



GAVI ALLIANCE

EVALUATION OF GAVI SUPPORT TO CSOs

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EVALUATION REPORT

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ACRONYMS AND ABBREVIATIONS¹

Acronym	Full description
APP	Advocacy and Public Policy team (GAVI Secretariat)
APR	Annual Progress Report
BPHS	Basic Package of Health Services
CCRDA	Consortium of Christian Relief Development Association
CEPA	Cambridge Economic Policy Associates
CRO	Country Responsible Officer
CSO	Civil Society Organisation
cMYPs	comprehensive Multi-Year Plan
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
DRC	Democratic Republic of Congo
DTP3	Diphtheria-Tetanus-Pertussis third dose
EC	European Commission
EPI	Expanded Programme on Immunisation
FBO	Faith Based Organisation
FMA	Financial Management and Accountability
GAVI	GAVI Alliance
GHP	Global Health Partnership
GNI	Gross National Income
HDI	Human Development Index
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HR	Human Resource
HSCC	Health Sector Coordinating Committee
HSFP	Health Systems Funding Platform
HSS	Health Systems Strengthening
ICC	Inter-agency Coordinating Committee
IEC	Information, Education and Communication
IHP	International Health Partnership
IRC	Independent Review Committee
ISS	Immunisation Services Support

¹ A glossary of terms used in the report is presented in Annex 1.

Acronym	Full description
JSI	John Snow, Inc.
LDC	Least Developed Country
LMIC	Low Medium Income Country
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MLM	Mid-Level Management
MOH	Ministry of Health
MoU	Memorandum of Understanding
NVS	New Vaccine Support
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
ODA	Official Development Assistance
PAHO	Pan American Health Organisation
PKK	Pemberdayaan Kesejahteraan Keluarga (Indonesian Family Welfare Movement)
PPP	Public Private Partnership
RFP	Request for Proposal
RH	Reproductive health
RWG	Regional Working Group
SANRU	Sante pour Tous et par Tous
SIDA	Swedish International Development Cooperation Agency
SEARO	South East Asia Regional Office
TA	Technical Assistance
TAP	Transparency and Accountability Policy
TOR	Terms of Reference
TWG	Technical Working Group
UNDP	United Nations Development Programme
UNICEF	The United Nations Children's Fund
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organisation
WHOSIS	World Health Organisation Statistical Information System

EXECUTIVE SUMMARY

This is the Evaluation Report on GAVI's support to Civil Society Organisations (CSOs) prepared by CEPA², with input from Eliot Putnam (CEPA Associate).³ Introduced in 2006 with a budget of US\$29.2m, the GAVI CSO programme comprises: (i) Type A support, to strengthen the coordination and representation of CSOs by providing lump sum grants between US\$10,000-100,000, available to all 72 GAVI eligible countries⁴; and (ii) Type B support, for ten selected pilot countries to help implement the GAVI Health Systems Strengthening (HSS) proposal or comprehensive Multi-Year Plans (cMYPs). The CSO support was set up as a pilot, initially for the period 2007-09 and subsequently extended to 2010, with further extensions in 2011.

The evaluation of GAVI's support to CSOs has been structured around three inter-related themes on policy rationale and programme design, implementation and results. As such, our emphasis has been on reviewing the 'process' of the support and the immediate results (or outputs). It is not possible (or practical) to find evidence on results in many instances – however, we have sought to understand the 'potential' for results, where feasible. Figure 1 presents our evaluation framework and questions.

Figure 1: Evaluation framework

	I. Policy rationale and programme design	II. Implementation	III. Results
High-level evaluation questions	To what extent is the overall design of the pilot and individual country programmes relevant in terms of country needs, GAVI objectives and principles?	To what extent have the programmes been implemented effectively and efficiently at country, regional and global levels?	To what extent has GAVI support to CSOs been effective in meeting its objectives at the country level?
Evaluation sub-questions	<ol style="list-style-type: none"> 1. How does the rationale for GAVI's support for CSOs fit with its overall aims and objectives, as well as country needs? 2. Has the design of the GAVI CSO programme (Type A and Type B) been consistent with the achievement of the proposed programme objectives and country requirements? 3. To what extent are the GAVI approved and funded CSO programmes in countries relevant in supporting its objectives and country needs? 	<ol style="list-style-type: none"> 4. How have the various GAVI institutions (i.e. the Secretariat, Partners, CSO Task team, IRC, etc) contributed to the effective implementation of the programme? What are the factors that have supported or hampered their role in implementation? 5. To what extent has GAVI CSO support been implemented effectively in countries? What are the factors that have supported or hampered implementation? 	<ol style="list-style-type: none"> 6. What evidence is there of positive (or negative) results from the GAVI CSO support at the country, regional and global levels? 7. Has the programme resulted in any unintended consequences at the country-level?

Various evaluation methods have been used to gather evidence on the CSO programme performance, including desk-review of documents, consultations with GAVI's global and country stakeholders for the programme, comparator analysis, five country studies (Afghanistan, Democratic Republic of Congo (DRC), Ethiopia, Indonesia and Pakistan), an electronic survey targeting stakeholders across GAVI eligible countries, and a limited amount of data analysis.

² www.cepa.co.uk

³ As per the terms of reference, this report does not provide forward-looking recommendations for GAVI CSO support. Annexes to this report and the country studies are enclosed as separate documents.

⁴ Eligible under GAVI Phase II.

These methods have been used for all three themes of our evaluation framework, albeit with some methods being more relevant for particular evaluation questions than others. We have considered the robustness of our conclusions, based on the quality of the evidence source, degree of uniformity in the opinions of different stakeholder groups, and consistency in findings at the country level.

Overall, our assessment is that GAVI’s support to CSOs is, in principle, important to achieve the country’s and its own immunisation objectives, particularly in countries where CSOs play a key role in immunisation service delivery and supporting activities. However, there have been a number of issues with the programme design and implementation, warranting a ‘significant re-think’ of the support going forward. These issues have diminished the programme results achieved to date, although there is evidence of some positive outputs and outcomes.

Policy rationale and programme design

GAVI’s support to CSOs is relevant to its overall objective of increasing access to immunisation, given the role and contribution of CSOs in achieving country immunisation and health system objectives. However, immunisation is different from other health interventions in country, in that the Expanded Programme on Immunisation (EPI) is predominantly government-led. As a result, the *extent* of relevance of supporting CSOs varies according to the country context and strength of the EPI. Our analysis suggests that CSO support is *strongly* relevant to GAVI’s objective of increasing immunisation access in countries where government delivery channels are weak/ non-existent – such as is the case in some fragile and conflict/ post-conflict countries (e.g. Afghanistan). In other countries where the public sector is functioning as the principal mode of delivery for immunising children, CSOs might support demand creation or complementary health systems strengthening (HSS) activities, indirectly serving GAVI’s objective. Here, the nature of the role of CSOs, and the degree to which their contributions are “critical” to achieving immunisation outcomes, vary by country (e.g. arguably, GAVI’s support to CSOs is more relevant in Pakistan or Ethiopia than in Indonesia, where its relevance is at best *weak*).

GAVI Type A support for mapping CSOs is useful in countries where CSOs are engaged in the immunisation sector. However, the Type A nomination of CSOs to the country Inter-agency Coordinating Committee (ICC)/ Health Sector Coordination Committee (HSCC) equivalent is less important, since, in several supported countries, CSOs have been a part of these committees prior to GAVI support and/ or these committees are functioning fairly poorly. Type B support is particularly important in countries where CSOs play a key role in the delivery of immunisation.

Significant weaknesses in programme design have been identified for both Type A and B support. The principal issues are:

- A lack of clarity on programme objectives and the absence of a prospectively defined results framework, creating considerable ambiguity on what GAVI seeks to achieve through this programme. It is not clear how GAVI aims to encourage the development of the role of CSOs and their improved coordination with the government in different types of country health settings/ systems, especially as the relative role and capacities of the public sector in immunisation service delivery vary by country.

- Structuring Type A and B support as two separate windows (and separate from the HSS programme) has resulted in high transaction costs for GAVI and countries (in terms of separate proposal, approval, disbursement, and reporting processes). Also, inappropriate sequencing of the two forms of support has led to inefficiencies – it would have been more sensible to complete the CSO mapping first to allow countries to better identify suitable CSOs for Type B support.

GAVI is unique in its approach of channelling CSO funds through governments. This has had mixed results and has been largely dependent on the strength of government-CSO relationships as well as government capacity to manage the available funds. In some countries (e.g. Ethiopia), this approach has worked well and contributed to government ownership and coordination of the programme as well as improved accountability. In other countries (e.g. DRC), government bureaucracy has resulted in considerable delays in the transfer of funds to CSOs. In Afghanistan and Pakistan, due to concerns over government stability and their capacity to manage the funds, the support was routed through WHO and UNICEF respectively – albeit at an additional management cost. In general, CEPA’s view is that channelling funds through the government is an appropriate ‘default’ approach, although similar to the current situation, there should be some flexibility for routing funds through alternative approaches (e.g. GAVI Partners, CSOs that have passed GAVI’s financial/ fiduciary checks⁵) when the government channel is not appropriate.

Implementation

We have considered the role of the GAVI institutions (including the Secretariat and Partners) and how the programme support has been implemented in countries.

GAVI’s delivery model, with a Geneva-based Secretariat and in-country support from its Alliance Partners (particularly WHO and UNICEF), has not been effective for the CSO programme. Secretariat staff have had limited capacity/ resources and senior management support to engage effectively with countries – both in terms of creating awareness of the programme and providing ongoing guidance to countries. Further, GAVI’s systems and processes (e.g. financial management, fiduciary checks, country reporting) are more geared towards dealing with governments rather than with multiple CSOs of varying sizes and functions. WHO and UNICEF in most countries have had limited engagement in the implementation of the programme⁶, in part due to insufficient clarity from GAVI on their role. Their ability to support the programme is also compromised by limited previous experience of engaging with CSOs (particularly WHO).

A major obstacle in implementation has been the significant delays in the approval of country proposals and disbursement of funds by GAVI. Six of the Type A supported countries experienced delays of over three months in approval and/ or disbursement. Type B funding has been affected more severely, with all of the seven supported countries experiencing large delays in approval and the various tranches of disbursement. For instance, Pakistan received the first tranche of Type B funds almost 12 months after submitting their proposal. They then had to

⁵ The Type A extension funds for Togo and Afghanistan have been approved by GAVI to be routed directly to the designated CSOs.

⁶ WHO and UNICEF have been more involved in the programme design stage through their membership on the country health coordination committees.

wait for over 19 months to receive the second tranche (due after 12 months). Other countries such as Ethiopia and Indonesia are yet to receive the second payment from GAVI. The delays in disbursement are mostly on account of GAVI's internal processes, including the Transparency and Accountability Policy (TAP)/ Financial Management and Accountability (FMA) processes, approval of APRs, etc., but also due to country-specific factors.

The delays have had several adverse repercussions on the programme, including: changes in anticipated programme costs which has sometimes necessitated re-programming; unexpected standstills and/ or reduced effectiveness of CSO activities; and weakened relationships between the CSOs and governments (as they have been unable to deliver services as agreed).

Our review of the Independent Review Committee (IRC) model indicates that it is less suited to this programme, as the IRC has limited experience in dealing with CSOs and is not equipped to adequately take account of country specificities. The CSO Constituency, on the other hand, has been a cost-effective platform for GAVI to communicate with the CSO community across countries. There are some questions regarding the effectiveness of CSO Task Team inputs on the design of the support, given the major design issues identified with the programme.

Our evaluation of the country implementation experience has provided some interesting insights and conclusions, including:

- Type A mapping approaches employed by countries have been broadly reasonable, however there have been limited efforts to validate and update the data.
- Type B support has funded a total of 43 CSOs in the five countries studied, of which 21 are indigenous and have received at least 53% of all funds allocated to CSOs. In general, the approach to CSO selection has been varied in terms of process, rigour and the extent to which the HSCC equivalent body has been involved. Furthermore, the transparency and fairness of the process has been questioned in some countries.
- In addition to disbursement delays by GAVI, other Type B implementation issues include: limited experience of governments in contracting and funding CSOs, coordination difficulties between government and CSOs, and a lack of supporting health infrastructure.
- Management costs in some countries have been a large proportion of total grants (up to 50% for Type A and 25% for Type B), reducing the budget available for the supported activities. While overhead costs for small grant programmes can be high due to the absence of economies of scale, the considerable variation in management costs as a proportion of grants suggests some inefficiencies.

Results

Absence of a prospectively defined results framework has impeded assessment of the performance of the programme as: (i) there is no benchmark or goal against which progress can be assessed; and (ii) relevant progress data has not been collected in a systematic and complete manner. The APR format and the quality of information provided are not conducive for programme monitoring and results measurement; implying that essential information, such as the use of Type B funds by activity, is not being collected.

As part of our evaluation, we have sought to develop a results framework for the CSO programme, which defines the logical flow of outputs, outcomes and impacts for Type A and B support. However, given the nature of these forms of support (Type A in particular) and the timing of this evaluation (i.e. country implementation is either ongoing or recently completed), an impact evaluation is not possible. Our assessment has therefore focussed on outputs assessment and their potential contribution to outcomes, where observable. In summary:

- Type A support has resulted in (a) six countries producing mapping reports, although there is limited evidence of their use in practice (except in DRC where it was used to select Type B CSOs); and (b) five countries nominating CSOs to the ICC/ HSCC equivalent committees, although the utility of representation is questioned due to often poorly functioning committees (as noted above) and/ or the extent to which the nominated CSOs represent their broader constituency.
- Type B support has resulted in the delivery of a range of activities, including community mobilisation, advocacy, training, support to health centres, provision of equipment/ supplies, and delivery of immunisation. However, for some countries, delays in approval and disbursement have adversely impacted the achievement of results, and in fact, have retracted from the progress to date.
- While Type A support was envisioned to strengthen the coordination and representation of CSOs, we find that Type B support has supported this outcome to a greater extent. There are specific examples where CSO support has improved the coordination of CSOs (e.g. in Pakistan, CSOs formed an effective consortium for Type B support) and with government (e.g. in Indonesia, GAVI CSO support has led to an increase in the number of government funded projects involving CSOs in the health sector).
- Some improvements in vaccine coverage rates in project areas have been reported through Type B support, but these are difficult to attribute to GAVI support.

CSO support has also resulted in some positive unintended consequences, including more meaningful participation of the CSO Constituency and Steering Committee in GAVI through access to country inputs; and capacity building of CSOs, particularly in financial management. It has also resulted in some negative unintended consequences, such as weakening relations between CSOs and government (e.g. due to CSOs not being able to deliver on their commitments on account of disbursement delays from GAVI).

GAVI's support to CSOs for immunisation is of added-value as few donors support this sector. However, there are concerns around the predictability and sustainability of the support. In terms of predictability, the short term and pilot nature of funding has discouraged countries from making long term plans for engaging with CSOs. The experience and prospects on sustainability are more mixed – where governments have been working closely with CSOs in immunisation (e.g. in Afghanistan) some Type B activities will continue to be supported by the government, but this is not always the case (e.g. in DRC). In other countries, where CSO activities funded have not been 'essential' to the national EPI, sustainability prospects are weak (e.g. Ethiopia).

1. INTRODUCTION

This report provides an evaluation of GAVI's support to Civil Society Organisations (CSOs).⁷ It has been prepared by Cambridge Economic Policy Associates (CEPA), along with input from Eliot Putnam (CEPA Associate).

1.1. Evaluation objectives and aims of this report

As noted in the Request for Proposal (RFP), the aim of the evaluation is to “assess the policy rationale, programme design, implementation and results of the pilot phase of GAVI support to CSOs”.⁸ The primary audience for this report is the GAVI Alliance Board, in order to inform their consideration of the structure and design of GAVI's support to CSOs going forward.

The focus of the evaluation is on both Type A and B support, with the purpose being to:

- document how resources have been expended to support CSO activities in immunisation, child health, health systems strengthening, and government/ CSO partnerships;
- document the effectiveness of the programme;
- provide lessons learnt from the experience;
- evaluate the performance of the programme with regard to strengthening CSO engagement at country-level in service delivery, coordination & policy development; and
- inform future programme design and activities for maximum benefit to country partners and beneficiaries.

Following our appointment for this evaluation, we held some initial consultations with select stakeholders of the programme, to understand their expectations and priorities for the review. Within the evaluation objectives, they emphasised the importance of the following aspects of our review: an assessment of the fit of GAVI's support vis-à-vis the role of CSOs in countries; a critical appraisal of whether the channelling of CSO support through governments works; development of a suitable results framework; and an assessment of programme outputs and outcomes to date (recognising difficulties in assessing impact). This feedback has been incorporated in our evaluation approach.⁹

Our assessment of the GAVI CSO support to date builds on the analysis and findings of previous reviews of the programme.¹⁰ Whilst several of our conclusions confirm the findings of these earlier reviews, we have also presented some new insights gained during our evaluation.

⁷ Annexes to this report and the country studies are enclosed as separate documents.

⁸ RFP for Evaluation of GAVI support for CSOs, dated April 2011. As per the terms of reference, this report does not provide forward-looking recommendations for GAVI CSO support.

⁹ CEPA's Inception Report (dated 22 August 2011) details our evaluation approach. Summary information is also included in Section 2 of this report.

¹⁰ CEPA (September 2011): “Second Evaluation of GAVI” and Eliot Putnam (December 2009): “GAVI Alliance Support for CSOs: An Analysis of Type A funding”.

1.2. Background to GAVI CSO support

GAVI launched its support for Health Systems Strengthening (HSS) in December 2005, recognising that broader health systems constraints were impeding an increase in, and sustainability of, immunisation coverage. Following this, acknowledging the role of CSOs in public health (to a substantial degree in several GAVI countries), GAVI constituted a Civil Society Task Team in 2005 to propose mechanisms on how civil society could be engaged with GAVI governance and implementation. Based on the recommendations of the Task Team, the GAVI Alliance Board approved the CSO support as a pilot programme in November 2006, with the following aim:

*“... [to] build sustainability at a country level by involving local civil society organisations in the planning and delivery of immunisation, child and other health services, and encouraging cooperation and coordination of efforts between public sector and civil society”.*¹¹

A total of US\$29.2m was approved for the CSO programme, comprising two types of support:

- (i) *Type A* to strengthen the coordination and representation of CSOs, by providing lump sum grants between US\$10,000-100,000 to conduct a mapping exercise of CSOs operating in the country and support their nomination on country coordination and planning bodies. The support was made available to all 72 GAVI-eligible countries.¹²
- (ii) *Type B* for ten selected pilot countries to help implement the GAVI HSS proposal or comprehensive Multi-Year Plans (cMYPs). Examples of activities to be funded under this support include: provision of technical assistance, community mobilisation, health systems strengthening activities, and immunisation service delivery.¹³

Figure 1.1 presents the CSO programme portfolio to date. In contrast to Type B support, there has been limited uptake of Type A support, with only 16% of the available funds being approved for countries. However, a number of countries approved for Type B support have not yet been disbursed their full amount of funding.¹⁴

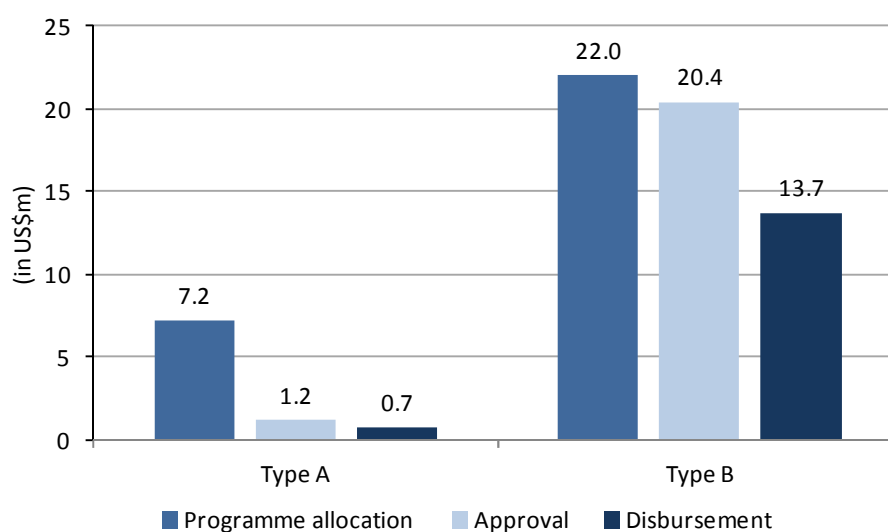
¹¹ GAVI Alliance (2007) “Guidelines for GAVI Alliance CSO Support: Support to Strengthen the Involvement of Civil Society Organisations in Immunisation and Related Health Services”.

¹² Eligible under GAVI Phase II.

¹³ Adapted from the GAVI CSO guidelines.

¹⁴ Ghana has received no disbursements to date. DRC, Ethiopia and Indonesia are awaiting disbursement of part of their approved funds.

Figure 1.1: Uptake of CSO Type A and B support (2008-11)^{15, 16}



Countries that have received Type A funding include Afghanistan, Democratic Republic of Congo (DRC), Ethiopia, Indonesia, Pakistan, Ghana, Cameroon, Burundi, Togo and Georgia. With the exception of Cameroon and Togo, these are also Type B pilot countries. Three of the ten Type B pilot countries have not received the support – Bolivia, Georgia and Mozambique.¹⁷

Both types of support were initially time-limited over 2007-09, and then extended until December 2010, given delays in implementation and poor uptake of Type A support. However, despite the extension, there have been no new approvals of Type A funding in 2010. On the other hand, a significant amount of Type B funding (US\$6.6m out of the total US\$22m commitment) had been approved in 2010.

Further extensions were introduced in 2011:

- For Type A support, an additional US\$460,938 (from the original commitment of US\$7.2m) was made available for the existing Type A beneficiary countries.¹⁸ Following a competitive process, the funds have been awarded to Afghanistan and Togo.
- For Type B support, US\$7.2m of ‘bridge financing’ has been approved to ensure that the programmes funded are not interrupted prior to the potential transition to the Health Systems Funding Platform (HSFP).¹⁹

¹⁵ The cut-off date for this evaluation has been agreed with GAVI as July 2011.

¹⁶ Source: Finance Data, July 2011 GAVI Alliance

¹⁷ Bolivia and Mozambique submitted Type B applications to GAVI but these were not approved/ taken forward.

¹⁸ The objective is to build on the CSO coordination and networking achieved through previous support.

¹⁹ The bridge funding is in addition to the original Type B commitment of US\$22m and has been approved for a period of 12 months. Governments need to submit ‘light touch’ proposals (as the original Type B proposal was only for two years) for which the Secretariat has delegated approval authority. All GAVI eligible pilot countries (excluding Indonesia) can apply for the ‘bridge funding’. Reference: GAVI Alliance Board meeting, 7-8 July 2011, Board Decisions.

1.3. Structure of the report

The report is structured as follows:

- Section 2 presents our evaluation framework, methods and limitations;
- Sections 3-5 present our evaluation of the policy rationale and programme design; implementation, and results of GAVI CSO support; and
- Section 6 concludes.

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

- Annex 1 provides a glossary of key terms used in the main report.
- Annex 2 presents the bibliography and data sources;
- Annex 3 provides the list of consultations conducted during the evaluation;
- Annex 4 presents the structured interview guides (for global consultees, country-level consultees and for comparator organisations);
- Annex 5 presents the e-survey questionnaire and our analysis of responses;
- Annex 6 provides information collated from country proposals and Annual Progress Reports (APRs);
- Annex 7 presents alternate CSO approaches of comparator organisations;
- Annex 8 presents a summary of key discussions at the GAVI Board and Programme and Policy Committee (PPC) meetings on the CSO support;
- Annex 9 provides a summary of meetings of the GAVI Civil Society Task Team, CSO Constituency, CSO Steering Committee, and Forum;
- Annex 10 sets out the previous evaluation recommendations and examines the progress made by GAVI in implementing them to date; and
- Annex 11 provides the rationale for country selection for our five country studies.

The country evaluation reports for Ethiopia, DRC, Indonesia, Pakistan, and Afghanistan are included as separate documents.

2. EVALUATION FRAMEWORK AND METHODS

2.1. Evaluation framework and questions

The evaluation is structured around three inter-related themes as follows:

- (i) **Policy rationale and programme design** – relevance and alignment of CSO support with GAVI’s objectives and country needs and the suitability of programme design.
- (ii) **Implementation of GAVI CSO support** – experience with implementation of the support, both at the global (i.e. Secretariat/ Partner roles and performance) and country level (i.e. execution of country proposals and activities).
- (iii) **Results of the programme** – an assessment of the outputs, and where possible outcomes, of the support to date and any unintended consequences.²⁰

Our evaluation approach takes into account that: (i) GAVI CSO support is a pilot programme, initially set up for the period 2007-09 (and subsequently extended to 2010, with further limited extensions in 2011); and (ii) some countries are currently implementing activities under the support, making it difficult to measure actual results. Therefore, our focus has been on reviewing the performance of the pilot, and assessing what aspects of the support have worked well, and what have not. As such, our emphasis has been on reviewing the ‘process’ of the support, and the immediate results (or outputs). It is not possible (or practical) to find evidence on results in many instances – however, we have sought to understand the ‘potential’ for results, where feasible.²¹

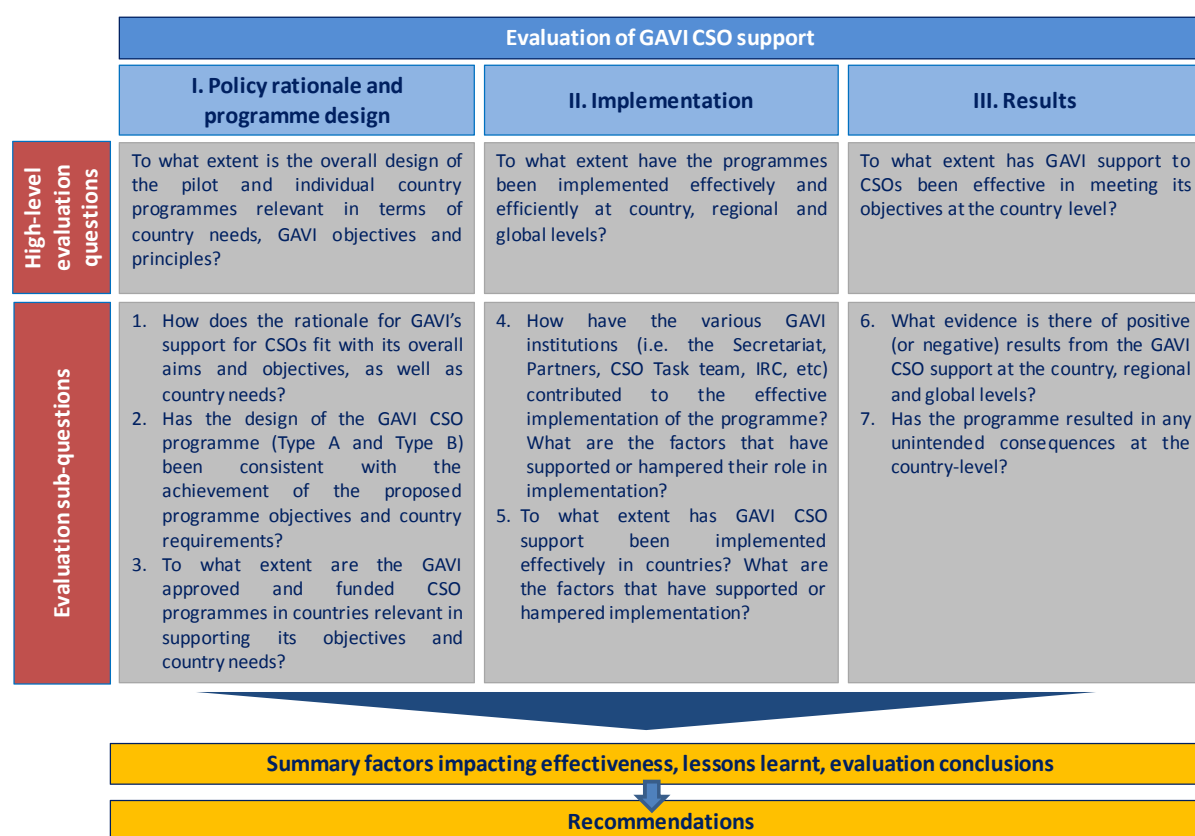
Figure 2.1 presents this framework and the detailed evaluation questions and sub-questions.²²

²⁰ Impact evaluation for the CSO programme is not feasible given the limited time for implementation of the funded activities and lack of a direct causal link with impacts such as improvements in mortality and morbidity.

²¹ This is in line with the proposals under several theory-based approaches to evaluation. See for example: Weiss, Carol H., “Theory-Based Evaluation: Theories of Change for Poverty Reduction Programs” Weiss, Carol H. (2000). “Theory-based evaluation: theories of change for poverty reduction programs.” In O. Feinstein and R. Picciotto (eds.), *Evaluation and Poverty Reduction*. Operations Evaluation Department, The World Bank, Washington, D.C.

²² These questions include the high-level questions proposed by GAVI as a part of the RFP.

Figure 2.1: Evaluation framework



We note that GAVI has commissioned this evaluation to assess the effectiveness of the programme, as the pilot draws to an end. However, previous reviews of the GAVI CSO programme (CEPA's second evaluation of GAVI and Eliot Putnam's review of Type A support) have covered substantial ground and the key issues facing the programme are well known. With this in mind, the objective of our evaluation has been to bring together the available evidence to present a comprehensive assessment of the programme. In addition, as part of this evaluation, we have reviewed Type B support in more detail than has been done before, and assessed the policy rationale for the programme. We have also drawn upon some country-level sources of evidence through five detailed country studies (earlier reviews of CSO support did not involve country studies). These country studies have added considerable insight on the functioning of the programme on ground. Combined with an extensive review of country proposals and APRs, they have enabled us to undertake a more detailed analysis of the implementation and results of the programme, than carried out previously.

2.2. Evaluation methods

We have employed a number of methods for this evaluation – key amongst these being the structured interviews and country studies. Given the nature of this evaluation – in that it is not amenable to data-based evaluation approaches – we have structured our consultations and country studies to be as comprehensive (as practicable) and representative of a mix of perspectives and circumstances. For example, in our interviews, we have sought to consult with a broad range of stakeholders for the GAVI CSO programme (global and country; those directly involved such as the Secretariat and the Independent Review Committee (IRC); and those with

broader perspectives (e.g. the Board and previous evaluators)). For the country studies, we have analysed countries with different types of health systems and those that have received both types of CSO support. In addition, we have also conducted an e-survey to add to the evidence base and reach out to a wider set of country stakeholders than possible through other evaluation methods.

A description of the evaluation methods and their limitations is provided below:

- *Desk-based review of documents.* This has included an extensive review of GAVI documentation on the CSO programme including relevant Board/ Committee/ Task Team papers, guidelines, country proposals, APRs and meeting notes as well as the broader literature on the role of CSOs in the health sector. Annex 2 provides a bibliography. The key limitation here has been the poor and variable quality of the country proposals and APRs, which has made analysis of the information very difficult (e.g. inconsistencies between proposals and APRs, and between subsequent APRs).
- *Data analysis.* This has included analysis of the trends in country approvals and disbursements, as well as available outputs and outcomes data (both from GAVI proposals and APRs as well as general health metrics). Annex 2 lists the data sets used. The above-noted limitation of the country proposals and APRs have restricted our analysis of results using data.
- *Comparator analysis.* We have reviewed the CSO support provided by comparable organisations. This has mainly been based on desk-based review of policy documents, along with some consultations. Comparators have been selected based on the extent to which they are actively involved in supporting CSOs in health (e.g. through specific windows of support, programmatic prioritisation, etc) and include: (i) Global Health Partnerships (GHPs), most notably the Global Fund – comparisons here are particularly instructive given the broader similarities in structure and funding mandate with GAVI – and Stop TB; (ii) bilaterals and multilaterals, including the UK Department for International Development (DFID), United States Agency for International Development (USAID), Swedish International Development Cooperation Agency (SIDA), Irish Aid, and the World Bank; and (iii) other donor/ philanthropy mechanisms for CSO support, most notably Tides²³.
- *Structured interviews.* Fact finding and evaluation interviews were conducted with various global stakeholders including the GAVI Secretariat, Board members, CSO Constituency members, GAVI IRC members, Regional Working Group (RWG) members and comparator organisations. In addition, we consulted with a number of country stakeholders such as government, CSOs, GAVI Partners (beyond the country studies described below) by telephone. Annexes 3 and 4 provide the list of consultations and interview guides. Key limitations include: lack of response from some of the contacted stakeholders (a few global-level potential consultees have not responded to our requests for consultation (despite repeated reminders) and some have declined to participate; in

²³ Tides provides management services for donor funds for CSOs and has partnered with some of the largest institutions in the philanthropic community including Ford Foundation, the Bill and Melinda Gates Foundation and the World Health Organisation.

addition, we have had limited response from country consultees contacted by telephone²⁴); biases in respondents' perceptions; and lack of knowledge on the GAVI CSO support.

- *Country studies.* Five country studies were carried out under this evaluation – Ethiopia, Indonesia, DRC, Afghanistan, and Pakistan.²⁵ These countries have been selected as they have been approved for both types of CSO support, with a sizeable proportion of their approved funding being disbursed²⁶ early on and hence they have had some time for implementation. In all countries, CEPA engaged local consultants to support the evaluation work. The evaluation team visited three of the five countries – Ethiopia, Indonesia, and DRC. For Afghanistan and Pakistan, local consultants developed the country evaluation report, with CEPA guidance and review. Stakeholders consulted included government, CSOs (both those that have received GAVI CSO support and those that have not), GAVI Partners, and in-country bilateral donors. The country study reports are included as separate documents. Key limitations include any country selection bias; incomplete coverage of stakeholders (although we have consulted with a wide group of stakeholders, some consultees might inevitably have not been covered); limited coverage of Type B supported sites; and biases in respondents' perceptions.
- *E-survey.* An evaluation e-survey was conducted with the purpose to (a) quantify views/ perspectives (where sensible) on the performance of the CSO programme; and (b) reach a larger audience than possible through the structured interviews and country visits. The survey was primarily targeted at GAVI eligible countries – both those that received and did not receive CSO support. We received a total of 203 responses, with 50% from CSOs²⁷, 23% from GAVI Partners, 16% from government, and 3% from donor organisations/ foundations. The remaining respondents (8%) were GAVI staff, health researchers and independent consultants, amongst others. Detailed results of the e-survey are presented in Annex 5. The key limitation of the e-survey is the poor quality of some of the qualitative responses (e.g. some responses are not directly relevant to the question at hand); concerns on the representativeness of the responses; and respondent fatigue/ potential misunderstanding of the questions.

These methods have been used for all three themes of our evaluation framework, albeit with some methods being more relevant for particular evaluation questions than others. For example, the country studies have provided more information on the programme implementation and results questions, as compared to the structured interviews.

In general, however, we have attempted to employ multiple methods for the analysis so as to enhance the strength of the conclusions (see Section 2.3 below). Where the evaluation methods have provided conflicting evidence/ opinions, we have stated this clearly in the report, along with CEPA's view on an appropriate conclusion. This is most often the case with interview

²⁴ In terms of country-level consultees, we have had some success with stakeholders in Mozambique, Georgia, Burundi and Togo. However, we did not hear back from Ghana, Bolivia, Cameroon and other GAVI eligible countries that have not received CSO support to date.

²⁵ The rationale for country selection is presented in Annex 11.

²⁶ At least one disbursement.

²⁷ 25% who have received GAVI CSO support and 25% who have not.

evidence, given differing views of the multiple stakeholders. For the country studies, where a particular finding is not common across all countries, we have highlighted this providing details on the specific example as relevant.

2.3. Assessment of strength of conclusions

Given the qualitative nature of this evaluation, we think that it is useful to assess the strength of our conclusions. This would enable GAVI to interpret our conclusions in a more balanced manner. Building on our approach in the GAVI second evaluation, we have sought to assign a ‘robustness score’ to the main findings, which summarises our judgement on the strength of the conclusion.

We define a three point scale (A-C) for the robustness scoring based on the:

- (i) quality of the evidence source (e.g. accuracy and completeness of information in the country proposals and APRs; and consultees’ knowledge about CSO support);
- (ii) degree of uniformity in the opinions of different stakeholder groups (e.g. whether the findings on a particular issue are supported by a majority view and/ or across evidence sources such as interviews, e-survey, etc.); and
- (iii) consistency in findings at the country level – allowing for differences in country context (predominantly based on the country studies and selected country consultations).

Table 2.1 defines the robustness scores. We have assessed the strength of the conclusions for each evaluation question, rather than for the specific issues analysed by question. In interpreting these scores, readers should note that these are **relative** rankings and are intended to provide an indicative assessment of the strength of a finding/ conclusion.

Table 2.1: Definition of robustness scores

Rank	Name	Description
A	Strong	<ul style="list-style-type: none"> • Supported consistently by the full range of evidence sources (i.e. good triangulation); and/ or • Evidence sources used are of high quality/ reliable (e.g. factual data or solid sample size); and/ or • Represents a broadly consistent finding across countries (accounting for different country contexts).
B	Medium	<ul style="list-style-type: none"> • Supported by more than one evidence source; and/ or • The quality of the underlying information is reasonable; and/ or • Represents a finding from some countries.
C	Weak	<ul style="list-style-type: none"> • Supported by one evidence source (i.e. no triangulation); and/ or • The quality of the underlying information is poor; and/ or • Finding is inconsistent across countries.

3. POLICY RATIONALE AND PROGRAMME DESIGN

The first pillar of our evaluation framework relates to policy rationale and programme design. The high-level evaluation question is as follows:

To what extent is the overall design of the pilot and individual country programmes relevant in terms of country needs, GAVI objectives and principles?

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

- How does the rationale for GAVI's support for CSOs fit with its overall aims and objectives, as well as country needs?
- Has the design of the GAVI CSO programme (Type A and B) been consistent with the achievement of the proposed programme objectives and country requirements?
- To what extent are the GAVI approved and funded CSO programmes in countries relevant in supporting its objectives and country needs?

We present below our analysis and findings on the policy rationale (Section 3.1) and programme design (Section 3.2) of GAVI CSO support. Each of the above sub-questions are considered, presented by key theme or issue.

3.1. Policy rationale

3.1.1. Relevance of GAVI's support to CSOs

In our view, GAVI's CSO programme is relevant to its overall objective of increasing access to immunisation and also in relation to country needs. This view is widely supported, as indicated by the consultation feedback and the overwhelmingly large number of e-survey respondents that have agreed with the statement "*GAVI's support to CSOs fits well with the organisation's overall objective of increasing access to immunisation in the world's poorest countries*". However, the *extent* of relevance varies according to specific country circumstances.

While CSOs play an important role in country health systems in general²⁸, the case of immunisation is somewhat different:

- First, immunisation has predominantly been a government-led intervention through the Expanded Programme for Immunisation (EPI) – the delivery of vaccines in particular has been through the public sector.²⁹
- Second, as a result of this, the role of CSOs and their capacity to support immunisation have varied based on whether governments have been able to provide EPI to their entire populations. Where government systems are weak/ absent, CSOs play a vital role, including in the delivery of vaccines. In some countries though, where CSOs may be involved in delivering vaccines to some parts of the population, this is often not

²⁸ Apart from a few ex-Soviet countries, where CSOs are mostly non-existent.

²⁹ This is not the case for other health sector interventions such as HIV/AIDS, where for example, CSOs play an important role in encouraging the use of preventative measures such as condoms and distributing them.

recognised as such and included as part of public sector immunisation. However, in most countries, the role of CSOs has focused on ‘demand creation’ (e.g. community mobilisation, advocacy) and/ or complementing government efforts by providing supporting services to strengthen health systems for immunisation (e.g. training of health workers, technical assistance, provision of equipment or supplies, etc.).

Figure 3.1 illustrates the varying country contexts in the five countries studied for this evaluation. As can be seen from the figure, CSO roles have evolved differently based on the country status and role/ capacity of the governments in EPI.

Figure 3.1: Differing country contexts^{30,31}

Country context criteria		Afghanistan	DRC	Ethiopia	Indonesia	Pakistan
COUNTRY & EPI STATUS	Country income and governance status	<ul style="list-style-type: none"> • LDC • Very low HDI • Fragile 	<ul style="list-style-type: none"> • LDC • Very low HDI • Fragile 	<ul style="list-style-type: none"> • LDC • Very low HDI 	<ul style="list-style-type: none"> • LMIC • Medium HDI 	<ul style="list-style-type: none"> • LMIC • Low HDI • Security challenges
	EPI status and govt. role	<ul style="list-style-type: none"> • Weak status; health services contracted out by Govt to NGOs 	<ul style="list-style-type: none"> • Weak status; limited Govt capacity; highly dependent on donor support (over 90%) 	<ul style="list-style-type: none"> • Mostly Govt dominated; largely externally funded; some key gaps in imm. systems 	<ul style="list-style-type: none"> • Relatively stronger & better funded; but impacted by recent decentralisation 	<ul style="list-style-type: none"> • Primarily Govt delivered; recently health has been devolved to provinces
ROLE OF CSOs	Extent of development of CSO community	<ul style="list-style-type: none"> • Number of international and local CSOs active in health sector including in immunisation 	<ul style="list-style-type: none"> • Modest but growing role of CSOs; with GAVI support CSOs active in at least 42 of 515 health zones 	<ul style="list-style-type: none"> • Number of CSOs active in MCH; coordination through umbrella bodies 	<ul style="list-style-type: none"> • Disparate CSOs across country working on MCH; no coordination mechanism 	<ul style="list-style-type: none"> • Number of local and international CSOs active in health, MCH and imm.
	CSO roles in imm.	<ul style="list-style-type: none"> • Service delivery, including planning & supervision • Advocacy • Community mobilisation • Health systems strengthening for immunisation 	<ul style="list-style-type: none"> • Service delivery • Advocacy • Community mobilisation • Health systems strengthening for immunisation 	<ul style="list-style-type: none"> • Community mobilisation • Supporting public health systems • Marginal role in service delivery in hard to reach areas 	<ul style="list-style-type: none"> • Community mobilisation 	<ul style="list-style-type: none"> • Advocacy • Community mobilisation • Health systems strengthening for immunisation • Service delivery

Our analysis suggests that CSO support is *strongly* relevant to GAVI’s objective of increasing immunisation access in countries where government delivery channels are weak/ non-existent – such as in some fragile and conflict/ post-conflict countries. Here, CSOs are (most often) engaged in the delivery of vaccines, establishing a direct link with GAVI’s immunisation objective. In addition, their complementary role in supporting health systems is integral to achieving immunisation outcomes – as the government system on its own may not be able to achieve the country’s immunisation targets. Afghanistan and DRC are good examples.

³⁰ Acronyms/ abbreviations used in the figure: LDC (Least Developed Country); LMIC (Low Middle Income Country); HDI (Human Development Index); MCH (Maternal and Child Health); Govt (government); imm (immunisation).

³¹ Country income status based on DAC criteria for ODA recipients (<http://www.oecd.org/dataoecd/9/50/48858205.pdf>); HDI status is for 2011 (<http://hdr.undp.org/en/statistics/>); governance status based on previous GAVI co-financing categories (Phase II).

In other countries where the public sector is functioning as the principal mode of delivery for immunising children, CSOs, through their demand creation or immunisation supporting/complementary roles, indirectly serve GAVI's objective. Here, many countries have expressed that CSO support is relatively less significant, given the many gaps/ priorities facing the country immunisation systems. Nonetheless, in these countries, CSOs may have a limited but important role in delivering vaccines to hard-to-reach areas or neglected population groups, helping to enhance equity of coverage. Also, their complementary support contributes to strengthening the capacity of country health systems to deliver immunisation and other health services.³²

Since the nature of CSO roles differ across countries, there is merit in a case by case consideration of the specific country circumstances to determine the extent to which they are 'essential' to supporting improvements in immunisation coverage. Arguably, given the EPI context, GAVI's support to CSOs is more relevant in Pakistan or Ethiopia than Indonesia (where its relevance is at best *weak*).

3.1.2. Relevance of Type A and B support

Conceptually, both forms of GAVI's CSO support are relevant to the objectives of GAVI and country needs. The GAVI Board paper on the introduction of the support³³ notes its basic premise:

- there is little information on CSOs involved with immunisation at the country level, and their representation on the Inter-agency Coordinating Committees (ICCs) has predominantly focused on organisations involved with polio and measles (i.e. rationale for Type A support); and
- CSOs can add value and complement the goals, objectives and activities of the immunisation cMYP and/ or the HSS proposal (i.e. rationale for Type B support).

However, in practice, the relevance of the two forms of support has varied across countries.

Type A mapping exercise

Countries have generally found the concept of the CSO mapping exercise useful, although this is regarded as more important in countries where CSOs are involved in supporting immunisation (e.g. Afghanistan). Information on the number and type of CSOs, their expertise, capacity and geographic focus is expected to help governments (and donors) coordinate better with CSOs in the country to deliver health objectives. The relevance of the mapping exercise is also reflected by the fact that many countries have attempted to carry out this mapping previously but have not succeeded – for example, Ethiopia and Ghana.³⁴

³² The CSO programme was conceived to be a part of GAVI's Strategic Goal 1 in Phase II: "*to contribute to strengthening the capacity of country health systems to deliver immunisation and other health services in a sustainable manner.*"

³³ "Enhancing civil society participation in the GAVI Alliance", GAVI Alliance Board Meeting, 29 November 2006, Doc A.2 – Civil Society in the GAVI Alliance.

³⁴ The mapping exercise has not been completed in Ethiopia as they have not been able to source a suitable consultant for the available funds. In addition, some country stakeholders have suggested that the recent CSO Law enacted in Ethiopia has created an environment wherein the government was 'hesitant' to undertake this exercise, as it did not want to appear to be 'controlling' the CSOs by instituting a mapping exercise. However, in general, the mapping exercise has been regarded as important by the country stakeholders consulted.

However, some other countries have noted that information on CSOs is readily available through the country CSO registration authorities and/ or CSO associations (where they exist) – as is the case for most PAHO and SEARO countries. Type A mapping support is therefore not relevant in these countries.

Type A nomination of CSOs to country planning and coordination bodies

The relevance of this particular form of Type A support varies by country:

- In most countries, CSOs are already represented on the Health Sector Coordination Committee (HSCC)/ ICC prior to GAVI's CSO support. Eight of the ten Type A supported countries (excluding Pakistan and Indonesia) state in their proposals that CSOs are members of these bodies.³⁵ This includes participation from both international and indigenous or umbrella CSO groups. Some of these have a polio focus, although it is not possible to confirm the focus of all member CSOs, based on the proposal and APR information. Further, in some countries, the HSCC/ ICC are poorly functioning bodies and hence representation (at this stage at least) has limited value (Ethiopia and Indonesia are examples). In these countries, the nomination exercise is not so relevant.
- In a few other countries (e.g. Pakistan), CSOs have previously not been involved in the HSCC/ ICC, and their nomination will provide them with a greater 'voice' as well as benefit the HSCC/ ICC through access to CSO perspectives and experience.

E-survey responses indicate that one of the reasons why countries did not apply for the funding (particularly Type A support, given that Type B support was only available to 10 pilot countries) is because they do not view the support as being relevant.

Type B support

Given the flexibility of Type B funding, it has supported both the demand creation and delivery (i.e. delivery of vaccines and complementary health systems activities) roles of CSOs in countries.³⁶ The degree to which the activities supported have been relevant varies based on the country context and strength of the EPI.

There is an argument that the value of Type B support is limited by not funding the 'watch-dog' role of CSOs that seeks to improve accountability of government delivery systems. However, in our assessment, this restriction on the use of Type B support is reasonable given: (a) potential conflict with GAVI's mandate and model of working with/ through government EPI systems; and (b) other forms of accountability/ performance management mechanisms used by GAVI

³⁵ The proposals of two countries – Ghana and Togo - provide information only on their HSCC constitution and hence CSO membership cannot be confirmed for the ICC.

³⁶ In some countries, funding has been provided to non-governmental academic institutions for research, data collection and capacity building. For example, the Aga Khan University in Pakistan received funds to provide evidence based estimates of the burden of vaccine preventable infections for rotavirus and measles in rural and urban areas of Sindh.

(such as results-based funding, independent monitoring and evaluation (M&E) studies) which seek to ensure that EPI systems meet defined coverage targets.³⁷

3.2. Programme design

This section provides an assessment of key aspects of the programme design including: (i) suitability of programme objectives; (ii) programme structure (e.g. pilot nature, size of funding, flexible nature); (iii) approach to channelling of funds; and (iv) synergy and alignment with the GAVI HSS window.

3.2.1. Programme objectives and intended results

A fundamental design issue with GAVI CSO support has been the lack of clarity on the programme objectives and intended results.

The programme recognises the role of CSOs in public health and immunisation. However, there is a tenuous link between the stated aims of the support and GAVI's objective of improving access to immunisation.³⁸ The 'theory of change' for the programme has not been clearly defined, especially given the heterogeneity in country contexts and role of CSOs.

In our judgement, there is considerable ambiguity on what the programme seeks to achieve. For example, it is not evident whether the programme aims to increase immunisation coverage or enhance the capacity and recognition of CSO contributions to health systems/ immunisation.³⁹ It is not clear how GAVI aims to encourage the development of the role of CSOs and their improved coordination with the government in different types of country health settings/ systems, especially as the relative role and capacities of the public sector in immunisation service delivery vary by country – this has been consistently echoed by global and country stakeholders. However, we note that the recent Type A extension application forms (vis-à-vis the older forms) require stronger linkages to be demonstrated between any proposed activity and their contribution to stronger health systems and immunisation delivery. We view this as a positive development in terms of clarifying the intent of the support. However, this refined objective of the Type A extension has arguably brought the support closer to Type B activities, since a few of the proposed activities go beyond strengthening CSO partnerships and networks to improving CSO capacity.⁴⁰

³⁷ The 'watch-dog' role at the global level is undertaken in some measure through the work of the Steering Committee and broader CSO constituency.

³⁸ The aim of the CSO programme as noted in the GAVI guidelines is to: "...build sustainability at a country level by involving local civil society organisations in the planning and delivery of immunisation, child and other health services, and encouraging cooperation and coordination of efforts between public sector and civil society". GAVI Alliance (2007) "Guidelines for GAVI Alliance CSO Support: Support to Strengthen the Involvement of Civil Society Organisations in Immunisation and Related Health Services".

³⁹ Many CSOs in Pakistan were unsure if an increase in immunisation coverage was the overall objective of the support. One CSO wanted to design a programme for prevention of maternal to child transmission of HIV as they thought it was within the remit of GAVI CSO support. In Ethiopia and Indonesia, the aims of the programme were considered to be too broad and loosely defined, whereby it was not clear how any supported CSO activity might translate into tangible immunisation-related outcomes.

⁴⁰ Annex 6 summarises the aims and activities included in the new Type A extension proposals for Afghanistan and Togo. Some proposed activities for Togo (e.g. training CSOs, monitoring CSOs involved in the HSS programme) are similar in nature to Type B support.

Another related but major issue is that the programme does not have a prospectively defined results framework setting out the desired outputs, outcomes and impacts of Type A and B support. A detailed risk analysis on factors that could affect results has also not been carried out. The GAVI Strategy 2007-10⁴¹ and the 2011-15 Strategy⁴² do not set out outcome/ impact indicators for the CSO programme (although the 2011-2015 Strategy does have some goal-level indicators). A CSO programme ‘monitoring and evaluability study’ commissioned by GAVI in 2008 has also not been implemented. The absence of clear direction/ targets for the programme has considerably weakened the capacity for M&E and results.

3.2.2. Programme structure

We consider a number of features of the programme structure below.

Pilot nature

GAVI CSO support was set up as a pilot programme, initially for the period 2007-09 and subsequently extended to 2010, with further extensions in 2011. Since the CSO programme was a new form of support for GAVI, the pilot approach has been viewed favourably. In theory, the pilot (if implemented properly) could enable course correction based on operational lessons learnt, as GAVI decided how to scale up its support.

However, the pilot nature of the programme has posed some issues at the country level:

- The two year window is too short for CSOs to design and implement their activities. Delays in disbursement have further restricted this window, particularly impacting Type B implementation.
- The transition plan after the pilot period has not been considered by GAVI in advance, adversely affecting the predictability and sustainability of the support. While the Type A extension and bridge financing for Type B have been recently instituted, countries are still uncertain on the future of GAVI CSO support.

Definition of CSO

GAVI has adopted a very wide definition of CSOs. As noted in the programme guidelines, CSOs include “organisations with aims consistent with the spirit and purpose of the GAVI Alliance, focused on immunisation, child health, and health systems strengthening”. As a consultee noted, with this definition, almost all organisations in a country could qualify for GAVI CSO support.

While a wide definition allows for country specificities to be incorporated into the programme, it has caused further ambiguity on the objectives and remit of the programme. For example,

⁴¹ The CSO indicators included in the 2007-10 Strategy are all related to programme inputs and processes. These include: (a) mechanisms for proposed Civil Society window operational by 2007; (b) percentage of total ‘Type A’ Civil Society funds disbursed; (c) percentage of total ‘Type B’ Civil Society funds disbursed to ten pilot countries; and (d) M&E research framework for impact assessment of CSO support developed and lessons learned disseminated and used to inform practice.

⁴² The GAVI 2011-15 strategy also does not provide clarity on the expectations of CSO support, stating that the strategic objective of CSO support is to “strengthen CSO engagement in the health sector”.

GAVI's definition includes academic institutions and even health consultancies, but it is not clear how these would contribute to increased immunisation.

Structuring two separate windows for Type A and B

Two separate streams of funding for Type A and B support, with separate proposal, approval and disbursement processes, have been considered inefficient as it has led to higher complexity and transaction costs for all the concerned parties (countries, CSOs, GAVI, Partners). This is particularly the case given the small size of the programme and its original window of two years.

The link between the two types of support is evident from the fact that only Type B support countries applied for Type A support, with the exception of Togo and Cameroon.⁴³

Sequencing of support

Type A and B support have been made available to eligible countries in no particular order. However sequencing the support, by providing funds for the CSO mapping and nomination first, followed by Type B support would have been more sensible. This would have allowed for the identification of relevant CSOs in the country, who could then have been appraised for Type B funding. The implementation of Type B support in DRC faced this problem, where the initial selection of CSOs for Type B support (undertaken prior to the Type A mapping exercise) did not work well. Based on the mapping report, the government then re-selected CSOs with a stronger local network to carry out the proposed Type B activities.

Overall budget and size of funding

The overall budget for the CSO support is small⁴⁴, although it is arguably appropriate for a pilot.⁴⁵ We have received mixed feedback on the suitability of the size of the Type A and B support.

- For Type A support, some countries have completed their mapping exercise with the available funds (e.g. DRC, Pakistan, Indonesia), whereas others have not (e.g. Ethiopia). However, most countries note that the mapping exercise has not been comprehensive enough – with insufficient funds cited as a key reason.⁴⁶ The limited amount of funding available has also disincentivised uptake of this support. In addition, while the allocation of Type A funds to countries based on their birth cohort ensures a 'fair' approach for countries, it is: (i) not related to the activities being funded; and (ii) does not take into account disparities in costs of activities across countries. Hence, in our view, this criteria is not suitable.

⁴³ We understand that Togo's political will and leadership in the government motivated them to map CSOs to improve their joint working with Government, as also the expectation to apply for Type B support, when it opens up to other GAVI countries. Cameroon undertook the Type A mapping, in readiness to apply for Type B CSO support in the future. (Source: CEPA's work during the GAVI second evaluation)

⁴⁴ Less than 0.5% of GAVI's total programme outlay. GAVI Alliance (2010) GAVI Alliance Progress Report.

⁴⁵ One of the comments to this question states that: "the size of funding dedicated to CSOs should reflect their contribution to immunisation programmes, which varies by country. Where CSOs play a major role, the size of funding has been inadequate. Where CSOs do not play a big role, too much funding may distort health budgets and undermine government immunisation programmes."

⁴⁶ Others include time availability, difficulties due to geography, etc.

- There has been considerable variation in the size of Type B grants by CSO and by country (see Table 3.1). The smallest grant has been under \$60,000, and the largest over \$1.5m. In most countries, 1-2 CSOs have received a larger share of resources.

Table 3.1: Summary of Type B funding to CSOs⁴⁷

Indicator	Afghanistan	DRC	Ethiopia	Indonesia	Pakistan
Smallest grant to a CSO	\$282,575	\$165,562	\$209,462	\$225,201	\$59,421
Largest grant to a CSO	\$427,700	\$1,535,920	\$1,715,094 ⁴⁸	\$1,428,000 ⁴⁹	\$541,861
Average grant size	\$332,854	\$908,501	\$606,630	\$861,664	\$202,670

Based on feedback, our view is that the Type B grant size is typically suited for the proposed activities, but can support only a small project area with localised results. However, we have received feedback from some CSOs (particularly international CSOs) that the funding has not been sufficient to cover their management and administration costs. These CSOs have noted that there is no provision for vehicles or human resource compensation in the grant (i.e. the focus is on the activities) and hence they have had to subsidise the costs of administering GAVI grants through the funds available from other donors. They have also commented that they have applied for the CSO funding for ‘network building with GAVI rather than for the money itself’.

Similar to Type A, the rationale for allocating Type B funds to countries based on the number of children not immunised and UN country status does not take into account country specificities and cost differences, although the criteria are arguably better suited to the types of activities funded.

Flexibility in grants and programme design

Flexibility of Type B funding has the advantage of allowing countries to tailor programme activities according to their/ CSO needs. However, country governments have noted that given their inexperience in structuring and funding a CSO programme, it would have been useful if GAVI had provided some additional guidance on how the support could be used – especially in the context of poorly defined objectives of the programme.

For Type A support, while the activities have been pre-defined by GAVI, countries have noted that they would have benefitted from more guidance on how to carry out a mapping exercise and the appropriate processes for nominating CSOs.

In addition, the programme has been designed with limited flexibility for mid-course correction. For example, in Indonesia, the originally selected CSOs were replaced, however the new CSOs were required to take up the same proposed activities by GAVI, even though they were not perfectly aligned with their areas of work (and the timeframes had shifted on account of the change of CSOs). Further, the CSOs are facing some issues with achieving their targets due to changes in circumstances.

⁴⁷ Source: Proposals for all countries are included in this table, except Pakistan. For Pakistan, the country proposal does not provide allocation by CSO and this has been obtained from additional information provided by the Secretariat. However, there are some inconsistencies in the data, and we have not been able to resolve these.

⁴⁸ This amount is allocated to one CSO that has seven sub-recipient CSOs.

⁴⁹ This amount is allocated to a consortium of three CSOs.

It can be argued, that within reason and allowing for speedy approval by GAVI and the government, it would make sense to include some simple and efficient mechanisms to allow for reasonable changes to be made to programme activities – in the event that there are any major issues/ course correction is required.

Selection of Type B pilot countries

In our view, the selection criteria⁵⁰ and the choice of the pilot countries, whilst ensuring a mix of country and CSO contexts, were not very appropriate. Given the limited programme budget and the need to demonstrate results, the selection could have been more strategic. In other words, the specific role of CSOs in immunisation/ health systems in the countries vis-à-vis GAVI's immunisation objectives could have been better pre-examined to ensure that the support is relevant both from the country's and GAVI's perspectives. The case of fragile/ crisis countries, where CSOs play a central role in immunisation service delivery, is a good example here.

Also, some basic filters in selection could have been employed – such as whether CSOs play a key role in immunisation and related health systems (e.g. Georgia may not have been selected), or whether the government and other agencies in country would encourage GAVI to support CSOs (e.g. Bolivia may not have been selected).

Application and monitoring requirements and GAVI forms

The application and monitoring requirements have been viewed as cumbersome by many global stakeholders, especially in proportion to the small size of funding. However, our country consultations did not suggest any issue and in fact found broad acceptance of the application and monitoring requirements (although this feedback has been from countries that have received both forms of support). The e-survey results indicate that programme proposal and reporting requirements are considered appropriate (a majority of respondents 'strongly agree' or 'agree' on their appropriateness).

However, several countries (for example, Ethiopia, Indonesia and Mozambique) commented that the time provided for proposal submissions was inadequate.⁵¹

CEPA's assessment is that given: (i) the small value of grants; and (ii) that, unlike other GAVI windows, this support involves interaction and information exchange with government and CSOs, the support could have benefitted from simpler/ streamlined proposal and reporting requirements. For example, the new Type A extension proposal format is reduced in length and sets out a logical set of questions to be completed by countries (background and updates, objectives and activities, and M&E). Importantly, the APR format is not conducive for programme monitoring and results measurement, with essential information such as use of funds by activity not being collected.

⁵⁰ The pilot country selection criteria were high numbers of un-immunised children; varying degrees of functioning CSO network; harmonisation with other GHPs' HSS support countries; and geographic diversity but focus on Sub-Saharan Africa (5 on the list); fragile states (3 on the list); and Francophone countries (2 on the list). GAVI (2007) "Guidelines of GAVI Alliance CSO support".

⁵¹ Some CSO representatives in country also mentioned that they attended the introductory meeting on the GAVI CSO support but then could not apply as the timelines for proposal submission were too tight.

As previously noted, the new Type A extension application forms are a considerable improvement over the previous format (e.g. reduced length, clarity in requested information, etc.). The quality of the proposals is also greatly improved, for example, there are clearer links between programme activities and outputs.

3.2.3. Approach to channelling of funds

GAVI's approach to channelling funds for CSO support has primarily been through country governments. Where this has not been feasible, funds have been routed through the GAVI Partners in country for an additional management cost (e.g. in Pakistan and Afghanistan). Whilst this is in line with GAVI's model of working with/ through country governments, it has been raised as a key issue by a number of global stakeholders on account of the nature of CSO-government relations in countries wherein governments may lack motivation to support CSOs; and government bureaucracy may result in delays in fund disbursements to CSOs.⁵²

Our interviews in countries, however, suggest a mix of experience in practice.⁵³ In Ethiopia, Indonesia and Burundi, routing funds through governments has worked reasonably well. For example, the Ethiopian government disbursed funds to CSOs soon after receipt from GAVI.⁵⁴ The government and CSOs in these countries appear to have a good working relationship, and neither party highlighted any specific issues with this approach. Rather, it was noted that channelling funds through governments is beneficial as it ensures⁵⁵:

- ownership by the government, which facilitates operations at the local level where CSOs need the governments' cooperation to implement their programmes;
- coordination with government activity, which is relevant in the context of the government-led nature of immunisation and complementary roles of CSOs; and
- increased accountability.

Some of the CSOs (at global and country level) noted that a challenge in being funded directly is that they may not have the capacity or resources to meet the financial and M&E reporting requirements of GAVI. Rather, they prefer working through the government who is better placed to coordinate and report to GAVI.

In DRC however, while government and CSOs have a reasonably good working relationship, channelling funds through the government has been very inefficient, leading to large delays in fund disbursements to the CSOs (there was an initial delay on five months in government

⁵² In some countries, channelling funds through governments also has tax implications. For example in Georgia, government pay-outs are taxed, reducing the support to CSOs. In Indonesia however, funds routed via government are tax free (otherwise subject to local tax).

⁵³ Except in Pakistan's case where funds are channelled through UNICEF and the recent devolution of the MOH to provinces and the prevailing uncertainty regarding EPI makes channelling funds via the government impractical.

⁵⁴ We do not have information on the precise time period for transfer of funds to CSOs, but understand that this was fairly efficiently done.

⁵⁵ There have however been some delays in the disbursement of funds from governments to CSOs. For example, in Indonesia we understand that the government is trying to streamline its disbursement procedures. Other issues include strict and frequent reporting requirements by the government and a high degree of government involvement in programme implementation – both resulting in additional costs to the CSOs. For example, in Indonesia, some CSOs noted that they are obliged to invite government representatives to all programme activities and pay for their transport and per diem costs – we note that this may have added benefits as well as costs.

disbursement of funds to CSOs and a further delay in the disbursement of the second tranche which took around 18 months on account of GAVI, government and country-specific issues).^{56,57} It has been noted that in fragile/ conflict countries, governments may not have sufficient capacity to serve as the most effective mechanism for fund channelling. In Indonesia, while the approach of channelling funds through the government was supported by most stakeholders, delays of nine and three months were incurred in the two successive tranches of funding from government to CSOs. For the first tranche, the government faced political pressure when transferring external resources to CSOs and wanted to develop a grant implementation manual before the transfer of funds. For the second tranche, the delay was due to the replacement of staff appointed by the government to manage the CSO grant.

Thus, GAVI's approach to channelling funds has worked in some country contexts, but has been more problematic in others. Findings from the e-survey also suggest a mix of views on whether this approach works well or not – with an almost equal number of responses agreeing, disagreeing and having neutral views on this issue. Not surprisingly, CSOs are mostly against GAVI's current approach, while country government officials and GAVI Partners are supportive of this approach.

We note that GAVI's approach to funding is quite different from that followed by other GHPs and bilateral organisations (see Box 3.1 below), where CSOs usually receive funding directly from donor organisations.

Box 3.1: Lessons from alternate approaches to funding CSOs⁵⁸

Several GHPs and bilateral organisations have engaged with and directly funded CSOs for a number of years. However, our understanding is that a majority of their funding (but not exclusively) has been provided to large international CSOs who often sub-contract smaller/ local CSOs for implementation. For example, the Global Fund provides direct support to CSOs (currently about 40% of their grants). These grants are mostly US\$20m+ in size, and have been awarded mainly to international CSOs (acting as Principal Recipients (PRs)) who have a number of local CSOs as sub-recipients (SRs) for the grant.

Discussions with some GHPs and bilaterals suggest that, in their experience, direct funding to CSOs has been effective. The Global Fund experience reveals that CSOs are effective implementers and have received the largest percentage of the highest performance ratings, in comparison to other entities involved in grant implementation.⁵⁹ However, the five year Global Fund evaluation report points out that “CSOs at sub-recipient level have their own capacity limitations with respect to scale of grants” and hence require capacity building for financial management and M&E.⁶⁰

Another approach to funding CSOs has been through contracting Management Agents. For example, USAID often engages John Snow, Inc. (JSI) or Jhpiego in countries, who then channel funds to local CSOs and other organisations. Other bilaterals have also followed this approach (e.g. Irish Aid in

⁵⁶ We note here that an aide memoire has been signed indicating that GAVI can directly transfer funds to CSOs.

⁵⁷ The first tranche of \$2.9 million for Type B activity, disbursed by GAVI in April 2008, was stuck for months in the MoH system, and when released was reduced by \$35,000 in fees. A similar issue was faced for the second disbursement, where delays were on account of GAVI's TAP/FMA checks, GAVI's rejection of the proposed fiduciary agent for transfer of funds to CSOs and financial issues in the country.

⁵⁸ The information contained here draws on our consultations with comparator organisations as well as in-country consultations with donors during the field visits.

⁵⁹ Year-end figures from 2006 show that 83% of civil society PRs were A or B-1 rated. Grants are rated on the scale of A (meets or exceeds expectations), B1 (moderate), B2 (inadequate but potential demonstrated), and C (unacceptable).

⁶⁰ Macro International Inc. (2009), “The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Synthesis of Study Areas 1, 2 and 3”.

Ethiopia). This allows the bilateral to fund local CSOs but avoids additional burden on their limited capacity to engage with multiple small grant recipients.

CSO support by GHPs/ bilaterals has often included technical assistance (TA) to CSOs. For example, as part of the Global Fund support in Indonesia, UNDP provides TA services to both government and CSOs for effective grant management (being appointed by the country PRs and not The Global Fund).⁶¹ We understand that the focus of the TA for government is primarily on grant management (e.g. financial management, procurement, supply management), while for CSOs, the support also extends to programmatic support and human resources (HR) management; and both grant recipients are performing well. Our view based on discussions with UNDP, is that this model of providing TA to support grant recipients presents a useful approach for more effective grant management, especially when funds are routed directly to CSOs.

Partly in response to criticism for this approach, GAVI has, for the first time, approved the direct transfer of funds to CSOs in Afghanistan and Togo for the Type A extension funding in 2011. These were requested by the HSCCs in these countries. Direct funding has involved additional effort and costs for GAVI in undertaking fiduciary and financial management checks on the beneficiary CSOs. In our view, this departure from GAVI's model of working through governments and the implications for changes in its systems/ management overheads need to be justified vis-à-vis the additional benefit of funding CSOs directly (assuming this is based on exceptional country-driven requests).

In general, CEPA's view is that channelling funds through the government is an appropriate 'default' approach, although similar to the current situation, there should be some flexibility for routing funds through alternative approaches (e.g. GAVI Partners, CSOs that have passed GAVI's financial/ fiduciary checks) when the government channel is not appropriate.

3.2.4. Synergy and alignment with the HSS window

A central objective of the Type B support is to "help implement GAVI HSS proposals or cMYPs". It was expected that HSS support would be enhanced by identifying and involving CSOs as promoters of immunisation programmes at the community level and as supporters of EPI activities in health zones targeted for HSS support. The broader aim, of course, is greater utilisation of immunisation services and increased coverage.

Evidence from our evaluation indicates that this has not been consistently achieved across the supported countries. For example:

- Mapping exercises supported with Type A funding have led to the identification of CSOs with strong community links, dedicated to promoting immunisation programmes and developing related health systems (such as in DRC and Pakistan).
- The objectives of the HSS programme and Type B support are aligned by definition, with the Type B funding designed to support the country HSS plans. However, the synergies between the two windows have been less consistent in terms of implementation:

⁶¹ Another interesting aspect of the GF grant is that CSOs have become PRs only recently, and were previously sub-recipients to the government PR. This has helped build capacity and experience amongst the CSOs on fund management.

- In DRC, for example, the GAVI-supported CSO consortium is providing various types of capacity building support to CSOs in 42 health zones, but only 11 of those zones are also beneficiaries of GAVI HSS assistance.
- In Indonesia, while the target areas and interventions are the same for both GAVI CSO and GAVI HSS support, the implementation timings have not been aligned.
- In Pakistan, CSO funds were channelled through UNICEF and the Pakistan EPI, while HSS funds were disbursed to the Ministry of Health (MoH) (outside of the EPI), reducing the extent of coordination between the two.

3.3. Key findings on policy rationale and programme design

Table 3.2 provides a summary of the main findings on this evaluation theme, as well as our view on the strength of the conclusions.

Table 3.2: Summary findings on policy rationale and programme design

Area	Key findings ⁶²
Policy rationale	± GAVI's CSO support is relevant to achieve its immunisation objectives and meet country needs, but the extent of relevance varies by country context and the strength of the EPI system.
Programme design	<ul style="list-style-type: none"> – There is a lack of clarity on programme objectives and the intended results framework has not been defined. – The structuring of Type A and B as two windows of support (and separate from the synergistic HSS programme) is inefficient. Their sequencing has often not been logical – Type A should precede Type B support. – There is considerable potential for coordination between GAVI CSO and HSS support, but in practice, there has been limited synergy in implementation. ± The adequacy of the size of funding for Type A and B support has varied by country/ activities supported. ± GAVI's approach of channelling CSO funds through country governments, while subject to a lot of criticism, has not worked badly for some countries.
<p>Strength of conclusions: Robustness rating: 'A'</p> <p>Our conclusions on the policy rationale and programme design are relatively 'strong', given what we regard as a high quality and generally consistent evidence base for our findings on this theme, including well informed views from global consultations, e-survey results, and practical feedback from countries studied.</p>	

⁶² Findings have been marked according to whether they are positive (+), negative (-) or mixed (±).

4. IMPLEMENTATION

The second theme of our evaluation framework focuses on the implementation of CSO support. We look at two aspects of implementation namely, the role of the GAVI institutions such as the Secretariat and Partners; and how the programme has been implemented in countries.

The high-level evaluation question and detailed sub-questions are presented below.

To what extent have the programmes been implemented effectively and efficiently at country, regional and global levels?

- How have the various GAVI institutions (i.e. the Secretariat, Partners, CSO Task team, IRC, etc) contributed to the effective implementation of the programme? What are the factors that have supported or hampered their role in implementation?
- To what extent has GAVI CSO support been implemented effectively in countries? What are the factors that have supported or hampered implementation?

We consider these questions in turn below, with Section 4.1 focusing on the role of the GAVI institutions and Section 4.2 on country implementation.

4.1. Role of GAVI institutions

We examine the role and contribution of each of the GAVI institutions in supporting the implementation of Type A and B support.

4.1.1. GAVI Secretariat

GAVI's 'lean model' of delivering its programmes through a Geneva-based Secretariat and in-country support from its Alliance Partners (such as WHO and UNICEF) is part of its 'value add'.⁶³ However, we have found this structure to be less than adequate for the CSO programme. While the majority of e-survey responses agreed with the statement: "*GAVI's delivery model is suitable for supporting the implementation of the CSO programme*", an overwhelming majority of our telephone interviews and feedback from country visits highlighted issues with GAVI's 'remote' model for supporting the CSO programme.

The reasons for why the model has worked less well for the CSO support are discussed below (as well as in Section 4.1.2 on GAVI Partner roles).

Limited capacity and resources to manage the CSO programme

The CSO programme budget of \$29.2m (Type A and B support) is less than 0.5% of GAVI's total programme outlay.⁶⁴ Secretariat resources have therefore focused on the larger programmes such as NVS and HSS. The role of the Secretariat in the CSO programme implementation has been constrained by various factors such as:

⁶³ CEPA (2011) GAVI Second Evaluation Report

⁶⁴ GAVI (2010) GAVI Alliance Progress Report

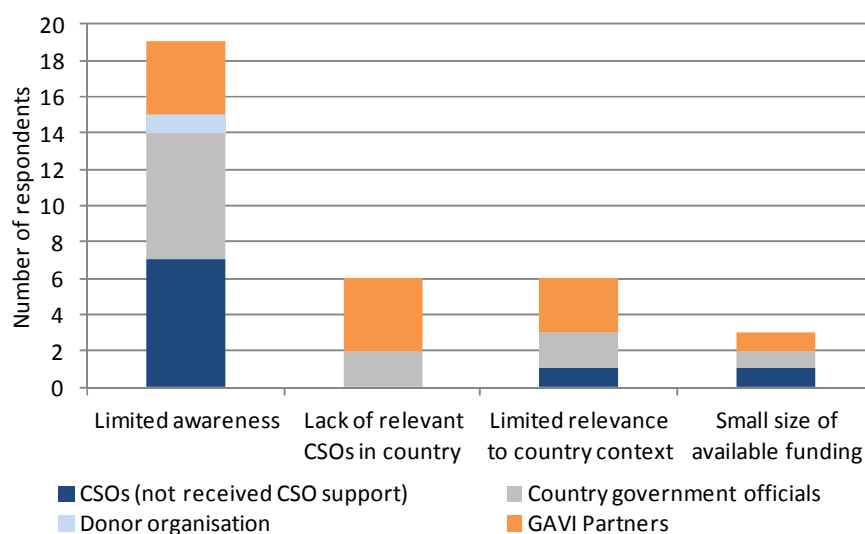
- History of working through beneficiary country governments, resulting in the GAVI systems and processes (e.g. financial management, country reporting, M&E, risk mitigation, etc.) being geared for relatively large forms of support (commodities or grants) to a single government entity rather than dealing with multiple small-scale CSOs across countries.
- Lack of an ‘executive champion’ and senior leadership (to support the CSO Programme Manager) to drive the programme ahead, address implementation bottlenecks, and escalate major issues in a timely manner to GAVI’s governing bodies, or ‘course correct’, as required.
- Limited capacity to interact with, guide and supervise country progress given that the capacity of the few Country Responsible Officers (CROs) has been stretched thinly across GAVI programmes in the CSO support recipient countries. Secretariat capacity to validate country reports on achievements is also constrained by the small size of funding and sub-national nature of activities (for Type B support in particular).
- Differences within GAVI management and staff on understanding the importance and role of CSOs in immunisation, and how GAVI might best structure its support to CSOs.

We note, however, that after the Hanoi meeting in November 2009 GAVI increased its capacity for CSO support to some extent. In particular, overall coordination with CSOs was tasked to the Advocacy and Public Policy (APP) team in the Secretariat. The APP was mandated to serve as the Secretariat focal point for all (including CSO) advocacy and public policy related matters and to work with the governance team to support CSOs in organising themselves to be an effective constituency. The Programme Delivery team has continued to be responsible for the oversight, review and redesign of the CSO support window and coordination between these two teams in the Secretariat is encouraged.

Varying degrees of programme awareness across countries

We understand that GAVI had organised awareness workshops in some of the Type B CSO pilot countries at the start of the programme (for example, in Pakistan, DRC, and Ethiopia). Given the small budget and limited Secretariat resources assigned to the programme, it was not feasible to publicise the programme across all the GAVI countries that are eligible for Type A support. Amongst other factors (such as flaws in the programme design), limited understanding of the CSO programme objectives and activities has contributed to the low uptake of Type A support. While we note the low response rate to this questions, the e-survey feedback indicates that a lack of awareness was the most significant reason for countries not applying for CSO support (see Figure 4.1 below).

Figure 4.1: Responses to e-survey question: 'Why did your country not apply for GAVI CSO support?'



Lack of clarity on the programme objectives and intended results has been a key constraint affecting implementation and results. It was suggested that the Secretariat could have done more to raise awareness and dispel any programme-related misconceptions.

Delays in programme processes

Tables 4.1 and 4.2 present the timings of the CSO processes for both Type A and B support⁶⁵ (with delays over three months at any stage highlighted in red – although we note that even three months is arguably a long lead time). Whilst 5-6 out of the ten countries approved for Type A support faced a delay over three months, all of the seven Type B countries experienced large delays. As a point of reference, the Global Fund took an average of 23 calendar days to disburse the approved funds in 2010.^{66,67} Further, a lack of timely communication by GAVI on reasons for the delay and disapproval of applications has impacted the relationship between GAVI, country governments, and CSOs.⁶⁸

Table 4.1: Type A support: process timings

Country	Submission to Secretariat approval (in months)	Approval to disbursement (in months)
Afghanistan	1.3	8.5
Burundi	6.8	20.2
Cameroon	6.7	1.2
DRC	3.9	6

⁶⁵ This analysis draws upon, and has been updated since, the GAVI second evaluation.

⁶⁶ Key Performance Indicators: Year-End Report On Results For 2010 And Proposed Modifications For 2011, The Global Fund

⁶⁷ We note that both Afghanistan and Togo submitted proposals for Type A extension funds in March 2011 and both proposals had been approved (but funds not disbursed) as of 22 July 2011. This represents a significant improvement from the time taken for the Secretariat to approve the initial Type A proposals where the average time taken was over three months.

⁶⁸ Our country consultation with Mozambique suggests that CSOs were not informed about the reasons for disapproval of the Type B application which deterred them to submit a new application for the support.

Country	Submission to Secretariat approval (in months)	Approval to disbursement (in months)
Pakistan	2.5	8.6
Ethiopia	2.5	2.3
Georgia	2.1	2.3
Ghana	1.6	1.2
Indonesia	2.5	2.3
Togo	3.2	0.6
Bolivia	n/a	n/a
Kyrgyz Rep	n/a	n/a

Source: GAVI Secretariat

Table 4.2: Type B support: process timings (as of July 2011)

Country	Submission to Board approval (in months)	Board approval to first disbursement (in months)	First to second disbursement (in months)
Afghanistan	5.7	11.1	14.1⁶⁹
Burundi	11	17⁷⁰	-
DRC	0.9	5.5	32⁷¹
Ethiopia	8.7	2.1	Pending
Indonesia	2.8	5.2	Pending
Pakistan	8.6	3	19.5
Ghana	26	Pending	-

Source: GAVI Secretariat

Typical reasons for the delays include:

- *Application to approval:* Secretariat requests for proposal clarification or re-submission, timelines for IRC/ Board meetings, other GAVI internal delays, etc.
- *Approval to disbursement:* Identifying the right country recipient of funds (including signing a memorandum of understanding (MoU) with GAVI Partner/ MoH to transfer funds), completion of FMA procedures for selected countries, delays in approval of APR, GAVI internal processes, country specific political and other factors, etc.

The delays in approval and disbursement have deterred the commencement of the programme in several countries, making the originally envisioned two year pilot impractical. Country studies reveal that:

⁶⁹ The third disbursement to Afghanistan was made in 2011, at least 5-6 months after the second tranche paid in July 2010.

⁷⁰ All of Burundi's approved support was disbursed in a single tranche.

⁷¹ The funds have been provided by government from existing HSS funds to the CSO programme. GAVI is yet to disburse the CSO funds due to FMA results and status with the financial agent in DRC.

- Approval and disbursement delays have sometimes necessitated re-programming, as the ground situation (including anticipated costs) had changed. These delays have also caused planning and coordination issues for CSOs, who are implementing other donor programmes simultaneously.
- Disbursement delays in the second tranche of funding have implied that CSO activities have either stopped or are being funded temporarily from other sources (with the expectation that the GAVI disbursement will come through). In some cases, activities completed to date have been rendered useless (e.g. in Indonesia, two CSOs completed ‘training of the trainer’ activities with the first tranche of funding, however, considerable delays in the second tranche of funds have implied that they will have to re-train staff or train new replacement staff). These delays have also weakened relationships between the CSOs and governments as they have been unable to deliver services as agreed.⁷²

All of the five country studies revealed issues with approval and/ or disbursement delays. In some cases, the delays are due to country-specific factors (e.g. financial issues with the lead CSO in DRC). However, delays as a result of GAVI’s internal processes, particularly due to the TAP/ FMA processes, have not been viewed favourably by countries. Their reasoning is that the CSO programme has been set up as a pilot with a limited timeframe for implementation and GAVI needs to examine the broader implications of halting its funding, especially when not caused specifically by the CSO programme. CEPA agrees with this issue, to the extent that the stoppage of funding has taken away from progress and results in many countries, although we recognise the importance of fiduciary checks for cash-based programmes.

4.1.2. GAVI Partners

Across its programmes, GAVI relies on its Partners’ country offices to assist in implementation. In general, this approach has proved to be somewhat problematic given the specific demands of CSO support, as well as the working of the Partners:

- Unlike other GAVI programmes, CSO support relies on a range of in-country CSO recipients of funding – who vary in terms of their size, scale of operations, technical and financial capacity, and relationship with the government. Smooth programme implementation therefore requires regular communication with, guidance to, and monitoring of multiple CSOs across countries – which is difficult to ensure without some form of country presence/ support.
- The primary partner and responsibility of WHO and UNICEF are country governments. In addition, WHO has limited experience of engaging with or funding CSOs. Further, there is no clear MoU or agreement between GAVI, its Partners, and the country government on the role of the Partners in programme implementation. Country Partner representatives stated that their being a signatory to the APRs is a ‘mere formality’ since they are often not close enough to the programme.

⁷² This is particularly the case with local government relationships, where they are not well aware of the issues relating to GAVI funding.

The Partners have been involved to a greater extent in the design (rather than in the implementation) of the CSO programme through their participation in the country ICC/ HSCC. In Afghanistan and Pakistan, the WHO and UNICEF country offices (respectively) have been the conduit of both Type A and B funds. Although the channelling of funds through Partners has worked well, the management fees charged seem quite high (7% by UNICEF in Pakistan and 6% by WHO in Afghanistan) – especially given that their role is only routing of funds and does not involve any grant management, M&E, etc.^{73,74}

4.1.3. Independent Review Committee

This section discusses the suitability of the IRC model to the CSO programme, i.e. how the design and execution of the IRC processes have supported programme implementation. We have primarily drawn upon the findings from previous HLSP evaluations of the IRC (2010) and HSS (2009), as well as our consultations on this assignment. Our view is that whilst the IRC model has some advantages such as independence, it lacks the ability to adequately take into account the country level specificities that are crucial to the design and success of the CSO programme. The main challenges are discussed below:

- *Limited CSO experience.* The IRC members are highly respected in their respective fields, but their ability to make optimal decisions is compromised by limited experience of dealing with CSOs.⁷⁵ In addition, our interviews suggest that due to GAVI policies, IRC members often have no/ limited direct familiarity with the country specific issues relating to the proposal.⁷⁶
- *Limited information and inadequate assessment techniques.* We found that some of the information provided in country proposals and APRs is often incorrect or of poor quality. IRC members are sent a large volume of information⁷⁷ prior to meetings, which is likely to affect the quality of their analysis. Furthermore, it is not easy to undertake a desk based review of complex national health systems.⁷⁸

We also note that the IRC needs to communicate with countries through the GAVI Secretariat and CROs, which can be problematic especially where there are complex country issues which may require in-depth, face-to-face discussion.

⁷³ We note that the management fees charged are standard practice across donor agencies. Its cost implication for a small-budget pilot CSO programme is however large.

⁷⁴ In Pakistan, UNICEF has also supported programme implementation by housing the GAVI CSO Support Coordinating Unit. This Unit was established under the National EPI, Ministry of Health and comprises an overall coordinator, a monitoring and evaluation officer, and an administrative and finance officer.

⁷⁵ While some IRC members have more than one specialisation, the HLSP IRC Review (2010) found that ‘on average the most common areas of professional expertise in a committee are: broad public health (27% of members), HSS (27%), health economics (18%), immunisation services (9%), epidemiology (9%) and cold chain (9%)’. We note that the committees specifically engaged with the CSO programme have more focussed expertise in areas such as health systems, public health and health economics, although this is not quantified.

⁷⁶ Also, the HLSP review notes that IRC members that are ‘overly familiar’ with, or have contributed to country applications, or are from countries being considered for funding, are not allowed to participate.

⁷⁷ One stakeholder noted that they received up to 80 documents to review prior to a IRC meeting.

⁷⁸ In particular, HLSP recognised that in countries where the HSCC ‘did not exist or was not active or mature enough...this was hardly ever identified by the IRC’ – a feature which could have knock-on effects for the CSO programme. HLSP (2009) “HSS Evaluation”

We have not undertaken an in-depth review of the IRC outputs, however our view, based on a reading of the IRC reports for the case study countries, is that these appear to be reasonably detailed and of a good standard.

4.1.4. CSO Steering Committee, Forum, Constituency and erstwhile Task Team

Table 4.3 presents the role and contribution of these CSO bodies to the programme.

In general, these institutions, particularly the CSO Constituency, have captured the ‘voice’ of CSOs involved in immunisation/ health systems at the global and country level. They also provide a cost effective platform for GAVI to communicate with the CSO community.

However, there have been concerns regarding the inputs provided by the erstwhile Task Team on the development of the CSO programme, given some of the major design issues. Also, although the CSO Steering Committee and Constituency have raised programmatic and other CSO engagement issues with the Secretariat, these have not yet been acted upon (Annex 9 provides a summary of some of the discussions held at Steering Committee/ Constituency meetings. These discussions pick up a number of the issues highlighted in this evaluation with the programme design and implementation, e.g. fund channelling, CSO definition, limited awareness of the support, delays in disbursement, etc.).

Table 4.3: Role of CSO agencies in GAVI

Entity	Role	Contribution to date
CSO Task Team	Created in 2005 to develop strategies to encourage the engagement of more CSOs, following which the CSO support mechanism was created.	<ul style="list-style-type: none"> – Questions regarding effectiveness of Task Team inputs given the number of design issues with the support. + Task Team reviewed and recommended Type A proposals to the Secretariat. + Developed ‘Call to Action’ to emphasise the role of CSOs in immunisation. Helped develop GAVI’s CSO Constituency.
CSO Steering Committee	Successor of the CSO Task Team constituted in March 2010. Supports the Board member on CSO issues and participates in ongoing GAVI Alliance work. Also develops civil society position papers/ responses.	<ul style="list-style-type: none"> + Provided ongoing support to the CSO Board member (and alternate) on CSO and other programme related issues.⁷⁹ + Conduit between the CSO Constituency, the Secretariat, and the Board, particularly in relation to the approval of a CSO policy and Type B support bridge financing.
CSO Constituency	The CSO Constituency comprises the CSO Board member and alternate, CSO Steering Committee, and a broader group of CSOs. ⁸⁰ The Constituency has an assigned communications focal point.	<ul style="list-style-type: none"> + A representative body of CSOs, providing a platform for GAVI to obtain CSO views on programmes/ other issues. The Focal Point provides the required communication linkage between the various members. The Constituency has recently started a website with information on CSO meetings, immunisation news and updates, a CSO

⁷⁹ Including providing inputs on Indian pentavalent vaccine support, a progress report on accelerated vaccine introduction and GAVI’s cash based support (including CSO support).

⁸⁰ A ‘super set’ of all global and country level CSOs involved with GAVI.

Entity	Role	Contribution to date
		<p>database, etc. and also a quarterly newsletter called ‘The Civil Society Dose’.</p> <ul style="list-style-type: none"> + Discussed challenges in CSO programme design along with issues relating to advocacy and resource mobilisation and prioritisation, supply strategy and co-financing, HSFP, etc. – While the Constituency has been active in highlighting issues related to CSO support, GAVI has not yet addressed many of them.

We understand that a nine-member Oversight Advisory Group (OAG), drawn from both the CSO Steering Committee and the wider CSO Constituency has been constituted to provide guidance and technical assistance to the eight HSFP pilot countries for building in-country CSO platforms to increase civil society participation in the platform throughout the life of the project.

4.2. Country implementation

This section presents how Type A and B support have been implemented in countries, highlighting aspects that have worked well and those that have not. We begin by presenting some of the reasons for the limited uptake of Type A support, in particular why some of the Type B pilot countries did not apply.

4.2.1. Uptake for Type A and B support

Only ten of the 72 GAVI-eligible countries have applied and been approved for Type A support, and seven of the ten pilot countries for Type B funding. We summarise the reasons for this below – drawing on the previous Putnam (2009) and CEPA (2011) evaluation studies, as well as consultation and e-survey feedback on this evaluation.

Type A support

The reasons for the limited uptake of Type A support have been well documented in the Putnam review, and confirmed in the responses on our e-survey.⁸¹ In summary:

- Countries have found this support less relevant given the limited role of CSOs in immunisation and a number of other pressing priorities in the sector (such as the introduction of new vaccines). In addition, some countries (e.g. PAHO and SEARO countries) have collated CSO mapping/ registration information previously.
- Some fundamental flaws in the programme design have reduced country incentives to apply. These include a lack of clarity of programme objectives; relatively small size of

⁸¹ We have been unable to consult with any GAVI-eligible countries that have not received Type A support as part of this evaluation, as we have not heard from the contacted persons despite follow-up. However, we have received their feedback in the e-survey (45 responses). In addition, we have incorporated the views from our work on the GAVI second evaluation, where we visited five non-applicant countries (Bangladesh, Bolivia, Mali, Nigeria and Uzbekistan).

available funding, especially in proportion to the application requirements⁸²; and channelling of funds through government (noted as an issue by CSOs).

- Limited awareness about the programme amongst country government and CSOs – in part due to limited publicity on the support by the GAVI Secretariat (and Partners), but also because governments have not disseminated information on the availability of this support to CSOs.
- Putnam’s review points out that some West African countries were keen to apply for this support but could not do so because of an absence of financial support from GAVI and its Partners for proposal preparation. Further, a lack of capacity in the government to manage the programme has also reduced its uptake.

Type B support

Three pilot countries - Bolivia, Georgia and Mozambique – did not receive Type B funding. The underlying reasons and country contexts have varied, as detailed below:

- Bolivia initially submitted a proposal with the support of PAHO. However, the application was not complete and hence not accepted by GAVI.⁸³ Political instability, the limited role of CSOs in immunisation, misunderstandings about the nature of CSOs to be supported (whether international or indigenous local organisations⁸⁴), and changing priorities resulted in Bolivia not submitting a revised application.
- In Georgia, there is strong government ownership and delivery of the EPI initiative. There are very few CSOs working in immunisation, reducing the relevance of and keenness to apply for this support.
- Mozambique submitted a proposal to GAVI, however, it was rejected on grounds of not adequately involving CSOs. Despite revisions, the proposal was still not approved. Thereafter, we understand that the government lost interest (their HSS proposal was also rejected at the same time). The country was provided with limited guidance on the proposal requirements and GAVI Partners were not aware of the functioning of the programme. We understand from the Secretariat that CSO support for Mozambique is now awaiting integration with the IHP+, however, country stakeholders consulted do not appear to be aware of this.

Our findings raise the question of the appropriateness of these countries being selected as pilots for Type B support (Georgia in particular, but also Bolivia). It also suggests that GAVI could have possibly done more to implement the pilot successfully – for example, by identifying

⁸² Given this issue, countries that have applied for Type A support are also the Type B pilot countries (except two countries). The incentives were greater in this case, due to reduced transactions costs and higher combined budget for both types of support.

⁸³ The application was submitted in Spanish (GAVI do not normally accept applications in Spanish), was not signed by the relevant authorities and included an incorrect budget.

⁸⁴ We learnt from our visit to Bolivia as part of the GAVI second evaluation that the government misunderstood that the CSO programme was about supporting US NGOs, as opposed to – potentially important – local grass roots organisations.

another suitable country when Bolivia and Georgia did not profess interest and providing more guidance when Mozambique did not re-submit its proposal.

4.2.2. Implementation of Type A support in countries

Mapping exercise

We have reviewed the information contained in the country proposals and APRs on the approaches employed for conducting the mapping exercise. This has been supplemented by interviews in the case study countries, as well as broader global/ country consultations.

In general, the mapping approaches employed by countries have been reasonable. For example, countries have consulted existing databases, developed questionnaires for CSOs, followed up through interviews, etc. (see Annex 6 for a summary description of the mapping approaches across countries). However, some issues (that potentially reduce the utility of the output) with the mapping approaches include:

- There has been limited involvement of CSOs in developing the approach for mapping and related data collection. This might have reduced the effectiveness of the exercise, given that in some cases governments may not have sufficient motivation to develop this product.
- While some countries have outlined steps to validate or clean the data, the extent to which these have been systematically carried out is not known. For example, the Pakistan APR states that the appointed consultant visited the offices of each CSO to verify the information, which may not have been feasible.⁸⁵
- There do not appear to be systems/ processes in place in countries to update the mapping report – which would seem sensible given the purpose of this exercise. The DRC, Ethiopia and Indonesia proposals/ APRs make some reference to plans for updating the mapping report. However, our interviews in Indonesia suggest that there are no such plans as of now, and in Ethiopia, the mapping exercise has not yet been conducted.

Nomination of CSOs on country HSCC and ICC equivalents

We have reviewed the information contained in the country proposals and APRs on the process for nomination of CSOs on the HSCC and ICC equivalents, and supplemented that with feedback from the country studies. We question the accuracy of the APRs on this issue, as the provided information seems incorrect for some countries given that there has been no specific nomination activity as part of Type A support (e.g. Ethiopia, Indonesia and DRC).⁸⁶ However, this is not the case for all countries (e.g. for Afghanistan, Pakistan and Togo, where the APR and

⁸⁵ Feedback from some stakeholders in the country suggests that a few of the CSO organisations included in the Pakistan mapping exercise are not functional.

⁸⁶ In Ethiopia, the CSO organisations were already participating in the HSCC and ICC and no additional CSOs were included as a result of the GAVI support. In Indonesia, the Type B (and other) CSOs have attended HSCC meetings, however it is unclear to them if they are considered as members/ representatives of the CSO constituency. In DRC, there was no specific mention of the use of Type A funds to nominate CSOs on these bodies.

country interviews are consistent and Type A funding has been used to increase CSO representation in the national planning body).

Nonetheless, based on the APRs, countries have followed different approaches to nomination:

- Direct selection of CSOs – based on pre-determined criteria (although the criteria have not been clearly specified);
- Election of CSOs – either by the existing members of the ICC/ HSCC equivalent bodies, or by the CSOs that were invited for an initial workshop on the mapping exercise (e.g. Afghanistan, Burundi and Ghana);
- Evaluation of proposals from CSOs – CSOs have been invited to submit proposals for their participation on the ICC/ HSCC equivalent bodies (e.g. Togo).

Each approach obviously has its trade-offs, in terms of participatory nature/ CSO involvement, transparency in selection, competition, capability of CSOs selected, etc. It is difficult to assess the quality of these processes based on desk research, especially given the issues with reliability of APR information. We do, however, note that GAVI should ideally have provided more guidance on the process for nomination to ensure transparency and the selection of the most suitable/ representative CSO.

Grant management

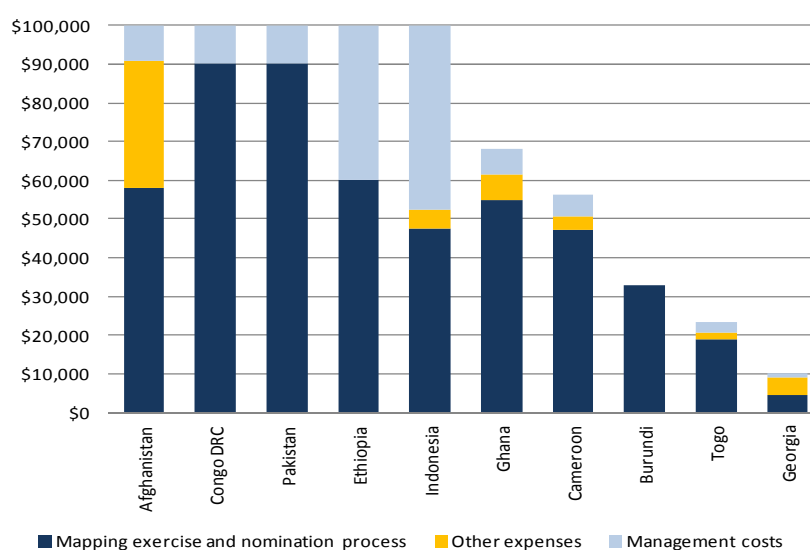
We have examined the proposed use of Type A funds from the country proposals (see Figure 4.1 below; Annex 6 provides details on our methodology).⁸⁷

Management costs in relation to the mapping exercise and nomination process have varied considerably by country. For example, management costs account for 40% of the total proposed costs in Ethiopia and almost 50% in Indonesia.⁸⁸ While country comparisons are not very helpful here, we note that GAVI has approved relatively high management costs for some countries (especially given equal grant size). GAVI might also provide guidance to countries on acceptable levels of management costs, given the small size of this support (although we recognise the limited economies of scale available for small grants).

⁸⁷ It has not been possible to separate costs for the mapping exercise and nomination process, based on the data provided in the country proposals. This is not surprising, given our findings on the limited use of the funds for the latter.

⁸⁸ The Type A proposal for Indonesia notes costs of US\$47,484 for the establishment of a management team.

Figure 4.2: Analysis of proposed costs by category⁸⁹



4.2.3. Implementation of Type B support in countries

Selection of CSOs

Type B support has funded a total of 43 CSOs in the five countries studied⁹⁰, of which 21 are indigenous and have received 58% of all funds allocated to CSOs. Table 4.4 below details the proportion of Type B funds allocated to indigenous CSOs by country.

Table 4.4: Summary of Type B funding to CSOs⁹¹

Country	Proportion of funds allocated to indigenous CSOs
Afghanistan	47%
DRC	37%
Ethiopia	73%
Indonesia	100%
Pakistan	34%

Countries have had different experiences with regards to the selection of CSOs for Type B support. For example:

- In DRC, the initial selection of CSOs was not well informed (since Type B support started prior to the Type A mapping) and had to be repeated. The second round of

⁸⁹ Other expenses include sundry expenses such as equipment and stationary, communications and transport; banking fees and currency exchange losses; and proposal development costs (we understand that this was used for the development of Type B proposals).

⁹⁰ Although not a part of the Type B programme per se, we note that a number of additional CSOs were funded in Indonesia through excess Type B management costs which had been allocated to the MOH to manage the CSO grant. See Indonesia country report for more details.

⁹¹ Source: Proposals for all countries included in this table, except Pakistan. For Pakistan, the country proposal does not provide allocation by CSO and this has been obtained from additional information provided by the Secretariat. However there are some inconsistencies in the data, which we have not been able to resolve.

selection benefitted from the mapping output and resulted in a strong consortium of CSOs spanning a wide range of interests, competencies and geographical expertise.

- In Ethiopia, the selection process appears to have been fairly rigorous, with active involvement of the country HSCC equivalent and use of a range of selection criteria to assess the suitability of the applicant CSOs (e.g. whether the CSOs work in hard-to-reach areas, have experience and a track record in immunisation).
- In Indonesia, the selection process involved an initial orientation workshop and selection by a Technical Working Group (TWG).⁹² The process has been criticised as the selected CSOs are perceived to be close to or supportive of government. However, our country interviews suggest that there were not obvious alternative organisations to select, which have extensive local networks and a track record for community mobilisation.

In general, the approach to CSO selection has been varied in terms of rigour and the extent to which the HSCC equivalent body has been involved (and hence can be considered as a fair and transparent approach). Similar to Type A support, countries would have benefitted from greater supervision/ guidance from GAVI in this process – which might arguably have also translated into better results.

Working through CSO consortia and umbrella groups

In a number of countries, CSOs have formed consortiums to implement Type B funding (see Table 4.5 for some examples).

Table 4.5: CSO umbrella organisations

Country	Description
DRC	Type B support is led by a five member consortium established for this purpose. The consortium is headed by SANRU – an indigenous, church-based organisation, which is widely respected for its competence and leadership in rural health care.
Indonesia	One of the CSO-recipients is a consortium of faith-based organisations, which targets the different religious leaders and populations in the project regions. ⁹³
Ethiopia	A consortium has been formed by the CSO umbrella group (Consortium of Christian Relief Development Associations (CCRDA)), which has wide experience of being contracted by donors as well as sub-contracting implementing CSOs. ⁹⁴

These approaches have worked well in the mentioned countries. Coordination amongst the CSO activities is fostered through the consortium (for example, in DRC, the CSOs in the consortium target specific geographic areas), and it has encouraged more effective participation by CSOs (e.g. the CSOs included in the CCRDA consortium in Ethiopia could present a united ‘voice’ to the government). In some cases, it has also contributed to improved M&E – for example, CCRDA verifies the progress/ results of its sub-recipients before providing M&E information to the government.

⁹² Constitution of this group is not clear to us, however we were informed that it was coordinated by the MOH and HSCC member organisations.

⁹³ The consortium includes both Muslim and Christian FBOs.

⁹⁴ In particular, CCRDA has experience of working with USAID, SIDA and Global Fund.

Implementation issues in country

Delays in disbursement of funds from GAVI is the principal issue that has adversely impacted implementation. In addition, limited interaction with/ guidance from the GAVI Secretariat and Partners in country has been an issue. Other country-specific issues (relevant to some or most of the supported countries) include:

- *Government management of GAVI grants.* The performance of governments managing GAVI grants has varied by country. In Pakistan, the GAVI CSO Coordinating Unit – a government entity – has been instrumental in programme implementation, whereas, in other countries such as DRC and Indonesia, the government has caused some delays in disbursing funds to CSOs.
- *Coordination difficulties between government and CSOs.* Poor coordination amongst CSOs has caused difficulties for governments to liaise with them. In addition, frequent turnover of government staff has caused problems for CSOs in accessing information – this issue was highlighted in Pakistan and Ethiopia, in particular.
- *Lack of supporting health infrastructure.* Where CSOs have been involved in service delivery, they have faced issues due to the absence of supporting infrastructure and facilities which would normally be provided by governments. For example, in Ethiopia, CSOs have provided equipment and supplies (such as kerosene) to health facilities to provide immunisation – a service which would normally be provided by the government.
- *Inflation of costs.* Countries (including Pakistan, Indonesia and Ethiopia) noted that many of their costs, particularly transport costs, had risen since they submitted proposals – this has not been helped by delays to the programme and the long distances to remote project areas, resulting in lesser funds being available for programme activities.
- *Low uptake of services and wastage.* There have been reported instances where the uptake of services has been lower than expected. For example, in Ethiopia, a number of health workers that were invited for trainings did not attend. It also transpired that around 20% of trained staff were not in relevant positions within three months of being trained, suggesting that the wrong staff had been trained.

Use of funds

It has not been possible to carry out an activity-based analysis of the proposed Type B budget or actual expenditure by CSOs in countries due to lack of data. This is a major limitation in GAVI's M&E framework as country proposals and APRs do not collect this critical information. We have, however, attempted to classify the focus of country Type B budgets, based on our understanding of the scope of activities from our country consultations (Table 4.6). This assessment is at best weak, as it draws on partial information available to CEPA during the country visits as well as our judgment on the emphasis of the funding. Boxes that are grey indicate that the majority of country funds were spent on this theme or activity.

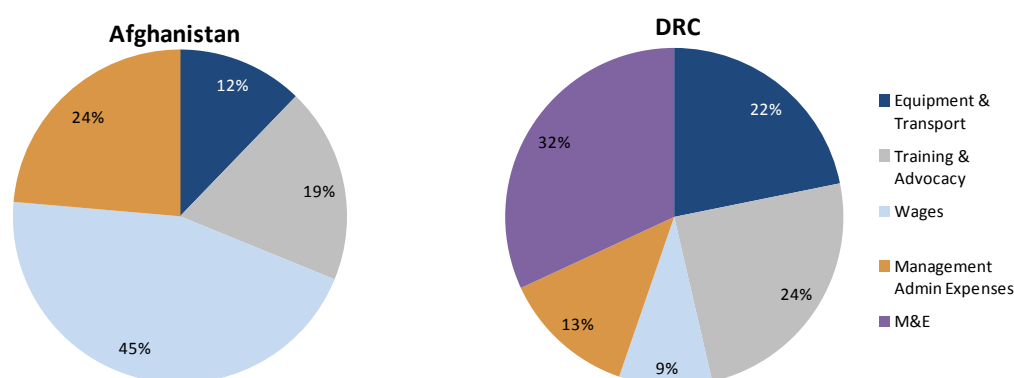
Table 4.6: Indicative use of funds

Theme/ activity	Afghanistan	DRC	Ethiopia	Indonesia	Pakistan
Training of health workers and other health staff	✓	✓	✓		✓
Community mobilisation (including training for community mobilisation)		✓	✓	✓	✓
Provision of equipment and supplies to public health facilities		✓	✓		✓
Immunisation service delivery (via CSOs or other non-governmental providers)	✓	✓	✓		✓

We have had access to some limited data from the GAVI Secretariat on use of funds by activity for Afghanistan and DRC – see Figure 4.3.⁹⁵

- It is difficult to draw any meaningful results from this presentation, except that the countries seem to have spent an additional 10-25% on management and administration related expenses, over and above the management costs presented in Figure 4.3 below.
- The exact amount spent on equipment (in the category ‘equipment and transport’) is not clear, but we note that any capital expenditure (assuming it meets an unmet need) provides longer term/ more sustainable benefits for the country’s EPI, vis-à-vis operating expenses such as wages.

Figure 4.3: Summary of activities supported⁹⁶



Management costs

Country proposals provide information on grant management costs and we have attempted to classify these by stakeholder – government, CSOs, GAVI Partners, and HSCC costs (see Figure

⁹⁵ Data provided to us for other countries was not useable for this analysis.

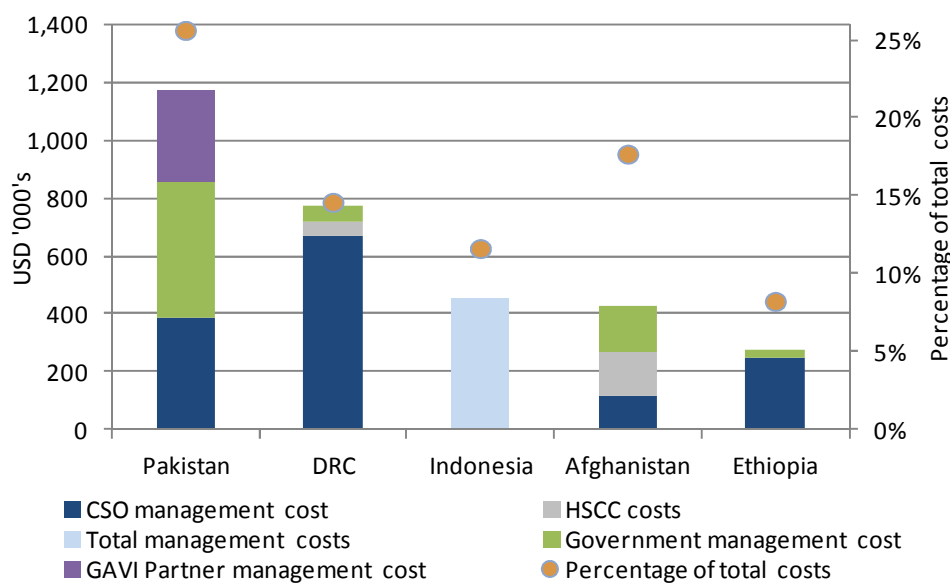
⁹⁶ The figures for DRC represent the total budgeted amount for all CSOs. The figures for Afghanistan include only year 1 actuals for the CSOs.

4.4).⁹⁷ As can be seen from the figure, total management costs by stakeholder have varied considerably by country. In particular:

- Management costs are highest in Pakistan, both in absolute terms and as a percentage of total costs. UNICEF management costs are equal to 7% of the total budget (\$321,090) – excluding these, management costs as a percentage of total costs are 19% (\$850,000), still the highest of all countries.
- The structure of management costs has also varied considerably, for example CSOs in DRC incur a higher level of management costs than in other countries while the government incurs the majority of management costs in Pakistan.

While it is difficult to compare across countries (given the difference in activities funded, government/ CSO management capacity, country circumstances, etc), it would appear reasonable to us that GAVI should consider, or provide guidance on, the nature of management costs incurred by the different stakeholder groups and the extent to which these are necessary. For example, in Pakistan, where UNICEF is channelling the funds, it not clear why the government also incurs a large amount of management costs.

Figure 4.4: Type B management costs by category⁹⁸(represented in absolute terms by the bars (primary axis) and as a percentage of total costs by the orange balls (secondary axis))



4.3. Key findings on implementation

Table 4.7 provides a summary of the main findings on this evaluation theme, as well as our view on the strength of the conclusions.

⁹⁷ In some cases the allocation of management costs is not clear and we have used our judgment on the most suitable categorisation.

⁹⁸ Note that we do not have a break-up of management costs by stakeholder category for Indonesia.

Table 4.7: Summary findings on implementation

Area	Key findings ⁹⁹
Role of GAVI institutions	<ul style="list-style-type: none"> - GAVI's delivery model – in terms of a Geneva-based Secretariat and country support through its Partners – has not worked well for the CSO programme. + The CSO Constituency is a cost-effective platform for GAVI to communicate with the CSO community across countries, however, GAVI has not yet addressed most of programme issues raised by the Constituency. - There are questions regarding the effectiveness of Task Team inputs on the design of the support, given the numerous design issues identified. - The IRC model lacks the ability to adequately take into account country level specificities that are crucial to the success of the CSO programme.
Country implementation	<ul style="list-style-type: none"> ± Mapping approaches employed by countries have been broadly reasonable, however there have been limited efforts to validate and update the data. - Management costs in some countries have been a large proportion (up to 50% for Type A and 25% for Type B), shrinking the budget available for the supported activities. - GAVI delays in proposal approvals and disbursement have been a key constraint in implementation, along with the limited experience of governments in contracting and funding CSOs, coordination difficulties between government and CSOs, and a lack of supporting health infrastructure.
<p>Strength of conclusions: Robustness rating on role of GAVI institutions: 'A'</p> <p>Our conclusions on the role of GAVI institutions are strong, being based on feedback from a number of global and country consultations. The conclusions are also echoed in previous evaluations of GAVI CSO support.</p> <p>Robustness rating on country implementation issues: 'B'</p> <p>We would rate our conclusions on the country implementation issues considered as relatively weaker, since they draw on proposal and APR data, which has been poor and of variable quality/ reliability. This has been supplemented by interview evidence during the field visits, which has added considerable richness to the analysis, however (i) draws on examples from a few countries; and (ii) may not represent the views of all stakeholders in the country.</p>	

⁹⁹ Findings have been marked according to whether they are positive (+), negative (-) or mixed (±).

5. RESULTS

The third theme of our evaluation framework is on results – i.e. focusing on programme outputs, and where possible, outcomes of Type A and B support. The timing of this evaluation does not allow for impact assessment, given that countries have either recently completed, or are currently implementing, the support and the time lags involved in achieving any health impact. Further, it is difficult to attribute any causal link between Type A coordination/ networking activities and impact, which is also a problem for the more ‘downstream’ Type B activities in most countries as well.

The high-level evaluation question is as follows:

To what extent has GAVI support to CSOs been effective in meeting its objectives at the country level?

We have looked at two sub-questions¹⁰⁰:

- What evidence is there of positive (or negative) results from the GAVI CSO support at the country, regional and global levels?¹⁰¹
- Has the programme resulted in any unintended consequences at the country-level?

The section is organised as follows: Section 5.1 highlights the issues resulting from the absence of an M&E framework for the CSO programme and provides a suggested approach (which has been employed for this evaluation); Sections 5.2 and 5.3 describe the available evidence on outputs and outcomes; Section 5.4 describes some ‘unintended consequences’; and Section 5.5 comments on the additionality, predictability and sustainability of the support.

5.1. Results framework

As noted in Section 3.2, a fundamental issue with the programme design has been the absence of a prospective results framework with clearly defined outputs, outcomes and impacts. This has implied that:

- *There is no benchmark or goal against which progress can be measured.* Without a clearly laid out results framework, including indicators and targets, it is difficult to assess whether a programme has been successful (or not). Retrospective definition of such a framework implies that baseline data/ information has not been recorded/ collected to measure results.
- *Results from country APRs are difficult to assess and compare.* Countries have not defined suitable or consistent results frameworks (in their proposals) which specify and link outputs, outcomes and impacts. This makes it challenging to judge programme performance in and across countries.

¹⁰⁰ Note that we had proposed to consider another sub-question here on the factors that have impacted the effectiveness of the support at the country-level. However, these factors have been captured as part of the other questions and in our overall assessment, and as such we have not duplicated our findings here.

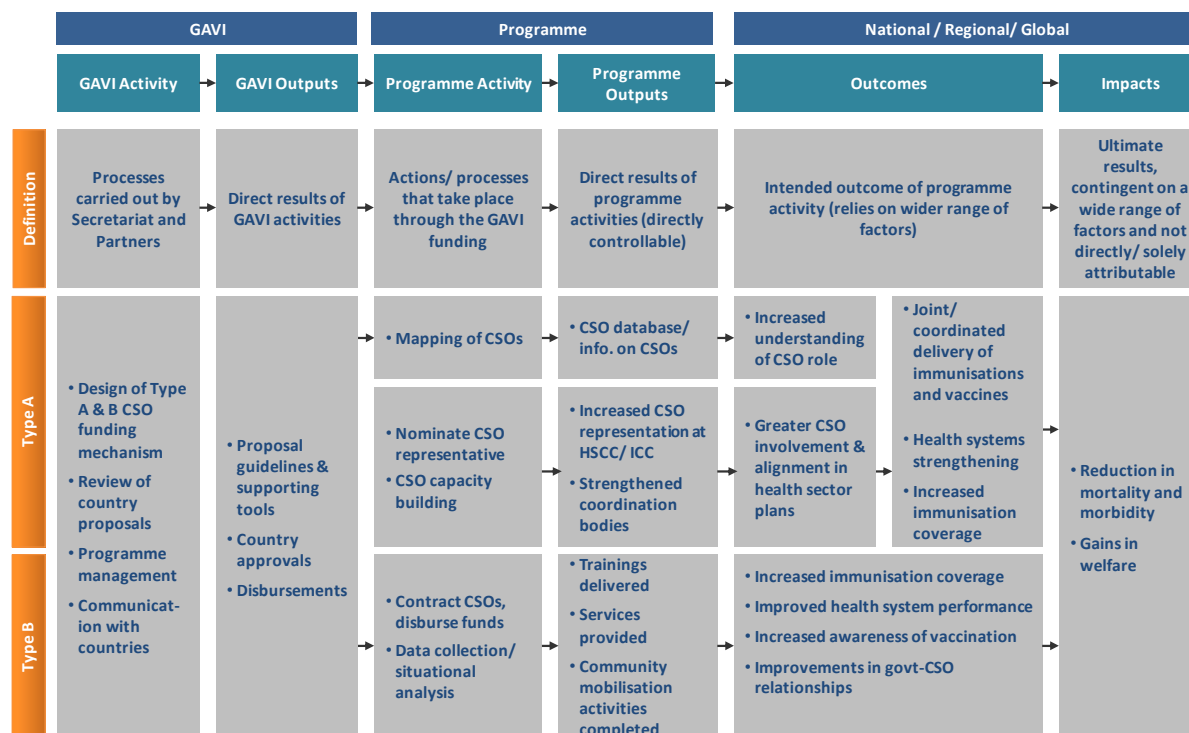
¹⁰¹ While CSO support has been directed to countries, we assess whether there have been any additional results at the regional and global levels e.g. increased awareness of GAVI arising from the CSO window.

In general, the APRs, which serve as the main M&E tool for GAVI are of very poor quality. It is difficult to trace activities between country proposals and APRs, as well as between subsequent APRs.

Our understanding is that GAVI had commissioned the development of an M&E framework and plan for the CSO support, however, this has not been used in practice.¹⁰² CEPA’s review of this framework suggests that while it is a useful and comprehensive document (e.g. it identifies important risks and assumptions), we do not fully concur with the proposed categorisation and the definition of some of the outputs, outcomes and impacts of Type A and B support. For example, the report defines improvements in immunisation coverage as an impact, while in our view, this is an outcome (albeit indirect) of the support. In addition, the logic models do not clearly explain the linkages between the various stages of results – e.g. the Type A logic model notes outcomes of “increased country level understanding of CSO role” and “increased CSO representation on HSCC/ ICC” and impacts of “increased immunisation coverage” and “improved health systems performance”, but does not explain the chain of events to link them.

As part of our evaluation, we have sought to develop a results framework for the CSO programme (see Figure 5.1 below). This framework defines the logical flow of outputs, outcomes and impacts for Type A and B support. Type A funding is intended to promote awareness of CSO operations and improve their representation (rather than to implement a specific plan/ programme like Type B), and hence its logic model involves a slightly longer chain of results to outcomes and impacts (with the caveat that the causal link is at best weak). Type B funding is comparatively more ‘downstream’ in nature, however the link to impacts is still difficult to observe, especially when the activities aim to strengthen health systems, rather than deliver immunisation.

Figure 5.1: Results framework



¹⁰² JSI (2002): “Monitoring and Evaluability Study for the GAVI Alliance Support for CSOs”.

Given the issues in measuring impact, we have expanded on the outputs and outcomes described in the results framework above, to develop a set of indicators that can be used to measure progress (see Table 5.1 below). We have included a mix of quantitative and qualitative indicators that can help assess the results of the programme. Key to note are the following:

- While the Type A output indicators would apply to all supported countries, for Type B, these would vary by the specific activities funded in country.
- Outcome indicators may not be observable in many countries given the time lag from implementation. Where there is some evidence, it clearly cannot be attributed to GAVI CSO support alone.

Table 5.1: Sample indicators for country level assessment

Outputs		Outcomes
Quantitative	Qualitative	
Type A		
<p><i>Mapping exercise:</i></p> <ul style="list-style-type: none"> • Completion of CSO mapping exercise 	<p><i>Mapping exercise:</i></p> <ul style="list-style-type: none"> • Has the mapping exercise been used by country or global stakeholders in engaging with CSOs (e.g. in identifying suitable CSOs for Type B support or for other donor or government programmes)? • Is the mapping report comprehensive in terms of its coverage? • Has the CSO mapping been updated regularly? 	<ul style="list-style-type: none"> • Increase in the number of CSOs involved in immunisation service delivery and related health systems strengthening • Increase in the number of joint health/immunisation initiatives between government and CSOs • Inclusion of CSOs in the country health system plans/ HSS proposals • Increase in number of CSO partnerships/networks for health sector (e.g. formation of consortia)
<p><i>Nomination process:</i></p> <ul style="list-style-type: none"> • Completion of CSO nomination process • Number of additional CSOs on the ICC/HSCC as a result of Type A funding • Number of additional indigenous CSOs on the ICC/HSCC as a result of Type A funding • Number of ICC/HSCC meetings where CSOs have been present 	<p><i>Nomination process:</i></p> <ul style="list-style-type: none"> • Was the nomination process conducted fairly and transparently? • Is the additional CSO representation appropriate/meaningful (e.g. are the nominated CSOs generally representative of CSOs in country; are CSOs able to voice their views at the ICC/HSCC meetings)? • Are these committees effective and thereby does the nomination enhance CSO ‘voice’ on relevant issues? 	
Type B		
<ul style="list-style-type: none"> • Number of children vaccinated by CSOs (including marginalised/ hard to reach populations) • Number of trained health workers • Number of community health education trainings • Number of research materials developed under the programme (primary data collection, surveys, reports) 	<ul style="list-style-type: none"> • Have the activities focused on immunisation? • Have the activities been delivered on time and effectively? • Has the training been relevant and of a high standard, and covered all persons that require training? • Have the research materials developed been used for policy purposes? 	<ul style="list-style-type: none"> • Improvements in coverage rates in the project area (including equity of coverage rates) and reductions in drop-out rates • Improvements in capacity of health centres for delivery. • Higher demand for immunisation due to the community mobilisation efforts.

5.2. Outputs of Type A and B support

5.2.1. Type A mapping

Of the ten countries that have applied for Type A support¹⁰³, six have completed their proposed mapping exercise (as per the latest APRs and interviews).¹⁰⁴ Additional comments with regards to the nature of the mapping output and its utility are discussed below:

- *Utility in practice not clear.* While the mapping exercise was viewed as important by countries in theory, it is not clear whether the final reports have been used by all of the governments/ other stakeholders to further engage with the identified CSOs. In DRC for example, the mapping report helped identify relevant CSOs for Type B support, however, similar evidence is not available for other countries. Some countries indicated that the final report had only been circulated within the government and could have been shared more widely with other development partners. For example, in Indonesia, UNDP was interested to hear of the mapping report, as they were expecting to undertake a similar study on CSOs.
- *Limited coverage of CSOs.* Some countries commented that the mapping exercise was not comprehensive enough in terms of coverage of CSOs and the information provided. Key reasons for this include limited budget, short time frame and difficulty in sourcing information for inaccessible/ remote regions. While we have not been able to examine this in detail, it raises the question of whether the mapping reports have been more useful when compared with any existing database of CSOs available in countries (e.g. available at the CSO registration authorities or CSO umbrella/ associations).
- *Limited plans for updating.* The majority of Type A countries do not have plans/ budget to update the mapping exercise. Therefore, it is likely that the mapping report might lose significance over time.
- *Varying nature of the final product.* A high-level review of the mapping reports available¹⁰⁵ suggests that countries have produced different results. For example, Georgia and Indonesia have produced a database of CSOs (which as per our understanding is the expected output from this exercise), whereas Afghanistan's mapping report provides a summary of the donor and CSO perception of the role of CSOs as well as recommendations to improve CSO roles. We note that the GAVI Secretariat has not specifically requested this report from countries.

¹⁰³ Afghanistan, Burundi, Cameroon, DRC, Ethiopia, Georgia, Ghana, Indonesia, Pakistan and Togo applied for Type A support.

¹⁰⁴ These countries are Afghanistan, DRC, Georgia, Indonesia, Pakistan and Togo.

¹⁰⁵ We have been provided with the mapping reports for Afghanistan, Pakistan, Georgia and Togo by the GAVI Secretariat. In addition, we have also briefed through the Indonesia report while in country.

5.2.2. Type A CSO nomination

The nomination process has been completed by five out of the ten countries that applied for Type A support.^{106,107} However, the utility of the CSO nomination is in question because of:

- *Poorly functioning HSCC and ICC.* In a number of countries, the ICC/ HSCC does not function particularly well and hence the merit of additional representation from CSOs is questionable. For example, in Indonesia, the HSCC focuses on GAVI funding alone and is not a forum for coordination of other government and donor programmes. In addition, we understand that the HSCC meetings are used to inform members on issues that have already been implemented, rather than for planning.
- *Limited capture of the 'voice' of the CSO Constituency.* Whether the nominated CSOs are truly representative of other CSOs has been brought into question in a number of countries. This is primarily because of the limited coordination of CSOs in countries, and hence the nominated CSOs may represent their specific organisations only, rather than civil society at large. Further, where CSOs are closely aligned to government¹⁰⁸, they may represent partisan/ 'politically correct' views.

5.2.3. Type B support

This section provides a summary of some of the key outputs of Type B support for the five case study countries.

We have attempted to assess progress against the proposed outputs (using our definition of outputs included in the results framework¹⁰⁹), drawing on the information contained in the proposals and APRs. Given the absence of a prospectively defined results framework, poor M&E information in the APRs and the challenge in validating these outputs (given their small size and sub-national nature), this assessment is at best weak.¹¹⁰ We present our judgement on the summary status, which draws on the available data and is supplemented by information obtained during the country visits.

Table 5.2 below presents a summary of the outputs of Type B support. Annex 6 provides detailed country-level tables and also describes our approach and limitations. In summary, considerable progress has been achieved by countries in delivering outputs through the Type B funding. However, for some countries, delays in approval and disbursement have adversely affected the impact of these outputs.

¹⁰⁶ These are Afghanistan, Pakistan, Georgia, Togo and Ghana.

¹⁰⁷ For Ethiopia and Indonesia, the APRs state that additional CSOs were nominated to the ICC/ HSCC equivalent bodies, although interviews in country suggest that this is not attributable to GAVI CSO support. Given these findings, we would exercise caution over the APR claims in countries where we have not been able to verify these results, namely Georgia, Ghana and Togo.

¹⁰⁸ For example, PKK in Indonesia.

¹⁰⁹ Countries have not defined outputs in a uniform and consistent manner in the APRs.

¹¹⁰ Progress is particularly difficult to measure and contextualise given the lack of data and information on targets, timelines and the use of specific, measureable, attainable, relevant and time bound (SMART) indicators.

Table 5.2: Progress on outputs

Country	Activities	Progress against proposed outputs
Afghanistan	<ul style="list-style-type: none"> • Training and deployment of more than 80 (out of 88 proposed) community midwives to deliver immunisations (and other MCH services) in four underserved provinces. • Contracted and trained more than 50 (out of 50 proposed) private sector providers of health care to provide access to EPI and basic RH services in insecure and underserved areas and establish a replicable model of partnership. 	<p>Afghanistan has made considerable progress achieving its proposed outputs.</p>
DRC	<ul style="list-style-type: none"> • Provided financial support to 5 CSOs in each of 42 Health Zones (reduced from the original 65). • Training of outreach workers in promoting immunisations. • Trained 150 health workers in EPI management. • Undertook advocacy activities at the national and provincial levels. 	<p>DRC has made some progress, although less than that proposed in some cases.</p>
Ethiopia	<ul style="list-style-type: none"> • Trained: 1,100 HEWs in immunisation related activities - who subsequently trained a further 2,600 HEWs; 153 MLMs and 511 HEWs were trained on EPI Mid-Level Management (MLM); 2,200 Volunteer Community Health Workers to educate and mobilise the community; and 23 Ethiopian Orthodox Church clergies on EPI and community mobilisation - who subsequently trained a further 1,776 clergy on EPI and community mobilisation. • Other activities that were delivered included: supervision of newly trained HEWs; the procurement of equipment and supplies to support routine immunisation activities; community mobilisation workshops and rallies; community health education; nutritional screening; and antenatal care services. 	<p>Ethiopia has made considerable progress in achieving many of the proposed outputs. However, delays from GAVI in disbursing the second tranche of funds has taken away from these results considerably (e.g. weakening relationships between CSOs and local govt, rising costs).</p>
Indonesia	<ul style="list-style-type: none"> • Trained: community volunteers (cadres) in 2,400 villages in capacity building and health promotion who have reached 7,200 families; 35 trainers of trainers, 70 mid-level managers, 267 private health workers, 450 private sector staff and 216 community and religious leaders on the importance of immunisation and MCH; 78 trainers of midwives and 365 midwives on immunisation and MCH; and 10 national level, 45 provincial level and 80 district level trainers on community mobilisation for Scout groups - this led to 32 Scout groups being trained and 320 families receiving information on the importance if immunisation. • Other activities that have been undertaken include: development of training modules; M&E studies; baseline studies; coordination meetings; and the development and distribution of IEC and advocacy materials. • In addition, out of the management costs for Type B support, 41 non-GAVI CSOs were trained in EPI 	<p>Indonesia has made considerable progress in achieving its proposed outputs, although delays in disbursement from GAVI has halted the activities of two of the CSOs, with their outputs being of limited use given the nature of activities completed to date (e.g. training of trainers only).</p>

Country	Activities	Progress against proposed outputs
	and MCH and asked to submit proposals for funding to immunisation dropout rates in selected areas. 5 CSOs received support as a result.	
Pakistan	<ul style="list-style-type: none"> • Delivered trainings in EPI and MCH to 992,231 individuals residing in neglected and hard-to-reach communities, 7029 health volunteers and 5149 health care providers. • Supported the immunisation of approximately 77,712 children.¹¹¹ • Held 4,153 health sessions for immunisation promotion activities. • Other activities that have been undertaken include: establishing or revitalising 1,706 village health committees and 20 MCH centres; supporting national immunisations campaigns; surveillance and surveys. 	<p>Pakistan has made considerable progress in achieving its proposed outputs, which is broadly confirmed by the UNICEF country office.</p>

¹¹¹ This was mostly conducted in collaboration with government through camps organised in hard to reach areas – we note that this excludes some CSOs who did not record numbers.

5.3. Outcomes of Type A and B support

We have examined outcomes in terms of: (i) increased awareness of the role of CSOs; (ii) improvements in coordination amongst CSOs and government, including an increase in joint initiatives; and (iii) improvements in coverage rates.

Increased awareness of the role of CSOs

Through both Type A and B support, GAVI has increased awareness on the role of CSOs in immunisation and health as well as highlighted the importance of a harmonised approach (i.e. one that involves multiple stakeholders) to delivering better health outcomes. This has been viewed as an important global consequence of the programme, although it cannot be attributed to GAVI alone.

Improvements in coordination and evidence on joint initiatives

Type A support was expected to strengthen the coordination and representation of CSOs through the mapping report (by making government aware of relevant CSOs) and nomination to the ICC/ HSCC (by giving the CSOs a ‘voice’). This could potentially lead to the implementation of joint initiatives by government and CSOs. Many APRs state that government-CSO coordination has improved as a result of Type A funding, although given the limited extent to which outputs have been achieved, including their utility in practice, we would tend to question the accuracy of this information.

A majority of the e-survey responses are broadly divided between those that agree and are neutral with the statement “*Coordination between CSOs and government in countries has improved as a result of GAVI Type A support*”. Our country studies/ consultations suggest that Type B support has achieved greater results than Type A.

While it is difficult to measure ‘improved coordination’ – apart from perhaps subjectively – there are some specific examples, as noted below:

- In Pakistan, Type A support identified 21 CSOs, 15 of which created a consortium to receive Type B funding. This was viewed as a foundation building exercise to coordinate activities of CSOs and foster their interest in the immunisation sector.
- In Indonesia, there is some evidence that GAVI CSO support has had a catalytic impact on the number of government funded projects involving CSOs in the health sector. In particular, we understand that more funds have been allocated to CSOs in the recent re-programming of the HSS support. In addition, 18 CSOs have been funded by the government as part of a ‘healthy behaviour campaign’ which was designed using lessons learned from the GAVI CSO programme.
- In Afghanistan, while the government has a long history of working closely with CSOs, it has provided additional funding to CSOs to carry out similar activities as under Type B support (i.e. training of community midwives and PPPs in insecure areas, which was not emphasised previously) in provinces not covered by GAVI CSO support.

Improvements in immunisation coverage

Some countries have reported improvements in immunisation coverage (see Table 5.3 below), however, in our view, these need to be interpreted with caution, given:

- the tenuous links between Type B support and coverage rates in some countries – for example, in Ethiopia, given the nature of activities undertaken (complementing government health systems) it is not clear if these improvements can be attributed to GAVI CSO support. Also, the outcomes relate to the specific project areas; and
- weak supervision of CSO activities and challenges in the verification of coverage claims.

Table 5.3: Evidence of improvements in immunisation coverage levels

Country	Proposed outcomes	Reported progress	Summary status
Afghanistan	<ul style="list-style-type: none"> • DTP3 coverage in the targeted areas of Uruzgan and Farah to rise from 30% and 70% to 80% and 80% respectively. 	<ul style="list-style-type: none"> • At January 2011, Farah had reached 80% coverage, while Uruzgan had reached 65%. 	<p>Considerable progress has been made in achieving the proposed outcomes, with one region reportedly achieving its target.</p>
DRC	<ul style="list-style-type: none"> • DTP3 immunisation coverage raised from 74% to 90% in 65 Health Districts. • Measles immunisation coverage raised from 74% to 90% in 65 Health Districts. • TT2+ immunisation coverage raised from 71% to 90% in 65 Health Districts. 	<ul style="list-style-type: none"> • In 2009, DTP3 coverage reached 83%, however, due to a lack of funding, in 2010 this fell to 78%. • In 2010, coverage was recorded at 82%. • In 2010, coverage was recorded at 80%. 	<p>Some progress has been made in increasing immunisation coverage levels, although this has been impacted by availability of funding.</p>
Ethiopia	<ul style="list-style-type: none"> • Increase pentavalent coverage by 35% in remote, hard to reach and pastoral communities, and measles by 25%; decrease pentavalent drop-out rates to 10%; increase TT2+ coverage rates for pregnant women by 10% and 25% for non-pregnant women. • EPI coverage to reach 90% in project areas. 	<ul style="list-style-type: none"> • Pentavalent coverage increased from 48% to 70% in Gambella, 5% to 72% in Sherkole woreda and 68% to 85% in Benishangul. • Measles coverage reached 71% in Gambella and 73% in Benishangul. • Immunisation coverage is reported at ‘around 90% in the project ‘woredas’. 	<p>Immunisation coverage levels are reported to have risen dramatically in some project areas.</p>
Indonesia	<ul style="list-style-type: none"> • Increased immunisation coverage in 5 selected provinces to increase by 10%. 	<ul style="list-style-type: none"> • Not reported. 	<p>N/A</p>
Pakistan	<ul style="list-style-type: none"> • Increase DTP3 coverage in project areas to over 80%. 	<ul style="list-style-type: none"> • Not reported. 	<p>N/A</p>

5.4. Unintended consequences

We define ‘unintended consequences’ as those that are not planned for or anticipated as part of developing the programme objectives and design. These consequences can either be programme related (i.e. a consequence of the programme that was not accounted for initially) or exogenous to the programme (i.e. an observed result that is outside of the programme – such as any global or regional-level effects).

GAVI’s support to CSOs has led to some unintended consequences, although the exact nature of these and the extent to which they have prevailed are difficult to measure. The observed unintended consequences of the CSO programme are set out below. This is not an exhaustive listing (especially of programme related issues that are noted elsewhere), but provide an indication of the nature/ types of unintended consequences – both positive and negative. Further, we note that by definition, negative consequences would typically be unintended.

Positive unintended consequences

This section provides our evaluation findings on positive unintended consequences. Our findings suggest that GAVI CSO support has resulted in some positive unintended consequences that are both programme and non-programme related.

- *Supporting meaningful contribution of the CSO Constituency and Forum in GAVI.* The recent formation of the GAVI CSO Constituency and CSO Forum was motivated by several factors, one amongst them possibly being the CSO programme’s role in highlighting the importance of CSOs in immunisation. In particular, the programme helped identify key country-level CSOs, some of who are now members of the CSO Constituency. As a result, the Constituency has developed into a broader and more representative entity, leading to more meaningful interactions with the Steering Committee and GAVI. The Steering Committee has also benefitted from a number of country perspectives, which has helped it present a more balanced picture of country-level issues in various GAVI fora.
- *CSO capacity building.* There is anecdotal evidence to suggest that GAVI CSO support has enhanced the capacity of CSOs, particularly in financial management.¹¹² This could be expected to have a more lasting impact, not least because these CSOs may become more attractive to other donors for future support.
- *Support for GAVI fund raising.* Many have noted that GAVI’s support to CSOs has been a contributory factor in its fund-raising success in its recent pledging meeting in June 2011 (although some GAVI Partners have also played a strong advocacy role here to involve CSOs). This resonates with the priority that many bilateral donors and foundations have placed on supporting CSOs as important agents of community level change.

¹¹² Some CSOs in Indonesia noted that GAVI CSO support has improved their own capacity to coordinate themselves, respond to grants and financially manage themselves.

Negative unintended consequences

This section provides our evaluation findings on negative unintended consequences. Our findings suggest that GAVI CSO support has resulted in some negative unintended consequences that are programme specific. These points have also been noted elsewhere in the report (or in the supporting Country Reports).

- *Weakened relations between CSOs and government.* While this is clearly not an intention of GAVI CSO support, in some countries the programme has resulted in weakened relations between CSOs and the government. The reasons for this have varied by country – e.g. in Ethiopia, CSOs have not been able to deliver on their committed services/ equipment to local governments due to delays in disbursement from GAVI; in Pakistan, research organisations (funded through GAVI CSO support) have found contrary evidence on the burden of vaccine preventable infections and contrary coverage data estimates (as compared to government estimates), resulting in strained relationships.
- *Limited predictability.* The short term nature of the CSO pilot window, along with disbursement delays has deterred CSOs in countries from planning long term interventions, as discussed in Section 3.2.2.

5.5. Additionality, predictability and sustainability of the support

Additionality

GAVI's support to CSOs has been largely additional in DRC, Ethiopia, Indonesia and Pakistan. Other donors in these countries (e.g. Global Fund, USAID, DFID) that support CSOs have not focused on immunisation objectives.

In Afghanistan, USAID, World Bank and the European Commission (EC) fund CSO delivery of the Basic Package of Health Services (BPHS), which includes immunisation. GAVI CSO support is very small in comparison to the funding made available by these other donors, however, additional funding in Afghanistan is useful given that funds have been directed at underserved/ high priority areas. In terms of the specific activities funded under Type B support, training of community midwives is also supported by other donors (but we do not have sufficient information on whether GAVI funding has displaced other donor sources of funding), however, our understanding is that the PPP approach is a new activity and other donors have not supported this previously.

Predictability

GAVI CSO support to countries has not been viewed as predictable. The two main reasons for this are presented below:

- First, the short term and pilot nature of funding (for Type A and B support) have discouraged countries to make long term plans for engaging with CSOs and integrating them into the long term country immunisation plans. Rather, CSO support has been viewed as a one-off/ temporary form of support.

- Second, delays in disbursements and a lack of communication from GAVI on these delays have made implementation timelines unpredictable. Also, the uncertainty regarding the future of CSO support from GAVI has deterred longer term planning of CSO involvement in immunisation programmes.

Sustainability

We consider both financial sustainability (i.e. whether funding made available for CSOs for their proposed activities can be sustained after GAVI support) and the sustainability of the benefits of the programme (i.e. whether the programme has helped to build sustainable immunisation/health systems).

- *Financial sustainability.* The experience and prospects to date on financial sustainability appear to be mixed. Where governments have been working closely with CSOs in immunisation, there is some evidence on sustainability, although not for all countries (e.g. in Afghanistan, some Type B activities will continue to be supported by the government, however, this is not the case in DRC). In other countries, where CSO activities funded have not been ‘essential’ to the national immunisation programme, sustainability prospects are weak (e.g. Ethiopia). Indonesia is one country where we found some evidence of government continuing to fund the community mobilisation activities of the Type B CSOs after GAVI support. The government had been funding these organisations (prior to GAVI support) and suggested that their positive experience with GAVI support motivates them to continue to work with CSOs.
- *Sustainability of the benefits of the programme.* There are some examples of outcomes of Type A and B support, such as improved coordination between CSOs and governments, that could have a long term benefit. Similarly, training activities or capital expenditure (such as equipment purchase) funded under Type B support are likely to have beneficial effects after the GAVI programme concludes. Other activities funded by the CSO programme may have shorter benefit horizons.

5.6. Key findings on results

Table 5.4 below provides a summary of the main findings on the results of GAVI CSO support, as well as our view on the strength of our conclusions.

Table 5.4: Summary findings on results

Area	Key findings ¹¹³
Type A outputs	<ul style="list-style-type: none"> ± The mapping exercise has been completed by six countries, although there is limited evidence to date of its use in practice (except in DRC). – The nomination process has been completed by five of ten countries, although its usefulness is in question, given: poor functioning HSCC/ ICC in some countries; and the extent to which the nominated CSOs represent their broader constituency.
Type B outputs	<ul style="list-style-type: none"> ± A number of outputs have been achieved through Type B funding – including completion of training, provision of logistical and technical assistance support to health centres and immunisation delivery. However, for some countries, delays in

¹¹³ Findings have been marked according to whether they are positive (+), negative (-) or mixed (±).

Area	Key findings ¹¹³
	approval and disbursement have impacted the efficacy in achieving these outputs, and pose a high risk of retracting from the progress achieved to date.
Type A & B outcomes and impacts	<ul style="list-style-type: none"> + There are some examples of improvements in coordination of CSOs and increase in government funding of their activities, following GAVI support. ± Improvements in coverage rates in project areas have been reported through Type B support, although it is difficult to attribute to GAVI support.
Unintended consequences	<ul style="list-style-type: none"> + Some unintended consequences of GAVI CSO support include: fostering more meaningful participation of the CSO constituency and Steering Committee in GAVI through access to country inputs (positive) and weakened relations between CSO and government in some countries (negative).
Additionality, predictability and sustainability	<ul style="list-style-type: none"> + CSO support has been largely additional to other forms of development aid in our case study countries. – Predictability of GAVI funding has been an issue given its pilot nature and ‘short window’. ± In some countries activities funded under Type B support are being funded by country governments/ other donors (e.g. the PPP approaches in Afghanistan), however in other countries there is limited evidence on sustainability of funding after GAVI support.

Strength of conclusions: Robustness rating: ‘B/C’

Our conclusions here are less strong than the previous two themes as they primarily draw on poor/unreliable data contained in the APRs. While these have been supplemented by helpful findings from the country visits, it has not been possible to verify the accuracy of the data. CEPA has collated the various sources of evidence to draw a summary judgement on the results of the GAVI CSO support to date.

6. SUMMARY AND CONCLUSIONS

The CSO programme was introduced as a pilot in the second phase of GAVI's operations, recognising the role of CSOs in immunisation/ health systems and the need for them to work in coordination with the public EPI systems to achieve GAVI and country immunisation objectives. Our evaluation reinforces the unequivocal view across stakeholders that GAVI's introduction of a programmatic engagement with CSOs is positive and of added value.

However, the pilot has highlighted that, more so than GAVI's other programmes, CSO support needs to be tailored to each country's context, EPI situation, and CSO roles in order to maximise the value of the programme. At present, the activities funded under Type B have been more relevant and useful than Type A, particularly where Type B activities have helped deliver immunisation services – for example, in fragile country contexts like Afghanistan and DRC, and in hard-to-reach areas and to marginalised populations as can be found in Pakistan and other countries.

The programme's effectiveness has, however, been overshadowed by some fundamental design and implementation issues, primary amongst them being:

- unclear programme objectives and absence of a prospectively defined results framework;
- lack of a logical rationale to create two types of support and in addition to the HSS programme (despite obvious synergies between these, as well as the transaction costs of multiple 'windows' of support for both the countries and GAVI);
- lack of suitability of GAVI's delivery model to this programme in terms of constraints in Secretariat capacity and Executive backing for the programme, combined with limited involvement/ clarity of roles of GAVI Partners in country;
- mismatch between the demands of country proposal preparation, lengthy GAVI approval and disbursement processes and the consequent delays vis-à-vis the 'two year' window envisioned for the pilot; and
- poor incentives for countries to apply for Type A support on account of small grant size, disproportionate application requirements, limited awareness of the programme, and limited experience of government engaging with CSOs, among other factors.

These issues were also reflected in the previous evaluations of the CSO support (Putnam Type A review and CEPA's GAVI second evaluation). Some of 'new' insights we have gained on this evaluation are as follows:

- GAVI's approach of channelling CSO funds through governments has worked in some country contexts and has improved government ownership, accountability and coordination with CSOs (e.g. in Ethiopia, Burundi, and Indonesia – despite some disbursement delays). However, this approach has been less appropriate/ effective in some countries, particularly those with weak governments (e.g. routing of funds through WHO and UNICEF respectively in Afghanistan and Pakistan due to the inability of the government to receive funds; and delays in routing funds through the government in DRC). In general, CSOs were more concerned with receiving funds on time, than how the funds were routed by GAVI. For the Type A extension funding, GAVI has approved

the funding of CSOs directly in Togo and Afghanistan at the request of the country HSCCs – although the experience and results of this approach need to be evaluated.

- Management costs in some countries have been a significant proportion of the support (up to 50% for Type A and 25% for Type B), reducing the budget available for the supported activities – although we acknowledge that overheads are typically higher for small grants on account of lower economies of scale.
- The information contained in the proposals and APRs are generally of poor and variable quality (and at times, inconsistent), limiting GAVI's ability to reliably measure results. For example, GAVI and countries do not systematically capture data on the expenditure of Type B funds by activity in countries, which is a major deterrent in assessing impact.
- Both Type A and B support have delivered some positive outputs, although the utility of the Type A mapping output and nomination exercise are less evident. The potential for Type B support to contribute to improvements in immunisation coverage outcomes in the project areas (as well as better coordination between CSOs and governments) is much more evident in Afghanistan and DRC than the other countries studied. Significant approval and disbursement delays by GAVI have often diminished and/ or retracted from results, given the changes in local circumstances and costs, and at times, the need to re-programme.
- The programme has resulted in both positive (such as more meaningful participation of the CSO Constituency and Steering Committee in GAVI through access to country-level CSOs; and capacity building of CSOs particularly in financial management) and negative (weakened relations between CSO and government and limited country-level predictability) unintended results.