Q&A for Ask Me Anything on EVM and cIP

Tuesday, April 15, 2025

This Q&A document compiles all the questions raised during our first "Ask Me Anything" (AMA) session on the Effective Vaccine Management (EVM) assessment and Continuous Improvement Plan (cIP) process. The session brought together experts from WHO, UNICEF, and partner organizations to answer both high-level and technical questions about EVM and cIP, from how to get started, to how the tools can be applied at national and subnational levels. Whether you're planning an assessment, developing a cIP, or supporting implementation, you'll find practical insights throughout.

Recording of the session (in English): https://youtu.be/dLqDMul8XEY

For more information on EVM and cIP, please visit our EVM Hot Topic page: https://www.technet-21.org/en/evm

How can the quality of data collection and entry in EVM 2.0 be ensured, and what data quality assurance measures are used during EVM assessments to ensure accuracy and reliability, such as supervision, audits, or data verification?

High-quality data in EVM assessments is key for a reliable cIP. This is ensured through:

- **Qualified Assessors**: Selection of experienced assessors is essential; lack of cold chain or vaccine management knowledge can compromise data quality.
- **Training**: Assessors are trained to use the tool effectively and spot inconsistencies during fieldwork.
- **Built-in Validation**: EVM 2.0 supports real-time data checks to catch errors during entry.
- **Supervision**: Oversight is important, but assessors should work independently from facility staff to avoid bias.
- **Post-Review**: Data is validated by managers and, in national assessments, reviewed by the global EVM Secretariat.

Together, these steps and tool enhancements ensure more accurate, reliable data than before.

In EVM 1.0, we used hard copies to double-check data if needed. In EVM 2.0, since data is collected online, how can we check it after it has been entered?

In EVM 2.0, data entered via the mobile app can still be reviewed before submission. Assessment managers can edit entries prior to uploading them to the website. After data collection, assessors typically meet to review and validate responses together, using built-in tools to spot outliers or errors. Unlike EVM 1.0, EVM 2.0 allows continuous revisions and re-uploads until the assessment is finalized, enabling more timely and accurate validation.

How can we ensure that the EVM assessment is established as a core requirement for improving the performance of national immunization programs within health policy frameworks?

To embed EVM into health policy, it must be purpose-driven from the outset, with the cIP as the central goal—not an afterthought. Engaging key stakeholders beyond immunization teams—such as Ministries of Health, Finance, and Works—is essential for resource mobilization and cross-sectoral ownership. Countries can also build momentum by linking EVM with existing supply chain initiatives and integrating it into National Immunization Strategies. EVM should be conducted every 3–5 years, with interim targeted assessments. Promoting its use in higher-income countries will further validate its global relevance. Updated cIP guidance is underway to strengthen its alignment with broader health strategies.

How are service points selected during national assessments? Is the sampling random or probability-based? Proportional to the target population? Are the same facilities reassessed in multiple EVM rounds, for example, in Gavi-supported countries?

Service points are selected using a random, probability-based sampling method, proportional to the target population at the lowest distribution level—usually health facilities. While EVM 1.0 used Excel and EVM 2.0 uses an online tool, the sampling methodology remains the same, ensuring statistical validity through defined confidence and precision levels. Facilities are not deliberately reassessed across EVM rounds, though central-level sites may recur due to limited numbers, especially in small countries.

How can stakeholders outside of immunization programs be strategically engaged to provide central support? And how can operational levels (districts, local government areas) be better supported, given that this is where beneficiaries are ultimately served?

Engagement of non-immunization stakeholders should start early, during EVM planning. Key

strategies include formalizing logistics working groups, involving stakeholders in national planning documents, and using strategic moments (like trainings or results-sharing) to build buy-in. The cIP process is a prime opportunity to bring in broader perspectives and align with wider health priorities. At the operational level, targeted assessments allow local actors to conduct their own EVM evaluations and create tailored cIPs, fostering ownership and strengthening subnational capacity.

Does the tool assess or record information about the number and/or type of healthcare workers at each service point?

The tool collects information only about the immunization and vaccine management staff at each service point, specifically those involved in cold chain and vaccine management. Nurses or other healthcare workers not directly involved in immunization are not included. Additionally, the tool includes recommendations that certain tasks should be carried out by at least two staff members, which emphasizes the importance of involving key personnel in immunization processes.

Did the EVM 1.0 assessment record GPS coordinates at the service point level?

In EVM 1.0, GPS coordinates were not recorded because the data collection was done via hard copy forms. However, EVM 2.0, which uses an app for data collection, can record the GPS coordinates of each service point, providing more accurate location tracking.

How can a small community district EVM assessment be conducted, and how can a cIP be developed and monitored at the subnational level? Is there a tool for this?

With proper training, district-level managers can use tools on the EVM website to conduct their own targeted assessments and create localized cIPs. EVM 2.0 is flexible—it can be used for individual health facilities, not just national programs. After developing and implementing a cIP, follow-up assessments can track progress. Tools are available through the EVM platform, with access granted via account request through the website's "My Facilities" space.

What if remote or underrepresented areas are not included in the national EVM cluster? Can additional health centers be assessed, and how would that be reflected in the EVM results and cIP?

Yes, EVM 2.0 allows for targeted assessments alongside the national sample. While the national assessment must follow random, population-based sampling for comparability, targeted assessments can focus on remote, underrepresented, or excluded areas—like specific provinces or the private sector. These assessments don't change the national score but are

included in the final report and cIP, helping tailor improvement efforts and address equity gaps. Countries can conduct as many of these as needed to ensure full representation.

What are the strengths and weaknesses of the EVM 2.0 tool? What do users like most, and what aspects could be improved?

EVM 2.0 is praised for its user-friendly digital interface, practical features, and flexibility. Users appreciate:

- Ease of use with interactive guidance and capacity-building tips
- Photo/document uploads for attaching evidence
- Heat map visuals that clearly highlight weaknesses
- Completion tracking to ensure full data capture
- Offline functionality, ideal for low-connectivity areas
- Targeted assessments for specific provinces or facilities
- Assessment comparison tools for root cause analysis
- Integrated cIP tool that simplifies planning and monitoring

Challenges include:

- Account setup delays, particularly during trainings
- Length of the questionnaire, which some find burdensome
- Lack of standardized reporting templates to support documentation
- cIP ownership gaps when key stakeholders aren't involved early

Despite these, users agree that EVM 2.0 is a robust, evolving tool that remains central to immunization system strengthening.