SECOND GAVI EVALUATION

GAVI ALLIANCE

13 September 2010

GAVI SECOND EVALUATION REPORT

Prepared by:

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In association with:

Applied Strategies

CEPA

CONTENTS

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ACRONYMS AND ABBREVIATIONS

AD	Auto-Disable
ADIP	Accelerated Development and Introduction Plan
AFRO	Regional Office for Africa (WHO)
AMC	Advance Market Commitment
AMRO	Americas Regional Office (WHO)
APR	Annual Progress Report
AS	Applied Strategies
AVI	Accelerated Vaccine Initiative
CDC	Center for Disease Control and Prevention
CGD	Center for Global Development
CEPA	Cambridge Economic Policy Associates
cMYP	comprehensive Multi Year Plan
CSO	Civil Society Organisation
CTT	Co-financing Task Team
DAH	Development Assistance for Health
DALY	Disability-Adjusted Life Year
DQA	Data Quality Audit
DQS	Data Quality Self-assessment
DTP	Diphtheria, Tetanus and Pertussis
EPI	Expanded Program for Immunisation
EURO	Europe Regional Office (WHO)
FMA	Financial Management Assessment
FSP	Financial Sustainability Plan
FTF	Financing Task Force
GFA	GAVI Fund Affiliate
GHP	Global Health Partnership
GIVS	Global Immunisation Vision and Strategy
GPEI	Global Polio Eradication Initiative
HepB	Hepatitis B
Hib	*Haemophilus influenzae* type B
HR	Human Resource
HSCC	Health Sector Coordination Committee
HSS	Health System Strengthening
ICC	Inter-agency Coordination Committee
IFFIm	International Finance Facility for Immunisation

INS	Injection Safety Support
IRC	Independent Review Committee
ISS	Immunisation Services Support
JRF	Joint Reporting Forms
JSI	John Snow, Inc.
LICUS	Low Income Countries Under Stress
LMIC	Lower Middle Income Countries
MenA	Meningitis A
M&E	Monitoring & Evaluation
MMIS	Making Medical Injections Safer
MNCH	Maternal and Newborn Child Health
MOU	Memorandum Of Understanding
MTSP	Medium Term Strategic Plan
NIP	National Immunisation Program
NVS	New and underused Vaccines Support
ODA	Overseas Development Assistance
ODF	Official Development Financing
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organisation
PATH	Program for Appropriate Technology in Health
PDP	Product Development Partnership
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PPP	Public Private Partnership
RFP	Request for Proposal
RVP	Rotavirus Vaccine Program
SDF	Strategic Demand Forecast
SEARO	South East Asia Regional Office (WHO)
SG	Strategic Goal
SP	Supporting Paper
TAP	Transparency and Accountability Policy
ToR	Terms of Reference
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VF	Verification Factor
WHO	World Health Organisation
YF	Yellow Fever

EXECUTIVE SUMMARY

1. Introduction *(Section 1)*

This document is the GAVI Second Evaluation Report prepared by CEPA. The evaluation commenced in December 2009 and spanned over the last nine months. It seeks to answer two high-level questions (the 'Request for Proposal (RFP) Questions'):

- **To what extent has the GAVI Alliance met its four Strategic Goals (SGs)?** (which we refer to as GAVI's 'results')
- **To what extent has the GAVI Alliance added value at the global and country levels, over and above what would have been accomplished without the Alliance?** (which we refer to as GAVI's 'value add')

The evaluation focuses on an assessment of the Alliance's results and value add across all of its SGs since inception, but with a primary focus on 2006 to present (Phase II).

The terms GAVI and GAVI Alliance are used interchangeably to refer to the global health partnership founded in 2000 that we are evaluating. These terms are intended to cover GAVI since inception, despite changes in the precise institutional and legal form of GAVI.

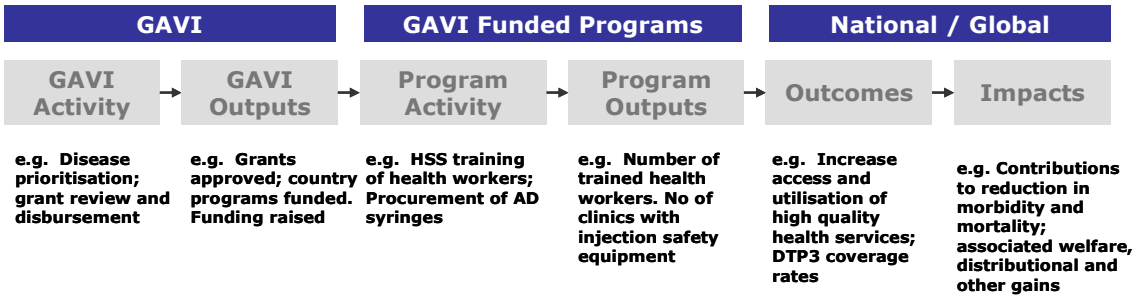
Given that GAVI is an Alliance that works through its Partners to deliver its mission and objectives, the evaluation is about the achievements of the Partners, the GAVI Board, and Secretariat. An evaluation of GAVI's governance structures is however, not within scope.

The evaluation has been organised around GAVI's four SGs. This report is therefore supplemented by four SG Reports which contain the detail of our analysis. In addition, there are a series of Supporting Papers (SPs) which contain analyses and evidence that are applicable across the four Goals; for example, the five country reports. As per the terms of reference, we have prepared a separate Recommendations Paper which sets out our recommendations and discussion of options for GAVI in Phase III.

2. Methodology and approach *(Section 2)*

Figure 1 summarises the hierarchy of Activities, Outputs, Outcomes and Impacts that we have used to provide a framework for the evaluation.

Figure 1: Hierarchy of Outputs, Outcomes and Impacts



GAVI results

In evaluating GAVI results, we have sought to assess the ultimate impacts that have resulted from GAVI Activity and Outputs. However, we have inevitably been constrained by the availability of data and the challenge of attribution. There is therefore a greater emphasis placed on the analysis of GAVI Activity and Outputs, and Program Activity and Outputs (where possible), rather than Outcomes and Impacts. In addition, as agreed at the outset, we have not sought to independently verify or repeat existing work that has been conducted to estimate GAVI's impact on deaths averted.

GAVI value add

We define value add as: "the net impact after allowing for what would have happened if funding had not been available, or alternatively been made available for GAVI's program activities but through other routes". Assessing GAVI's added value has inevitably been a challenge – given the difficulty of defining and finding evidence of alternative hypothetical states of the world (i.e. the counterfactual).

Our approach has been to look for areas where GAVI activity has improved results, where it has been unique, where it has resulted in faster action, or where it can be thought of as being new or innovative. We have also distinguished between what we see as 'financial', 'programmatic', and 'organisational' value add.

Evidence

Across GAVI's four Goals, we have identified seventeen Evaluation Questions that further organise the analysis and evidence and allow us to make judgments about the RFP Questions.

The nature of analysis and evidence varies by Evaluation Question – in part determined by the availability of data. But in general, our approach has been to bring together, and where possible, 'triangulate' quantitative and qualitative evidence from different sources. Types of evidence include review of documentation, quantitative analysis of performance data, regression analysis, benchmarking analysis, structured interviews, electronic survey, Expanded Program for Immunisation (EPI) manager survey, country studies, and case studies of comparators.

In order assess the strength of our conclusions against each Evaluation Question; we have allocated a 'robustness scoring' to each main finding. The definitions of the four scores (A to D) is based on an assessment of both:

- the extent to which we have a range of evidence (e.g. quantitative and qualitative) and different sources (e.g. different databases) that point to the same conclusion – we refer to this as 'triangulation'; and
- the underlying quality of individual data types and evidence sources (e.g. as determined by sample size, reliability/ completeness of data).

3. Cross cutting issues and methodological limitations *(Section 3)*

This section of the report sets out a small number of evaluation findings about GAVI that are relevant across all of the Strategic Goals (hence 'cross cutting' issues). It also discusses methodological limitations which the reader needs to be aware of in reviewing our findings.

The identified cross cutting issues do not take away from the strengths and added value achieved by the Alliance across its activities. But we believe that they are important in determining the ability of GAVI to measure its performance and allocate scarce resources efficiently going forward. They are also relevant to the methodological limitations. The three areas of issues that we have highlighted are: [3]

- The way in which GAVI's strategy and performance framework links activities, outputs and objectives is quite weak, and there is also a lack of clarity on who within the Alliance (e.g. Partner or Secretariat) has ownership of a particular objective and related indicator.
- There is a relative absence of regular and systematic recording of GAVI Activity, Program Activity and Output data, and of clearly defined performance indicators / metrics (preferably 'output' and 'outcome' based) against which performance across the organisation can be monitored.
- Across the evaluation, we have come across instances where it seems that GAVI has launched programs or committed to activities and has not identified (or has been slow to identify) wider implications in terms of funding, delivery model, or availability of resources, suggesting a need for better prioritisation of Secretariat and Partner resources.

Some of the methodological limitations discussed in this section of the report arise from the cross cutting issues above. Other limitations relate to data quality and constraints, challenges in measuring value add and defining appropriate counterfactuals and comparators, limited sample of country visits, biases inherent in qualitative interview or survey feedback, etc.

4. Overview of GAVI Outputs, Outcomes and Impacts *(Section 4)*

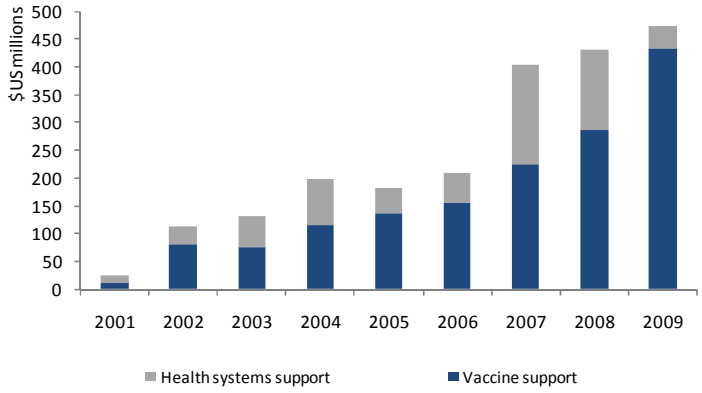
GAVI's ultimate mission is 'to save children's lives and protect people's health by increasing access to immunisation in poor countries'. In this section of the report, we have provided an overview of GAVI's patterns of funding and estimated impacts by World Health Organisation (WHO) (in terms of deaths averted).

GAVI provided a total of $2.2bn in disbursements to 75 countries over the period 2000-09, with Phase II seeing a rise in disbursements. In terms of types of support, vaccine-related support dominated health system-related support in every year (see Figure 2).[4]

[3] We are aware that GAVI is working to address some of these issues such as through the development of its Strategy 2011-15, data warehousing efforts, etc.

[4] We define "type of support" to be either vaccine-related (i.e. New and underused Vaccine Support (NVS)) or health system-related (i.e. Immunisation Services Support (ISS), Injection Safety Support (INS), Civil Society Organisations support (CSO), and Health Systems Strengthening support (HSS)).

Figure 2: Total GAVI disbursements by type of support (2001-09)



Key points to note in relation to the distribution of this support by countries are as follows:

- Support per surviving child has been targeted at weaker GAVI eligible countries; in particular the Low Income Countries Under Stress (LICUS) countries and those in the "poorest" and "fragile" financing groups. These countries have received high total disbursements per surviving child.
- The balance of support provided between health system related support and vaccine support varies by country group. The low Diphtheria, Tetanus and Pertussis (DTP3) coverage countries in particular received a relatively high proportion (per surviving child) of health system related support as compared to countries with high DTP3 coverage rates. This is driven primarily by GAVI's rule relating to DTP3 coverage in Phase II (only countries with DTP3 coverage exceeding 50% were eligible for vaccine support).

WHO estimates that the impact of GAVI's vaccine support has been to avert 3.4m future deaths caused by pertussis, *Haemophilus influenzae* type B (Hib) or Hepatitis B (HepB) as at the end of 2008 and nearly 4m future deaths prevented projecting to the end of 2009. Whilst there is considerable uncertainty about these estimates, our judgement is that even taking account of a substantial margin of error they point to a very significant achievement of GAVI (including all of its Partners and the Secretariat).

We have not conducted a full cost effectiveness analysis of GAVI's activities. However, we can relate the estimates of future deaths averted to GAVI's disbursements. Based on total NVS disbursements to 2009 of $1.5bn, the notional, undiscounted cost per death averted is $382.[5]

Our analysis of studies on the cost-effectiveness of immunisation suggest that these estimates are at the lower end of the range and are consistent with a level of cost per discounted Disability-Adjusted Life Year (DALY) that is deemed to be cost-effective when compared with other health interventions. We do not place an excessive degree of weight on this comparison because our analysis is relatively simple. However, given the orders of magnitude, the analysis is consistent with the view that GAVI's support has been a cost-effective intervention.[6]

[5] Based on total disbursements to 2009 of $2.2bn (including ISS, HSS, INS and CSO), the notional undiscounted cost per future death averted is $544.

[6] Based on the $100 per discounted DALY (Barder and Yeh, 2006).

5. Evaluation by Strategic Goal *(Sections 5 – 8)*

Sections 5 – 8 of the report provide our assessment of GAVI's results and value add by Goal. Each section is a summary of the full analysis and evidence-base presented in the respective SG reports. To avoid duplication, we do not repeat or seek to summarise the analysis here. The key evaluation findings in relation to value add (in addition to the 'cross cutting' findings referred to above) are set out below.

6. Evaluation conclusions *(Section 9)*

The final section of the evaluation report brings together our conclusions across the Evaluation Questions, and presents a synthesis of our evaluation of GAVI. This is organised by 'financial', 'programmatic' and 'organisational' value add (considering both global and national aspects of value add).

The limitation of this thematic disaggregation is that, in practice the existence of 'value add' in one area is dependent on performance and added value in other areas. Given this, we try (as far as possible) to identify the interdependencies. In addition, the summary below also covers key aspects of GAVI's results vis-à-vis its objectives (as contained in Sections 5 – 8 of the report).

6.1 Financial value add

Our conclusions in relation to GAVI's financial value add at the global level are as follows:

- **Despite a fair wind, GAVI has attracted funding to immunisation that probably wouldn't have occurred in its absence.** Considerable increases in funding for immunisation, and GAVI in particular, need to be seen in the context of large increases in total Overseas Development Assistance (ODA) and higher increases in health ODA. In addition, the influence of the Gates Foundation in providing very substantial levels of long-term funding has been important in 'crowding-in' donor funding, and this needs to be recognised alongside any value add attributed to GAVI itself. However, there is good evidence to suggest that GAVI has been able to attract additional funding for immunisation, and its major donors would not have contributed to immunisation on the scale that they did without it.
- **A big area of financial added-value has been through International Finance Facility for Immunisation (IFFIm), where GAVI's role has been unique.** In our view, IFFIm passes the test in terms of more (additional) and predictable resources and therefore added-value. Although GAVI was not part of the initial IFF concept design, it played a critical role in adapting and implementing it for immunisation. IFFIm has been able to substantially increase the period of bilateral donor financial commitments to GAVI, and (together with Gates funding) has provided the certainty of funding that has underpinned the ability of GAVI to commit to fund existing NVS programs through to 2015.
- **GAVI's role in the ongoing implementation of the Advance Market Commitment (AMC) pneumococcal pilot is also identified as a significant achievement.** As with IFFIm, GAVI's involvement in the AMC increased at a later stage – with the

selection of the pneumococcal pilot and the appointment of the Alliance for hosting the AMC Secretariat. Feedback suggests that the key features of GAVI that made it capable of supporting the AMC included the fact that it was an Alliance of the key immunisation partners, its track record in aggregating demand and introducing and financing vaccines in poor countries, and a relatively flexible organisation structure. These features distinguished it from other potential partners - *a priori* evidence of GAVI's additionality.

At a national level, our key findings in relation to value add are as follows:

- **GAVI's basic programmatic approaches and the development of tools to support countries' financial planning was a key source of innovation in Phase I.** GAVI's requirement for countries to prepare Financial Sustainability Plan (FSPs)/ comprehensive Multi Year Plan (cMYPs) has supported the improvement of planning and budgeting process in countries – which is an important area of value add.

- **Co-financing has supported country ownership, but it has contributed relatively little to financial sustainability and changes to the policy have been a cause of confusion at the country level.** There is a general view that the introduction of co-financing has been an important development supporting country ownership of immunisation decisions (even if the levels are probably too low in the overall context of financial sustainability). But our assessment is that the process (time taken to introduce the policy and then frequent revisions and updates) and the coverage of the policy (integration of issues of financial sustainability and country eligibility) have been areas of poor performance in Phase II.

- **GAVI's choice of vaccines and its basic funding model – despite its contributions to tools and country approaches – has had a negative impact on country financial sustainability.** All evidence points to the conclusion that the prospects for financial sustainability for low-income GAVI-eligible countries is very low indeed. Financial sustainability is expected to be a more surmountable challenge in low-middle income GAVI eligible countries. We also conclude that GAVI's choice of vaccines and presentations (i.e. combination vaccines) has not in practice been based on a realistic consideration of the potential for low-income countries to take on financing of these vaccines after GAVI support ends (whether through their own or other donor resources). In our view, there has been a failure to recognise explicitly, or communicate clearly, that financial sustainability (for low-income countries at least) would not be achievable in the medium term for the vaccines that GAVI supports.

Programmatic value add

Our findings in relation to GAVI's programmatic value add are:

- **There is strong evidence that GAVI's flagship program, NVS, has accelerated countries' introduction of life saving vaccines and immunisation outcomes – which might not have happened in its absence.** Analysis confirms that the introduction of HepB and Hib containing vaccines (and to a lesser extent Yellow Fever vaccine) was accelerated across GAVI countries after the Alliance was formed and suggests that fewer countries would have introduced these vaccines in the absence of

GAVI. Similarly, the country demand for pneumococcal vaccines is greater and faster than any other vaccine to date, but introduction may be delayed. Except for early introduction of rotavirus vaccine in some Latin American countries, there is no evidence that demand or introduction has been accelerated. GAVI-eligible countries are capable of quickly taking vaccine programs to scale; therefore, GAVI's current model appears to be effective. In supporting countries to make policy decisions on the introduction of vaccines, GAVI financing and the work of its partners has significantly improved the evidence base on disease burden, vaccine safety and effectiveness, cost-effectiveness data, and programmatic feasibility data. Finally GAVI has delivered timely forecasts for underused and new vaccines for use across the partners and with suppliers.

- **However, it has not contributed to a reduction in vaccine prices – as originally anticipated – with serious implications for country affordability and sustainability.** An area of weak GAVI performance has been its impact on vaccine prices. GAVI has not achieved the anticipated level of price decreases for Yellow Fever and pentavalent vaccine. GAVI has not actively addressed strategies for reducing vaccine prices and has continued to rely on natural market forces. If there continues to be minimal supplier competition (pentavalent vaccine) or unstable supply (Yellow Fever), vaccine prices will remain high. In addition, transient markets (HepB and Hib mono- and tetravalent vaccines) may have unintended consequences regarding GAVI vaccine prices and vaccine suppliers' motivation to enter GAVI markets. Our consultations, including with the vaccine industry suggest that GAVI 'could have done much more' in this area. Our view is that the failure to prioritise this issue by working strategically and proactively with industry partners is a key weakness of the Alliance. In addition, while GAVI has improved the supply stability for Yellow Fever and pentavalent vaccines (the two primary underused vaccines used by GAVI-eligible countries) and helped increase the number of suppliers prequalifying vaccines, supply stability has not been achieved for either vaccine through 2009. Finally, the accuracy of the underused vaccine forecasts has varied widely across the procurement rounds.

- **GAVI is unique in financing associated vaccine technologies through its injection safety program, which has clearly been successful and sustainable – although waste management remains an issue.** GAVI is the only donor financing injection safety in routine immunisation and evidence points towards the achievements and added value of GAVI in this area. The Injection Safety Support (INS) support has led to the adoption/ increased uptake of injection safety equipment across GAVI countries. Further, this program has demonstrated the highest sustainability in terms of sustained use and financing of safety kit after GAVI support (although we note the relatively lower prices of Auto-Disable syringes (AD) in comparison with the GAVI vaccine support). An unintended 'negative' consequence of this program has been the poor safe disposal/ sharps waste management in countries – primarily due to a lack of resources in countries.

- **GAVI's focus on health system bottlenecks in countries through its Health System Strengthening (HSS) window is deemed necessary for increasing coverage, but there are several issues in relation to the effectiveness of its delivery model, and the dilution of GAVI's focus and its comparative advantage.** It is

widely agreed that the dedicated GAVI HSS window has raised the profile of immunisation amongst global and national HSS stakeholders and demonstrated some positive features such as flexibility and promoting 'country ownership' (regarded as a key area of country value add vis-à-vis other donor approaches). However, HSS approved activities are broader than immunisation in scope. This raises questions of the extent to which HSS has diluted GAVI's core focus and diverted limited resources and efforts from effective delivery and monitoring of its existing programs. There are also several issues relating to the effectiveness of GAVI's HSS delivery model – although some of these are expected to be addressed in the HSS Funding Platform.

- **The Immunisation Services Support (ISS) program has also received 'mixed' feedback. Although generally regarded as being highly innovative, the impacts achieved and scope for sustainability are less conclusive.** GAVI ISS is highly valued by countries as being the only source of donor funding to expand routine immunisation coverage to the unreached. Country consultations indicate that its flexible and rewards-based funding has incentivised immunisation efforts at sub-national levels (although there are diminishing incentive effects after a certain level of coverage). Our regression analysis shows only some weak evidence of a positive impact of ISS disbursements on DTP3 coverage. However, the utilisation analysis of ISS funds disbursed indicates that on average about 50% of ISS funds available to a country in a year remain unutilised. Concerns on sustainability of the funding have also been raised.

- **The Civil Society Organisation (CSO) support program has been slow to take off on account of some fundamental design and implementation issues.** The CSO program is yet to contribute substantively to enhancing CSO engagement in immunisation and health systems across GAVI countries, although its potential is recognised. GAVI needs to address a range of design and process issues with the program (for example, clarity in program objectives, increasing program awareness at country level, cumbersome application process despite small grant sizes, delays in approval and disbursement, etc.) to ensure greater uptake (especially of Type A support) and impact. A clearer definition of outputs, outcomes, as well as performance indicators and targets is required to be able to assess the program's results and added value.

Organisational value add

Our findings in relation to GAVI's organisational value add are as follows:

- **GAVI's approach of working through its Partners, particularly at country level, goes to the heart of its Alliance model and 'lean' structure.** GAVI's 'lean' organisation model that finances governments directly and works though existing in-country Partners is largely unique and contributes to its efficiency. During Phase II, GAVI's administrative overheads as a proportion of Official Development Financing (ODF) have declined significantly –making it broadly comparable with the Global Fund (despite being significantly smaller), and lower than the Gates Foundation and other bilateral and multilateral donors. The Inter-agency Coordination Committee (ICC) mechanism in country is indicative of effective partnering amongst all immunisation donors and stakeholders. However, we understand this approach is less effective for

GAVI's HSS activities and there has been some feedback that the CSO and private sector stakeholders in country need to be engaged more meaningfully.

- **Evidence suggests that GAVI's program application and monitoring processes and communication at country level need to improve further, although a significant positive characteristic of GAVI's approach is 'country ownership'.** GAVI's program processes have improved over time and have been considered favourably in comparison to the Global Fund. A value addition of GAVI's processes at the country level, that set it apart from other donors, is the level of 'country ownership' it provides. However, areas of weakness were identified with regard to: (i) the effectiveness of GAVI communications with countries; and (ii) its approach to capturing and proactively monitoring country level data. We believe that the weakness of GAVI's monitoring and communication is partially related to a lack of clarity about the relative roles of Implementing Partners and the Secretariat in particular.

- **GAVI's partnership of public and private immunisation stakeholders is on one hand a key driver of its innovation, but on the other, a contributing factor to the challenges of work planning, budgeting, and performance monitoring**. The key value add of the Alliance is bringing together all the relevant public and private stakeholders in immunisation – that no other existing entity has achieved. The different skills and experience mix has clearly been important in promoting new and better ways of improving routine immunisation - in both programmatic and financial spheres. That said, there have been some relative failures. For example, we regard the work planning and budgeting process as an area of weak performance – and one which reflects a failure to tackle effectively the issues of roles and accountability. Other challenges are the lack of a coherent link between the GAVI strategy, indicators/ outputs and activities, the absence of systematic tracking of performance and GAVI's ability to capture and produce basic financial and performance information monitoring continues to create inefficiencies and risks for the organisation.[7]

- **As GAVI has evolved, there have been changes to the structure of the Partnership (and Secretariat) and nature of its innovations – but our view is that these have not detracted significantly from its added value.** The changing nature of the partnership to be more 'formal' or 'corporate' and the increasing role and independence or 'self-sufficiency' of the Secretariat has been a common theme in our evaluation of GAVI as a partnership. There are conflicting views on how these changes have impacted on value add. We note that uncertainty about responsibilities and accountabilities and the nature of the relationship between the Secretariat and Partners remains an issue and that has detracted from the efficiency of the organisation in Phase II.

  Our findings suggest that the nature of innovation and areas of GAVI's focus and contributions have changed over its two phases. Although we recognise that there is a change in the relationship between key Partners (WHO / UNICEF) and GAVI, we are not convinced that this has had a detrimental impact on levels of innovation. We think that a lessening in innovation on tools and approaches to financing routine immunisation

[7] We understand that work is ongoing to develop data warehousing systems to improve M&E.

was perhaps inevitable given the need to focus on delivery (and the need for 'proof of concept' i.e. GAVI's ability to support the introduction of new vaccines in eligible countries.) In addition we do observe innovation in other areas such as innovative finance and HSS.

- **GAVI has increased the interest in and commitment to immunisation at global and country level – borne out, as a minimum, by increased levels of funding.** There is *a priori* evidence to support the view that GAVI has broadly succeeded in increasing awareness and interest in immunisation at both the global and national levels. This success has primarily been as a 'by-product' of GAVI's fundraising (and innovative finance) activities and its programmatic expenditure. The quality, planning and quantity of GAVI's global advocacy activities has improved over Phase II – although there are still implementation challenges including in coordinating Partners, and widening the Partnership's advocacy messages and channels. Feedback about national level advocacy has been mixed, and varied between countries, mainly reflecting uncertainty about where it makes sense for advocacy messages and activities to be 'GAVI' as opposed 'GAVI Partners'.

1. INTRODUCTION AND BACKGROUND

1.1. Introduction

It is now more than ten years since the GAVI Alliance ('GAVI'[8]) was formally launched at the World Economic Forum in January 2000, with a mission **"to save children's lives and protect people's health by increasing access to immunisation in poor countries"**. This mission has remained largely unchanged through the decade, with GAVI's activities being divided into two broad phases: Phase I (2000-05) and Phase II (2006-10). GAVI is currently in the process of developing its strategy for a third phase of activity from 2011-15.

This is the final report of the GAVI Second Evaluation led by CEPA over the last nine months. It sets out the main findings and synthesis of our evaluation of GAVI's achievements against its four Strategic Goals (SGs):

- To contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner. (SG1)
- To accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security. (SG2)
- To increase the predictability and sustainability of long-term financing for national immunisation programs. (SG3)
- To increase and assess the added-value of GAVI as a public private global health partnership through improved efficiency, increased advocacy, and continued innovation. (SG4)

This report is accompanied by four separate SG reports, which provide the detailed analysis and evaluation material on each of the SGs. Readers with limited time should focus on this report, referring to the SG reports for further detail on the analysis.

In addition, there are a series of Supporting Papers (SPs) which contain analysis and evidence that is applicable across the four goals – for example, the five country reports.

1.2. Terms of reference

1.2.1. GAVI Request For Proposal (RFP)

The Terms of Reference (ToRs) for the evaluation were set out in the Second Evaluation RFP document[9] - and are reproduced in Annex A of this report. The ToRs describe the evaluation objectives as being an assessment of GAVI Alliance's results and value add at global and country levels. In particular, it poses two high-level evaluation questions:

(i) to what extent has the GAVI Alliance met its four SGs?; and

[8] In what follows, we use the terms 'GAVI', 'the Alliance' and 'the Partnership' interchangeably to refer to the GAVI Alliance.

[9] RFP Number RFP-EVA2240609

(ii) to what extent has the GAVI Alliance added value at the global and country levels, over and above what would be accomplished without the Alliance?

The scope of the evaluation is an assessment of the Alliance's results and value add across all of the SGs since inception, but with a primary focus on 2006 to present. The evaluation is also required to review the extent to which the strengths and weaknesses identified in the first evaluation have been sustained or addressed.[10]

A review of the GAVI governance structure is not part of the scope of this evaluation, given its recent review and subsequent re-organisation. (Note that CEPA was appointed in 2007 to advise the then GAVI Fund and Alliance Boards on governance options and so exclusion of this element is appropriate).

1.2.2. Understanding of evaluation requirements

We set out here the way in which we have understood GAVI's requirements and expectations in terms of the focus of the evaluation and the methodology. Our understanding reflects both: (i) the RFP and responses to clarification questions (as part of the selection process); and (ii) discussions with GAVI as part of the inception phase of the project.

Focus of evaluation

GAVI has emphasised the importance of:

- identifying key lessons learnt from GAVI's work since 2000 (but particularly since 2006), in order to inform its future strategic priorities and direction;
- the evaluation being more than simply an audit of what GAVI has achieved in the past and rather a consolidated synthesis of performance to date, in particular focusing on how GAVI can be made more efficient, effective, deliver better outcomes, and have higher impact; and
- addressing (as far as is possible given available evidence) the 'difficult' questions of how results are measured for each of GAVI's SGs, and the extent of value added of GAVI as a Global Health Partnership (GHP).

Focus of methodology

Given the broad scope of the evaluation, the limited timeframe, and the need for cost-effectiveness, GAVI has emphasised that our methodology needs to:

- draw on and make the most of the existing program specific evaluations conducted in Phase I and Phase II, and the Phase I evaluation conducted by Abt Associates;[11]
- limit the number of country visits given the extensive country-based work carried out as part of earlier evaluations; and

[10] The first evaluation covered the Phase I period from GAVI inception (2000-05), and was submitted in 2008.

[11] Abt Associates Inc. (2008): "Evaluation of the GAVI Phase I Performance (2000–2005)".

- present clearly how conclusions have been reached - showing explicitly how we have used various sources of evidence, and setting out the limitations of the evidence sources.

Other points to note about evaluation scope are as follows:

- We have agreed with the Secretariat that November 2009 would be the cut-off date for our analysis (unless otherwise specified). Nonetheless, where appropriate, we at least note some of the progress made on key areas since November 2009 to date; and
- As per the TOR we have prepared a separate Recommendations Paper which sets out the evaluation team's recommendations and discussion of options for development of GAVI's strategy and priorities in Phase III. This paper should therefore be read in conjunction with the Recommendations report.

1.3. Evaluation process

Our primary contact in GAVI throughout the evaluation has been Abdallah Bchir (Senior Specialist, Evaluation Policy and Performance). We are very grateful for his guidance and support throughout the process.

Key points to note about the process are as follows:

- We have not had any direct interaction with the GAVI Evaluation Committee[12] or the Board collectively - although we understand that the Evaluation Committee has reviewed our outputs, and we have spoken to Board members individually. We have not been asked to present our findings directly to the Board.
- We have had good access to senior members of the Secretariat at the outset of evaluation. We have also had extensive comments from Secretariat colleagues on two drafts of our reports. We have sought to take account of these comments where they are factual or provide a reasonable challenge to our analysis. However, we note that there is an inevitable 'conflict of interest' – which emerges particularly where we are drawing attention to weaker performance.
- The second draft of the report (which was the first full draft) has been provided to World Health Organisation (WHO), United Nations Children's Fund (UNICEF), and the World Bank. At the time of submission of this report, we have not received any comments or corrections from these Partners. We have also provided the second draft of the report to experts at Center for Disease Control and Prevention (CDC), Program for Appropriate Technology in Health (PATH) and John Hopkins for comment and received some limited comments.

[12] Except for a telephone consultation meeting with the Chair of the Committee early in the assignment.

1.4. Implementation of GAVI Phase I evaluation recommendations

The evaluation of GAVI's performance during Phase I (2000-05) was completed in October 2008 by Abt Associates.[13] A number of key issues/ areas for improvement were highlighted by the evaluation, and recommendations were made to address these.

CEPA has interviewed the GAVI Secretariat to understand the progress made on the recommendations of the Phase I evaluation. The Secretariat believe that all recommendations are either in the process of being implemented/ partially implemented or have already been implemented.[14] Some of the recommendations that have already been implemented include the following:

- The evaluation recommended that in order to improve support to countries, GAVI should ensure appropriate procedures are introduced for reported improprieties and other non-compliance. We understand that this has been implemented through the introduction of Financial Management Assessment (FMA) and the Transparency and Accountability Policy (TAP).
- It was recommended that evaluation mechanisms should be strengthened by commissioning a team to ensure there is Partner consensus on the evaluation framework. We understand that an evaluation policy was approved by the Board in June 2008, and a Board evaluation committee has been set up. A Monitoring and Evaluation (M&E) framework and strategy for 2010-15 has been drafted and additional positions have been created within the Secretariat for M&E.

We note however that some of the key findings and areas of weakness that were highlighted in the Phase I evaluation also emerge in the current evaluation – implying in our view that there is more work to be done.[15] Some of the main areas of overlap in the findings between the two evaluations are as follows (although we note that work is ongoing to address some of these issues):

- First, the Phase I evaluation noted that GAVI has not been very successful in influencing vaccine supply and pricing. The evaluation recommended that GAVI should increase its efforts to understand the vaccine market in order to develop realistic long-term pricing projections and goals; and to inform its procurement strategy, strategic planning and sustainability policy. The current evaluation also notes that GAVI has not contributed to a reduction in vaccine prices, as originally anticipated. We conclude that the lack of prioritisation of this issue by working strategically and proactively with industry Partners has been a failing of the Alliance.
- Second, the evaluation concluded that lack of long-term planning and conflicting objectives (promoting new vaccines versus improving sustainability) have limited progress toward financial sustainability at the country level. It was recommended that GAVI should reassess its sustainability definition and approach to ensure there is broad

[13] Abt Associates Inc. (2008).

[14] The implementation status of the Phase I evaluation recommendations is based on Secretariat feedback alone, and does not reflect CEPA's analysis/ judgement on progress.

[15] It is noted however that the Phase I evaluation has only recently been completed in 2008.

Partner agreement on the importance of sustainability relative to adding new vaccines, and to develop a long term financing plan for all vaccines. Our evaluation also concludes that GAVI's choice of vaccines and its basic funding model – despite its tools/ approaches that have supported countries' financial planning – has had a negative impact on country financial sustainability.

- Third, the evaluation highlighted that poorly defined roles and responsibilities of stakeholders and management entities was an important area of weakness. A number of recommendations were made for promoting an effective Partnership. Our evaluation concludes that on the one hand, GAVI's partnership of private and public stakeholders has been a key driver of innovation, but on the other, it has served as a contributing factor to the challenges of work planning, budgeting and performance monitoring. We find that while there have been improvements in the structure and quality of the work planning and budgeting process in Phase II, they still seem to reduce the effectiveness of the Partnership and raise issues of Partner roles and accountability.

- Finally, the evaluation also concluded that there is room for improvement for following-up on country specific issues and that in-country mechanisms for monitoring use of funds were not effective in some countries. A number of recommendations were provided to help improve GAVI's support to countries including initiating discussions with Partners at the country/ regional level to identify critical problems, developing a process for ensuring resolution of problems identified with recipient countries, etc. The evidence from our evaluation also suggests that GAVI's program application and monitoring process as well as communication at the country level need to improve.

Further details on the status of implementation of the Phase I evaluation recommendations (as reported by the Secretariat) are provided in Supporting Paper 5.

1.5. Structure of report

The rest of this report is structured as follows:

- Section 2 sets out our methodology in detail.
- Section 3 presents the cross cutting evaluation issues and methodological limitations.
- Section 4 provides a summary of publicly available information on key GAVI outputs and outcomes, by way of context.
- Sections 5 to 8 summarise the conclusions emerging from each of our detailed evaluation reports on the four goals.
- Section 9 summarises what we regard as the headline conclusions of the evaluation.

The report has the following Annexes:

- Annex A: Study ToR
- Annex B: List of Supporting Papers
- Annex C: Sources of evidence

2. METHODOLOGY

2.1. Evaluation questions

As noted above, the evaluation aims to answer the two 'RFP Questions':

- To what extent has the GAVI Alliance met its four SGs? (which we have referred to as GAVI's 'results')
- To what extent has the GAVI Alliance added value at the global and country levels, over and above what would have been accomplished without the Alliance? (which we have referred to as GAVI's 'value add')

To address these questions, we have organised the evaluation by SG. Under each SG we identified a number of Evaluation Questions that further organise the analysis and allow us to make judgments about the RFP Questions. Table 2.1 over page sets out the evaluation questions (which are numbered SG1.1, SG1.2 etc).

The nature of the evaluation question under each SG differ slightly as follows:

- SG1: The questions are organised around the specific GAVI programs that are most directly relevant to health systems (i.e. Injection Safety Support (INS), Immunisation Services Support (ISS), Health System Strengthening (HSS), and Civil Society Organisation (CSO)) and contribute to the Goal.
- SG2: The questions relate to sub-themes or issues that contribute to the overarching SG of accelerating the uptake and use of underused and new vaccines (through its New and underused Vaccines Support (NVS) program and related initiatives on Accelerated Development and Introduction Plan (ADIPs), etc), and improve vaccine supply security in countries.
- SG3: As with SG2, the questions pick up on the themes / issues contained in the overall SG.
- SG4: The questions here are also issues / themes that relate to the SG4. Given that this Goal relates to GAVI as a whole, aspects of the questions here are already picked up in the questions under the other SGs.

We recognise that there are alternative ways to have organised these questions (for example ISS might be regarded as being an important contributor to SG2). However, we believe that the allocations below are reasonable – and are also consistent with the approach suggested by GAVI in the RFP documents.

Table 2.1: Evaluation Questions

No.	Question
SG1: Health systems strengthening	
SG1.1	What have been the results and value add of GAVI's INS program at country and global levels?
SG1.2	What have been the results and value add of GAVI's HSS program at global and country levels?[16]
SG1.3	What have been the results and value add of GAVI's ISS program?
SG1.4	What have been the results and value add of GAVI's CSO program?
SG2: Vaccine support	
SG2.1	To what extent has GAVI accelerated the uptake of underused and new vaccines by partner countries?
SG2.2	To what extent have countries introducing underused and new vaccines been able to take them to scale quickly, i.e. achieve full scale coverage?
SG2.3	To what extent has GAVI improved the stability of global and country level vaccine supply?
SG2.4	To what extent has GAVI made vaccines and related technologies more affordable?
SG2.5	To what extent has GAVI contributed to the advancement of the evidence base required for countries to address the policy decision related to introduction of new vaccines?
SG2.6	To what extent has GAVI developed and used vaccine demand forecasts that are accurate and timely?
SG3: Predictable and sustainable financing	
SG3.1	To what extent has GAVI increased the level of global financial resources from donors for immunisation activities?
SG3.2	To what extent has GAVI increased the predictability and sustainability of global financial resources from donors for immunisation activities?
SG3.3	To what extent has GAVI promoted and increased the sustainability of immunisation funding at the national level?
SG3.4	To what extent is the existence of innovative financing mechanisms - International Finance Facility for Immunisation (IFFIm) and Advance Market Commitments (AMC) -dependent on the existence of GAVI in its current structure and form?
SG4: GAVI's added value as a global Public Private Partnership (PPP)	
SG4.1	Has the distinctive organisational structure contributed to the efficiency, effectiveness and impact of GAVI? If so how?
SG4.2	To what extent has GAVI increased awareness of, interest in, and commitment to immunisation and child health?
SG4.3	Has the GAVI focus on collaboration with a wide range of private and public stakeholders contributed to its effectiveness and impact?

[16] In the inception report, we had split the HSS question into two, examining results and added value respectively. However, having collected the evidence, we believe there are strong overlaps/ inter-linkages between the two questions, on account of which we have merged into one question (similar to the other three SG programs).

2.2. Definitions and approach

2.2.1. GAVI Alliance, Partners and Secretariat

We set out here a number of key definitions that we have used in the evaluation documents. The list is not exhaustive

The '**GAVI Alliance**' or '**GAVI**' or '**Alliance**' or '**Partnership**' are used interchangeably to refer to the GHP founded in 2000 that we are evaluating. The terms are intended to cover GAVI since inception, despite changes in the precise institutional and legal form of GAVI.

'Partners' refer to institutions that are members of GAVI. Given the nature of GAVI as an Alliance that works through its Partners to deliver its mission and objectives, Partners may be involved in: (i) developing GAVI's policies and programs; (ii) supporting delivery; and (iii) governance of the Alliance. A full list of Partners (and the important category of Unaffiliated Board Members) and their typical roles are set out in the SG4 report.

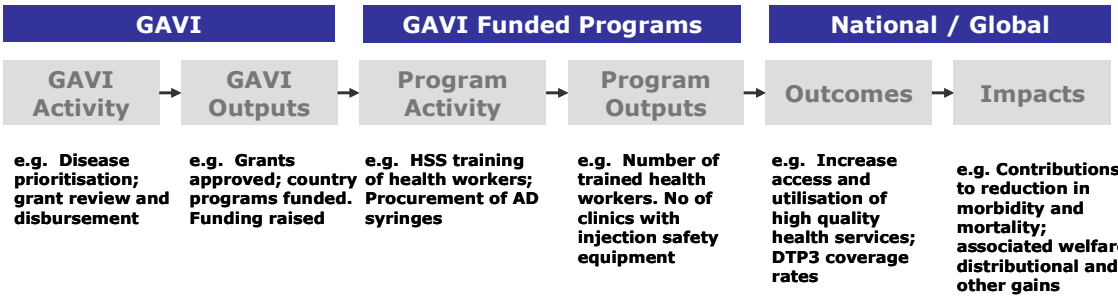
We refer specifically to WHO, UNICEF, and the World Bank as '**Implementing Partners'** given their specific additional roles and mandates in country-level technical assistance and procurement.

The '**GAVI Secretariat**' or '**Secretariat**' are the staff employed by GAVI. They are responsible for GAVI's day-to-day operations, and are accountable (through the Chief Executive Officer) to the GAVI Board. As noted in the SG4 Report, the size and role of the Secretariat have increased over time as the nature of GAVI has changed from a relatively loose 'alliance' to a more formal 'partnership'. In this context, although our evaluation is explicitly an evaluation of GAVI not of the GAVI Secretariat, the role of the Secretariat, particularly in Phase II, has increasingly become an integral part of GAVI's performance.

2.2.2. Hierarchy of activities, outputs and outcomes

In any program evaluation, there is a hierarchy of activities, outputs, outcomes and overall impacts. There are no right definitions. However, it is very important to be clear about terminology. Figure 2.1 and the descriptions below provide details of the framework and definitions that we have used in this evaluation.

Figure 2.1: Hierarchy of outputs, outcomes and impacts



GAVI activities relate to the processes carried out by the Secretariat and Alliance Partners contributing to GAVI's work (e.g. in Board or other Committee meetings). These activities include things such as disease or vaccine prioritisation, setting policies like the co-financing policy, and grant review and disbursement processes.

GAVI outputs are the direct results of GAVI activities, many of which are measured as process indicators in the GAVI dashboard, such as grants approved and disbursed; proportion of eligible countries funded.

Program activity and (intermediate) outputs such as number of health workers trained relates to the actions / processes that GAVI funds but which are carried out by Partners (e.g. procurement activity carried out by UNICEF, or HSS programs delivered in country) and which result in 'intermediate or program outputs'. These intermediate outputs contribute to the achievement of the ultimate outcomes and impacts.

Outcomes may be at national, regional or global levels, and are the intended outcomes of program activity. A key distinction between outputs and outcomes is that outputs are typically directly controllable (e.g. number of health workers trained). In contrast, outcomes (e.g. improvements in access and utilisation of health services) are likely to rely on a wider range of factors than those directly controlled by a particular project or program.

Impacts in the context of GAVI's activity relate to the ultimate achievement of reductions in child mortality and morbidity. They also relate to wider social and economic effects (e.g. economic welfare, distributional impact and reduced disease burden). Impacts are the most difficult aspects of the results hierarchy in terms of their attribution to the program, and are lagged in time.

2.2.3. Application of the hierarchy – measuring 'results'

The analysis conducted for most Evaluation Questions has tended to focus on an assessment (in terms of results) of GAVI Activities and Outputs, and Program Activity and Outputs. In some cases, we have also been able to assess Outcomes (e.g. Diphtheria, Tetanus and Pertussis (DTP3) coverage). The extent to which we have been able to go down the results hierarchy varies by SG and Evaluation Question.

The GAVI Alliance Strategy 2007-10 sets out the hierarchy of outcomes, outputs and indicators to support the achievement of the organisation's overall goal. However, several of the indicators are largely process and input indicators, and not quite indicative of results achieved (for example, percentage of countries that received a specific program support). Also, the absence of both a baseline and target (and at times, consolidated performance information) for many indicators implied that an assessment of results could not be made. For example, one of the HSS output indicators is 'all countries receiving HSS support for at least two years will have addressed health system constraints as indicated in their original proposal'. This information is not reported by countries in the Annual Progress Reports (APR), without which the linkage between HSS constraints and activities often cannot be established. Also, there are no target figures or baselines in place to measure progress against these indicators. Where data was available, we have sought to measure results as far down the hierarchy as practical.

A weakness of our study (to some degree anticipated in our proposal) has been the extent to which we have quantified ultimate impact or ultimate cost-effectiveness indicators of immunisation. This reflects time availability and the need to focus on the way in which GAVI as a partnership has achieved results and the extent of its value add. Given this, we rely on WHO estimate of deaths averted as the basic relevant measure of impact (see Section 4).

2.2.4. Measuring 'value add' (additionality)

A key part of this evaluation has been the consideration of the extent to which GAVI has added value in its activities, compared to what would have been achieved in its absence.

Definition

Our understanding of added value is based on the economic concept of 'additionality' and is defined as: **"the net impact after allowing for what would have happened if funding had not been available, or alternatively been made available for GAVI's program activities but through other routes".**

Types of value add

In seeking to assess value add, we believe that it is appropriate to distinguish between 'financial' and 'programmatic or organisational' additionality as follows:

- GAVI's financial value add or additionality, is the extent to which funding for immunisation might not have been available in GAVI's absence.
- GAVI's programmatic or organisational value add, is the extent to which, for the same level of funding (e.g. through pre-existing multilateral or bilateral aid channels) GAVI has achieved more or better impact.

Further, we have also considered whether GAVI's additionality has been at a global or country level.

The relevance of these particular definitions of value add has varied by SG, but the focus of our analysis has been on any incremental contribution of GAVI as an Alliance over and above the counterfactual of what might have resulted from its individual Partners operating independently (again, allowing for issues of attribution, validity of counterfactuals, data bias, etc).

In considering different elements of GAVI's performance across its goals, we have also kept in mind the following characteristics of 'added value':[17]

- *More (additional):* actions that were being conducted before, but there are now more of them at a markedly increased level of activity;
- *Improved:* actions that were being conducted previously but are now appreciably more effective, efficient, or strategic;
- *Unique:* actions/ contributions that are exclusive or exceptional to GAVI;
- *Faster:* actions that were being conducted previously but now at a more accelerated pace;
- *New or Innovative:* actions that are entirely new or original to GAVI and initiated because of GAVI.

[17] These are borrowed from the draft of the Literature Review of Added Value shared with us by the GAVI Secretariat.

Approaches to assessing value add

The way in which we have sought to assess value add varies by evaluation question:

- In some cases, it is primarily about establishing whether the evidence points to the fact that GAVI specifically has contributed to a certain achievement (i.e. attribution to GAVI). To do this, we have used a combination of quantitative analysis (where possible) and stakeholder feedback on whether they attribute a particular result to GAVI.
- In other cases, it requires explicit consideration of a counterfactual. It is difficult to identify a single and ideal counterfactual for GAVI, given its goals and range of programs. Different counterfactuals are relevant to each aspect being evaluated. Examples of counterfactuals include:
    - considering the case where funds are provided through traditional multilateral channels (or not provided by donors at all) in the absence of GAVI in the case of SG3;
    - assuming that vaccine adoption and uptake rates continuing on a pre-GAVI trend for our analysis of SG2; etc.

  Where possible, we have incorporated some quantitative analysis of these counterfactuals – relying on existing data and making assumptions where necessary. In most other cases, our use of explicit counterfactuals has been limited to structured interviews and consultations during country visits, in order to explore views about what might have happened in the absence of GAVI.
- A third approach is to assess (through case studies) the techniques used by comparator organisations to achieve similar or related objectives (albeit most often in a different context). Again, we have tried to identify suitable comparators for GAVI, depending on the program / goal being assessed. The Global Fund has been a key comparator to assess GAVI value add across several areas. In other cases, we have drawn on other appropriate comparators such as say, the World Bank and the United States Agency for International Development (USAID) for HSS; the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Making Medical Injections Safer (MMIS) for INS; etc. We have sought to verify information about comparator organisations through interviews. However this has not always been possible.

2.3. Sources and use of evidence

2.3.1. Evidence source

The availability and nature of evidence varies by evaluation question and this is set out in each of the separate SG reports. In general though, our aim has been to bring together, and where possible, 'triangulate' a range of possible quantitative and qualitative evidence sources/ types of analysis – as set out below in Table 2.2.

We discuss each evidence source and relevant methodology issues in more detail in Annex C. Supporting Paper 3 "Evaluation Methodology Material" brings together all of the relevant

documents / questionnaires / interview guides that have been prepared by CEPA / AS and used in the course of the evaluation.

Table 2.2: Evidence source summary

Evidence source or analysis	Description
Review of documentation	Review of available GAVI documentation, documentation from GAVI Partners, and related academic and 'grey' literature. This analysis has been particularly important in answering the first element of the RFP questions (i.e. whether the SGs have been met).
Quantitative analysis	Analysis of trends, growth rates and levels of relevant metrics that track GAVI outputs and progress in achieving its SGs. Analysis of data received from GAVI Partners to assess GAVI results and value add. Comparison of trends also supports judgements about value add.
Regression analysis	Where we have a consistent time series or cross-sectional data with a reasonable number of observations, we have conducted regression analysis to support the assessment of hypotheses about the contribution of GAVI to relevant outputs and outcomes.
Structured interviews	Telephone or in person interviews conducted with a range of GAVI stakeholders, including Board and Committee members, constituency members, and external experts - covering both achievement of GAVI's SGs and value add.
Surveys	We have conducted two surveys that contribute to our understanding of both RFP questions. The first was an opinion-based e-survey of GAVI stakeholders. The survey was sent to approximately 1,000 recipients and we received 282 responses (a 28% response rate). The second is a short written survey with Expanded Program for Immunisation (EPI) managers in GAVI eligible countries. This survey was sent to EPI managers in all 76 countries, and we received 23 responses (a response rate of 30%).
Country studies	We have conducted five country visits to supplement our other analysis. Given the number of country studies, the intention has not been to get a representative or significant sample. Rather we have sought to visit a country that have not already been studied in previous GAVI evaluations (other than Mali which was a part of the Phase I evaluation) and provide a range of experience and issues.
Benchmarking /case studies of comparators	This analysis is particularly important in contributing to judgement about the extent to which the existence of GAVI Alliance has added value compared to the alternatives. However, it has also proved very challenging to conduct meaningfully. Where possible, we have supplemented desk-based analysis with interviews with relevant comparator institutions – although this has been limited.

2.3.2. Presenting and summarising evidence

In each of the SG reports, we have used a consistent approach to presenting and assessing evidence in order to reach conclusions.

There are separate sections for each Evaluation Question. These start with a statement of the scope of the evaluation and the sources of evidence/analysis that we have used in reaching

conclusions. The sources of evidence are summarised for ease of reference in a common table format (for most questions). Having presented the detailed evidence/analysis, we then summarise the emerging themes and findings that relate to the particular Evaluation Question.

To assess the strength of a conclusion, we have allocated a 'robustness scoring' to each main finding[18]. The definitions of the four scores (A-D) are set out in Table 2.3 below. But in general, we are making an assessment of both:

- the extent to which we have a range of evidence types (e.g. quantitative and qualitative) and different sources (e.g. different data bases) that point to the same conclusion – we refer to this as 'triangulation'; and
- the underlying quality of individual data types and evidence source (e.g. as determined by sample size, reliability and completeness of data).

Table 2.3: Robustness ranking for evaluation findings

Ranking	Description
A	The finding is consistently supported by the full range of evidence sources, including quantitative analysis and qualitative evidence (i.e. there is very good triangulation); and/ or the evidence source(s) is/ are of relatively high quality and reliable to draw a conclusion (e.g. solid sample sizes are available and there are no major data quality or reliability issues).
B	There is a good degree of triangulation across evidence, but there is less or 'less good' quality evidence available. Alternatively, there is limited triangulation and not very good quality evidence, but at least two different sources of evidence.
C	Limited triangulation, and/ or only one evidence source that is not regarded as being of a good quality.
D	There is no triangulation and/ or evidence is limited to a single source and is relatively weak; or the quality of supporting data/ information for that evidence source is incomplete or unreliable.

Points to note for readers in interpreting these scores are as follows:

- They are not absolute measures of the robustness of the evidence base. Rather they are **relative** rankings that are intended to allow the reader to get an indication of our assessment of the strength of a finding.
- The scores are themselves judgemental and reflect our assessment of the evidence base that exists or that we have been able to identify as part of our evaluation.
- It is important to note, that it is possible for us to have 'good' triangulation of 'high quality' evidence but a mixed or ambiguous conclusion on GAVI performance. This might occur if we have a good range of evidence that all points to mixed performance.

[18] In our Inception Report, we had anticipated assigning a robustness scoring to the evidence as opposed to the conclusion. Our judgement is that the revised approach is preferable – since it is more tractable and has less repetition. Further, assigning a robustness rating to the conclusion allows us to take account of the strength of the range of evidence sources applicable in drawing that conclusion.

3. CROSS CUTTING ISSUES AND METHODOLOGICAL LIMITATIONS

The main challenges of this evaluation are common to most evaluations in global health (and other development sectors). They include problems of data quality and consistency, difficulties in attribution, and challenges associated with establishing and identifying evidence of the counterfactual (i.e. what would have happened in the absence of an intervention).

This section sets out the methodological limitations to provide an appropriate level of caution on the robustness of our findings. However, we believe in general that we have developed a good understanding of GAVI during the evaluation process - and therefore that the broad direction of our main findings are robust, even if precise estimates of impact or specific statements are subject to debate.

Notwithstanding the strengths and added value achieved by the Alliance across its activities (as pointed out in the assessment of each of the SGs), the evaluation has identified a small number of relative shortcomings that are relevant to GAVI's performance across the goals.

We address them here in Section 3.1 (rather than later in the report) because they are directly relevant to the methodological limitations of our evaluation. We also believe that they are very important for the ability of GAVI to measure performance and allocate scarce resources efficiently going forward.

3.1. Key cross-cutting issues identified in the evaluation

For clarity, we have split the issues into three separate areas:

- the way in which GAVI's strategy and performance framework links activities, outputs and objectives in a coherent way;
- how this strategy is operationalised, including data collection and performance management; and
- the need for better prioritisation of Secretariat and Partner resources.

3.1.1. Links between SGs, activities and outputs; and defining performance indicators

Based on our evaluation, we believe that an area of weak performance has been that GAVI has not sufficiently aligned its activity (and particularly the Work Plan) with its strategy, resulting in GAVI activities that do not explicitly link to desired outputs and specific objectives which contribute to the achievement of a SG. There is also a lack of clarity on who within the Alliance (e.g. Partner or Secretariat) has ownership of a particular objective and related indicator.

The GAVI Alliance Strategy 2007-10 sets out the hierarchy of outcomes, outputs and indicators to support the achievement of the organisation's overall goal. However, most of these indicators are input / process indicators, and several are not defined granularly enough to facilitate measurement. Further, the absence of both a baseline and target for many indicators implies that an assessment of progress cannot be made.

The Board is aware of this issue and the work being undertaken on the new GAVI Alliance Strategy is, as we understand it, seeking to tackle this.

3.1.2. Data collection and performance monitoring

A key weakness of the GAVI Alliance that has emerged across our evaluation of SGs is the relative absence of:

- regular and systematic recording of GAVI Activity, Program Activity and Output data (see Figure 2.1 in Section 2 above); and
- clearly defined performance indicators / metrics (preferably 'output' based) against which performance across the organisation can be monitored.

Contributing factors to this might include:

- the historic segregation of GAVI's financial and programmatic functions (in the GAVI Fund and Alliance) – which may have contributed to a lack of focus on how funding has been spent and what outputs have been achieved; and
- the fact that GAVI was a hosted organisation up to 2009, reliant on UNICEF systems as opposed to its own tailored systems.

But, in our view, the issue is more fundamental. It relates to two failures: (i) failure of the organisation (including the Secretariat) to prioritise M&E of its activities; (ii) failure to tackle issues of accountability between the GAVI Alliance and its key Implementing Partners.

From the perspective of this evaluation, we have spent a significant amount of time compiling (or following up with GAVI to compile) and seeking to establish relatively basic facts about GAVI Activities, Program Activities and Outputs. An important outcome of the evaluation should be, at a minimum, for the GAVI Alliance to put in place the systems to capture data and performance indicators to improve future evaluations. We understand that the development of a data warehousing system is in progress, which aims to address this issue.

From a wider perspective, we think there are significant risks for GAVI in terms of the extent to which it tracks its activities and performance. Indeed, it is very surprising to us that GAVI (as a multi-billion dollar GHP) has not historically tracked and maintained the key databases needed to have a good understanding of its own activities and outputs.[19]

3.1.3. Need to prioritise resources

GAVI has rightly been recognised for its innovation across a number of its programs (nationally and globally); and its relative agility is also regarded as a source of value add. However, it is important to recognise the trade off that exists here.

Across the evaluation, we have identified a number of cases where it seems that GAVI has launched programs or committed to activities and has not identified (or has been slow to identify) wider implications in terms of funding, delivery model, or availability of resource.

[19] Note that the attempts to measure Outcomes and Impacts are more mixed. We recognise the uncertainties and challenges associated with DTP3 coverage rates, and that this has been the focus of considerable and ongoing work. In addition, although we have not independently verified WHO estimates of deaths averted, our presumption is that the methodology and estimates are reasonable within an appropriate margin of error (Source: WHO Report on GAVI Progress 2000-2009, 15th October 2009).

Examples include:

- Pentavalent vaccine priority and expectations of vaccine price decline in an immature market with a single supplier.
- A relative failure to anticipate (and resource) changes in delivery model requirements of a large 'cash-based' program like HSS, and belated introduction of the FMA process.
- Issues in the delivery model for the CSO program, and not having consulted on this with the CSOs and other relevant stakeholders – resulting in poor uptake.

Of course, it is always easy to identify these issues with the benefit of hindsight and this should be taken into account. But, more generally, our sense is that there has been a tendency for GAVI to prioritise new activities as opposed to 'stabilising' the delivery of existing programs (with implications in terms of trade-offs given limited resources and limited Secretariat and Partner time).

In addition, we note that GAVI's ability to conduct full analysis of key policy / program issues and assessment of its own value add is affected by the availability of data. Despite the fourth SG being around the organisation's added value as a PPP, there is no defined framework in place for the Alliance to assess whether any of its activities/ programs (particularly any new initiatives) might add value within the global (and national) health aid architecture.

3.2. Methodological limitations

The SG-specific methodological limitations are described in each of the SG reports. However, some overall limitations of the analysis are noted below. We have presented these limitations in two parts: (a) those arising from the cross cutting issues identified above; and (b) other limitations.

3.2.1. Limitations that relate to cross cutting issues

The lack of definition of strategic objectives and actively monitored indicators (referred to in 3.1.1 above) has made the measurement of results and added value challenging. As noted above, where a performance indicator has been defined, there is a relative absence of baseline data and / or targets. More generally, it has often not been clear who within the Alliance (e.g. Partner or Secretariat) is responsible to report on progress.

As mentioned in Section 3.1.2, there are a range of data issues that have constrained the scope and quality of the evaluation. In general, significant amounts of key data were not: (i) accessible in a readily analysable format; (ii) complete; or (iii) accepted as authoritative or at least a 'best' estimate or value. In particular:

- Basic finance and performance data on GAVI programs and outputs was not available in a ready, analysable and aggregated format from GAVI's inception to date, and either we or the Secretariat have had to compile some of this data for the evaluation based on the best available inputs from the Secretariat and GAVI Partners. This resulted in delays – which were significant given the short duration of this evaluation.

- Data that would have enriched various analyses for the Evaluation Questions were not available (for example, program process performance indicators; information on uses of funds by countries once disbursed; consolidated vaccine information on prequalification dates, vaccine presentation and formulation, and prices; etc).
- Multiple sources for the same data (e.g. vaccine introduction dates) did not always match. To avoid confusion, we have cited the data sources used and any discrepancies identified.

3.2.2. Other limitations

Other limitations of the evaluation are noted below. However as mentioned at the start of this section, a number of these limitations are common to most evaluations in global health.

- We have not independently verified the assumptions/ basis of calculation of the WHO / GAVI estimates of outcomes and impacts (e.g. deaths averted). We have also referred to some of the literature on cost effectiveness of vaccine interventions, which we have not independently verified.
- Despite our attempt to focus on 'value add', we have struggled to find evidence sources / comparators that give very strong quantitative support for conclusions about GAVI value add. For example, the absence of an obvious 'control group' of countries makes establishing what might have happened in the absence of GAVI challenging.[20] We have therefore had to rely, in a large number of cases, on qualitative feedback through interviews and country visits on developing counterfactual scenarios.
- We agreed (with GAVI) to limit the number of country studies conducted as part of this evaluation to five – given the level of country analysis conducted in other evaluations. However, it is important to recognise our direct country findings (i.e. excluding findings from other Evaluations) are based on a limited sample. In order to mitigate we conducted a written survey of EPI managers. Although the response rate was not unreasonable (30%), the depth of responses was limited.
- We have tried to interview a wide range of GAVI stakeholders at global, regional, and country levels; and triangulate the qualitative feedback received, where possible. However, for some specific questions (e.g. specific program performance), the feedback received from interviews has been limited, not allowing us to draw strong inferences. Further, having undertaken a backward looking audit, we have relied on the strength of respondent recall on the issues being investigated.
- For some areas, specifically SG4 (around the value add of the PPP), we have had to rely to a greater degree on respondent's perceptions and desk reviews. Given the limited availability of other data sources, we note that the synthesis and conclusion are therefore more reliant on CEPA's judgements.

[20] Countries with annual per capital income below $1,000 are eligible for GAVI support; therefore non-GAVI eligible countries would all be higher income countries and not the most appropriate control group. Further, the number of GAVI-eligible countries that did not receive support under a specific program is quite small in number, so they also cannot be used as a control group. Where appropriate, we compare data/ performance between GAVI countries and non-GAVI middle income countries to examine observable differences, although realising that they are not an ideal comparison group.

- To assess the strength of each conclusion, we have allocated a 'robustness score' to each main finding (as described in Section 2.3.2 above). We think that this strengthens our analysis in terms of transparency, but the relative rankings are inevitably judgemental and reflect our assessment of the evidence base.

4. OVERVIEW OF GAVI OUTPUTS, OUTCOMES AND IMPACTS

GAVI's ultimate mission is 'to save children's lives and protect people's health by increasing access to immunisation in poor countries'. The focus of this evaluation has been the way in which GAVI has operated and the extent to which is achieved results and added value in working to achieve this mission.

As noted in Section 2, we have not used the available budget for this evaluation to independently verify or repeat existing work that has been conducted to estimate impact on child mortality. However, such estimates and a broad understanding of cost-effectiveness are a fundamental starting point for everything that follows.

In this section, we therefore provide:

- references to some of the literature on cost effectiveness of immunisation in terms of health impact;
- an overview of GAVI's patterns of funding;
- details of the estimated impacts achieved in GAVI-supported countries in terms of deaths averted (as estimated in the 2009 WHO-GAVI Progress Report),[21] i.e. 'Impacts' in our results hierarchy; and
- a judgement on the extent to which GAVI's estimated cost effectiveness at an aggregate level is consistent with the evidence of immunisation cost effectiveness from detailed studies.

We note that the chain of causality linking GAVI 'Outputs' and 'Impacts' is complex, and we do not propose to try to link them here. Rather we present them here by way of context for our evaluation by SG. It is also important to emphasise that this section does not purport to represent a detailed or rigorous assessment of ultimate impact – which is out of our scope.

4.1. Cost effectiveness of immunisation interventions

There is substantial evidence to suggest that, in general, vaccines are a cost-effective health intervention – and therefore a 'good buy' for donors seeking to achieve health impact and reducing child mortality in particular.

We have not reviewed the entire literature. But we present here a number of sources of evidence:

- A report by the Center for Global Development (CGD)[22] suggests that, as a rough guide, development interventions can be considered highly cost-effective if they achieve a cost per Disability-Adjusted Life Year (DALY) saved of less than $100. They note that several studies have found that the cost per DALY saved in low- and mid-income countries falls well below this threshold. Even for the most costly example they report (Hepatitis B

[21] We also compared the 2009 report with the 2008 report, and found there were no major revisions to the data presented in the earlier report.

[22] Barder and Yeh: "*The Costs and Benefits of Front-loading and Predictability of Immunisation*". (Center for Global Development Working Paper Number 80, January 2006)

(HepB) vaccine in low-income countries with prevalence below 2%), the cost per DALY saved is estimated to be $42-$59.

- A report by the Disease Control Priorities Project[23] reports that for low- and mid-income countries the cost per DALY gained for basic childhood vaccines could be as little as $7 (as compared with $102 for treatment of tuberculosis, for example).
- Studies of vaccine introductions supported by GAVI tend to substantiate this (see Table 4.1 below).

Table 4.1: Estimated cost per DALY gained for GAVI interventions

Vaccine (presentation)	Country	Cost per discounted DALY gained	Cost per death averted	Reference
Hib (pentavalent)	Kenya	$38	$1,197	Akumu et al (2006)[24]
Hib (monovalent)	Indonesia	$102	$4,438	Gessner et al (2008)[25]
Hib (pentavalent)	Indonesia	$74	$3,102	Gessner et al (2008)
HepB (tetravalent)	Mozambique	$52	$436	Griffiths et al (2005)[26]

Table 4.1 also reports the cost effectiveness measure as cost per death averted for comparability with the approaches used by WHO in its estimates of GAVI impact.

4.2. Uptake of GAVI support

GAVI provided a total of $2.2bn in disbursements to 75 countries over the period 2000-09. This sub-section contains details of how this support was divided by: (a) type of support; and (b) certain categories/ groupings of countries. In this section, we define "type of support" to be either vaccine-related (i.e. NVS) or health system-related (i.e. INS, ISS, HSS and CSO).

Figure 4.1 shows the profile of disbursements over time for both types of support. It shows both the rising level of disbursements into Phase II and the fact that vaccine-related support dominates health-system related support (including for INS, ISS, HSS and CSO programs) in every year.

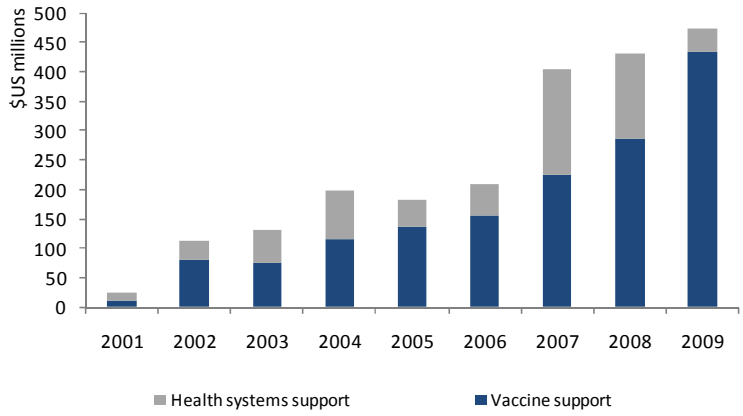
[23] "Using Cost-Effectiveness Analysis for Setting Health Priorities" (accessed from www.dcp2.org).

[24] Akumu, English, Scott & Griffiths: *"Economic evaluation of delivery* Haemophilus influenzae *type b vaccine in routine immunisation services in Kenya"*. (Bulletin of the World Health Organization, 2007).

[25] Gessner, Sedyaningsih, Griffiths, Sutanto, Linehan, Mercer, Mulholland, Walker, Steinhoff & Nadjib: *"Vaccine-Preventable* Haemophilus influenza *Type B Disease Burden and Cost-Effectiveness of Infant Vaccination in Indonesia"*. (The Pediatric Infectious Disease Journal, 2008).

[26] Griffiths, Hutton & Das Dores Pascoal: "*The cost-effectiveness of introducing Hepatitis B vaccine into infant immunisation services in Mozambique"*. (Health Policy and Planning, 2005). Note that the authors place greater emphasis on the discounted cost per DALY.

Figure 4.1: Total disbursements by type of support (2001-09)



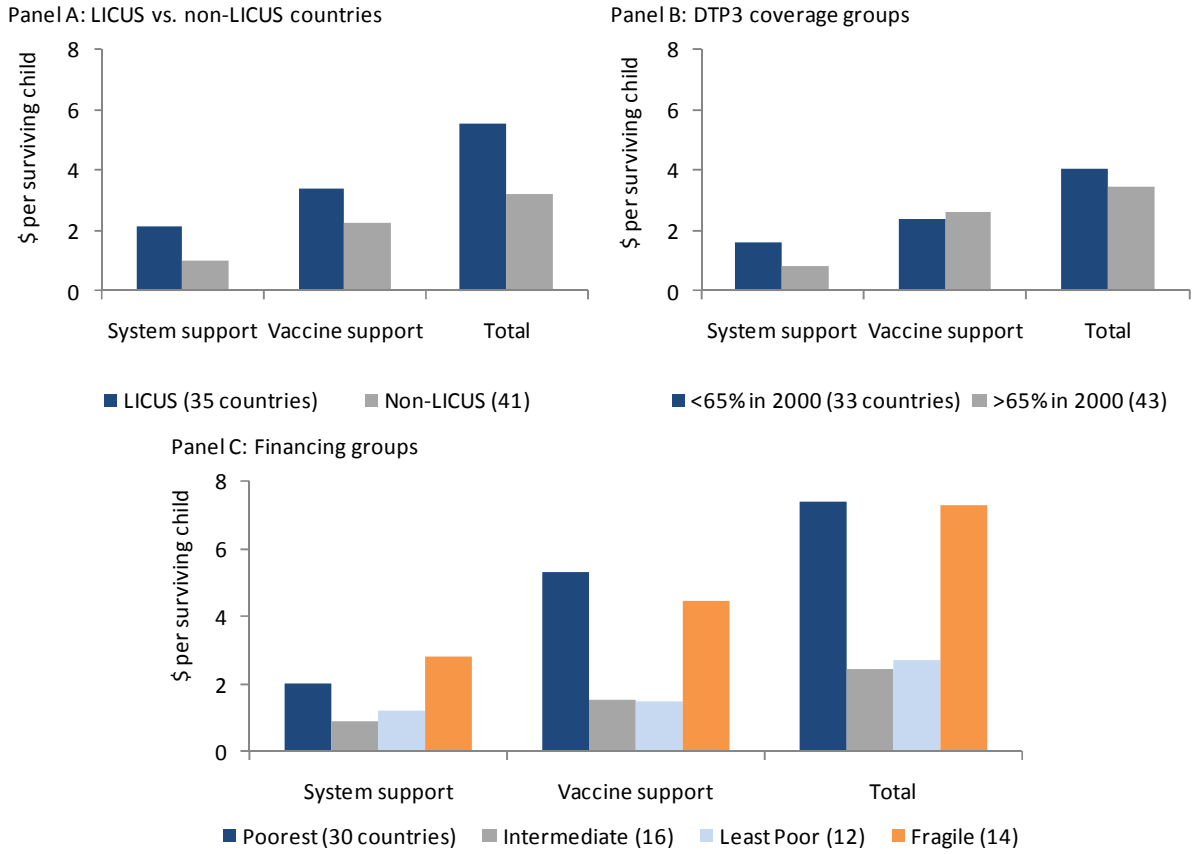
4.2.1. By country categorisation

The distribution of resources between country types varied between vaccine support (i.e. NVS) and system support (i.e. ISS, HSS, INS and CSO). Figure 4.2 below shows the breakdown of disbursements per surviving child by three different country groupings:

- LICUS vs. non-LICUS countries;
- countries with DTP3 coverage below 65% in 2000 versus those with coverage above 65% in 2000; and
- GAVI's financing groups (i.e. least poor, intermediate, poorest and fragile).[27]

[27] We exclude the four countries no longer eligible for support as they are not in any financing group. They are Albania, Bosnia and Herzegovina, China and Turkmenistan.

Figure 4.2: Disbursements per surviving child by country group and type of support (2001-09)



The above evidence suggests that support per child has been targeted at children in weaker GAVI eligible countries: in particular the LICUS countries and those in the "poorest" and "fragile" financing groups. These countries receive high total disbursements per surviving child.

The balance of support provided between system support and vaccine support varies by country group. The low DTP3 coverage countries in particular received a relatively high proportion (per surviving child) of system support. For these countries, 41% of disbursements per surviving child were for system support, compared with 24% for the high DTP3 coverage countries. This difference reflects GAVI rules: only countries with DTP3 coverage exceeding 50% are eligible for vaccine support.

To some extent a similar pattern is in evidence when comparing LICUS and non-LICUS countries. For the weaker LICUS countries, 39% of disbursements per surviving child were for system support, compared with 30% for the non-LICUS countries. However, there is less evidence of such a pattern across financing groups. Overall, it appears that GAVI's rule relating to DTP3 coverage is the main driver of the balance between system and vaccine support.

4.3. Estimated results

This section presents a brief summary of the findings of WHO's recent GAVI progress report.[28] The report contains an assessment of GAVI's impact on vaccine coverage and mortality

[28] 'WHO report on GAVI Progress 2000-2009 & Projected Achievements 2009-2010' by Department of Immunisation, Vaccines, and Biologicals (15 October 2009).

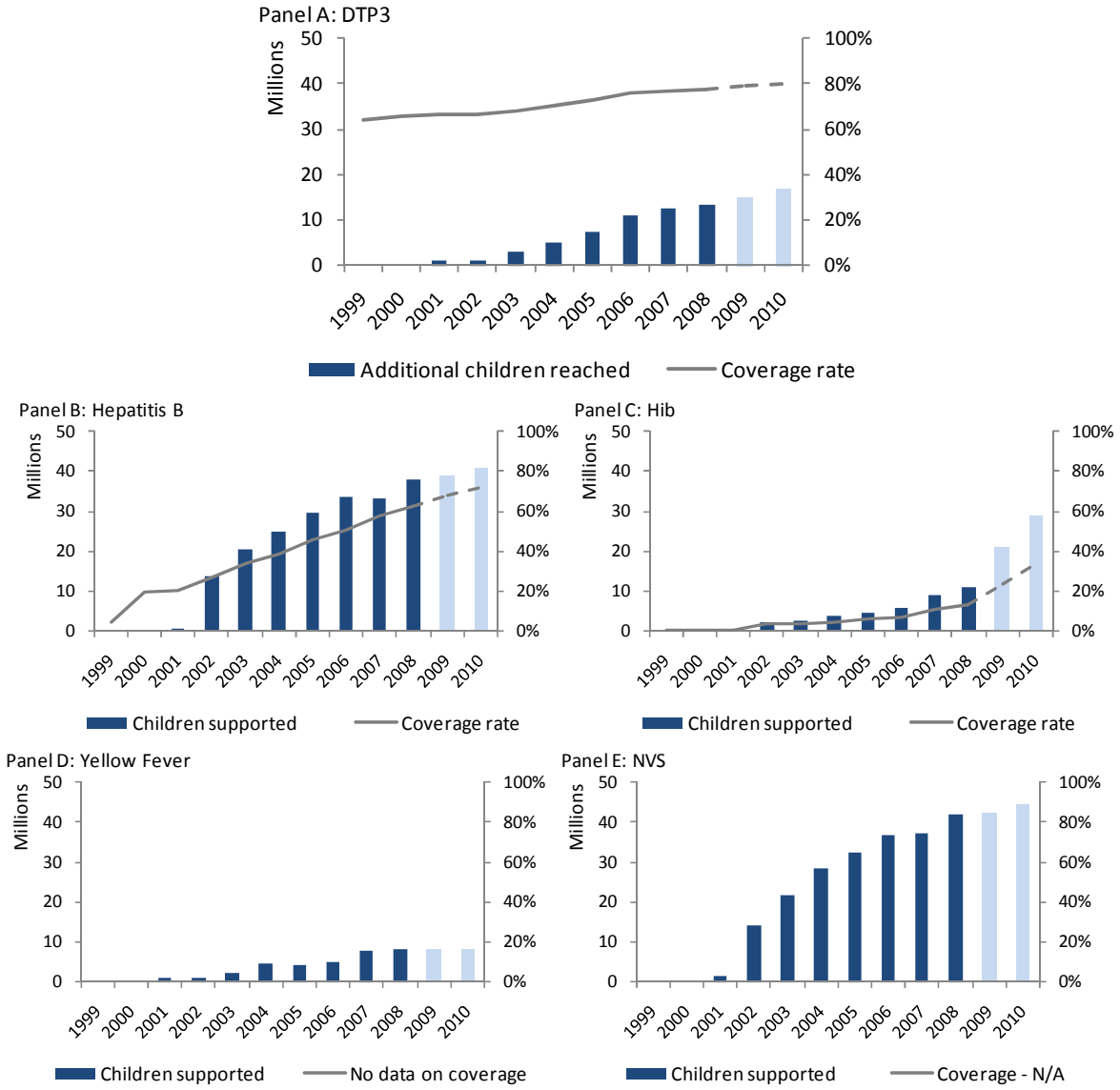
estimates from 2000-08, as well as projections of GAVI's potential impact from 2009-10. It also contains a summary comparison with the previous 2008 report.

The full version of the report provides details of the methodology used.

Vaccine coverage

WHO reports on the number of children reached with different antigens, as supported through the GAVI Alliance. These are estimates for 1999-2008 and projections for 2009-10. Figure 4.3 below presents coverage rates and the derived children reached/supported[29] for four key antigens – DTP3 (Panel A), HepB (Panel B), Hib (Panel C), Yellow Fever (YF) (Panel D). Panel E represents HepB, Hib and YF added together.

Figure 4.3: Derived no. of children supported and coverage rates[30]



[29] The DTP3 statistics measure the additional children "reached". In this context, GAVI ISS funding is intended countries to increase their coverage rate but does not support the vaccine directly.
The statistics for the other antigens measure the additional children "supported", since GAVI NVS funding supports each vaccine directly.

[30] Children reached/supported plotted against the left hand scale. Coverage plotted against right hand scale.

The WHO report attributes the majority of additional children immunised in supported countries (relative to a baseline year of 1999) to GAVI support. In particular:

- All of the cumulative 54m additional children receiving DTP3 between 2000 and 2008, are recorded as being reached by GAVI.
- Of the cumulative 286m children fully immunised against HepB between 2000 and 2008, 194m (68%) are attributed to GAVI.
- Of the cumulative 42m children fully immunised against Hib between 2000 and 2008, 39m (92%) are attributed to GAVI.
- Of the cumulative 34m children fully immunised against YF between 2000 and 2008, 33m (99%) are attributed to GAVI.

We note that there are alternative possible interpretations of attribution. The number of children reached by GAVI for DTP3 immunisation is particularly difficult to calculate, given that GAVI's system-wide programs (ISS in particular) as well as vaccine programs provide relevant support. In addition, alternative assumptions could have been made regarding the appropriate baseline level of coverage, against which the number of additional children is measured. We do not explore alternative assumptions here, and instead simply note that alternative approaches appear likely to result in lower estimates of GAVI's impact.

Mortality impact

The report contains mortality impact estimates representing future pertussis, Hib and HepB deaths averted in cohorts (i.e. the estimated and projected impact over the lifetime of children born in the given year).[31] These estimates are shown in Table 4.2.

The estimates suggest that that 3.4m future deaths caused by pertussis, Hib or HepB have been averted through GAVI Alliance support as of end 2008. Projecting to the end of 2009, this figure increases to nearly 4m future deaths prevented.

[31] These figures represent the total number of future deaths that have been averted, not the deaths averted in the current year. They are not directly comparable to other officially published figures by WHO, which are estimates of deaths averted in a single year.

Table 4.2: Mortality impact estimates (thousands) – Future deaths averted in cohorts (Pertussis/ Hib/ HepB)[32]

	Pertussis	Hib	HepB	Total	Cumulative
Estimates					
2000	-		-	-	-
2001	4		6	10	10
2002	9	20	278	307	317
2003	24	22	349	394	711
2004	41	29	390	460	1,171
2005	73	33	435	541	1,712
2006	87	42	468	597	2,310
2007	70	72	360	502	2,812
2008	68	82	401	559	3,370
Projections					
2009	101	130	381	612	3,982

Comparison with detailed studies of immunisation cost effectiveness

Section 4.1 provided a number of references to detailed studies on cost effectiveness.

Based on the data in the WHO report, we are not in a position to calculate a directly comparable estimate of GAVI's cost effectiveness because:

- The estimates in the WHO report cover three diseases that are supported by GAVI as part of several different presentations (monovalent, tetravalent and pentavalent), and the disbursement data in this section is presented at an aggregate level; and
- WHO presents its estimates on a death averted basis, as opposed to the more readily comparable cost per discounted DALY.

A full examination of GAVI's cost effectiveness would therefore require additional data and a detailed methodology, and is outside the scope of this evaluation.

However, for context, we can relate the above estimates of future deaths averted to GAVI's disbursements. Including projections for 2009, GAVI has averted an estimated 4m future deaths. Based on total NVS disbursements to 2009 of $1.5bn, this is a notional, undiscounted cost per future death averted of $382. Even based on total disbursements to 2009 of $2.2bn (including ISS, HSS, INS and CSO), the notional undiscounted cost per future death averted is $544.

Although it is a significant over simplification to relate these figures to the more detailed studies[33], we note that they provide estimates that are at the lower end of the range of the costs per death averted in Table 4.1 (i.e. $436 - $4,438). These costs were for GAVI vaccines and all

[32] The drops in 2007 and 2009 for HepB are due to cessation of support for China and Indonesia, respectively. The drop in Pertussis from 2007 is due to end of Phase I ISS support.

[33] It is noted that the comparison here is not perfect given that the detailed studies in Table 4.1 focus on country level costs alone.

have costs around or below the $100 per discounted DALY referred to as a benchmark for cost-effectiveness.

We do not propose to put too greater emphasis on this comparison given the simplicity of the analysis. However, given the order of magnitude of these measures, the analysis here does not contradict the view that GAVI's support, as for vaccine support in general, is a cost-effective intervention[34]. Indeed this appears to be true even if the number of deaths averted estimated were to be significantly lower that the WHO estimates.

[34] Based on the $100 per discounted DALY (Barder and Yeh, 2006)

5. EVALUATION OF SG1: STRENGTHENING OF HEALTH SYSTEM

5.1. Introduction

In this section, we summarise our evaluation of GAVI's performance on SG1:

> "To contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner."

This goal includes four out of the five GAVI programs namely, INS, HSS, ISS, and CSO. A total of $952m of funding was approved by GAVI for SG1 programs over the period 2001-10 for 73 countries, of which approximately $646m has been disbursed to date. Additional approvals have also been made until 2015, taking total approvals to just over $1bn over the period 2001-15.

Table 5.1 below sets out the four Evaluation Questions examined under this SG – structured by GAVI program. We consider each in turn before bringing the analysis together to draw conclusions about whether GAVI has achieved SG1 and its value add.

In considering the issues/ themes for each program, we present the key evaluation findings and the robustness rating that we associate with the supporting evidence. Where there are multiple but related issues being considered as part of an area of analysis, we provide a table with the robustness rating and rationale for each issue. In other cases, we set out the robustness rating as part of the issue finding/ description.

More detail can be found in the SG1 Evaluation Report.

Table 5.1: Evaluation Questions

No.	Question
SG1: Health systems strengthening	
SG1.1	What have been the results and value add of GAVI's INS program at country and global levels?
SG1.2	What have been the results and value add of GAVI's HSS program at global and country levels?
SG1.3	What have been the results and value add of GAVI's ISS program?
SG1.4	What have been the results and value add of GAVI's CSO program?

5.2. SG1.1: Results and value add of INS program

The INS evaluation by John Snow, Inc. (JSI) reviewed 58 countries that were approved for funding in the period 2002-04 (although the countries that were approved in 2004 received INS support until 2006). In what follows, we examine both the Phase I and II INS countries - comparing performance indicators across both Phases. However, where data has not been readily available in analysable formats, the focus has been on the 13 additional countries that were approved for INS funding in the period 2005-09.[35]

The analysis conducted as part of this evaluation strongly suggests that the INS program has been a success. The main area of INS strong value add is GAVI's role in introducing and increasing the sustained usage of Auto-Disable (AD) syringes and safety boxes in countries.

We present below our findings on the various issues that have been explored as part of the INS review, together with a robustness score based on the strength of the evidence.

5.2.1. GAVI INS has achieved strong results and added value in terms of introducing / increasing *uptake* of safety equipment in countries for routine immunisation. However, it has not contributed to reductions in the price of safety equipment or the spread of safety practices beyond routine immunisation

Indicators on uptake of 'safety equipment' (AD syringes and safety boxes) in the WHO-UNICEF Joint Reporting Forms (JRF) clearly point to improvements in their usage in GAVI Phase I and II countries (although attribution to GAVI is difficult).

JRF indicators on injection safety for INS countries (after the period of GAVI support) suggest that these countries have higher levels of safety equipment uptake than middle income countries that are not eligible for GAVI support. GAVI is also the only donor supporting injection safety for immunisation (the smaller MMIS program promoted safety practices in HIV/ AIDS). These limited comparisons point to the success of the program and GAVI value-add, in terms of its unique contribution in the faster uptake of injection safety equipment and practices for immunisation.

This conclusion is strengthened by qualitative feedback from the surveys, country visits, and structured interviews – in particular, there was unambiguous support (88% of respondents agree/ strongly agree) in the e-survey for GAVI's role in improving injection safety practices and standards in GAVI countries.

With respect to price reductions of safety equipment, evidence suggests that whilst some positive gains have been made, they pre-date GAVI's support. Similarly, while GAVI might have been instrumental in uptake of safety equipment for routine immunisation, its influence on broader health areas is more limited and less conclusive.

Table 5.2 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

[35] The countries approved for INS support for the period 2005-07 are Benin, Guinea Bissau, India, Moldova (cash), Mongolia, and Nicaragua; for 2006-08 are Bosnia (became ineligible in 2006), Cuba, Liberia (cash), Madagascar, and Malawi; for 2008-10 are Cote d'Ivoire, and Nigeria.

Table 5.2: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Uptake of safety equipment in countries	All three JRF uptake indicators considered have improved for Phase I and II countries. Same outcome as per analysis of data from WHO.	B	Despite data issues as above, results are unambiguous.
Comparison of uptake of safety equipment in GAVI and non-GAVI eligible countries	INS program has added value in safety kit uptake for GAVI countries compared to ineligible countries. But attribution to GAVI is difficult. Less conclusive evidence of added value for safety policy indicators.	C	Tentative conclusion, given JRF data limitations.
Attribution of safety and waste management policies in country to GAVI support	Very positive feedback (88% agree/ strongly agree) from the e-survey and structured interviews on GAVI role in safety policy/ practices, but less so for waste management.	B	Large positive e-survey response, consistent with consultation feedback.
Analysis of comparator MMIS	GAVI has demonstrated strong relative value add being the only INS donor in immunisation and compared to MMIS activities in HIV/ AIDS sector.	C	Review of documentation.
GAVI prices secured for safety equipment; Promotion of new safety equipment manufacturers, especially in developing countries	Prices have fallen over years (pre-dates GAVI) as number of suppliers have also increased. GAVI's demand is helpful but difficult to attribute to fall in prices.	B	Based on INS Evaluation findings, and country visits.
Impact on safety practices in the broader country health systems	Largely influenced safety policies, practices, and training for routine immunisation in Phase II countries, and to a more limited extent in wider health systems such as HIV/ AIDS, family planning, curative care etc. GAVI role difficult to attribute.	C	Limited APR information of Phase II INS countries, few EPI responses and country visits.

5.2.2. Another area of strong results is the *sustained use and funding* of safety equipment in routine immunisation after GAVI support

The analysis of APRs of Phase I and II countries undertaken by CEPA suggests that countries that have completed INS funding by 2006 have sustained financing of safety equipment after the end of GAVI's support. For those countries with data on funding sources,[36] the majority (66%) reported that safety equipment funding was only from the government (high sustainability). 23% reported total reliance on donor support, and the remaining 11% a mix of government and donor funding.

We do not have evidence from APRs to track continued use of safety equipment, but the EPI manager survey feedback and country visits point to sustainability in use.

The demonstrated benefits of safety practices during GAVI support is presumed to have been instrumental in its continued use and funding after GAVI support, although attribution to GAVI

[36] 56 of the 59 Phase I countries and six of the 13 Phase II countries are included.

is difficult. Despite AD syringe prices being slightly higher than the price of disposables, GAVI's contribution to the uptake and sustained use of AD syringes underscores its added value.[37]

Table 5.3 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

Table 5.3: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Sustainability of funding for safety equipment	Majority of Phase I and II countries (>65%) reported 'high sustainability', based on APRs. Consultations and country visits also suggest sustainability of funding.	B	Patchy and incomplete APR information, but conclusion consistent with interview and field visit feedback.
Sustainability in use of safety equipment	All 19 countries that replied to the EPI manager survey question on this topic noted continued use after GAVI support.[38] Country visits confirmed the same.	C	Based on limited responses on the EPI manager survey, and five country visits.

5.2.3. GAVI's role in introduction of *safety policies/ plans*, particularly in Phase II countries, is somewhat more ambiguous. An area of concern is injection *safe disposal and waste management* practices

Our country visits provide evidence that GAVI has played a catalytic role in the introduction/ strengthening of safety policies in some countries (e.g. Bangladesh). Analysis of JRF data suggests that GAVI INS has had a positive impact on policy indicators. Safety policy impact in Phase II support countries may have been slightly less successful than the impact in Phase I. However, we note the caveats of few countries/ data points for Phase II support, and the general limitations of the JRF data.

With regard to sharps waste management, whilst awareness has increased over time, most countries are lagging in terms of investing in safe disposal (e.g. incinerators). Several countries have requested greater GAVI support in this area.

Table 5.4 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

[37] http://www.unicef.org/supply/index_vaccine_safety.html. AD syringes, as per the UNICEF procurement, cost about 2 cents more per unit. However, given the volume of purchase, our country feedback suggests that the price differential matters.

[38] A total of 23 responses were received for the EPI manager survey, of which 19 responded specifically to this question i.e. there were four blank responses to this question.

Table 5.4: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Introduction of safety policies/ plans/ budgets	JRF data analysis suggests that INS impact on safety policy is positive, but stronger impact for Phase I support countries (although Phase II countries are smaller in number). Where policy introduced, difficult to attribute to GAVI.	C	Issues in terms of missing data, self-reporting bias, etc.
Impact on safe disposal/ waste management	Remains an area of concern across most countries. Awareness of sharps safe disposal has gone up, but practices lag behind (especially use of incinerators), especially due to shortage of resources.	A	Triangulated from APR data of Phase II countries, country visits, EPI manager survey, and structured interviews.

5.3. SG1.2: Results and value add of HSS program

The recent HSS evaluation notes that it is too early to measure the results of the program and also difficult to attribute any changes in outcomes to GAVI funding. We therefore focus our assessment of HSS on the strategy, approach, delivery model, and where possible, proposed/ expected results indicators at the country level. On the basis of this assessment, we have developed judgements on program effectiveness. We supplement this with a comparative analysis of the program vis-à-vis other HSS donors to assess GAVI's relative value add.

The importance of GAVI's HSS program in addressing health system bottlenecks has been widely recognised, but questions are raised on whether the program dilutes GAVI's immunisation focus and if GAVI is appropriately equipped to deliver this support.

We present below the findings on various issues explored as part of the HSS review, and provide our assessment of the robustness of the supporting evidence.

5.3.1. The HSS strategy of addressing key system bottlenecks is positive, but it has diverted limited GAVI resources and time away from the core focus on immunisation

An examination of the approved HSS proposals as well as feedback from structured interviews and country visits suggests that HSS activities are not immunisation specific but address wider child health and health system issues such as in service delivery or human resource capacities (as per its design).

Several stakeholders believe that GAVI's health system programs do contribute to increased and sustained immunisation coverage (e-survey responses[39]). Stakeholders have suggested that given the burden that GAVI-funded vaccines put on health systems, its support through HSS is justified. However, others question if it is efficient for GAVI to have its own HSS window, especially in the face of other organisations such as the World Bank, WHO, USAID, etc also supporting the strengthening of health systems. There is some concern that HSS may not be

[39] It is to be noted that the specific e-survey question referred to all of GAVI's health system support programs (INS, ISS, CSO, HSS), although many of the respondents appear to have interpreted this to mean the HSS program.

GAVI's comparative advantage and that it is diverting resources and attention away from GAVI's core business of immunisation.

We have assessed the robustness of this finding as a 'B', as it draws upon multiple evidence sources such as the review of documentation, structured interview feedback, and the electronic survey – however no evidence source being particularly comprehensive/ complete.

5.3.2. Several issues detract from the effectiveness of GAVI's HSS delivery model, although flexibility and country ownership are positive features

GAVI HSS primarily funds service delivery and Human Resource (HR) gaps, which arguably are the main health system constraints in countries. The country ownership and flexibility in defining the areas of HSS support are valued, particularly by the beneficiaries and other country stakeholders.

However, consistent with the recent HSS evaluation, we question whether GAVI's current delivery model (i.e. limited HSS capacity in-house, absence of country/ regional presence, and limited knowledge of country HSS context) is best suited for such a large cash-based program.

Other operational issues that were raised in the consultations, e-survey and EPI manager survey responses, and the country visits that potentially reduce overall effectiveness of the HSS model include:

- delays in the HSS approval and disbursement processes (especially after the introduction of FMA);
- the institutional coordination issues at country level, that result from the separation of planning and EPI departments in the Ministries of Health as well as between the Inter-agency Coordination Committee (ICC) and the Health Sector Coordination Committee (HSCC) equivalent committee for oversight; and
- the weaknesses in M&E at the country level.

The HSS Platform is expected to address some of the key issues identified in GAVI's delivery model such as improved country level processes and coordination, stronger M&E systems, etc.

We have assessed the robustness of this finding as a 'B', as it is based on the triangulation of a number of evidence sources such as the recent HSS evaluation, review of other documentation, country visits, structured interview feedback, and the surveys. However we note that none of these evidence sources are of a very high quality.

5.3.3. It is difficult to establish GAVI's added value vis-a-vis comparator HSS donors, as there is a balance of evidence of some positive characteristics in GAVI's approach and of other less valued aspects

Comparing GAVI with other HSS donors such as the Global Fund, World Bank, and USAID, indicates that GAVI HSS support is the most recent and smallest program in value terms. That said, several aspects of its approach are positively regarded by beneficiaries in particular:

- GAVI's dedicated HSS window is valued by countries. The alternative approach used by the Global Fund involves bundling health system funding together with support for the

purchase of pharmaceuticals (and supply chain management) for its three target diseases. We are not in a position to judge which particular approach is preferred, however country feedback highlights GAVI's added value through its separate HSS funding.

- GAVI also has a greater degree of predictability and transparency in its allocation of HSS funding compared to the Global Fund (although the recent FMA process and the GAVI's current funding gap have reduced certainty somewhat).[40]
- GAVI's principles of flexibility and country ownership for HSS have also been valued, in comparison with other approaches to HSS.

On the other hand, as mentioned above under the delivery model, GAVI's value add compared to other HSS donors is diminished by:

- increasing the demands on institutional coordination at country level (unlike say the World Bank, that works with the existing country systems and processes);
- lack of harmonisation with other donor systems such as for financial management and performance reporting; and
- relatively weak M&E systems (in comparison, Global Fund's performance rating of its Principal Recipients - audited by independent Local Fund Agents - and disbursements linked to milestones offer useful lessons (although this is reported to increase the reporting and administrative load on countries)[41]).

The e-survey and interview feedback are also ambiguous on GAVI's relative value add vis-à-vis other HSS donors.

Looking ahead, GAVI's key role in conceptualising, designing and implementing the Health System funding platform is expected to better meet the Paris aid principles and reduce the administrative burden on countries. The involvement of GAVI as a key partner in the Platform (along with the Global Fund, World Bank, WHO and other donors) recognises its contribution to HSS globally and at country level (despite its relative size in terms of HSS funding)

Table 5.5 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

[40] The relative strengths and weaknesses of GAVI's HSS approach vis-a-vis the Global Fund are also described in the HSS Evaluation Report.

[41] Please note that we are commenting here only the impact of such a structure on Global Fund's M&E, but do not claim to comment on the benefits of the structure as a whole.

Table 5.5: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Comparative analysis with other HSS donors	GAVI is the only donor with a specific HSS program, although its funding levels are lower than Global Fund, World Bank, USAID, etc. Some comparative strengths such as flexibility, predictability; but results orientation/ M&E is particularly weak.	B	Primarily a review of documentation, supplemented by some interviews. E-survey and EPI manager survey feedback is mixed.
Role in common financing platform	Despite its small HSS funding size, key partner in designing, shaping/ implementing common platform.	C	Review of documentation and interviews.

5.3.4. It is too early to assess HSS impact at country level but we have found limited evidence that the proposed HSS activities seek to address key system bottlenecks

Our very limited evidence from the country visits (of which only Mali has begun to spend the GAVI HSS funds)[42] underscores the conclusion by the HLSP HSS evaluation that it is too early to measure results at country level. However, a review of selected HSS proposals and APRs, and the limited EPI manager survey responses suggest that there is broad alignment between identified health system constraints in the country and proposed HSS activities (although most often, these are wider than just immunisation).

Also, based on our analysis of APRs, we understand that vaccine introduction grants provided by GAVI have typically been used to strengthen health systems (e.g. through training, logistics support, M&E, etc.), which might mitigate the greater burden that new vaccines place on a country's health system. This provides evidence of GAVI's possible contribution to HSS with respect to introducing new vaccines, which might arguably help to increase coverage.

Our assessment of the robustness of this finding is a 'C', as there is only limited relevant evidence from the country visits and selected HSS proposals/ APRs, and it is too early to measure results.

5.4. SG1.3: Results and value add of ISS program

The earlier ISS evaluations by Abt Associates covered Phase I of GAVI,[43] when most countries were nearing the end of their investment funding phase. Since 2005, most countries are in the rewards phase of their ISS funding, which is the period of focus of this evaluation.[44]

Our assessment provides some weak evidence of a positive impact of ISS on DTP3 coverage and highlights the valued benefits of ISS innovations in terms of flexibility and the Data Quality

[42] Of the five field visit countries, Bolivia, Mali and Nigeria have been disbursed HSS funds, but Bolivia and Nigeria are yet to begin utilising them. Bangladesh is awaiting disbursement of the HSS funds pending signature of the FMA aide memoire by its government.

[43] The evaluation reports were submitted by Abt Associates Inc. in 2004 and 2007.

[44] However, we are constrained by absence of data from GAVI on the break-up of investment and rewards ISS funding by country. This data could have been potentially useful to analyse the extent of reward funding by country typology, DTP coverage, etc.

Audit/ Self-assessment (DQA/ DQS) requirements. But there are concerns regarding low utilisation of funds, poor sustainability and weak data quality.

5.4.1. ISS approved funds have benefitted the 'poorest' and LICUS countries. However there is no clear evidence on the additionality of the ISS funding.

Analysis of the total ISS approved funding ($381m over 2001-13) shows that almost half of the ISS recipient countries are classified as "Poorest" (although this category contains the largest number of countries).

Total ISS approvals were made roughly half to LICUS countries (49%), and the other half to non-LICUS countries (51%).[45] However, annual ISS approvals to "Fragile" countries decline after 2007, which might suggest that the situation in fragile and LICUS countries disadvantage them from attaining the DTP annual coverage targets to be eligible for rewards funding.

Additionality of ISS funding is difficult to establish conclusively in the absence of reliable data across countries.

Table 5.6 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

Table 5.6: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
ISS funding by country typology	Almost half of the ISS approval countries are the 'poorest'. 'Least poor' countries receive the smallest approval. Approvals to 'Fragile' countries have declined since 2007. ISS approvals are split roughly equally between LICUS and non-LICUS countries, although LICUS approvals have fallen faster since 2007.	A	Based on ISS data from GAVI.
Additionality of ISS funding compared to other donor funding	Tentative conclusion that introduction of GAVI ISS funding does not diminish non-GAVI sources of finance.	D	Case study on only four countries' based on comprehensive Multi Year Plans (cMYP).

5.4.2. The utilisation of ISS funds by countries has been low. At the same time, countries have reported issues regarding sustainability of ISS funding post GAVI's support

Despite the generally balanced distribution of ISS funds, on average, about 50% of the ISS funds available in a year[46] remain unutilised by the countries in that year. To some extent, this may be reflect the fact that ISS funds have been disbursed towards the end of the year. However the relatively large proportion of unutilised funds, and also the consistent pattern of low utilisation

[45] This distribution is consistent with the data presented in Section 4 above on disbursements per child being highest to LICUS countries.

[46] This includes both funds disbursed in the current year by GAVI and any balance carried over from previous years.

over time[47] might also suggest that some countries have limited absorptive capacity for these funds.

We recognise however that an alternative explanation is that countries are deciding to retain some ISS funds for the short/ medium term, given that there is no certainty of receiving the award funding in future years. We have not found evidence to corroborate or disprove this hypothesis.

Although the ISS funds are less than 5% of a country's immunisation services expenditure, since GAVI ISS support is the only donor funding focussed on expanding coverage to reach the unreached, sustainability of areas funded by ISS post GAVI support (or on suspension of the program) is a concern.

Table 5.7 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

Table 5.7: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Utilisation of ISS funding	On average, about 50% of ISS funds available to a country in a year (previous year's balance + new disbursements) remain unutilised.	B	APR analysis and GAVI disbursements data analysis present similar outcomes.
Sustainability of ISS funding	Being the only donor funds targeted at expanding coverage, sustainability of ISS funded areas is a concern either if the program is suspended (e.g. in 2009; Mali and Uganda) or after GAVI support ends.	C	Limited cMYP analysis and a few interviews/ country visits.

5.4.3. There is some weak evidence of a positive impact of ISS on DTP3 coverage. Geographic equity analysis shows some evidence of improvement since GAVI funding, although these improvements are not necessarily attributable to the ISS program in particular.

Regression of ISS disbursements on the DTP3 coverage rate shows a positive coefficient, however it is not statistically significant.

In addition, we have extended Lu et al's model[48] with updated data covering 1996-2008, to assess if the impact of ISS disbursements on DTP3 coverage rates varies depending on a country's initial coverage rate. In this model, there is some evidence of a positive impact of ISS disbursements on DTP3 coverage – however, it is only statistically significant for countries with initial coverage of 65%-80% (rather than below 65%, as Lu et al found). We have also extended this analysis through a range of different regression models, and based on the results, conclude that there mixed evidence of distinct relationships across countries grouped by their baseline coverage rate.

[47] We have examined data over the three year period.

[48] Lu et al (The Lancet, 2006): "Effect of the Global Alliance for Vaccines and Immunisation on diphtheria, tetanus, and pertussis vaccine coverage: an independent assessment".

Evidence from structured interviews and the country visits has highlighted that GAVI is one of the only donor programs that provides support for increasing coverage rates for routine immunisation and the ISS funds are used to reach previously unreached areas. Thus we conclude that there is some evidence of a positive impact of ISS funding on coverage rates.

Our analysis of metrics on equity of coverage rates shows some evidence that GAVI countries (also compared to lower-middle income non-GAVI countries) have improved in terms of geographic equity since GAVI funding was introduced. The proportion of high coverage districts has increased, while the proportion of low coverage districts has decreased. However, there is no obvious relationship between ISS support introduction in the Phase II countries and improvements in equity indicators.

Table 5.8 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

Table 5.8: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Impact of ISS funding on DTP3 coverage	Some evidence of a positive impact of ISS disbursements on DTP3 coverage – however, it is only statistically significant for countries with initial coverage of 65%-80% (although the evidence on this statistical significance is also mixed).	B	This effect is difficult to estimate with precision, and is partly dependent on model specification, indicating a lack of robustness. Country visits and interviews also suggest likely positive impact.
Geographical equity (between districts)	Evidence of improvement in geographical equity since introduction of GAVI; attributable in part to GAVI, although not specifically to ISS funding.	C	JRF indicators the only source of information, and sample size of countries varies by year.

5.4.4. The DQA/ DQS tools have been innovative and demonstrated GAVI's added value in improving data reliability and reporting in countries

Most countries that have had two DQAs have experienced significant improvement in their DTP Verification Factor[49]/ reduction in the variance between official and WHO-UNICEF coverage rates. Stakeholder and country feedback suggest that DQA is a strong value add of GAVI, as it supports countries to improve their data collection and reporting systems and has enhances country ownership of the process. Moreover, the GAVI DQA has positively influenced the development of similar tools by organisations such as the Global Fund, JSI, WHO-led consortium, etc. and is a clear example of successful partnering in the Alliance to develop this innovative tool.

That said, feedback also highlighted that the issue of data quality deserves greater time and attention within GAVI and that there is scope to further strengthen the process (for example, in Mali and Nigeria, data quality issues persist despite DQAs). Drawing on lessons from implementation, GAVI has planned a review of the tool as part of its Work Plan (2010).

[49] The VF is the ratio of the recounted number of infants from the primary data source (records) and the number reported as receiving DTP3 in the monthly summary reports from all health units visited during the DQA.

We assign a robustness rating of 'A' to this finding, since it is triangulated from country visits, review of documentation, e-survey, EPI manager survey, and interviews. The review of documentation involves a data review which is of reasonably good quality and the structured interviews/ e-survey comments have been fairly consistent.

5.4.5. Whilst the performance basis and flexible cash characteristics of ISS are innovative, their effectiveness and impact vary by country and context

Both these innovative features of ISS funding were upheld as beneficial when the program was introduced. Over 70% of adjusted[50] respondents to the e-survey either agree / strongly agree that performance based rewards and provision of 'flexible cash' are key examples of the value add of GAVI's ISS program.

In particular, countries value the flexibility aspect of the program, and several countries have shared the benefits of the ISS rewards to the sub-national level (which we understand have resulted in better incentives and improved coverage). However, several issues have also been raised regarding data reporting and the misuse of ISS' flexible funds – in fact, the program was suspended in 2008 due to data accuracy concerns.

In terms of the performance-based feature, as the coverage levels in countries increase, the incentive effects of the rewards based approach appear to diminish making it difficult to bear the increasing marginal cost of reaching the last 10-20% of the unvaccinated population.

We have assessed the robustness of this finding as a 'B', since it is triangulated from country visits, review of documentation, e-survey, EPI manager survey, and interviews, but no evidence source is of a very high quality/ comprehensive on its own.

5.5. SG1.4: Results and value add of CSO program

Although the CSO program pilot of $30m was approved by the GAVI Board for a two year window of 2007-09, its delayed implementation and poor uptake of the Type A support led to the Board decision to extend the program into 2010.

The CSO program has been slow to take off amongst GAVI's programs on account of some fundamental design and implementation issues. A clearer definition of outputs, outcomes, as well as performance indicators and targets is required to be able to assess the program's results and added value.

We present below the various issues explored as part of the CSO review. Although it is too early to judge the CSO program performance, we undertook a desk review of the ongoing activities in the supported countries and also compared GAVI's CSO approach to other GHP and donors supporting CSO engagement.

[50] Adjusted % is calculated after taking out the 'not aware/ no view' and the blank responses to the statement.

5.5.1. The current design and processes of the CSO program are not deemed conducive to reach its objectives

A variety of issues have been raised regarding the structure of the CSO program that inhibit increased CSO engagement as originally envisioned. These include lack of clarity/ awareness in program objectives at country level; validity of the selection criteria for Type B pilot countries and eligibility of all GAVI countries for Type A; cumbersome application process despite its much smaller grant sizes than other GAVI program windows; need for governments to apply and routing of CSO funding through the government or Partners; etc. At the extreme, some stakeholders even question the merit and cost effectiveness of CSO being a stand-alone program (vis-a-vis being integrated, for example, with HSS).

Table 5.9 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

Table 5.9: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Design and uptake of Type A and B CSO support	Low uptake of Type A support, due to limited awareness of the program and a range of design issues in the program.	A	Validated by program data, interview feedback, and country visits.
CSO processes from country application to disbursement	Cumbersome application, delays in approval, and disbursement only through government/ Partners have posed issues.	A	Based on process data from GAVI.

5.5.2. Whilst program results are too soon to measure, the current definition of CSO outputs and performance indicators/ targets make it difficult to assess performance

Delays in approval and disbursement of CSO funds have meant that it is too early to measure outputs or outcomes, and none of the CSO countries have yet reported results in the latest 2008 APRs. Analysis of *expected* results in the future, case studies on Type B countries, and feedback from GAVI Country Responsible Officers for selected CSO countries show that:

- Type A CSO mapping funded by GAVI have yielded (or are proposed to result in) the participation of CSO representatives in the health coordination bodies in the country and in improving the understanding by the government of CSO activities in the immunisation and broader health sector in the country (e.g. Togo, Cameroon).
- Type B 'proposed' results vary from greater CSO involvement in delivering immunisation services in remote areas to more generic activities such as training and capacity building, greater cooperation with government activities, improved quality of Maternal and Newborn Child Health (MNCH) services, etc.

The CSO indicators[51] in the GAVI Alliance Strategy 2007-10 are mostly input and process indicators and do not therefore support measurement of program outputs and outcomes. One of

[51] These include (a) Mechanisms for proposed Civil Society window operational by 2007, (b) % of total 'Type A' Civil Society funds disbursed, (c) % of total 'Type B' Civil Society funds disbursed to 10 pilot countries,

the indicators is an M&E framework for CSO impact assessment – but our understanding is that this is still to be developed. Therefore, our assessment is that the CSO program needs a clear definition of outputs, and performance indicators and targets to be able to objectively assess progress on its objective of increased CSO engagement in countries.

We assign a robustness rating 'C' for the supporting evidence here as the 'expected' results are case study based (rather than field visits). The e-survey results are also quite divided in terms of whether the CSO program has contributed to facilitating/ expanding the role of CSOs in delivering immunisation and health services.

5.5.3. Other CSO funding organisations demonstrate a more robust and tailored approach to engaging CSOs and offer useful lessons as GAVI reinvigorates its CSO program

We take GAVI's renewed focus on CSO engagement (reinforced at the Vietnam Forum and Board meeting in November 2009) as a given, in the context of the potential to involve CSOs in immunisation (advocacy/ capacity building/ remote areas access, etc.). To some limited extent, GAVI has helped raise the profile of CSOs at the global level (particularly in their engagement in immunisation and health systems strengthening) through the program as well as through including CSOs as a key constituency.

Although CSOs do not have a defined role in the common HSS platform, it is presumed that GAVI's (and Global Fund's) participation might support the case for more focussed CSO involvement.

In contrast to GAVI's approach, other CSO-supporting donors such as Global Fund treat CSOs in the same way as other grant recipients. In other words, CSOs can receive as much funding and need to pass similar qualifying criteria and performance rating milestones as government recipients. The monitoring frameworks are also stronger, enabling disbursements linked to performance. Although we recognise the strengths of GAVI's model in terms of supporting the development of capacity in the public sector and working through the government, we believe that these alternative approaches offer useful lessons on potential flexibility in the GAVI CSO program.

Table 5.10 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

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and (d) M&E research framework for impact assessment of CSO support developed and lessons learned disseminated and used to inform practice.

Table 5.10: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Comparator CSO approaches	Comparisons with Global Fund, Stop TB, USAID etc. suggest that others are more advanced than GAVI on CSO engagement, although potential to involve CSOs for immunisation is recognised.	B	Mostly based on a review of documentation of comparator CSO approaches, and some interviews.
GAVI's role in expanding CSO role in immunisation	GAVI added value in bringing CSOs to the table with other immunisation Partners. No defined role yet for CSO in the proposed common financing platform.	C	Analysis limited to the few CSO support countries and at global level.

5.6. Summary and conclusions on SG1 performance

The previous sections presented our findings on each of the SG1 programs. In this section, we bring together the evidence across the SG1 evaluation questions to assess the extent to which the goal has been met.

SG 1 is to *'Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner.'*

Strengthening of health systems is a very large and complex goal that requires understanding of country contexts and customisation of the interventions to address issues specific to each country. Further, unlike GAVI's vaccination goal, the outputs in relation to this goal are less tangible, more lagged in time, and more challenging to measure.

We do not propose to compare the relative effectiveness of GAVI spends on vaccination and health system related activities. However, there is inevitably a question as to whether GAVI's HSS activities have diluted GAVI's core immunisation focus or have advanced it.

Stakeholder views vary on this question but there is general agreement that health system bottlenecks impede higher immunisation coverage and that GAVI can help develop more sustainable systems. Nonetheless, based on some interview feedback and CEPA's judgement, we have concluded that the emphasis on health system programs in Phase II (and increasing their funding window over time) has not been without costs in terms of GAVI's performance. In particular, investment of scarce human and financial resources away from delivery of its core vaccine programs has constrained what has been achieved in other vital areas such as in advocacy/ fund-raising, financial and risk management, and M&E. This is not necessarily a bad result, but we note the trade-off.

We now provide a more detailed assessment of the two RFP questions for SG1. In answering the first question of whether the goal has been met, we examine the contributions of the four SG1 programs in terms of the two components of the goal:

a. strengthening the capacity of the health system to deliver immunisation and other health services; and

b. sustainability.

We then present the evidence on the second RFP question on what might have been accomplished in the absence of the Alliance (i.e. the counterfactual).

5.6.1. RFP Question 1: Results achieved on SG1

Table 5.11 below summarises the extent to which GAVI's first goal has been met. Other than the INS program and to some extent the ISS program, it is difficult to say whether the goal has been met as yet.

Table 5.11: Contribution by the SG1 programs to the goal

SG1 definition: *'Contribute to strengthening the capacity of the health system…'*
☑ INS has contributed to adoption/ increased uptake of injection safety equipment for immunisation, and improved safety standards/ practices in GAVI countries. However, on the downside, it has increased the burden for sharps waste management and disposal in countries. ? By definition, HSS aims to plug gaps in the wider health systems (and not just immunisation), but contributions are too early to measure and the value of HSS grants are very small (vis-à-vis total health expenditure) to make a wide-ranging impact. ? There is mixed feedback on whether ISS rewards have strengthened immunisation systems – on one hand, it is a small proportion of total immunisation expenditure and over 50% of funds disbursed to a country remained unutilised in a given year. On the other hand, there is some weak evidence of a positive impact of ISS disbursements on DTP3 coverage. By financing unfunded parts of the immunisation system (that no other donor funds), it has enhanced immunisation capacities in countries, especially to reach remote areas. ? The CSO program is yet to contribute substantively to enhancing CSO role/ engagement in immunisation and health systems, although its potential is recognised.
SG1 definition: '*...to deliver immunisation and other health services in a sustainable manner.'*
☑ INS has probably done best in terms of sustainability, as both the use and funding for safety equipment have been sustained after GAVI support across a majority of GAVI countries. ? Too soon to comment on sustainability of HSS and CSO, given the nascent stage of their implementation. ☒ ISS funding being 'rewards' in nature might be difficult to sustain once the program support ends and these areas remain unfunded by the governments (more so, since no other donor funds immunisation coverage to the unreached). Also, views have been expressed that the ISS reward criteria do not incentivise 'sustaining' high coverage levels after a certain threshold, when increases in coverage are expensive and difficult.

5.6.2. RFP Question 2: GAVI added value

By definition, the value add of GAVI is assessed by the hypothetical situation of the GAVI Alliance not existing. Our judgements in this area are primarily based on feedback from stakeholder consultations both at global and country levels. Where possible, we have tried to analyse available data that supports our ability to attribute a particular result to GAVI. Also, by drawing comparisons with other organisations supporting HSS initiatives, we have tried to establish GAVI's relative strengths or 'additionality' in this area.

The following have emerged as areas of **strong value add** under SG1:

- Increased levels of global awareness on injection safety practices as well as adoption/ higher uptake of safety equipment across GAVI countries are regarded as strong

contributions of GAVI. Stakeholder interviews and country visits highlighted that in the absence of GAVI INS, the widespread and sustained use of AD syringes and safety boxes for routine immunisation (and wider healthcare programs in some countries) might not have occurred. No other donor has financed a similar safety program in routine immunisation at such scale (although UNICEF procures/ supplies AD syringes and safety boxes).

- Value add of the ISS program in terms of GAVI being the only donor to explicitly finance activities focused on increasing routine immunisation coverage to unreached areas. Country feedback suggests that this has helped finance immunisation system bottlenecks (such as lack of human capacities at district level, cold chain facilities, etc.), which in the absence of GAVI, might have remained unfunded. The value add is however tempered by concerns about sustainability – since several countries may be unable to finance these areas after GAVI support.

- The DQA/ DQS processes are regarded as valuable innovations of GAVI in improving the quality of immunisation data measurement and reporting by countries. Although more remains to be done, the increase in the coverage Verification Factor in countries where a second DQA was conducted presents some evidence of its value add. The DQA/ DQS have also been pathfinders in influencing the development of similar tools by the Global Fund, JSI, WHO, etc. and have demonstrated successful working together of the Alliance Partners.

- GAVI's approach to program implementation has promoted country ownership and inclusiveness of country stakeholders in the design and development of the program proposal and areas of spend. Country feedback suggests that this is an area of GAVI value add, as countries would not have felt the same sense of program ownership if the funds were channelled through the traditional aid sources (viewed in these cases as 'donor programs'). The flexibility offered by GAVI to countries to define the areas of greatest need in terms of funding gaps and bottlenecks (for example, in the case of HSS and ISS programs) is also valued.

Based on our comparison of GAVI's approach with alternate donors in this area, we infer **some degree of value add** in the following SG1 areas:

- GAVI has been critical in placing immunisation on the global map of HSS strategy and funding. Although GAVI's value of HSS funding is relatively small and recent compared to other donors, its approach in terms of flexibility and country driven processes have influenced the global health aid architecture. The testimony to GAVI's sphere of influence in this area is its lead role in the common platform along with Global Fund, World Bank, WHO, and other donors.

- The innovation of performance based rewards for ISS funding, although not introduced by or unique to GAVI, has reported some added value in terms of providing incentives to immunisation officers in countries (particularly at district level, in countries where rewards have percolated downwards) to increase coverage levels to areas previously un-serviced. For example, in Bangladesh, the government and GAVI Partners agreed that in the absence of the rewards based ISS, the coverage of the national EPI program would

not have risen to the 2008 levels of c. 94% from around 80% in 2003.[52] A majority of the e-survey respondents also agreed with the statement that performance based rewards and provision of 'flexible cash' are key examples of the value add of GAVI's ISS program.

[52] That said, several suggestions have been proposed on re-designing the ISS rewards criteria and funding levels to continue to act as an incentive to sustain/ increase coverage levels.

6. EVALUATION OF SG2: VACCINE SUPPORT

6.1. Introduction

This section, prepared by Applied Strategies[53], summarises the findings of GAVI's SG2 achievements. SG2 was:

> "To accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security."

This goal covers GAVI's flagship program – New and Underused Vaccine Support (NVS). As part of its NVS program, GAVI provides support for the following six vaccines: HepB, *Haemophilus influenzae* type B (Hib), YF, pneumococcal, rotavirus, and measles second dose.[54] This evaluation covers five of these six vaccines. The measles second dose program is not included in this evaluation because only two countries have adopted the measles second dose with GAVI support (Vietnam and Korea DPR), and the program only represents 0.12% of GAVI approvals from 2001-15.[55]

YF, HepB-, and Hib-containing vaccines were approved for support in 2000 and are referred to as *'underused'* vaccines in the evaluation. Pneumococcal and rotavirus vaccines, approved for support in 2006, are referred to as *'new'* vaccines.[56]

Although the GAVI Board approved the meningitis A (MenA) conjugate vaccine strategy as outlined in the investment case and funded a MenA emergency response capability ($55.2m) during its June 2008 meeting, the Board has not yet approved funding of MenA preventive campaign activities.[57,58] Therefore, MenA vaccine was not included in this evaluation.

As noted in Section 4, $2.1bn of GAVI funding was approved for NVS support for the period 2001-10, spread across 76 countries in Phase I and 72 countries in Phase II, of which approximately $1.5bn has been disbursed as of the end of 2009.[59] Additional approvals have also been made to 2015, taking total approvals to just over $3bn over the period 2001-15.[60]

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[53] Applied Strategies has worked with GAVI on numerous projects in the past, including the: (i) new vaccine introduction readiness assessment project (co-sponsored by the Gates Foundation, GAVI, and the World Bank); (ii) pneumococcal vaccine pilot AMC supplier consultations and economic expert group support projects; (iii) GAVI 2009-2013 vaccine investment strategy project; and (iv) GAVI existing and pending vaccine portfolio metrics analysis and prioritization project. Applied Strategies has also supported the PneumoADIP in its efforts to: (i) develop appropriate strategic demand forecasting methods and models; (ii) plan and facilitate two industry and key global health stakeholder roundtables to discuss demand forecasting issues and challenges and review and refine the strategic demand forecasting methods and models, respectively; (iii) design and develop the demand forecasting component of its GAVI investment case; and (iv) conduct demand forecasting and financial implications analyses for the pilot AMC candidate paper submitted to the AMC pilot recommendation committee. Applied Strategies provided strategic demand forecasting model delivery and training support to RVP for use in its GAVI investment case. In addition, Applied Strategies provided supply and demand forecasting support to the Hib Initiative for GAVI-eligible countries in general and India states more specifically.

[54] http://www.gavialliance.org/support/what/nvs/index.php (accessed July 2010).

[55] 'GAVI Phase I & II consolidated approvals & disbursements' spreadsheet, provided by the GAVI Secretariat, 10 March 2010.

[56] Final Summary Report, GAVI Alliance & Fund Board Meeting, 28–29 November 2006.

[57] Final Summary Report, GAVI Alliance & Fund Board Meeting, 25-26 June 2008

[58] Final Summary Report, GAVI Alliance & Fund Board Meeting, 29-30 October 2008

[59] GAVI Phase I & II consolidated disbursements.xls (e-mail from GAVI Secretariat, 10 March 2010).

[60] Ibid.

The six questions Evaluation Questions that we have used to evaluate this SG were provided by GAVI and are summarised in Table 6.1. Each question is analysed separately and summarised in greater detail (e.g. by vaccine) within each question.

This evaluation was intended to include data from 2001-09, however, where appropriate, 2010 data was included. At GAVI's request, SG2.4 (vaccine affordability) includes 2010 data.

Table 6.1: Evaluation Questions

No.	Question
SG2: Vaccine acceleration and supply security	
SG2.1	To what extent has GAVI accelerated the uptake of underused and new vaccines by partner countries?
SG2.2	To what extent have countries introducing underused and new vaccines been able to take them to scale quickly, i.e. achieve full scale coverage?
SG2.3	To what extent has GAVI improved the stability of global and country level vaccine supply?
SG2.4	To what extent has GAVI made vaccines and related technologies more affordable?
SG2.5	To what extent has GAVI contributed to the advancement of the evidence base required for countries to address the policy decision related to the introduction of new vaccines?
SG2.6	To what extent has GAVI developed and used vaccine demand forecasts that are accurate and timely?

6.2. SG2.1: Uptake of new and underused vaccines

To what extent has GAVI accelerated the uptake of underused and new vaccines by partner countries?

For this Evaluation Question, we analysed the impact GAVI had on accelerating introduction of underused and new vaccines in the 76 countries eligible for GAVI support from 2000 to 2009.

The assessment:

- Compared the number and rate of vaccine introduction in GAVI-eligible countries prior to and after GAVI formation as a measure of acceleration.
- Identified key events and GAVI Alliance actions that may have contributed to changes in rate of country vaccine introduction.
- Conducted two comparative analyses to provide additional insight on accelerated vaccine introduction.
- Conducted a counterfactual analysis assuming introduction starting from 2000 would have followed pre-GAVI introduction rates if the GAVI Alliance had not been formed.
- Summarised and interpreted responses from electronic surveys, structured interviews, and country visits.

The evidence suggests that GAVI has added value by accelerating the introduction of underused vaccines. However, it is too soon to tell whether pneumococcal and rotavirus vaccine introduction has been accelerated.

The evidence supporting this conclusion is summarised by vaccine.

6.2.1. GAVI has added value by accelerating the introduction of underused vaccines

YF vaccines

The cumulative number of countries introducing a YF vaccine increased from 46% to 86% between 2001 and 2009. The average number of country introductions per year increased by 38% post-GAVI. The counterfactual analyses suggest that, compared with pre-GAVI trends, 2−6 countries have adopted earlier than would have been expected in the absence of GAVI funding. In addition to accelerating introduction, this evaluation found that the GAVI Alliance has played a major role in improving YF vaccine coverage rates and vaccination sustainability by financing routine infant immunisation and a vaccine stockpile for outbreak and preventative campaigns.

HepB-containing vaccines

Overall, the cumulative number of countries introducing a HepB-containing vaccine increased from 29% to 97% since GAVI's inception. The average number of country introductions per year increased by 3-fold post-GAVI. The counterfactual analysis suggests that, compared with pre-GAVI trends, 23 – 34 additional countries adopted a HepB-containing vaccine earlier than would have been anticipated in the absence of GAVI funding.

Hib-containing vaccine

Overall, the cumulative number of countries introducing a Hib-containing vaccine increased from 7% to 83% since GAVI's inception, with the greatest increase occurring from 2007 onward after the global WHO recommendation was issued.[61] The average number of country introductions per year increased by more than 10-fold post-GAVI. In addition, the counterfactual analysis supports this finding, showing that 48 – 52 countries adopted a Hib-containing vaccine than would have in the absence of GAVI.

6.2.2. GAVI has accelerated demand for pneumococcal vaccines, but it is too soon to tell whether introduction will be accelerated

The evidence showed that GAVI has accelerated the demand for pneumococcal vaccines, based on 21 approved country applications as of June 1, 2010.[62] However, it is too early to tell whether the GAVI Alliance has accelerated actual introduction of pneumococcal vaccines. Accelerated introduction is at risk due to the current GAVI funding gap and the potential impact of the new eligibility policy.[63]

6.2.3. GAVI has not accelerated demand or introduction for rotavirus vaccines

Although early rotavirus vaccine introduction has been seen in several Latin American countries, it is too soon to tell whether rotavirus vaccine introduction will be accelerated. Current AVI

[61] Weekly Epidemiological Record (2006) 81(47):445-452.
[62] AVI, personal communications, Feb-Jun 2010.
[63] Board decision to approve new eligibility policy in June 2010, personal communication, GAVI Secretariat, July 2010.

introduction projections indicate rotavirus could introduce more slowly than pneumococcal and HepB- and Hib-containing vaccines. As of June 2010, only 6% of GAVI countries are projected to introduce rotavirus vaccines within 5 years of the 2006 GAVI funding decision (14% within 5 years of the global WHO recommendation).[64] This is significantly slower than YF, HepB-, and Hib-containing vaccine introductions, where 80%, 47%, and 13% of remaining GAVI-eligible countries had introduced within the same funding timeframe. In addition, 35% of pneumococcal introductions are projected to occur within 5 years of GAVI funding.

Several challenges will need to be overcome to accelerate the introduction of rotavirus vaccines, including overcoming the current GAVI funding gap and increasing the level of advocacy for rotavirus introduction, especially with the upcoming changes in GAVI eligibility.[65]

6.2.4. Qualitative evidence also suggests that GAVI has made a significant contribution to accelerating the introduction of underused vaccines and has an opportunity to accelerate new vaccine introduction.

The nature of GAVI's value add here relates (by definition) to achieving introduction faster than would have been the case without GAVI funding. In our structured interviews we have also explored views about the extent to which these results would have been achieved if additional funding had been channelled through other sources. Our sense from these interviews is that most people believe that the focus created by the Alliance – including bringing together organisations (across constituencies) to work jointly - was key to this achievement. However, there are also some observations (see SG2.5 on ADIPs) that suggest that there may have been opportunities to improve performance by more country and industry engagement.

Some respondents also recognized the adverse role the financial crisis may have on future vaccine introductions.

Table 6.2 provides the robustness score for these conclusions.

Table 6.2: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
GAVI's impact on accelerating YF vaccine introduction	• GAVI had a positive impact on accelerating YF vaccine introduction into YF endemic countries. - The cumulative number of countries introducing YF increased from 46% to 86% since GAVI's inception. - The average number of country introductions per year increased by 38% post GAVI. - The counterfactual analysis indicated earlier adoption than expected for 2 – 6 more countries. • In addition, GAVI stockpile funding mitigated use of infant vaccines for outbreak control, thereby improving vaccination coverage rates and immunisation program sustainability.	A	Data comes from reliable sources and all evaluation analyses support the conclusion.

[64] AVI, personal communications, Feb-Jun 2010.
[65] Board decision to approve new eligibility policy in June 2010, personal communication, GAVI Secretariat, July 2010.

Issue/ Theme	Findings	Robustness	
GAVI's impact on accelerating HepB-containing vaccine introduction	• GAVI had a significant impact on accelerating HepB-containing vaccine introduction. - The cumulative number of countries introducing HepB-containing vaccines has increased from 29% to 97% since GAVI's inception. - The average number of country introductions per year increased three-fold post GAVI. – The counterfactual analysis indicated earlier adoption than expected for 23 – 34 more countries.	A	• Data comes from reliable sources (e.g., WHO introduction year database). All evaluation analyses (e.g. e-survey, interviews) support the conclusion.
GAVI's impact on accelerating Hib-containing vaccine introduction	• GAVI had a significant impact on accelerating Hib-containing vaccine introduction, especially after 2007. - The cumulative number of countries introducing Hib-containing vaccines has increased from 7% to 83% since GAVI's inception. - Average number of country introductions per year increased greater than 10-fold post GAVI. – Counterfactual analysis indicated earlier adoption than expected for 48 – 52 more countries.	A	• Data comes from reliable sources (e.g., WHO introduction year database). All evaluation analyses support conclusion.
GAVI's impact on accelerating pneumococcal vaccine introduction	• GAVI has accelerated demand based on approved GAVI applications (n=21; 2 introduced, 19 awaiting introduction). • It is too soon to know GAVI's actual impact on accelerated introduction, but accelerated introduction may be at risk due to the current funding gap and new GAVI eligibility policy.	A	Data comes from reliable sources (e.g., GAVI applications submitted, GAVI Board documents), but conclusions are based on a single analysis of application projections.
GAVI's impact on accelerating rotavirus vaccine introduction	• Current projections based on actual introductions (n=4) and approved applications (n=6) indicate rotavirus introduction could be slower than previous GAVI-funded vaccine introductions. – Only 14% of GAVI countries are projected to introduce within 5 years of the global WHO recommendation decision compared to 80%, 49%, and 13% of remaining YF, HepB-, and Hib-containing introductions in the first five years of GAVI funding, respectively, and compared to 30% of projected pneumococcal vaccine introductions over the first five year funding timeframe.	A	Data comes from reliable sources, but conclusions are based on a single analysis of application projections.

6.3. SG2.2: Achievement of full scale coverage

To what extent have countries introducing underused and new vaccines been able to take them to scale quickly, i.e. achieve full scale coverage?

For this part of the evaluation, we determined the time to peak vaccination coverage for vaccines introduced by GAVI-eligible countries and explored the factors that may influence how quickly peak coverage was reached. This analysis focused on YF, HepB-, and Hib-containing vaccines only because there was insufficient data to assess new vaccines.

The evaluation:

- Calculated time to achieve peak coverage for all GAVI-eligible countries that have introduced YF, HepB-, or Hib-containing vaccines with GAVI NVS support.
- Analysed country APRs and incorporated relevant qualitative information to identify causes associated with longer times to achieve peak coverage.[66]
- Examined the relationship between time to achieve peak coverage for HepB- and Hib-containing vaccines for different groupings of countries as follows: receipt of GAVI ISS support, WHO region, GAVI financing tier, and country size.
- Conducted a comparative analysis of time to peak coverage for Hib-containing vaccines introduced in GAVI-eligible lower middle income countries (LMICs) versus time to peak in non-GAVI LMICs.

The evidence indicates that most countries were able to scale vaccine introductions to peak coverage rates within 2 years. The evidence supporting this conclusion is summarised below.

6.3.1. GAVI's reliance on countries achieving peak coverage rates quickly has been effective.

GAVI's current model of providing countries with the financial and technical support to prepare for and introduce a vaccine appears to be effective.

For YF vaccines, > 80 percent of countries reached peak coverage within three years of vaccine introduction. For HepB- and Hib-containing vaccines, ≥ 80 percent of countries reached peak coverage within two years of vaccine introduction.

The analysis also showed that median time to peak coverage rate was longer for vaccine additions (2 to 3 years, HepB and Hib monovalent vaccines and YF vaccines, respectively) compared to vaccine switches (1 year).

Table 6.3 provides a summary of SG2.2 conclusions and associated robustness scores.

Table 6.3: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
Country ability to scale quickly	• GAVI's reliance on countries to take vaccine programs to scale is an effective model because countries are able to quickly take	B	• The small number of evaluable cases for YF and Hib-containing vaccines

[66] http://www.gavialliance.org/performance/country_results/index.php (accessed May-Jul 2010).

Issue/ Theme	Findings	Robustness	
	vaccine programs to scale. – For YF, >80% of countries reached peak coverage within 3 years. – For HepB-containing vaccines, >80% of countries reached peak coverage within 2 years. – For Hib-containing vaccines, nearly 90% of countries reached peak coverage within 2 years.		makes it difficult to extrapolate results across all country introductions. • Variations in reported and estimated coverage rate data (as much as +/- 20%) could change time to peak coverage results by at least 1 year.
Scalability based on vaccine type	• Time to peak coverage is longer for vaccines considered additions vs. vaccines considered switches. – Median time to peak for HepB monovalent vaccine additions is 2 years and 3 years for YF vaccines. – Median time to peak for HepB and Hib tetravalent and pentavalent vaccine switches is 1 year.	B	• The small number of evaluable cases makes it difficult to extrapolate results across all country introductions. • Variations in reported and estimated coverage rate data would not impact the difference between additions and switches.
Comparison between GAVI and non-GAVI lower middle income countries	• GAVI and non-GAVI lower middle income countries are capable of achieving peak coverage within two years when introducing a Hib vaccine switch.	C	• Small sample sizes limit the robustness of this conclusion.

6.4. SG2.3: Stability of vaccine supply

To what extent has GAVI improved the stability of global and country level vaccine supply?

For the purposes of this evaluation, supply stability was defined as having sufficient supply to meet demand over time, with more than one supplier.

Ideally, analysis for this evaluation question would have used vaccine supply capacity dedicated for use in GAVI markets compared to actual country demand to determine whether supply was sufficient to meet demand over time. Unfortunately, these data were not available and therefore proxy data was used.

For supply capacity, the number of prequalified suppliers and UNICEF's product availability assessments were used as proxies. For demand, the GAVI Secretariat recommended using approved doses since country estimates were not always accurate. However, because of inconsistencies between approved doses and shipped doses, we included both.

With these proxy measures for supply and demand, the evaluation:

- Compared UNICEF's product availability assessments and the number of available prequalified suppliers to GAVI doses approved and UNICEF doses shipped data to assess supply availability versus demand and determine supply security for YF and HepB- and Hib-containing vaccines.

- Documented the number of available prequalified suppliers for pneumococcal and rotavirus vaccines.
- Documented historical supply-related events and information to provide insight on supply challenges, where appropriate.
- Reviewed country APRs to identify country level supply shortages. (Although note that no meaningful results were obtained since the majority of APRs contain incomplete information.)
- Compared the number of WHO prequalified suppliers prior to GAVI inception and as of the end of 2009 as an indicator of GAVI's role in improving supply stability.
- Summarised and interpreted responses from electronic surveys, structured interviews, supplier interviews, EPI manager surveys, and country visits.

6.4.1. GAVI has added value by improving supply stability for underused vaccines by creating a more stable market that attracted more prequalified suppliers.

YF vaccines

Since GAVI's inception, three additional YF vaccines have been prequalified. Although YF supply stability was improved from 2004−08, it was not sustained beyond 2008, and UNICEF continues to project YF vaccine supply limitations from 2010-12.

HepB-containing vaccines

GAVI has achieved supply stability for HepB mono- and tetravalent vaccines because of the entry of more suppliers and the decline in demand due to the shift to pentavalent vaccines. The number of HepB monovalent vaccine suppliers nearly doubled and the number of tetravalent vaccine suppliers increased 5-fold since GAVI's inception. In addition, UNICEF's product availability assessments show a supply excess for HepB monovalent vaccines from 2004 onward and from 2007 onward for HepB tetravalent vaccines.

Pentavalent vaccines

GAVI has improved supply stability for pentavalent vaccines by attracting more prequalified suppliers, but supply has remained 'limited' through 2009. A single pentavalent supplier served the entire GAVI market from 2001 through 2005. A second supplier entered the market in 2006, and two additional suppliers entered the market in 2008. However, from 2005 on, UNICEF assessed pentavalent supply as limited. UNICEF has projected supply excess from 2010-12.

6.4.2. GAVI has added value by creating an attractive market for pneumococcal vaccine suppliers.

GAVI has secured two 10-year commitments for 30m doses per year from both GSK and Pfizer beginning in 2012 and 2013, respectively. In addition, GAVI has secured approximately 50m doses total from these suppliers for use in the 2010-12 timeframe, which is predicted to be

sufficient to meet 2010-11 demand. Supply beyond these initial commitments is still uncertain given AMC supply tenders are issued on an annual basis.

6.4.3. GAVI has not yet secured any commitments for rotavirus vaccines.

UNICEF has not yet completed a procurement round for rotavirus vaccines. While early demand is expected to be met by the two current prequalified suppliers, more supply will be needed to meet the demand of current GAVI-eligible countries in later years.

6.4.4. Qualitative confirms that view that GAVI has made a significant contribution to improve supply stability of underused vaccines particularly

Based on our interview and survey evidence it seems clear that the existence of targeted funding (for underused vaccines) through GAVI has clearly played a very significant role in improving supply stability for under-used vaccines. At the highest level, this has been about the creation of a potentially viable markets (i.e. with both a reasonable size and reliability of demand and procurement) in low income countries. These markets did not exist or were significantly weaker prior to GAVI.

Another point to not from interviews with suppliers (as well as with most Board members) is the observation that the existence of the Alliance has significantly improved industry's relationship with both UNICEF and WHO. This is both an important contributor to and by product of the achievement of improved supply stability. In Phase I this was associated with engagement through GAVI structures. However, in Phase II, there is a sense that industry role as a 'partner' (as opposed to a 'supplier') has been diluted[67]. Our judgement is therefore that the contribution of GAVI structures to supply security has not continued to develop in Phase II (although we understand that the bilateral relationships between industry and UNICEF particularly have continued to improve).

Table 6.4 summarises the conclusions for SG2.3 and provides the associated robustness score for each.

Table 6.4: Summary findings and robustness

Issue/ Theme	Findings	Robustness	
GAVI impact on stability of YF vaccine supply	• GAVI has improved YF vaccine supply stability from 2004−08. - Three additional products have been prequalified since GAVI's inception. - UNICEF reports combined with product availability assessments indicate supply excess from 2004–08 (10 dose vial). - UNICEF product availability assessment indicates 'limited' to 'very limited' supply in 2009 and 'still fragile' from 2010−12.	C	Multiple data issues (e.g. missing data); qualitative supply assessments only; use of proxies.

Issue/ Theme	Findings	Robustness	
GAVI impact on supply stability of HepB mono- and tetravalent vaccines	• GAVI has achieved supply stability for HepB mono- and tetravalent vaccines. – The number of prequalified HepB monovalent suppliers increased from two to nine since GAVI's inception. – The number of prequalified HepB tetravalent suppliers increased from one to five since GAVI's inception. – UNICEF product availability assessments indicated supply excess of HepB mono- and tetravalent vaccines from 2004 and 2007 onward, respectively. • However, due to the shift to pentavalent vaccines, there is now very limited demand for both products.	C	Multiple data issues (e.g. missing data); qualitative supply assessments only; use of proxies.
GAVI impact on supply stability of pentavalent vaccines	• GAVI has not improved pentavalent vaccine supply stability. – Three additional products have been prequalified since GAVI's inception. – UNICEF product availability assessment indicates improvement from very limited supply in 2004 to limited supply from 2005 onward. • UNICEF has projected adequate supply in 2010-12.	C	Multiple data issues (e.g. missing data); qualitative supply assessments only; use of proxies.
GAVI impact on supply stability of pneumococcal vaccines	• GAVI has secured two 10-year commitments for 30m doses per year beginning in 2012 and 2013. • GAVI has also secured approximately 50m doses total for use in the 2010−12 timeframe, which is predicted to be sufficient to meet 2010-11 demand. • Supply beyond these initial commitments is still uncertain.	A	• The two suppliers have agreed to provide ~31m doses for 2010−11 demand. AMC supply contracts are in place with both suppliers to provide 30m doses each per year for up to 10 years beginning in 2012 and 2013.
GAVI impact on supply stability of rotavirus vaccines	• GAVI has not yet secured any supply commitments for rotavirus vaccine.	A	• No supply contracts in place.

6.5. SG2.4: Vaccine affordability

To what extent has GAVI made vaccines and related technologies more affordable?

GAVI defines affordability as a vaccine "price that countries can eventually finance in a sustainable manner".[68] Therefore, this section evaluates the extent to which the GAVI Alliance

[68] Doc # AF-9 Vaccine market development, GAVI Board meeting 6-7 December 2005.

has made vaccines more affordable to countries. The GAVI Alliance's impact on the affordability of related technologies (i.e. INS) is included in the SG1 evaluation section, and thus will not be addressed here. In addition, a wider analysis of GAVI's contribution to 'sustainability,' of which price is clearly an important part, is contained in the SG3. The focus of the analysis and judgements here relate to the extent to which GAVI has supported or achieved reductions in vaccine prices.

This evaluation:

- Summarised GAVI's supply strategy principles and vaccine pricing strategy.
- Examined weighted average UNICEF vaccine prices for GAVI markets over time (2001–10), and corresponding trends in vaccine supply and demand, for YF, HepB- and Hib-containing vaccines.
    - New vaccines could not be assessed because of the lack of data (rotavirus) or a single price point (pneumococcal) in the 2001−10 timeframe.
- Conducted a comparative analysis between UNICEF-negotiated GAVI vaccine prices and UNICEF-negotiated non-GAVI vaccine prices and Pan American Health Organisation (PAHO) negotiated vaccine prices for YF, HepB- and Hib-containing vaccines
    - Pneumococcal and rotavirus vaccines are compared to PAHO and US public market prices, as data are available.
- Compared market characteristics of size (infant population) and income level served (low vs. middle income countries) between UNICEF GAVI and PAHO to gain insights on potential purchasing power and tiered pricing.
- Compared current country costs of routine non-GAVI EPI vaccines to the cost of underused and new vaccines for additional insights on 'affordability'.
- Summarised and interpreted responses from other sources (e.g. electronic survey, structured interviews, and country visits)

6.5.1. GAVI has not improved the affordability of YF vaccines.

The weighted average price for a 5 and 10 dose presentation has increased by 19% and 13%, respectively; from 2004 to 2010 (2001−04 prices were not available). This price increase occurred despite an improvement in YF vaccine supply through the addition of three prequalified suppliers and based on UNICEF's product availability assessment.

6.5.2. GAVI has improved the affordability of HepB-containing vaccines.

GAVI has improved HepB mono- and tetravalent vaccine affordability; however, these vaccines are no longer in demand. The weighted average price of 10-dose presentations of HepB mono- and tetravalent vaccines have declined by 32% and 37%, respectively. HepB monovalent vaccines in 10 dose presentations (most frequently used presentation) are now $0.19/dose and 10 dose HepB tetravalent vaccine is now $0.65/dose (2010 weighted average prices). Even though these vaccines are more affordable to countries, demand has decreased significantly since

pentavalent vaccines are the preferred vaccine type. The price decline seen for these vaccines was a result of an excess of supply and decreasing demand.

6.5.3. GAVI has not improved the affordability of pentavalent vaccines through 2009, although prices have started to decline in 2010.

GAVI has not yet made pentavalent vaccines affordable, but they have recently improved the price. GAVI attracted three additional pentavalent vaccine suppliers to the market between 2004–09. The price of the liquid/lyophilized formulation did not decline through 2009, however, a 16% decrease did occur in 2010. This decline was likely driven by decreased demand due to the increased liquid formulation supply. Additional price reductions are expected once the second liquid/lyophilized product enters the market (prequalified in May 2010).

The liquid pentavalent vaccine formulation, introduced in 2007, declined in price by 9% between 2007–09 and by 20% through 2010. The presence of three liquid pentavalent vaccine suppliers by 2008 drove the price declines.

Although GAVI can be credited with attracting additional suppliers to the pentavalent vaccine market, the price declines to date have been driven by competitive market forces. While any declines in price do make the vaccine more affordable to GAVI-eligible countries, the declines to date are not sufficient to make the vaccine affordable in a sustained way once GAVI financing support is no longer available.

6.5.4. GAVI has added value through the AMC to get pneumococcal vaccines priced significantly lower than middle income markets.

GAVI has not yet made pneumococcal vaccines affordable, but work done through the AMC has ensured pneumococcal vaccines are priced significantly lower than middle income country prices. Through the Advanced Market Commitment (AMC), pneumococcal vaccines will be provided to GAVI-eligible countries at $3.50/dose for the near term. This is 16% of the weighted average price of pneumococcal vaccines negotiated for PAHO markets ($21.75/dose).

6.5.5. GAVI's impact on rotavirus vaccine affordability cannot yet be evaluated.

UNICEF has not yet completed a procurement round for rotavirus vaccines and therefore, no GAVI vaccine price is available for this evaluation.

6.5.6. It is unlikely GAVI-eligible countries will be able to afford underused or new vaccines without GAVI financing.

The cost of fully immunising an infant with BCG, MCV, tOPV, YF, and pentavalent vaccines with GAVI financing is currently $1.38 ($0.78 for non-GAVI vaccines). Without GAVI support, country vaccine costs would increase to $10.71, which is a 7.8-fold increase. If countries were to add a pneumococcal vaccine, current country costs with GAVI financing will be $1.83 per fully immunised infant. In the absence of GAVI financing, country vaccine costs would increase more than 11-fold to $21.21 per fully immunised infant. Immunizing infants without GAVI funding is not expected to be affordable at current vaccine prices in most GAVI-eligible countries. This conclusion is supporting by the SG3 evaluation findings.

6.5.7. Vaccine pricing has been an area of weak performance by GAVI.

Overall, our judgement is that vaccine pricing has been an area of weak performance by GAVI. In reaching this conclusion, we recognise that:

- The ability to achieve price reductions is affected by a wide range of cost and market factors, which may not easily be in GAVI (or UNICEF's) control; and
- Without GAVI financing, countries would not be able to introduce and take to scale critically important and impactful vaccines.

The primary failure in our view is that GAVI has not been sufficiently proactive in understanding the nature of price drivers for its key vaccines or in working with suppliers to maximise price reductions through explicit strategies. Given the complexity of these markets, we cannot say what the results of a more proactive approach would have been, but it is clear that relying on natural market forces to reduce vaccine prices can be a slow process.

The expectation has been and remains that GAVI would put strategies in place to make vaccines more affordable for GAVI-eligible countries beyond what could be achieved by natural market forces. The fact that this has not happened in Phase II, especially after it was identified as a major issue after Phase I, is a clear failure by GAVI.

Going forward, we note that it is more important than ever for GAVI to prioritise this effort as newer and more expensive vaccines enter GAVI's portfolio.

Table 6.5 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

Table 6.5: Summary of SG2.4 conclusions and associated robustness

Issue/ Theme	Findings	Robustness	
Role of GAVI supply strategy in improving affordability	• Although GAVI supply and procurement strategy documents have emphasised the need for 'affordable' vaccines, GAVI has not put a plan in place for either Phase 1 or Phase 2 • GAVI intends to submit a revised supply strategy in 2011 that is expected to include a plan to address vaccine pricing.	A	• Information comes from reliable sources (e.g., previous GAVI evaluations, GAVI Board documents, and GAVI procurement documents). •

Issue/ Theme	Findings	Robustness	
GAVI's impact on YF vaccine affordability	• GAVI has not improved YF vaccine affordability. – GAVI WAP for 5- and 10-dose vials increased by 19% and 13% between 2004 and 2010, respectively. – This price increase occurred even though the number of prequalified products increased from two to four however, only two suppliers received UNICEF awards. – This price increase occurred even though UNICEF reported supply excess of the 10 dose presentations from 2004-08 which represents the majority (66-77%) of shipped doses.	A	• Data comes from reliable sources (e.g. UNICEF product menus for WAP). • Missing 2001-03 vaccine prices for several vaccine presentations will not change conclusions.
GAVI's impact on HepB monovalent and tetravalent vaccine affordability	• GAVI has improved HepB monovalent vaccine affordability. – Prices for 10 dose HepB monovalent decreased by 32% from 2004-09. – The number of prequalified suppliers increased to nine by 2008. – Demand decreased to 12m doses by 2009 (without India) due to pentavalent preference. • GAVI has improved HepB tetravalent vaccine affordability. – The price of the 10 dose HepB tetravalent presentation decreased by 37% from 2004-09. – The number of prequalified suppliers increased to five by 2007. – Demand decreased to 1m doses by 2009 due to pentavalent preference.	A	• Data comes from reliable sources (e.g. UNICEF product menus for WAP). • Missing 2001-03 prices will not change conclusions.
GAVI's impact on pentavalent vaccine affordability	• WAP of pentavalent vaccine has only recently decreased, but GAVI has not yet made this vaccine 'affordable'. – Single supplier exists for GAVI market through 2006. – Two suppliers supplying GAVI market by 2008. – Liq/lyo presentation WAP did not decline from 2001-09 ($3.50/dose) but recently declined 16% to $2.95/dose in 2010. – Liquid presentation WAP started higher than liq/lyo presentation in 2007 ($3.75/dose) and decreased 20% to $3.01/dose in 2010.	A	• Data comes from reliable sources (e.g. UNICEF product menus). • Comparisons limited due to 2-dose liq/lyo and 1-dose liquid formulations, but will not change conclusion

Issue/ Theme	Findings	Robustness	
GAVI's impact on pneumococcal vaccine affordability	• Through the AMC, GAVI has secured pneumococcal vaccine prices that are significantly lower than middle- or high-income markets.	A	• Data comes from reliable sources (e.g. AMC supply agreements). •
GAVI's impact on rotavirus vaccine affordability	• Rotavirus vaccine prices cannot be evaluated since UNICEF has not yet negotiated a price for GAVI countries.	A	• Data comes from reliable sources (GAVI Secretariat, UNICEF).
GAVI's impact on country-level vaccine affordability	• It is unlikely GAVI countries can afford underutilised or new vaccines once GAVI financing support ends. – The cost of fully immunising an infant with YF and pentavalent vaccines will increase > 7-fold. – The cost of fully immunising an infant with YF, pentavalent, and pneumococcal vaccines will increase > 11-fold.	A	• Data comes from reliable sources (e.g. UNICEP product menus, GAVI Phase II financing policy). • Limited country input, but all relevant comments have been consistent.

6.6. SG2.5: Advancing the evidence base

To what extent has GAVI contributed to the advancement of the evidence base required for countries to address the policy decision related to the introduction of new vaccines?

The GAVI Alliance has funded organisations chartered with advancing the evidence base for YF, Hib-containing, pneumococcal, and rotavirus vaccines to accelerate vaccine introduction in GAVI-eligible countries. This section reviews the GAVI Alliance's contribution to the advancement of the evidence base required for countries to make an informed vaccine introduction decision.

A qualitative analysis approach has been taken based on two recent comprehensive reviews on the GAVI-funded ADIPs and Hib Initiative and on GAVI through Phase I and an extensive review from journal articles and other publicly available documentation from the GAVI-funded ADIPs (PneumoADIP, RVP) and Hib Initiative, Accelerated Vaccine Initiative (AVI), YF Initiative, and WHO websites. [69,70,71,72,73,74,75,76]

Relevant responses from electronic surveys, structured interviews, targeted interviews with the GAVI-funded PneumoADIP, RVP, and Hib Initiative, and country visits were summarised and included for additional insight.

The evidence showed that GAVI has played an important role in the advancement of the evidence base required for country policy decisions.

[69] Milstien J, Cohen JC, Olsen IT. An evaluation of the GAVI Alliance efforts to introduce new vaccines via the ADIPs and the Hib Initiative. HSLP, February 2007.
[70] Chee G, et al. Evaluation of the GAVI Phase I performance (2000–2005). (2008) Bethesda, MD: Abt Associates Inc.
[71] http://www.pneumoadip.com/ (accessed 14 May 2010).
[72] http://www.rotavirusvaccine.org/ (accessed 14 May 2010).
[73] http://www.hibaction.org/ (accessed 14 May 2010).
[74] http://www.who.int/csr/disease/yellowfev/introduction/en/index.html (accessed 17 May 2010).
[75] http://www.who.int/mediacentre/factsheets/fs100/en/ (accessed 17 May 2010).
[76] Pearman J. Briefing Session: AVI Overview. GAVI Partners Forum, Hanoi, Vietnam, 18 November 2009.

6.6.1. GAVI has added value by advancing the evidence base required for vaccine introduction decision-making.

YF vaccines

Through the GAVI-funded YF Initiative, GAVI has significantly advanced the evidence base for YF vaccine introduction. Prior to 2007, the YF Task Force, a collaboration between WHO and UNICEF, provided the technical expertise and evidence for vaccine support to GAVI through an investment cast. In 2007, the YF Initiative was launched with a $58 million grant from the GAVI Alliance.[77] This partnership between the GAVI Secretariat, WHO, and UNICEF supported studies to collect disease burden data needed to identify high risk groups for vaccination in target countries, as well as funded monitoring of vaccine quality and safety and support of operational research.[78]

HepB-containing vaccines

Though WHO recommendations and vaccine introduction guidelines, GAVI has contributed to the evidence base for HepB vaccine introduction. GAVI did not fund an ADIP-like organisation to accelerate introduction of HepB vaccines. For HepB, the evidence supporting vaccination has been communicated through WHO recommendations and vaccine introduction guidelines. GAVI did provide financial assistance to WHO to develop lab surveillance and conduct serosurveys for hepatitis.[79]

Hib-containing vaccines

Through the GAVI-funded Hib Initiative, GAVI has significantly advanced the evidence base for Hib vaccine introduction, GAVI advanced the evidence base for Hib vaccine introduction through its funding of the Hib Initiative in 2005 with a $37m grant.[80] The Hib Initiative played a significant role in estimating the burden of Hib disease, securing a global recommendation for use of Hib vaccines, calculating the cost-effectiveness of Hib vaccine introduction, raising global awareness about the importance of Hib vaccination, and advocating at the country level to promote adoption of Hib vaccines.

Pneumococcal vaccines

Through the GAVI-funded PneumoADIP, GAVI has significantly advanced the evidence base for pneumococcal vaccine introduction GAVI advanced the evidence base for pneumococcal vaccine introduction by funding the PneumoADIP a total of $57.8m beginning in 2003.[81] GAVI's funding of PneumoADIP was intended to expedite the development of pneumococcal vaccines and accelerate their introduction in developing countries.[82] As part of this effort, PneumoADIP quantified the pneumococcal disease burden by establishing regional surveillance networks, estimated vaccine health impact, calculated cost-effectiveness of pneumococcal

[77] Global health partners mobilize to counter yellow fever, WHO Press Release, 16 May 2007.
[78] http://www.who.int/csr/disease/yellowfev/yfbooklet_en.pdf (accessed 27 July 2010).
[79] Doc #AF.3 – AVI update & ADIPs/WHO budget extensions, GAVI Alliance & Fund joint EC meeting - 6 May 2008.
[80] Doc #AF.3 – AVI update & ADIPs/WHO budget extensions, GAVI Alliance & Fund joint EC meeting - 6 May 2008.
[81] Ibid.
[82] Doc #AF.6 – Accelerated Vaccine Introduction. GAVI Alliance and Fund Board Meeting, 15 June 2008.

vaccination, raising awareness in the global media, advocating for pneumococcal vaccine introduction at the regional level. PneumoADIP also developed the investment case which formed the basis of GAVI's decision to provide financial support for the introduction of pneumococcal vaccines through its NVS program. Beginning in 2009, AVI will generate health and economic impact data, fund special studies, and advocate at the global and regional level for the adoption of pneumococcal vaccines.

Rotavirus vaccines

Through the GAVI-funded RVP, GAVI has significantly advanced the evidence base for rotavirus vaccine introduction. GAVI advanced the evidence base for rotavirus vaccine introduction by funding the RVP a total of $53.7m beginning in 2003.[83] GAVI's funding of RVP was intended to expedite the development of rotavirus vaccines and accelerate their introduction in developing countries.[84] In partnership with the WHO and U.S. CDC, RVP supported vaccine development through Phase I, II, and III clinical trials for rotavirus vaccines in South Africa and Bangladesh, advanced the evidence base for rotavirus disease burden, estimated the cost-effectiveness of rotavirus vaccination, and advocated for rotavirus vaccine adoption in Latin America and Europe.[85] In addition, RVP created the investment case which formed the basis for GAVI's decision to financially support rotavirus vaccines in its NVS program. Beginning in 2009, AVI will generate health and economic impact data, fund special studies, and advocate at the global and regional level for the adoption of rotavirus vaccines.

6.6.2. Qualitative evidence suggests that GAVI has made a significant contribution to advancing the evidence base for vaccine introduction decision-making.

Qualitative responses from the e-survey, structured interviews, targeted interviews with former ADIP and Initiative staff, and country visits are consistent with this conclusion. Particular points of interest are as follows:

- A number of respondents noted in particular that the creativity and innovation that occurred in the early stages of the ADIPs were because of GAVI's "light touch" in management. This hands-off approach allowed the ADIPs to be nimble and respond to perceived research and communication needs quickly. Several respondents thought that in Phase II GAVI's approach to managing these activities has become more hands on - improving accountability, but reducing flexibility. Respondents thought some of this occurred during the transition from the ADIPs to AVI and that AVI is still trying to find its mandate.
- Respondents noted GAVI's recent financial situation meant there was an increased focus on fundraising and worried this would stall progress on advancing the evidence base for new vaccines.

[83] Doc #AF.3 – AVI update & ADIPs/WHO budget extensions, GAVI Alliance & Fund joint EC meeting - 6 May 2008.
[84] Doc #AF.6 – Accelerated Vaccine Introduction. GAVI Alliance and Fund Board Meeting, 15 June 2008.
[85] http://www.rotavirusvaccine.org/clinicalresearch.htm

- One issues raised in relation to performance of ADIPs was the extent to which a lack of engagement by ADIPs at the country level and the relative lack of contract with industry partners has reduced the effectiveness of this work.

Table 6.6 summarises our findings and provides the associated robustness score for the evidence set in support of the conclusion.

Table 6.6: Summary of SG2.5 conclusions and associated robustness

Issue/ Theme	Findings	Robustness	
GAVI contribution to the evidence base for YF vaccine introduction	• Through monetary contribution to YF Initiative, GAVI has made contributions to advance the evidence base for YF vaccine introduction.	B	• Based on desk review with limited triangulation.
GAVI contribution to the evidence base for HepB-containing vaccine introduction	• Through WHO recommendations and vaccine introduction guidelines, GAVI has made contributions to advance the evidence for HepB-containing vaccine introduction.	B	• Based on desk review with limited triangulation.
GAVI contribution to the evidence base for Hib-containing vaccine introduction	• Through the GAVI-funded Hib Initiative, GAVI has made substantial contributions to the evidence base for Hib vaccine introduction.	A	• Conclusion was based on desk review, previous evaluations, and interview results. • All evidence sources were in agreement.
GAVI contribution to the evidence base for pneumococcal vaccine introduction	• Through the GAVI-funded PneumoADIP, GAVI has made substantial contributions to the evidence base for pneumococcal vaccine introduction. • It is too early to tell what the AVI contributions have been.	A	• Conclusion was based on desk review, previous evaluations, and interviews. • All evidence sources were in agreement.
GAVI contribution to the evidence base for rotavirus vaccine introduction	• Through the GAVI-funded RVP, GAVI has made substantial contributions to the evidence base for rotavirus vaccine introduction. • It is too early to tell what the AVI contributions have been.	A	• Conclusion was based on desk review, previous evaluations, and interviews. • All evidence sources were in agreement.

6.7. SG2.6: Accurate and timely vaccine demand forecasts

To what extent has GAVI developed and used vaccine demand forecasts that are accurate and timely?

GAVI employs both supply chain forecasts (1-3 year forecasts developed for underused vaccines already on the market) and strategic supply forecasts (15-20 year forecasts for products typically >5 years from launch such as pneumococcal and rotavirus vaccines).

GAVI definitions for 'timely' and 'accurate' do not exist. Therefore, timeliness was based on when the forecast was made available to the end user and whether the end user perceived the forecast to have been "in time" for its intended use. An accurate demand forecast was perceived

to be within a specified variance range when compared to actual data. Variances were expected to be higher for strategic demand forecasts given the greater uncertainty compared to supply forecasts.

The evaluation includes YF, HepB mono- and tetravalent, pentavalent, pneumococcal, and rotavirus vaccines only given the demand for Hib mono- and tetravalent vaccines has been minimal.[86]

The evaluation:

- Documented the GAVI application and vaccine procurement process to inform the selection of demand forecasts for use in this evaluation.
- Compared demand forecast data for YF, HepB mono- and tetravalent and pentavalent vaccines to available forecast data, quantity procured, and shipped doses to the GAVI approved doses to determine variances.
- Compared demand forecast data for pneumococcal and rotavirus vaccines to actual country adoptions, and projected adoptions based on approved GAVI applications to determine variances.
- Sought input from WHO, UNICEF, and the GAVI Secretariat on the use and perceived accuracy of the demand forecasts.
- Sought input from suppliers on the use, timeliness, and accuracy of GAVI demand forecasts.

The evidence showed that GAVI has delivered timely forecasts for underused and new vaccines for use across the Partners and suppliers. Forecasting 'accuracy' has not been defined, and the accuracy of the underused vaccine forecasts still vary widely. It is too early to assess the accuracy of the forecasts for new vaccines.

The evidence supporting this conclusion is summarised below by vaccine.

6.7.1. GAVI has delivered timely forecasts for use across its partners and with suppliers

GAVI has added value by delivering timely forecasts for use across its partners and with suppliers (WHO forecasts produced for UNICEF, UNICEF forecasts produced for suppliers, and GAVI-funded ADIP and AVI forecasts produced for GAVI and UNICEF). The process for creating and updating demand forecasts is well established for the underused vaccines, and has recently been established for the new vaccines.

6.7.2. The accuracy of forecasts for underused vaccines varied widely across the procurement rounds

- For YF vaccines, the accuracy of the UNICEF LTA forecasts varied widely (up to 500%) across the procurement rounds, but appear to have improved over time.

[86] Approved Doses Syringes and Safety boxes 5_01_10, Document emailed from GAVI Secretariat in February 2010.

- For HepB monovalent vaccines, WHO forecasts varied widely (variances from -81% to 159%) across the first and second procurement rounds.
- For HepB tetravalent vaccines, WHO forecasts varied widely (variances up to 712%) across the first and second procurement rounds.
- The accuracy of the UNICEF LTA and annual updated forecasts were much better than the WHO forecasts (variance from -28% to 66%)
- For pentavalent vaccines, WHO forecasts varied less than for YF and HepB tetravalent vaccines (variance -4% to 118%) across the second and third procurement rounds.
- The UNICEF LTA and annual updated forecasts from 2002-09 were slightly better than the WHO forecasts (variance from -43% to 98%)
- It is too soon to evaluate the accuracy of the new vaccine forecasts (pneumococcal and rotavirus vaccines)

Table 6.7: Summary of SG2.6 conclusions and associated robustness

Evaluation Question SG2.6: To what extent has GAVI developed and used vaccine demand forecasts that are accurate and timely?			
Issue/Theme	**Findings**	**Robustness**	
Timeliness of underused and new vaccine demand forecasts	• Forecasts were delivered in a timely manner for their intended use.	A	• All available documentation and individual input indicate forecasts were provided in a timely manner
Accuracy of YF vaccine demand forecasts	• The accuracy of the LTA forecasts varied widely (up to 500%) across the procurement rounds, but appear to have improved over time.	C	• WHO forecasts were not available. • Missing LTA and annual updated forecast data. • Little input from GAVI partners on what constitutes an "accurate" forecast. • Lack of actual demand data to explain variances. – Doses approved used as a proxy, but varied inconsistently with procured and shipped doses.
Accuracy of HepB monovalent vaccine demand forecasts	• The accuracy of the WHO forecasts varied widely (variances from -81% to 159%) across the first and second procurement rounds.	C	• LTA and annual updated forecast data not available. • Little input from GAVI partners on what constitutes an "accurate" forecast. • Lack of actual demand data to explain variances. – Doses approved used as a proxy, but varied inconsistently with procured

Evaluation Question SG2.6: To what extent has GAVI developed and used vaccine demand forecasts that are accurate and timely?			
Issue/Theme	**Findings**	**Robustness**	
			and shipped doses.
Accuracy of HepB tetravalent vaccine demand forecasts	• The accuracy of the WHO forecasts varied widely (variances up to 712%) across the first and second procurement rounds. • The accuracy of the LTA and annual updated forecasts were much better than the WHO forecasts (variance from -28% to 66%).	C	• Missing WHO, LTA and annual updated forecast data. • Little input from GAVI partners on what constitutes an "accurate" forecast. • Lack of actual demand data to explain variances. – Doses approved used as a proxy, but varied inconsistently with procured and shipped doses.
Accuracy of pentavalent vaccine demand forecasts	• The accuracy of the WHO forecasts varied less than for YF and HepB tetravalent vaccines (variance -4% to 118%) across the second and third procurement rounds. • The accuracy of the LTA and annual updated forecasts from 2002–09 were slightly better than the WHO forecasts (variance from -43% to 98%).	C	• Missing WHO, LTA and annual updated forecast data. • Little input from GAVI partners on what constitutes an "accurate" forecast. • Lack of actual demand data to explain variances. – Doses approved used as a proxy, but varied inconsistently with procured and shipped doses.
Accuracy of pneumococcal vaccine demand forecasts	• Too early to evaluate the accuracy of the forecasts.	-	• Actual demand data over time not yet available.
Accuracy of rota vaccine demand forecasts	• Too early to evaluate the accuracy of the forecasts.	-	• Actual demand data over time not yet available.

6.8. Summary and conclusions on SG2 performance

The GAVI Alliance was formed in 2000 to address the delay between vaccine licensure and wide-scale introduction in the world's poorest countries. GAVI's NVS program is the foundation this mission, and the six questions used to evaluate GAVI's performance on SG2 are designed to assess the various components of a successful program to accelerate vaccine introduction:

- Countries must be willing to introduce (SG2.1).

- Once they have introduced, countries must be able to achieve full scale coverage to ensure maximum lives are saved (SG2.2).
- In order to introduce and sustain vaccination, countries must have access to a stable vaccine supply (SG2.3).
- In order for countries to sustain vaccination when GAVI funding ends, vaccines must be affordable (SG2.4).
- Sufficient evidence is required for countries to make the policy decision to introduce a new vaccine (SG2.5).
- Vaccine forecasts must be timely and accurate in order to support supplier decisions to develop a vaccine, donor decisions to finance a vaccine, and adequate and secure supply is available to meet demand (SG2.6).

While the evidence shows that GAVI has played a major role in accelerating the introduction of vaccines, created a model that allows most countries to achieve peak coverage quickly, improved the supply stability for the majority of the underused vaccines, and contributed to the evidence base required for country decision-making, there is little evidence to suggest that GAVI has made vaccines more affordable. Finally, GAVI has delivered timely forecasts for use across the Partners and with suppliers, but the accuracy of the forecasts still varies widely.

Based on this evaluation, GAVI has been only partially achieved its SG2 goal.

- GAVI has *'accelerated the uptake of underused vaccines'*, but it is too soon to tell whether they have *'accelerated the uptake of new vaccines'*.
- GAVI has *'improved vaccine supply stability'* of YF and pentavalent vaccines, but has not yet achieved supply stability for YF. GAVI has secured pneumococcal supplies for the near term, but it has not yet secured rotavirus vaccine supply.
- Through the GAVI-funded ADIPs and Initiatives, GAVI has contributed significantly to advancing the evidence base required for country policy decisions related to vaccine introduction. In addition, the ADIPs have delivered timely forecasts used by GAVI and suppliers.
- GAVI has not made vaccines more affordable to countries over the evaluation period.
- GAVI has delivered timely demand forecasts, but the accuracy of the forecasts has varied widely across the procurement rounds.

6.8.1. Summary of results achieved on SG2

Table 6.8 below summarises the extent to which GAVI's second goal has been met.

Table 6.8: Contribution by the SG2 programs to the goal

Accelerated the uptake and use of underused and new vaccines and associated technologies and improved vaccine supply stability	
☑ GAVI has played an important role in accelerating the introduction of YF, HepB and Hib vaccines. ? GAVI has played an important role in accelerating the demand of pneumococcal vaccines, but it is unclear whether introduction will be accelerated. ☒ It is too soon to say whether GAVI has accelerated the introduction of rotavirus vaccines, but based on current AVI projections, rota introduction is expected to be slower than other GAVI vaccine introductions ☑ The findings show GAVI-eligible countries are capable of quickly taking vaccine programs to scale. ☑ ☒ GAVI has improved the stability of YF supply through 2007, but supply stability has worsened from 2008 onward. ☑ GAVI has improved the stability of pentavalent vaccines through 2009 and is expected to achieve supply stability for 2010 and beyond.	☑ GAVI has secured pneumococcal vaccine supply sufficient to meet 2010–11 demand and to meet a significant proportion of demand from 2012–22. ☒ GAVI has not yet secured any supply commitments for rotavirus vaccine. ☒ GAVI has not yet made YF vaccines more affordable to countries. ☒ GAVI has just recently improved the affordability of pentavalent vaccines, but more is needed to ensure these vaccines are affordable to countries in the absence of GAVI. ☑ GAVI has played an important role in the advancement of the evidence base required for country policy decisions. ☑ GAVI has delivered timely forecasts for underused and new vaccines for use across the partners and with suppliers. ? The accuracy of the underused vaccine demand forecasts varies widely

7. EVALUATION OF SG3: IMMUNISATION FINANCING

7.1. Introduction

This section summarises our findings and conclusions in relation to GAVI's achievement of SG3:

> "To increase the predictability and sustainability of long-term financing for national immunisation programs."

Our evaluation of GAVI's performance against this SG has focused on a global-level assessment of GAVI's performance in increasing the level, predictability and sustainability of donor resources for immunisation, including through the innovative financing mechanisms of International Financing Facility for Immunisation (IFFIm) and Advanced Market Commitments (AMC); as well as its role in promoting and increasing financial sustainability of country immunisation programs.

Table 7.1 sets out the four Evaluation Questions that are examined under SG3.

Table 7.1: SG3 evaluation questions

SG3 evaluation questions	
SG3.1	To what extent has GAVI increased the level of global financial resources from donors for immunisation activities?
SG3.2	To what extent has GAVI increased the predictability and sustainability of global financial resources from donors for immunisation activities?
SG3.3	To what extent has GAVI promoted and increased the sustainability of immunisation funding at the national level?
SG3.4	To what extent is the existence of innovative financing mechanisms – IFFIm and AMC – dependent on the existence of GAVI in its current structure and form?

We present a summary of the main issues for each evaluation question in turn, before bringing the analysis together to draw conclusions about how GAVI has performed against SG3, including its value add if any. In considering the issues for each program, we present the key evaluation findings and the robustness rating that we associate with the supporting evidence.

Details of the analysis and conclusions for each of these Evaluation Questions are provided in the SG3 Report.

7.2. SG3.1: Level of global donor financial resources for immunisation

SG3.1: To what extent has GAVI increased the level of global financial resources from donors for immunisation activities?

The scope of this evaluation question covers the following: (i) the level and rate of growth of GAVI resources, within the context of total global resources for immunisation, health, and development aid more generally; and (ii) whether the resources raised through GAVI for

immunisation are additional[87] or have resulted in a displacement from other channels of immunisation funding.

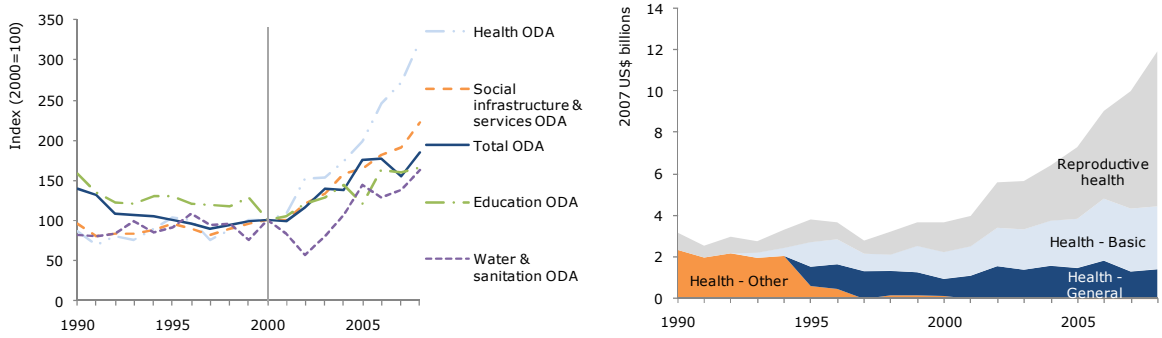
Our assessment is based primarily on quantitative analysis of data (including regressions), supplemented by feedback from structured interviews – mainly with a subsection of GAVI's donors. The latter has been particularly useful in validating the data analysis and also in interpreting the results (for example in understanding GAVI's value add).

We present below the main findings and conclusions from this review.

7.2.1. Considerable increases in funding for immunisation should be seen against the backdrop of large annual increases in total ODA and even higher annual increases in health ODA. However, there is good evidence to suggest that GAVI (i) has been important in capturing increases for immunisation; and (ii) has made a contribution to driving the overall increases.

Total donor development assistance and donor funding for health rose steeply throughout the decade since 2000. Within this, as shown in Figure 7.1(a) and (b), health sector funding has grown in importance compared to ODA sectors. Within health, funding for reproductive health/HIV has grown particularly rapidly.

Figure 7.1: (a) Comparison of health ODA to other ODA sectors; (b) Trends in the components of health sector ODA



While the data suggests that immunisation funding as a whole has not grown as fast as reproductive/HIV funding, there is some relatively weak evidence to suggest that within immunisation, non-polio immunisation funding has done better than polio immunisation funding.

An examination of the channels of donor funding for immunisation confirms that GAVI has becoming increasingly important compared with bilaterals and the multilaterals. Analysis of key health-sector bilateral donors also suggests that contributions to GAVI as a proportion of their funding for health/ maternal and child health have increased over the decade.

[87] The term 'additional' here relates to whether or not donor funding of GAVI has increased total funding for immunisation regardless of the channels for this funding. We separately discuss the question of 'value add' i.e. whether GAVI has led to increased resources for immunisation compared to the counterfactual that GAVI did not exist. 'Displacement' here refers to the extent to which increases in funding for GAVI have resulted in reductions in funding channelled through other agencies (primarily WHO and UNICEF).

There is consistent feedback from donors and other stakeholders that GAVI has attracted donor funding because of the following key features:

- Its focus on immunisation and provision of direct support to national immunisation programs.
- Its structure as an Alliance, bringing together and aligning the key stakeholders in immunisation.
- Its relatively flexible and 'lean' structure compared with existing multilateral and bilateral channels.

Donors state that they would not have channelled the same amount of money for immunisation in the absence of GAVI. Our conclusion therefore is that there is good evidence to suggest that GAVI (i) has been important in capturing the increases in donor funding for immunisation; and (ii) has made a contribution to driving the overall increases.

In terms of attribution to GAVI, however, we note that the Gates Foundation has played a critical role in 'crowding-in' other donor investments into GAVI.

We have assessed the robustness of this finding as an 'A', as it is supported by multiple sources of evidence (data and feedback from interviews/ e-survey).

7.2.2. The evidence suggests that WHO non-polio immunisation expenditure has increased – indicating that GAVI's funding has been additional (in respect of WHO). However, it has become more difficult for WHO to access bilateral funding for non-GAVI related immunisation priorities – although it is not clear if this can be attributed to GAVI.

In examining this issue, we have looked at a number of evidence sources, including: (i) analysis of data from WHO on their expenditure on non-polio immunisation over the period 2000-09[88]; (ii) regression analysis to test the relation, if any, between WHO health funding and GAVI funding; and (iii) interviews, primarily with the donor community, but also with wider stakeholders; and (iv) e-survey responses.

WHO non-polio immunisation expenditure

WHO expenditure on non-polio immunisation has increased over the period 2000-09.[89] [90] This is evidence to support the view that GAVI's funding has not lead to any 'absolute displacement' for WHO (i.e. actual reductions in total funding received by WHO for non-polio immunisation).

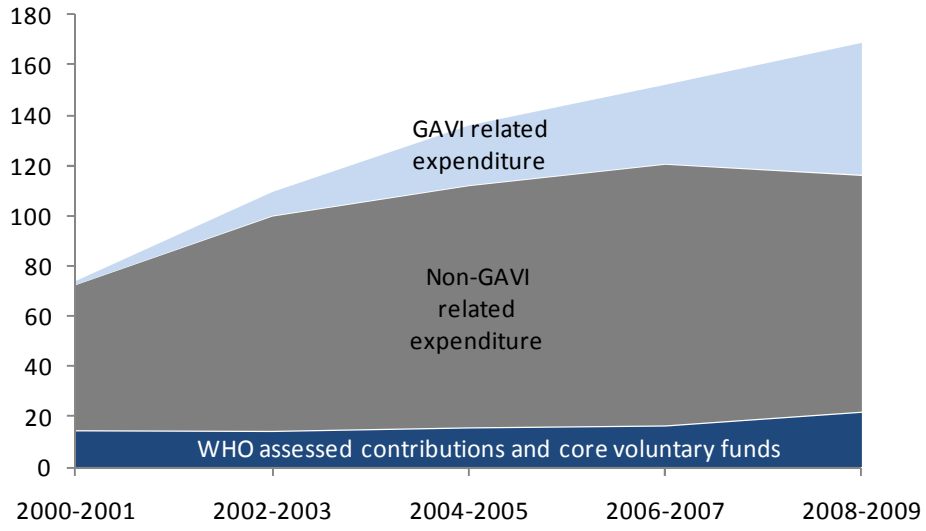
[88] We have not had access to polio-related WHO immunisation expenditure, and are not therefore in a position to consider immunisation more broadly. Note that IFFIm has provided funding to WHO for polio immunisation as well. Initially, in 2006, $191m of funding was approved for WHO (for a polio stock pile), and in 2007, $104.6m of this was transferred to GPEI.

[89] While total WHO expenditure has declined as a proportion of total Development Assistance for Health (DAH) (it comprised 19.7% of total DAH in 1990, 11.6% in 2000 and 7.1% in 2007), it has grown in importance in terms of non-polio immunisation expenditure (its share grew from 15.3% in 2003 to 17.8% in 2006/7). However we note that the immunisation funding database covers a short period of time only (2003-07) and hence this may not be fully reflective of the trend.

However, within the total expenditure, there have been significant shifts in the sources of funding that WHO has received for immunisation (see Figure 7.2):

- contributions from 'WHO assessed and core voluntary funds'[91] for immunisation have been broadly flat and have increased marginally in the last biennium;
- funding from the GAVI sources (i.e. work plan, ADIP/ Hib Initiative funds) have increased dramatically (within this increases in GAVI Work Plan funding have more than off-set reductions in 'bilateral funding for GAVI-related activities'). [92]
- funding from sources for 'non-GAVI' related expenditure have increased, although have reduced slightly in the last biennium.[93] These trends mask a significant reduction in earmarked bilateral support, which has been largely offset by funding from other sources (e.g. from the Gates Foundation).

Figure 7.2: Trends in WHO immunisation expenditure, by source of funding category ($m)



Despite increases in total expenditure on immunisation, these trends are consistent with the concern expressed by WHO that it has become more difficult to attract bilateral funding for non-GAVI related immunisation priorities (especially given that over 95% of the core funds allocated to immunisation are used to support the salaries of WHO immunisation staff).

We have requested further information on total WHO expenditure broken down by donor source – but WHO have been unable to provide this within the time available for this evaluation.

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[90] We understand that GAVI, through IFFIm, has provided funding to WHO for polio immunisation as well. Initially, in 2006, $191m of funding was approved for WHO (for a polio stock pile), however in 2007, $104.6m of this was transferred to GPEI. This is not included in the analysis.

[91] 'WHO assessed funding' is compulsory for donors/ membership fees. 'WHO core voluntary funds' is non-compulsory/ voluntary funding from donors.

[92] We note that over the mid 2000s, some bilateral donors provided funds directly to WHO for GAVI related activities, but this has been discontinued. All bilateral funding for WHO is now channelled through the work plan.

[93] This includes all voluntary contributions (from bilateral government donors, private foundations, etc) that are not directly linked to GAVI.

Given this, we do not have enough evidence to distinguish between two possible explanations of this shift in WHO's funding sources:

- if reductions in earmarked bilateral donations for immunisation have been offset by increased un-earmarked contributions from bilateral donors, then this displacement is, in effect, an internal WHO allocation decision (which may or may not relate to GAVI);
- alternatively if increases in core contributions from bilateral donors have not offset reductions in earmarked bilateral donor support for immunisation, it may suggest that either GAVI has had some impact, or that donors have independently reduced the amounts of ODA that they are prepared to channel through WHO.

During our structured interviews, some donors noted clearly that their funding to GAVI has not come at the cost of their funding to multilaterals; while others accept that some element of displacement from WHO is plausible. The same is true of the e-survey response – with almost an equal number of respondents agreeing and disagreeing on whether funding to GAVI has displaced funding to multilaterals.

Wider WHO health expenditure

We have carried out a simple regression analysis to assess the relationship between funding to GAVI and WHO total health expenditure. Given the possibility of omitted variables, as well as the use of expenditure data as a proxy for funding, we have not been able to draw meaningful conclusions from this analysis, despite the existence of statistically significant relationships.

Conclusion

The evidence suggests that WHO non-polio immunisation expenditure has increased – indicating GAVI funding additionality (in respect of WHO). However, it has become more difficult for WHO to access bilateral funding for non-GAVI related immunisation priorities – although it is not clear whether this can be attributed to GAVI or is because of internal WHO resource allocation decisions/ independent decisions of donors on the amount of ODA they would like to channel through WHO.

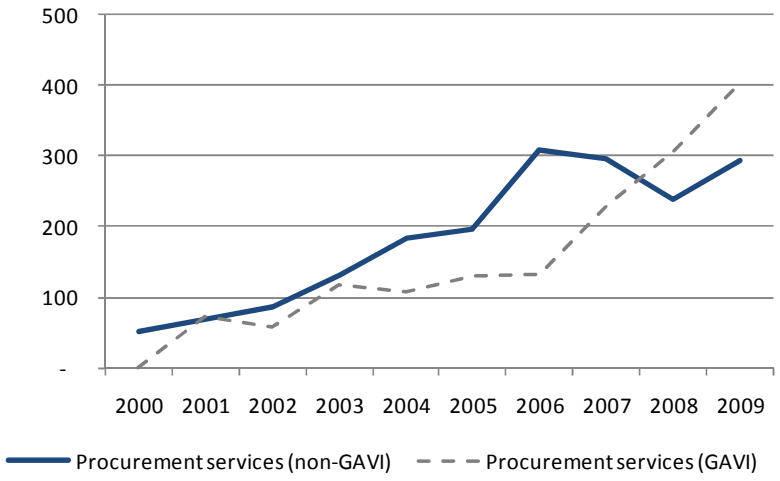
We assign a robustness rating of 'B' to this finding, given that the data evidence from WHO mostly triangulates with the interview and e-survey evidence.

7.2.3. The evidence indicates that there has not been a decline in total funding of UNICEF immunisation – indicating that GAVI funding has been additional (in respect of UNICEF). GAVI is now the largest customer for UNICEF procurement services for immunisation.

UNICEF expenditure on immunisation has increased over the period 2000-09. This indicates that funding to GAVI has been additional with respect to UNICEF.

Within the total expenditure, funding for immunisation procurement activities has been increasing – with that for GAVI related procurement being higher than non-GAVI related procurement from 2008[94] – see Figure 7.3.

Figure 7.3: UNICEF expenditure on immunisation procurement ($m)



Other key points to note from our analysis are as follows:

- Data from UNICEF suggests that the percentage of funds from total UNICEF regular and voluntary funds (Medium Term Strategic Plan (MTSP) funds) has declined marginally over the period. This suggests that UNICEF immunisation department is not being provided the similar level of funds for its activities.
- Funding from the GAVI Work Plan has increased over time (albeit with a decline in 2005); however it represents only a small proportion of UNICEF immunisation expenditure.
- Similar to WHO as discussed above, we have carried some additional regression analysis to assess the relationship between funding to GAVI and wider UNICEF health expenditure. Given the possibility of omitted variables, as well as some data issues, we have not been able to draw meaningful conclusions from this analysis, despite the existence of statistically significant relationships.

Conclusions

In the case of UNICEF, the data does not point towards displacement of funding in favour of GAVI. However with the increase in the proportion of GAVI support for more expensive vaccines, GAVI has now become the most important customer for UNICEF's procurement services for immunisation.

We assign a robustness rating of 'B' to this finding, given that the data evidence from UNICEF mostly triangulates with the interview and e-survey evidence.

7.2.4. Summary and conclusions

[94] We understand this reflects the purchase of pentavalent vaccine in large birth cohort countries.

SG3.1: To what extent has GAVI increased the level of global financial resources from donors for immunisation activities?

Summary

Table 7.2 summarises the key evaluation findings on SG3.1 along with the robustness rating.

Table 7.2 SG3.1 – findings and robustness ratings

Issue/ Theme	Findings	Robustness	
Contribution of GAVI to an increase in donor immunisation funding	Considerable increases in funding for immunisation should be seen against the backdrop of large increases in total ODA and higher increases in health ODA. However, there is good evidence to suggest that GAVI (i) has been important in capturing these increases for non-polio immunisation; and (ii) has made a contribution to driving the overall increases.	A	Conclusion supported by multiple sources of evidence (data and feedback from interviews/ e-survey).
Additionality of resources raised through GAVI for immunisation	Total WHO and UNICEF immunisation expenditure has risen over the decade – indicating GAVI funding additionality. However there is some element of displacement of bilateral donor funding, to WHO. We have not been able to conclude about the extent to which this is attributable to GAVI or internal resourcing decisions within WHO.	B	Multiple evidence sources arrive at this conclusion.

Conclusions

Our evaluation work on the assessment of GAVI's performance on raising the level of donor resources for immunisation suggests that it has made a significant contribution to increasing donor funding for immunisation. Its immunisation focus, alliance nature and relatively flexible structure have attracted increasing amounts of donor resources – which would not have been allocated to immunisation in the absence of GAVI. Thus, one of GAVI's key value add has been its impact on raising substantial resources for immunisation. Although we note that in terms of attribution it is important to recognise the role of the Gates Foundation particularly in crowding in donor resources.

The data that we have access to from WHO and UNICEF suggests that funding for immunisation for both organisations have increased – suggesting that GAVI funding has been additional relative to these key Partners. However, for WHO particularly, there has been a significant change in sources of funding. There is also evidence to suggest that it has become more difficult for WHO to access bilateral funding for non-GAVI related immunisation priorities. Given this, our judgement is that it is reasonable to conclude that there has been a limited element of displacement of bilateral funding to the multilaterals (WHO in particular). (although it is not clear whether this can be attributed to GAVI, independent decisions by donors, or because of internal WHO resource allocation decisions).

7.3. SG3.2: Predictability and sustainability of donor immunisation finance

SG3.2: To what extent has GAVI increased the predictability and sustainability of global financial resources for immunisation activities?

This evaluation question examines several aspects of the predictability and sustainability of donor resources to GAVI, as a key driver of its own ability to make longer-term commitments to countries, enabling them to plan their routine immunisation programs and support efficient procurement of vaccines – which is a key aspect of GAVI's potential value add.

As a part of this assessment, we have examined the number, profile, diversity and length of commitment period by GAVI donors, and compared this with the experience of two other GHPs - the Global Fund and the Global Polio Eradication Initiative (GPEI). We have also examined the impact of IFFIm on predictability and the predictability of GAVI funding in turn to countries.

The main source of evidence for this analysis has been the comparison of a series of donor funding metrics, as well as data from country cMYPs. This is supplemented by feedback for the structured interviews and the e-survey (which have been useful in interpreting the results from the data analysis as well as gauging the general perception of GAVI on its achievements in this sphere).

We present below the main findings and conclusions from this review.

7.3.1. GAVI has performed well in accessing longer-term direct[95] or 'traditional' contributions from its donors, similar to other GHPs such as the Global Fund. GAVI's success has been in raising its profile and putting itself in a position to benefit from the maximum commitments that bilateral and other donors make available to priority investments.

The data indicates that GAVI has performed reasonably well in accessing longer-term direct donor funding commitments, and, as of 2009:

- the average period of its funding is 1.7 years for all direct commitments from bilateral and private donors[96] and the weighted average (by size of grant agreement) is 4.4 years;
- more than half of its donors have committed to at least one grant agreement of 3+ years.

In addition, Gates funding to GAVI (seed funding of $750m followed by a further $750m over 10 years), has made a strong contribution to predictability.

Comparisons with the Global Fund suggest that GAVI has done no better in accessing longer-term commitments from donors. This reflects the fact that maximum funding commitment periods from bilateral donors are determined by individual donor government policies/

[95] We use this term to relate to traditional donor grants / agreements (i.e. as distinct from commitments through innovative financing mechanisms).

[96] The average duration of agreement by bilateral donors alone is 1.5 years.

practises.[97] In addition, we also do not observe any material differences in the volatility of funding to these organisations.

We conclude therefore that GAVI has performed well in accessing long-term direct contributions from its donors. GAVI's success has been in raising its profile and putting itself in a position to benefit from the maximum commitments that bilateral and other donors make available to priority investments. The features of GAVI that have supported this achievement in relation to predictability are the same as those that have influenced its ability to increase the levels of funding for immunisation (e.g. focus, flexibility and partnership).

We assign a robustness rating of 'A' to this finding, as is based on a direct review of available data and confirmed by interview evidence.

7.3.2. Through IFFIm, GAVI has secured considerably longer periods of donor commitments, which have improved predictability of donor funding for immunisation. However, there are advocacy and planning challenges that are likely to be more acute as a result of IFFIm frontloading.

In our assessment of the contribution of IFFIm to predictability and sustainability, we distinguish between: (i) the donor commitments to IFFIm; and (ii) expected IFFIm disbursements to the GAVI Fund Affiliate (GFA) for GAVI.

Donor commitments to IFFIm

The existence of IFFIm has resulted in legally binding commitments from donors for 15-20 years. In the words of one consultee – this has been 'game changing' with regards to supporting both predictability and sustainability of funding for immunisation. As discussed below (Evaluation Question SG3.4), GAVI has played an important role in this achievement.

Expected disbursement from IFFIm to GFA

A total of $3.7bn is being made available to the GFA through IFFIm over the period 2006-15.[98] This funding, over a 10-year period, along with grant agreements for direct funding by donors for GAVI, has resulted in an average duration of funding (weighted by size) of 6.4 years.

These disbursements reflect proceeds from the bonds that have been and are expected to be issued on the back of the donor commitments. Although there is clearly some element of risk associated with the level and timing of these issues (e.g. such as the disorderly conditions observed during the recent financial crisis or 'credit crunch'), there is a high probability that these resources will be forthcoming. This gives GAVI a level of funding predictability from bilateral donors that is unprecedented. It is this commitment that has provided the basis for GAVI's ability to continue to commit to providing support for all current NVS grants through to 2015.

IFFIm has therefore had a very significant, positive effect on the predictability of donor funding for immunisation – and has provided the basis for a significant element of GAVI's value add in

[97] We note that some donors, have been looking at ways to increase lengths of commitment (e.g. DFID's recent long commitments to both GAVI and the Global Fund, with a rolling three year binding element).

[98] We note that not all of the disbursement is for direct use by GAVI, although a substantial portion is. GPEI received some funding from the GFA in its initial years.

Phase II (and into Phase III) in terms of its ability to provide long-term support for national programs.

However, in the context of country-level financial sustainability, there are a number of planning and fundraising challenges that arise. While the case for front-loading donor commitments through IFFIm is strong, it does present a challenge to GAVI in ensuring that the imperative to immunise children now is not at the expense of predictability – i.e. the expansion of GAVI's programs that IFFIm has supported can be funded beyond 2015.

In principle this is an issue that GAVI might face at the end of any grant. However, given the nature of IFFIm this problem may be more acute to the extent that:

- front loading has resulted in a level of support for immunisation that is not sustainable when it is competing directly with other priorities; and / or
- the long 'tail' of remaining donor commitments to IFFIm (after IFFIm disbursements to GFA have ceased) acts a drag on new donor commitments beyond 2015.

Conclusions

We conclude that through IFFIm, GAVI has secured considerably longer periods of donor commitments, which has improved predictability of donor funding for immunisation. However, it does present a challenge for GAVI in ensuring that frontloading through IFFIm is not at the expense of predictability beyond 2015.

We assign a robustness rating of 'A' to this finding, as is based on fact and not subject to contention.

7.3.3. GAVI has performed less well in terms of the number and diversity of donors as compared to other GHPs such as the Global Fund and GPEI.

We have compared the direct donor contributions to GAVI with direct donor contributions to the Global Fund and GPEI. This analysis indicates that GAVI has a smaller and less diverse donor base. For example, GAVI does not receive direct funding from some of the G8 donors[99] and the range of 'non-traditional' (i.e. non-OECD) bilateral and private philanthropy donors is low. Even if we consider the IFFIm donors, this finding still holds when compared to the Global Fund – although we recognise that the Global Fund supports a larger portfolio of countries.

Feedback from consultees suggested reasons for GAVI's relatively weaker donor base:

- The success of IFFIm may have made GAVI less proactive in fund-raising, as compared to other organisations – which is a relative failing.
- Access to predictable funding thus far has led to a greater emphasis by GAVI on fund management as against fund mobilisation.

We assign a robustness rating of 'A' to this finding, as is based on a direct review of available data and is supported by interview evidence.

[99] Including IFFIm and AMC, GAVI receives funding for seven of G8 donors.

7.3.4. There is evidence to suggest that GAVI has increased country-level predictability of donor immunisation finance, however, its current funding gap has undermined this achievement and its reputation.

We have analysed country cMYPs, that include forecasts for planned financing for routine immunisation, to assess the predictability of GAVI funding as compared to other sources. Information on the forecasted financing is available by: (i) source of financing (i.e. government, GAVI, other donors, etc); and (ii) 'secure' and 'probable' sources of finance. This forecast data reflects commitments by funding source to the countries, but also involves an element of perception/ expectation by the countries.

We find that recipient countries consider GAVI to be a relatively predictable source of finance for routine immunisation, as evidenced by: (i) GAVI providing the highest proportion of 'secure' finance amongst external sources of finance; and (ii) GAVI, (along with government and multilateral finance) being relatively stable over time, especially when compared to bilateral finance (see Table 7.3 below).

Table 7.3: Predictability of financing sources

Source	Year 2	Year 3	Year 4	Year 5	Year 6
Amount provided as % of Year 2 amount[100]					
Government		110%	114%	116%	115%
GAVI		122%	137%	127%	118%
Multilaterals		114%	104%	103%	104%
Bilaterals		59%	57%	56%	58%
Proportion rated "secure"					
Government	94%	90%	83%	82%	83%
GAVI	93%	73%	67%	65%	64%
Multilaterals	79%	61%	38%	31%	33%
Bilaterals	69%	42%	10%	9%	7%

However qualitative evidence (from structured interviews and the e-survey) highlights some concerns that have undermined this achievement and put at risk GAVI's reputation in providing predictable finance:

- Consultees referred to the current funding gap that GAVI faces and the uncertainty that this has created for countries – and the consequent impact on national immunisation planning and budgeting.
- Another area of concern on the predictability of GAVI funding was whether GAVI might be able to fund its share of the AMC price of $3.5/ dose in light of the resource constraints it currently faces.

There is a general view that the funding gap and the decision to put applications on hold has weakened GAVI's perceived predictability – one of its key value additions.

[100] Includes all finance whether it is rated as secure or probable.

We assign a robustness rating of 'B' to this finding, as is based on analysis of cMYP data and also structured interviews, however there are some limitations in terms quality of cMYP data quality and interview sample size.

7.3.5. Summary and conclusions

SG3.2: To what extent has GAVI increased the predictability and sustainability of global financial resources for immunisation activities?

Summary

Table 7.4 summarises the key evaluation findings on SG3.2 along with the robustness rating.

Table 7.4 SG3.2 – findings and robustness ratings

Issue/ Theme	Findings	Robustness	
Length of commitment by donor to GAVI	GAVI has performed reasonably well in accessing long term commitments from donors (direct/ 'traditional' funding); although no better than other 'high priority' investments (e.g. Global Fund). However through IFFIm, GAVI has managed to secure donor commitments for 5-10 years – which is unprecedented	A	Based on a direct review of available data and confirmed by interview evidence.
Volatility of funding to GAVI	There is no significant difference in the volatility of direct donors funding to GAVI and the Global Fund.	A	Based on a direct review of available data and is not subject to contention
Impact of IFFIm on predictability	IFFIm has had a significant positive effect on the predictability of donor funding for immunisation.	A	Based on fact and is not subject to contention
Number and type of donors for GAVI	GAVI has a raised funds from a smaller and less diverse set of donors than GHP comparators like Global Fund and the GPEI.	A	The analysis on donor profile is based on reasonable quality data.
Predictability of GAVI funding to countries	GAVI has improved predictability of donor funding for immunisation to countries, as exhibited by the larger proportion of its future funding being noted as 'secure', as compared to other bilateral and multilateral donors. However its current funding gap, has undermined the predictability of its funding.	B	Based on analysis of cMYP data and also structured interviews. Although some limitations in terms quality of cMYP data quality; and interview sample size

Conclusions

Our evaluation work suggests that GAVI has had a positive impact on improving the predictability and sustainability of global financial resources for immunisation. Access to predictable/ sustainable funds by GAVI has contributed to its ability to make longer-term commitments to countries – one of the key aspects of its potential value add.

It has benefitted from long-term commitments from donors, particularly through IFFIm, which has had a very significant, positive effect on the predictability of donor funding for immunisation – and has provided the basis for a significant element of GAVI's value add in Phase II (and into Phase III) in terms of its ability to provide long-term support for national programs. There are however advocacy and planning challenges that are likely to be more acute as a result of IFFIm frontloading.

An area where GAVI has performed less well is in broadening its base of donors – as other GHPs such as the Global Fund and the GPEI have done.

We also note that the existence of the current funding gap for new vaccines has diluted GAVI's reputation to provide predictable funding to countries for their immunisation programs.

7.4. SG3.3: Financial sustainability at the country level

SG3.3: To what extent has GAVI promoted and increased the sustainability of immunisation funding at the national level?

There are two key aspects to our evaluation of GAVI's performance in relation to financial sustainability: the first relates to GAVI's activities, policies and approaches to supporting countries' financial planning; and the second is concerned with the overall impact of GAVI's funding of immunisation in eligible countries on financial sustainability.

We have used multiple sources of evidence in our evaluation of GAVI's performance in this area – drawing extensively on the GAVI Board documents and financial sustainability literature, and data included in Financial Sustainability Plans (FSPs) and cMYPs and data on government health expenditure, as well as feedback from stakeholders (both through global and country level consultations as well as the e-survey).

We present below the main findings and conclusions from this review.

7.4.1. GAVI has been innovative with regards to developing tools and policies that have supported country financial planning for routine immunisation, however, frequent revisions or updates to key policies suggests that the overall message with regards to financial sustainability is still not clear.

We have conducted a desk-based review of relevant reports, supplemented by feedback from structured interviews and country visits, of the key policies, tools and approaches supported by GAVI that have aimed to promote financial sustainability at the country level. In particular, we have looked at: (i) FSPs in Phase I and cMYPs in Phase II; and (ii) the current co-financing policy, also within the context of the previous Bridge Financing concept. We have also reviewed the approaches to financial sustainability of some comparator organisations.

In summary, our review indicates the following:

- The introduction of FSPs was an important innovation of GAVI (and of the Financing Task Force (FTF) in particular). The process generated a much needed focus on immunisation costs and financing at the national level; and contributed to a greater understanding within countries, and amongst global stakeholders, of the financial implications for countries when introducing new vaccines.

- The transition to using the cMYPs was useful in that it allowed for the integration of immunisation planning and financing with broader strategic planning of the health sector. It has also reduced the burden on countries by not having to prepare a separate FSP in order to access GAVI funding. However some countries have noted that while the cMYPs have facilitated better planning, implementation of these plans remains an issue.

- Although the Bridge Financing concept was developed, it was never implemented, even though considerable consultations were carried out with countries and GAVI communicated its intent to implement this policy. Instead, the GAVI Board approved the principle of co-financing in December 2005. This caused uncertainty particularly for countries particularly. Stakeholders have expressed concern on this revision of approach/ policy, and the consequent implications in terms of uncertainty/ unpredictability for countries.

- The co-financing policy is a step in the right direction in terms of financial sustainability, and GAVI's introduction of this policy has been an innovation in development practice. Our assessment is that the introduction of co-financing has been important in supporting country ownership of immunisation decisions (even if the levels are probably too low in the overall context of financial sustainability). But the process of development of the policy, as well as its coverage have been areas of poorer performance:

    - The time taken to introduce the policy and then frequent revisions and updates to the policy have caused confusion, both within the organisation and at the country level. In addition, with further work ongoing in this area, the overall message with regard to financial sustainability is still not clear. (It is expected the Co-financing Task Team (CTT) will finalise the policy for Board review by end 2010 – only at the end of Phase II).

    - It is surprising that the policies introduced during Phase II (such as those relating to country eligibility (and graduation), as well as vaccine support) have not done more to integrate the issues of financial sustainability and country eligibility.

Our conclusion is therefore, that GAVI has been innovative in developing tools/ policies for better national level financial planning, that aim to support financial sustainability. But in Phase II, the overall message with regard to financial sustainability has not be clear – given frequent revisions / updates to key policies. This has resulted in a degree of confusion and uncertainty for countries.

We have assessed the robustness of this finding as an 'B', as it is based on a review of available documentation, supplemented by discussions with global and national level stakeholders (both through direct consultations and the e-survey).

7.4.2. The prospects for financial sustainability of GAVI funding for low-income countries is a significant challenge. The challenge for low-middle income countries however is much less marked, but is still not clearly assured.

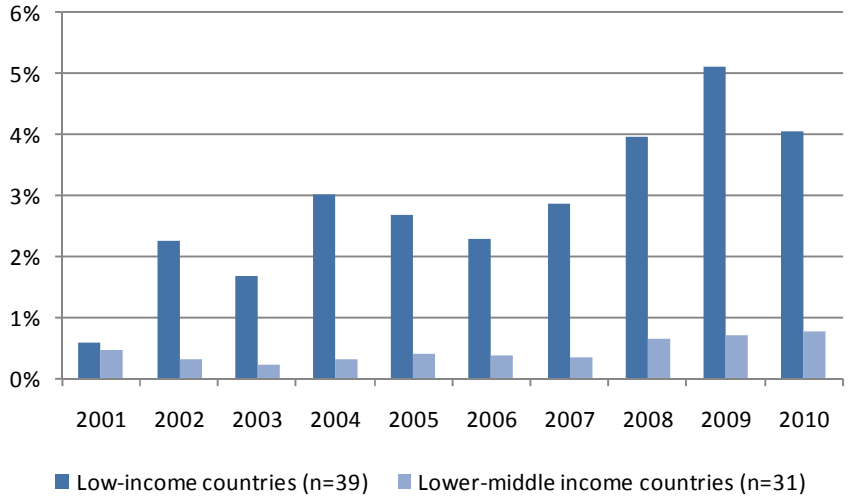
We have assessed the prospects for financial sustainability of GAVI-eligible countries through a number of different evidence sources: (i) GAVI support for low and low-middle income GAVI-eligible countries as a proportion of their government health expenditure; (ii) data included in country FSPs and cMYPs; (iii) forecasts of vaccine expenditure as a proportion of government health expenditure; and (iv) country and program case studies on countries ability to continue to finance vaccine (and other immunisation expenditure).

GAVI support as a proportion of government health expenditure

We have used the benchmark of 1% of public health expenditure on vaccines, to assess the prospects for financial sustainability for GAVI-eligible countries, based on the recent work by the CTT.[101] Analysis of average GAVI disbursements for vaccines as a proportion of government health expenditure (see Figure 7.4) indicates that:

- The levels of GAVI support for most low income countries are at levels (relative to a 1% benchmark) that mean that self-financing is likely to be a significant challenge (even before the introduction of rotavirus and pneumococcal).
- For low-middle income countries the challenge appears much less marked – given that GAVI support is less than 1% of government health expenditure on average.

Figure 7.4: Average GAVI disbursement for vaccines as a percentage of total government expenditure on health

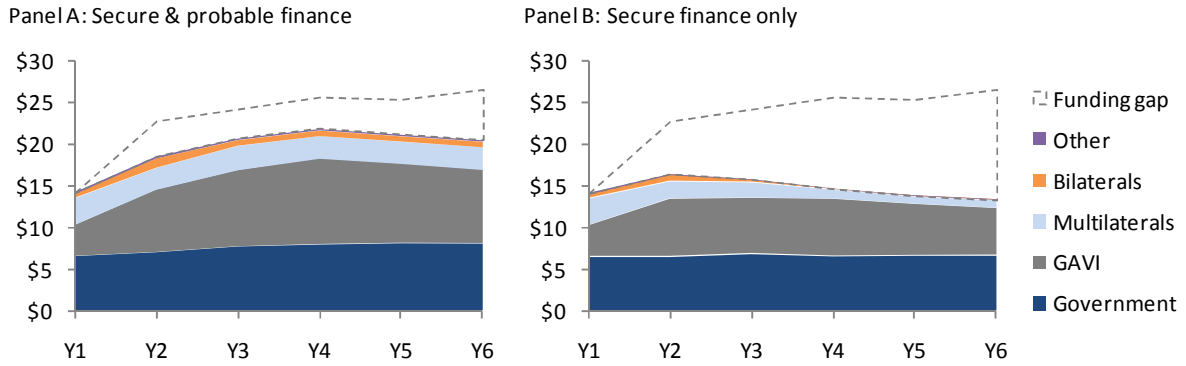


[101] We note the recent work of the CTT that points to a benchmark of 1% of public health expenditure on vaccines. This reflects preliminary data on non-GAVI eligible countries in Latin America who have been early adopters of new vaccines, where vaccines generally account for less than 1% of public health expenditure.

Analysis of FSP/ cMYP data

Analysis of FSP/ cMYP data suggests weak prospects for financial sustainability for most low-income GAVI-eligible countries in the short to medium-term at least with: rising expenditures; increasing funding gaps; greater reliance on GAVI (particularly for new vaccines); and limited rise in financing by government (and other non-GAVI donors) – see Figure 7.5 for summary trends in forecasted financing from the cMYPs.

Figure 7.5: Financing of total planned expenditure per infant on routine immunisation (cMYP data)[102] [103]



Forecasts of vaccine expenditure as a proportion of government health expenditure

Recent analysis of the GAVI CTT and our analysis of a subset of potentially graduating countries (based on cMYP data) suggests better prospects for potentially graduating countries (as compared to the average). However, the fact that cMYP analysis shows that, on average, government finance for these (potentially graduating) countries is still less than two-thirds of the forecasted expenditure on routine immunisation, suggests some caution in assuming that financial sustainability is assured.

Case studies on countries ability to continue to finance vaccine (and other immunisation expenditure)

The summary findings, based on country/ GAVI program case studies, are as follows:

- There is not much experience of countries having to fund vaccines previously supported by GAVI as most countries have switched to the pentavalent combination and hence continue to receive GAVI support. The few countries that have continued to use the HepB monovalent vaccine are mostly lower-middle income countries (and in fact, the only low-income country has not yet identified a replacement funding source).
- In terms of GAVI non-vaccine support, there have been problems with sustaining ISS funded activities in some countries, however, sustainability of INS support has been a success (although we note that AD syringe costs are low compared with GAVI supported vaccines).

[102] Note that the FSP and cMYP analysis considers routine immunisation funding/ expenditure only (i.e. campaigns are excluded).

[103] Trends have been analysed by 'plan year' as against calendar year. This is because the period of the cMYP varies between countries. The X axis denotes plan years 1 to 6 (Y1-Y6).

- Of the five field visit countries covered in the evaluation, with the exception of Bolivia, all countries were generally of the view that sustainability of GAVI-funded expenditure (vaccines in particular) in the short- and medium-term would be challenging.

Conclusions

Our overall conclusion is that the prospects for financial sustainability for countries is poor, particularly for GAVI-eligible low-income countries. The challenge for low-middle income/ potentially graduating countries however is much less marked, however is still not clearly assured.

We have assessed the robustness of this finding as a 'B', because we have multiple sources of evidence, although some caveats in relation to data quality and completeness have been noted.

7.4.3. GAVI's choice of vaccines to support presents a challenge for financial sustainability at the country level.

We have reviewed the implications of GAVI's choice of vaccine support on financial sustainability, based on a desk-review of available documentation as well as consultations with GAVI stakeholders, including country-level stakeholders.

The review suggests the following:

- Not surprisingly, the introduction of the pentavalent vaccine presents a challenge for financial sustainability as: (i) the Hib vaccine is considerably more expensive than the traditional vaccines and the HepB vaccine; and (ii) introduction of the pentavalent vaccine has resulted in the replacement of previously government or bilateral donor funded DTP/ HepB monovalent vaccine by GAVI (similar to the case for GAVI funding for the tetravalent combination).
- The pneumococcal and rotavirus vaccines were added to the GAVI NVS portfolio without knowledge about the final vaccine price that could be obtained. While the price of the pneumococcal vaccine is now determined through the AMC, for the rotavirus vaccine, there is still no official UNICEF price. These two vaccines will pose great challenges in terms of financial sustainability both because they are likely to be relatively expensive and because the supply situation is uncertain so that the price can easily fluctuate (notwithstanding the existence of AMCs).

Thus we conclude that GAVI's choice of vaccines and presentations (i.e. combination vaccines), while targeted at some diseases with incidence of mortality, have not been based on a realistic consideration of the potential for low-income countries' to take-on financing of these vaccines (whether through own or other donor resources).

We have assessed the robustness of this finding as an 'A', as the conclusion borne out by facts, as against subjective opinion.

7.4.4. Summary and conclusions

SG3.3: To what extent has GAVI promoted and increased the sustainability of immunisation funding at the national level?

Summary

Table 7.5 summarises the key evaluation findings on SG3.3 along with the robustness rating.

Table 7.5 SG3.3 – findings and robustness ratings

Issue/ Theme	Findings	Robustness	
GAVI's approach/ efforts at improving financial sustainability for countries, in terms of the supporting institutions and policies.	GAVI's support of tools and policies have helped countries' in their financial planning/ budgeting for immunisation. However, in Phase II the overall message with regard to financial sustainability has not be clear – given frequent revisions / updates to key policies.	B	Based on a review of available documentation, supplemented by discussions with global and national level stakeholders (both through direct consultations and the e-survey)
Prospects for financial sustainability	The prospects for financial sustainability of GAVI funding for low-income countries is a significant challenge. The challenge for lower-middle income/ potentially graduating countries is much less marked, although it is still not clearly assured.	B	Multiple sources of evidence support this conclusion, although some caveats with the data are noted.
Implications of the choice of vaccine on country level financial sustainability	GAVI's choice of vaccines, including the combination vaccine formulations and the new vaccines of pneumococcal and rotavirus, present a challenge for financial sustainability at the country level.	A	Conclusion borne out by facts, as against subjective opinion

Conclusions

Our review of the extent to which GAVI has promoted and increased financial sustainability of immunisation funding at the national level suggests first that GAVI has been innovative in terms of developing tools/ policies to support country level financial planning; however, frequent updates or revisions to policy has led to uncertainty on GAVI's overall approach to financial sustainability

Second, however, the prospects for financial sustainability are weak, particularly for low-income countries. The question is whether this may be regarded as a failure of GAVI, given that funding of comparatively expensive vaccines unambiguously 'saves lives', even if there is little prospect of financial sustainability for low-income countries at least.

In our view, in the narrow context of this aspect of this evaluation question, the evidence clearly points to the fact that GAVI's funding has not supported the achievement of financial sustainability. This relates in part to the (perhaps naive) assumption at the outset that GAVI

would be able to reduce prices. But perhaps more important are GAVI's decisions to provide support for 'new' life- saving vaccines, which were not part of the original portfolio. In Phase II this has been as much a feature of GAVI's success (in funding routine immunisation), as also presenting a significant challenge for financial sustainability.

In our view the main issue that arises from our review is whether there has been sufficient clarity within the organisation (and in its external communication) on the issue of financial sustainability. Indeed, part of the uncertainty in Phase II on co-financing relates to a failure to recognise explicitly, or communicate clearly, that financial sustainability (for low-income countries at least) would not be achievable in the medium term for the vaccines that GAVI supports.

Clarity on this point might have made it easier to define the co-financing policy in a way that distinguishes between the objectives of the policy for different categories of countries (in terms of income and eligibility) and potentially different vaccines. This is a similar conclusion to that reached by the authors of the Phase I evaluation report.

We understand that the CCT is looking to address some of these issues in their revision of the co-financing policy – although this is not within the time frame of our evaluation.

7.5. SG3.4: Innovative financing mechanisms

SG3.4: To what extent is the existence of innovative financing mechanisms – IFFIm and AMC – dependent on the existence of GAVI in its current structure and form?

This evaluation question aims to address the issue of GAVI's role in the design and implementation of IFFIm and AMC – in the context of achieving SG3 on increasing predictable and sustainable financing for immunisation. The focus of this evaluation question is <u>not</u> an assessment of the overall results or the impact of these innovative financing mechanisms. Rather, we seek to answer whether GAVI's role was essential or unique in achieving progress to date, or if GAVI has generally played a positive role in achieving progress.

The key sources of evidence for this assessment have been structured interviews, review of documentation and the e-survey responses.

We present below the main findings and conclusions from this review.

7.5.1. GAVI has played an important and value added role in the development and implementation of IFFIm

Our evaluation suggests that GAVI has played an essential role in facilitating the innovative financing mechanism of IFFIm.

Although it was not part of the initial concept development / design of the IFF, it provided a suitable and attractive partner for its application to immunisation. In particular its suitability reflected:

- Donor confidence in GAVI as a focused and reasonably effective mechanism for provided immunisation grants directly to governments; and

- GAVI's existence as a platform that was capable of supporting the implementation of a complex and innovative financing structure. This related in particular to its relative legal and governance flexibility compared with alternative channels (including multilaterals) and key personnel.

In terms of implementation we also conclude that GAVI played an important role. It was the principal with ultimate responsibility for establishing the IFFIm entities and for managing the process and the inputs of diverse stakeholders and advisers.

We have assessed the robustness of this finding as an 'B', as it is based on a reasonable range of evidence (including a review of documentation, interview feedback from relevant stakeholders and e-survey responses), but is not amenable to quantitative analysis.

7.5.2. GAVI's active contributions to the design and implementation/ hosting of the pneumococcal AMC have been instrumental in taking the concept to market

In the case of AMC as well, GAVI has played an important role with clear value add. GAVI's major involvement commenced on selection of the pneumococcal vaccine as the AMC pilot as well as the appointment of the Alliance for administering the AMC. In particular, its suitability reflected for these roles was brought about through:

- its Alliance structure and strengths of its Partners;
- proven experience (through its Partners) in introducing new vaccines in developing countries, and related to this, its ability to aggregate country vaccine demand and forecast supply volumes; and
- a relatively flexible organisation and governance structure.

GAVI's successful experience with implementing IFFIm also provided confidence to the international donor/ development community of its capacity to implement the AMC.

We have assessed the robustness of this finding as an 'B', as it is based on a reasonable range of evidence (including a review of documentation, interview feedback from relevant stakeholders and e-survey responses), but is not amenable to quantitative analysis.

7.5.3. Summary and conclusions

SG3.4: To what extent is the existence of innovative financing mechanisms – IFFIm and AMC – dependent on the existence of GAVI in its current structure and form?

Summary

Table 7.6 summarises the key evaluation findings on SG3.4 along with the robustness rating.

Table 7.6 SG3.4 – findings and robustness ratings

Issue/ Theme	Findings	Robustness	
GAVI's role in the design and implementation of IFFIm	GAVI has played a unique and very important role in the development and implementation of IFFIm – demonstrating strong value add	B	Based on review of documentation, interview feedback from relevant

Issue/ Theme	Findings	Robustness	
			stakeholders and e-survey responses
GAVI's role in the design and implementation of AMC	GAVI's role in the design and implementation of the pneumococcal pilot AMC has been instrumental in facilitating its operationalisation and implementation	B	Based on review of documentation, interview feedback from relevant stakeholders and e-survey responses

Conclusions

In the absence of a ready counterfactual, it is difficult to reach a strong conclusion on whether these mechanisms would have gone ahead without GAVI. However, the majority of the feedback suggests that it would have been more difficult to structure these mechanisms through the traditional multilateral aid architecture, and that GAVI's PPP structure and immunisation focus made it a particularly suitable platform for these instruments.

7.6. Summary and conclusions on SG3 performance

SG3: "To increase the predictability and sustainability of long-term financing for national immunisation programs."

One of GAVI's key value adds as a global financing mechanism lies in its ability to provide increasing amounts of funding to support national immunisation programs, in a manner that is both:

- *predictable*, so as to allow countries to plan for their immunisation programs and support the efficient procurement of vaccines;
- and *sustainable,* so that countries can continue to meet the expenditure required to provide immunisation services to its population.

Based on the analysis conducted for the four evaluation questions under SG3, our assessment is that GAVI has overall been successful in increasing the *predictability* of funding for national immunisation programs although this has been undermined more recently; but supporting *sustainability* of its financing has been an area of weaker performance.

8. EVALUATION OF SG4: GAVI ADDED VALUE AS A PPP

8.1. Introduction

In this section, we summarise our findings on GAVI's achievement of the fourth SG, which is to:

> "increase and assess the added value of GAVI as a public private GHP through improved efficiency, increased advocacy and continued innovation"

The goal covers GAVI's performance as a whole – across its programs and operations. In that sense a number of the results relevant here have already been covered under the reviews of the first three SGs. However, unlike the other three SGs this goal is about 'how' GAVI as a Partnership develops and implements its programs and activities, i.e. its *modus operandi* or way of doing business.

Given this, the focus of our evaluation of this SG is to pick up the gaps and additional points that pertain to GAVI as an institution and as a PPP in particular.

More detail can be found in the detailed SG4 Evaluation Report.

Table 8.1 below sets out our three Evaluation Questions under this SG. As with the other summary sections, we consider each in turn before bringing the analysis together to draw conclusions about whether GAVI has achieved SG4 and its value add (if any).

Table 8.1: Evaluation Questions

No.	Question
SG4: GAVI's added value as a global PPP	
SG4.1	Has the distinctive organisational structure contributed to the efficiency, effectiveness and impact of GAVI? If so how?
SG4.2	To what extent has GAVI increased awareness of, interest in, and commitment to immunisation and child health?
SG4.3	Has the GAVI focus on collaboration with a wide range of private and public stakeholders contributed to its effectiveness and impact?

8.2. SG4.1: Organisational structure

Has the distinctive organisational structure contributed to the efficiency, effectiveness and impact of GAVI? If so how?

For the purpose of this Evaluation Question, we take the distinctive organisational structure to relate to two particular aspects of the way in which GAVI seeks to organise itself and conduct its business.[104] These include:

- The stated feature of the GAVI Alliance as a 'lean' financing entity that works in countries through its Implementing Partners (particularly WHO and UNICEF) and does not itself 'do' or 'implement'.

[104] We have not attributed much weight to the word 'distinctive' in terms of analysis of differences with other institutions.

- The emphasis on being 'light touch' by avoiding earmarking, supporting nationally-defined priorities and minimising GAVI's burden on country governments.[105]

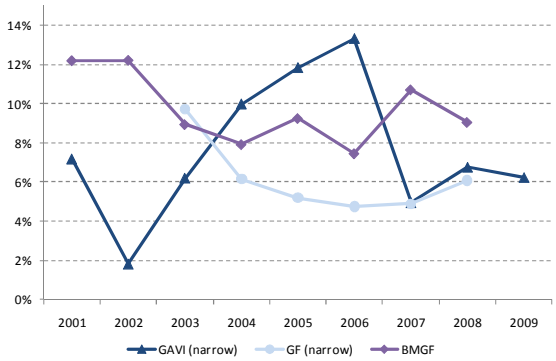
The analysis and evidence that we rely on in coming to a conclusion on this Evaluation Question includes both specific analysis conducted as part of this SG question as well as findings emerging from other Evaluation Questions.

8.2.1. GAVI is right to see its 'lean structure' as a contributor to its value add. But this will be eroded if recent increases in operating costs combined with a reduction in disbursements continue.

An important aspect of GAVI's 'unique selling point' in Phase I and Phase II has been its claim to have a 'lean' structure that maximises the amount of resources that it passes on to countries (subject to appropriate fiduciary standards). As part of our evaluation, we have conducted a high-level review of GAVI's overhead costs, by benchmarking various measures of 'donor cost efficiency' against comparator organisations. These measures are based on those used in Easterly and Pfutze (2008)[106] – which provides a series of comparators. In undertaking the analysis, we have considered what we refer to as both 'narrow' and 'wide' measures of operating costs – where the 'wide' measures includes estimates of Work Plan expenditure as part of operating costs.

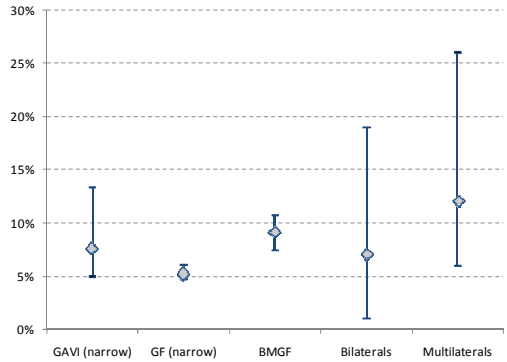
Figures 8.1a and 8.1b show how the primary measure ('narrow' administrative costs as % of disbursements) for GAVI compares with comparators. During Phase II, this measure for GAVI declined significantly from a peak of 13% to around 6% in 2008 (and in 2009 and 2010 on a projected basis). Figure 8.1a shows a time series compared with Global Fund and the Gates Foundation[107] and Figure 8.2b compares GAVI's Phase II average with Global Fund and the Gates Foundation as well as average bilateral and multilaterals.

Figure 8.1a: Admin overheads as % of ODF, 2001-09



Source: GAVI / the Global Fund / the Gates Foundation / CEPA Analysis

Figure 8.1b: Admin overheads / ODF, Phase II average



Source: GAVI / the Global Fund / the Gates Foundation / CEPA Analysis / Easterly and Pfutze (2008)

[105] Both the terms 'lean' and 'light touch' have been used by Secretariat and Board Members in relation to GAVI's approach.

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

[107] Source: GAVI /Global Fund / Gates Foundation / CEPA Analysis

In our view, it is reasonable for GAVI to claim to be relatively lean in terms of the current level of the 'narrow' measure of administrative overheads compared with a reasonable group of comparators (including Global Fund, the Gates Foundation, and a number of bilaterals and multilaterals), particularly when resource mobilisation and economies of scale are taken into account. However:

- This claim is not obviously supported for GAVI in the middle years of the decade (i.e. spanning the end of Phase I and the beginning of Phase II);
- Leaping administrative overheads low relative to disbursements will require increases in disbursements relative to current commitments (i.e. excluding funding for rotavirus and pneumococcal) or reductions in administrative costs; and
- We note that: (i) these estimates of overhead cost do not include the time and other costs associated with Partner involvement in GAVI Alliance structures (e.g. committees and Working Groups) and governance arrangements; and (ii) these conclusions only hold to the extent that it is reasonable to exclude Work Plan costs from our primary estimate of administrative overheads (i.e. use of a 'narrow' measure). Adding in the cost of the Work Plan increases the ratio of overheads by as much as 10%.

We have assessed the robustness of this finding as a 'B' – reflecting the fact that it is based on benchmarking analysis with a reasonable number of comparators, although recognising that there are some data consistency and comparability issues.

8.2.2. The introduction of the TAP and FMA in Phase II has been an appropriate development of GAVI's organisation structure and processes. But feedback suggests that implementation challenges and some aspects of design need to be tackled for it to contribute effectively to improved efficiency.

The introduction of the TAP in Phase II has been an appropriate development of GAVI's organisation structure – reflecting the increased importance of cash-based programs and a relative weakness in its systems to mitigate the risk of misuse of funds.

Our judgement is that the policy and aims of the FMA compare reasonably well with comparators. We also note that GAVI has purposefully attempted to implement a relatively light touch and flexible (in terms of risk rating of countries) approach – which is a reasonable position to take in terms of balancing risks and increased burdens.

However, there are clearly some issues that will need to be explored in due course when the system is evaluated, that relate to: (i) how it fits within the approval process and the impact such as delays in disbursements; (ii) how to better harmonise with other donor FMAs / country financial systems and processes; (iii) improving communication to countries and streamlining institutional responsibilities for the FMA completion process; (iv) possible technical assistance to countries to undertake the FMA on time; and (v) the level of resourcing devoted to the areas.

The robustness of this finding is deemed to be a 'C' – since it is primarily based on desk review of GAVI and comparators with little external verification; together with a limited amount of evidence from interviews and survey.

8.2.3. Opinion about GAVI's program-related processes have improved but the areas of weakness include (i) the effectiveness of GAVI communications with countries; and (ii) its approach to capturing and proactively monitoring country level data. We are surprised that GAVI does not systematically monitor performance information on its own processes.

Our evaluation of GAVI's application, review, approval, disbursement, M&E process relies on a desk review of the processes including some analysis of approval rates and times[108]; survey and interview evidence; and our country visits.

As part of our work, we have also reviewed the Independent Review Committee (IRC) Evaluation report. Our additional work does not point to different conclusions about the strengths and weakness of the IRC element of the application process. Points of emphasis or judgements that we would draw GAVI's attention to are as follows.

Processes improving

There is a fairly consistent picture that emerges from our work that GAVI's application documents and processes have evolved and improved over time in response to feedback.

The quantitative analysis that we have been able to conduct on first-time approvals and the time period between IRC review and recommendation points to improvements over time, nevertheless the average period of 192 days[109] is quite lengthy. It is a relative failure that data on disbursement times across GAVI's programs (except for the CSO program) has not be collected or monitored on systematic basis.

Need for better tailoring of application and approval processes

Although the multiple-choice responses in the e-survey suggest that a majority of respondents would like to see the application requirements better tailored, this is not borne out in either the e-survey qualitative responses or from our interviews. In addition, the findings from the country studies suggest that countries are positive about the application requirements and processes.[110] Given this, we do not feel that we are able to draw a strong conclusion.

However, our judgement is that:

- There will continue to be opportunities to simplify and improve the application process. But, it is important to recognise (given the communication challenges for GAVI) that there are costs associated with continually shifting requirements. Our country studies and interviews point to a concern that despite WHO / UNICEF support, countries are not always completely sure about the requirements.
- The requirements of the application process strike a reasonable balance between: (i) requiring countries to demonstrate their ability to use GAVI resources effectively; and (ii) the need to minimise GAVI's 'donor burden' on countries and the GAVI Partners. This

[108] Time from first IRC review to IRC recommendation to the Board.

[109] This analysis was based on NVS timelines only as granular data is not available for other programs.

[110] This appears to have been the case even in countries facing significant capacity issues within the government.

suggests to us that there is not a strong case to vary the basic application information requirements by country. Rather, our view is that there is a case for more / better targeted technical assistance to countries for proposal preparation coupled with clear communication by GAVI / Partners on the requirements of the application process (see below).

- There may be more of a case to consider options for varying the application process by program and / or size of grants (for example, lighter touch application requirements/ process for the small CSO grants). However, we have not considered this in detail and recognise that it is not a trivial exercise to get this right – and that there is a risk that costs of change could outweigh the benefits.

Communication is improving, but has been one of the most frequent criticisms

There is a strong and repeated message that communication between GAVI and countries has at times been poor – which hinders the effectiveness of its processes. Our view again is that this has been improving over time (for example with the introduction of AVI), but that it remains an issue.

We think that this is related to the ongoing debate about the role and responsibilities of Implementing Partners and the Secretariat (see below). However the main point to note here is that there is a relative weakness in communication on matters that relate to GAVI processes and application requirements.

M&E

The general messages that we draw from our evaluation of GAVI's M&E are as follows:

- GAVI's monitoring of country performance at the centre (i.e. Board and Secretariat) appears to be relatively weak. Our sense is that the process of putting the APRs together at the country level can be, when it works, an important part of country level management of immunisation programs – which the Implementing Partners are closely involved with. But we are not clear that APRs have played more than an administrative role when they get to the Secretariat – and there is little proactive use of this data. However, we recognise there are tradeoffs in a 'light touch' approach, of which, limited M&E is one such aspect.

- GAVI's model of working through its in country Partners (primarily WHO and UNICEF) means that it relies on these Partners to a significant degree for performance monitoring. This reliance has lessened to some degree as the Secretariat has grown and as policies and practices (such as the TAP) have developed. However, we have noted that there is an ongoing issue in relation to the role and responsibilities, and accountabilities of Partners at the national level. This reflects the fact that country officers see their role and accountability as being primarily in relation to technical support of the NIP. They do not see themselves as grant providers / or funders who are concerned primarily with effective use of donor money and / or fiduciary accountability. This then raises questions about the appropriate level of country and / or regional resource and / or presence of the Secretariat.

The robustness of these findings are assessed as follows:

- Findings on the performance of program application, review, approval and disbursement processes are rated 'B' – since findings from different aspects of analysis (previous program / IRC evaluations, our interviews, country visits, surveys and data on timelines), are generally consistent, however there is a small degree of disparate comments / views.
- Findings on M&E processes are rated 'A' since we have been able to triangulate evidence from previous program / IRC evaluations, our interviews, country visits, surveys and APR assessment are all consistent.

8.2.4. E-survey evidence points to general agreement with the proposition that GAVI strikes a good balance between being 'light touch' and ensuring accountability. But a significant number of donor and multilateral constituency responses do not agree.

Question 22 of the e-survey is directly relevant to this evaluation question. It asked stakeholders to respond to the statement: "GAVI's relatively 'light touch' approach achieves the right balance between country ownership / accountability and flexibility". Although more than 60% either 'agreed' or 'strongly agreed' with this statement, the amount of variation in responses was relatively high. In particular a significant number of multilateral and donor constituency responses indicated that they did not agree with the statement. The reasons for this vary. Roughly equal numbers of respondent who disagreed (and provided comments) noted either: (i) that there should be more accountability and monitoring; or (ii) that increased requirements have reduced the extent to which GAVI can be seen as light touch.

Respondents who agreed with the statement (and provided comments) believe that flexible funds are free of rigid government budget processes and that the light touch has enabled countries to make efficient and relatively independent decisions at the country level. This reliance on local systems has contributed towards capacity building.

We have rated our findings in this area as a 'C' in terms of robustness, given they are based on only the e-survey – albeit with a large sample size.

8.2.5. Evidence from other parts of the evaluation suggest that countries regard the flexibility of GAVI's programs as being positive, and that GAVI's structure has added value in terms of increasing country ownership compared to alternative approaches to funding.

Other findings that are relevant to this Evaluation Question are as follows:

- **Flexibility of 'cash-based' programs.** Our analysis of cash-based programs (particularly ISS and HSS) consistently point to an appreciation (at the country-level) of the relative flexibility available in use of resources. As part of this evaluation, we do not have the evidence to be able to conclude that this has necessarily resulted in improved impact. However, taking the Paris Principles as a point of departure, it seems reasonable to conclude that this is *a priori* evidence of effective aid.

- **Country ownership.** Based on our analysis, e-survey, interviews and country studies, we believe that it is reasonable to conclude that GAVI's programs do relatively well in terms of ensuring country ownership. This reliance on local systems has contributed towards capacity building. As part of our interviews we have also found evidence that supports the view that the design of GAVI's distinctive organisational structure has contributed to country ownership. The fact that GAVI exists as a financing entity that is distinct from in-country Implementing Partners (WHO and UNICEF), and has it owns application process that requires sign off from the Ministry of Health increases ownership. The counterfactual here is that if funding had been channelled through WHO / UNICEF the government would not have seen it as their money, since there is no requirement for interagency consultation or Ministerial sign off.

Our robustness rating for this finding is a 'B' given that findings are drawn from a range of evidence sources including interviews, country studies, program evaluations and e-survey – and have generally consistent findings.

8.2.6. Summary and conclusion

Has the distinctive organisational structure contributed to the efficiency, effectiveness and impact of GAVI? If so how?

As noted above, for the purpose of this Evaluation Question, we take the distinctive organisational structure to relate to: (i) GAVI's structure as a 'lean' financing entity that works in countries through its Implementing Partners; and (ii) GAVI's emphasis on being 'light touch'.

Summary

Table 8.2 summarises the key evaluation findings on SG3.1 along with the robustness rating.

Table 8.2 SG4.1 – findings and robustness ratings

Issue/ Theme	Findings	Robustness	
Overhead efficiency	GAVI is right to see its 'lean structure' (in terms of overhead costs as a proportion of ODF) as a contributor to its value add – during Phase II, administrative overheads as a proportion of ODF have declined from a peak of 13% to significantly to around 6% in 2008 (and in 2009 and 2010 on a projected basis). Comparisons with other organisations support GAVI's to claim to be relatively lean in terms of overheads in Phase II, but dependent on a continued level of disbursements.	B	Primarily based on benchmarking analysis with a reasonable number of comparators. Some data consistency and comparability issues.

Issue/ Theme	Findings	Robustness	
Transparency and Accountability	GAVI's introduction of the TAP in Phase II has been an appropriate development of GAVI's organisational structure and policy. But feedback suggests that implementation challenges and some aspects of design need to be tackled for it to contribute effectively to improved efficiency.	C	Primarily based on desk review, with little external verification. Limited amount of evidence from interviews and survey.
The performance of program application, review, approval and disbursement processes	GAVI's application documents and processes have evolved and improved over time in response to feedback. However, disbursements are subject to often significant delays and communication between GAVI and countries has at times been poor.	B	Findings from different aspects of analysis (previous program / IRC evaluations, our interviews, country visits, surveys and data on timelines) are generally consistent with a relatively small degree of disparate comments / views.
The performance of program M&E processes	General messages relate primarily to monitoring. Key points to note are that GAVI's monitoring of country performance at the Alliance level (i.e. as opposed to by Implementing Partners in country) appears to be relatively weak, and we are surprised that GAVI does not systematically monitor performance information on its own processes. There is an ongoing issue in relation to the role and responsibilities, and accountabilities of Partners at the national level.	A	Findings from previous program / IRC evaluations, our interviews, country visits, surveys and APR assessment are all consistent.
The 'light touch' approach	E-survey evidence points to general agreement with the proposition that GAVI strikes a good balance between being 'light touch' and ensuring accountability. But a significant number of donor and multilateral constituency responses do not agree.	C	Findings based on only the e-survey – albeit with a large sample size
Organisational structure	Evidence from other parts of the evaluation suggest that countries regard the flexibility of GAVI's programs as being positive, and that GAVI's structure has added value in terms of increasing country ownership compared with alternative approaches to funding immunisation.	B	Findings are drawn from a range of evidence sources including interviews, country studies, program evaluations and e-survey – and have generally consistent findings.

Conclusions

Our overall conclusion is that GAVI's structure (i.e. a financing entity that works in countries through its Implementing Partners) and processes are improving over time, and have contributed both positively and negatively to the efficiency, effectiveness and impact of GAVI:

- positively through the flexibility and relatively light touch of its programs and processes, which allows a lean structure and minimises burden on countries;
- positively through the contribution of the structure in supporting country ownership (which we believe would have been less in the event that GAVI's additional resources had been channelled directly through UNICEF / WHO); and
- negatively given the impact that the structure has on proactive country monitoring and communication to ensure accountability and support national Partners. We believe that – although things have been improving – the relative weakness of GAVI's monitoring and communication is partially related to a lack of clarity about the relative roles of the Implementing Partners and the Secretariat in particular.

On this last point we are clear that there is an inherent tension between WHO / UNICEF's mandate to provide technical support and the role of acting as GAVI's representative in terms of monitoring and communications. In part this reflects the important political relationships in countries that they need to protect, but it is also a practical issue associated with knowledge of GAVI process and priorities.

Whilst it is not necessarily possible (or even desirable) to completely resolve this tension, our conclusion is that there may be things that GAVI could do going forward to tackle the relative weaknesses identified above. In our view this is not about having a country presence. But it is about prioritising the country monitoring and support roles of the Secretariat – working closely with Implementing Partners in country and improving communications to countries.

8.3. SG4.2: Awareness and commitment to immunisation

To what extent has GAVI increased awareness of, interest in, and commitment to immunisation and child health?

Our analysis for this Evaluation Question seeks to consider GAVI's advocacy impact at both the global and national levels. We distinguish in our analysis between advocacy inputs (GAVI's advocacy efforts and activities) and advocacy outputs (results of advocacy activity or indicators of changes in awareness / interest in immunisation and child health).

The focus of the analysis conducted specifically for this evaluation question, has been to identify quantitative indicators of advocacy inputs and outputs that have not been covered in our analysis of GAVI's contribution to immunisation funding and its programmatic activities that relate directly to advocacy (e.g. ADIPs, AVI). However, in making a judgement in the round we take into account the conclusions reached in other aspects of the evaluation.

8.3.1. There is currently a good strategic foundation for GAVI's advocacy work, however GAVI does not systematically collect or monitor indicators to measure its own activity or advocacy outputs over time.

The approval and implementation of a GAVI advocacy strategy (as recommended in the Phase I evaluation) did not begin until June 2009. This is now supported by a series of documents that aim to convert objectives into an advocacy implementation plan.

Our judgement is that the work undertaken provides a good basis for advocacy going forward – although it has occurred relatively late in Phase II. However, we note the inherent challenge for GAVI in defining and implementing an advocacy strategy that goes wider than GAVI fundraising or its program activities, particularly at the national level. This reflects the wider interest and mandates of key Partners outside of GAVI. In addition, GAVI does not systematically collect or monitor indicators to measure its own activity or advocacy outputs over time.

An important limitation of our analysis is the absence of (i) baseline data on awareness and interest in immunisation at the beginning of the period; and (ii) systematic collection or monitoring of data / key performance indicators to measure GAVI's performance against any baseline or over time. The fact that this data is not collected also makes it very difficult for GAVI to monitor its own performance in this area.

We have assessed the robustness of this finding as a 'C' – reflecting the fact that our assessment of the strategy is consistent with feedback from the Board, a desktop review of GAVI literature and interaction with the Secretariat, although recognising the limitations in terms of the availability of data.

8.3.2. There is evidence for recent increases in GAVI advocacy activity and publications and advocacy material is now of a high quality. However, there are some concerns about the attribution of responsibilities and success.

In reaching conclusions, we have relied on stakeholder interview and survey evidence as well as a limited desk review conducted by CEPA. Our broad conclusion is that GAVI has performed reasonably well in terms of its global advocacy work (in terms of quality, quantity and channels) and has taken steps to improve this over the years. Simple analysis of the number of GAVI press releases suggests that this aspect of activity has increased slightly between Phase I and Phase II. However, the review of GAVI documentation shows that over 2010, GAVI has clearly demonstrated a proactive approach in global advocacy efforts, and innovation in advocacy channels to reach a broader, 'non-traditional' audience. Our understanding in evaluating Phase II is that significant improvements have only occurred at the end of the period.

Challenges remain – which reflect both the nature of the Alliance and the underlying relative lack of profile of many of GAVI's target diseases. Particular challenges raised by stakeholders include:

- putting in place an appropriately targeted and detailed advocacy strategy which gets the right balance between Secretariat and Partner activity;
- getting the right balance between simplicity / appeal and rigour in advocacy / fundraising messages and GAVI's other communications; and

- ensuring that there is an appropriate attribution of responsibilities and success between GAVI itself and Partners.[111]

The robustness scoring for this finding is a 'C' – our assessment is based on consistent feedback from structured interviews and a number of different GAVI documents, but the rating takes into account the fact that this theme does not lend itself to quantitative analysis.

8.3.3. There is *a priori* evidence of increased interest in immunisation at the global level. Most respondents to the e-survey believe that GAVI has played a significant role in this – as borne out in increased global funding for routine immunisation.

The indicators that we have considered suggest awareness in immunisation has increased over the period 2000 to 2009, and grown considerably since GAVI was established. This evidence is strongest from our analysis of Lancet journal articles. It is supported by our review of the number of third-party articles referenced on the GAVI website, although drawing conclusions on this is clearly dependent on unchanged GAVI website management practice over the period.

Responses to the e-survey question on GAVI's contribution to raising the profile of immunisation are overwhelmingly positive. We interpret this as relating in large part to the increased level of resources available to routine immunisation through GAVI – which is a clear message that emerges from our structured interviews (see also our analysis of SG3).

Together with the total increases in resources available to immunisation and to GAVI (as suggested in our analysis of SG3), we take the above to provide reasonable *a priori* evidence of increased global interest and commitment to immunisation.

We have assessed the robustness of this finding as a 'C'. This reflects the generally consistent findings from a limited a number of qualitative and quantitative evidence sources, but allows for data / methodological limitations in quantitative analysis.

8.3.4. Evidence from a variety of sources points to a strong influence of GAVI in raising the profile of immunisation at the national level. This is primarily as a result of GAVI's program funding (both levels and approach) and the input of GAVI Partners at the country level – as opposed to advocacy activity per se.

Available indicators of the importance and profile of immunisation at the national level are consistent with the view that GAVI has made a positive contribution. Evidence from our country visits and other parts of our evaluation support this view. Indeed it seems clear that GAVI and its country-based Partners (WHO, UNICEF and the World Bank particularly) have made significant contributions to the profile of immunisation in GAVI eligible countries through:

- Inclusive processes which bring together different government and other stakeholders in decision making and application review and approval (i.e. through the ICC or HSCC equivalent bodies), and increase country ownership.

[111] There is recognition that GAVI's impact in terms of its activity at the national level is actually determined by its program activity and funding – as opposed to more general advocacy activity, and that country-level advocacy is currently largely undertaken by GAVI Partners (see Section 8.3.5 for more detail).

- Direct, program specific impacts of its funding in countries and in the provision of evidence on the introduction of new and underused vaccines.
- The indirect contribution of GAVI funding on the profile of immunisation in countries more generally.

Findings from various sources of evidence indicate that (i) it is understood that country-level advocacy is currently largely undertaken by GAVI Partners; and (ii) more could be done. However, there is also recognition that GAVI's impact in terms of its activity at the national level is actually determined by its program activity and funding – as opposed to more general advocacy activity.

This evidence supports the view that there is a degree of uncertainty in the Partnership about the focus of GAVI's advocacy activity at the national level – as noted in our review of the advocacy strategy. Furthermore, there is a lack of clarity on the activities of Partners as members of the GAVI Alliance, as against other Partner activities outside their capacity as Alliance members.

The robustness of this finding is deemed to be a 'B', given evidence from a range of sources (including program evaluations, interviews, country studies, JRF and website data) generally offer a consistent message.

8.3.5. Summary and conclusion

To what extent has GAVI increased awareness of, interest in, and commitment to immunisation and child health?

Summary

Table 8.3 summarises the key evaluation findings on SG3.1 along with the robustness rating.

Table 8.3 SG4.2 – findings and robustness ratings

Issue/ Theme	Findings	Robustness	
GAVI Advocacy and Communications Strategy	Our judgement is the work undertaken provides a good basis for advocacy going forward. However, we note the inherent challenge for GAVI in defining and implementing an advocacy strategy that goes wider than GAVI fundraising or its program activities, particularly at the national level. This reflects the wider interest and mandates of key Partners outside of GAVI. In addition, GAVI does not systematically collect or monitor indicators to measure its own activity or advocacy outputs over time.	C	Our assessment of the strategy is consistent with feedback from the Board, a desktop review of GAVI literature and interaction with the Secretariat, although there are some limitations in terms of the availability of data.
GAVI advocacy efforts	There is evidence of recent increases in GAVI advocacy efforts at the global level supported by the Secretariat. Interview evidence suggests that GAVI publications and advocacy material is now of a high quality. But there are some concerns about the attribution of responsibilities and success.	C	Our assessment is based on feedback from structured interviews and a number of different GAVI documents, but this theme does not lend itself to quantitative analysis.

Issue/ Theme	Findings	Robustness	
Global advocacy	There is *a priori* evidence of an increase in interest in immunisation at the global level. This evidence is strongest from our analysis of Lancet journal articles and is supported by our review of the number of third-party articles referenced on the GAVI website. Most respondents to the e-survey believe that GAVI has played a significant role in this – as borne out increases in global funding for routine immunisation.	C	Findings from a limited number of qualitative and quantitative evidence sources, but allows for data / methodological limitations in quantitative analysis.
National advocacy	Evidence from a variety of sources points to a strong influence of GAVI in raising the profile of immunisation at the national level. This is primarily as a result of GAVI's program funding (both levels and approach) and the input of GAVI Partners at the country level – as opposed to advocacy activity per se.	B	Findings from a number different aspects of this evaluation (program evaluations, interviews, country studies, JRF and website data) generally offer a consistent message.

Conclusions

There is *a priori* evidence to support the view that GAVI has broadly succeeded in increasing **awareness** and **interest** in immunisation at both the global and national levels. This success has primarily been as a 'by-product' of GAVI's fundraising (and innovative finance) activities and its programmatic expenditure.

Increased donor funding for immunisation is also indicative of greater **commitment.**

Other key points are as follows:

- Although we have focused most of our work on immunisation (as opposed to child health) our assessment is that there is relatively little evidence to support an impact on awareness on child health issues – which is clearly broader.
- Our evaluation suggestions that the quality, planning and quantity of GAVI's global advocacy activities has improved over Phase I – although there are still implementation challenges, including in coordinating Partners, and widening the Partnership's advocacy messages and channels.
- Feedback about national level advocacy has been mixed, and varied between countries. This reflects uncertainty about where it makes sense for advocacy messages and activities to be 'GAVI' as opposed 'GAVI Partners'. National level advocacy would benefit from a strategic approach considered in the advocacy strategy, and a mechanism of lessons learned between countries.
- Clear progress indicators and monitoring would enable a more robust assessment of advocacy performance in future.

8.4. SG4.3: Effect of PPP on impact

Evaluation Question SG4.3: Has the GAVI focus on collaboration with a wide range of public and private stakeholders contributed to its effectiveness and impact?

The focus of this question is about the way in which the 'Alliance' or 'Partnership' concept has worked in practice and the extent to which it has contributed to GAVI's effectiveness and impact.

As with Evaluation Question SG4.1 (in relation to the contribution of GAVI's organisational structure), we draw on both specific analysis conducted for this question and wider evidence from the evaluation as a whole. In what follows we present the specific analysis first and then the other evidence before concluding.

The specific analysis conducted for the evaluation includes:

- An analysis of the extent to which different players have contributed to the Alliance – set against the stated benefits of the Alliance.
- A review of the Work Plan and Budgeting process – the main mechanism (outside of the Board structures) that seeks to define how the Partnership works in practice.
- An analysis of GAVI's strategy and monitoring documents for the period 2007-10.

For the avoidance of doubt – and in line with the TOR – we are not evaluating the governance function of the Alliance. Also note that we have considered substantive issues relating to the Work Plan under evaluation question SG4.3 (on Partnership).

8.4.1. There is evidence to support the view that the partnership of public and private sector is a key driver of GAVI's achievements through its ability to raise funding, align key global and national players in immunisation, and support innovation.

Based on a desk review of Board and Executive Committee minutes there is *a priori* evidence, to suggest that: (i) the Alliance is able to access the appropriate mix of skills and expertise (from Board Members or others); and (ii) that at its best it succeeds in bringing together all of the stakeholders in immunisation. The level of this engagement and its impact (e.g. in terms of innovation and challenge) is not possible to judge from the minutes. However, we note the relative lack of recorded input from private sector / industry representatives.

Responses to the e-survey statement: "GAVI's multi-stakeholder Alliance model has been core to achieving its immunisation objectives" are overwhelmingly positive. Most respondents (>80%) either 'agreed' or 'agreed' strongly with the statement.

Interview evidence confirms this general picture. There is a general sense across all responses that the multi stakeholder partnership has worked in terms of bringing together all of the legitimate stakeholders in immunisation and creating a focus on immunisation that did not exist prior to GAVI.

- Areas where this inclusiveness and focus is deemed to have added value (i.e. where more is achieved together than separately) are as follows: (i) the ability to attract additional donor resources given the focus on immunisation compared with alternative channels

(including multilaterals); (ii) the alignment of global and national immunisation funding processes which provides clarity on roles and responsibilities and, when it works, avoids duplication (or use of unproductive time in deciding who should do what); and (iii) the ability to access a range of skills at the Board level including finance and investment expertise as well as on immunisation.

- Weakness associated with inclusiveness identified include: (i) the fact that decision making can be more protracted and bureaucratic given the size of the Board and the number of stakeholders involved; (ii) the significant time, governance and other costs (incurred by Partners and Secretariat) associated with operating the Partnership; and (iii) the risk that decisions and positions can be 'watered' down, which reduces effectiveness.

Our robustness rating for this finding is a 'C', since this is based on desk review of GAVI documents, the e-survey and interview evidence only, and the theme is not amenable to quantitative analysis.

8.4.2. The changed nature of the Partnership remains an area of concern for some. Although we are not convinced that this has had a detrimental effect on its level of innovation, the role of the Secretariat has remained an issue particularly for some Implementing Partners, which has detracted from the ability of the organisation to operate efficiently.

The changing nature of the Partnership to be more 'formal' or 'corporate' and the increasing role and independence or 'self-sufficiency' of the Secretariat is another common theme in the structured interviews and the 'open response' section of the e-survey.

- For some of the interviewees positive aspects of this related to improved decision making and governance, and also more clarity on roles.

- Others emphasised the negative aspects – particularly the reduced involvement of Implementing Partners in development of key policies (compared with the Secretariat) and reduced sense of ownership of the Alliance – reducing the added value (e.g. through the extent of innovation in systems and tools to support immunisation in country).

Given the importance of this issue for respondents, we have attempted to bring together what we have heard to make a judgement about the extent to which the changes have had an impact on GAVI's level of innovation, and its efficiency and effectiveness.

Change in innovation

The findings in our evaluation do suggest that the nature and areas of GAVI's focus and contributions have changed over its first two phases:

- In Phase I, GAVI's key contributions (or areas of innovation) were in terms of the tools (FSPs/CMYPs, DQA/DQS) and approaches (e.g. the funding windows, and approach of working through Partners) to support country planning, financing and monitoring of routine immunisation programs.

- In Phase II, the amount of innovation in terms of tools and approaches to support routine immunisation appears to have reduced (as many of the critical tools needed were developed in Phase I); and we observe a shift in GAVI's energy /resources and focus onto other areas of innovation – most notably innovative finance and the HSS window. [112]

Although we recognise that there is a change in the relationship between key Partners (WHO / UNICEF) and GAVI, we are not convinced that this has had a detrimental impact on levels of innovation. We think that a lessening in innovation on tools and approaches to financing routine immunisation was inevitable given the need to focus on delivery (and the need for 'proof of concept' i.e. GAVI's ability to support the introduction of new vaccines in eligible countries.) In addition we do observe innovation in other areas such as innovative finance and HSS, as noted above.

Role of the Secretariat and efficiency and effectiveness

Over Phase II there has clearly been a change in the role of the Secretariat. This reflects the move to a more formal partnership that has evolved in response to an increasing level of resources being channelled through GAVI (a measure of success).

This is described in the SG4 report as being a gradual shift in the nature of GAVI from the informal Alliance embodied in the Working Group, towards a 'partnership institution' in its own right (i.e. a principal itself) with a more independent Secretariat and formal governance arrangements.

We are not in a position to make a judgement about whether this change has led to an improvement in the efficiency or effectiveness of GAVI. However, we note that – for whatever reason – uncertainty about responsibilities and accountabilities and the nature of the relationship between the Secretariat and Partners remains an issue. Although we do not feel able to provide a view on the extent of this impact, we do believe that it has detracted from the efficiency of the organisation.

We have assessed the robustness of this finding as a 'D'. This reflects the fact that our conclusions here rely on interview evidence together with CEPA's existing knowledge of the organisation. Although it is important to recognise subjectivity here (given the importance of CEPA's judgement in weighting available evidence), we are confident that our conclusions here are correct.

8.4.3. The GAVI Work Plan and Budget is at the heart of the Alliance. Although there have been improvements, the time taken to resolve issues with the process and material had reduced the Partnership's effectiveness. There is still a feeling that the process does not get the right balance between accountability and empowerment of Partners supported with GAVI funds.

[112] During Phase II there have also been steps forward in the way in which GAVI makes decisions – e.g. the Vaccine Investment Strategy, and the way in which GAVI has sought to support accelerated introduction (i.e. ADIPs and AVI).

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

Given its importance, the Work Plan and Budget needs to be seen in the context of the development of GAVI – i.e. the evolution of more formalised governance structures, processes, and an expanded Secretariat. As already noted, there are clearly different views about the advantages and disadvantages of these changes – and particularly in terms of the relationship between the Technical Partners and the Alliance.

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

- Although the subject of considerable tension, the Work Plan is actually an indication of real Partnership – since it attempts to define explicitly the obligations that the Technical Partners have to the Alliance and vice versa. In its earlier form, it was described as being "the collective effort of Partners" and the "critical coordinating role" required for outcome optimisation.[113] It is interesting to contrast this with the Global Fund, where the engagement of the Multilateral Technical Partners in particular, is much less clear.[114]
- Prior to the 2008 Work Plan and Budget, the process typically appears to have been protracted and difficult; and Board approval has often been provided despite recurrent concerns about the structure and content of the material.
- Since 2008, the process and material appear to have improved significantly. However, concerns remain particularly about:
    - how to define GAVI related activity as against the Technical Partner normative mandates – this was reflected in the Work Plan Validation Process; and
    - defining work plan activities specifically against the achievement of GAVI's objectives and monitoring them at an appropriate level.

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

We have rated the robustness of this finding as a 'B' given our findings are consistent across a comprehensive desk review of GAVI documents, and interview evidence.

8.4.4. The nature of GAVI as an Alliance has made it more difficult to develop a coherent link between strategy, outputs and activities, and the format of reporting has inhibited its ability to monitor Alliance progress.

[113] GAVI Consolidated Work Plan 2003-04

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

As part of our evaluation, we have reviewed the way in which the 2008-10 strategy documents have been developed and used. Our conclusions are as follows:

- The original suite of 2008-10 strategy documents were comprehensive, but not as internally consistent as they might have been. In our view, the new 'Logical Framework' of the Revised Strategy documents is an improvement in the way the ultimate organisational goal, outcomes, outputs (sub-outputs), and activities are linked.
- The revised strategy is also an improvement in having a set of indicators of performance at the Output level. We recognise the challenge to any organisation of identifying indicators that are at the same time: (i) reliable; (ii) at an appropriate level of aggregation; and (iii) sufficiently controllable by GAVI. That said, we note that:
    - some indicators are not clearly defined (i.e. it is not clear from the description of the indicator what is being measured or what is the purpose of the indicator);
    - some indicators aim to quantify progress, but do not have a baseline or target; and
    - there is a reference to data sources for some indicators, but it is not clear who is responsible for collecting / calculating indicators or tracking progress against them.
- Although there is clearly complexity here given the role of Technical Partners in delivering Work Plan activities, it is striking that there is not an obvious link between activities and indicators, or ownership of indicators. In particular, it is not clear (i) how detailed Partner activities contribute to the achievement of the indicator; and (ii) who is the lead Partner for a particular indicator. (This point is particularly relevant to the discussion of the Work Plan and the ongoing preparation of the Alliance's integrated Work Plan).
- In GAVI's self-reported progress against its strategy (2009 Work Plan Information / Update), although outcomes and outputs are being reported against, indicators are not being used to assess output performance. In some cases indicators are not considered in assessing whether an output has been met (e.g. no indicators were met for Output 1.1 but Output was rated as 'met' / 'on-track'), and in others, information not in scope of the framework is used to assess outputs (e.g. in Output 4.4, the 'donations policy' is used to evidence progress on the Output even though the indicators only relate to a gender policy.
- Our view (on admittedly limited evidence) is that there is not a good understanding in the Alliance as to what the correct reference document is for the strategy, outputs, indicators. Furthermore, Partner reports (i) are in different formats; (ii) progress is not always directly reported against, or relevant to, the revised strategy; and (iii) separate reporting of activity and funding – all of which make an assessment of progress difficult. For example, UNICEF and WHO report at the activity / deliverable level, whereas World Bank reports at the SG level. Therefore, the Secretariat was not able to assess progress directly from Partner reports.

In addition, there were significant differences in CEPA's and GAVI's assessment of progress against the strategy, highlighting the challenges in using the strategy document and available evidence in assessing progress. Given the above, it is not clear how useful the strategy documents have been for GAVI in monitoring its own performance or for stakeholders to follow progress. We understand that there are plans for the Data Warehouse and Reporting Tool to address the lack of information by revising the dashboard to directly map against the revised strategy in the second part of the project (first part of project ended in June 2010). This would help to monitor progress, but by the time it is implemented, it is likely to have little or no impact on Phase II of GAVI (i.e. up until the end of 2010) – the focus of our evaluation.[115]

The robustness of this finding is deemed to be a 'B' as findings are consistent, and although they are based only on desk review, findings are objectively verifiable with GAVI documents and consistent with interview evidence.

8.4.5. Summary and conclusions

Evaluation Question SG4.3: Has the GAVI focus on collaboration with a wide range of public and private stakeholders contributed to its effectiveness and impact?

Summary

Table 8.4 summarises the key evaluation findings on SG3.1 along with the robustness rating.

Table 8.4: SG4.3 – findings and robustness ratings

Issue/ Theme	Findings	Robustness	
Contribution of Partners	There is evidence to support the view that the partnership of public and private sector is a key driver of the GAVI's achievements through its ability to raise funding, align key global and national players in immunisation, and support innovation.	C	Based on desk review of GAVI documents, the e-survey and interview evidence only. Not amenable to quantitative analysis.
Changing nature of the Partnership	The changed nature of the partnership remains an area of concern for some. Although we are not convinced that this has had a detrimental effect on its level of innovation, the issue of the role of the Secretariat remains a distraction for some Partners.	D	Our conclusions here rely on interview evidence together with CEPA's existing knowledge of the organisation. Although it is important to recognise subjectivity here (given the importance of CEPA's judgement in weighting available evidence), we are confident that our conclusions here are correct.

[115] We also understand there are team level KPIs, however, we were not provided with these and we have not found evidence to suggest that they have been important in monitoring or performance management.

Issue/ Theme	Findings	Robustness	
Work Plan and Budget	The GAVI Work Plan and Budget is at the heart of the Alliance. The time taken to resolve issues with both the process and the structure of materials appears (in CEPA's view) to not have supported the effectiveness of the Partnership. There is still a feeling that the process does not get the right balance between accountability and empowerment of Partners supported with GAVI funds.	B	Based on consistent findings in comprehensive desk review of GAVI documents and interview evidence.
Contribution of strategy and planning process to effectiveness	The nature of GAVI as an Alliance has made it more difficult to develop a coherent link between strategy, outputs and activities, and significant weaknesses remain. The format of reporting has inhibited its ability to monitor Alliance progress.	B	Based on consistent findings in desk review only, but objectively verifiable with GAVI documents and consistent with interview evidence.

Conclusion

Although a number of the detailed aspects of our analysis point to the challenges and difficulties associated with working in partnership, our basic conclusion is that GAVI's focus on collaboration between stakeholders has been an important contributor to its value add. The primary mechanism for this has been focus and inclusiveness on immunisation, which has supported increased finance, alignment of activity and created the potential for innovation. We say more about this in the overall evaluation conclusions.

The existence of tensions in any partnership is not, in our view, an indicator or success or failure per se. What matters is how partners and the partnership as a whole deal with these issues. This is primarily an issue of governance – which is not part of the scope of this review.

However, to some extent, these tensions impact on the operational effectiveness of GAVI. For GAVI in Phase II the main ongoing issues relate to the development of the nature of GAVI from the informal Alliance embodied in the Working Group, towards a 'partnership institution' in its own right (i.e. a principal itself) with a more independent Secretariat and formal governance arrangements.

We do not comment on the relative merit of different positions here. However our conclusion is that:

- some of the ongoing issues about role and responsibilities and Work Plan accountability can only have reduced the Partnership's effectiveness – to the extent that it has diverted time and attention from the core mission and objectives; but
- that we have not seen evidence that these issues have materially impacted on GAVI's contribution and value add in Phase II.

8.5. Summary and conclusions on SG4 performance

The fourth and final goal of GAVI is to **'increase and assess the added value of GAVI as a public private GHP through improved efficiency, increased advocacy and continued innovation'.**

The previous sections presented our findings by evaluation question. In this section, we bring together the evidence across the SG4 evaluation questions to assess the extent to which the goal has been met. In particular, we present our conclusions on the:

- Whether there has been improved efficiency, increased advocacy and continued innovation?
- Whether (for each) it is reasonable to conclude that that GAVI's performance has increased its value add?

8.5.1. Efficiency

In the absence of efficiency indicators collected by GAVI to monitor its performance against this SG we have found it difficult to reach conclusions here. However, based on the information that is available to us we believe that there have been some efficiency improvements:

- We observe an improvement in the narrow overhead cost efficiency measure (i.e. administrative overheads excluding Work Plan expenditure as a proportion of overheads). This reflects the fact that disbursements have increased at a faster rate than administrative costs.
- Of course overhead cost efficiency is a relatively narrow measure of efficiency – since it does not capture the quality of disbursement (i.e. development impact or costs borne by Partners). However, evidence of improvements in many aspects of GAVI's operations over Phase II (e.g. in the applications processes; the quality and quantity of advocacy input) suggest that impact has increased at least in proportion to disbursement.[116]

However, there are exceptions that have been referred to above and in our discussion of each evaluation question. Perhaps the main example is the monitoring of country performance at the Alliance level (i.e. as opposed to by Implementing Partners in country) and GAVI communications with countries. We believe that both of these detracted from efficiency and GAVI's added value, (although we have noted that there is inevitably some trade-off here between being 'light touch' and monitoring performance).

A further issue that has not been discussed as part of other evaluation questions relates to the development of GAVI's basic financial and information monitoring systems. A specific review of these systems was not part of our scope. However, during the course of our evaluation, we have reached an overall view that management of financial and performance information has not been a priority during Phase II. This reflects specific issues that we have had in accessing reliable data (easily and quickly) but also the apparent absence key indicators of performance.

[116] We have not conducted an assessment of the GAVI cost per average death averted over time. In principle we would expect this to increase as GAVI moves to higher cost, new vaccines. However, we do not regard this as an indicator of efficiency in this context.

We understand that there are explanations for this (e.g. related to the historic role of Partners and the Secretariat, and the separate existence of the UNICEF hosted Alliance and the Fund); and that there have been improvements in the last two years. However, our judgment is that this aspect of GAVI has detracted from its efficiency, and is surprising given that it is one of the largest GHPs.

8.5.2. Increased advocacy

There is *a priori* evidence to support the view that GAVI has broadly succeeded in increasing awareness and interest in immunisation at both the global and national levels. This success has primarily been a 'by-product' of GAVI's fundraising (and innovative finance) activities and its programmatic expenditure. Increased donor funding for immunisation is also indicative of greater commitment.

In our view these achievements are supportive of the value add of GAVI as a GHP.

We are aware that there are complicated issues here that relate to displacement – i.e. the concern that increased funding for GAVI will come at the expense of funding to GAVI Partners. Indeed our analysis of SG3 provides some (inconclusive) evidence which suggests that there may have been an element of displacement in earmarked bilateral funding to WHO and other bilateral funding to national immunisation programs.

However, our view of value-add reflects: (i) the fact that WHO in particular remains an integral part of GAVI; and (ii) the simple assumption that increased resources for immunisation in total (regardless of immunisation priority / channel) should be regarded as a positive contribution.

8.5.3. Continued innovation

Although the nature of innovation and areas of GAVI's focus and contributions have changed over its first two phases, it has continued to innovate.

- In Phase I, GAVI's key contributions (or areas of innovation) were in terms of the tools (FSPs / cMYPs, DQA / DQS) and approaches (e.g. the funding windows, and approach of working through Partners) to support country planning, financing and monitoring of routine immunisation programs.
- In Phase II, the amount of innovation in terms of tools and approaches to support routine immunisation appears to have reduced (as many of the critical tools needed were developed in Phase I); and we observe a shift in GAVI's energy / resources and focus onto other areas of innovation – most notably innovative finance and the HSS window.

In terms of the extent of value add, there is a concern (raised by some stakeholders) that this shift in the nature of innovation – despite its continuation – has reduced the added value of the Partnership.

This is a difficult issue and we do not have evidence which would support a strong conclusion.

However, our view is that a lessening in innovation on tools and programmatic approaches in immunisation was inevitable given the need to focus on delivery. Some of our interviewees

referred to the importance to GAVI of getting 'proof of concept' of its ability to support the introduction of a new vaccine across all of its eligible countries.

The issue therefore for us is not about the changing nature of innovation – which we believe has continued to add value. Rather the question is whether the energy and resource required for some of this value add has reduced the effectiveness of the organisation in delivering the basics. Our view is that this has occurred, although we are not in a position to make a judgment about its net impact on GAVI's value add.

8.5.4. Overview

On the basis of the analysis conducted in the evaluation we conclude that GAVI has been reasonably successful in improving efficiency, increasing its advocacy and continuing innovation. We believe that this has, in general continued to add to GAVI's value add. In particular:

- We observe an improvement in the narrow overhead cost efficiency measure (i.e. administrative overheads excluding Work Plan expenditure as a proportion of overheads). This reflects the fact that disbursements have increased at a faster rate than administrative costs. Furthermore, GAVI's application, review and approval processes have improved over time and achieve a reasonable balance between competing objectives. These improvements are, in our view, consistent with improved efficiency.
- The quality of GAVI advocacy material and level of advocacy activity have increased over time. There is *a priori evidence* of an increase in interest in immunisation at the global level and it is widely accepted amongst stakeholders that GAVI has been pivotal in putting immunisation back on the map.
- Although the nature of innovation and areas of GAVI's focus and contributions have changed over Phase I to Phase II, GAVI has continued to innovate.

Notable exceptions include the following:

- The monitoring of country performance at the Alliance level (i.e. as opposed to by Implementing Partners in country) and GAVI communications with countries. We believe that both of these detracted from efficiency and of GAVI's added value to some degree in Phase II.
- Although there have been significant improvements in recent years, the time taken to resolve issues related to the Work Plan and Budget process has constrained the organisations ability to improve efficiency.
- GAVI's ability to capture and produce basic financial and performance information monitoring. Again, although performance has improved in the latter half of Phase II, our judgment is that this aspect of performance creates inefficiencies and risks for the organisation.

9. CONCLUSIONS

This final section brings together our evaluation findings and conclusions across questions, and presents our synthesis at both the SG level and for GAVI as an institution.

9.1. Introduction

In 2009, GAVI celebrated its 10-year anniversary. According to the WHO 2009 Progress Report, GAVI's achievement over the decade (excluding any impacts from its HSS window) has been to avert the unnecessary deaths of nearly 4m children from preventable diseases caused by pertussis, Hib or HepB.

As noted in Section 2 of this report, the focus of our evaluation of GAVI has not been to 'second guess' or seek to improve on these estimates of impact. (Nor has our focus been to make comparisons of the implied cost per death averted by GAVI compared with other parts of the health sector or other donor organisations). Rather, the questions that we have sought to explore are the extent to which the Alliance has achieved the results set out in its SGs in support of maximising its impact; and has added value at the global and country levels, over and above what would be accomplished without the Alliance.

This section seeks to bring together our conclusions on these two questions. It is structured as follows:

- Section 9.2 offers a thematic discussion of value add and other key evaluation findings – which aims to summarise the most important (although not all) conclusions in the evaluation. In some areas we have simply reproduced conclusions from other parts of this report for ease of reference.
- Section 9.3 provides a tabular summary of the key 'results' and 'value add' conclusions of the evaluation, by Goal.

For the avoidance of doubt, the intent here is to summarise GAVI's performance to date (with primary focus on Phase II); we do not seek to provide any recommendations as to how the Alliance can improve its operations to achieve its mission. This is the subject of a short 'Recommendations Paper' submitted by us separately.

9.2. Conclusions on value add and other evaluation findings

In this section, we attempt to provide a synthesis of our findings in relation to the second RFP evaluation question – i.e. the value add of GAVI. We have organised this section by the three broad categories of additionality referred to in Section 2.2.4 – financial, organisational and programmatic. Within each section, we consider both global and country aspects of value add where appropriate.

In addition, in thinking about what constitutes 'value add', we consider the following characteristics:

- *More (additional):* actions that were being conducted before, but there are now more of them at a markedly increased level of activity;

- *Improved:* actions that were being conducted previously but are now appreciably more effective, efficient, or strategic;
- *Unique:* actions/ contributions that are exclusive or exceptional to GAVI;
- *Faster:* actions that were being conducted previously but now at a more accelerated pace;
- *New or Innovative:* actions that are entirely new or original to GAVI and initiated because of GAVI.

The limitations of this thematic disaggregation is that, in practice the existence of 'value add' in one area is dependent on performance and added value in other areas. Given this, we try (as far as possible) to identify the interdependencies.

9.2.1. Financial value add

The starting point for our overall assessment of GAVI has to be its contribution to increased resources. In the absence of significant increases in donor funding for routine immunisation, it seems clear that the level of deaths averted could not have been achieved. Our detailed assessment of the existence (or otherwise) of GAVI financial value add is set out in Section 6 of this report.

Global

1. *Despite a fair wind GAVI has attracted funding to immunisation that probably wouldn't have occurred in its absence…*

Considerable increases in funding for immunisation should be seen against the backdrop of large increases in total ODA and higher increases in health ODA. In addition, throughout Phase I and Phase II, the influence of the Gates Foundation in providing very substantial levels of long-term funding has been important in 'crowding-in' donor funding, and this needs to be recognised alongside any value add attributed to GAVI itself.

However, there is good evidence to suggest that GAVI has been able to attract additional funding for immunisation, and its major donors would not have contributed to immunisation on the scale that they did without it. Key features of GAVI that have supported its early ability to attract more (additional funding) included:

- its financial and programmatic focus on routine immunisation and provision of direct support to national immunisation programs.
- its structure as an Alliance, bringing together and aligning the key stakeholders in immunisation.
- its relatively flexible / lean structure compared with existing multilateral and bilateral channels.

2. *…and a big area of financial added value has been through IFFIm, where GAVI's role has been unique in immunisation.*

In our view, this passes the test in terms of more (additional) resources and therefore added-value. But, there is a sense in which, during Phase I, the value-add for most donors related at least in part to the new or innovative aspects of GAVI's organisational and programmatic approach – as opposed to specific global financial innovation[117].

By contrast in Phase II with the introduction of IFFIm, this has changed. As we have concluded in Section 6, although GAVI was not part of the initial IFF concept design, it played a critical role in adapting and implementing it for immunisation. Our judgement is that the role that it played was both innovative and unique (in immunisation) given: (i) GAVI's legal and governance flexibility compared with alternative channels (including multilaterals); and (ii) key personnel in the GAVI Fund Board and the Secretariat.

3. *IFFIm's key innovation is that it has dramatically improved the period of bilateral donor commitments to GAVI, supporting its ability to provide predictable support to country immunisation programs.*

The key innovative feature of IFFIm is its commitment technology. Its effect has been to substantially increase the period of bilateral donor financial commitments (and subject to financial market conditions) to GAVI – in fact to a level that broadly matches the 10 year commitment made by the Gates Foundation starting in 2005. Notwithstanding issues relating to GAVI's current funding gap (or indeed advocacy and planning challenges that it faces as IFFIm disbursements to the GFA decline), IFFIm disbursements (together with Gates funding) have provided the certainty of funding that has underpinned the ability of GAVI to commit to fund existing NVS programs through to 2015 (which is an important aspect of GAVI's financial and programmatic added value compared with other country-level funding).

4. *GAVI's role in the ongoing implementation of the AMC pneumococcal pilot is also identified as a significant achievement.*

As with IFFIm, GAVI's involvement in the AMC increased at a later stage - with the selection of the pneumococcal pilot and the appointment of the Alliance for hosting the AMC Secretariat. It is well known that pneumococcal disease is the number one vaccine preventable cause of death in children. The AMC pilot, through incentivising suppliers to produce suitable and affordable vaccines, has built up significant country demand for the vaccine. Feedback suggests that the key features of GAVI that made it capable of supporting the AMC included the fact that it was an Alliance of the key immunisation Partners, its track record in aggregating demand and introducing and financing vaccines in poor countries, and a relatively flexible organisation structure. These features distinguished it from other potential partners - *a priori* evidence of GAVI's additionality.

[117] Although the establishment of the GAVI Fund as a 501(c)3 provide the basis for specific financial innovation in Phase II.

National

5. GAVI's basic programmatic approaches and the development of tools to support countries' financial planning was a key source of innovation in Phase I.

GAVI has been innovative in terms of its approach and the development of tools that support countries in planning and financing of its immunisation programs. Its requirement for countries to prepare FSPs/ cMYPs has supported the improvement of the planning and budgeting process in countries – which is an important area of value add. Criticisms of FSPs (including the fact it was separate from the national multi-year plan and did not allow for integration with the broader strategic planning and budgeting of the health sector) appear to have largely been tackled in the cMYPs.

6. Co-financing has supported country ownership, but it has contributed relatively little to financial sustainability and changes to the policy have been a cause of confusion at the country level.

There is a general view that the introduction of co-financing has been an important development supporting country ownership of immunisation decisions (even if the levels are probably too low in the overall context of financial sustainability). But our assessment is that the process and the coverage of the policy have been areas of poor performance in Phase II:

- The time taken to introduce the policy and then frequent revisions and updates to it have caused unnecessary confusion, both within the organisation and at the country level. In addition, with further work ongoing in this area, the overall message with regard to financial sustainability is still not clear.
- It is surprising that the policies introduced during Phase II have not done more to integrate the issues of financial sustainability and country eligibility – e.g. by a greater distinction between low and low-middle income GAVI-eligible countries; and better incentives to increase payments (we understand that this is being undertaken now as part of the co-financing task team work).

7. GAVI's choice of vaccines and its basic funding model – despite its contributions to tools and country approaches – has had a negative impact on country financial sustainability.

All of the evidence points to the conclusion that the prospects for financial sustainability for low-income GAVI-eligible countries is very low indeed. Financial sustainability is expected to be a more surmountable challenge in low-middle income GAVI eligible countries. We also conclude that GAVI's choice of vaccines and presentations (i.e. combination vaccines) has not in practice been based on a realistic consideration of the potential for low-income countries to take on financing of these vaccines after GAVI support ends (whether through their own or other donor resources).

The question of course is whether this should be regarded as a 'failure' given that funding of comparatively expensive vaccines unambiguously 'saves lives' even if there is little prospect of financial sustainability for low-income countries at least. Our view is as follows:

In a limited sense, there is a 'failure' on financial sustainability – in that GAVI has not achieved its original objective of being time-limited. This partly relates to the issue of price reductions (see

discussion below). But perhaps more important are GAVI's decisions to provide support for 'new' life-saving vaccines, which were not part of the original portfolio. In Phase II, this has been as much a feature of GAVI's success (in funding routine immunisation) rather than one of 'failure'.

The only issue that arises from our review is whether there has been sufficient clarity within the organisation (and in its external communication) on the issue of financial sustainability. Our judgement is that part of the uncertainty in Phase II on co-financing relates to a 'failure' to recognise explicitly or communicate clearly that financial sustainability (for low-income countries at least) would not be achievable in the medium term for the vaccines that GAVI supports. There is of course the added question of the increased burden that introduction of GAVI's vaccines imposes on already weak country health systems – whilst the ISS and HSS program seek to address this (as also many other health donors), it remains a large and complex issue.

9.2.2. Programmatic value add

Additional financial resources alone do not necessarily assure added value (if these are neutralised by counteracting ineffective interventions or other factors). However, to its credit, GAVI has also achieved a series of innovations on the programmatic side, where there is clear evidence of its added value. By definition, the programmatic impacts are realised at country level, although GAVI has also successfully influenced the global health aid architecture and debate in several ways, including by raising the profile of routine immunisation.

Also, we note that given some of GAVI's programs (HSS and CSO) are relatively new, it is too early to measure results. In particular, the CSO program faces some fundamental design and implementation challenges that are being addressed now, so as to increase uptake and achieve its stated objectives.

8. There is strong evidence that GAVI's flagship program, new vaccine support, has accelerated countries' introduction of life saving vaccines and immunisation outcomes – which might not have happened in its absence.

Analysis of WHO country introduction data and the majority of feedback from the surveys and interviews confirm that the introduction of Hep B and Hib containing vaccines (and to a lesser extent for YF vaccine) was accelerated across GAVI countries after the Alliance was formed. Counterfactual projections of country introduction suggest that fewer countries would have introduced these vaccines in the absence of GAVI.[118]

Similarly, the country demand for pneumococcal vaccines is greater and faster than any other vaccine to date and rotavirus has been introduced in some Latin American countries – although wider introduction of both vaccines might be delayed.

In supporting countries to make policy decisions on the introduction of YF, Hib-containing, pneumococcal, and rotavirus vaccines, GAVI financing and the work of its Partners has significantly improved the evidence base on disease burden, vaccine safety and effectiveness, cost-effectiveness data, and programmatic feasibility data. This has been achieved in particular

[118] However, there is no evidence of GAVI improving the time to reach peak coverage in countries - which has generally been within two years of vaccine introduction.

through the work of the GAVI-funded YF Initiative, Hib Initiative, Pneumo ADIP, and RVP, as well as through its Partner WHO.

Beyond facilitating vaccine introduction, GAVI has improved vaccine supply stability for Yellow Fever and pentavalent vaccines (the two primary underused vaccines used by GAVI-eligible countries), and helped increase the number of suppliers prequalifying vaccines. Industry feedback suggests that GAVI's demand forecasts and funding decisions played a key role in guiding and influencing manufacturing decisions to serve these markets, which they may not have entered, if not for GAVI-driven demand. However, supply stability has not yet been achieved for either Yellow Fever or pentavalent vaccines through 2009.

9. However, GAVI has not contributed to a reduction in Yellow Fever and pentavalent vaccine prices – as originally anticipated – with serious implications for country affordability and sustainability

An area of weak GAVI performance has been its impact on vaccine prices, where GAVI has not achieved the anticipated level of price decreases across the vaccines it supports (Yellow Fever and pentavalent vaccines). Evidence shows that while the UNICEF/ GAVI market is significantly larger and represents lower income countries than the PAHO market, there were relatively small differences between UNICEF and PAHO prices across underused vaccines. As also discussed in the financial value add section above, this has serious repercussions on country financial sustainability and dependence on GAVI.

It has been well documented that GAVI's original assumption that creating a large market for these vaccines would lead to a rapid reduction in vaccine prices has not occurred. Throughout the last 10 years, GAVI has not actively addressed strategies for reducing vaccine prices and has relied on natural market forces. If there continues to be minimal supplier competition (pentavalent vaccine) or unstable supply (Yellow Fever), vaccine prices will remain high. In addition, transient markets (HepB and Hib mono- and tetravalent vaccines) may have unintended consequences regarding GAVI vaccine prices and vaccine suppliers' motivation to enter GAVI markets.

Our consultations, including with the vaccine industry, suggest that GAVI 'could have done much more' in this area. Our view is that the failure to prioritise this issue by working strategically and proactively with industry partners is a key weakness of the Alliance. It is more important than ever for GAVI to focus on this area in Phase III, as newer and more expensive vaccines enter GAVI's portfolio.

10. GAVI is unique in financing associated vaccine technologies through its injection safety program, which has clearly been successful and sustainable - although waste management remains an issue.

GAVI is the only donor financing injection safety in routine immunisation to this scale (through both its INS program and bundled with the NVS support). Both quantitative and qualitative (survey, interviews, and country visits) evidence point towards the achievements and added value of GAVI in this area. The INS support has led to the adoption/ increased uptake of injection safety kit across GAVI countries. E-survey responses and our comparison of uptake indicators in GAVI countries in the period prior to GAVI support, as well as with GAVI ineligible low and lower-middle income countries highlights higher uptake after GAVI INS support, establishing its value add.

Further, this program has demonstrated the highest sustainability in terms of sustained use and financing (majority through government budget, and rest through other donors) of safety kit after GAVI support (although we note the relatively lower prices of ADs in comparison with the GAVI vaccine support). An unintended 'negative' consequence of this program has been the poor safe disposal/ sharps waste management in countries – primarily due to a lack of resources.

11. GAVI's focus on health system bottlenecks in countries through its HSS window is deemed necessary for increasing coverage, but there are several issues in relation to the effectiveness of its delivery model, and the dilution of GAVI's focus and its comparative advantage.

The stated objective of GAVI's HSS is to increase and sustain immunisation coverage by financing key health system bottlenecks. It is widely agreed that this dedicated window has raised the profile of immunisation amongst global and national HSS stakeholders and demonstrated some positive features such as promoting 'country ownership' (regarded as a key area of country value add vis-a-vis other donor approaches).

However, a recent review of HSS approved activities found clear evidence that they are broader than immunisation in scope, extending to maternal and child health and the wider health system (as per its design). This raises questions of the extent to which HSS has diluted GAVI's core focus and diverted limited resources and efforts from effective delivery and monitoring of its existing programs. This is not to underestimate the importance of wider health system issue for sustained routine immunisation performance. Rather, we simply note what we believe is a reality, given the limited resources available to the partnership in the form of Partner and Secretariat time and resources.

There are also several issues relating to the effectiveness of GAVI's HSS delivery model, including institutional separation from EPI in countries, delays in review and disbursement, weaknesses in M&E, etc. However, some of these are expected to be addressed in the HSS Funding Platform. GAVI's inclusion in the Platform and lead role in shaping and implementing it (with the World Bank, Global Fund, and WHO) is testimony to its value add in this area, despite being a relatively recent and small HSS donor (in value terms).

12. GAVI's ISS program has also received 'mixed' feedback. Although generally regarded as being highly innovative, the impacts achieved and scope for sustainability are less conclusive.

The innovations of the ISS program are widely regarded (despite some recognised limitations). These include the role of DQA/ DQS processes in improving reporting and quality of immunisation data in countries and influencing the development of similar tools by other donors; and the 'performance based' and 'flexible cash' characteristics to increase coverage. The e-survey responses concurred on the value added aspects of these program features, notwithstanding some reservations expressed about data quality and reliability, potential of misuse of funds, risk of funds lying idle, etc.

GAVI ISS is highly valued by countries as being the only source of donor funding to expand routine immunisation coverage to the unreached. Country consultations also indicate that its rewards-based funding has incentivised immunisation efforts at sub-national levels – although there are diminishing incentive effects after a certain level of coverage, when the costs of servicing the last mile population increase disproportionately. In addition, the extent to which

EPI managers understood the nature of the rewards incentive and the importance of pushing those incentives down to the district level was mixed.

Somewhat contrary to the qualitative feedback, our quantitative/ regression analysis shows only some weak evidence of a positive impact of ISS disbursements on DTP3 coverage (statistically significant only at the 65-80% coverage level, following Lu et al's approach). Further, the utilisation analysis of ISS funds disbursed indicates that on average, about 50% of ISS funds available to a country in a year remain unutilised – implying poor absorption capacity or countries deciding to postpone usage (given variability of rewards funding).[119]

9.2.3. Organisational value add

13. GAVI's approach of working through its Partners, particularly at country level, goes to the heart of its Alliance model and 'lean' structure.

GAVI's 'lean' organisation model that finances governments directly and works though existing in-country Partners is largely unique and contributes to its efficiency. Particularly during Phase II, GAVI's administrative overheads as a proportion of ODF have declined significantly – reflecting significant increases in disbursement and a flattening of the administrative cost base.[120] At these levels, GAVI is broadly comparable with the Global Fund (despite being significantly smaller), and lower than the Gates Foundation and other bilateral and multilateral donors. As noted in the financial value add section, donor feedback confirms that this key feature has been an important contributor to GAVI's value add in attracting additional funding for routine immunisation.

The ICC mechanism which discusses, reviews and signs-off on all of GAVI's immunisation related country activities is indicative of effective partnering in countries amongst all immunisation donors and stakeholders (although, we recognise that its effectiveness varies by country). However, we understand this approach is less effective for GAVI's HSS activities - which might need a more country driven/ customised approach and greater knowledge of country context. Also, there has been some feedback that the CSO and private sector stakeholders in country need to be engaged more meaningfully – we recognise that the former is a core objective of the CSO program.

Nonetheless, GAVI's working through 'Implementing Partners' in countries has led to synergies in building upon the individual capacities and strengths of the Partners towards reaching a common immunisation mission – a clear proof of the Alliance's added value.

14. Evidence suggests that GAVI's program application and monitoring processes and communication at country level need to improve further, although a significant positive characteristic of GAVI's approach is 'country ownership.'

GAVI's program application, review and approval processes have improved over time and achieved a reasonable balance between competing objectives. They are also considered favourably in comparison to the Global Fund. However, areas of weakness identified as part of

[119] Our evidence however does not prove or disprove this hypothesis on why ISS funds remain unutilised.

[120] This is based on a 'narrow' measure that included Secretariat administrative costs alone, and does not include Work Plan costs or those related to the ADIPs.

the evaluation include: (i) the effectiveness of GAVI communications with countries; and (ii) its approach to capturing and proactively monitoring country level data. We are surprised that GAVI does not systematically monitor performance information on its own processes in terms of timing/ efficiency of review, approval and disbursement.

We believe that – although things have been improving – the relative weakness of GAVI's monitoring and communication is partially related to a lack of clarity about the relative roles of Implementing Partners and the Secretariat in particular. There is clear tension here between WHO / UNICEF's mandate to provide technical support and the role of acting as GAVI's representative in terms of monitoring and communications. In part, this reflects the important political relationships in countries that they need to protect and their day jobs. But is also a practical issue associated with knowledge of GAVI process and priorities.

Whilst it is not necessarily possible (or even desirable) to completely resolve this tension, our conclusion is that there may be things that GAVI could do going forward to tackle the relative weaknesses identified above. In our view, this is not about having a country presence, but it is about prioritising the country monitoring and support roles of the Secretariat – working closely with Implementing Partners in country and improving communications to countries.

However, a value add of GAVI's processes at country level is the level of 'country ownership' it provides through flexibility to governments to define the funding priorities/ activities for a program, channelling funds through the existing government systems, and reporting back by governments on performance (through the country APRs). Our country visits highlighted that this sets GAVI apart from the bilateral and multilateral donors.

15. GAVI's partnership of public and private immunisation stakeholders is on one hand a key driver of its innovation, but on the other, a contributing factor to the challenges of work planning, budgeting, and performance monitoring.

There is strong consensus from the e-survey responses that GAVI's multi-stakeholder model has been core to achieving its immunisation objectives. The key value add of the Alliance is bringing together all the relevant public and private stakeholders in immunisation – that no other existing entity has achieved. Partners contribute to the Alliance through participation in strategy and policy-setting, advocacy, fund-raising, vaccine development and procurement, country support and immunisation delivery. The different skills and experience mix has clearly been important in promoting new and better ways of improving routine immunisation - in both programmatic and financial spheres.

That said, there have also been instances of tension among Partners – perhaps unavoidable in an Alliance of this nature. An area of weak performance through the years has been the work planning and budgeting process – which is at the core of the Alliance. Although there have been improvements in the structure and quality of material in Phase II, they still seem to reduce the effectiveness of the Partnership and reflect a failure to tackle effectively the issues of Partner roles and accountability.

Our review of GAVI documentation and qualitative feedback point to the fact that performance monitoring/ accountability has been an area of relatively poor performance. The lack of a coherent link between the GAVI strategy, indicators/ outputs and activities and absence of

systematic tracking of performance (at least to the extent we understand it) is a case in point. We appreciate that these are partly inevitable in a complex Alliance of this nature.

GAVI's ability to capture and produce basic financial and performance information monitoring. Again, although performance has improved in the latter half of Phase II[121], our judgment is that this aspect of performance continues to create inefficiencies and risks for the organisation – and has been a surprise given GAVI's size and focus as a financing entity.

16. *As GAVI has evolved, there have been changes to the structure of the Partnership (and Secretariat) and nature of its innovations – but our view is that these have not detracted significantly from its added value.*

The changing nature of the partnership to be more 'formal' or 'corporate' and the increasing role and independence or 'self-sufficiency' of the Secretariat has been a common theme in our evaluation of GAVI as a partnership. There are conflicting views on how these changes have impacted on value add.

- Positive aspects relate to improved decision making and governance particularly in the latter part of Phase II. Evaluation of the changes in governance arrangements has not been part of the scope of this study, so we simply note this point.
- Negative aspects relate to reduced involvement of the Partners in development of key policies (compared with the Secretariat) and reduced sense of ownership of the Alliance by the Partners. The concern is that these features have had a detrimental impact on two of the key perceived drivers of value add – i.e. efficiency and innovation.

Our conclusion on these points take into account findings across the entire evaluation as well as our knowledge of GAVI. However, it is important to recognise that these conclusions are subjective and reflect CEPA's judgement about the weight to give to different views / evidence presented in the evaluation.

We are not in a position to make a judgement about whether the change in the role of the Secretariat has led to an improvement in the efficiency or effectiveness of GAVI (or otherwise). We note that uncertainty about responsibilities and accountabilities and the nature of the relationship between the Secretariat and Partners remains an issue. Although we do not feel able to provide a view on the extent of this impact, we do believe that it has detracted from the efficiency of the organisation in Phase II.

The findings in our evaluation do suggest that the nature and areas of GAVI's focus and contributions have changed over its first two phases:

- In Phase I, GAVI's key contributions (or areas of innovation) were in terms of the tools (FSPs/ CMYPs, DQA/ DQS) and approaches (e.g. the funding windows, and approach of working through Partners) to support country planning, financing and monitoring of routine immunisation programs.
- In Phase II, the amount of innovation in terms of tools and approaches to support routine immunisation appears to have reduced; and we observe a shift in GAVI's energy and focus onto other areas – most notably innovative finance and the HSS window.

[121] We also understand that work is ongoing to develop data warehousing systems to improve M&E.

Although we recognise that there is a change in the relationship between key Partners (WHO / UNICEF) and GAVI, we are not convinced that this has had a detrimental impact on levels of innovation. We think that a lessening in innovation on tools and approaches to financing routine immunisation was inevitable given the need to focus on delivery (and the need for 'proof of concept' i.e. GAVI's ability to support the introduction of new vaccines in eligible countries.) In addition we do observe innovation in other areas such as innovative finance and HSS.

17. *GAVI has increased the interest in and commitment to immunisation at global and country level – borne out, as a minimum, by increased levels of funding.*

There is *a priori* evidence to support the view that GAVI has broadly succeeded in increasing awareness and interest in immunisation at both the global and national levels. This success has primarily been as a 'by-product' of GAVI's fundraising (and innovative finance) activities and its programmatic expenditure. Increased donor funding for immunisation is also indicative of greater commitment.

Although we have focused most of our work on immunisation (as opposed to child health), our assessment is that there is relatively little evidence to support an impact on awareness on child health issues – which is clearly broader.

Our evaluation suggests that the quality, planning and quantity of GAVI's global advocacy activities has improved over Phase II – although there are still implementation challenges, including in coordinating Partners, and widening the Partnership's advocacy messages and channels.

Feedback about national level advocacy has been mixed, and varied between countries. This reflects uncertainty about where it makes sense for advocacy messages and activities to be 'GAVI' as opposed 'GAVI Partners'. National level advocacy would benefit from a strategic approach considered in the advocacy strategy, and a mechanism to share lessons learned between countries.

Clear progress indicators and monitoring would enable a more robust assessment of advocacy performance in future.

9.3. Evaluation by SG

The table below summarises the evaluation findings across the four goals[122]. The findings are classified based on whether they represent positive results/ value add achieved by GAVI, or limited (or indeed negative) results or value add. There is inevitably a degree of overlap between the two RFP questions of results and added value. For example, GAVI might have achieved results on a particular program and also added value on account of being unique or 'additional' to other donors in this space.

These detailed findings have formed the basis of our conclusions for the Alliance as a whole.

[122] Please note that the table captures the main areas of analysis but is not exhaustive in terms of all the themes/ issues covered across SGs and the rationale/ reasons for a particular finding. For further information on these as well as the quality of evidence/ robustness rating of the conclusion, please refer to the respective SG report.

Table 9.1: Conclusions on GAVI performance by SG

SG	Areas of positive results/ value add	Areas of limited or 'negative' results/ value add
SG1: Health systems strengthening	• INS program has achieved results in terms of increased levels of global awareness on injection safety practices, introduction of safety policies/ plans/ budgets (although more impact in Phase I countries), and adoption/ higher uptake of safety kit across GAVI countries - which have been sustained after GAVI support. GAVI has also added value in safety kit uptake for GAVI countries compared to ineligible countries (although attribution is difficult). • GAVI's role in shaping the HSS funding platform is considered added value (and raises the profile of immunisation), particularly given its small value of HSS funding vis-à-vis other HSS donors. Its flexible and country ownership driven approach are deemed more effective than the multilateral approach to aid. • ISS focus on increasing coverage to unreached is valued (especially given lack of other donors in this space), but there is only some weak evidence of positive impact of ISS disbursements on DTP3 coverage (statistically significant for 65-80% coverage only, following the Lu et al approach). • DQA/ DQS processes are regarded as value added innovations in improving the quality of immunisation data measurement and reporting by countries, and have influenced development of similar tools by other organisations.	• HSS program health outcomes/ impact are difficult to measure and attribute to GAVI, and to link to immunisation outcomes. • CSO program has some fundamental design and implementation issues, resulting in lack of awareness in countries and poor uptake (especially of Type A support). Results are too early to measure, but definition of outcome indicators and KPIs and targets need to be clearer to measure performance. • 'Performance basis' and 'flexible cash' aspects of ISS are regarded as innovations, but stakeholder views are mixed on their effectiveness and value add. • INS impact on country safe disposal/ waste management practices remain a major concern (and are regarded by some as an unintended area of GAVI 'negative' value add)

SG	Areas of positive results/ value add	Areas of limited or 'negative' results/ value add
SG2: Vaccine support	• GAVI has accelerated country introduction rates following its funding for YF and Hep-B- and Hib-containing vaccines. • There is strong evidence of GAVI accelerating country demand for pneumococcal vaccine, although introduction may be delayed. • GAVI-eligible countries are capable of quickly taking vaccine programs to scale; therefore, GAVI's current model appears to be effective. • GAVI has secured pneumococcal vaccine supply for the near term. • It has advanced the evidence base required for country policy decisions on the introduction of YF, Hib-containing, pneumococcal, and rotavirus vaccines.[123] GAVI has delivered timely forecasts for underused and new vaccines for use across the Partners and with suppliers.	• Except for the early rotavirus vaccine introduction in Latin America, there is no evidence that demand or introduction has been accelerated. • GAVI has improved the stability of YF and pentavalent supply, but has not yet achieved supply stability. • GAVI has not yet secured any supply commitments for rotavirus vaccine. • GAVI has not yet achieved the anticipated price decreases in its vaccines to make them more affordable and sustainable for countries. • Accuracy of forecasts has not been defined, however, the accuracy of the underused vaccine forecasts still varies widely

[123] For HepB, the evidence for vaccination has been communicated through WHO recommendations and vaccine introduction guidelines

SG	Areas of positive results/ value add	Areas of limited or 'negative' results/ value add
SG3: Financing	• GAVI has contributed to an increase in the level of total global resources for immunisation. • GAVI funding is additional to a large extent. Some evidence of a change in the sources of funding for WHO (with access to bilateral funding for non-GAVI related immunisation priorities being more difficult)– although attribution to GAVI is not certain. • GAVI has performed well in accessing longer-term/ predictable commitments from traditional donor sources – and this is an essential part of its value add. IFFIm funds have contributed in large measure to predictability. • GAVI has also increased predictability of funding to countries (compared to traditional donors) – however, the current funding shortfall has undermined this. • GAVI has played an important role in the development and implementation of innovative financing mechanisms such as IFFIm and AMC.	• In comparison with other GHPs, GAVI appears to have been less good at diversifying is donor base. • Financial sustainability at national level remains a major concern – both for new vaccines as well as immunisation system strengthening activities. Stakeholders believe this is a 'negative' area of GAVI results/ added value.

SG	Areas of positive results/ value add	Areas of limited or 'negative' results/ value add
SG4: Added value as a global PPP	• GAVI's 'lean structure' and 'light touch' approach are contributors to its value add, but this will be eroded if recent increases in operating (and Work Plan) costs combined with a reduction in disbursements continue. • There is strong consensus from the e-survey that GAVI's multi-stakeholder model has been core to achieving its immunisation objectives. • GAVI has contributed positively to increasing awareness of, interest in, and commitment to immunisation at global and country levels.	• GAVI's work planning and budgeting process and materials have improved over time, but seem to have detracted from the effectiveness of the Alliance (although representative of the Partnership). • Program M&E processes at country level and GAVI's financial and performance reporting are weak; and there is limited clarity in roles, responsibilities and accountability of Partners. • Some improvement in program application processes over time, but delays in review and disbursement remain (192 days on average from IRC review to recommendation). Also, communication at country level is reported to be weak. • The nature of GAVI as an Alliance has made it more difficult to develop a coherent link between strategy, outputs and activities – reducing the effectiveness of monitoring / tracking performance.

ANNEX A: GAVI TOR

Purpose of the evaluation

The evaluation is being commissioned by the GAVI Alliance Secretariat at the request of the Alliance Board. The purpose is to assess GAVI results and the partnership added value over and above what would be accomplished without the partnership. The results will be considered by the Board in the planning and development of GAVI's next phase of operations (2011-201515). The expected results will help expand the strengths and address the weaknesses of the GAVI Alliance in order to improve the capacity of the Alliance to achieve its mission.

Background and Context for this Consultancy

The GAVI Alliance was launched in 2000 to increase immunisation coverage and reverse widening global disparities in access to vaccines. Governments in donor and developing countries, UNICEF, WHO, the World Bank, non-governmental organisations, foundations, vaccine manufacturers, and public health and research institutions work together as partners in the Alliance to achieve common immunisation goals, in recognition that only through a strong and united effort can much higher levels of support for global immunisation be generated.

The GAVI Alliance mission is to save children's lives and protect people's health by increasing access to immunisation in poor countries. The GAVI Alliance Strategy positions GAVI's work within the broader context of child survival and the Millennium Development Goals. The Alliance also makes a major contribution to meeting global goals outlined in the WHO/UNICEF Global Immunisation Vision and Strategy (GIVS) by supporting immunisation programs and health systems in the world's poorest countries.

GAVI has defined the following SGs for 2007-201010:

- Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner
- Accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security
- Increase the predictability and sustainability of long-term financing for national immunisation programs
- Increase and assess the added-value of GAVI as a public private global health partnership through improved efficiency, increased advocacy, and continued innovation

The 2007 - 2010 Roadmap translates the long-term strategy into annual milestones for the years 2007, 2008, 2009 and 2010. For more information on the GAVI Alliance, please consult the website at www.gavialliance.org.

The GAVI Evaluation Policy can be found at:
http://www.gavialliance.org/resources/17__GAVI_Evaluation_Policy.pdf.

Evaluation scope

This evaluation will assess GAVI Alliance's results and added value at global and country levels. The evaluation should extend as far down the results chain as possible, with an assessment of outputs, outcomes and impact where feasible, with an acknowledgement of methodological and temporal limitations.

An initial evaluation of GAVI, focused mainly on process, was completed in 2008 and covered the first five years of GAVI (2000-200505). This evaluation, to commence in the 4th quarter of 2009, will

address GAVI results and added-value since inception, but with a primary focus on the years 2006 to the present. The evaluation should also review the extent to which the strengths and weaknesses identified in the Phase I evaluation have been sustained or addressed, but while maintaining a primary focus on results and added-value.

The evaluation will not include an assessment of GAVI's governance structure, which has recently been re-organised.

Evaluation questions

The main questions to be answered by the evaluation are as follows:

- To what extent has the GAVI Alliance met its four SGs?
- To what extent has the GAVI Alliance added value at the global and country levels, over and above what would be accomplished without the Alliance?

In order to encourage innovation in the approach and methods used, only the high level evaluation questions are provided here. An illustrative set of sub-questions based on the high level evaluation questions are provided in Annex 1. Bidders may propose using the illustrative set of sub-questions provided in Annex 1, or they may propose their own sub-questions based on the high level evaluation questions provided above and assess the feasibility of delivering the findings to questions.

Methodology

The primary audience is the GAVI Board and the secondary audience is the GAVI Secretariat and partners. Firms bidding on the evaluation are strongly encouraged to propose innovative methodological approaches in response to the evaluation questions.

The following principles should also guide the methodology:

- Be issue oriented, forward looking and cost effective.
- Capitalise on ongoing and past findings.
- Take advantage of relevant venues for stakeholder feedback. (Regional Working Group meetings, etc)

Moreover, to ensure credibility, the Evaluation should be conducted in accordance with the following principles:

a) Independence and impartiality
b) Involvement of stakeholders3
c) Transparency
d) Reference to international norms and definitions such as the OECD Development Assistance Committee (DAC) principles

ANNEX B: SUPPORTING PAPERS

Table B.1: Supporting Papers

Supporting Paper:	
1.	Bibliography
2.	List of consultations
3.	Evaluation methodology material
4.	Country Evaluation Reports – Bangladesh, Mali, Nigeria, Bolivia, Uzbekistan
5.	Assessment of progress based on Phase I evaluation recommendations
6.	Summary results from the electronic survey
7.	Summary results from the questionnaire to EPI managers in GAVI-eligible countries
8.	Monitoring GAVI's performance against its Strategic Indicators (2007-10)
9.	Literature review summary
10.	Annexes to SG reports – SG1, SG3, SG4

ANNEX C: SOURCES OF EVIDENCE

Table 2.1 in Section 2 of this report provides a summary of the evidence sources that we have used. In this annex we describe the evidence source in more detail, and draw attention to any particular methodological issues. We also comment on the expected robustness of the various evidence sources.

C.1 Review of documentation

GAVI documentation and data

As part of our review we have conducted an extensive review of GAVI documentation. Most the reports and papers we have reviewed are publicly available on the GAVI website. However, we have also reviewed internal working papers and confidential documents provided to us by the Secretariat and others.

GAVI colleagues have in general been very helpful in pointing us to the most appropriate sources and papers. In additional GAVI provided the evaluation team with a number of electronic document files at the beginning of the project. However, this has inevitably been an iterative and time consuming process given the range of documentation and our relative lack of knowledge at the start of the evaluation.

In most cases, where we have requested a document we have been given access. The main exception to this is the UNICEF and GAVI MOU – which we have not been able to see (given UNICEF refusal). We understand that this MOU has commercially confidential information and is therefore sensitive. However, it is disappointing that UNICEF has not been prepared to allow access (or to offer to engage with us on the content) given the importance of UNICEF as GAVI's preferred procurement agency (for GAVI eligible countries outside of the Americas). We feel that this decision has significantly affected our ability to understand the issues surrounding pricing of vaccines procured by GAVI.

Academic and 'grey' literature

As part of the project inception, the GAVI Evaluation Manager has provided us with a long list of relevant third-party literature. We have also identified relevant literature in the course of our analysis and through structured interviews. Whilst we have not conducted a formal literature review, we have tracked the papers that have been reviewed, and have referenced them specifically where they have been important in reaching conclusions.

C.2 Quantitative analysis

The nature of quantitative analysis varies by evaluation question. But in general it has involved reporting of trends, growths rates and levels of: impact indicators (e.g. deaths prevented); outcome indicators (e.g. DTP3 coverage rates); funding and expenditure (e.g. Development Assistance for Health (DAH) database, ODA flows); and GAVI activities and outputs (e.g. Approvals and Disbursements); e.g. GAVI Program activities and outputs (where available) (e.g. shipments data)

Points to note about access and availability of data for the evaluation are as follows:

- as part of the process the evaluation team identified an error in GAVI's disbursement data. This led to a significant delay in the availability of basic data for the evaluation process (and some duplication of work) since the relevant series had to be reconstructed by Secretariat colleagues from primary sources.
- information that is available through GAVI processes (e.g. Program Applications, FMAs and APRs) is not always been collated or collated in readily analysable form. We have therefore had to conduct a significant amount of data entry / manipulation in order to analyse the data on a systematic basis. (e.g. APR responses, disbursement timing data for NVS)

C.3 Structured interviews

Structured interviews with various GAVI stakeholders and individuals have been an important source of evidence for many of the Evaluation Questions.

Objectives and interview types

The objectives of these interviews are twofold:

i. solicit stakeholder views on the key Evaluation Questions that relate to the performance of GAVI and its value add.

ii. gather data and other evidence that supports our analysis of results and value add.

Although most interviews provided information relevant to both objectives, the mix had depended on the interviewee. We have therefore categorised our proposed structured interviews as follows.

- **Top-level interviews** – which have been conducted with current and ex-Board Members (and or alternates) or other senior representatives of stakeholders[124]. For these consultees, we have sought to focus particularly on questions relating to perceptions of value-add and contextual factors to explain GAVI's results.
- **Subject-specific interviews** – which have been conducted with senior individuals / representatives, and where we have focused on particular aspects of the evaluation or one or more SGs. This group includes, for example Advisory Group or Task Team chairs; and subject-specific experts.
- **Fact finding/ data interviews** - In addition to the above structured interviews, we have accessed valuable sources of 'interview-based evidence' on more detailed or specific points from:
    - Secretariat staff about GAVI processes and activities;
    - comparator organisations to understand their programs / activities in relation to GAVI as well as data gathering for benchmarking costs; and

[124] These will include a balanced mix of constituency members that are not on the GAVI Board.

- WHO/ UNICEF/ World Bank and academic experts on data/ metrics relevant for the evaluation.

Conducting interviews and interview guides

To support our interviews we have prepared a Full Structured Interview guide that has informed all of our interviews. It is organised around GAVI's SGs and our Evaluation Questions. To support this (for internal use only) we have also produced an annotated version

In advance of any interview, we provided interviewees with background on the evaluation and an indication of the particular aspects of the evaluation where we are seeking opinion, comment, and evidence (based on the background of the individual and his/ her role in relation to GAVI).

For the 'Top-level' interviews, we ent an abbreviated set of questions. For Subject-specific interviews, we typically sent the Full Structured Interview Guide (including an indication of the questions/ goals that we would like to focus on). For fact finding interviews, we typically sent the Full Structured Interview Guide as background, together with more detailed data / or process questions as necessary.

These documents are available in Supporting Paper 2.

C.4 Surveys

As part of the evaluation we conducted two formal surveys: an e-survey of all GAVI stakeholders and; a written survey of EPI managers in GAVI eligible countries. More details of both surveys are again in Supporting Papers 6 and 7. Key point to note are set out here.

E-survey

The e-survey was a web-based opinion survey conducted in April 2010. It was sent to all GAVI stakeholders for whom we have e-mail contact details. In total this amounts to approximately 1,000 individuals[125], and includes all individuals invited to the Partners Forum in Hanoi, current and ex Board Members, the Secretariat, and other consultees and GAVI contacts. We received a total of 293 responses, a response rate of around 29%.

EPI manager survey

The EPI manager survey was sent to a total of 95 EPI representatives from 76 countries. We received responses from 23 countries.

C.5 Country studies

As part of the evaluation, we have conducted five short country studies. The number of country studies conducted reflects a desire by GAVI to limit the burden of the evaluation on countries,

[125] The survey was sent to 1,735 email addresses. However, to determine the number of individuals it was sent to it is necessary to account for incorrect, obsolete and multiple addresses. We cannot provide a precise number but based on undelivered messages we estimate the number of unique contacts to be around two-thirds of the total. This should be taken as an indicative figure only.

and takes account of the extensive country-based work conducted as part of other GAVI evaluations (e.g. the HSS evaluation and the HSS tracking study).

The aim of the country studies has therefore been to add perspective and additional evidence to the evaluation, rather than to get a representative or statistically significant sample (of all GAVI eligible countries).

Each country study has been conducted with a local expert institution (listed below) and the Country reports produced jointly with CEPA in agreed common format. The country reports are available in Supporting Papers 4.1-4.5.

We have sought to visit a country that have not already been studied in previous GAVI evaluations and provide a range of experience / issues.

Country selection

The countries selected for studies were Bangladesh, Bolivia, Mali, Nigeria, and Uzbekistan. The process for selecting these countries was as follows.

CEPA suggested selection as part of our Proposal. This suggestion was rejected by GAVI on various grounds (including that a number of the countries had already been studies recently). We therefore agreed the following principles for selection

- History and a range of GAVI supported programs and vaccines.
- Mix of geographical locations (AFRO/ AMRO/ SEARO/ EURO), country classifications (poorest, intermediate, least poor), population sizes (10-160 million), and timing of adoption of HepB and Hib vaccines (see Annex A).
- Different levels of DTP3 coverage.
- Countries that have generally not been visited/ studied in the earlier GAVI evaluations to obtain some fresh perspectives (with the exception of Mali, which was a part of the GAVI Phase I evaluation)
- Safety and security.

The five countries where then chosen in consultation with relevant Secretariat colleagues.

Table C.1 below presents GAVI's total approved funding to date and commitments until 2015 in these countries, as well as the profile of GAVI programs funded/ committed. Table C.2 lists some of the specific issues of interest in the selected countries.

Table C.1: GAVI program profile in selected countries ($ m)[126]

Country	Approved total GAVI funding		Committed funding	Funding/commitment by program		
	2000-08	2009-10	2011-15	2000-08	2009-10	2011-15
Bangladesh	55.7 (2.8%)	102.8 (8%)	0 (0.00%)	NVS: 23.1 ISS: 23.3 INS: 9.3	NVS: 87.7 ISS: 1.4 HSS: 13.7	n/a
Bolivia	3.7 (0.2%)	7.7 (1%)	6.4 (0.65%)	NVS: 1.8 ISS: 0.2 HSS: 0.7 INS: 1.0	NVS: 6.1 ISS: 0.25 HSS: 1.4	NVS: 6.1 ISS: 0.32
Mali	29 (1.5%)	27.3 (2%)	37.1 (3.7%)	NVS: 21.3 ISS: 5.5 HSS: 1.4 INS: 0.8	NVS: 23.7 HSS: 0.18 ISS: 3.4	NVS: 37.1
Nigeria	95.3 (4.8%)	41.9 (3%)	24.8 (2.49%)	NVS: 20.7 ISS: 47.4 HSS: 22.1 INS: 5.1	NVS: 11.5 HSS: 21.4 INS: 9.02	NVS: 23.6 HSS: 1.2
Uzbekistan	6.2 (0.3%)	14.72 (1.09%)	0 (0.00%)	NVS: 4.6 ISS: 0.7 INS: 0.9	NVS: 14.72	n/a

Table C.2: Specific issues of interest in the selected countries

Country	Reasons for interest
Bangladesh	• Received a significant proportion of GAVI support, especially in 2009-10 for pentavalent vaccine (earlier for HepB). • Relatively large population size.
Bolivia	• Approved for NVS funding for rotavirus vaccine. • One of the ten pilot countries for CSO funding. • Procurement mechanism outside of UNICEF (through PAHO). • Co-financed rotavirus vaccine significantly more than the GAVI minimum.
Mali	• Francophone country with large size of GAVI grants. • Provided co-financing for vaccines ($0.12m for YF in 2008). • Relatively low DTP3 coverage (66% average coverage over past five years). • NVS support for three vaccines – HepB, pentavalent, and YF. • Studied in the GAVI Phase I evaluation – would be interesting to track progress/ changes since then.

[126] Figures in brackets denote percentage of total approved/committed GAVI funding.

Country	Reasons for interest
Nigeria	• Large country with federal and decentralised structure. • Governance issues, received lot of funding but issues in terms of implementation/ results. • NVS support for YF vaccine.
Uzbekistan	• NVS support for HepB and pentavalent vaccine – jump in HepB coverage from near 0% in 2001 to just below 100% in 2002. • Procurement problems. • Co-financing has been an issue in the country.