GAVI Health System Strengthening Support Evaluation

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Pakistan Case Study

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Abbreviations and Acronyms

APR	Annual performance report
BCG	Bacillus Calmette-Guérin
CMYP	Comprehensive multi-year plans for immunization
DFID	Department for International Development
EmNOC	Emergency Obstetric and New Born Care
EMRO	WHO Eastern Mediterranean Regional Office
EPI	Expanded Program on Immunisation
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisation
GAVI HSS	GAVI Health System Support
GDP	Gross Domestic Product
GoP	Government of Pakistan
GTZ	Gesellschaft für Technische Zusammenarbeit
HSDP3	Health Strategic Development Plan 3 (Ethiopia)
HMIS	Health Management Information System
HP 2009	Health Policy 2009 (Pakistan)
HSPU	Health Systems and Policy Unit
IHP	International Health Partnership
IMNCI	Integrated Management of Neonatal and Child Illnesses
IMR	Infant Mortality Rate
IRC	Independent Review Committee
LHW	Lady Health Workers
MDG	Millenium Development Goal
MMR	Maternal Mortality Rate
MoU	Memorandum of Understanding
MTDP	Medium Term Development Plan
MTDB	Medium Term Development Budget
MUSD	Million US dollars
M&E	Monitoring and Evaluation
NHSCC	National Health Sector Co-ordination Committee
NMCH	National Mothers and Children Health Program
PDHS	Pakistan Demography and Health Survey
PHC	Primary Health Care
PC	Central Planning Commission
PMU	Program (project) Management Unit
PRSP	Poverty Reduction Strategy Paper (Program)
SWAp	Sector Wide Approach
UN	United Nations
UNICEF	The United Nations Children's Fund
UNFPA	United Nations Populations Fund
U5MR	Under 5 mortality rate
WHO	World Health Organisation
WR	WHO country representative

Summary, Conclusions & Recommendations

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

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

To date, Pakistan's GAVI HSS experience has been dominated by severe implementation problems. Lessons from the first unsuccessful application were learnt and successfully applied to the second GAVI HSS application effort, which was approved for funding. In general, the second application reflects well the health priorities of Pakistan, and the design of its operational structure includes many features expected by GAVI of its applicants. However, the application was pushed through under tight time pressures, and hence may not have allowed for a complete process of participation and sharing amongst partners. Effective costing and a precise implementation/monitoring/evaluation system were also not sufficiently covered. However, on paper the application clearly served the purposes of both GAVI and Pakistan.

The reasons for the current severe implementation problems can be grouped into the following categories:

- There is an imbalance between the technical support given to Pakistan during the application phase and the period after application approval (i.e. with more assistance to the former than the latter phase).
- There are structural challenges in the Pakistan system of health governance – particularly with regards to:
    - Regulations around the acceptance and disbursement of funding from external partners which were not fully taken into account in terms of a smooth grant start up phase (i.e. either because they were not correctly understood, or were considered too time-consuming).
    - Federal vertical programs which are insufficiently co-ordinated and the stewardship role of the Federal Ministry of Health (FMoH) that is difficult to execute.

  - The organisational structure inside the FMoH created parallel management and co-ordination structures, including a Project Management Unit (PMU) function that was understaffed and underfinanced.
  - Devolution efforts which leave a number of issues concerning the handling of foreign aid unresolved.

- There were also a number of important contextual factors that impacted negatively on the GAVI HSS implementation:
  - The GAVI HSS start up phase coincided with a period of serious political upheaval and security challenges in Pakistan. This impacted negatively on the governance and oversight capacity of the FMoH.
  - Internal leadership/stewardship problems may also exist within the FMoH that exacerbate this situation. If so – they are outside the scope of enquiry of this study.

- The management and coordination of the aid architecture in Pakistan has been slow to develop and lacks the necessary structures and processes - this has contributed to problems of alignment and harmonization in general - GAVI HSS processes are no exception.

Two important questions arise from these observations:

1. Could these problems have been anticipated through an improved process of risk analysis at the point of country application?
2. Could an improved understanding of risks have corrected the subsequent implementation problems at an earlier stage, and if so, by what means?

Early detection of risks for the GAVI HSS in Pakistan would, in the present system, be the responsibility of IRC. IRC feedback on the application indicates that they were aware of challenges to implementation and the M&E framework, and they requested clarifications on the same. However, whilst clarifications were received these were not always satisfactory and did not necessarily address several of the structural challenges and contextual factors mentioned earlier. A closer reality check at country level might have alerted the GAVI to the likely implementation challenges. We are not aware whether or not a pre-review of the Pakistan grant ever took place.

A possible recommendation for countries like Pakistan, where implementation problems are foreseen – or are very likely to occur – would be to treat them differently from countries that

already have their main governance and management capabilities in place. The following steps are suggested for consideration:

- A risk analysis should be undertaken as part of the early GAVI HSS process. The demand from GAVI HSS about details concerning structures and processes for implementation/M&E should be stricter wherever risks are detected.
- Undertaking a risk analysis through the existing IRC model would be problematic, as this is the kind of assessment that should be done in country. Therefore, a modified IRC model that enables a country 'reality check' may be necessary.
- In large grants where implementation is at risk funding might be phased, so as to allow for a full organisation of the implementation/M&E apparatus before operational funding for planned activities is given. Alternatively, time should be allowed for the development of the project management structures during year one of the HSS proposal.
- APR directives should be better tailored to the needs of an individual country, i.e. both in content and timing (i.e. some countries may not need APR's at all, while other countries may need more regular assessments with a focus on critical issues for implementation).
- Countries at risk – such as Pakistan – could be given particular resources for the management of processes such as "tailored'' or "country customized" APR's.

The stalled GAVI HSS implementation in Pakistan is a special case but not unique. Nor are its prospects for success without hope. Even at this rather late stage, remedial actions could be taken to bring it back on course, with the possibility that it may still contribute results to the 2012 final evaluation. It is the impression of the consultants who undertook this case study that such commitment does exist in Pakistan.

The security situation is clearly an obstacle that must be overcome, and for which solutions and responsibility are outside of the health sector and the GAVI HSS. There are also large areas in Pakistan where the security problems are less prominent.

There is an infrastructure of primary health care in the system of which the Lady Health Worker Scheme is a strong platform for building upon. A new and modern health policy will soon be in place, for which the GAVI HSS is an important instrument of implementation. A large increase of funding to the health sector is now being proposed. Stability on the political scene is slowly returning after the difficult times of upheaval. There are signs of opportunity.

1 Evaluation Scope, Approach & Methodology

The experience from many years of work with the Expanded Programme for Immunization (EPI) has shown that health system elements such as service organisation, staff salary, availability of transport, co-ordination with Maternal and Child Health (MCH) services and drug logistics, are important determinants of immunization coverage levels. Thus it was a very logical step for GAVI to broaden its predominantly disease orientated focus on immunization to include an element of health system support (HSS).

This is a case study that presents evaluation findings of GAVI HSS progress and experience in Pakistan. The purpose and scope of the evaluation includes the following 5 study 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?

This report consists of 6 chapters – the evaluation scope, approach and methods are explained in the opening chapter (Chapter 1); key features of Pakistan's health system, including 'system readiness' for GAVI HSS are explained to provide important contextual information (Chapter 2); with the GAVI HSS application process (Chapter 3), implementation and progress explained in subsequent chapters (Chapter 4). The report concludes with an assessment of how well GAVI HSS aligns to GAVI values (Chapter 5); and some overall conclusions and recommendations are drawn (Chapter 6).

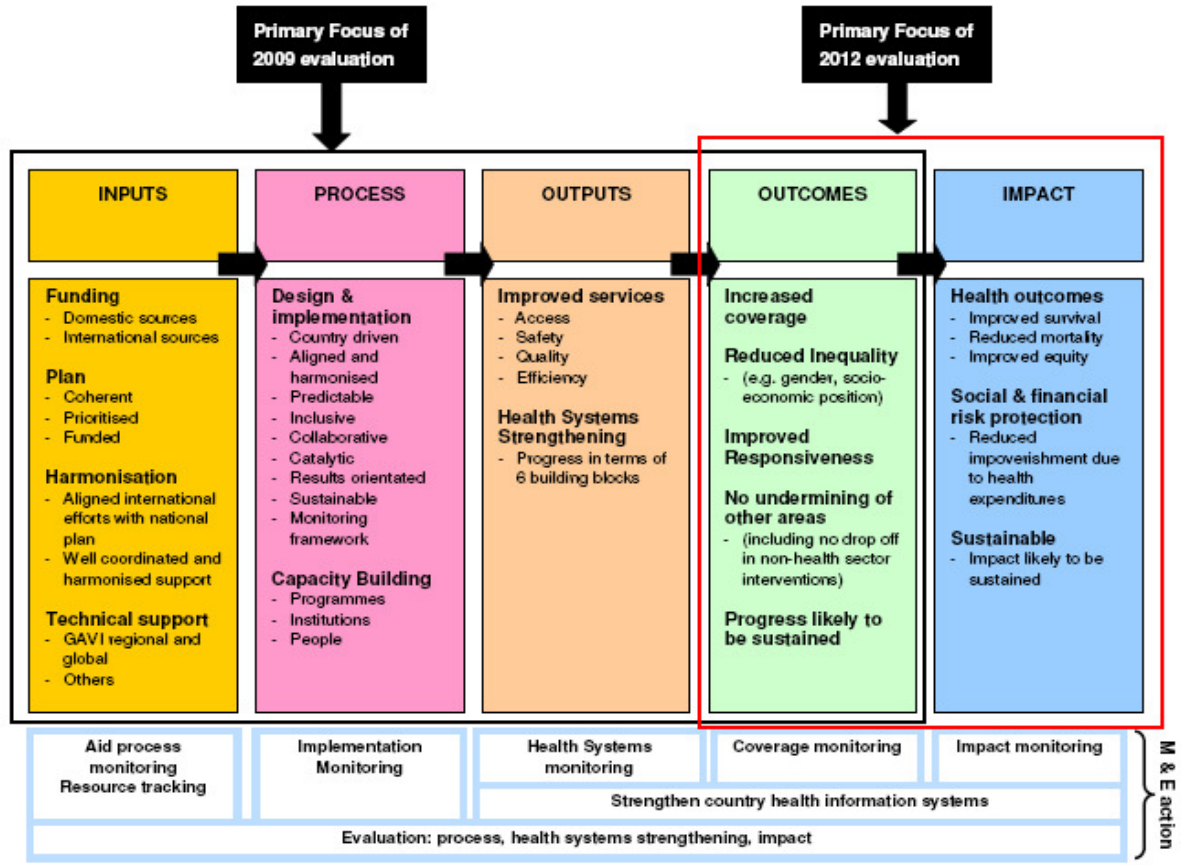
1.1 Approach

This is one of 11 in-depth case studies that have been conducted in GAVI HSS recipient grant countries: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied – but more superficially – because they did not involve country visits and were examined via a desk study review of available documentation combined with email/phone

interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Figure 1 summarises the conceptual framework that guided HLSP's approach to these country level evaluations. It can be seen that the primary nature of this GAVI HSS evaluation in 2009 is that of a process evaluation. This is appropriate given the length of time GAVI HSS has been active and in situ. Subsequent planned evaluations (2012) will be more advanced and will focus on assessing outcomes achieved

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



This GAVI HSS evaluation focuses on the following main questions (Box 1):

Box 1: Examples of Questions for the HSS Evaluation Study

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

The Pakistan case study presented in this report is an in-depth study based on a country visit. Methods and data sources used were a combination of available documents drawn from the GAVI HSS database, locally available documents in Pakistan, along with semi-structured interviews with key informants. A list of interviewees is attached in Annex 2.

1.2 Study Limitations

Initially, the consultant team intended to interview key informants at both federal and provincial level (i.e. two provinces) in the Islamic Federal Republic of Pakistan. However, at the time of this visit (May 2009), visits to the provinces could not be completed for security reasons. It is therefore likely that important perspectives are not captured in this report, with a possible risk being the focus and presentation of results and data is dominated by a federal perspective.

1. 4 Acknowledgements

The Federal Ministry of Health, all the UN organisations in Islamabad and development partners from bilateral organisations and NGO's have generously contributed with time and information to this study – the consultant team is deeply grateful.

2 Pakistan's Health System: Context for GAVI HSS

2.1 An Overview

Pakistan has a large population – 167 million – and huge variation in living conditions. Its health system is devolved to provinces and districts but main elements of its primary health care are still handled centrally by three federally run programs, including the EPI program on vaccinations, the national mothers and children program (NMCH) and the primary care and Lady Health Workers' program. Other vertical programs exist and play a role – but these three are most significant in relation to GAVI HSS. They exist in a complex partnership at the provincial and district level. The federal role in the health sector is executed by the Federal Ministry of Health (FMoH) but also to some extent by the Ministry of Population Welfare.

The private sector plays a very large and decisive role in the Pakistan health system. Private provision represents all kind of health services of both good and very poor quality. Lack of regulation of the private sector, considerable problems of management and stewardship at all levels of the health system – but particularly the federal level – in conjunction with significant needs to improve human resource management are the overriding challenges in the health system.

2.1 Progress towards Maternal and Child Health MDGs

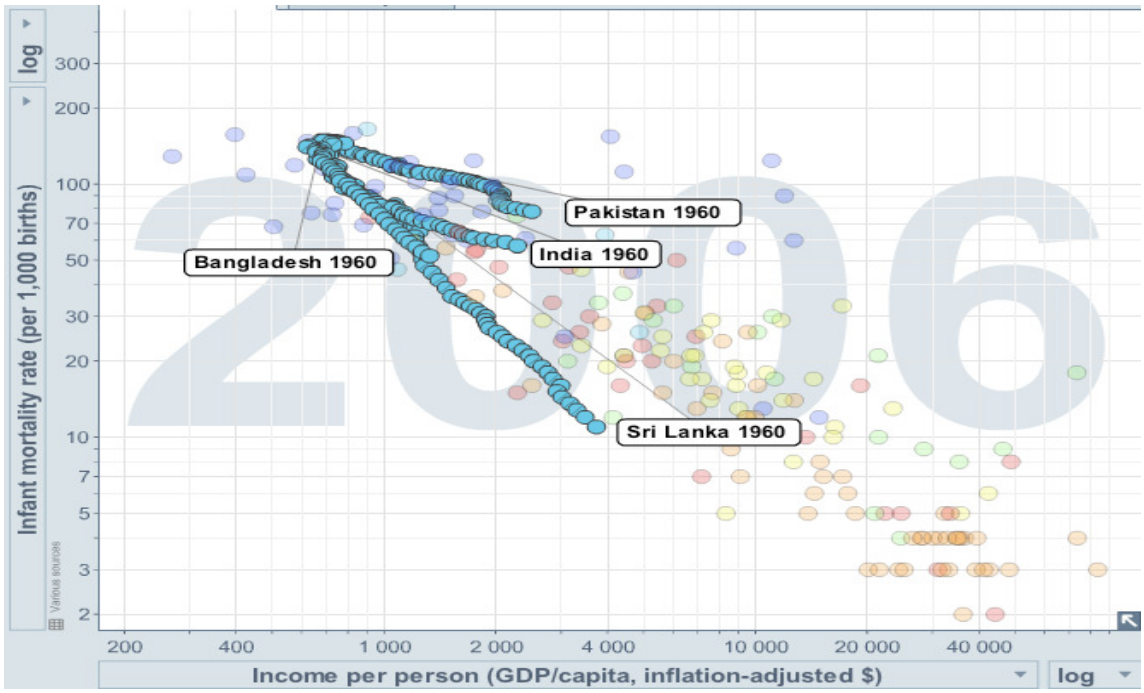
There have been some positive gains in the general population health status in Pakistan over time (i.e. steady but slow). While communicable diseases continue to dominate in terms of main cause of death, there are signs of a rapid increase of non-communicable diseases, with typically high levels of cardiovascular mortality. Pakistan is a clear case of a country with a "double burden of disease".

With regards to children and women, the status and rate of change of health progress (including MDG relevant areas) indicate that MDG 4 and 5 targets may not be reached. Variation in health status, as well as access to and utilisation of health services between regions are very large.

Three fundamental observations are:

- **Observation 1:** Improvement – though steady – is slower than in neighbouring countries (Fig 1) and the level of IMR is lower than expected considering the country's level of economic development.

Fig 1 IMR and economic development level in four countries from 1960 to 2006. Source: Gapminder.com.



While the long term development as presented in Figure 1 is – although slow – clearly positive, recent observations from the Pakistan Demography and Health survey 2006-07(PDHS)1 indicate an absence of improvement in child health in later years (table 1).

Table 1 Child health presented as mortality rates in Pakistan Demographic and Health Survey (PDHS 2006-07)

Year	Years preceding observation	Neonatal mortality	Post-neonatal mortality	Infant mortality rate	Child mortality rate	Under 5 mortality rate
2002-2006	0-4	54	24	78	18	94
1997-2001	5-9	52	24	76	18	92
1992-1996	10-14	56	30	86	19	103

- **Observation 2:** Present levels of IMR and U5MR are higher than other countries in the neighbourhood (Table 2).

[1] National Institute of Population Studies (NIPS) 2008:*Pakistan Demographic and Health Survey 2006-07*:

Table2 IMR and U5MR Comparisons Across Four Countries [2]

Country	IMR 2000	IMR 2006	% change of IMR per year	U5MR 2000	U5MR 2006	% change of U5MR per year
Pakistan	85	78	1	108	97	2
Bangladesh	66	52	2	92	69	4
India	66	57	1,5	89	76	2
Nepal	64	46	3	86	59	6

- **Observation 3:** Variations between provinces and districts are very large

Vaccine data describing coverage levels are available in Pakistan either via survey data presented in the PDHS, the Pakistan integrated household survey (PIHS) 2006-07, or in facility based Health Management Information System (HMIS) data for the period up to 2004. Data on vaccination program coverage from PDHS shows high levels of BCG vaccination (80.3 % of eligible children) but considerably lower levels of complete vaccination (47.3 %). The PIHS data for the period 1995-1996 to 2001-2002 demonstrates no clear increase over time. Variation between provinces – studied in the HMIS report – is considerable with the proportions of children fully immunised, varying from 93% in Pakistan administered Kashmir to 12% - 14 % in Northern Areas and Balochistan, respectively. Trends over time from HMIS data are unclear. Trends in BCG and measles reporting indicate a fall in coverage from 2006 to 2007[3]. In other sources with a more long term view DPT 3 coverage shows successful program implementation with 46 % coverage in 1996 and 83 % coverage 10 years later.[4]

2.2 Health Financing

Health expenditure in Pakistan focuses on the private sector. In spite of highly ambitious plans, the public health service is losing financial ground. It is reasonable to describe the public health sector in Pakistan as seriously underfinanced and by comparison to its neighbours particularly financially weak (Table 3). This situation is important when considering the country rationale and need for applying for GAVI HSS financing.

Table 3 Government percentage of total health expenditure and Government health spending as % of total government spending, selected countries and selected years. SOURCE: WHO health statistics database on WHO.INT June 10, 2009

[2] Source WHO health statistics database on the web (WHO.int June 10 2009)
[3] National Health Information System, Government of Pakistan, Ministry of Health 2009: *National Integrated Report – 2008.*
[4] WHO statistical database on WHO.Int

Country	% of Government contribution to total health expenditure		% health of all Government expenditure	
Health statistics	1996	2006	1996	2006
Pakistan	26,8	16,4	2,2	1,3
Bangladesh	32,8	36,8	5,9	7,4
India	25,9	19,6	4,2	3,4
Nepal	26,2	30,5	4,3	5,3

The development of the health sector is being left behind in comparison to other government sectors. Plans for a considerably stronger development of the health sector existed in the Poverty reduction planning (PRSP) but they have not, as yet, been realised. Indications of stronger commitment to the health sector exist in present budget preparations.

2.3 Health System Readiness & GAVI HSS

Strategic preparedness for GAVI HSS did exist. However, overarching health systems co-ordination strategy relies on a relatively brief policy document from 2001. This document has no clear costing attached which reduces its strategic strength. A new Health Policy for the period 2010 to 2015 is to be presented in July/August 2009. Its relationship to the Medium Term budget framework - and thus to its financial viability - is unclear. The launch of the GAVI HSS program may have been stronger, and arguably focused on issues of greater importance, had the timing of GAVI HSS development and introduction better coincided with the new central Health Policy framework.

Box 2 below lists four sub-sector health documents that stand out as particularly important to GAVI health systems support.

Box 2: Key health sector documents for GAVI HSS

- The National Maternal and Newborn Child Health (NMCH) Program from 2005 that passed the central planning commission for implementation in November 2006 and was intended to be implemented from January 2007 till 2012.[5]
- The NMCH plan is further strengthened by analysis provided on the general maternal health situation in an analysis/recommendations based on the situation in a sample of districts.[6]
- The National Program for Family Planning and Primary Health care. "The Lady Health Workers Programme" 2003-2007. This program also has passed the central planning commission and is thus highly relevant for support from the GAVI HSS.[7]
- The comprehensive Multi-year National Immunisation Strategic plan 2005-2010 serves as the major strategic documents also for the GAVI HSS preparations.

Interviews demonstrate that the NMCH plan was particularly important as a foundation for the GAVI HSS second application.

[5] Government of Pakistan, Ministry of Health 2006: *National Maternal Newborn and Child Health (NMCH) Program 2006-2012*
[6] Government of Pakistan, Ministry of Health, National HMIS Cell in Collaboration with Unicef Pakistan: *Assessment of Emergency Obstetric Care Services in Selected Districts of Pakistan 2006*
[7] Government of Pakistan, Ministry of Health: *The Lady Health Workers Programme 2003-2008"*

3 GAVI HSS APPLICATION PROCESS

To date, Pakistan has submitted two applications for funding to GAVI HSS – the first in November 2006, the second in May 2007. The first application was unsuccessful in terms of funding approval. The second attempt was successful. This chapter describes key aspects of the design and application process for both of separate applications, and examines the factors that influenced the success of funding for one and not the other.

3.1 First Application

Design and Content

Pakistan belonged to a small group of early applicants for GAVI HSS resources – probably because of established and successful relations between GAVI and Pakistan regarding the funding of its EPI program. Initially GAVI HSS was understood in Pakistan to be a broadened approach to improved immunisation coverage. An understanding of the concepts of a strengthened health system as a means to impacting on the objectives of MDG 4 and 5 grew in importance during the application process, and eventually become a dominating feature of the application. Pakistan's first application adopted a highly decentralised implementation model based on provinces and districts. It was clear that the vaccination coverage issues – a prime GAVI HSS objective – played a peripheral role; with the content of the application adopting a broader systems approach.

Box 3: Main Content Areas of the First GAVI HSS for Pakistan

- **Planning and monitoring**: Including efforts around institutional strengthening on all three main levels of the public health system – national, provincial and district.
- **Human resource development**: Particularly focusing on district level development and the development of a population based assessment of staff structure.
- **Logistics management:** Including a computer-based system for transport and the repair/ storage of commodities and supplies
- **Health system management and stewardship**: Including legal and institutional development for provision of health services public/private, inter-sectoral co-ordination, policies for public-private partnerships and the development of legally regulated minimum service standards in primary health care.

Application Development Process

In sum, this application was not funded for two reasons:

(a) Lack of inclusiveness and sustainability: The application process and proposed implementation model suffered from problems of leadership within the FMOH and was overly driven by one of the vertical programs – namely EPI. Problems related to application /programme inclusiveness and sustainability were linked to this. This partially explains why the process was originally driven by the vertical EPI program and sent to GAVI in its name, with the EPI program acting on behalf of the Federal Ministry, FMOH. The two other programs associated with the GAVI objectives – the National Maternal and Child Health Program (NMCH) and the Primary Health Care and LHW program (LHW) did not seem not to have been fully operational at the time – particularly as there were concerns at the time about the leadership of the these programs.

(b) Abstract HSS approach: The application also suffered from serious inconsistencies and an overly abstract approach to health system strengthening.

In terms of detail – this is captured by the following description of the application process.

- A **first planning meeting** for the GAVI HSS application took place in July 2006, chaired by the Director General Health, in which organisational aspects of the application for GAVI HSS funding was focused on the formation of a National Health sector Coordination Committee (NHSCC).[8]

- A **second meeting** in August 2006 decided on the formation of a Core Group of representatives mainly from the EPI program, their academic counterparts, UNICEF and WHO. It is striking that the FMOH did not participate. WHO and UNICEF were both asked for technical assistance for costing the comprehensive multi-year plans for immunization (cMYP) and for an assessment of the health system. Of interest with regards to this

[8] The NHSCC was constituted on July 12 2006 for "securing, utilizing and monitoring of the HSS funds" by the Federal secretary health. It was chaired by the Director General Health and included a limited number of central/senior managers of the FMOH and representatives of provinces, UNICEF and WHO plus the national programme manager of the EPI program. The Terms of Reference was formulated to require consensus for decisions taken. The vote of the DG of FMOH was binding on all members. The "Core Committee" – while operational at a much earlier stage, was constituted in June 2008. It included managers from the three relevant programs, representatives of UNICEF and WHO, but no representatives from provinces and was chaired by the Additional Secretary Health/coordinator HSS. To an extent, it appeared to duplicate the role of the NHSCC though at a lower level in the FMOH hierarchy.

meeting were strong arguments for the involvement of the private sector, for integration between the three main vertical programs in planning and implementation for the GAVI HSS, and an emphasis on demand generation activities.

Work on the forthcoming application included also an assessment of the Health System in Pakistan. The resulting document – emerging from the EPI program - was finalised in October 2006 after a one day meeting of stakeholders during which a prioritisation process took place concerning an analysis of the health system in Pakistan. It seems clear that this exercise played a fundamental role in outlining the framing of the application.[9]

- In the **third meeting** of the NHSCC and its Core Group an additional "working group" was selected to write the actual application. Its work was presented at a joint National Interagency Coordination Committee and NHSCC – now chaired by the Federal Secretary Health. Two important presentations served as a basis for the meeting: (1) WHO-EMRO presented proposed immunisation strategies to be supported by the GAVI HSS; (2) The Planning Director of the FMOH presented a health systems approach and a highly decentralised implementation model. These approaches were given a final blessing by the Federal Secretary Health:

  A highly decentralised implementation model under the leadership of the FMOH was included in the application as well as provisions for provincial programme implementation units.

Feedback from GAVI Independent Review Committee

The GAVI Independent Review Committee (IRC) and GAVI board assessment of the application was highly critical about:

- The general inconsistency of data across the application.
- The process for developing the application was not inclusive.
- The application leadership was not in the FMOH but a vertical program.
- The vertical program rather than FMOH seemed set to continue in the role of co-ordinator for program implementation.
- The proposed plan to set up parallel structures.
- Objectives and activities did not link up.
- The lack of analysis of partner support had negative implications for sustainability.

[9] Analysis/Assessment of Health System in Pakistan and HSS proposal. *Expanded Programme on immunisation, National Institute of Health, Islamabad. October 2006.*

In GAVI terminology a "re-submission" was required which meant a rejection of the application and a completely new approach was called for.

3.2 Second Application

Design and Content

The 2007 application differs in many respects from the unsuccessful first GAVI HSS application in 2006. Its analysis of constraints and strengths of the Pakistan health system was less academic and more practical in application. Similar to its fore-runner application from 2006, the second application was handicapped by the fact that its overall strategy direction was derived from the - still valid but aged - 2001 Health Policy document. It is not known to what extent the 2005 Medium Term Budget Framework was taken into account in the development of the application.

The analysis of barriers to achieving MDG 4 and 5 in the application was strongly pro-primary health care. The LHW scheme was singled out as a particularly useful resource to improving IMR and MMR, as well as the basic health units and district hospitals (i.e. which were identified as requiring a strengthening of infrastructure, staffing and supplies). The application focused on the need to improve staff training in IMNCI and EmONC. Also noticeable was a strong emphasis on addressing training needs in the private sector. It also strongly emphasised that addressing challenges of resource and skill could only be done with improved management at the district level. The application also reflected findings about barriers to improving health and health services. In sum, the application requested funding for 23.5 million USD over two years (2009 and 2010). The main areas in the application are summarised below (Box 4).

Box 4: Main Content Areas of the Second GAVI HSS Application

- A policy to implement IMNCI widely in Pakistan
- A policy to improve referral links for emergency obstetric care including also a HR element of EmONC
- To start a process of improved immunisation coverage in marginalised parts of the country by widening the role of LHW to include vaccination
- Primary health care elements of the health system to be given considerably improved access to utilities and consumables
- To strengthen district capacity for planning and management
- Human resource issues – including private sector - brought to the forefront of strategic health system issues
- Support and supervision for peripheral health system elements to be strengthened
- Resources to be set aside for provincial and federal levels in terms of supervising, monitoring and evaluating health systems performance

Application Development Process

The application process re-started on March 10, 2007. Again the time for drawing up proposals was limited – the target date was May 15 which allowed for a two month period of proposal development. At the first meeting an analysis of the critical review of the first effort was made and a roadmap drawn up for a new GAVI HSS proposal.

A strategic meeting of the combined NICC and NHSCC took place one month before the final date for submission of Pakistan's second HSS application to GAVI. At the end of this meeting the Federal Minister for Health summarised six important elements of the application:

- The FMOH must take the lead;
- The MNCH program was to be improved and thus used as a basis for the forthcoming
- Application;
- Horizontal linkages between programs (EPI, LHW/PHC and NMCH) to be strived for;
- The private sector was to be included in the program work and in the application;
- Managerial capacity at the implementation level was to be strengthened;
- Marginalised and underserved areas were to be taken note of and included in the application.

A Working Group for the evolving HSS proposal was requested to include substantial inputs from the LHW and NMCH programs as well as inputs from the Health Services Academy. The working group with strong representation from the UN system (WHO, UNICEF) and with representation from two of the three programs (EPI and NMCH) worked extremely hard to develop a new application in the limited time set aside for the purpose. The group was chaired by the DG Health of FMoH, and two more representatives of the FMoH. Seven DG Health officials from provinces, representatives of UNICEF and WHO and the National Program Manager of EPI were active in this group. There was no NGO / CSO or private sector involvement. Bilateral partners were active too – particularly DFID and USAID – and GTZ participated.

External TA was used. According to interviews it was funded with GAVI HSS pre-application funding. At a later stage – i.e. preparing for implementation in FMoH - TA was frequently used, and was mostly covered by funding from GAVI HSS. Bilateral partners also provided financial support for external TA to GAVI HSS.

Comments made by development partners during interview indicated that work and time pressures did not allow for effective and sufficient contributions from outside this hardworking

group which may have negatively affected both the quality of the application and a sense of inclusion among other stakeholders.

A later meeting of the NHSCC aimed at building consensus on the proposed application from the Working Group. The proposal presented at the meeting had three foci:

- To improve capacity of the district health management teams;
- to improve access to quality comprehensive IMNCI and EMNOC services;
- to enhance the effectiveness of prevention and promotion MNCH outreach services.

This application confined its time frame to two years and sought a smaller budget of 24 million USD. A second phase, with a proposed three year time frame, was considered the 'next step' for a subsequent later and separate application.

The working group presented its final draft to the Ministry of Health close to the application deadline and got its blessing after brief consideration of postponing application submission to a later round of GAVI HSS applications. Endorsement documents were signed by the Secretary Health and the Secretary Finance as well as the Chair of the NHSCC on May 11 2007.

Approach to GAVI HSS Monitoring & Evaluation in Pakistan

Box 5 lists the types of output and outcome and impact indicators adopted as monitoring and evaluation (M&E) measures for the second GAVI HSS application in Pakistan.

Box 5: Output, Outcome and Impact Indicators Used in Pakistan's HSS Application

Output indicators

- % of districts with annual health plan
- % of districts comprehensively mapped
- % of private sector health facilities with a trained health care provider following IMNCI protocols
- % of health facilities (DHQs/THQs) with functional neonatal units
- % of LHWs providing vaccination
- % of DHQs Hospitals providing 24/7 comprehensive obstetric care

Note: None of these indicators had baseline values cited in application. They are to be updated as a result of the Demographic and Health Survey, and will be available in June 2007. All indicators have targets mostly set for 2008.

Impact and Outcome indicators

- U5MR
- IMR
- % of deliveries assisted by skilled birth attendants
- Contraceptive Prevalence Rate
- National DPT3 coverage
- Number/percentage of districts achieving > 80 % DPT coverage

Note: These indicators all have baseline values

Data collection for monitoring GAVI HSS is probably (though this is not clearly spelt out) to be done using the HMIS system, where possible. An interview with the HMIS Director indicated that no specific activity had taken place to date in order to realise this. His first exposure to the monitoring framework appeared to be when the interviewer shared his copy of the application form with him. So – in theory the M&E system for GAVI HSS should be building and using current systems in Pakistan. However, it appeared to the consultant team that there was a lack of 'on the ground' evidence of this.

The 2008 APR 2008 included a table (Table 4.8) with a general overview of targets achieved. While repeating the outcomes cited above (Box 5), no information about current status – or movement towards these outcomes was reported.

No corresponding table relating to output indicators is provided in the 2008 APR. Instead reporting focused on "activities". Partial (and sometimes very limited) progress is reported on 10 activities of 34 activities (see Table 4.3 in 2008 APR). The 2008 APR – whilst slightly more complete than earlier APR's, seems to suffer from a lack of reporting from WHO and UNICEF (i.e. both responsible for a range of HSS related activities). In follow up interviews with these agencies, representatives stated that they had not reported to FMoH (as agreed in the MoU).

Support of Country and Regional / International Development Partners to the Application Process

Interviews conducted with key stakeholders suggested that a range of development partners at different levels played an important role in the development of the second GAVI HSS application:

- A Cairo meeting with WHO EMRO and its member countries helped streamline the application process in Pakistan
- Technical assistance provided by WHO EMRO was instrumental in the actual drawing up of the application
- WHO, UNICEF and UNFPA at the country level were all actively involved in writing the final application document in very intensive work sessions

Key informant interviews indicated that the UN partners saw the GAVI HSS process as strategically important, both for Pakistan, and for global strategies important to their respective organisations.

Feedback from GAVI Independent Review Committee

The IRC recommended that the GAVI Alliance Board approve the application subject to satisfactory clarifications concerning:

- Improved consistency between indicators and objectives for M&E
- Improved analysis of complementing funding from major partners of the GoP
- Clarity about the organisational structure of co-ordination within the public health system
- Clarity about implementation management

On July 26 2007, the GAVI board gave its final approval. In a letter to the Minister of Health, disbursement of $ 16,898,500 was approved for the last quarter of 2007.

It seems reasonable to conclude that a learning process had evidently taken place between the first application from Pakistan to GAVI HSS in 2006, and the subsequently successful application in 2007:

- The successful application drew upon a more solid basis of strategic preparedness and costed activity plans
- The application was clearly related to achieving MDGs 4 and 5 – more so than immunization issues
- The involvement from the main three programmes was clear. Also provinces were at least given an understanding of the proposed plans and a chance to react and comment.

Yet there were also weak aspects of this application too:

- It was written in a short time by a small group in which the two UN partners played a role that could arguably be considered as reducing government ownership of the product and which permitted only limited inclusion of major stakeholders.
- It addressed few chronic and strategic health system deficiencies, thus possibly prolonging the 'survival' of a highly criticised system.
- Proposed implementation mechanisms were not well founded on general GoP procedures.

4 Implementation & Progress of GAVI HSS in Pakistan

4.1 Implementation Progress to Date

Our 'stock take' of GAVI HSS progress in Pakistan in June 2009 found that implementation to date has been limited. While selected training activities have been completed, and preparations for procurement have been undertaken, the majority of proposed activities remain currently outstanding in terms of implementation.

Table 4: Progress on Completed Activities for GAVI HSS Application: Status June 1st 2009[10]

Objective	Completion status according to application[11]	Actual completion status by June 1, 2009
Improve national maternal health care coverage to more than 70% and EPI coverage to more than 95 % within 5 years	15/19	6/19
Enhance effectiveness of district health care delivery service through strengthening human resource development, organizational management, leadership capacity, logistics, supplies and infrastructure	4/10	0/10[12]
Improve community and civic society organizations involvement in health system decision-making mechanisms	3/3	0/3
Other (research, survey and assessments, office supplies and technical support)	2/2	0/2

While the general picture presented in Table 4 is that of big delays, some encouraging observations can also be made: The EPI training of Lady Health Workers has seen real progress. 17000 LHW have been trained in EPI methods to improve on immunisation coverage in peripheral parts of Pakistan.

Positive observations can also be made on INMCI and EmONC regarding training of private health providers. Both these activities have considerable strategic importance. Additionally 4 provinces and the capital city of Islamabad have been supported with HSS officers. These

[10] This table is based on information in a personal communication to the author from within the WHO Islamabad office.
[11] Two activities have been merged with a third. The total number of activities in this group has thus been reduced to 17.
[12] Two activities are well under way but not completed.

officers are particularly important since they serve as GAVI HSS implementers working with WHO administered activities. Recruitment has also been ongoing for a Health Policy Unit in the FMOH. This unit is discussed in some detail below.

A work plan[13] was presented in May 2009 within the national program for family planning and primary health care that demonstrates preparations for procurement of drugs and equipment using GAVI HSS funding, as well as preparations for certain management development activities and the revitalisation of LHW health committees. On the same occasion a plan for training and implementation of LHW-MIS software was presented. A time plan indicates implementation from May to July 2009.

Although some positive signs can be seen the main picture of big delays remains true. The main reason for this revolves around problems regarding disbursement of funds.

Of a total of 16.879 MUSD for the first year, FMoH is responsible for the disbursement to implementers of 7.456 MUSD. WHO is responsible for active use of US$3.462 million and UNICEF is in charge of US$5.962 million.[14]

Two problems – both of considerable complexity – largely explain the delay of GAVI HSS implementation in Pakistan.

(a) Disbursement Delay: Disbursement of funding was expected from GAVI to Pakistan in the last quarter of 2007. In reality it took place in August 2008 – nearly a year later than originally expected. The cause of this delay is complex and relates to problems of financial management in both the Government of Pakistan and GAVI.

The delay was caused partly by slow progress in discussions between GAVI and the FMoH on basic disbursement strategies. A change of mind by GAVI in terms of agreeing to direct HSS funding to UN partners in Pakistan (i.e. the proposed implementation model) contributed to further delays. When funds were finally secured, lack of activity from FMOH in the early stages exacerbated the problem. Additionally the MoF insisted on the use of formal financial management rules within GoP. This approach would lead to a handling of the matters of disbursement in the Planning Commission under the Prime Minister. Since there is large number of issues waiting to be resolved on this level, FMoH aspired to make

[13] Undated document from the program for family planning and primary health care.
[14] Data from NHSCC minutes of September 19 2008. This figures do not concur with the figures in table x.

a short cut, by avoiding the Planning Commission. The prolonged discussion around this theme is the second cause of disbursement delay.[15]

b) System Inertia, Strain & Lack of Trust:

It is important to note, that Annual Progress Reports for GAVI HSS are very incomplete. This is most unfortunate since thereby focus on the implementation problems in Pakistan GAVI HSS was lost. Interviewees confirm that the low level of implementation in combination with incomplete reporting has affected relations to donors and UN partners and reduced the trust needed for effective collaboration. It is possible that poor reporting for which FMoH cannot reasonably be named the sole culprit, has contributed to an unfair level of distrust in relation to FMoH that easily could damage the possibilities of GAVI HSS success. For the moment it seems improbable that a 'catch up' in terms of the original implementation plan of two years can be achieved.

Added to this, the partnership implementation model is complex and whilst not a 'cause' of implementation delay may be a contributory factor.

Complex Partnership Model of Implementation

The implementation model of GAVI HSS in Pakistan as described in the original funding application relies on the clear leadership role of the FMoH and its Secretary of Health. The Secretary should lead the Program Management Unit (PMU) within the Planning and Development Cell of the FMOH. In reality the management model is more complex. Funding (as described in the APR for 2007) was divided three ways into the health sector – Table 5:

Table 5: funding for 2008 GAVI HSS in Pakistan in APR 2007[16]

Funds to be transferred to	US$ (in millions)
UNICEF	6.617
Ministry of Health	3.129
WHO	7.133
Total budget for year 2008	16.879

[15] Recent information indicates that a compromise has been reached in July 2009 which will allow FMoH to disburse funding from GAVI HSS to the implementing operators up until month of September 2009 bypassing the planning commission. From September and onwards the financial management rules of GoP will apply and the Planning Commission be involved.

[16] The figures from the APR 2007 do not concur with later figures but do still reflect the principles for the Pakistan implementation model.

It is important to note that, to a high degree, the implementation of GAVI HSS in Pakistan has become a matter for two UN bodies. Less than 20% of the GAVI HSS funding for "year one" is retained in the hands of the FMOH. The MoU gives far-reaching powers to the two UN bodies and reporting back to the FMOH seems to have been very limited (e.g. 2008 APR). Both WHO and UNICEF confirmed that no formal reporting documents have been submitted.

The implementation roles between the three main implementers are not uncomplicated but have a partial underlying logic:

- UNICEF handles four procurement issues (four activities)
- FMoH focuses particularly on mobilisation, management, infrastructure and policy development issues (sixteen activities)
- WHO focuses on training where the clear goal is improvement in integrated approaches to child health (IMNCI and vaccinations) and emergency obstetric care. An element of research, policy development and monitoring is also part of the WHO part of the GAVI HSS agenda. (Seventeen activities).

Of the three implementers WHO seems to have the widest agenda. This is further underlined by the role WHO is given to assist with the building of the main structure for FMoH's implementation work – the PMU. The complications of this financing model are discussed below.

The basis for this "out-sourcing" of responsibility for implementation is a Memoranda of Understanding (MoU) between WHO and UNICEF on the one hand and the FMoH on the other. The MoU describes the relationship between the Government and the two UN bodies as being based on a trust fund in UNICEF and in WHO financed by Government to implement an important share of the activities of the GAVI HSS application. Within this planning and financial framework WHO and UNICEF are given full responsibility for implementation with reservation for alterations within the framework. Such changes presume consultations with Government. UNICEF and WHO shall submit three-monthly reports on activity progress and yearly statements of income and expenditure on a yearly basis.[17] The MoU with WHO was signed on the 19 of September 2008.

[17] According to personal communications with the author from WHO and UNICEF, no such reports have been produced and sent.

Governance & Management Challenges as Contributory Factors

Much responsibility for avoidable delays lies with the senior management of the FMOH. However, GAVI's change of mind in terms of its willingness and ability to channel funds via UN partners also played an important role. This explanation requires further elaboration:

Funding Architecture: Interviews refer to problems with financial management rules concerning Ministries in Pakistan. An ideal solution would have been to have funding from GAVI HSS incorporated into the general government budget structure that carries operational responsibility for implementation. According to FMOH interviews this would have caused additional delays because of the involvement of the Planning Commission of the GoP (lead by the Prime Minister) and a six months handling time.

Co-ordination problems: The committee structure used and the internal organisation of the FMOH for handling the implementation process may also have contributed to the delay. The mandates of the NHSCC and the CC are not mutually exclusive, which leads to uncertainty about where decisions are taken. This seems also to have contributed to inadequate allocation of resources for the monitoring of the implementation process (see below on the establishment of the HSPU).

GAVI HSS implementation is cross-sectoral and cuts across lines of responsibility in terms of 'center', 'regions' and 'districts'. Co-ordination becomes a problem because of the simultaneous high degree of devolution and centralisation to programmes. In this situation FMOH must play an effective role of stewardship to push the implementation process forward and monitor progress. The stewardship role was bestowed to a specialised structure inside the FMOH – a Program Implementation Unit that first needed to be set up with funding from GAVI and development partners.

The establishment of this main implementation unit for GAVI HSS – the Health System and Policy Unit (HSPU) serves with examples of problems associated with such a unit and specific governance problems inside the FMOH.

The main role of the HSPU seems to have been to cover for the fact that the FMOH has little experience and does not have the internal structures, internal processes and manpower to deal with project ("activity") implementation. The combined role of a health strategy unit and a program implementation unit is not ideal – but it could make recruitment of critical manpower resources possible. Although never really spelled out in this way - interviews indicate that this was the underlying argument for establishing a PMU - HSPU.

The HSPU is known by several different names. From the point of view of the GAVI HSS its main function has been to serve as a manager of implementation - including monitoring - in addition to being responsible for policy making functions.

Importantly, such management needs to include authority for co-ordination yet actual implementation lies in the three programmes (EPI, FP and LHW and NMCH respectively), in Districts and Provinces and in WHO/UNICEF. The HSPU does not carry such authority.

The co-ordination role includes: planning, support to implementation agents, management of cross sectoral co-ordination, financial management oversight, economic and operational monitoring of progress and reporting. These tasks are already part of the mandate of other structures of FMOH. Duplication inside the FMOH occurs with the establishment of a Program Implementation Unit. Consequently, 'turf conflicts' and delayed action in terms of setting up the unit have occurred.

Dual Reporting Lines: The organisation of the HSPU inside the FMOH contributes to events. Originally it was established as an organisational unit directly under the Secretary Health (note, this was the final situation in June 2009). At the same time, it was established as part of the Planning and Development cell of the Ministry which is headed by a subordinate to the Director General Health. This results in the manager of the PMU/HPSU having double reporting lines.

Challenges establishing the HSPU: The funding mechanisms were never clear for the HSPU. They were not part of the original application to GAVI but have been assumed to be financed by resources from the GAVI HSS. Since it also has a role as a strategic development agent for more general policy and strategy development, a heavy reliance on GAVI funding may include serious problems of sustainability.

The HSPU story includes a very broad variety (staff selection, management, localities, roles in relation to other FMoH units) of problems handled in a long series of meetings. Partial activity was started with the help of consultants but attrition has, at times, caused additional problems for GAVI HSS activities. A manager for HSPU was finally appointed in June 2009. Other key staff are still missing.

The key issues exemplified by the example of the HSPU unit concern important governance matters:

- Solutions were available for inclusion of the HSPU in the FMOH hierarchy - the solution may not have been ideal but it was better than no solution.
- Financing was available – though it would have called for changes in the GAVI HSS activities. Arguably, such changes were quite legitimate.
- The process of selecting staff for the unit did take place, but the final decision was delayed.
- Large and small problems for the HSPU unit continued over two years and prevented the establishment of the main structure for GAVI HSS implementation. While the discussions continued – with many interruptions and some repetitions – time was running out for implementation of important and urgently needed support to the Pakistan health system.

5 Alignment of HSS to GAVI Principles in Pakistan

This chapter aims to examine the alignment of HSS in Pakistan to GAVI's principles, which are similar in tenet to those of the Paris declaration on aid effectiveness.

The ten principles that GAVI seeks to promote via its development assistance are reviewed in turn below as applied to Pakistan. These principles are:

- Country ownership;
- Alignment;
- Harmonisation;
- Additionality;
- Catalytic effect;
- Innovation;
- Sustainability;
- Predictability of funding;
- Inclusiveness and;
- Equity; poverty focus.

The analysis presented here has inherent weaknesses because of the slow progression of implementation, i.e. with the exception of the application form and very early activity there is limited evidence upon which to draw conclusions.

5.1 Country ownership

The evaluation of **country ownership** seeks to consider the extent to which the GAVI HSS plans and processes in Pakistan are driven by national priorities and endorsed by the highest Pakistani authorities. Endorsement is clearly in place.

The present GAVI HSS in Pakistan is the result of a re-drawn application after the rejection of a first effort. Criticism of the first application concerned to some extent efforts proposed to solve "up-stream" abstract problems rather than problems with a more direct bearing on vaccination coverage and the realisation of MDGs 4 and 5. The rejection of this approach from Pakistan may have reduced country ownership. On the other hand the critique from GAVI was to a large extent technical rather than political. The basis of the approved application was the NMCH program plan. GAVI HSS in its present format is largely a reflection of this plan.

The situation is less clear from the point of view of implementation. Two UN bodies carry a heavy weight of implementation responsibility and the extended problems of FMOH leadership and stewardship points to a reduced level of country ownership; at least temporarily.

It is important to note that this assessment of country ownership refers to the Federal level only. The federal structure of the country at a minimum also requires a consideration of the 'ownership' of the provincial level as well. Security issues made efforts to do this impossible.

The late development of the medium term development framework (MTDF) means that the Federal level (FMOH) has had insufficient instruments available earlier on in the process to allow it to perform its stewardship and oversight function. It is not clear, whether the principles of the MDTF and MTDB have had an impact on the drawing up of the applications. These comprehensive planning formats are not mentioned in the meetings of the GAVI HSS structures in Pakistan. Nor are they mentioned in interviews; hence the low scores in Table 4. Similar views around insufficient integration of vertical and horizontal plans are also found in the 0-draft to the Health Policy for 2009. [18]

Monitoring of GAVI HSS progress is a decisive instrument for a country to drive a health policy process. M&E of GAVI HSS implementation is under development and there are positive features that need to be acknowledged. While the regular HMIS cell in the FMoH has produced a first integrated HMIS yearbook, the integration between these efforts and the GAVI HSS implementation seems to be almost non existent. The role to build an M&E framework has been assigned to the HSPU in the FMOH which – as described above – is still only partly (and very recently) functioning. The low quality of the APR on GAVI HSS is a serious drawback for the judgement of the status of M&E in Pakistan.

In summary: from the points of view of Country Ownership, Pakistan's handling of GAVI HSS demonstrates that ownership is far from perfect and that problems of leadership, stewardship and governance capacity create a situation where other bodies establish important roles.

5.2 Alignment and harmonisation

The GAVI HSS application is **aligned** to strategic principles manifested via the NMCH plan, the LHW plan and the more comprehensive MDTF and MTDB. The government plan in the application is an expression of a general evidence based "toolbox" of instruments for achieving

[18] The problems of integrating health policy making, strategic planning and budgeting over the three levels of the devolved health sector is a matter of interest for much effort. For an analysis see for instance: Price Waterhouse Coopers: MTBF Project 2003: Review of the Policy Development, Budgeting and Financial Management in the Ministry of Health, Pakistan.

MDG 4 and 5 (though with a clear Pakistani touch) and partners are basically using that same toolbox for their own planning.

Donors' alignment with government processes and systems does not go far in Pakistan. The main thrust of "aligned" participation originate in WHO and UNICEF which have clearly put their strength behind drafting an effective GAVI HSS plan and lending strong support to its implementation. It is clear that this energetic support can reduce the position of government. Implementation efforts by the two UN bodies are performed with their own systems, and reporting back on progress is strikingly absent. Bilateral donors demonstrate a frustrated approach to alignment. USAID tends to go its own way working with local government and private sector. DFID and GTZ express the view that the situation for harmonised and aligned activity from their side is less than ideal. World Bank has been working for a more aligned format of health aid, but seems to have withdrawn from earlier more progressive positions. In summary: Interviews with a selection of development partners seemed to indicate that they generally share the views of government in this respect; expressing frustration about aspects of implementation of the principles.

Interviews with development partners confirm that they have been consulted on important strategic matters around GAVI HSS and structures exist in which such consultation can be made in a collective form. There are few clear signs that GAVI HSS has been taken to serve as a tower of light for the health system support activities inside major donor organisations. Lack of trust in FMoH capacity to implement plans, however, makes them cautious and abide their time.

The UN partners have a pioneering planning system running. The existence of this plan could make it possible to find a link between global initiatives and UN programs. The "4 ones" plan in Pakistan includes a situational analysis that must have also included GAVI HSS. However it is not clear to this date what impression it has had on the "Health and Population" element in the joint UN plan.

There is clear agreement among partners that the transactional burden on government from multiple aid flows is heavy. Development partners seem to have contributed generously to FMOH and programmes with technical assistance that reduces the transactional burden on the ministry. The sustainability of this form of harmonisation is of course limited but the effort should be appreciated. The system of government M&E framework is not built in such a way that it could become a real alternative to the dedicated M&E framework as anticipated in GAVI HSS at the moment.

GAVI HSS has caused partners to be very active in supporting the Federal ministry with technical assistance that might contribute positively to open and frank relations between partners and between partners and government. Again, the sustainability of this form of active support from development partners has drawbacks.

5.3 Additionality

There is no indication of a direct replacement effect following the arrival of GAVI HSS money, but also no evidence that actions have been taken to avoid displacement effects of additional funding.

The issue of anticipatory reductions of country resources to health is more complex. It is not unusual that 2009 macroeconomic reports – such as those regularly issued by IMF – include analytical discussions on the issue of possible fiscal restraint in light of expanded donor contributions to public consumption/investment. This would – if made policy by a country – be a clear example of "non-additionality" in this anticipatory sense of the word. Late reports on Pakistan[19] indicate recommendations about increased fiscal restraint in view of the present macro-economic conditions, but donor funding has not been particularly selected as a way of reducing the anti-"pro-poor" effects of such measures. No particular reference to GAVI HSS funding has been found.

On the other hand, the Pakistan record of government spending on health as percentage of total government expenditure is exceptional in comparison to surrounding countries. From an already low level of 2.2 % 1996, the figure has steadily decreased to 1.3 % 2006 (last year for which figures have been available). Similarly the general government expenditure on health as percentage of total expenditure on health was reduced from the very low level of 26.8 % in 1996 to 16.4% ten years later. This could have been interpreted as government reliance on outside aid to replace the government's own resources but very recent information indicates that government funding for health is now turning upwards to higher levels. The verdict on additionality of GAVI HSS resources is therefore positive.

5.4 Catalytic effect

GAVI HSS funding could have a catalytic effect in Pakistan if implementation proves successful. Broadening of LHW activity to include immunisation may also create a stronger

legitimacy for their (already much appreciated) work and thereby help to solve the serious demand problem for public health services. Efforts to bring private sector into a closer relationship with public health through training in IMNCI and EmONC could similarly represent a new beginning towards more comprehensive and coordinated health services.

5.5 Innovative effects

Low implementation of GAVI HSS plans makes judgement on innovative effects difficult and rather speculative. A positive score can still be awarded based on forthcoming plans contained in the GAVI HSS application. The effort to change the general structure of immunisation using the Lady Health Workers is a truly innovative effort to find solutions in the direction of a less fragmented primary health care provision structure. Many steps may still have to be taken to truly integrate the efforts of EPI, LHW and MNCH (including the Basic and Rural Health Units) but the broadening of the task of LHW is clearly both innovative and relevant.

5.6 Inclusiveness and poverty focus

Health Policies and health strategies in Pakistan are strongly associated with non-government partners, considering the low share of the “health provision market” under government control. The stewardship role of government in Pakistan needs an unusually strong element of openness to private sector and to NGOs. Much of the private sector lacks formal organisation for relations with government. The formalised private health sector has an established contact partly through the fact that health professionals often have a dual position in both public and private provider structures.

GAVI HSS has taken note of the important role of the private sector and GAVI CSO continues along this line. A certain preparedness to be open to private sector influence and support is clear in the application.

A strong element in the GAVI HSS application and its implementation is the focus on gender issues. The important cultural restraints on demand for public health services based on gender roles is addressed through a strong emphasis of LHW development. However a similar clear focus on poverty is not distinguishable. The general character of the plan though, is on primary health care, which gives GAVI HSS in Pakistan a poverty profile.

5.7 Sustainability

The establishment of sector planning in the format of the MTDF and MTDB have clearly improved the preparedness for sustainable health financing. GAVI HSS funding sustainability analysis needs to include a judgement on the possibility to uphold the levels of training for LHW that will address an increasing number of health workers from an already high level. Efforts of training private sector health staff could be costly when applied to the whole of the privates sector, but the fact that private sector staff is also employed in the public sector could make training issues less vulnerable to sustainability challenges.

5.8 Predictability of funding

The predictability of funding in the case of GAVI HSS in Pakistan is closely related to ownership / governance problems discussed above (see Table 1). Severe disbursement problems have considerably reduced predictability of funding. The fact that GAVI HSS is budgeted for a shorter period than the originally foreseen five years contributes to aggravate the predictability problem for GAVI HSS in Pakistan. At present a general uncertainty exists; partly because of feared GAVI HSS reactions to the slow implementation tempo.

5.9 Results orientation

Results orientation can in theory be associated with the activity structure and with the M&E framework of GAVI HSS. In one case, economic incentives are included in the activity outline. But in general there is no thematic effort to address incentive structure issues. The M&E framework suffers from lack of baseline data for output indicators making result orientation difficult.

Annex 1 List of Reference Documentation

GAVI document database:

Annual Progress Report 2009, Pakistan incl IRC review

Annual Progress Report 2007, Pakistan incl IRC reviews

Annual Progress Report 2008, Pakistan incl IRC reviews

Application form for PAKISTAN, GAVI Alliance Health System Strengthening (HSS) Applications, May 2007

Proposal for support of: Health System Strengthening Under Global Alliance for Vaccines and Immunization Phase 2. November 2006

HSS IRC Review: Pakistan November 2006

IRC Recommendation to GAVI Alliance Board Novemmber 2006

Publications from Government of Pakistan, Ministry of Health:

National Health Policy 2009, Stepping Towards Better Health, March 2009 Zero Draft -19 feb 2009-07-10

National Health Policy 2001, The Way Forward, Agenda for Health Sector Reform, December 2001

National Maternal Newborn and Child Health (MNC) Program, 2006-2012. November 2006

Assessment of Emergency Obstetric Care Services in Selected Districts of Pakistan 2006, (With UNICEF)

Yearbook 2005-2006 (no date)

National Maternal Newborn and Child Health (NMCH) Program 2006-2012

Assessment of Emergency Obstetric Care Services in Selected districts of Pakistan 2006

The Lady Health Workers Programme 2003-2008

National Integrated Report – 2008. Analysis based on National HMIS. LHWs-MIS & Other data sources

Documents from Government of Pakistan, Ministry of Health/ National Institute of Health /Ministry of Finance:

Notification no. F.6-4/2006-Plg on constitution of a Core Committee for GAVI Support for Health System Strengthening.

Office Memorandum no FEPI/GAVI/01/01(01) HSS on National Health Sector Coordination Committee

Draft: Financial Management System for GAVI (Global Alliance for Vaccines & Immunisation) Support for Health System Strengthening. Annex II 1285. No date

Training & Implementation of LHW-MIS Softeware, (no date)

Work Plan National Program for FP & PHC MOH, GAVI HSS 2008/09

Minutes of the NICC/NHSCC meeting, April 4 2008

Minutes of Meeting, National Health Sector Coordination Committee (NHSCC) Meeting held in the committee room, Ministry of Health on 19th September 2008 at 11.00 A.M

Minutes of Meeting of 1st Core Committee of GAVI-HSS (July 25 2008)

Minutes of Meeting of the 2nd Core Committee GAVI – HSS

Minutes of the Meeting of 3rd Cre Committee Held on 4th September 2008

Minutes of 4th meeting of Core Committee of GAVI_HSS Held on 16th January 2009 at 1200 noon in MoH, Islamabad

Minutes of 5th Meeting of Core Committee of GAVI HSS held on 15th April 1200 Noon in Ministry of Health Islamabad

Ensuring a Demographic Dividend: Unleashing Human Potential in a Globalised World (draft summary of the Poverty Reduction Strategy Paper – II

Analysis/Assessment of Health System in Pakistan and HSS proposal, EPI October 2006

Documents from WHO country office of Pakistan:

Health System & Policy Unit (HSPU) – Concept Note (no date)

Agreement Between THE WORLD HEALTH ORGANIZATION (WHO) and the Federal MINISTRY OF HEALTH, GOVERNMENT OF PAKISTAN (referred to as MoU)

Other Documents:

Price Waterhouse Coopers*: MTBF Project 2003: Review of the Policy Development, Budgeting and Financial Management in the Ministry of Health, Pakistan*

Annex 2 List of Interviewees

Name	Representing
Khushnood Akhtar Lashari	Secretary of Health FMOH
Altaf Hussain Bosan	National EPI program
Bile Kahlif	WR WHO
Hasan Abbas Zaheer	National Aids Control Program
Hemlai Sharma	Unicef
Imran Durrani	GTZ
Inaam ul haq	World Bank Islamabad
M Hulki Uz	UNFPA
K.M. Siddiq Akbar	FMOH
Melissa Corkum	UNICEF
Michael O'Dwyer	DFID
Mohammad Ismail Virk	Save the Children UK
Mohammad Azam Saleem	FMOH
Paul Ruckert	GTZ
Quadeer Ahsan	USAID Pakistan
Raheela Muhammad Ali	FMoH
Raj Kumar	GAVI
Raza Zaidi	DFID
Saleem Wali Khan	UNFPA
S. M. Mursalin	National HMIS cell
Werner Buehler	WHO
William Conn	USAID
Hemlal Sharma	UNICEF

Annex 3 Summary GAVI HSS Evaluation Approach

The GAVI Alliance HSS Evaluation Study Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.
There are five main objectives and areas of evaluation:

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?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such as way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be **complemented by the results of 6 on-going GAVI HSS Tracking Studies** being conducted by the JSI-InDevelop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions mentioned above.

Annex 4 Typology of areas for HSS support

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