



## GAVI Health Systems Strengthening Support Evaluation 2009

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Volume 2 Full Evaluation Report

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The GAVI HSS evaluation 2009 is presented in three main volumes:

Volume 1 Key findings and recommendations

Volume 2 Full evaluation report

Volume 3 Case studies, approach and methodology - this is presented in 3 parts:

Volume 3a Eleven in-country case studies (ZIP Folder)

Volume 3b Ten desk-based case studies (ZIP Folder)

Volume 3c Study guidelines & summary of responses on GAVI HSS Support Mechanisms

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This report is dedicated to all those, whose lives the GAVI Alliance is attempting to improve or save.

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## Abbreviations and acronyms

APR	Annual Progress Review
cMYP	Comprehensive Multi-Year Plan
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
DPT3	3 <sup>rd</sup> Dose of Diphtheria, Tetanus & Pertussis Vaccine
DRC	Democratic Republic of Congo
EPI	Expanded Programme of Immunisation
FMA	Financial Management Assessment
GAVI	The GAVI Alliance
GCT	Global Challenge Team (for this evaluation)
HMIS	Health and management Information System
HMN	Health Metrics Network
HQ	Headquarters
HSCC	Health Sector Coordination Committee
HSSP	Health Sector Strategic Plan
ICC	Inter-Agency Coordination Committee
IFI	International Finance Institution
IHP+	International Health Partnership Plus
IRC	Independent Review Committee
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental organisation
OECD/DAC	Organisation for Economic Cooperation & Development/ Development Assistance Committee
PMU	Project Management Unit
PRSP	Poverty Reduction Strategy Paper
RfP	Request for Proposals
SC	Steering Committee
SWAP	Sector-wide Approach
TA	Technical Assistance
TAP	Transparency and Accountability Policy
TC	Technical Cooperation
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
WB	The World Bank
WHO	World Health Organisation

## **1. Background, purpose and method**

### **1.1 Background to GAVI HSS**

The GAVI Alliance was launched in 1999 to increase immunization coverage and reverse widening global disparities in access to vaccines. Recognizing that achieving immunization coverage is dependent upon strong service systems, the Alliance Board took the first steps to expand GAVI support to health systems strengthening (HSS) in early 2005.

The initial proposal recommended that the HSS window remain open to all eligible countries for the 2006-15 period, with a maximum funding level of US\$1.8 billion. In December 2005, the GAVI Alliance and Fund Boards agreed to invest an initial \$500 million in the HSS Window until 2010 to address the wider systems related bottlenecks that may hinder the provision of immunization services. The 2005 Board Decision also called for evaluations of the window in 2009 and 2012, as proposed in the investment case.

The objective of GAVI HSS is to achieve and sustain increased immunization coverage, through strengthening the capacity of the health system to provide immunization and other health services (with a focus on child and maternal health). Countries are encouraged to use GAVI HSS funding to target the “bottlenecks” or barriers in the health system that impede progress in improving the provision of and demand for immunization and other child and maternal health services.

In February 2008, the GAVI Board approved a further increase to the GAVI HSS window of \$300 million. As of June 2009 \$524 million was committed to countries and \$255 million was disbursed, which leaves a balance of \$265 million to be disbursed for HSS in future. Much of the coordination of the HSS investment is through the Alliance partners, while at the global level a GAVI HSS task team provides oversight of the HSS work plan.

### **1.2 Evaluation objectives**

Five main questions were identified by GAVI for this evaluation and were turned into the evaluation objectives:

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

3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in- depth evaluation of impact of GAVI HSS in 2012?

These five question areas are used to structure this evaluation report – sections 2-6 respectively, as follows:

Report structure – Volume 2		IV. Scope of work As in RfP	Deliverables
Report	What is covered?		
Section 2	Objective 1	1a, 1c, 1d, 1e	Volume 1 Volume 2 Volume 3
Section 3	Objective 2 & GAVI Principles	1a, 1b, 2a, 2b	
Section 4	Objective 3	2b	
Section 5	Objective 4	Not in SOW	Volumes 1 and 2
Section 6	Objective 5	3a, 3b, 3c	Volumes 1 and 2 Draft TOR 2012 GAVI HSS Evaluation (stand alone draft)
		Database of HSS grants & indicators	Separate Stand alone Excel Spreadsheet (+ parts of Volume 2)

It was expected that the above objectives would provide the GAVI Alliance with recommendations in three main areas:

- to inform the Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
- 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)
- to enhance the quality of the 2012 evaluation.

Finally, an effort was made by the evaluation team to provide the GAVI Alliance with insights and recommendations on the implications of this evaluation for ongoing discussions among the World Bank, the GFATM and the GAVI Alliance. This was done through a separate note prepared for the September meeting of the Program and Policy Committee (PPC) of the GAVI Alliance and through references to this issue made in Volume 1 (key findings and recommendations) of this Evaluation.



### 1.3 Summary of evaluation approach and method

This section summarises the approach and methods, which are more fully described in Annex 6.

Our evaluation approach is based on the recognition that given the relatively recent start of GAVI HSS programmes in countries, the evaluation was unlikely to detect any outcomes (i.e. increased coverage) or impact (i.e. improved survival) resulting from GAVI HSS funding. Instead, we focused on what was being targeted and achieved in terms of processes (e.g. proposal design, approval and implementation) and, wherever possible, on outputs (e.g. improved services).

Where possible, we have made judgements about the likelihood of transformation of processes and outputs into outcomes and impact (see for example section 5, the added value of GAVI HSS, and section 6 (the impact of GAVI HSS – the 2012 evaluation). In addition, we have attempted to assess how well GAVI HSS in countries is following: the principles of the Paris Declaration on Aid Effectiveness and of the Accra HLF Agenda for Action; and other principles and values articulated in the GAVI Guidelines for HSS Applications.

We have also attempted to respond to a large number of questions included both in the Request for Proposals as well as in the Technical Proposal submitted by HLSP at bidding stage.

The key themes and questions to guide data collection and analysis, and to ensure internal consistency were set out at an early stage in the Evaluation Study Guidelines (Volume 3c).

Our main sources of information were

- 11 in-depth case studies and 10 desk studies conducted by the evaluation team (submitted respectively as Volumes 3a and 3b), covering Burundi, Cambodia, DRC, Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia as case studies; and then Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen as desk studies.
- interviews with key informants, particularly in relation to objective 3 of the evaluation (the GAVI HSS support systems); Annex 1 contains a complete list of people met and Volume 3C a summary of responses provided to our email and phone interviews;
- available documents, including results from other evaluation studies and articles relating to GAVI HSS or to health systems strengthening matters; a list of key documents is in Annex 2.

Table 1 below provides additional information on the 21 countries covered in our sample.

**Table 1: Selected countries and type of studies for the GAVI HSS Evaluation**

	HSS Round	Population '000 *	Region	Size HSS Grant *	Date GAVI Approval letter *	Type of HSS assessment
Burundi	1	8,173	C Africa	\$8,252,000	12 Mar 07	In Depth
Cambodia1	1	14,197	S E Asia	\$1,850,000	1 Mar 07	In Depth
Cambodia 2	5			\$8,465,500	14 Aug 08	
DRC	2	60,644	C Africa	\$56,814,500	14 Aug 08	In Depth
Ethiopia	1	81,021	E Africa	\$76,494,500	13 Jun 07	In Depth
Kyrgyzstan.	1	5,259	C Asia	\$1,155,000	1 Mar 07	In Depth
Liberia	2	3,579	W Africa	\$4,090,000	1 Mar 07	In Depth
Nepal	4	27,641	S Asia	\$8,667,000	13 Jun 07	In Depth
Pakistan	3	160,943	S Asia	\$23,525,000	14 Feb 08	In Depth
Rwanda	3	9,464	C Africa	\$5,605,000	8 Aug 07	In Depth
Vietnam	2	86,206	S E Asia	\$16,285,000	8 Aug 07	In Depth
Zambia	3	11,696	E Africa	\$6,605,500	13 Jun 07	In Depth
Bhutan	4	649	S Asia	\$194,000	8 Aug 07	Desk Study
Honduras	2	6,969	C America	\$435,500	18 Feb 08	Desk Study
Georgia	4	4,433	E Europe	\$9,670,000	13 Jun 07	Desk Study
Ghana	4	23,008	W Africa	\$2,534,500	14 Feb 08	Desk Study
Kenya	3	36,553	E Africa	\$9,903,000	18 Feb 08	Desk Study
Nicaragua	4	5,532	C America	\$1,387,500	18 Feb 08	Desk Study
Nigeria	4	144,720	W Africa	\$44,704,000	1 Aug 07	Desk Study
Sierra Leone	4	5,743	W Africa	\$2,215,500	18 Feb 08	Desk Study
Sri Lanka	4	19,207	S Asia	\$4,505,000	14 Feb 08	Desk Study
Yemen	3	21,732	Mid-East	\$4,505,000	14 Feb 08	Desk Study

Source: \* WHOSYS Database

## 2. GAVI HSS experience at country level

This section provides a description of the GAVI HSS process and its results in countries presented under the main phases of the HSS process. It provides the information requested as Objective 1 of the evaluation study, and also covers the main strengths and limitations of the said phases, which falls under Objective 2 of this evaluation.

*Objective 1 - What has been the experience at country level with GAVI HSS in terms of each of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?*

*Objective 2 - What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?*

Before analysing the GAVI HSS process at country level a few facts about GAVI HSS to date:

- By December 2008 a total of 51 countries had applied for GAVI HSS funds, of which 44 were eventually successful and got their grants approved. In addition, eight countries were asked to either resubmit their proposals (7) or got a conditional approval (1).
- By June 2009 the GAVI Alliance had committed a total of \$524 million to HSS grants and had spent \$255.7 million to that date. This means that the committed yet unspent budget for HSS amounts to \$268 million. Most applications are for 4-5 year periods, as per their health sector strategic plans.
- Countries apply for HSS (or any other type of GAVI) grants by Rounds. Typically there are 2 Rounds per year, usually in May and September. There had been 6 Rounds by December 2008.

**Table 2: Countries applying for HSS grants, by December 2008, by Round, as per WHO/SYS database**

Round No.	Country	HSS approval status	Date GAVI Board Approval Letter	Date 1st tranche sent	Total fund approved/requested
1	Burundi	A (Approved)	12-Mar-07	04-Sep-07	\$8,252,000
1	Cambodia	A	01-Mar-07	04-Nov-07	\$1,850,000
1	Ethiopia	A	13-Jun-07	13-Apr-07	\$76,494,500
1	Korea, D Rep.	A	08-Feb-08	13-Nov-08	\$4,361,000
1	Kyrgyzstan	A	01-Mar-07	09-Jul-07	\$1,155,000
2	D R Congo	A	14-Aug-08	02-Aug-08	\$56,814,500
2	Georgia	A	18-Feb-08	13-Aug-07	\$435,500
2	Liberia	A	01-Mar-07	27-Jul-07	\$4,090,000
2	Vietnam	A	08-Aug-07	08-Jul-07	\$16,285,000
3	Afghanistan	A	08-Aug-07	23-Dec-07	\$34,100,000
3	Cameroon	A	08-Aug-07	11-Aug-07	\$9,846,000
3	Kenya	A	18-Feb-08	29-Apr-08	\$9,903,000
3	Pakistan	A	14-Feb-08	22-Aug-08	\$23,525,000
3	Rwanda	A	08-Aug-07	30-Oct-07	\$5,605,000
3	Yemen	A	14-Feb-08	29-Oct-07	\$6,335,000
3	Zambia	A	13-Jun-07	10-Dec-07	\$6,605,500
4	Bhutan	A	08-Aug-07	24-Apr-08	\$194,000
4	Central African R	A	18-Feb-08	29-Apr-08	\$3,163,000
4	Ghana	A	13-Jun-07	30-Apr-07	\$9,670,000
4	Honduras	A	14-Feb-08	30-Apr-08	\$2,534,500
4	Madagascar	A	18-Feb-08	30-Apr-08	\$11,216,500
4	Malawi	A	18-Feb-08	10-Jun-08	\$11,343,000
4	Nepal	A	13-Jun-07	30-Apr-08	\$8,667,000
4	Nicaragua	A	18-Feb-08	28-Jun-08	\$1,387,500
4	Nigeria	A	01-Aug-07	30-Apr-08	\$44,704,000
4	Sierra Leone	A	18-Feb-08	09-Dec-08	\$2,215,500
4	Sri Lanka	A	14-Feb-08	30-Apr-08	\$4,505,000
4	Sudan North	A	14-Feb-08	03-Mar-08	\$16,153,000
4	Tchad	A	14-Aug-08	23-Sep-08	\$4,978,500
4	Uganda	A	14-Feb-08	NA	\$19,242,000
5	Armenia	A	01-Jul-08	12-Jan-08	\$291,500
5	Bolivia	A	14-Aug-08	22-Dec-08	\$2,093,000
5	Burkina Faso	A	14-Aug-08	23-Sep-08	\$4,978,500
5	Cambodia	A	14-Aug-08	29-Sep-08	\$8,465,500
5	Cote D'Ivoire	A	01-Jul-08	29-Sep-08	\$8,697,500
5	Guinea Bissau	A	14-Aug-08	23-Sep-08	\$1,428,000
5	Indonesia	A	14-Aug-08	20-Mar-09	\$24,827,000
5	Mali	A	14-Aug-08	23-Sep-08	\$4,764,500
5	Myanmar	A	14-Aug-08	NA	\$32,780,500
5	Tajikistan	A	14-Aug-08	NA	\$1,315,500
6	Azerbaijan	A	12-Dec-08	NA	\$1,182,500
6	Bangladesh	A	12-Dec-08	NA	\$13,671,500
6	Cuba	A	02-Dec-08	NA	\$2,369,500
6	Eritrea	A	12-Dec-08	NA	\$2,778,000
6	Senegal	A	12-Dec-08	NA	\$3,585,500
NA	Benin	R (Resubmission)			
NA	Djibouti	R			
NA	Gambia	Aco (Approved with conditions)			
NA	India	R			
NA	Laos	R			
NA	Mozambique	R			
NA	Tanzania	R			
NA	Togo	R			

## 2.1 HSS proposal design, application and approval processes

### 2.1.1 Introduction to HSS design and application processes

Countries wanting to apply for HSS funding may do so at regular intervals (Rounds) set by the GAVI Alliance and displayed on its website. In our case and desk studies, all countries learnt about the availability of HSS funding through country or regional UNICEF and WHO offices and requested the help of these two organisations – also referred to in this reports as “technical partners”- to prepare the design of the HSS proposals.

Once the decision is made to apply for funding, countries then download the GAVI HSS application template that contains useful information on the approach to developing the proposal, and includes a description of key requirements such as how to identify the barriers to immunisation, child health and maternal health that the HSS proposal will eventually target.

Once the proposal is ready, it is sent to the GAVI Alliance Secretariat where an Independent Review Committee – the IRC (HSS) convenes in Geneva to assess the proposals received in that Round (or resubmitted from previous Rounds) and makes a recommendation to the GAVI Board. The recommendations of the IRC fall into three categories: rejection of the proposal; conditional approval, amounting in practice to a resubmission; acceptance with clarifications, where proposal is accepted subject to some issues being clarified in response to observations by the panel; and (unconditional) approval, when the proposal is accepted as is.

Some initial observations on application processes include the following (please refer to Table 3 below)

- Approval with clarifications is by far the most common response from the IRC.
- Time from submission of HSS proposal to formal GAVI Board approval ranges from 4 to 6 months.
- Countries often hear about the IRC’s recommendation through the GAVI Secretariat even before the Board approval in order to give advanced warning to countries and prevent delays in first year implementation.
- The average elapsed times from submission of proposal to formal GAVI Board approval for all HSS grants are as follows: Round One = 4 months; Round Two = 5.5 months; Round Three = 5.5 months; Round Four = 6 months (adjusted average); Round Five: 15 months - only one application (Cambodia’s 2nd) included<sup>1</sup>. This represents a swift process by any standards.

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<sup>1</sup> Elapsed times for Round 6 countries are not included as their HSS grants were approved in December 2008, the end of the period covered in this evaluation.

**Table 3: Key dates in GAVI HSS application approval process in the sample of 21 countries**

Country	Round No.	Total months submission to approval	Proposal submitted	Request re-submission	Re-submission of proposal	Conditional approval	Submission of country response to conditions	Request for clarifications	Submission of country response to clarification	Date of GAVI Board Approval letter
Burundi	1	4.5	3 Nov 06					24 Nov 06	15 Jan 07	12 Mar 07
Cambodia	1	4	3 Nov 06							1 Mar 07
Cambodia	5	15	11 May 07	15 Jun 07	7 Mar 08					14 Aug 08
DR Congo	2	7.5	3 Nov 06			24 Nov 06	2nd Mar 07	25 Apr 07	31 May 07	13 Jun 07
Ethiopia	1	4	3 Nov 06					24 Nov 06	15 Jan 07	1 Mar 07
Kyrgyz Republic	1	4	3 Nov 06					24 Nov 06	15 Jan 07	1 Mar 07
Liberia	2	3.5	2 Mar 07					25 Apr 07		13 Jun 07
Nepal	4	11.5	2 Mar 07	25 Apr 07	5 Oct 07					14 Feb 08
Pakistan	3	8.5	3 Nov 06	24 Nov 06	11 May 07			15 Jun 07		8 Aug 07
Rwanda	3	3	11 May 07					15 Jun 07	14 Jul 07	8 Aug 07
Viet Nam	2	7.5	3 Nov 06			24 Nov 06	2 Mar 07		31 May 07	13 Jun 07
Zambia	3	3	11 May 07						14 Jul 07	8 Aug 07
Bhutan	4	4.5	5 Oct 07							18 Feb 08
Georgia	2	3.5	2 Mar 07					25 Apr 07	31 May 07	13 Jun 07
Ghana	4	4.5	5 Oct 07					28 Nov 07		14 Feb 08
Honduras	4	9	11 May 07					15 Jun 07	7 Nov 07	18 Feb 08
Kenya	3	9	3 Nov 06					24 Nov 06	11 May 07	1 Aug 07
Nicaragua	4	5.5	5 Oct 07					28 Nov 07		18 Feb 08
Nigeria	4	5.5	5 Oct 07					28 Nov 07		18 Feb 08
Sierra Leone	4	15.5	3 Nov 06			24 Nov 06	5 Oct 07	28 Nov 07		14 Feb 08
Sri Lanka	4	11.5	2 Mar 07	25 Apr 07	5 Oct 07			28 Nov 07		14 Feb 08
Yemen	3	3	11 May 07						14 Jul 07	8 Aug 07

### 2.1.2 Strengths of the HSS proposal design process

Presented below are strengths identified in relation to the design and application processes for GAVI HSS grants.

**Simplicity** - Our interlocutors in case study countries generally found the process of designing HSS proposals non-prescriptive, simple and straightforward, while the HSS guidelines were also considered user-friendly (particularly in comparison with the GFATM procedures, some respondents pointed out).

**Country ownership and alignment** – In most countries the design process was led and driven by government units and departments, often supported by “design teams” and ‘task forces’ comprising health partners and technical partners like WHO and UNICEF who often acted as technical resources and facilitators. Involvement of civil society and private health providers in design processes was found to be very limited with a few exceptions (Honduras), this depending on the specific country circumstances and role played by the private sector in health care. In general HSS proposal were found to be aligned with national strategies and plans in terms of supporting priority areas and objectives. However, few proposals demonstrate a clear link between the constraints identified and the objectives specified for GAVI HSS funding, or between the objectives and the activities proposed to attain them. Equally weak has been the selection of progress indicators (as discussed later in the APR section).

**Inclusive design** - Most countries have been “inclusive” in the design process by involving combinations of different levels of ministries, and their technical and development partners. Bilateral health partners played more the role of reviewers through their membership of the HSCC or ICC and given the GAVI requirement that they approve the HSS proposal internally before submission to GAVI. It was common for districts and provinces to be involved in the design in the case of proposals where implementation is decentralised, as in Rwanda, Honduras, Yemen or Vietnam. In Cambodia the approach was rushed due to tight proposal submission deadlines. Civil Society was rarely given much notice of meeting or advance papers to comment on. They also felt that they could have played a more prominent role in terms of implementation and monitoring. In Nepal, there was a strong inclusive bottom up approach through regional workshops. However, Civil Society involvement in discussions at central level was felt to be far weaker

**Good technical support** – The major role in supporting governments in the application process was played by WHO and UNICEF, often using their involvement in the Inter-Agency Coordination Committee for immunization (ICC). These technical partners often triggered the decision by the country to apply for HSS

funding. In all cases they provided technical support through staff time, by organising regional workshops (Manila, Cairo, Nairobi, Cameroon, Ouagadougou, Tegucigalpa, Sri Lanka, and Istanbul) and through facilitation or meetings and coordination of design processes while helping the governments be on the driving seat. Our country studies suggest that the role of the World Bank in technically supporting application processes in country was marginal or none. This probably responds to a standard division of labour prevailing in most countries by which the World Bank is seldom involved in immunisation related issues.

**Proposal preparation grants** - the GAVI HSS preparation grant (to a maximum of \$50,000) has been well received and used, but with mixed interpretation on whether the funds were meant for the government or for the technical partners.

**HSS design can strengthen coordination on health systems work** - There is some evidence that GAVI HSS funds have served to strengthen existing coordination mechanisms around HSS issues, promoting clarity on HSS and the roles of all health partners in this domain. In DRC, while a National Steering Committee for HSS existed, the arrival of GAVI funds encouraged its operationalisation, sending a strong signal to health sector partners that HSS issues are a priority for the Ministry of Public Health. In Nepal, the HSCC coordinated with the Technical Working Group for Health and Child Health Unit to produce the HSS proposal. In sum there is great potential for the GAVI HSS proposal development process to help formalise and promote ownership of HSS issues, but there is also a risk that GAVI HSS is not engaging the right teams with the requisite HSS knowledge, interest and expertise to make the most of GAVI HSS opportunity.

### 2.1.3 Areas for improvement of HSS design and proposal preparation

The most important question to be answered in relation to proposal design is whether proposals identified the right system bottlenecks and whether the interventions addressed such bottlenecks in an effective, convincing manner. We deal with this important issue elsewhere in this report (see Section 2.3 and 3.1) so the following areas related to ways to strengthen the process of designing HSS proposals and less so about their specific contents (even if these 2 dimensions are closely linked).

Several areas were found to allow for improvement:

**Who (in the MOH) should lead the HSS proposal design?** Where proposal development is led by the EPI team or ICC two risks have been identified: 1) that the proposal writing team may have insufficient HSS expertise to write a good proposal and 2) MoH ownership of HSS issues can be undermined at a strategic



level. GAVI guidance does promote the active leadership of the Health Sector Coordination Committee (HSCC) in the proposal development process, but clearly this has not been the case in some countries (Rwanda, Zambia, Burundi, and Pakistan, among others). We found that immunisation departments had not always worked well or even at all with planning departments and there was often insufficient involvement of senior, coordinating levels of ministries in the HSS proposal preparation.<sup>2</sup> In some countries, such coordination structures simply did not exist or were not active or mature enough, but this was hardly ever identified by the IRC as an important weakness that might compromise additionality, complementarity or sustainability of HSS funding requested. In these countries there was a danger that HSS was seen as just another source of money for immunisation or the EPI department was not strong enough in HSS thinking or programme design (Rwanda) so as to engage other partners. The sign-off of proposals cannot be taken as a guarantee that they are understood and coordinated at a high level.

**Focus on Immunisation or MCH services?** While originally HSS proposals were required to focus specifically on barriers to immunisation more recent application guidelines encourage countries to use GAVI HSS funding to target also barriers “that impede progress in improving the provision of and demand for immunisation and other child and maternal health services”. Several respondents pointed to the significant differences between targeting immunisation bottlenecks or attempting to target maternal and child services as well, as the latter would encompass a much broader spectrum of interventions and hence a different methodology and higher levels of funding.

**Were HSS proposals complementary?** - Almost universally, countries see GAVI HSS funds as a flexible opportunity to fill gaps, but whether gap filling means that HSS funding is complementary is a different matter. These evaluators were often unable to assess whether the HSS proposal complemented or was integrated with the funding provided by other partners. This is not necessarily a fault of the HSS grant preparation model but a result of the complex nature of health systems support in many countries, where it is often unclear who is funding what, where, and if what they are funding can be rightly categorised as “health systems funding”.

As the IRC has noted in the past<sup>3</sup> very few proposals provide adequate information on integration with other efforts and funding for HSS activities, presenting assessment problems for the IRC. While countries with SWAp-type arrangements

<sup>2</sup> This was not a weakness of the GAVI model but the unfortunate result of many years of donors designing their own projects in relative isolation from sector coordination structures.

<sup>3</sup> See for example *Consolidated Report of the IRC reviewing HSS proposals* of November 2007.

appear to do better in this respect there were several practical problems for assessing complementarity in our case studies. Firstly, many proposals fail to describe other sources of HSS funding in any depth or do so in a simplistic manner (but one must admit also that demonstrating this on paper is not easy and a more in-depth assessment may be needed). Secondly, HSS proposals may be complementing perceived needs but the proposed *interventions* may not be complementary. In Rwanda a detailed district needs assessment exercise was conducted, yet the same HSS interventions were being applied in all districts irrespective of need or of what other health partners were already funding, this resulting in perceived duplication by health partners interviewed.

Most proposals appear to address important constraints on delivery of services, and are consistent with previous country assessments, but linkages between wider health systems weaknesses and specific immunisation needs are not always well articulated. On the other hand some countries (Ethiopia, Kenya) were found to target HSS funding beyond and above immunisation or MCH concerns alone by targeting elements of the health sector plan that lacked sufficient funding.

**Focus on underperforming districts** - The emphasis on underperforming districts came through in several country proposals where countries have made a conscious decision to focus on improving coverage in these districts. In DRC low immunisation coverage was one of the criteria used for selecting health zones that GAVI HSS would focus on. The same applied to countries like Vietnam, Honduras or Pakistan, where areas where health or other indicators were worse than the national average had been selected. Although the original GAVI guidelines did not specify a focus on under-performing districts, *equity* was highlighted in its definition of health system strengthening. The 2007 revised guidelines were more explicit in encouraging applications to consider targeting the 'hardest to reach', and in 2009 GAVI encourages '...approaches to achieve sustainable universal coverage within the context of Primary Health Care. This includes identifying hard to reach groups, marginalised populations and addressing issues of inequity (including those based on gender)'. In general, HSS proposals did not have a clear or visible focus on under-served groups, although many of those targeting underperforming districts included high presence of hard to reach population groups, like tribal communities in Vietnam.

**More proactive involvement of the health sector coordination structures and actors** - Ensuring that HSS design complements other efforts would require deeper involvement of sector coordination structures in HSS design processes than was observed in many countries. There were exceptions of course, and Ethiopia, Honduras or Cambodia could demonstrate high involvement of the sector coordination structures in HSS design. However, in most of the 21 countries

studied there was a risk that the current approval process places too much emphasis on ensuring that partner *signatures* are in place rather than engaging all partners in the decision making processes that would promote real joint-ownership and complementary interventions. There is also an additional risk that if partners are not fully engaged with the process and 'bought-in' during its conception, the likelihood of achieving coordination and harmonization of HSS interventions, especially at operational levels will be significantly reduced.

In sum, *internally* the process of putting together a passable HSS proposal appears to be working reasonably well. Where HSS expertise does not exist some countries have made efforts to use TA to bring in this expertise. However the significant weakness lies in the inclusive and participatory nature of the process; few countries, if any have ensured meaningful engagement with civil society or private sector partners. Further, even when key development partners have signed-off on proposals, the assumption cannot be made that they have actively contributed to its development.

## 2.1.4 Pre-review, review and approval of HSS proposals

### Pre-assessment and pre-review of HSS proposals

Before HSS proposals are sent to the GAVI the process of pre-assessment takes place by which country partners (HSCC and others) review the proposal and eventually sign it. Once submitted to the GAVI the WHO (country or regional offices, usually both) is tasked with reviewing the proposal before this is sent to the IRC. That process -known as the pre-review- consists on a thorough review of the proposal using a standard template developed by the GAVI. The pre-review focuses on ensuring compliance with the GAVI HSS application guidelines and consistency of the data included in the applications.

The pre-review reports include – at the beginning - a summary of questions, as follows:

- Are the programme data available within the proposal? Are the support documents available? Are the signatures available?
- What is the level of consistency (1) within the proposal, (2) between the proposal and accompanying documents, (3) between the proposal and external sources?
- Was the proposal drafting process inclusive?
- Are the activities in the proposal aligned with health policies, and complementary with other partner support?
- Is the management and monitoring of the implementation of the GAVI HSS proposal described?

As can be seen all questions are relevant and point to key stages during the proposal development process. Unfortunately we could not see much evidence that action had been taken when answers to the questions were not satisfactory. For example:

- Many proposals did not include important information (i.e. volumes of funding by other donors) and signatures of key sector stakeholders in the HSCC were often missing.
- Inconsistency issues were highlighted but it was not clear whether or how these would be resolved.
- Alignment issues were described and proposal indicators were checked, but important issues such as whether activities, process and outcome indicators were closely related or would permit attribution or would enable effective monitoring of results were often overlooked.
- The management, monitoring and implementation were described, but it is not that these were sufficiently analysed in most cases.

In conclusion, the pre-review process often acted as a pre-alert for issues that the IRC might later pick up, but because it is basically a checklist of whether things have been done (rather than how these have been done) its value for the purposes of proposal assessment was somewhat reduced. Much would depend thus on the ability of the IRC to actually pick up the right issues and be able to resolve these during the process of clarifications. This is discussed elsewhere.

### **The IRC review process**

The IRC review has been one of the perceived strengths of the GAVI funding model. It is seen as providing an independent, transparent and authoritative assessment of proposals. HSS proposals are reviewed by a specific IRC (known as the IRC HSS – different from the IRC that reviews other GAVI windows like INS, NVS, etcetera). The HSS IRC usually meets twice a year, in Geneva, to assess the HSS proposals submitted after each round, or re-submitted proposals from previous rounds for which clarifications were sought in previous IRC meetings. The IRC is meant to provide the GAVI with a recommendation as to whether a proposal should be approved or whether, as is more often the case, clarifications need to be provided or important issues need to be resolved prior to their making a positive recommendation. IRCs provide detailed reports to the GAVI, parts of which are cut and pasted into the letters that the GAVI writes to countries in response to their HSS applications. These evaluators had the chance to review the IRC reports and correspondence between the GAVI Secretariat and the countries in the 21 case and desk studies that we conducted.

The Independent Review Committee has provided transparent and professional assessment of GAVI proposals ever since GAVI was launched. Its members are carefully selected among highly competent health professionals. Our impression is that their judgement and observations were most of the times relevant, impartial and fair. However, we were less convinced but the process that follows on the initial IRC assessment, for the following reasons:

- The IRC must make their assessment on the basis of the proposal and accompanying documents, but given the complex nature of HSS proposals these do not always allow for a thorough assessment of the feasibility of what is being proposed. For example, IRC reviewers can hardly assess on the basis of information provided: whether the applying country has sufficiently robust financial management, HMIS or implementation systems; whether the country has the capacity to monitor the HSS grant; whether the HSS proposal is truly complementary, and whether funding will be truly additional; whether HSS results will become available on-time and will be acted upon and disseminated to the right sector coordination structures; etcetera. A more detailed description of issues is provided below (common gaps observed).
- The IRC make their assessment in isolation and are not allowed to consult with country counterparts, which limits their ability to assess a number of complex issues, included the ones cited above. This leads to a process of correspondence between the GAVI Secretariat and the country stakeholders that we considered to be too formal or rigid for the purposes of clarifying complex issues.
- Our impression was also that the clarifications that were provided by the countries in writing did not always address the points raised by the IRC in a satisfactory manner, in spite of which many proposals still got a positive recommendation. Common areas picked up by the IRC that were not sufficiently improved in most cases were the choice of monitoring indicators, the clarity of implementation arrangements or the necessary conditions that would need to be in place for the HSS proposal to be feasible.
- The window of time during which the IRC HSS were expected to assess proposals – around 2 weeks- is probably insufficient for the purposes of evaluating HSS proposals that are set in complex health systems and national realities. Even if the IRC members had been familiar with the health system of the applying country it might not be possible for them to contextualise certain important issues.
- It was felt that many issues raised by the IRC could have been more easily and swiftly discussed and resolved if the IRC could do a real, not a formal “reality check” of the HSS proposal in country through more direct engagement between reviewers and bidders.

Our opinion as evaluators is that the IRC model in its current form fails to respond to the complexities of HSS proposals. There are positive elements in the IRC model that ought to be maintained for HSS, like its independence, but the way in which the proposals are assessed should be substantially redesigned.

**Common gaps observed in the IRC assessment.**

The following are several issues identified in the course of this evaluation linked to the IRC review model.

**HSS is complex – country context is key.** Even the best applications and the most knowledgeable reviewers would fail to capture the complexities of some HSS proposals because these need to be properly contextualised. For the IRC it is not possible to perform such contextualisation on the sole basis of the written proposal given both the shortcomings linked to HSS proposal design mentioned earlier (poor quantification of donor HSS activity, hard to prove complementarity and additionality, weak HSCC engagement, etcetera) and given that a written proposal must be short and concise by necessity and cannot possibly clarify all the questions that reviewers might like to ask. A more practical approach might be to consider an IRC review process taking place in country and making use of the existing sector coordination structures, information channels and key informants instead of attempting to do this from far away Geneva. Getting the IRC to the country level need not compromise their independence in any way.

**Country ownership and alignment –** In most countries the design process was led and driven by government units and departments, often supported by “design teams” and ‘task forces’ comprising health partners and technical partners like WHO and UNICEF who often acted as technical resources and facilitators. Involvement of civil society and private health providers in design processes was very limited, with a few exceptions (Honduras). Most of the proposals submitted failed to provide a balanced assessment of, for example, the role of private providers or the NGO sectors in health care delivery, this resulting in most proposals focusing on strengthening the public sector, which is not necessarily the same as strengthening the national health system.

**Internal inconsistencies in HSS proposals.** Few proposals in our 21 case studies demonstrate a clear link between the constraints identified and the objectives specified for GAVI HSS funding, or between the objectives and the activities proposed to attain them (more detail on the weaknesses of the results chain later in section 2) . Equally weak has been the selection of progress indicators (as discussed later in the M&E and APR sections).

**Clarifications provided are often superficial.** In spite of the short time available the IRC usually spotted a large number of crucial weaknesses in the HSS proposals, and then requested clarifications on these. However, the process of clarification (that often took months) also required the IRC to accept or reject clarifications with a limited assessment of whether the clarifications provided from the country really addressed the concerns initially expressed. In Vietnam for

example, the questions raised by the IRC were very pertinent (sustainability, implementation structures, monitoring capabilities, etcetera), yet the nature of the clarifications sought was complex and would have required a greater period of time for the reviewers to be convinced that the Government of Vietnam had dealt with their concerns in a convincing manner.

However, because allowing more time to resolve these issues might result in a delay in the disbursement of funds and in the start up there is a perverse incentive on all parties to get over with the clarification process as swiftly as possible. The result of all these issues combined is that some clarifications may never be fully addressed. In the case study countries we found many examples of issues that remained unresolved at design which later resurfaced, even “haunted” some HSS grants. Examples of frequently unresolved issues include: clarity of monitoring arrangements; choice of progress indicators; absence of risk management arrangements; sustainability concerns, such as in relation to cash incentives paid to staff or recurrent costs provided to health facilities; etcetera.

A more effective approach whenever the IRC raised matters of substance that were unlikely to be solvable swiftly might have been *for the IRC to request that the said issues be incorporated into a revised proposal*, recognising that the said matters are often nothing but other “barriers” to health systems performance that it will take time and effort to overcome. But that would not solve the problem that the IRC needs to be more engaged with the country stakeholders at the time of ‘negotiating’ clarifications, *so a complementary approach should also be to bring the IRC review process to the country level, in order to enable a more direct dialogue and engagement between reviewers and bidders.*

### **Brief discussion of the need to redesign the IRC process for assessing HSS proposals**

In its current format the IRC model based on a distant assessment performed within a narrow window of time fails to take account of the intrinsic difficulty of assessing complex HSS proposals. The ultimate victims of a weak assessment are both the countries whose proposals are not solid enough and the GAVI Alliance whose investments may be exposed to unacceptable levels of risk. This is why we have strongly recommended the GAVI Alliance and its Secretariat that in the case of HSS grants<sup>4</sup> they should either substantially redesign the IRC model or consider alternative options, such as subcontracting the process of HSS proposal review to an external provider tasked with reviewing all incoming HSS proposals through more direct engagement with country actors and country realities. In Volume 1 we will argue that the first option of re-designing the IRC would be more difficult to manage and would place additional transaction costs on the GAVI Secretariat, which is

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<sup>4</sup> We are not assuming that the IRC model serves better in the case of other GAVI windows such as ISS, NVS or INS – this will be the subject of a separate study to be conducted in the second part of 2009.

why we favour the second option as it would enable the Secretariat to subcontract the whole review process, not just its individuals. A third route we did consider was similar to that being piloted in some IHP+ countries for Joint Assessment of National Strategies, but we felt that such route –while promising- is not sufficiently developed yet for it to be used by the GAVI in the immediate future.

All these matters are put in context in Volume 1 as one of the main recommendations from this evaluation. We do recognise that bringing and adapting the HSS proposal review to the country level is a major departure from the current “one size fits all” model used by the Alliance<sup>5</sup>. However, we cannot see an alternative to it if the Alliance is to manage programmatic and fiduciary risk effectively. Should the GAVI accept our recommendation it should task the GAVI Secretariat with undertaking an appraisal of available options (the ones in the previous paragraph, and may be others). This cannot be possibly covered to the required depth in this evaluation, in part because it is beyond its scope but also because the GAVI Alliance would need to first accept our recommendation for anyone to explore these matters in the proper manner.

To undertake a country-based, differentiated assessment there is no need to change the nature of the Alliance and the fact that it is not present at country level. In fact it would meet a common aspiration by partner countries and address concerns that the current HSS proposal review process is too distant and not transparent enough, and that IRC members may not always be sufficiently aware of country realities for them to make fair and realistic observations to the Alliance.<sup>6</sup> Concerns about the country-based assessment resulting in higher transaction costs should be weighted against the current model that also imposes transaction costs while not fully achieving the ultimate aim of a solid proposal that deserves GAVI HSS support. In fact, face to face clarifications of complex matters may take less time than the formal process of correspondence on clarifications being used to date – both can and should be complementary.

These evaluators did consider whether alternative options exist to a modified IRC. We thought for instance whether greater involvement of WHO or UNICEF at proposal clarification stage would solve the identified problems, and while their engagement during proposal clarifications can hugely facilitate things –as we witnessed in several countries- they cannot replace for an independent, transparent and external assessment.

A modified IRC would offer the additional opportunity of better aligning the GAVI HSS design and approval model with ongoing initiatives aiming at more joined up assessment (and funding) of health systems strengthening initiatives. The IHP+ for example is

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<sup>5</sup> The issues are similar to those faced by the GFATM and its Technical Review Panel approach reviewing Phase 1 of GFATM grants.

<sup>6</sup> This point was raised by several speakers on day 1 (15<sup>th</sup> September) of the workshop held in Stockholm where the preliminary findings of the GAVI HSS Tracking Study were discussed. Similar points had been made to us during our case studies in Zambia, Ethiopia and Rwanda.



proposing that its members (that include the GAVI Alliance) undertake Joint Assessment of National Strategies (JANS). The JANS process has been created so that a country's health or specific health-related programme strategy is assessed against agreed, common criteria, reducing the number of multiple design appraisals that donors currently impose on countries. The benefit for GAVI of using the outcome of the JANS process is that the full range of contextual, managerial and governance factors, as well as technical factors, would be done in countries. An adapted IRC could either take part in the joint assessment process or use the outcome (which will be an assessment profile) to make a more informed decision about HSS funding.

### Time-frame and level of inputs required

In terms of timing of proposal development the 2009 GAVI guidelines estimate a period of 6 months from submission of proposal through to the receipt of funds in country. We know that not all countries have achieved this time-frame – a variable pattern can be observed in relation to this in Table 4 below. However, a number of factors are involved in possible delays including the internal country context and political cycles, not only the IRC and GAVI secretariat. In some countries applications were submitted and approved within 2-3 months.

**Table 4: Time from submission to disbursement in 21 sample countries**

Country	Round No.	Date Proposal submitted	Formal GAVI Board Approval	Date of 1 <sup>st</sup> tranche disbursed	Months from approval to disbursement of 1 <sup>st</sup> tranche <sup>7</sup>	Months from submission to disbursement
Burundi	1	3 Nov 06	12 Mar 07	4 Sep 07	6	10
Cambodia	1	3 Nov 06	1 Mar 07	4 Nov 07	8	12
Cambodia	5	11 May 07	14 Aug 08	29 Sep 08	1.5	16
DR Congo	2	3 Nov 06	13 Jun 07	2 Aug 08	2	9
Ethiopia	1	3 Nov 06	1 Mar 07	13 Apr 07	1.5	5
Kyrgyzstan	1	3 Nov 06	1 Mar 07	9 Jul 07	4	8
Liberia	2	2 Mar 07	13 Jun 07	27 Jul 07	1	4
Nepal	4	2 Mar 07	14 Feb 08	30 Apr 08	2.5	13
Pakistan	3	3 Nov 06	8 Aug 07	22 Aug 08	0.5	21
Rwanda	3	11 May 07	8 Aug 07	30 Oct 07	2.5	5
Viet Nam	2	3 Nov 06	13 Jun 07	8 Jul 07	1	8
Zambia	3	11 May 07	8 Aug 07	10 Dec 07	4	7
Bhutan	4	5 Oct 07	18 Feb 08	24 Apr 08	2	6
Georgia	2	2 Mar 07	13 Jun 07	13 Aug 07	2	5
Ghana	4	5 Oct 07	14 Feb 08	30 Apr 08	2.5	6
Honduras	4	11 May 07	18 Feb 08	30 Apr 08	2.5	11
Kenya	3	3 Nov 06	1 Aug 07	29 Apr 08	8	17
Nicaragua	4	5 Oct 07	18 Feb 08	30 Apr 08	2	6
Nigeria	4	5 Oct 07	18 Feb 08	28 Jun 08	4	8
Sierra Leone	4	3 Nov 06	14 Feb 08	9 Dec 08	10	15
Sri Lanka	4	2 Mar 07	14 Feb 08	30 Apr 08	2.5	13
Yemen	3	11 May 07	8 Aug 07	29 Oct 07	2	6

<sup>7</sup> Rounded up to nearest 0.5 of month. Information taken from GAVI Spreadsheet: HSS Approvals and Disbursements last update 25-05-09 (2) REVISED TOTAL.xls

### 2.1.5 Summary of recommendations

- Encourage countries to think strategically about their applications and consider the timing factor i.e. the need for HSS to be adapted to annual plans and budgeting cycles from the onset.
- Allow more time in the application development cycle to allow meaningful involvement of districts in the case of decentralised proposals.
- Ensure a balance of skills in the proposal development team (with requisite HSS expertise) and make the available experience on proposal development gathered by the GAVI Secretariat to benefit bidding countries. This would require more proactive involvement of the GAVI Secretariat or its designated proposals reviewers in the proposal development stage from the onset. Get the right people involved in design – not just EPI people.
- Treat shorter-term proposals as ‘inception phases’ to a longer term intervention, thus reducing the need to design two separate interventions and the time burden associated with proposal planning and development.
- GAVI may also consider being a bit more flexible in setting the benchmark for allocating HSS funds linked to GNP in certain countries whose GNP is borderline (see discussion on predictability in 3.2.4: caveats and potential improvements).
- If the Rounds approach is maintained the GAVI Secretariat should improve the timing of approval processes, disbursement of funds and APR reporting timelines to country processes and cycles
- Reconsider the IRC model and take the proposal review and clarification to the country level to as to ensure that:
  - a. it is able to assess the proposal within the country and also HSS context – use the platform of the Joint Assessment process where countries have developed this;
  - b. it allows for deeper discussion between the country and itself/ GAVI, particularly about results monitoring and implementation issues, and;
  - c. it is able to address and help resolve complex HSS issues through the clarification and approval process, or –when issues cannot be resolved- build these issues into the HSS proposal

## 2.2 Start up and early implementation

This section of the report covers the issues identified during the HSS grant start up period i.e. the months following receipt of the first tranche of HSS funds.

### 2.2.1 Technical support for the start up phase

Whilst, in most countries, significant amounts of technical support were deployed to develop HSS proposals, support has usually ended once proposals are approved. For example, the Rwanda study reports that “whilst technical support was available at the design stage it does not look like there is any such support for implementation”. Similarly,

the Vietnam study stated that “While both WHO and UNICEF were actively involved in proposal design, their involvement almost ceased at the time of supporting HSS grant implementation to the point that they hardly play any role in overseeing the quality and accuracy of HSS-related APR reporting”. Similar points were made in several other countries from our sample (Kyrgyzstan, Liberia, Nepal, Zambia, Nigeria, Sierra Leone, Sri Lanka, Yemen).

With this lack of technical support at start up (or additional analysis by implementers), many issues that were not fully appraised or resolved during design are not receiving the attention needed. As a result, some countries are experiencing slow start up periods (Nepal, Liberia, DRC) or are leaving important implementation or monitoring issues unresolved (Rwanda, Vietnam, Pakistan, Honduras).

Implementation of HSS programmes can be complex, involving many implementation sites or requiring new management systems. Their monitoring may also be difficult for the same reasons and because optimistic (i.e. unrealistic) assumptions are often made at design stage about the capacity of the national HMIS to deliver the data needed for M&E of the HSS grant. Technical support at start up would have brought a reality check that might have resulted in improved implementation.

Why did technical support cease after the design stage in many countries? One reason is because it was not clear to countries or to the potential providers of such support (WHO, UNICEF) or to GAVI that there was a need for it, a view confirmed in interviews with WHO and UNICEF and with those responsible for HSS early implementation. A number of countries (e.g. Burundi, Bhutan among others) also clearly did not feel the need for further technical support once the application was approved and funding provided. There was a strong feeling that any further support needs could be handled ‘in house’. Such sentiments may also be responsible for the perception that communications are not as smooth as they could be between government and in-country partners.

The role of the technical partners in supporting HSS grants at start up or later during implementation is not clearly defined in any country or in any HSS document. In general, there is very little familiarity at the country level with the arrangements and work plan made at the global level between GAVI, WHO and UNICEF. Frequently, other health sector partners have little knowledge of how HSS implementation is progressing and whether there may be opportunities for them to support the process. In spite of the fact that many HSS grants include substantial funds for technical support, little if any use is made of this at start up. In sum, there is neither demand for technical support nor clear articulation of how it might be supplied, or by whom.

The key issues highlighted by the above findings are:

- The requirement for technical support during the start-up and implementation phases should be much more clearly identified at the proposal development stage and during the approval process following IRC review. The proposal assessment process should identify areas that should receive attention during start up. This process would be strengthened if proposal assessment involved greater interaction with in-country sector coordination bodies whose members tend to have a better understanding of the feasibility of certain elements of the HSS proposal.
- GAVI should make applicants aware that issues identified by the IRC at design stage should receive particular attention at start up – including formation of the implementation structures and processes - , and that these should be reported on specifically in the first APR. For this, GAVI must ensure that the APR (monitoring) IRC is made aware of those issues too, recognising that this does not happen at the moment because design and monitoring IRCs involve different people and processes, and because countries are not specifically required to explain how key start up issues have been dealt with.
- Needs for technical support may be hard to predict, and demand for it is weak, not only at start up phase. GAVI should seek clearly stated agreements outlining the role that technical partners like WHO and UNICEF are expected to play in supporting the HSS grants at the time of start up and implementation and, as discussed later, in the production of the APR reports. In individual country contexts, GAVI will need to be assured that the technical partners have the skills and capacity for this – it cannot just be assumed. This is an example of the wider need for tighter specification of what is required of technical partners and for more capacity within GAVI to commission and evaluate this (see Section 4). GAVI will have to ensure adequate resources are made available for the technical support needed. In some cases this may be built into the HSS grant for countries to commission the support. In all cases GAVI should work to raise demand.

### **2.2.2 Who implements HSS? Issues on PMU**

Issues about technical support are linked to the type of implementation structures adopted for HSS implementation. The approach adopted by countries to manage their HSS grants varies considerably, and GAVI is quite open and flexible about this. Generally, GAVI promotes arrangements that avoid the setting up of parallel structures, and whilst many countries have given responsibility for implementing and reporting to existing units and departments, some countries have created separate project management units (PMU). Some, as with Viet Nam and Burundi, use a combination of both approaches, with a small

PMU within the planning department while implementation follows the established financial procedures and management systems.

The choice of implementation management model affects the start up phase. In Liberia, which has a relatively modest HSS proposal (US\$ 4 million) the decision was made not to create a PMU but to work through the structures of the MoH. This has worked quite well, but time was required to get those structures established and staffed, resulting in some delays in implementation. In Honduras it was found that disbursing the US\$2.5 million HSS grants and monitoring the HSS activities and indicators in 104 municipal governments required a lot of additional work that delayed start up by 9 months.

Whilst using a PMU to manage the HSS grant risks following a vertical and project-like implementation approach, it may be necessary sometimes, as in Pakistan, which has a fairly large HSS grant (US\$23.5 million), and where a highly decentralised implementation structure was originally envisaged that included the provision for provincial programme implementation units. At the central level, the Secretary of Health aims to exercise leadership through a PMU within the Planning and Development cell of the Federal Ministry of Health. Responsibility for implementing the programme is split between FMOH, WHO and UNICEF. In sum, the implementation model for the Pakistan programme is complex, but it received very little attention at the proposal design stage, which contributed to very serious delays.

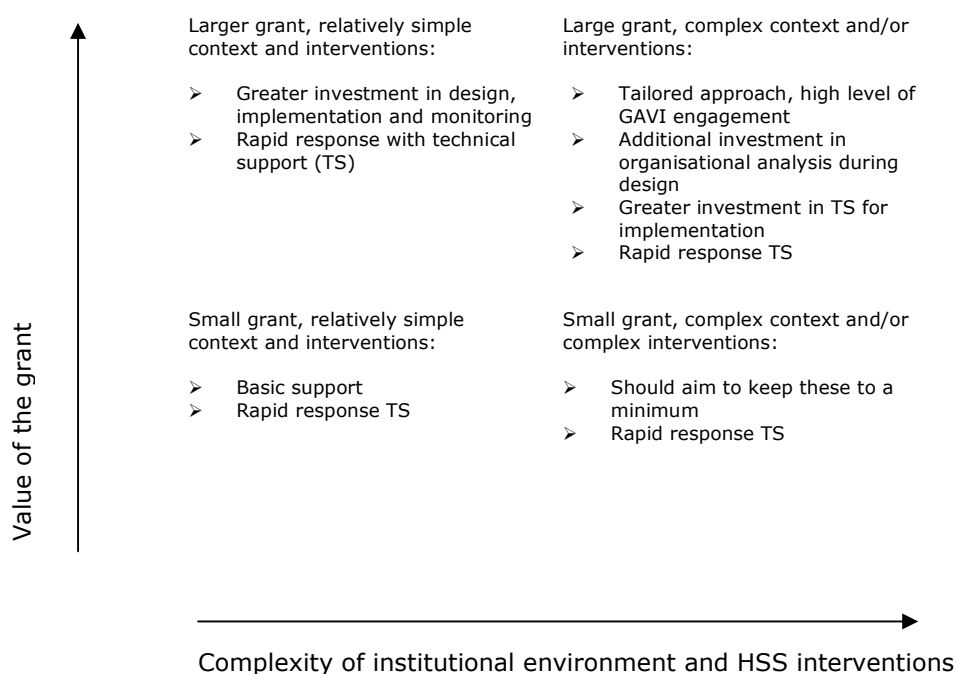
Nigeria also experienced significant delays in the implementation of its US\$44 million HSS programme. Part of the problem was a dispute between the Federal MoH and the National Primary Health Care Development Agency (NPHCDA) about where the HSS money should be deposited and who should control it. This should have been clarified during design, and closely followed up by GAVI as mentioned above.

The key issues highlighted by the above findings are:

- GAVI is right to promote the integration of implementation arrangements within normal country mechanisms whilst, at the same time, being flexible and acknowledging that country circumstances may sometimes require a project-specific PMU. However, closer attention is needed before and during start up to assess the implications of implementation arrangements as some of these may involve huge transactions costs (Honduras does not use a PMU structure but handles the release of HSS funds and their accounting through a parallel mechanism) or lead to delays (Nigeria, Pakistan, DRC), or indeed may identify needs and opportunities to move HSS support upstream to help strengthen normal country processes and mechanisms.

- Support to start up arrangements is crucial to control risk for larger grants and those where implementation is complex and will be made through many spending units. Whenever these elements are combined with a weak governance structure and/or with weak financial management capacity, there is high probability of serious problems or delays with HSS grant implementation, so GAVI should pay greater attention to design and start up, and be able to respond faster and more effectively to problems than it is able to do now. The relationship between the cash value of the grant and the complexity of arrangements in relation to risk is shown in the diagram below.

**Diagram 1: Categories of HSS Programmes**



### 2.2.3 Alignment of disbursements with country cycles

In some countries, HSS implementation has been delayed by the need to undertake a Year 1 HSS activity and expenditure planning exercise after grant approval and the receipt of Year 1 funding. But these delays were not then reflected in a revised plan for disbursement of HSS funds by GAVI. More engagement by GAVI during the start up phase could ensure better alignment between disbursements and annual activity plans.

Even where the HSS activity and expenditure plan appear fully aligned, delays may occur that GAVI should try and resolve more proactively. For example, although Nepal received HSS support in May 2008, delay in approval of the Government's budget meant that activities could not begin until late 2008. But since Nepal's Financial Year begins on the 15<sup>th</sup> of July, the result was that no HSS implementation occurred during FY 07/08 and

activities will now have to be implemented in Year 2. This will put quite a lot of pressure on the system to deliver. Similar situations of mismatch between disbursement and the country FY have been observed in many case study countries.

The key issue highlighted by the above findings is:

- GAVI should improve the alignment of its disbursements with the country fiscal year and planning cycles, and make decisions on the timing of HSS disbursements during the start up phase to prevent mismatches made at the onset of the HSS grant that later negatively affect implementation and budget calculations for the years to come.

**Table 5: Common issues faced by HSS proposals that deserved greater attention at Start-up phase**

Examples of issues that would have required increased attention at start-up phase	Burundi	Cambodia	DRC	Ethiopia	Kyrgyz Republic	Liberia	Nepal	Pakistan	Rwanda	Vietnam	Zambia
Centralised management of HSS Grant makes identification of local technical support needs difficult	√					√		√	√	√	
WHO & UNICEF insufficiently involved at start up - unclear role	√						√	√	√	√	
The HSS grant management model and links between central and peripheral implementing units may not be strong enough	√					√			√		
Delays in developing Year 1 implementation plan after approval of HSS funding			√			√		√		√	√
Greater attention needed on how HSS grant will be monitored and reported about, and the roles of various parties in this	√	√	√			√	√	√	√		√
Progress indicators not clear or realistic - sensibility and attribution of proposed HSS indicators needs substantial reviewing		√				√	√		√	√	√
Lack of fit between the Government and GAVI annual reporting systems	√	√		√			√		√	√	
Lack of fit between receipt of HSS funds and first year of HSS implementation		√	√				√	√	√	√	
Late arrival of first HSS tranche			√					√			

NB: The 10 Deeper Desk Studies were not included in this analysis as insufficient information was available on start-up issues



## 2.3 Monitoring and evaluation issues in country

Three themes can be discerned that help structure the findings of the evaluation:

1. The strength and inclusiveness of HSS planning processes;
2. The degree of alignment of GAVI HSS M&E with, and dependence on, national M&E frameworks
3. The quality of monitoring and the choice of indicators.

### 2.3.1 Strength of planning processes in country

Planning processes are the foundations for a good monitoring system. In the HSS approach there are at least 2 elements to be considered: one refers to the specific GAVI HSS planning processes while the second is about their integration and fit with country planning processes. Strong and inclusive planning is likely to result in more appropriate and measurable indicators and more comprehensive monitoring.

Whilst GAVI HSS proposal design has tended to be inclusive, annual operational planning has varied greatly in terms of its integration with overall sector planning processes and who is involved in them. In general the planning, monitoring and reporting processes used for the GAVI HSS grants ran in parallel and separately from national systems. This seems to be a result of various factors, including the timing of the HSS Rounds or, to be more precise, the fact that HSS disbursements take place according to the GAVI planning cycle (part of which is linked to the rounds) that often do not match the country planning and budgeting cycles. More flexibility on the GAVI side to time disbursements to country planning cycles could substantially improve a number of issues linked to alignment and harmonisation of HSS grants.

Another important factor (discussed later in this report) is the need for HSS countries to use a reporting mechanism – the APR - that is hard to integrate with national planning and reporting systems and where accountability of GAVI grants is primarily to GAVI and only then, if at all, to sector coordination structures and national stakeholders. When these issues are combined with the perceived weaknesses of the country reporting and accountability systems by those designing the HSS proposals the result has been a tendency for the HSS grants to be conceived as and to behave like self-contained projects, at the expense of the catalytic, dynamic elements that the HSS grants are expected to bring.

Many respondents perceived that GAVI should gradually favour use of country systems but recognised that this depends less on GAVI but on whether other donors lead by example and set such trends through improved alignment and harmonisation. As evaluators we think that the GAVI should make a stronger, country-based assessment of planning, monitoring and coordination arrangements for HSS grants at design and during the start

up phase. This would need stronger communication channels between the GAVI Secretariat and the countries for better timing of disbursements.

### **2.3.2 Issues related to national M&E capacity and capabilities**

M&E frameworks or plans for GAVI HSS have generally been only as strong as the existing national M&E capacity and capability. Challenges to monitoring of GAVI HSS funding are highly correlated with the ability of the country to monitor health sector activity more generally, and the levels at which GAVI HSS indicators are reported – particularly for outcome indicators.

- Cambodia, Ethiopia, Liberia, Nepal and Zambia all have strong health sector coordination committees. These provide reasonable oversight for and monitoring of various health sector activities, including those funded by GAVI HSS.
- In other study countries, notably Burundi, DRC and Rwanda, GAVI HSS monitoring is either not included in the monitoring of more general health sector activities or the health sector coordination is not yet well developed. In the case of DRC, GAVI HSS funding is geared towards strengthening health sector coordination, but this is not the case in Burundi or Rwanda.
- All of the above countries continue to experience challenges with their routine monitoring systems, in terms of data quality and completeness. The irony is that, where GAVI HSS funds are managed more on a project basis, activity reporting is fairly strong. And where GAVI HSS monitoring is more integrated into country systems, reporting may be more unreliable. This is not an argument for GAVI HSS to move to even more project oriented monitoring, but rather for a greater emphasis on using the funding to strengthen national monitoring systems more generally.

It appears that no assessment of the monitoring capacity and capability of the organisations responsible for these functions was made by the GAVI Secretariat or IRC during grant application or at start up. An assumption appears to have been made that if the HSS proposal made a reasonable case for how GAVI HSS funding would be monitored that this would translate into reasonable reporting of GAVI HSS indicators.

#### **Levels of disaggregation**

In many of the study countries GAVI HSS funds are concentrated on supporting interventions at decentralised levels of districts or provinces. Monitoring of inputs, outputs and outcomes is done regularly through HMIS at each of these levels, but tends to be aggregated and reported only at a national level. It is therefore very difficult, without, doing specific calculations, to monitor the effects of GAVI funding at the levels where it

probably matters most – at implementation level. This was certainly the case in Burundi and Rwanda, while Cambodia did present disaggregated data in its APR.

### 2.3.3 Issues related to the choice of indicators

A number of important issues were identified in relation to the choice of indicators for measuring GAVI HSS performance in our study countries. Details of these can be found in the country case study reports. Examples of the indicators in use have been included in Table 6 (next page) while only the main issues will be summarised here.

- 1) It is not clear that GAVI is monitoring the right things for HSS.
  - a) Activity monitoring is probably the most developed so far in countries, and is what is being reported on.
  - b) Input monitoring (i.e. tracking the use of HSS funds) is less certain, in that there are no checks on financial reporting, or in that reporting is on disbursements rather than expenditure (particularly in the decentralised HSS grants like Rwanda or Burundi).
  - c) Where nationally agreed HSS indicators exist (e.g. Cambodia) they are not being routinely used to measure GAVI HSS progress, which seems a missed opportunity.
  - d) In some cases key indicators that would measure outputs of GAVI HSS (e.g. supervision in Viet Nam) have been taken out of the APR indicator and activity list.
  
- 2) Related to the above – ‘downstream’ HSS grants<sup>8</sup> (e.g. Cambodia, Burundi, Ethiopia, Rwanda) can more easily see the links from inputs through processes to outputs, as outputs are activity based and fairly concrete. Upstream grants have a harder story to tell (DRC, Nepal. . .) about what they will have achieved with GAVI HSS funding – but the story is likely to be more interesting and fundamental. 2012 evaluation should have specific studies commissioned to examine just this issue.
  
- 3) The results indicators are very much focused on EPI indicators, even though many of the HSS activities are geared towards improving maternal and child health status more generally. It might be preferable to use HSS indicators similar to those being proposed by WHO and the World Bank<sup>9</sup> and summarised in table 7 (2 pages below), especially as many of the indicators are already included in country level HMIS. Although the indicators shown in the guidelines are only indicative many countries adopted those before considering the feasibility of measuring them and their attribution/usefulness.

<sup>8</sup> For a discussion on downstream or upstream orientation of HSS grants please refer to section 3.1.

<sup>9</sup> WHO (2008) Toolkit for Monitoring Health System Strengthening.  
[http://www.who.int/healthinfo/statistics/toolkit\\_hss/en/](http://www.who.int/healthinfo/statistics/toolkit_hss/en/)

Table 6: Outcome and Output Indicators for GAVI HSS In-Depth and Tracker Study Countries

Country	% DPT3 / pentavalent coverage	% districts with < 80 coverage	< 5 mortality	% measles coverage	% 6-12 months receiving Vit. A	% mosquito net coverage	% assisted deliveries	% children receiving IMCI protocol treatment	% women attending 4 ANC visits (or ANC Coverage)	CPR rates	<5 malnutrition rates	% children with pneumonia receiving approp. tx	# of facilities/districts implementing Minimum (Basic) Package	# of districts reaching performance targets indicated in annual plan	Average OPD utilisation	% of rayons with 90% of facilities receiving integrated supportive supervision at least once during the year	% of government health spending allocated to primary care
Burundi	X	X	X	X		X											
Cambodia	X	X	X						X				X	X			
DRC	X	X	X	X													
Ethiopia	X		X	X	X		X	X									
Kyrgyzstan	X	X	X													X	X
Liberia	X	X	X										X				
Nepal	X	X	X				X		X			X					
Pakistan	X	X	X										X				
Rwanda	X	X	X		X		X								X		
Viet Nam	X	X	X	X			X			X	X						
Zambia	X	X	X	X	X				X								

Please note the three first are GAVI HSS required indicators.

- 4) Significant problems with attribution of HSS indicators are described. It may be easier to measure and say something about attributing results to GAVI HSS funding in countries where specific provinces or districts have been supported as they can then be compared to other parts of the country that haven't received GAVI HSS support. Such a comparison would also allow a testing of the assumptions about reducing inequalities in immunisation coverage. A methodology could be developed for starting this process now for countries where support is given at decentralised levels. This is further discussed in Section 6 on the 2012 evaluation.
- 5) Assumptions have been made by most countries about the relationship between the causes of the problems identified, the inputs needed, and the outputs and outcomes expected, but these assumptions were at times unrealistic or simply wrong. For example, a commonly made assumption has been that a focus on districts with poor immunisation coverage would boost those districts and reduce their difference with better performing districts (Burundi, Cambodia, DRC, Zambia, etc.), but this may only be true if other variables are similar (per capita funding, accessibility, system's capacity, etcetera) or remain constant. Another frequent assumption is that improving emergency obstetric care coverage can lead to higher levels of immunisation coverage (Burundi): just because availability of better obstetric correlates with better health indicators does not mean that one causes the other. Etcetera.

**Table 7: HSS Indicators from WHO Toolkit for HSS Monitoring**

HSS Building Block	Selected HSS Indicators
Service Delivery	<ul style="list-style-type: none"> <li>Number and Distribution of health facility by 10,000 population</li> <li>Number of OPD visits</li> <li>Proportion of health facilities that meet basic service capacity standards</li> </ul>
Human Resources	<ul style="list-style-type: none"> <li>Number of health workers per 10,000 population</li> <li>Distribution of health workers – by geography, specialisation, place of work and sex</li> </ul>
Information Systems	<ul style="list-style-type: none"> <li>Two or more data points available for child mortality in the last five years</li> <li>Population projections for districts and smaller administrative areas available in print and electronically, well documented</li> <li>Number of institutional deliveries available, by district, and published within 12 months of preceding year</li> <li>National database with public and private sector health facilities, and geo-coding, available and updated within last 3 years</li> <li>National database with health workers by district and main cadres updated within last 2 years</li> <li>Annual data on availability of tracer medicines (including vaccines) and commodities in public and private health facilities</li> </ul>
Medical Commodities	<ul style="list-style-type: none"> <li>Percent of facilities that have all tracer medicines and commodities in stock: on the day of visit, and in the last three months</li> <li>Ratio of median local medicine price to international reference price</li> </ul>

	(median price ratio or MPR) for core list of drugs
Financing	<ul style="list-style-type: none"> <li>• Total Health Expenditure per capita in international and US\$</li> <li>• Ratio of household out-of-pocket expenditures to total health expenditure</li> </ul>
Governance	<ul style="list-style-type: none"> <li>• Existence of an up to date national health strategy linked to national needs and priorities</li> <li>• Existence of policies on drug procurement which specify the most cost-effective drugs in the right quantities; and open competitive bidding of suppliers for quality products</li> <li>• Existence of an updated, comprehensive multi-year plan for childhood immunisation</li> <li>• Existence of key health sector documents, which are published and disseminated regularly (such as budget documents, annual performance reviews, health indicators)</li> <li>• Regular sector reviews and monitoring?</li> </ul>

The implication of all the issues above is that in the majority of our case study countries the GAVI is unable to monitor satisfactorily (according to its own principles and standards) the HSS grants at input, output or process levels. This in turn implies that GAVI cannot clearly demonstrate that HSS funding is performance based. Outcome and impact monitoring is also weak and will be extremely difficult to demonstrate even by 2012.

Overall, clearer norms are needed for measuring HSS. The WHO toolkit is a start but needs trying out and refining to gain some evidence on the basic elements required to demonstrate HSS progress, i.e. to say 'this health system has been strengthened'.

Our findings are consistent with what has been reported to date, including in the IRC reports, as shown below in an excerpt from a consolidated IRC report:

*"This (monitoring) was still a difficult area for many countries. Sometimes the objectives were not SMART, and sometimes there was a poor match between the indicators and the activities. It is clear that this continues to be an area of need for technical assistance.*

*It also raises the question of the appropriateness of the guidelines in regard to "output" indicators. It appears to be very difficult for countries to identify suitable indicators which fall between process and outcome and which would link clearly to GAVI support.*

*In some cases there appeared to be confusion over whether the monitoring and evaluation expected was for the GAVI- supported HSS activities or whether the establishment of a broader M&E system was expected."*

Source: IRC HSS Consolidated report, November 2007.

## 2.4 Annual progress reporting (APR)

*All funded countries must submit APRs to GAVI for IRC review, by the deadlines above, using the relevant **GAVI guidelines and forms**. Countries should work closely with the HSCC and local partners including Civil Society Organizations (CSOs) and are recommended, before the deadline, to share a draft report with the Regional Working Group for a pre-review before final submission. Please note that a satisfactory APR is a requirement for continued GAVI support. Source: GAVI Website*

From its origin GAVI has aimed to be a Performance Based Financing (PBF) organisation linking the Board approval of new disbursements to evidence of progress through the Annual Progress Report (APR) review process. This applies to HSS grants. The APR is the annual opportunity for countries to demonstrate progress against their grants, so this evaluation study has placed considerable attention on assessing whether and how the APR process works for the HSS component.

### **Box 2.1: The APR process outlined**

- All countries receiving GAVI funds are expected to submit an Annual Progress Report to the GAVI Secretariat in Geneva. For this they use an APR template that can be downloaded from the GAVI website and that is regularly updated.
- Most countries submit the APR reports electronically. They should be received by the GAVI Secretariat by the 15<sup>th</sup> May every year. Some countries unable to meet the May deadline submit their reports in October.
- In Geneva an Independent Review Committee (IRC) made up of approximately 10 reviewers gathers for 2 weeks to review all APR reports received. Usually a minimum of two IRC reviewers check each APR and prepare a report. A consolidated IRC report reflecting IRC views on the APR outcome as a whole is also produced.
- The IRC report provides a separate assessment for each of the GAVI "windows" (INS, ISS, NVS, HSS) and, on the basis of progress reflected in the APR, makes a recommendation to the GAVI Alliance Board on whether the next tranche of GAVI funds should be disbursed (for each window).
- The GAVI Alliance Board receives the recommendations of the IRC and on that basis authorises or not the GAVI Secretariat to release the next tranche of funds. The GAVI Board usually adheres to the recommendation of the IRC.
- In their letter to the country the Executive Secretary of the GAVI Secretariat informs the country about the decision on continued funding and annexes – if appropriate – relevant comments made by the IRC on the APR.
- In certain circumstances (usually in the initial stages of a grant) the Secretariat may approve the release of funds before receiving the APR in order to enable the country access to funds as per the agreed plan. This happened in the early HSS rounds.
- Countries receiving GAVI funds have been quite compliant with the APR process. In the 2009 APR

34 countries submitted their APR reports in May and 35 were expected to do the same in the October window.

- In the 2008 APR covering activities and expenditure in 2007, all 11 countries expected to report on HSS grants did so. There were more countries receiving HSS grants at the time but only those who received funds for more than 3 months in 2007 were expected to report on HSS as per GAVI regulations.

Sources: GAVI Alliance Secretariat; GAVI Website; Martinez, J 2008.

At the time of this evaluation, not all APRs covering 2008 are available.

The following questions will be covered in this section of the evaluation report:

- How aligned is the APR processes with country systems?
- What was the quality of HSS reporting (focus, data reliability, etc) in the countries under study?
- What results were reported in relation to the HSS grants? How did these relate to the M&E framework?
- Can decisions on continued funding be made on the basis of reported results? Is HSS funding performance based?

#### **2.4.1 How aligned is the APR process with country systems?**

In the large majority of the countries under study the APR process is not well aligned with country planning, budgeting or reporting systems. Issues were raised by respondents on the format of the APR reporting, and the fact that it was very GAVI-specific and project like. Completing the APR report for HSS purposes is time consuming and involves high transactions costs, particularly for small countries like Rwanda, Burundi and Bhutan, for example, but also for larger countries like Viet Nam and Ethiopia. See Table 8 next page for a sample of issues identified in the case studies.

A frequent complaint is that GAVI requires countries to submit separate reports when alternative reporting arrangements already exist in the countries where health sector reviews are established procedures. Whilst sector reviews often do not deliver the HSS grant specific information required by GAVI, this could be addressed if necessary. The main obstacle to GAVI using existing country systems was perceived to be its lack of country presence and taking part in sector review processes.



**Table 8: Issues identified in relation to the 2008 APR in 21 evaluation case studies**

	Burundi	Cambodia	DRC	Ethiopia	Kyrgyzstan	Liberia	Nepal	Pakistan	Rwanda	Vietnam	Zambia	Bhutan DD	Honduras DD	Georgia DD	Ghana DD	Kenya DD	Nicaragua DD	Nigeria DD	Sri Lanka DD	Sierra Leone DD	Yemen DD
APR Submitted May 09?	Yes	Yes	Yes		Yes	Yes	No		Yes	Yes	Yes	Yes	Yes	Yes			No		No		
APR contained HSS information?	Yes	Yes	Yes		Yes	Yes	No		Yes	Yes	Yes	Yes	Yes	Very ltd			NA		N.A.		
HSS data verified by WHO or UNICEF	In part	In Part	No		¿	Yes	¿		No	No	Yes	Yes	Yes	Yes			NA		N.A.		
Quality of data for activity level	Fair	Fair	High		High	High	n/a		Poor	High	Poor	High	Poor	Poor			NA		N.A.		
Activity reporting integrated in HMIS or national systems?	No	No	Yes		Yes	Partly	Yes		No	No	No	Yes	No	No			??		N.A.		
Nº of HSS indicators reported/how many in proposal?	16/16	6/6	6/6			7/7	N/a		3/6	7/8	6/6	3/3	N.A	1/5			NA		N.A.		
Quality of HSS progress indicators	Fair	??	Poor		¿?	Fair	Fair?		Poor	??	Poor	??	N.A.	Poor			NA		N.A.		
APR (HSS) discussed at HSCC level?	No	No	No		Yes	Yes	Yes		No	No	Yes/ICC	Yes	No	Yes			??		N.A.		
APR aligned with sector review?/ Was perceived a problem?	No/?	No/?	No / Yes		Yes	No/yes	No		No/yes	No/yes	No/?	No	No	??			??		N.A.		
Alternative annual sector reviews in place?	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Not clear			Yes		N.A.		

There is also an issue about the timing of APR reporting, in terms of its lack of synchronisation with the country Fiscal Year (FY) and other established planning and budgeting processes in the Ministry of Health. In the case of countries where the FY coincides with the calendar year (used by GAVI for APR reporting) countries cannot provide an APR covering the previous year before the ministry of health has been able to prepare its annual report or before the sector review had taken place. Countries cannot attach sector or programme audit reports to the APR reports because they are either incomplete or still undergoing scrutiny.

All the above was found to have implications for the extent to which the HSS sections of the APR reports were reviewed and assessed by the sector coordination mechanisms, as required in the APR guidelines. Few countries were able to comply with what is implied in the guidelines, and the role of the HSCC was often found to be limited to signing the report rather than validating the information contained in it.

#### 2.4.2 The quality of HSS reporting

Countries are required to report on the activities, expenditure, and the HSS progress indicators provided in the proposal. Findings from the country case studies are:

**Quality of activity reporting.** With a few exceptions (Rwanda, Zambia, Pakistan) activity reporting was found to be of sufficient quality to link HSS investments with specific interventions undertaken in the sector. However, countries found it difficult to report on activities in the given space or to reflect the wealth of activity in HSS proposals being implemented in a decentralised manner (Rwanda, Vietnam).

**Integration of activity reporting.** Countries have not integrated GAVI HSS activity reporting with other forms of HSS reporting or with the national HMIS. The feasibility and associated costs of activity reporting have not been assessed at design or start-up stages, leading to serious constraints on being able to demonstrate HSS progress in the APRs.

**Reporting on HSS expenditure.** Most countries are able to show financial transfers or disbursements made to spending units (facilities, districts, institutions) but few can provide any evidence that the HSS funds have been actually spent or used for the agreed activities. This and the absence of audit reports means that, in most cases, it is not possible to assess expenditure of HSS funds from the APR.

**Reporting on HSS progress indicators.** Reporting on HSS indicators is very variable across the sample of countries, but in general few countries report on all HSS indicators. There are many disparities between the values of the HSS indicators shown in the APR and those reported in other parts of the country. Poor data verification (see next point) combined with selection of indicators and absence of baseline data in most countries was

found to seriously compromise the possibility of GAVI being ever in a position to measure the impact of HSS interventions in a meaningful manner.

**Poor verification of data quality used in the APR.** Insufficient evidence is provided in most cases about the sources and calculations used to estimate progress on HSS indicators. This fact, combined with a general absence of verification of the information provided in the HSS section of the APR report (by either the sector coordination group or the UN technical agencies) makes such information unreliable for performance monitoring purposes.

In sum, while the quality of APR reporting has been generally considered of acceptable quality in other GAVI windows<sup>10</sup> this is not the case for HSS related information, which is often unreliable in spite of the huge efforts and considerable costs involved in gathering it. This was not only the observation of these evaluators but a concern of the IRC who, in their 2008 consolidated report of the APR concluded that although countries provided some information on progress of HSS funded activities, “the IRC is of the opinion that the reporting was weak and inadequate in the case of most countries” (page 12)<sup>11</sup>. A recent review of the APR model undertaken in 2008 by independent consultants looked at 11 APR reports containing an HSS section and came to similar conclusions<sup>12</sup> in terms of poor reliability of HSS related information, often linked to the limitations of the APR model based on a distant IRC when applied to complex HSS grants.

### 2.4.3 HSS complexity and risk mitigation issues

Currently, the responsibility for routine measurement of the performance of GAVI Alliance support resides exclusively in the annual APR process. According to the GAVI Alliance Secretariat<sup>13</sup> the APR process is intended to:

1. Provide an opportunity for the Monitoring IRC to assess the performance of GAVI Alliance support provided in the previous calendar year through a number of different windows;
2. Be the formal decision making process that triggers the release of future tranches of support and also approves future vaccine schedules;
3. Identify and mitigate programme risk.

<sup>10</sup> Evaluation of the GAVI Alliance Phase 1 – Executive Summary, by Abt Associates. The Phase 1 evaluators do not question the IRC model but point to weaknesses linked to the ability of the GAVI Secretariat to act on IRC recommendations that we discuss in section 4.

<sup>11</sup> IRC 2008. Consolidated Report of the Assessment of the APR reports submitted in May 2008.

<sup>12</sup> Martinez J, 2008. Review of the Health Systems Support (HSS) component of Annual Progress Reports submitted to the GAVI alliance in 2008. .

<sup>13</sup> GAVI Alliance. Review of Annual progress reports for Measuring HSS Performance. Terms of Reference, November 2008.

In our opinion the APR process in its current form fails on all three counts when applied to the HSS window. Firstly, the focus on performance is lost because of poor quality or unverified HSS information. It is assessed through a distant IRC mechanism unable to interpret the information provided - mainly because of limited understanding of the country context. Therefore, the release of future tranches of funds is triggered more by the compliance with the APR process than by performance considerations<sup>14</sup>.

But it is at the level of mitigating programme risk that the HSS APR process is clearly failing. The reasons are similar to those mentioned earlier (reliability of programme information, distant IRC, etcetera) but one should add financial accountability matters linked to poor financial reporting, financial verification or auditing of HSS funds in the APR reports<sup>15</sup>. The GAVI Alliance has already taken steps for improved financial accountability of present and future grants through the Transparency and Accountability Policy (TAP), so our advice would be to separate the financial accountability issues from the APR process to the extent possible. Expenditure on HSS activities (or HSS funds disbursed to spending units as a proxy) should still be reported on in the APR, but the matching of that information with accounts available in country should be done more thoroughly and separately by the GAVI Alliance Secretariat (not by the IRC) or within a common country framework of financial monitoring in a SWAp context.

Where GAVI HSS funds are part of an existing financial arrangement (such as a pool fund or sector budget support) where accounting and audit procedures are shared by a group of donors, the risk incurred by GAVI is likely to be considerably less.

#### **2.4.4 Recommendations to improve HSS annual progress reporting**

The APR model is not providing the information that the GAVI needs to monitor progress of HSS investments and to mitigate programme risk. Problems relate partly to the rather rigid format of the APR template, but our main concerns relate to the poor integration with and little use of country systems of the APR process. The APR results in high transactions costs – to the GAVI, to its partners and to the recipients of HSS grants for no visible benefit to any of them. The APR as applied to HSS grants must change.

There are 2 main scenarios to consider for improving HSS annual reporting:

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<sup>14</sup> The issue here is less to do with the complexities of measuring HSS performance than with defining at proposal design stage what will be considered acceptable performance in the case of each HSS grant.

<sup>15</sup> It is not that countries do not abide by the audit requirements set in the HSS grant documents. Rather the issue is that the audit cum financial management assessments are seldom attached to the APR reports – APR timing issues partly to blame - or the data contained in such documents cannot be easily verified in Geneva in the case of complex HSS grants where activities (in APR reports) and budget line items (in audit reports) seldom coincide.

- a) **Scenario A** applies to countries that have well established sector monitoring and reporting systems, that have made substantial progress towards harmonisation and alignment of health sector aid and of health programmes and where governance structures are considered reliable enough for GAVI to use the systems that other health partners have agreed to use. In our sample of in-depth case studies the majority of countries would fall into this category, either because there is a functional SWAp in place or simply because the country has the essential instruments for greater sector coordination and alignment in place. In these countries the GAVI should make an effort to use the country sector review and monitoring systems and work with other partners to improve these as necessary. GAVI activities may still be reported annually along the lines of the current APR template, but the process of gathering such data should change substantially and become part (in time and modus operandi) of the broader health sector review.
- b) **Scenario B** affects a few countries where either coordination arrangements are not in place, or are too incipient, or where governance issues are of serious nature. In these countries the GAVI should also try to work alongside other partners but may need to use stand alone procedures similar to the current APR process.<sup>16</sup>
- c) **Bring the review –and reviewers- to the country level.** In both scenarios above the GAVI should give serious consideration to bringing the GAVI reviewers close to the country level so that they too adapt to and use the country systems. Options for this would be similar to those discussed in 2.1.4 and 2.1.5 in relation to the IRC HSS. In this case it would be a modified IRC Monitoring (or a contracted entity) that would be tasked with conducting the APR in ways that foster focus on results and mutual learning. In the case of Scenario B countries the APR would probably be heavier on the country given the higher programme risks involved, but the APR as such would not be in any way heavier than the current one while it would at least increase the chances of the GAVI getting what it needs and the country assessing its own progress. The crucial point is to ensure that - as the HSS guidelines suggest - the Health Sector Coordination structures “approve plans and annual budgets, interpret results and coordinate HSS grant with other HSS efforts”.
- d) **Strengthen the Start up measures.** The first step to improve the quality of HSS progress reporting is to strengthen the start up measures that follow on the disbursement of the first tranche of HSS funds. It is at this time when the reality check of the HSS proposal should take place to ensure that (a) implementation arrangements are in place and properly integrated within the implementing

<sup>16</sup> The evaluators were of the opinion that countries where planning, coordination arrangements or governance are very weak the whole purpose of injecting cash into the health system should be looked at carefully at application time, and the appropriate risk mitigation measures taken.

organisation, and that (b) monitoring arrangements (including the availability of essential baseline data)– are explicit and feasible when capacity issues in the implementing organisation are taken into account. Where ICC is the main coordination structure for HSS grants ensure the ICC reports to the higher level sector coordination structures.

In sum we are advocating for a completely new way of conducting annual progress reviews, but one where UN technical partners and other sector stakeholders still have an important role to play. For example:

- e) **The accuracy of the HSS information provided in the APR reports must be strengthened** through greater, more proactive engagement of both the health sector coordination structures and the UN Technical partners, especially WHO. For this the WHO needs a firm mandate where its responsibilities for supporting HSS monitoring and reporting are clearly spelt out. The associated costs that these activities entail should also be more explicitly acknowledged and funded at the country level (rather than through the current GAVI work plan that is hardly relevant or known to UN country office staff interviewed).
- f) **There needs to be greater clarity about the focus of the APR process.** The HSS process should (most years) focus on activity reporting, i.e. on inputs, processes and service indicators such as availability, coverage, accessibility or utilisation of essential services, and on the use of HSS funds. Changes in HSS progress indicators linked to health outcomes like IMR, or to average national service coverage indicators like DPT3 should be measured over longer periods. Selection of indicators should be more aligned with the sector progress indicators used in that country and their measurement should be linked to established processes such as the DHS, MICS or similar surveys.

Many of these recommendations seem to be already among the GAVI Alliance plans. For example, a recent report of the HSS task team admitted that “a wide-ranging discussion was held with partners on new approaches to monitoring GAVI HSS, and consensus was developed to move towards a more harmonised approach with country processes”.<sup>17</sup> In that document, for example, separate, more harmonised monitoring and reporting arrangements are advocated for IHP+/pooled financing countries. The challenge is significant though, since the GAVI should attempt to move fast in that direction and this would require substantial strengthening at the level of the GAVI Secretariat, as discussed elsewhere in this report (see 4.2).

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<sup>17</sup> Co-Chairs Report HSS Task Team for the period January-July 2008. Final. Page 3.

## 2.5 Results, Outputs and Outcomes

It has always been anticipated that, in the short time since countries have begun using their GAVI HSS funds, results will be hard to detect during this evaluation, and indeed this has been the case. In the absence of hard data, case study teams were asked to make judgements about whether programmes were heading in a positive direction and were likely to achieve results eventually. As noted in the sections on M&E and on the APR process, the weaknesses in both have resulted in a lack of results data being generated routinely, even where it appears during case studies that progress is occurring. Moreover, the great diversity of interventions selected by countries makes generalisations difficult.

Table 9 shows which countries were able to report on their output and outcome indicators in the 2008 and 2009 APRs (covering activities during 2007 and 2008 respectively). This table complements information provided earlier in Table 8.

### 2.5.1 Results to date

#### Policy results

Case studies and wider international interviews indicate that GAVI HSS is having some influence at the level of policy debate on health systems support. For example:

- Many countries saw quickly that GAVI HSS grants offered a new form of flexible funding and this has helped focus attention in countries on the needs for health systems strengthening. Even in countries that already had access to potentially flexible funding for HSS in the form of budget support (Ghana, Zambia, Rwanda), GAVI HSS funding has had this effect, and is viewed not only as welcome additional funding but also more flexible with which to achieve results in practice since it was under the control of the MOH. Rwanda, Vietnam, and others mention this advantage.
- The GAVI HSS model has attracted considerable interest among donors and countries alike, and has helped turn the attention of the international development community to the need for more health systems funding and to unresolved issues in health systems development now being addressed by new financing initiatives, IHP+ and the Joint Funding Platform for Health Systems.
- GAVI HSS has helped focus attention on the importance of good governance, functioning aid and sector coordination mechanisms combined with sufficiently robust planning, budgeting and financial management systems as key facilitating factors for HSS grants to go from design to implementation, and for wider systems strengthening generally. It has highlighted also that, in some cases, the grants are too small to make much impact on the kind of change needed.

**Table 9: How HSS countries reported on their HSS output and outcome indicators in their APRs for 2007 and 2008**

Round No.	Country	Date GAVI Approval Letter	Date 1st disbursement sent	HSS section in APR for 2007	Outcome progress reported	Output progress reported	HSS section in APR for 2008	Outcome progress reported	Output progress reported
1	Burundi	12 Mar 07	4 Sep 07	Yes	Yes	Yes	Yes	Partial	Partial
1	Cambodia	1 Mar 07	4 Nov 07	Yes	Partial	Partial	Yes	Partial	Partial
2	DRC	14 Aug 08	2 Aug 08	NA	NA	NA	Yes	Partial	Partial
1	Ethiopia	13 Jun 07	13 Apr 07	Yes	Partial	Partial	Yes	Partial	Partial
1	Kyrgyzstan	1 Mar 07	9 Jul 07	NA	NA	NA	Yes	Yes	No
2	Liberia	1 Mar 07	27 Jul 07	NA	NA	NA	Yes	Yes	Yes
4	Nepal	13 Jun 07	30 Apr 08	NA	NA	NA	Yes	Partial	No
3	Pakistan	14 Feb 08	22 Aug 08	Yes	Partial	No	Yes	Partial	No
3	Rwanda	8 Aug 07	30 Oct 07	NA	NA	NA	Yes	Partial	No
2	Vietnam	8 Aug 07	8 Jul 07	Yes	Partial	No	Yes	Yes	Yes
3	Zambia	13 Jun 07	10 Dec 07	NA	NA	NA	Yes	Partial	Yes
4	Bhutan	8 Aug 07	24 Apr 08	NA	NA	NA	Yes	No	No
2	Georgia	18 Feb 08	13 Aug 07	Yes	Partial	Partial	Yes	Partial	Partial
4	Ghana	13 Jun 07	30 Apr 07	NA	NA	NA	Yes	Partial	Partial
4	Honduras	14 Feb 08	30 Apr 08	NA	NA	NA	Yes	Partial	No
3	Kenya	18 Feb 08	29 Apr 08	NA	NA	NA	Yes	Partial	Partial
4	Nigeria	1 Aug 07	30 Apr 08	NA	NA	NA	No	NA	NA
4	Nicaragua	18 Feb 08	28 Jun 08	NA	NA	NA	No	NA	NA
4	Sierra Leone	18 Feb 08	9 Dec 08	NA	NA	NA	Yes	Yes	Yes
4	Sri Lanka	14 Feb 08	30 Apr 08	NA	NA	NA	No	NA	NA
3	Yemen	14 Feb 08	29 Oct 07	NA	NA	NA	Yes	Partial	Partial



## 2.5.2 Outputs and outcomes

### HSS activities

The large majority of the 21 case study countries were implementing HSS activities and reporting their implementation more or less as planned using the APR format (see Tables 8 and 9). Frequently, however, HSS activities are not clearly linked to GAVI HSS disbursements or expenditures, preventing their attribution to that funding. In some cases, expenditures are not detailed but just assumed to be equivalent to disbursements, in others HSS funds are consolidated with and indistinguishable from other funding being applied for similar purposes.

### Outputs

Tables 10-13 show available output data for the four Round 1 countries where implementation has been underway for over one year and with one full year, 2008, reported on in the APRs submitted in 2009. Available data show that HSS funds in these countries are supporting the agreed activities and are beginning to point to results, although these are often obscured by poor availability of baseline data.

**Table 10: Outputs reported in Burundi**

<b>BURUNDI – ROUND 1</b>			
<b>Outputs</b>	<b>Baseline 2005</b>	<b>Key OUTPUT Progress 2007-2008</b>	<b>TARGET 2011</b>
Number of health districts support by GAVI-HSS with a maternal referral system available and a functional counter reference	1/12	<b>12/12</b>	12/12
Number of doctors trained in CEmOC <sup>1</sup>	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	0	<b>100%</b>	100%
% of facilities with integrated management of childhood infection (PCIME) approach	0	26%	100%

**Table 11: Outputs reported in Cambodia**

<b>CAMBODIA – ROUND 1</b>				
<b>Outputs</b>	<b>Baseline 2005</b>	<b>Key OUTPUT Progress 2007</b>	<b>Key OUTPUT Progress 2008</b>	<b>TARGET 2010</b>
No of training courses conducted in planning and financial management capacity building	0	9 training courses for Provincial Health Departments (PHDs) in 16 Operational Districts (OD)	6 training courses in planning procedure in AOP for 296 PHDs / ODs /HCs staff across 10 ODs	20
No. of districts and health centres that have signed a contracting model of performance based management agreements (PBMA)	0	10 ODs signed and commenced PBMA for selected MCH services. 30 other ODs signed PBMA for improved immunization	139 health centre contracts signed	20
No of staff that have completed IMCI training	0	3 IMCI Clinical Training Courses in which 78 health staff trained	234	No target
No of health centres / district staff trained in health centre and financial management/budgeting processes	0	All HCs in 15 selected ODs received introduction training on new Financial Management Manual	Provinces / districts in 10 HSS areas trained in guidelines. Supervision for financial management in 5 ODs, and joint supervision with the monitoring team on two occasions in each of the 10 ODs.	All HCs in 20 selected ODs
% of health centres reporting budget expenditures properly	14%	1st quarter Second Generation Imprest Account liquidation statements have been received from all 10 PHDs.		66%

**Table 12: Outputs reported in Ethiopia**

<b>ETHIOPIA – ROUND 1</b>				
<b>Outputs</b>	<b>Baseline 2005</b>	<b>Key OUTPUT Progress 2006/07</b>	<b>Key OUTPUT Progress 2007/08</b>	<b>TARGET 2009/10</b>
% of woredas with timely funding for HEWS refresher course	29%	<b>95%</b>	-	95%
% of TVET schools with resources for apprenticeship	44%	<b>100%</b>	-	
No of health workers (HC level) trained in IMNCI	191	-	703	1270
# HEWS attending refresher courses per year	-	1603	<b>4471</b>	> 3400
% of woredas receiving funding for undertaking IRT for HEWS	-	29%	-	95%
No. of woreda health team members trained on IRT	-	659	-	95%
No. of HEWs who have received 1 session of IRT	-	1603	-	24,900
No. of health posts equipped with Health Post Kit	-	2346	3720	7340

**Table 13: Outputs reported in the Kyrgyz Republic**

<b>KYRGYZ REPUBLIC – ROUND 1</b>					
<b>Outputs</b>	<b>Baseline 2005</b>	<b>Key OUTPUT Progress 2006/07</b>	<b>Key OUTPUT Progress 2008</b>	<b>Key OUTPUT Progress 2009</b>	<b>Target by 2010</b>
# of vehicles purchased (and as % of planned)	0	Not in progress	<b>18 (67%)</b>	<b>Complete</b>	27
# of planned cold chain equipment purchased (and as % of planned)	0	Not in progress	<b>30 (300%)</b>	<b>Complete</b>	10
# of planned rayon level vaccine warehouses repaired (and as % of planned)	0	Not in progress	<b>36 (225%)</b>	<b>Complete</b>	16
# of trainers trained at the oblast and rayon level in immunization, IMCI, and other maternal and child health programs	0	Not in progress	15	In progress	26
# of FAPs receiving training in "WHO Practice of Immunization" (and as % of planned)	0	Not in progress	170	In progress	420
# of mobile teams established (and as % of planned)	0	Not in progress	Not in progress	In progress	40
# of primary care providers receiving performance incentive (and as % of planned)	0	Not in progress	8	35	85
# of NGO's working with urban migrants on health issues and which are in regular contact with the RHPC	0	Not in progress	14	14	20
% of measles and rubella cases that received lab confirmation	50%	NA	<b>100%</b>	NA	90
% of government health spending allocated to primary health care	28%	25% (2006) 25.6% (2007)	-	-	-

### Outcomes

Estimation of any changes in health outcomes resulting from GAVI HSS funding requires data to be available for 2008. Of the three core GAVI indicators, only data for DPT3 coverage is available, estimates of which were made available by WHO on 6 August 2009. District level coverage is not available after 2007, and the most recent U5MR data is typically for 2005. The attached tables and charts therefore focus on this DPT3.

Table 14 explores a possible relationship between DPT3 coverage and the Round in which funding was made available (countries which did not receive funding are excluded). A further comparison is made to counties that were eligible for GAVI HSS funding but made no proposal. For this group, the period 2007-2008 appears to have been on average one of little change in coverage levels. Over the longer period 2006-2008, the mean change is

somewhat larger though there is considerable variation in progress, with fifty percent of countries with declining coverage (not shown in table).

The Round GAVI HSS countries made much more substantial progress over both periods but as only four countries were involved (note that Korea DPR is excluded as it did not receive funds), it cannot be assumed that this is attributable to GAVI HSS funds. Data from the remaining Rounds show a mixed pattern, with a decline over 2007-2008 for the four countries in Round 2 following a substantial rise over the earlier period.

**Table 14: Change in DPT3 coverage 2007-2008 / 2006-2008 by GAVI HSS round**

Round	Number of countries	DPT3 Coverage Percentage points change 2007 to 2008		DPT3 Coverage Percentage points change 2006 to 2008	
		Mean	Median	Mean	Median
No proposal	33	0.2	0.0	2.1	0.0
1	4	2.8	4.5	5.8	6.0
2	4	-1.3	-1.5	3.5	4.5
3	6	1.3	1.0	2.7	2.5
4	11	0.2	0.0	0.7	0.0
5	10	0.1	0.0	0.4	0.0
All	68	0.3	0.0	2.0	0.0

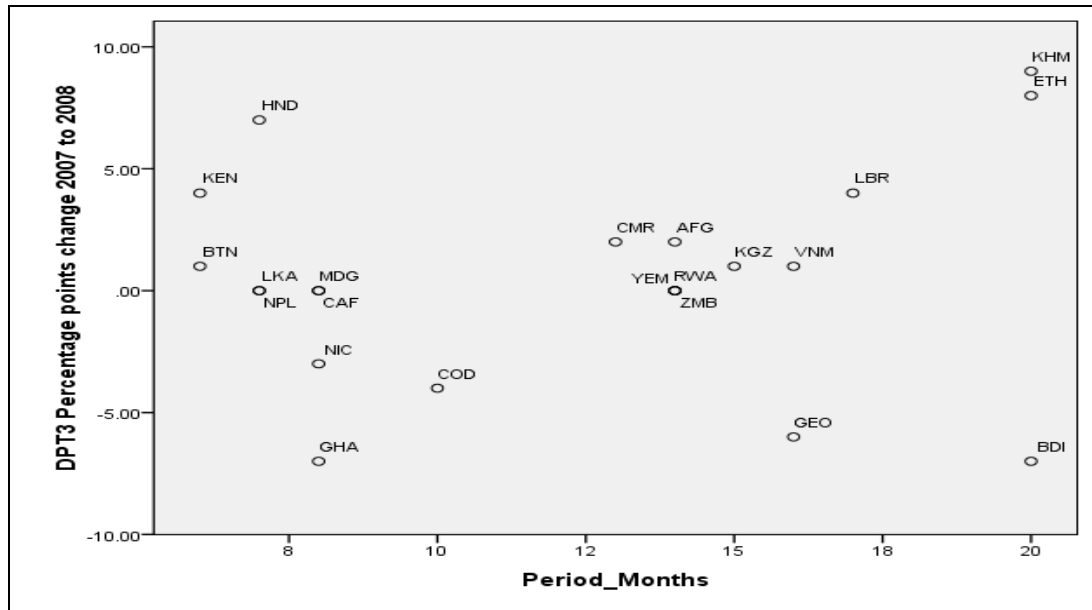
Table 15 compares those in their first year of GAVI HSS funding with those in their second. Again, the pattern seems to be that substantial gains were made over 2006-2008 for both of these groups, with some suggestion that those in year two performed a little better over 2007-2008. It should be noted, however, that, as indicated above, countries not receiving GAVI HSS funding made similar gains, though with a greater proportion performing badly.

**Table 15: Change in DPT3 coverage (%) 2007-2008 / 2006-2008 by year of funding**

Round	Number of countries	DPT3 Coverage Percentage points change 2007 to 2008		DPT3 Coverage Percentage points change 2006 to 2008	
		Mean	Median	Mean	Median
No proposal	33	0.2	0.0	2.1	0.0
Year 1	10	-0.2	0.0	2.8	4.0
Year 2	12	1.2	1.0	3.5	3.0
All	55	0.3	0.0	2.5	1.0

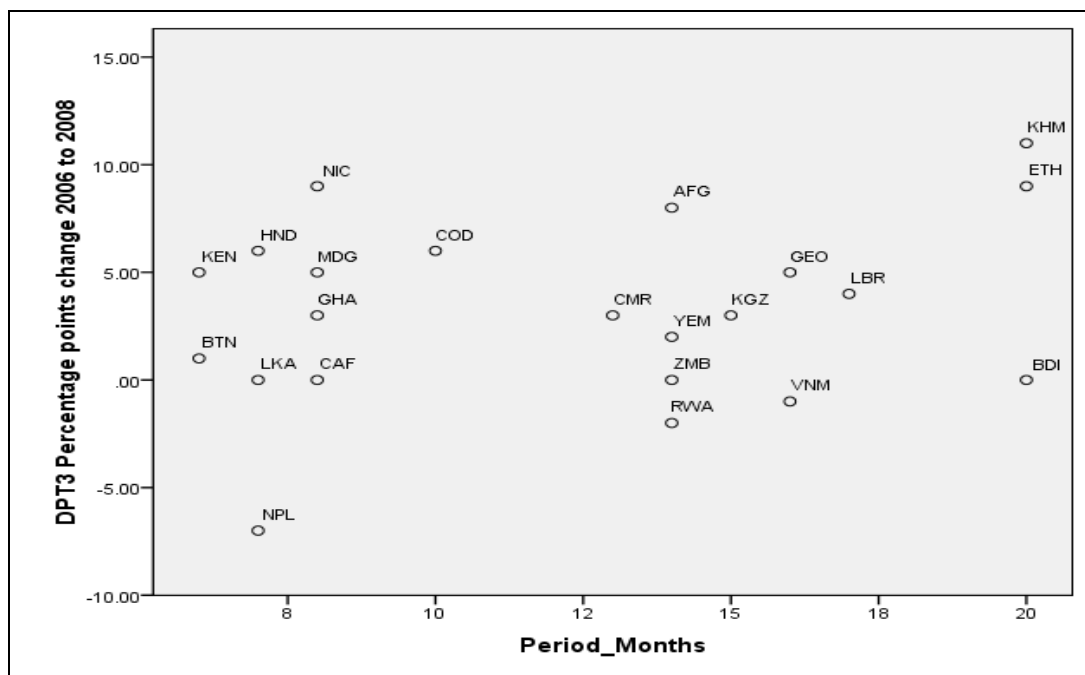
Figure 2 charts the relationship between the overall period of GAVI HSS funding in months (at the start of 2009) and the percentage point change in DPT3 coverage over 2007-2008 (from WHO SYS) for each country receiving funds. Again the results are inconclusive, with a slight tendency for longer periods of funding to be associated with better performance but very high variation in outcomes.

**Figure 2: Change in DPT3 coverage (%) 2007-2008 by period of GAVI HSS funding**



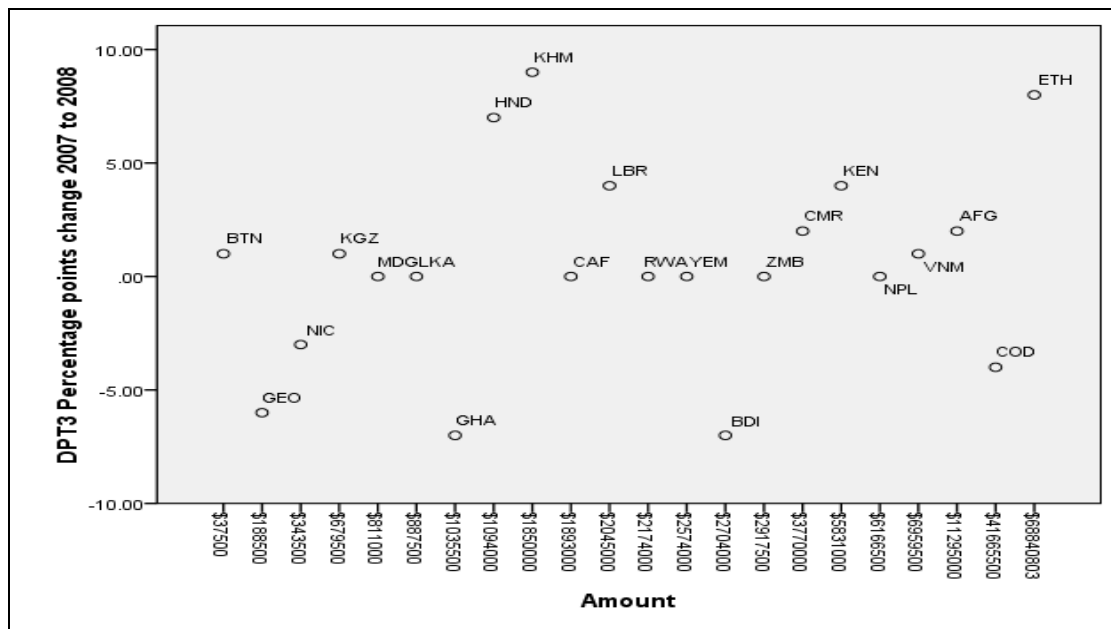
Neither is there evidence of a relationship in changes in DPT3 coverage over the longer period, 2006-2008 as shown in Figure 3, or between the absolute level of GAVI HSS funding and change in DPT3 coverage over 2007-2008 as shown in Figure 4.

**Figure 3: Change in DPT3 coverage (%) 2006-2008 by period of GAVI HSS funding**



It would clearly be useful to separate out the effects of amount and length of funding but this is problematic given the limited number of countries considered. All countries with at least six months funding are included.

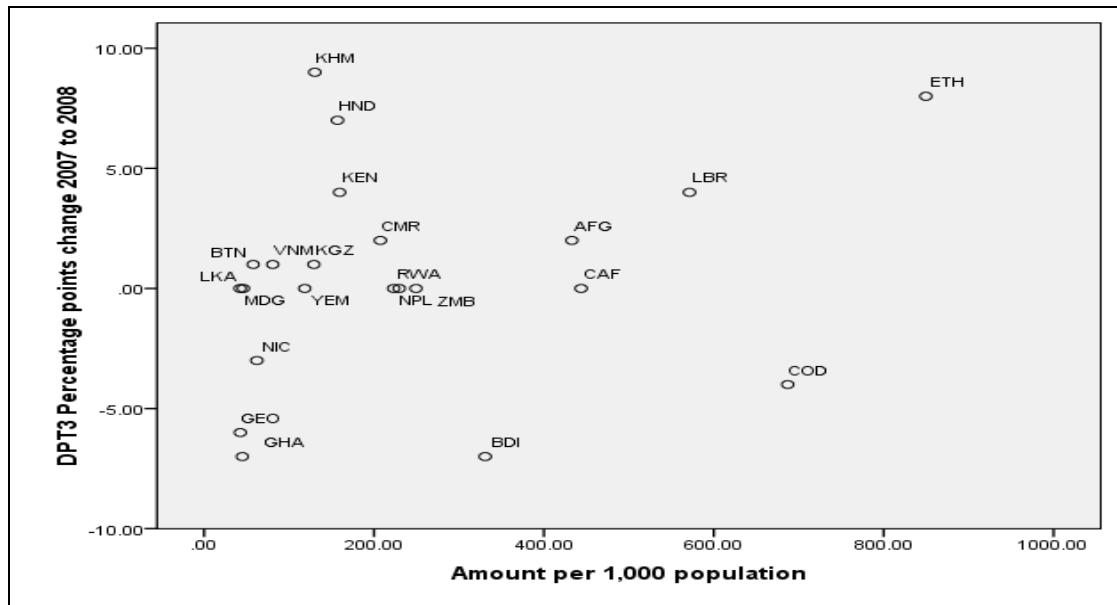
**Figure 4: Change in DPT3 coverage (%) 2007-2008 by amount of GAVI HSS funding\***



\*For countries with at least 6 months funding

Figure 5 shows change in DPT3 coverage by funding per 1,000 population. Again, there seems very little evidence of a relationship, though a simple regression would probably give a spurious significant result because of the high performance of one country, Ethiopia, which received substantial funding. Excluding Ethiopia from the chart removes any suggestion of any relationship.

**Figure 5: Change in DPT3 coverage (%) 2006-2008 by GAVI HSS funding per 1,000 population\***



\*For countries with at least 6 months funding

Section 6 of this evaluation presents issues about measuring progress of the GAVI HSS programmes as part of a discussion of the GAVI HSS evaluation 2012.

Tables 16-18 show the three GAVI HSS core indicators by country for 2002-2008, and targets for 2009-2012.

**Table 16: Available data for DTP3 % national coverage for case study countries**

Indicator Baseline, Target and Progress	BUR	CAM	DRC	ETH	KYR	LIB	NEP	PAK	RWA	VIE	ZAM	BHU	GEO	GHA	HON	KEN	NIC	NIG	SRI L	SIE L	YEM
<b>INDICATOR 1: DTP 3 (%)</b>																					
Baseline 2002	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	36	-	-	-
Baseline 2004	-	-	-	-	-	-	-	-	-	-	-	-	78	85	-	-	-	-	-	-	-
Baseline 2005	-	-	-	-	90	87	-	64.5	95	95	91	95	-	-	-	-	-	-	-	-	-
Baseline 2006	90	90	-	-	-	-	93	-	-	-	-	-	-	-	87	-	87	-	96	59	85
Target 2009	-	-	+20	80	-	-	-	-	96	-	-	-	-	-	-	-	-	-	-	80	-
Target 2010	-	94	-	-	96	92	95	-	-	95	95	-	95	-	90	-	-	80	-	-	90
Target 2011	93	-	-	-	-	-	-	-	-	-	-	-	-	90	-	-	-	-	-	-	-
Target 2012	-	-	-	-	-	-	-	96	-	-	-	95	-	-	-	-	99.5	-	99	-	-
Progress 2007	99	-	-	-	88	88	-	-	-	92	-	-	98	-	88	-	-	-	-	-	-
Progress 2008	101	91	-	-	95	92	-	73	97	-	-	-	-	92.5	93	-	97	-	-	-	-



**Table 17: Available data for DTP3 % Districts > 80% coverage for case study countries**

Indicator Baseline, Target and Progress	BUR	CAM	DRC	ETH	KYR	LIB	NEP	PAK	RWA	VIE	ZAM	BHU	GEO	GHA	HON	KEN	NIC	NIG	SRI L	SIE L	YEM
<b>INDICATOR 2: DTP3 % districts &gt; 80% (# of districts specified where % not given)</b>																					
Baseline 2005	-	23 <sup>1</sup>	-	69	-	-	-	25	95	-	58	18#	85	77	-	-	-	-	-	-	-
Baseline 2006	-	-	-	-	-	-	77	-	-	-	-	-	-	-	32	-	71	40	100	1#	58
Target 2009	-	-	-	85	-	-	-	-	100	-	-	-	-	-	-	-	-	-	-	11#	-
Target 2010	-	-	-	-	-	-	100	-	-	-	65	-	100	-	80	-	-	80	-	-	100
Target 2011	-	-	-	-	-	-	-	-	-	-	-	-	-	80	-	-	100	-	-	-	-
Target 2012	-	-	-	-	-	-	-	-	-	-	-	20#	-	-	-	-	-	-	100	-	-
Target 2013	-	100	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Target 2015	-	-	-	-	-	-	-	80	-	-	-	-	-	-	-	-	-	-	-	-	-
Progress 2007	94	-	-	81	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Progress 2008	-	-	-	74	-	-	-	-	-	-	-	-	-	83	89	-	-	-	-	-	-

1 Equivalent to 18 out of 76 in 2006

**Table 18: Available data on under-5 mortality for case study countries**

Indicator Baseline, Target and Progress	BUR	CAM	DRC	ETH	KYR	LIB	NEP	PAK	RWA	VIE	ZAM	BHU	GEO	GHA	HON	KEN	NIC	NIG	SRI	SIE	YEM
<b>INDICATOR 3: U5M (/1000 live births)</b>																					
Baseline 2003	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	102
Baseline 2004	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	194	-
Baseline 2005	-	82	213	123	29.7	-	-	103	152	-	168	60.5	-	95	-	-	-	-	-	-	-
Baseline 2006	-	-	-	-	-	-	61	-	-	-	-	-	-	-	26	114	35	194	16	-	-
Target 2007	-	-	-	-	-	225	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Target 2009	-	-	185	89	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	150	-
Target 2010	-	-	-	-	28	-	55	-	-	-	134	-	-	-	20	100	-	185	-	-	85
Target 2011	120	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	30	-	-	-	-
Target 2012	-	-	-	-	-	-	-	<65	-	-	-	35	-	-	-	-	-	-	12	-	-
Progress 2007	176	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Progress 2008	-	-	148	-	-	110	-	-	-	-	-	-	-	-	-	92	-	-	-	-	-

### 3. Strengths and weaknesses of GAVI HSS

This section covers the second objective of our evaluation study, as follows:

*Objective 2 - What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?*

Many strengths and areas for improvement have been already covered in Section 2 of this evaluation report. Therefore, in order to avoid repetition this Section will focus on two main areas, as follows:

- Is GAVI HSS funding being used for the right things?
- Is GAVI HSS adhering to the principles of aid effectiveness and to the defined HSS principles?

#### 3.1 Is GAVI HSS funding being used for the right things?

*Although partners disagreed about whether those applications were properly aligned with national planning and budgeting processes and cycles , there was a convergence of opinion about the presence of a number of deficiencies to cast doubts about their conceptual soundness and the value being obtained for the money being invested. .. Questions were raised about the adequacy of health sector constraint diagnoses. .. Some important constraints were consistently overlooked such as financing and fund flow. There was often a disjunction between problems identified and solutions proposed. For example, replacement parts and other consumables were often proposed to increase the availability of essential medical products, yet there was little attention towards enhancing management and procurement systems. (Naimoli 2009, on GAVI HSS application quality – page 14)*

##### 3.1.1 Focus and content of HSS proposals / programmes

Countries have selected a variety of uses for GAVI HSS grant funding, as shown in Table 17 (next page). Please note that while the table provides an overview of the types of HSS interventions it **does not show** three important pieces of qualifying information needed to provide a full picture of what GAVI HSS comprises in each country:

- a) How significant is each intervention area in relation to both the whole GAVI HSS proposal and in relation to broader country efforts in this area;
- b) The proportion of funding allocated to each intervention area;

- c) Whether or not the activities are to have an impact on upstream or downstream HSS.

Almost all countries have pitched projects 'downstream' in immunisation and MCH services delivery and in immediate support to delivery of those services, and sometimes in selected districts. Predominantly, country programmes cover training, strengthening management and supervision, and procurement of supplies and equipment and improving associated management, and many include improvements to information collection and use.

In general, countries have not tried to use GAVI HSS funding for more fundamental 'upstream' change in health systems, with a few exceptions like Yemen, or Pakistan (but the proposal was turned down by the IRC as being "too academical"). Our assessment of a major focus on downstream issues by most HSS proposals is broadly consistent with earlier assessments which found that, although countries had identified more upstream than operational level constraints, they proposed to allocate much more of the budget to operational than to upstream interventions.<sup>18</sup>

This is not surprising: service delivery level interventions are more manageable, likely to show tangible results in the shorter term, and are the emphasis of GAVI HSS guidelines, whilst more systemic change must be more politically driven and requires substantial investment. As a result, countries are not using GAVI HSS funding to target fundamental structural change in how national health sectors are financed or in how providers are employed, just to show 2 examples of important upstream needs in many countries.

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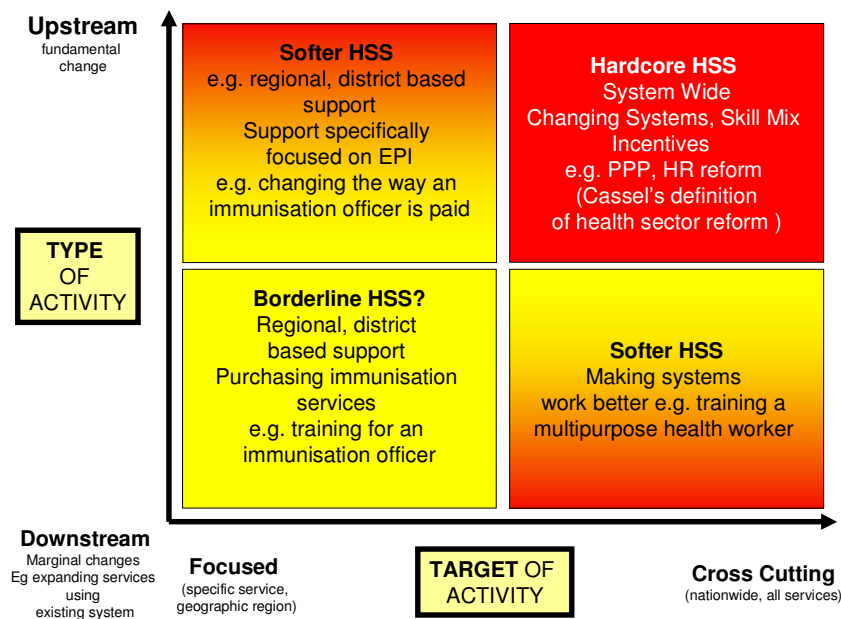
<sup>18</sup> See for example :“Country Initiatives to lift health systems constraints – lessons from 49 GAVI-HSS proposals” WHO/UNICEF/GAVI Alliance 2008, or “Key Features of the 2006-2007 proposals: a report to the GAVI HSS task team” by Hill et al. 31<sup>st</sup> August 2007.

Table 19: Categories of Intervention across 21 countries studied

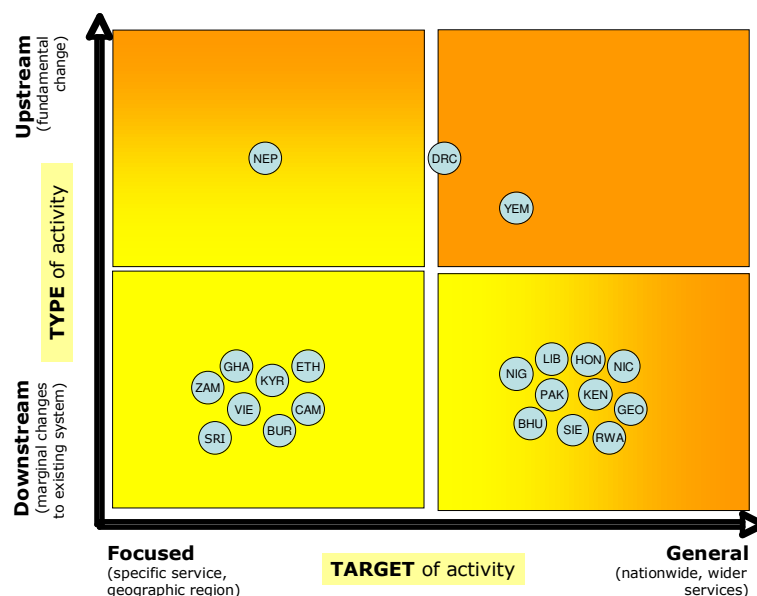
Categories of Intervention	BUR	CAM	DRC	ETH	KYR	LIB	NEP	PAK	RWA	VIE	ZAM	BHU	GEO	GHA	HON	KEN	NC	NG	SR L	SIE L	YEM
<b>Health workforce mobilization, distribution and motivation</b>																					
Incentives & performance based schemes	√	√	√		√			√	√	√	√		√							√	√
Basic and in-service training	√	√	√	√	√	√	√	√	√	√		√	√	√		√	√	√	√	√	√
Quality assurance initiatives		√												√			√		√		
<b>Organisation and management of health services</b>																					
Performance based contracting (e.g. with NGOs, CSOs, private providers)		√			√																
Improving HMIS	√		√	√		√	√	√		√				√			√	√	√		
Monitoring and Evaluation		√	√	√	√	√		√	√				√	√	√	√					√
Support for provincial and federal levels in supervision, monitoring and evaluation of health system performance & support to external review and evaluation								√													
Operational research		√																			
Strengthening management performance and supervision practice at all levels	√	√	√	√	√	√		√	√	√		√	√	√	√	√	√	√	√	√	√
Identifying and improving service provision and utilization for 'hard to reach' populations		√					√	√						√	√	√	√			√	√
Supporting implementation of more coordinated and integrated delivery of services (including immunization and other child health services)	√	√	√			√		√	√						√	√					√
Financial management improvements		√	√		√									√	√						√
Influencing demand for care	√	√			√	√			√												
Innovative strategies to improve health services		√			√					√				√							
Improving communications email internet computers etc							√					√									
Advocacy activities aimed at policy makers, parliamentarians, local govt. officials and the public					√																
<b>Supply, distribution and maintenance systems for drugs, equipment and infrastructure</b>																					
Supplies management (inc. vaccines and related supplies)			√			√			√	√				√				√			
Equipment management (e.g. cold chain etc)			√	√	√				√	√	√			√	√	√		√	√	√	
Transport management					√	√	√				√		√	√	√	√		√	√	√	
Infrastructure development			√	√	√		√	√	√		√							√	√		

Diagrams 2 and 3 below attempt to show the focus of the HSS proposals. Diagram 2 is a simple conceptual diagram for interpretation of Diagram 3, where we have reflected where the 21 case and desk studies would feature. Please note that Diagram 3 oversimplifies the reality of many HSS grants that combined elements of upstream and downstream interventions and may cover also both focused and cross-cutting interventions. In categorising each HSS proposal we did our best to consider which of the above categories were receiving the largest financial allocations.

**Diagram 2: Possible focus of HSS proposals**



**Diagram 3: Where do the 21 countries feature in terms of focus of HSS interventions**



### 3.1.2 Implications

The evidence available so far from country case studies is that:

- countries have identified some of their real constraints on expanding services coverage (see 2.1, 2.5.2 and Table 16) and have selected, generally, sensible objectives in reducing those constraints, although the potential of HSS activities to fully address those objectives varied markedly as was often weak;
- programmes have been very much country driven, and most are quite well aligned with national policies and sector strategies (if not so much with country processes);
- the flexibility of the GAVI HSS approach has enabled countries to design programmes around their real needs, not constraining them to preconceived problems or solutions;
- most countries are beginning to achieve results in terms of getting programmes underway, although some have had slow starts, and activities are normally consistent with those specified in the approved grant applications.

In learning lessons about future investment in HSS, however, a few issues stand out:

- Is GAVI HSS funding sufficient to make a real difference? Is it acceptable to GAVI that some interventions may only achieve a marginal change in the absence of other complementary investments?
- Is HSS funding appropriately **targeted**? How important are other upstream system changes that GAVI is not dealing with and how will countries be supported to achieve them?
- Has GAVI HSS been supportive of effective health aid architecture at country level or does it often create “semi-vertical” health projects of difficult fit with ongoing efforts such as those in IHP+ countries?

Furthermore, we know that overcoming the inertia in health systems, improving performance and sustaining that improvement requires significant upstream changes in the way public sectors are financed, staff employed and incentives applied, and requires good sector governance, solid planning, budgeting and financial management, and effective aid and sector coordination.

The following section looks at the extent to which the GAVI HSS process is meeting principles of good aid effectiveness from which it may be possible to draw some lessons for this joint programming initiative.

### **3.2 Is GAVI HSS meeting principles of aid effectiveness?**

This section analyses the extent to which the HSS grants adapt to the HSS principles depicted in the GAVI website and in the HSS proposal guidelines. Most of the HSS principles are either identical to or adapted from the principles for aid effectiveness depicted in the Paris Declaration for Aid Effectiveness and consistent with the Accra Agenda for Action. Each of the GAVI principles was covered through a list of questions depicted in our evaluation study guidelines (see Volume 3 C). Country specific reference to the application of these principles can be found in each of the 21 case studies that make up Volume 3.

Before we begin the review the following observations can be made:

1. The number and focus of principles has changed over time. Wording of principles is not always internally consistent with that shown in the HSS proposal guidelines.
2. Linked to the former we would argue that there is not a common understanding on what some of these principles mean in practice, so they are difficult to operationalise. Nor are they necessarily internally consistent. For instance, interventions may be innovative for a while only; the catalytic effect may come as an afterthought not spotted at design but still relevant; alignment with strategic plan does not imply alignment with annual planning and reporting systems.
3. At times some principles may be seen to contradict each other: results oriented versus innovative; aligned versus catalytic; etcetera. Such contradictions may be overcome but they too can create confusion.
4. Some principles e.g. additionality may actually undermine Government systems (i.e. conditions mean MoF not fully in control over resource allocation & macro-economic stability policies) and may be extremely difficult or costly to prove.
5. We did not find any means by which the GAVI Alliance Secretariat monitors the implementation of these principles. More attention seems to have been placed on principles at design stage than during implementation. This should change: principles need monitoring.
6. Quantifying progress against GAVI HSS Principles. We spent quite some time attempting to quantify GAVI HSS principles. A proposed methodology was presented during an analysis workshop that the evaluation team held in June 2009, and the consensus was not to attempt to quantify any results in relation to principles for the following reasons:
  - a. Most GAVI HSS principles were not made explicit to countries applying for HSS funds (at least not until second set of application guidelines were produced in 2007), neither had countries been ever informed that they



would eventually be evaluated against these. It was therefore felt that to attempt quantification at this stage would be unfair.

- b. Implementation has been too short in most countries for quantification purposes.
- c. Quantifying progress against principles would effectively be providing countries with a 'score' and inevitably these 'scores' could be compared across countries and regions. The evaluation team were concerned that this may result in unfair, over simplistic comparisons drawn without taking into account important contextual issues.
- d. The results of this exercise would have included a certain degree of subjectivity as there is often not a gold standard and also because there are a number of dimensions to each principle (e.g. alignment at design, at implementation, at review, at reporting, etcetera).
- e. In spite of these limitations we did address progress against principles in all 21 case and desk studies using a common approach. Our assessment was however qualitative in nature and can be found in the case studies included as Volume 3 of this evaluation. The findings are summarised below.

### 3.2.1 Country-driven

GAVI Alliance Health System Strengthening (HSS) support is intended to address weaknesses identified by implementing countries. They are encouraged to use recent immunisation programme and health sector analyses, National Health Sector Plans and similar inputs to identify weaknesses and gaps in current funding.

The case studies indicate that the decision to apply for GAVI HSS funding and that proposal design were both very much country driven, responding to country identified priorities. In some cases Ministers of Health themselves were directly involved in preparing GAVI HSS applications, along with other key ministry staff and stakeholders. Some countries were invited by the GAVI Secretariat to apply for HSS funding, often on a pilot basis, and in these cases the national governments embraced the opportunity, seeing the HSS window as a means of funding interventions or districts that were at that point under-funded. WHO and UNICEF along with the Inter-Agency Coordination Committees (IACC) provided strong technical support and facilitation to the government counterparts and task forces responsible for HSS design and application.

Specifically, country leadership was evidenced in our case studies through:

- a) Minister and senior director involvement in proposal design, writing the application or reviewing it;
- b) Task teams or similar being created to undertake proposal design under clear leadership from government;
- c) External consultants working directly to or under senior ministry staff guidance on

proposal design;

- d) Countries have made changes to agreed strategies after funding was approved based on a changing analysis of need and priorities at national level (Cambodia, Pakistan, Yemen).

The last point (d) offers a degree of challenge to the GAVI Secretariat and the IRC. There does not appear to have been a mechanism created for countries to signal to the Secretariat or IRC that they need to make changes to specific interventions that are funded by GAVI HSS. In all cases where changes have been made these have been reviewed and agreed through country level processes, usually via a meeting of the health sector coordination committee or the ICC, depending on which group has oversight of HSS funding.

### 3.2.2 Country-aligned

HSS should be consistent with the existing objectives, strategies and planning cycles of government health sector policy, aligned with government management systems and financial procedures, and reflected in national budgets wherever possible.

#### Strengths

The GAVI HSS grants were found to be generally aligned with national policies and plans, particularly at strategic level where HSS proposals adapted well to health sector strategic plans. The HSS proposals often made reference to how the interventions to be funded via GAVI HSS fit with national strategies and programmes and, in some cases (Ethiopia, Rwanda) the HSS funds were reflected in the MTEF too. We also found that an effort had been made at design for the GAVI HSS monitoring indicators to be part of the countries' HMIS, although efforts seldom led to a real integration for reasons discussed in section 2 as discussed in section 2 (2.2 and 2.3).

#### Areas for improvement

We found many examples where improvements can and should be made to adapt the GAVI HSS model to the country systems rather than the other way around. In fact, many respondents pointed to the blatant contradiction of a funding scheme aimed at strengthening national health systems that uses separate and parallel mechanisms for annual planning, budgeting, monitoring and reporting. For example, GAVI requirements for reports to be related to calendar years, with annual reports submitted by 15th May is a problem for countries on different fiscal years: this has created challenges for financial reporting in particular, but it also means that the current HSS model of linking support as per strategic plans prevents "bridge HSS funding" for the next plan. In second generation

HSS grants GAVI should attempt to time HSS proposal design to the year when the next strategic plan begins so as to enable the country to know whether it will be able to count on GAVI's HSS predictable funding.

Questions were also raised by country stakeholders as to why GAVI couldn't make better use of country health sector annual reports and meetings which provide the information GAVI needs about progress against country indicators, though not specifically tailored for GAVI HSS reporting. In some cases where GAVI funds are managed through government accounts and as the fiscal year is different (or processes slower) the country cannot get its accounts audited in time to meet GAVI deadlines (e.g. in Viet Nam). Nepal has decided not to abide by GAVI HSS deadlines for its 2008/09 report as the health sector's annual report, on which the HSS report is based, is only available in July of each year. In Ethiopia and Liberia, where GAVI HSS funding is 'on plan' and 'on budget' this has not been a problem as government systems are flexible and robust enough to report on different funds passing through central accounts. In Ethiopia and DRC GAVI HSS approach has helped to stimulate more alignment with national planning and reporting mechanisms.

In sum, the following issues are worth highlighting:

**Alignment of GAVI HSS and Annual Operational Plans** was seldom if ever observed, mainly because it was not clear to those implementing GAVI HSS grants whether changes to the annual HSS plans could be made (i.e. whether they would be acceptable to the GAVI)

**Alignment with established annual monitoring and reporting systems** was found to be particularly absent in most cases. As explained in sections 2.5 and 2.6 there is a long way for HSS review processes - APR and IRC in particular- to be adapted to and brought down to the level of the prevailing country systems such as joint Health Sector Reviews, Annual Health Sector Reports, etcetera. It was felt that alignment should improve in terms of processes, formats and timing.

**Alignment with sector coordination mechanisms** was found to be weak, particularly after the HSS design phase when HSS grants in several countries became almost invisible to national coordination mechanisms. There were of course worthy exceptions such as Ethiopia or Bhutan.

### 3.2.3 Harmonised

HSS should add value to (not compete with) current or planned efforts to strengthen the health systems by national governments, civil society and health sector partners.

Among the strengths of the GAVI HSS model we single out the efforts made at design for the HSS grants to avoid the creation of parallel implementation structures (PMUs) for grant management. Whenever grants were used the GAVI (through the IRC) emphasised the importance of using country systems, as the examples of Vietnam, Ethiopia and Burundi clearly demonstrate.

However, many of the shortcomings discussed under alignment apply to harmonisation as well, and suggest that the GAVI can and should do more to harmonise HSS with other health partners. In general HSS grants made attempts at design for HSS to complement the “efforts” by health sector partners. However, such attempts often had to be rather superficial by necessity because of one or more of the following factors:

- a) In some countries health sector coordination was not strong enough so as to enable harmonisation and complementarity;
- b) Even where sector coordination worked better HSS proposals often failed to depict clearly what other donors were funding, or where (geographically) was such funding being targeted,<sup>19</sup> which limited complementary strategies by HSS grants that had a decentralised (district, provincial) focus;

Because of these reasons above it was difficult for these evaluators to demonstrate if HSS funds were complementary to other sources. We also failed to see the complementarity of GAVI HSS with the HSS components of the Global Fund to fight Aids, Tuberculosis and Malaria. The main reason for that was that Global Fund contributions to health systems are “consistently limited by unaligned and non-harmonised activities and systems” that limit its own ability to complement other efforts, as a recent evaluation has stated in relation to the Global Fund’s contribution to health systems strengthening (Sherry et al. 2008). We found some IRC reports agreeing with us on the problems to assess complementarity of GAVI HSS interventions generally and in relation to the GFATM in particular<sup>20</sup>.

In practice, the model of using a distant IRC to assess the HSS proposal and GAVI’s lack of presence in country conspire against greater complementarity and harmonisation: both are principles that need to be addressed not just at design but through a constant effort over

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<sup>19</sup> The IRC identified this issue in its consolidated report following the review of 8 HSS proposals in November 2007. They observed that table 8.3 (to reflect donor activity) was not always used, and considered that *“this is an issue of particular concern for the IRC. It is very difficult to make a robust assessment of this area in the absence of such information. In fact, a short description of the activities supported by other donors and their relationship to activities proposed for GAVI support would actually be more useful than lists of other donor funds available without such information”*.

<sup>20</sup> In the same consolidated report cited earlier the IRC comments that “the complementarity of GAVI HSS support with that of GFATM and others was often not clear. This was identified as an issue resulting in requests for clarifications or conditions for 7 of the proposals”.

time, just as any other health partner. The same recommendations made in sections 2 and 4 to strengthen HSS design; review and support would improve the harmonisation of future HSS grants.

### 3.2.4 Predictable funding

From GAVI HSS Information Website: HSS support is, in principle, available for the life of National Health Sector Plans (or equivalent).

From GAVI HSS Guidelines: GAVI HSS support is available for the duration of the National Health Sector Plan (or country equivalent) or until 31 December, 2015 (whichever is sooner). Any possible future applications for GAVI HSS support from 2010 will depend on the outcome of an evaluation taking place in 2009

Whilst traditionally much debate on predictability has focussed on the implications of donor funding for aid dependence there is increasing acceptance that predictability of donor funding (or lack of it) is a major developmental constraint.<sup>21</sup> In broad terms we took predictability to reflect the degree of uncertainty related to the implementation of GAVI's procedures. Taking this definition we distinguish between:

- pre and post approval unpredictability: were the application guidelines clear and consistently applied?
- short and long term post approval predictability: were resources delivered in a timely fashion within the budget year, and from year to year? If not, why not? Did the approved application provide Government with the necessary information (and resources) to support the development (and implementation) of long term strategic planning?

### Strengths

Predictability is one of the stronger features of the GAVI HSS model as perceived by our respondents and by these evaluators. Perception of predictability was very strong when it was compared with other sources of funding –particularly bilateral funding in countries where health sector support is still dominated by large amounts of weakly coordinated project aid. Rwanda, Vietnam, Burundi, DRC and other countries provided such perception. The fact that GAVI HSS did not include a Phase 1 evaluation type of clause as in the case of the GFATM was probably one reason why many respondents also considered GAVI HSS more predictable than GFATM HSS.

A major strength of GAVI HSS is its transparent allocation formula which lets countries know exactly how much they are entitled to request which removes a key element of uncertainty present, for example, in the Global Fund. On the other hand, countries face

<sup>21</sup> Foster M & Keith A. The Case for Increased Aid. December 2003.

considerable uncertainty in knowing whether a proposal will actually be approved. This is not helped by the fact that, as GAVI quite rightly tries to be flexible, the guidelines are not very prescriptive. Many respondents complained that the IRC lacked sufficient knowledge about the country context or did not judge proposals consistently. A key question for the Board to consider is whether the approach should become more prescriptive (focusing for example on more innovative or catalytic proposals) or whether the make up or working of the IRC might need to change (as we recommend in 2.1 and 2.4), or both.

In terms of post approval predictability GAVI HSS generally performs well. A number of countries (Bhutan, Kyrgyz Republic, Honduras, Vietnam, Pakistan and a few others) did complain about late receipt of GAVI tranches, although in some cases late disbursements were due to the reliance on Government systems. In Nepal, for example, activities were held up by late approval of the Government budget. Although, the approach adopted was entirely valid it does highlight some of the risks of aligning with government systems and the trade offs between the different principles. In the Kyrgyz Republic, by contrast, GAVI HSS funds were “taken off the SWAp” to avoid a disruption in funding.

GAVI HSS *will* perform exceptionally well in terms of long term predictability. Support is provided for the duration of a national plan which runs to as long as 8 years in Cambodia and far longer than most other donors in country are prepared to permit. To date though the picture may appear less positive this reflecting the fact that GAVI HSS has often been introduced into countries towards the end of their plan periods (e.g. for 1 year for Cambodia for its first proposal). This led some respondents to question whether it was worth all of the effort. However, as GAVI HSS funding is increasingly awarded at the start of any health plans (for which HSS design should precede the launch of the plan!) this should be less of a problem.

### **Caveats and potential improvements**

There are two possible caveats to predictability relating to the possibility that funds might not be forthcoming either because Governments do not perform or GAVI does not have the money.

- The first reflects the fact that support is not guaranteed but is dependant upon satisfactory progress as set out in the APR. It is far from clear what the basis for withholding funds would be – just how bad would performance have to be? There also seems to be little clarity on what the process would be? Would there be a first warning? Would any decision take immediate effect or would it be applied in the next financial year? Would all funds be withheld or could just a proportion be withheld? Although this has not been an issue to date<sup>22</sup> as no countries have seen their funds withheld for performance related issues, this being a result of a

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<sup>22</sup> Some countries have seen their HSS funds delayed for reasons outside HSS, as happened in the case of Burundi where the HSS tranche was delayed for a year pending clarification and refund of ISS monies. However, this is clearly not an HSS performance issue.

deliberate GAVI policy (mentioned in some internal GAVI documents but not widely known) of giving countries a margin of about 2 years for HSS implementation structures to be properly developed before assessing performance as such. GAVI might consider how to give more explicit guidance on this issue.

- The second source of uncertainty relates to the question of whether GAVI actually has the resources available to meet its obligations to countries who meet the requirements for disbursements. Efforts have been made to get a clear idea of the likelihood of this but despite repeated requests GAVI has been unable to provide the necessary information. The risk of this is understood to be very low.

One specific issue which emerged relates to the fact that countries whose per capita income exceeds \$365 face a huge reduction in their allocation. (Cambodia allocation for phase 2 was a little over half that in phase 1.) . The idea of a transparent formula is a good one and GAVI's wish to focus resources on those most in need by giving a higher allocation to countries with a lower per capita income is also laudable. The problem relates to the transition and its implications for the allocation of resources. Does a country with a per capita income of \$366 really "need" twice the level of resources as one with an income of \$364? The Board should revisit this issue. One approach might be to agree high and low allocation countries at a point in time and stick with it and having no transition between groups, or to reduce the differential.

One suggestion from interlocutors in case study countries for improving the predictability of HSS funding was to bring HSS disbursement in line with the country's annual planning cycle, so that planning of HSS activities could take place as part of remaining sector planning. We endorse this recommendation.

### 3.2.5 Additional

HSS funds must be additional to the government's existing budget and not displace previously allocated health sector resources.

In practice, it is extremely difficult to assess whether HSS funds are additional because assessing displacement requires a level of scrutiny of budget management practices that exceeds the scope of this evaluation. Likewise, it would take the GAVI a faint amount of dedicated work to prove that its HSS funds are truly additional should it decide to attempt such a task in order to monitor this principle.

Most countries in our case studies considered that HSS funding was additional, but this was an impression rather than a fact, and only on one occasion did our interlocutors

openly admit that they could not prove that HSS funds were additional due to the decentralised nature of HSS implementation<sup>23</sup>.

Where considered the team's judgement was that funds were usually, in part, if not fully additional implying that in the absence of GAVI HSS funds activities would not have been carried out at all or carried out much more slowly.

### 3.2.6 Inclusive, collaborative and accountable

All key stakeholders (beyond immunisation) should be involved in HSS. Government entities, partners, civil society, and the private sector should all be informed and involved, as appropriate, in the planning, implementation and evaluation stages.

Section 2 has shown that while HSS design processes were open, inclusive and collaborative with UN technical agencies and often had made a serious attempt to involve health sector coordination structures. However, such inclusiveness and collaboration was considerably reduced -even ceased- as HSS implementation began. Several factors have been identified (all included already in Section 2):

- In countries where HSS was implemented by the EPI department (Rwanda, Zambia, Cambodia) or by a dedicated management unit (Burundi) the integration of HSS with the HSCC was weak. Often all that the HSCC contributed to HSS was its signature to the APR reports, if at all, while HSCC members remained largely unaware of progress with HSS.
- In countries with stronger sector coordination and accountability mechanisms HSS was better integrated with other efforts.

We found little evidence in our case studies that the HSS grants had made efforts to engage civil society organisations or NGOs in the design or implementation of HSS proposals, except in the cases where such organisations already played a role in delivering certain immunisation related services. We did not consider that to be a limitation of the HSS model but a reflection of the status quo in each country. A similar comment can be made in relation to gender focus of HSS proposals, also absent from most proposals, but this does not mean necessarily that the HSS interventions could not have a positive effect in reducing gender bias as many HSS interventions would have children and their mothers as primary beneficiaries and stakeholders.

We have included accountability as a key GAVI principle because it is implied in many other principles and mutual accountability is a Paris principle. In general, the accountability of HSS grants was quite satisfactory and was found to be directly related to

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<sup>23</sup> Only in Vietnam did the government admit that the additional and complementary nature of HSS funding might be at risk in some provinces given their considerable budgeting and resource allocation autonomy that is outside the remit of the MOH.



their alignment and integration with sector planning, monitoring and implementation mechanisms. In the few cases where HSS implementation or oversight had been allocated to EPI departments or to isolated PMUs HSS grant accountability was found to have been negatively affected (as in Rwanda and Burundi).

### 3.2.7 Catalytic

From GAVI HSS Information website: HSS should not result in the creation of stand-alone, independently managed projects. Ideally, it should be an agent for catalytic change where possible – for example, testing pilot projects that could subsequently be scaled up by government.

From HSS Guidelines: Countries are expected to target the GAVI HSS support to catalytic initiatives where possible, such as support to new national health system strengthening initiatives or pilot initiatives in a geographically discrete area that could subsequently be scaled up to cover the whole country. Likewise the GAVI Alliance encourages countries to use the HSS support to develop new innovative models or approaches for national health system strengthening

There seems to be little consensus on what these two terms –innovative and catalytic– actually mean and how they differ although useful examples of relevant activities are spelt out in the guidelines.

The team took catalytic to mean GAVI HSS having an impact over and above just the effects of their particular interventions i.e. making Government, districts, health workers, other donors do things they would not have done otherwise – similar in concept to “externalities” as commonly used by economists but not necessarily implying innovative activities. Innovative was taken to mean a new way of doing things in the country in question. There is also a spectrum of innovative from small, incremental changes to more radical, fundamental changes and the principles were also considered from that perspective

Given the relatively limited scale of GAVI HSS funding and the huge systems challenges these principles seem broadly appropriate. GAVI cannot do everything itself and will need to harness expertise and resources from others. However, we need to be aware that the developing world is littered with successful pilots (islands of excellence) which were not subsequently rolled out. To avoid this fate it will be important to ensure that any approaches adopted are country led, that any approaches are rigorously evaluated (to ensure they are worth rolling out) and that sustainability is fully considered. Pilot approaches are more effective in some settings than others (Nepal was suggested as an example – China is often cited in this respect) and GAVI would wish to be confident that proposals involving innovative approaches are realistic and well designed with thought given to how any roll out process might take place.

From the case studies reviewed it is apparent that most programmes involved components which were innovative, catalytic (or likely to be) or both. In Cambodia, for example, support for performance based initiatives preceded and informed Government current move towards internal contracting. This was both innovative (not necessarily a new idea but GAVI provided the first opportunity to implement it) and catalytic (in that it informed the design of a fundamental change in how the health system operated). The same could be said of the performance based financing approach in the Kyrgyz Republic which is both innovative and likely to be catalytic (the programme will be rolled out to all districts with Government funding) and will also influence the design of a much broader adoption of the approach supported by the World Bank-led Results based Initiative. In Vietnam it was claimed that the incentives being paid by the GAVI and other donors to Village Health Workers (VHWs) might have influenced the decision by the Prime Minister for the government to provide incentives to all VHWs. In Yemen a new concept of outreach provision of de-verticalised primary health care is clearly innovative. DRC HSS funding was seen as having been responsible for catalysing greater cross-government ownership the previously developed, but unfunded, system strengthening strategy. Our interlocutors in DRC and Ethiopia also considered that the HSS had sharpened focus on the need to strengthen alignment at sector level.

In summary, GAVI HSS is supporting a number of innovative and catalytic activities – often focused on quite fundamental issues. It is too early in most cases to say what the effects will be although there are some positive signs already. It is crucial, however, that any innovative activities are rigorously evaluated, that any results are credible and appropriate action is taken on the basis of them. Plans are usually in place to do this – but it is important that these are followed up at the 2012 evaluation.

### 3.2.8 Innovative

GAVI encourages health service innovation. HSS can be used to test new strategies or approaches or to adapt learning and best practice from elsewhere.

This has been already discussed under “Catalytic” above.

### 3.2.9 Results-oriented

Implementing countries must link strategies for tackling barriers to specific indicators that show how use of HSS funds will improve immunisation and other forms of child and maternal health care. The results should be evident at local level. Progress towards agreed goals will be monitored by GAVI Alliance partners including WHO, UNICEF, the World Bank and the Health Metrics Network.

Evaluating the results orientation of GAVI HSS funds could involve a number of methodological challenges linked to how results are defined and measured. For the

purposes of this section results will refer to the achievement of indicators as described in out study methodology (see methods in 1.3) i.e. the transition from input and process indicators (funds, activities, implementation arrangements, etcetera) to outputs, outcomes and impact that is achieved in the countries under study. In other words, we have made no attempts to define any kind of standards for HSS performance for issues similar to those discussed in section 6 (the impact of HSS interventions and the 2012 Evaluation).<sup>24</sup>

One of the most serious findings of this evaluation is that the GAVI HSS model in its current form is failing to show results even in cases where such results are being achieved due to a perverse combination of factors that have been covered in Sections 2.3 and 2.5. Issues have been grouped as follows:

- **HSS design issues.** While GAVI HSS funding doesn't impose its own set of indicators it should do much more to encourage countries to use the indicators that would seem more appropriate to their circumstances and monitoring frameworks. Weak HSS planning is often at the origin of weak monitoring of results. Assessment of the monitoring capacity and capability of the organisations responsible for M&E and HMIS appears to have been weak or inexistent at design or start up phases.
- **Capacity issues.** Challenges to monitor GAVI HSS are highly correlated with the capabilities of the country to monitor health sector activity more generally. While such capabilities are often weak, GAVI's tendency to work in parallel to established country planning and reporting systems defeats the double purpose of strengthening the national planning systems or measuring the health systems' impact of its interventions.
- **What is being monitored?** It is not clear that GAVI is monitoring the right things for HSS. Output monitoring (mainly of HSS activities) seems to be the most developed so far in countries. It is less clear in the case of input monitoring given the commonly found lack of checks for links between financial and activity reporting in our case studies. The results indicators are very much focused on EPI indicators, even though many of the HSS activities are geared towards improving maternal and child health status more generally. Significant problems of attribution of HSS progress indicators plague the HSS monitoring frameworks in both upstream and downstream HSS strategies.
- **Use of HSS information.** Where HSS indicators exist (e.g. Cambodia) they are not always being used to measure GAVI HSS progress, although there are exceptions like Ethiopia where HSS and sector indicators are often the same. In

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<sup>24</sup> For a review of methodological issues linked to the measurement of performance based results please refer to Pearson M (2008) in the list of References.

some cases key indicators that would measure outputs of GAVI HSS (e.g. supervision in Viet Nam) have been taken out of the APR indicator and activity list. In decentralised HSS grants monitoring of inputs, outputs and outcomes is done regularly through HMIS but tends to be aggregated and reported only at a national level, which further complicates the measurement of progress and the use of information.

- **Rigidity of some HSS monitoring frameworks.** Assumptions have been made by most countries about the relationship between the causes of the problems identified, the inputs needed, and the outputs and outcomes expected, but these assumptions may not always work. Furthermore, even if assumptions were right there may be a need to modify HSS strategies along the way, which is difficult given some rules about reprogramming of HSS budgets. Overall, clearer norms are needed for measuring HSS. The WHO toolkit is a start but needs trying out and refining to gain some evidence on the basic elements required to demonstrate HSS progress.
- **The APR process does not adapt well to HSS needs.** The APR process is the cornerstone for HSS performance monitoring and there are many signs that it is not working for HSS grants. In section 2.6 we have referred to issues linked with the *Quality of activity reporting* and with its *lack of integration* with country reporting systems or with the national HMIS. *Reporting on HSS expenditure* has also been found to be weak as few reports can provide any evidence of HSS funds being spent or used for the agreed activities. In general there is *poor verification of data quality used in the APR*. Insufficient evidence is provided in most cases about the sources and calculations used to estimate progress on HSS activities or indicators.
- **Weak results orientation increases the risks of HSS funding to GAVI.** Not only is performance monitoring weak but the financial and programme risks taken by the GAVI are very high. Once in a year stock taking is not enough particularly when such stock taking is so deficient.

The implication of all the issues above is that GAVI cannot clearly demonstrate that the funding of HSS grants is based on performance, because the results that would be needed to assess performance are either not the ones being reported or the reporting is weak. Our findings are consistent with what has been reported to date by several studies, articles and internal GAVI reports, including the reports submitted by members of the IRC (both IRC Design and IRC Monitoring) in relation to HSS monitoring (see sections 2.5 and 2.6).

### 3.2.10 Sustainability

From HSS Information Website: Implementing countries must take into consideration how the recurring financial and technical requirements of health service improvement of HSS support can be sustained beyond the period of GAVI support.

From HSS Guidelines: Countries should consider the medium to long-term financial implications of GAVI HSS support. In this context it will be important to consider and describe how the need for future financing for issues such as maintenance, hiring of new staff, new staff allowances or salary top-ups will be sustained after the GAVI HSS funding has come to an end. This is especially important for major capital expenditures related to new infrastructure, transport, equipment, hiring of new staff and staff allowances or incentives.

The team considered sustainability from a number of perspectives:

- **financial sustainability** –whether the long term costs been assessed and whether funding sources have been identified
- **sustainability of benefits** – whether the benefits achieved will be sustained i.e. not simply a matter of continuing to provide the money?
- **sustainability of human resources** – whether there be sufficient staff to continue such support once HSS funding is completed. This is likely to be particularly important if the HSS application supports salary supplements/performance based pay

It is worth stating up front that - unlike the other principles - achieving sustainability cannot be guaranteed by GAVI and the Ministry of Health alone. In addition, although steps can be taken to improve the prospects for sustainability during proposal implementation sustainability cannot be truly tested until after GAVI funding ends. It is also difficult to assess the degree to which good intentions (commitments) about future sustainability actually represent a *guarantee* of future funding. Presumably good intentions are better than nothing and intentions set out by the Ministry of Finance may achieve higher credibility, but all remain intentions none the less. Ultimately, therefore it is difficult to make definitive statements about progress towards sustainability. Rather than spend too much time on this it probably makes more sense for GAVI to focus its attention on whether programmes are *worth* sustaining e.g. through independent assessments and tracker studies.

We approached the issue in a number of ways. Firstly, we reviewed the content of proposals to assess the balance between components which were of a one off nature (with no recurrent costs) and those with ongoing recurrent costs. Secondly, we looked at the extent to which Governments had a good track record in terms of sustaining externally

funded programmes – notably in terms of taking over the vaccine costs for national programmes and also more broadly at the country's general fiscal prospects.

In general, the assessment of financial and programme sustainability issues in the original HSS proposals and then in the post-approval period was quite superficial. This was caused by a combination of factors which preclude closer engagement between the GAVI Secretariat –or its IRC- and the country at design, start up and implementation stages. Superficial assessments were a concern in the case of proposals supporting performance based financing (Burundi, Rwanda, Vietnam, Yemen, and DRC). These perhaps pose the biggest sustainability challenges – they have large recurrent costs, rely on the availability of human resources and it is far from clear that they always provide benefits at reasonable cost. It appeared to these evaluators that often GAVI (or the IRC) had too readily agreed to support these initiatives without sufficient stock taking of government track record and other variables that might shed light on the chances for financial sustainability.

Some proposals raised larger financial sustainability issues than others. The findings suggest there is a balance between investments which are one-off in nature and those which have ongoing costs. In the case of the former the issue is less one of financial sustainability but whether they achieve the expected benefits and continue to do so. Key examples here would be the training of auxiliary health workers in Nepal or village health workers in Vietnam. Does the training cover the right areas? Does it actually lead to any changes in behaviour? If they do will trainees actually be using those skills in 5 years time (given that many of them are already late-middle age and may retire soon).

Many of the countries reviewed had a good track record in terms of taking over the running costs of immunisation programmes (e.g. covering the costs of traditional vaccines). The fact that programmes seemed to have enjoyed significant country ownership would indicate that countries will wish to sustain the programmes if they possibly can. Whilst this is reassuring it provides no guarantee for the future.

In terms of general fiscal prospects carrying out a detailed analysis of fiscal space on a country by country basis was outside the scope of this evaluation. However, it is possible to say that since GAVI HSS was established, fiscal prospects in GAVI HSS recipient countries have, on the whole, worsened (there may be exceptions but we cannot tell which) largely as a result of the global financial crisis. Thus, it would be reasonable to say that financial sustainability risks have increased since establishment of the GAVI HSS window.

It is also suggested that any joint programming approach to supporting health systems strengthening takes a more proactive approach in this area – benefiting from the expertise of the World Bank which has a comparative advantage in this area. This should not only be proposal specific in terms of being more explicit about ongoing funding requirements –

simply extending the GAVI Financial Sustainability Plan (FSP) approach to HSS would help but would not be enough. It should also include a broader fiscal analysis – ideally within an MTEF framework - which sets the ongoing HSS funding requirements in the context of the needs to sustain other programmes such as those from USAID and other bilaterals, general sector support programs and Global Fund programmes which often have far higher recurrent implications. It is also worth noting that GAVI itself is adding to country sustainability challenges through its other channels (e.g. the recent introduction of the pentavalent vaccine in the Kyrgyz Republic).

### 3.2.11 Improving equity

From HSS Guidelines: GAVI HSS encourages approaches to achieve sustainable universal coverage within the context of Primary Health Care approaches. This includes identifying hard to reach groups, marginalised populations and addressing issues of inequity (including those based on gender). The GAVI Alliance’s Gender Policy aims to promote increased coverage, effectiveness and efficiency of immunisation and related health services by ensuring that all girls and boys, women and men, receive equal access to these services. To attain the MDGs there is a need to address gender inequalities and their impact on access to and use of essential health services, including immunisation and child health services.

The approach to equity is mixed. In some countries certain districts or provinces have been targeted based on a range of criteria, including current immunisation performance, availability of infrastructure/transport/human resources as well as socio-economic indicators: Vietnam, Bhutan, Burundi, DRC, Honduras (focused on 104 municipalities), Nicaragua (which focused on specific municipalities), Zambia (12 districts), Yemen (64 districts), Cambodia (10 ODs), Nepal (varies by component), Sri Lanka and Ghana all fall into such category. However, there is often little focus on ensuring that those most in need *within* those geographical areas are targeted. This is an important distinction in countries where, for instance, socio economic status plays a higher role in accessing health care than geographical location.

In other countries a national approach is adopted in some cases more because all areas are seen as equally poor (Liberia, Sierra Leone) or others where it was seen as the best way to move forward (as in Rwanda, where new districts might not have had at the time of design sufficient planning experience to enable a more differentiated district approach). No cases were found of equity based indicators in the M&E framework. In some cases plans are in place to carry out socio economic surveys to assess impact on different groups (Kyrgyz). These could usefully feed into the 2012 evaluation.

## 4. HSS support at national, regional and global levels

This section covers the second objective of our evaluation study, as follows:

*Objective 3 - How has GAVI HSS been supported at regional and global levels – what are the strengths of these processes and which areas require further improvement?*

Support to GAVI HSS was evaluated using the various main stages of the GAVI HSS process (as displayed in Table 20) and the various participants providing support at each of those stages. Sources of information included were:

- the country case studies, in which evaluators looked at the roles of the main participants in each country concerned, the results of support and the views of participants where possible, both from those providing support and from those receiving it;
- interviews, phone discussions and a small email survey covering members of the various organisations, agencies and committees involved.

All WHO Regional Offices, HSS Task Team members, IRC (proposals) members, and IRC (APR) members were invited to participate, and all those agreeing were followed up. Further interviews and discussions were held with a selection of GAVI Secretariat staff, and with senior staff in each of the WHO, Global Fund and IHP+. Resulting informants are listed in Annex 1. A summarised compilation of comments received is provided in Volume 3c.

Both in-country case studies and interviews with informants internationally were structured with check lists of issues by each major stage of the GAVI HSS process, but respondents were encouraged to provide their own views on the strengths and weaknesses of the HSS process. It was agreed that sources would be kept confidential.

This evaluation did not include an organisational audit of GAVI or any other participating organisation and, therefore, does not attempt to provide in-depth recommendations for restructuring or internal management processes.

This review of support follows other earlier related work including a recent review of technical support within the GAVI Alliance (McKinsey. 2008).

### 4.1 The GAVI HSS process and the supporting roles

The GAVI Alliance is a global health partnership representing stakeholders in immunisation from both private and public sectors: developing world and donor governments, private



sector philanthropists such as the Bill & Melinda Gates Foundation, the financial community, developed and developing country vaccine manufacturers, research and technical institutes, civil society organisations and multilateral organisations like the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the World Bank. Working together, Alliance members achieve objectives, that no single agency or group could achieve on their own.

The GAVI HSS process relies heavily on support to countries provided from a range of 'technical partners', namely WHO, UNICEF and the World Bank. The process is summarised in the chart below. It was a decision by GAVI to establish the HSS process in this way, with a lean in-house staff and reliance on technical partners to make the process work. However, the operational implications of technically supporting HSS grants at country level could only be guessed at the time the HSS scheme was launched. More recent work, such as the one undertaken by McKinsey (2008) reviewing the issue of technical support within the GAVI Alliance began to shed light on issues that this evaluation has simply confirmed. In a nutshell, delivering technical support for HSS within complex and fragmented national health systems requires clear roles, responsibilities and terms of engagement with the entities expected to provide such support.

In this evaluation the following key problems were observed resulting from inadequacies in the support received by countries for HSS grants:

- Although they may be country-driven and inclusive, many proposals are technically and financially weak. Although many focus on important constraints to service delivery, few have convincing linkage between constraints, objectives of the proposed HSS programme, activities to achieve those objectives, indicators that measure them, and specifications for how activities will be implemented and how indicators will be monitored. Partly this is a result of confusion sown by GAVI HSS documentation and demands for indicators that are not very appropriate to HSS (see sections 2.3 and 2.4), but mainly it is a result of weak planning capacity in ministries and weak technical support for HSS in countries.
- GAVI knows remarkably little about what is actually going on in some of the countries implementing programmes with GAVI HSS funding. It is not assessing or managing risk adequately, and some country programmes are extremely high risk. Whilst much of this problem results from a review process that is structurally unsound (see section on APR), much also results from a lack of technical support to countries from GAVI or its technical partners both during design and start up to ensure that monitoring and evaluation and reporting systems are in place, or how they are to be put in place or strengthened as part of implementation.

- GAVI could improve its learning about HSS in practice by making better use of the very many studies commissioned from the Secretariat and of the feedback that the IRCs (HSS and Monitoring) deliver regularly in their consolidated reports. To be fair the GAVI has commissioned important studies linked to HSS lately (such as the Tracking Studies) but there is a general weakness in the capacity of the Secretariat to synthesising information and letting countries know about it. We have also found a number of examples during this evaluation suggesting that the Secretariat has little institutional knowledge or memory of the details of country HSS situations and the environments in which HSS investments are being made, or such information is stored in different parts of the Secretariat and not always easily available to its members. In general, there is a lack of synthesis of lessons and dissemination of them. Much of what learning occurs is at IRC level, and although IRCs have attempted to draw lessons, these are offered from the outside, not generated by the routine business of GAVI and so are not owned and often not acted upon.

The sections below look at the support roles played by the major participants in the GAVI HSS process.

**Table 20 - GAVI HSS process and support, and roles of main participants**

Steps in HSS process	Support to countries provided by	Type of support
Design, monitoring and improvement of HSS policies, processes and mechanisms	GAVI Secretariat (GS) GAVI HSS Task Team	Advisory to GAVI not to country
Information about HSS process	GS GS Country Support Team (CST) WHO/UNICEF country and regional staff	Pre-prepared materials: GAVI Handbook, HSS Guidelines, APR Guidelines, Good practice document, FAQs Response to queries Information re HSS availability and process
Country programme design and application <ul style="list-style-type: none"> <li>• Civil society involvement</li> <li>• MOH/HSCC to lead and sign off</li> <li>• MOF to sign off</li> </ul>	GAVI HSS partners: <ul style="list-style-type: none"> <li>• WHO, UNICEF regional and country staff</li> <li>• Consultants appointment by country</li> <li>• Inter-agency coordinating committee (ICC)</li> </ul>	Technical input on HSS, support for consultant procurement and use of GAVI TA grant \$50,000 for consultant
Country level pre-assessment <ul style="list-style-type: none"> <li>• Sign off by MOH, HSCC, MOF</li> </ul>	Country-level stakeholders including partners coordinated by HSCC, ICC External reviewers if requested	Peer review, country experience Technical review

Post application review		
Pre-review by WHO:	WHO Regional or country staff	Consistency check, Assessment Guide to IRC (support to process not country)
IRC application assessment: <ul style="list-style-type: none"> <li>Approval</li> <li>Approval pending minor clarification</li> <li>Conditional approval pending additional information</li> <li>Resubmission required</li> </ul>	Assessment by Independent Review Committee (IRC) commissioned by GAVI Secretariat	
Financial Management Assessment (FMA)	Assessment by GAVI: <ul style="list-style-type: none"> <li>Macro assessment: PEFA and CFAA country reports</li> <li>Micro assessment: country visit and negotiation</li> </ul>	(support to process not to country)
Country response to GAVI decision	As above for programme design	As above for programme design
Financial transfers		
Programme implementation under MOH	WHO, UNICEF, WB External support specified in application	Technical support
Audit	External auditors	(support to process not to country)
M&E and Operations Research	TA if specified in application	Technical support
Annual Progress Report: <ul style="list-style-type: none"> <li>covers all GAVI supported activities</li> <li>progress on indicator targets</li> <li>financial management information</li> <li>sign off by ICC or HSCC</li> </ul>	Support available from WHO, UNICEF, WB	Technical support

## 4.2 Support role played by GAVI Secretariat

The organisational model adopted by GAVI follows from its origins and self-perception as a funding body not an implementing or technical support body, and results in several advantages for an HSS programme. The 'lean' structure allows a flexibility to act relatively quickly without excessive bureaucratic layers of decision and approval – although it could be questioned whether the demands by the Board to approve each and every HSS grant and to be able to do this but twice a year rather defeats this. And in theory at least, and mostly in practice, GAVI can get money out of the door relatively quickly once a decision is

made. In addition, GAVI has attracted some competent and committed staff, and countries have found the Country Support Team helpful.

But the assumption that this business model is also appropriate for the new HSS role that GAVI has taken on does not seem to be right. HSS is not EPI. Countries are not strong in the skills required to plan, manage and monitor delivery system components that require coordination across various policies and departments. They require support, and given the ambitious time scale and programme size set by GAVI, this amounts to a lot of support.<sup>25</sup>

For HSS, GAVI is not providing sufficient support to countries directly, and is unable to ensure that others are doing so. Part of this is simply the result of in-house under-staffing of the HSS programme. Whilst it is admirable to try to maintain GAVI as a lean organisation and farm out services to others, this does not eliminate the need for staff: the contracting out of services to partners still requires in-house staff and skills to do it effectively. GAVI HSS is dealing with substantial sums of money and HSS is complex in that it covers lots of different needs and contexts in different countries, and is managed by country implementers working within country health systems that by definition need strengthening.

A second major issue is that GAVI is not on the spot in countries to provide pro-active support before things go wrong, or even to identify the need for it. Lessons from this evaluation point clearly to the need for:

- more in-country support for project development and design, for stronger cost and budgeting work, for essential start up measures to address design or system constraints, for implementation and for progress reporting, and
- more in-country assessment and interrogation of performance results, a function that cannot be undertaken satisfactorily at an annual meeting of an IRC in Geneva, or by major evaluation every three years.

It cannot be assumed that WHO or other partners can undertake these functions adequately. WHO in-country staff must have a 'WHO' rather than a 'GAVI' agenda in that they must work with and retain the trust of governments long term and not risk upsetting them by the directness, challenge and interrogation that is sometime necessary – and even if they did, WHO is not in control of the GAVI HSS purse strings and will inevitably feel powerless in some situations as a result. Moreover, WHO in-country staff do not always have the required skills in health systems and may better understand immunisation than the human resource, financing and organisational systems that deliver it.

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<sup>25</sup> Many issues covered in this section are similar to the findings of the GAVI Phase 1 evaluation. Our assessment of a disproportion between means and ends at the level of the GAVI Secretariat were reinforced by the ambitious nature of the GAVI 2007-10 Roadmap and of its linked annual work plans.

While we did not undertake a full assessment of the GAVI Secretariat our findings are remarkably similar to those from earlier evaluations. For instance the 2008 GAVI Phase 1 evaluation made the following observations:

*'...there is room for improvement in areas such as translation of documents, notification of funding transfers, and better communication of the rationale for IRC recommendations. The GAVI Secretariat should propose a process for ensuring resolution of problems identified within recipient countries that includes briefings for the Country Support Team of problems identified through one-time evaluations, improving Country Support Team and Finance and Administration coordination regarding funding transfers, and most importantly establishing a process for regular internal review of the problems identified and resolution status' (p18)*

*'There should be an ongoing regular mechanism for ensuring that the structure of the Secretariat (size, staffing, role and authority) serves the partnership effectively. The GAVI Board should ensure the development of a framework and regular process for assessing the Secretariat's structure and performance, ensuring adequate input from GAVI partners' (p20).*

### **4.3 Support role played by the GAVI HSS Task Team**

The Task Team was established to advise the Secretariat, although in practice its reporting structure is not clear. In the early days of GAVI HSS, the task team played a major role in initiating and getting things done, with members happy to assist where they could and in the absence of a real GAVI HSS staffing.

That has changed as, for one thing, members have realised that GAVI was not building a staff able to do many of the things that clearly needed doing and that had been identified by the Task Team as necessary – the 'tracking studies' result from Task Team dissatisfaction with what is known about grant implementation in countries, for example. At the same time, the Task Team is run by its international agency members – WHO, UNICEF and World Bank – and increasingly it seems (according to a few interviewees) for the benefit of those agencies with representatives reporting more to their own agencies than to GAVI.

The Task Team has no opportunity to support countries directly, and it is tempting to conclude that it has outlived its usefulness, but to abolish it now without compensating action in-house might result in an even worse situation as the Task Team still includes some competent and knowledgeable staff who compensate for some of the weaknesses of the Secretariat, even if that may not be their role.

#### 4.4 Support role played by GAVI HSS technical partners

GAVI HSS technical partners are primarily WHO, UNICEF and World Bank, although in some countries UNFPA and the representatives of some bi-lateral development partners have taken an active part in the GAVI HSS design. Potential advantages of these partners in supporting the GAVI HSS process include their permanent presence in countries, and usually, their good knowledge of the national situation.

Some WHO regional offices have provided worthwhile introductory workshops for countries (supported by GAVI staff or consultants) to familiarise them with the GAVI HSS opportunity and process requirements. Some – many in fact – have gone beyond this and have helped enable country programmes. However, most have ceased to play a role once projects have been approved, but generalisations about the specific roles and the relative success with which they have been performed are difficult since there is tremendous variation among regions and some positive examples of continued support provided to countries, as is the case of PAHO in Honduras and Nicaragua.

At country level, some WHO staff have strengths in HSS and have made good technical contributions to the design of GAVI HSS proposals and, in a few cases, to their annual review through the APR. In others, performance has not been so good. Much depends on individuals and on the role that WHO plays in that particular country.

But much does not. One clear finding is that the terms of engagement for technical support have been unclear and not exposing the adequacy or otherwise of the technical support available. Activities are outlined only in annual work plans (devised by GAVI at global level and not much in evidence on the ground in case study countries), and there is an absence of contractual specification of what exactly is required, what skills are needed, and who exactly is competent to provide it. And these work plans form the basis for transferring GAVI HSS funding.

GAVI figures (see Tables 21a and 21b below) suggest that WHO was paid US\$3,108,350 for HSS work plan support in 2008 plus funding of US\$2,521,990 in staff costs, and these are both budgeted to increase for 2009 and 2010. This includes grant money for proposal development (US\$50,000 per country) some of which may be handed on by WHO to consultants appointed by governments (or approved by government if WHO makes the appointment), and a 7% service charge by WHO on the total. Spread over approximately 16 countries preparing applications, this amounts to about US\$352,000 per country per year for technical support almost all of which is for front-end activities. About 75% of this goes to WHO regions, and 25% to WHO HQ. Including similar transfers to UNICEF and World Bank, it amounts to about US\$438,000 per country per year.

**Table 21a: GAVI HSS transfers to technical partners US\$**

	2008			2009		
	work plan	staff	total	work plan	staff	total
WHO	3,108,350	2,521,990	5,630,340			
UNICEF	363,800	-	363,800			
World Bank	651,000	367,500	1,018,500			
<b>totals</b>	<b>4,123,150</b>	<b>2,889,490</b>	<b>7,012,640</b>	<b>5,455,350</b>	<b>3,147,370</b>	<b>8,602,720</b>
countries applying	16					
\$/country WHO			351,896			
\$/country total			438,290			537,670

Source: GAVI Alliance Secretariat. Adapted by authors.

Clearly, quite a lot of technical support could be procured for this, hand picked for appropriateness rather than just because it is there in country – if only GAVI had the capacity to help procure it.

Table 21b: GAVI HSS Partner Costs according to the 2008 Work Plan

## GAVI HSS partner costs 2008 work plan

MILESTONE	ACTIVITIES	TOTAL ACTIVITY	TASKS								
			WHO	UNICEF	World bank	Secretariat					
1.4.1: By end 2008, partner support mechanisms at regional and country level will be in place to cover 60% of all GAVI eligible countries. (see footnote 1)	1.4.1.1	Provide regions and countries with Technical Support mechanisms for developing HSS proposals, using the principles of harmonisation, alignment and capacity building.	2,161,000	<p><b>WHO - Regional</b></p> <p>Grants to 16 countries for proposal development in 2008 (this does not include the countries for 2007)</p> <p><b>WHO - Hq</b></p> <p>Technical backstopping of regional and country teams for policy dialogue, policy development, strategic planning and budgeting to include ensuring efficient links to the IHP+ work (will involve minimum of 7 countries - in 2007 work plan SG 4)</p>	800,000	Up to 4 countries @ \$50,000 each may apply for funds transfer via Unicef for proposal development grant	200,000	Through an operational grant, support Bank country units to address health system constraints to improving health outcomes, in general and vaccine-preventable diseases, in particular. Funds will be used to support country teams and governments in undertaking relevant analysis, engaging in policy dialogue, and sharing findings through papers and participation in relevant regional or global meetings	651,000	To respond to requests for proposal preparation grants flowing directly to countries or through civil society - assuming 4 countries @ \$50,000 each	200000
	1.4.1.2	Institute a review process for HSS country proposals based on harmonization, alignment and capacity building principles	470,000	<p><b>WHO - Regional</b></p> <p>A lumpsum provision of \$30,000 for general program costs to support development of regional peer review procedures and monitoring of HSS country operations at each of 9 regional sites. (3 subregions in AFRO, regional AFRO and the other regions - mainly for travel and country travel regional peer review mechanisms includes country participants travel)</p> <p><b>WHO - Hq</b></p> <p>Support for development of peer review mechanisms of country proposals including the undertaking of 2 to 3 (Pre-reviews of HSS country proposals Pre-reviews at HQ budgeted assuming 3 per year travel expenses for HQ staff to peer review)</p>	270,000					Funding for HSS IRC in strategic goal 4	
	1.4.1.3	Provide at least 3 opportunities for the HSS TT and 1 for the GAVI HSS for an exchange experiences	160000			Assume 1 HSS TT meeting will be hosted by Unicef	40000			Funds for 2 HSS TT and 1 HSS fora meeting, allows invitations of civil society and academic institutions if necessary - could be transferred to partner if hosting	120000
	1.4.1.4	Provide 7 opportunities for inter regional and sub-regional exchanges of information on GAVI HSS (one per each of 8 sites)	730,000	<p><b>WHO - Regional</b></p> <p>Hold Regional / Sub regional health system and partners managers' meetings once in the year for each region or (sub-region in AFRO) for training and inter-country exchange and review of progress or of proposals. (Training for heads of planning from countries plus technical staff from WHO offices - plus Unicef officers. Geared towards implementation issues regional working group of partners which help set the agenda assumes \$100,000 per site - includes consultants for facilitation - need to be sure that regional work shops address specific programmatic issues to become a forum of learning and info exchange - country missions NOT IN AFRO BRAZZAVILLE)</p> <p><b>WHO - Hq</b></p> <p>participation in global &amp; regional consultations including country training workshops (travel and TT meetings assuming held travel for 2 people)</p>	700,000						
1.4.1	Totals	3,521,000		2,310,000		240,000		651,000		320,000	



## GAVI HSS partner costs 2008 work plan

MILESTONE	ACTIVITIES	TOTAL ACTIVITY	TASKS				World bank	Secretariat			
			WHO	UNICEF							
1.4.1: By end 2008, partner support mechanisms at regional and country level will be in place to cover 60% of all GAVI eligible countries. (see footnote 1)	1.4.1.1	Provide regions and countries with Technical Support mechanisms for developing HSS proposals, using the principles of harmonisation, alignment and capacity building.	2,161,000	<p><b>WHO - Regional</b></p> <p>Grants to 16 countries for proposal development in 2008 (this does not include the countries for 2007)</p> <p><b>WHO - Hq</b></p> <p>Technical backstopping of regional and country teams for policy dialogue, policy development, strategic planning and budgeting to include ensuring efficient links to the IHP+ work (will involve minimum of 7 countries - in 2007 work plan SG 4)</p>	800,000	Up to 4 countries @\$50,000 each may apply for funds transfer via Unicef for proposal development grant	200,000	Through an operational grant, support Bank country units to address health system constraints to improving health outcomes, in general and vaccine-preventable diseases, in particular. Funds will be used to support country teams and governments in undertaking relevant analysis, engaging in policy dialogue, and sharing findings through papers and participation in relevant regional or global meetings	651,000	To respond to requests for proposal preparation grants flowing directly to countries or through civil society - assuming 4 countries @\$50,000 each	200000
	1.4.1.2	Institute a review process for HSS country proposals based on harmonization, alignment and capacity building principles	470,000	<p><b>WHO - Regional</b></p> <p>A lumpsum provision of \$30,000 for general program costs to support development of regional peer review procedures and monitoring of HSS country operations at each of 9 regional sites. (3 subregions in AFRO, regional AFRO and the other regions - mainly for travel and country travel regional peer review mechanisms includes country participants travel)</p> <p><b>WHO - Hq</b></p> <p>Support for development of peer review mechanisms of country proposals including the undertaking of 2 to 3 (Pre-reviews of HSS country proposals Pre-reviews at HQ budgeted assuming 3 per year travel expenses for HQ staff to peer review)</p>	270,000					Funding for HSS IRC in strategic goal 4	
	1.4.1.3	Provide at least 3 opportunities for the HSS TT and 1 for the GAVI HSS for a exchange experiences	160000			Assume 1 HSS TT meeting will be hosted by Unicef	40000			Funds for 2 HSS TT and 1 HSS fora meeting, allows invitations of civil society and academic institutions if necessary - could be transferred to partner if hosting	120000
	1.4.1.4	Provide 7 opportunities for inter regional and sub-regional exchanges of information on GAVI HSS (one per each of 8 sites)	730,000	<p><b>WHO - Regional</b></p> <p>Hold Regional / Sub regional health system and partners managers' meetings once in the year for each region or (sub-region in AFRO) for training and inter-country exchange and review of progress or of proposals. (Training for heads of planning from countries plus technical staff from WHO offices - plus Unicef officers. Geared towards implementation issues regional working group of partners which help set the agenda assumes \$100,000 per site - includes consultants for facilitation - need to be sure that regional work shops address specific programmatic issues to become a forum of learning and info exchange - country missions NOT IN AFRO BRAZZAVILLE)</p> <p><b>WHO - Hq</b></p> <p>participation in global &amp; regional consultations including country training workshops (travel and TT meetings assuming held travel for 2 people)</p>	700,000						
1.4.1	<b>Totals</b>	<b>3,521,000</b>		2,310,000		240,000		651,000		320,000	

1.4.2	By end 2008 25% of GAVI eligible countries have been approved for Health System Strengthening (HSS) support	Refer to activities under milestone 1.4.1										
1.4.3	By end 2009, and in each subsequent year, 100% of countries that have received GAVI HSS support for 2 years or more will be able to demonstrate progress in addressing the health system constraints identified in their original proposals	1.4.3.1	Make partner Technical support mechanisms available to countries and regions for implementing HSS proposals	1,210,000	WHO - Regional	210,000	Provide technical support to countries that have included OR into their proposal, to strengthen national capacity and provide opportunity for knowledge generation and information exchange. Provide additional technical support to countries in implementing HSS proposals	100,000	\$400,000 for provision of technical support for countries retained by secretariat and released upon country or monitoring IRC requests for technical support that are not within original country HSS proposals	300,000		
						240,000	Support for Technical support teams of regions/sub-region to respond to at least three countries for three country support missions in the year. (Joint visits to countries between WHO and Unicef team of experts reviewing constraints analysis includes travel expenses and consultants for 7 regional sites)		Activities to strengthen a more country driven approach to provision of technical support and allows for more support to technical assessment of support	300,000		
						60,000	WHO - Hq		Support to the development and operationalisation of partner coordination mechanisms as well as of technical support modalities at regional and country levels including duty travel missions. (Consultants analytical work for analysis and supporting data through country and regional institutes)			
1.4.3	Totals			1,210,000		510,000		100,000		600,000		
1.4.4	By end 2008, the monitoring, evaluation and operational research framework for impact assessment of HSS support will be operationalised and lessons learnt will be disseminated and used to inform practice	1.4.4.1	Continue design of evaluation study	600,000	WHO - Hq				Start of Evaluation process based on results of evaluability study	600,000		
		1.4.4.2	Develop country level institutional capacities for monitoring, evaluation and research for in-country HSS implementation	175,000		25,000	Support to the development of capacity for participation in observatory functions at country and regional levels take forward agenda of info flow gathering linking with other ongoing activities such as HMN and other HIS - using existing - selecting 5 countries		Management and dissemination of GAVI HSS knowledge bank	150,000		
		1.4.4.3	Streamline monitoring of GAVI HSS in light of other ongoing Global Health Initiatives	40,000		40,000	Participation in development and role out of the dash board for monitoring HSS (consultants only putting tool kit on how to roll out HMN dashboard)					
		1.4.4.4	Provide lessons on GAVI HSS best practices	90,000		20,000	Contribute to documentation of lessons learnt at regional and country levels (set up a template to allow countries to putting the lessons together)		Follow up from tracking study and highlighting observatory work	50,000		
									Documenting, disseminating and managing lessons learnt	20,000		
1.4.4	Totals			905,000		85,000				820,000		
	TOTAL			5,636,000	WHO	2,905,000	Unicef	340,000	World Bank	651,000	Secretariat	1,740,000
	7% PSC for WHO and Unicef			227,150	7% PSC	203,350	7% PSC	23,800	PSC included in total			
	GRAND TOTAL			5,863,150								

Footnote 1: Milestone 1.4.2 reflects the ultimate milestone implied in 1.4.1, so activities in 1.4.1 contribute to milestone 1.4.2. There are therefore no more activities under 1.4.2

## 4.5 Support role played by Independent Review Committees

Strengths and weaknesses of the IRC proposal assessment and APR review stages have been mentioned in sections 2.1 and 2.4 respectively. Whilst these committees may bring a perceived degree of objectivity into assessment, the support they are able to provide to countries to improve the quality of designs or reporting is limited. Whilst they have been able to pick up some major problems, inconsistencies and weaknesses in the bottlenecks-objectives-activities-indicators chain, the IRC has limited knowledge of country realities and limited ability to verify data submitted. The once or twice-a-year functioning of the committees is not conducive to continuity in constructive feedback to countries, and IRCs have little or no follow up capacity to ensure that corrections are made or that their recommendations are taken account of. This may not have mattered so much for the immunisation work of GAVI, but HSS is more complex and very different from country to country.

IRC Members rely heavily on their individual experience which may not always be the most relevant, and there are some comments that the approach can be a bit 'academic' and devoid of practical implementation knowledge. There is no doubt, however, that members invariably work very hard during the evaluation sessions and generally do a good job in the circumstances. Some IRC members are well aware of the limitations of the IRC model particularly in the frustrations it often entails for providing sufficient evidence and for verification.

The costs of these annual or bi-annual sessions in Geneva must be added to the transfers to technical partners in looking at the costs of running the HSS process.

## 4.6 Conclusions and recommendations

*"Governance has been problematical ... The lack of adequate oversight may be traced, in part, to some combination of failure to enlist appropriate Alliance entities in this activity,, limited capacity among GAVI policy bodies to pass judgement on complicated HSS-related policy matters, a crowded GAVI policy agenda (which requires a major investment of time from these same bodies), and over-reliance on the 2009 external evaluation."* (Naimoli 2009, p20)

Altogether, the current GAVI HSS process for technical support to countries for programme design, start up and implementation, and performance review is too 'stand back and then review' and not enough 'engage and help'. Without significant support, many countries do not have the capacity to use GAVI HSS funds effectively and efficiently and to resolve internal tensions in favour of system strengthening rather than the *status quo* of vertical programmes. Current mechanisms for performance review are weak, and the potential in some countries for serious misuse and leakage of funds requires the need for much tighter

accountability and more effective risk-management. This too will be undertaken better through closer engagement throughout the process rather than after the event.

At the same time, there are big (upstream) structural problems with public sectors that constrain the delivery of immunisation, MCH and other primary care services, and that work against efficiency and synergy gains possible through full integration. Closer engagement through tailored technical support could help countries draw attention to and act upon these constraints. This will be an essential component of future system strengthening efforts through 'joint programming' with other global actors.

If GAVI HSS support is to continue, GAVI must develop in-house HSS capacity. It should develop an HSS Unit able to:

- Provide and commission the support needed by countries at all stages of the GAVI HSS process. The nature of this will vary greatly from country to country and the HSS Unit must be able to assess this and act upon it.
- Engage with countries (and with the emerging new joint design initiatives) in their design of HSS programmes, which may include helping them identify opportunities for strengthening upstream processes and mechanisms. This does not mean doing it for them. It means engaging i.e. working with them, supporting, bringing benchmarks and comparative knowledge, constructively interrogating plans, and ensuring that implementation structures and monitoring are in place or that there is a clear, measurable, priced, step-by-step plan to put them in place as part of the HSS programme. It means better projects and stronger capacity building.
- Ensure that by the time programmes are ready for final approval, that they are already assessed in country by the process of technical support engaged in producing them.
- Develop more practical knowledge of HSS to improve the coverage and quality of immunisation and primary care (and of countries contexts), and make this knowledge available through normal business processes of working with countries. This work should be coordinated with the research soon to be commissioned by BMGF to try to improve understanding of what works for routine immunisation.
- Undertake the programme approval and review functions in house, perhaps with the addition of a few outsiders like members of the IRCs at the moment. For maximum effectiveness, and to support country planning and budgeting processes and cycles, this would require replacing the bi-annual funding rounds and the annual progress review processes with assessment and review throughout the year. In turn this would

require the Board to approve block funding based on twice-a-year estimates of forward funding requirements assuming a programme of high levels of approval.

One possibility for GAVI to attain the above, whilst limiting the size of an internal GAVI HSS unit, would be to tender for a call down contract with a private sector provider. The pre-qualified contractee will provide experts at short notice upon request from the GAVI HSS unit to support countries as needed. Individual consultants providing the support could include suitable in-country WHO or other agency staff, contracted and paid for by the private sector provider. The resource centre or call down contract should be re-tendered or renewable every few years. This would need to be reconciled with joint platform TS requirements.

The GAVI HSS Task Team should be terminated and replaced by a small GAVI HSS Advisory Team, run by and chaired by GAVI and reporting clearly to GAVI, and with representatives from WHO, UNICEF and World Bank only as members there to offer advice and to retain communication channels with the agencies they represent. The private sector provider retained by GAVI can facilitate meetings.

## 5. The 'value-added' of GAVI HSS

*Objective 4 – What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?*

### 5.1 Putting the GAVI Contribution into Perspective

Although the size of the GAVI HSS window is large in absolute terms it needs to be set within the context of overall funding flows for health.

The relative role played by GAVI in financing health care as a whole is typically quite low - but does vary significantly by country. Table 22a below shows that GAVI funding is modest in some countries (15% or more of government health spending in Myanmar, Burundi and Liberia and over 3% in Liberia, Myanmar and Ethiopia). On average, GAVI HSS accounts for around 3% of government spending and 0.7% of total health spending.<sup>26</sup>

GAVI HSS accounts, on average for around 4% of total development assistance for the health sector. Again there is wide variability with the figures rather higher in countries which receives little donor support from other sources

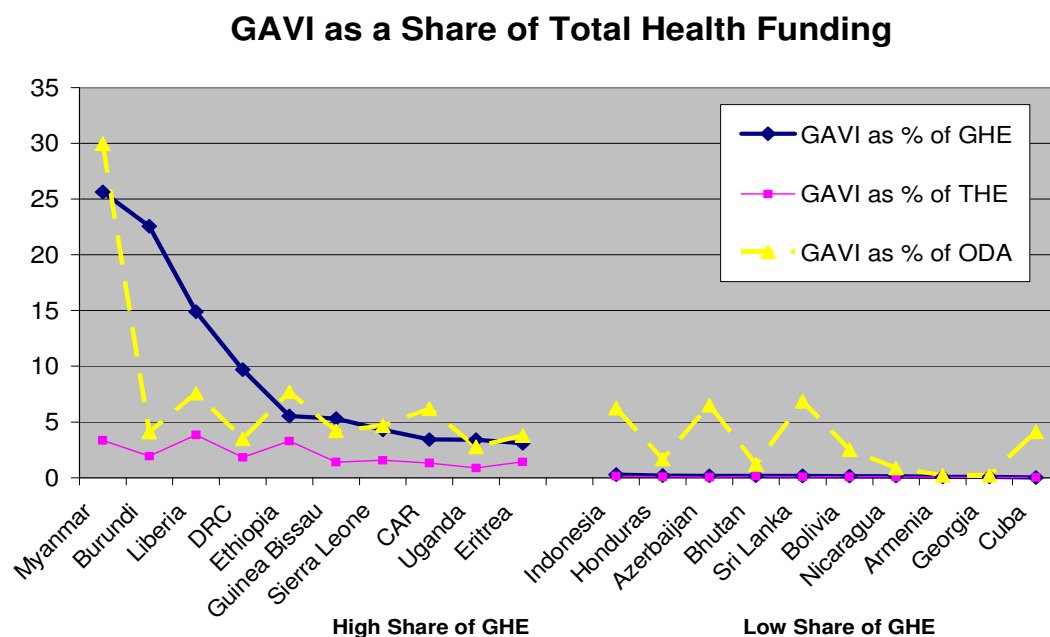
**Table 22a: GAVI HSS and key health financing ratios**

Rank	Country	GAVI HSS as % of GHE	Country	GAVI HSS as % of THE	Country	GAVI HSS as % of ODA
1	Myanmar	25.6	Liberia	3.8	Myanmar	30.0
2	Burundi	22.6	Myanmar	3.4	Pakistan	14.0
3	Liberia	14.9	Ethiopia	3.3	Ethiopia	7.7
4	DRC	9.7	Burundi	1.9	Liberia	7.6
5	Ethiopia	5.5	DRC	1.8	Sri Lanka	6.8
	Unweighted Average	3.0	Unweighted Average	0.7	Unweighted Average	4.1

The degree of variability is illustrated in the following chart which shows the GAVI eligible countries where GAVI support provides the highest and lowest shares of government

<sup>26</sup> These figures are likely to overestimate GAVI's true role as the spending figures refer to 2006 and most countries will have seen substantial increases in health spending since both from domestic and donor sources. Equally the GAVI figures refer to approvals and not actual disbursements which may be less

health expenditure. As noted above though the GAVI HSS role is modest in some countries in many it is negligible.



Clearly from a sustainability perspective it is particularly important that in the countries where GAVI plays a large funding role the investments made prove beneficial and that close attention is paid to long term recurrent implications. Where GAVI HSS accounts for a large share of donor support there may also be greater scope for influencing the aid effectiveness debate than where this is not the case. These findings are broadly consistent with those of Brenzel (Note on GAVI HSS April 28, 2008) though the figures presented here suggest the financing role of GAVI to be rather lower than the earlier analysis.

Detailed figures on key financing ratios and also on key background data by country are provided in Annex 3b.

As well as comparing HSS support to what countries already spend it is also useful to set this spending against what countries *should* be spending. The recently published report(s) of the Task Force on Innovative Financing for Health Systems have suggested that countries need to spend around \$54 per head to fund a guaranteed package of essential services and build the health system platform required to support it. This is around 200 times what is currently being spent through GAVI HSS. Thus, whilst one would expect GAVI support to add value it is important to be realistic about what the window as currently financed could be expected to achieve.

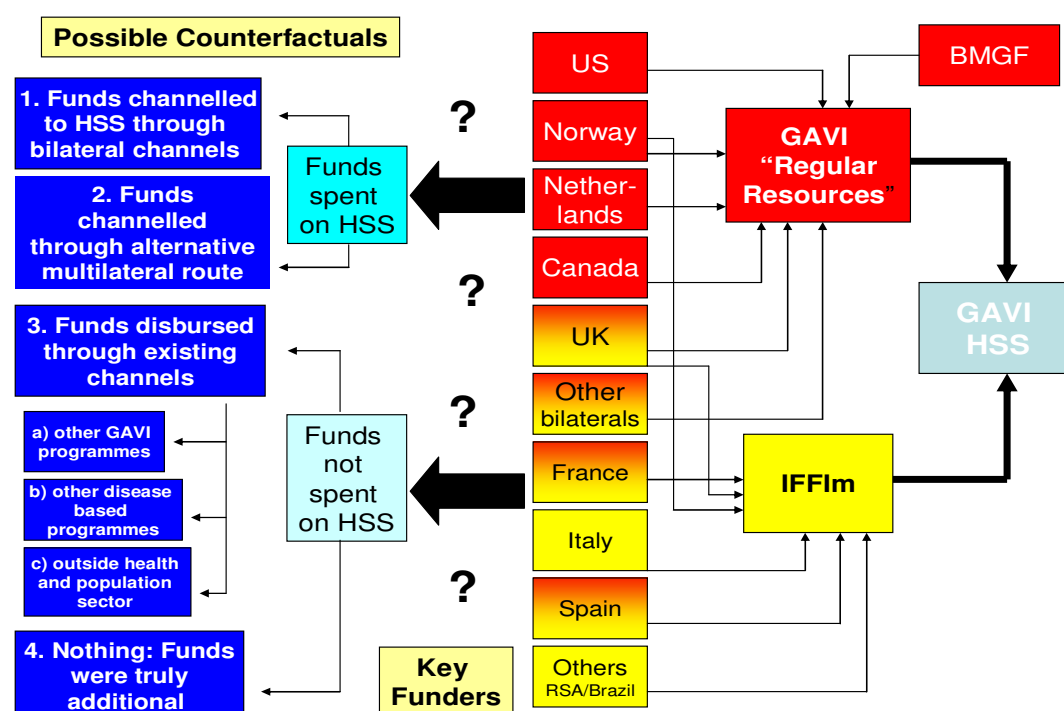
## 5.2 Conceptual framework for assessing value added

To estimate the 'value added' by GAVI HSS, requires some plausible assumptions about what would have happened without it. Simply assuming nothing would have happened would lead to misleading conclusions about its impact. What is to be assumed instead, however, is not knowable with certainty. This section outlines a range of possible scenarios and assesses their implications for the added value of GAVI HSS. Given the range of donors funding GAVI HSS (see Annex 3 for a summary of main sources), and the different funding mechanisms used (IFFIm and normal donor funding), it is likely that a combination of these scenarios might have occurred.

Figure 6 shows the key funders of the different mechanisms supporting the GAVI HSS window, and identifies four main scenarios distinguishing between cases in which:

- funds might have been channelled to HSS but through other routes, and
- funds would not otherwise have been spent on HSS.

**Figure 6: GAVI HSS funding mechanisms and possible alternative scenarios**



\* See annex 3 for detail on GAVI funding sources

Under the former, funds might have been channelled through existing bilateral donor programmes or through new or existing multilateral routes e.g. World Bank loans, a multi-donor trust fund, or the Global Fund.

Under the latter, funds might have been spent on other GAVI programmes (e.g. vaccines, ISS), other disease-based programmes (e.g. through the Global Fund), or may even have



been spent outside the health sector. Finally, there may be cases in which funds might not have been used as development assistance at all and were, therefore, truly additional to total ODA. This might have included funding from Brazil, South Africa, and BMGF.

Table 22b presents views on what the implications would have been had each of these alternative scenarios occurred, including likely implications for the GAVI HSS principles, and for outcomes. Given that, at this stage, it is not possible to say much about the quantitative impact of GAVI HSS, the scenarios are considered qualitatively. More detailed analysis might be possible in the 2012 evaluation.

**Table 22b: Implications of different scenarios and assessment of their likelihood**

POSSIBLE SCENARIO	LIKELIHOOD	IMPLICATIONS
Funds used for health systems strengthening	1. Funds channelled to HSS through bilateral routes	Medium <ul style="list-style-type: none"> <li>Probably less harmonised and aligned than GAVI HSS (depending on donor)</li> <li>More fragmented approach</li> <li>Less rational (and equitable) allocation of resources by country</li> <li>Possibly more emphasis on upstream HSS activities</li> <li>More intensive technical support at the country level</li> <li>Likely to be less predictable</li> </ul>
	2. Funds channelled through alternative multilateral route e.g. Global Fund, World Bank (loans), multi-donor trust fund	Medium <ul style="list-style-type: none"> <li>Lack of specific HSS window suggests overall support for HSS would decline (GF), lack of demand from country level (W Bank loan), or would have taken some time to get off the ground leading to delayed impact (new MDTF)</li> <li>Likely change in HSS focus with heavier emphasis on downstream HSS activities and performance based approaches (GF) or upstream activities including financing and sustainability issues (World Bank/MDTF) and performance based approaches</li> <li>Less aligned and harmonised approaches</li> <li>Probably higher aversion to fiduciary risk so less flexible</li> <li>Less predictable</li> </ul>
Funds not used for health systems strengthening	3a HSS funds spent instead on other GAVI programmes	High <ul style="list-style-type: none"> <li>Reduced support for HSS</li> <li>Possibly increased immunisation coverage in the short term but serious doubts about the sustainability of such improvements</li> <li>Might have revealed/confirmed need to address HSS barriers, thus triggering response</li> </ul>
	3b: Funds channelled through disease based programmes	High <ul style="list-style-type: none"> <li>Reduced support for HSS</li> <li>Less harmonised and aligned</li> <li>Less predictability</li> <li>Greater pressure on weaker health systems, perhaps reducing cost effectiveness.</li> <li>Might have increased need for systematic approach to HSS</li> </ul>
	3c: Funds channelled into existing development programmes outside the health and population sector	Medium <ul style="list-style-type: none"> <li>Reduced support for HSS</li> <li>Decline in overall support for health and population – unclear impact on overall development prospects</li> </ul>
	4. Nothing: funds were additional and would not have been provided for any use other than for GAVI HSS	Low, but possibly the case for private sector and developing country contributions <ul style="list-style-type: none"> <li>Less aid overall - GAVI HSS provided additional resources</li> </ul>

### 5.3 Our assessment of GAVI HSS added value

In short, our assessment is that the establishment of a GAVI HSS window might have resulted in more country led, aligned, harmonised, flexible and predictable forms of support for HSS than other HSS approaches might have resulted in. It may also have resulted in greater support for HSS than would otherwise have been the case, given that alternative uses of funds might have served to further undermine health systems or have been lost to the sector.

However, GAVI HSS may also have promoted fewer upstream approaches than might have been possible under other scenarios, and might have reduced the perceived need for more fundamental health system change.

In some cases, GAVI may have spread itself too thinly for measurable impact to be achieved even in some downstream interventions, by either providing amounts of funds that are too small or that are not matched by essential complementary funding, or by not taking sufficient account at the time of HSS grant application of governance, financial management or implementation capacity weaknesses in order to better manage risk<sup>27</sup>, or by combinations of these issues.

A more detailed analysis is annexed (Annex 4) which sets how GAVI HSS fares against a range of impact and process indicators. This illustrates two of the key questions that should inform future decisions on joint programming of resources for HSS:

#### **Which HSS investments offer the greatest impact - upstream or downstream and in which circumstances?**

GAVI HSS funding is generally not being used for upstream HSS investments. If the view is taken that, in particular circumstances, these downstream interventions do not offer the best value for money and that upstream interventions are needed, then any joint programming approach needs to find a way of supporting such interventions.

#### **Which criteria are the most important and are most closely related to impact?**

The information in Annex 4 would tend to suggest that if sustainability and results orientation are most important, the current GAVI HSS model has little to offer. If country leadership, alignment and harmonisation, and predictability are the most important then the GAVI model should form the basis of any approach.

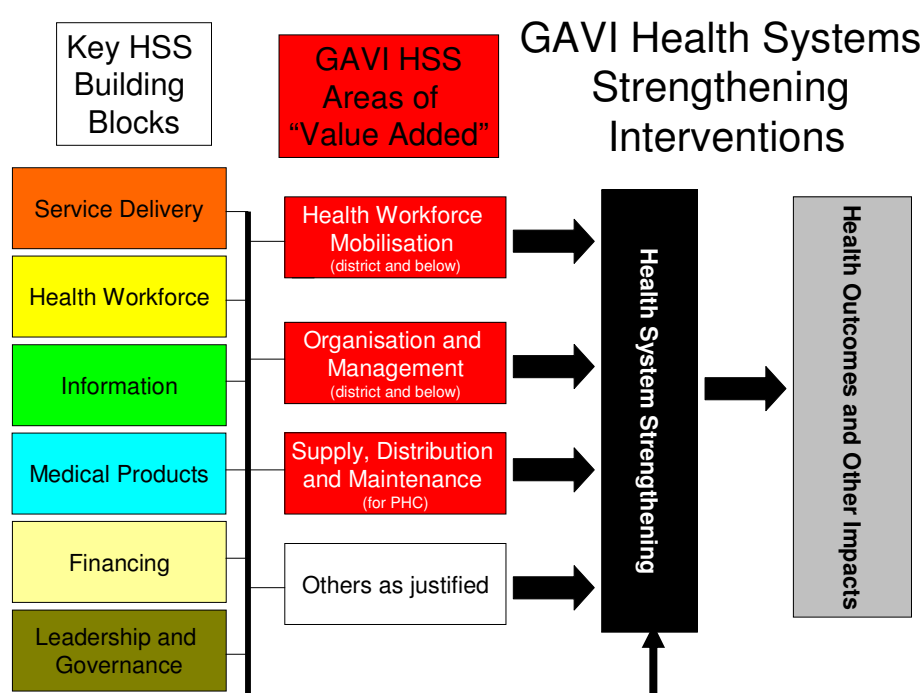
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<sup>27</sup> This is to say that in some countries GAVI should have rejected the application in the light of better assessment of weaknesses that will affect HSS grants and that GAVI cannot deal with or fund alone.

What does GAVI bring to the table that no other funding source can? Any health partner could fund the same proposals supported by GAVI HSS if it so wanted. The main difference is that while most donors would have a view about what to fund (focus of interventions) and how to fund it (aid modality and financing instrument) the GAVI HSS model allows countries flexibility to decide on both aspects as long as the proposal contributes to improved delivery of immunisation and MCH services.

GAVI guidelines suggest the six WHO HSS building blocks as a helpful framework for identifying strategies and activities for HSS support, although countries are allowed to include other areas in their proposals provided they can demonstrate a plausible link with immunisation outputs. These building blocks are shown in Figure 7.

**Figure 7: HSS building blocks and GAVI HSS added value**



Analysis of the case study proposals suggests that most of the GAVI HSS funded activities do fall within the priority areas outlined by GAVI. Very few activities are focused on financing issues, for example, making it unsurprising that sustainability issues do not feature highly.

In summary GAVI HSS would appear to add value by bringing to bear additional (or at least partially additional) resources aimed at strengthening some, but not all, of the HSS building blocks and doing so in a way which promotes country ownership, harmonisation

and alignment, and predictability in particular, more than would have been the case without it.

Another area where GAVI appears to add value is its flexibility and willingness to follow Government priorities and accommodate changes in approach. At the same time weaknesses in other areas such as the lack of adequate M&E frameworks, a lack of focus on sustainability and the very willingness to be so flexible, mean the approach is high risk with little guarantee that results can be demonstrated even where they occur and concerns that benefits might not be sustained.

## 6. The impact of GAVI HSS – the 2012 evaluation

*Objective 5 – What needs to be done, and by when, at country, regional and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?*

### 6.1 Introduction

The following detailed requirements for this component were listed at various points in the Request for Proposals (RfP).

#### ToRs

3a) Using data from country studies, develop a logical framework to show how to best evaluate in 2012 whether or not HSS investments: a) correlate with, and b) influence, GAVI HSS indicators (i.e. immunization coverage rates and U5 mortality rates) from HSS activities to processes to outputs/outcomes/impacts<sup>28</sup>.

3b) Based on 3a provide recommendations for the TOR of the GAVI HSS evaluation in 2012, including proposed objectives, scope, evaluation questions; data and information that need to be collected (e.g. identify national HMIS gaps to address, in order to facilitate evaluation of GAVI HSS funding on health outcomes), as well as the systems that need to be put in place between 2009 and 2012 at country, regional, and global levels. Include a timeline for implementing the TOR for the 2012 evaluation.

3c) Make a recommendation as to what global, regional and national structures and mechanisms need to be in place to support the continuation of the HSS window above the current \$800 million limit. Set out specific areas to assess in 2012 that would indicate if changes proposed by the 2009 evaluation lead to expected improvements in process, outcome, or impact of the HSS investment.

#### Deliverables

The following deliverables are noted – these have been included in a separate document as stand alone Draft TOR for the 2012 Evaluation.

(a) Proposed TOR for the 2012 Evaluation, including data and information that must be collected and analyzed, and systems that need to be put in place to support the evaluation.

(b) Proposed specific recommendations to strengthen the conceptual framework for the 2012 evaluation, indicating what elements and additional research would be needed to better assess the impact of GAVI HSS funding. (c) Define areas for further specification

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<sup>28</sup> This would be one framework for the sum of activities and strategies to be financed by GAVI HSS based on proposals approved through November 1, 2008

and refinement of the evaluation questions and data collection activities to be conducted in 2012.

(d) Identify areas for further study that specifically would improve the quality of the 2012 Evaluation.

## 6.2 Specific questions for this evaluation component

4.3 What should be the main aims and scope of an evaluation of GAVI HSS in 2012?

4.4 What additional frameworks need to be put in place at country level in preparation for the 2012 evaluation?

4.5 What types of process indicators might be recommended to countries to monitor in the future, and how can these be monitored within country systems or with a strengthened APR?

The RfP ToRs thus place great emphasis on using the 2012 evaluation to assess the links between GAVI HSS investments and the three core outcome/impact indicators: national DTP3 coverage; the number/percentage of districts achieving  $\geq 90\%$  DTP3 coverage; and the under five mortality rate. The aim, presumably, is to assess the extent to which changes in these indicators might be attributable to GAVI funding. Both the in-depth and desk-based country studies suggest that (a) this will be a highly problematic activity and (b) it is equally important to explore implementation processes because the quality of implementation and the context in which it takes place may often prove more important in determining results than the specific type of initiative adopted.

As discussed in detail below, the central message from this study is that the 2012 evaluation will offer an extremely valuable *learning opportunity* for the GAVI, and perhaps for other partners who may wish to set up a new joint funding platform for health systems strengthening. Such an approach should not dismiss the attribution question but would rather shift the focus from 'do GAVI HSS investments work?' to 'what types of GAVI support work best in given contexts for different population groups?' It would imply that the evaluation would emphasise purposively selected, in-depth case studies using mixed-methods research rather than a large scale statistical evaluation involving all or a large sample of GAVI HSS countries. Individual case-studies would still explore input-outcome linkages but using disaggregated – regional or facility level – data. The main advantages would be (a) that this would remove at least some of the problems associated with the 'background variation' that is inevitable when assessing widely varying interventions in different countries and (b) that allocating additional resources to in-depth studies should allow researchers to seek out the most reliable and relevant data with which to attempt measurements of outcomes and, in some cases, may be attribution as well (see later).

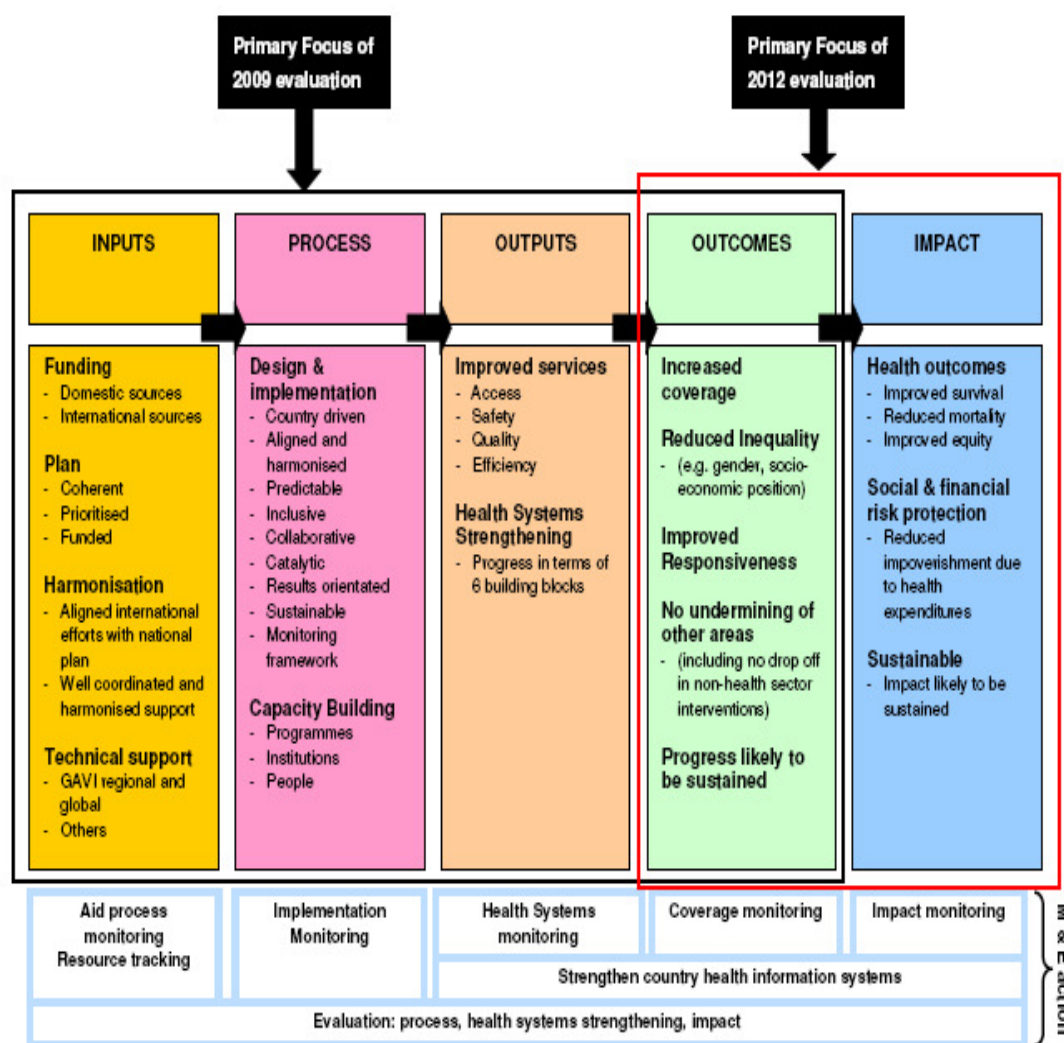
### 6.3 Our approach to the task of drafting the 2012 evaluation

Work on Objective 5 (or component 5 as also referred to in study guidelines) began with the design of the required conceptual framework<sup>29</sup> (figure 1) that was seen as capturing the expected links between GAVI HSS inputs and the targeted outcome/impact measures. The aim of this framework (based on the IHP+ framework) was to ensure the compilation of detailed and, where possible, quantified information relating to these intermediate processes, which would allow at least a reasonable discussion about attribution.

Overall, there was agreement among those undertaking the country studies that this framework provided a good starting point. However, a number of issues were raised in relation to its application. One key area which was seen as needing greater emphasis within the evaluation framework was that of appropriate institutional arrangements for intervention management. In Burundi, for example, the GAVI HSS Management Unit within the MoPH has no technical health staff. This has resulted in a *“heavy focus on financial management and reporting”*. This approach appears to have encouraged a high degree of *accountability* for the application of GAVI HSS funds but less concern as to their overall *effectiveness*. For example, central control over funding 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”*.

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<sup>29</sup> We note that item 3a of the ToRs refers to a ‘logical’ framework. However, we have assumed that a ‘conceptual’ framework, as indicated in delivery item b, was intended.

**Figure 8: Conceptual framework linking inputs to impact**

A more generally expressed concern was the value of the conceptual framework in terms of tracking specific indicators was limited by the lack of robust data management systems at country level. This frequently made it extremely difficult even to assess the links between activities and proposed outputs, let alone outcomes. It was suggested that there was little point in designing a results based monitoring framework if the indicators required by that framework were simply not going to be available. One of the most evident and common findings of the present evaluation has been the poor quality – reliability, completeness, timeliness, etc. – of GAVI HSS data. There is considerable evidence from the country studies that monitoring of HSS grants has been superficial.

Overall, though some indicators are estimated, in many cases there is no serious monitoring *process* and little alignment between reporting, M&E and accountability. Countries are primarily expected to report on activities. Results indicators are typically not available, probably because they are not seen to matter, in that funds will still be



disbursed even if countries not providing evidence that they are achieving results. Evidence from other recent evaluations would suggest that this situation probably reflects a more widespread tendency to be over optimistic as to the possibilities of generating reliable data in many developing countries<sup>30</sup>. Why have so many indicators been specified and not used? The most likely explanation would seem to be that countries will often promise more than is possible in order to access funds, perhaps under the (usually mistaken) assumption that supported capacity building will allow them to implement the proposal M&E framework in due course.

There seems to be a high risk that the desire by GAVI for specific outcome indicators that may be very difficult to compile and the desire by countries for funding may conspire to prolong the existing highly unsatisfactory situation unless decisive action is taken.

- One option considered by this study would be to move away from a specific GAVI HSS monitoring framework and use existing national systems to report progress. This would obviously be very much in line with the spirit of the Paris Declaration and with GAVI's own principles, and this should also be the direction in which the HSS grants should move as argued in Section 2. However, these systems are generally very weak and it would be a very costly and potentially risky strategy to try and bring them to the required level.
- The suggested alternative would be to work with individual countries to develop an agreed 'minimal' set of HSS indicators that would be both acceptable to the GAVI and deliverable using existing data gathering and compilation procedures. This might, for example, imply an increased emphasis on output indicators that could serve as plausible proxies for current outcome indicators.
- Another recommendation made elsewhere in this report is that there is an urgent need to strengthen pre- and post-approval (start up) assessment if monitoring systems are to improve by 2012. The inclusion of countries in the 2012 evaluation that have been subjected to this process may well provide interesting lessons.

Working within the above conceptual framework, one initial observation common to many of the country studies was that GAVI HSS will not be able to claim "pure" attribution, even at the time of the 2012 evaluation. One reason for this assessment was simply that it is essentially combining its resources with those of other donors to support a wide range of activities targeting better immunisation and child health.

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<sup>30</sup> Note the adverse comments on the results monitoring framework in Sherry, J., Mookherji, S., & Ryan, L. (2009). Five-Year Evaluation of the Global Fund to Fight AIDS, TB and Malaria, Synthesis of study areas 1,2 and 3. Global Fund to fight AIDS, Malaria and Tuberculosis.

## 6.4 What can be realistically measured in 2012, and how?

The primary aim of the present 2009 evaluation was *“to allow lessons to be learnt from the first two years of implementation.”* Given the relatively short period over which GAVI HSS had been implemented and hence the limited possibility of identifying measurable impacts, the evaluation restricted its ambitions to an assessment of the possible *contribution* of GAVI funds and to an exploration of the question *“what would have happened without them?”* (see discussion on value added in Section 5). There is an assumption in the RfP that *“By the 2012 evaluation, the impact of health systems strengthening activities funded by GAVI on immunization coverage (and other health goals) can be assessed”*.

While the 2012 evaluation will be much better placed to assess indicators relating to the outcome and impact columns of the conceptual framework, it was strongly recommended by those undertaking the country studies that equal attention should again be paid to these interim steps in order to provide the information needed to lend weight to plausibility arguments relating to the overall contribution of GAVI funding. It seems likely that the innovations that this funding has the potential to catalyse are much more around facilitating new systems, procedures and structures within ministries that could position them to be more effective in terms of overall health sector leadership and programme management. These sorts of outcomes are less tangible than those expressed in the proposal and results framework, but are at least, if not more, important to monitor and review at the end of the current programme’s funding.

This relates to a general assessment that the possibilities for the impact assessment implied by item 3a in the ToRs will still be constrained in 2012. Apart from the issues of joint funding and support for ‘upstream’ activities raised above, that evaluation will also need to address the fact that HSS is very much *not* a standardised intervention. There are countries receiving both very substantial and relatively small HSS contributions and applying those contributions in very different ways. In the countries studied in the current evaluation it seems clear that impacts will vary substantially depending both on the specific aspects addressed and the resources allocated to them. They will also vary depending on the overall context (political, economic, social, etc.) in the countries where interventions have been made. Given this reality, there seems little value in searching for a “perfect” HSS approach that could be uniformly applied. The general observation was that in terms of identifying potential best practice ‘the devil is in the detail’ and hence that quality rather than quantity of information should be the primary aim. This suggests a 2012 evaluation based on in-depth case studies and paying due regard to questions relating to processes, institutions, implementation capacity and behavioural change as well as to outcomes and impacts.

### 6.4.1 Focus on sub-national level

The generally advised strategy in terms of a case study approach is to aim through purposively sampling a diversity of HSS grants in terms of their focus and their fit with

national systems instead of the more traditional sampling (that we attempted in this 2009 evaluation) of sampling according to WHO region, population size, immunisation coverage, length of GAVI HSS support, fragile states, etc. Of course nothing prevents a combination of the 2 approaches to sampling as long as the main criteria remains the nature and focus of the HSS grant, as this is what will if at all deliver the lessons that the 2012 evaluation is aiming at.

The issue of attribution would typically/in most cases be relocated from the national to the sub-national level. Many of the country studies identify the possibilities of exploring the impact of the GAVI HSS funding by looking at outcome variation by region or even facility, especially where it is possible to make direct comparisons between those receiving and not receiving HSS support. It is recognised that the data issues raised above are typically even worse at regional or facility level but this disadvantage is seen as outweighed by the possibility of undertaking analysis of input-output-outcome links within a relatively uniform context and for a relatively uniform intervention.

Our proposal, reflected in the current draft TOR submitted separately does imply that urgent steps would need to be undertaken (we suggest by 2010) to ensure that reasonably reliable disaggregated data are available, including for baselines, an issue which should be addressed when the negotiations on monitoring indicators proposed above are undertaken. A review of other potentially useful sources, for example supporting DHS surveys to over-sample in relevant districts, could also be undertaken.

Within country, regional comparisons may prove particularly useful in countries where, as in a number of the present case studies, the national EPI indicators show reasonably high levels of coverage at national level. In such cases it is difficult to assess GAVI HSS achievements in terms of aggregate immunisation rates. One suggested strategy is to compile trend estimates at provincial/health zone, district and, where feasible, facility level, to provide a more refined picture.

#### **6.4.2 Issues for 2012 emerging from our Case Studies**

It would be of particular interest to compare GAVI HSS funded and non-funded areas. In some of the case study countries there has been an assumption that supporting higher level staff will generate significant effects on supervision and performance at lower levels, for example districts and facilities. This assumption would merit further testing and review. It would also be interesting to undertake district and facility level comparative studies, focusing on immunisation, assisted birth and ANC utilisation rates. Community surveys or focus groups could be used to test this hypothesis which would have important implications for the design of HSS if correct. These could also usefully explore changes in perceptions of communities about the health facilities covered by GAVI HSS. This type of analysis would help answer several key questions in relation to HSS support in addition to looking at impact on service quality and use:

- Has HSS funding reached all intended districts and health facilities (hospital and health centres) within them? Were funds received on time and reflected in the district health plans?
- Have HSS funds (and other MCH related funds) been spent by the districts and health facilities (absorptive capacity)?
- Has HSS funding been matched by other necessary inputs at district/facility level to bridge the gaps for improved immunisation and MCH services? What key inputs were missing that reduced the efficacy of HSS funding?
- Is there evidence that supervision, outreach services and demand generation activities have improved/increased over the period of HSS funding, whether or not as a direct result of HSS funding?

The above points are important not just to assess the effectiveness of HSS funding but to better tailor any future HSS grants. They are particularly important where this funding is supporting initiatives relating to provider behaviour. For example, in some countries there were concerns that service providers may be focusing more on achieving aggregate performance targets than on ensuring access for the poor and the underserved in their catchment areas (Rwanda, Burundi, and Vietnam). The above analysis would assist in the design of HSS funded initiatives that would be more poverty oriented, more demand driven and more focused on disadvantaged populations.

At the national level, one important concern raised by the Cambodian report is a suggestion that in the short term the GAVI approach may have served to entrench fragmentation by encouraging the use of multiple funding channels to support selected components of health service delivery, paying insufficient attention to the need to ensure the continuum of care. In a number of cases one issue has been uncertainty relating to the evolution and implementation of government health sector policies. One key requirement is for the GAVI to ensure that there is transparent agreement as to how Governments intend to move forward and how GAVI HSS will be integrated into these plans. The 2012 evaluation could seek evidence of the extent to which this integration has been achieved, with a particular focus on the extent to which activities which are not supported directly may have suffered. As suggested in the report on Nepal, given that neo-natal mortality accounts for over half of child deaths, it would be particularly important to look for evidence as to the degree of integration between child health, maternal and new born care services and the extent to which there is an evidence based approach to new born care innovations and integrated micro planning.

On a similar theme, the overall GAVI HSS approach was intended to complement as far as possible support provided by other donors, notably the Global Fund. However, in practice the country case studies found very little evidence of this. The analysis of alignment and harmonisation of the GAVI HSS complementarities happened, if at all, at one point during design, but in general this was quite superficially done, mainly to fill in the relevant section of the application. A key question for GAVI is whether it should be aiming in most cases to

become a pooled donor and whether this might be feasible by 2015 if not sooner. The 2012 evaluation might look for evidence of clear thinking on this issue, for example specification of the conditions under which pooling would be an option.

In many cases there is little evidence thus far that attempts at harmonisation in terms of upstream investments are leading to significant changes in the behaviour of service managers and providers, for example in terms monitoring and supervision. It is perhaps unrealistic to think that such behaviours – much of it a product of the way donors have provided support over many years – would change overnight. One area which might be readily assessed from this perspective is that of supported training programmes. For example, it would be useful to undertake a review of training activities that included a tracking study of a sample of participants to see if they are implementing what they have learned or have reverted to previous practices.

**Annex 5** shows a sample of issues taken from eight among our case 11 studies where additional research would shed light on the effectiveness and impact of the HSS model. We anticipate that some of these countries would be included in the 2012 Evaluation. For 4 countries included in our annex (DRC, Ethiopia, Nepal and Zambia) more information should become available shortly through the tracker study, which should probably help at the time of drawing the baselines for the 2012 evaluation should these countries be selected.

### **Large countries**

The 2012 evaluation will need to give due consideration as to how to effectively assess the GAVI HSS programme in large countries which are geographically, economically and socially diverse in order to ensure that decentralised levels are well represented. In a number of case study countries, for example the Democratic Republic of the Congo, limited time and logistics, as well as the spread of GAVI HSS activities at decentralised levels meant that it was only possible to obtain a relatively cursory view of how GAVI HSS supported activities had been implemented outside of the capital. It would seem essential in 2012 to allocate sufficient resources in such cases to ensure that a wide range of zonal and provincial staff from different parts of the country can be involved in any study. One main use of the 2012 evaluation could be to help the GAVI better manage risk in such circumstances. On the evidence of the country studies, risk management thus far would seem to be almost non-existent. There is almost total reliance on APRs that were have found to be of very limited value for this purpose.

### **Post-conflict countries**

The country case study in Liberia suggests that in such post-conflict countries it is probably reasonable for GAVI to focus on a small range of technical areas with no specific geographical or population focus, particular if the needs of the health system in terms of reconstruction and rebuilding are fairly uniform and the need is to rebuild ministries and

key systems. Where GAVI HSS funding has been used to provide significant investment to develop human resource and training functions at the national and local levels, substantial improvements to the provision of primary health care across the country might be expected. Similarly, support provided to strengthening national and local health information and M&E systems should bring important benefits to the way the health system is managed. It will be important when designing the 2012 evaluation to look at the impact of GAVI HSS funding in such countries at both macro and micro levels.

### **Looking at impact beyond immunisation**

In some countries the current set of indicators is very focused on immunisation, making it unlikely that the current monitoring framework will be able to effectively highlight other important improvements to the health system produced through GAVI HSS funding. For example, in Zambia the main focus of the GAVI HSS strengthening work is on providing non-salary incentives to encourage trained health workers and CHWs to work in difficult, rural areas. Whilst it is clearly necessary to monitor some core indicators which demonstrate how effectively the immunisation system is functioning, it would also be useful to have some more specific indicators which could indicate the impact HSS funding is having in achieving specific objectives.

For example, where the emphasis is on training programmes it would be useful to know what proportion of facilities in intervention areas have trained health staff and the proportion of women attended by them during delivery. It would also be important to gather evidence on recruitment and retention, and to estimate staff turnover rates. Similarly, where there are significant investments in infrastructure it would be useful to undertake a survey to measure improvements made in intervention districts. Rather than looking at aggregate national averages, indicators need to be reported on by intervention district and, where possible, compared with baseline data for that district.

### **Evaluating innovative approaches**

One additional interesting possibility for the 2012 evaluation would be to identify and assess a range of innovative interventions apparently made possible by GAVI HSS support. To do this effectively, it would be important to ensure that these assessments are undertaken in a rigorous and scientific manner. If this is to happen, then thought needs to be given as soon as possible as to how best to identify candidate interventions and ensure that adequate resources have been allocated to effectively monitoring their implementation.

## Annex 1 Authors, team, researchers & key informants

Please note that Case and Desk Studies contain additional names of people approached in each country: our acknowledgements and gratitude to them all.

<b>Authors (team)</b>	<b>Main areas each covered</b>
Javier Martinez	Team leader, Rwanda, Vietnam, Honduras
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Cindy Carlson	DRC, Burundi, Bhutan, IHP+ context
David Lewis	Liberia, Zambia, Nigeria, Sierra Leone
Henry Lucas	Objective 5, HSS database support
Helen Maw	HSS Database, Georgia, Nicaragua, DRC
Mark Pearson	Objective 4, Cambodia, Nepal, Kyrgyzstan
Claes Ortendahl	Pakistan, Ethiopia, Kenya, Yemen

### Global Challenge Team Main involvement

Nel Druce	Reports, Analysis Workshop, study oversight
Veronica Walford	Inception and Final reports
Patrick Kenya	Inception and Final reports
Ken Grant	Final report, Note to GAVI PPC

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<sup>31</sup> Interviewed by Team Leader end of 2008 by phone on HSS APR process

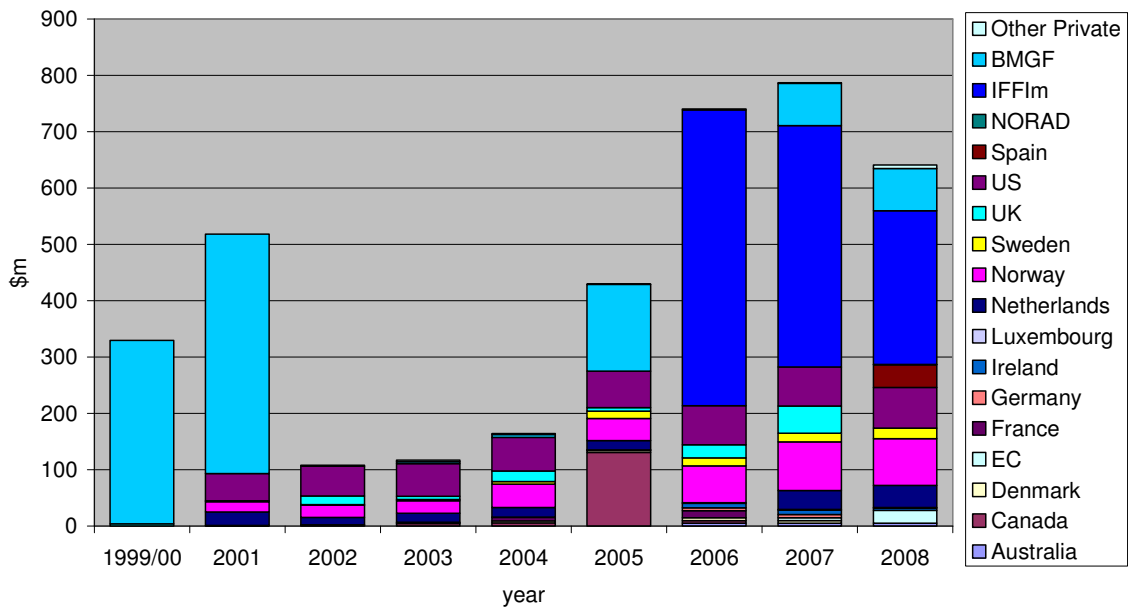


## Annex 2 References

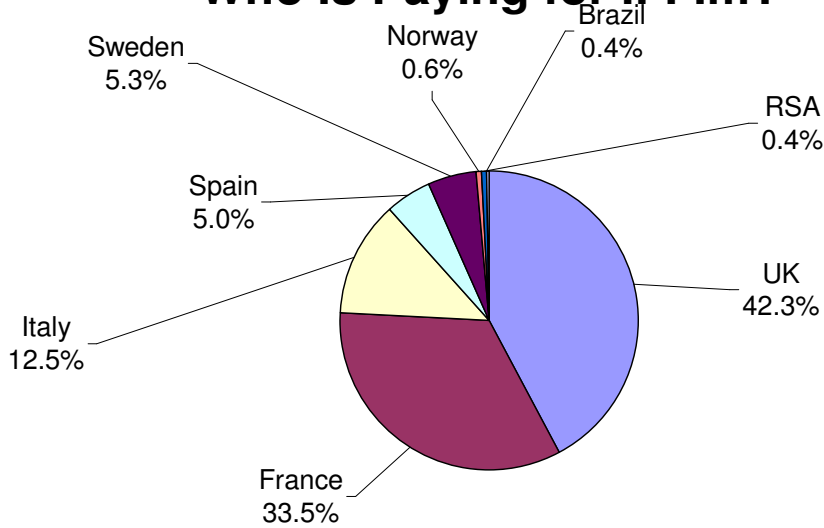
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**Annex 3a GAVI – Funding Sources by Donor and Year**

**GAVI - Funding Sources by Donor and Year**



**Who Is Paying for IFFIm?**



## Annex 3b GAVI HSS and Key Health Financing Ratios: Country Data

Country	GAVI as % of GHE	GAVI as % of THE	GAVI as % of ODA
Burundi	22.6	1.9	4.1
Cambodia (2007)	1.6	0.4	1.9
Cambodia (2008-15)	1.1	0.3	1.3
DRC	9.7	1.8	3.5
Ethiopia	5.5	3.3	7.7
Kyrgyz Republic	0.4	0.2	1.6
Liberia	14.9	3.8	7.6
Nepal	3.0	0.9	5.8
Pakistan	2.7	0.4	14.0
Rwanda	1.4	0.6	1.1
Vietnam	0.3	0.1	4.6
Zambia	0.4	0.2	0.6
Bhutan	0.2	0.1	1.2
Georgia	0.1	0.0	0.2
Ghana	0.9	0.3	1.4
Honduras	0.2	0.1	1.7
Kenya	0.6	0.3	2.0
Nigeria	1.0	0.3	5.2
Nicaragua	0.1	0.1	0.9
Sierra Leone	4.3	1.6	4.7
Sri Lanka	0.2	0.1	6.8
Yemen	0.4	0.2	0.7
Afghanistan	2.9	0.9	3.3
Armenia	0.1	0.0	0.2
Azerbaijan	0.2	0.0	6.5
Benin	-	-	-
Burkina Faso	0.7	0.4	1.3
Bangladesh	1.1	0.4	2.3
Bolivia	0.1	0.1	2.5
Central African Republic	3.4	1.3	6.2
Cote D'Ivoire	1.1	0.3	3.1
Cameroon	1.1	0.2	3.0
Congo, Republic of	-	-	-
Cuba	0.0	0.0	4.1
Djibouti	-	-	-
Eritrea	3.1	1.4	3.8
Gambia	-	-	-
Guinea Bissau	5.3	1.4	4.2
India	-	-	-
Indonesia	0.3	0.1	6.2
Korea, Democratic Rep.	-	-	-
Lao	-	-	-
Madagascar	2.5	1.6	3.2
Mali	0.8	0.4	2.3
Myanmar	25.6	3.4	30.0
Mozambique	-	-	-

Malawi	1.9	1.3	2.2
Sudan North	n/a	n/a	n/a
Sudan South	n/a	n/a	n/a
Senegal	0.6	0.3	2.8
Tchad	0.6	0.3	1.8
Togo	-	-	-
Tajikistan	1.4	0.3	4.9
Tanzania, United Republic	-	-	-
Uganda	3.4	0.9	2.8

## Annex 4 Comparison of GAVI HSS with Possible Counterfactuals

The table sets how GAVI HSS fares against a range of impact and process indicators, the latter made up largely of the GAVI principles. It then considers what might have happened – in terms of performance against these criteria – had the funds been channelled through alternative routes. Performance better than GAVI HSS is denoted in green, performance worse than GAVI HSS in red, and in orange when there is likely to be little or no difference in performance. However, this needs to be carefully interpreted. More of particular criteria should not be associated with higher impact i.e. it is far from clear that more catalytic or innovative investments are better, more traditional ones or that upstream HSS investments are better than downstream ones or that results based approaches work.

	(1) GAVI HSS Window	Counterfactuals					
		Funds spent on HSS		Funds not spent on HSS			
		(2) Supporting HSS through Bilateral Programmes	(3) Funds channelled through alternative multilateral route (e.g. Global Fund, World Bank (loans), Multi-donor trust fund)	(4) Funds spent through existing GAVI channels (ISS, vaccines)	(5) Funds channelled through disease based programmes e.g. Global Fund	(6) Funds channelled outside health and population sector	(7) Nothing – GAVI HSS was additional
Immunisation Impact	Yet to be proven. If successful in improving immunisation cover will improve health outcomes	Same as GAVI HSS?	Same as GAVI HSS?	Short term – higher impact?	Lower	Lower	n/a
				Long term – lower impact?			
Development Impact	If successful an extremely cost effective investment	Same as GAVI HSS?	Same as GAVI HSS?	Short term – higher impact?	Generally lower esp in long term. Immunisation investments generally more cost effective than GF investments	Depends – but in general lower	n/a
				Long term – lower impact?			
Country Led	Yes – aims for broader ownership within Government (EPI + Planning)	Possibly more involvement in programme development (reflecting in country)	Possibly more involvement in programme development. Greater earmarking	Led by part of Government (EPI)	Led by part of Government	Possibly more involvement in programme development (reflecting in country)	n/a

	(1) GAVI HSS Window	Counterfactuals					
		Funds spent on HSS		Funds not spent on HSS			
		(2) Supporting HSS through Bilateral Programmes	(3) Funds channelled through alternative multilateral route (e.g. Global Fund, World Bank (loans), Multi-donor trust fund)	(4) Funds spent through existing GAVI channels (ISS, vaccines)	(5) Funds channelled through disease based programmes e.g. Global Fund	(6) Funds channelled outside health and population sector	(7) Nothing – GAVI HSS was additional
		presence) might reduce degree of country ownership	of funds			presence) might reduce degree of country ownership	
Alignment	Yes – participates in SWAp where in place usually as parallel funder. APR is additional	SWAp friendly donors might have provided more aligned support than GAVI HSS	Likely to be less aligned – certainly Global Fund. World Bank - high aversion to fiduciary risk making alignment less likely ... but lower risks	Less aligned	Limited use of country systems	SWAp friendly donors might have provided more aligned support than GAVI HSS	n/a
		SWAp unfriendly donors less aligned support				SWAp unfriendly donors less aligned support	
Harmonisation	Yes – attempts to harmonise where supportive environment in country	SWAp friendly donors might have provided more harmonised support than GAVI HSS	Less likely to be harmonised - certainly Global Fund	Less harmonised	Rare efforts to harmonise not always successful e.g. Mozambique	SWAp friendly donors might have provided more harmonised support than GAVI HSS	n/a
		SWAp unfriendly donors less aligned support				SWAp unfriendly donors less aligned support	
Predictability	Yes. Typically longer term funding than other donors. Some weaknesses in annual disbursement and uncertainty pre approval	Short planning horizons remain for most bilateral donors	Typically short time horizon.  Proposal rather than formula based allocation	Usually shorter term funding horizon	Shorter planning horizons/proposal based approach	Typically short time horizon. Proposal rather than formula based allocation	n/a
				... but clarity on amount of funding available	Greater clarity on the basis on which funds will be released n/a		

	(1) GAVI HSS Window	Counterfactuals					
		Funds spent on HSS		Funds not spent on HSS			
		(2) Supporting HSS through Bilateral Programmes	(3) Funds channelled through alternative multilateral route (e.g. Global Fund, World Bank (loans), Multi-donor trust fund)	(4) Funds spent through existing GAVI channels (ISS, vaccines)	(5) Funds channelled through disease based programmes e.g. Global Fund	(6) Funds channelled outside health and population sector	(7) Nothing – GAVI HSS was additional
Inclusive (and Collaborative)	Mixed. Short time frames have restricted. In some countries weak civil society involvement.			Narrower consultation process			n/a
Catalytic (and Innovative*)	Yes. Most proposals include innovative, pilot programmes	Will depend case by case	Will depend case by case	Will depend case by case	Will depend case by case	Will depend case by case	n/a
Results Oriented	Mixed – true for proposals with downstream elements – less so for those with major upstream components where results more difficult to measure	Stronger results focus	Stronger results focus	ISS more results focused	Stronger results focus	Stronger results focus?	n/a
Sustainability	Mixed – balance between one off investments and those with recurrent financial implications.	Wider involvement at country level likely to mean greater attention paid to sustainability e.g. support for PFM and MTEFs	Global Fund – little attention paid to sustainability	Financial Sustainability Plans address the issue to a degree	Global Fund – little attention paid to sustainability	Specific issues related to counterpart funding	n/a
			World Bank led programmes more likely to address financial sustainability concerns			More attention paid to sustainability related issues	n/a

Equity	Yes Formula based approach ensures equitable country allocations. Most proposals focus on strengthening performance of weaker districts	GAVI's allocation formula more likely to promote global equity than individual donor decisions	GAVI's allocation formula more likely to promote global equity than individual donor decisions	GAVI's allocation formula more likely to promote global equity than individual donor decisions	GAVI's allocation formula more likely to promote global equity than individual donor decisions	GAVI's allocation formula more likely to promote global equity than individual donor decisions	n/a
		In Country – Depends?	In Country – Depends?	In Country – Depends?	In Country – Depends?	In Country – Depends?	n/a
Additionality*	Generally yes at the country level. (Financing costs of IFFIm actually reduce overall level of resources)				Designed to be additional		n/a
Programme Content	Mix. Balance between upstream and downstream/proven and innovative	Potentially more upstream support for HSS	Potentially more upstream support for HSS – World Bank Downstream focus – Global Fund	Downstream focus	Downstream focus – less likely to have broad HSS benefits for immunisation	Depends	n/a
Flexibility	High degree of flexibility on how funds can be used – reallocation of funds easy	Likely to be less flexible. Reprogramming more complex	Likely to be less flexible. Reprogramming more complex	Yes – ISS “rewards” can be spent on anything. Does not require GAVI approval		More likely to focus on upstream HSS activities	n/a
				Vaccines – less flexibility			
Transactions Costs	Relatively low - project proposal is required as is APR. Preparation grants covers some design costs/projects cover some implementation costs	Might actually reduce transactions costs – one less donor No APR	Higher transactions costs e.g. associated with higher fiduciary requirements (e.g. Local Funding Agent)	Higher – due to additional requirements	Higher transactions costs (passed on to partners)	Depends	n/a

X IFFIm involves higher financing costs as an entity than if the individual funders had supported the programme separately. The IFFIm premium was estimated to be of the order of x% per annum pre credit crunch and has probably widened since



## **Annex 5 Examples of issues to be covered in the 2012 evaluation, by country**

### **(Taken from the Case Studies of the 2009 Evaluation)**

Please note that this Annex is also in the Draft TOR for the 2012 Evaluation submitted separately to the GAVI Alliance.

#### **Bhutan**

Given the size of the grant and limited range of activities, as well as the very organised monitoring and reporting systems apparent in Bhutan, the 2009 evaluation study recommends that it would be interesting to 'dig deeper' in 2012 in terms of understanding how GAVI HSS funding mechanisms can add value to the overall HSS picture in a country. The report suggests that the Bhutanese government appears to have been pragmatic and realistic about what they could achieve with the very small amounts of funding available to them. They are interested in seeing how they can also use the experience of working within a flexible funding mechanism such as GAVI HSS to leverage other, more flexible funding from other development partners, in particular the Global Fund. The 2012 evaluation could usefully help the government to examine the degree to which this leveraging may have worked.

#### **Burundi**

In countries such as Burundi where progress against national EPI indicators in 2009 showed reasonably high coverage at national level, assessment of GAVI HSS achievements solely in terms of overall immunisation rates had limited value, a more interesting approach involved breaking down trends in immunisation coverage at district level. It is suggested that the 2012 evaluation assessment should continue with this and go further to look at what is happening at facility level. Many district medical officers indicated that there are still discrepancies in performance between the health facilities that they supervise for reasons they find hard to explain.

In light of the above, it was proposed that a 2012 evaluation in Burundi should look at:

- Comparative district immunisation rates and assisted birth rates
- Comparative health facility immunisation rates and assisted birth rates
- Changes in perceptions of communities about health facilities covered by GAVI HSS.
- The hypothesis offered by health staff that improvements in prenatal and maternity care encourage mothers to use post-birth services, including vaccination.
- Whether districts have taken on annual planning and reporting responsibilities using agreed national templates.

#### **Cambodia**

The key issues identified in Cambodia by the 2009 evaluation focused on the relationship of GAVI HSS to other funding initiatives. It was argued that in the short term the GAVI approach may have help served to entrench fragmentation, not only by encouraging the use of multiple funding channels to support different parts of the Minimum Package of Activities (MPA) (and not others) but also, for example, by failing to address issues related to referral, thus reducing the scope for ensuring the continuum of care the proposal set out to achieve. This may have been simply a reflection of short-run resource constraints. By 2012 it is possible that the full MPA will have been covered and that the model in the 10 HSS Operational Districts (ODs) harmonised with those in the HSSP 2 ODs. It would be reasonable for GAVI to seek clarification on which way Government intends to move forward and to have seen some evidence of this by 2012. The 2012 evaluation might also examine the extent to which activities which are not supported directly have suffered

The overall design of the HSS intervention emphasised the need to complement support provided by other donors notably the Global Fund. However, in terms of downstream activities there was little evidence in 2009 that specific activities, for example in relation to supervision, were any more integrated than they had been previously. It was suggested that it might have been unrealistic to think that such behaviours – much of it a product of the way donors have provided support over many years – would change overnight. The 2012 evaluation would provide a more reasonable timeframe within which to seek progress.

The above concerns lead to a suggestion that key questions for a 2012 evaluation might include:

- Is there a clear vision for how GAVI plans to take forward the harmonisation agenda? Will it join the pool? When, under what conditions?
- To what extent has the Government developed a clear vision for how GAVI HSS ODs will be aligned with approaches in other districts – possibly including a shift towards a more integrated approach focused on the MPA package as a whole – as originally envisaged? If so, has this resulted in a sustained and balanced increase in utilisation of essential services (as defined in the MPA and CPA packages).
- To what extent are which the more upstream GAVI HSS investments leading to changes in behaviour at national and sub-national levels?

### **Democratic Republic of the Congo**

It was argued that the 2012 evaluation would need to give due consideration as to how best to evaluate the GAVI HSS programme in countries the size of the DRC in order to ensure that decentralised levels are well represented. In 2009, the extent of the decentralisation of GAVI HSS activities, and the limited time and logistical support available, imposed considerable constraints on evaluation of the implementation of GAVI HSS supported activities outside of Kinshasa. The study would have been more complete if resources had been available to fully involve zonal and provincial staff from other parts of the country.

The slow start up of the programme, and related weak progress against HSS indicators mean that a more thorough evaluation will need to be done in 2011 at the notional end point of the DRC programme. However, it was suggested that the innovations that GAVI HSS funding has the potential to catalyse were primarily around facilitating new systems, procedures and structures within the MOPH that could position the ministry to take on much stronger leadership and programme management in future. These sorts of outcomes were seen as being less tangible than those expressed in the proposal and results framework, but at least as important. It was thus important that the 2012 evaluation should focus on processes and systems as much as on the outputs and outcome.

It was also regarded as very important to review the comparative impact of GAVI HSS support in relation to what is happening in other provinces and health zones. In particular, the programme has made an important assumption that, by supporting provincial medical inspection offices, there will be a significant effect on supervision and performance at health zone and health facility level. This assumption will need further testing and review in 2012.

In light of the above, it was proposed that a 2011/2012 evaluation of HSS funding focus on:

- Comparative provincial and health zone immunisation rates, with comparisons made with non-GAVI HSS funded provinces and health zones
- Analysis of the institutional framework within the MOPH and how well the CAG is functioning and is integrated within the MOPH more generally.

### **Ethiopia**

Ethiopia was seen an essential choice for the 2009 evaluation given that it was one of the earliest recipients of GAVI HSS support and has thus far received by far the highest level of funding. The case study suggests that it also stands out as being particularly successful in terms of:

- rapidly designing a country specific application with strong links to pre-existing strategic planning that very quickly achieved acceptance by the GAVI;
- adopting a relatively limited start up period and incorporating the principles of harmonisation and alignment from the start, taking advantage of existing well developed institutions for co-operation with the broad donor community;
- bringing existing instruments of procurement, financial management and monitoring to bear on the GAVI HSS interventions.

Ethiopia will probably also be one of the first countries of the GAVI HSS implementers to demonstrate actual results, making it a potentially useful demonstration country in terms of what the GAVI health system intervention can bring out in a positive procedural and institutional context.

From the point of view of the 2012 evaluation, this would suggest that the following issues should be addressed:

1. To follow up on the achievements of the first phase of the GAVI HSS to determine if the later implementation phase proved equally successful.
2. To ascertain the extent to which pre-existing procedures and institutions contributed to the success of the GAVI HSS intervention.
3. To analyse the additional benefits arising from specific components of the GAVI HSS intervention as compared to a fuller integration of GAVI resources into SWAp processes and basket funding by the broader partner community.
4. To undertake a detailed analysis of the Ethiopia experience with the aim of isolating the specific influence of the GAVI HSS intervention on outputs, outcomes and impacts, as distinct from that of the government and the community of development partners.

### **Liberia**

The first GAVI HSS grant to Liberia was focused on a small range of specific technical areas but did not have a geographical focus. All 15 counties are being supported during the period of the existing proposal. The 2009 study found the rationale provided by the Ministry of Health and Social Welfare (MoHSW) for this decision compelling. At the end of the civil war most Liberians lived in poverty and most lived in distant rural areas. The needs of the health system in terms of reconstruction and rebuilding were fairly uniform across the country. In 2006, the MoHSW was a shell, without capable staff or effective systems. In this context, the decision was made to focus the GAVI HSS resources on efforts to rebuilding the MoHSW and its key systems. PHC across the country was to be supported by investing in the recruitment and training of CHWs and the provision of training to deliver the Basic Package of Health Services (BPHS). It is suggested that the situation in 2012 may be different and that it would seem sensible to revisit this approach at that stage to see if it is still relevant. This could feed into the development of any future HSS proposal to give it a greater focus on the population groups who make less use of the health system for financial, social or other reasons.

The study suggests that improvements in immunisation coverage at the end of the HSS grant are likely to be modest given that there were high immunisation coverage rates in Liberia at the time of the design stage. However, as the HSS funding is being invested in developing systems and processes in addition to supporting the roll-out of the BPHS, significant improvements in the effectiveness of the health system can be expected at a number of different levels. The significant investment provided to develop the HR and training functions at the national and local levels together with the support of the BPHS and the training of CHWs can be expected to bring substantial improvements to the provision of primary health care across the country. Similarly the support provided to strengthening health information and the M&E systems both at the national and local levels should bring important benefits to the way the health system is managed.

The study argues that it would be important when designing a 2012 evaluation to look at the impact of GAVI HSS funding at the macro and micro levels. Questions that will need to be asked include:

- What have HSS funds been used for and why were the decisions made to use them in this way?
- What has been the impact of the activities supported?
- How effectively have they been employed? Have they complemented other sources of funding or have they been the sole source for certain activities?
- What has been the quality of the activities supported? Are the interventions supported leading edge and evidence based?
- How has the use of the GAVI funding had an impact at the service delivery level? What have been the specific impacts at that level?
- How have the planning and coordination processes worked? Have these been effective?
- Has the funds been used in the ways originally envisaged in the HSS proposal? If not, what has been the process to re-orientate funding and was this in-line with GAVI requirements?
- Has value for money been achieved? Are there alternative ways in which the resources could have been used which would have generated greater impact?

### **Nepal**

The 2009 Nepal study identified the following key areas to focus on in the 2012 evaluation:

- Is there is a clear vision for how GAVI plans to take forward the harmonisation agenda. Will it pool funding? When, under what conditions?
- Can it be demonstrated that more upstream investments are leading to significant changes in behaviour? This might include a review of the training programmes including a tracking study of a sample of beneficiaries to see if they are still practising
- What is the evidence on the integrated delivery of CB-IMCI, MCH and NCP (new born care package) – especially given that neo natal mortality accounts for over half child deaths
- Has GAVI HSS funding contributed to a more uniform structure and approaches to MCH in urban areas?
- To what extent is there a clear way forward following rigorous assessments of pilot approaches to promoting new born care and integrated micro planning

### **Rwanda**

The improvements/increases in immunisation coverage at the end of the HSS grant are likely to be modest given that immunisation coverage rates in Rwanda that were already high at design stage. The 2009 study therefore suggests that it would be better for the purposes of assessing the effectiveness and additionality of HSS funding to assess immunisation coverage rates – and perhaps coverage rates for selective MCH services as well – by district and by health centres within each district, instead of using national consolidated figures.

This approach could then be extended to assess the utilisation of HSS funds by district and by health centres within each district. This exercise would in turn enable a closer look at the best and worst performing health facilities in the context of HSS and other inputs (funding, commodities and technical support) received. It is argued that this type of analysis would help answer several key questions in relation to HSS support in Rwanda:

- Has HSS funding reached all intended districts and health facilities (hospital and health centres) within them? Were funds received on time and reflected in the district health plans?
- Have HSS funds (and other MCH related funds) been spent by the districts and health facilities (absorptive capacity)?
- Has HSS funding been matched by other necessary inputs at district/health centre level to bridge the gaps for improved immunisation and MCH services? What key inputs were missing that reduced the efficacy of HSS funding?
- Is there evidence that supervision, outreach services and demand generation activities have improved/increased in the 3 years of HSS funding, whether or not

as a direct result of HSS funding? (i.e. attribution less important as overall performance)

The above points are seen as important not just to assess the effectiveness of HSS funding but to better tailor any future HSS grants for which Rwanda may apply. Though this may happen as early as 2010 when the current HSS grant finishes. Another reason why answering the above questions is important is because GAVI HSS funding is partly supporting a scheme – the PBF – where a number of issues linked to provider behaviour are being explored. For example, there are concerns that service providers may be focusing more on achieving service targets than on ensuring that services achieve improve coverage and quality in terms of the poor and underserved in their catchment areas.

A future HSS grant should, the report suggests, improve its targeting on underserved areas instead of delivering the same kind of generic inputs across the districts. Also, given that by 2010 most Districts in Rwanda will likely have a community-based PBF in place the above analysis would help tailor an eventual HSS proposal to the said scheme thus making the HSS grant more poverty oriented, more demand driven and more focused on the population groups who make less use of health facilities for financial, social or other reasons. These issues would be key areas for a 2012 evaluation, though the design of such an evaluation would depend on the nature of any proposal submitted in 2010.

### **Zambia**

Immunisation coverage rates in Zambia are already high making the probability of anything more than small improvements unlikely. The 2009 study notes that the current set of GAVI HSS indicators is very focused on immunisation, making it unlikely that the current monitoring framework will be able to effectively highlight other important improvements to the health system produced through the HSS funding. There will be need to extend the monitoring framework if the 2012 evaluation is to effectively address these issues.

For example, the main focus of the GAVI HSS strengthening work in Zambia is on providing non-salary incentives to encourage trained health workers and CHWs to work in difficult, rural areas. The study suggests that this is a novel approach that has been well thought through and targeted appropriately. If it is successful, some very useful lessons will emerge. The study argues that it will be important to consider how best to undertake a targeted assessment of this activity.

Whilst it is useful to have some indicators which demonstrate how effectively the immunisation system is functioning, it would also be useful to have some more specific indicators which could indicate the impact HSS funding is having in achieving its particular objectives. It will be important to know how many facilities in the intervention areas have trained health staff, how many communities have active CHWs, and the turnover rates for CHWs. In addition, it would be also be useful to look at the impact the GAVI HSS funding is having on the numbers of being women attended by a trained provider during delivery etc. Similarly, given the significant investment in infrastructure, it would be sensible to undertake a survey to measure related improvements in the intervention districts. Clearly, rather than looking at aggregate national averages, indicators would need to be reported by intervention district and then compared with a baseline picture for that district.

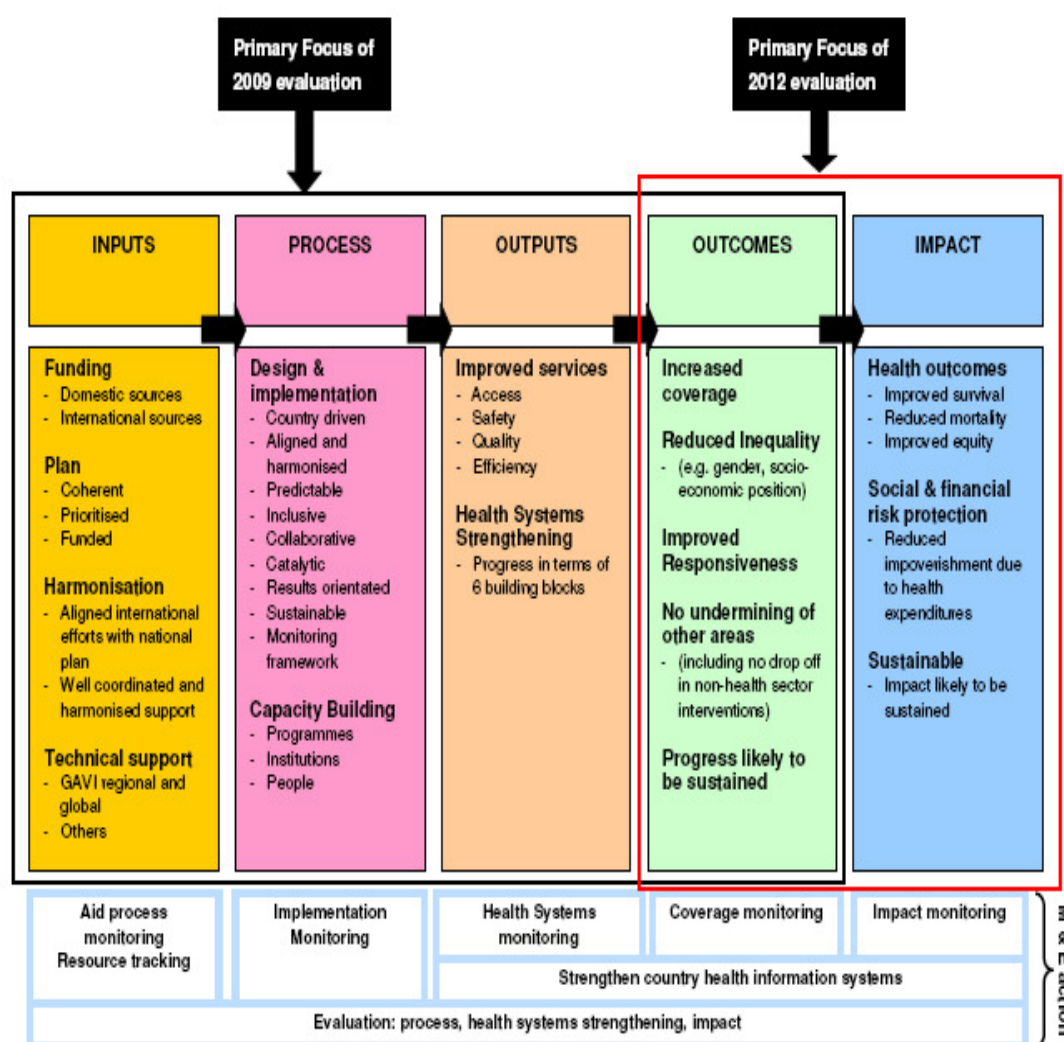
The above suggests a number of important questions that should be asked in 2012:

- Is there evidence that the recruitment and retention of trained health workers and CHWs in the selected districts has improved?
- What have been the effects on health service provision outreach etc.
- Is there greater user engagement with the health system?
- Are there any other factors beyond the GAVI HSS support to which improvements could be attributed?

## Annex 6 Evaluation approach and method

Our evaluation approach is based on the recognition that given the relatively recent start of GAVI HSS programmes in countries, the evaluation was unlikely to detect any outcomes or impact resulting from GAVI HSS funding. Instead, we focused what was being targeted and achieved in terms of processes and outputs; this conceptual framework is explained in Figure 1, and is based on the health systems M&E framework developed under the IHP+).

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



Where possible, we have made judgements about the likelihood of transformation of processes and outputs into outcomes and impact. In addition, we have attempted to assess how well GAVI HSS in countries is following:

- the principles of the Paris Declaration on Aid Effectiveness and of the Accra HLF Agenda for Action;



- other principles and values articulated by GAVI itself as guiding principles for grant application and programme implementation in its Guidelines for HSS Applications.

We have also attempted to respond to a large number of questions included both in the Request for Proposals as well as in the Technical Proposal submitted by HLSP at bidding stage.

In April 2009 we developed a set of **Evaluation study guidelines** incorporating key themes and questions to guide data collection and analysis, and to ensure internal consistency. The Evaluation study guidelines were largely based on those prepared for the GAVI HSS Tracking Study<sup>32</sup> (kindly provided to us by the JSI/InDevelop-IPM Tracking Study team) to which we added other specific questions for our evaluation. The evaluation study guidelines have been submitted separately as part of this evaluation as Volume 3C.

### Data sources, sampling and data collection issues

The main sources of information for our evaluation study are:

- 11 in-depth case studies and 10 desk studies conducted by the evaluation team; each includes a summary of key findings, a list of key informants and of key documents used; the list of countries is in Table 1. The country studies have been submitted separately to the GAVI Secretariat in two ZIP files known as Volume 3a (the eleven in-depth case studies) and 3b (the ten Desk Studies). GAVI Secretariat as Volumes 3a and 3 b.
- interviews with key informants, particularly in relation to objective 3 of the evaluation (the GAVI HSS support systems); Annex 1 contains a complete list of people met and Volume 3C a summary of responses provided to our email and phone interviews;
- other available documents, including results from other evaluation studies and articles relating to GAVI HSS or to health systems strengthening matters; a list of key documents is in Annex 2.

#### In-depth studies

Country selection for the **in-depth case studies** was discussed with the GAVI Secretariat in April 2009. The sampling frame for our evaluation was the 44 GAVI eligible countries for whom GAVI HSS grants had been approved by December 2008 (Table 2, section 2). The main selection criteria were, in this order:

- The six countries already included in the GAVI HSS Tracking Study** – DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia – were ideal candidates for this evaluation. We included them in keeping with the aspiration of the

<sup>32</sup> The GAVI HSS Tracking Study was commissioned by the GAVI Secretariat towards the end of 2008 to respond to a request of the GAVI HSS Task Team to better track the use of GAVI HSS resources in a sample of countries. The Tracking Study has been implemented by the JSI/InDevelop-IPM team.

GAVI Secretariat for the Tracking Study to “contribute to and complement” the findings of the GAVI HSS Evaluation. In addition, the Tracking study includes some of the first HSS countries (Rounds 1 and 2) that offer the longest implementation led times as well as two of the largest HSS grants (Ethiopia and DRC).

- b. **An additional five countries (Burundi, Cambodia, Liberia, Pakistan<sup>33</sup> and Rwanda)** selected mainly from Rounds 1, 2 and 3 to ensure that sufficient led time had elapsed since grant approval for preliminary findings to be available. Within these countries we also aimed at a more even geographical distribution of our total sample of in-depth countries.

Our intended **approach** to in-depth case studies varied slightly depending on whether these were undertaken in “Tracking Study” countries or not.

- a. In the five countries that were not part of the Tracking Study a single country visit of between 2 and 3 weeks in length was undertaken. This was preceded by a thorough document review and a selection of key informants (both with the help of the Evaluation Study Guidelines and using the list of GAVI contacts in each country). National researchers and consultants were appointed to pair up with our evaluation consultants (or “country leads”). They jointly produced a draft report that was sent to country stakeholders for initial feedback; a second draft was prepared in early June on time for the analysis workshop held by the evaluation team (see later).
- b. There is not much difference in approach between “Tracking Study” and “non Tracking Study” countries in our evaluation, as both involved country visits by our evaluation consultants and their pairing with national consultants. However we had not foreseen from the beginning that this would be the case. At proposal stage, we made the assumption that the six Tracking Study country teams would deliver a substantial proportion of the information needed for the GAVI HSS evaluation and that as a result fewer evaluation resources (time and people) would be needed in those six countries. Based on the information available to evaluation proposal writers in HLSP we also assumed that preliminary results from the Tracking Study would be ready by June 2009, in time for our preliminary analysis workshop. Unfortunately both assumptions proved incorrect<sup>34</sup> and a change of strategy was made early in the evaluation study to cover the six tracking study almost in the same way as the remaining five in-depth case studies. Visits to Tracking Study countries may have been a bit shorter than in the remaining five in-depth

<sup>33</sup> Yemen, a country from Round 3 had been initially selected for study, but security concerns for our researchers led us to shift Yemen for Pakistan, another Round 3 country.

<sup>34</sup> The timelines and implementation arrangements of the 2 studies were analysed by the Evaluation team members in March and were found to be too different for results to converge on time. Various efforts were made to keep the information lines for both studies open and for Tracking and Evaluation consultants to collaborate in specific countries, which did happen to some extent.



countries, mainly due to available resources but also thanks to support given by the Tracking Study teams in the form of names and contacts of relevant key informants. The only exception to the overall approach to in-depth case studies was Kyrgyzstan, where the assigned evaluation consultant was unable to travel to that country for personal reasons. As a result, the Kyrgyzstan case study was collated in July, after the June analysis workshop, and it is largely based on the findings of the Tracking study researchers, to whom we are deeply indebted and thankful.

### Desk studies

We included ten additional **Desk Study countries** in order to complement and further support the findings from the eleven in-depth studies. These countries would provide additional information on the processes of HSS grant design and application, M&E and – to some extent – start-up and early implementation issues (this depending on the availability and quality of HSS proposals and APR reports). Desk study countries were also selected with a view to balance the country sample by geographical distribution, DPT3 coverage, size of per-capita GAVI HSS allocation, presence or not of a health sector-wide approach or IHP+ processes. It was agreed that wherever possible desk-based information available on the HSS process would be qualified through phone or email interviews with country counterparts such as national or regional GAVI Focal Points, or other well informed sources, as and when possible.

**Table 1: Selected countries and type of studies for the GAVI HSS Evaluation**

	HSS Round	Population '000 *	Region	Size HSS Grant *	Date GAVI Approval letter *	Type of HSS assessment
Burundi	1	8,173	C Africa	\$8,252,000	12 Mar 07	In Depth
Cambodia1	1	14,197	S E Asia	\$1,850,000	1 Mar 07	In Depth
Cambodia 2	5			\$8,465,500	14 Aug 08	
DRC	2	60,644	C Africa	\$56,814,500	14 Aug 08	In Depth
Ethiopia	1	81,021	E Africa	\$76,494,500	13 Jun 07	In Depth
Kyrgyzstan.	1	5,259	C Asia	\$1,155,000	1 Mar 07	In Depth
Liberia	2	3,579	W Africa	\$4,090,000	1 Mar 07	In Depth
Nepal	4	27,641	S Asia	\$8,667,000	13 Jun 07	In Depth
Pakistan	3	160,943	S Asia	\$23,525,000	14 Feb 08	In Depth
Rwanda	3	9,464	C Africa	\$5,605,000	8 Aug 07	In Depth
Vietnam	2	86,206	S E Asia	\$16,285,000	8 Aug 07	In Depth
Zambia	3	11,696	E Africa	\$6,605,500	13 Jun 07	In Depth
Bhutan	4	649	S Asia	\$194,000	8 Aug 07	Desk Study
Honduras	2	6,969	C America	\$435,500	18 Feb 08	Desk Study
Georgia	4	4,433	E Europe	\$9,670,000	13 Jun 07	Desk Study
Ghana	4	23,008	W Africa	\$2,534,500	14 Feb 08	Desk Study
Kenya	3	36,553	E Africa	\$9,903,000	18 Feb 08	Desk Study
Nicaragua	4	5,532	C America	\$1,387,500	18 Feb 08	Desk Study
Nigeria	4	144,720	W Africa	\$44,704,000	1 Aug 07	Desk Study
Sierra Leone	4	5,743	W Africa	\$2,215,500	18 Feb 08	Desk Study
Sri Lanka	4	19,207	S Asia	\$4,505,000	14 Feb 08	Desk Study
Yemen	3	21,732	Mid-East	\$4,505,000	14 Feb 08	Desk Study

Source: \* WHOSYS Database

### **Assessment of GAVI HSS support systems**

In addition to the country case studies, the evaluation has consulted a wide selection of individuals involved in the GAVI HSS process. These include GAVI staff, members of the GAVI HSS Task Team, members of the Independent Review Committees convened to assess proposals and to review the Annual Progress Reports submitted by countries, WHO staff in Geneva, regional and country offices, the Global Fund to Fight AIDS, TB and Malaria, and IHP+. These consultations were undertaken through meetings, phone calls or responses to email questionnaire. Responses from these informants can be found in Volume 3C (Study guidelines & responses on GAVI HSS Support Mechanisms).

### **Sampling method and validity issues**

Case studies and desk studies provide the basis for the findings, conclusions and recommendations of our Evaluation study. Given that the Evaluation objectives focus on the experience of GAVI HSS grants to date, our sample was purposely biased to countries where GAVI HSS had been in place for longer time, so as to increase evidence and lesson learning. This means that most of the results that we bring in this evaluation study may not be necessarily “statistically representative” of all GAVI HSS countries. At the same time all results presented in the study have an intrinsic value as they are based on real facts and experiences documented by the evaluation team in 21 countries. We have attempted to reduce bias and strengthen our arguments by mentioning the names of the countries where our observations applied more strongly, and by trying to differentiate between findings from case and desk studies and those from the remaining HSS countries that we also studied – albeit more superficially - when putting together the GAVI HSS database for this evaluation.

As requested in the Terms of Reference for this evaluation, we also looked at statistical association between country variables linked to the HSS grants and HSS indicators (DPT3 and IMR). However, our attempts did not yield any results, partly because implementation has been too short, and partly due to weak links in the chain of HSS inputs, processes, outputs, outcomes and impact that have been described thoroughly in the evaluation report.

In sum, this study has combined an evaluative design that looked at the same variables across countries with an analytical and descriptive design aimed at richness of information based on experience. Other types of design were considered at the outset and then rejected, as HSS interventions are by no means uniform or comparable given their different focus and the background variation where each takes place. The aim was and is, as requested in the Terms of Reference, to emphasise experience with GAVI HSS implementation to date in order to learn how the GAVI HSS “business model” has worked when applied to a variety of countries and national health systems. Further issues linked to the evaluation of GAVI HSS are discussed in section 6 of the report in relation to the 2012 GAVI HSS Evaluation.

## Data Analysis and validation issues

The analysis of data and its validation are briefly described next.

- a. In-depth case studies.** Each of the eleven case studies<sup>35</sup> produced by HLSP and national consultants was sent to agreed country stakeholders for initial feedback. The second draft was then prepared and sent for internal peer review (i.e. other Evaluation consultants) after which a third draft was produced. The third draft was then quality assured following HLSP's standard quality assurance procedures and resulted in the eleven final case studies sent to the GAVI Alliance Secretariat as Volume 3a (a ZIP file) by August 2009.
- b. Desk studies.** Desk studies were undertaken by the same consultants who undertook the in-depth case studies and the analysis of support systems, which strengthened the chances of using a consistent methodology for all 21 countries, albeit with different degrees of depth. The first draft was first peer reviewed internally by evaluation team members checking for consistency with Evaluation Study Guidelines. The second drafts were then quality assured following HLSP's standard quality assurance procedures and resulted in the final ten draft desk studies sent to the GAVI Alliance Secretariat as part of Volume 3b (a ZIP file) by August 2009.
- c. Draft reports of each the GAVI HSS support systems, the GAVI 2012 Evaluation and the GAVI HSS Database** were circulated among evaluation team members in early June, just before the analysis workshop. These draft reports were further polished on the basis of feedback received from evaluation consultants, and second drafts were finally reviewed by the evaluation Team Leader.
- d. Analysis workshop held between 23 and 25 June 2009.** All evaluation products mentioned above were discussed as part of an internal analysis workshop comprising the evaluation consultants and a member of our Global Challenge Team (see next). During the workshop the evidence emerging from the case studies and from the analysis of support systems was presented, discussed and analysed. The workshop was structured along the five evaluation objectives, with particular focus on writing bullet points and country examples that showed strengths and weaknesses, emerging lessons and preliminary recommendations. Members of the evaluation team were tasked with transforming the above bullet points into short reports that eventually became parts of the full evaluation report. In this way we made the evaluation

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<sup>35</sup> With the exception of Kyrgyzstan, as explained earlier.

team to perform as data collectors, analysts and report writers, decreasing the chances of “writer” bias.

- e. **Global Challenge Team.** After the analysis workshop a first draft report was prepared before the end of July 2009. The first draft of Volumes 1 and 2 was then shared with all evaluation team members and with our Global Challenge Team (GCT). The GCT is a group of four health systems experts external to the evaluation tasked with reviewing evaluation by-products and with challenging unsubstantiated conclusions and statements.<sup>36</sup> A second draft of Volumes 1 and 2 was written taking feedback received into account. This draft was internally quality assured and sent to the GAVI Secretariat by the agreed deadline of 29 August 2009.
- f. **GAVI HSS Evaluation Advisory Panel.** The evaluation team were fortunate to count on the feedback provided by an external Advisory Panel reporting to the Senior Evaluation Officer of the GAVI Secretariat. The Advisory panel provided verbal and (at times) written feed back to the evaluation team leader following the Inception report, the May progress report and the August first draft report.
- g. **Final drafting.** Several members of the GAVI Secretariat provided written comments to the first drafts of Volumes 1 and 2. In addition, a feedback meeting was organised in Geneva on 8 September 2009 where various members of the GAVI Secretariat provided verbal feedback and discussed the study findings. The final draft report was submitted by the due deadline of 30 September incorporating the feedback received at the September meeting.

## Study challenges, limitations and other considerations for GAVI

A number of factors may have affected some aspects of the evaluation study.

The timeframe was challenging – six months for delivering 11 case studies, 10 desk studies, a GAVI HSS Database, the Terms of Reference for the 2012 evaluation and the linked by-products (study guidelines, inception reports, progress reports, etcetera). Setting up and preparing for the country visits was also challenging, particularly in a few countries where in spite of letters by the GAVI Alliance to the Health Ministers and to country stakeholders, responses to our requests for help were not received on time<sup>37</sup>. As the study began in March and all country visits needed to take place within April and May, there was just a month for selecting national consultants, developing and testing the

<sup>36</sup> The Global Challenge Team influenced various stages of the GAVI HSS evaluation by providing feed back to our Inception report and by some of its members participating in key stages of the study, including the analysis workshop.

<sup>37</sup> In some countries lack of initial response simply reflected out of date lists of contact persons in regions or countries.

methodology, collecting data in countries and submitting the first draft reports for country review in time for the analysis workshop. Such time pressure was keenly felt among our key informants and may have affected our ability to undertake detailed data collection, particularly in the periphery where many HSS grants are being implemented.

Another challenge came from the realisation that the Tracking and Evaluation studies would not be able to collaborate as much as intended in our proposal due to totally different timelines, as explained earlier in this Annex. Thus, our assumptions that the Tracking Study would provide the evaluation study with additional details on implementation and on the use of HSS funds did not materialise. Better coordination within the GAVI Secretariat at the time of commissioning both studies would have helped to overcome many problems faced by the evaluation team, and particularly with reallocating the original evaluation study resources among a larger number of countries requiring an in-depth approach. This might have compromised the depth of our analysis in a few Tracking Study countries. However, when the preliminary results of the Tracking Study were discussed on 15 September in Stockholm, the findings (in relation to how the GAVI HSS model adapted to their situation) were remarkably similar – if not identical- to the findings of our evaluation, which further strengthens the perceived validity of either study.

According to the original Request for Proposals and to our technical proposal the Evaluation study would be overseen by a Steering Committee comprising (presumably) different parts of the Alliance and perhaps some independent members. We saw this arrangement as the umbilical cord linking us to members of the Alliance, resulting in greater ownership of the evaluation results, faster access to key informants and, more importantly, in a continued feedback from those involved in HSS implementation on our approach, methodology and interim results. Unfortunately the Steering Committee was substituted by an external advisory panel reporting to the Senior Evaluation Officer in the GAVI Secretariat. While their feedback was useful, relevant and greatly appreciated, it was not the same as getting a continued “view from the inside”. We feel that a Steering Committee would not have compromised in any way our independence as evaluators, but that it might have strengthened our assessment of the nature of the Alliance and of its support to the GAVI HSS window.

Last but not least, a consideration for GAVI on security arrangements for external consultants. Consultants need to feel safe and protected to do their work well, particularly in countries where security concerns may put their lives at risk. It was a concern to us that GAVI was not able to provide our consultants with adequate security arrangements in a few higher security risk countries where HLSP does not have field staff. Although we made alternative arrangements and took extra care, it would have been preferable to have access to standard security arrangements and procedures provided for consultants who work under the United Nations umbrella, which we assumed would be available through

GAVI Alliance partners such as WHO and UNICEF. However, such protection was requested by the team leader and apparently refused.