/Reach Every Child
RFP	Request for Proposal
RI	Routine Immunisation
TA	Technical Assistance
TCA	Targeted Country Assistance
ToR	Terms of Reference
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation

Executive Summary

This meta review of PEF TCA in six countries conducted throughout 2019 has generated significant learning, findings and recommendations to strengthen PEF TCA going forward and within the wider context of Gavi 5.0. The table below summarizes key findings and recommendations emerging from a cross-country analysis, which if implemented would contribute to improved PEF-TCA performance and enhanced evaluability. The recommendations can be broken into three groups: those that relate to improving performance and results (1, 2, 3, 4, 5 and 6) those relating to improving processes and sustainability (1, 2, 7, 8, 9 and 10), and those which relate to improved future evaluability (1, 7, 10 and 11), with some recommendations arching across all of these different parts of the PEF TCA system.

Overarching findings/ theme from meta-review	Recommendation
1. Moving from a single year to a multiyear approach to planning and funding TCA The 12-month cycle for TCA funding decisions is fragmented and too short a timescale for addressing key bottlenecks or building strategic approaches which can support sustainable capacity development. This is exacerbated by delays in release of funds during the year. This is a major source of inefficiency (e.g. low burn rates) in the TCA process. The results that can be achieved in year are typically around process and planning, which limits the scope to create incentives around intermediate and final outcomes, functionality of the system and sustainable improvements in performance.	Leverage the effectiveness and sustainability of TCA by situating it within a **multi-year approach to planning, at least 3 years and preferably 5 years**. This would allow partners to plan over 3-5 years, with appropriate break points/trigger mechanisms for Gavi to confirm release of funds. This in turn would allow more efficient and strategic use of funds. In this way, the TCA plans would be more clearly aligned with the planning timescales of the countries through the cMYP process. The multi-year approach would be more consistent with timescales for delivering results (as opposed to activities or outputs).
2. Monitoring of results within a <u>systems</u> approach The approach to measuring results currently focuses either on activities, short term outputs and planning processes or on final outcomes (coverage). Neither of these are directly focused on the intended bottlenecks, which can make most difference to performance. Nor does this confront the fact that results are delivered by the system as a whole, including many key drivers which are only indirectly affected by TCA. TCA does not deliver results on its own, it is intended to be catalytic use of relatively small amounts of funding.	Focus the results monitoring process for TCA around a **limited number of indicators of intermediate outcomes** which directly measure changes in the targeted aspects of functionality within the system. This will simultaneously free partners from micro-management and the burden of reporting on too many indicators, increase their autonomy and flexibility in adjusting activities based on evolving contexts and lessons learned, while ultimately enhancing their accountability to deliver results. These should be located in a clear but simple theory of change that is adapted for the country context and shows how TCA fits within the whole immunisation and health system, as well as other funding windows including Gavi HSS and other donors' relevant investments. Adoption of this and other recommendations would significantly improve the evaluability of PEF-TCA in the future.
3. Moving from a focus on planning to a focus on implementation Much of the current PEF TCA currently focuses on development of plans and strategies and less on supporting their effective implementation. This partly	**Build a greater focus on multi-year and strategic outcomes**. See recommendation (above) on multi-year planning process. Give high priority to working with expanded partners in the private sector with **strong skills in implementation and delivery**. In some countries these have already

Overarching findings/ theme from meta-review	Recommendation
reflects the annuality of the PEF TCA funding decisions and the way the JA process works. The SCM role is one which is very involved at the point of engagement in identifying TCA priorities, and partners to meet the country needs, but less involved in the implementation other than monitoring the self-reporting on milestones (activities and finances) in the One TA plans.	been engaged e.g. Solena in Nigeria, Acasus in DRC and Ethiopia. SCMs to be more involved in monitoring and providing **feedback** to partners about their implementation throughout the cycle of activity, but at least on a 6 monthly basis, and sharing of learning on implementation between partners.
4. Working at subnational level TCA initially has tended to focus at national level. In most countries, a good start has now been made on working at regional, state and local level, including use of pilots in targeted areas, but it has not yet been fully developed or taken to scale. This is particularly important in all countries because of: - the need to target specific regions and districts where under-immunisation is most acute (by percentage and absolute number of children) - the implementation and delivery issues are typically most pronounced at local level rather than national and the solutions need to address the bottlenecks where they exist	Give greater and specific **priority to TCA aimed at bottlenecks at subnational level.** This can be done by building on the progress already made e.g. on state level entry points in Nigeria, district level pilots in Ethiopia, but making this the overriding priority. It will require a strategic approach to building linkages with organisations that have a comparative advantage and presence at local level (see below on selection of TCA partners).
5. Selection of TCA partners The intended shift in TCA, to using expanded partners who can add value and provide innovative solutions in addressing specific bottlenecks, has so far been quite limited. While the JA process has improved transparency and inclusiveness for identifying priorities, there is no obvious or transparent link between results achieved/performance and decisions on TCA funding – many partners and government counterparts are confused about how such decisions are taken by Gavi**.** Decisions on allocating TCA funds are clearly a sensitive issue, given the membership of the Gavi alliance and the ongoing changes in other areas e.g. ramp down of polio funding. On the other hand, there can only be limited willingness of expanded partners to continue to engage in processes which do not lead to shifts in resources, while the puzzlements and frustration of national governments in how this works was also evident.	**Partners should be selected on merit,** based on their **comparative advantage** and proven past performance in delivering results against specific bottlenecks and their capacity for offering a strategic, innovative approach to delivering the intended results in future. **A much greater level of contestability should be built into the selection process** to ensure better value for money, including for example: - use of performance-based budgeting so that resources are allocated according to results achieved - applying the RFP selection principles both for core and expanded partners on a level playing field - separating the process of identifying priorities within the JA (which should be inclusive) from the selection process of TCA partners (which should be transparent and fair but at arm's length)
6. Relevance of TCA TCA is addressing issues which are central to improving coverage in most aspects. It is potentially a highly relevant instrument which can be catalytic. However, there are gaps in certain areas.	Further strengthen relevance by **increasing the focus on the following areas** which are currently not getting as much attention as they deserve: - Demand generation**.** This involves working with local organisations including CSOs

Overarching findings/ theme from meta-review	Recommendation
	- Public financial management, to ensure resources actually reach the service delivery level - Core results-based management skills at national, regional, and district levels focused on driving measurable increases in coverage
7. Quality and impact of TCA The country assessments have identified various examples of TCA which appear to be directly addressing identified bottlenecks and have a good likelihood of supporting improvements in coverage and equity. This provides some confidence that TCA can deliver impact, however, this is not consistent. In most cases the likely quality and impact of TCA is not clear, either because the monitoring processes are not assessing outcomes so no evidence is produced, or because partners are using a 'business as usual' approach which has limited innovation and not managed to catalyse change e.g. on data quality.	Improve **incentives for quality and impact** of TCA by - Shifting the focus of monitoring towards assessing directly the intended effects of TCA within a systems approach (see below on monitoring of results within a systems approach) - Focusing on the management and implementation aspects within the delivery chain, particularly at local level (see below on working at subnational level) - Taking steps towards increased transparency and contestability in allocation of TCA funding and linking to results (see below on selection of TCA partners)
8. Adapting TCA modalities to context – a wider range of instruments Up to now much of the discussion around TCA modalities has been an unhelpful debate about the merits of embedded TA versus short-term consultancy. This polarisation is not useful and no single modality is effective in every setting, nor will it work unless designed with intent and effective measurement of results around capacity building. There was a clear view from many respondents that TA modalities need to be adapted to the context, especially to the capacity of the government partners, the setting and the geography. The range of TA modalities currently being used is quite narrow.	Develop a **wider approach to TCA modalities,** piloting and testing and making deliberate and clear choices of modality to suit the context. - Gap-filling approaches may be essential in certain contexts where existing capacity is weak - Use of short-term consultants can be useful for targeted, specific needs. - A more strategic and purposeful approach to capacity building (backed up by clear approaches to skills transfer and measurement) is required in other settings. - Embedding TA can be an effective approach in some settings but needs to take account of whether specific issues (e.g. differences in pay levels with local staff) are undermining their effectiveness, and proximity to embedded staff is no guarantee skills will transfer, therefore clear setting of measurable capacity development targets need to accompany this. - The intended results of TA should be set out in terms of reference and monitored. - Consider alternative capacity enhancement modalities including remote training/learning, coaching/mentoring, secondments and exchanges, etc.
9. Sustainability of TCA In the countries considered, graduation and exit from Gavi funding are key priorities within the next 5-10 years. Despite this, 'the urgent is consistently driving out the important'. A more sequenced and long-term approach is a major gap. Against this background, the degree of clarity over how PEF TCA is intended to catalyse sustained	Articulate much more **strongly and clearly how sustainability is to be achieved,** linking it to the multi-year approach set out above. This would include for example: - Building capacity of national partners - Explicit modalities aimed at skills transfer, backed up by measurement of capacity building - A greater role for CSOs at national level and organisations that are able to mobilise resources

Overarching findings/ theme from meta-review	Recommendation
increased in coverage and equity is very limited, as opposed to simply targeting urgent bottlenecks in the short term (12-18 months).	- Clear phased exit plan, with core competencies to be transferred by specific dates The focus on measurement of skills and competencies will also enhance PEF-TCA evaluability.
10. Coordination processes – are they providing sufficient scope for accountability and learning? The standard coordination processes exist in all 6 countries considered (e.g. ICC, taskforces, working groups, NITAG) but they are not necessarily optimal in the sense of creating the space for regular, effective interactions which are leading to high quality discussions and decisions. The JA process currently mainly focuses on an annual discussion (at least in the 6 countries considered here). This limits accountability, although in principle it should be possible to have an effective process of in-year mutual accountability and peer review to strengthen accountability. Within the current process, there is limited scope for strategic learning built into TCA. The space for such discussions is severely limited by several factors including EPI capacity to engage (e.g. Zambia, Ethiopia), weak incentives	Consider best practice in other TCA countries to identify mechanisms for **effective peer review and TCA coordination in between JA processes**. If a Multi-year approach is taken to TCA funding allocation, ongoing reviews, in addition to the JA, will need to occur, for example monitoring of performance of partners and feedback mechanisms. Identification of opportunities for regular strategic learning, between partners in country, but also for South-South learning. Alignment of TCA planning and implementation with cMYP and meaningful coordination with national governments EPI teams to ensure activities and coordination are based around country needs to avoid duplication of systems and processes. Greater knowledge of, and harmonisation with, other technical assistance (regardless of who is funding it), as well as knowledge of immunisation-supportive work in the broader health systems strengthening space to increase the catalytic potential of TCA and avoid duplication of effort.
11. Independent evaluation of TCA The evaluability of TCA remains a challenge for reasons picked up in earlier work - There are limited data/building blocks to draw on during the process of country assessment. - The bandwidth to engage in the evaluation process because of the relatively small scale of TCA within the overall system, although against that constraint there has been a strong response by many of the partners to the process. SCMs have limited time to engage and many other pressures on their time. Their incentives to support the process are weak and the commenting and follow up process has been inadequate. - The intended mechanisms for achieving results (theory of change) have not been agreed or articulated clearly enough, in relation to other Gavi funding flows, system level interactions and sustainability.	Reconsider how TCA should be evaluated to make optimal use of available resources: - Further evaluation of TCA should only be undertaken **after intended models of TCA** have been well articulated and results systems have been sufficiently strengthened to provide **usable data and building blocks** on outcomes - Instead of evaluating TCA individually as an instrument, consider whether there is merit for it to be evaluated as **part of a more holistic approach to evaluation of the immunisation system**. - Set out **clear rules of the game for engagement** by Gavi staff during the process including expectations around commenting and follow up on recommendations. - Clarify to PEF-TCA providers that **independently evaluated performance on a periodic basis** will feed into decisions on budget and portfolio allocations for subsequent years' TCA. Without clear positive financial incentives for performance that are independently monitored, core partners are less likely to move beyond "business as usual."

The final section of this report sets out the practical and implementation considerations of these recommendations for Gavi 5.0, summarised in the diagrams below[1].

[1] These diagrams will be updated and refined, but represents early conceptual thinking of how a new multi-year PEF TCA cycle might look in practice

Figure 1: Current PEF TCA cycle of activity

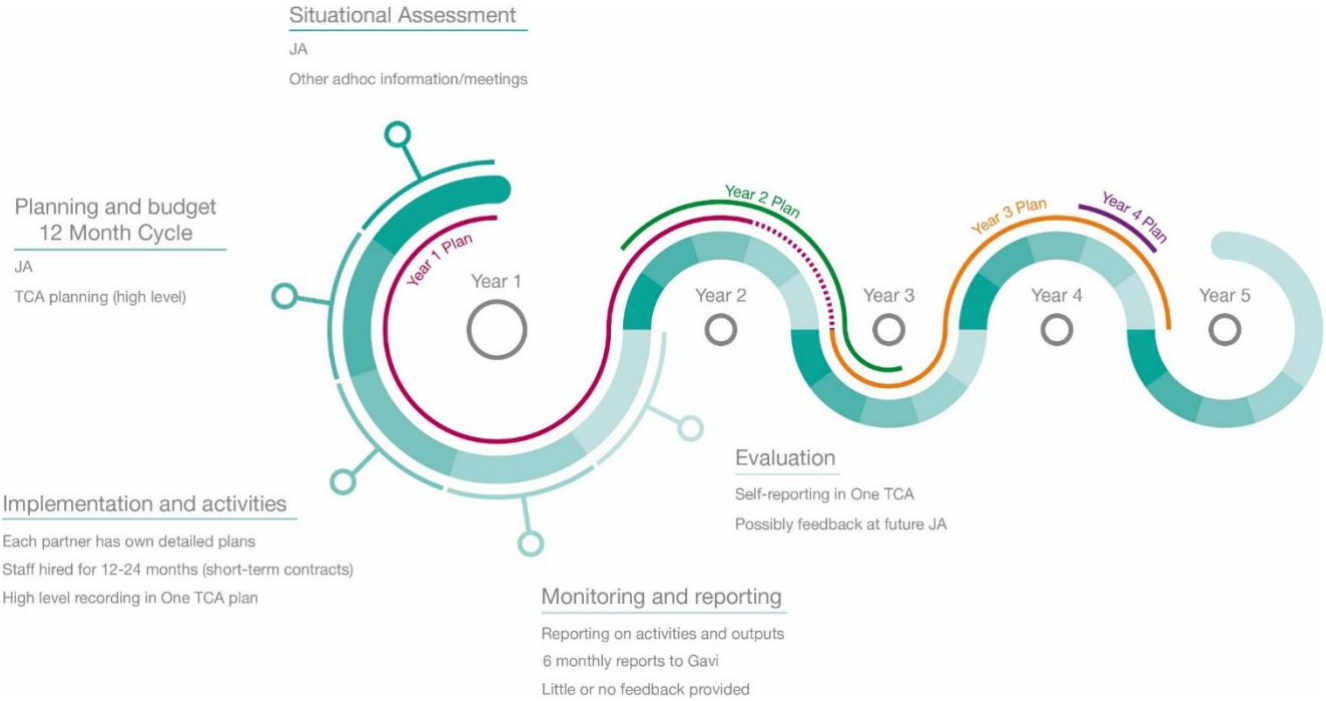
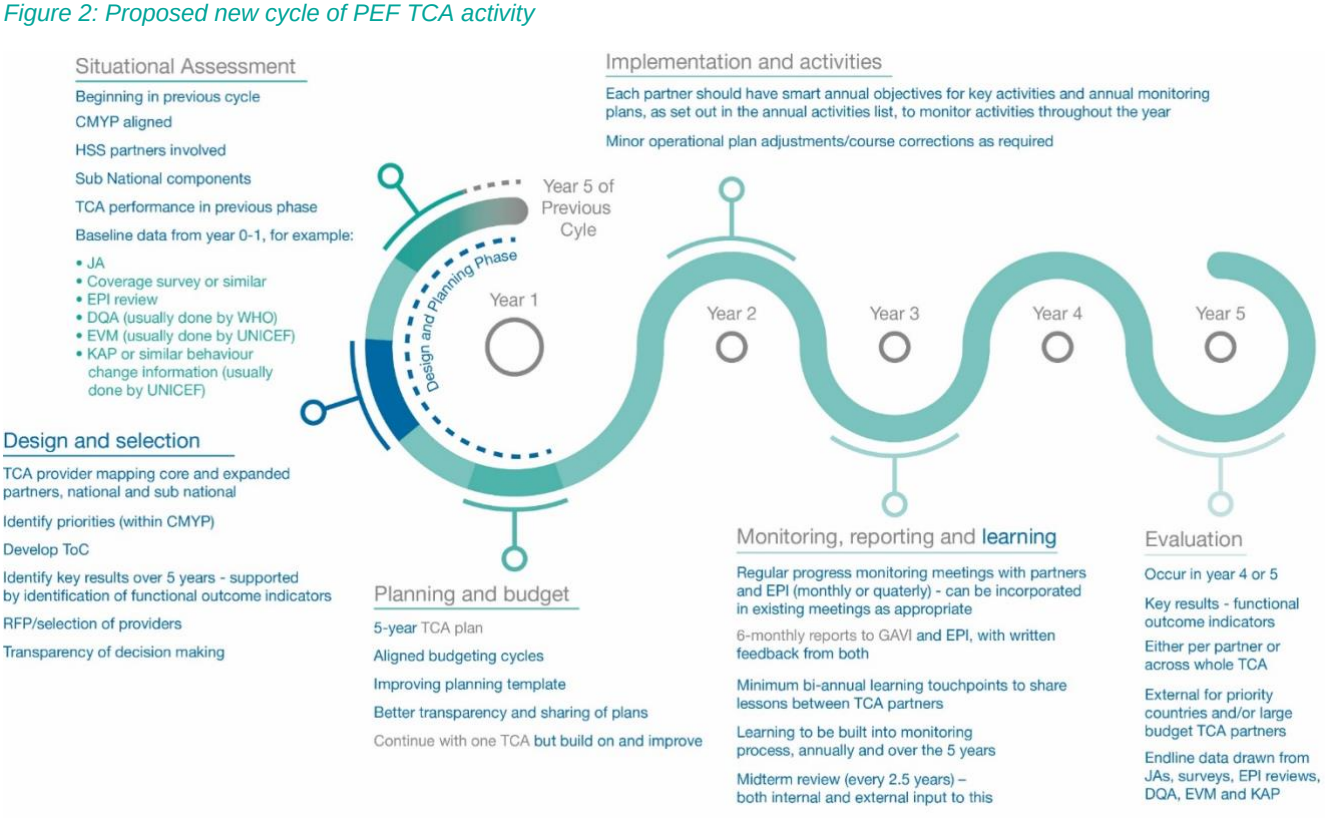


Figure 2: Proposed new cycle of PEF TCA activity



Introduction

Context

Gavi adopted the Partners' Engagement Framework (PEF) in 2016 as a new strategic approach for delivering "requisite normative guidance and technical assistance (TA) to countries in alignment with the new Alliance focus on continuing new vaccine roll out, and accelerating equitable and sustainable coverage of immunisation".[2] The PEF is the new way of planning, funding, operationalising and monitoring technical assistance to countries, by leveraging the comparative strength of partners, both existing and new, as well as funding activities of core partners for setting global norms and standards in immunisation. Through this framework, Targeted Country Assistance (TCA) - technical assistance tailored to country needs - is the most distinctive feature of PEF and accounts for the largest share of PEF funding.

Following the evaluation process of PEF-TCA which commenced in 2016, led by Deloitte, the Gavi Evaluation Advisory Committee requested an evaluation assessment to:

- Take stock of the lessons learned so far and assess if the PEF-TCA program can be evaluated, given identified gaps during the first phase
- Consider how any gaps could be addressed
- Provide options and recommendations for evaluation design in the next stage

IOD PARC conducted this evaluability assessment, which raised many similar issues in Deloitte's earlier work, for example the lack of a Theory of Change (ToC) means it difficult to measure results. However, the time between the two evaluability assessments meant that greater evidence had been generated through the bedding in and evolution of the Joint Appraisal (JA) process. The methodology therefore proposed was to pilot bottom up approach with two pilot country visits, and a further four country visits, the outcome of which generated some consistent and important message across all six countries, consolidated in this meta review and its recommendations. The recommendations reflect some of the initial evaluability challenges as well as new suggestions to improve not just the performance and results of PEF TCA, but it's processes, sustainability and future evaluability.

Purpose and Objectives

The purpose of the six individual country assessments[3] was to:

- Investigate the quality, efficiency and effectiveness of technical Assistance (TA) within the context of the PEF-TCA and country priorities
- Identify factors which have constrained or enhanced the achievement of results
- Make recommendations on how the TA provided can be strengthened (including shifts of activities, roles of different partners, model of TA etc.)
- Identify how M&E and data sources can be strengthened to enable Gavi and partners to measure performance and strengthen interventions based on emerging lessons and good practice.

While the objective of this meta review, based upon the synthesis of the country assessments, is to:

- Provide Gavi with global and country level recommendations to strengthen management of PEF TCA going forward

[2] GAVI Partners' Engagement Framework and Alliance Accountability Framework. Report to the Board, June 2016, p. 1.
[3] Terms of Reference are attached at Annex 1

- Provide country and global level recommendations relating to relevance, efficiency, effectiveness and sustainability, with specific recommendations on improvements to the monitoring of results, impact and quality
- Outline how these recommendations can support and enable Gavi 5.0.

Approach and Methodology

At the start of 2019 two pilot visits were taken to Zambia and Myanmar, following these visits further countries to visit were identified in consultation with Gavi, with country selection based on practical and timing issues, while seeking to ensure a mix of tier 1 and tier 2 countries, as well as different country contexts including fragile states. Following the pilot visits the methodology and data collection tools were refined to ensure the methodology and processes for the further four country visits to Democratic Republic of Congo (DRC), Nigeria, Papua New Guinea (PNG) and Ethiopia, were robust and inclusive as possible, details on data collection are set out in Annex 2. At the end of each country visit IOD Parc presented the preliminary findings in an exit briefing in order to begin to collect feedback from in-country stakeholders, while each country report underwent a commenting and review process from Gavi, and country partners where appropriate.

Once the country visits were completed the team held a two-day analysis workshop to identify additional strategic and structural issues emerging from across all of the country visits. These initial findings and recommendations were shared with the Gavi PEF team for feedback, in order to produce this report and its recommendations.

Limitations

Each country assessment had limitations associated with the operating context, time frames, access to information/ data, or unique country circumstances, and these are noted in each country report.

With regard to this meta-review a key limitation is the number of countries which were assessed; however, the intention is not to provide every country with a tailored review, but to draw common findings, lessons and recommendations from across multiple different country contexts. Additionally, even although that even sub-national TA is a significant theme of importance, time constraints meant that country evaluations were generally conducted at the national level and we were not able to consult with or directly observe TA at sub-national levels.

An overarching limitation for every country assessment, and also for this meta review is the lack of a Theory of Change for PEF TCA either at country level, or at the global level. It is also important to note that PEF TCA in its current format has only been operating since 2016, and has been continually evolving, therefore this report represents snapshot in time, and a continuation of the development of PEF TCA, building on learning from the programme as well as from this evaluation. Nevertheless, a number of recommendations are proposed that would address some of the limitations mentioned, thereby enhancing the future evaluability of PEF-TCA.

Findings

Summary of cross cutting findings from the 2019 Assessments

Overall there is good alignment between TCA priorities and country priorities, as demonstrated through the Joint Appraisal process in each country, although twelve-month funding cycles and lack of strategic direction in prioritizing funding activity and impact remain an issue. There has gradual improvement in quality of annual TCA plans and milestones through the development of One TA plans, although they remain output orientated rather than results focused. There is evidence of strengthened government ownership in some countries, and work on leadership management to continue this work. These findings are summarized in Figure 1 below, with detailed findings and recommendations for each individual country assessment set out in Annex 3.

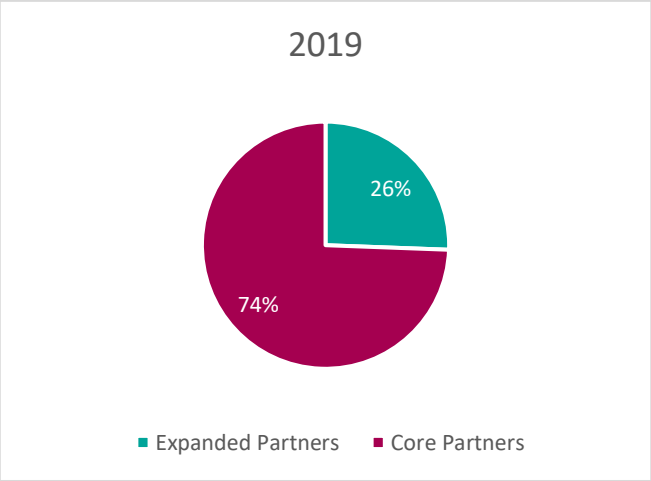
Figure 1: Cross cutting country findings

Finding	Zambia	Myanmar	DRC	Nigeria	PNG	Ethiopia
An annual cycle is too short for delivering sustainable change	✓	✓	✓	✓	✓	✓
Measurement of results is focused on activities and outputs, not results and impact	✓	✓	✓	✓	✓	✓
A lack of overarching strategic vision to guide prioritisation of funding decisions	✓	✓	X	✓	✓	✓
The quality of TCA is hard to measure and lacks consistency of approach	✓	✓	✓	✓	✓	✓
Coordination processes exist, but are not optimal	✓	✓	✓	✓	✓	✓
Positive changes in funding to expanded partners (Figure 2 below)	✓	X	✓	X	X	✓
A move to working at sub national levels, where many bottlenecks exist is evident	✓	X	✓	X	X	✓
Evaluation of TCA could be improved	✓	✓	✓	✓	✓	✓

Split of TCA funding in six assessed countries in 2019

There have been some significant changes in funding flows to expanded partners, who in some cases have a stronger comparative advantage in working at sub national levels and are therefore better able to address key bottlenecks in the immunisation system. However, the split of funding between core and expanded partners across all six countries, illustrated in Figure 2 below, shows that although some progress is being made in diversifying funding, the majority of TCA funding still goes to core partners. However, this varies significantly across countries with, for example 60% of TCA funding in Zambia being allocated to expanded partners, with no TCA funding going to expanded partners in PNG in 2019. A breakdown of TCA funding allocation for each country, and partner, from 2018-2019 is detailed in Annex 4.

Figure 2: Average split of TCA funding across all six countries in 2019 between core and expanded partners



Challenges in measuring TCA results and impacts

In all of the countries assessed there was no explicit Theory of Change, making it difficult to assess both the realism of the impact pathways and whether or not PEF-TCA providers were delivering the outputs, outcomes, and impacts that align with those pathways. The lack of a clear Theory of Change also meant that there was often a paucity of SMART[4] indicators which could be assessed from baseline to endline in order to assess the impacts of PEF-TCA. In many countries, delivery of activities and outputs does not closely correlate with changes in immunisation coverage, due to factors both within the control of PEF-TCA provider (relevance and quality of deliverables) as well as external factors beyond their control (data quality and wider health system issues). Self-reporting by partners against activities and outputs can sometimes be problematic, with a relatively high number of activities being listed as “in progress” even when they are significantly delayed, however, the bias towards positive self-reporting is not unique to PEF-TCA providers.

Similarly, national-level coverage and equity are also subject to a number of external factors, and it is therefore not possible to attribute improvements (or declines) in this measure to effective (or ineffective) PEF-TCA delivery. Moreover, in many of the countries assessed, the quality of administrative coverage data is highly problematic with significant gaps between reported administrative data and coverage survey results, and many equity-related indicators – particularly those related to gender, ethnicity, poverty, and other non-geographic factors – are only available on an irregular basis when surveys are conducted making these statistics even less useful in assessing the performance of PEF-TCA. Indicators more closely associated with system capacity – the main

[4] Indicators which are Specific, Measurable, Achievable, Realistic and Time bound

focus of PEF-TCA – are available for some immunization pillars such as supply chain (EVM) and data (DQA), and impact-level (coverage surveys) but these are not currently aligned with the PEF-TCA cycle, limiting their usefulness in evaluability.

Finally, there was a lack of agreement on the purpose of PEF-TCA. Some respondents focused primarily on the delivery of activities and outputs; some referred to the gap-filling reality in very low-capacity contexts; while a small number of respondents articulated the impact in terms of capacity development at either the individual level (skills) or institutional level (capacities). In virtually all cases, it was noted that the current annual planning cycle of PEF-TCA does not incentivize a focus on sustainable capacity development, which is viewed as a medium- to long-term endeavor in these challenging contexts.

Relevance and alignment

Prioritisation

In the majority of the assessments the content of the PEF-TCA was found to be broadly relevant and well aligned to the identification of priorities within the most recent Joint Appraisal or similar exercise. This alignment appeared to increase over the time period reviewed, particularly as both the JA formats and the PEF-TCA planning/reporting tools evolved to become more specific with regards to technical assistance issues, for example in Zambia all partners interviewed felt that the JA process had improved each year and was allowing for a better understanding of the key issues, particularly bottlenecks at the sub-national level. While in theory the Expanded Programme on Immunisation (EPI) unit of each national government should be playing a driving role in the prioritisation, and alignment, process, in reality most EPI units are understaffed and under resourced.

While a small number of issues may not have received requisite attention (such as Demand Promotion), the overall picture suggests that PEF-TCA providers were active across the major priority themes of concern in all countries. While covering all issues, in several countries (DRC, PNG, Zambia) concern was expressed that TCA was *too comprehensive,* i.e. that it attempted to cover all issues with limited resources, resulting in a fragmentation of efforts and lack of prioritization. While almost every immunisation activity could be included under cMYP plans PEF TCA funds are limited in nature and intended to be catalytic and unblock bottlenecks and address key challenges, not have a ‘scatter gun approach’ to funding prioritisation.

Planning and coordination

A number of planning and coordination mechanisms were found to exist in the six countries assessed to support prioritisation and alignment, not least the Joint Appraisal process. However, challenges still exist in the following areas of alignment and harmonisation:

- Alignment with government through the cMYP and other strategies as well as with leadership of the EPI team through the JA process, varied significantly across the different countries: Gavi’s alignment with government timescales, as well as the capacity of the EPI team being constraining factors.
- Alignment with other PEF TCA providers was varied, in some countries (Myanmar, DRC, Ethiopia) there was evidence of alignment, however, this was more challenging in other contexts illustrating a lack of effective and ongoing information sharing between PEF TCA implementers on the ground, at national and sub-national levels.

- With regard to the capacity of PEF-TCA partners to agree on common/shared methods and approaches we found relatively little evidence that positive innovations pioneered by one TCA actor were taken up by others.
- While there were clearly attempts made to align TA with the content and focus of Gavi HSS funding, the significant delays and suspensions in funding disbursement (in some countries) meant that there were some cases where TA and other support were poorly aligned. It was clear that in most countries there was a lack of clarity on the linkages between HSS and TCA and that Gavi need to do more to communicate and clarify this.
- There was also very weak coordination with other donors who were working in the immunisation landscape, despite the fact that other donors' investments were in some cases much larger with significant implications for immunisation outcomes.

Efficiency and effectiveness

TCA modalities

While multiple TCA modalities exist, it was noted in a number of countries that Leadership, Management and Coordination (LMC) support to government and the EPI team in particular is a necessary condition for other technical activities to be effective – i.e. if the core management skills are not there, all the technical enhancements in the world won't result in more vaccinated children. Related to this is the importance of embedded TA –in almost every country there were examples of embedded TA in the EPI unit, either from staff (often from WHO or short/ long term consultants). However, there was little evidence of how this type of TCA support is monitored in terms of outputs, and what success looks like. It is often assumed (and not just by PEF TCA funding) that by embedding experts to work with national civil servants that knowledge transfer will happen as a matter of course, simply by working together. Additionally, national governments and EPI teams are often significantly under resourced and staffed so embedded staff end up 'gap filling', rather than building the capacity of the government staff. That is not to say that in some high resource constrained environments, or in emergency situations that gap filling, or the use of short term consultants, may not be required or necessary, but that TCA modalities should be deliberately chosen to meet the country specific needs. In the allocation and monitoring of funding Gavi should be clear in each TCA modality used, and if staff are embedded to support specific activities then that should be stated, if they are to build specific capacities then that that too should be stated, and appropriately monitored to determine what capacity has been built, in whom, how, and by what timescale.

Working at the Sub National Level

Another issue that came up in almost every country context with regard to both efficiency and effectiveness was that of working at the sub national level. Significant blockages and challenges in reaching under immunised populations exist not just at the national level but are particularly challenging at the sub national level. It is here where children are actually vaccinated, and hard to reach populations either in rural areas, previous conflict zones, or urban slums, risk slipping through the net. The reasons for this are multiple and include issues with supply chain, access to trained health care staff or lack of demand promotion and communication. While some of the countries assessed have expanded partners who are delivering TCA at sub national levels, sometimes down to district level where they have a comparative to do so for example DRC, Ethiopia and Zambia, these are at early stages and need to go further. Other countries are starting to consider how to engage more at the sub national level, but there is still some way to go. Part of the problem lies in the split of funding which is more likely to be allocated to core partners than to expanded partners, as outlined in Figure 2 above. Given that in many cases expanded partners have a comparative advantage in

working at the sub-national level, this default allocation of resources to core partners creates a barrier to the further intensification of sub-national TA.

Partner Selection

It was also noted that there are currently few incentives for cost-effectiveness built into the PEF TCA system. While the Secretariat has in some cases revised or requested changes to proposed PEF TCA plans (usually when they exceed the allotted budgetary envelopes), core partners in particular are virtually guaranteed to receive continued funding regardless of how cost-effective they have been. There was little sense that core partners have a strong incentive to address relatively high cost structures or to be innovative in identifying ways to deliver support efficiently. This was contrasted with the situation of expanded partners, who faced a number of contractual requirements that created pressure to deliver on time and on budget in order to attempt to received renewed funding in subsequent years (and indeed, several expanded partners' contracts were not renewed, for various reasons).

Results & Impact

Evidence on results and impact was mixed, with the lack of a ToC or results orientated monitoring system making it difficult to assess what results had been achieved and what the impact of this was, as such:

- Clearer evidence on results would require better data and a well-developed theory of change on how TA is intended to deliver results or build capacity. Even if these were available it would not be straightforward to unpick the effects of TA, given the complexity of the landscape for Routine Immunisation (RI) and health system more widely
- It is not easy to attribute changes in immunisation coverage in any rigorous or reliable way to catalytic role of TA, though it may well have contributed
- TCA plans need to move beyond the numbers and focus more on outcomes, impact and results. A shift to performance-based financing and a results-based approach, linking resources and effort to outcomes and impact, would allow partners to focus more on high-level change.
- There are some clear examples of results, but these tend to be in areas such as cold chain improvement which. given the existing monitoring system. means that counting the number of, for example, fridges installed is an easier metric to measure than whether skills have been transferred or individual/ institutional capacity built.
- There have been successful new vaccine introductions in a number of countries but when it comes to more medium- long-term efforts that are about strengthening systems, results are again more difficult to assess. For example, in several countries where introduction of Measles 2nd dose was successful, the subsequent gradual increase in coverage is very slow.

Best Practices

While there were many examples of good practice, good working relationships and high quality, hardworking and dedicated people delivery TCA in every country visited, a few notable examples of innovative and effective practices have been illustrated below. These examples have been chosen for their potential to be scaled up and out more widely, thus giving concrete examples of how to strengthen PEF TCA at the national, regional or district levels. A successful global PEF TCA programme should

be sharing and encouraging the use of peer learning, particularly with regard to hard to reach populations and challenging country contexts. Examples of good practice in each of the countries assessed is set out below.

Mashako Plan in DRC

In October 2018, the DRC EPI unit launched the Mashako Plan: an emergency plan to restart routine immunization. The plan covers 9 provinces which were deemed to be particularly vulnerable and are home to approximately half of all children in DRC who have not been fully immunized. The key objective of the plan is to increase immunization coverage by 15 percentage points in 18 months through five activities:

1. Ensuring the permanent availability of vaccines and supplies at the local level;
2. Increasing opportunities for immunisation of children;
3. Regular monitoring of the plan and adaptation of the approach to the results obtained;
4. Verification of activities in the health zones and health districts; and
5. Coordination of EPI actions with the provinces and other Ministry of Health (MoH) programmes

This plan was cited frequently by partners during the assessment team's visit to Kinshasa and has broadly been hailed as a success due to the collaborative, participatory and practical approach to its development. Indeed, unlike previous criticism of the lack of specific prioritisation processes, this plan demonstrated a successful evidence-based planning approach which enabled the partners to align on a narrow set of priority activities and to set realistic targets for implementation, focusing in addressing key bottleneck issues – wherever in the health system they arise.

Cold Chain strengthening in PNG

UNICEF has consistently been supporting cold chain strengthening with one of their major achievements being the refurbishment of the cold chain network in PNG including the replacement of gas- and mains electricity- powered refrigerators with new solar-powered units in 808 facilities. A hybrid solar and wind energy supply for cold chain equipment is currently being trailed. UNICEF is also demonstrating effective coordination between different Gavi funding streams, for example, part of the HSS grant is used to procure cold chain equipment, while TCA provides funding for a cold chain specialist to provide training and capacity building for vaccine management, maintenance and repair to the national Cold Chain team, as well as technicians or health workers in the provinces, where possible, demonstrating support at national, regional and district health post level – wherever in the system support is needed.

Community level work in Zambia

Zambia was one of the countries with more than 60% of its funding allocated to expanded partners and has also shown significant work with national Civil Society Organisations (CSOs). The Zambia Civil Society Immunisation Platform is a good example on leveraging the capacity of partners in the area of communication and advocacy. Funding to the Churches Health Association of Zambia (CHAZ) enabled them to accessed previously hard to reach populations in the country, as well as building the capacity of national CSOs, increasing the sustainability of immunisation partners more generally – a key issue for countries approaching graduation from Gavi support in particular. This work was considered effective and efficient in improving access, communication and advocacy in hard to reach populations. Interestingly, this technical assistance was in fact funded via the Health Systems Strengthening window rather than PEF-TCA; this highlights the opportunity to better leverage synergies between Gavi funding windows to enhance capacity, particularly at the grassroots level.

Leadership, management and coordination support in Nigeria

There was a necessary hiatus of Gavi's work in Nigeria when attention was for some time diverted to the essential need for agreeing the Accountability Framework and resetting the overall context for Gavi's engagement. Following this the focus was on re-establishing the funding side on a firm footing with clear accountabilities. This took time but the intensive engagement around the Nigeria Strategy on Immunization and Primary Health Care Systems Strengthening (NSIPPS) process and the setting up of the National and State level Emergency Routine Immunisation Coordination Centres were key steps forward, supported by the work of WHO in leadership, management and coordination strengthening with the government. Gavi's engagement in Nigeria demonstrates a strong awareness of efficiencies that could be gained through effective coordination at national and state levels; identification of complementarities and synergies with donors/partners; alignment and harmonisation; and accountability of all stakeholders.

Reach Every District/Reach Every Child in Ethiopia

The micro-planning process as part of the UNICEF Reach Every District/Reach Every Child (RED/REC) approach was widely cited as a successful endeavour. It is a standardised and collaborative approach to developing microplans, either at regional and district level, that works well with strong engagement with local stakeholders. As part of their TCA activities in 2019, PATH supported the development and implementation of the new RED/REC guide which was then used at both national and sub-national levels. The engagement of the community directly in the planning process has also been successful in raising awareness within local communities of the need for immunisation; understanding the local context and challenges and ensuring the microplan is tailored to the context of the region/zone. Social mobilisation teams have also been engaged at the local level to assist in demand generation and in targeting defaulters, which has led to an improvement in coverage and equity.

New Vaccine introduction in Myanmar

There are a number of technical areas where the TCA has been uniformly rated as excellent by the stakeholders interviewed in Myanmar, one of which being the support provided for New Vaccine Introductions (NVI) and the campaigns accompanying them. Most recently, the introduction of Japanese Encephalitis vaccine – which was supported by WHO, UNICEF, (and PATH via non-Gavi funding) – is a good example where the introductory campaign achieved high coverage including in "hard-to-reach" areas. In addition, the speedy support from UNICEF and WHO to respond to an (ultimately non-related) Adverse Event Following Immunisation (AEFI) was credited with minimising the potential negative fallout to the campaign and introduction. Both the technical partners and EPI staff highlighted this as a major success of the 2016-2018 period.

Sustainability

Several factors pose barriers to sustainability:

- The TCA modality itself: the annual funding mechanism limits what can be planned and achieved in just one year, while a common modality - capacity building - is frequently an on-going process that requires multi-annual planning and funding.
- The health system, including immunisation activities and resources is heavily dependent on donor funding.
- TA is more focused on supply side than demand side. In the medium to longer term, both capacity building, community engagement and demand promotion will need to receive greater attention, since improved coverage depends on community awareness of, and willingness to, use services.

- We did not observe any ‘Exit Plans” – formal or informal – which would indicate a clear timeframe and roadmap toward the sustainable transfer of key functions or responsibilities from PEF TCA providers to the government.

It is also important to be realistic about the nature and objectives of PEF TCA. For example, in relatively mature and high-performing health systems that are approaching Gavi graduation it is entirely appropriate to assess to what extent PEF TCA is contributing to the sustainable improvement in the capacity of the EPI and broader health system to deliver immunisations with high levels of coverage and equity. Conversely, in low-capacity contexts that continue to face humanitarian crises, outbreaks, and where coverage remains critically low (and specifically where MOH/EPI structures and staffing are insufficient) it is not realistic to expect PEF-TCA to deliver sustainable improvements in capacity in short-term timeframes. In these cases, a certain amount of “gap-filling” may be appropriate in order to avert serious further deteriorations in coverage, even though in other contexts. These limitations in sustainability cannot be fully laid at the door of PEF TCA providers. As noted above, the timeframes they were given were very short, and sustainability also suffered from factors beyond their control including lack of appropriate counterparts and/or high staff turnover within country EPI and Health Systems generally, and lack of funding in the health system more generally.

Progress by Gavi on issues identified in TCA assessments to date

Gavi to contribute to this section.

Recommendations

Based on the six country assessments, and the analysis of this meta review the recommendations below represent strategic change to the way that PEF TCA is panned, implemented and monitored at the global and the country level. While many of these recommendations build on the recommendations in each country report, when taken together at the macro-level they would represent a significant shift in the current model. In particular, a cross-country analysis of this nature helps to identify structural recommendations that could be applicable across the entire Gavi portfolio, as opposed to country-level 'tweaks' which may not fully address the underlying issues. Examples of this include Recommendations 1, 2, 5, and 11. A macro-level perspective also enables identification of certain patterns that appear across multiple geographies, suggesting the need for greater emphasis, as is the case with Recommendations 4, 6, and 9.

Systems Approach

Taking a systems approach the recommendations can be broken into three groups: those that relate to improving performance and results, those relating to improving processes and sustainability, and those which relate to improved future evaluability, with some recommendations (such as a move to multi-year funding) arching across all of these different parts of the PEF TCA system. While the implementation of each will pose their own unique challenges and benefits, it is important to view them within a systems approach. For example, recommendations that will drive improvement in results relate to working at the sub national level, performance-based allocation and management of resources and working more with relevant expanded partners. While recommendations relating to process and evaluability include a move to multi-year funding, developing a clear Theory of Change, incentives and monitoring to support this and modalities which support sustainability. However, the results and the processes will drive each other - if there is a clear strategic direction from Gavi, with multi-year funding available and regular monitoring of results, as well as a transparent and fair process to allocate funds this should directly enable more expanded partners to apply for TCA funding, and therefore enable PEF TCA (and Gavi more widely) to reach the under immunised children at sub national levels. The recommendations are therefore symbiotic in nature each driving change, and improvement to the system, not simply to individual components of it – this is a key outcome of this meta review.

While this review did not specifically look at how TCA interacts with other Gavi funding streams it is clear that this systems thinking could also be applied to Gavi funding more generally, with clearer linkages made between different funding streams to strengthen Gavi's country facing activities, particularly going forward as Gavi 5.0 is operationalised.

Evaluability of PEF TCA

An overarching recommendation (11), which again will be driven and enabled by the presenting recommendations relates to enhancing the effectiveness of future PEF-TCA, aim to address the significant evaluability issues identified in the previous evaluability study. Developing clear Theories of Change will help clarify the objectives of PEF-TCA in each country – an essential prerequisite for evaluation. Embedded in the Theory of Change would be selected priority indicators, focused on individual skills and immunization system capacities – the targets of PEF-TCA. This will reduce the currently heavy reporting burden and proliferation of unhelpful milestones and indicators. A shift towards the use of 3rd party data (use of tools like coverage surveys, EVM, DQA, and formal 3rd party TCA evaluation) will reduce the biases inherent in self-reported performance by both PEF-TCA providers and low quality country administrative data, especially if these can be aligned with a unified country planning and TCA cycle thereby providing baseline and endline data using existing tools and methods. Adding a more explicit focus on learning, exchange, feedback as core elements of the JA process, and linking performance with future funding will also ensure that this improved evaluability translates into enhanced PEF-TCA effectiveness, thereby completing the cycle of implementation, evaluation, and improvement.

The recommendations

Given the opportunities that Gavi 5.0 realises these recommendations are interrelated and intended to be transformative in nature, and allow PEF TCA to achieve its aims of being catalytic, reaching the most hard to reach populations (and therefore bottlenecks) and crucially that Gavi be able to adequately manage activities and measure results, while allowing space for shared learning and innovation within a sustainable, and evaluable, system.

Recommendation 1: Leverage the effectiveness and sustainability of TCA by situating it within a multi-year approach to planning, at least 3 years and preferably 5 years. Moving from a focus on planning to a focus on implementation. In this way, the TCA plans would be more clearly aligned with the planning timescales of the countries through the cMYP process. The multi-year approach would be more consistent with timescales for delivering results (as opposed to activities or outputs).

Recommendation 2: Develop a Theory of Change for PEF TCA supported by monitoring of results within a systems approach with results monitoring process for TCA focused around a limited number of indicators of intermediate outcomes which directly measure changes in the targeted aspects of functionality within the system. Intermediate outcomes of interest could include a mix of administrative-sourced last-mile operational indicators (number and type of sessions conducted) as well as third party indicators of immunization component performance like EVM and DQA. The role of SCMs should be revised to both support and hold this system to account. The aim would be to monitor the intended results directly at the level of the relevant bottleneck while also providing a clear 'line of sight' from intermediate outcomes to improvements in coverage/equity. Combined with recommendation 1, this should significantly address the current barriers to a more objective evaluation of PEF-TCA performance.

Recommendation 3: Build a greater focus on multi-year and strategic outcomes. See recommendation (above) on multi-year planning process, as part of this give high priority to working with expanded partners, including in the private sector, with strong skills in implementation and delivery. SCMs to be more involved in monitoring and providing feedback to partners about their implementation throughout the cycle of activity, but at least on a 6 monthly basis, with sharing of learning on implementation between partners. Shifting to a 5 year cycle also makes PEF-TCA more "evaluable" because the expected change is more "meaningful" and "measurable" than what can be observed over the current annual cycle. A condition of success for this move to multiyear funding will depend on how collaborative and consultative Gavi is in developing new systems and processes to support this including, for example, applications forms, reporting templates, and considering how to improve speed of disbursement rates. This consultation process should include core and expanded partners to avoid the creation of processes that work against the intention to reach bottlenecks and under immunised, or zero immunised children through working with appropriate partners and levels, as addressed in recommendation 4 and 5 below.

Recommendation 4. Give greater and specific priority to TCA aimed at bottlenecks at subnational level. This will require a strategic approach to building linkages with organisations that have a comparative advantage and presence at local level (see below on selection of TCA partners). There are challenges of working at sub national level, and the voices of those working at this level, including what they perceive to be barriers to working with Gavi at present is an issue which should be given careful attention as the benefits of working at sub national level is clear, and essential, to achieve Gavi's aims going forward.

Recommendation 5: Partners should be selected on merit, based on their comparative advantage and proven past performance in delivering results against specific bottlenecks and their capacity for offering a strategic, innovative approach to delivering the intended results in future. A much greater level of contestability should be built into the selection process to ensure better value for money, for example:

- use of performance-based budgeting so that resources are allocated according to results achieved
- applying the Request for Proposal (RFP) selection principles both for core and expanded partners on a level playing field
- separating the process of identifying priorities within the JA (which should be inclusive) from the selection process of TCA partners (which should be transparent and fair but at arm's length)

Recommendation 6: Further strengthen relevance by increasing the focus on the following areas which are currently not getting as much attention as they deserve:

- Demand generation. This involves working with local organisations including CSOs
- Public financial management, to ensure resources actually reach the service delivery level
- Core results-based management skills at national, regional, and district levels focussed on driving measurable increases in coverage

Recommendation 7: Improve incentives for quality and impact of TCA by:

- Shifting the focus of monitoring towards assessing directly the intended effects of TCA within a systems approach (see below on monitoring of results within a systems approach)
- Focusing on the management and implementation aspects within the delivery chain, particularly at local level (see below on working at subnational level)
- Taking steps towards increased transparency and contestability in allocation of TCA funding and linking to results

Recommendation 8: Develop a wider approach to TCA modalities, piloting and testing and making deliberate and clear choices of modality to suit the context. For example:

- Gap-filling approaches may be essential in certain contexts where existing capacity is weak
- Use of short-term consultants can be useful for targeted, specific needs
- A more strategic and purposeful approach to capacity building (backed up by clear approaches to skills transfer and measurement) is required in other settings
- Embedding TA can be an effective approach in some settings but needs to take account of whether specific issues (e.g. differences in pay levels with local staff) are undermining their effectiveness, and proximity to embedded staff is no guarantee skills will transfer, therefore clear setting of measurable capacity development targets need to accompany this
- The intended results of TA should be set out in terms of reference and monitored

Recommendation 9: Articulate much more strongly and clearly how sustainability is to be achieved, linking it to the multi-year approach set out above. This would include for example:

- Building capacity of national partners
- Explicit modalities aimed at skills transfer, backed up by measurement of institutional capacity building
- A greater role for CSOs at national level and organisations that are able to mobilise resources
- Clear phased exit plan, with core competencies to be transferred by specific dates

While we do recommend taking a more systems-based approach (see Recommendation 11 below), focusing on skills transfer and measurement of institutional capacities embedded in the exit plans will also increase evaluability.

Recommendation 10: Consider best practice in other TCA countries to identify mechanisms for effective peer review and TCA coordination in between JA processes. If a Multi-year approach is taken to TCA funding allocation, ongoing reviews, in addition to the JA, will need to occur, for example monitoring of performance of partners and feedback mechanisms. Identification of opportunities for regular strategic learning, between partners in country, but also for South-South learning.

Recommendation 11: Reconsider how TCA should be evaluated to make optimal use of available resources:

- Further evaluation of TCA should only be undertaken after intended models of TCA have been well articulated and results systems have been sufficiently strengthened to provide usable data and building blocks on outcomes
- Instead of evaluating TCA individually as an instrument, consider whether there is merit for it to be evaluated as part of a more holistic approach to evaluation of the immunisation system, based on a clear Theory of Change incorporating all elements of Gavi engagement and contrition to immunisation objectives..
- Set out clear rules of the game for engagement by Gavi staff during the process including expectations around commenting and follow up on recommendations.
- Continued external, third party party evaluations for selected countries prioritised by volume of PEF-TCA resources and/or immunisation system performance.
- Ensuring that some of the existing assessments that could give us more reliable data to assess performance (coverage surveys for coverage; DQA for data; EVM for supply chain; KAP for Demand; etc.) are aligned in terms of timing to provide data at “baseline” and “endline” of the PEF-TCA/CmYP cycle linking to multi year funding and results based programming decisions.

Gavi 5.0: Practical implementation of recommendations

The table below summarises the pertinent elements/components of the "existing" model (Gavi 4.0) recognizing that the approach continues to evolve, and highlights the proposed practical changes, adjustments, or enhancements that could contribute to enhancing the contribution of PEF-TCA in achieving the goals and objectives of Gavi 5.0, based upon the findings and recommendations outlined above.

Figure 3: Tailoring the overarching recommendations from 4.0 to 5.0.

Gavi 4.0 PEF-TCA	Gavi 5.0 PEF-TCA
Planning, budgeting, and implementation is on a 12-16 month cycle. This incentivises a focus on short-term activities, for example producing plans/strategies/reports; creates difficulties in staff retention; makes it difficult to recover from delays; virtually impossible to measure results.	**Planning, budgeting, and implementation on a 5-year cycle, aligned with the cMYP.** This allows for a focus on medium-term capacity development, better staff retention; shift from producing a strategies/plans to supporting their implementation. Provides enhanced flexibility for partners (annual adjustments) within a framework of greater accountability.
Measurement and reporting on activities and outputs; no overall medium-term vision for strengthening institutional capacities. Weak link between reported activities and ultimate coverage impacts.	**Theory of Change identifies functional outcome indicators** in key immunisation pillars, enabling greater measurability and accountability. Reduced burden of reporting on excessive numbers of activities. Focus on actually measuring changes in capacity, which is the actual objective of PEF-TCA.
Performance primarily measured by activity completion and budget execution; virtually no implications for positive or negative performance (Core partners). Lack of incentivisation for positive performance; continued investments in sub-optimal activities and non-performing partners; incentivising spending of funds rather than quality or impact.	**Performance primarily measured against delivery of desired results**, defined as enhanced capacity and effectiveness of national immunization system. **Performance directly impacts future receipt of Gavi PEF-TCA funds**, enabling rewards for positive performance and reduction/elimination of non-performing support. **Focus on results instead of spending** should result in greater cost-effectiveness**.**
Reporting, Monitoring & Evaluation is all self-reported. This leads to a tendency to present overly optimistic results, and minimize problems until they reach serious levels. Variable levels of self-critique lead to decreased visibility and lessons learned. **Lack of feedback on reports by EPI and Gavi** limits TCA providers' opportunities to improve and course-correct, limits usefulness of reporting exercise and de-motivates partners.	**Introduction of 3rd party monitoring (mid-term) and evaluation in priority geographies** leads to more objective assessment of strengths and weaknesses. **Alignment of cycles and indicators with reliable independent data sources** like coverage surveys, EVN, Data Quality Survey (DQS), Knowledge Attitude and Practice (KAP), etc. leverages investments in those exercises to measure TCA results. **Systematic 3-way feedback on reports** ensures TCA providers' reports are meaningful and useful for course correction and improvement.

Non-competitive (core partners) and non-transparent provider procurement process. This leads to sub-optimal results, decreased innovation, lack of alignment between needs and agency comparative advantages, gaps in functional capacities, and other distortions.	**More competitive and transparent TCA procurement** results in greater innovation, increased supply, better alignment of comparative advantages, cost-effectiveness, etc. This option should in particular be considered where past performance/improvements have been sub-par, where TCA budgets are high, etc.
Low visibility on ongoing PEF-TCA execution and progress between partners at country level hinders coordination, leveraging potential synergies. **No explicit opportunities for cross-learning.**	**Enhanced ongoing information sharing** enables better coordination and synergies between TCA partners and with other funding streams including HSS. **Deliberate periodic learning events** enable cross-pollination of good practices and lessons learned between EPI, Gavi, and partners.
Focus of TCA primarily at national level, with emerging shifts to sub-national levels. This means that sub-national inequities have yet to be fully addressed. There is often limited visibility into service-delivery level issues, and tendency for one-size fits all solutions imposed from above. Bottlenecks at the last-mile level (for example non-receipt of operational funds for whatever reason) result in breakdowns in service delivery.	**Strengthened focus on tailored sub-national TCA,** delivered by those partners best positioned to provide these services. Greater visibility will enable more accurate targeting of critical bottlenecks with locally-appropriate solutions, and faster response to operational-level issues to address service-delivery issues.
Primary focus on conventional immunisation system topics. This has resulted in good progress in some countries on immunization technical areas, meaning that remaining bottlenecks are often on non-immunization HSS issues (results-based management, budgeting, PFM, etc.).	**Greater emphasis on emerging areas of under-capacity,** including core management, PFM, and Demand Generation (which, while a conventional topic, has been under-emphasised in the Gavi 4.0 period with clearly visible consequences). This will require mobilisation of expanded partners and potential new private sector partnerships to ensure fit-for-purpose/comparative advantage.
Tendency to repeat traditional activities/approaches even in contexts where they have proven ineffective. This has led to low returns on investment for TCA in certain countries and on certain issues, and under-utilization of proven but innovative models and approaches.	**Incentivize trial of innovative approaches in cases of systemic under-performance.** This can include both core partners (UNICEF urban initiatives, WHO MOV protocols, etc.) and expanded partners (Acasus for core management; various emerging SC solutions, etc.). This will spur innovation, leverage existing investments in new approaches, and reduce losses from continued reliance on traditional models that are ill-suited to specific contexts.
Gradual increased coordination between different technical assistance funding windows, with particular lack of alignment for CSO- and World Bank-led assistance in many contexts.	**Single unified PEF-TCA plan encompassing all technical assistance providers** ensures greater coherence and effectiveness of different PEF-TCA providers.
Little/no coordination with other health partners' capacity development efforts	**Strengthened coordination and alignment with other health partners' efforts** leads to greater effectiveness, efficiency, and improves the

resulting in duplication, stranded investments, lack of synergies, and reduced effectiveness.	integration of immunization within the movement for universal primary healthcare.

Annex 1: Terms of Reference

PEF Targeted Country Assistance (TCA) review

Purpose
Gavi has invested in the provision of technical assistance to support the national immunization program through partners. There is a need to assess quality and better understand the efficiency and effectiveness of TCA and how it is linked with results. To that purpose we are aiming to conduct a set of standard assessments in a number of countries

The purpose of this exploratory work is to

a) Assess the effectiveness and efficiency of the implementation of targeted country assistance (TCA) (in a number of priority countries) to identify the main drivers of results what is not working.
a) Support the MoH and relevant stakeholders to define the theory of change (TOC) framework based on plausible linkages to the TCA support in contributing to Gavi's investments (HSS, vaccine introductions and campaigns, CCEOP) to support C&E. Additionally the theory of change will also reflect the strategic approach/es of technical assistance to achieving the results.
b) Based on the review of effectiveness and the Theory of Change, generate recommendations on:
    - How to improve the TCA provided to the country (including shifts of activities, roles of different partners, model of TA etc.)
    - Identify what needs to be model to measure performance including linkages with other Gavi results frameworks such as GPF.

Scope and process

Countries

Tentatively (to be confirmed) **Mali, Democratic Republic of Congo DRC, Afghanistan, Zimbabwe and Somalia.**

Their review would be based on the following:

- A desk review of
    - HSIS NVS and SIA grants and objectives
    - Review of HLRP and IRC recommendations over the past 3 years
    - PEF reporting, including milestones reports and PEF functions
    - Minutes of country TCA review meetings (including at ICC, and JA)
    - Past Joint Appraisal reports
    - Country performance documents (including 'Country Metrics', EPI reviews, etc.)
- Interviews of critical stakeholders at country level, including:
    - MoH staff (EPI manager and other key EPI team members, national logistician; If relevant EPI staff at subnational levels)
    - Partners staff implementing TA at country level (including WHO, UNICEF, CDC, World Bank and other expanded partners)
    - Senior Country Manager / Programme Officer / Country Team

Countries will be finalised after consideration of PEF tier, region, fragility the magnitude of TCA, PCA status, relevance to other Gavi processes (ACE, MTR).

Deliverable and timeline

For each country, the consultants would produce a 3-5 page summary of their review (with relevant annexes) to describe the conclusions and insights of their work.

TOR finalised / countries identified	19 October 2018
Potential consultants contacted	19 October 2018
Consultants contracted	1 November 2018
Desk review initiated	Q4
Stakeholder meetings organised	Q4
In-country visits as applicable	Q4
Draft report submitted	mid December
Final report submitted	7 January 2019
Discussion by PEF Management Team	End January

Annex 2: Data Gathering

Country	Date of Country Visit	Number of Interviewees (represents organisations or individuals, as appropriate)
Myanmar	14-18 January 2019	25
Zambia	21-25 January 2019	13
Nigeria	24–28 June 2019	15
DRC	8-12 July 2019	26
PNG	19–23 August 2019	19
Ethiopia	25-29 November 2019	18
Total		**116**

Annex 3: Individual Country Findings and Recommendations

Democratic Republic of Congo

The assessment of PEF-TCA in DRC occurred in the context of continued stagnation or possible declines in the performance of routine immunization, based on the preliminary results of the soon-to-be released 2018 Multiple Indicator Cluster Survey (MICS). Not only has DRC faced a number of security and political crises, but it has also struggled to deal with a range of disease outbreaks including Yellow Fever, Ebola, and Measles. The responses to these outbreaks, alongside other SIAs and the daunting challenge of healthcare provision across a massive country with limited health infrastructure and low levels of government investments in health and immunization have negatively impacted the performance of the RI system. The EPI unit has benefitted from TCA from Gavi since 2016, and provided through core partners (UNICEF, WHO, World Bank and CDC) as well as expanded partners (JSI, Acasus, GIZ and PATH).

DRC Country Findings and Recommendations

#	Key finding	Recommendations
1	Core management within the EPI and DEP remains weak, with poor returns on Gavi significant investment of both Gavi-supported and government t-funded human and financial resources.	• Investment in LMC-related TA, expanding performance-based culture/process to core RI processes and embedding support. • Review of EPI HR to improve effectiveness and align compensation with performance and consideration of financial incentives, conditioned upon independent performance measurement and improved EPI HR management.
2	Capacity building and skills transfer has been limited by a range of factors.	• Focus on building EPI capacity across the core components of the immunization program with specific capacity building plans for each TA partner with competencies identified, measurable indicators and nominated government counterparts. • TA transition to an “embedded” model within EPI and DEP and in-country CDC TA to build capacity on relevant topics.
3	Gaps and delays in government financing for vaccine purchase continue to handicap all efforts to strengthen RI.	• Identify and support implementation of solutions to the routine vaccine procurement financing crisis including re-initiation of capacity development for political actors at national and provincial levels to build support for immunization financing. • Re-institute immunization financing/advocacy component and strengthen the links between advocacy for immunization financing (PATH) with technical studies on financing (WB).
4	Slow disbursement of Gavi and government funds for EPI and DEP significantly hampers effectiveness of TA and RI performance.	• Improve forecasting, timeliness and quality of finance requisitions; improve capacity of DEP and PEV on PFM; build CAGF capacity particularly on procurement; propose expedited approvals process for PEV funding requisitions. • Maintain support for provincial TA for financial management; focus additional resources within GIZ to improve timeliness of

DRC Country Findings and Recommendations		
#	**Key finding**	**Recommendations**
		disbursements and establish measurable targets for average time required for approvals.
5	TA deliverables of high technical quality resulted in limited/no tangible improvements in RI due to lack of funding for implementation; on the other hand, significant HSS1&2 investments did not always deliver tangible performance improvements.	• Reduction in priorities for HSS3 based on the lessons learned/principles of the Mashako Plan; re-allocation of funds to maximise impact of Gavi-funded technical assistance. • Review HSS3 to ensure that sufficient funds are available for implementation of key promising interventions including (i) VillageReach logistics model; (ii) JSI urban immunization approach; and (iii) UNICEF supported National Immunization Communications Plan.
6	TA for the development of the 3 hubs was highly-sub optimal and the return on investment for this item was extremely poor.	• 3rd party review of Hubs experience to identify lessons learned and develop recommendations to improve this type of initiative. • Ensure that TA partners selected to lead specific components have the technical and operational expertise to deliver on their commitments; ensure closer government & Gavi monitoring of TA performance on "big-ticket" items to better manage risks.
7	Weaknesses in performance management at the province, zonal, and health center levels which will be of increasing importance with ongoing processes of decentralisation/health system reform	• Regular performance management reviews and tracking at all levels; closer supervision of provincial and zonal EPI staff; develop incentives for positive performance. • Support and expand TA at the DPS level; ensure better coordination and alignment on TORs between UNICEF and WHO-supported provincial consultants; ensure more frequent supervisions to provincial and zonal levels in priority provinces.
8	Few opportunities for exchange of experiences, lessons, and best practices between TA providers; lack of communication may lead to overlaps and delays.	• Establish a regular forum within existing mechanisms (Technical and Strategic CCIA, Task Forces, etc.) for specific discussion on experiences and best practices in TA; strengthen exchanges/links between technical TA and 'management' TA.
9	There is little/no feedback and/or real-time monitoring of TA performance by GAVI or the government.	• Ensure formal written and oral feedback by Gavi and PEV/DEP/SG for TA providers' reports; strengthen ongoing monitoring of TA performance by the government on a bi-monthly or quarterly basis via the SG/CCIA as appropriate.

Nigeria

Nigeria represents one of the most complex and challenging environments for Gavi, despite being classified as a middle-income country with considerable economic capacity and resources. It has the largest number of unimmunised children of any country at 4.3 million and immunisation work is dominated by polio. Immunisation coverage is improving following the declaration of RI as a national emergency but due to the federal structure, the political economy, the need to strengthen accountability and ensure resources reach their intended targets, and the wide variations in needs and coverage rates, the Gavi team have adopted a very 'hands on' approach in Nigeria, engaging at state-level and limiting the engagement of expanded partners. Nigeria was scheduled to transition from Gavi support in 2021. However, consistently low immunisation coverage rates, multiple outbreaks of infectious

diseases and poor health outcomes amidst on-going political-economic challenges, led to the decision to adopt an extended transition period until 2028. The bulk of Gavi's TCA is provided by core partners UNICEF, WHO, CDC, and the World Bank.

Nigeria Country Recommendations		
#	**Key finding**	**Recommendations**
1	Accountability Framework is strongly focused on fiscal and financial conditions for sustainability. Therefore, risk that institutional capacity might fall by the wayside if clear results and effective TA models are not forthcoming, since a focus on gap filling and working predominantly through core partners are both unsustainable.	• Reconsider the balance between 'getting immediate results' and 'building capacity' for sustainable longer-term results. Supporting actions could include: • Develop theory of change and monitoring framework around capacity, building on One TA Plan and NSIPSS discussions. • Develop shared understanding of drivers of capacity building and longer-term results and support with an accountability framework and improved data for results and outcomes.
2	The shift towards working at state level in the 8 priority states makes sense, responds to earlier recommendations and analysis and is well aligned with the needs of Nigeria.	• Build further on the state-level engagement already underway with similar work on theory of change, outcomes measurement and supporting learning around capacity building in the eight priority states, drawing on the experience of national Nigerian partners, BMGF, the World Bank, CHAI and others who have engaged at state level.
3	The decision to focus TCA support on core partners could be deliberate and strategic on Gavi's part, but currently this is not transparent and does not appear to be well justified.	• Strengthen the quality of TCA both at federal and state levels by improving the incentives – driven by greater contestability in how funds are allocated – which in turn will help to further improve the focus of work by the core partners. An essential first step (already started) is mapping what other partners can offer and bringing in expanded partners more actively, with funding.
4	No clear framework for monitoring TCA outcomes and no clear feedback mechanisms that can inform TCA planning and create better incentives for results.	• Strengthen monitoring and evaluation of capacity development as part of the Gavi approach to PEF TCA. Without this, it will be impossible to track whether Gavi and partners are on track to support a meaningful transition out of Nigeria in 9 years, rather than continuing to focus on gap filling activities.
5	TA partners are involved in identifying TA priorities, which enhances planning transparency, but communication and follow-up around the delivery of TA needed.	• Strengthen transparency and communication to partners on internal processes within TCA, explaining its decision making so that partners can understand Gavi's decision making and intent and work out how best to contribute to TCA.

Ethiopia

Despite a federal system with a long history of rolling out immunisation and rapid improvements in the development context of the country over the last 20 years, long-term improvement has stalled with outbreaks of measles in some areas and the country struggling with under-immunisation, particularly amongst children, with 1 in 4 not immunised. The political climate has led to security issues in the last 2 years and has affected access to parts of the country, exacerbating existing issues such as hard-to-reach communities and stretched resources and leading to wide inequities in immunisation coverage. Gavi has provided TCA to Ethiopia's EPI team since 2017, through core partners (UNICEF, WHO, the

World Bank and CDC) and expanded partners (CHAI, JSI, Acasus, CCRDA, CDC Foundation, Oslo University and PATH in 2019). In 2019, Ethiopia received a total of $3,495,849 in TCA funding.

Ethiopia Country Recommendations		
	Key finding	**Recommendations**
1	TCA is not always well-defined, "success" is unclear and links with wider HSS mechanisms are also not always clear. This leads to a lack of clarity on how best to monitor TCA performance.	• Agree a clear definition of TCA and how this fits with wider Gavi health system strengthening mechanisms. • A more strategic and sequenced approach to capacity building based on an in-depth country needs assessment. • Greater alignment of HSS and TCA activities and planning.
2	No specific TCA coordination mechanism and no formal platform for partners to provide updates, share experiences and learning or discuss challenges faced.	• Establish a coordination mechanism specifically for TCA partners to regularly share updates on progress, challenges faced, lessons learned etc. • Ensure ownership of coordination mechanism with either EPI team managing or partners rotating role of "chair" of the group.
3	Milestones are still primarily focused on process and outputs and monitoring of TCA activities/results is also weak, with little oversight or accountability.	• Shift to performance-based financing, developing and focusing more on outcome and impact-based indicators. • Strengthen the TCA monitoring mechanism to ensure greater oversight of activities and progress.
4	The JA process takes place over three days, with no formal advance preparatory work setting out TCA country priorities for partners to discuss internally or as a group. This does not allow for sufficient time to plan a proposal aligned to country priorities or aligned with other partners' work.	• Move to a four-step JA process; **1**: EPI team map and present country priorities to partners; **2**: Partners develop proposals, with inter-organisational discussions; **3:** TCA plan is developed during the JA, with activities divided amongst partners based on merit, technical and geographic expertise and strength of proposals. Agreed milestones and indicators are more focused on outcomes and impact. An associated funding timeline is also provided by Gavi; **4:** Final TCA plan endorsed by the ICC
5	One-year TCA funding is a short timeframe for planning and implementing activities linked to capacity building.	• Consider moving to multi-annual funding cycles for TCA activities.
6	TCA fund disbursement is not aligned with the country planning and funding cycle. This affects planning and implementation of activities and can lead to inefficiency.	• Align TCA fund disbursement with the country planning and funding cycle. Develop a clear timeline for fund disbursement and ensure funds are disbursed on time. • Strengthen fund disbursement mechanisms to ensure timely and transparent transfer of funds from national to subnational levels.
7	Recognition of the need to move beyond a national-level focus but still great need for capacity building and skills transfer at the local level.	• Increase capacity building activities around vaccine management, monitoring, cold chain and budgeting at service delivery points, conducting a capacity needs assessment to guide and support this.
8	Engagement with national CSOs and NGOs has decreased.	• Align engagement with national CSOs and NGOs with the longer-term Ethiopia strategy and include national CSOs and NGOs as expanded partners, leveraging their technical expertise and understanding of local contexts.

		• Conduct a needs assessment focused on capacity gaps and develop a strategic and sequenced approach to address these.

Zambia

Zambia is classified as 'high performing' by Gavi and between 2000 and 2018 received just under $164m of Gavi support (disbursed). Prior to recent falls in GNI per capita had entered the 'pre-transition' phase and coverage for immunization has been relatively high over the long term. However, performance is not yet fully reaching Gavi performance targets and sustained improvement has been a challenge. Overall constraints in resources and capacity in the health system is a critical factor impacting on progress in EPI, so the PEF TCA context is closely related to wider health issues in Zambia faced by the government, and by other funders, including that provided by Gavi through its HSS programme. TCA implementing agencies in Zambia include agencies WHO, UNICEF, CDC and PATH

Zambia Country Recommendations		
#	**Key finding**	**Recommendations**
1	Majority of TCA work at the national level where core partners have comparative advantages. However, many key bottlenecks are at local level.	• To improve the relevance and likely impact of TCA, the EPI team and partners should work with expanded partners to keep looking for opportunities to develop TCA rapidly at subnational level where some of the most critical bottlenecks seem to exist.
2	Linkages across child health services and disease areas are crucial for making best use of limited resources yet they are not always effectively made.	• In further developing TCA, there should be a strong push to make effective and frequent linkages to other parts of HSS and other disease areas, to leverage the expertise and capacity they bring and coordinate with those working on other aspects of maternal and child health and specific disease areas such as HIV and malaria.
3	Capacity constraints impacted the efficiency and effectiveness of TCA, which also shows itself in some weaknesses in follow up, accountability and implementation of TCA.	• In addition to identifying issues and needs, the JA prioritization process needs to give a very clear focus to issues around resource mobilization and delivery, and also to improving the monitoring and accountability parts of the system. This is with a view to achieving a more realistic balance between what is expected and what can be resourced and delivered.
4	The JA processes provide an important and inclusive forum for discussions, are well planned and achieve high levels of ownership and participation.	• The EPI team should restructure the agenda for the JA meeting to devote more time to the follow up actions part of the discussion. To support this, consider bringing in an external facilitator, freeing up the EPI manager and staff to engage on other roles within the discussion. If local partners are to be more involved then further consider accessibility issues.
5	The space for strategic thinking on TCA and EPI are squeezed by urgent work in other areas – such as the cholera outbreak last year.	• Consider ways to make space for periodic analytical work to build the strategic and diagnostic thinking on how TCA is intended to work. It could also include management/ leadership strengthening and advocacy for increased allocation of resources from MoH to the EPI team.
6	No 'theory of change' which would set out how results and impact of TCA are intended to be achieved.	• The recommended strategic work should include articulating a clear theory of change, as the basis for shared analysis on the key bottlenecks in the system, and where to deploy resources and the linkages to HSS and other disease areas.

Papua New Guinea

PNG is a challenging and expensive operating environment with few international partners, stretched government capacity and a population that is spread unevenly across the country. In addition, the structure and organisation of PNG's health sector is complex, described as an "evolving decentralised architecture", the health budget has decreased over the last five years and there is a critical shortage of human resources for health. Therefore, Gavi is highly regarded and valued as a development partner in PNG, as are Gavi's core TCA partners, WHO and UNICEF. Between 2001 and mid-2019, Gavi's total support to PNG amounted to $44.5 million. The largest proportion of this funding was allocated to grants for the introduction of vaccines, as well as vaccine doses and injection safety devices, alongside GoPNG recurrent budget allocations.

PNG Country Recommendations		
#	**Key finding**	**Recommendations**
1	No over-arching Theory of Change to articulate and monitor the expected outcomes of TCA in a coherent manner. Therefore difficult to track the annual and cumulative outcomes of TCA.	• Co-develop, with NDoH, a ToC that articulates the longer-term 'vision of change' for TCA in PNG in the extended Accelerated Transition period. Could align with PNG's new NHP 2021-2030 and cMYP 2021-2025 and could form part of a more comprehensive Gavi country ToC for PNG which could articulate the complementarity of funding channelled through different mechanisms with the purpose of strengthening effective, sustainable immunisation service delivery in PNG.
2	In the absence of robust mechanisms and frameworks to plan and monitor TCA such as an integrated M&E framework, its effectiveness cannot be definitively assessed.	• Develop a coherent M&E Framework to monitor progress towards the achievement of results outlined in the ToC. A comprehensive One TCA plan should be developed and the contribution of this TCA to measurable results in the M&E Framework should be evident. Draw on/learn from the World Bank's M&E framework for its new HSS grant and the PPF M&E Framework on how to monitor and measure capacity strengthening. Such cross learning be helpful to monitor capacity strengthening outcomes as part of TCA funding.
3	There is a lack of country ownership and mechanisms to engage on strategic capacity development issues for RI.	• NDoH co-ownership of results and leadership capacity could be strengthened by instituting more robust accountability and reporting on TCA to NDoH, potentially around the NDoH Health Sector Coordination Forum.
4	No set agenda that provides continuity to the discussion of TCA activities/follow-up or matters of strategic concern.	• Draw on positive, enabling changes happening in the health sector to facilitate and/or participate in regular opportunities for joint reflection on progress and to share lessons among GoPNG, TCA Partners and other donors.
5	Currently, UNICEF and WHO are the main recipients of TCA funding in PNG, with the World Bank, CDC and CHAI receiving much less. With a perceived lack of competition for TCA funding for core partners, but not expanded partners, comes a risk of inefficiency,	• Consider the nature of technical expertise required and potential TCA partners that could support the EPI unit to provide effective RI as part of integrated PHC delivery at sub-national level. Draw on a donor mapping currently being completed to explore options for greater coherence between the PEF-TCA and other donor interventions. Identify and explore opportunities to extend TCA partnerships to International and local NGOs, and explore options to incentivise effective capacity development approaches on the part of TCA partners.
6	Core partners consistently raised the high transaction costs associated with Gavi funding as a major challenge.	• Explore opportunities to limit transaction costs associated with TCA funding for core and expanded partners, bearing in mind that it often runs parallel to HSS funding.

Myanmar

Myanmar has extremely low levels of spending on healthcare in general and has significant geographical and ethnic variations in immunisation coverage in its population of 55.3 million people.

These internal inequities – including significant numbers of under-immunized children in urban areas – have resulted in outbreaks of VPD in recent years including both Diphtheria and Measles, not only in remote/hard-to-reach areas but also in the largest city, Yangon; Rohingya refugees in Bangladesh have also experienced Diphtheria outbreaks, confirming their low immunization rates. Despite this, Myanmar has recently successfully introduced a number of vaccines including for Japanese Encephalitis, PcV3 and the switch to MR, and has plans for national introductions of both HPV and Rota in the coming 1-2 years. Additionally, due to Myanmar's relatively high GNI, it is considered to be in 'preparatory transition' phase for Gavi support. PEF/TCA implementing agencies include WHO, UNICEF, CDC, World Bank and PATH.

Myanmar Country Findings		
#	**Key finding**	**Recommendations**
1	PEF-TCA has focused at the national level but there are significant capacity gaps at the state and regional levels.	• Focus on strengthening capacity of state and non-state partners at Township and lower levels to plan, deliver, and monitor immunization services in hard-to-reach, urban, special and other locations with under-immunized children. • Continue to re-focus TCA staff in embedded locations at national and sub-national levels. • Exercise caution in the use of short-term, cascaded training approaches to avoid overburdening the lower levels
2	PEF-TCA has not focused on financial sustainability, which is key given the government is introducing two new vaccines, and its share of co-finance of immunisations is set to increase.	• Explore strengthened TCA on costing, financial sustainability, and other policy issues (for example HR recruitment / retention at grassroots level) impacting immunization performance • Ensure strong coordination between EPI, WB and other PEF-TC providers regarding the intended support the WB will be providing to health financing.
3	Currently a reliance on short-term, cascading capacity building methods with little follow-up.	• Through having more staff in Naypyidaw, UNICEF and WHO could increase 'on the job' mentoring and capacity building to EPI staff. • Explore use of alternative capacity building tools/methods, including e-based methods, job aids, mentoring/coaching, etc.
4	Coordination of TA between donors and communication between governance and oversight bodies can be improved.	• Leverage HSS2 to enhance alignment between TCA and other donors' investments in health system capacity. • Enhance communication with relevant HSCC technical working groups.
5	Currently, PEF-TCA monitoring is at output level and there is insufficient reflection about what works and how to deliver effective TCA.	• Ensure TCA supports effective regular performance management and review by all levels to focus accountability on increasing coverage. • Ensure future years' TCA plans include outcome indicators • Adopt mechanisms for periodic in-country review & reflection on TCA progress & performance, possibly by ICC
6	Effective PEF-TCA is provided but has emphasis on plans/strategies which are not necessarily costed or contextually relevant.	• Consider developing costing plans. • Ensure TCA produces quality plans/strategies and supports their effective implementation
7	PEF-TCA focuses on EPI, rather than the broader health system.	• Consider how other parts of the heath system need/can be strengthened by TCA to support the work of EPI/immunization.

Myanmar Country Findings		
#	Key finding	Recommendations
		• Ensure participation of other relevant health actors in the JA but maintain ownership of the relationship by EPI.

Annex 4: Breakdown of TCA funding (2018-2019)

Available upon request.