GAVI Health System Strengthening Support Evaluation

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Burundi Case Study

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Acronyms and Abbreviations

BEmOC	Basic Emergency Obstetric Care
BPS	Provincial Health Office
BSS	Sector Health Office (now Districts health offices)
CCIA	Inter-Agency Coordination Committee (ICC)
CDS	Centre de Santé
CEmOC	Complete Emergency Obstetric Care
CPSD	Partnership Coordination Group for Health and Development(HSCC)
CV	Couverture Vaccinale
DTC-HepB-Hib	Vaccin Antidiphtérique-Antitétanique-anticoqueluque antihépatite B et antihaemophilus influenzae de type b
EPI	Expanded Programme of Immunisation
EPISTAT	Epidemiology and Statistics Unit
GAVI	Global Alliance for Vaccines and Immunisation
GIVS	Global Immunization Vision and Strategy
IEC	Information, Education et Communication
MICS	Multi Indicators Cluster Survey
MOPH	Minister of Public Health
MPDR	Ministry of Development Planning and Reconstruction
MTEF	Medium Term Expenditure Framework
OMS	Organisation Mondiale de la Santé
ONGs	Organisations Non Gouvernementales
PCIME	Integrated Management of Childhood Infection
PEV	Expanded Programme of Immunisation
PMA	Minimum Package of Activities
PNDS	National Health Development Plan
SIS	Health Information System
TMN	Maternel and Neonatal Tetanus
UNICEF	United Nations Fund for Children
USD	United States of America Dollar (Dollar Américain)
VAR	Measles Vaccine
VAT	Tetanus Vaccine
Vit A	Vitamin A
VPO	Oral Polio Vaccine

Summary of key findings, conclusions and recommendations

This summary of the Burundi country case study answers the first two GAVI HSS evaluation questions, namely:

1. What has been the experience at country level with GAVI HSS in terms of each of the following aspects: design, implementation, monitoring, integration (harmonisation and alignment), management and outputs/outcomes;
2. What have been the main strengths and weaknesses of GAVI HSS at the country level, and what are the specific areas that require further improvement?

It also highlights some key issues related to how well the Burundi HSS programme fits with GAVI's principles.

The GAVI HSS proposal design was very much country driven and country led, after the GAVI Secretariat approached Burundi to be one of the HSS pilot countries. The proposal was developed along the lines of Burundi's health sector priorities at the time, especially the national health development plan's objectives to reduce maternal and neonatal mortality and to improve the performance of health services more generally. The design also very explicitly targeted four provinces that had the poorest immunisation and assisted delivery rates, which were not being supported by any other organisation and which had some of the highest population density in the country. The original objectives of the GAVI HSS proposal remain relevant to Burundi today as it prepares for its first SWAp, which places particular emphasis on supporting decentralised structures as a means to improving overall health services and health indicators.

Programme implementation has had some successes, with most first year activities accomplished as planned. Provincial and district teams that we met with were very appreciative of the support they had received for undertaking supervision work and maintaining supplies to health centres so far. They also were very appreciative of having been helped to set up an emergency reference system and having had training in CEmOC and BEmOC; allowing them to respond to obstetric emergencies more effectively. It should be noted that a recent evaluation by UNFPA of the National Reproductive Health Programme training modules in emergency obstetric care identified that some were lacking a number of essential components, which will now be introduced into the national training programme. It is likely that those already trained with GAVI HSS funding will need to undertake a training update.

On the other hand, a number of key first year activities were not fully implemented, especially in training district and health centre staff. No training has taken place for district health office staff in district management skills or in computer and information analysis skills (despite all district offices receiving computer equipment), while very few health centre staff have yet benefited from the planned IMCI training. Much of the reason for this lies with the fact that the programme is heavily reliant on central ministry capacity to do training at decentralised levels and this capacity remains weak. There is capacity at provincial level to undertake IMCI training, and probably health information training if provided with some support, but this will require a significant shift away from the highly centralised management of interventions that currently occurs.

The pace of implementation has been severely hampered by the one year delay in disbursing the second year's financing, so that second year activities will only begin in July 2009 (two months into year 3) at the earliest. This delay has had a significant impact on the start up of performance-based-financing (PBF) in the GAVI HSS provinces, which has become a source of some discouragement for many service providers and other health staff. Beyond the delays to introducing PBF, there are also serious concerns that there are insufficient funds in the GAVI HSS budget to operate a PBF scheme at the levels indicated by good practice. This needs reviewing with consideration given to seeking complementary sources of funding to ensure the scheme is run properly. The delay in funding has also meant that mosquito net distribution has been mediocre to date.

Monitoring of GAVI HSS activities takes place at a number of different levels and with different degrees of integration into general health sector monitoring. Provincial and district levels appear to have fully integrated supervision plans, which include supervision of GAVI HSS activities as part of the routine supervision work. This is not surprising as GAVI HSS is funding interventions that are amongst the MOPH's highest priorities (namely activities to reduce maternal and neonatal mortality and improving the quality of health services more generally). Supervisory activities at decentralised levels have been boosted tremendously by the support provided by GAVI HSS, and in fact most stakeholders indicated that without this funding, they would still be stuck in their offices with no means of getting around to health centres and hospitals on a routine basis. Staff working in provincial and district offices would benefit from more formal training in supportive supervision so that they can maximise their efforts to improve health service quality in their districts. Furthermore, monitoring at decentralised levels would be greatly improved if districts in particular, were given training in preparing their own annual action plans and then on reporting progress against these.

Problems with monitoring were more apparent at central ministry levels. Central ministry monitoring of GAVI HSS activities is not well integrated into routine supervisory visits to decentralised levels, and only one GAVI HSS supervisory visit has occurred from the central level so far during the life of the project. Furthermore, there has been no discussion of GAVI HSS activities as part of the MOPH's annual sector review (Mission Conjointe Gouvernement-Partenaires). Oversight of GAVI HSS activities at central level appears to be focused mainly in a national technical working group set up specifically to monitor GAVI HSS financial management, while the CCIA (Burundi's ICC) reviews and approves annual action plans and annual progress reports. Up to now the CPSD, Burundi's Health Sector Coordinating Committee, has had no oversight function of GAVI HSS activities. Furthermore, key stakeholders, including WHO and UNICEF have found that communication about programme planning and progress has not been satisfactory. They are often presented with already completed documents with little time provided to discuss and adjust these.

The state of play with **harmonisation and alignment** of the GAVI HSS programme with MOPH is related to many of the findings described in the above monitoring section. As mentioned earlier, GAVI HSS interventions are very aligned with national priorities as outlined in the National Health Development Plan (2006 – 2010), and with key government policies of decentralisation and performance based financing. In this sense GAVI HSS support is an essential actor in helping to implement government priorities in the four provinces covered by the programme. However the weak integration of GAVI HSS into central ministry accountability and supervision structures means that there can be little exchange and learning between GAVI HSS and other health system strengthening efforts in the country. Much greater effort will need to be made to ensure that GAVI HSS can both contribute to system strengthening learning during the next two year transition phase and ensure that its activities are included in planning for the next National Health Development Plan (2011 – 2015).

The first disbursement of GAVI HSS funding went into a Ministry of Health account, managed by the Ministry of Finance. This funding was off-budget and managed separately by the GAVI HSS Management Unit. Due to problems with GAVI EPI funds that occurred when the Government consolidated its accounts and 'lost' US$1.3million of GAVI financing, the GAVI Alliance Secretariat has now reached agreement with the Government of Burundi that its funding will pass through, and be administered by, WHO Burundi. This trend is counter to efforts being made at country level to develop better aligned and harmonised financing systems in the health sector, including the development of a health sector MTEF and agreement between some donors to pool funding in a common basket. However it is also

understandable given the events that occurred in 2007. It will be important for the GAVI Alliance to review and reconsider its approach as MOPH systems and procedures evolve and improve over the next few years.

Management of GAVI HSS is provided by a separate GAVI HSS Management Unit within the MOPH. As with the EPI Unit, the GAVI HSS coordinator reports to the Director General of Health in the Ministry. The unit is guided by a detailed Procedures, Accountability and Financial Management Manual and is responsible for all financial and programmatic reporting on GAVI HSS activities. As none of the staff in the management unit are technical health staff, the focus on their activities has so far been on managing the day to day operating aspects of the programme, with a heavy focus on financial management and reporting. The coordinator has been very active in liaising with other ministry departments to assist with technical training and supervision, and has built a particularly good relationship with the National Reproductive Health Programme. He has also ensured regular meetings of the GAVI HSS technical working group, which oversees financial management of the programme in particular.

Almost the entirety of GAVI HSS resources are spent and reported on at central level. All training, capital costs and running costs are funded and managed from the HSS central account, with a tiny proportion of funds transferred to districts (to pay for ambulance driver's top-up payments). This evaluation has found that, while there is a good degree of control over how GAVI HSS resources are spent, using the current system means that there is no transfer of responsibility to decentralised levels, and therefore no means of building capacity, especially in district teams, to plan for and manage their own resources. Also, the division of resources, such as fuel and funds for maintenance, between districts is uniform and does not take into account the very varied circumstances, such as distances travelled or number of health facilities that need to be supervised or road conditions in the district.

District teams currently do not undertake annual activity planning and are not required to report on activities, other than to provide monthly supervision reports along with a record of vehicle use and fuel consumption. If GAVI HSS interventions are to be sustained in the long run, these teams will need to develop the capacity to plan, manage and report on their work. The GAVI HSS programme in Burundi is in a prime position to facilitate this happening in the four districts supported, and indeed needs to make this a priority from now until the end of the programme.

A further issue that needs urgent attention is the implication of the one year delay in implementing 2nd year activities. This issue was brought out particularly in this evaluation's debriefing meeting, where participants suggested that dialogue with the GAVI Alliance Secretariat should begin now as to whether the programme can prolong its lifespan into 2012 (it is currently due to finish in 2011) or whether there needs to be a substantial effort made now to accelerate programme implementation.

It is very difficult at this mid-point in the programme to report meaningfully on **programme results.** Provincial indicators show that there has been a significant improvement in those indicators targeted by GAVI HSS, namely EPI coverage and assisted deliveries. District level results are more patchy (and difficult to access due to how the HMIS software is configured). There is no doubt that the number of assisted deliveries has increased significantly due to more staff being trained in emergency obstetric care and the setting up of the emergency referral system in each district. This is encouraging more women to use their health centres for prenatal and obstetric care. However, estimating the exact contribution that GAVI HSS interventions have made to this increase is confounded by the fact that Burundi made all prenatal and delivery care free in 2006, which has also improved access to health services for women.

Experience of performance-based-financing in other districts of Burundi have indicated that such contracting arrangements have substantially improved immunisation coverage, as health teams are more motivated to seek out children and women who have either not yet been vaccinated or who have dropped out of the programme in order to meet their business plan targets. The GAVI HSS provinces should begin benefiting from PBF by mid-2009, and there should be a similar improvement seen over the next few years.

With regards to **GAVI principles**, the Burundi programme is well aligned with government health policy and strategies as articulated in national five-year planning documents. However, GAVI HSS interventions are poorly harmonised as they are run very much on a project basis, reflecting the primary *modus operandi* of development assistance to health sector in Burundi at present. As the Ministry of Public Health moves towards signing a Compact and setting up a health SWAp, government stakeholders and the GAVI Alliance may need to review how the programme is managed and reported on so that management and reporting are far more harmonised within ministry systems.

GAVI HSS funding is additional, in the sense that interventions are taking place in areas of the country where little other health sector support is provided. However it is not catalytic as the

financing covers the same sort of activities in the four 'GAVI' provinces that are covered in almost all other provinces in the country by other donors. The MOPH and the GAVI Alliance should in future look at how second generation GAVI HSS funds can help to build new systems and structures that will enhance the health sector wide initiatives that are beginning to be put in place.

Conclusions and recommendations

GAVI HSS interventions are highly pertinent and appropriate to improving maternal and child health in Burundi. They are responding to health sector priorities laid out in national planning documents and to needs expressed by health providers and service users. Emergency obstetric care, supervision and supply support activities are all highly appreciated and have helped to improve access to and the quality of care in the four GAVI HSS provinces.

This evaluation recognises that the programme has only been able to implement one year's worth of activities within the two years it has operated so far, due to financial issues beyond its control. Our findings should therefore be seen more as a pointer to where emphasis needs to be placed over the next few years to ensure that programme objectives are achieved. Three main areas need to be focused on:

For the Burundi Ministry of Public Health

1) **Support provincial and district teams to take on greater management responsibility.**
   - **a)** Work with MOPH and the CPSD to make sure that the differential roles and responsibilities of district and provincial teams are clear and well understood;
   - **b)** Support a programme of management and supervision training for provincial and district health teams;
   - **c)** Support district and provincial level annual activity planning and fund according to needs identified in plans;
   - **d)** Increasingly devolve responsibility for managing GAVI HSS resources to the appropriate level (provincial or district), with good monitoring systems in place;
   - **e)** Give greater responsibility for training health centre and district staff to provincial teams where they have the technical capacity to undertake training.

2) **Improve GAVI HSS integration into central ministry programmes and overall accountability**
   - **a)** Ensure that GAVI HSS supervision becomes part of routine MOPH supervisory visits to decentralised levels;

b) Work towards having GAVI HSS and Global Fund HSS activities coordinated by a single technical working group within the CPSD;

c) Clarify the differential roles and responsibilities of the CPSD and the CCIA as regards GAVI HSS in general;

d) Ensure that GAVI HSS programme activities are reviewed and discussed during 'Mission Conjointe' meetings;

e) Improve communications between the HSS management unit and GAVI focal points in country. GAVI focal points need to pay particular attention to improving the clarity of HSS financial reporting.

3) Accelerate performance-based-financing across the four provinces

a) Undertake a detailed costing exercise of how much it will actually cost to operate PBF in the four provinces at the level indicated as 'good practice' (generally accepted to be around US$ 2 -3 per person per district);

b) This costing exercise should include consideration of including district health teams, at the very least, within PBF;

c) Should the cost of implementing quality PBF in the four provinces be higher than the budget provided by GAVI HSS, the HSS management unit should seek out complimentary sources of funding to cover all the costs, or else reduce the number of districts that will be supported with GAVI HSS funding.

For GAVI HSS (in relation to lessons learned for future HSS support)

1. Ensure more in-depth analysis of country systems in place to manage HSS funding. Where operational systems and procedures do not exist or are nascent, provide technical support to countries to help set these up.
2. Retain flexibility about changes that may need to be made as HSS supported activities progress. In the case of Burundi this would include allowing for a scaling back of the number of districts to be covered by all activities, especially performance based financing.
3. Review the HSS funding allocation formula, which appears to disadvantage countries with small populations but very large health system needs.
4. Reconsider the policy of penalising one track of GAVI funding, where it is managed completely separately from other GAVI funds, when another track has demonstrated poor financial management.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Burundi in May-June 2009 as part of the GAVI HSS Evaluation Study. This is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested for HLSP. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 3.

1.2 Brief conceptual framework of the Evaluation

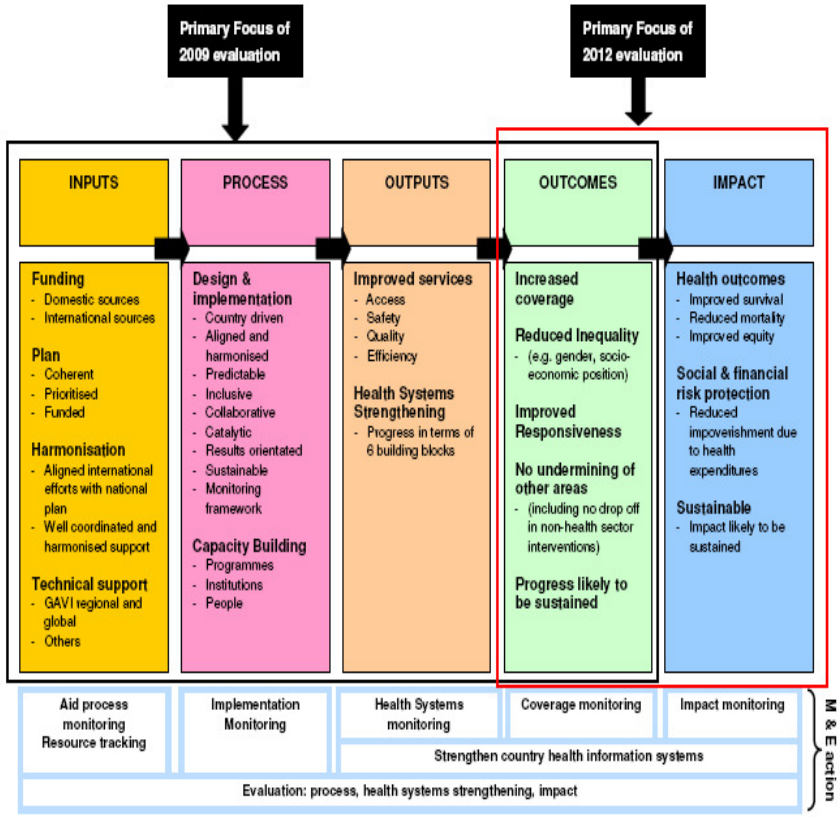
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation –the first one ever conducted on the GAVI HSS component - will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and

national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

1.3 Approach to the Country Case studies

All 11 countries included for in-depth review underwent at least one country visit by the HLSP country lead consultant helped by one or more national consultants or national research institutions depending on the circumstances.[1] In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia) the HSS evaluation team were able to count on the invaluable support and previous work of another study team conducting the so called GAVI HSS Tracking Study in those countries. The Tracking Study - led by the JSI/InDevelop - IPM covers very similar areas (albeit form a different angle) to those aimed at in our HSS Evaluation study, so it was highly synergistic for us to be able to use the Tracking Study guidelines and their extensive network of contacts and country knowledge for the purposes of our own evaluation study. To all members of the Tracking Study team including their country collaborators we wish to express our most sincere thanks and appreciation for their generous collaboration.

In Burundi as in other countries the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called "Focal Points" based at either the World Health Organisation (WHO) or UNICEF. A number of people provided as contacts in Burundi were found to have recently changed post, both in the Ministry of Health as well as in some international organisations. Fortunately we were able to meet with former post holders who had more historical and in-depth knowledge of the GAVI HSS project, as well as some of the new post holders. The programme of interviews and people met can be found in Annex 1.

Once the letters had been sent the Country Lead Consultants began the process of documentation (see list of documents reviewed in Annex 2), they approached potential country researchers to work with them and they began preparing the country visits with country and regional stakeholders. In the case of Burundi the country visit took place between the 25th May and the 5th June 2009. This relatively short visit was sufficient given that both authors of this report had previous work experience in Burundi and were familiar with its national health system, and in the case of the national consultant, very familiar. Meetings were divided between interviews with key stakeholders and informants in Bujumbura and interviews with provincial and district health staff in Gitega, Bururi and Kayanza provinces, since the focus of GAVI HSS funded activities is at these two levels.

[1] The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etcetera.

1.4 Limitations of the Study

While the support afforded by Ministry of Public Health personnel and others was invaluable in ensuring that evaluation team members had good access to information and key informants, the short time scale did mean that we had to take a snapshot of the past and current state of GAVI HSS interventions in Burundi. We were only able to visit two of the four provinces supported by GAVI HSS, though we did have the opportunity to interview the Medical Director for Kayanza who was visiting Bujumbura during the evaluation. We also learned at the beginning of the study that the GAVI HSS management unit had commissioned a mid-term evaluation of GAVI HSS to be done by the National Institute of Public Health (INSP) in April 2009, but the report was still being written while we were conducting our own evaluation. Fortunately the team leader of this other evaluation chaired our de-briefing meeting on our last day and indicated that his team's findings were very similar. The INSP report was shared with the team the week after completion of the country level work, and relevant findings (particularly in terms of data) have been incorporated into this report.

1.5 Acknowledgements

We would like to thank the Ministry of Health in Burundi, in particular Dr. Sosthene Hicuburundi, acting Chef de Cabinet and Mr. Desire Ndikumana, GAVI HSS Management Unit Coordinator for the support received for this evaluation study. Thanks are also expressed to WHO and UNICEF, and to all the staff visited in provincial and district health offices who gave freely of their time and views. The full list of people met for this study is included in Annex 1.

2 Snapshot of the Burundi health system

2.1 Progress towards MDGs

Burundi underwent almost 11 years of fairly brutal civil war, between 1993 and 2004. In 2004 a national consensus was reached on a new constitution for the country, and transition to a civilian regime took place in 2005 through national elections.

The conflict had serious repercussions on people's security, livelihoods and health. During the crisis years, GDP fell almost 3% per year, so that by 2004 per capita incomes had fallen to only $83/year, from $214/year in the early 1990s.[2] This makes Burundi one of the poorest countries in Africa and the world. Given that in 1992 the country's human development ranking was 165th out of 174 countries, the intervening crisis years only exacerbated Burundi's problems further. In 2006, poverty rates in Bururi were found to be about 72%, while Gitega and Kayanza were at

[2] PRSP Burundi 2006

90%. These are three of the four provinces supported by GAVI HSS (Mwayo did not exist as a province at the time of analysis for the PRSP)[3].

Similarly vaccination rates fell from 80% in 1992 to only 55% in 1997 though had increased again to 78% by 2004. Community surveys undertaken to prepare the 2006 PRSP found that public satisfaction with health services generally, and maternal health services in particular, were very low, with levels of satisfaction generally below 50%.[4]

Table 1 Burundi's main social indicators

Indicator	2005 Baseline	2007/08 Targets	MDG/PRSP Target
HDR Index Rank		167[5]	
Total Population		7.9 million[6] (2005)	
GDP per capita		US$ 110[7]	
Public spending on health (% budget)		2%[8]	
Life Expectancy at Birth	n/a	48.5 years	
Maternal Mortality	800/100,000		392/100,000
Infant Mortality	114/1000		65/1000
% Assisted Births	n/a	25%	
<5 use of ITNs	n/a	1%	

During Burundi's conflict, health infrastructure remained reasonably intact, the war meant that health staff were often unable to work in many of the most affected areas, and public services saw a significant decline. The gap left by the public sector was filled by humanitarian aid projects, which supported the provision of health services through using a combination of international emergency medical staff and national staff. Both national and international NGOs are now major service providers for both the health sector and multi-sectoral HIV and AIDS interventions. The country now has a plethora of health projects and initiatives that are not very well coordinated, a multiplicity of salary structures for people offering the same level of services (but whose pay differs depending on who they work for) and a high degree of verticalisation of funding, staffing, supervision, procurement and reporting systems. The health information system remains particularly weak partly because of the multiple, overlapping demands from projects and because of weak capacity to collect data and ensure good data entry at peripheral levels.

[3] Ibid
[4] Ibid
[5] UNDP Human Development Report 2007-2008
[6] Ibid
[7] World Bank (2009) Project Appraisal Document – Health Sector Development Support, 19 May 2009 Draft
[8] Ibid

2.2 The response from the health system

The objectives set by the government in the 2006 - 2010 PRSP are to:

i. reduce the infant mortality rate from 114 deaths per 1,000 live births to 90 in 2010 and 65 in 2015;
ii. reduce the maternal mortality rate from 800 deaths per 100,000 live births to 560 in 2010 and 392 in 2015;
iii. raise the proportion of births assisted by health personnel from 17 percent in 2002 to 35 percent in 2010 and 60 percent in 2015;
iv. increase immunization coverage to 85 percent in 2010 and 90 percent in 2015;
v. reduce the percentage of children with low body weight from 30 percent to under 10 percent in 2010;
vi. reduce the percentage of children with growth retardation from 52.5 percent to 35 percent and low body weight from 39.2 percent to under 26 percent in 2010.

Based on the above targets the National Health Development Plan (PNDS) has four primary objectives[9]:

1. Reduction of maternal and neo-natal mortality ratios
2. Reduction of infant and juvenile mortality
3. Reduction in morbidity data due to communicable and non-communicable diseases
4. Reinforcement of the performance of health services

The Ministry of Public Health has an EPI Unit that is headed by the EPI Director. He reports to the Director General for Public Health, who reports to the Chef de Cabinet. Burundi has benefited from GAVI support since 2001. Before then the EPI programme was primarily supported by UNICEF. Burundi applied for GAVI funding in 2001 for three areas of work: Immunisation system support, injection security and introducing new vaccines. This support led to a significant improvement in immunization coverage between 2001 and 2006, and Burundi was awarded US$ 1.3 million by GAVI to be used for awarding those units that were vaccinating 10% or over more children than targeted. By 2006 national coverage was around 85%, though the national figures masked a large degree of variation between provinces and health districts. National trends in key immunisation rates from 2005 (baseline year for the RSS proposal) and now are as follows:

[9] Plan National de Developpment Sanitaire 2005 Ministry of Health and the fight against HIV and AIDS

Table 2 Key Immunisation Trends in Burundi

Indicators	2005[10]	2006[11]	2007[12]	2008[13]
TRADITIONAL VACCINES				
Vaccinated infants up to 2008 (report attached)/ to be vaccinated in 2008 and beyond with 3rd dose of DTP (DTC3)	94%	92%	99%	101%
NEW VACCINES				
Vaccinated infants up to 2008 (report attached)/ to be vaccinated in 2008 and beyond with 3rd **pentavalent** dose	94%	92%	99%	101%
Loss rate up to 2008 for (*new vaccines*	n/a	25	10	10
SAFETY OF INJECTIONS				
Vaccinated pregnant women/ to be vaccinated with titanic anatoxine	113582	301085	232463	330432
Infants vaccinated BCG	95%	92%	105%	108%
Infants vaccinated measles	89%	92%	103%	99%

Burundi is an IHP+ country and has committed itself to moving towards a health SWAp starting in 2010 or 2011.

The coalition government set up in 2005 is working to overcome the many challenges presented by maintaining peace and by normalising service provision. As in a number of other post-conflict countries, Burundi has been piloting performance based financing (or contracting as it is referred to in Burundi) for health facilities as a means of standardising and improving health provision across the country while enhancing service delivery more generally. Performance-based-financing (PBF) tries to reinforce a 'whole systems' approach to health service delivery, but this approach continues to be seriously constrained by the number of vertical initiatives that have to be responded to from central level. While the government hopes to roll out PBF to the whole country at present different provinces (or even different districts within provinces) can have different performance indicators and different payment schedules.

Health system strengthening is happening almost exclusively on a province by province basis with little input as yet into strengthening central level health systems. Provinces therefore vary in the degree to which they are being supported, and what areas of support they are receiving, as much

[10] GAVI Proposal for Burundi HSS (2006) Ministry of Public Health and Fight against AIDS, Bujumbura
[11] Burundi Annual Progress Report 2007 for GAVI (2008) Ministry of Public Health, Bujumbura
[12] Ibid
[13] Burundi Annual Progress Report 2008 for GAVI (2009 Ministry of Public Health, Bujumbura

depends on each separate funding partner's definition of HSS. The most usual HSS efforts have been focused on rehabilitating and re-equipping infrastructure that was destroyed or damaged during the years of conflict, and some provinces have had performance based contracting for a few years, as this was a key interest of their partners. In most cases, re-equipping, staff training and logistics support has been very much focused on the particular priority area of the individual donor.

A further interesting feature of the Burundi health system is the setting up of health 'districts'. These districts do not correspond to any other administrative structure in Burundi and are based solely on the catchment areas of existing community hospitals (e.g. those below provincial hospital level). Most health district staff used to be based at provincial level and have been moved out to offices in the corresponding hospital; so the setting up of districts has not had a significant impact on provincial staff establishment numbers. However, as districts are not recognised by any legal act or decree they have not been provided with any budget to implement their expected activities, primarily supervision and reporting. Only provinces receiving external support have been able to assure district functioning in any meaningful way.

The Minister has set up a multi-stakeholder committee, the National Health Development Council (CPSD), or equivalent of a Health Sector Coordinating Committee, as a forum to begin creating more standardised systems and policies across the country. Overall the country is still very much in transition, with project aid continuing to dominate as the main aid modality. Once the IHP+ Compact is signed and there is broad agreement on moving towards basket funding, the government hopes that a larger number of donors, including GAVI, will contribute to the health basket.

3 The GAVI HSS proposal – inputs, outputs and progress to date

This section describes the main processes and progress to date as regards GAVI HSS funding in Burundi. These are further analysed in Section 4.

3.1 HSS proposal design

Burundi was 'invited to submit' a GAVI HSS proposal in 2006 as part of the HSS pilot, so the effort was not initiated by the Burundi Government. However the invitation to submit was timely, in that the PNDS had just come out with a focus on HSS. Government actors therefore decided that this was too good an opportunity to miss. The original plan was to use HSS funding to help strengthen EPI systems across the whole country. The Government was informed that they would only be able to apply for US$8 million by GAVI, and so decided to limit the proposal to four provinces. The four provinces were chosen according to two main criteria: They had the worst immunisation

coverage in the country and they were not being assisted by any other partners. No consultants were used for developing the proposal. All key documents were written by Ministry staff, including the Minister himself, and representatives of key partners, such as WHO, UNICEF and NGOs involved in implementing health systems strengthening interventions. Most of the writing occurred during a one week retreat where this was all that the drafting team focused on. Five 'fields' of action were developed in the proposal to support the implementation of the HSS objective of the PNDS:

1. Development of the technical capabilities of health personnel, health committees and community health agents;
2. Rehabilitation and equipment of district CDS and Hospitals;
3. Organization and management of health services;
4. Reinforcement of the key interventions in maternal and children's health;
5. Control, monitoring and evaluation of the activities of the medical districts by the central level;
6. Expertise within the framework of the execution of the RSS actions.

The proposal that was eventually developed built on various approaches that were being piloted in Burundi, notably providing support to district health offices to ensure that they could undertake their supervision and support functions. The four GAVI HSS provinces are made up of a total of 12 health districts. The HSS proposal focused on support for reducing maternal and child mortality by:

- Enhancing district health office supervision and monitoring capacity (to identify bottlenecks for MCH service provision, including EPI and solving these);
- Improving emergency obstetric care skills at health centre and district hospital levels;
- Improving emergency referral services for women in labour;
- Increasing the distribution of insecticide treated nets to more women and children;
- Expanding performance based salary supplements to 'incentivise' all health staff to improve MCH services, including EPI outreach;
- Improving demand-side aspects through training and support for community health workers.

Each of the district offices was to receive two vehicles – one to ensure the delivery of supplies from provincial to health facility levels, and one to ensure regular supervision of health facilities. Each province was also due to receive a supervision vehicle. District and provincial offices were also to be equipped with IT equipment so that they could enter health facility data and analyse it, as well as be able to send it in electronic form to provincial level. The HSS proposal also concentrated on improving maternal health indicators by focusing on increasing capacity to deliver emergency obstetric care (EmOC) at all levels in a province. This support was to include training for doctors in

Complex EmOC, nurses in Basic EmOC and training a few nurses to become anaesthetic technicians. Increasing the supply of trained providers was to be complemented by increasing the demand for assisted deliveries by working through community health workers. Furthermore, GAVI HSS was to set up a radio network across all provinces so that health centres could radio for an ambulance to come and collect women needing more complex care than is available at that level, while the fuel, maintenance and honorarium of ambulances and drivers were also to be covered by the project. Finally GAVI HSS funding was to be used to consolidate performance across the health sector by introducing PBF in districts not yet benefiting from any programme.

Rather than have GAVI HSS funding managed through the EPI programme, a decision was taken to set up a separate GAVI HSS Management Unit that would act as a project management unit within the Ministry of Public Health, reporting to the Director General of Health. The Ministry of Public Health clearly felt that they needed to have a specific unit to take responsibility for managing GAVI HSS interventions. This would ensure a reasonably rapid start-up of the programme as opposed to having this management function integrated into an existing programme, such as EPI. There is a risk that the capacity developed within the GAVI HSS management unit to manage this sort of programme could be lost to the MOPH once GAVI funding ceases.

3.2 HSS application and approval processes

Towards the end of November 2006, the draft proposal was sent to members of the Inter-Agency Coordinating Committee (CCIA) who provided comments and suggestions for changes and additions. The primary criticism of the proposal was that it was trying to cover too much (4 provinces) with a US $ 8.227.000 budget. In particular, some members raised concerns that there would not be sufficient funds to fully implementing performance-based contracting in all 12 districts of the four provinces.

Decision making around the proposal and drafting was primarily top-down. As such there was little time and no resources available for analysing and inputting community generated contributions in the proposal. However, the interventions planned for GAVI HSS funding were developed on the basis of research on the 'state of Burundi's health' in 2004, which had included wider consultation. The following provides a time line of inputs for GAVI HSS proposal development and implementation.

Table 3 Calendar of Events related to GAVI HSS

Activity	Who involved	Date
State of Burundi's Health Study	▪ All the ministries which contribute to the improvement in health ▪ Development partners ▪ The civil society ▪ Research institutions	2004
National Health Sector Policy (2005 – 2015)	Government of Burundi	2005
National Health Development Plan (2006 – 2010)	Ministry of Public Health and fight Against HIV and AIDS	2005
GAVI HSS proposal developed	MoHP, Ministry of Finance, Ministry of PlanningWHO, UNICEF, UNFPA, Cordaid	November 2006
GAVI HSS proposal sent to ICC	ICC members	December 2006
GAVI HSS proposal submitted to GAVI		December 2006
MOPH clarifications to GAVI on proposal	MoPH staff, WHO and UNICEF	January 2007
HSS proposal accepted for funding		February 2007
First tranche of funding sent (US$ 2,755,600)		April 2007
GAVI 2007 APR with HSS section submitted		15 May 2008
Second tranche of funding sent (US$ 2,274,000)		April 2009
GAVI 2008 APR with HSS section submitted		15 May 2009

3.3 HSS start up measures

The first disbursement of US$2,727,000 was made in April 2007. In line with the HSS proposal a separate HSS Management Unit was set up to coordinate all GAVI HSS funded activities. There are six staff, including the coordinator, administrative assistant, management accountant, finance secretary, office assistant and driver. The unit has no technical staff and relies heavily on other MoPH departments for support in the technical areas of the programme.

The start-up of the programme was felt by various stakeholders interviewed to have been handicapped by the lack of guidelines from GAVI about how to begin the programme. All protocols and norms appear to have been developed from zero, though based on current MoPH practice. The GAVI HSS management contracted a local consultancy group to write up a Procedures, Accounting and Finance Manual to help guide internal administrative and accountability procedures. Once the Management Unit was in place and functioning implementation of activities began in late July 2007. As such, the MOPH was only able to use some of the funding received during the 2007 calendar year, and rolled the rest over into 2008 to cover 2007 activities that could not be completed during the year. This proved to have been fortuitous as explained below.

No other disbursement was received after the first US$2,7 million, as Burundi experienced a significant problem with its normal EPI account (US$1,3 million designated for awarding good performing health units 'disappeared' for around 12 months, and was used to help pay for an outstanding government debt to the national petroleum company. This amount has only just been completely paid back in March 2009.) The 2008 disbursement has now been sent and, under a new arrangement, received into WHO Burundi's accounts. The MoPH has to set up a new commercial bank account to receive GAVI HSS funds from WHO. It does seem curious that, even though the government had separated GAVI HSS from GAVI EPI, the GAVI Alliance Secretariat seemed to have 'punished' the HSS component for financial problems experienced by the EPI programme.

WHO will not forward HSS funding to the GAVI HSS account until the RSS Management Unit prepares a new Annual Action Plan for 2009 for using the 2008 disbursement. Reporting and accounting arrangements have also become substantially heavier, as the GAVI HSS coordinator will have to provide a report every three months to WHO of activities achieved, funds spent and funds left in the HSS account. WHO will then have to analyse the report before releasing the next tranche of funding. A further inconvenience for using the WHO system is that WHO charges 15% of the amount sent to their account to cover the costs of administering this

fund.

When the HSS programme was started in the MOPH it was assumed that it would be monitored through routine MOPH processes for monitoring health sector activities at provincial level and below. This includes multi-disciplinary supervisory visits from the Directorate General of Health. The MOPH created an HSS steering group to monitor overall GAVI HSS activities, with membership overlapping quite a bit with the Cadre de Coordination Inter-Agence (CCIA or ICC). The Procedures Manual also makes clear that the CCIA is responsible for approving Annual Progress Reports (as these are combined with the EPI report) but that the CPSD takes responsibility for approving the annual action plan and budget, as per GAVI guidance. In 2007 and 2008 the annual action plans and budgets were not approved by the CPSD but instead by the CCIA. Further analysis of how well current monitoring arrangements are working can be found in Section 4.3 below.

3.4 Annual Progress Reporting (APR) on HSS

In this section we discuss issues linked to the process and quality of APR reporting on HSS and to the relevance and alignment of APR HSS reporting in the context of Burundi's established health reporting and accountability mechanisms.

The HSS section of the APR is written by the GAVI HSS Management Unit coordinator. The findings in the section are based on reports received from provinces, which in turn aggregate the findings from districts' annual reports. The consistency of annual reporting and formats varies greatly below provincial level. For example, in Gitega province, only districts that benefit from performance based funding provide an annual report of activities. In Kayanza province, which has not yet had PBF introduced district level reporting does occur, but not based on any particular format.

In actual fact, most of the information needed to complete the HSS APR is provided from central ministry level, as no HSS funds are dispersed to provincial or district accounts. All fuel, maintenance, training costs and top-ups to ambulance drivers are paid for from the national HSS account. This can be understood as there are limited systems in place yet at decentralised level for implementing and accounting for project funds, and districts in particular have low capacity. However, once health districts become officially recognised[14] and government plans for a programme based approach to the health sector are realised, maintaining current funding and reporting practices will contradict new accountability mechanisms. As such, GAVI HSS will

[14] Funding for district budgets have been included in the government's 2009 budget, but the legislation setting up districts has not yet been passed by the Senate, so the Ministry of Finance will not release funding. It is expected that the necessary legislation will be passed in mid-2009 and some of the budget will be released. Once this has been done the MOPH is also planning management training for district teams, using WHO developed materials (Director General of Health, personal communication)

need to revise its current management strategies, and support provinces and districts to take on the bulk of responsibility for planning, managing resources and reporting. This would help to strengthen decentralised reporting and accountability.

Once the GAVI HSS coordinator has drafted the report, it is sent it to the two focal points in the WHO and UNICEF country offices. On receiving and integrating their comments the report is then sent to the WHO HSS regional focal point in Libreville for further analysis and feedback. Once this feedback is incorporated, the APR is presented to the CCIA for approval before sending to the GAVI secretariat.

This evaluation has found the APRs very difficult to interpret due to the use of different reporting formats in 2007 and 2008, especially for financial reporting, and because 2007 was reported in FBu (with no US$ exchange rate provided) and 2008 reported in US$. There was also no clear indication of the US$ balance brought forward and used for 2008 activities. However, by working through both sets of financial figures for both reports it is possible to make out differential spending against the two years. It is worrying that none of the reviewers felt this to be a problem when scrutinising the financial reports. It is a concern that in-country reviewers, both in government and in WHO and UNICEF did not appear to comment on this problem, though this may be because the annual audit was positive.

3.5 HSS progress to date

During the first year of implementation (2007) the Burundi GAVI HSS programme made good progress on a number of initial activities included in the proposal and in the conceptual framework. These were carried-over with the under-spend from 2007 into 2008. Progress against the indicators of the conceptual framework can be found in Table 4.

Table 4: Progress against GAVI HSS Indicators

Indicator	Baseline[15] 2005	2007[16]	2008[17]	Target 2011
Outcome Indicators				
DPT 3 coverage	83%	99%	101%	98%
Pentavalent Coverage	94%	99%	101%	98%
Number of health provinces achieving at least 80% pentavalent coverage	14 /17	17 / 17	17 / 17	17 / 17
% mosquito net coverage of children < 5:	15%	32%		
% routine measles coverage	78%	102%	99%	90%
Deaths from measles	0	0	0	0
Output Indicators				
Number of health districts support by GAVI-HSS with a maternal referral system available and a functional counter reference	1 / 12	12 / 12	12 /12	12 / 12
Number of doctors trained in CEmOC[18]	0	54%		100%
Number of nurses trained in anaesthesia	0	36%		100%
Number of nurses trained in BEmOC	0	19%		100%
% of district care structures having been supervised per month	0	91%		100%
Number of MCH Awareness weeks supported		100%		100%
% of facilities with integrated PCIME approach	0	26%		100%
% of facilities using performance based contracting to motivate staff	0	0%		100%
% of medical districts possessing a correct, completed and protected database	0	0%		100%

Stakeholders at provincial and district levels, as well as health centre staff that we met, were almost unanimous in what they felt had been the most positive aspects of GAVI HSS support so far. The main aspects that they have been most happy with have included:

- The setting up of, and continued support for, an obstetric emergency referral system. The radio network and ambulances, combined with training doctors and nurses working at district hospitals and below are seen to have contributed significantly to improvements in maternal health care and outcomes;
- The provision of vehicles for supervision and supply at district level, which has meant that

[15] GAVI HSS Proposal 2007 – 2011, Ministry of Public Health and fight against HIV&AIDS, 2006
[16] GAVI Annual Progress Report 2007, Ministry of Public Health, Bujumbura, 2008
[17] GAVI Annual Progress Report 2008, Ministry of Public Health, Bujumbura, 2009
[18] The rest of the data from here below comes from the combined activities in 2007 and 2008, which were completed using GAVI HSS year 1 funding.

district teams can actually do their supervisory work. This has been particularly important as the government has not yet provided any running costs to health districts and only pays salaries of staff. The government should begin supporting district running costs during 2009 (see footnote 14);

- The provision of computers so that data entry and reporting for the HMIS is much easier, and can be done at district level rather than at provincial level. There was great variation between the districts visited as to how well they were managing data input and analysis. Provincial level offices were found to be using and aggregating district inputted data, though data quality remains somewhat suspect.

The primary barrier to progressing against many of the GAVI HSS indicators was the hiatus in funding in 2008. 2008 output targets have not been achieved at all, representing a significant obstacle to achieving GAVI HSS's end of programme targets in 2011.

Other problems cited by a number of stakeholders have included:

- Weak capacity and capability at central level to support IMCI training for districts and health centres;
- Weak capacity to use information technology especially at district level, and poor central capacity to support district training in information systems;
- Lack of a standard format for action planning and annual reporting at provincial and district level. In districts where PBF has been set up by another organisation, there are standard formats to use, but these have not been introduced across all districts. WHO has recently produced guidelines for district health management that includes reporting formats, supervision guidelines and other useful tools that GAVI HSS provinces should be able to utilise when these are formally introduced;
- The 'one size fits all' approach to the allocation of fuel and maintenance to districts. There are significant differences in the number of health facilities each district covers, its geographical size, and the condition of the roads. Supervisors in Rumonge District in Bururi Province, for example, have to travel around 80 kms one way to reach their furthest health facility on extremely rough roads, compared to Matana and Rutovu Districts, which are considerably smaller. Those districts with the most distance to cover complain that their quarterly fuel allocation is quickly used up;
- Only partial coverage of the full costs of running the GAVI supplied vehicles, and minimal coverage of ambulance maintenance were included in the proposal. Road conditions in Burundi are very hard on vehicles and they often require minor repairs, and sometimes have major maintenance costs. Many stakeholders particularly cited the need to buy new tires for district and provincial ambulances. As these were not bought with GAVI HSS

funds (but rather by the Ministry just before GAVI HSS began) the responsibility for full maintenance of these vehicles has not been accepted by the GAVI HSS management unit.

The evaluation team also learned that district teams have had almost no involvement in annual planning exercises. In January 2009 the District Chief Medical Officers were invited to participate in the national health action planning exercise for FY 2009/10 for the first time. This took place at the provincial level. They play no part in GAVI HSS annual action planning (nor do provincial health offices) despite the fact that the Procedures Manual (Section 3.3.1.3) outlines a highly structured approach to annual planning, which includes a 'preparatory meeting' with all representatives of the Management Unit, the provincial offices and the district offices. Up to now there has been no input from any level below the Management Unit into the annual action plan, nor any input by other implementing partners, which explains to some extent the 'one size fits all' approach to programme implementation.

3.6 End of HSS Assessment

As can be seen from Table 4 on progress against national EPI indicators, which show quite high coverage at national level, it will be difficult to assess GAVI HSS achievements solely in terms of immunisation rates. The GAVI HSS 2012 evaluation should make a detailed breakdown of immunisation coverage at district and health facility levels to give a more nuanced picture than is provided by national or even provincial data. Many district medical officers indicated that there are still differences or discrepancies in performance between health facilities that they find hard to explain. One medical director suggested that it might be a problem with the denominator being used.

In light of the above, the 2012 evaluation of HSS funding should look at:

- Comparative district immunisation rates and assisted birth rates;
- Comparative district maternal and neonatal survival rates;
- Comparative health facility immunisation rates and assisted birth rates;
- Survey of changes in perceptions of communities about the health facilities in general and maternity services in particular in districts covered by GAVI HSS;
- The community survey or accompanying focus groups should also test the hypothesis offered by health staff that improvements in prenatal and maternity care encourage mothers to continue bringing their children for post-birth services, like vaccination;
- Have districts taken on annual planning and reporting responsibilities using agreed national templates?

In terms of second generation GAVI HSS support, the GAVI Alliance, together with the government of Burundi, should consider how GAVI HSS funding can better support both 'upstream' health systems work (e.g. central level reforms and management) alongside support to decentralisation efforts. Due consideration will also need to be given to how to better integrate HSS management within the MOPH, whether within the DG Health or the Planning Unit, rather than having a separate PMU. Also, a view will need to be taken as to whether MOPH systems are robust enough, as a result of IHP+ processes, to harmonise and align more thoroughly both financial management and reporting.

3.7 Support systems for GAVI HSS

No specific technical support was received for proposal development apart from the inputs provided by the three UN agencies and international NGOs in country. Some MOPH staff did benefit from a GAVI workshop in Cameroon on how to develop the HSS proposal, which those attending did say was very helpful. As Burundi was a pilot country, GAVI had not yet made available the US$50,000 for proposal development.

Technical support for implementation has consisted of the following:

- Emergency obstetrical care training – done by the National Reproductive Health Programme (paid for by GAVI RSS funds);
- Review and analysis of action plans and APRs – done by the GAVI HSS steering committee;
- Review and commentary on action plans and APRs – done by GAVI HSS regional support persons.

The GAVI HSS staff in Bujumbura feel they get very good support from WHO and UNICEF, from the regional HSS support persons and from the GAVI HSS francophone programme officer in Geneva. The WHO focal point is WHO Burundi's HSS specialist who is actively engaged with preparations for the health SWAp and IHP Compact, as well as supporting GAVI HSS. Regional and global level officials have never visited the programme in Burundi but they are, by all accounts, very responsive to questions and provide constructive feedback.

IRC comments on the proposal and on APRs were mixed in terms of their relevance to the Burundi situation. One of the critical comments made in the Letter of Clarifications referred to the need for the 'HSCC or its equivalent be involved in this process, both in its technical support function and in confirming its support for the proposal, in response and reply to the above clarifications' and yet this does not appear to have been followed up, in particular when the 2007 APR was signed

off by the ICC only. This raises some questions about the degree to which a fairly remote body can undertake an adequate appraisal of proposals or judge progress reviews. A more coherent review strategy could be for GAVI to make use of and/or take part in Burundi's health sector appraisal and reviews, and to dedicate some financing to support these in Burundi.

4 Alignment of HSS with GAVI principles

This section will attempt to analyse the extent to which the Burundi HSS grant adapts to the following GAVI principles, some of which have been slightly modified to accommodate specific questions being asked in this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?
- Equity oriented

4.1 Country Driven

The development of the GAVI HSS proposal was very much country led, even though the original impetus for submitting an HSS proposal to GAVI came from the invitation to be a pilot country. However, it is very much the case that the MoPH engaged very quickly with the idea as it fit directly with the health priorities identified in their health sector plan. Once a few staff had received training in how to develop a GAVI HSS proposal, the entire drafting process was done by MOPH staff and in-country partners. This was the same for responding to the GAVI IRC clarifications.

All technical support for implementing GAVI HSS activities also remains country led and country based. The HSS programme has, to date, stuck with using MOPH technical departments to provide ongoing training and support, though they recognise there are still some significant problems with the capacity of some departments to respond to requests for assistance. Due to the lack of responsiveness, some provinces (notably Kayanza) have asked for assistance in IMCI and HMIS training from other partners working in the province. The HSS Management Unit should consider other ways of ensuring that training that has been budgeted for, can be delivered by seeking alternative partners outside the MOPH, if necessary.

The other significant concern expressed by country stakeholders, particularly in the central

ministry, is that the US$8 million budget ceiling was woefully inadequate for the needs that the HSS programme is trying to address. The former EPI director, who played an important role in the proposal development, stressed several times during our interview that Burundi had been keen to submit a proposal that would allow HSS activities to cover the whole country. However, when presented with a budget ceiling, the ministry decided to target assistance to four provinces.

4.2 Is GAVI HSS aligned?

4.2.1. Alignment with National Plans and Systems

The GAVI HSS proposal was completely aligned with the National Health Sector Plan and priorities outlined in the National Health Policy. As noted above, the fourth objective of the PNDS is "to reinforce the performance of the health services"[19], while the PRSP also highlights the need to strengthen health services and structures as an aid to economic and social development.

The interventions funded by GAVI HSS are also within the scope and capacity of most of the health system to support HSS related activities. Almost all inputs are provided 'in kind', such as vehicles, fuel and maintenance costs for supervision and supply provision; and radio equipment and solar energy installations. Training for emergency obstetric care is done by the National Reproductive Health Programme training team, which receives direct funding from the central GAVI RSS management unit. This training has proceeded mostly as intended, following the 2007 action plan and is well received. Other training, in HMIS and in IMCI, to be done by the MoPH's health information team (EPISTAT) and National Programme for Childhood Diseases (PCIME) has not been carried out as planned, despite funding being available, due to poor capacity within these departments and different perceptions within these teams on how to provide the support needed.

There is, if anything, too much reliance on central level departments and staff, which would appear to be hampering programme implementation. A number of people mentioned that there are staff at provincial level capable of doing the training needed in districts and health centres, and that GAVI HSS funding should be directed to supporting provincial staff to do training instead. In Kayanza province the medical director has taken matters into his own hands and asked for training support from an NGO working in the province. If provinces were given more responsibility for ensuring training they could then decide how best to deploy human and funding resources they have available for training, and where expertise is lacking, could call on

[19] Plan National de Developpement Sanitaire (2005) Ministryof Public Health and the fight against AIDS, Bujumbura

the central level to provide additional support. In this way, GAVI HSS funding could lead the way in giving more responsibility to decentralised levels as Burundi moves towards greater decentralisation overall.

4.2.2 Alignment with budget and reporting cycles

The GAVI HSS reporting and budgeting year (January – December) is quite different from the annual national planning, budgeting and reporting cycle (May – April). The GAVI HSS management team find it fairly complicated to align data and information on inputs and outputs from these two different fiscal years. The fiscal year difference does not impact on any other MoPH staff, as it is the responsibility of the HSS management unit to adjust the routine reports to the GAVI reporting year.

Reports are generated from data that is already routinely collected by the MoPH, or by reports of specific activities that the GAVI HSS management team have requested ministry departments to produce, or from the GAVI HSS team's own procurement and supply activities.

4.3 Is GAVI HSS Harmonised?

Burundi is only now developing a health SWAp in preparation for signing an IHP Compact. The country already has a national health policy and multi-year plan, has put in place a health sector MTEF and a results framework. The MoPH is now working on a detailed action plan as the last step towards signing the Compact.

As these initiatives are not yet in place, GAVI HSS support has not had any particular national framework to harmonise with, except for the PNDS. On the other hand, many stakeholders felt that GAVI HSS activities could be much better integrated overall into the work of the MOPH in terms of coordination and supervision.

As far as coordination is concerned, the Procedures Manual, written in 2007, had already assigned responsibility for reviewing and approving annual action plans to the CPSD but its members have, to date, not discussed or reviewed anything to do with GAVI HSS. Our interview with the CPSD co-chair indicated a complete lack of knowledge of what GAVI HSS was doing and where the programme fits in the larger scheme of things. There is an urgent need for the GAVI HSS unit to comply with its own agreed procedures and ensure there is much better communication with the CPSD more generally, especially as the MOPH is about to put in place a two year transition programme that is built around strengthening decentralisation more generally.

GAVI HSS technical supervision from central level is supposed to be done by a multi-disciplinary group representing different MOPH departments. As far as we could tell, only one such supervisory mission has occurred to date, in the first trimester of 2009. However this supervisory visit was set up only to review GAVI HSS activities in the four provinces, rather than integrating a review of GAVI HSS activities into an overall health sector supervisory visit. This seems very much a missed opportunity for developing better integrated supervision. Fortunately, the same approach is not seen at provincial or district levels, where GAVI HSS funding is used to support more general health supervisory visits.

The GAVI HSS Management Unit has also been in discussion with Health Net TPO and Cordaid, both significant actors in setting up and supporting performance-based-contracting, to ensure that GAVI support activities are harmonised with those of other partners working in the four provinces. The CPSD has also begun working on harmonising performance-based-contracting for all of Burundi so that all partners conform to a national framework, but this is unlikely to be agreed before 2010. Until then, new PBC partners are asked to harmonise locally and be ready to change when the new framework is introduced.

As noted above, GAVI HSS funding is not on-budget and not harmonised with other financial management systems. In fact, progress on harmonisation has been hampered due to GAVI Alliance concerns over mishandling of EPI funds by the Ministry of Finance. Funds are now being channelled through WHO and into a separate GAVI HSS account at a commercial bank.

While the set up of the separate management structure, and now separate bank accounts, can be understood within the Burundi context, this does mean GAVI remains a project. The current ways of working will need to be reviewed should GAVI HSS funding continue beyond 2011 as by then the Ministry will have put in place or matured a number of systems and mechanisms to ensure better accountability, reporting and management overall.

4.4 Is GAVI HSS funding predictable?

The first year of funding was disbursed according to plan. The problems with funding in year two have been described elsewhere as have the changes in funding arrangements due to the problems experienced by the EPI programme in 2007. The one issue to flag here is that predictability of GAVI HSS funding has been seriously impacted by the decision to withhold year 2 HSS disbursement, and to change the whole funding mechanism, on the basis of problems that had nothing to do with GAVI HSS management in Burundi. Further thought needs to be

given by the GAVI secretariat on how to respect the principle of predictability for components that appear to be performing well, even if other areas of GAVI funding are not working as well.

The current funding agreement is due to last until 2012, as Burundi was accorded a five year agreement from 2007 – 2012. The current PNDS runs from 2006 to 2010, and preparations are beginning to develop the next five year health plan, in line with agreements to be made through the Compact and ongoing harmonisation work. The draft results framework indicates that Burundi's priorities for the health sector remain largely unchanged, with more effort being needed to consolidate progress so far, including in strengthening health systems. As there is a good level of dialogue between the GAVI HSS Management Unit, MOPH directors, the GAVI HSS Steering committee and the GAVI Alliance Secretariat, the GAVI HSS coordinator is confident that any adjustment in government priorities can be catered for in subsequent years of funding.

4.5 Is GAVI HSS accountable, inclusive and collaborative?

Financial accountability mechanisms appear to be relatively strong for GAVI HSS. Having a specific unit set up to manage and account for GAVI HSS activities has been useful for this. This unit benefits from having an Administration, Accounting and Financial Procedures Manual which provides guidance on administrative and financial management procedures. There are regular meetings of the GAVI HSS steering group (Comité Technique National), which ensures accountability within the Ministry. The HSS steering group is comprised of the Chef de Cabinet MOPH, Director of National Public Health Institute, Director of Health Services and Programmes, Director of National Blood Transfusion Center, Director of National Programme of Reproductive Health, EPI Director, Director of Health and Equipment Infrastructure, Director of Human Resources, EPISTAT head, IMCI focal point, Planning unit representative, WHO, UNICEF and UNFPA.[20] However, both WHO and UNICEF focal points felt that communication on GAVI HSS activities remains very weak and they often have little time to provide technical input into how to improve the programme overall.[21]

We did find some confusion about who approves annual action plans and annual progress reports. In theory the CPSD is supposed to act as the GAVI HSS steering committee, with responsibility to approve GAVI RSS annual action plans[22]. In practice no discussion of GAVI

[20] Manuel de Procédures Administratives, Comptables et Financières, GAVI RSS, BIFE Bujumbra December 2007
[21] One example of how weak we found communication to be is that neither focal points in WHO or UNICEF had any knowledge of the Public Health Institute's mid-term review that had just been carried out, and only learned from us that the study had been done.
[22] Ibid

HSS has ever occurred in the CPSD and the co-chair of the committee expressed complete ignorance of any aspect of the programme.[23] The GAVI HSS coordinator has said that he expects that the 2009 action plan will go to the CPSD for approval, but up to now action plans have been approved by the CCIA, which also reviews and approves the GAVI Annual Progress Reports. Given the problems in communication and confusion as to where ultimate decision making authority lies there are risks that governance arrangements are not as strong as they need to be.

Despite these problems, there is evidence that the GAVI HSS management unit does make some effort at being both inclusive and collaborative at the national level. For example, there is a good collaborative relationship with implementing partners in the areas of PBF and obstetric training.

Where inclusiveness has not yet been fostered is at district level and below. This is because districts are not yet facilitated to provide action plans that correspond to needs they have identified in the course of their work, but are rather passive recipients of the programme assistance provided. To be truly inclusive, the HSS programme will need to support districts to do their own needs analysis and to plan accordingly, so that the national annual action plan has at least some elements of being demand driven. Some aspects of this may begin happening when PBF is introduced in districts and health facilities and they then have to prepare business plans on a regular basis.

The GAVI HSS management unit has been audited twice in May 2008 and April 2009 and audit reports were positive.

4.6 Does GAVI HSS have a catalytic effect?

At present it would be difficult to judge whether GAVI HSS has a catalytic effect in Burundi, due primarily to the fact that its work is only visible at provincial level and below, and the fact that the funding ceiling is so limited. It is fairer to say that GAVI HSS works hard to build on initiatives and experiences of other organisations, and to fit into the general direction of national policy and strategy on HSS.

This is not to say that there is no potential for HSS funding to be catalytic in future. GAVI support to district teams and to MCH services may provide a model for how other districts should develop in future. Also, the GAVI HSS focus on funding a package of activities that aims to reduce

[23] Personal communication, Emeline Saunier, DFID and co-chair CPSD

maternal, neonatal and child mortality could provide a model for how to combine health system strengthening support with clear operational health objectives. In order to do this, the outputs and results of the GAVI HSS work will need to continue to have a good 'airing' in MOPH review and coordination meetings and be linked to stronger, decentralised planning and management support. It is also difficult to see the degree to which GAVI HSS funding can be catalytic given the limits on the budget. There is an unfortunate bias towards high population / high birth rate countries in the GAVI HSS resource allocation formula that appears to work to the detriment of less populated countries that have high needs. Section 4.10 on additionality shows how limited the GAVI HSS inputs are compared to other funding organisations employing the same strategies.

4.7 Is GAVI HSS Results Oriented

The GAVI HSS proposal uses a results-based framework, against which progress is reported in the APRs. However, most indicators are output rather than outcome oriented, with assumptions made about the link between output and outcome. The main indicators being used are provided in Section 3.5 above. Many of the results indicators are measured only every five years, during Demographic and Health Survey or UNICEF's MICS. It is therefore not very clear whether performance plays a part or will play a part in guiding funding decisions by GAVI. The fact that the GAVI HSS results framework is known only to the PMU and a few others, and the fact that GAVI HSS progress is not discussed during sector review meetings, means that there is no means of wider national assessment of whether the HSS grant is really targeting barriers, whether these can be overcome, and in what circumstances, etcetera.

At present it is very difficult to have access to good district level data for monitoring GAVI HSS indicators at that level. EPISTAT does not appear to allow for district level analysis (at least at provincial level) so that any attempt to get district disaggregated data has to be done manually. Since the project was set up to support the worst performing provinces in the country, which also necessarily include some of the worst performing districts, it is very important that efforts are made to track district progress over the next few years. The MOPH will need to see how to incorporate district level analysis and synthesis into its EPISTAT software to help facilitate this, while district staff will need significant support in improving their computer and data analysis skills so that they can track their own progress.

4.8 GAVI HSS sustainability issues

Financial sustainability of GAVI HSS activities is not feasible in the medium term given the very weak state of Burundi's overall finances, and in particular the amount of government funding

committed to the health sector (< 4%). This is a very aid dependent country, where foreign aid plays a particularly dominant role in financing the health sector. Despite this rather bleak picture, there appear to be positive moves towards improving financial sustainability through the development of a health sector MTEF, the IHP+ Compact and other related initiatives. Burundi's development partners are looking to increase their health inputs, with some putting their funding into a common basket to support national priorities like decentralisation. The new World Bank Health Sector Development Support Project (HSDSP) has been set up to strengthen many of the central level systems that will be critical for giving other donors the confidence to increase their support for health sector more generally. The HSDSP economic appraisal suggests a positive outlook for health financing as the move towards the Compact, a SWAp and other systems strengthening initiatives gathers speed.[24]

GAVI HSS has an important role to play in ensuring programmatic sustainability by supporting the capacity building of decentralised structures. The current practice of not allowing provinces and districts to manage any GAVI HSS funds is not helpful for enhancing their capacity to manage and be accountable. In line with the MOPH transition plan, and GAVI HSS's own proposal, much more effort now needs to go into training district and provincial staff in general management skills, and then giving them increasing responsibility for managing GAVI HSS funds. There are risks involved in doing this, but if the current, highly centralised, management arrangements persist, then there is less likelihood that district staff will have the capacity to sustain any activities that they have responsibility for managing.

[24] World Bank (2009) Project Appraisal Document, Health Sector Development Support Project, Republic of Burundi

4.9 Does HSS funding help improved equity

It is too early to state to what degree HSS funding may actually be improving equity. What we can say is that the underlying principles used to determine the GAVI HSS interventions and target provinces should mean that the programme will help to move what were underperforming provinces as far as immunisation coverage and assisted deliveries, closer to the national average. As the programme has only had one year of funding so far, which has been spread to try and continue two years of activities, the full impact of what GAVI HSS interventions could achieve has not yet been felt. The INSP mid-term evaluation found that while the four provinces have all seen improvements in various indicators, including the GAVI HSS indicators, there are a number of districts that remain well below the national average, so that there is clearly much more work to be done.

4.10 Other issues

4.10.1 Additionality

The following table summarises the inputs of different funding partners to health systems strengthening initiatives in Burundi. These initiatives are mostly implemented at provincial and district levels, and include performance based financing, clinical training, district management training, HMIS support and infrastructure development.

Funding Partner	Amount	Period Covered	Average $/ year	Geographical Area
GAVI HSS	US$ 8 227 600	07/07 – 05/11	US$ 2,056,900	Four Provinces
Projet Sante Plus	US$ 11,000,000	04/08 – 12/10	US$ 6,286,000	Four Provinces
DFID	US$ 12,000,000	08 – 09	US$ 6,000,000	National
Cordaid	€ 6,163,649.16	2009 - 2010	€ 3,081,824.58	Seven Provinces
HealthNet - TPO	US$ 1,000,000	09-10	US$ 500,000	Two districts in Gitega province
World Bank	US$25,000,000	09/09 – 12/13	US$ 8,250,000	Four Provinces + National
Swiss Cooperation	US$ 6,000,000	07 – 09	US$ 2,000,000	One Province
Belgian Cooperation	US$ 14,000,000	Three years	US$ 4,600,000	One district + Ministry
WHO	US$ 1,700,000	One Year	US$ 1,700,000	National
Global Fund	US$ 24,321,268	Five years (2009-2013)	US$ 4,864,254	National

The table indicates that, on an annual basis, GAVI HSS funding represents approximately 6% of the total support for HSS activities in Burundi in 2009. More tellingly, GAVI HSS annual support in relation to the number of provinces it is covering is low in comparison to all other donors. So while

those interviewed indicated that GAVI HSS funding is certainly additional, in that the funding supports provinces that would otherwise have struggled to find a 'sponsoring' donor, the GAVI Alliance and the Government of Burundi are challenged to demonstrate how sufficient the funds are to cover needs adequately.

4.10.2 The Counterfactual

All stakeholders indicated that, had GAVI HSS funding not been available, then the four provinces would not have been able to move as quickly as they have to set up maternity referral systems and to have district supervision systems working as well as they are. In this sense, GAVI HSS in Burundi is a good, solid project that is making a difference while the money lasts. This was almost certainly seen as a high priority for the government in 2006 when developing the application for GAVI HSS, as politically and morally the new government needed to show that it could improve health services in neglected provinces.

The challenge now is to build on the operational experience, and good will developing amongst different teams, to see how GAVI HSS funds can help to catalyse more effective decentralisation based on the experience of reinforcing the capacity of district teams in the four 'GAVI' provinces. The HSS coordinator will also need to work more closely with, and be more integrated into, the health sector systems that are being developed at present.

Annex 1 Programme of Work and List of People met

When	Who Met	Institution
Monday 25 May		
10 am arrival		
14:00	Dr. Alain Desire Karibwami, co-evaluator	
16:00	Desire Ndukimana, Coordinator	GAVI HSS Management Unit, MoPH
Tuesday 26 May		
9am	Sosthene Hicuburundi	Acting Chef de Cabinet, Planning Advisor, MoPH
11 am	Dr. Jean-Francois Busogoro	
3 pm	Dr. Donatien Ntakarutimana	Medical officer, Health NET-TPO
5 pm	Dr. Hilaire Ninteretse	Health Coordinator, USAID Burundi
		Former EPI Director, MoPH (now Director of Health Programmes and services)
Wednesday 27 May		
8 am	Desire Ndukimana, Coordinator	GAVI HSS Management Unit, MoPH
2 pm	Dr. Ciza Alphonse, Focal Point	WHO Burundi
4 pm	Dr. Michel Bossyit, Director	Cordaid Burundi
Thursday 28 May		
12 pm	Dr Ciza Denis Oscar, Medical Chef de Gitega	Gitega, Provincial Health Office
2 pm	M. Jean-Berchmans Bahumba	Principal Supervisor, Gitega Health District
	Dr Elysée Nahimana	District Medical Officer, Gitega Health District
Friday 29 May		
9 am	Meeting of all health centre and hospital heads and district medical officers (see attached list)	Gitega Province
Saturday 30 May	Report Writing and	
12 pm	Dr. Eric Manirakiza, Medical Chef of Kayanza	Kayanza Provincial Health Office
Sunday 31 May	Report writing	
Monday 1 June		
8 am	Dr. George Nsengiyumva, Regisseur	Projet Sante' Plus (EC funded RSS project)
		DFID Burundi
11:30 am	Ms Emeline Saunier, Service Delivery Coordinator	
3 pm	Desire Ndukimana, Coordinator	GAVI HSS Management Unit

4 pm 5 pm	Dr. George Gahungu, Director Serge Nkurikiye, Coordinator	National Reproductive Health Programme EPISTAT (HMIS Unit)
Tuesday 2 June Am Pm	Dr. Anglebert Nicimpaye, Medicin Chef Gloriose Nahimana, Principal Supervisor Cyprien Ndayizamba, Supervisor Samuel Sindayihebura, Supervisor Nestor Ndayajemwo, Manager Dr. Theoneste Nimpagaritse, Medicin Chef Olivella Ndayubaha, Supervisor Léopold Ndayizeye, Supervisor Bernadette Ciza, Supervisor Séraphine Niyonsaba, Accounts Assistant Novat Mbonigaruye, HMIS	Rumonge Health District Bururi Health District
Wednesday 3 June 9 am 11:30 am Afternoon	Mr. Gerard Wakanyoni, Gestionnaire Dr. Onesime Nambazimana, Medicin Chef Ms Modeste Ngendakuriyo Principal Supervisor Report Writing	Bururi Provincial Health Office Matana Health District
Thursday 4 June 10 am 17:30	Dr. Celestin Traore, Health Programme Coordinator Dr. Deo Manirakiza, Maternal and Child Health Officer Report Writing and Preparation for Debriefing Pamphile Kantabaze, Human Development Coordinator	UNICEF World Bank
5 June 8 am 9 am	Dr. Norbert Birintanya, Director General of Health **Debriefing Meeting** Dr. Olivier Basenya Mr. Desire Ndikumana Dr. Deo Manirakiza Dr. Alphonse Ciza Dr. Jean-Francois Busogoro Dr. Donatien Ntakarutimana	Ministry of Public Health Principal Planning Advisor, MOPH Coordinator, GAVI HSS Management Unit UNICEF WHO Health Net –TPO USAID

6 June	Report Writing and Departure for Nairobi	

Gitega Meeting Participants

N°	Name	Health facilty	Fonction
1.	Aurelie Nkurunziza	Health facilty of Murenda	Responsible
2.	Bernard Akaboti	Health facilty of Maramvya	Responsible
3.	Evariste Ntakarutimana	Health facilty of Mubuga	Responsible
4.	Gaspard Nahimana	Health facilty of Nyabiraba	Responsible
5.	Frédérique Nzorijana	Health facilty of Nyangwa	Responsible
6.	Yvonne Mutasi	Health facilty of Buhoro	Responsible
7.	Sr Xavera Uzamushaka	Health facilty of Murayi	Responsible
8.	Dr. Salvator Toyi	Health facilty of Mushasha	Responsible
9.	Fr. Albin Ruberintwari	ODAG	Coordinator
10.	Longin Mbikemunda	Health facilty of Gasunu	Responsible
11.	Alfred Harerimana	Health facilty of Buhinda	Responsible
12.	Jean Bosco Niyondiko	Health facilty of Mahwa	Responsible
13.	Lydie Bimenyimana	Health facilty of Rutoki	Responsible
14.	Rosalie Miburo	Health facilty of Gishubi	Responsible
15.	Annonciate Nyandwi	Health facilty of Mugera	Responsible
16.	Jean Marie Nzeyimana	Health facilty of Rwisabi	Responsible
17.	Spès Nzeyimana	Health facilty of Bukinga	Responsible
18.	Euphrasie Kabura	District of Kibuye	Supervisor
19.	Mélance Havyarimana	District of Kibuye	Supervisor
20.	Népomuscène Niyonkuru	Health facilty of Ryansoro	Responsible
21.	Jean Claude Buzohera	Gitega Provincial Health Office	Supervisor
22.	Pascal Bigirimana	Health facilty of Kibuye	Responsible
23.	Pasteur Bamporubusa	District of Kibuye	
24.	Théodora Nindabiye	Health facilty of Buraza	Responsible
25.	Françoise Ndimurwanko	Health facilty of Bukirasazi	Responsible
26.	Dieudonné Hatungimana	Gitega Provincial Health office	Reproductive health programme coordinator
27.	Gordien Nduwimana	Health facilty of Gisikara	Responsible
28.	Dieudonné Hitimana	Health facilty of Bungere	Responsible
29.	Vianney Ahishakiye	Health facilty of Kirimbi	Responsible
30.	Jean Claude Nizigiyimana	Health facilty of Bugendana	Responsible
31.	Fébronie Mudende	District of Gitega (Kibimba)	Supervisor
32.	Béathe Niyonkuru	Health facilty of Giheta	Responsible
33.	Bénigne Niyongabo	District of Gitega (Kibimba)	Supervisor
34.	Godelieve Nahimana	Health facilty of Gitega prison	Responsible
35.	Joselyne Ntirampeba	Health facilty of Gitega	Responsible
36.	Jeanine Nizigiyimana	District of Gitega (Kibimba)	Gestionnaire
37.	Claudine Nkurunziza	District of Gitega (Kibimba)	Supervisor
38.	Joselyne Nibizi	District of Gitega (Kibimba)	Supervisor
39.	Jacqueline Kwizera	Health facilty of Makebuko	Responsible
40.	Joyeuse Akimana	District of Ryansoro	Supervisor
41.	Mélance Sabushimike	District of Ryansoro	Supervisor
42.	Maggy Ndayikengurukiye	District of Ryansoro	Supervisor
43.	Martin Nsengiyumva	District of Kibuye	Supervisor
44.	Dominique Sibomana	Ntita Hospital	Gestionnaire
45.	Solange Kaneza	District of Ryansoro	Responsible
46.	Alice Ndayisaba	Gitega provincial health office	Supervisor
47.	Diomède Basengiyumva	Health facility of Nyarunazi	Responsible
48.	Jeanne Barayandema	Health facility of Bukoro	Responsible
49.	Nestor Nduwayo	Health facility of Mugaruro	Responsible
50.	Angelo Uwimana	Health facility of Nyakarambo	Responsible
51.	Jean Berchmans Bahumba	Health facility of Kibimba	Responsible
52.	Fulgence de Gonzague Simbabawe	Gitega provincial health office	Supervisor
53.	Marie Hélène Rukundo	Gitega provincial health office	Gestionnaire

54.	Gertrude Nkoribipfubusa	Gitega provincial health office	HMIS
55.	Dr. Richard Havyarimana	District of Ryansoro	Medical Chief
56.	Dr. Elysée Nahimana	District of Gitega	Medical Chief
57.	Dr. Eric Sindimwo	District of Mutaho	Medical Chief

Annex 2 List of Documents reviewed

BIFE/GAVI HSS (2007) Manuel de Procédures Administratives, Comptables et Financières, BIFE Bujumbra December 2007

Government of Burundi (2005) Poverty Reduction Strategy

Government of Burundi (2008) Annual Situation Report 2007 Submitted to the GAVI Alliance

Government of Burundi (2009) Annual Situation Report 2008 Submitted to the GAVI Alliance

INSP (2009) Mid-Term Evaluation of GAVI HSS, Bujumbura

MSPSP (2005) Plan National de Developpement Sanitaire, Bujumbura, Burundi

MSPSP (2006) Form for Burundi Proposal for GAVI Health System Strengthening Support

MSPSP (2007) Response to Requests for Clarification from GAVI IRC

MSP (2008) Synthese de la 2nd Mission Conjointe de Sante enter Gouvernement et Partenaires. November 2008

MSP (2009) Plan d'Action a Moyen Terme 2009 – 2011, First Draft

MSP (2009) Déclaration de consensus sur le financement de la gratuité et le financement basé sur la performance des 16 et 17 mars 2009, Bujumbura

MSP (2009) Plan D'action A Moyen Terme, Groupe « Décentralisation », First Draft

Projet SANTE PLUS (2009) Rapport narratif du DP1, 1/6/2008 – 31/5/2009, Bujumbura

World Bank (2009) Project Appraisal Document, Health Sector Development Project, 13 May 2009 Draft

Annex 3 Summary GAVI HSS Evaluation Approach

Méthode de l'étude d'évaluation du RSS de GAVI Alliance

En février 2009, le cabinet de conseil HLSP Ltd a été chargé de l'évaluation 2009 du soutien au renforcement des systèmes de santé (RSS) de GAVI. Cette évaluation devra déterminer dans quelle mesure les opérations à l'échelon national et le soutien aux niveaux mondial et régional, ainsi que les tendances dans les systèmes de santé et la vaccination vont dans la bonne direction (positive). Des données quantitatives et qualitatives seront recueillies et analysées aussi bien de manière rétrospective que prospective, depuis le moment où le processus de demande a commencé dans le pays jusqu'à la mise en œuvre, le suivi et l'évaluation du projet à ce jour.

Il existe cinq principaux objectifs et domaines d'évaluation :

1. Quelle a été l'expérience du RSS de GAVI au niveau national en ce qui concerne *chaque* point suivant : conception, mise en œuvre, suivi, intégration (harmonisation et alignement), gestion et produits/résultats ?
2. Quels ont été les principaux points forts du RSS de GAVI au niveau national, et quels domaines précis faut-il encore perfectionner ?
3. Comment le RSS de GAVI a-t-il été soutenu aux niveaux régional et mondial – quelles sont les forces de ces processus et quels domaines requièrent des améliorations ?
4. Quelle a été la valeur ajoutée du financement du RSS de GAVI, par comparaison à d'autres modalités de financement du RSS ?
5. Quelles mesures faut-il prendre et qui devra s'en charge, aux niveaux national, régional et mondial pour préparer une évaluation plus approfondie de l'impact du RSS de GAVI en 2012 ?

L'évaluation du RSS de GAVI préparera cinq études de cas nationales détaillées. Elles seront structurées de manière que les consultants indépendants faisant équipe avec les consultants locaux passent du temps dans votre pays pour réunir des informations sur l'expérience nationale. Nous prévoyons jusqu'à deux visites dans votre pays entre mai et juin 2009. La première visite sera principalement consacrée à des entretiens avec des acteurs clés du pays pour préciser les domaines d'intérêt, à l'information et au recueil de données initiales. Au cours de cette visite, l'équipe d'évaluation chargera peut-être aussi une institution de recherche locale de mener des recherches ultérieures sur des activités/districts particuliers. Pendant la seconde visite, nous prévoyons de réaliser des entretiens avec d'autres personnes concernées, d'assembler les données et de les présenter à toutes les parties prenantes. Nous examinerons avec les acteurs nationaux l'utilité de mener un atelier de validation de fin de mission afin d'informer le pays des résultats des études de cas approfondies, et de les valider.

De plus, les résultats des études de cas approfondies seront complétées par les résultats des six études de suivi du RSS de GAVI actuellement mises en œuvre par le groupe de recherche JSI-InDevelop-IPM. Enfin, l'équipe d'évaluation du RSS étudiera tous les dossiers de demande de RSS, les propositions de RSS et les rapports de situation RSS préparés jusqu'à présent pour créer une base de données des pays bénéficiant d'un soutien RSS. Toutes ces sources d'information réunies permettront de répondre aux cinq questions de l'étude citées ci-dessus.

Annex 4 Typology of areas for HSS support

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA ($50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	*Internal process*	IRC-HSS
IRC recommendations	*Internal process*	IRC-HSS
Decision on proposals	*Internal process*	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring