GAVI ALLIANCE

EVALUATION OF GAVI HEALTH SYSTEMS STRENGTHENING SUPPORT TO NEPAL THROUGH THE POOLED FUNDING MECHANISM

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FINAL REPORT

Submitted by:

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In association with:

Health Research and Social Development Forum

CEPA

HERD

HEALTH RESEARCH AND SOCIAL DEVELOPMENT FORUM

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ACRONYMS AND ABBREVIATIONS

Acronym/ Abbreviation	Description
APR	Annual Progress Review
AWPB	Annual Work Plan and Budget
BCG	Bacillus Calmette–Guérin vaccine
CEPA	Cambridge Economic Policy Associates
cMYP	comprehensive Multi-Year Plan
CSO	Civil Society Organisation
DFID	UK Department for International Development
DHS	Demographic and Health Survey
DTP3	Diphtheria-Tetanus-Pertussis vaccine
EDP	External Development Partner
EPI	Expanded Programme on Immunisation
FMA	Financial Management Assessment
Gavi	Gavi Alliance
GDP	Gross Domestic Product
GoN	Government of Nepal
HERD	Health Research and Social Development Forum
HMIS	Health Management Information System
HSS	Health Systems Strengthening
IHP+	International Health Partnership
IRC	Independent Review Committee
JANS	Joint Assessment of National Health Strategy
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
JFA	Joint Financing Arrangement
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
M&E	Monitoring and Evaluation
MCH	Maternal and child health
MCV	Measles containing vaccine
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MoU	Memorandum of Understanding
MTR	Mid-Term Review
NGO	Non-Governmental Organisation
NHDP	National Health Development Plan
NHSCC	National Health Sector Coordination Committee
NHSP	Nepal Health Sector Programme
NVS	New Vaccine Support

Acronym/ Abbreviation	Description
PPICD	Policy, Planning and International Cooperation Division
SG2	Strategic Goal 2
SWAp	Sector Wide Approach
UNDP	United Nations Development Programme
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

GLOSSARY

Term	Definition
Annual Progress Review (APR)	A report submitted by countries to Gavi providing information on performance, utilisation of funds and implementation issues across all funding windows.
Annual Work Plan and Budget (AWPB)	The Nepal annual health sector budget that delineates "on budget" activities for the coming fiscal year i.e. those which will be reflected in the "Red Book" (see below). The Policy, Planning and International Cooperation Division (PPICD) within MoHP is responsible for leading the development of the AWPB.
comprehensive Multi Year Plan (cMYP)	Country government plan for immunisation. Gavi requires countries to submit a cMYP when applying for Gavi support.
Joint Annual Review (JAR)	Coordination meeting held each January between GoN, EDPs, CSOs and other state and non-state actors. It is an integral part of the SWAp and enables a joint review of progress to date and to identify priorities for the coming year.
Joint Consultative Meetings (JCM)	According to Article 20 of the JFA, four JCMs are to be held each year, chaired by the Secretary of MoHP: - First JCM (March): MoHP and EDPs receive the health budget ceiling, and based on this, set high level health and corresponding operational priorities. Following this meeting EDPs usually meet bilaterally with Health Divisions to discuss specific priorities. - Second JCM (April): 2-3 day workshop held to review the previous year's expenditure and prepare the upcoming year's AWPB. During this meeting, donors are required to make their funding commitments. - Third JCM (June): Draft consolidated AWPB is reviewed and final discussions held. - Fourth JCM (late summer): AWPB is signed off.
Joint Financing Arrangement (JFA)	Agreement between the Government of Nepal and the health sector EDPs (both pooling and non-pooling partners). The JFA sets out the joint provisions and procedures for financial support to the NHSP.
Medium Term Expenditure Framework	3-year budget planning tool used to plan GoN budget allocations. It is prepared by the NPC based on the previous years' sector-level (e.g. social services sector) and sub-sector level (e.g. health) expenditure.
Red Book	The official document detailing the GoN budget. All items that are "on-budget" are said to be "in the Red Book".
Transaction accounting and budget control system (TABUCS)	TABUCS is a financial management software which has been introduced for all cost centres within MoHP to improve the timeliness and quality of MoHP's financial reporting through better data collection and the introduction of effective financial controls. This system automatically generates required financial reports.

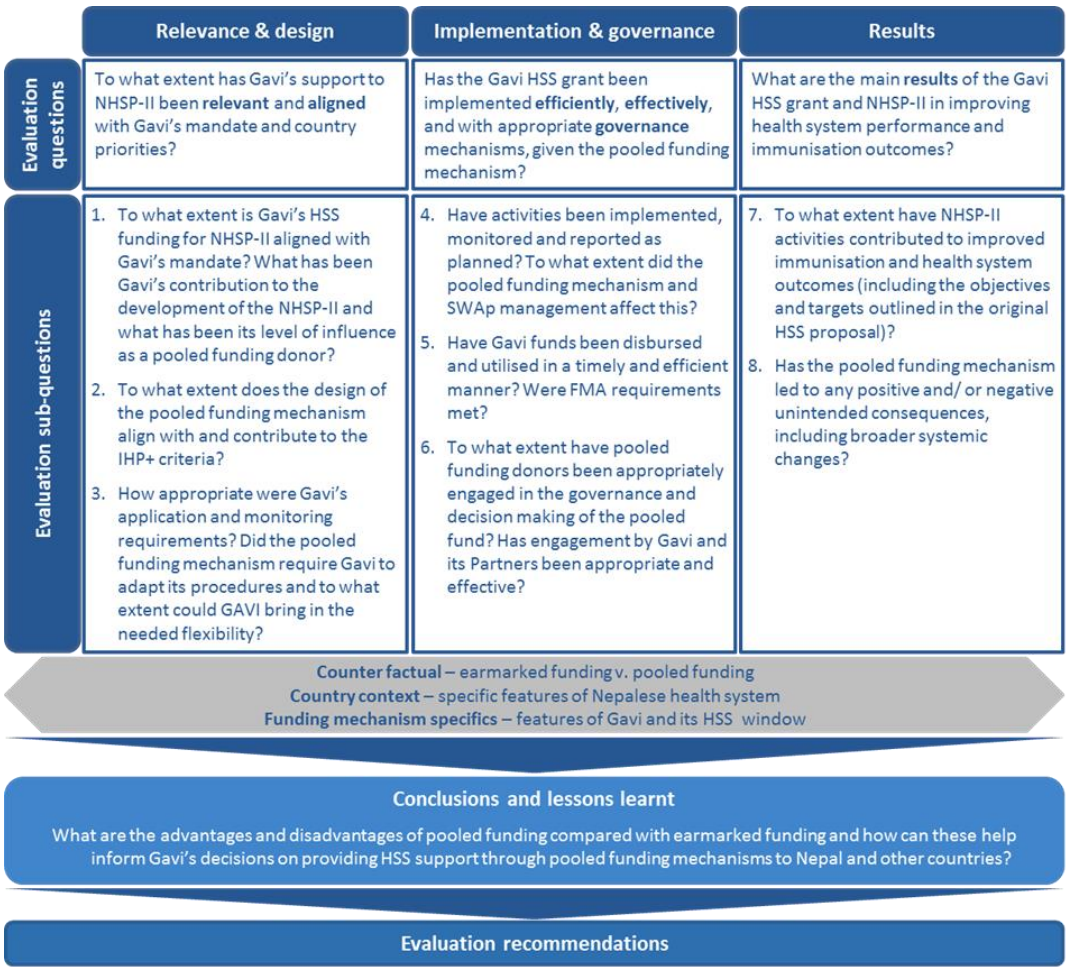
EXECUTIVE SUMMARY

This is the executive summary of the evaluation report on Gavi Health Systems Strengthening (HSS) support to Nepal through the pooled funding mechanism. The report has been prepared by Cambridge Economic Policy Associates (CEPA) in partnership with the Health Research and Social Development Forum (HERD) in Nepal, with input from an Expert Advisory Panel set up for this assignment.

Introduced in 2005, Gavi's HSS window supports its health systems goal (Strategic Goal 2, SG2) of "*contributing to strengthening the capacity of integrated health systems to deliver immunisation*". Gavi HSS support has predominantly been in the form of earmarked grants to countries; however, Gavi has been providing HSS support to Nepal through a pooled funding mechanism since 2010, following discussions on the Health System Funding Platform at that time as well as the growing experience of the sector wide approach (SWAp) in Nepal. The overall aim of this evaluation is therefore to "*identify the key advantages and disadvantages of provision of support through a pooled funding mechanism and highlight essential lessons that could be useful to guide Gavi's future HSS support in Nepal and other countries*".

Figure 1 below presents our evaluation framework and questions.

Figure 1: Evaluation framework



A mixed-methods approach has been employed for this evaluation including: desk-based document review, structured telephone interviews, in-country consultations in Nepal (centre and districts), counterfactual analysis, quantitative analysis and country case study analysis.

Our overall conclusion is as follows:

The channelling of Gavi's HSS support to Nepal through the pooled funding mechanism has been of added value to Nepal and has afforded a key number of advantages to Gavi including leveraging of its limited HSS funds and reduction in transaction costs, while not overly diluting its immunisation focus, and rather, adhering more strongly to aid effectiveness principles. As such, our recommendation is that Gavi should continue to provide HSS support to Nepal through a pooled fund (and more generally, strategically and selectively consider this approach for other Gavi-eligible countries). However, Gavi has not been able to effectively leverage its influence as a pooled funding donor in Nepal, and there have been a number of inefficiencies in the proposal development process and related communications, which require improvement.

Our main findings across the evaluation dimensions as well as our summary conclusions and recommendations are presented below.

Evaluation dimension 1: Relevance and design

Gavi's HSS support to Nepal through the pooled fund is well-aligned with both Gavi's mission of "*saving children's lives and protecting people's health by increasing access to immunisation in poor countries*" and the SG2 objective, given that immunisation, and its integration within broader HSS, is a top priority in the country, both in policy and practice. In particular, immunisation and HSS are priorities of Nepal's second National Health Sector Programme (NHSP-II; 2011-15) – the sector-wide programme for the health sector and the programme to which the pooled funds are committed.

In considering the counterfactual of whether HSS funding would have been more aligned with its mandate had Gavi provided earmarked rather than pooled funding, our conclusion is that in the case of Nepal this does not necessarily hold true, given that immunisation is a priority and core programme. The risk of dilution of Gavi's immunisation focus may exist through a pooled fund approach, but at present there is no strong evidence to suggest that this has indeed been the case. To some extent it is also difficult to make a strong conclusion in this regard due to insufficient clarity on the objectives and scope of Gavi's HSS support.

More generally, a common characteristic among pooled fund donors is having a mandate for sector-wide support, which they have been able to provide more efficiently through a pooled fund with reduced transaction costs. Additionally, pooled fund donors have also had a degree of higher risk appetite due to reduced control over fund expenditure and management. Considering these aspects from Gavi's perspective we note that Gavi has a more unique focus,

however a high risk appetite in terms of willingness to accept more risk in order to achieve better immunisation outcomes.[1]

One of the often cited benefits to donors of funding through a pooled fund is that it provides a seat at the "policy-making table" and thereby greater ability to influence sector-wide priority setting and progress monitoring than would be the case with project funding. However, Gavi has not fully leveraged this opportunity effectively for two reasons. Firstly, limited Secretariat capacity has resulted in minimal country engagement, most notably having had little influence in the ongoing development of NHSP-III. Secondly, as has also been raised in other Gavi evaluations, there has been ineffective in-country representation by Alliance Partners, with the extent to which Partners having represented Gavi's operational and programmatic interests over and above their own specific work programmes in the country being in question.

Additionally, Gavi's proposal development process has not been efficient for the country to date (resulting in considerable transaction costs for Nepal), although with the issuance of new guidelines by Gavi, it can be expected that these processes will become more relevant/ streamlined going forward. Nevertheless, the Gavi Secretariat has been able to reduce its own transaction costs for grant approval by leveraging assessments and support provided by other donors to the pooled fund. As well, monitoring arrangements under the pooled fund, in terms of the acceptance of NHSP M&E documentation by Gavi, have worked well for the country.

Finally, the pooled funding mechanism in Nepal (and Gavi's contribution within this) has positively contributed towards IHP+ criteria, particularly in terms of country ownership and harmonisation. However, there is room for improvement in terms of mutual accountability, with both donors and the Government calling for more transparency around internal processes and activities.

Evaluation dimension 2: Implementation and governance

In general, planned NHSP-II activities have been implemented well with a number of recent initiatives aimed at strengthening government capacity, including establishment of a Financial Management Working Group within the Ministry of Health and Population (MoHP); a move towards electronic financial management; an increase in Health Management Information System (HMIS) coverage; and the introduction of a Procurement Improvement Plan.

However, the implementation of NHSP-II has been negatively impacted by several challenges, including: (i) political instability impacting timely approval of the health budget; (ii) delayed fund approvals and disbursements impacting quality implementation; (iii) weak capacity for planning and coordination; (iv) weak procurement and supply chain systems; and (v) a lack of human resources impacting service delivery. Whilst these challenges have impacted the

[1] Gavi. (2014k).

efficacy of the implementation of Gavi funds through the pool, such challenges are also likely to have impacted earmarked funding from Gavi (albeit to a lesser extent).

In particular, many of the capacity-building initiatives being introduced by the Government relate to improving financial management capacity, in response to weak capacity under NHSP-II and the serious implications that this carries. Financial management capacity constraints include: inadequate Government budgeting systems and processes, including parliamentary processes; limited absorption capacity despite an increasing health budget; and lengthy and complex auditing processes, coupled with an understaffed Office of the Auditor General (OAG). This has resulted in pooled fund donors (including Gavi) having to delay disbursements to the country, or disburse less than their initial commitments. One stakeholder noted that the health sector has lost as much as $23m in pooled fund donor money in a given year due to these reasons.

Notwithstanding these issues, key 'value adds' of the pooled fund's financial arrangements include:

- Gavi is able to leverage the cash flow flexibility of other donors within a larger pot of money, particularly given that DFID frontloads its support, rather than reimburses expenditure as in the case of Gavi.
- More generally, Gavi has been able to substantially leverage its limited HSS funds given that Gavi HSS support represents 5% of the pooled fund donor contributions and 1% of the total government budget for NHSP-II.
- Pooled fund partners (including Gavi) have been able to benefit from additional fiduciary oversight and auditing provided by the World Bank, which reduces the fiduciary risk stemming from the previously noted financial management constraints. Thus, as Gavi does not have to carry out its own Financial Management Assessment (FMA), there are much reduced transaction costs, as well as avoiding the funding delays that the FMA process has created in other countries.

Our conclusion is that despite weak capacity for financial management (which has deterred donors such as the Global Fund from joining the pool), the additional pooled fund fiduciary oversight systems are beneficial for Gavi and reduce financial management transaction costs. The ongoing support provided to the pooled fund by donors such as DFID and the World Bank suggest a level of confidence in the system which may provide adequate credence and assurance to Gavi – although we note that this is an important issue for ongoing review.

With regards to M&E, there has been a strong improvement under NHSP-II. Whilst there is a limited focus on immunisation in the Joint Annual Review (JAR), this is adequately compensated for by detailed data currently received through Gavi Annual Progress Reviews (APR) for vaccine support. The two key governance mechanisms for the pooled fund – the JAR and the Joint Consultative Meetings (JCMs) – are also working well, with substantial donor engagement (albeit limited from Gavi).

Evaluation dimension 3: Results

Nepal has made impressive achievements in child and maternal health in recent years, although inequity in health service provision and immunisation coverage in particular continues to be a challenge given geographic, human resource and infrastructure disparities between regions. In particular:

- Nepal is expected to reach the MDG 4 and 5 targets. Immunisation coverage levels have been steadily improving over the past three decades and Nepal has met (or almost met) the NHSP-II immunisation coverage target of maintaining immunisation coverage levels above 90% across antigens.
- Nepal performs well against Gavi's three goal-level HSS indicators, with a drop-out rate of less than 1% in 2012/13 (well below Gavi's 2015 target of 9%)[2], DTP3 coverage rate of 92% for 2011 (an improvement from the 74% reported in 2000 and above Gavi's target of 82%)[3] and equity in immunisation coverage at 10.8 percentage points.[4] Whilst this falls within Gavi's threshold of 20 percentage points, Nepal faces a large socio-economic disparities.

Stakeholders have indicated that the pooled fund has played an important role in facilitating these results by enabling a greater government focus on implementation through the reduced burden of coordinating multiple donor grants, improving predictability of donor funding and allowing for more coordinated and flexible donor funding.

Conclusions, lessons learned and recommendations

Our conclusion is that Gavi's HSS support to Nepal through the pooled funding mechanism is of added-value both to Nepal and Gavi. From the country perspective, there is a strong demand for donor funds to be provided through this mechanism, given greater flexibility and reduced transaction costs for the government. From the perspective of Gavi, the analysis is more complex, with a number of advantages and disadvantages of providing HSS support through the pooled fund in Nepal. Advantages of supporting through a pooled fund for Gavi have been: (i) continued alignment with Gavi's mission and objectives; (ii) strong support for Gavi operating principles, including IHP+; (iii) greater leveraging of limited Gavi HSS funds; and (iv) leveraging of other donor support for reduced transaction costs. There have also been a number of key issues with regards to Gavi providing pooled fund support, including: (i) limited policy-influencing role due to lack of capacity of the Secretariat and ineffective representation from in-country Partners; (ii) increased risks in effective implementation and financial management of HSS funds; and (iii) potential "loss of visibility" and lack of attribution of results, given Gavi's contribution is combined with that of the government and other

[2] DoHS. (2013/2014); Gavi. (2015b).
[3] UNICEF. (2013); Central Bureau of Statistics. (2014).
[4] Reported here using MoHP. (2012e).

donors. Notwithstanding these issues, we also note that Nepal is making important achievements in child and maternal mortality, immunisation coverage and a number of metrics measuring health systems improvements. Further, by analysing the progress made on the activities included in the original HSS proposal, we find some limited evidence to suggest that pooled funding support is more relevant for system-wide improvements whereas earmarked funding helps take forward tangible or discrete projects and capital investments.

On balance, we conclude that Gavi HSS support through the pooled fund is of added value to Gavi, and our recommended approach for Gavi HSS funding in Nepal going forward. Whilst there is potentially some risk of dilution of Gavi's immunisation focus as well as financial and fiduciary risks, our assessment is that this may be acceptable given Gavi's higher risk appetite for HSS support. However, as noted, Gavi has not been able to substantially or effectively leverage its influence as a pooled funding donor, an area which requires more focus.

As such, our recommendations for Gavi HSS support to Nepal are:

1. Continue to provide HSS support through the NHSP pooled fund, whilst keeping the strategy, priorities and actual functioning of the pooled fund under review, in order to ensure support continues to be effective and aligned with Gavi's mandate.
2. Continue to focus attention on government financial management capacity, with the possibility of increasing fiduciary risk monitoring processes (e.g. by keeping abreast of other donor assessments of the strengths and weaknesses of financial management in Nepal).
3. Fully leverage its role as a pooled fund donor to actively influence policy through clearly defined country Partner representation and targeted Secretariat engagement.
4. Provide timely and clear guidance on Gavi application and other processes, with clear channels of communication through Partners.

Further, we provide recommendations for Gavi's overall approach to pooled funds:

5. Provide greater clarity on the scope and objectives of the HSS window and establish the intended purpose/(s) of providing HSS support through pooled funds. Given Gavi's specific mandate, a precise "theory of change" and clear country selection criteria need to be established upfront to ensure value for money from its pooled funding support.
6. Conduct a review of the country context and pooled fund functioning, to assess whether providing HSS support through a pooled fund is appropriate. The essential preconditions of a strong prioritisation of immunisation and a well-functioning SWAp are required for Gavi to provide pooled funding for a country.
7. Develop a tailored approach for the M&E of HSS pooled fund support. Whilst we do not consider a separate M&E policy for pooled fund support is needed, we recommend that Gavi tailors its current M&E approach in order to be relevant and appropriate for pooled funding.

1. INTRODUCTION

Cambridge Economic Policy Associates (CEPA) has been appointed by Gavi, the Vaccine Alliance, to conduct an evaluation of its Health Systems Strengthening (HSS) support to Nepal through the pooled funding mechanism. The assignment has been delivered in partnership with the Health Research and Social Development Forum (HERD) in Nepal and an Expert Advisory Panel constituted for this assignment comprising Bo Stenson, Kul Gautam and Stein-Erik Kruse.

1.1. Evaluation objectives

As per the Terms of Reference, the overall aim of the evaluation is to "*identify the key advantages and disadvantages of provision of support through a pooled funding mechanism and highlight essential lessons that could be useful to guide Gavi's future HSS support in Nepal and other countries*".[5]

The evaluation focuses on the design and relevance of Gavi HSS support through the pooled funding mechanism and seeks to understand key issues faced in implementation, including with regards to the level of Gavi's engagement, covering the grant period of 2010 to mid-2014. The emphasis is on inputs, processes and outputs (to the extent possible) associated with Gavi's support, in line with the objective of the assignment which is to draw lessons on Gavi HSS support through pooled funds.[6] These evaluation objectives are consolidated in a detailed evaluation framework, presented in the next section.

The evaluation is particularly pertinent as Nepal is looking to apply for the next round of Gavi HSS support and hence lessons documented in this evaluation will inform Gavi's review of Nepal's submission. More generally, a pooled funding approach may also be adopted in other Gavi-eligible countries and this evaluation aims to highlight advantages and disadvantages of such an approach for Gavi.

1.2. Background and context

This section presents a brief background on the Nepal health sector and Gavi HSS support to the country to date.

1.2.1. Nepal health sector

The last decade or so has seen significant policy change within the Nepal health sector, including most notably, a move towards a sector wide approach (SWAp). In 2001, an OECD/

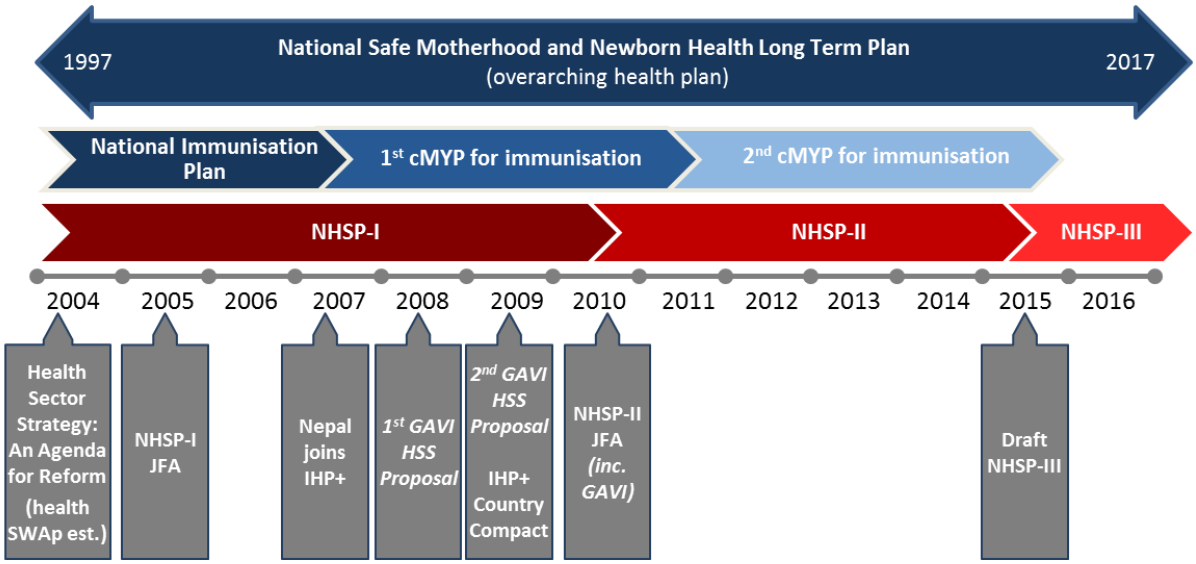
[5] Gavi. (2014g).

[6] This focus was requested in the RFP, also since the Nepal Health Sector Programme-II (NHSP-II) has a monitoring and evaluation (M&E) framework that is already tracking key indicators such as immunisation outcomes and overall impact.

DAC review of aid to Nepal recommended that the government mitigate fragmented and uncoordinated donor involvement by increasing national control.[7] In response to this review, there was a move towards a SWAp and a more strategic approach to health planning. This move was encouraged due to promising results being reported from the country's education SWAp, which had begun in 1999 with the Basic and Primary Education Programme Phase II.

Figure 1.1 presents a timeline of key health policies and plans in Nepal (as relevant to Gavi's HSS support), which are discussed further below.

Figure 1.1: Key health policies and events relevant to Gavi HSS support



In 2003, the MoHP formulated the 2004-07 "Health Sector Strategy: An Agenda for Reform" to guide a transformation of the health sector towards a SWAp, with an emphasis on the MDGs. The following year, the first Nepal Health Sector Programme (NHSP-I; 2004-10) was established. This was the first sector wide programme in Nepal, with one of the key aims being to increase development assistance effectiveness through donor harmonisation and alignment with existing health policies and plans. According to the review of NHSP-I (which forms the introduction of NHSP-II), this first national programme led to marked improvements in health outcomes, partly due to the gradual abolishment of user fees for all at the primary level and for targeted groups at the secondary level.

Importantly, it paved the way for Nepal's health SWAp, which was established in 2004 with 11 external development partners (EDPs) who signed a "Statement of Intent to Guide the Partnership for Health Sector Development in Nepal". It is noteworthy that one year before the Paris Declaration on Aid Effectiveness, Nepal was already engaged in improving health sector aid effectiveness through country-led coordination mechanisms and developing donor partnerships.

In support of this approach, a Joint Financing Arrangement (JFA) between GoN, DFID and the World Bank was signed in 2005 (with others joining later, including AusAID (now DFAT) and

[7] Vaillancourt, D; (2009)

Gavi as pooled funding partners in 2009 and 2010 respectively). Nepal was selected as an IHP+ country in 2007, thereby committing the country to practicing internationally agreed principles for effective aid and development co-operation in the health sector.[8] The "Nepal Health Development Partnership Compact" was signed in February 2009 by the MoHP and eight EDPs which further commits to strengthen the health sector SWAp.

In 2010, Nepal commenced with the NHSP-II (2010-15), which is a continuation of NHSP-I with both technical and financial support from donors. NHSP-II has an enhanced focus on achieving the MDGs, reducing inequalities in health service utilisation and ensuring sustainable financing so as to achieve essential health care for all. The Nepal Immunisation Programme (IP) 2012-16, a component of NHSP-II and also referred to as Comprehensive Multi-Year Plan (cMYP), guides the annual work plan and budget to achieve the country's immunisation-related goal to reduce child mortality, morbidity and disability associated with vaccine preventable diseases.[9]

NHSP-II is supported through a second JFA with eight EDPs, including pooled funding contributors (DFAT, DFID, IDA/ World Bank, and Gavi) and non-pooled funding contributors (USAID, UNICEF, UNFPA and WHO), in addition to the GoN budget. Funding from the pooled funding contributors is provided as non-earmarked sector budget support for the implementation of NHSP-II, whereas funding from non-pooled funding contributors may be earmarked for specific aspects of NHSP-II.

In December 2013, Nepal began to draft the NHSP-III (2015-20). This plan will be formed of three documents: (i) Strategic Plan; (ii) Implementation Plan, which will be costed; and (iii) M&E Framework. A near final version of the NHSP-III was presented at the JAR in March 2015, which is expected to be endorsed by the Council of Ministers by June 2015.

Since the establishment of the SWAp and the national health sector programmes, steady progress in key health indicators has been made, although this has not been uniform across all indicators. Most notably, Nepal had made good progress in child and maternal health indicators, and is on track to reach the MDG 4 and 5 targets.[10] Immunisation coverage has been on an upward trend over the past three decades, with DTP3 coverage in excess of 80% since 2006 and measles coverage in excess of 93%. However, high rates of inequality between regions, geographic areas (e.g. mountain, hill, terai), socio-economic status and urban/ rural still persist in Nepal.

[8] http://www.internationalhealthpartnership.net/en/

[9] More specifically, the objectives of the IP are to: achieve and maintain at least 90% vaccination coverage for all antigens both at national and district levels by 2016; enhance human resources capacity for immunisation management; ensure access to vaccines of assured quality and with appropriate waste disposal; achieve and maintain polio-free status; maintain maternal and neonatal tetanus elimination status; achieve measles elimination status by 2016; accelerate control of vaccine preventable diseases through the introduction of new and underutilised vaccines; expand vaccine preventable disease surveillance; and continue to expand immunisation beyond infancy.

[10] MoHP. (2014i).

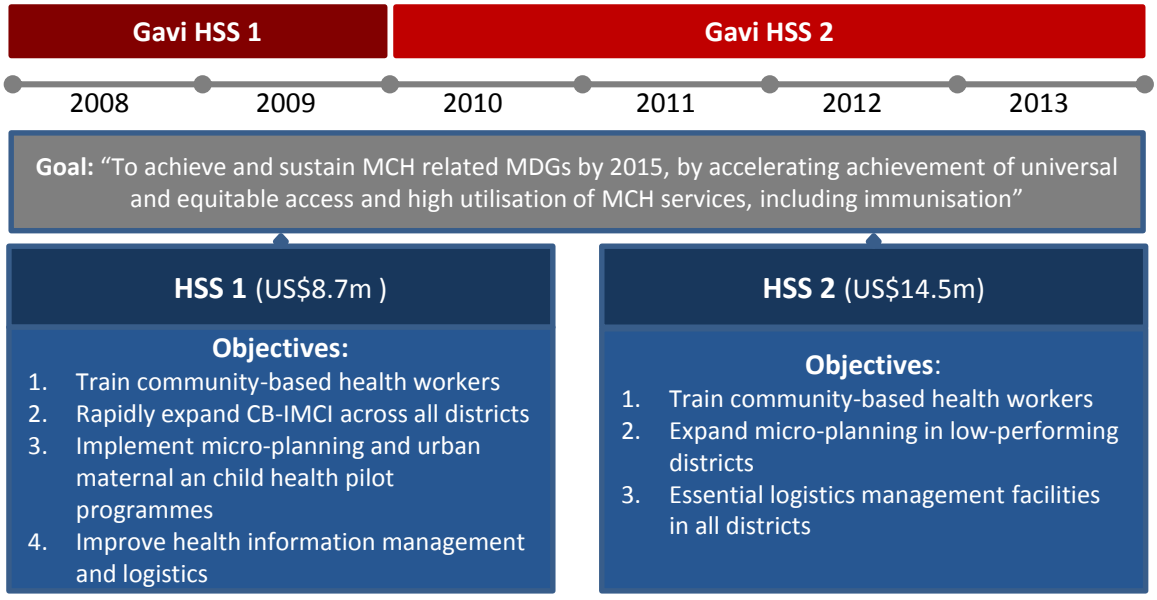
1.2.2. Gavi HSS and funding for Nepal

Gavi introduced its HSS window in 2005 and has mainly provided earmarked grants for specific project activities, although we understand that it has also explored alternative funding mechanisms, such as coordinated donor support through the Health Systems Funding Platform and more recently support through pooled funds in select countries. Pooled funding is a financing mechanism for harmonising aid flows from multiple donors through a single instrument such as a trust fund, pooled fund or basket fund.

Nepal has been eligible for Gavi support since its establishment and has received funding through a range of windows including: vaccine support (totalling US$40.5m; US$27.5m for penta, US$8.7m for tetra, US$2.4m for pneumo and US$1.9m for HepB mono), HSS (US$19.2m), Immunisation Services Support (ISS; US$3.3m), Vaccine Introduction Grants (US$1.5m), and Injection Safety Support (INS; US$1.2m) over the period 2002-14.

To date, Gavi has provided two HSS grants to Nepal, as shown in Figure 1.2, and discussed further below.

Figure 1.2: Overview of Gavi HSS grants to Nepal



Following the rejection of Nepal's initial HSS application, Gavi accepted a revised proposal for US$8.7m over the period 2008-09, which was provided as per Gavi's standard HSS requirements and procedures. Despite implementation delays and some issues with the grant design, an evaluation of the support conducted in 2009 found the experience of Gavi's first HSS grant to Nepal was found to be broadly positive, including strong alignment with country priorities, harmonisation with other donors, predictability of funding, potential for sustainability and catalytic impact of funds.[11]

[11] HLSP. (2009b).

Gavi subsequently accepted a second HSS proposal for US$14.5m over the period 2010-13.[12] The submission was made at the time when the Health Systems Funding Platform was being developed, which resulted in Gavi initiating discussions with GoN on providing HSS support through the pooled fund. Following an agreement between Gavi and the country, funds for this second grant were ultimately provided as non-earmarked cash support through the country pooled funding mechanism.

In January 2015, Nepal submitted a third HSS proposal to Gavi. However, this evaluation does not cover this proposal.

1.3. Report structure

The report is structured as follows:

- Section 2 presents the evaluation framework and methods, including limitations;
- Sections 3-5 discuss our analysis and findings on the relevance and design, implementation and governance, and results of Gavi HSS support;
- Section 6 concludes and highlights key lessons learnt; and
- Section 7 presents recommendations from this evaluation.

The report is supported by the following annexes (included as a separate document):

- Annex 1 provides a bibliography;
- Annex 2 provides a list of consultees and the interviewee guides;
- Annex 3 presents the district visit report;
- Annex 4 provides a case study of Gavi HSS support to the pooled fund in Ethiopia;
- Annex 5 reviews the alignment of the pooled fund and Gavi HSS support with IHP+ principles;
- Annex 6 compares the requirements of the Annual Progress Review (APR) with the information available in the Joint Annual Review (JAR);
- Annex 7 describes key processes and issues with health budgeting and financial management in Nepal;
- Annex 8 presents key trends in government and donor financing for health; and
- Annex 9 presents a review of the progress made on the Gavi HSS proposal objectives under NHSP-II.

[12] MoHP. (2009b).

2. EVALUATION FRAMEWORK AND METHODS

This section presents our evaluation framework and key qualitative and quantitative evaluation methods, including limitations.

2.1. Evaluation framework

The evaluation is structured around a framework of three chronological and inter-related dimensions (Figure 2.1 over page), with a series of review questions on each dimension, encompassing:

(i) *Relevance and design* – an assessment of the relevance of Gavi HSS support through the pooled fund in relation to Gavi's mandate, extent of alignment with the IHP+ criteria and appropriateness of the proposal and monitoring requirements, taking into consideration the country context.

(ii) *Implementation and governance* – a review of the efficiency and efficacy of the implementation of the NHSP-II and the pooled funding mechanism, including issues such as financial management, reporting and governance.

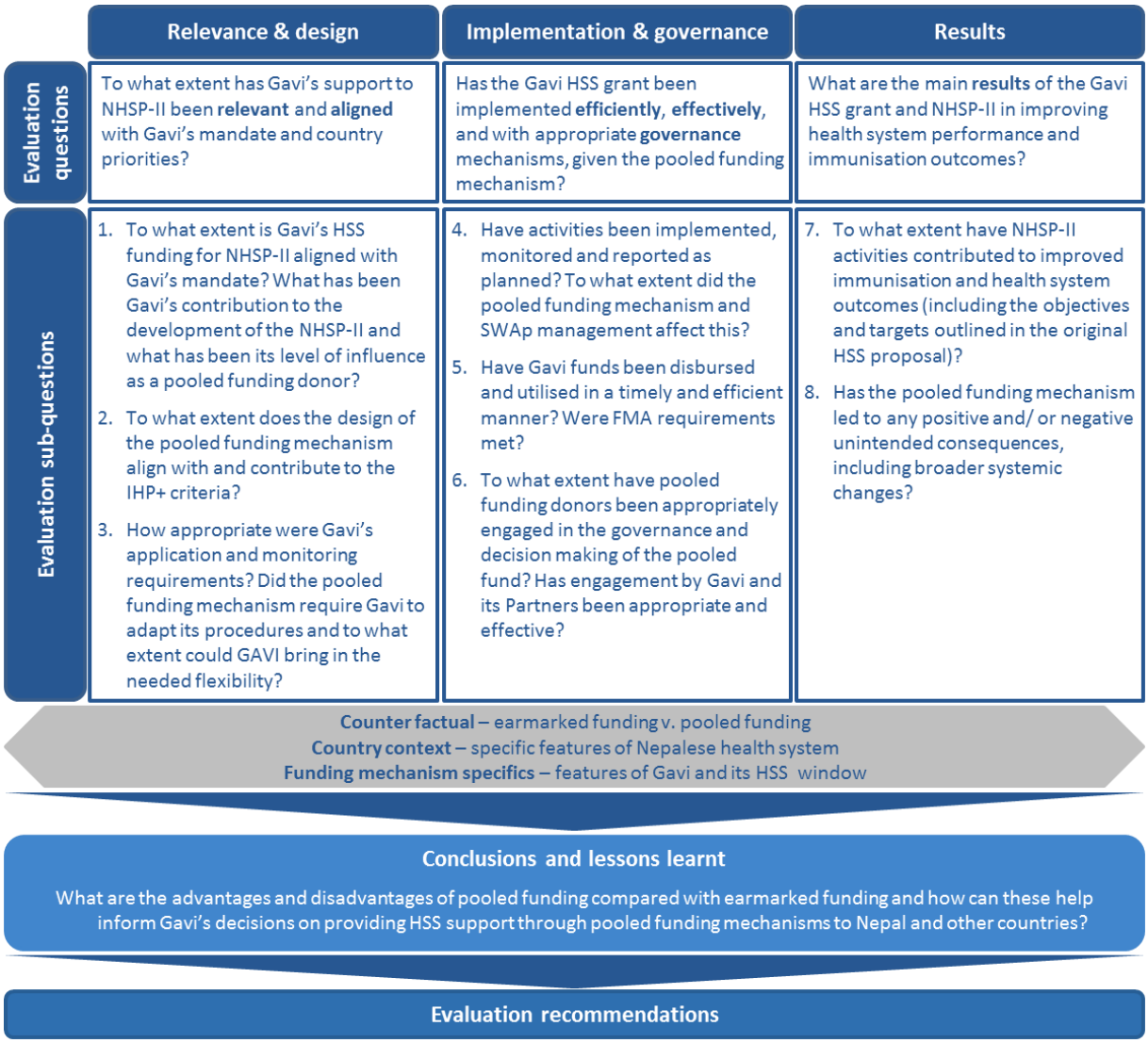
(iii) *Results* – an assessment of the progress made on immunisation and HSS under the NHSP-II (covering both planned and unintended results).

Each of these dimensions has been assessed with the following "cross-cutting issues" in mind:

- *Counterfactual:* How might the experience and results have differed if Gavi had provided "traditional" earmarked funding as compared to contributing to the pooled funding mechanism?
- *Country context:* What are the specific features of the Nepalese health system (and broader country-specific factors) that might have driven the success or failure of the pooled funding mechanism?
- *Funding mechanism specifics:* What are the specific features of Gavi and its HSS window that may have supported the success or failure of the funding to Nepal?

Based on our findings across the evaluation questions, we have developed key conclusions and lessons learnt as well as recommendations for Gavi HSS support to Nepal going forward and to other eligible countries more generally. This includes recommendations on a suitable approach to M&E of Gavi support to pooled funds.

Figure 2.1: Evaluation framework



2.2. Evaluation methods and limitations

The evaluation has been conducted using a mixed-methods approach, as detailed below.

Our evaluation conclusions are based on a collation of the available evidence (drawing on the evaluation methods described above), also assessing the quality (i.e. data quality, type of stakeholder group consulted for a particular evaluation question) and uniformity (i.e. triangulation) of the evidence.[13] These have been supplemented by our informed judgment on the interpretation of the evidence, drawing on our knowledge and experience with

[13] Our work follows the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee's (DAC) principles of evaluation (OECD. (2008).) including independent, impartial, transparent and inclusive (i.e. engaging with relevant stakeholders during the various stages of the evaluation, and in particular, in-country stakeholders) delivery. Our evaluation also adheres, as closely as possible, to the key principles of Gavi's evaluation policy. (Gavi. (2012d).)

evaluations and the functioning of health systems (including inputs from both the core team comprising CEPA and HERD as well as the Expert Panel structured for this assignment).

Desk-based document review

We have undertaken a comprehensive review of the following documents:

- *Gavi specific documents:* including HSS documents (Board papers, policy documents, application guidelines); Nepal's HSS proposal and annual APRs; IRC review documentation on Nepal's proposal and APRs; and previous Gavi evaluations (the HSS evaluation and tracking studies, Gavi Phase II evaluation).
- *Nepal country documentation:* including key policy documents (the NHSP I and II, draft NHSP III, comprehensive multi-year plan (cMYP), Joint Financing Arrangement); and M&E documents on the NHSP II and the health sector in Nepal (JARs, MoHP Annual Report, HSS Programme Quarterly Reports, other HMIS reports, mid-term review of the NHSP II).
- *Broader relevant literature:* on aid effectiveness, IHP+, SWAps and pooled funding mechanisms.

Annex 1 provides a bibliography.

Structured telephone interviews

Structured interviews were conducted with:

- select members of the Gavi Secretariat;
- Gavi's Independent Review Committee (IRC);
- members of Gavi's Strategic Goal 2 Management Group; and
- HSS focal points from other donor agencies.

Annex 2 provides a list of consultations and presents the interview guides used.

In-country consultations in Nepal

Two members of the CEPA team, along with HERD, carried out a week-long consultation visit to Nepal, focusing on stakeholders including MoHP (Central and District level), Ministry of Finance (MoF), Gavi Partners (UNICEF, WHO), and EDPs (both pooled and non-pooled funders).

Annex 2 presents the list of consultations and interview guides, which were tailored for Government officials and EDPs respectively.

Counterfactual analysis

A key approach employed extensively in this evaluation is counterfactual analysis, specifically assessing how the current experience and results under the pooled fund may have differed had Gavi providing "traditional" earmarked funding to Nepal. Given that this counterfactual situation is hypothetical in nature, our analysis has been informed by comparing the experience of: (i) Gavi's first grant (earmarked) with the current grant (pooled); and (ii) donor funding currently provided to Nepal through the pooled fund with that which is not channelled through the pooled fund (e.g. USAID and GFATM). More specifically, this analysis has included:

- Under dimension 1, we assess the extent to which Gavi's HSS earmarked and pooled funding may have been more or less aligned with its overall immunisation mandate and the extent to which Gavi's current grant supports the IHP+ criteria compared with its traditional earmarked funding approach.
- Under dimension 2, we examine whether the noted challenges with government implementation of NHSP-II would have had a larger/ smaller implication had Gavi provided earmarked funds.
- Under dimension 3, we review whether the priorities and activities identified in the HSS proposal for a earmarked contribution from Gavi have progressed under the NHSP-II.
- The full analysis of the counterfactual is brought together in the concluding section, which considers the "value add" of providing support through the pooled funding mechanism.

The analysis is based on a desk-review of documents and stakeholder feedback (both in-country and through telephone interviews), along with the team's judgement given our understanding of Gavi funding and the Nepalese context. We were also able to draw on the experience in Ethiopia to compare how a pooled fund functions in other contexts.

District visits

Field visits were conducted to three districts (Bhaktapur, Rasuwa and Chitwan) to provide a deeper understanding of how NHSP-II activities have been planned, implemented and monitored; and within this, whether immunisation has been prioritised and any impact of NHSP-II achievements and challenges on service delivery at the district level. Specifically, these visits enriched the evaluation by providing the following information:

- Dimension 1: The extent to which immunisation activities are prioritised in practice at the district level;
- Dimension 2: The extent to which NHSP-II planning, fund disbursement and monitoring processes affect district level implementation; and

- Dimension 3: Identifying any unintended consequences at the district level.

The selection process for these three districts was primarily based on HERD's in-depth knowledge and understanding of the health-sector in Nepal. We also used objective criteria to ensure a wide range of districts (e.g. high/ low performing, varied ecology and per capita budget allocation) and took into consideration accessibility from Kathmandu, given the evaluation timeframe. Annex 3 presents a summary report on these visits.

Quantitative analysis

Quantitative analysis was conducted on secondary data and was used to triangulate information from country consultations, district visits and desk research. Data analysis included:

- Immunisation and health systems results achieved through the NHSP-II, including an analysis of: (i) progress against MDG 4 and 5; (ii) key immunisation metrics; and (iii) key HSS metrics (included in Section 5 and Annex 9). Analysis from the immunisation and health systems results was used to inform the counterfactual of which priorities and activities from the HSS proposal have indeed achieved results under NHSP-II
- Government and donor financing trends to analyse government commitment to health funding and the relative importance of Gavi, also compared to other donors. This included time series analysis of: (i) Government and EDP budget, expenditure and absorption rates; (ii) Gavi commitment and disbursements; and (iii) contributions to the pooled fund disaggregated by donor (included in Section 4 and Annex 8).
- Analysis of health indicators and budget data for the three districts covered by the team (included in Annex 3).

Country case study

We undertook a review of Gavi's HSS support and the pooled funding mechanisms in Ethiopia, with the aim to examine enablers and challenges to Gavi HSS support to pooled funds in other countries, so as to inform our recommendations on an appropriate approach for Gavi HSS support through this approach more generally. This review has informed the overall evaluation in terms of assessing the appropriateness of Gavi processes, the relative importance of financial management processes, how differences in pooled fund design affect implementation, and most notably in shaping the recommendations.

The case study was conducted through a focused appraisal of the country proposals, IRC review documentation and the latest APR/ M&E document, as well as consultations with the Gavi country officer and in-country partners. Annex 4 presents this analysis.

2.2.1. Evaluation limitations

The limitations of our evaluation methods are noted below.

- **Stakeholder availability:** A key limitation faced by this evaluation was the non-availability of key informants (including the Director of the Child Health Division at MoHP and other stakeholders key to this evaluation), due to an ongoing investigation by the Commission for the Investigation of Abuse of Authority (CIAA) into allegations of corruption. Many of the planned in-country consultations were therefore held with officers who had recently arrived in post, with limited knowledge of Gavi HSS support. However, we were able to minimise the impact of this through holding consultations with retired MoHP staff who had been present during the initial discussions for Gavi HSS support and provided particularly relevant information. HERD's country experience and contextual knowledge also allowed for a more informed interpretation of the interview feedback.
- **Stakeholder bias:** Given that stakeholder consultations have been a key evidence source for this evaluation, there is scope for bias and subjectivity in feedback. We have attempted to minimise the impact of this by triangulating views across stakeholders and other sources of evidence, to the extent possible.
- **District selection**: As part of the evaluation, three districts were chosen in which to conduct field visits. Though care was taken to ensure a broad representation in terms of socio-economic and geographical features, the selection was somewhat limited by accessibility due to the time constraints of the evaluation. Further, we appreciate that a selection of three districts out of the 75 in Nepal cannot be taken as a fully representational example.
- **Quantitative analysis**: Due to discrepancies in some of the government and donor health financing data provided by the GoN, it was not possible to conduct the planned time series analysis of commitments, disbursements and absorption rates disaggregated by pooled and non-pooled donors. This analysis would have further informed the counterfactual argument of whether budget absorption rates differ between pooled and non-pooled donors. The analysis was therefore only possible for EDPs as a whole.
- **Counterfactual analysis:** By definition, a counterfactual analysis is hypothetical in nature and is therefore heavily based on consultation feedback and the team's judgement. The assumptions used have been clearly highlighted throughout the report.
- **Country case study:** The original intention for this evaluation was to conduct a comparative analysis of two case studies (Ethiopia and Niger). Due to competing priorities, information could not be obtained on Niger. This analysis is therefore limited due to lack of comparative data. Additionally, information pertaining to Ethiopia was often limited. Conclusions drawn from this comparison are therefore at a high level.

3. EVALUATION DIMENSION 1: RELEVANCE AND DESIGN

The relevance and design pillar of the evaluation framework addresses the question:

To what extent has Gavi's support to NHSP-II been *relevant* and *aligned* with Gavi's mandate and country priorities?

Within this, we have looked at three sub-questions:

- Qs 1: To what extent is Gavi's HSS funding for NHSP-II aligned with Gavi's mandate? What has been Gavi's contribution to the development of the NHSP-II and what has been its level of influence as a pooled funding donor?
- Qs 2: To what extent does the design of the pooled funding mechanism align with and contribute to the IHP+ criteria?
- Qs 3: How appropriate were Gavi's application and monitoring requirements? Did the pooled funding mechanism require Gavi to adapt its procedures and to what extent could Gavi bring in the needed flexibility?

We have not specifically assessed the relevance of pooled funding support for Nepal, as this is assumed as a given. This assumption was confirmed throughout consultations, where GoN stakeholders referenced the pooled fund in a very positive light, reporting that it provides flexibility in funding allocation, reduces transaction costs and reporting burden, amongst others. Question 2 on the alignment with the IHP+ principles also covers some of these aspects.

Each of the sub-questions are considered in turn below by key theme or issue (Sections 3.1-3.4), followed by summary findings on the relevance and design of Gavi HSS support to Nepal (Section 3.5).

3.1. Alignment with Gavi's mandate

We have reviewed the extent to which Gavi HSS support to the pooled fund in Nepal has been aligned with Gavi's mission and objectives, also considering the counterfactual of whether traditional earmarked HSS support would have been *relatively more (or less)* aligned. We have also considered the relevance of a pooled fund approach given the nature of Gavi as a donor, also drawing lessons from the approach of other donors in Nepal.

Gavi's mission of *"saving children's lives and protecting people's health by increasing access to immunisation in poor countries"* has remained constant since its inception. Its health systems goal (Strategic Goal 2, SG2) of *"contributing to strengthening the capacity of integrated health systems to deliver immunisation"* has also remained broadly consistent since the start of its HSS support in 2006. However, we note that the specification of this goal has changed to some extent over time: from a broader goal covering immunisation and other health services under Gavi Phase II (2007-10), to a focus on immunisation delivery as an

integrated component of health systems under the recently approved Phase IV (2016-20).[14,15] We flag this difference upfront as we think it is important to consider in the context of the *relative relevance* of a pooled versus earmarked HSS funding approach to Gavi's mandate.

3.1.1. Pooled funding approach and Gavi's mandate

In general, Gavi's HSS support to Nepal through the pooled fund is well aligned with Gavi's mission and objectives. The overall goal of Nepal's proposal for Gavi HSS support is *"to achieve and sustain maternal and child health related MDGs by 2015, by accelerating achievement of universal and equitable access and high utilization of maternal and child health services, including immunization"*.[16] The objective of the support*, "to address significant system barriers faced by the health system in ensuring adequate MCH services including immunization services*", shows the HSS focus.[17] Indeed, the aims of the HSS proposal are clearly aligned to Gavi's SG2 strategic objectives of contributing to resolving the constraints of delivering immunisation and increasing equity in access to services.[18]

However, while the proposal formed the basis for Gavi approval of HSS support, once Gavi had decided to contribute to NHSP-II through the pooled fund, this document became somewhat irrelevant. That said, a review of NHSP-II shows that it is also well aligned with Gavi's mandate, with both immunisation and HSS given a clear priority. Specifically:

- The immunisation programme is designated as a "priority programme" or "P1" under NHSP-II, with the prioritisation of both immunisation and HSS further outlined in the NHSP-II Implementation Plan: "*The Ministry commits to making significant progress toward a more integrated health systems approach during the period of NHSP-2. Immunisation will be integrated with other public health interventions so as to achieve synergies among effects"*.[19]
- Our consultations confirm this prioritisation, with a senior MoHP official stating that "w*hilst there are several P1 programmes in NHSP-II, immunisation is the only programme which is also prioritised in practice".* Our district-level consultations also echoed this prioritisation of immunisation in practice. Immunisation activities are well

[14] Gavi's Strategic Goal 1 for 2007-10 was "*to contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner*". In June 2014 the Gavi Board further updated SG2 for 2016-20 to "*increase effectiveness and efficiency of immunisation delivery as an integrated part of strengthened health systems*".

[15] The focusing of Gavi HSS support on immunisation and/ or broader health services reflects, as we understand, the dichotomy in the Gavi Board on the appropriate scope of Gavi HSS. CEPA's evaluation of the Gavi Alliance in 2010 also concludes the following with regards to Gavi HSS support at that time: "*The importance of Gavi's HSS program in addressing health system bottlenecks has been widely recognised, but questions are raised on whether the program dilutes Gavi's immunisation focus*". The discussion is also provided in: Gavi. (2012c). (Prepared by the HSS Team, Gavi Secretariat).

[16] MoHP. (2009b).

[17] MoHP. (2009b)., Page 25.

[18] Gavi. (2015c).

[19] MoHP. (n.d.)., Page 28.

reflected in the district annual work plan and budget (AWPB) and, despite severe funding disbursement issues (discussed below), are little affected due to the importance assigned.

- The MoHP budget allocation to immunisation has increased over time (US$9m in 2009-10 to US$17m in 2014-15, with some declines over the period 2012-14 following political instability); and this is despite relatively larger fluctuations in the total MoHP health budget.[20]
- This priority is further highlighted by the fact that the Immunisation Service Act (which will enshrine in law the right to all vaccinations included in the national immunisation programme for every child and pregnant woman) has recently been approved by the Cabinet and is soon expected to be approved by Parliament.

We note that in terms of NHSP-II M&E, the JAR only tracks one immunisation indicator and there has been little mention of immunisation-specific issues or activities in the JAR Aide Memoires over the years. Our consultations with in-country stakeholders and the Gavi Secretariat suggest that to some extent this limited tracking of immunisation under the JAR is on account of the range of other priorities of different donors contributing to the pooled fund (e.g. DFID's focus is on Gender, Equality and Social Inclusion (GESI) and family planning, and the World Bank on performance-based grants) and is not reflective of any lesser prioritisation of immunisation. While limited tracking in the JAR runs the risk of reduced emphasis, it is clear from our in-country consultations that this has not been the case. Indeed, immunisation coverage and other key indicators are routinely tracked through Health Management Information System (HMIS) reporting and have improved over time (although inequity in coverage remains a key issue).

Thus our overall conclusion is that Gavi's HSS funding for NHSP-II is strongly aligned with Gavi's overall mandate given that immunisation and its integration within broader HSS are indeed considered a top priority in Nepal, both in policy and in practice.

3.1.2. Consideration of the counterfactual

The question of whether HSS funding would have been more aligned with its mandate had Gavi provided earmarked rather than pooled funding relates to the issue of the scope of Gavi's SG2, which while becoming more immunisation focused over time, does not preclude broader HSS as a whole. Indeed, with the changing SG2 objective over time, there has been a degree of confusion amongst stakeholders as to the precise objective and focus of Gavi's HSS support.

There is mixed evidence as to whether pooled funding would dilute Gavi's *immunisation focus* as compared to earmarked funding. On the one hand, pooled funding priority setting is outside the control of the Child Health Division (of which the Expanded Programme on

[20] Source: MoHP Finance Section, data compiled by CEPA/ HERD

Immunisation (EPI) is a part) and also subject to some element of the vagaries of politics. Each year the GoN Resource Committee prepares an overall budget envelope for the country, which also defines the budget ceiling for MoHP.[21] The decision on priorities within this budget (and therefore the pooled fund) are then discussed by National Planning Commission (NPC), MoF and MoHP during several rounds of discussion. The majority of these decision-making bodies are therefore outside of the MoHP. However, with previous earmarked support, the Child Health Division (including EPI) was more involved and had more of a say in the use of the funds. Indeed, one senior MoHP official raised concern over the pooled funding planning process, feeling that there was a need for the NPC to develop health sector-specific guidelines as to how funds are allocated to ensure the priorities set by MoHP and EDPs are met, rather than enforced by the NPC. This concern was also raised due to reports of ministers abusing the flexibility of pooled funds for their own political gain, such as building or subsidising hospitals in their constituencies, or to further their own interests, such as financing attendance at international conferences.

On the other hand however, as clearly presented above, immunisation has been accorded priority in policy and practice in Nepal and hence it can be expected that a pooled funding approach by Gavi in Nepal would not dilute its immunisation focus.

In addition to the above, we consider that Gavi's SG2, while intended to focus on immunisation outcomes, encompasses a broad range of HSS activities that may be delivered through both a pooled and earmarked approach. We note the following:

- The first and second HSS proposals submitted by Nepal to Gavi have included a number of activities that are focused on broad-based HSS rather than immunisation specific activities (e.g. as would be the case if there were specific activities such as development of the cold chain). For example, the second HSS proposal includes activities on financial management training for district-level staff, establishment of social auditing mechanisms, and construction of birthing centres.[22,23]
- Given the increasing vaccination coverage rates in Nepal, the key immunisation issue now facing the country is that of 'last mile' coverage. Several stakeholders consulted felt that with a targeted approach, it was possible to achieve the 80% coverage rates, however, in order to cover the last mile, the whole system needs to be strengthened which is best delivered through a pooled fund approach. On the other hand, experience from campaigns, such as the eradication of polio and guinea-worm disease, suggest that a targeted approach is required to cover the last mile. We appreciate therefore that further evidence is required on establishing evidence on the most appropriate approach for Nepal to reach 100% coverage.

[21] The Resource Committee is a high level body chaired by the Prime Minister and including the Minister of Finance and Vice Chair of the NPC.
[22] MoHP. (2009b).
[23] The evaluation of the first Gavi HSS support to Nepal also notes that while the support was generally found to address key constraints, there was found to be a lack of clarity on the definition of HSS.

On balance, our conclusion is that in the case of Nepal, given that immunisation is a priority and core programme, Gavi HSS funding through the pool is not less aligned with its mission and objectives than earmarked funding. The risk of dilution of Gavi's immunisation focus may exist, but at present there is no strong evidence to suggest that this has indeed been the case.

3.1.3. Consideration of donor characteristics

Our consultations have highlighted interesting points in terms of the relevance of pooled fund to other donor mandates; in particular as to why donors have or have not joined the pool. Box 3.1 summarises the characteristics of pooled and non-pooled fund donors.

Box 3.1: Key reasons why donors have or have not joined the pooled fund in Nepal[24]

Pooled fund donors	Non-pooled fund donors
•The majority of pooled fund donors (DFAT, DFID, KfW and World Bank) are donors who have a **mandate for sector wide support**, for which they reported a pooled fund approach being most appropriate. •Donors reported that supporting a pooled fund can considerably reduce **transaction costs**. •DFID noted needing a **higher risk appetite** in order to provide HSS support, given the reduced control over how funds are spent.	•USAID indicated their **global funding policies and principles**, do not permit contributions to be routed through pooled funds. •Some donors, e.g. UNFPA, reported **lack of attribution** and **need for targeting use of funds** to areas specific to their mandate, both of which are diluted within a pooled fund. •UNFPA, UNICEF & WHO have not joined as they are **technical assistance** providers. Whilst they do provide some project funding, such as UNICEF's support at district level, their overall mandate is not as a funder. •Global Fund stated **lack of confidence** in the functioning of the pooled fund. They are one of the few donors not to have signed the JFA.

As presented, a common characteristic of pooled fund donors is having a mandate for sector wide support, which they have been able to provide more efficiently through a pooled fund with reduced transaction costs. Additionally, in deciding whether or not to join the pooled fund, donors have considered their level of risk appetite, where risk in this context is defined in terms of: (i) reduced control over how funds are spent; and (ii) fiduciary risks of fund mismanagement associated with channelling money through government systems. In terms of the latter, it is of significant note that this was the key barrier for the Global Fund to join the pooled fund in Nepal, stating that the risk of corruption was too high and oversight functions were not strong enough.

[24] We note that the situation is different in Ethiopia, where technical assistance donors, such as UNICEF and WHO, have joined the pooled fund. This is largely due to the range of pooled funds that exists in Ethiopia, each with a varied mandate, which enables such engagement.

Considering these characteristics for Gavi, we note that it has a more focused mandate on immunisation. As a funding entity, securing efficiencies in delivery would be an important advantage for Gavi (and we discuss the experience with efficiency of funding in Section 4). Furthermore, we understand that Gavi's risk appetite for HSS funding in particular is relatively high in terms of the reduced control over how funds are spent. Indeed, as stated in Gavi's recently developed Risk Policy, in relation to SG2, and therefore HSS funding in general, Gavi has a *"higher risk appetite"*, defined as a willingness to accept more risk in order to achieve better immunisation outcomes.[25] However, in terms of fiduciary risk, Gavi is clear that it will not tolerate misuse of funds and therefore has a much lower risk appetite for this aspect.

As such therefore, the rationale for other donors providing pooled fund support has somewhat of a mixed implication for Gavi's approach.

3.2. Gavi's level of influence

One of the often cited benefits to donors of funding through a pooled fund is that it provides a seat at the "policy-making table" and thereby greater ability to influence sector-wide priority setting and progress monitoring than would be the case with project funding. As noted by one of the EDP partners consulted: "*a pooled fund partner's leverage of influence is much larger than when they implement only a single project".*

In considering Gavi's level of influence, we note that Gavi is an alliance whose business model is not to establish a country presence, rather to be represented in-country by its Partners – WHO and UNICEF – with whom Gavi has a global partnership agreement. We have therefore assessed the extent to which Gavi has been able to leverage this influencing opportunity by assessing the effectiveness of: (i) the Gavi Secretariat's direct involvement, noting that this is by design limited; and (ii) Partner in-country representation of Gavi.

Our findings on Gavi Secretariat's direct role are as follows:

- In terms of the **development of NHSP-II**, there is no evidence to suggest that the Gavi Secretariat has engaged at all in this process, shown by the absence of the Secretariat in those attributed as contributors in the planning documentation.[26] Such lack of involvement may be expected given that NHSP-II was developed before Gavi had agreed to fund through the pool. However, there has also been limited mention of the Gavi Secretariat's contribution to the accompanying Implementation Plan and M&E Framework which were developed in 2010 and 2012 respectively (i.e. after Gavi pooled fund support had commenced). The Gavi Secretariat supported a situational analysis that kick-started this M&E work, however it was not present at any of the Framework development workshops or attributed as a contributor (in both available documentation and as indicated during our in-country consultations).[27]

[25] Gavi. (2014k).
[26] MoHP. (2010c)., Annex 6: Contributions
[27] MoHP. (2012d)., Annex 5: Contributions

- This limited contribution has continued in the **development of NHSP-III**, which at the time of this evaluation was in the final stages of drafting. The Gavi Secretariat has had little influence or input in defining the strategic direction, in comparison to other pooled fund donors, all who have been actively involved through a physical presence.[28]
- Gavi Secretariat attendance at **pooled fund planning and coordination meetings** such as the Joint Consultative Meetings (JCMs) has been limited. These meetings are critical for the AWPB development process, and where other pooled fund donors actively participate and guide the AWPB.
- In terms of attendance at in-country **pooled fund monitoring meetings**, the Gavi Secretariat has been more proactive, and has attended the JAR meetings each year. This is in line with Gavi policy, which encourages participation at JARs, which are identified as an effective way to *"reduce transaction costs and leverage additional resources for immunisation, and catalyse recognition of immunisation goals in outputs such as the Aide Memoire"*.[29] There is some evidence to show that this Gavi Secretariat engagement has resulted in desired changes. One example, cited by the Gavi Secretariat, of using JARs to affect Gavi-relevant policy change was in highlighting the need to strengthen and upgrade the cold chain system during the 2014 JAR. This has indeed had the desired effect, with the 2014 Aide Memoire stating that "*the Government will allocate required funds for upgrading the cold-chain system in the AWPB for the year 2014/15*".[30]

Gavi's in-country Partners (WHO and UNICEF), while non-pooled donors, play an important role in engaging on issues related to the pooled fund with the government and other EDPs. However, across all of our in-country consultations, the extent to which these Partners can (and have) forward(ed) Gavi's agenda over and above their own specific work programmes in country was questioned. There is currently an implicit assumption within Gavi that WHO and UNICEF will make time to represent Gavi's operational and programmatic interests, however this may not necessarily be the case in practice. In particular:

- In terms of adequately representing Gavi requirements and processes, this has not been the case in practice, with a lack of clarity remaining amongst MoHP officials around Gavi proposal processes and the overall aims and terms of Gavi funding.
- It is more difficult to assess the adequacy of representation in terms of programmatic and strategic aspects, given that immunisation and HSS are also clear priorities for both WHO and UNICEF. However, as one senior MoHP official stated, *"WHO and UNICEF are not always concerned about Gavi-related issues*" and are mostly focused on their own programmes in country (for example, UNICEF's focus has been on the

[28] Cramer, M. (2014).
[29] Gavi. (n.d.-a).
[30] MoHP. (2014n)., Page 7

implementation of its key project on developing district investment cases). Further, it has been suggested that both agencies focus on supporting routine implementation through bilateral engagement with Government Divisions rather than actively engaging in high-level and strategic priority setting at the JARs and JCMs.

These issues have been raised several times in different Gavi evaluations. Both CEPA's evaluation of Gavi's Phase II and the process evaluation accompanying the 2013 Gavi Full Country Evaluation identify the same two issues: (i) the "*lack of clarity about the relative roles of the Implementing Partners and the Secretariat in particular"* and the need to "*ensure that policies and processes specific to Gavi support are well articulated and understood by all stakeholders".*[31] These issues are also highlighted in the current draft version of Gavi's 2014 Full Country Evaluation.[32]

In comparison, the other pooled fund donors (DFID and the World Bank in particular), who have an in-country presence, participate in all NHSP-II related meetings and have an active voice during the JCMs and JARs.[33] Notwithstanding their relatively larger contributions to the pooled fund as compared to Gavi, their presence in country ensures an engaged and ongoing relationship with government partners to support and influence policy and decision making. This level of influence is also enjoyed by non-pooled partners such as USAID as signatories of the JFA.

As such our conclusion is that while Gavi has had some influencing power under NHSP-II, it has not leveraged the opportunity extensively. The Secretariat has had limited capacity and it is our view that the in-country partnership needs to be strengthened in Nepal. Whilst it may be questioned to what extent donors should influence government policies given IHP+ considerations, however the fact that other donors are leveraging this opportunity to further their priority areas whilst Gavi is not, represents, in our assessment, a missed opportunity. In particular, the Secretariat has not inputted into the development of NHSP-III, which will be the guiding document for any future support to the pooled fund.

In contrast, however, our understanding is that Gavi's experience in Ethiopia has been quite different, where Gavi has had a greater level of influence, with two independent evaluations mentioning the catalytic role played by Gavi in incentivising other development partners to also join the pooled fund (more details are provided in Annex 4).

Given the structure of the JFA, wherein both pooled and non-pooled partners are participants, should Gavi have provided traditional earmarked funding but still supported the SWAp (i.e. considering the counterfactual) it would have had an opportunity for policy influence (as for

[31] CEPA. (2010). P111; Gavi. (2014 l). P5.
[32] Gavi. (n.d.-e).
[33] For example, the World Bank cited several examples of how they have influenced the AWPB process, including introducing performance-based grants to hospitals and a health insurance pilot programme – both of which have the hallmark of World Bank global priorities. DFID have also introduced innovations such as the Transaction Accounting and Budget Control System (TABUCS) and play a key coordinating role, both as EDP Chair and through the NHSSP technical assistance project.

example it would be invited to the various planning and coordination meetings which are attended by the non-pooled partners such as USAID, WHO and UNICEF). However, the pooled fund donors, due to their vested interest in influencing how their contributions are spent, have a stronger voice on the decision-making and review of the use of funds than non-pooled donors, and in turn these opinions receive more attention from the government (especially on the use of the pooled funds). As we describe above, this opportunity has not been leveraged extensively by Gavi.

3.3. Alignment with IHP+ criteria

In this section, we examine the extent to which the pooled fund (and Gavi's contribution within this) has been aligned with the IHP+ Global Compact (including the key principles of the Paris Declaration on Aid Effectiveness and the Busan Partnership Agreement) and the Nepal Health Development Partnership Compact (developed in 2009).[34,35] The overarching objective of the IHP+ is to mobilise well-coordinated support for one national health plan. Therefore, the theoretical link between pooled funding and the principles of the IHP+ is strong.

There have been several reviews of Nepal's performance against the aid effectiveness principles, which conclude that there has been good progress against most indicators.[36] Our assessment of the situation in Nepal is as follows (with further details in Annex 5):

- In terms of **ownership** (i.e. supporting a country-led and owned strategy), the pooled fund supports the NHSP-II, which is led and delivered by the GoN, with increasing government leadership and ownership of successive NHSPs. Thus Gavi's contribution to the pool supports greater country ownership of its funding.
- **Alignment** (i.e. supporting the country's objectives and working through local systems), is facilitated through the JFA, in which all EDPs have acknowledged official government systems and government leadership/ coordination of these. Reports show there to have been an increasing use of these systems, which have become further streamlined.[37] However, consultations also reported the practice of donors pushing their individual priorities in pooled fund planning meetings, with a recent

[34] IHP+. (2009).
[35] It is important to note that Nepal initiated a Sector-Wide Approach (SWAp) in 2004, when it implemented its "Health Sector Strategy: An Agenda for Reform" (MoHP. (2004).), which was followed by NHSP-I. These focused on improving donor harmonisation and alignment of donors with the national health policies and plans. Thus, Nepal was already focusing on what became the IHP+ principles before they were enshrined in the Global Compact and the Country Compact and before it launched the pooled funding mechanism for the health sector.
[36] Vaillancourt, D; et al. (2012).; MoHP. (2014f).
[37] Vaillancourt, D; et al. (2012).

report stating that EDP support "*often reflects individual donor and INGO priorities and agenda".*[38]

- In terms of **harmonisation** (i.e. the principle of efficient coordination of the activities of funding partners), Nepal's pooled donors are committed to supporting one health strategy and accept a single reporting procedure – the JAR – which has high participation. Further, independent projects and transaction costs for the MoHP have decreased since the introduction of the SWAp.[39] Gavi's contribution to the pool has also supported harmonisation, although additional unwarranted transaction costs have been incurred through its proposal requirements and guidance (see next section).
- In terms of the level of emphasis on **results**, the pooled fund performs positively. Consultations with pooled fund partners revealed that partners are in general happy with the M&E Framework and the focus on results has been strengthened over time. Consultations with the government indicate that increased harmonisation has meant that they can concentrate on delivering activities and achieving results.
- However, **mutual accountability** appears the weakest area in Nepal: "*this is where the Paris Declaration has yet to break through"*.[40] During our consultations, government concern was expressed over the perceived lack of transparency of donor priorities and processes, and a view that JARs should be joint forum to share best practices and information, rather than a "one sided" reporting of progress by the government. Indeed, the issue of aligning donor priorities within a pooled fund was also highlighted through the Ethiopia case study, with this area also being the weakest.

In summary, our conclusion is that in general the pooled fund is aligned with the IHP+ criteria and has positively contributed towards aid effectiveness in the country, with this contribution improving over time. There is room for improvement with regards to mutual accountability and transparency, with both donors and the government calling for more transparency about internal processes and activities. The strong alignment with the IHP+ principles is one of the key reasons for GoN demand for EDPs to make their contribution through the pooled fund.

Gavi's contribution to the pool supports the aid effectiveness principles (with the main anomaly being its proposal procedures). As such, in terms of the counterfactual, its standardised earmarked funding approach to HSS would have been less aligned with the IHP+ principles.[41]

[38] NHSSP. (2010). Additionally, there have been issues regarding the alignment of technical assistance from EDPs with Nepal's priorities, and the proper utilisation of this assistance (although not directly relevant for Gavi as it is not a technical assistance provider). MoHP. (2014f).
[39] MoHP. (2014i).
[40] Vaillancourt, D; et al. (2012)., p.8
[41] This is not to suggest that its earmarked funding would have been misaligned with the IHP+ principles, which would indeed be supported to a large extent given Gavi's approach of proposal development and

3.4. Appropriateness of application and monitoring requirements

We have reviewed the appropriateness of Gavi's application and monitoring requirements for its HSS support to the pooled fund in Nepal, and specifically whether Gavi brought in the needed flexibility for the country.[42]

3.4.1. Application requirements

Nepal submitted its proposal for Gavi HSS funding following the standard requirements for Gavi HSS support. The decision to channel the funds through the pooled funding mechanism grew out of discussions around Health Systems Funding Platform and was not specifically planned for during the time of Nepal's proposal submission. Gavi also did not have any pre-determined criteria in order to decide whether or not to fund through a pool. As such therefore, the question of the appropriateness of Gavi's application requirements is somewhat irrelevant as the proposal itself was not used as intended.

We make the following points with regards to the appropriateness of the application development and review process and related transaction costs for the country and the Gavi Secretariat:

- Given the move from earmarked to pooled funding, we consider that more effort and transaction costs than required were spent by the country in developing the proposal. Government stakeholders inform us that the main proposal development was conducted through a 5-day residential workshop with seven people from MoHP, UNICEF, WHO and consultants.[43]
- Once it was decided to channel the agreed funding through the pooled fund, there was no formal communication or documentation from Gavi to the country to notify this change. This has led to a lack of understanding and differences in opinion amongst government stakeholders (and in-country Alliance Partners) as to whether or not the activities and objectives in the original proposal are still relevant when prioritising pooled fund spending.
- As the three-year term included in the proposal has been used as the timeframe for Gavi funding to the pooled fund, Nepal has missed the opportunity to secure

implementation by the government and also due to the existence of the SWAp in Nepal. The evaluation of Gavi's first HSS grant to Nepal (which was earmarked) concluded on good alignment of the support with the key IHP+ principles.

[42] Section 4.1 below considers whether the monitoring requirements instituted for this funding have been suitable for Gavi's needs.

[43] Following learning from Nepal's first application process, the transaction costs this time around were relatively lower. For example, for the first proposal, government officials travelled to Sri Lanka for a regional workshop on HSS proposal development, numerous in-country workshops and stakeholder meetings were held, and an external consultant for hired to support the process; during the second proposal, the government was well-versed with Gavi's requirements and did not need to incur these additional costs.

additional HSS support from Gavi for the full five year term of the NHSP-II. It is our understanding that this is due to a lack of information and miscommunication on the fact that Nepal could have requested a cost extension.[44]

- From the perspective of the Gavi Secretariat, transaction costs for approving funding to the pool have been substantially lower as they have been able to use feasibility and fiduciary risks assessments conducted by DFID and the World Bank, rather than conducting these in-house. As one consultee noted, Gavi was able to "*ride on the coattails"* of other donors and benefit from the due diligence they had already conducted. Specifically the Gavi Secretariat did not need to conduct a Financial Management Assessment (FMA). Additionally, DFID and the World Bank had already negotiated the terms for pooled funding engagement, including technical and financial reporting mechanisms, which Gavi has been able to sign up to.

However, it appears that lessons learnt from the second proposal development process have not been incorporated into Nepal's third application, which was submitted to Gavi in January 2015. Specifically:

- *Lack of clear and timely guidance from Gavi on proposal procedures: The* government has been developing its proposal for Gavi HSS funding since November 2014 alongside its development of NHSP-III. However there has been no clarity on the required format and procedures for its submission (until recently – see next point). To date, Government stakeholders have held three workshops, each with 10-15 people lasting three days, to develop a proposal as per Gavi's standard requirements (as no guidance was provided to the contrary – by the Gavi Secretariat or its in-country Partners), while also questioning the utility of this approach given their view that the NHSP-III document should be accepted as the basis of funding from Gavi (as is the case with other pooled funding partners). Indeed, this lack of guidance from Gavi on proposal procedures was also found to be the case in Ethiopia.
- *Not fully comprehensive guidelines and ineffective communication to resolve outstanding issues:* A revised checklist for the HSS application has been recently introduced which whilst bringing in additional flexibilities to the application for pooled fund support, still leaves areas which lack clarity. This checklist requires a reduced amount of information, with no need for objectives or activities to be specified for Gavi support, instead relying heavily on existing national plans and assessments.[45] However, no clarification is provided in this document on the role of the National Health Sector Coordination Committee (NHSCC), which we understand has been re-established in Nepal, following its disbanding once a pooled funding approach was

[44] Although, slow fund absorption has meant delayed disbursements from Gavi, with the last disbursement being provided in late 2014.

[45] These bespoke guidelines align Gavi much closer with the processes of other pooled funders in Nepal, who do not require separate applications and rely instead on existing NHSP documentation. For example, DFID use NHSP policies and then conduct their own internal assessments and project appraisals.

adopted. Additionally, an approved National Health Plan is required, which in Nepal's case is still in draft form. It is our opinion that lack of full guidance and related communications has continued to result in redundant transaction costs at the country level.

In summary, our assessment is that the proposal development process has been less efficient than could have been for the country to date, although with the issuance of new guidelines by Gavi, it can be expected that these processes will improve and become more relevant/ streamlined going forward. From the perspective of the Gavi Secretariat, it has been more efficient by way of being able to leverage activities already conducted by other donors for most of its requirements.

3.4.2. Monitoring requirements

Once Gavi had approved that its HSS funding to Nepal would be channelled through the pooled funding mechanism, the requirement for submitting an APR was removed and replaced by the annual JAR, as set out in the JFA. This is fully in line with other pooled fund donors, who also rely on the JAR, rather than imposing additional reporting requirements on MoHP.

This decision to remove the APR requirement shows a clear commitment by Gavi to adapt its monitoring procedures for a pooled fund mechanism. This is despite the JAR providing far less detailed immunisation specific information than requested in the APR. This also shows further flexibility on Gavi's part, given the additional transaction costs imposed on the Secretariat and IRC in reviewing a wide range of national documents in order to receive the required information, rather than receiving this in one targeted report. The relevance of monitoring for Gavi's requirements is further discussed in Section 4.1.2.

3.5. Key findings on relevance and design

- Gavi's HSS support to Nepal through the pooled fund is well aligned with Gavi's mission and objectives given that immunisation, and its integration within broader HSS, is a top priority in the country, both in policy and practice. As a result, the evidence to suggest greater alignment through earmarked funding is not strong.
- Whilst contributing through a pooled fund is most appropriate for donors with a sector wide mandate, it provides efficiencies through reduced transaction costs, which is relevant for Gavi. In addition, the higher risk of a pooled funding approach appears to be acceptable to Gavi for its HSS support.
- Whilst a key benefit of funding through a pooled mechanism is that it provides a seat at the "policy-making table", Gavi has not fully leveraged this opportunity due to limited Secretariat capacity and ineffective representation by in-country Partners.

- The pooled funding mechanism in Nepal (and Gavi's contribution within this) has positively contributed towards IHP+ criteria, particularly in terms of country ownership and harmonisation. However, there is room for improvement in terms of mutual accountability, with both donors and the government calling for more transparency about internal processes and activities.
- There has been a lack of efficient management of the proposal development process under NHSP-II as the Government invested time and effort in developing a proposal which was not utilised given the move to pooled funding. Lessons from the experience under NHSP-II have not been incorporated in the next phase of Gavi HSS support to Nepal, with the lack of clear and timely guidance from Gavi and ineffective communication having continued under the current application phase for HSS support under NHSP-III. Monitoring arrangements under the pooled fund, in terms of the acceptance of the JAR by Gavi, have however worked well for the country.
- The Gavi Secretariat has been able to reduce its transaction costs for grant approval by leveraging the assessments and support provided by other donors to the pooled fund.

4. EVALUATION DIMENSION 2: IMPLEMENTATION AND GOVERNANCE

The implementation and governance pillar of the evaluation framework addresses the question:

Has the Gavi HSS grant been implemented efficiently, effectively, and with appropriate governance mechanisms, given the pooled funding mechanism?

Within this, we have looked at three sub-questions:

- Qs 4: Have activities been implemented, monitored and reported as planned? To what extent did the pooled funding mechanism and SWAp management affect this?[46]
- Qs 5: Have Gavi funds been disbursed and utilised in a timely and efficient manner? Were FMA requirements met?
- Qs 6: To what extent have pooled funding donors been appropriately engaged in the governance and decision making of the pooled fund? Has engagement by Gavi and its Partners been appropriate and effective?

Each of these sub-questions are considered in turn below by key theme or issue (Sections 4.1-4.3), followed by summary findings on the implementation and governance of Gavi HSS support to Nepal (Section 4.4).

4.1. Efficacy of grant implementation

As the Gavi HSS grant was provided to the NHSP-II pooled fund, we review the efficacy of government implementation of NHSP-II to assess efficacy of grant implementation. The suitability and efficacy of monitoring and reporting arrangements are also examined.

4.1.1. Government implementation of NHSP-II

As noted in Section 3.2, the development of NHSP-II has been far more country-led than the previous sector-wide health programme. The overall plan was followed by a number of supporting documents, notably the NHSP-II Implementation Plan, M&E Framework and the Governance and Accountability Action Plan. Since the NHSP-II has been in place, the AWPB process has improved, particularly in terms of being more output and outcome (rather than activity) focused, as reported during our in-country consultations.

[46] This evaluation question has been slightly amended from that included in the Inception Report to exclude a review of the "coordination" of the Gavi grant, given this follows the pooled fund governance procedures and the NHSCC coordination mechanism is defunct. These issues are discussed in Section 4.3.

In general, planned NHSP-II activities have been implemented well with a number of successes.[47] For example, Box 4.1 highlights EPI-specific activities under NHSP-II which have progressed well and those which have faced some challenges.

Box 4.1: EPI-specific NHSP-II activities

Activities that have progressed well	Activities facing challenges
•Expanded coverage of routine immunisation •Implementing targeted national immunisation campaigns •New vaccine introduction •Implementation of micro-planning approach, especially in low performing districts and municipalities to improve equity of coverage •Extended community mobilisation leading to declaration of full immunisation villages	•Weak cold chain and vaccine management, including lack of physical infrastructure, maintenance and replacement of the cold chain equipment at central, regional and peripheral levels •Lack of follow-up and supportive supervision to ensure effective implementation of district and municipality level micro-plans •Low immunisation coverage in urban areas

Of particular note are a number of recent initiatives to support strengthening of government capacity including: the establishment of a Financial Management Working Group within MoHP (which has developed financial management guidelines and a Financial Management Improvement Plan)[48]; the introduction of the TABUCS financial management software to improve health financing management; increase in coverage of HMIS (which is now better able to disaggregate data); and to further transparency and value for money, the introduction of a Procurement Improvement Plan.

Notwithstanding these key developments, there have been several challenges affecting NHSP-II implementation. Particular issues identified during desk-based research and consultations include the following:

- **Political instability impacting timely approval of the health budget:** Due to political instability, the Parliament has either been dissolved or delayed in decision making,

[47] HEART. (2013). The NHSP-II Mid-Term Review (MTR) reports that six of the nine NHSP-II outputs are making progress, including on reducing cultural and economic barriers to access, improving sector management, improving service delivery, increasing health knowledge and awareness, and improving M&E and health information systems. Areas with limited progress are reported as being strengthening of human resources for health, health governance and financial management and sustainable health financing. Our review also flags these as key challenges.

[48] These include Audit Clearance guidelines, Internal Control guidelines and TABUCS guidelines, available in NHSSP. (2011).

resulting in significant delays in budget approval.[49] This has also resulted in a high turnover of key ministerial and health sector leadership positions, which has in turn slowed health sector reform and the institutionalisation of successes achieved over the years.

- **Delayed fund approvals and disbursements impacting quality implementation:** Severe delays in budget approvals by the Parliament have resulted in at least a 3-4 month delay in fund disbursements each year.[50] During our three district consultations, we learnt that in the absence of budget approval, only essential activities (which includes immunisation) are conducted in the first trimester of the fiscal year, following which activities that are planned to be conducted across a 12-month period are implemented in less than nine months. This has a negative impact on the quality of service delivery, including immunisation services. Indeed, a similar situation was witnessed in Ethiopia, where activities were to be implemented in less than eight months for similar reasons.
- **Weak capacity for planning and coordination:** Despite a move towards a decentralised system, the health sector planning and budgeting system remains largely centralised. Whilst planning mechanisms do exist at the district level (e.g. district reviews and District Health Plans), consultations reported that districts are largely considered as implementing units and play a minimal role in annual planning and budgeting. Additionally, despite efforts led by MoHP's Policy, Planning and International Cooperation Division (PPICD) to improve coordination platforms between health departments, stakeholders reported that intra-divisional coordination in annual planning is weak, leading to fragmented planning and duplication of activities. It was also reported that year-to-year planning and priority-setting lack innovation, with incremental changes in activities over successive years.
- **Weak procurement and supply chain systems:** Despite ten years of dedicated procurement system capacity building support from the World Bank, there is little evidence that capacity has improved during this time. Procurement and supply chain management weaknesses have led to frequent drug stock outs. For example, during our visit there was a reported shortage of measles, mumps and rubella (MMR) and Bacillus Calmette–Guérin (BCG) vaccines at the central level.[51] Further, issues with corruption have hampered progress – recent events highlight this fact, with 12

[49] In the 2012-13 fiscal year, no Parliament was held and the previous year's budget was used, resulting in lower spending ability.

[50] A specific immunisation-related example is the delay of PCV10 introduction, which was planned for November 2014, but only initiated in early 2015 due to budget approval delays

[51] This stock-out had indeed reached one of the districts visited – Chitwan – who also reported having recently experienced shortages of Japanese Encephalitis vaccine for more than six months and on some occasions a shortage of syringes.

members of MoHP arrested in early November 2014 by the CIAA due to allegations of corruption with the management of procurement.

- **Lack of human resources impacting service delivery:** Shortages of skilled staff at all levels of the health system have negatively impacted the implementation of activities. This is further compounded by frequent staff transfers and poor staff retention. The NHSP-II Mid-Term Review (MTR) flags human resources as a key challenge for the health system.

Thus, despite important improvements over the years, Nepal's health system faces a number of key challenges with regards to effective planning, management and delivery. The functioning and results of the pooled fund, and Gavi's contribution within this, is also impacted by these issues. This therefore highlights one of the key risks of donor funding to a pool – that the funding is not protected from "macro level" problems and is hampered by the level of government capacity. Indeed, poor financial management and related fiduciary risks are the reason why the Global Fund does not want to join the pool.[52]

In considering the counterfactual, it may be argued that an earmarked HSS grant would not be as vulnerable to these issues. However, given Gavi's approach of funding country governments and working through country systems, the above issues would also impede effective implementation to some extent. Additionally, the extent to which HSS funding would be flexible enough to respond to such unexpected issues is also to be questioned.

4.1.2. Monitoring and reporting

We review the overall efficacy of the M&E arrangements for NHSP-II, as well as the extent to which the M&E information generated is relevant for Gavi's monitoring purposes.

Efficacy of the NHSP-II M&E arrangements

The NHSP-II M&E Framework was finalised in 2012, and the following year, the NHSP-II Logical Framework was published to report against the Framework. These are widely regarded as being relatively effective and successful developments – indeed, the MTR notes that M&E and health information systems have improved under NHSP-II.[53]

Nepal has also made considerable progress in HMIS, which are being used by decision makers to guide policy making. These improvements are a continual process, with a further revision of HMIS indicators, reporting tools, validation mechanisms and data use currently underway.[54] Additionally, joint monitoring of field activities by the MoHP and EDPs was established at the beginning of NHSP-II and the visit reports are discussed at the annual JAR meeting.

[52] The Global Fund has suspended its grants to the government as a Principal Recipient (PR) and requested that these be transferred to non-governmental organization (NGO) PRs.
[53] HEART. (2013).
[54] MoHP. (2014d).

However notwithstanding these improvements, a number of concerns have been raised on the functioning of the M&E tools and systems, both in the MTR and during our consultations. Specifically:

- There has been a **lack of an agreed M&E framework at the outset of NHSP-II**, as this was introduced two years later.[55] As a result, priority areas were not clearly delineated in NHSP-II and this may have impacted the appropriate distribution of resources across the sector.
- There has been a **lack of alignment between the belatedly developed M&E Framework and other health information systems**, such as the HMIS. This suggests that there is room for further improvement of the M&E Framework relative to its links with other existing information management systems.[56]
- Consultees suggested that M&E strengthening is constrained due to **a lack of skilled human resources,** including IT and epidemiologists, **inadequate infrastructure and insufficient funds**. The 2013 JAR Aide Memoire supports this, noting that there has only been limited progress in terms of human resource management.[57]

Whilst there remain a good number of issues requiring improvement, the M&E capacity and systems have been improving over time and a number of the donor partners consulted in country are pleased with the level of progress.

Suitability of M&E arrangements for Gavi's purposes

We have reviewed the M&E arrangements for Gavi funding from the country perspective earlier in this report and concluded that they work well for Nepal. Regarding the relevance of the NHSP-II M&E framework for Gavi's requirements, we make the following points:

- Information provided through the JAR has been viewed as adequate by the Gavi Secretariat and IRC, although our assessment is that this is largely due to the flexibility shown by Gavi. The JAR is a reporting instrument for the health sector as a whole, and therefore presents general health data. There are no details on immunisation-related activities undertaken in the year and there is only one directly immunisation-focused progress target in the JAR ('% of one-year-old children who immunised against measles').[58] The APR, on the other hand, understandably requests more specific details on the immunisation-related activities undertaken and progress on a range of

[55] Despite this delayed introduction, baselines are included in this framework at the outcome level, although many date from the last DHS in 2006 and therefore progress will not be limited to that achieved during NHSP-II.
[56] There has been poor coordination of information generated through routine systems and surveys, resulting in limited use by managers, policy makers and development partners. Consultees suggested that better integration of the various M&E systems, including surveys, is needed in order to improve data quality and to better inform the planning and budgeting process.
[57] MoHP. (2014o).
[58] Originally this indicator was % of children under 12 months of age immunised against Diphtheria-Tetanus-Pertussis (DTP) and measles, but was changed in order to provide a better proxy for full immunisation and to use routinely available HMIS data once the M&E Framework was introduced.

immunisation focused indicators. A detailed comparison of these two documents and analysis of the efficacy of the JAR is provided in Annex 6.

- However, this limited immunisation focus reported in the JAR is compensated by detailed immunisation monitoring data that Gavi receives through APRs for vaccine funding. We understand that Gavi is planning to phase out the APR and transition to a comprehensive online portal that seeks to pre-populate data from the WHO-UNICEF Joint Reporting Forms and reduce duplicative reporting. This will collate similar indicators to those currently collected.
- Some of the additional management-related information requested in the APR is included in different JAR documents (there were a total of 8 documents in 2014) and reports provided by the World Bank (on financial management). Accordingly, the Gavi Secretariat would need to review multiple progress documents instead of the one APR to monitor the grant and understand progress achieved. This means a transfer of transactions costs from the government to Gavi which can be viewed as a good thing in itself.

Thus, the M&E arrangements under the pooled fund in Nepal work adequately for the purposes of the Gavi Secretariat, partly because it has access to the more detailed information on immunisation required by Gavi from other reporting sources.[59] Additionally, Box 4.2 presents the approaches taken by other pooled fund donors, in terms of the M&E adaptations they have made for pooled fund support.

Box 4.2: M&E approaches employed by other pooled fund donors[60]

In addition to the JAR, **DFID** measures the results of its funding support to the NHSP-II by estimating its share of funding within the total health budget and assuming the same proportion of results achieved can be linked to its funding contribution. A similar approach has also been followed by DFID in Ethiopia for its contributions to the MDG Performance Fund. DFID also develops "value for money" case studies on select interventions that it has helped support, in order to gain a better understanding of relative costs and results. These are intended to be used widely, to guide both DFID and MoHP policy and management decisions.

In contrast, the **World Bank** accepts that when supporting a pooled funding mechanism, attribution of results is not possible. When recipient governments are able to decide on the allocation of pooled donor funds, it is no longer appropriate or practical to directly attribute activities or results for individual donors (especially given the 'fungibility' of funding). Instead the World Bank focuses on whether its funds have 'contributed to' observed outcomes, rather than 'caused' observed outcomes. The World Bank uses JAR information to prepare papers which detail the structure of its contribution, rationale and purpose, its implementation and the sustainability of the interventions and overall results that the funding is supporting. A discussion of contribution is also presented that provides credible information on the impact of investment, without the need to infer a causal link between funding and results.

[59] We understand that in 2014 as part of a stronger focus on results, Gavi increased the M&E requirements for HSS grants and included performance based funding indicators for HSS grants. As such, going forward it is likely that Gavi will need to extend further flexibility to Nepal in terms of reporting requirements.
[60] Phillipson, R., & Neupane, S. (2012).

4.2. Efficiency of fund management

In this section, we review the efficiency of the management of Gavi funds within the pooled fund, specifically examining why there have been delays with fund disbursement and whether Gavi's FMA requirements have been met.

As shown in Table 4.1, Gavi HSS support represents 5% of the pooled fund donor contributions and 1% of the total government budget for NHSP-II.

Table 4.1: GoN and donor contributions to the pooled fund (NPR, bn)[61]

Funding source	Total contributions (2010-15)	% of pooled fund	% of overall health budget
GoN	78.0 (US$803.8mn)	-	76%
World Bank	12.1 (US$124.7mn)	50%	12%
DFID	8.8 (US$90.7mn)	36%	9%
DFAT	1.3 (US$13.4mn)	5%	1%
Gavi	**1.1** (US$11.3mn)	**5%**	**1%**
KfW	1 (US$10.3mn)	4%	1%
Total	**102.3 (US$1.1bn)**	**-**	**100%**

Source: Financial Management Report, MoHP, 2015

Given Gavi's contribution is channelled through the pooled fund, as per the JFA, procedures on financial management follow the standard government processes and procedures, with additional fiduciary oversight and auditing by the World Bank. Annex 7 describes these processes in more detail. While the alignment with national procedures and systems is likely to have a positive impact in terms of long-term sustainability, there are a number of key issues with financial management in the country, including:

- **Inadequate GoN budgeting systems and processes, including parliamentary processes**: As previously discussed, the Parliament substantially delays approval of the AWPB, which hampers MoHP's ability to progress NHSP-II, with limited routine activities in the first trimester and excessive pressure for delivery in the latter months of the fiscal year. These delays have a particularly negative impact on implementation at the district level (Box 4.3 provides a summary and Annex 3 has more details). In addition, public financial management systems in Nepal are designed at a macro-level and do not cater to specific sector needs. For example, MoHP is required to comply with line item-based budgeting, when performance-based budgeting may be more appropriate for reporting on health outcomes.

[61] Exchange rate of NPR 97: USD 1. Data for 2014-15 is budget rather than actual contributions.

Box 4.3: Effect of budget delays at the district level

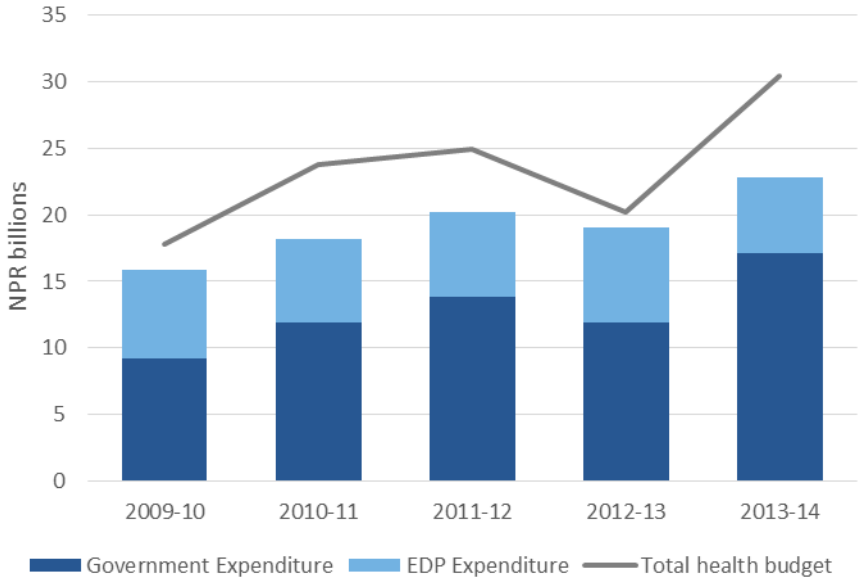
Visits to districts highlighted the impact of delayed budget approval on activity implementation:

- *Difficulty in execution of planned activities*: Whilst routine services are not affected, delivery of programmes, such as community mobilisation and drug procurement, has been severely affected. This resulted in a high burden of activities later in the year, thus bringing in to question overall quality of service delivery.
- *Delay in staff salary payments*: Though the delays have not affected the payment of salaries of regular staff, salaries of temporary staff can only be paid once full funds have been disbursed to the districts, resulting in poor staff retention.
- *Delay in procurement of essential commodities*: Delays result in a limited availability of essential commodities including free drugs (and consequently an erosion of public confidence in the health sector).

- **Increasing health budget, with growing government share, however limited absorption capacity:** MoHP has been able to substantially increase the total budget for NHSP-II over time, as a result of both increased allocations by GoN and EDPs (with an increasing relative share of the GoN) (refer Figure 4.1). Despite these increases, the absorption rate remains low and variable from year to year, mainly due to delays in budget approvals and lengthy procurement processes. The absorption rate for pooled fund donors is also low as their funding is structured as a reimbursement on an agreed proportion of government expenditures (to foster additionality).[62] A consultee noted that the implication of this is that the health sector has lost as much as $23m of pooled fund donor money in a given year. DFID has started providing upfront payments to the government with its rationale being that it does not want to penalise MoHP with lower funds due to delays in Parliamentary procedures. We note that a particular advantage of Gavi's funding approach as compared to other pooled fund donors is that Nepal will not lose out on Gavi funds because of slow absorption, as disbursements can be rolled into subsequent years.

[62] Absorption rates of government funding are higher than that for EDPs due to auditing practices. Pooled fund donors provide on-budget funding and corresponding expenditures are reported in the Red Book; whereas non-pooled donors funding is both on and off budget with off-budget expenditures not being regularly reported to the government.

Figure 4.1: Health sector budget and expenditure[63]



Source: MoHP budget information provided to HERD

- **Lengthy and complex auditing processes, coupled with an understaffed Office of the Auditor General (OAG)**: The OAG carries out a year-end review which is also shared with the World Bank. The process of the OAG review and finalisation involves some delays due to issues with reconciliation of expenditure given poor financial management capacity within government, limited reporting of EDP off-budget expenditure, etc. As a result, by the time the World Bank approves the audit, as well as recommends to the other pooled fund donors to make their final reimbursement, further delays have taken place.

Thus, while government funding for the NHSP-II has been increasing over time, financial management remains a key issue for the health sector in Nepal. The experience in Ethiopia is also similar, although perhaps somewhat more severe, as described in Box 4.4.

Box 4.4: Effect of financial management capacity issues in Ethiopia

Our case study on Ethiopia identified the following issues:

- *Late release of annual plans:* In addition to many of the issues noted for Nepal, a further constraint creating budget delays for Ethiopia is the fact that annual plans are only developed once the Government has confirmed the budget for the given fiscal year. Collectively, these constraints lead to significant budget delays and underspending.
- *Unpredictable budget allocations:* Government budget allocations for health services vary from year to year and are not predictable, thereby restricting financial planning capacity.

[63] There was a reduction in total health budget in FY 2012-13 due to no Parliament being held and subsequently no national budget being approved for that year, resulting in the previous year's budget being used.

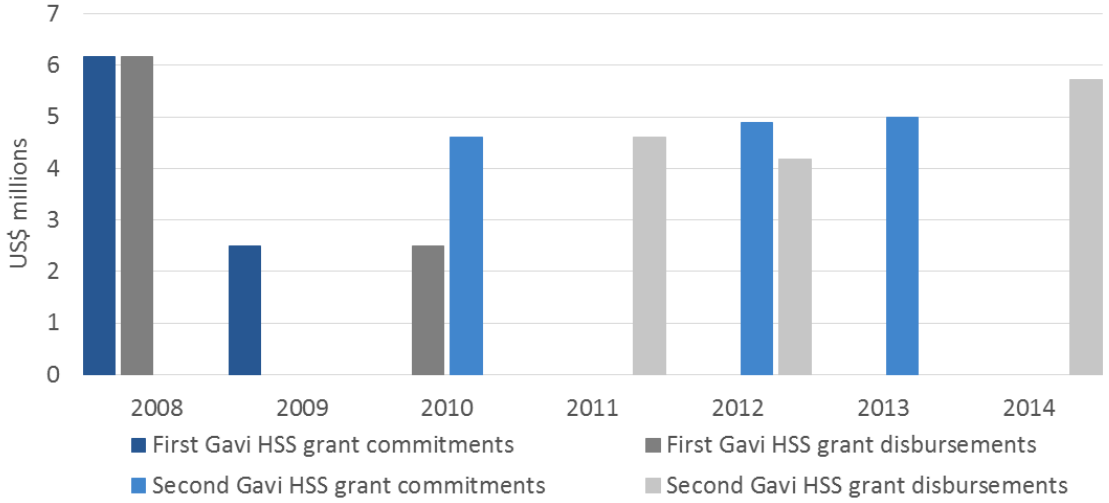
- *An overambitious health sector plan and budget:* Finally, government financial management capacity issues are exacerbated by an over-ambitious health sector plan and budget.

These issues have resulted in a very low absorption capacity by the government, resulting in a loss of US$100m of committed pooled fund donor monies in the 2013-14 fiscal year. As well, only half of activities for which funds have been approved, have been implemented.

The implications of the pooled fund financial arrangements and experiences are two-fold for Gavi:

Firstly, Gavi disbursements to the pooled fund have been delayed each year, with most notably 40% of Gavi's second HSS grant only disbursed in 2014. Figure 4.2 below shows these delays of up to a year. However the figure also shows the experience of the first Gavi HSS grant where there were also disbursement delays (i.e. which helps us assess the counterfactual situation). We conclude that budget delays and low absorption mean both funding approaches suffer, although given the closer alignment with government systems through the pooled fund, these were more pronounced under the second HSS grant.[64]

Figure 4.2: Gavi HSS funding commitments and disbursements to Nepal[65]



Source: Gavi website

Further, a key 'value add' of the pooled fund financial arrangements is that Gavi is able to leverage the cash flow flexibility of other donors within a larger pot of money, particularly given that DFID frontload their support rather than reimburse. If Gavi were to provide direct funding outside of the pooled fund, any delay in Gavi sending funds would impact on MoHP's ability to implement and fulfil earmarked activities. Gavi's HSS funding to the pool on the other hand allows for MoHP to rationally allocate funds between programmes and transfer funds from one programme to another as appropriate – a degree of flexibility that would not exist with earmarked funds.

[64] Indeed, the evaluation of HSS-1 notes that delays to implementation were largely due to political turmoil and government budgeting systems/ processes.
[65] Gavi. (2015a).

Secondly, the financial management and audit support provided by pooled fund partners (primarily the World Bank but also DFID) has been leveraged by Gavi. Gavi has been able to waive the requirement of an FMA for Nepal given the financial auditing mechanism that has been agreed by all JFA signatories. This is a significant achievement for Nepal, especially given that recent Gavi reports show that FMA requirements in other countries can create bottlenecks and delays in fund disbursement.[66]

In considering the counterfactual, some consultees argued that the fiduciary risk of fund mismanagement associated with the pooled fund (e.g. corruption, fund misuse) is less than would be the case under direct funding due to stronger oversight within government systems and the World Bank, whilst others (namely the Global Fund) felt that the pooled fund presented greater fiduciary risk (given their lack of confidence in government capacity and procedures). Our conclusion is that the additional fiduciary oversight systems within the pooled fund are beneficial for Gavi and reduce transaction costs for financial management. The ongoing support provided to the pooled fund by donors such as DFID and the World Bank suggest a level of confidence in the systems which may provide adequate credence and assurance to Gavi.

4.3. Appropriateness of pooled fund governance mechanisms

There are two key pooled fund governance mechanisms in Nepal, namely the JAR and JCM, as defined in the JFA. The appropriateness and effectiveness of these are discussed, in terms of their functionality and the value of the role played by donors, and in particular, the engagement of Gavi and its in-country Partners.

JAR and JCM

Stakeholders on the whole view the **JAR** as an effective platform for annual performance review of the NHSP-II. In particular:

- Both health policy and financial management have received prominent attention at each of the past three JARs, with the five key health policies discussed at the most recent meeting.[67]
- A broader range of issues are increasingly being discussed (e.g. included major health related research and studies; partnership, alignment and harmonisation; progress on procurement; and progress on GESI), with eight thematic reports prepared for discussion prior to the 2014 JAR.

[66] Gavi. (n-d.-e).

[67] The key policies are as follows: (i) National Health Policy; (ii) National Health Act; (iii) National Population Policy; (iv) Urban Health Policy; and (v) State Non-state Partnership Policy.

- Consultations reported the quality of JAR meetings to have improved over the years, particularly in terms of the breadth of participants, which now includes CSOs and academia, as well as GoN, EDPs, and INGOs.

There are also useful accountability mechanisms built in to the process and progress of the previous year's recommendations are discussed in detail, although as discussed previously, these are relatively weak.[68] In general, the monitoring and follow-up of the Aide Memoire's recommended activities have remained a challenge to the JAR, partly due to the lack of allocated responsibility or dedicated timeframes for actions (also noted in the NHSP-II MTR).

In addition, in order to make the JAR meeting a more effective platform going forward, there is a need to streamline the meeting with other performance review meetings. In particular, consultees noted that MoHP organise both an annual performance review meeting focused on service delivery, and the JAR meeting which focuses on health system and policy issues, and the need to better integrate the two meetings.

JCMs are also viewed as being effective at establishing meaningful communication and dialogue between MoHP and EDPs. These are viewed as key meetings where MoHP and EDPs discuss budgets and activities for the coming year. However, it was noted that there is a greater need to ensure timely JCMs, as these are often delayed due to delays in budget preparation and submission to Parliament. In general, there remains a need to better institutionalise both the JAR and JCMs, to ensure that their timings are not impacted by issues or constraints elsewhere in government.

In summary, notwithstanding the few issues noted above, governance and decision making mechanisms for the pooled fund work well in Nepal. There is strong and effective EDP engagement, with particularly strong roles played by DFID in technical coordination and the World Bank in fiduciary oversight. This is also echoed in a recent MoHP report, stating that the JAR and JCMs have strengthened donor harmonisation and alignment, as well as fostered partnership in the health sector.[69]

Gavi and in-country Partner engagement

As previously discussed, the Gavi Secretariat's direct engagement in governance mechanisms is limited to attending the JAR, with further representation provided through their in-country Partners WHO and UNICEF – however, they have not necessarily focused on the Gavi agenda.

Whilst the JAR may be an effective mechanism to review progress and discuss forthcoming priorities, the annual budget is not set during this meeting. Rather, these decisions are taken during bilateral meetings between the first and second JCMs and then discussed communally at the second JCM. The Gavi Secretariat is not regularly present at either of these opportunities and consultations (with government and other EDPs) indicated that in-country

[68] MoHP. (2014o).
[69] MoHP. (2014f).

Partners do not tend to influence budgetary decisions in the direction of Gavi priorities. This is due in part to the lack of a vested interest in how pool funds are spent, in comparison with other pooled donors, and in part due to the previously discussed focus on bilateral engagement to further their own programmes rather than engagement with pooled fund mechanisms.

Thus, whilst Gavi's in-country Partners are involved in the governance of the pooled fund, their engagement does not effectively take into account Gavi's priorities.

4.4. Key findings on implementation and governance

- Political instability contributing to budget approval and disbursement delays, weak government capacity for planning, financial management and procurement, as well as lack of human resources has negatively impacted the implementation of the NHSP-II. However several capacity-building initiatives are being introduced and efforts at improving some of the noted issues are being made. These issues would impact the efficacy of implementation of Gavi funds through the pool, however would also be relevant for earmarked funding (albeit to a lesser extent) given Gavi's approach of channelling funds through country governments.
- Financial management capacity under NHSP-II has been weak, resulting in Gavi having to delay its disbursements to the country. This was also an issue under Gavi's first earmarked HSS grant, albeit to a lesser extent. Pooled fund donor fiduciary oversight has resulted in reduced transaction costs for Gavi, as it does not need to itself spend resources in this area.
- There has been a strong improvement in M&E under NHSP-II, and the JAR as the main M&E requirement for pooled fund donors (including Gavi) works well. Whilst there is a limited focus on immunisation in the JAR, this is adequately compensated for by detailed data currently received through Gavi APRs for vaccine support.
- The two key governance mechanisms for the pooled fund, JAR and JCMs, are working well, with substantial donor engagement, albeit limited from Gavi.

5. EVALUATION DIMENSION 3: RESULTS

The results pillar of the evaluation framework addresses the following question:

What are the main results of the Gavi HSS grant and NHSP-II in improving health system performance and immunisation outcomes?

Within this, we have looked at two sub-questions:

- Qs 7: To what extent have NHSP-II activities contributed to improved immunisation and health system outcomes (including the objectives and targets outlined in the original HSS proposal)?
- Qs 8: Has the pooled funding mechanism led to any positive and/or negative unintended consequences, including broader systemic changes?

Each sub-question is considered in turn below – NHSP-II key results (Sections 5.1) and unintended consequences (Sections 5.2) – followed by summary findings on results (Section 5.3).

5.1. NHSP-II key results

We have reviewed the key immunisation and health systems results achieved under the NHSP-II. We have also reviewed the progress made on the objectives and targets included in the original HSS proposal (to the extent that this information is available from the NHSP-II M&E framework) to understand whether these have progressed in the absence of earmarked funds from Gavi.

5.1.1. Improvements in immunisation and HSS

We consider immunisation and health sector performance in terms of progress against MDGs 4 and 5, key immunisation coverage indicators and select HSS metrics that are aligned with Gavi's mandate.

MDGs 4 and 5

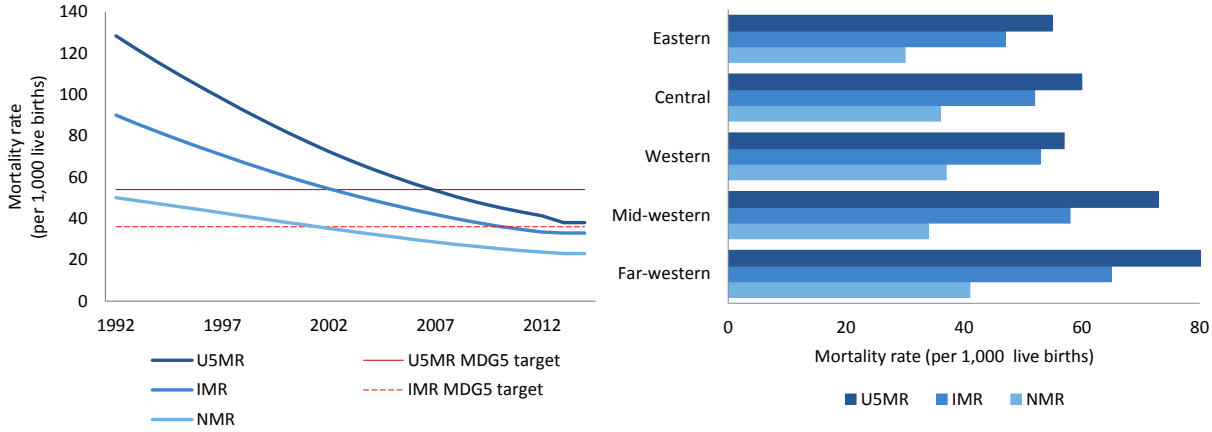
Nepal has made good progress in terms of child and maternal health, with the country expected to reach the MDG 4 and 5 targets.[70,71]

Despite substantial progress in early childhood mortality rates, there remain significant inequalities across development regions due to the uneven distribution of health services across the country – as shown in Figure 5.1 below. For instance, infant mortality ranges from 55 per 1,000 live births in rural areas, compared to 38 in urban. Additionally, progress has not been uniform across all indicators. The 2014 JAR Aide Memoire reports that although the

[70] UNDP Nepal. (2014a).
[71] MoHP. (2014i).

target for under-5 mortality rate has been met, targets for infant, neonatal and maternal mortality rate have only reached 90% progress against their targets.

Figure 5.1: Early childhood mortality rates: (a) by year (1992-2012); and (b) by development region (2011)



Source: (a) World Bank. (2015).; (b) MoHP. (2012e).

Maternal health indicators have also made encouraging progress, as was recognised by the United Nations, with Nepal being awarded a Millennium Development Goals Award for significant improvements in maternal health in 2010. However, contraceptive prevalence and antenatal care coverage remain low (Table 5.1).

Table 5.1: Maternal and reproductive health indicators

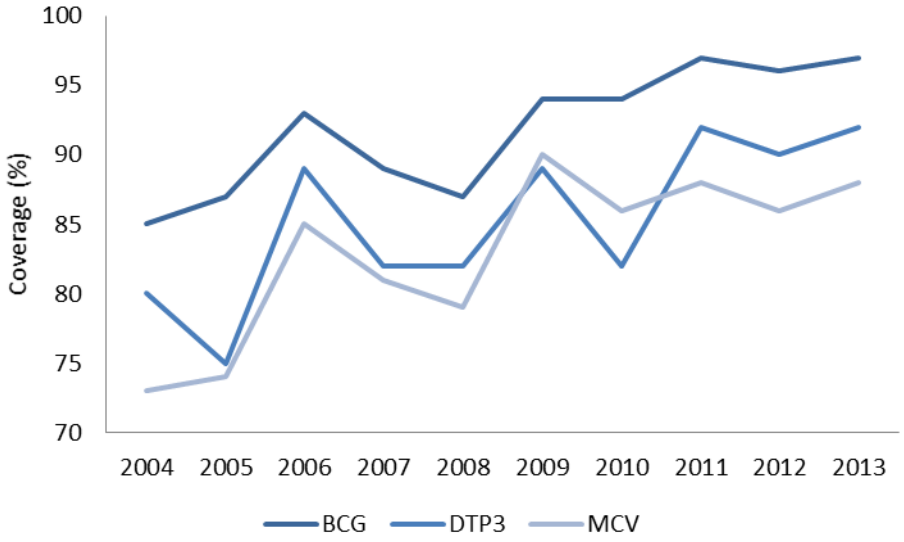
Indicator	2000[72]	2011[73]	2014[74]	MDG target[75]
Maternal mortality ratio (per 100,000 live births)	415	281	N/A	213
Proportion of births attended by skilled birth attendant (%)	11	36	56	60
Contraceptive prevalence rate (%)	35	43	50	67
Antenatal care coverage – at least four visits (%)	14	50	60	80
Unmet FP need for family planning (%)	27	27	25	15

Key immunisation metrics

Immunisation coverage has been on an upward trend over the past three decades. Large improvements were made in the 1980s and early 1990s with the implantation of the First Long Term Health Plan (1975-90) and the 1979 Expanded Programme on Immunisation. Whilst levels have seen some rises and falls over the past decade, since the introduction of NHSP-II in 2010, coverage have largely been on the increase (Figure 5.2).

[72] UNDP Nepal. (2014c).
[73] MoHP. (2014i).
[74] Central Bureau of Statistics. (2014).
[75] UNDP Nepal. (2014c).

Figure 5.2: National immunisation coverage in Nepal (2004-13)



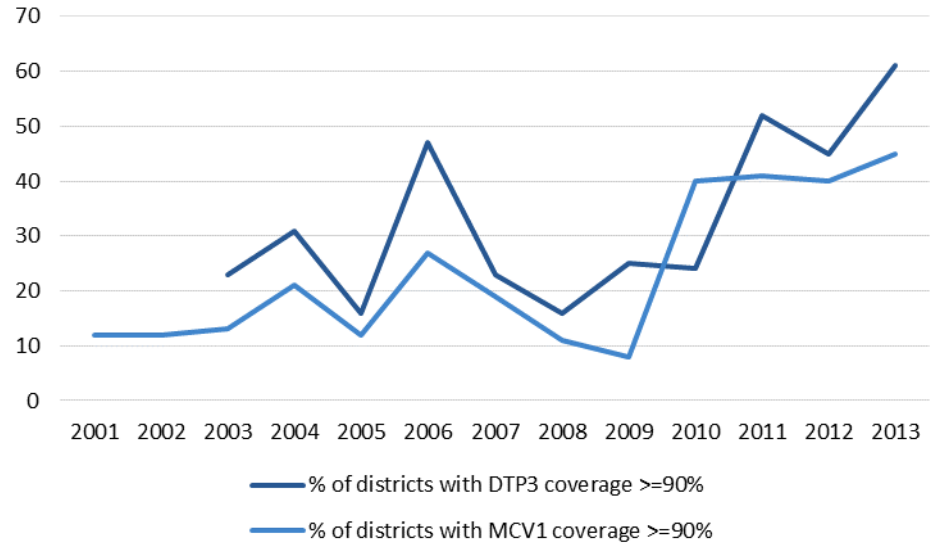
Source: WHO/UNICEF estimates

More specifically:

- In terms of measles coverage, UNICEF recently published the findings of the Fifth Multiple Indicator Cluster Survey (MICS5) showing a measles immunisation coverage rate of 92.6%, a notable increase from the 71% reported in 2000 JAR – implying that Nepal has successfully achieved this MDG4 target of 90% by 2015.
- The most recent Gavi APR indicates that the current estimated BCG, OPV3, DTP3, and DTP-HepB-Hib coverage rates are each approximately 95% in 2013; although MICS5 reports slightly less optimistic figures of 88% and above.[76]
- In general, a key priority for NHSP-II (through the National Immunisation Program) is for MoHP to maintain immunisation coverage levels above 90%, and the above suggests that the MoHP has met, or almost met, these targets.[77] This trend is further shown in Figure 5.3 as well.

[76] Data discrepancies between data sources is an important issue in a number of countries reflecting capacity issues with country HMIS.
[77] DoHS. (2011).

Figure 5.3: Percentage of districts with DTP3 and MCV1 coverage rates of over 90%



Source: Annual WHO/UNICEF JRF data

Although Nepal was experiencing stock-out issues with BCG and MMR vaccines towards the end of 2014, in general stock-outs issues have greatly improved. Between 2003-13, Nepal has only reported three instances of DTP stock-outs, each lasting less than three months and none reported since 2010.[78]

There was general agreement amongst country consultees that the National Immunisation Program is successful. Consultees have attributed this success in part to Gavi, with one MoHP official stating that "*tremendous change has been felt since Gavi funding began*" (although we appreciate that this comment refers to Gavi support as a whole rather than specifically to HSS funding (earmarked or pooled)).

HSS metrics

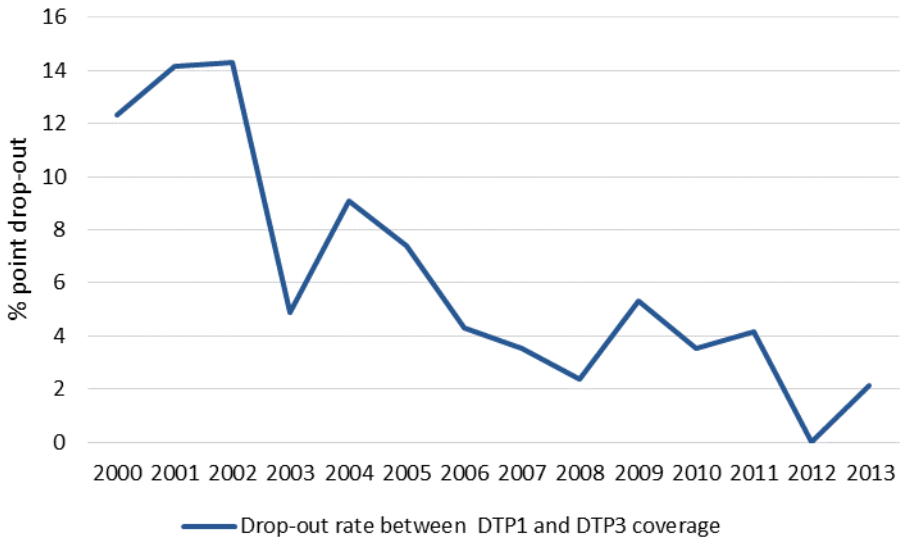
Nepal performs well against Gavi's three goal-level HSS indicators:

- The **drop-out rate** between DTP1 and DTP3 was less than 1% in 2012/13, which is well below Gavi's 2015 target of 9%, although this did increase slightly the following year (Figure 5.4).[79]
- The **DTP3 coverage** rate was 92% for 2011, although the recently released MICS5 data reports 88.3% (as noted above).[80] Although the latter figure is lower it is still a substantial improvement from the 74% reported in 2000 and above Gavi's target of 82%.[81]

[78] Source: Annual WHO/UNICEF JRF data
[79] DoHS. (Sample2013/2014); Gavi. (2015b).
[80] UNICEF. (2013); Central Bureau of Statistics. (2014).
[81] Gavi. (2015b).

- Following Gavi's approach to measure **equity in immunisation coverage**, Nepal stands at 10.8 percentage points.[82] Whilst this falls within Gavi's threshold of 20 percentage points, it still represents wide socio-economic differences, which are also reflected in geographic differences (as shown in Figure 5.1 above).

Figure 5.4: Dropout rate between DTP1 and DTP3 coverage 2000-2013



Source: Annual WHO/UNICEF JRF data

In summary, Nepal has made impressive strides in MDGs 4 and 5 and key immunisation coverage and HSS indicators. However, equity in health service provision and immunisation coverage in particular continues to be a challenge given geographic, human resource and infrastructure challenges between regions.

Our consultations in country indicated that the pooled fund has played some role in facilitating these achievements by:

- reducing the burden on government to coordinate multiple donor grants and thereby allow it to focus on implementation;
- presenting a stronger communal voice to advocate for change;
- improving the predictability of donor funding (given that the pooled donors provide their budget commitments at the start of each year);
- allowing for more coordinated and flexible donor funding, wherein the government is not impacted by the timing of donor disbursements (especially given the reimbursement approach followed by most of the pooled funding donors); and

[82] Gavi calculate this indicator as the difference between DTP3 coverage in the poorest and highest wealth quintiles, reported here using MoHP. (2012e).

- having a higher absorption rate than direct funding, given that pooled fund activities have greater government buy-in or ownership, resulting in more rational allocations of resources between programmes based on need.

It can be assumed that Gavi's support for the pooled fund has also contributed to these achievements however caution needs to be applied to a strong conclusion here, given: (i) the inherent attribution issues of pooled funding; (ii) Gavi's relatively small contribution to the pooled fund – 5% of donor funding; and (iii) the fact that nearly 40% of Gavi's HSS funding was only disbursed in 2014 (Figure 4.2).

5.1.2. Consideration of the counterfactual: Progress against objectives and targets included in the HSS proposal

We have conducted an analysis of the extent to which the objectives and activities defined in Nepal's HSS proposal have been achieved. While these objectives/ activities are not specifically reported under NHSP-II, we have reviewed the JAR documentation to map any relevant indicators that would help assess progress achieved.

This review feeds into our analysis of the counterfactual: would the immunisation and health system priorities as identified in the proposal have progressed without Gavi earmarked funding? As a starting point, our assumption is that had Gavi funding been earmarked, the objectives and activities listed in the proposal would have been achieved.

We present high-level findings from this mapping exercise in Table 5.2 below, with full details provided in Annex 9.

Table 5.2: Progress against HSS-2 objectives and activities

Objective (by 2012)[83]	Information in JAR	Progress
Strengthened human resources for health (HRH) To certify 1,700 community-based health workers to manage delivery of MCH and immunisation services in grass-root level health institutions. ***Rationale & key activities:*** To integrate delivery of MCH services, particularly in difficult to reach areas, through providing community health worker training.	**Good information** JAR reports on the number of Female Community Health Volunteers (FCHVs) trained and the NHSP-II MTR details progress in difficult to reach areas.	**Good progress** By 2014, Nepal had achieved 90% of its NHSP-II target of having trained 52,000 FCHVs. However, both NHSP-II MTR and consultations reported that the problem of understaffing remains in rural and remote areas, with minimal progress made on the NHSP-II MTR HRH recommendations.
Improved service delivery To develop organisation and management capacity for	**Poor information** Aside from one activity (social audits) there is	**Unable to report** Due to the lack of available information, it is not possible to

[83] We provide information on the rationale and key activities as well as the focus is not fully communicated through the objective statement alone.

Objective (by 2012)[83]	Information in JAR	Progress
district health service delivery in 15 low performing districts and 25 municipalities. ***Rationale & key activities:*** To ensure successful service delivery through building district health management capacity, through a range of initiatives including social auditing mechanisms and reactivating mother's groups.	limited available information through existing monitoring mechanisms on the specific initiatives suggested in the Gavi proposal.	report progress against this objective. However, good progress has been made in terms of social audits, which the NHSP-II MTR reports as being an important development.
Improved physical assets and logistics management To ensure all 75 districts acquire essential logistics management facilities. ***Rationale & key activities:*** To strengthen weak logistics in remote districts, with a particular focus on purchasing hardware and construction of birthing centres and "health huts" in particularly hard to reach areas.[84]	**Limited information** JAR provides some information on budget allocations for the operation of equipment, although this was not reported against in 2014, and the MTR reviews the progress of infrastructure projects and logistics institutional capacity.	**Limited/ mixed progress** The MTR notes that good progress has been made in establishing systems and controls for procurement of pharmaceutical supplies, although there has been little progress in distribution and stock management. Additionally, district level procurement was identified as a "*major concern*".[85] Health hut construction has not progressed at all.

Our review of the reported progress suggests that whilst certain areas linked to systems strengthening have progressed well, other areas, particularly on "project-based" activities have seen limited progress. Thus both HRH and logistics management have been prioritised under NSHP-II and some progress has been made (although severe systemic problems remain in both areas). On the other hand, some of the targeted activities (particularly related to capital investments and goods procurement) such as the purchasing of vehicles, construction of birthing centres and health huts have seen limited progress.

Therefore, in consideration of the counterfactual, these findings provide some evidence to suggest that an HSS approach through pooled funding is relevant for system-wide improvements whereas earmarked funding helps take forward tangible or discrete projects and capital investments. However further analysis and assessments are needed to make a strong conclusion in this regard.

[84] These primary health care structures would provide immunisation, FP, education, and other health related services. The local community would provide land and share 50% of total cost for the construction of huts.
[85] MoHP. (2013d).

5.2. Unintended consequences

We define "unintended consequences" as aspects which were not planned for or anticipated through the pooled fund.

The pooled fund mechanism in Nepal has led to several unintended consequences, which have been identified through stakeholder consultations, and for the most part are positive, as presented below:

Unintended positive consequences

- **Sustainability of funding through the pooled fund:** In-country consultations reported that projects implemented through the pooled fund were far more likely to be integrated into the health system and thus sustained, rather than projects funded through donor earmarked support. Examples of this include the TABUCS system, which was initially financed by DFID as a pilot project, but "on-budget" through the pooled fund. As such it has always been seen as an integral part of the HSS efforts and has subsequently been scaled up nationwide using the core health budget. This is in comparison with UNICEF's District Investment Case programme, an "off-budget" earmarked project which analyses bottlenecks in district service provision through community discussions. Whilst this has provided particularly promising results, several stakeholders felt that it was unlikely that this would be scaled up as part of the health system.
- **Greater donor involvement in the health budgeting processes:** Under the first phase of the pooled fund (i.e. as part of the first JFA signed in 2005), donors were only informed of the health budget at the same time as the budget was passed by Parliament. This was clearly not acceptable to pooled funders, who wanted to have some influence over how the health budget was apportioned. Discussions between pooled donors and government resulted in the JCM process being instigated in the second JFA. This joint pooled fund donor voice has therefore led to a clearer budgeting process, which, although not fully transparent, does provide some leverage against the health budget being used for political purposes and to further ministerial, rather than sector, priorities. This represents a significant benefit for Gavi, who were not involved in these discussions at all.

Gavi-specific positive unintended consequences

- **Reporting:** A further positive consequence specific to Gavi, is that M&E evidence from Nepal include more detail than Gavi would have been able to collect outside of a pooled fund. Specifically, the JAR presents more detailed data on inequity than had been provided through APRs. This is particularly relevant for Gavi given the second strategic objective of SG2 to "*increase equity in access to services*".

Unintended negative consequences

- **Limited impact on improving procurement:** One of the key roles played by the World Bank as a pooled fund donor is that of providing fiduciary oversight. It is therefore clear that additional checks and balances are required on the national procurement processes. As such, procurement using pooled funds is required to adhere to World Bank procurement guidelines. However it is not clear how following two procurement systems, the World Bank and the Nepalese, is strengthening the health system.
- **Limited innovation:** Whilst there have been some examples of innovative pilot projects being implemented under NHSP-II, in general our consultations and the literature have shown that a pooled fund approach is not conducive to innovation, rather focusing on standard sector-wide programming.[86] This is also reflected through consultations at the district level, where the lack of innovation was highlighted, with the same programmes being funded each year.

5.3. Key findings on results

- Nepal has made significant progress on MDGs 4 and 5, immunisation coverage and select HSS indicators under NHSP-II, although inequity in in health service provision and immunisation coverage remains an issue. Consultations indicate that the pooled fund has played an important role in facilitating results.
- Our review of the extent of progress of the HSS proposal objectives under NHSP-II provides some suggestion of system-wide improvements progressing better under pooled fund support as compared to project-based and capital investment focused initiatives, which may progress better with earmarked funding.
- Unintended consequences of the pooled fund are largely positive in terms of fostering sustainability and improved governance.

[86] Structured Dialogue. (n.d.).

6. CONCLUSIONS AND LESSONS LEARNT

This section brings together our assessments in the previous sections to consider the following concluding question:

What are the advantages and disadvantages of pooled funding compared with earmarked funding and how can these help inform Gavi's decisions on providing HSS support through pooled funding mechanisms to Nepal and other countries?

We consider the overall functioning of the pooled fund in Nepal and the key factors enabling or hindering its performance. We then draw conclusions on the relative advantages and disadvantages of the two approaches to Gavi HSS support in Nepal (pooled and earmarked funding) from the country and Gavi's perspectives. In our assessment, we review the "added value" of providing HSS support to the pooled fund as compared to traditional earmarked funding, defined in terms of the additionality or net benefit and thus whether there have been additional/ more and/ or improved processes and results.

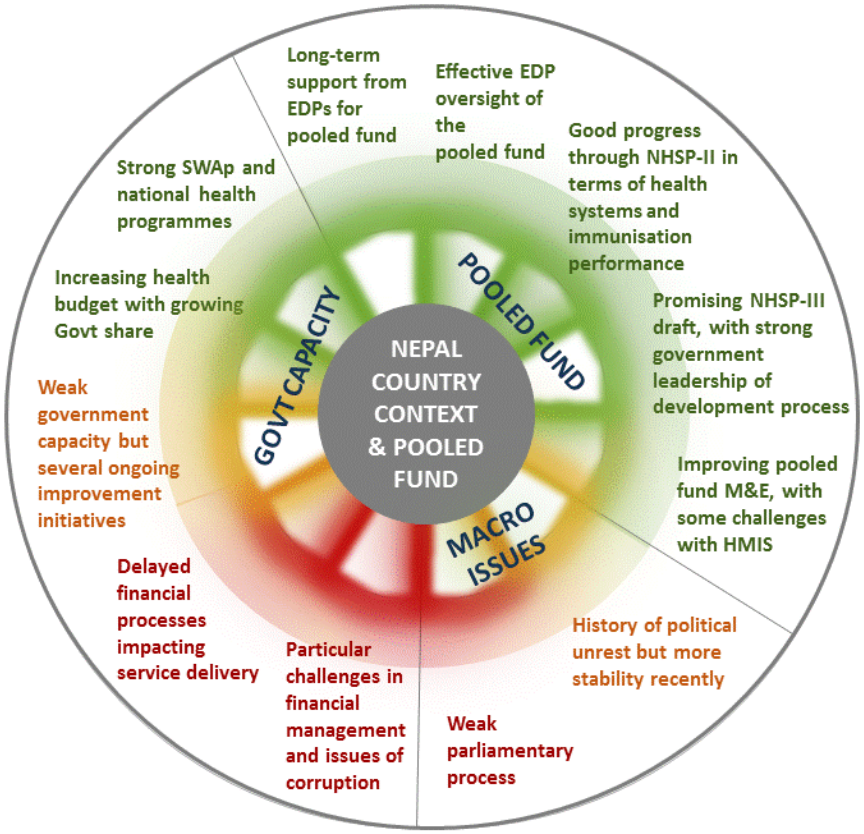
6.1. Nepal's pooled fund and key driving factors

As set out in Figure 6.1, there are a number of features of Nepal's country context and systems as well as the nature of the pooled fund that determines its efficacy. In particular:[87]

- *Macro issues* including a history of political unrest (but with more stability in recent years) have impacted the efficacy of the government policy-making processes.
- *Government capacity,* as the key implementer, is critical for the efficacy of pooled fund delivery. Several challenges relating to planning, financial management and procurement have been discussed in Section 4.1, but there are also ongoing/ continuous improvement efforts – although recent issues with corruption may have thwarted some of the positive outlook of stakeholders. Nevertheless, the government has a strong commitment of working through a SWAp and increasing financing of the health sector.
- *Nature of the pooled fund:* A key strength in Nepal is its long-term experience with and commitment to a SWAp, as well as successive improvements in the national health sector programme. Strong support from the majority of the EDPs and their active involvement in governance and fiduciary oversight are important positives contributing to the efficacy of the fund and strong progress achieved on key health outcomes.

[87] It is important to note that these features describe the Nepalese context as of today, and it may be the case that some of these may improve or worsen over time, so it is important to keep these under review.

Figure 6.1: Features of Nepal's country context and pooled fund (presented using a 'traffic light approach' which reflects relative rather than absolute progress – green (supporting factors), amber (relatively weaker but improving) and red (key constraints)



Our conclusion, based on an assessment of the interplay of the range of these features, is that the implementation of the NHSP-II, and the pooled fund within this, has generally been positive. In particular, notwithstanding the challenges, there has been increasing government ownership of the development and delivery of the national health plan, introduction of a number of capacity-building initiatives to support better management, a well-performing pooled fund governance system, and substantial progress made on a number of key health outcomes.

6.2. Added value of a pooled fund approach from the country perspective

Despite the fact that the decision to channel funds through the pooled fund was initiated by Gavi, there is indeed a strong country demand for donor funds in general, including Gavi funds, to be provided through this mechanism. Section 3.3 outlines the clear benefits to the government from this approach in terms of facilitating ownership, reducing transaction costs from donor alignment and harmonisation, and consequently allowing for greater focus on delivery of results.

While there have been some inefficiencies for the country in relation to Gavi's proposal requirements, going forward these are expected to be avoided given the issuance of tailored proposal guidelines for pooled fund support by Gavi. The acceptance of the country

monitoring arrangements through the JAR, provision of flexible monies and timely disbursements work well for the country (especially given that the timing of Gavi disbursements does not impact country planning and implementation as the monies are provided as a reimbursement and represent a small proportion of total donor contributions to the pooled fund). A particular advantage of Gavi's funding approach as compared to other pooled fund donors is that the country does not lose out on funds from Gavi as a result of slow absorption (as Gavi does not need to forgo its allocation to the country in a year and can delay disbursements to align with country expenditure).

As such therefore, from the country perspective, and as reiterated through consultations with government stakeholders, Gavi support through the pooled fund is strongly recommended.

6.3. Added value of a pooled fund approach from Gavi's perspective

From the perspective of Gavi, the analysis is more complex with a number of advantages and disadvantages of providing HSS support through the pooled fund in Nepal, also in comparison with the traditional earmarked funding approach. We draw on our consideration of the counterfactual throughout the report to note the following for Gavi, considering how both approaches relate to its mandate and delivery model:

Advantages of a pooled fund approach in Nepal

- **Continued alignment with Gavi's mission and objectives:** As discussed in Section 3.1, Gavi's HSS support to the NHSP-II pooled fund has been aligned with its overall mission and objectives, given the priority accorded to immunisation and delivery through integrated HSS in country health plans/ programmes and actual practice. Given this specific context of Nepal, we have not been able to strongly conclude that an earmarked approach would be better aligned.
- **Strong support for Gavi operating principles, including IHP+:** A pooled fund approach also more strongly adheres to the operating principles defined in Gavi's Strategy 2011-15 – in particular the third (supporting national priorities and processes) and the fifth (maximising cooperation and accountability) principles.[88] In general, this approach furthers Gavi's support for the IHP+ principles.
- **Greater leveraging of limited Gavi HSS funds:** An important advantage afforded to Gavi through the pooled fund approach is that it has been able to leverage its limited funding for HSS by contributing to a larger pool of donor funding for health sector improvements in Nepal. Gavi's focus is on vaccine procurement for countries, with HSS support representing a relatively small proportion of its total funding (cash-based programmes need to represent 15-20% of funding in any given proposal round, as agreed by the Gavi Board in 2010).[89] Indeed as noted in Section 4.1, Gavi's HSS support

[88] Gavi. (2011c).
[89] Gavi. (2010f).

for NHSP-II represented 5% of the donor funding to the pool (and 1% of the overall health budget).

- **Leveraging of other donor support for reduced transaction costs:** Further, by providing HSS funding to the NHSP-II pooled fund, Gavi has been able to leverage the in-country presence of other pooled fund donors for considerably reduced transaction costs to Gavi throughout the life-cycle of the HSS grant (Table 6.1).

Table 6.1: Gavi's leveraging of pooled fund donor support and reductions in transaction costs

Grant life-cycle	Role of other donors and Gavi's leverage
Proposal development	DFID and the World Bank completed comprehensive feasibility assessments, including the Joint Assessment of National Health Strategy (JANS) tool, thus reducing assessments required to be undertaken by Gavi (including the FMA).
Grant negotiation	Pooled donors had carried out extensive negotiations with GoN on pooled fund mechanisms through establishing first JFA. The second JFA built heavily on this model.
Grant management	Gavi leverages in-country donor oversight and management (including World Bank's fiduciary risks management role) in the utilisation of the Gavi grant monies.
Grant monitoring	NHSP-II M&E framework was developed by GoN with assistance from other EDPs. Monitoring mechanisms, such as JAR and JCMs (where Gavi has also participated), have been established and reporting formats agreed upon.

Disadvantages and key issues

However, in addition to the above-noted advantages there are also a number of key issues with regards to Gavi providing pooled fund support in Nepal.[90]

- **Constraints posed by Gavi delivery model to influencing policy.** The primary issue relates to some practical challenges posed by the Gavi delivery model for effective HSS support through the pooled fund. As noted, Gavi has not been able to influence policy making in Nepal in a substantial way (as other pooled donors have been able to) and it is not actively involved in pooled fund governance. This has been due to both limited Secretariat capacity, as well as lack of effective representation by Gavi's in-country Partners. As such, this represents a "missed opportunity" for Gavi given the potential offered through the participation in the pooled fund.
- **Increased risks in effective implementation and financial management.** Pooled funds are not protected from macro issues such as political instability. This has been a particular issue in Nepal, leading to delayed decision making and budget approval. For Gavi and other pooled donors, this has resulted in fund disbursement being slower

[90] On a more conceptual level, and from a "macro" donor perspective, it may be viewed as somewhat inefficient for the range of bilateral pooled fund donors in Nepal (DFID, DFAT, KfW, etc.) who also fund Gavi, to channel their funds for HSS support in Nepal both bilaterally and through Gavi. We recognise however that a more detailed consideration of these issues is outside the scope of our work.

than expected. It has also impacted on the quality of service implementation, given that annual activities have been squeezed into a nine-month period. Financial management as a whole has been a weakness in Nepal, notwithstanding fiduciary oversight by the World Bank. Whilst we acknowledge that given Gavi's funding approach through country government, similar issues would occur under earmarked funding, exposure to these issues does seem to be heightened through a pooled fund approach.

- Potential **"loss of visibility"** of Gavi's HSS support in Nepal given that earmarked support could be tangibly linked to certain activities and their results, which is not the case with a pooled fund approach.
- **Lack of attribution.** More generally, results reported under a pooled fund approach are less attributable to Gavi, however this challenge was also faced during the earmarked funding approach (given the nature of HSS).

Concluding discussion

In summary, given: the relatively well functioning pooled fund and national health programme in Nepal, with improving health outcomes and impacts over time; prioritisation of immunisation in the country and therefore alignment with Gavi's overall mandate; contribution to aid effectiveness principles; and leveraging of its limited HSS funds and reduction of transaction costs, we conclude that Gavi HSS support through the pooled fund is of added value to Gavi, and our recommended approach for Gavi HSS funding in Nepal going forward as well. Whilst there is potentially some risk of dilution of Gavi's immunisation focus (notwithstanding our conclusion above) as well as financial and fiduciary risks (given the current state of government capacity in Nepal), this may be acceptable given Gavi's relatively higher risk appetite for HSS support. Gavi has however not been able to substantially or effectively leverage its influence as a pooled funding donor, an area which requires more focus.

7. RECOMMENDATIONS

This section presents our recommendations on Gavi HSS support through a pooled fund in Nepal and other Gavi-eligible countries more generally.

The recommendations are based on our evaluation findings and conclusions as well as suggestions made by country stakeholders for Nepal – although ultimately these are based on our judgement on a sensible approach for Gavi going forward. We describe the main thrust of our recommendation, although do not provide details in terms of "how" Gavi might implement any of the proposed suggestions.

7.1. Gavi HSS support through the pooled fund in Nepal

Our overall conclusion is that Gavi HSS support through the pooled fund in Nepal works well and has been of added value to both the country and Gavi. Specifically in terms of Gavi, the pooled funding approach has allowed it to leverage its limited HSS funds and reduce transaction costs, while not overly diluting its immunisation focus, and rather, adhering more strongly to aid effectiveness principles.

However, there have been some key challenges in the delivery of this support, particularly in terms of the limited policy influencing role of Gavi as a pooled fund donor (due to limited Secretariat capacity and ineffective representation by in-country Partners). There have also been some inefficiencies in the proposal development process and related communications. More generally, it is recognised that pooled fund support provides a degree of risk with regards to effective government implementation and financial management, with a number of key issues with regards to efficiency of these processes in Nepal.

Given these conclusions, we make a number of specific recommendations with regards to Gavi HSS support in Nepal, as follows:

Recommendation 1: Continue to provide HSS support through the NHSP pooled fund, whilst maintaining a review of the strategy, priorities and actual functioning of the pooled fund.

Given the range of benefits, and our judgment that these are relatively larger than the costs entailed, we recommend that Gavi continue to provide HSS support to Nepal through the pooled funding mechanism.

However, it would be important for Gavi to keep the following under review:

- continued focus of the NHSP on immunisation, and thus alignment with Gavi's overall mandate;
- efficacy in government implementation, particularly in terms of successive improvements in financial management capacity over time; and
- progress in achievement of planned results/ health outcomes through the pooled fund.

In order to ensure each of these areas adequately meets Gavi's requirements, Gavi could set carefully designed thresholds for Nepal, which, if crossed, would require a reconsideration of supporting the pooled fund. Relevant thresholds could include, for example, an annual increase in the government budget for immunisation, implementation of key reforms relating to improvement of financial management, certain targets for key immunisation and health systems strengthening indicators.

Recommendation 2: Continue to focus attention on Government financial management capacity, with the possibility of increasing fiduciary risk monitoring processes.

While we conclude that Gavi HSS support through the pooled fund in Nepal does not pose a large fiduciary risk, we recognise that there could be changes over time and thus this is an important area for ongoing review and monitoring.

Closely linked to our recommendation above, we suggest that Gavi continue to monitor the level of fiduciary risk posed through the pooled fund. While not increasing its transaction costs, Gavi should continue to coordinate with in-country pooled fund donors and keep abreast with their assessment of the strengths and weaknesses of financial management in Nepal.

Recommendation 3: Fully leverage its role as a pooled fund donor to actively influence policy through both clearly defined Partner representation and targeted Secretariat engagement.

Given Gavi's limited policy influencing role as a pooled fund donor to date, we make the following specific recommendations:

- Gavi needs to have a clear agreement with WHO and UNICEF in terms of the roles they are expected to play with regards to representing Gavi's strategic and programmatic interests in country. It is likely that this would require bespoke agreements to be drawn up with Partner country offices, which provide specific directives in terms of their role (such as which issues to advocate for on behalf of Gavi and which meetings to participate in).[91]
- Given the strategic importance of the NHSP-III in guiding support provided through the pooled fund, Gavi (i.e. Secretariat and in-country Partners) should engage in any future revisions/ updates to these policy documents in order to ensure continued alignment with Gavi's mandate and fully leverage this opportunity to influence policy.
- Gavi should play a larger role in developing the NHSP-III M&E Framework, which is currently underway. Indeed, this was an opportunity which stakeholders flagged as having been a missed opportunity under NHSP-II. Therefore, in order to ensure

[91] We believe that this is an important issue but it obviously has wider ramifications and thus may require an initial high-level agreement between the Gavi secretariat and its main operational partners, WHO and UNICEF.

measureable and relevant monitoring of immunisation, Gavi should be more involved in the development of the NHSP-III M&E Framework, and specifically its indicators.[92]

- Whilst the Gavi Secretariat currently prioritises its limited resources to attend the JAR, it is our view that a second visit to Nepal each year to attend the first JCM (where priority-setting is initiated) and to conduct targeted bilateral discussions with the Child Health Division would be of significant value add in terms of the influencing opportunity that such a visit would bring.
- Finally, it would be beneficial for the Gavi Secretariat to have greater engagement with in-country stakeholders. This could include receiving and reacting to minutes of key meetings, such as monthly EDP meetings where strategic coordination is discussed and immunisation-specific technical working groups, so as to provide clarity on areas for which WHO and UNICEF should be championing.

The above recommendations are aimed at supporting Gavi to play a better policy influencing role, in line with its delivery model and capacity. Our suggestion on Gavi enhancing its role in this regard is so that it can ensure that immunisation continues to receive the required priority and target any "weak spots". However this needs to be balanced with the aid effectiveness principles of country ownership and steer away from a practice of the range of pooled fund donors splitting up the "NHSP-pie" to align with their mandate.

Further, whilst we have developed recommendations which we deem to be feasible, we are also aware that several may incur increased transaction costs. However, Gavi's delivery model through in-country Partner representation is a significant cost saving of itself and therefore investments made to improve the efficacy of this arrangement would have long-term benefits.

Recommendation 4: Provide timely and clear guidance on Gavi application and other processes, with clear channels of communication through Partners.

Given the high transaction costs at the time of developing the HSS proposal for NHSP-II and again at present during the development of the proposal under NHSP-III, we recommend that Gavi ensure efficient processes and minimised transaction costs (for both Nepal and Gavi) around its application and other requirements such as funding extensions/ renewals. This needs to be achieved through:

- clear and timely guidance from the Gavi Secretariat;
- strengthening the link between the Gavi Secretariat and the Partner agency country offices in Nepal, with a better flow of information, and potentially more staff training on Gavi procedures and requirements; and

[92] However, caution is needed to avoid unintended negative consequences – the maxim 'what gets measured gets managed' – of overly focusing on immunisation indicators to the detriment of others.

- creating more efficient channels of communication through clearly indicating to country governments how they may approach Gavi for any clarifications and questions, as well as ensuring a "benchmark" timeline for response.

7.2. Gavi's approach to pooled funds

Based on our review of the experience in Nepal, which has been broadly positive, we recommend that Gavi continue to explore the option of providing HSS support through pooled funds in other countries.

We make the following recommendations for Gavi to consider in developing its approach to providing HSS support through pooled funds.

7.2.1. HSS objectives and linkages with pooled funding support

Our evaluation has highlighted that there is a lack of clarity on the intended objectives of the HSS window, specifically with regards to the focus on immunisation outcomes and/or broader health systems strengthening. While successive Gavi strategies have indicated a focus on the former, the very concept of HSS implies that immunisation outcomes should be promoted through actions at the health systems level.

Providing such clarity is critical as pooled funding support does imply a broadening of Gavi's funding, from immunisation-specific to sector-wide support. This may be relatively more straightforward to manage for donors such as DFID and World Bank who provide sector-wide support; but with Gavi being a donor with a specific mandate, a precise "theory of change" and clear selection criteria need to be established upfront to ensure value for money from its pooled funding support.

Given these conclusions, we make the following general recommendation with regards to Gavi's HSS approach:

Recommendation 5: Provide greater clarity on the scope and objectives of the HSS window and establish the intended purpose/(s) of providing HSS support through pooled funds.

We view this as an essential first step before embarking on providing pooled fund support to other countries – not only to ensure clarity to countries on the objectives of Gavi support to pooled funds, but also to ensure better monitoring and review of progress of its funding within Gavi.[93]

Related to this recommendation, we make the following additional suggestions:

[93] We acknowledge the challenges of clarifying HSS objectives, given the divergence of opinions within Gavi, however feel that clarity of approach is important to ensure pooled funding support is able to effectively meet Gavi's objectives.

- Gavi should consider *how best its delivery model can meet its objectives* – in a similar vein to our recommendations for Nepal above, Gavi should consider how it can effectively utilise its country Partner base and limited Secretariat capacity.
- Gavi should clearly *communicate* its HSS and pooled fund support objectives and principles to stakeholders, including country governments and in-country Partners, to avoid any confusion.
- Gavi should consider which types of pooled funds are most relevant to its HSS objectives. For example, in Nepal there is one pooled fund covering the whole health sector, whereas Ethiopia has a range of pooled funds, each with a different aim or technical focus. As such, we feel this would be an interesting area for Gavi to study and analyse further, as part of developing a clearer strategy/ approach to pooled funding.

7.2.2. Identification of countries for pooled fund support

While clear HSS and pooled funding objectives would help select countries for support, we provide some thoughts on how Gavi might approach this.

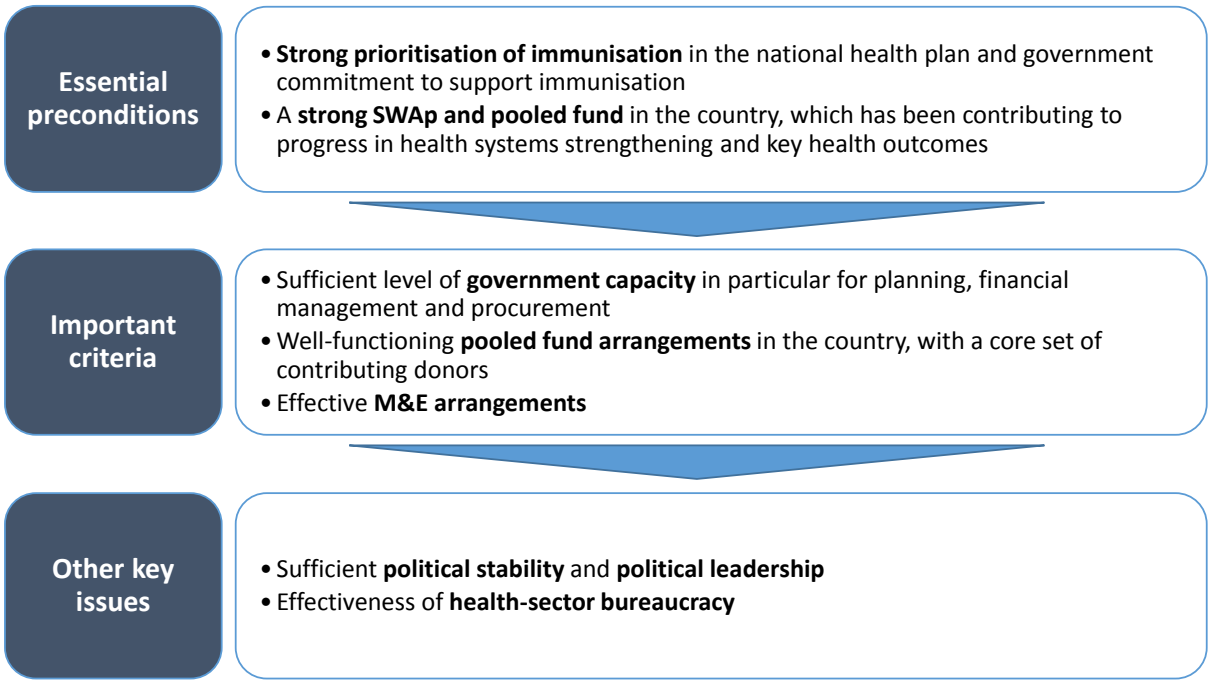
We recommend that by no means should a pooled fund approach be adopted across the board or extensively; rather, we suggest the following:

Recommendation 6: Conduct a review of the country context and functioning of the pooled fund to assess whether providing HSS support through a pooled fund is appropriate.

Figure 7.1 provides some key criteria for Gavi to consider when selecting countries to provide HSS support through a pooled fund. In particular:

- We consider that **"essential preconditions"** in terms of strong prioritisation of immunisation and a well-functioning SWAp are required for Gavi to provide pooled funding support for a country. These criteria ensure the alignment of Gavi's contribution with its overall mandate as well as effective (and low risk) funding.
- Gavi would then need to assess the extent to which the noted **"important criteria"** are in place. For example, given that Gavi would look to "leverage" the existence of other donor support in negotiating pooled fund arrangements with governments, rather than expend limited Secretariat capacity, the extent to which these are already in place is highly relevant for Gavi.
- Finally, country-level macro issues will also need to be assessed, in terms of the level of risk Gavi is prepared to accept. Whilst some politically unstable countries may have strong and well-functioning bureaucracies that ensure robust management and accountability, other countries may have more stability but less effective systems in place. Therefore, the effectiveness of the health sector-specific bureaucracy should also be assessed, as in some cases this can compensate for broader political instability.

Figure 7.1: Criteria to identify countries for pooled fund support



Whilst we note that these criteria are already considered by Gavi to assess country support, we have further highlighted these here given the greater significance they have under a pooled funding approach.

We recognise that there is no "model" or "ideal" country which would perfectly meet all the above noted criteria and hence this assessment needs to be taken in a "relative" rather than "absolute" sense (relative to other countries and relative to its own experience in previous years). Further, a number of these conditions are not static, but fluid in nature, and hence pooled fund support to a country that may initially meet some/ all of these criteria needs to be kept under constant review for any changes/ key risks that may arise over time.

7.2.3. Approach to M&E

Finally, we provide some recommendations on a suitable approach for Gavi with regards to M&E for its HSS support through pooled funds. These draw on our review of the current M&E arrangements under NHSP-II and the approaches of other pooled fund donors.

Recommendation 7: Develop a tailored approach for the M&E of HSS pooled fund support.

Whilst we do not consider a need for a separate M&E policy for pooled fund support, we provide the following suggestions on how Gavi should tailor its current M&E approach in order to be relevant and appropriate for pooled funding:

- In keeping with the IHP+ principles of alignment and harmonisation, Gavi should continue to accept M&E information generated from the pooled fund M&E

mechanisms (i.e. the JAR in Nepal). Gavi should also aim to align its monitoring cycles with those of the country, to the extent possible.[94]

- Gavi should focus on assessing the "contribution" of its funding to overall results, rather than aiming to assess "attribution". However, Gavi, and particularly the Gavi Board, needs to decide how important attribution of results is for its HSS funding. If Gavi aims to enhance its HSS support through pooled funds, looking further into the paradigm shift experienced by the World Bank in moving away from the need for attribution may bring some interesting lessons – particularly given that DFID's approach of assigning a certain percent of results is less relevant for Gavi's smaller HSS contributions.
- Given the long term gestation lags for HSS activities to deliver results (and more so through a pooled fund approach given the funding is not targeted at a small set of discrete activities), Gavi should: (i) aim to track longer term health systems performance; and (ii) manage expectations of its key stakeholders on the timeline for results.
- Where particular information desired by Gavi is not provided through existing country M&E arrangements (and is unlikely to be provided through M&E system strengthening), Gavi could carry out select case studies. This may be particularly instrumental where there is specific evidence of Gavi support/ approaches having resulted in positive or negative change and for which learning lessons would be beneficial. Given Gavi's immunisation focus, such a targeted case study approach could be a relevant investment for Gavi to better understand the value add of its HSS support without placing additional burden on MoHP.
- More generally, where M&E structures in country are weak, Gavi should provide additional support to strengthen their M&E arrangements – e.g. by sharing best practices/ guidance during in-country meetings. Also, given that pooled fund M&E reporting is often criticised for focusing on the completion of process tasks (e.g. procurement of health supplies) rather than on performance and achievement of targets or objectives, Gavi should encourage adequate monitoring and reporting of results.[95]

[94] We understand that this may indeed be somewhat feasible going forward as while previously Gavi's monitoring IRC met only once a year in July, the plan under Gavi's grant application, monitoring, and review process is to conduct reviews by a High Level Review Panel in May, July and October.
[95] Vaillancourt, D. (2009).